



Meeting Report 4th Heads of Health Meeting

27–28 April 2016, Grand Pacific Hotel, Suva, Fiji



Prepared by the Pacific Community, 2016





4th Heads of Health Meeting

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Suva, Fiji, 27–28 April 2016

Meeting Report

Day 1: 27 April 2016

ITEM 1: Opening ceremony

Welcome and remarks by the Chair and introduction of speakers:

1. Opening remarks were made by Dr Audrey Aumua, Pacific Community (SPC), and Dr Yunguo Liu, World Health Organization (WHO).

ITEM 2: Review of outcomes, HoH, PHMM and FEMM 2015; directives and progress

2. This item was dealt with under 'Other agenda items'.

Improving the use of taxation policy on tobacco, alcohol and unhealthy food & drinks as a response to the NCD crisis in the Pacific

3. An information paper was tabled at the meeting, with no accompanying presentation.

Draft of status of taxes on alcohol, tobacco, sugary drinks and unhealthy food

4. An information paper was tabled at the meeting, with no accompanying presentation.

ITEM 3: Non Communicable Diseases

Progress in implementing the Pacific NCD Roadmap

5. The delegate reminded the meeting of the background to the development of the NCD Roadmap, and updated the meeting on progress at the regional level, including the 11th Pacific Health Ministers Meeting in April 2015 reaffirming ministers' commitment to the Healthy Islands (HI) vision, the partnership between WHO and McCabe Centre for Law & Cancer in Melbourne, the Pacific MANA NCD dashboard, the FEMM meeting 2015 Action Plan, ongoing efforts to introduce food safety regulations requiring nutrient labelling on processed foods, a discussion paper on sugar-sweetened beverages (SSBs) tax in PICTs has been completed by SPC, to assist PICTs in progressing the NCD Roadmap's recommendation to taxing SSBs.
6. Country-level progress included tobacco control, taxing unhealthy food and drinks, including SSBs, controlling alcohol abuse through continued tax increases, public awareness and restricted access to alcohol, most PICs have been implementing ongoing awareness programmes on diet and physical activity, many PICTs are implementing PEN protocols at national or sub-national level, efforts have been made to improve the availability and accessibility of NCD-related data have advanced, including monitoring of NCDs progressing at the country level, such as through STEP and hybrid surveys.



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7. The paper recommended that the meeting note the considerable actions undertaken regionally related to the Pacific NCD Roadmap but recognise that further actions are needed, given the extent and scale of the NCD crisis, which includes an acceleration of actions to tackle tobacco use, utilisation of taxes to support behavioural change and support for effective interventions; and that that annual updates be provided to Heads of Health on status of actions, utilising the Pacific MANA (Pacific Monitoring Alliance for NCD Action) NCD dashboard.

Discussion

8. The World Bank (WB) indicated that it was available to have further discussions about other actions that the WB is involved in.

Progress in developing Pacific MANA (Pacific Monitoring Alliance for NCD Action)

9. The delegate reminded the meeting that Pacific MANA refers to the Pacific Monitoring Alliance for NCD Action. The paper summarised progress in developing MANA, and discussed mutual accountability, based on the MANA dashboard.
10. The delegate updated the meeting on the 'Innovation' element of the three MANA strategic objectives (to support monitoring innovation and develop mutual accountability systems), in particular child BMI surveillance – the MANA Coordination Team has undertaken a review of current child BMI surveillance in the region.
11. Monitoring the food environment, including pricing, access in settings, and exposure to advertising, was one of the proposed areas of innovation for Pacific MANA. Under the alliance, C-POND, supported by the University of Auckland, has worked on developing and testing protocols.
12. Further refinement of the dashboard has been undertaken, including review of the key actions under the dashboard, comparison with existing dashboards (e.g. in USAPIs), and careful testing of the criteria, including mock assessments on a sample country to test whether criteria are clear and unambiguous.
13. The paper proposed three discussion points:
 - a. Discussion point 1: Further action is needed at country level to effectively monitor child obesity. What priority areas should be supported by partners and members of the MANA alliance?
 - b. Discussion point 2: What support can MANA alliance provide to assist with the use of these protocols?
 - c. Discussion point 3: How does the MANA dashboard for NCDs sit alongside the proposed Healthy Island indicators? Is the proposed monitoring approach for NCD dashboard appropriate?
14. Discussion was around making that data comparable across countries and that it caters for the specific data collected by countries
15. Cook Islands asked that the word obesity be removed, and that it instead refer to child health – obesity has blame connotations.
16. Niue agreed for an agreed protocol at the national level, to standardise what each country is doing and the data it is collecting.



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17. Tonga asked how countries will deal with childhood obesity when a baseline is established, as monitoring on its own will not solve the problem. The meeting discussed recommendations from the WHO process that outline approaches.
18. In relation to what MANA can provide, the delegate indicated that it comes back to identifying the need, and the alliance can determine what technical agencies can provide that support. There is work around establishing a system to build baselines for low and high BDMI.
19. Federated States of Micronesia (FSM) asked the meeting if there was a suggested system for progressive evaluation of programmes, rather than waiting for the 5-10 year lag in data for assessing impact.
20. Tokelau suggested that community engagement is very important – for example World Health Day should be seriously observed to take stock of health outcomes.

ITEM 4: Healthy Islands Monitoring Framework

Presentation – Overview and progress

21. The delegate (Chair) summarised the history and development of the Healthy Islands (HI) vision and monitoring framework, and outlined the considerable actions that have been undertaken regionally related to the Pacific NCD Roadmap, although further actions were needed, given the extent and scale of the NCD crisis. Work on the framework had culminated in a draft monitoring framework, with proposed indicators, for review by the Heads of Health. Four critical areas are in need of review: proposed additional indicators for inclusion; proposed changes to existing indicators; the utility of ‘optional’ indicators; and reporting mechanisms. These were set out in the paper and discussed with the meeting.

Presentation – Civil registration and vital statistics (CRVS)

22. The delegate summarised the development of CRVS commitments and planning in the Pacific region, and noted there have been strong political commitments to improving CRVS from PICTs. SPC and the Brisbane Accord Group have been working to support Pacific Island Countries to improve CRVS since 2011 under the Pacific Vital Statistics Action Plan.
23. CRVS is required for 18 indicators currently in the draft framework, and a further 23 require accurate population data.
24. Ministers of health have committed to: establishing a multi-sectoral coordination mechanism or mechanisms to improve CRVS systems (and HIS); undertaking an assessment of the key challenges and issues for generating reliable timely data; developing and sharing detailed improvement plans that include locally agreed targets for improving data; and investing in building human resource capacity in areas such as data analysis and interpretation of vital statistics to inform policy development and planning.
25. The paper encouraged Pacific heads of health to:
 - ensure CRVS is on the national development agenda;
 - take a key role in the national CRVS committee or equivalent (if not already doing so);
 - formalise national plans and set targets under the Regional Action Framework;
 - work with the national statistics offices to define roles and responsibilities and ensure available data is published regularly; and
 - advocate for investment in CRVS infrastructure and systems.



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26. The delegate indicated that a key challenge is to ensure that improvements in Pacific HIS and CRVS systems not only contribute to more complete birth and death registration – so that no one is left behind – but are also reflected in improvements in data quality and availability to ensure that we have sound evidence for policy and planning.

Discussion

27. The comment was made that the indicator of children should refer to fathers as well as mothers in civil registration. The delegate indicated that mentioning mothers ensured that children born to single mothers were not excluded from registration.

28. A question was raised about technology and support for registry offices, and it was indicated that there are some South-South support initiatives underway as well as some funding for direct technical assistance.

29. Samoa indicated that rates of infant mortality being expressed as per 100,000 people does not make sense for smaller islands. The response indicated that rates are important for comparison, however ‘rare’ events such as maternal mortality may lend themselves to other rate expressions, such as actual numbers.

Group work

30. Groups reported to the meeting on the recommended indicators for the four Healthy Islands Monitoring Framework themes, in order to update the draft Monitoring Framework.

31. The following draft Monitoring Framework (Version 3.0) was presented to the meeting, which was addressed in the group work.

32. The draft Healthy Islands Monitoring Framework is comprised of 44 indicators. Where possible, core indicators have been sourced from global frameworks (e.g. the SDGs) to ensure harmonisation and adherence to international standards. In line with the agreed key principles, the indicators cover a range of process and outcome measures. Process measures are likely to be of more interest to the Heads of Health, and are more sensitive to change, and as such, appropriate for annual reporting. Outcome measures have also been included, to provide countries with inspirational targets and goal-setting. Of the 44 indicators, 24 can be collected via routine administrative systems on an ongoing basis; these make up the core indicators of the framework. The 20 complementary indicators refer to indicators that require data collected from surveys, such as census or special household surveys, and, as such, would only be updated every five to ten years, pending survey cycles.

33. Indicators highlighted in yellow refer to those requiring additional comment or clarification.

No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
1. Strong leadership, governance and accountability					
CORE indicators					
1.1	Health worker density and distribution	Number of health workers per 1,000 population.	Preferred: Health worker registry.	Cadre; Place of	SDGs

¹ Where possible, definitions have been adapted from the *2015 Global Reference List of 100 Core Health Indicators* (WHO)

² SDGs (Sustainable development Goals); WHS (WHO World Health Statistics); NCD (Pacific MANA NCD Dashboard / WHO Global NCD Monitoring Framework)



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
		<p>Numerator: Number of health workers by cadre*; Denominator: Total population.</p> <p>*Cadres can include: medical practitioners, specialist medical practitioners (surgeons, anaesthetists, obstetricians, emergency medicine specialists, cardiologists, paediatricians, psychiatrists, ophthalmologists, gynaecologists, etc.), nursing and midwifery professionals, environmental health officers, dieticians, traditional and complementary medicine professionals, among others.</p>	<p>Other: National health workforce database.</p> <p>Published reports: SPC 'NMDIs' (online database); OECD 'Health at a Glance' (annual report); Asia-Pacific Human Resources for Health Report.</p>	employment (urban or rural).	
1.2	Total current expenditure on health	<p>Total current expenditure on health as a percentage of gross domestic products (GDP).</p> <p>Numerator: Sum of all current expenditure on health (in a 12-month period); Denominator: Gross domestic product.</p>	<p>Preferred: Administrative reporting systems.</p> <p>Other: National Health Accounts.</p> <p>Published reports: SPC 'NMDIs' (online database); OECD 'Health at a Glance' (annual report).</p>	-	WHS
1.3	Death registration coverage	<p>Percentage of deaths that are registered (with age and sex).</p> <p>Numerator: Number of deaths registered in a given time period (usually one year); Denominator: Total number of deaths in the same time period.</p>	<p>Preferred: Household surveys.</p> <p>Other: Civil registration and vital statistics systems.</p> <p>Published reports:</p>	Place of residence; Registered with cause (ICD).	WHS
1.4	International Health Regulations (IHR) core capacity index	Percentage of attributes of seven core capacities* that have been attained at a specific point in time.	<p>Preferred: Key informant survey.</p> <p>Other: Assessment of national</p>	-	SDGs



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
		<p>Numerator: Number of attributes attained; Denominator: Total number of attributes.</p> <p>*The seven core capacities as agreed by Pacific Countries and Territories are: (1) Early warning surveillance capacity that captures both indicator-based surveillance (IBS) and event-based surveillance (EBS); (2) Established rapid response team or EpiNet team; (3) Completion of DDM1 or DDM2 modules of the SHIP; (4) Fulfilment of IHR capacities at international points of entry; (5) Review of Public Health Emergency and Response Plan; (6) L1 LabNet core capacity for rapid detection of outbreak-prone diseases; (7) L2 laboratories that have attained minimum accreditation capacity.</p>	<p>surveillance systems reports; Review of PPHSN services report; and Review of national IHR core capacities reports.</p> <p>Published reports: Kool J, et al (2012) Pacific-wide simplified syndromic surveillance for early warning of outbreaks Global Public Health: An International Journal for Research, Policy and Practice, 7:7, 670-681; Paterson B et al (2012) Sustaining surveillance: Evaluating syndromic surveillance in the Pacific. Global Public Health 1 – 13.</p>		
1.5	Evidence of annual health review and annual health plan with budget	<p>Evidence of a formally communicated, annual health plan with budget, with formal review processes in place.</p> <p>Rating: 0 No evidence of annual health plan or annual budget; 1 There is evidence that an annual health plan is in development, or no reports or reviews are available; 2 Annual health plan with budget is developed, communicated and</p>	<p>Preferred: Administrative information systems.</p> <p>Other:</p> <p>Published reports:</p>	-	-



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
		resourced.			
COMPLEMENTARY indicators					
1.6	Out-of-pocket payments for health	Share of total current expenditure on health paid for by households out-of-pocket, expressed as a percentage of total current expenditure on health (this is the households' out-of-pocket expenditure). Numerator: Total household out-of-pocket expenditure for health (12 month period); Denominator: Total current expenditure on health.	Preferred: Administrative reporting systems. Other: Households consumption survey and national health accounts. Published reports: OECD 'Health at a Glance' (annual report).	-	WHS
2. Avoidable diseases and premature deaths are reduced					
CORE indicators					
2.1	Adult mortality rate from NCDs (30 to 69 years)	Unconditional probability of dying between the exact ages of 30 and 70 years from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases. Numerator: Number of deaths between ages 30 and 70 years due to the four causes; Denominator: Number of years of exposure.	Preferred: Civil registration with high coverage. Other: Population-based health surveys with verbal autopsy. Published reports: WHO 'World Health Statistics' (15-60 years); SPC 'NMDIs' (15-60 years).	Place of residence; Sex.	SDGs
2.2	Maternal mortality ratio	The annual number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100 000 live births, for a specified time period.	Preferred: Civil registration with high coverage and medical certification of cause of death and regular assessment of misreporting and underreporting. Other: Household surveys; population census;	Age; Place of residence.	SDGs



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
		<p>Numerator: Number of maternal deaths;</p> <p>Denominator: Number of live births.</p>	<p>special studies.</p> <p>Published reports: WHO 'World Health Statistics'; SPC 'NMDIs'.</p>		
2.3	Mortality rate from road traffic injuries	<p>Number of road traffic fatal injury deaths per 100,000 population (age-standardised).</p> <p>Numerator: Number of deaths due to road traffic crashes;</p> <p>Denominator: Population.</p>	<p>Preferred: Civil registration with full coverage; population surveys; police reports.</p> <p>Other: Population-based health surveys with verbal autopsy; administrative reporting systems (police reports).</p> <p>Published reports: Global Road Safety Report.</p>	Age; Sex.	SDGs
2.4	Life expectancy at birth	<p>The average number of years that a new born could expect to live if he or she were to pass through life exposed to the sex- and age-specific death rates prevailing at the time of his or her birth, for a specific year, in a given country, territory or geographical area.</p> <p>Numerator: From life tables;</p> <p>Denominator: From life tables.</p>	<p>Preferred: Civil registration with high coverage.</p> <p>Other: Household surveys and population census; sample registration system.</p> <p>Published reports: SPC 'NMDIs'.</p>	Sex; Place of residence.	WHS
2.5	Availability of essential medicines and commodities	<p>Percentage of health facilities with essential medicines and life-saving commodities.*</p> <p>Numerator: Number of facilities with essential medicines in stock;</p>	<p>Preferred: Special facility surveys.</p> <p>Other: Routine facility information systems.</p> <p>Published reports:</p>	Facility type	-



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
		Denominator: Total number of health facilities.			
	<p>*WHO-recommended essential core list of medicines: bronchodilator inhaler, steroid inhaler, glibenclamide, metformin, insulin, angiotensin-converting-enzyme (ACE) inhibitor, calcium channel blocker, statin, aspirin, thiazide diuretic, beta-blocker, omeprazole tablet, diazepam injection, fluoxetine tablet, haloperidol tablet, carbamazepine tablet, amoxicillin tablet/capsule, amoxicillin suspension, ampicillin injection, ceftriaxone injection, gentamicin injection, oral rehydration salts, zinc sulfate.</p> <p>Essential NCD medicines: at least aspirin, a statin, an ACE inhibitor, thiazide diuretic, a long-acting calcium channel blocker, metformin, insulin, a bronchodilator and a steroid inhalant.</p> <p>Priority medicines for women and children: amoxicillin tablet/capsule, amoxicillin suspension, ampicillin injection, ceftriaxone injection, gentamicin injection, oral rehydration salts, zinc sulphate, oxytocin injection, magnesium sulphate injection.</p> <p>Suggested core list of medicines for pricing/affordability surveys: Salbutamol inhaler 100 mcg per dose (200 doses); beclomethasone inhaler 100 mcg/dose (200 doses); glibenclamide 5 mg tablet; metformin 500 mg tablet; insulin regular 100 IU/ml, 10 ml vial; enalapril 5 mg tablet; amlodipine 5 mg tablet; simvastatin 20 mg tablet; aspirin 100 mg tablet; hydrochlorothiazide 25 mg tablet; carvedilol 12.5 mg tablet; omeprazole 20 mg tablet; diazepam 10 mg/2 ml injection; fluoxetine 20 mg tablet; haloperidol 5 mg tablet; carbamazepine 200 mg tablet; amoxicillin 500mg capsule/tablet; amoxicillin 250 mg/5 ml suspension; ampicillin 500 mg injection; ceftriaxone 1 G vial; gentamicin 80 mg/2 ml injection; oral rehydration salts (sachet for 1 litre); zinc sulfate 20mg tablet; oxytocin injection (5 or 10 iu); magnesium sulfate 50% injection 10 ml vial.</p>				
2.6	Diabetes-related amputation rate (non-accidents)	<i>Definition under development as part of MANA dashboard. Focus on lower limb amputations excluding digit only. Exclude traumatic amputations not associated with diabetes.</i>	Preferred: Published reports:	Age; Sex; Place of residence.	-
2.7	Share of total taxes in the retail price of cigarettes	Share of total taxes in the retail price of most widely sold brand of cigarettes. Rating: 0 No tobacco tax collected; 1 Tobacco tax legislation in development, or tax is <25%; 2 Tobacco tax over 25% of retail price	Preferred: Administrative reporting systems. Published reports:	-	NCD
2.8	Excise taxation system for alcoholic drinks	Excise taxation system is based on ethanol content or beverage type. Rating: 0 No alcohol excise tax; 1 Alcohol excise taxation is being developed based on beverage type or ethanol content; 2 Alcohol excise taxation	Preferred: Administrative reporting systems. Published reports:	Star rating.	NCD



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
		system is in place and based on ethanol content or beverage type.			
2.9	Level of tax on all sweetened-sugary beverages (SSBs)	<i>Definition under development as part of MANA dashboard. Will include all SSBs (sweetened milk, juice drinks, energy drinks, sodas, cordials and drink mixes). Focus on excise rather than import tax.</i>	Preferred: Administrative reporting systems. Published reports:	-	NCD
2.10	NCD multi-sector taskforce established and operational	A genuine multi-sectoral taskforce or equivalent has been established, is operating with clear, regular high-level lines of communication, is inclusive of all relevant stakeholders and there is evidence that it is catalysing and monitoring actions on NCDs. Rating: 0 A multi-sectoral NCD taskforce has not been established, or is in active (meets <twice annually); 1 There is evidence that a multi-sectoral NCD taskforce is being established, or no reports are available; 2 Multi-sectoral NCD taskforce established and operating (2+ meetings annually) and annual reports (or equivalent) are available.	Preferred: Administrative reporting systems. Other: Published reports:	-	NCD
COMPLEMENTARY indicators					
2.11	Deaths and injuries from occupational exposure and accidents	<i>Definition in development as part of the SDGs.</i>	Preferred: Published reports:	Age; Sex; Place of residence.	SDGs
2.12	Demand for family planning satisfied with modern methods	Percentage of women of reproductive age (15-49 years) who are sexually active and who have their need for family planning	Preferred: Population-based health surveys. Other:	Age; Marital status; Place of residence.	SDGs



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
		<p>satisfied with modern methods.</p> <p>Numerator: Number of women with family planning demand who use modern methods; Denominator: Total number of women in need of family planning.</p>	Published reports:		
2.13	Cervical cancer screening	<p>Proportion of women aged 30–49 years who report they were screened for cervical cancer using any of the following methods: visual inspection with acetic acid/vinegar (VIA), pap smear, human papilloma virus (HPV) test.</p> <p>Numerator: Number of women aged 30-49 years who report ever having had a screening test for cervical cancer using any of these methods: VIA, pap smear and HPV test; Denominator: All female respondents aged 30-49 years.</p>	<p>Preferred: Population-based (preferably nationally representative) surveys.</p> <p>Other: Facility-based data.</p> <p>Published reports:</p>	Age; Place of residence.	NCD
2.14	Coverage of services for severe mental health disorders	<p>Percentage of persons with a severe mental health disorder (psychosis, bipolar affective disorder, moderate-severe depression) who are using services.</p> <p>Numerator: Number of people receiving services; Denominator: Total number of people in need.</p>	<p>Preferred: Household surveys.</p> <p>Other: Facility information systems.</p> <p>Published reports:</p>	Age; Sex.	-
2.15	Current tobacco use among persons aged 15 years and over	<p>Age-standardized prevalence of current tobacco use* among persons aged 15+ years.</p> <p>Numerator: Number of</p>	<p>Preferred: Population-based (preferably nationally representative) survey.</p>	Age; Sex; Place of residence.	SDGs



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
		<p>current tobacco users aged 15+ years. “Current users” include both daily and non-daily users of smoked or smokeless tobacco; Denominator: All respondents of survey aged 15+ years.</p>	<p>Other:</p> <p>Published reports:</p>		
<p>*“Smoked tobacco products” include the consumption of cigarettes, bidis, cigars, cheroots, pipes, shisha (water pipes), fine-cut smoking articles (roll-your-own), krekets, and any other form of smoked tobacco. “Smokeless tobacco” includes moist snuff, plug, creamy snuff, dissolvable, dry snuff, gul, loose leaf, red tooth powder, snus, chemo, Gurkha, chain, gudakhu, zarda, quiwam, dohra, tuibur, nasway, naas/naswar, shammah, betel nut, toombak, pan (betel quid), iq’mik, mishri, tapkeer, tombol and any other tobacco product that is sniffed, held in the mouth, or chewed.</p>					
2.16	Intimate partner violence	<p>Percentage of currently partnered girls and women aged 15-49 years who have experienced physical and/or sexual violence by their current intimate partner in the last 12 months.</p> <p>Numerator: Number of girls and women who currently have an intimate partner, and who report experiencing physical or sexual violence by their current intimate partner in the past 12 months; Denominator: Total number of girls and women aged 15-49 years surveyed who currently have or had an intimate partner.</p>	<p>Preferred: Household surveys.</p> <p>Other:</p> <p>Published reports:</p>	Age group.	SDGs
2.17	Heavy episodic drinking	<p>Adults (aged 18+ years) who report drinking six (60g) or more standard drinks in a single drinking occasion.</p> <p>Numerator: Number of adults reporting consuming 60g or more of pure alcohol on at least one occasion monthly; Denominator: all respondents of the survey.</p>	<p>Preferred: Population-based (preferably nationally representative) survey.</p> <p>Other:</p> <p>Published reports:</p>	Age; Place of residence; Sex.	NCD
2.18	Insufficiently physically active adults	Age-standardized prevalence of insufficiently	<p>Preferred: Population-based</p>	Age; Place of	NCD



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
		<p>physically active~ persons aged 18+ years.</p> <p>Numerator: Number of respondents where all three of the following criteria are true: Weekly minutes* of vigorous activity <75 minutes, Weekly minutes* of moderate activity <150 minutes, Weekly metabolic equivalent minutes** <600 * Weekly minutes are calculated by multiplying the number of days on which vigorous/moderate activity is done by the number of minutes of vigorous/moderate activity per day. ** Weekly metabolic equivalent minutes are calculated by multiplying the weekly minutes of vigorous activity by 8 and the number of weekly minutes of moderate activity by 4 and then adding these two results together; Denominator: All respondents of the survey aged 18+ years.</p>	<p>(preferably nationally representative) survey (i.e. STEPS).</p> <p>Other:</p> <p>Published reports:</p>	<p>residence; Sex.</p>	
<p>~Percentage of adults aged 18+ years not meeting any of the following criteria: 150 minutes of moderate-intensity physical activity per week; 75 minutes of vigorous-intensity physical activity per week; an equivalent combination of moderate- and vigorous-intensity physical activity accumulating at least 600 metabolic equivalent minutes per week (minutes of physical activity can be accumulated over the course of a week but must be of a duration of at least 10 minutes).</p> <p>*Metabolic equivalent (MET) is the ratio of a person’s working metabolic rate relative to the resting metabolic rate. One metabolic equivalent is defined as the energy cost of sitting quietly and is equivalent to a caloric consumption of 1 kcal/kg per hour. Physical activities are frequently classified by their intensity, using the metabolic equivalent as a reference.</p>					
3. Children are nurtured in body and mind					
CORE indicators					
3.1	Under-five mortality rate	The probability of a child born in a specific year or period dying before reaching the age of 5 years, if subject to age-specific mortality rates of that period, expressed per 1000	<p>Preferred: Civil registration with high coverage.</p> <p>Other: Census and surveys</p>	Sex; Place of residence.	SDGs



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
		live births. Numerator: number of deaths among children aged 0-4 years (0-59 months of age); Denominator: number of live births (person-years of exposure).	Published reports: UNICEF 'State of the World's Children' (annual); WHO 'World Health Statistics' (annual); SPC 'NDMIs'.		
3.2	Infant mortality rate	The probability that a child born in a specific year or period will die before reaching the age of 1 year, if subject to age-specific mortality rates of that period, expressed as a rate per 1000 live births. Numerator: number of children who died before their first birthday (0-11 months of age); Denominator: number of live births (years of exposure).	Preferred: Civil registration with high coverage. Other: Census and surveys. Published reports: UNICEF 'State of the World's Children' (annual); SPC 'NMDIs'; WHO 'World Health Statistics' (annual) SPC 'NDMIs'.	Sex; Place of residence.	SDGs
3.3	Neonatal mortality rate	Probability that a child born in a specific year or period will die during the first 28 completed days of life if subject to age-specific mortality rates of that period, expressed per 1000 live births. Numerator: number of children who died during the first 28 days of life; Denominator: number of live births (years of exposure).	Preferred: Civil registration with high coverage. Other: Census and surveys. Published reports: UNICEF 'State of the World's Children' (annual); SPC 'NMDIs'; WHO 'World Health Statistics' (annual); SPC 'NDMIs'.	Place of residence.	SDGs
3.4	Adolescent birth rate	Annual number of births to women aged 15-19 years per 1000 women in that age group. Numerator: number of live births to women aged 15-19 years;	Preferred: Civil registration with high coverage; census and surveys. Other: Population census; household	Marital status; Age (girls <15 years of age); Place of residence.	SDGs



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
		Denominator: exposure to childbearing by women aged 15-19 years.	surveys. Published reports: UNICEF 'State of the World's Children' (annual); SPC 'NMDIs'; WHO 'World Health Statistics' (annual).		
3.5	Low birth weight among new-borns	Percentage of live births that weigh less than 2500 grams. Numerator: number of live-born neonates with weight less than 2500g at birth; Denominator: number of live births.	Preferred: Administrative information systems. Other: Population-based health surveys. Published reports: UNICEF 'State of the World's Children' (annual); SPC 'NMDIs'.	Place of residence.	SDGs
3.6	Births attended by skilled health personnel	Percentage of live births attended by skilled health personnel during a specified time period. Numerator: number of births attended by skilled health personnel (doctors, nurses or midwives) trained in providing life-saving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, childbirth and the postpartum period, to conduct deliveries on their own, and to care for newborns; Denominator: the total number of live births in the same period.	Preferred: Household surveys. Other: Routine facility information systems. Published reports: UNICEF 'State of the World's Children' (annual); SPC 'NMDIs'; WHO 'World Health Statistics' (annual).	Age; Place of residence.	SDGs
3.7	Birth registration coverage	Percentage of births that are registered within 12 months in a civil registration system.	Preferred: Household surveys.	Place of residence; Sex.	SDGs



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
		<p>Numerator: number of births registered; Denominator: total number of births.</p>	<p>Other: Civil registration and vital statistics systems.</p> <p>Published reports: UNICEF 'State of the World's Children' (annual); WHO 'World Health Statistics' (annual).</p>		
3.8	Evidence of healthy food policies in schools	<p>Evidence of national endorsed policy or guidelines, which are enforceable, mandating/controlling food supply in schools and on school grounds.</p> <p>Rating: 0 No evidence of endorsed policy or guidelines; 1 There is evidence that policies or guidelines are in development; 2 Policy or guidelines are developed, endorsed and communicated.</p>	<p>Preferred: Administrative information systems.</p> <p>Other:</p> <p>Published reports:</p>	-	-
COMPLEMENTARY indicators					
3.9	Antenatal care coverage	<p>Percentage of women aged 15-49 years with a live birth in a given time period who received antenatal care, four times or more.</p> <p>Numerator: number of women aged 15-49 years in a given time period who received antenatal care four times or more; Denominator: total number of women aged 15-49 years with a live birth in the same period.</p>	<p>Preferred: Household surveys.</p> <p>Other: Routine facility information systems.</p> <p>Published reports: UNICEF 'State of the World's Children' (annual); SPC 'NMDIs'.</p>	Age; At least one visit; Place of residence.	UNICEF
3.10	Care seeking for symptoms of pneumonia	Percentage of children under five years of age with suspected pneumonia	Preferred: Household survey.	Place of residence; Sex.	WHS



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
		<p>(cough and difficult breathing not due to a problem of the chest and a blocked nose) in the two weeks preceding the survey taken to an appropriate health facility or provider.</p> <p>Numerator: Number of children with suspected pneumonia in the two weeks preceding the survey taken to an appropriate health provider; Denominator: Number of children with suspected pneumonia in the two weeks preceding the survey.</p>	<p>Other:</p> <p>Published reports:</p>		
3.11	Children under five years old who are overweight	<p>Prevalence of weight-for-height in children aged 0-59 months defined as above +2 standard deviations of the WHO Child Growth Standards median.</p> <p>Numerator: number of children aged 0-59 months who are overweight; Denominator: number of children aged 0-59 months who were measured.</p>	<p>Preferred: National nutrition surveys; growth monitoring clinical records via national surveillance systems.</p> <p>Other: Population-based surveys with nutrition modules. Published reports: UNICEF 'State of the World's Children' (annual); WHO 'World Health Statistics' (annual); SPC 'NMDIs'.</p>	Age; Place of residence; Sex.	SDGs
3.12	Children under five years old who are stunted	<p>Percentage of stunted (moderate and severe) children aged 0-59 months.</p> <p>Moderate stunting: height-for-age below -2 standard deviations from the WHO Child Growth Standards median;</p>	<p>Preferred: Population-based household surveys.</p> <p>Other: National surveillance systems. Published reports:</p>	Age; Place of residence; Sex.	SDGs



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
		<p>Severe stunting: height-for-age below -3 standard deviations from the WHO Child Growth Standards median.</p> <p>Numerator: number of children aged 0-59 months who are stunted; Denominator: total number of children aged 0-59 months that were measured.</p>	<p>UNICEF 'State of the World's Children' (annual); WHO 'World Health Statistics' (annual).</p>		
3.13	Exclusive breastfeeding rate	<p>Percentage of infants 0-5 months of age who are fed exclusively with breast milk.</p> <p>Numerator: number of infants 0-5 months of age who are exclusively breastfed; Denominator: Total number of infants 0-5 months of age surveyed.</p>	<p>Preferred: Household surveys or specific-population based surveys.</p> <p>Other: Routine growth monitoring clinical records.</p> <p>Published reports: UNICEF 'State of the World's Children' (annual); WHO 'World Health Statistics' (annual)</p>	<p>Sex; Place of residence.</p>	SDGs
3.14	Insufficient physical activity in adolescents	<p>Percentage of adolescents (10-19 years) participating in less than 60 minutes of moderate to vigorous intensity physical activity daily.</p> <p>Numerator: number of respondents for whom the number of days per week with <60 minutes of moderate to vigorous intensity activity is <7 days; Denominator: All adolescent respondents of the survey.</p>	<p>Preferred: School-based or population-based (preferably nationally representative) survey.</p> <p>Other:</p> <p>Published reports:</p>	<p>Age group; Place of residence; Sex.</p>	NCD
3.15	Overweight and obesity in adolescents	<p>Percentage of adolescents (10-19 years) who are</p>	<p>Preferred: Population-based</p>	<p>Age group; Place of</p>	NCD



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
		<p>overweight (defined as having a BMI ≥ 25 kg/m²) and obese (defined as having a BMI ≥ 30 kg/m²).</p> <p>Numerator: Number of respondents aged 10-19 years who are overweight. Number of respondents aged 10-19 years who are obese;</p> <p>Denominator: All respondents of the survey aged 10-19 years.</p>	<p>survey in which height and weight were measured.</p> <p>Other:</p> <p>Published reports: SPC 'NMDIs' (<i>obese only</i>); WHO NCD Statistics.</p>	residence; Sex.	
(4) Ecological balance is promoted					
CORE indicators					
4.1	Evidence of climate change policies	<p>Evidence of a formally communicated, integrated low-carbon, climate-resilient, disaster risk reduction development strategy (e.g. a national adaptation plan process, national policies and measures to promote the transition to environmentally friendly substances and technologies.</p> <p>Rating: 0 No evidence of climate change policies; 1 There is evidence that climate change policies are being established, or no reports are available; 2 Climate change policies are developed, implemented and resourced.</p>	<p>Preferred: Administrative information systems.</p> <p>Other:</p> <p>Published reports: Adapting to the health impacts of climate change in a sustainable manner. Damian Hoy, Adam Roth, Christelle Lepers, Jo Durham, Johann Bell, Alexis Durand, Padma Narsey Lal and Yvan Souares; Globalization and Health 2014, 10:82.</p>		SDGs
COMPLEMENTARY indicators					
4.2	Deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	<i>Definition in development as part of the SDGs.</i>	<p>Preferred:</p> <p>Other:</p> <p>Published reports:</p>	Age; Place of residence; Sex.	SDGs
4.3	Population using	Percentage of	Preferred:	Place of	SDGs



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
	modern fuels for cooking/heating/lighting	households/population using modern fuels and technologies for cooking/heating/lighting as defined by the recommendations set forth in the WHO guidelines for indoor air quality: household fuel combustion. Numerator: Number of households (population) using modern fuels and technologies for cooking/heating/lighting; Denominator: Total number of households (population).	Household surveys; population census. Other: Estimation and modelling. Published reports:	residence; Fuel type; End use (i.e. cooking, heating, lighting).	
4.4	Population using safely managed drinking-water services	Population using a basic drinking-water source (piped water into dwelling, yard or plot; public taps or standpipes; boreholes or tube wells; protected dug wells; protected springs and rainwater) which is located on premises and available when needed; free of faecal (and priority chemical) contamination and/or regulated by a competent authority. Numerator: Population using safely managed drinking-water services; Denominator: Total population.	Preferred: Household surveys; population census; data from administrative or regulatory frameworks. Published reports: SPC 'NMDIs'.	Place of residence.	SDGs
4.5	Population using safely managed sanitation services	Population using a basic sanitation facility (flush or pour-flush toilets to sewer systems, septic tanks or pit latrines, ventilated improved pit latrines, pit latrines with a slab, and composting toilets) which is not shared with other households and where	Preferred: Household surveys; population census; data from administrative or regulatory frameworks. Published reports:	Place of residence.	SDGs



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No.	Indicator name	Definition ¹	Data source(s)	Disaggregation variables	Link to other frameworks ²
		<p>excreta are safely disposed in situ (e.g. in a sealed latrine pit until they are safe to handle and re-use, such as an agricultural input) or transported to a designated place for safe disposal or treatment (e.g. treatment facility or hygienically collected from septic tanks or pit latrines by a suction truck or similar equipment that limits human contact and thereafter transported to a designated location such as a treatment facility or solid waste collection site).</p> <p>Numerator: Population using safely managed sanitation services; Denominator: Total population.</p>	SPC 'NMDIs'.		

Issues for group discussion:

- 1) Whether there is a need to develop additional core indicators, refer to Table 1
- 2) Whether there is a need to change the indicators, refer to Table 2
- 3) Whether it is necessary to develop 'optional' 3 indicators separate from the 'core' and 'complementary' indicators, refer to Table 3
- 4) Review the 'core' and 'complementary' indicators (page 4-18) and their 'definition' and 'data sources'. Whether there are any better data sources (global estimation, global annual report mechanism, etc.)
- 5) Feedback on the proposed online reporting mechanism, page 19-21

Strengthening leadership, governance and accountability (PNG, Australia, Cook Islands, New Caledonia, CNMI, Samoa, Tokelau, USA)

Presenter: Solomon Islands

Reducing avoidable disease burden and premature death (Guam, Fiji, Palau, Tuvalu, Australia)

Presenter: Wendy Snowdon

Nurturing children in body and mind (Marshall Islands, New Zealand, Australia)

³ To cater for countries who wish to report on indicators specific to national reporting requirements?



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Presenter: (SPC)

Promoting ecological balance (Tonga, Vanuatu)

Presenter: Tonga

Discussion

34. SPC suggested that the meeting consider the relevance of data for collection.
35. Meeting discussion on group 2 violence against women. Cook Islands indicated that this will be a difficult indicator to capture at the country level – women are speaking out more, but still under-reported. The first point of care is family, not hospitals and police. This will be a very difficult indicator to report on, and requested advice from the meeting about what countries were expected to report on.
36. Tonga asked whether these types of issues should be left as complementary indicators, and not be moved up to core. Cook Islands confirmed that this would be appropriate.
37. What the groups have recommended, and shifting between complementary and core, will be compiled.

ITEM 5: Reproductive, maternal, new-born and child health

Pacific Framework for Regionalism – A Review of Cervical Cancer Situation and Response in the Pacific Island Countries and Territories (PICTs)

38. The purpose of the session was to provide an overview of the cervical cancer situation and response in the Pacific region, and to discuss policy considerations and an operational research agenda for the region. It was not intended as a detailed individual analysis of the situation in and response of specific PICTs. The delegate discussed cervical cancer in the Pacific region in the context of global prevalence – it is a serious cancer globally and in the region. The Pacific Region carries a high burden of cervical cancer, with approximately 800 new cases of cervical cancer and 500 preventable deaths per year.
39. Human Papilloma Virus (HPV) is the most common sexually transmitted infection (STI) globally, and oncogenic types 16 and 18 are the major cause of cervical cancer. Persistent infection with oncogenic, high-risk HPV genotypes is strongly associated with the development of cervical cancer. A large majority (>80%) of cervical cancer cases occur in the less developed regions, where it accounts for almost 12% of all female cancers.
40. The delegate discussed primary and secondary prevention. The major primary prevention is HPV vaccines. The main secondary prevention is cervical cancer screening, which is effective if the cancer is caught early. Cost is a factor in the region, in terms of structured screening methods and capacity issues.
41. Cost-effective, evidence-based and feasible primary and secondary prevention strategies exist, but are not compressively implemented in the region. Cancer screening is not routinely available or conducted in most PICTs, with only two of 21 PICTs having achieved coverage of cervical cancer above 40%.



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42. Given the burden of cervical cancer within the region, there is a need for a coordinated effort to implement vaccination and screening programmes as a means to reduce morbidity and mortality among Pacific Island women.
43. Given the nature of the Pacific region, with many small island countries, a regional approach to review current cervical cancer prevention practices and to develop plans to address cervical cancer prevention is important.
44. There is also a need for policy coordination in the areas of collaboration for the development of effective implementation plans, a joint pool of technical assistance, bulk vaccine procurement and the development of a joint operational research agenda.
45. Specific policy coordination was proposed:
 1. HPV vaccination in national immunisation schedules should be included in all PICTs as a means to improve women's health and survival throughout the region.
 2. Using annual Gross Domestic Product per capita as the threshold for cost-effectiveness, HPV vaccination of adolescent girls in the Pacific is estimated to be cost-effective and potentially cost-saving, particularly given that a two-dose rather than a three-dose regime is now recommended. The current price of the vaccine would still constitute a large part of the health budget for many PICTs. A regional financing mechanism allowing bulk purchase for economies of scale, and reliable vaccine supplies, should be explored to support national vaccination programmes.
 3. Reaching high coverage rates of HPV vaccination is essential for achieving the full preventive effect of the vaccine. School-based delivery systems have been shown to be the most effective approach to achieving high vaccine coverage among adolescent girls in other parts of the world. Independent of which delivery mechanisms PICTs opt for, it is essential to ensure adequate monitoring to improve current vaccination coverage and for continuous improvement and evaluation of the effects of the prevention programme.
 4. The currently available vaccines can prevent only up to 70–80% of cervical cancers with optimal coverage. PICTs' national cervical screening programmes should therefore be strengthened by ensuring adequate monitoring and follow-up for achieving appropriate coverage rates among PICT women. However, this endeavour should not delay vaccine introduction.
 5. HPV vaccine is a well-established prevention strategy against cervical cancer globally, but the Pacific region has its specific limitations and barriers, and also often lacks country-specific data. Therefore, addressing operational research questions is essential to improving the effective introduction and monitoring of HPV prevention in PICTs.
 6. PICTs vary greatly in size and health programme capacity. Typically, there are few resources available to introduce and monitor interventions. Several development and technical partners are involved in cervical cancer prevention in the region. In order to ensure coordinated, high-level technical support, and to assess what resources are important and available, and how to best benefit from them, a Regional Consensus is needed with the aim to:
 - develop regional targets, an operational research agenda and an action plan for cervical cancer prevention in the region; and
 - establish a network of experts and Expanded Programme on Immunisation (EPI) focal persons within Ministries of Health within the region to ensure continuous and coordinated efforts towards reducing HPV related morbidity and mortality.
46. Specific operational research questions were proposed:
 1. How is HPV vaccination to girls and/or boys perceived and accepted in PICTs?
 2. What is needed in terms of baseline and monitoring to evaluate the effect of the HPV vaccine?



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3. What vaccine coverage is needed for eradication/elimination of cancerous HPV in a small island population?
4. What is the most efficient mode of vaccine delivery in the PICTs?
5. How could cervical cancer screening programs (including HPV testing) complement HPV vaccination programmes?
6. What is the cost of vaccine delivery in island states and what is the cost-effectiveness ratio for HPV vaccination in different PICTs?
7. What support from regional and international actors are most important for a successful vaccination program implementation in a PICT setting?

Expanded Programme on Immunisation (EPI) – Strengthening Immunisation Programs in the Pacific

47. Two delegates summarised a consultant's report, Strengthening Immunisation Programs in the Pacific. Immunisation is a global 'best buy' and the backbone of primary health care. While considerable progress has been made in the Pacific, delivering substantial benefits, the gains are fragile and immunisation faces continuing challenges across the region. The summary report draws on a larger study of immunisation in the Pacific. A Heads of Health sub-committee endorsed the terms of reference for this larger study, and asked that this summary report be presented to the full Heads of Health meeting. It presents an overview of the immunisation situation in the Pacific, key issues and problems, and presents possible options for Heads of Health consideration.

48. Key messages from the report:

- Immunisation has delivered substantial benefits in the Pacific and is central to primary health care. It remains a global 'best buy' in public health and should be a high priority for government health expenditure.
- All Pacific Island countries have remained polio-free since 1989; endemic transmission of measles has been interrupted; all countries except Papua New Guinea (PNG) have eliminated maternal and neonatal tetanus; and Hepatitis B infection rates have been substantially reduced.
- Despite significant progress, immunisation programmes remain fragile. Vaccination coverage is inadequate to prevent outbreaks of vaccine-preventable diseases that pose an ongoing threat to all countries.
- In 2015 all global and regional immunisation targets, with the exception of the introduction of new and underused vaccines, are off track.
- New vaccines promise to further improve health outcomes; however sustainability is a mounting concern, and the cost may be unaffordable without ongoing external support.
- Health budgets are stretched by multiple demands; external support is reducing; and countries have limited room for fiscal expansion. Ministers of health have recognised that available resources could be used more effectively.
- Immunisation is one of many core health services that are undermined by severe health system constraints that impact on access, equity, quality and overall performance of programmes. It is not possible to deliver and sustain high levels of vaccination coverage without strengthening the wider health system.
- Most future gains will be made through action at the country level to strengthen health and immunisation systems. The effectiveness of sector leadership, performance management and accountability for results will be important factors in assuring these gains.
- There are opportunities to improve the effectiveness of development assistance to better support country plans, budgets and systems.



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- Immunisation is a regional public health good and, as such, there is a clear case for greater oversight at the regional level, through the meetings of Heads of Health, to monitor risk, highlight key issues of concern and initiate coordinated action before outbreaks occur.
- Establishment of a Strategic Advisory Group (SAG) at the regional level could improve coordination around an immunisation and health systems strengthening agenda.

49. The paper made two key proposals, based on raising the visibility of critical immunisation issues with senior members of government and development partners:

- Proposal 1: Include immunisation as a standing agenda item at meetings of Heads of Health, linked to a broader discussion on health security.
- Proposal 2: Establish a Standing Advisory Group on immunisation, to support under-performing countries and bring issues to the attention of heads of health.

50. Recommendations made by the presentation:

51. At the country level:

- Focus on more effective and efficient use of existing resources, given falling aid levels and limited fiscal space in PICs
- Integrate immunization programs and strengthen the health system that underpins progress: good planning and budgeting is key
- Ensure the sustainability of financing for New Vaccines.

52. At the regional level:

- Immunisation is a regional public health good, low coverage is a threat to all: there is a rationale for regional action
- A range of global and regional immunization frameworks already exist: the challenge is to improve accountability.

Discussion

53. The meeting indicated general support for the value of a regional approach and standards although individual countries noted resource and other constraints.

54. There was also a suggestion [Samoa] for a requirement to have a record of up-to-date immunisation for movement between countries.

55. There was some disagreement [Tonga] about the accuracy of statistics presented for immunisation rates that was presented.

56. Comments stressed the importance of not losing the focus on sustaining the gains made already on immunisation.

57. The regional protection factor was raised: when all countries have high immunisation rates the region is protected.

58. The issue was raised of the need to avoid complacent populations who don't see outbreaks of once-common diseases.



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59. The Chair summarised the discussions from Day 1.

ITEM 6: Remarks by Fiji National University (FNU) VC – The Role of FNU in developing a Sustainable Pacific Human Resource for Health

60. The Vice-Chancellor presented the rich academic and cultural history of Fiji National University, and the Medical School, and noted the development of cutting edge accredited courses in the training of health care personnel both in the region and internationally. The presentation was noted with appreciation.

61. Among interested discussion, RMI asked about FNU medical professionals to do training outside. FNU is happy to provide in-country training, especially where there is funding, but it is essential to 'keep the home fires burning', and not disadvantage local students. As FNU looks to provide in-country training outside Fiji, it is essential to ensure that FNU can attract short-term high-level staff to take care of students in Fiji.

ITEM 7: Remarks from USP – Opportunities for Human Resource capacity in the Region

62. The Associate Professor outlined the unique regional nature of USP – One of two regional universities in the world (the other is the University of the West Indies).

63. Public health programmes:

- Offered at the University of Papua New Guinea and the Fiji National University
- Both are located in the Medical Schools
- Regional forums continue to highlight the lack of health professionals in the regional, particularly those in the area of health management
- The region is not well served in the area of public health.

64. USP's School of Public Health:

- A stand-alone school independent of a medical school
- Purely to address issues of obesity, diabetes and other NCDs, problems related to climate change, urbanisation, health risks following natural disasters, periodic epidemics of vector borne diseases, health management, etc.
- Focus on maintenance of health and prevention of diseases.

65. The approach for programme development in public health:

- Develop high quality programmes at undergraduate and postgraduate levels
- Complement what other institutions are offering
- Have multiple entry points and pathways into the programme
- Include all relevant stakeholders in the development of the programmes to ensure they meet the demands of PICs.

66. Future plans for the public health area include the following:

- Continue consultations with relevant stakeholders
- Invite stakeholder input into programme development
- Identify relevant accrediting/registration body as a quality assurance measure
- Work with national institutions that offer Certificates and Diplomas to investigate cross credit arrangements.



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67. There was discussion around joint programmes and donor support for the Pacific in areas that are important to the Pacific, such as New Zealand.

ITEM 8: Epidemic Preparedness and Response

Pacific Public Health Surveillance Network (PPHSN) – 20 years on: Accomplishments, challenges and way forward

68. The SPC presentation outlined the value of the PPHSN, and described where we are now, where we want to be, challenges, and proposals and strategies for progress in the PPHSN.

69. PPHSN provides regional solutions to national issues on surveillance, ensures regional health security, and contributes to the national, regional and international health development agenda.

70. Challenges were presented for the programmes: PacNet, LabNet, EpiNet, PICNet, PSSS and SHIP/DMM:

71. PacNet:

- Delay in sharing of information and unwillingness on countries to share information
- Service of PacNet-restricted not fully used by countries
- Need for further technical improvements to quality of data shared.

72. LabNet:

- Effective collaboration between Clinical laboratories and Public Health laboratories
- LQMS implementation
- Dissemination of LQMS to district and sub district levels
- Funding issues
- Effective collaboration between Clinical laboratories and Public Health laboratories
- LQMS implementation
- Dissemination of LQMS to district and sub district levels
- Funding issues.

73. EpiNet:

- Formal appointment of national EpiNet Teams and ensuring that appropriate skills are developed through DDM/SHIP or other formal training programmes.
- Ensuring that proper remuneration structures are in place commensurate with qualifications attained so that they are retained.

74. PICNet:

- Ensuring adequate resources to continue services.

75. PSSS:

- Ensure improvements to national surveillance system whilst maintaining a regional system
- Data collected is analysed and used nationally for appropriate public health action and that the system is maintained and improved by countries.

76. SHIP/DMM:

- Ensuring that skills gained from participating in DDM/SHIP lead to practical improvements in surveillance and response in country.



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77. Proposals for progress in the PPHSN were presented:

- Build on strong foundations and strengthen existing services
- System of monitoring and evaluating performance
- Link between communicable and non-communicable disease surveillance is well demarcated and strengthened.

78. Strategies for achieving progress were presented:

- Formal evaluation of PPHSN services and proposed strategy for linking communicable disease and non-communicable disease surveillance
- Clearly define coordination and governance structures for PPHSN that will ensure good governance and accountability to countries, allied partners and development partners
- Strengthen existing services by attracting resources.

Pacific Zika Virus Action Plan – Updates on progress, challenges and way forward

79. WHO presented on the Zika virus background and characteristics, and infection profile. There is no vaccine, and treatment is symptomatic. The paper described the global transmission situation: from 2007 to April 2016, 66 countries and territories have reported Zika virus transmission.

80. The situation of Zika in the Pacific was described:

- First identified in the South Pacific in Yap Island FSM in 2007. Estimated >75% of the population affected. No hospitalisations or complications reported
- ZIKV outbreak occurred in French Polynesia 2013–2014 with DEN 1, 3. Cases of GBS and congenital malformations under investigation
- 2014-16 reported cases/outbreaks from American Samoa, Cook Is, Easter Is, Fiji, Kosrae, FSM, Marshall Islands, New Caledonia, Samoa, Solomon Is, Tonga, Vanuatu
- Closest strain to the one that emerged in Brazil was isolated from samples from case-patients in French Polynesia (Asian lineage).

81. WHO is concerned about the Zika situation based on the following issues:

- Temporal and spatial association between Zika virus outbreaks and an increase in congenital malformations and dysfunctions (including microcephaly) and neurological complications (e.g. GBS)
- Declared a Public Health Emergency of International Concern (PHEIC) on 1 Feb 2016
- Now there is scientific consensus that Zika virus is a cause of microcephaly and GBS (i.e. neurotropic and neurovirulent)
- WHO requests that all countries report their first detection of Zika virus and evidence of outbreaks through the IHR (2005) (International Health Regulations core capacity index).

82. The Zika virus has enormous implications globally and for the Pacific region. Information sharing and technical cooperation about Zika in the Pacific were outlined:

83. Alerts, reports and IHR:

- Pacific Syndromic Surveillance System
- PacNet postings
- WHO websites
 - www.who.int
 - www.wpro.who.int
 - www.paho.org
- EIS – Event Information Site for National IHR Focal Points



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- US CDC
- ECDC.

84. Technical collaboration:

- Between WHO, SPC, CDC and PIHOA
- With Pacific nations/territories
 - Facilitating and funding lab testing with Pacific labs/reference labs
 - Support for SOPs, protocols
 - Contingency planning for Zika
 - Investigating disease clusters potentially related to Zika
 - Bringing in regional and global resources e.g. Global Outbreak Alert and Response Network (GOARN).

85. Prevention is the key to addressing the Zika virus:

- Raise awareness of HCWs about potential Zika risks, especially HCWs providing prenatal care, natal and post-natal care
- Provide risk reduction information to pregnant women, women planning pregnancy, and their male partners
- Promote the use of:
 - Personal insect repellents
 - Mosquito screens in housing and health facilities
 - Appropriate clothing
 - Bed nets when resting during the day
- Information for travellers about mosquito bite prevention.

86. Public health interventions were described:

- Social mobilisation and risk communications
- Scale up vector control, especially source reduction activities e.g. community clean up campaigns to reduce breeding sites
- Review and update dengue/arbovirus prevention and control plans (multi-sectoral coordination)
- Scale up and/or enhance clinical, epidemiological and entomological surveillance. Strengthen surveillance of dengue-like illness (DLI)
- Test cases of DLI for ZIKV and chikungunya when dengue is excluded
- Establish links with international reference laboratories for testing
- Establish baseline incidence of neurological complications and congenital malformations
- Review hospital preparedness / surge capacity (vulnerability mapping)
- Monitor and report birth anomalies and other suspected complications of the virus.

87. Sources of information for the public were described.

88. It was mentioned that IHR core capacity should be in place in countries. It is important in countries having confidence in their ability to respond to common disease outbreaks.

Discussion:

89. RMI has a confirmed case. RMI noted a contingency plan in the presentation, and requested advice about a contingency plan.

90. French Polynesia's (FP) Zika outbreak – it is the worst public health emergency in FP. At the time of the outbreak there was very little information available. Surveillance was of utmost importance in detecting the



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outbreak. Sentinel GPs indicated that they had diagnosed suspicious cases. Originally diagnosed as Dengue, but tests indicated it was Zika. Public health crisis ensued, and caught FP by surprise, given the lack of information about Zika. Hospitals were inundated and ICU services were swamped. Childhood birth anomalies were detected at very high rates. The implications are ongoing for treatment and management. Media was voracious and demanded constant information. Any health crisis immediately translates into a political crisis.

91. FP was commended for its leading work in identifying the link between the virus and birth abnormalities. Risk communication and risk perception is an important planning aspect.
92. Samoa experienced Zika for the first time. Having a separate part of the ministry for disease surveillance has helped to identify and manage outbreaks. Had a positive case in August 2015, and there was a hiatus in diagnoses for several months. Samoa was informed by NZ that there were imported cases in NZ from Samoa. Samoa sent specimens for testing, and one lab gave 50% positive results, and one gave no positive results. Samoa is still experiencing cases but does not know what testing to trust.
93. WHO indicated that it is still not clear what is the best specimen to test. But dry blood on filter paper may not be the appropriate way, because there is not enough blood collected. ESR tests on the bottle of serum. Urine has a higher level than the serum.
94. Discussion about underreporting in the region. Only one in 5 cases are symptomatic so that contributes to that. Also the symptoms are relatively mild so many cases do not present to medical services, which also contributes to underreporting.

ITEM 9: Global and Regional Initiatives

Sustainable Development Goals (SDGs) 2016–2030

Presentation: UNDP

‘Health in the 2030 Agenda: Could less be more?’

95. Two features of this new Agenda succeeding the 8 Millennium Development Goals (MDGs) are noteworthy. First, the increased number of goals and associated targets (169). Second, only one goal: SDG3-Ensure healthy lives and promote well-being for all at all ages appears to be dedicated to health, compared to 3 out of the 8 MDGs. The question is whether that herald less emphasis on health, or whether ‘less is actually more’. The presentation would consider the opportunities and challenges this implies, and outline some of the considerations that led to the formulation of the SDGs. It would then look at the Health goal and targets and indicators as well as issues that cut across many different SDGs to argue that the new Agenda actually presents more opportunities for health than a first glance suggests.
96. *PART 1. The MDG era: Spectacular achievements and limitations*
97. The MDG agenda (2000–2015) rallied a considerable amount of political commitment and resources. It was hailed as ‘the most successful global anti-poverty push in history’. ‘Health’ held a prominent place, with 3 explicitly dedicated Goals (MDGs 4, 5 and 6). The approach focused on a narrow set of diseases (AIDS, TB and malaria) as well as conditions leading to high maternal and infant mortality. The ambition was to significantly reduce morbidity and mortality in developing countries. That strategy was arguably effective.



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98. At the aggregated level, progress has arguably been spectacular. The target of reducing poverty by half has been achieved and even exceeded. Access to improved drinking water (MDG7) was a big win too, with 2.6 billion people reached five years ahead of schedule. Gender parity in primary education (MDG3) which was achieved in two-thirds of the world. On the health front child mortality (MDG4) decreased by 53% and maternal mortality (MDG 5) by 44% (both just shy of the target), and although MDG 6 was not fully met, the HIV, TB and malaria epidemics were largely ‘turned around’.
99. However, these global accomplishments mask profound disparities between and within regions and countries. Despite global achievements progress has been uneven. For example, for global poverty, on one hand it has considerably reduced but this is essentially due to the spectacular performance of relatively few, but enormously populated, countries. Five of these great performers account for half of the world’s population. On the other hand, the majority of the poor now live in Middle Income Countries, and income inequality has dramatically worsened in the recent period. It is now generally considered that one-fifth of the world owns 80% of the global wealth, and the top 1% richest have as much as the bottom 56% poorest. So, in a sense the world has never been richer and more unequal at the same time.
100. The Pacific Islands region mirrors this inequality. Although overall progress on the MDGs was good, vulnerability and exclusion are increasing. Progress in health is also uneven. Despite significant efforts to address communicable, maternal and child health concerns, premature mortality and avoidable morbidity persist, largely owing to the growing burden of non-communicable diseases which were unaddressed in the MDG agenda.
101. *PART 2. From MDGs to SDGs: continue the momentum and respond to emerging challenges*
102. A common criticism of the MDGs is that it was ‘one size fits all, and quite prescriptive. Countries were pointed to the same health priorities, regardless of epidemiological or disease profile. In the Pacific region, for example, funding and technical support from donors through mostly vertical programmes has been disproportionately in favour of communicable and infectious diseases. This has contributed to fragmented activities, distorted resource allocation, segregated expertise and too modest synergies across programmes. Less attention was paid to strengthening health systems. Similarly, cooperation and coherence across sectors with important stakes in health, such as education, food production, trade, transport and infrastructure, and water and sanitation is perhaps not as strong as it could be.
103. So framing a new global health agenda needed to address several dimensions simultaneously. First, the SDGs ambition to be universal. In that sense the framework has to accommodate the needs of countries catering for ageing populations with foreseeable costs (rising), as well as the needs of ‘young’ countries still grappling with high morbidity and mortality from more readily preventable diseases. The process leading to the formulation of the SDGs had a lot to do with that. It was more inclusive and engaged, with multiple levels including the general public. (The World We Want).
104. Second the SDGs have to ‘finish the unfinished businesses’ of the MDGs, and MDGs 4, 5, 6 remain high priorities in their own right – particularly where important disparities persist. At the same time, newly emerging global health challenges are to be tackled. Non-communicable diseases, for example, have surpassed communicable, maternal and perinatal causes of mortality and morbidity, particularly in lower and middle income countries. Diabetes, alone, driven by the intractable global rise in incidence of overweight and obesity has quadrupled since 1980.
105. There are emerging or re-emerging infectious diseases outbreaks and epidemics that remain universal threats (HIV, TB, SARS, H1N1, Ebola, Dengue, Hepatitis, Zika, etc.), while antibiotic resistance is increasing. This leads to a more complex and mixed burden of diseases putting further stress on health systems.



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106. Third, climate change, growing environmental degradation, rapid unplanned urbanisation and dietary and lifestyle shifts all have major impacts, both actual and potential, on human health and on the systems that support it. All of these are clearly beyond the health sector's reach and require more integrated approaches. For multiple health outcomes to be sustained, greater attention on the social, economic and environmental determinants of health – such as housing, transport, urbanisation, resource redistribution, food production and trade – is inevitably needed.
107. Lastly, the earnest resolve of the SDGs to 'leave no one behind' implies a much broader emphasis on social justice, human rights and equity issues in relation to health which are dimensions that were not well addressed under the MDGs.
108. *PART 3. Health in the SDGs Agenda*
109. The wording of SDG3 – 'healthy lives' and 'wellbeing' – implies a much broader scope compared to the diseases-centric MDGs. In March 2016, a set of 13 targets and 26 indicators were agreed. These range from the 'usual suspects' – HIV, TB, malaria, and maternal and child health – to new priorities such as NCDs, neglected tropical diseases, mental health, road traffic injuries, and universal access to sexual and reproductive health. There is also universal health coverage, a focus on pollution related mortality, access to affordable medicines, research and development, a specific target for health financing, workforce development and retention, and strengthened capacity for management of global health risks.
110. Also the interlinkages between the different SDGs form an interlinked 'network':
- SDG3, for example, is closely connected to at least eight other goals which address important social or structural determinants of health
 - SDG2 zero hunger targets malnutrition
 - SDG5 gender equality tackles gender based violence and recognizes unpaid care work
 - SDG6 clean water and sanitation improves environmental health outcomes
 - SDG8 Decent work and economic growth, addresses aspects of occupational health
 - SDG11 Sustainable cities and communities and SDG12 responsible consumption and production deal with some important NCD risk factors.
111. The other SDGs have indicators directly or indirectly relevant to health. Moreover, some targets are relevant to several SDGs at the same time. This is the case for target 3.8, for example, which relates to achieving universal health coverage linking with both inequality (SDG10) and poverty (SDG1). The same for 3.7 linked to education, health and gender, or 3.9 linking health to sustainable cities (11), poverty (1) and water and sanitation (6).
112. This has obvious implications for monitoring. It introduces new complexities that will need to be worked out. For example, to what extent which targets contribute to what goals, and who/which sector is responsible? More targets and indicators also means more data to be produced and analysed. Data then needs to be 'disaggregated by income, sex, age, race, ethnicity, migratory status, disability and geographic location, or other characteristics, in accordance with the Fundamental Principles of Official Statistics (General Assembly resolution 68/261)'. Monitoring the SDGs will require a significant step up for national statistical systems, in developing as well as developed countries.
113. It is evident that the SDGs constitute a much more integrated and interconnected framework than the MDGs. It is in many way much more supportive of 'Health in All policies' than the MDGs were. While the goals are adopted globally, individual countries will now need to undergo a critical process, referred to as 'SDGs localisation'. This will allow them to determine the most relevant targets and indicators in national



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and subnational contexts, and to identify their means of implementation. This will imply a balancing act between sectoral and cross-sectoral action; setting up an institution responsible for inter-ministerial coordination but also to learn from the 'forgotten' MDGs (those goals/targets that were the least mainstreamed into national or local development strategies/plans. These are the sort of things that UNDP, along with other partners, are ready to support.

114. If at first glance the Post 2015 Agenda seems less imposing for global health than its predecessor, in reality it is far more universal, ambitious and perhaps relevant for an increasingly interconnected and rapidly changing world. While the MDGs may be perceived as a 'one size fits all, top down' (albeit successful) framework, the SDGs inversed this, and align the global to the local with a resolute ambition to fill persisting gaps, tackle emerging issues across the development spectrum and leave no one behind. The new Agenda should be well received by the proponents of a more integrated and comprehensive approach to health, particularly for 'Health in All policies'. In addition, by binding all countries – rich and poor – the SDGs may provide greater avenues for cooperation in perhaps a less unilateral way than the previous Agenda.
115. While low and middle income countries will continue to benefit from the technological and financial support from their wealthier counterparts, the latter can also learn from the former. However, a hugely ambitious and more complex agenda inevitably brings its own set of challenges. Nevertheless, it is a much more 'open' agenda than its predecessor, and with much greater coherence between health and other key dimensions of development: the opportunities to get things right have never been greater.
116. The meeting acknowledged the presentation.

Human resources for health

Presentation: Regional Internship Working Group

117. The presentation was titled: *Lessons learned from the return of foreign trained medical graduates into the pacific health workforce*. The delegate took the meeting through the case study of the Cuban health system, in relation to the training of a medical workforce.
118. There is a proliferation of medical training opportunities outside the region — most prominently, in Cuba.
119. Cuban health reflects well on the Cuban health system, including average life expectancy of 77 years.
120. The medical workforce is characterised by:
 - Low salaries (approx. USD 150/month) – high doctor-to-population ratio
 - Highly (sub-)specialised
 - Domestic redundancy – work with Cuban Medical Brigade overseas.
121. Undergraduate medical training has a strong community medicine and humanitarian focus. There are differences in burden of disease, e.g. no malaria, little TB. It is highly theoretical, and short on practical skills.
122. The Pacific Regional Internship Working Group Meeting met in March, with the objectives to examine experiences and identify lessons on the integration and deployment of foreign trained medical graduates (FTMG); and consider whether a Pacific Regional Internship Standard is needed, i.e. for accreditation and recognition — and how that could be achieved. There were discussions based on lessons learned from first



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cohorts of FTMGs returning to Kiribati, Solomon Islands, Tuvalu and Vanuatu (most of whom took internships in Cuba).

123. The Pacific Regional Internship Working Group Meeting produced 12 key principles for implementing medical internship programmes:

1. Case load and case mix
2. Supervisory capacity
 - Minimum of 1 M.Med graduate in each discipline
 - Supervisor:student ratio at least 1:4
 - Clinical/medical education support for supervisors
 - Supplementary role of visiting specialists
 - Importance of pastoral support
3. Minimum core specialties
 - 4 core clinical specialties:
 1. Medicine
 2. Obstetrics and gynaecology
 3. Paediatrics
 4. General and orthopaedic surgery
 - Special topics must include:
 1. Anaesthesia and transport medicine
 2. Ophthalmology
 3. Emergency department
4. Balance between time-based and competency-based approaches
 - Agreed list of competencies (including 'must know')
 - Safe to practise: full medical registration
 - Able to work semi-autonomously in rural or outer island primary care setting in partnership with other HCWs
 - Competent work force can help contain budget risks
 - Continuous and end-of-block assessments
 - Supervisor reports, log book, end-of-block OSCE

Standard = Bridging programme + 2 years
5. Teaching facility (minimum standards for teaching hospital)
6. Structured short courses
 - ACLS, APLS, EmONC, PTC, essential pain management
 - Intern feedback: boosts confidence in complex settings
7. Additional integrative content
 - Primary care, public health, research project
8. HR legislation and standards
 - Formal role/position within health work force
 - Remediation policy for those that do not satisfy requirements within maximum agreed time
9. Links between programme management, regulatory structures
10. Academic accreditation
11. Deployment plans
12. Increase in collaboration between undergraduate training and internship programmes.

Final observations

124. It is possible to run a regional internship programme, but it takes:
- time (sometimes longer than expected)



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- resources (human, financial and health system)
- good collaboration between health, workforce agency, regulatory agency and academic partners
- careful attention to rigorous assessment processes.

125. The programme can generate significant positive externalities (i.e. positive 'ripple effects' on hospital system and health work force).

126. Two higher-level recommendations made by the Regional Internship Working Group:

1. That a generic Regional Internship Standard be developed to guide Pacific Island countries and providers of continuing professional development programs, based on the 12 factors that contribute to a successful internship program
2. That a regional accreditation process be explored for the internship programs operating in the region (flexible, not prescriptive, to accommodate the different needs and circumstances in different PICs):
 - (a) as a quality assurance mechanism, and
 - (b) as a step towards possible regional medical registration.

Discussion:

127. Recommendations made by the presentation:

128. Programmes are not just about Cuba and not just about doctors. It is important to include other categories of health worker in these internships. E.g. nurses and other health workers. On the country level it depends on individual development needs, followed by discussion with development partners. Start with the analysis of the criteria, then assess the required resources.

129. Support for a regional internship that meets these standards. Training should be a regional approach – identifying what we want, and who is going to deliver it. It is still ad hoc, but it is timely to address this agenda at the regional level. Support for standardisation with 12 factors. On recommendation 2, looking for more information on that to make a country decision, based on registration. Presenter identified that R2 has implications for resource mobility.

130. Standardised training was supported, but needs to be looked at in context of the skill set and upskilling that countries have tried to develop in local doctors. Speaker saw no conflict with these legitimate issues and in having a regional benchmark.

131. It would ease the burden on institutions around the region if we set up this regional standardised internship programme.

Chair:

132. The Chair indicated that we must remember our graduates, who undertake five years of medical training, and then a further two years' internship – to ensure that they are not overly burdened through any deficiencies in our systems.

Nursing specialisation: Strengthening specialised clinical services in the Pacific – nursing education and career pathways

Presentation: Director of Nursing, Fiji School of Medicine



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133. The current situation for medical professionals in the Pacific region is represented as follows:
- More doctors are returning to the PICs with specialist training
 - There is increased public demand and expectations for specialist services
 - Clinical nursing is lagging further behind in the delivery of specialist services.
134. Current specialty areas are: midwifery; mental health; primary eye care; nurse practitioner
135. Specialty areas needed are:
- Paediatric and Neo-natal care
 - Perioperative Nursing
 - ICU/ Acute Care Nursing
 - Emergency Medicine Nursing
 - Orthopaedic Nursing
 - ENT Nursing
 - Anaesthetic Nurse Technicians.
136. Sub specialty areas: cardiac, EEG, RHD, dialysis and endoscopy nurses
137. The nursing profession in the Pacific needs:
- Recognition of clinical nursing specialisation
 - Increase PG clinical training programs
 - Career pathways and remuneration
 - More opportunity for clinical nursing scholarships and attachment fellowship
 - Review of legislation and regulations.
138. Proposals:
1. Facilitate a forum for nursing education providers and nursing leaders to develop generic standards, competencies and scope of practice for regional benchmarking of nursing specialisation.
 2. MoH to create and support clinical nursing career pathways and appropriate remuneration.
 3. MoH to consider parallel training in specialist areas (doctor, nursing training).
 4. Consider scholarships for specialised clinical nurse training.

Discussion:

139. The meeting indicated general support for the recommendations.
140. It is necessary to be very clear about what it is countries want to change in their legislation. These are good proposals as far as indicating what MoHs can do. But nursing groups need to understand that remuneration is based on job description, hence the need to look at what is offered out there and what is supported. The question is: should ministries put aside scholarships they can offer, and priorities? Heads of ministries need to go out and determine how to prioritise nursing training – to look at what they want for their countries – and heads should create the pathways for what should happen. The care that nurses provide at the bedside is critical, and sometimes that is not recognised in the job description. It is necessary to let people see that in the job description, and this should support the remuneration claims.
141. The proposal regarding training and specialisation in nursing was supported. Considering small population countries, there are many more nurses than doctors, and they often are the only hospital staff, so are multi-skilled. A range of volume of patients are seen. Nursing training providers could look at lateral entry for nurses to provide support in remote islands.



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142. There is a view that countries cannot avoid having specialist training. Unless this training is effective and meets common standards, the remuneration and job attainment will not be supported.

Chair:

143. The meeting agreed with the recommendations, and the need for pathways for the recognition of skills knowledge and accreditation of training programmes. The meeting recognised the need for legal requirements and amendments to legal policies and legislation at the country level. Heads of health need to be taking that on board and pursuing that through relevant processes in government to get that level of recognition of nursing specialists. The meeting recognised the difficulties in smaller islands and the need for multi-skilling and multi-tasking for nursing professionals.

SSCSiP – 7th Stakeholder Reference Group meeting

144. The meeting noted that at the 7th Stakeholder Reference Group meeting of SSCSiP, held in Suva on 25 and 26 April 2016, the following recommendations were endorsed by country members for presentation to the 4th Heads of Health meeting:
1. Countries to further develop information systems to report on the proposed WHO global surgical indicators (POMR), and to identify technical support to monitor and report on cost benefits, return on Investment.
 2. National workforce plans need to address established and evolving priorities for specialised clinical services delivery (including for example returning Specialists, ENT and audiology, biomedical technology, and nursing related specialties) in order to identify training needs, negotiate scholarship support and predict future workforce gaps.

ITEM 10: Healthy Islands Monitoring Framework – updated version based on group work feedback

145. The meeting discussed the amended framework and made further amendments in accordance with the group work, and these are attached below, as the Healthy Islands Monitoring Framework Version 3.5 (summary).
146. The updated Healthy Islands Monitoring Framework is comprised of 51 mandatory indicators (35 core indicators and 16 complementary indicators):
- 35 core indicators: mandatory and can be collected via routine administrative systems annually
 - 16 complementary indicators: mandatory, but require data collected from surveys, such as census or special household surveys, and as such, would only be updated every five to 10 years pending survey cycles
 - 27 optional indicators: selected countries will use them for their national indicators to monitor the Healthy Islands vision.
147. Proposed next steps:
- 1) HoH to endorse the below list of core indicators
 - 2) HoH to task the Secretariats and Health Information Managers meeting (30 May–1 June 2016) to decide a detailed definition and source of data for each core and complementary indicator, as well as appropriate monitoring mechanism
 - 3) HoH, in collaboration with the Secretariats, to produce its first annual progress report in accordance with this monitoring framework by next year's Pacific Health Ministers Meeting.



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Chair:

148. The next steps were endorsed by the meeting.

Healthy Islands Monitoring Framework Version 3.5 (summary)

(Yellow highlighted parts represent additions or modifications after the HoH meeting discussion on Day 1.)

No	Indicator name	Linkage
(1) Strong leadership, governance and accountability		
1.1	Health worker density and distribution	SDGs
1.2	Total current expenditure on health	WHS
1.3	Death registration coverage	WHS
1.4	International Health Regulations (IHR) core capacity index	SDGs
1.5	Evidence of annual health review and annual health plan with budget	-
Complementary indicators		
1.6	Out-of-pocket payments for health	WHS
	Optional indicators 1.O.1 Evidence of nationally representative National Health Account 1.O.2 Unemployment rate 1.O.3 Proportion of population living below the national poverty line	
(2) Avoidable diseases and premature deaths are reduced		
2.1	Adult mortality rate from NCDs (30 to 59 years)	SDGs
2.2	Number of maternal mortality (or, ratio)	SDGs
2.3	Mortality rate from road traffic injuries	SDGs
2.4	Number of suicide (or suicide rate)	
2.5	Life expectancy at birth	WHS
2.6	Availability of essential medicines and commodities	-
2.7	HIV prevalence among the general population aged 15-49 years	
2.8	PMTCT coverage (pregnant women receiving anti-retroviral treatment for HIV)	
2.9	Service coverage for people with increased risk for CVD	
2.10	Tuberculosis incidence	
2.11	Diabetes-related amputation rate (non-accidents)	
2.12	Share of total taxes in the retail price of cigarettes	NCD
2.13	Excise taxation system for alcoholic drinks	NCD
2.14	Level of tax on all sweetened-sugary beverages (SSBs)	NCD
Complementary indicators		
2.15	Contraceptive prevalence rate	SDGs
2.16	Cervical cancer screening	NCD
2.17	Coverage of services for severe mental health disorders	
2.18	Current tobacco use among persons aged 15 years and over	SDGs
2.19	Intimate partner violence	SDGs
2.20	Heavy episodic drinking	NCD
2.21	Insufficiently physically active adults	NCD
	Optional indicators 2.O.1 Fruit and vegetable consumption 2.O.2 Gonorrhoea incidence rate	



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	2.O.3 Malaria incidence 2.O.4 HIV prevalence among key high-risk populations 2.O.5 Life expectancy at age 60 2.O.6 Top 10 causes of death by age group and gender 2.O.7 Proportion of persons with disabilities who need assistive devices and have them 2.O.8 Status of reaching the milestones of relevant NTDs as envisaged in the global roadmap on NTDs to 2020 2.O.9 Unmet needs for contraception 2.O.10 NCD multi-sector taskforce established and operational	
(3) Children are nurtured in body and mind		
3.1	Under-five mortality rate	SDGs
3.2	Infant mortality rate	SDGs
3.3	Neonatal mortality rate	SDGs
3.4	Adolescent birth rate	SDGs
3.5	Low birth weight among newborns	SDGs
3.6	Births attended by skilled health personnel	SDGs
3.7	Birth registration coverage	SDGs
3.8	Evidence of healthy food policies in schools	-
3.9	Rates of congenital syphilis	
3.10	Rates of HIV positive mothers	
3.11	HPV vaccine coverage among adolescents	
3.12	Immunization coverage rate for DTP3	
3.13	Immunization coverage rate for measles	
Complementary indicators		
3.14	Antenatal care coverage	UNICEF
3.15	Children under five years old who are overweight	SDGs
3.16	Children under five years old who are stunted	SDGs
3.17	Exclusive breastfeeding rate	SDGs
3.18	Insufficient physical activity in adolescents	NCD
3.19	Overweight and obesity in adolescents	NCD
	Optional indicators 3.O.1 Secondary school completion rates 3.O.2 Youth literacy rate 3.O.3 Enrolment in primary school 3.O.4 Evidence of adoption of the convention on the rights of the child 3.O.5 Adolescent suicide rate <i>[amended during plenary discussion Day 2]</i>	
(4) Ecological balance is promoted		
1	Percentage of population using safely managed water services	SDGs
2	Percentage of population using safely managed sanitation services	SDGs
3	Number of projects related to strengthening health systems to be resilient to climate change and natural disaster	
Complementary indicators		
4	Population using modern fuels for cooking/heating/lighting	SDGs
5	Number of vector-borne diseases outbreaks	
	Optional indicators 4.O.1 Typhoid fever incidence 4.O.2 Percentage of urban population living in slums or informal	



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settlements 4.O.3 Population in urban areas exposed to outdoor air pollution 4.O.4 Percentage of urban solid waste regularly collected and well managed 4.O.5 Share of coastal and marine areas that are protected 4.O.6 Annual change in forest area and land under cultivation 4.O.7 Official climate financing from developed countries that is incremental to ODA (in US\$) 4.O.8 Area of public and green space as a proportion of total city space 4.O.9 Losses from natural disasters, by climate and non-climate-related events (in US\$ and lives lost)	
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ITEM 11: Upcoming Meetings

World Health Assembly (WHA) – May

149. The meeting will start on 23 May in Geneva, to close on 28 May or early morning on 29 May. The provisional agenda was attached.

Pacific NCD Summit – June

150. *Translating Global Commitments to Local Action: Nuku'alofa, Tonga, 20–22 June, 2016.* Summit opened by his Majesty King Tupou VI.

151. The underlying objective is to accelerate efforts to address the NCD crisis and address those at the political level. To address the need to engage political leaders. To highlight local efforts that work well in South-South intervention.

152. Aims to:

- address the need for more urgent and stronger high level political leadership;
- review and accelerate implementation of the Pacific NCDs Roadmap;
- highlight local interventions that work;
- strengthen current funding arrangements and explore new sources of funding; and
- identify opportunities to strengthen collaborative efforts to response to NCDs and using diabetes as a practical case study.

153. Partners:

- Australia Department of Foreign Affairs and Trade (DFAT), New Zealand Aid Programme (NZAP), Pacific Community (SPC), United Nations Development Fund (UNDP), World Bank (WB), World Diabetes Foundation (WDF) and World Health Organization (WHO)

154. Programme:

- Day 1: Global Focus
- Day 2: Pacific Region Focus
- Day 3: Diabetes as a case study
- Plan to highlight Pacific programmes from PICTs.

155. Participants:



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- From countries
 - Some Heads of State/Government
 - Either the Minister for Health or CEO
 - NCDs/Diabetes Focal point.
- From partners
 - Australia Department of Foreign Affairs and Trade (DFAT), New Zealand Aid Programme (NZAP), Pacific Community (SPC), United Nations Development Fund (UNDP), World Bank (WB), World Diabetes Foundation (WDF) and World Health Organization (WHO).

156. Keynote speaker: Helen Clark – Administrator, UNDP: SDGs and NCDs

Regional Committee Meeting (RCM) – October

ITEM 12: Other Matters

Pacific Possible

Presentation: World Bank

157. Pacific possible work is based on modelling out 20 years. The initial work is based on 6 countries, and based on the NCD roadmap. This is about strengthening the evidence base for better planning over time.

158. A paper that will come out in May will detail this work more comprehensively. The work will be presented at the NCD Summit in June.

ITEM 13: Key Decision Points

159. The Secretariat presented all decision points, to which minor amendments were made by the meeting.

Chair:

160. The meeting agreed to all decision points.

ITEM 14: Closing

161. WHO and SPC:

162. WHO and SPC expressed gratitude for the excellent leadership of the Chair and Co-Chair, and thanked country representatives and partners to the meeting. WHO and SPC made observations about the health agenda and priorities in the Pacific region – this meeting is an opportunity to listen about and understand Pacific health priorities. The Heads of Health meeting really does belong to the Heads of Health. SPC indicated that it welcomed comments, especially negative comments, so that SPC can better assist and serve the needs and priorities of Pacific Island countries and territories. SPC advised the meeting that half of the Public Health team had moved to Suva, Fiji, in order to better connect to countries and partners.



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Chair:

163. The Chair concluded the meeting. In the last few days the meeting had heard about the burdens of NCDs, cancers, and the many issues of health service delivery in our countries and region. The onus is on all health ministries to lead health progress in our countries and in the Pacific region. The Chair wished all Heads of Health strong leadership and success, as they dwell on strategies in the health areas that the meeting has worked with. The Chair thanked SPC and WHO for assisting the meeting and in the documentation that assisted the decisions. The Chair thanked observes and partners, and looked forward to strengthening those relationships, and wished all safe journeys back to their respective countries.
164. The Chair welcomed Cook Islands as the next Chair, for the 5th Heads of Health Meeting. The location will be advised in due course by WHO and SPC.



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Key Decision Points

Progress in implementing the Pacific NCD Roadmap

The meeting:

- noted progress in implementing the Pacific NCD Roadmap in various Pacific Island countries and territories (PICTs) including tobacco control, taxes on unhealthy food and drinks, and controlling alcohol abuse through tax increases, public awareness and restricted access;
- acknowledged that many PICTs are implementing PEN (Package of Essential NCD Interventions) at national or sub-national level, and making efforts to improve monitoring of NCDs and the availability and accessibility of NCD-related data, such as through STEP and hybrid surveys;
- recognised that further actions are needed, given the extent and scale of the NCD crisis, including acceleration of actions to tackle tobacco use, utilisation of taxes to support behavioural change and support for effective interventions;
- agreed that annual updates be provided to Heads of Health on the status of actions, utilising the Pacific MANA NCD dashboard.

Progress in developing MANA (Pacific Monitoring Alliance for NCD Action)

The meeting:

- agreed that further action is needed at country level to effectively monitor child obesity, but requested that the emphasis is on child health rather than on obesity as an isolated issue;
- noted that monitoring the food environment, including pricing, access in settings, and exposure to advertising, was one of the proposed areas of innovation for Pacific MANA;
- noted that the Pacific MANA NCD dashboard has been refined, including review of key actions, comparison with existing dashboards, and testing of the criteria;
- requested intermediate indicators on knowledge, attitude and practice, noting a knowledge hub has been set up that may be able to collate and share this information;
- expressed a need for intermediate monitoring and evaluation of progress in addition to STEPS every five years;
- requested improved communication between the secretariat and countries on MANA, including in relation to governance.



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Civil registration of vital statistics (CRVS)

The meeting:

- recognised the excellent progress across the region in collection and use of CRVS;
 - encouraged countries to formalise national plans and set targets under the Regional Action Framework;
 - encouraged investment in national health information infrastructure and systems, including for CRVS.
-

Healthy Islands Monitoring Framework

The meeting:

- endorsed a list of core indicators;
 - tasked the secretariat and health information managers meeting (30 May–1 June 2016) with deciding detailed definitions and sources of data for each core and complementary indicator as well as an appropriate monitoring mechanism;
 - agreed that HoH, in collaboration with the secretariat, will produce the first annual progress report as per this monitoring framework by next year's Pacific Health Ministers meeting.
-

Reproductive, maternal, new-born and child health

The meeting:

- acknowledged the presentation on approaches to prevention of cervical cancer;
- noted ongoing work on the cost-benefits of various approaches to cervical cancer prevention.

The secretariat undertakes to update Heads of Health on the outcomes of further consultation with stakeholders.

EPI review

The meeting:

- agreed that immunisation is a regional public health good and best buy, with low coverage a threat to all;
- acknowledged the importance of sustaining gains already made on immunisation;



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- expressed support for a regional approach and standards;
 - recognised the preference of some countries for national approaches and the constraints to improved coverage;
 - proposed that the secretariat will provide an update on immunisation coverage in the region at the next HoH meeting based on revised data provided by countries over the next 12 months;
 - further proposed that the secretariat will work with countries to strengthen regional immunisation coverage.
-

The role of Fiji National University (FNU) in developing a Sustainable Pacific Human Resource for Health

The meeting:

- noted with interest the review of the role of the Fiji School of Medicine/Fiji National University in educating the Pacific health workforce;
 - noted the request for provision of in-country training by FNU, but recognised the constraints, including dilution of resources at the university itself;
 - requested FNU to continue dialogue with members requesting in-country training, particularly where sufficient funding is available;
 - noted that the field epidemiology training programme developed jointly between FNU, the Pacific Community (SPC), the World Health Organization (WHO) and the Pacific Islands Health Officers' Association (PIHOA) will be presented to the FNU Senate in June for final approval.
-

Opportunities for human resource capacity in the region

The meeting:

- noted the University of the South Pacific's (USP) plans for a School of Public Health, to open in 2018, as a stand-alone school independent of a medical school;
- noted that the school will offer graduate and postgraduate courses with a focus on maintenance of health and prevention of disease;
- acknowledged that USP will consult all relevant stakeholders in the development of programmes to ensure they meet PICT requirements;
- noted that USP will identify a relevant accrediting authority as a quality assurance measure;
- noted also that USP will investigate potential partnerships with other universities and cross-credit arrangements with national institutions.



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Global and regional initiatives

The meeting acknowledged the presentation from the United Nations Development Programme (UNDP) on the Sustainable Development Goals 2016–2030.

Human resources for health

The meeting:

- agreed that a generic Regional Internship Standard be developed to guide Pacific Island countries and providers of continuing professional development programmes, based on the 12 factors that contribute to a successful internship programme;
 - supported the concept of a Regional Accreditation process subject to further information, particularly in relation to addressing concerns around resource mobility:
 - a) as a quality assurance mechanism, and
 - b) as a step towards possible regional medical registration.
-

Nursing education and career pathways

The meeting:

- recognised the need for pathways for the recognition of skills, knowledge and accreditation of training programmes, and for relevant policies and legislation at the country level;
 - supported the concept of a forum for nursing education providers and nursing leaders to develop generic standards, competencies and scope of practice for regional benchmarking of nursing specialisation;
 - agreed that ministries of health should create and support clinical nursing career pathways and appropriate remuneration, and consider parallel training in specialist areas (doctor, nursing training);
 - agreed that countries should consider scholarships for specialised clinical nurse training;
 - recognised difficulties in smaller islands and the need for multi-skilled and multi-tasking nursing professionals.
-



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Epidemic preparedness and response

Pacific Public Health Surveillance Network (PPHSN)

The meeting:

- acknowledged the value of the work of PPHSN in alerting countries to outbreaks;
 - noted the importance of surveillance in detecting outbreaks, including of previously unknown diseases in the region such as zika and chikungunya;
 - acknowledged the value of the information provided by surveillance networks;
 - agreed on the value of contingency planning in lessening the potential impact of outbreaks.
-

Pacific Zika Virus Action Plan

The meeting:

- recognised the serious implications of zika outbreaks for health systems, as testified by the experiences of French Polynesia and Samoa;
 - acknowledged the need for communication strategies to keep communities and media accurately informed;
 - requested further information on laboratory testing for zika.
-



4th Heads of Health Meeting

4th HEADS OF HEALTH MEETING

(Grand Pacific Hotel, Suva Fiji, 27–28 April 2016)

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