14TH PACIFIC HEADS OF HEALTH MEETING

25–27 APRIL 2023, DENARAU, FIJI

Report prepared by the Pacific Community

CONTENTS

Abbreviations

AIHW	Australian Institute of Health and Welfare
CRVS	civil registration and vital statistics
EMR	electronic medical record
HIMF	Healthy Islands Monitoring Framework
HIS	health information system
HMIS	health management information system
ICD	International Classification of Diseases
ICT	information and communications technology
M&E	monitoring and evaluation
MoH	Ministry of Health
NCD	noncommunicable disease
PHMM	Pacific Ministers of Health Meeting
PHoH	Pacific Heads of Health
PICTs	Pacific Island countries and territories
SDG	Sustainable Development Goal
UHC	universal health coverage
SPC	Pacific Community
USAPI	US Affiliated Pacific Islands
WHO	World Health Organization

14th PACIFIC HEADS OF HEALTH (PHoH) MEETING

25–27 April 2023, Denarau, Fiji

Meeting papers and presentations are available at https://phd.spc.int/2023-phoh14-meeting-documents. *PHoH recommendations are in Annex 1. The list of participants is in Annex 2.*

Opening ceremony

1. Following the prayer by Cook Islands, garlands were presented to the Chair, Dr Siale 'Akau'ola, CEO of Tonga's Ministry of Health; Dr Paula Vivili, Deputy-Director General Science and Capability, SPC; and Dr Mark Jacobs, WHO Representative to the South Pacific, and Director Pacific Technical Support.

Welcome remarks

2. The Chair welcomed all delegates, development partners and observers, noting that the PHoH meeting is a regional process that evolves with the appointment of new Heads of Health.
   He acknowledged the recent achievements of Pacific Island people, including Dr Amelia Latu Afuhaamango Tuipulotu, who was appointed to the role of Chief Nursing Officer, WHO, and Sir Colin Tukuitonga, who was made a Knight Companion of the New Zealand Order of Merit for services to Pacific and public health.
   He also recognised the work of the Pacific Public Health Surveillance Network (PPHSN), which celebrated 25 years in 2022.
   The Chair acknowledged the contribution of Pacific health workers during the COVID-19 pandemic and the resilience of Pacific Island countries and territories (PICTs). PHoH had a heavy responsibility, including dealing with funding challenges, the effects of climate change on health, and workforce attrition. The ability to measure progress was important, with measures in place including the Healthy Islands Monitoring Framework (HIMF).
   The meeting had an extensive agenda, with significant recommendations to be forwarded to the Pacific Health Ministers Meeting (PHMM) in August 2023.
   The Chair thanked partners for their support, expressing confidence that, with them, PICTs could achieve the goal of universal health care (UHC).

Remarks on behalf of the Secretariat and implementing partners

3. Dr Jacobs, WHO, welcomed participants and said lessons from COVID included the value of face-to-face discussion. He thanked those who had contributed papers and presentations.

Health governance

Presenters: Sunia Soakai, Deputy Director of the Public Health Division, SPC, and Dr Mark Jacobs, WHO

4. Sunia Soakai described the Regional Health Architecture, under which Pacific bodies such as PHMM and PHoH, and organisations such as SPC, WHO, PIHOA and technical working groups, operate. He also described SPC's role and PHD's expertise and key result areas.

5. Dr Jacobs described the Western Pacific Region (WPR), which includes all PICTs. WHO has seven Pacific offices. Key areas of support are climate change, NCD, health systems, and outbreaks and emergencies. WHO's services are frequently delivered in collaboration with SPC. Support mechanisms include WHO Collaborating Centres. WHO's global mission, as part of the General Programme of Work 2019–2023, is to reach its Triple Billion targets: 1 billion

people benefiting from UHC, 1 billion more people better protected from health emergencies, and 1 billion more people enjoying better health and well-being.
Upcoming meetings include the World Health Assembly (WHA) in May 2023 and the WHO Regional Committee for the Western Pacific in October 2023. A new Country Cooperation Strategy – a multi country strategy for PICTs – is being developed and will be signed by the end of 2023. It will be a concise document that reflects key issues.

6. The Chair noted that both SPC and WHO stressed the role of PHoH in deciding policy.

2050 Strategy for the Blue Pacific Continent

Presenters: Melinia Nawadra, Pacific Islands Forum Secretariat (PIFS), and Miles Young, Director of the Human Rights and Social Development Division, SPC

7. Melinia Nawadra: The 2050 strategy was endorsed by Pacific leaders in July 2002. It is a collective approach to seven thematic areas:
    1. Political leadership and regionalism
    2. People-centred development
    3. Peace and security
    4. Resources and economic development
    5. Climate change and disasters
    6. Ocean and natural environment
    7. Technology and connectivity

    Health outcomes, which fall under People-centred development, are critical to achieving the Blue Pacific strategy. An implementation and monitoring plan is being developed and will be presented to leaders at the end of 2023. The outcomes of PHoH will feed into the implementation plan. Implementation will be supported by four Multi-Stakeholder Expert Groups:

    1. Political Leadership, Regionalism, Peace and Security
    2. People-centered Development
    3. Resources, Economic Development, Technology and Connectivity
    4. Climate Change, Disasters, Oceans and Environment
8. Miles Young: SPC is a co-chair of the People-centred Development Cluster. Current work is on goals and outcomes over three periods. Circulars have been sent to members requesting feedback on the goals. Countries were urged to provide feedback, which should come through their ministries of foreign affairs. Development partners and civil society were also invited to provide feedback.

Discussion

9. French Polynesia noted there were many similarities between the Healthy Islands vision and the Blue Pacific Continent strategy and suggested revising the vision to ensure consistency with the strategy.
10. Cook Islands suggested that provision of feedback on the goals should be part of PHoH's recommendations.

Health Information and digital health

3rd Healthy Islands Monitoring Framework Report (HIMF) – Progress review

Presenter: Shane Walter Hurrell, Chief Information Officer, Tonga MoH

11. The HIMF is 'Pacific created, and Pacific led'. Countries use the framework to monitor their progress towards the Healthy Islands vision. It has 48 indicators, and a progress review is conducted every two years with support from SPC and WHO. According to the most recent review, all PICTs have made progress towards the Healthy Islands vision, but there were considerable variations.
12. **Selected results**
    - Life expectancy from birth: Ranged from low in PNG (56.8 years) to high in Pitcairn Islands (86 years).
    - Under-5 mortality rate: Ranged from 0 in Pitcairn to 53 per 1,000 in Kiribati.
    - Birth attended by skilled workers: Reduced numbers for FSM and PNG.
    - Access to health services including immunization: 100% immunization in several PICTs.
    - NCD prevention including excise taxes on tobacco and alcohol: All PICTs have a system in place. Samoa and Tonga have made progress.
    - Health-care worker density: Varies across PICTs.
    - Health-care resources: Increasing over time in most PICTs.
    - Access to safe water, sanitation, and use of clean fuels: Varied across PICTs. Reduced access for Samoa, Tonga, and Tuvalu.
13. The HIMF should provide a foundation for health sector decision-making, with better use being made of the data beyond reporting indicators every two years. This will require:
    - high-level commitment from leaders to provide resources and promote collaboration between ministries.
    - leveraging the expertise of health information professionals from the Pacific Health Information Network (PHIN), with support from WHO and SPC, to coordinate progress reviews in-country.
    - developing recommendations to revise the framework, with support from WHO and SPC, to ensure HIMF remains fit-for-purpose.
14. Dr Jacobs, WHO, added that the detailed HIMF report is not quite ready. Points made at the PHIN meeting included getting buy-in from other sectors and aligning reporting with SDG reporting. The next review will reflect COVID impacts and may show significant changes.

Discussion

15. Susan Ivatts, World Bank, suggested including real-time data in the report to PHMM to ensure Ministers received current information. COVID has brought added resources, but also challenges in addressing the pandemic.
16. Tokelau: Tokelau data is missing unfortunately. Tokelau can share data manually, but some of the areas monitored do not sit with health – the MoH needs to work with other sectors.
17. French Polynesia's data also has not been updated. There has been some turnover in relevant staff.
18. Wallis and Futuna is trying to put an improved monitoring system in place. Like French Polynesia, high staff turnover has hindered monitoring.
19. FSM noted there are two sets of data in the report – country data and global estimates – and asked if there was any attempt to explain the variations in data.
20. Dr Jacobs agreed on the need to include an explanation in the document on the variations, which may sometimes be due to different measurement. Sunia Soakai noted that differences were sometimes due to lack of national data.

21. Australia: The use of data in Australia has changed. People became interested in data during COVID. There is also an appetite for health data from other government sectors such as Treasury and Finance. It is important to make a case for health funding.
22. Tonga agreed with the World Bank on the need for updated data. Tonga increased the tax on tobacco, but now Tongans are rolling their own.
23. Solomon Islands has a considerable way to go to reach global standards. The logistics of gathering data are a challenge, which may be addressed by progress on information systems.
24. Cook Islands suggested including oral health in the indicators.
25. Sunia Soakai, SPC, said he would take the comments and suggestions back to the HIMF Secretariat.
26. Dr Kafoa, SPC, stressed that the Pacific region is ahead of all regions globally in collectively gathering data. Health information officers in PICTs are often not recognised. Their work should be recognised.

Advancing health information and digital transformation in the health sector

Presenter: Shane Walter Hurrell, Tonga

27. PICTs have an opportunity to use the momentum generated by the pandemic to develop their HIS and to take a long-term approach. The current situation in many PICTs includes lack of a digital health strategy, inadequate investment and resources, lack of leadership and governance, and siloed HIS. There are not enough staff to carry out the transfer of a manual system to a digital one. PICTs urgently need a practical, people-centred vision focused on systems that are accessible and integrated and include other sectors such as civil registration and vital statistics (CRVS).
28. **Examples of country activities:**
    - Fiji has developed a digital health strategy, that includes governance, architecture, digital systems, and change management, which is essential for successful implementation.
    - Tuvalu has implemented a telehealth system, using a Very Small Aperture Terminal (VSAT), that connects the main hospital to primary health clinics on eight outer islands. The system enables remote consultation and improved patient management and has reduced the number of domestic and overseas referrals. It is also used to provide education and training for health workers.
    - Tonga is implementing an integrated HIS that caters for 4 hospitals, 14 health centres and over 15 reproductive health clinics. The initial cost for Tonga was USD 7.5 million, which includes 5 years of maintenance support.
29. The presentation included a number of recommendations emphasising cooperation and interoperability, the establishment of internal institutional mechanisms to enforce adherence to technical standards and sharing of best practices through subregional mechanisms such as PHIN, Directors of Clinical Services, and Directors of Nursing and Midwifery (Annex 1).

Discussion

30. The Chair reminded delegates that the paper would go to PHMM and invited their input.
31. Tuvalu wants to ensure that its telehealth system will be relevant to digital health.
32. Sunia Soakai noted that each PICT must decide their best approach.
33. Fiji: noted the need for a forum or structure for discussing and sharing information.
34. Samoa is developing a new strategy including bring more staff on board.
35. French Polynesia is interested in interoperability, which is a huge challenge, and the emphasis on change management.

36. Australia agreed on need for change management and with Fiji's comment on forums for information sharing. Post COVID, there seems to have been a permanent shift to digital health, and to telehealth, which was useful for Australia's remote communities. Australia supported the recommendations.
37. USA: Digital health accelerated with COVID. At the same time, it created additional work for providers. The key points are sustainability and interoperability. Infrastructure is important in both digital health and telehealth. USAPI still have a considerable way to go in implementing their HIS.
38. Cook Islands supported the recommendations. It is at the mid-stage of moving to digital health (with WHO support). Connectivity is an issue. Another issue is the need to link all the information for each patient. Information is available manually but must be made available digitally.
39. New Zealand has had similar experiences as Australia and USA and is making efforts to leverage recent gains. New Zealand supported the recommendations.
40. Kiribati supported the recommendations. It is at the early stages of revising its health system under a World Bank project).
41. RMI noted the need for equitable access to DH information, especially for outer island residents.
42. UNFPA noted the work by PICTs on interoperability and hoped new HIS would reduce the time spent by health workers on data gathering.
43. UNICEF said that the process of creating a common vision needs to include other sectors and stakeholders, not forgetting content providers. Inclusive stakeholder consultation is essential. UNICEF supported the recommendations.
44. World Bank suggested including a commitment to prompt data sharing in the recommendations.
45. Dr Kafoa noted the relevance of PHIN to advancing digital health systems and acknowledged two founders who were present – Dr Audrey Aumua and Dr Frances Bingwor.

Human resources for health

Fiji National University (FNU) update on regional health training programmes[1]

Presenters: Dr Donald Wilson, Acting Dean, College of Medicine, Nursing & Health Sciences (CMNHS), FNU, and Dr William May, Acting Vice-Chancellor, FNU

46. FNU has five colleges including CMNHS and has re-established a regional office to look after regional students. In addition to certificates and short courses, FNU offers:
    - bachelor degrees in medicine, dentistry, pharmacy, physiotherapy, laboratory science, medical imaging, nursing, public/environmental health, health service management, health promotion and nutrition;
    - postgraduate diplomas in dermatology, internal medicine, anaesthesia, intensive care, child health, mental health, family medicine, OBG, surgery, emergency medicine/nursing, pathology, midwifery, oral surgery, and ophthalmology.
    - masters degrees (clinical and research) and PhDs.

47. A total of 2250 students are enrolled in 2023 – 85 fewer than in 2022. The MBBS is the most sought-after programme. However, 52% of regional students failed their first year. There is a 'no repeat' policy so failed students are terminated.

[1] Note: This presentation was delayed till Day 2 after an agenda change.

48. The first batch of Masters in Emergency Nursing graduated in 2022. Other new programmes include: MMED in Intensive Care Medicine, MMED in Dermatology, Masters in SRH, and Postgraduate Diploma in Perioperative Nursing.
49. Programme developments for 2024: In response to PICT requests, FNU has made recommendations on family medicine, midwifery, nurse practitioner training, enrolled nursing, and a PG diploma in ear, nose and throat (ENT) (to go on offer). There are continuing discussions on an MMED Orthopaedics, PGD Radiology, a diploma in health counselling, and short courses.
50. Research: An average of 80 Masters projects are completed every year in addition to the projects completed under the DDM/PGCFE programme.
51. The Pacific Health Observatory and the FNU/CMNHS Research Repository have both been launched. The repository is a knowledge translation platform and research repository for all Pacific health literature, especially unpublished work.

52. FNU made the following recommendations and requests to countries:
    - FNU requested countries not to award conditional scholarships to students unless they have an offer letter from FNU. Delays in confirmation of offer letters may be due to incomplete application forms (applications normally close at the end of November).
    - The PG selection process happens in the preceding Semester 2 (for the following year's intake). Clinical Masters applicants need to register with the Fiji Medical Council, which takes time. It is strongly recommended that trainees send documents in time and register online with the FMC.
    - As part of Phase 2 of the PCSWHIP Programme, FNU is working with the Nossal Institute to develop a Country Training Needs Analysis. Countries are asked to respond to the request from Nossal.
    - FNU requested countries to support its calls for programme advisory board membership, to ensure its programmes capture regional industry perspectives.
    - PHoH were asked to agree to a small working group to discuss issues related to regional student intake, performance/attrition, and other challenges. The WG will report back to PHoH out of session with a view to tabling a paper at PHMM for approval. The suggested make-up of the WG is representatives from Fiji and FNU, and one each from Melanesia, Micronesia, and Polynesia, and PIHOA and SPC.
    - Development partners were asked to support regional marketing of programmes, and to consider sponsoring regional students of programmes with low student intake (e.g., MMED Psychiatry and Masters of SRH), and new PG programmes.

Discussion

53. FSM asked how FNU recruits students for the MBBS programme from outside Fiji.
54. Palau asked if there were an allocated number of places for PICTs besides Fiji.
55. Samoa expressed strong interest in the new nursing courses, noting that, previously, nurses have gone for midwifery because of remuneration; the development of the Master of Orthopaedics course; and the availability of more online training. Samoa supported the working group.
56. Vanuatu would like to enrol more students in the community nursing and midwifery courses, and asked if there were any special primary care courses, noting it lacked rural doctors.
57. Dr May, FNU, responded as follows:

- The MBBS programme has specific entry requirements. The current proportion of students is 80% Fiji, 20% regional. The working group will discuss this proportion and the proportion allocated for other courses.
- Community nursing is under development. The family medicine programme is geared to primary care.

58. PIHOA said the country comments were a testament to their trust in FNU. PIHOA had two requests:
    - Given that local institutions are struggling for faculty, could FNU consider faculty sharing.
    - Primary and secondary schooling is a problem in remote areas. Could development partners support FNU outreach to remote PICTs.
59. Dr Wilson said USP had approached FNU to establish a school in Solomon Islands. FNU was happy to consider collaboration and to share faculty where feasible.
60. Working group: It was agreed in discussion between Dr Wilson and Dr Vivili that the working group will come back with a draft paper by mid-June 2023. SPC will reach out to potential members of the working group.
61. Dr Kafoa thanked Dr May and Dr Wilson for the presentation and FNU's response to requests for training, including providing the Diploma in Perioperative Nursing. He suggested that PHoH ask their governments to strengthen their own institutes in addition to seeking training from FNU and advised countries to inform FNU early of their workforce plans and need for student places.

Rethinking human resources for health

Presenter: Ms Deki, Technical Officer, Human Resources for Health, Pacific Health Systems, WHO

62. A bar graph of the health workforce in PICTs per 10,000 population showed large differences between PICTs. While there are health workforce focal points in PICTs, the process is not working well. The data reported came from various sources including global reports.
63. PICTs have made progress over the past 10 years. However, the current distribution of health workers against those needed to achieve UHC is not on track to achieve minimum service values by 2030. Renewed commitment is required. It is possible to have lower health worker density and make progress towards UHC, as Fiji has shown.
64. A shortage of health workers everywhere and aggressive international recruitment is further increasing the outmigration of Pacific health workers. This is an issue that must be tackled at country level. Health leaders and politicians are aware of the problems, and it is important to ask why strategies have not been developed, implemented, or reconsidered.
65. Several PICTs have done good work. Examples of best practice include the following:
    - Tonga – expanded the MOH HR division and enhanced health workforce planning and policies, including implementing WHO's workload indicator of staffing need (WISN) methodology to review staffing levels and determine requirements.
    - PNG formed a TWG to guide the implementation of the National HRH Strategic Plan 2021–2030, and reviewed curriculums for nurses and community workers. PNG also used the WISN tool to guide deployment and reviewed the role of village health volunteers.
    - Cook Islands, PNG, Samoa, Kiribati, and Tonga PICTs all have updated workforce plans.
    - In addition to these PICTs, Solomon Islands and Vanuatu have reviewed aspects of nursing training.
    - The South Pacific Chief Nursing and Midwifery Officers Alliance (SPCNMOA) is leading a subregional quality improvement programme.

66. Urgent action is needed to address:
    - continuing shortages of health workers in specific areas.
    - consistent provision of continuing professional development (CPD).
    - scale-up of regional mechanisms to standardise the quality of training (regulation of training institutions and curriculums).
    - continued development of digital health, including telemedicine, remote monitoring, and service delivery.
67. Recommendations for PHoH included:
    - ensuring systematic management of the health workforce.
    - ensuring health workers are fit for purpose (high-quality, regulated training).
    - increasing internal funding and aligning investment with policies and strategies.
    - addressing the migration of health workers, including through bilateral agreements/WHO Code of practice on the International Recruitment of Health Personnel.
68. Additional recommendations for Ministers of Health included:
    - development of up-to-date strategic plans and policies.
    - accreditation of training programmes and implementation of CPD.
    - consideration of a regional platform to enable reciprocity, workforce expert pools and standards.
    - increased internal funding and investment for implementing policies and strategies.
    - addressing the increased internal and international migration of health workers.
69. Recommendations for development partners included:
    - aligning health workforce support, including scholarships, with government priorities.
    - facilitating sharing of best practices for health workforce planning and management.
    - supporting regional internet infrastructure for health workforce institutes and regional hospitals.

Discussion

70. Cook Islands noted that the recommendations for Ministers of Health did nothing to ensure that a Minister would fight for extra funding. In relation to health worker recruitment, consideration should be given to establishing a pool of experts that PICTs could call on. Apart from these points, Cook Islands endorsed the recommendations.
71. Samoa noted that it is supported by workers from Fiji and American Samoa. In terms of training – when people leave for training this depletes health worker reserves. More in-country training would help to address this problem. Samoa supported the recommendations.
72. Fiji suggested including language in the recommendations asking development partners who receive Pacific workers to provide resources for training replacement staff.
73. Tuvalu is working with SPC, Australia and the Fiji MoH to attract staff and agreed with the comments on retention. Tuvalu requested setting a requirement that migrating health workers are cleared by the health CEO – often only very short notice is given. Tuvalu supported the recommendations.
74. Vanuatu acknowledged the support of partners and other PICTs in addressing health worker shortages and supported the recommendations.
75. French Polynesia also supported the recommendations. Establishment of a pool of experts would represent progress. French Polynesia has many specialists who could contribute to such a pool.
76. Solomon Islands has just revised its health strategy (2022—2031) with WHO and is guided by its role delineation policy. Placing doctors in rural areas can be complex, requiring provision

of housing and equipment. Solomon Islands suggested including Ministries of Health and Finance in discussions of increased funding.

77. FSM has a low proportion of health workers per capita. There was a programme to train physicians in Micronesia, but some are now at the retirement stage. FSM thanked other PICTs who supported its health workforce. It is working on retention of doctors. FSM endorsed the recommendations.
78. Australia noted Fiji's comment on health workers moving to New Zealand and Australia. In Australia, there is also the issue of health workers moving out of the health sector.
79. UNICEF: WHO recently released an updated WHO health workforce support and safeguards list that suggests active discouragement of health worker recruitment through inter-government agreement.
80. PIHOA: Strong directive recommendations are needed, given that most of the points have been made before. For example:
    1. PIFS and the Pacific Islands Development Program (PIDP) need to understand the struggles of the health sector. They should be invited to all PHoH meetings and held to account on the issues.
    2. Health financing – there are brain drains. Health workers who remain in PICTs have multiple roles.
    3. There is a focus on doctors and nurses, but there is also a lack of administrative staff, procurement, etc.
    4. Education systems – is there enough of a pipeline of graduates? The education sector must be part of the discussion. The tertiary sector is often not represented at the regional level apart from FNU and USP. There needs to be discussion of maintaining sufficient faculty in regional institutions and community colleges to provide training.
81. UNFPA asked for the recommendations to be contextualised so they can be adapted to various PICTs.
82. PIHOA noted the need to maintain a pipeline. It was also important to encourage graduating high school students to join the health workforce.
83. Sunia Soakai, SPC, noted the comments on a pool of experts and Fiji's suggestion on development partner recruitment.
84. Dr Kafoa thanked Tokelau's Acting Director of Health for sharing a story on the severe difficulties encountered in the medical evacuation of a patient in late pregnancy and encouraged Tokelau to tap into networks that can provide support.

Health care financing

PICTs World Bank Public Expenditure Review – Double shock/Double recovery: What does this mean for improving UHC in PICTs?

Presenters: World Bank Pacific Health Team

85. Pacific economies will take time to recover post-COVID, which will affect health spending. In 2020, every PICT economy contracted, and recovery has been lagging because of the later opening of borders. There has been high inflation also, especially in 2022. Some countries will experience debt distress.
86. Most PICT health funding comes from the public purse. Health care access in PICTs is not linked to ability to pay. Health spending has been maintained at least in dollar terms, even though some PICTs are among the most aid-dependent countries globally. On average, PICT governments allocate 13% of their total expenditure to health.
87. In preparation for future health and climate emergencies, PHoH need to focus on three areas:
    1. Sustaining public financing for health.

2. Maintaining preventive activities and healthcare services for vulnerable populations.
3. Improved quality, efficiency, and equity of health spending.

88. PICT progress in recent years includes protection of health spending; low out-of-pocket spending on health; steps to reinvigorate governance mechanisms; improved supply chain management; and accelerated adoption of digital tools.
89. Key questions for PICTs now are:
    1. What is best use of health resources – more staff or more resources?
    2. What can you do better to manage the supply chain for medical essentials?
    3. How can you improve the coordination and management of overseas and local referrals?
90. The recommendations for PHoH focused on:
    - improving the quality of spending, including through greater efficiency and high impact interventions.
    - strengthening corporate and clinical governance to build resilience and progress towards UHC.
91. Recommendations for development partners focused on actively supporting MoH efforts to improve the quality of their expenditure and governance.

Discussion:

92. Cook Islands said it would have no new money for health for the next 2 years and would have to make decisions on cuts, possibly of non-core/contract roles. Cook Islands particularly approved the request to development partners to support PICT implementation of decisions.
93. Australia asked whether the World Bank saw structural changes in health spending.
94. Fiji said the idea of improving capability and making expenditure planned and predictable was challenging. Approval processes had to be discussed with finance counterparts. MoH does not always spend what has been allowed.
95. Solomon Islands noted the increased cost of financing medical supplies, both for freight and procurement. The increased cost of goods affected the sector's ability to procure and distribute supplies.
96. World Bank responded that:
    - there was no data on structural changes for PICTs.
    - high expense areas such as staffing are easier to predict. Stopping and checking expenditure regularly will help.
    - supply chain management will be a topic for a Friday workshop to be hosted by the World Bank.
97. The take-home message for PHoH was the urgency of achieving the quality, efficiency and equity of public spending, and prioritising high return-for-investment areas.

Non-Communicable Disease (NCD)

Implementation of the Pacific NCD Roadmap

Presented by Solomon Islands

98. The NCD Roadmap was endorsed by PHoH in 2014. Implementation of the MANA dashboard (a monitoring mechanism) began in 2018. The Pacific Legislative Framework for NCD was endorsed by PHMM in 2022. SDG 3 targets include reducing premature mortality from NCDs by one third by 2030.
99. All PICTs have made some progress, e.g., in taxing tobacco, alcohol and sugar-sweetened beverages, and imposing restrictions on marketing unhealthy foods. Solomon Islands formed

the Wellness NCD Alliance, which has engaged youth, improved knowledge, and participation, and strengthened the effectiveness of some measures.

100. However, overall action has been slow. Progress requires a whole of government, whole of society approach with many actions requiring collaboration between sectors. Urgent action is needed to:
    1. scale up action to match the size of the NCD crisis. This requires leadership.
    2. strengthen enforcement of measures relating to commercial and environmental determinants.
    3. ensure that competing events, such as natural disasters, do not divert funds from NCD management.
    4. provide timely data to drive decision-making.

101. Proposed recommendations for PHoH:
    - Take leadership roles in governance, management services, health promotion and accountability; and
    - collaborate with non-health sectors in policies and legislation, and behaviour change interventions.

102. PHoH were also asked to endorse proposed amendments to the MANA indicators to improve monitoring.

103. Recommendations for development partners included increased support for prevention, and more investment in technical and budgetary resources to improve monitoring and accountability.

Discussion:

104. French Polynesia agreed with the recommendations. It had an inter-ministerial meeting every 2 months, which highlighted 40 measures to be funded in different sectors, e.g., training teachers to present health information, and building footpaths to enable walking.

105. Wallis and Futuna: NCD is a scourge for Wallis and Futuna. At the end of 2022, working groups were set up to address the issues and 25 actions are ready to implement.

106. Cook Islands noted that the proposed amendments to the MANA dashboard indicators included adding the PM/Permanent Secretary/CEO to leadership of the national multi-sectoral NCD Committee.

107. USA said the recommendations for PHoH are well targeted and addressed the cross-cutting nature of NCD. The US struggles to address the enormity of NCD.

108. New Zealand has recently passed legislation to reduce the amount of nicotine in tobacco products from 2025, and to prohibit the sale of tobacco/products to anyone born on or after 1 January 2009. New Zealand will continue to support PICT efforts.

109. Dr Vivili, SPC, said it was 10 years since PHMM endorsed the roadmap, and it was time to review it. Most meeting participants would die from NCD and younger than otherwise. The amendment of the MANA indicator to involve the PM was proposed because there has been too little progress.

110. PIHOA agreed, saying a candid external review would be useful. The North Pacific is already conducting an NCD review.

111. Dr Jacobs, WHO, also agreed, noting the need to involve all sectors in the review, given that the drivers of obesity are not in the health sector.

Tackling the drivers of obesity, particularly for children and young people

Presenter: Dr Veisinia Matoto, Clinical Director, New Zealand Medical Treatment Scheme, Pasifika Medical Association (PMAG)

112. Overweight and obesity rates are continuing their upward trend in PICTs, driven by environmental/commercial, behavioural, demographic, and biological factors. Results include lost productivity, and premature death associated with behaviour learned in childhood. Health and non-health sectors must collaborate to address the problem of obesogenic environments, including through policy, legislation, and taxation.
113. Action/progress
    - PICTs can use the Pacific Legislative Framework to develop legislation.
    - Health-promoting school programmes in Fiji and Tonga are creating positive change.
    - Youth ambassadors have designed and implemented innovative health promotion campaigns, increasing understanding and awareness.
    - Marketing unhealthy food to children – RMI has reviewed policy and submitted legislation for approval. Six other PICTs have plans to implement/strengthen regulations.

114. Recommendations for PHOH focused on:
    - partnering with non-health sectors to implement and enforce food regulations, particularly on marketing unhealthy foods and sugar-sweetened beverages to children.
    - incorporating health-protecting mechanisms in trade agreements.
    - ensuring availability of facilities at school and in public spaces to promote physical activity for all including those with disabilities.
    - scaling up evidence-based interventions.
    - leading multisectoral NCD Committees.
    - strengthening coordination through the Pacific Ending Childhood Obesity (ECHO) network.
115. Recommendations for development partners focused on:
    - supporting PICTs in addressing commercial determinants, creating health-enabling environments, and scaling up interventions.
    - supporting strengthening of accountability and monitoring using the MANA dashboard.
    - advocating multi-agency and multisectoral action across the Council of Regional Organisations of the Pacific (CROP) and United Nations partners.
116. The paper and recommendations will be presented to PHMM.

Discussion

117. Fiji: The situation seems to have worsened since COVID. What level of endorsement is needed to reach an effective strategy? The tobacco industry is difficult to deal with – it is involved in sponsoring farmers and other charity work. Do we need stronger language?
118. French Polynesia agreed with Fiji, saying recommendations to ministers are not enough. Could PHoH put forward commitments to ministers.
119. Cook Islands supported the comments of Fiji and French Polynesia and endorsed the other recommendations.
120. Dr Mark Jacobs, WHO: Health ministers can control some aspects of NCD, but not the obesogenic environment. This must be a whole-of-society approach, including involving leaders beyond the health sector if we want to avoid the same conversation in 10 years' time.
121. Dr Kafoa, SPC: PIFS called for a people-centred approach. The wording of the recommendations should be part of the recommendations put to Forum leaders. When PIFS puts out a statement, 'health' is hardly mentioned. PHoH must advocate.

122. French Polynesia supported Dr Kafoa on raising the issue to Forum leaders, which must be a priority for them.

Update on the WHO NCD SIDS, 14-15 June, Barbados

Presenter: Sir Colin Tukuitonga, Associate Dean (Pacific) and Associate Professor of Public Health, Faculty of Medical and Health Sciences, University of Auckland

123. Progress on NCD prevention has been disappointing despite decades of effort. Sir Colin challenged PHoH to produce NCD recommendations with teeth for the outcome document to be sent to PHMM for endorsement, and to provide ideas on what can be done better for the WHO NCD Roadmap 2030.
124. The 4th UN High-Level Meeting on NCDs will be held in 2025. Sir Colin is Co-Chair of the High-Level Policy Expert Group.
125. Very few nations are on track to meet the SDG target for NCD (SDG Target 3.4: Reduce by one third premature mortality from NCD through prevention and treatment and promote mental health and well-being). In the past decade, there have been at least 15 strategies – 'so many with so little impact'.
126. Small Island Developing States (SIDS) deserve special attention because they are disproportionately affected by NCD as well as by climate change. Most SIDS have small and scattered populations. Their issues include food security, and resource and capacity constraints. Most are middle income and not eligible for the support available for low-income countries.
127. The Pacific NCD Roadmap is important for PICTs (e.g., it has encouraged taxation on unhealthy products) and should be updated.
128. What should be included in the Political Declaration, Barbados Ministerial Meeting (14–16 June 2023)? Suggestions include the following:
    - Pacific NCD Roadmap 2014
    - CARICOM Port of Spain Declaration 2007
    - Establish operational multi-dimensional vulnerability index.
    - SIDS-specific data portal
    - Concessional access to external funding
    - Action on commercial determinants, private sector influence
    - Act with one voice
129. PICTs are playing catch up. SIDS need to unite (with one voice) to achieve results, in the same way that PICTs have made their voice heard on climate change.

Discussion

130. The Chair attended the SIDS HL Technical Meeting on NCDs and Mental Health in Barbados in January 2023. It was suggested that the multidimension vulnerability index (MVI)[2] should be adopted by the UN HL meeting.
131. Sir Colin: Clearly, PICTs are vulnerable (e.g., to climate change) but have limited capacity to respond. The MVI could redefine eligibility for support, especially as existing tools disadvantage SIDS.
132. Cook Islands agreed that the MVI would affect Cook Islands. MoH leadership is important. Since COVID, the MoH has looked at primary care from a preventive perspective. In a new initiative, one island will become smoke-free island, with the scheme to be extended to other islands. The NCD strategy is also being revised.

[2] https://www.un.org/ohrlls/mvi

133. French Polynesia thanked Sir Colin for his directness. The health sector has fought NCD for 35 years. Current policies do not work – there is a need to refocus on people and families and to modernise the concept of health. People need to make own decisions. Budgets cannot be extended so the focus must be on prevention. French Polynesia has only three MoH staff dedicated to prevention. Research on attitudes and practices is also needed so PICTs know they are addressing the right issues.
134. FSM suggested putting forward a bold recommendation to ban tobacco. PICTs signed the WHO Framework Convention on Tobacco Control. They ban chemicals, why not tobacco? The issue may be clouded by the taxes gained from tobacco. In FSM, tobacco use is banned in public places and cultural spaces.
135. New Zealand urged that PICTs learn lessons from past UN HL Meetings to get what they want. It is a very political process that requires a strategic approach.
136. Tokelau wants to ban tobacco and is seeking to change from a sickness model to a wellness model, e.g., using local food rather than imported products.
137. Sir Colin responded as follows:
    - Pacific leaders were aware of the impact of NCD on their economies. PIFS has health as a standing item.
    - The roadmap has had an impact but needs reinvigoration.
    - A serious effort on tobacco is possible. Current measures have had impacts, e.g., there is declining use of tobacco in Tonga and Samoa; in New Zealand, less than 5% of young people smoke. In 2014, the Smoke-Free Pacific initiative was adopted but was not well implemented.
    - How do PICTs best use the HL Meeting? Trade in processed food and SSB may be an area where they can be effective.
138. He asked PHoH and other participants to continue the conversation by email: collin.tukuitonga@auckland.ac.nz
139. Sir Colin noted that his comments were his own and were not made on behalf of any organisation.

Eyes wide open: The emerging threat of vision loss in the Pacific

Update from The Fred Hollows Foundation (NZ)

Presenter: Dr Audrey Aumua, CEO, Fred Hollows Foundation (NZ)

140. The true extent of the burden of vision loss in the Pacific is unknown. The leading causes of blindness in the Pacific are cataracts, uncorrected refractive error, and diabetic retinopathy; 30% of people with diabetes are likely to develop diabetic retinopathy. In some PICTs, up to 69% of people with diabetes have some form of retinopathy. The prevalence of vision loss is projected to increase.
141. Vision loss has serious impacts on economies. The availability of eye care and access varies widely in PICTs. Data on vision loss is limited due to little research and data collection. Global estimates suggest that 90% is avoidable or treatable. Vision loss by diabetic retinopathy is reversible if caught early.
142. The estimated prevalence of blindness in the Pacific (based on global data) indicates that PNG has the highest rate, but all PICTs are affected. NCD prevalence suggests a blindness tsunami if no action is taken.
143. The Fred Hollows Foundation focuses on training the Pacific eye health workforce and supports training at the Pacific Eye Institute in Fiji and Divine Word University in PNG. The Pacific Eye Institute offers three postgraduate courses: Master of Medicine (MMed (Ophth); Postgraduate Diploma in Ophthalmology; and Postgraduate Diploma in Eye Care (PGDEC).

144. There is also a regional ophthalmology team, who respond on request. However, the workforce is not keeping pace with need. There are diverse eye health resources across PICTs but they are not integrated and eye health is not included in most PICT health strategies.
145. To provide accurate data on blindness prevalence, the Foundation and the University of Auckland will undertake surveys in five countries.
146. Recommendations for PHoH:
    - Recognize the growing burden of vision loss in the region, particularly diabetic retinopathy due to rising rates of diabetes.
    - Include eye care in HR planning to further develop a highly- skilled eye care workforce that can meet population needs.
    - Support the integration of eye health in national health planning, to ensure that eye care becomes part of UHC.
    - Invest in collecting data on eye health to better understand the true burden of vision loss and enable policy development, prioritisation, and reporting.
    - It may also be possible to negotiate a new indicator for the MANA dashboard.

Discussion

147. Samoa, Solomon Islands and Tonga all acknowledged the work of the Fred Hollows Foundation.
148. Samoa has one ophthalmologist and an 8-month backlog of patients. The recommendations should go to PHMM.
149. Solomon Islands needs to make the transition to providing its own services, especially as demand is rising. The NCD programme is 'all over the place' – it needs to be packaged and eye health needs to be integrated. It is included in the new strategic plan. Solomon Islands has an eye care team going to one province. That leaves eight other provinces. More testing is needed in outer regions. Progress will require budgetary support from partners.
150. Tonga now has two ophthalmologists and agreed that PICTs need to take ownership of eye health.
151. The Chair asked if there is evidence of diabetic retinopathy decreasing in a developing country, or in a developed country.
152. Dr Aumua said it is the only indicator that is rising. The Foundation will continue supporting training in PICTs but agreed on the need for countries to develop their own capacity. Long-term capacity is an issue.

Vulnerability of Pacific Island hospitals: Critical Infrastructure that must be addressed

Presenter: Dr Eileen Natuzzi, Georgetown University

153. A small study was carried out to assess the vulnerability of PICT hospitals. Results showed that of the 76 hospitals located in 14 PICTs, 58% are physically vulnerable based on their location, putting a total of 63% of the population at risk of losing services. Hospitals are not considered critical infrastructure, but they should be as they involve two sectors – health and infrastructure.
154. Climate change impacts will continue. Relocating/retrofitting hospitals is essential because of the high risks they face. In this regard, the COP27 Loss and Damage Fund agreement was a win for PICTs.
155. The Pan American Health Association (PAHO) builds safe and smart hospitals, e.g., Peebles Hospital Tortola, British Virgin Islands, which has withstood two cyclones to date.
156. Examples of action to safeguard PICT hospitals:
    - Niue Hospital – Relocated inland after twice being destroyed by cyclones.

- Tonga – Hospital on Lifuka relocated inland after original hospital was damaged by a cyclone.
- Tokelau – Because there was no option to relocate two hospitals on coral atolls, they were rebuilt on timber piles and concrete beams to withstand cyclones. They also provide a refuge during storms.
- Tuvalu – an infrastructure project has been undertaken to protect Princess Margaret Hospital.

157. The most vulnerable PICT hospitals are close to water, e.g., Palau. Relocation is budgeted under its Compact of Free Association with USA. The largest hospital at risk is the National Referral Hospital in Solomon Islands, which is exposed to flooding. Relocation is planned. Meanwhile, a gabion seawall has been built to protect the existing hospital.

158. **Recommendations for governments**

- Prioritise hospitals as critical infrastructure along with roads, bridges, ports, and airports.
- Advocate for more funding for adaptation relating to health and critical infrastructure.
- Recognise that hospitals span two critical sectors impacted by extreme weather events and rising sea levels when discussing priorities.
- Ensure there is sufficient funding to reduce the adaptation gap.

159. **Recommendations for development partners**

- Support programmes that address the unique threats that PICTs face.
- Recognise that Pacific Island hospitals are not 'luxury items' and invest in shoring them up to withstand extreme weather.
- Support and implement the UN Multi-dimensional Vulnerability Index and the COP 27 Loss and Damage Agreement.

Discussion

160. Dr Kafoa, SPC, acknowledged Dr Natuzzi and her associates for carrying out the assessment as volunteers.
161. French Polynesia: This topic should be dealt with by PHMM. The PAHO project is applicable to the Pacific. We could develop common systems/standards and include primary health-care centres. In French Polynesia, cyclone-proof shelters are being built in hospitals.
162. Fiji is currently assessing its health facilities and deciding what can be done to improve resilience. Numerous issues are involved including planning, waste management, maintenance, etc., beyond just buildings.
163. Cook Islands: Assessments should include health centres, not just hospitals. Cook Islands has been working on a proposal to the Green Climate Fund (GCF) for 5 years. They have been told they cannot build a new hospital but can renovate the existing one. The issue should be escalated to PHMM.
164. Solomon Islands has 400+ health facilities. Most are run down, and infrastructure spending is included in the new strategic plan. Work has begun on identifying a location for a new National Hospital after ADB recommended relocation.
165. Kiribati: In 2015, one of its hospitals was closed and it is now working on relocation. A plan for redevelopment of the Central Hospital was formulated 10 years ago at a cost of $100 million. The study presented looked at climate change from a coastal angle. It should include other climate impacts on health.

166. Australia asked that the proposed recommendations refer to hospitals as critical infrastructure, not as luxury items. Australia also asked if there were other examples where climate change funds have been used for hospitals.
167. Tuvalu said that as a small atoll country, it was difficult to relocate or rebuild hospitals, and asked that a focus on atoll countries be added to the recommendations.
168. Palau recognised that its hospital is at risk and asked for a recommendation that focused not just on hospital services, but on public health.
169. Dr Kafoa said the requests to escalate the recommendations to PHMM and to look at all health centres were noted. SPC is about to recruit a climate change health adviser and will prepare a paper for PHMM.
170. Dr Jacobs, WHO, said there is a perfect opportunity to escalate the issue to PHMM, given resilience is on the Ministers' agenda.
171. Dr Natuzzi said the study was a small one and there are plans to do a comprehensive review. She agreed that PAHO provides a useful tool and requested that PICTs inform the team about likely climate impacts on health.

Universal health coverage and primary health care (PHC)

Strengthening primary health care as a vehicle for advancing UHC

Presenter: Dr Yuki Suehiro, Chief of Health and Nutrition, UNICEF

172. Primary care can be defined as the care that a GP provides for individuals, while primary health care (PHC) includes public health as well as primary care. PICTs once provided quite good access to PHC, but patients now tend to bypass PHC in favour of tertiary care.
173. There was renewed political commitment to strengthening PHC systems in 2017, and this was included in national health strategic plans and other policies. However, implementation was delayed by COVID-19. The pandemic highlighted that PHC is central to health security and created momentum for accelerating PICT efforts to implement integrated, people centred PHC systems.
174. Urgent action is needed because of the burden of NCDs and inadequate focus on prevention and early detection; COVID disruption of normal health services such as immunization and contraception; and the current skew toward curative rather than preventive services.
175. Recommendations for governments:
    - Update role delineation policies and essential service packages that support integrated, 'people centred' PHC.
    - Define the investments (political, HR, economic) needed to operationalize them.
    - Address implementation bottlenecks.
    - Strengthen links between national and subnational governance.
    - Treat PHC as an investment, not a cost.
176. Recommendations for development partners:
    - Continue support for addressing implementation bottlenecks for PHC strengthening.
    - Prioritize investment in integrated PHC systems.
    - Provide technical assistance to PICTs undertaking PHC reform, while ensuring the process is led and owned by PICT governments.

Discussion

177. French Polynesia has had a programme to modernise PHC for the last 5 years. However, results are mediocre so far despite the realisation that a focus on hospitals is detrimental to PHC. Successes include politicians and community leaders listening to the rationale and

understanding the work, and efforts to integrate traditional health systems. A recently implemented system requires all health workers, including GPs, to do a field internship in a PC setting. They then understand the challenges.

178. Cook Islands is reorienting its PHC to community-based services. There are dedicated NCD clinics in the community clinics and consideration is being given to including oral health, eye health and mental health services. The aim is to provide early intervention. Cook Islands has health passports for children and may introduce them for adults. People will have access to their medical records through the new HIS.
    Cook Islands invited development partners to visit and suggested a day be put aside during PHoH to meet with development partners.
179. Samoa is returning to what worked in the past, such as mothers' groups. Its health sector plan focuses on PC.
180. UNFPA highlighted the question of scarce resources and the need to look at mechanisms for leveraging existing resources.
181. New Zealand has recently begun implementing a new health act. Its support for PICT health focuses on PHC.
182. USA focuses on equity and is moving to paying for care for the patient in the community. It is important to retain health workers in the communities they live in.
183. Tonga has focused on curative care and now needs to strengthen PHC, which will help address NCD. Health workers don't want to work in small health centres. Tonga needs partners to assist and also needs to revive some former practices, as Samoa mentioned.
184. Fiji: PHC is filled with junior doctors searching for a career. PHC should be established as a specialist career.
185. Dr Kafoa: Some PICTs recognise PC as a specialist area, and more PC specialists are being sponsored.
186. Debbie Sorensen, Pacific Medical Association, New Zealand: PC is a clinical speciality and career pathways need to be developed.
187. Susan Ivatts, World Bank: Prior to the pandemic, donor coordination was already happening in some PICTs and should be reinvigorated.

Innovative primary health care practice, a New Zealand Pasifika experience

Presenter: Debbie Sorenson, CEO, Pasifika Medical Association (PMA)

188. PMA has 200 employees and six properties. It also has a PACMAT team. PMA works across sectors including education and finance.
189. Pacific primary care is provided through two clinics in Auckland and one in Christchurch. The system is family led and services are free. Each clinic includes three teams – urgent response, family support, and mental health. Family support teams are in co-located pods. The urgent team sees anyone who turns up on the same day. The mental health team includes psychiatrists and psychologists.
190. The clinics measure 80 different indicators, and all data is monitored every 8 weeks.
191. What is working:
    - Working alongside people in culturally anchored ways.
    - Ensuring staff have the right training for relationship-based care.
192. PMA does not have all the answers but has some, particularly in trusting and listening to its communities.
193. Opportunities:

- Pacific models of integrated care.
- Move away from traditional medical practitioner consultation.
- Clinical placements for primary care training for doctors and nurses.
- Primary care practitioners available for in-country clinical training, virtual consultations, and primary mental health consultations.

Discussion

194. French Polynesia has reached the same conclusion on focusing on the family. PMA's experience is of great interest.
195. Niue benefitted from PMA services during the pandemic. PMA provided guidance and sent a team. The rapid response was excellent. Niue agrees with the family approach, which reflects Pacific communities.
196. On behalf of Tonga, the Chair thanked PMA for its support, including psychosocial support, after the tsunami.

Health Security

Updates from the Pacific Public Health Surveillance Network (PPHSN) and LabNet meetings 2022

Presenters: Dr Eric Rafai and Dr Litia Tudravu, Fiji

197. In September 2022, PPHSN celebrated its 25th anniversary. It includes LabNet, EpiNet, PICNet, PacNet and Syndromic Surveillance, as well as SHIP-DDM.[3]
198. Future development of PPHSN:
    - Comprehensive surveillance that includes access to timely information and up-to-date tools and technology; qualified multidisciplinary health professionals; and coordination of multi-stakeholder, multi-sector responses.
199. Examples of recent progress:
    - PPHSN will become Directors of Public Health and will meet at the same level as Directors of Clinical Health.
    - PPHSN will be reviewed in 2023; it is recommended that the review include a OneHealth approach.
    - Success of SHIP/DDM course – 51 students will graduate with a Postgraduate Certificate in Field Epidemiology in 2023; the Postgraduate Diploma in Applied Epidemiology is being delivered in four PICTs.
    - Five PICTs have developed Infection Prevention and Control (IPC) guidelines.
    - The Pacific Vector Network is being established under PIHOA, SPC and WHO.
200. Urgent action is needed to sustain the momentum generated in responding to COVID. Ongoing threats in the Pacific include the brain drain, climate change, increase in vector-, food- and water-borne disease, and zoonotic disease.
201. Recommendations for governments
    - Note the recommendations from the 2022 Regional PPHSN and LabNet meetings.
    - Direct ministry staff to share information and alerts on outbreaks or new risks on PacNet.
    - Support collaboration with other sectors in planning and budgeting for public health risks emerging from the human-animal-environment interface.

[3] Strengthening Health Interventions in the Pacific – Data for Decision Making programme.

- Sustain the progress made during the COVID-19 pandemic to strengthen surveillance, IPC and RCCE capacity.

202. Recommendations for development partners
    - Support the review of the PPHSN, update of the Strategic Framework and strengthening of the PPHSN's six service networks.
    - Support the establishment of the Pacific Vector Network.
    - Support HR capacity building and country sharing of best practices and lessons learned in addressing disease outbreaks.

LabNet

203. Examples of recent progress:
    - Automated polymerase chain reaction (PCR) in all PICTS
    - 11 PICTs have manual RT-PCR laboratories.
    - Whole genome sequencing available in Fiji and Guam
    - Antibiogram in development
204. Urgent action is needed to sustain these recent gains in skills and technology.

Discussion

205. Dr Thane Hancock, CDC, commended PICTs and PPHSN on a successful response to COVID and agreed with Dr Rafai on this opportunity to review the network and its role in advancing Pacific health security. CDC has used many PPHSN programmes and supports its expansion through the Pacific Vector Network.
206. Dr Mark Jacobs, WHO, expressed support for PPHSN.
207. Australia also supported PPHSN and asked what form the review will take.
208. Dr Kafoa said an independent entity will shortly be appointed to do the review. He thanked the partners who have made PPHSN work and acknowledged FNU's role in recognising SHIP as a formal qualification. The next steps for PPHSN could include predictive surveillance, i.e., predicting what diseases are likely to affect countries based on trends.
209. PIHOA supports SHIP in the North Pacific. CDC has given PIHOA funds for a SHIP review. There has been discussion by the PPHSN Coordinating Body on accrediting the SHIP diploma. It is a faculty-intensive programme, and it is difficult to recruit suitable staff. Opening SHIP to accreditation by TEPHINET4 will widen it and may support recruitment.

Strengthening health system resilience

Presenter: Moses E. Pretrick, Assistant Secretary for Health, FSM

210. Three priorities for resilient health systems:
    1. Infrastructure, finance, HR, and enabling policies to deliver essential health services.
    2. Early detection and early warning systems.
    3. Capability and readiness to respond.
211. To achieve this requires:
    - policies, budgets, and legislation to support uninterrupted essential health services.
    - multi-sectoral readiness to respond to emergencies.
    - all hazards emergency response systems that are stress tested and refined.
    - interoperable information system and technologies that connect public health and non-health sectors.

[4] Training Programs in Epidemiology and Public Health Interventions Network. *TEPHINET* is a global network.

- whole-of-society engagement in a shared vision of the health system and emergency readiness.

212. Examples of resilience development in PICTs:
    - Telemedicine hub in FSM.
    - Talanoa sessions in Kiribati on psychosocial/mental health support.
    - Assessment of health-care facilities in Fiji.
213. Preparation is essential given there is usually little warning of a disaster. Lack of action leads to disrupted health services, stress on health workers, continued vulnerability and affected livelihoods.
214. Recommendations for PHoH:
    - Define the minimum health service delivery package, including services that must remain uninterrupted.
    - Develop plans for implementing these services during an emergency.
    - Strengthen technical capacity to generate and use timely health information to predict and manage emerging health threats and minimize health system shock.
    - Understand key national gaps in capacity. This includes working with WHO and partners to complete assessments such as Joint External Evaluations and State Party Self-Assessment Annual Reporting.
215. Recommendations for PHMM:
    - Work with colleagues in other sectors to ensure that an enabling environment is in place for the implementation of a national minimum health service delivery package.
    - Advocate for cross-sectoral climate action that will benefit health.
    - Guide teams to use opportunities such as Joint External Evaluations, State Party Self-Assessment Annual Reporting, exercises and intra- or after-action reviews to identify best practices and areas for improvement.
    - Lead collaboration with non-health ministries.
216. Recommendations for development partners:
    - Support PICTs in development minimum health service delivery packages.
    - Support the development and strengthening of integrated information systems.
    - Support country efforts to boost the climate resilience and environmental sustainability of their health systems.

Discussion

217. Both Niue and Cook Islands questioned what was meant by ‘minimum health service delivery’.
218. Cook Islands: All PICTs should consider conducting health facility assessments, as Fiji has done. Cook Islands is concerned about future outbreaks of respiratory disease and has worked with WHO to draft a pandemic response plan that includes key equipment. Cook Islands is finalising a proposal to the GCF, which includes the resilience of health facilities, and is willing to share information with other PICTs.
219. Niue asked about the extent to which PICTs are being supported by climate change funding and whether the health sector is working with sectors who are getting this funding.
220. Dr Jacobs WHO: The minimum service package is the minimum services that a health-care facility can provide in an emergency, e.g., maternity care and vaccination.
221. French Polynesia: PICTs also need to consider HR resilience, especially in crises. Support teams and strategies are both required to reduce stress.
222. Samoa agreed with French Polynesia on the need for health worker support during a crisis. Samoa has a climate early warning system.

223. Palau noted supply chain issues and asked if PHoH could look at using military resources to provide supplies in emergencies.
224. Australia noted the point made by Niue on climate change funds and health, and those made by French Polynesia and Samoa on supporting health workers during crises. Australia is developing a Climate Change and Health Strategy. The recommendations should go to PHMM.
225. Tokelau noted the need to provide suitable housing for health workers as well as hospital infrastructure.
226. Fiji asked for more guidance on risk communication. Fiji worked ad hoc during the pandemic and would appreciate guidance.
227. Dr Vivili, SPC: Regarding the relationship between health and climate change – health must feature in PICT national plans or Joint National Action Plans or similar if PICTs wish to make a case for GCF funding. SPC and SPREP are accredited to the GCF, and SPC has numerous projects to go to the GCF, but only one is on health. GCF is not an easy partner, either in negotiating proposals or reporting.
228. PIHOA: Palau mentioned supply chain issues. Many PICTs have only one shipping line/airline. Some PICTs had no service during the lockdown. RMI and FSM were both affected, including by shortages of medical supplies. What specific assets can we deploy when needs arise? PICTs may need to review assets and ensure agreements are in place. Pool procurement provided support, but it took time. Sub-hubs of supplies could work better.
229. USA agreed with PIHOA on the need to strengthen systems in normal times.

Update on the working group on amendments to the International Health Regulations (IHR) and Intergovernmental Negotiating Body (INB)

Presenters: Sir Ashley Bloomfield, member of the Working Group, New Zealand; Aalisha Sahukhan, WRPO (online presentation)-

230. Sir Ashley reviewed the outcomes to date of the working group. There has been activity across the globe to follow up on Pandemic Preparation, Prevention and Response (PPPR) equitably. The global health architecture includes a UN High-Level Meeting on PPPR; work on amending the IHR; the Pandemic Treaty; sustainable financing of WHO; and the Pandemic Fund hosted by the World Bank.
231. The IHR were last revised in 2005. Revision is a member state process. There are numerous amendments to agree on, including technical amendments on the use of technology.
232. Important issues include oversight of member state compliance with the IHR, and equity. The WHA has directed that the amendments must address equity, e.g. capacity building in developing countries, access to affordable treatment and sharing of resources.
233. If PICT involvement is possible, it can be facilitated.
234. Aalisha Sahukhan: The WHA decided to form the INB, which is a member state group. The intent is that by WHA 2024, a draft pandemic treaty will be ready for consideration. Key issues for the treaty relate to global gaps in responses to COVID, including timely access to pandemic products (vaccines, etc.), resources and materials.
235. The emphasis on equity should ensure that all countries have access to products, though there is debate on how equity can be operationalized.
236. There is strong representation from the African Union and EU in the process. Fiji is representing the Pacific and Tonga has also sent a representative. But more Pacific representatives are needed to increase the Pacific voice. Real or virtual participation are both encouraged. It would be good to gather Pacific priorities together so they can be presented in high-level negotiations.

Discussion

237. Australia agreed that the negotiating process is difficult. Australia is trying to act as an informal coordinator and could support collective PICT input.
238. Dr Jacobs, WHO: WHO agrees with countries being in the room (it supported Fiji and Tonga) and could support a couple of PICTs to attend. Interested PICTs should contact WHO.
239. Sir Ashley agreed that PICT participation is critical and welcomed WHO support. New Zealand could also support the attendance of PICT representatives.
240. Aalisha Sahukhan stressed that the treaty is a legal document, so the work is detailed and requires preparation. PICTs were strongly encouraged to send a representative (either virtual or in person).
241. New Zealand: The instruments are important and have practical relevance for countries. Like Australia, New Zealand is prepared to support countries. WHO's support was acknowledged.
242. Dr Kafoa encouraged PICTs to take part in the processes described and thanked the presenters for their participation.

Reproductive, maternal, newborn, child and adolescent health (RMNCAH)

Implications of investments in SRH on the Pacific: Health and economic benefits from five PICTs

Presenters: UNICEF, UNFPA, and Pauline McNeil Boseto, Permanent Secretary of Health, Solomon Islands

243. The SRH Investment Case Study for Five PICTs (Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu) focused on two priorities for health and women's economic empowerment: expanding access to quality maternal health services and reducing unmet need for contraception. Findings showed that additional investment of $13.4 million between 2020 and 2030 would enable the countries to meet family planning and maternal health coverage targets. Samoa, Tonga, and Vanuatu are already meeting their target for reduced maternal mortality.
244. The current situation for all PICTs includes high unmet need, rising adolescent birth rates in some PICTs, and four countries with higher rates of maternal mortality.
245. The Chair, speaking on behalf of Tonga, said that although Tonga had achieved the SDG target for maternal mortality, there were unexpected maternal deaths in 2022. A quick internal review showed several pregnancies should not have happened, given the mothers had pre-existing conditions. An independent review will also be carried out with SPC. Dr 'Akau'ola expressed appreciate for UNFPA's work.
246. Recommendations for governments:
    - Increase domestic funding for SRH services and family planning supplies, as a basis for a sustainable transition from externally financed programs.
    - Ensure family planning, maternal health interventions, and supplies are included in essential health benefits packages.
    - Prioritise essential SRHR health services including in emergencies/ disasters.
    - Prioritise adolescent and youth SRHR.
247. Recommendations for development partners:
    - Ensure that services are accessible, skilled nurses, midwives, and health-care providers are available, and the services provided are locally accepted and of high quality.

- Support demand generation activities to increase awareness and change perceptions of SRHR and family planning interventions.
- Support research and further work to validate costs and estimate healthcare worker and other logistic requirements.

Discussion

248. Fiji: The high-level language of the recommendations must be translated into practical statements that teams can operationalise.
249. New Zealand is reforming its health system including for women. There is a focus on equity.
250. Niue: Collaboration of the health and education sectors has brought benefits including health promotion.
251. French Polynesia agreed with Niue on partnering with education to expand the knowledge of young people.
252. Wallis and Futuna: The health sector has been working with schools to educate students and potentially with mothers' groups.
253. Australia is committed to supporting SRH services, including improving access.
254. Melinia Nawadra said PIFS has been progressing work on SRH and GBV including involving the education sector. Fiji has a national plan for GBV. In March every year, the Commission on the Status of Women (CSW) is held in New York. These issues are always part of the discussions.
255. Dr Jacobs, WHO: Should the recommendations be to PHoH rather than to government. They could be reframed for PHoH.
256. The Chair requested the Secretariat to work with UNFPA on the recommendations.

Accelerating the health sector's response to sexual and gender-based violence

Presenter: Dr James Fong, Permanent Secretary, Fiji

257. An average of 39%–51% of Pacific women experience sexual or physical violence (SGBV) at the hands of their intimate partners in their lifetime, compared to an average of 27% globally. Despite these levels of violence, less than 4% of facilities in PICTs meet the criteria for providing services to injured women. Prevention and response, and life-saving interventions, are not integrated into PHC in many PICTs, especially in remote areas.
258. Four of the eight SRHR SDG targets are aimed at addressing SGBV (specifically SDG target 5.2 and SDG target 3.7). This correlates with the 2050 Blue Pacific Continent Strategy on achieving gender equality and eliminating violence against women and girls as a pathway to sustainable development.
259. All countries now have legislation or family law bills to protect women from violence. However, implementation is limited. Health workers are among the first responders. The health sector therefore has a critical role in the elimination of violence against women and girls, enabling them to live their lives free of violence, coercion, and discrimination.
260. Recommendations for governments:
    - Acknowledge that sexual and gender-based violence is a public health issue that requires an effective response provided by trained staff.
    - Ensure that health services are available for women and girls experiencing violence, including mental health care before, during and after emergencies.
    - Strengthen workforce capacity to treat survivors of violence, including the ability to identify and refer affected women.
    - Ensure sufficient budget allocations for management and capacity development, including for the implementation of RMNCAH plans.

261. Recommendations for development partners:
    - Invest in integrated provision of services, including capacity building of health workers.
    - Support governments with provision of supplies and commodities, and improved logistics.
    - Implement male engagement strategies and activities to transform harmful concepts of masculinity.

Discussion

262. USA: This is an important topic. Advancing SRH is core to the US's response.
263. French Polynesia: There is a lack of data and anthropological/sociological studies on GBV. Could development partners support research on GBV.
264. Solomon Islands thanked UNFPA for the assessment. SRH has not progressed much despite budget support ($10 million). There is considerable pressure on services because of the high birth rate. Solomon Islands thanked DFAT for supporting efforts to reduce teenage pregnancy, STIs etc. However, it still needs capacity to absorb funding and deliver services. This will be part of its strategic plan.
265. UNFPA will take the interventions and realign the recommendations. UNFPA thanked Dr Fong for increasing the health sector's response to GBV and hoped the presentation would stimulate other initiatives.

Other technical matters

Priority recommendations from the meetings of Directors of Clinical Services and Pacific Heads of Nursing and Midwifery

Presenter: Dr Ana Akauola, Chair of DCS

266. The DCS meeting was held in August 2022 and the PHNM meeting in September. Priority recommendations for both meetings focused on workforce, education, and leadership. COVID showed the need to improve health infrastructure and strengthen training in PICTs.
267. Progress will require more highly trained specialists, nursing specialisation, improved biomedical and laboratory services, IPC support, and enhanced digital health systems.
268. Recommendations for governments:
    - Align national workforce plans with national health plans with effective succession planning.
    - Standardise regional professional accreditation and pathways so qualifications are recognised across PICTs.
    - Align nursing strategic plans with career pathways and specialisation.
    - Align professional training programmes to the needs of the health sector, with collaboration between member countries and academic institutes.
    - Support regional internship programmes.
    - Support the Pacific domestic supply of nurses and standardise training and qualifications.
    - Support strategies for clinical governance, including regional policy.
    - Recognise the importance of nursing leadership, and Directors of Nursing or CNOs as leaders within MoH, and support nursing leadership training programmes.
    - Invest in health information systems.
269. Recommendation for development partners:
    - Support educational priorities for PICTs, at postgraduate and specialisation level

Discussion

270. Samoa fully supported the recommendations.
271. French Polynesia agreed that leadership is of fundamental importance. It is also important to advocate training.
272. Dr Hancock, CDC commended the progress in the workforce and asked if the study had looked at mid-level providers.
273. Dr Akauola said the study only looked at clinicians. The data will be updated before PHMM. All PICTs were asked to share their data (only nine have so far).

Revitalizing HIV, TB, and malaria programmes in the Pacific

Presenter: Dr Frank Underwood, PIRMCCM[5]

274. HIV – AIDS related deaths are increasing annually, particularly in Fiji and PNG. HIV vulnerability is high due to limited access to SRH services, but the burden is low.
275. TB – Four PICTs (Marshall Islands (483), Kiribati (424), Tuvalu (296) and Nauru (193) have a high TB incidence of more than 100 cases/100,000 population.
276. Malaria (Vanuatu) – The island of Tafea was declared malaria-free in 2017. Vanuatu has an ambitious plan to achieve malaria-free status by 2026 and cases were decreasing till 2022 when they tripled to 1143.
277. Innovations in HIV prevention and treatment include PrEP, an antiretroviral medication. Putting people and communities at the centre of response plans ensures no-one is left behind and leads to greater compliance with treatment. Community approaches have been successful in Samoa, Vanuatu, Tonga, and Cook Islands.
278. Recommendations for governments:
    - Uphold political commitments towards ending AIDS, TB, and malaria, and mobilise resources through international support or domestic funds to strengthen national responses by:
        - protecting health security and improving the detection of infections, treatment adherence, and monitoring.
        - recognising the importance of community leadership and enabling civil society to contribute to the implementation of programmes to expand essential services and cater for hard-to-reach populations.
279. Recommendations for development partners:
    - Provide technical assistance to:
    - improve strategic information to produce data that can inform national HIV/TB and malaria strategies.
    - build community leadership to implement community-led programming and monitoring.
    - enhance the potential of health technologies and innovations to advance responses to HIV, TB, and malaria.

Discussion

280. Dr Hancock, CDC, noted the mass screening for TB being carried out in RMI and FSM and hoped it will have an impact on eliminating TB from the islands.

[5] Pacific Island Regional Multi Country Coordinating Mechanism (PIRMCCM) of the Global Fund Grant for HIV, TB, and Malaria.

281. Dr Underwood: TB is everywhere. The challenge now is drug-resistant TB. Mass screening works where there are high levels of TB and is a possible way to decrease levels dramatically. Diabetes contributes to breakthrough infection.
282. UNDP: Government ownership is essential to avoid drastic impacts when a donor pulls out.
283. PIHOA: SPC was a Principal Recipient for the Global Fund from 2006 to 2013. It is sobering to see that similar recommendations are being made as in 2023. There have been improvements. Surveys need to be continued, if possible, under the Global Fund in addition to investment in rapid technology, especially in laboratories, to help us reach hard-to-reach communities.
284. The high incidence of STIs across the Pacific, including HPV infection, requires a targeted approach.
285. Tokelau thanked New Zealand for supplying HPV vaccine.

Other business

286. **Pacific Health Ministers Meeting, Tonga**, 20–22 Sept 2023
PHoH will have received invitations from Tonga.

287. **2023 Regional Committee Meeting**
Countries will receive information in due course.

288. **2023 World Health Assembly, Geneva,** 21–29 May 2023
Representatives can register online with their credentials. There will be a meeting of Pacific representatives during the Assembly.

Draft recommendations

289. Sunia Soakai, SPC, presented the recommendations, noting that they will be further revised for comment before presentation to PHMM.
290. The recommendations were accepted based on this proviso.

Meeting evaluation

291. An evaluation of the meeting was carried out using Slido

Closing remarks

292. The Chair acknowledged the contributions of PHoH and participants and observers. He thanked the Joint Secretariat for the organisation of the meeting.
He noted the encouraging direction of some presentations and the emphasis on working smarter. PIFS can take PHoH's voice to Pacific leaders. There may also be opportunities to join Pacific voices with those of the Caribbean. PHoH needs to continue advocating for the health of Pacific people and to match strategies with implementation. He thanked all partners for their essential support.

Farewell gifts

The meeting ended with the presentation of gifts to Ms Susan Ivatts of the World Bank and to the Chair, Dr Akauola. For both, this was their last PHoH meeting after many years of service.

Annex 1: Decisions of PHoH meeting, 25–27 April 2023

PHoH agreed on the following recommendations:

1. 2050 Strategy for the Blue Pacific Continent

1.1 PHOH

i. Note the progress made to develop the Implementation and Monitoring Plan for the 2050 Strategy.
ii. Note the key role of health outcomes in realising the 2050 Strategy Vision set by Leaders and the role that PHoH will play in achieving those outcomes.
iii. Revise the Healthy Islands vision to ensure a consistent approach with the Blue Pacific strategy.

1.2 Development partners

i. Note the progress made to develop the Implementation and Monitoring Plan for the 2050 Strategy.

2. 3rd Healthy Islands Monitoring Framework (HIMF) Report

2.1 PHOH

i. Make better use of HIMF data, beyond merely reporting indicators every two years.
ii. Strengthen HIMF implementation and use:
    a. Pacific created, Pacific led
    b. Require high-level commitment to mobilize adequate resources and promote cross-ministry collaboration.
    c. Leverage health information experts from the Pacific Health Information Network, with support from WHO and SPC, to coordinate progress review in-country.
    d. Develop recommendations to revise the framework, with support from joint secretariats, to ensure HIMF remains fit-for-purpose.
iii. Recognise the need for high-level commitment to mobilise resources and promote cross-country collaboration.
iv. Look at incorporating real-time data in the report to maximise its value and inform decision-making.
v. PICTs to follow up on missing data for some of the HIMF indicators.
vi. Recognise health information officers as key in day-to-day work.
vii. Affirm PICTs' ownership of health information for decision-making.

2.2 Development partners

i. Consider using country or regional estimates for reference, rather than global estimates. The former are more relevant to small PICTs with small populations than the latter.
ii. Send report to PICTs for review before the Ministers' meeting.
iii. Include oral health in the HIMF indicators.
iv. Align HIMF reporting with SDG reporting.

3. Advancing health information and digital transformation in the health sector

3.1 PHOH

i. Define, adopt, and document minimum technical standards and interoperability requirements for health information and digital health solutions.
ii. Develop and implement an evidence-based strategy and operational plan for health information and digital health development, based on the digital health maturity model. Special focus on:
    a. CRVS strengthening by ensuring notification and registration of births and deaths and cause of death assignment are consistent with the data standards.
    b. Deploying interoperable digital health interventions
    c. Allocating sufficient training and resources to support uptake.
iii. Sharing of best practices through established subregional mechanisms (e.g. Pacific Health Information Network, Directors of Clinical Services Meeting, and Directors of Heads of Nursing and Midwifery Meeting)
iv. PICTs to determine their digital maturity.
v. PICTs to share best practices through established subregional mechanisms.
vi. Ensure that digital health data integrates all patient health information, not only clinical information.
vii. Reduce inefficiencies in data collection and request prompt data sharing by PICTs.
viii. Involve stakeholders in digital health design and implementation.

3.2 PHMM

i. Lead coordination with ministries outside of healthcare to steer HIS and digital health advancement.
ii. Direct a country-owned health information and digital health transformation process by establishing institutional mechanisms that enforce adherence to technical standards.

4. FNU update on regional health training programmes

4.1 PHOH

i. Delays in release of offer letters for regional students (especially for MBBS prog) is usually due to waiting time for confirmation of scholarships from countries. FNU requests countries that the award of conditional scholarships to students is not made without an offer letter from FNU.
ii. Delays in confirmation of offer letters for applicants are also due to incomplete application forms before the close of applications (normally end of November).
iii. PG selection process happens in the preceding Sem 2 (for the following year intake). Clinical Masters applicants need to get registered with the Fiji Medical Council and this takes time. Strongly recommend that trainees send documents in time and register online with FMC.
iv. FNU requests support of countries towards our calls programme advisory board membership – to ensure FNU programmes capture regional industry perspectives.
v. Noted the request that Pacific Heads of Health ask their governments to strengthen their own training institutes.
vi. Recognised the difficulties of recruiting faculty for local institutions are struggling and requested FNU to consider faculty sharing.
vii. Also noted the request to PICTs to advise FNU early of their workforce plans and number of student places required.
viii. Recognised the benefits of in-country training where feasible.

4.2 Development partners

i. Support regional marketing of programmes
ii. Consider sponsorship of regional students to programmes that are currently running on low student intake.
    a. MMED Psychiatry
    b. Masters of SRH
iii. Requested that development partners support FNU outreach to remote PICTs.

5. Rethinking human resources for health

5.1 PHOH

i. Ensure that the right building blocks are in place for systematic management of human resources for health including:
a. A dedicated human resources unit within the MOH responsible for health workforce planning and policy development.
b. Relevant governance mechanisms for health workforce planning, policy development and implementation, including collaboration between health ministries, health professional training institutions and health professional regulatory bodies.
c. National human resources for health strategic plans and policies developed in line with national health strategic plans and packages of essential health services/role delineation policies. These should consider health labour market dynamics and future population health needs.
d. Health workforce databases or systems to inform planning and policy decisions, guided by global platforms such as National Health Workforce Accounts.
ii. Ensure that available health workers are fit-for-purpose and adaptive to current as well as future population health needs by:
a. Warranting that health professional training institutions are providing accredited pre-service training programs.
b. Institutionalizing mandatory continuous professional development for reskilling and upskilling, including on the transformative new models of digital and telehealth
c. Considering a regional regulation platform to enable reciprocity, workforce expert pools and standards across the region.
d. Accelerating implementation of the 'road map' developed in 2020 for the subregional Quality Improvement Programme for Nursing, with a focus on education and regulation.
iii. Increase internal funding and align investment for the implementation of priority health workforce policies and strategies, including:
a. Developing and implementing policies to retain health workers by introducing feasible incentives and better working conditions.
b. Optimizing skills mix and composition of integrated health care teams by:
- Mapping public health functions and the relevant health workforce.
- Reviewing and updating comprehensive, clear scope of practice and job descriptions.
- Strengthening the cadre of mid-level trained health workers, such as nurse practitioners and nursing specialization.
- Exploring task shifting and task sharing among health workforce teams, including the role of community-based health workers, such as village health workers.

c. Exploring the use of digital health and tele-health initiatives in expanding healthcare services.
iv. Explore opportunities and measures to address the evolving exponential increase in both internal and international migration of health workers by:
a. Analyzing the current situation and underlying causes;

b. Training greater numbers of health workers and adopting measures to attract and retain them, including decent working conditions and fair remuneration; and
c. Promoting sustainable and ethical mobility using global instruments such as the WHO Code of Practice on the International Recruitment of Health Personnel or bilateral agreements.

v. Consider ways of optimizing the use of the health workforce to achieve UHC.
vi. Explore further measures to address the increase in both internal and international migration of health workers.
vii. Align CPD with country health workforce priorities.
viii. Continue to include the education sector in discussion of professional development and provision of a pipeline of health workers.

5.2 PHMM

i. Ensure that national human resources for health strategic plans and policies are in place. The development of these plans and policies should be led by a dedicated HR unit in collaboration with key stakeholders, and informed by up-to-date health workforce data analysis, current labour market dynamics and population health needs.
ii. Ensure the accreditation of pre-service training programs and implementation of continuous professional development. Consider the use of a regional regulation platform to enable reciprocity, workforce expert pools and standards.
iii. Increase internal funding and align investment for the implementation of priority health workforce policies and strategies, focusing on attracting and retaining talent and optimizing skills mix, complemented using digital health and telehealth initiatives.
iv. Explore opportunities to address the increase in both internal and international migration of health workers by promoting sustainable and ethical mobility such as via the WHO Code of Practice on the International Recruitment of Health Personnel or bilateral agreements.

5.3 Development partners

i. Align health workforce support, including scholarship opportunities, with government priorities.
ii. Facilitate cross-country sharing of best practices in strengthening health workforce planning and management.
iii. Support regional internet infrastructure for health workforce institutes and regional hospitals to enable the use of digital health and tele-health initiatives, regional accreditation, regulation, and continuing development initiatives.
iv. Include PIFS and PIDP in PHOH meetings so they are part of health work force discussions.
v. SPC requested to come up with a catalogue of national training courses for sharing with countries.
vi. Contextualise the recommendations to fit the needs of PICTs at various levels.

6. PICTs World Bank Public Expenditure Review

6.1 PHOH

i. MOHs are encouraged to urgently improve the quality of expenditure to (i) get the most out of existing health dollars, and (ii) make the case for maintaining or strategically increasing the allocation to health from MOF and DPs.
a) High-cost areas where improved efficiency could free up existing money for health.
b) High impact interventions which have high health returns for investment

ii. MOHs need to strengthen corporate and clinical governance as a pre-requisite to achieving more equitable, efficient, and quality health results.
   a) Facilitating regular quality debate at country level on reported progress
   b) Adjusting money, staffing and other resources throughout the year where needed and possible to strategically improve health outcomes.
   c) Continuing efforts to get clarity on what resources are being provided by DPs to complement domestic resources, and so maximise health results.

6.2 Development partners

i. Actively and energetically get behind MOHs' efforts to improve quality of expenditure and governance. This includes:
   a) Responding in a timely and accurate way to government requests for information on what resources are planned and provided to help progress UHC and achieve national strategic plan priorities.
   b) Contributing to quality debate on progress with UHC and related indicators at country and regional forums. Actively use this analysis to contribute to the preparation, implementation, and monitoring of integrated annual workplans and budgets at country level for prioritised UHC service results.
ii. Recognise need for development partners to build MOHs' capacity to predict budget and expenditure.

7. Implementation of the Pacific NCD Roadmap: Progress, challenges and future direction

7.1 PHOH

i. Take leadership role in:
   a) Governance: Revitalising multisectoral national NCD committee to drive implementation and enhance collaboration with different sectors and stakeholders to address the root causes of NCDs in a holistic 'whole of government, whole of society and health in all policies approach'.
   b) Management services: Further improving primary health care services through investment and building capacity for early detection and management of NCDs as well as linking with other cross-cutting programs such as MCH, SRH, and infectious diseases.
   c) Health promotion: Ensuring NCD prevention and health promotion resources are innovative, user-friendly, and available for all target populations for utilisation.
   d) Accountability: Strengthening accountability through monitoring, evaluating, and assessing impact and trends of NCDs for policy, planning and decision making.
ii. To collaborate with non-health sectors in:
   a) Policies and legislation
   - Further strengthening fiscal policies through increased tax on unhealthy products particularly tobacco, alcohol, and SSBs to reach the recommended taxation targets, and utilizing tax revenue for health promotion.
   - Prioritising and addressing national and regional gaps on NCD policies and legislation (see annex 1), for example, regulation on marketing of unhealthy products, tobacco industry interference etc., through implementation of the endorsed Pacific NCDs Legislative Framework and other related frameworks.
   a) Behaviour change intervention: Creating innovative health promotion interventions using technology and media communication to inspire behaviour change targeting different population groups.

iii. Endorsement of MANA indicators: The proposed amendments of MANA Dashboard indicators recommended by the PICTs' national NCD focal persons to improve monitoring for policy development, planning and decision making.
iv. Review the NCD road map, recognising that gains made over the years are being reversed.

7.2 Development partners

i. Support PICTs in scaling up actions on NCD prevention through development and implementation of NCD polices and legislation, health promotion for behaviour change, and NCD management services.
ii. Advocate for and invest additional technical and budgetary resources to effectively monitor, evaluate and strengthen accountability mechanism in addressing NCDs at national and regional level.

8. Tackling the drivers of obesity, particularly for children

8.1 PHOH

i. Strengthen coordination and leverage partnerships with non-health sectors to take strong policy and legislative action built on evidence-based strategies that create health-enabling environments. For example:
   a. Implement and enforce food regulations, particularly on marketing of unhealthy foods and sugar sweetened beverages to children, and food fiscal policy.
   b. Incorporate health protections in trade agreements to set standards, mandate labelling, regulate marketing, prohibit trans-fats, and increase access to healthier foods.
   c. Ensure that facilities are available on school premises and in public spaces to promote physical activity for all including those with disabilities.
ii. Scale up evidence-based interventions that promote behaviour change particularly targeting children and young people, including through collaboration with non-health sectors. For example:
   a. Engage children, youth and communities in any innovative behaviour change interventions that promote physical activity and healthy eating, empowering them to be at the forefront in tackling obesity.
   b. Ensure obesity prevention and health promotion resources are innovative, user-friendly, and available for the target populations for utilization.
iii. Fully implement evidence-based interventions within the health sector including:
   a) Ensuring that Baby Friendly Hospitals follow their policies, promote breastfeeding, and follow the Code on the Marketing of Breast Milk Substitutes.
   b) Integrate child growth monitoring and obesity management into primary health care.
   c) Monitor child growth and children's BMI to increase data and trends on overweight and obesity for planning, policy development and decision making.
   d) Provide appropriate management services for children and their families who are overweight or obese including pregnant women with gestational diabetes.
iv. Note the strong advice to ensure NCD recommendations have teeth, to avoid continuing decades of worsening levels of disease.

8.2 PHMM

i. Lead national multi-sectoral NCD committees to drive 'whole-of-government' and 'whole- of-society' implementation of evidence-based interventions that address the root causes of obesity in a holistic manner across the life-course.

ii. Commit to scale up with timeline the implementation of the Pacific Ending Childhood Obesity (ECHO) priorities including i) promotion of physical activity, ii) introduction of fiscal policies on sugar sweetened beverages and unhealthy food products, and iii) the restriction of marketing of unhealthy foods and beverages to children.
iii. Hold government departments and other stakeholders accountable for progress in addressing the drivers of obesity through active monitoring and evaluation.
iv. Invest targeted budgetary resources to scale up national priority actions that create health-enabling environments and implement innovative interventions that promote behaviours change particularly targeting children and young people.
v. Empower civil society organizations and non-health sectors to be at the forefront in tackling the drivers of obesity and ensure regional and national collaboration in advancing the implementation.

8.3 Development partners

i. Invest and support PICs in addressing commercial determinants, creating health-enabling environments, and scaling up interventions in every aspect e.g., policy, planning, capacity building etc.
ii. Support the strengthening of accountability and the monitoring of implementation using the MANA dashboard. Conduct and share population-based surveys and operational research to monitor and evaluate health outcomes among Pacific children and young people.
iii. Advocate for multi-agency and multisectoral action across Council of Regional Organisations of the Pacific (CROP) and United Nations partners to support PICs' efforts to tackle the drivers of obesity.

9. Update on the WHO NCD Small Island Developing States

9.1 PHOH

i. To respond more effectively, most SIDS need additional support in specific disease areas. Many also require support in overall capacity development, infrastructure investment and routine data collection for NCDs and mental health, including death registration.
ii. Consider the suggestion to ban tobacco products.

10. Update from the Fred Hollows Foundation

10.1 PHOH

i. Recognize the growing burden of vision loss in the region, particularly diabetic retinopathy due to rising rates of diabetes.
ii. Include eye care in human resource planning to further develop a highly skilled eye care workforce that can increasingly meet complex population eye needs.
iii. Support the integration of eye health as part of their national health planning to drive national eye health priorities to progress towards integrated people-centred eye care as part of universal health coverage (UHC).
iv. Invest in collecting eye health data and information to better understand the true burden of vision loss and enable policy development, prioritization, and reporting.

11. Pacific Island Hospitals Infrastructure

11.1 PHOH

i. Commit to amplifying and prioritizing hospitals and primary health care facilities as critical infrastructure along with roads, bridges, ports and airports.

ii. Advocate for more funding to be allocated for adaptation as it pertains to health and critical infrastructure within your country and regionally.
iii. Recognize and give weight to hospitals spanning two critical sectors that are negatively impacted by extreme weather events and rising sea levels when discussing priorities.

11.2 Development partners

i. Address adequate funding to reduce the adaptation gap.
ii. Commit to recognizing and supporting programs that address the unique and "locked in" threats Pacific Island countries face.
iii. Continue to recognize that Pacific Island hospitals are essential items and invest in shoring them up to withstand extreme weather events.
iv. Support and implement the UN Multi-dimensional Vulnerability Index and the COP 27 Loss and Damage Agreement.

12. Strengthening Primary Health Care as a vehicle for advancing UHC

12.1 PHOH

i. Update role delineation policies and essential service package, incorporating appropriate and realistic models that support integrated, 'people centred' PHC.
ii. Define the political, human resource, and economic investments needed to operationalize them.
iii. Identify and address implementation bottlenecks.
iv. Strengthen linkages between national and sub-national governance.
v. Treat PHC as an investment, not a cost.
vi. Include eye and mental health screening at community level.

12.2 Development partners

i. Continue providing support to address implementation bottlenecks for PHC strengthening in full alignment with national priorities and implementation capacity in each of the PICTs.
ii. Prioritize the investment in integrated PHC systems, shifting away from financing for vertical programs.
iii. Provide technical assistance to PICTs in PHC reform process, while ensuring the leadership and ownership of the PICT governments.
iv. Provide support to PICTs to evaluate effectiveness of PHC.

13. Innovative primary health care practice, a New Zealand Pasifika experience

13.1 PHOH

i. Acknowledged the work being done by the Pasifika Medical Association (PMA) and its achievements.
ii. Recognised the effectiveness of PMA's model of family care, which reflects the Pacific communities it serves.
iii. Expressed appreciation for PMA's rapid response to countries during disaster events, e.g., for Tonga after the tsunami, and for Niue in dealing with the COVID pandemic.

14. Updates from the Pacific Public Health Surveillance Network (PPHSN) and LabNet Meetings 2022

14.1 PHOH

i. Note the recommendations from the 2022 Regional PPHSN and LabNet meetings.

ii. Direct ministry staff to share information and alerts on outbreaks or new risks on PacNet leading to better surveillance, preparedness, and responses by other countries.
iii. Support the coordination and collaboration of other sectors in planning and budgeting for public health risks emerging from the human-animal-environment interface.
iv. Sustain the progress made during the COVID-19 pandemic to strengthen surveillance, IPC and RCCE capacity to ensure that health systems are better prepared to respond to the threat of COVID-19, emerging diseases and remerging health threats and addressing climate change disease patterns impacting health.
v. Sustain the progress made available during the COVID-19 pandemic to strengthen laboratory capacity.
vi.

15. Strengthening health system resilience (including resilience to climate crises, and applying lessons learned from COVID-19 incl. mental health)

15.1 PHOH

i. Develop country-specific definitions of the minimum health service delivery package identifying which types of services must remain uninterrupted even in the event of health system shocks.
ii. Having developed this list of essential services to maintain, guide the health system (including all health facilities) to develop implementation plans for how they will switch to a focus on these services during an emergency or other shock.
iii. Ensure that an enabling environment is in place for this minimum health service delivery package including the relevant legislation and policies, standard operating procedures, infrastructure (including power generation), financing, staffing and workforce development, and resources (including supply chain).
iv. 4. Further work to ensure the climate resilience and environmental sustainability of the healthcare system.
v. Strengthen technical capacity to generate and use timely and integrated health information to predict and manage emerging health threats and to inform response efforts to minimize health system shock. This would include:
   a. Digitalization of primary health care health information systems to identify and manage disruptions in essential health services.
   b. Developing interoperable information systems between health (e.g., health facility, epidemiological and laboratory data systems) and non-health sectors (e.g., animal health, climate change, and meteorological and geologic hazards) to generate integrated health information that could predict and inform management of emerging threats.
   c. Coordinating multi-team capacity-building efforts, such as between those working on the surveillance system and lab capacity strengthening, to promote a culture of information sharing and break down (or preventing the building of) information siloes to allow for the timely sharing of information for decision-making in peacetime and, critically, during crises.
   d. Empowering decision makers from local to national level to translate the generated information into effective and appropriate response actions that would mitigate risk and impact on the healthcare system.
vi. Understand key national gaps in capacity, both in health threat identification and response, and in health system resilience.

a) Working with WHO and partners to complete assessments such as Joint External Evaluations and State Party Self-Assessment Annual Reporting, as well as performing risk assessments for priority pathogens and natural disaster threats.
b) Care should be taken that these are not performed for their own sake, but alongside results from tabletop exercises and response plan reviews to result in concrete and achievable next steps for health system strengthening.
c) During this process, transparency and engagement with the community is encouraged to provide visibility that the government is taking action to protect their interests and to encourage whole-of-society responses to emergencies.

vii. All PICTs should conduct assessments of the resilience of their health facilities, like the work done by Fiji.

viii.

15.2 PHMM

i. Work with colleagues in other sectors to ensure that an enabling environment is in place for the implementation of a national minimum health service delivery package, the delivery of which is ensured even during disasters, epidemics and other shocks (e.g. relevant policies and legislation, standard operating procedures, infrastructure, financing).
ii. Advocate for the cross-sectoral climate action that will benefit health while leading teams to ensure the climate resilience of the healthcare system.
iii. Guide teams to fully utilize opportunities such as Joint External Evaluations, State Party Self-Assessment Annual Reporting, exercises and intra- or after-action reviews to identify best practices and areas for improvement. Ensure that recommendations result in concrete action.
iv. Lead collaboration with non-health ministries to strengthen technical capacity to collect and analyse data on animal health, climate change, and meteorological and geologic hazards, and to develop cross-sector technical standards to facilitate interoperable information systems.

15.3 Development partners

i. Support PICs in their development of minimum health service delivery packages and follow their guidance on which areas need specific external support.
ii. Support the development and strengthening of information systems that integrate data from across different areas of the health system (i.e. clinical, epidemiology and laboratory)
iii. Support country efforts to boost the climate resilience and environmental sustainability of their health systems and to advocate for the multi-sectoral climate action that will benefit health.
iv. Ensure that efforts aimed at laboratory strengthening through increasing use of molecular technologies include an implementation timeframe of at least 2-3 years to allow countries to slowly absorb costs into the routine laboratory budget.
v. Ensure that support provided for increased readiness to address emerging disease threats should focus on both the minimum health service delivery package as well as supporting the ability to respond to emergencies and disasters. There will be common elements to both that require support, such as the augmentation of health care supply chains and assurance of adequate WASH in healthcare facilities.
vi. Secretariat to provide PICTs with guidance on risk communication during an emergency.

vii.

16. Update on the Working Group on Amendments to the International Health Regulations and Intergovernmental Negotiating Body (INB)

16.1 PHOH

i. Agreed on the critical importance of the Pacific region's participation in the process of amending the International Health Regulations.
ii. Acknowledged WHO's support for PICT representation, either in person or virtually.
iii. Recognised the emphasis on equity in revising the IHR.

17. Implications of investments in SRH on the Pacific: Health and Economic benefits from 5 PICs

17.1 PHOH

i. Governments should increase domestic funding allocation for SRH services and family planning supplies, informing a sustainable financing transition from externally financed programs.
ii. Family planning, maternal health interventions, and supplies must be included as essential health benefits packages within PHC, towards Universal Health Coverage.
iii. Prioritise, and maintain essential SRHR health services including in emergencies/disasters, despite budgetary pressures due to economic slowdown and additional costs of COVID-19 response as it is lifesaving.
iv. Prioritise adolescent and youth SRHR.

17.2 Development partners

i. Reaching the coverage targets is not solely dependent on direct intervention and health system funding. Implementers and development partners need to ensure that services are accessible, that skilled nurses, midwives, and health-care providers are available, and that the services provided are locally accepted and high in quality.
ii. Support demand generation activities to increase awareness and change perceptions of SRHR and family planning interventions.
iii. Support research and further work to validate costs and estimate healthcare worker and other logistic requirements and to understand the full financial requirements beyond the direct intervention and health system costs considered in this study.

18. Accelerating Health sector response to Gender Based Violence

18.1 PHOH

i. Acknowledge SGBV as a significant public health issue that requires a comprehensive rights-based health response inclusive of comprehensive sexual and reproductive health services, capacitated health personnel, health protocols, treatment and commodities, and health information management systems.
ii. Ensure that health services are available for women and girls experiencing SGBV including mental health care before, during and after emergencies.
iii. Strengthen workforce capacity development in SGBV clinical health sector response to survivors of SGBV, including the ability to identify and refer for further assistance.
iv. Ensure health sector budget allocations for SGBV management and capacity development including in the operationalization of RMNCAH implementation plans.
v. Need for collaboration with partners beyond health.

18.2 Development partners

i. Invest into integrated provision of SRH, SGBV and MHPSS services, including in the capacity building of health workers and during outreaches as vertical /silo approaches are no longer viable in increasing scale and improving quality of services. (Many development partners are

interested in investing in specific issues, which do not allow comprehensive provision of services).

ii. Support Governments with provision of supplies and commodities for SGBV and improving logistics management for GBV supplies and commodities.

iii. Develop and implement male engagement strategies and activities to challenge and transform harmful masculinities related to SRH and SGBV in the Pacific.

iv. Request development partners to support research on GBV.

19. Priority recommendations from Directors of Clinical Services and Pacific Heads of Nursing and Midwifery meetings

19.1 PHOH

i. Workforce – National workforce plans aligned to national health plans with effective succession planning.

ii. Standardise regional professional accreditation and pathways so qualifications are recognised across PICTs.

iii. Review/development of nursing strategic plans with alignment to career pathways and specialisation, nursing strategic frameworks.

iv. Education – Align health professional training programs to needs of health sector with collaboration amongst member countries and academic institutes; support regional internship programmes.

v. Nursing: support Pacific domestic supply of nurses, with a focus on standardisation of training and qualifications.

vi. Support strategies for clinical governance, including regional policy.

vii. Leadership and management – recognise the importance of nursing leadership, and Directors of Nursing or CNOs as leaders within Ministries of Health and support nursing leadership training programmes.

viii. Health technology: Invest in health information systems that can provide accurate, appropriate, and timely access to data/information to support/justify the need for interventions and resources.

19.2 Development partners

i. Support educational priorities for PICTs: at postgraduate and specialisation level.

20. Revitalizing the HIV, TB & Malaria response in the Pacific

20.1 PHOH

i. Pacific Island countries uphold their political commitments towards ending of AIDS, TB and Malaria and mobilize resources through international support or domestic funds to strengthen their national response by:

ii. Protecting healthy security through country ownership addressing problematic challenges focusing on health system strengthening through upscaling innovative health prevention tailor-made services for creating demand for HIV, TB & Malaria services and improving the detection of these infections, treatment adherence, and monitoring treatment in the Pacific.

iii. Recognize the importance of community leadership and create an enabling environment in which civil society can fully contribute to the implementation of programs to expand essential services and cater towards hard-to-reach populations.

iv. Need to revitalise HIV as it is slowly being forgotten.

20.2 Development partners

i. Development Partners in the Pacific support national actions through providing technical assistance towards:

a. Improving strategic information to produce data that can positively impact and inform national HIV/TB and Malaria strategies to address the gaps that exist in current programs.

b. Contribute towards the upskilling of civil society for community leadership to implement community led programming and monitoring.

c. Enhance the potential of health technologies and innovations to advance the HIV, TB and Malaria responses.

Annex 2: List of participants – PHoH meeting, 25–27 April 2023

14th Pacific Heads of Health Meeting

(Sheraton Resort, Denarau, Fiji, 25th -27th April, 2023)

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