

Heads of Health Meeting

Réunion des directeurs de la santé

REPORT OF THE
6th HEADS OF HEALTH MEETING
(Denarau, Fiji, 18–19 April 2018)

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Report of 6th Heads of Health Meeting

Meeting objective

1. To review, discuss and make recommendations to the Pacific Health Ministers Meeting (PHMM) on:
 - universal health coverage (UHC) and primary health care
 - the Healthy Islands monitoring framework
 - human resources for health
 - non-communicable disease (NCD)
 - health security
 - reproductive maternal and newborn child and adolescent health

1 Opening

2. The Chair, Dr Aumea (Josephine) Herman, Secretary of Health, Cook Islands, welcomed participants to the 6th Heads of Health meeting (HOH).
3. HOH was attended by representatives from: Australia, Cooks Islands, Federated States of Micronesia (FSM), Fiji, French Polynesia, Guam, Kiribati, Marshall Islands (RMI), Nauru, New Caledonia, New Zealand, Niue, Palau, Papua New Guinea, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, and Wallis and Futuna. Partner agencies represented included: the Australian Department of Foreign Affairs and Trade (DFAT), New Zealand Aid Programme, Pacific Community, World Bank (WB) and World Health Organization (WHO). Observers came from: the Australian National University, Centers for Disease Control and Prevention (CDC), Pacific Research Centre for the Prevention of Obesity and Non-Communicable Diseases (C-POND), Fiji National University (FNU), International Planned Parenthood Federation, Japan International Cooperation Agency (JICA) Fiji Office, Joint United Nations Programme on HIV/AIDS (UNAIDS), McCabe Centre for Law and Cancer, Ministry of Health, Labour and Welfare, Japan, New Zealand High Commission, Otago University, Pacific Island Health Officers' Association (PIHOA), Pacific Islands Regional Multi-Country Coordinating Mechanism (PIRMCCM), Pacific Regional Health Security Scoping Team (DFAT), Royal Australasian College of Surgeons (RACS), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), University of Fiji and the University of the South Pacific (USP). (Annex 4 provides a list of participants).

Keynote address: Chief Guest, Hon. Rosy Sofia Akbar, Minister of Health and Medical Services, Fiji

4. The Minister thanked SPC and WHO for convening the meeting and partner agencies for their continuing support of the region's health sector. She noted that Fiji was recovering from a natural disaster with flooding following a tropical cyclone. Similar experiences were shared by all Pacific Island countries and territories (PICTs), highlighting the need to prioritise health in addressing the traumatic effects of climate change. The recent Small Island Developing States (SIDS) consultation meeting on the WHO special initiative on Climate Change and Health jointly agreed on a Pacific Action Plan, with the process to be fast tracked for endorsement and launching at the World Health Assembly (WHA) in May. The Minister urged HOH to work closely with WHO to achieve this goal. Other important topics on the HOH agenda were universal health coverage (UHC) and primary health care. Better health information systems and an appropriately trained health workforce are part of achieving UHC. The Minister noted that the Healthy Islands vision is an enduring one and a monitoring framework is now in place

to support its continued implementation. The first report on the Pacific Monitoring Alliance for NCD Action (MANA) would be tabled at the meeting. NCDs are a huge problem for the region. Adults can make choices, but they need an environment that helps them make healthy choices for themselves and their children. HOH's responsibility was to advise ministers and provide the right options for addressing health challenges.

5. **Dr Audrey Aumua, SPC Deputy Director-General**, thanked the Minister for her speech and her recognition of HOH's role. She said HOH was an increasingly important platform for regional health issues and acknowledged the collaboration between WHO and SPC.

Remarks on behalf of the secretariat and implementing partners: Dr Corinne Capuano, WHO representative for the South Pacific, and Director, Pacific Technical Support

6. Dr Capuano delivered remarks on behalf of SPC and WHO, in the absence of the SPC Director-General and WHO Regional Director for the Western Pacific.
7. Referring to the Pacific Action Plan for the WHO special initiative on Climate Change and Health, she said the plan will cover the 22 PICTs and will build the climate resilience of existing health systems.
8. Health is a human right. UHC is part of achieving that right for all and can also improve the economic development of countries. The WHO Director-General recently appealed to Heads of State to show political commitment to health and take three concrete steps towards UHC in their countries. The role delineation policies being implemented in PICTs will strengthen the delivery of services that support UHC, as will better health information systems. It is also important that the skills of the health workforce align with the needs of populations.
9. The Healthy Islands monitoring framework, which was endorsed by Pacific Health Ministers in 2017, will also be relevant to measuring progress towards the Sustainable Development Goals (SDGs). NCD is a standing item for HOH and, with support from partners, PICTs are continuing to reduce health risks, such as tobacco use, through legislation and taxation. HOH enables sharing of information on these initiatives.
10. WHO and SPC have been collaborating to strengthen implementation of the International Health Regulations (IHR) and the Pacific Health Security Coordination Plan, which would be discussed during the meeting.

2 Review of progress on 2017 HOH and PHMM directives

11. The secretariat reviewed progress on key decisions from the 5th HOH and PHMM in 2017 relating to UHC, the Healthy Islands monitoring framework, human resources for health, NCDs including childhood obesity, and the NCD Roadmap. All of the issues noted were on the meeting agenda for further discussion. In just one example of progress towards the targets of the NCD Roadmap, 7 out of 21 PICTs have increased taxation on tobacco to 70 per cent of the total price and others are well on the way to achieving this percentage.
12. Reproductive, maternal, newborn, child and adolescent health (RMNCAH) was now included regularly on the HOH agenda. Health security and climate change and health continue to be challenges for PICTs and would also be discussed.

Recommendation

13. HOH noted the progress reported on issues covered in the 2017 meetings of HOH and Pacific Health Ministers, including Universal Health Coverage (UHC); the Healthy Islands Monitoring Framework; Human Resources for Health; non-communicable disease (NCD) including childhood obesity; and the NCD Roadmap, e.g. seven PICTs have increased tax on tobacco to 70 per cent of the total price, and others are moving towards meeting the target.

2.1 Review of Terms of Reference (TOR) for Heads of Health

14. The Secretariat said the TOR for HOH were first endorsed in 2013. They now needed updating due to changes in context, including the renewed emphasis on implementing the Healthy Islands vision, and the adoption of the Framework for Pacific Regionalism, which replaced the Pacific Plan. The proposed inclusion of the Pacific Island Health Officers' Association (PIHOA) as a key partner with SPC and WHO in the HOH secretariat also needed to be reflected in the TOR. Another suggested change was a link to the Micronesia Islands Forum in addition to the existing link to the Pacific Islands Forum (PIF). This change was proposed because not all PICTs are members of PIF.

Discussion

15. There was discussion of the timing of HOH with a suggestion it take place just preceding the two-yearly PHMM. The secretariat said that holding HOH at least four months before PHMM allows time to shape the agenda and make preparations. In addition, ministers have opportunities to meet during the WHA and WHO Western Pacific Regional Committee Meeting. Another comment related to the composition of HOH subcommittees and their functions.
16. At the Chair's suggestion, the meeting agreed that a small working group would examine the TOR that evening and report back to the whole meeting the following day with the proposed text. Australia, French Polynesia, Kiribati, New Zealand, Samoa and Solomon Islands agreed to take part in the working group.
(Note: the decision on the revised TOR is presented in section 11 of this report.)

WHO appointment

17. Samoa moved to congratulate former HOH Chair, Ms Elizabeth Iro, on her appointment as Chief Nursing Officer with WHO in Geneva, saying the Pacific could be proud of her achievement.

Recommendation

18. HOH welcomed the appointment of its former Chair, Ms Elizabeth Iro of Cook Islands, to the post of Chief Nursing Officer at WHO headquarters in Geneva and agreed to send her a letter of congratulations on behalf of Pacific HOH.

3 Universal Health Coverage (UHC) / Primary Health Care (PHC)

3.1 Regional analysis of role delineation policy

19. WHO defines UHC as meaning that all individuals and communities receive the health services they need without suffering financial hardship. It includes essential, quality health services, from health promotion to prevention, treatment, rehabilitation and palliative care. There are four main categories for assessing progress towards UHC in countries: reproductive, maternal, newborn and child health; infectious diseases such as tuberculosis; NCDs; and access to services and capacity.

20. In PICTs, role delineation policy (RDP) has been developed as a tool to help policy makers analyse and better shape their model of care towards achieving stronger health systems and UHC. RDPs assist in defining the scope of essential health services, the proposed level of care, the required human resources (doctor or nurse, for example), and available equipment, drugs and infrastructure.

Solomon Islands' experience in implementing its role delineation policy

21. Dr Tenneth Dalipanda, Solomon Islands' Permanent Secretary for Health, said implementing the RDP requires political support, including at provincial level in Solomon Islands. UHC is a critical target for the SDGs. It is included in Solomon Islands' National Development Strategy and is driving the National Strategic Health Plan 2016–2020. A service delivery package was developed but this has to be adapted to fit the context of different clinics.
22. Carrying out the RDP has required reforming the structure of the ministry. The most important area of reform is zone planning, with only 42 per cent of staff providing services for 82 per cent of people. There are challenges in achieving the right skill mix and allocating people to facilities that require staff. Staff need incentives to go to remote places even though there are issues with an oversupply of staff in urban areas.
23. Nurses are the backbone of the system and need good support from doctors. Medical graduates are coming from medical schools in Cuba and Taiwan as well as from regional institutions. Cuban graduates take a one-year bridging course supported by FNU and the first two cohorts are now registrars.

Discussion

24. The Chair thanked Dr Dalipanda and noted that Cook Islands has UHC in its strategic plan. An RDP helps demonstrate where there are gaps in services and capacity. She asked how many countries have RD in place and how many are implementing UHC through an RDP.
25. Tonga has developed an essential services package.
26. In reply to a question from Vanuatu on gaining political support for implementing RD and UHC, Dr Dalipanda said that countries already have systems in place. It is necessary to get support for adapting these systems and reforming them where necessary to ensure services and resources are in the right place. Organisational reform is critical to RD.
27. Samoa asked if traditional healers should be included in the RDP, noting that these healers are still a strong presence in Pacific Islands, partly because they are accessible.
28. Fiji asked how Solomon Islands ensured financial protection of vulnerable communities.
29. Dr Dalipanda replied that as part of overall policy, Solomon Islands is prioritising these groups, in both the most remote communities and in highly populated areas.
30. French Polynesia commented that it is reviewing how primary health care is organised and asked if Solomon Islands has indicators for monitoring implementation of reform.
31. Dr Dalipanda said a monitoring and evaluation framework is under development with WHO.

Recommendations

32. HOH:
 - i. noted the findings of the regional overview of UHC;
 - ii. agreed on the benefits of a role delineation policy for planning provision of essential health services and allocation of resources as part of progressing towards UHC;
 - iii. expressed interest in Solomon Islands' case study of its implementation of a role delineation policy, which is driving reform of its health system structure, and the challenges of matching human health resources with the needs of rural and remote populations;
 - iv. agreed that future HOH meetings will include monitoring of country implementation of role delineation policies.

4 Monitoring and reporting

4.1 Strengthening Health Information Systems to support implementation of the Healthy Islands

Monitoring Framework (HIMF)

33. The **Healthy Islands Monitoring Framework** was endorsed by Pacific Health Ministers in 2017. To ensure the framework indicators align with new guidance from WHO technical programmes, HOH were asked to consider four refinements of the indicators relating to:
 - frequency of antenatal visits;
 - schedule for HPV vaccination;
 - water supply;
 - sanitation services.

Group discussion and feedback

34. The meeting divided into four groups (Melanesia, Micronesia, Polynesia and Francophone countries) to discuss the proposed amendments of the HIMF indicators.
35. The Chair said the proposed change to the indicator for antenatal care was to have eight antenatal contacts, not four as previously, and asked if that was too high a bar for PICTs. She noted that PICTs could keep the indicator at four visits if that was considered more realistic, and move gradually towards the higher target.
36. All groups agreed that eight visits would be difficult to achieve for mothers in rural and remote areas.
37. Samoa noted its high maternal mortality rates compared to other PICTs. Most women made one antenatal visit. Four visits were realistic. Samoa has traditional birth attendants, who are more affordable.
38. Cook Islands considered eight visits were achievable with six visits already the norm.
39. Tonga asked if eight visits have been shown to reduce maternal mortality.
40. WHO replied that the aim was to reduce the likelihood of still births and perinatal death and ensure a positive pregnancy experience for mothers. A minimum of eight contacts for antenatal care can reduce perinatal deaths by up to 8 per 1000 births when compared to a minimum of four visits. The new guidelines also provide details on the care that should be provided during each of the eight visits. ANC services contribute to achieving SDG 3 (targets

include reducing the global maternal mortality ratio to less than 70 per 100,000 live births, and neonatal mortality to at least as low as 12 per 1,000 live births by 2030). The indicator relates particularly to provision of essential health services under target 3.8 – Achieve UHC.

41. The Chair noted the problem of women who were late in making their first visit, saying early booking should be encouraged.
42. Samoa strongly supported the need for mothers to book in the first trimester, noting that eight visits would have resource implications. It was important to increase contacts with those identified as at-risk, beginning at visit 1.
43. Other participants supported paying more attention to those identified as at-risk and providing follow-up care, regardless of the target number of antenatal contacts.
44. The Chair asked how the indicator would be monitored and suggested disaggregating reporting by at-risk mothers.
45. Participants agreed to the change in the indicator for the HPV vaccination schedule, with some also planning to include boys in the programme, depending on assessments of cost and logistics.
46. The Chair suggested the secretariat could investigate more affordable options for purchasing vaccines.
47. In response to questions on the change in the wording of the indicators for water supply and sanitation (from 'improving' to 'safely managing'), WHO said that 'improve' did not mean 'safe'. With the SDGs, the aim was to move to 'safe', especially from *E. coli*. Households must also manage their water sources, which could be difficult in rural areas. People needed to know their water was not contaminated.

Recommendations

48. HOH:
 - i. agreed to maintain the indicator for antenatal care at a minimum of four antenatal visits (with the first visit ideally to occur in the first trimester, and countries to consider moving towards a target of eight visits as resources permit);
 - ii. agreed to the change in the indicator for HPV vaccination (females < 15 years who have had two doses of HPV vaccine), with several countries indicating consideration of vaccinating boys;
 - iii. agreed to the changes in the wording of the indicators for water supply and sanitation (Population using **safely managed** water services, and Population using **safely managed** sanitation services);
 - iv. tasked the technical secretariat with revising the framework accordingly and with continuing to improve reporting methods for the 2019 reporting and beyond.

4.2 Electronic health information systems – eHIS

49. The President of the Pacific Health Information Network (PHIN) presented an update on health information systems in the region. PICTs share the vision for improving health through the use of digital technology. However, there are many data gaps due to disjointed health information systems, infrequent health surveys and insufficient coverage of civil registration

systems. Data collection can impose a high burden on frontline staff and many HIS require multiple entry of patient details at different points in the health system.

50. More than half of PICTs have an eHIS strategy in place, though there are wide differences in level of detail, maintenance, and involvement of stakeholders. Countries are implementing various electronic health information applications, e.g. Meditech, DHIS 2, mSupply, or MS Excel-based solutions. Improved harmonisation of reporting requirements would be beneficial at the regional level (between donors) as well as intra-country, with standardisation of data collection methods. In developing their eHIS, countries are urged to:
- put people at the centre of eHIS transformation by building in benefits for all stakeholders – from patients, to clinicians, to administrators, political decision makers and regional agencies;
 - ensure they have ‘right-sized’ eHIS committees and strategies to guide coherent national systems linked to larger e-health and e-government initiatives;
 - make frontline healthcare worker data needs a priority by considering eHIS approaches that meet the data needs of healthcare workers to ‘capture data once, use many times’;
 - develop guidance to inform national action for the significant challenges in the region, recognising that decisions on suitable unique identifiers and infrastructure may be more efficiently addressed at the regional level. Developing or identifying Pacific-appropriate tools or software would save individual countries time and effort.
51. A national patient identifier is the foundation for interoperability across the entire eHIS. A national health ID ensures that reliable data about an individual can be collected, that a uniquely identified person gets the services to which they are entitled, and that practitioners are able to make better predictions about people’s health needs. In many Pacific countries, health information systems and health programs are still fragmented. Patients may have multiple IDs from various health services, or may not have an ID at all, and health information is collected only in an aggregated manner. There is a pressing need to establish national IDs for health in countries and to harmonise the multiple identifiers that now exist. Multiple identifiers lead to inefficiencies along the continuum of care, including fragmented health records. Countries that have one ID for health have either established a separate health ID for patients or are using the national ID for citizens as a unique number to access health services.

Group discussion

52. Meeting participants again divided into groups to discuss four questions:

1. Are there policies or plans for personal identification that can be used in the health system or as a national identifier?
2. Do you have a legal framework for privacy and security?
3. Are you exploring any technology solutions, e.g. biometrics, software, etc.?
4. What are the challenges where your country could use support?

Feedback

53. Francophone countries (French Polynesia, New Caledonia and Wallis and Futuna) have agreed with France that they will put in place a single unique number (INSEE number) for all residents for national identification, social security and health insurance purposes.
- In French Polynesia and New Caledonia, people already have a unique identification number associated with their social security funds, which is also used for health.

- Wallis and Futuna does not have national or health IDs. A recent agreement between the health agency and the health insurance fund of metropolitan France encourages Wallis and Futuna to start the registration of its nationals by granting them a unique national number, as is done in France.
- In terms of the legal framework, each country has different systems depending on its relationship to France. French Polynesia and New Caledonia have adopted the same legal frameworks governing health information and identification as used in France. Wallis and Futuna has partially enforced the French laws.
- Francophone countries are not considering biometric systems at present but would like to advance the use of telemedicine. They need more technical assistance for telemedicine and for implementing requirements for safeguarding health data and medical records.

54. In Melanesian countries, everyone has a unique health number.

- Fiji also has several sectoral identification cards and there has been on-going political discussion about establishing a national ID. Fiji uses the national health ID for its citizens as a unique identifier across its hospitals.
- Vanuatu has a health ID but currently it is limited to some hospitals only. A national ID card is being set up for election purposes.
- Solomon Islands already has a voter registration ID for adults. The health sector is trying to expand the use of a national ID for minors by assigning a number at birth that will be used as a health ID.
- All countries have laws relating to ethics and privacy though there was uncertainty about the level of protection these offered.

55. Micronesian countries vary in their use of identifiers for health:

- US territories and affiliated areas such as Guam and Palau have defaulted to the social security number (SSN) as a unique identifier. In USA, Medicare uses the SSN as a patient identifier.
- In the absence of a national standard for patient IDs, many countries, including Federated States of Micronesia (FSM), Nauru, Guam and Kiribati, use a unique patient ID number in hospitals, but every hospital establishes its own numbers, creating problems for exchanging health data between facilities.
- Privacy laws vary, from hospital privacy policies to national legislation (such as the Health Insurance Portability and Accountability Act in Guam and the Northern Mariana Islands). Establishing legal frameworks governing the national ID and health identifiers was considered a challenge.
- Some vertical programmes have established their own identification systems, e.g. in Kiribati and Marshall Islands, there are biometric systems for patients with TB or chronic conditions.

56. For Polynesian countries:

- Cook Islands and Tokelau use practice management systems with a robust EMR (MedTech) in all hospitals and health centres. The system is highly interoperable and creates a unique patient number for each individual that is used across health care facilities as a health ID.
- Samoa and Tonga are both working with partners to develop e-government and e-health systems and are in the process of setting up national health IDs.
- New Zealand has a national health ID system.
- Privacy was important for all countries and all had relevant laws.

57. Australia said issues of privacy and security should be dealt with early in setting up IDs. The secretariat could provide guidance and Australia could share information from its own hard-won experience.
58. It was also suggested that countries should improve their civil registration and vital statistics (CRVS) systems to register all births and deaths (including those that occur outside health facilities), and improve linkages between civil registration and health sector systems.
59. The Chair said the adoption of IDs for health should be accelerated, with support from regional partners, noting some countries were more advanced than others in this process. She asked the secretariat to analyse the feedback from countries.

Recommendations

60. HOH:
 - i. acknowledged the findings of an assessment of electronic health information systems (eHIS) in Pacific Island countries;
 - ii. noted that countries use a variety of methods to assign identification to patients and that many systems are fragmented and unable to share data across the health system;
 - iii. recognised that development of eHIS must be done in accordance with the legal frameworks for privacy and security that exist in all countries;
 - iv. emphasised the need for careful assessment of the suitability of eHIS technology for country contexts and end user/healthcare worker needs, noting that some countries are implementing biometric solutions and can share their experiences;
 - v. agreed that common challenges for development of eHIS, such as unique identifiers and appropriate tools or software, can be more efficiently addressed at the regional level, with advice and support from regional organisations helping to manage limited country capacity.

5 Human Resources for Health

5.1 Director of Clinical Services Meeting – update

61. The secretariat presented the recommendations from the meetings of the Directors of Clinical Services and Regional Medical Councils and drew HOH's attention to:
 - (1) the Directors' specific recommendations on the establishment of a Regional Cancer Registry, and
 - (2) the agreement of Regional Medical Councils to establish a regional mechanism to support national frameworks for registration of health practitioners

Discussion

62. Cook Islands said the Directors of Clinical Services meeting agreed on the cancer registry to support gaps in data collection.
63. Vanuatu supported the proposal, saying it was struggling with developing such a registry. Vanuatu now has a pathologist who is collecting data and the country would like support from a regional hub.
64. Samoa supported the concept in principle – it is also trying to set up a registry. He asked for further information on the establishment and location of the regional registry, noting countries had many commitments and this was a lower priority for Samoa.

65. The secretariat said WHO has assisted some PICTs and four now have a reasonable registry. At the moment, data is mostly model data. US-affiliated states have a registry already with support from the University of Hawaii. WHO agrees the regional registry should be located at WHO Suva. It will collate regional information and also support countries in establishing their own registries. The data will be kept confidential. New Zealand and Australia were involved in the original discussion of the registry.
66. The Chair said Pacific researchers should be given priority to author publications that draw on data held by the registry. She noted work on setting it up had been progressed over time and asked the secretariat to provide the requested information to HOH (which subsequently made the recommendations below).

Recommendations

67. HOH:
 - i. endorsed the recommendations of the meetings of the Regional Medical Councils and Directors of Clinical Services, which were held on 16 and 17 April 2018 respectively (the recommendations are attached as Annex 2 and 3);
 - ii. approved the proposal to establish the Pacific Cancer Registry hub through the Global Initiative for Cancer Registry Development, facilitated by the International Agency for Research on Cancer and supported by partners including Australia, New Zealand, SPC and WHO;
 - iii. agreed that further consideration should be given to the necessary investments for implementation of the Pacific Cancer Registry.

5.2 Updates from Fiji National University (FNU) and the University of Fiji

FNU

68. The Dean of FNU's College of Medicine, Nursing and Health Sciences (CMNHS) updated HOH on its current health programmes, including progress made in activities previously discussed at HOH meetings. He emphasised that FNU remains interested in workforce development for the region. Enrolment is now approaching 3000 students. Solomon Islands is the major contributor of regional students, followed by Tonga, Vanuatu and Kiribati. There are more female than male students.
69. FNU has memorandums of understanding with the University of Otago and the Royal Australasian College of Physicians and is also working with the Australasian College for Emergency Medicine and James Cook University. The Dean acknowledged FNU's partners, in particular the grant agreement with DFAT and its generosity in funding the post of Associate Dean Regional, which was established to meet health workforce training needs, provide support for regional students and reduce attrition rates.
70. Several programmes are supported in countries, including the RMI Nurse Practitioner Programme. FNU also supports the PPHSN courses, Data for Decision-Making (DDM)/Strengthening Health Interventions in the Pacific (SHIP). There have been challenges in providing DDM and SHIP because the timing of courses, availability of candidates, and provision of grants do not align with FNU's enrolment schedule. The issue was discussed during the PPHSN meeting and a recommendation on the issue would be put to the meeting later in the agenda.

71. Online courses are available in countries. New programmes include a first responders certificate and postgraduate courses in family medicine, environmental health and emergency nursing.

University of Fiji School of Medicine

72. The Dean of the School of Medicine said courses are provided in medicine, surgery and nursing. Currently, 465 students (local and regional) are enrolled in Bachelor of Medicine and Surgery courses and the faculty is nearly fully staffed.
73. Entry to the School of Medicine includes an interview process and mature entry is possible. Duration of study is six years. From year four, students work in a hospital environment with the aim of producing doctors with exposure to both public health and tertiary hospitals. Internship placement is in Fiji. To date, 144 doctors have graduated from the school.
74. A new bridging programme in nursing is designed to upskill the nursing workforce. To meet student needs, the curriculum includes academic English and information technology. Future plans include courses in primary health and public health and masters programmes.

5.3 State of the Pacific reproductive, maternal, newborn, child and adolescent health (RMNCAH) workforce

75. UNFPA presented the preliminary findings of an assessment of the Pacific RMNCAH workforce, noting that SDG targets require a strong health workforce. The assessment was designed to provide a comprehensive picture using the 'effective coverage' or 'AAAQ' framework (Availability, Accessibility, Acceptability and Quality).
76. Findings showed negative trends in the adolescent birth rate, indicating a need to expand the availability of youth-friendly RMNCAH services. Adolescents make up the biggest percentage of Pacific Island populations, but youth-friendly services are rare in the public sector. High rates of unmet need, stillbirth and under 5 mortality show that services, especially antenatal care, must be more accessible.
77. Most countries meet global standards for nursing education but fall below when it comes to midwives, who are also an aging group. There is a need to strengthen the midwifery profession by developing a regional strategy that acknowledges the importance of midwifery as a specialist component of RMNCAH. Quality of care across RMNCAH needs to be improved through pre-service education, continuing professional development, regulation and licensing systems.
78. UNFPA plans to finish data collection by May 2018. When the analysis is complete, a regional report will be published with country profiles. The report will include disaggregated data to assist deployment decisions and will project needs to 2030.

Discussion

79. FSM commented that the rate for under 5 mortality had dropped for many countries and questioned the figures presented. UNFPA noted the data is being updated as more countries report.

Recommendation

80. HOH noted with interest the preliminary findings of UNFPA's assessment of the current RMNCAH workforce and projection of future needs and looked forward to the conclusions and recommendations of the completed study.

Condolences

81. The meeting expressed great sadness at the passing of Dr Burentau Teriboriki, Kiribati's Director of Hospital Services, and extended deep sympathy to his family and to Kiribati. A minute of silence was observed in his memory.

6 Health Security

6.1 International Health Regulations (IHR) / Pacific Health Security Coordination Plan

82. In the past year (Jan. 2017 – Mar. 2018), 39 outbreaks were reported from 17 Pacific countries and areas to the Pacific Syndromic Surveillance System (PSSS) and PacNet, and five natural disasters occurred. Dengue is the most important emerging vector-borne disease in the region with over 38,800 cases reported during the year. Three serotypes were identified as causing outbreaks. Since the IHR came into force in 2007, there have been four public health emergencies of international concern, including the zika virus outbreak in 2016. These events reinforce the need to develop and maintain IHR core capacities for emergency preparedness and response in all countries, including some capacity for self-sufficiency, at least in the first 72 hours of an event. An important principle of the IHR is 'containment at source', which requires in-country capacity to manage an event, noting that this capacity has to be tailored to the risk profile of individual PICTs.
83. Following the Ebola outbreak, in 2017 the WHO Director-General was called on to develop a five-year strategic plan for global health preparedness and response in line with the IHR. The plan has three pillars:
 - 1) **Building and maintaining countries' core capacities as required by the IHR** (with national action plans, recognising that health security is linked with health system strengthening).
 - 2) **Event management and compliance**, which includes surveillance, and strengthening the role of the IHR focal point in each country.
 - 3) **Measuring progress and accountability**, which links to the new IHR monitoring and evaluation framework (IHR MEF).
84. The IHR MEF was developed to assist countries in assessing their core capacities, particularly their readiness to respond to public health emergencies. It includes a new version of the State party annual report (mandatory), and three voluntary components – after action review, simulation exercises and Joint External Evaluation (JEE). Though voluntary, the voluntary components are important for quality assurance of systems and assessing readiness.

Pacific Health Security Coordination Plan (PaHSeC)

85. PaHSeC was endorsed by PHMM in 2017. Its purpose is to improve coordination between partners in the regional health sector, including by sharing information, with the aim of better supporting IHR capacity development in countries. There are also opportunities to provide funding to countries to strengthen IHR core capacity. DFAT (Australia) and MFAT (New Zealand) have provided such funding. Some core capacities, such as highly specialised functions, are better developed at the regional level. PaHSeC partners include DFAT, MFAT, PIHOA, SPC, WHO and the World Bank, but countries themselves are at the centre of health security and must ensure they have the core capacities necessary to protect their population.
86. WHO coordinated a recent meeting of PaHSeC partners to look at options for implementing the IHR MEF in the Pacific. It was agreed that the MEF was a guide for provision of both technical support and resources. The partners will develop a joint workplan to clarify 'who is doing what, where, when'. It will build on existing mechanisms and networks including the PPHSN. The JEE tool has been updated and is useful for assessing capacity/gaps. It also identifies the documents that support assessment.

Discussion

87. Tonga regards AMR (antimicrobial resistance) as an emerging threat but thinks it should come under APSED III (Asia Pacific strategy for emerging diseases and public health emergencies).
88. WHO responded that AMR includes infection control and is clearly included in the JEE tool.
89. The Chair said some Pacific countries, including Fiji and Tonga, experienced mumps outbreaks last year that contributed to the New Zealand outbreak. She asked if there should be a closer working relationship with New Zealand and Australia in terms of sharing surveillance information.
90. WHO agreed that such wider sharing should occur, also noting the current potential for spread of measles from the Philippines to North Pacific countries.
91. SPC said PacNet disseminated a weekly alert map of regional outbreaks with information gathered from the wider region, including New Zealand through the Institute of Environmental Science and Research (ESR).
92. Samoa acknowledged the surveillance network, which also included syndromic surveillance, but noted that core capacity has not yet improved. Last year, Samoa sent samples to ESR in NZ and to Tahiti for laboratory identification of possible zika. The laboratories produced different results and Samoa sided with the lab in Tahiti. As well as after-action review, he suggested pre-action review. Samoa knew zika would arrive so had prepared, including through border control. The surveillance network allows prediction and countries need to improve their labs and border security.
93. WHO said there are opportunities for regional risk assessment, e.g. by partnering with universities for modelling of risk. Preparedness and review are both important, and exercises are important in supporting them.
94. SPC, in relation to laboratories, said LabNet relied on countries to report discrepancies in reference lab results and was working with the labs mentioned to resolve the issue. Countries were asked to please report such results.
95. Australia reports to WHO on outbreaks and recently completed a JEE. It was a useful exercise, involving state/territory governments, but very resource intensive. The JEE process could be modified for PICTs.
96. WHO noted that the JEE was not developed for small island states (SIS). Last year, the Suva office worked with WPRO colleagues and others on how to apply the tool to SIS. Strategies include the use of regional approaches and working with other agencies, e.g. the International Atomic Energy Agency on radiation, to provide capacities and allow countries to assess risks and develop responses using JEE components as appropriate.

Recommendations

97. HOH:
 - i. noted the global developments pertaining to the five-year global strategic plan to improve public health preparedness and response, the changes to the State Party Annual Report, and the global momentum to implement all four components of the IHR Monitoring and Evaluation Framework, including Joint External Evaluation (JEE);

- ii. agreed to continue annual self-assessments of IHR core capacity implementation, including review of the level of national resource allocation to health security, to inform national IHR implementation plans;
- iii. agreed to actively encourage and support implementation of after-action reviews of outbreak and other emergency responses, and simulation exercises, on an annual basis;
- iv. noted the progress made in the inception phase of the Pacific Health Security Coordination Plan 2017–2022 (PaHSeC), and the opportunities for funding national and regional IHR/health security strengthening activities under PaHSeC.

6.2 Pacific Public Health Surveillance Network (PPHSN) update

98. In 2017, SPC submitted a project proposal to Agence Française de Développement (AFD) to strengthen the services of PPHSN to enhance support of Pacific Island countries in reaching their required IHR core capacities. The project, which has partial funding of EUR 3 million, will be implemented by the whole of PPHSN, with oversight from a steering committee. This committee, which is an extension of the PPHSN Coordinating Body (CB), first met on 13 April 2018 to approve the budget for year one and the procurement and contracting plan. The committee comprises the Chair (Fiji), Vice Chair (Tokelau), and representatives from AFD, DFAT, Guam, New Caledonia, PIHOA, SPC and WHO.
99. The project has three components:
 - 1) **Enhancing surveillance** including through upgrading the Strengthening Health Interventions in the Pacific (SHIP) programme in collaboration with FNU, and a laboratory mentorship programme for level 1 laboratory facilities.
 - 2) **Developing vector control skills** including skills in entomology.
 - 3) **Preparing for emerging risks** including through AMR surveillance and monitoring, and infection prevention and control.
100. At present only 5 of 22 PICTs have accredited laboratories. The project's laboratory support initiatives are geared towards eventual laboratory accreditation for at least three more countries. The project will provide the necessary technical assistance, but it is up to countries to decide on applying for full accreditation, especially as continued resources are needed to keep this status. An option is to apply for accreditation of specific tests.
101. The PPHSN strategic plan will be updated in consultation with countries, taking a One Health approach. PPHSN supports country EpiNet teams, which are responsible for national response to outbreaks. To meet growing challenges, it has been agreed that a regional response team is needed. SPC is a member of the Global Outbreak Alert and Response Network (GOARN). WHO provides the GOARN secretariat and all PICT requests for GOARN assistance go through WHO.
102. In other matters, the PPHSN–CB approved terms of reference for surveillance technical working groups, including the process for selecting members. It was also noted that delivery of the SHIP programme has presented challenges for FNU with difference in the timing of FNU enrolment, and candidates receiving grants and being available for studies. HOH was asked to support a request (through the ministries of education and health) to FNU to allow some flexibility in requirements.

Discussion

103. The Chair praised the initiative but noted the project is time-limited and there was a need to address gaps in laboratory capacity, especially making diagnostic tests available to countries for early response. She asked which countries are not included in GOARN.
104. WHO said GOARN was originally a network of technical agencies. There is a process for requesting membership, but any country can ask for support.
105. In relation to the sustainability of the AFD-SPC project, SPC said the project will build capacity in countries, which will help sustain the initiative. AFD is only part-funding the project. SPC, WHO and PIHOA are also contributing.
106. Tonga asked about the timeline in regard to support for entomology capacity.
107. The secretariat said training will be available mid next year using a modified WHO tool. There is also existing capacity in the region, e.g. PIHOA has recently hired a medical entomologist.
108. Samoa asked if the training being provided would duplicate that of the Pacific Paramedical Training Centre (PPTC) in New Zealand. One problem is that after training, staff come home and do not have the equipment for testing so they go to larger labs. He asked if the project could audit lab equipment and provide what was necessary to allow more tests to be performed in-house.
109. The secretariat said PPTC looks after four countries. The AFD project is a mentorship programme and will not duplicate PPTC's work. In terms of improving national capacity, countries can request support for some tests, e.g. performing PCR.
110. The PIHOA Executive Director described the lab referral system that it supports in the North Pacific. PIHOA administers the system and pays in advance for shipment of samples. Each country contributes to a fund to pay for the scheme and shipment. The system works well. However, there is still a need to strengthen labs at country level. Economies of scale have to be looked at, e.g. Guam could provide a reference lab service for some tests (such as PCR for dengue). She said PIHOA had support from CDC to recruit a medical entomologist.
111. Wallis and Futuna said the Institut Pasteur has investigated mosquitoes there. Type 2 dengue is present at the moment, which can be disastrous for a small population. Their partnership with the New Caledonia reference lab is valuable.
112. FSM asked if epidemiology capacity was still an issue. The secretariat replied that the DDM course has been provided for over 10 years by FNU. Graduates are now being accredited with a postgraduate certificate in field epidemiology. The course could potentially be offered in Francophone countries.
113. The Chair agreed that good relationships between labs are useful for PICTs. She also noted the role of border control strategies in outbreak control, given the importance of tourism to Pacific economies.

Recommendations

114. HOH:
 - i. noted that requests for assistance from the Global Outbreak Alert and Response Network (GOARN) should be made through WHO;

- ii. noted that SPC will be the umbrella organisation for submitting Pacific CVs for provision of international assistance through GOARN;
- iii. noted that the Agence Française de Développement-SPC funding of EUR 3 million for the PPHSN strengthening project is partial, with supplementary funding to be provided by PPHSN partners and Pacific Island countries;
- iv. acknowledged the need to provide continued resources to maintain laboratory accreditation, should specific countries opt for full accreditation;
- v. agreed to send a communiqué requesting FNU to review the current Postgraduate Certificate in Field Epidemiology programme document to make all five courses annualised, implemented over two years;
- vi. agreed to make a special request to FNU, via the Ministry of Health and Ministry of Education, for some flexibility to be granted in terms of enrolment requirements and timing of delivery of courses in the Data for Decision-making/Strengthening Health Interventions in the Pacific Programme.

7 Non-communicable Disease (NCD)

7.1 Impact of fiscal measures: Preliminary results from Tonga

115. A Tonga Government/World Bank Group team presented the preliminary results of a study of the effects of implementing fiscal policy on tobacco, alcohol, food and beverages (i.e. the 'NCD tax' policy) in Tonga. The research team is particularly interested in the effects of the NCD tax on consumer behaviour, pricing, and government revenue, and the relevance of findings to policy decisions. The work is due to be completed by the end of October 2018.
116. The NCD tax has had some positive results to date. The excise taxes on cigarettes, alcohol, and some foods have resulted in price increases for all the products. The increase in excise tax on cigarettes has made them less affordable and around 18 per cent of smokers have decreased their consumption, with lower volumes of cigarettes being imported. But availability of substitutes is a major issue. A significant number of smokers are using cheaper locally manufactured cigarettes, with a local brand overtaking the most popular imported cigarette brand between FY 2015–16 and FY 2016–17. Approximately 20 per cent of smokers are now using Tapaka Tonga, which is not subject to the excise tax and is cheap and accessible throughout the country. If this trend towards higher use of Tapaka Tonga is not addressed, the effects of the NCD tax policy will be weakened.
117. Consumption behaviour has varied for different food products affected by the tax. There is lower consumption of turkey tails and mutton flaps, but price increases have had less effect on consumption of chicken leg quarters and instant noodles. The main reason is the lack of cheaper healthy alternatives. Tonga has foregone some revenue because of a decline in imports of the products affected by the NCD tax.

Discussion

118. Participants were very interested in the design and application of the policy and the study's findings on its early effects, including consumers turning to substitute products.
119. Australia said tax has long been used to reduce smoking. Political leaders must feel there is community support for tobacco control. Other control mechanisms include restrictions on places for smoking, and plain packaging. The shift to homegrown tobacco is a concern. Companies find ways around tax policies, e.g. by providing cheaper products. Taxing tobacco

is relatively easy compared to taxing food. Alcohol falls between the two, with the industry arguing for special exemptions. Australia and WHO can share their experience in devising and applying these policies.

120. Vanuatu asked if higher prices had resulted in people developing substitutes for alcohol.
121. The team said the study is assessing the effects of alcohol substitutes. In Vava'u, it appears young people have moved to kava. Some households tried to brew their own alcohol, but village elders have forbidden it. However, there has been an apparent increase in drug use.
122. Tuvalu noted the excise tax was based on the CIF price and said that when Tuvalu did the same, tobacco companies supplied cheaper products. Tuvalu now taxes the quantity of tobacco.
123. Tokelau asked if there had been a change in NCD trends since the tax was introduced.
124. The research team said it was too early to discern trends, but the drop in smoking would have immediate benefits.
125. UNICEF said the political economy was a factor in introducing this type of fiscal policy and asked if the team worked with politicians beforehand.
126. The team did not discuss the development of the policy with politicians but was guided by WHO policy. They were aware of vested interests, e.g. Tonga has a gym that was funded by tobacco interests.
127. Samoa has also done work on tobacco control, but the government has agreed to a new tobacco enterprise and local tobacco is sold without tax. There are also challenges for enforcement of restrictions. Smoking is banned in public places but still occurs (60 per cent of the police force are smokers). An alcohol factory is producing small bottles of drinks with very high alcohol content. These are sold cheaply and are popular with young people. The Liquor Board is looking at tax based on alcohol level. In 2015, Pacific Health and Finance Ministers discussed WTO policies in relation to tax and agreed to inform larger countries that they should not export poor-quality foods such as turkey tails and mutton flaps to PICTs. He reminded larger countries that what is healthy for their populations is also healthy for Pacific Island people.
128. The Chair agreed imports of unhealthy foods were a problem, with outside corporates pushing products on to Pacific markets. She was also concerned that the PACER Plus trade agreement could expose PICTs to more such imports. Australia and New Zealand could provide support for PICT initiatives in this regard.
129. New Caledonia said it has increased tobacco tax, but people have turned to low quality 'roll your own' cigarettes. He noted that Iceland (pop. 338,350) implemented a model to tackle drug and alcohol misuse in young people. Data for 2016 show reduced alcohol consumption in youth – only 5 per cent drink alcohol. Tobacco and cannabis use has also fallen. The Icelandic model has three strategies: 1. Promote good parenting; 2. Place curfews on youth; 3. Raise natural endorphin levels, e.g. by providing sports facilities for more physical education. New Caledonia has implemented a model with three components: 1. education, including psychosocial skills; 2. a supportive environment, with new laws on cannabis use by youth; and 3. application of taxes. It is important that public policies target behavior at the individual level.

Recommendations

130. HOH:
 - i. noted the preliminary findings from the analytic work 'Improving the use of taxation policy on tobacco, alcohol, unhealthy food and beverages as a response to the NCD crisis in the Pacific: A country base study in Tonga';
 - ii. agreed to strengthen efforts to monitor the implementation and impacts of NCD tax policy interventions, particularly in countries that have raised NCD tax significantly in recent years, to ensure that the policy serves not just as a revenue generation tool for the government, but rather as a tool to enable people to adopt healthier lifestyles, leading to healthier populations and contributing to a healthy economy;
 - iii. agreed to use evidence to improve the design of NCD tax policy interventions.

7.2 Pacific MANA – Where are we?

131. The Pacific Monitoring Alliance for NCD Action (MANA) was established to coordinate and strengthen monitoring of preventive action. Its members include all PICTs and collaborating partners and organisations in the region. MANA is coordinated by a team comprising representatives from SPC, WHO, C-POND, FNU and PIHOA.
132. MANA's dashboard monitoring tool, based on a 'traffic light' colour scheme, enables PICTs to visually track progress on policies and legislation to prevent NCDs. The Coordination Team facilitates completion and endorsement of the dashboard for each PICT. To date, 14 PICTs have had their dashboards endorsed, while 7 PICTs are in the process of developing them or are awaiting endorsement. These will be included in the next report.
133. The dashboards that have been updated have been useful in bringing together information for countries. They show where policy and legislation are in place and where there are still gaps, e.g. in addressing tobacco industry interference, restricting alcohol advertising, reducing trans-fats, limiting marketing of unhealthy food to children, and promoting breastfeeding. The dashboards will be updated each year by the MANA Coordination Team working with country staff, and an annual report will be presented at HOH meetings and published on the Pacific NCD Network website. The Coordination Team noted that a multisectoral approach is important in operationalising MANA at county level.
134. MANA has four indicators for alcohol – licencing restrictions, tax based on alcohol content, drink driving laws and enforcement, and control of alcohol advertising. In relation to food, there has been little action on reducing trans-fats (also the case globally) and mixed progress on marketing to children. Good progress has been made on taxing sugar-sweetened beverages and some progress in increasing physical education in schools. Other indicators relate to healthy food policies in schools and development of dietary guidelines.
135. Participants agreed that the MANA dashboard is a useful tool, enabling countries to report every year and assess progress in different areas of NCD prevention and control.

Recommendations

136. HOH:
 - i. noted the update on MANA activities in the past year and key findings of the report 'Status of NCD policy and legislation in Pacific Island countries and territories, 2018';
 - ii. agreed on the value of using the Pacific NCD Dashboard, at the national level, to identify national priority areas for action and to track progress on NCD policy and legislation;

- iii. agreed to use the Pacific NCD Dashboard, at the regional level, as a mutual accountability mechanism to monitor country progress on NCD action, and to provide updates at each meeting of Heads of Health and Pacific Health Ministers.

7.3 Regional Legislative Framework for NCDs

- 137. The secretariat proposed three options for the Pacific Legislative Framework on NCDs. The concept of the framework was endorsed by HOH and approved by PHMM in 2017.
- 138. The three options (listed in terms of impact on addressing NCDs) were: 1. A framework incorporating all the legislative measures deemed necessary to address NCDs; 2. Focusing on the gaps that currently exist and adding these to existing legislative policies; and 3. Strengthening current practice and existing legislative measures.
- 139. The development of a regional legislative framework is aimed at harnessing the power of collective approaches to tackling the Pacific NCD crisis. Pacific leaders have already committed to acting together in prioritising NCDs, and to using the Pacific NCD Roadmap to guide implementation, with Pacific MANA providing a monitoring framework.
- 140. However, despite this action, the region continues to lose ground on NCDs. The environment in which people live plays a critical role in their NCD risk, and encouraging individual responsibility is not enough, especially when unhealthy choices are promoted and available. Legislative measures (including legislation, frameworks, conventions and policies) are therefore important tools in preventing NCDs.
- 141. The proposed Pacific Legislative Framework was likened to the WHO Framework Convention on Tobacco Control (FCTC), which all Pacific WHO members are party to. The FCTC has been important in driving legislation on tobacco control in countries and its benefits are recognised. Similarly, the Pacific Legislative Framework could drive collective and more effective action on NCDs.
- 142. The secretariat said it preferred Option 1 and that COMSEC (Commonwealth Secretariat) would provide support for the legal expertise required to develop the framework. A draft would be developed in consultation with PICTs and presented to HOH next year for further discussion.

Discussion

- 143. The Chair invited HOH to discuss the options presented.
- 144. Wallis and Futuna commented that Option 1 was the most ambitious and he approved it but cautioned that a Pacific framework could clash with existing frameworks in France.
- 145. Solomon Islands also preferred Option I but said there would first have to be an audit of existing legislation and policies in countries. There has been considerable work on alcohol legislation. However, enforcement is difficult, e.g. under FCTC, companies are not allowed to incentivise the sale of tobacco, but they are paying retailers' licence fees.
- 146. Australia was concerned about comparing a regional framework to FCTC, which is a convention. The framework would need to be adapted to local contexts and sovereignty.

147. Tonga supported the preferred initiative, noting the Pacific's high obesity and diabetes rates, and vulnerability to outside factors.
148. Samoa supported Option 1, saying the region had to take big steps, given that current action was not reducing NCD rates.
149. The secretariat said it fully recognised the work done in countries and was proud of the lead they had taken in addressing NCDs. The proposal was to bring relevant legislation together. Countries are committed to FCTC, which is why they take action on tobacco. A similar commitment could be made to addressing NCDs more widely.
150. The Chair recognised the meeting's consensus that the secretariat should work on Option 1, saying countries need to work together and with partners to lift the health status of their people.

Recommendations

151. HOH:
 - i. considered three proposed options for the next steps in progressing work on a Pacific legislative framework for NCDs;
 - ii. agreed the secretariat should proceed with developing Option 1 – A framework that incorporates all the legislative measures deemed appropriate to address NCDs, noting that because Pacific Island countries and territories are at different stages, a stepwise approach will be suggested for implementation;
 - iii. noted that the results of this work will be reported back to the meetings of Heads of Health and Pacific Health Ministers in 2019 for further discussion and a final decision.

7.4 Pacific ECHO

152. The Pacific Research Centre for the Prevention of Obesity and Non-Communicable Diseases (C-POND) presented an update on the Pacific ECHO (Ending Childhood Obesity) network.
153. Childhood obesity prevalence is increasing in Pacific countries. Pacific ECHO is a Pacific coalition for collective advocacy and action on population-based obesity prevention. Pacific Ministers of Health endorsed its establishment at the 68th Western Pacific Regional Committee Meeting in Brisbane (October 2017).
154. The first meeting of Pacific ECHO working groups (December 2017) in Nadi, Fiji, brought together PICT representatives, technical agencies and universities to establish the network and governance structure, and finalise three strategic proposals relating to physical activity, fiscal policies and restriction of marketing of unhealthy food and drinks to children.
155. Pacific ECHO will be governed by HOH and will report to HOH and PHMM through the MANA Coordination Team.
156. SPC and WHO recently made a joint submission to the Pacific Islands Forum Secretariat Regional Policy Consultation titled *Protecting our future generations from NCD – Pacific Ending Childhood Obesity (ECHO)*. They propose setting up a Pacific Commission on ECHO, building on the findings of the WHO global Commission on Ending Childhood Obesity, to look at best practice for the Pacific. A decision is awaited on whether it will be one of the priority areas taken forward to the Pacific Islands Forum Leaders' meeting.

Recommendations

157. HOH:

- i. endorsed the establishment of the ECHO network and the proposed governance mechanism;
- ii. supported the identified priorities of physical activity, fiscal measures and restriction of marketing of foods and non-alcoholic beverages to children as starting collective policy actions of the network;
- iii. noted the application submitted to the Pacific Islands Forum Secretariat Regional Policy Consultation titled 'Protecting our future generations from NCDs – Pacific Ending Childhood Obesity (ECHO)', which is aimed at prioritising ECHO at the regional level.

7.5 Pacific NCD Roadmap – Update on progress

158. The secretariat reported on the progress of regional and country efforts in implementing the Pacific NCD Roadmap, approved in 2014 at the Joint Forum Economic and Pacific Health Ministers Meeting.

159. **At the regional level:**

- PHMM in 2017 endorsed the final report from the Pacific NCD Summit including a commitment to timelines for Pacific NCD Roadmap implementation at national level.
- MANA dashboards were completed and endorsed for 12 PICTs;
- The inaugural Pacific Diabetes Associations Meeting was held in September 2017 in Nadi, Fiji, to strengthen the Associations and enhance collaboration for addressing diabetes in PICTs.
- Pacific youth were engaged in the 'wake up' project to improve young people's knowledge of NCDs.
- PICTs were supported on action towards achieving the goal of a Tobacco Free Pacific by 2025. MOUs were signed between WHO and the Oceania Customs Organisation to address illicit trade in tobacco, and with the South Pacific Tourism Organisation to increase smoke-free tourism and protect workers from second-hand smoke.
- PICT government representatives participated in intensive legal training in October 2017 in Melbourne on the role of law in preventing and controlling NCDs.
- The Pacific nutrition workshop was held in November 2017 in Nadi, Fiji.
- A Pacific subregional workshop on PEN (Package of essential NCD interventions) was held in October 2017 in Auckland to review progress and barriers to effective management of NCDs.
- The UN thematic group on NCDs initiated two separate working groups – NCDs and maternal and child health, and Tobacco farming alternatives.

160. **At the country level:**

- 10 PICTs increased taxes on tobacco products and others have strengthened tobacco control legislation, e.g. restricting labelling and advertising.
- Several countries have used taxation on specific foods, including sugary drinks, to support health promotion.
- Several countries have raised alcohol taxes, restricted access to alcohol and toughened laws on drink-driving.
- Most PICTs have been implementing ongoing awareness programmes on diet and physical activity.
- 13 PICTs are using PEN protocols at national or subnational level.
- National Diabetes Associations are being established or revived and strengthened with South-South collaboration from associations in Australia, Fiji, Guam and New Zealand.
- Several PICTs are producing new multisectoral national NCD plans.

Recommendations

161. HOH:

- i. recognised that while considerable action has been taken in relation to the NCD Roadmap, it is insufficient to effectively control the NCD crisis and further action is needed to accelerate implementation;
- ii. committed to timelines at the national level to implement the key recommendations of the NCD Roadmap, including quantified and measurable targets to achieve the roadmap priorities;
- iii. agreed that effectively tackling NCDs will require greater resources, and committed to exploring ways to increase funds to better align the level of funding to the NCD burden;
- iv. noted the opportunity for the Pacific voice to be heard at the Third UN High-Level Meeting on NCDs (27 September 2018).

8. Stunting – the Other Half

162. UNICEF reported that most countries in the Pacific, where data is available, have high rates of stunting. Stunting is identified by shortness for age among children under 5 years. It represents disturbance of growth during the first 1000 days, between conception and two years, and is also referred to as chronic undernutrition.
163. Rates of stunting have been going down in Asia and Africa but have stayed the same or increased in the Pacific. Impacts includes economic loss and adverse health outcomes for affected children. High rates of stunting coexist with high rates of overweight and obesity. A stunted child is more likely to become an overweight adult affected by hypertension, cardiovascular disease or diabetes.
164. Reducing rates of stunting requires coordinated action beyond the health sector, e.g. in improving sanitation (no open defecation), agricultural practices, child and social protection, and responsive care. Even though these actions are outside the health sector, the sector plays a critical role in reaching pregnant women and children within the first 1000 days, e.g. by promoting good antenatal care and breastfeeding. However, more concerted action is needed to address the factors preventing children from thriving in the Pacific. This action is detailed in the Nurturing Care for Early Childhood Development Framework, which will be launched during the 71st World Health Assembly in May 2018.

Discussion

165. New Zealand said the Tongan study on fiscal measures to address NCD showed there was a lack of affordable healthy food for families. Improving child nutrition required an integrated approach with multisector teams.
166. Tonga noted the problem may worsen with the effect of climate change on food production.
167. It was noted that Japan will host the Nutrition for Growth Summit in Tokyo in 2020 to promote efforts in the field of nutrition, which is a foundation for health. JICA can provide information for interested countries.
168. In answer to a question from PIHOA on the reference population for the data, UNICEF agreed that genetics is a factor in size for age, but diet is very important.

Recommendations

169. HOH recognised the importance of:
 - i. assuming a leadership role in advocating for coordinated, multisectoral action to tackle stunting;
 - ii. integrating all forms of malnutrition, including stunting, into national nutrition and dietary policies and re-evaluating options to increase investment to stop stunting, such as improving health sector performance and efficiency;
 - iii. ensuring national surveys routinely collect data on all forms of undernutrition including stunting and micronutrient deficiencies, especially anaemia;
 - iv. raising awareness among people on stunting, heightening understanding, causes, consequence and actions to be taken in the home to stop it.

9 Climate change and health

170. The secretariat presented an update on measures addressing climate change and health, noting the important interrelationship between island ecosystems and health. Although health can be regarded as the human face of climate change, it has not been prioritised in international and national approaches to climate issues. This situation is changing.
171. In 2017, 'climate change and health' was included on the PHMM agenda for the first time. The 'health impacts of climate and environmental change' was proposed as one of the central platforms of the WHO General Programme of Work for the 2019–2023 period. To build on the global climate change programme and intensify support for vulnerable areas, a WHO Special Initiative on Climate Change and Health in SIDS was launched at COP23 in collaboration with Fiji and the UNFCCC (United Nations Framework Convention on Climate Change) Secretariat, in Bonn, Germany (Nov. 2017). Subsequently, WHO convened the 'Meeting to Develop the Pacific Action Plan for the WHO Special Initiative on Climate Change and Health in SIDS' in Nadi, Fiji (March 2018). It was jointly chaired by the Cook Islands Minister for Health (Chair of PHMM) and Fiji Minister for Health and Medical Services (Fiji as COP23 President). Importantly the meeting brought together delegates from both the health and climate change sectors from 18 PICTs. The meeting was organised as part of the WHO 3rd Global Conference on Climate Change and Health, which was held in multiple WHO Regions.
172. The resulting Pacific Draft Action Plan on Climate Change is for the period of 2019–2023, with the vision that by 2030 all health systems in SIDS will be resilient to climate variability and change. The Plan focuses on four areas: empowerment, evidence, implementation and resources. A fast-track process, which was agreed on by the meeting, will lead to a finalised Action Plan for launching at a side meeting during WHA71 in May 2018. This side meeting will also discuss strategies to strengthen co-operation amongst SIDS Ministers of Health, such as establishment of a SIDS Ministers of Health network, and mechanisms to review progress and exchange experiences in different WHO Regions.

Discussion

173. The Chair noted that the draft action plan had been circulated to HOH, though with short notice. Participants commended the presentation and supported the recommendations.

Recommendations

174. HOH agreed to continue supporting the fast-track process for the launching of the Pacific Action Plan on Climate Change at the 71st World Health Assembly (WHA71) in May 2018.

10 – Other technical matters

10.1 Mental health

175. The secretariat presented an update on regional and country efforts to strengthen mental health under the Pacific Islands Mental Health Network (PIMHnet). Progress has been made, but there is a need for urgent action in each country to improve mental health and well-being and provide appropriate health services. Funding is low at less than 2 per cent of most PICT health budgets, and also low in comparison to the actual burden of mental health disorders in health systems (around 8 per cent). There is a shortage of staff in all areas of mental health, including community services, especially for treatment of alcohol and drug misuse. Disasters and NCDs, leading to stress and depression, are also increasing the need for mental health services.
176. In 2017, PHMM reaffirmed commitments to allocate funding to achieve universal coverage of mental health and social care services; increase the number of staff trained in mental health; strengthen emergency preparedness for mental health and psychosocial support; develop a multisectoral strategy for promoting mental health, preventing substance use disorders and suicide, reducing stigmatisation and discrimination and protecting related human rights; and create enabling environments to support people living with mental health conditions by mobilising community resources and networks. HOH was asked to consider ways of implementing these commitments.

Recommendations

177. HOH:
 - i. acknowledged the commitments made at the 12th Pacific Health Ministers Meeting on mental health;
 - ii. recognised that national efforts are needed to ensure adequate funding for mental health;
 - iii. agreed to include mental health personnel in national human resource planning and to continue to increase the range of health staff and other personnel trained in mental health;
 - iv. recognised the importance of having in place a multisectoral strategy for promoting mental health and preventing mental and substance use disorders and suicide;
 - v. agreed that mental health should be integrated in NCD, climate change and disaster risk management programmes;
 - vi. agreed on the need to include provision of mental health and psychosocial support in national emergency/disaster planning and responses.

11. Other business

11.1 Revised terms of reference for HOH

178. The secretariat presented the revised terms of reference following the review by the working group (*discussed in agenda item 2*). Revisions relate to clarification of the role of HOH; inclusion of PIHOA with SPC and WHO in the HOH secretariat; links with the Framework for Pacific Regionalism and the Micronesian Islands Forum; timing of the

meeting (four months before PHMM to allow time for preparation); membership of subcommittees; and the agenda template.

Discussion

179. Participants agreed that universal health coverage and primary health care, and a half-day closed session for HOH should be added as standing items on the HOH agenda.
180. The Chair added that the TOR for the PHMM will also be revised by a subcommittee. The revised draft will be distributed to members before it is presented to the next meeting of ministers.

Recommendations

181. HOH:
 - i. noted that the TOR for Heads of Health needed updating due to changes in regional context including the renewed emphasis on the Healthy Islands Vision, implementation of the Framework for Pacific Regionalism, and inclusion of the Pacific Islands Health Officers' Association (PIHOA) as a key partner with the Pacific Community (SPC) and WHO in the HOH secretariat;
 - ii. agreed to the changes tabled by the working group that reviewed the TOR during the meeting (the revised TOR are attached as Annex 1).

11.2 Areas of priority for the secretariat

177. The Chair asked HOH to indicate areas of priority for the secretariat to work on in the coming year for presentation at the next HOH meeting.
178. HOH agreed on the following priorities:
 - i. Development of a comprehensive immunisation schedule in the region that includes MMR (measles, mumps and rubella), and HPV, rotavirus, pneumococcal, and meningococcal vaccination, with assessment of costs and possible funding; and
 - ii. Exploration of procurement options, such as bulk buying, to enable countries to purchase high-quality vaccines more cheaply.
 - iii. Development and financing of the health workforce in terms of the match between country needs and the programmes and training provided by all regional institutions, including flexibility in use of funding streams in other recognised institutions in the region.

11.3 Upcoming events

182. The secretariat presented information on the World Health Assembly (WHA71), 21–26 May, Geneva, Switzerland, reminding delegates of requirements for registration, for originals of their credentials, and early accommodation bookings.
 - Delegates were asked to provide short statements (500 words) on three actions in their country towards UHC.
 - Tuvalu will deliver a statement of behalf of Pacific countries (noting this does not preclude other countries from making statements). Tuvalu said it wished to be inclusive in representing regional views and will distribute the draft for comment. WHO noted it can assist the country making the statement.
 - During WHA, a side meeting of Pacific Health Ministers will be held, with a tentative date of 21 May.

- Another side meeting will be on health and climate change in SIDS.
- The Regional Committee Meeting will be held in October. A note has been sent to ministries with a draft agenda.
- The candidacy and selection procedure for the post of WPRO Regional Director was also presented.

12 Key decision points

183. Heads of Health reviewed and endorsed the recommendations.

13 Closing

184. The Chair thanked HOH for their participation in the meeting and the Vice Chair for her support. She acknowledged the donor partners present and thanked the SPC and WHO teams for their work and assistance during the meeting. On behalf of HOH, the Chair again expressed condolences to Kiribati and to the family of Dr Teriboriki, saying his passing was a loss to his country and the region.

1. Introduction

Pacific Heads of Health (PHoH) operates under the auspices of the Pacific Health Ministers (PHM). The function of the PHoH is to improve the coordination² of the work of Ministries of Health and their respective partners, and to advise and oversee the implementation of decisions made by PHM as well as relevant health-related decisions made by the Pacific Islands Forum (PIF)³ and Micronesian Islands Forum (MIF)⁴. The overall aim is to strengthen the linkages between national and regional level mechanisms and improve the delivery of regional health policies and services in order to protect and improve the health of the people of the Pacific region.

2. Role

The role of PHoH is to ensure that PHM are provided with clear guidance, advice and support from their senior officials to enable PHM to make informed decisions on policy options that address regional health issues of strategic importance. It includes oversight of the implementation of the Pacific Healthy Islands Vision and regional priorities including those identified in the Framework for Pacific Regionalism (FPR).⁵

3. PHoH membership

Membership of the PHoH consists of HoH⁶ from Pacific Island countries and territories (PICTs) and includes Australia and New Zealand.

4. Operating principles

PHoH operates as a 'policy advisory' and technical group, providing governance for regional functions, including Regional Public Goods in health. Policy decisions are made at the country level through the usual government processes, with regional policy decisions made at the PHoH meeting (PHoHM), PHM meeting (PHMM), PIF and/or MIF. PHoH may, in consultation with their respective ministers, also advise other ministerial groupings when a health issue falls within their jurisdiction.

- Accountability – members are accountable individually to their respective Ministers of Health, and collectively to the PHMM.
- Pacific Healthy Islands Vision – to ensure a clear focus, the Pacific Healthy Islands Vision, its objectives, and the Healthy Islands Monitoring Framework (HIMF) should continue to shape the PHoHM.
- Aid effectiveness – PHoH will adhere to agreed aid effectiveness principles.

¹ 'Heads' of sector is the terminology used in other sectors under the PIF architecture to describe the Secretaries and Director Generals. Standard terminology in other sectors is to use the term 'Forum' to describe ministerial-level groupings, and 'Heads' of sector to describe official level groupings, e.g. Forum Economic Ministers, Heads of Statistics.

² The coordination functions of the PHoH involve technical discussions and debriefings, and policy decisions on regional work, which consider the country and context-specific work at the national level. There is a decision-making element to what PHoH does and undertakes during these meetings.

³ PIF includes Australia, Cook Islands, Federated States of Micronesia (FSM), Fiji, French Polynesia, Kiribati, Nauru, New Caledonia, New Zealand, Niue, Palau, Papua New Guinea, Republic of Marshall Islands (RMI), Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.

⁴ MIF includes Commonwealth of the Northern Mariana Islands (CNMI), FSM, Guam, Palau and RMI and is included because CNMI and Guam are not members of PIF.

⁵ The FPR was endorsed by PIF Leaders in July 2014 and replaces the Pacific Plan for Strengthening Regional Cooperation and Integration. It is intended to support 'focused political conversations and settlements that address key strategic issues, including shared sovereignty, pooling resources and delegating decision-making'.

⁶ Includes CEOs, Directors, Director Generals, Permanent Secretaries and Secretaries.

5. Responsibilities of PHoH

- Advise PHMM, PIF and MIF on health issues of strategic importance to the region and the development of a collective view on global health developments relevant to the Pacific region and opportunities for regional collaboration in health.
- Oversee the development, implementation and monitoring of activities related to the Pacific Healthy Islands Vision and identify priority areas for approval by PHMM (and PIF and MIF as appropriate), and ensure PHoH complements and adds value to national development and health strategies and plans.
- Advise PIF on the implementation of the Pacific Healthy Islands Vision and the Framework for Pacific Regionalism as it relates to health, within and outside the health sector.
 - o Provide advice and commission analysis to inform policy development by PHMM in relation to regional services and the delivery of Regional Public Goods.
 - o Direct the PHoH secretariat to commission analysis to inform decisions or evaluate performance of agreed functions or activities (working with other bodies as appropriate).
 - o Oversee implementation and ensure efficient mechanisms for cooperation on policy and technical health issues, which may include establishment of time-limited working groups.
 - o Provide Pacific health regional bodies, for example the Pacific Public Health Surveillance Network (PPHSN), with a mechanism to link with the regional architecture of PHM and PIF and MIF Leaders.
 - o Report to PIF and MIF, through the PHMM, on matters as requested by Leaders, including relevant regional agreements.

6. Pacific Heads of Health Meeting (PHoHM)

To ensure the PHoHM conducts its business in an efficient and effective manner, the following arrangements will be adopted with regards to chairing the meeting.

6.1 Chair

The country hosting the PHMM chairs the PHoHM. The chair's term starts at the beginning of the year of the PHMM.

6.2 Deputy chair

The deputy chair will assist the chair in facilitating meetings.

To ensure that a strong link with the PHMM is maintained, and institutional knowledge is shared from outgoing to incumbent chairpersons, the schedule for the chair and deputy chair is as follows:

	Chair for PHoHM	Deputy Chair for PHoHM
Year before PHMM	Host of last PHMM	Host of next PHMM
Year of PHMM	Host of PHMM	Host of last PHMM
Year after PHMM	Host of last PHMM	Host of next PHMM

7. PHoHM attendance

PICTs are encouraged to send their HoH to the annual PHoHM.

8. PHoHM conduct

PHoH will ensure meetings, out-of-session processes, subcommittee arrangements and secretariat arrangements are efficient, present a well-structured agenda, provide good and fair chairing, and ensure timely circulation of meeting papers and reports (at least 2 weeks prior to the PHoHM).

9. PHoHM subcommittees

PHoH may establish standing committees or working groups to progress its work as sub-committees. Standing committees operate under similar Terms of Reference, subordinate to PHoH. Consistent with the principles above, the number of committees and working groups will be kept to a minimum, and in most cases will be strictly time-limited.

To assist in facilitating the work of PHoH (especially out of session), a PHoH subcommittee will be made up of the following members:

- Chairperson
- Deputy chairperson
- Representative from Melanesia
- Representative from Polynesia
- Representative from Micronesia
- Representative from Francophone countries
- Representative from Australia and New Zealand

10. PHoHM schedule

The PHoH will meet annually, outside the May–August period when ministries are preparing their annual plans and budgets. In those years when the biennial PHMM is being held (noting that PHMs also meet annually at both the margins of the World Health Assembly (WHA) and WHO Western Pacific Regional Committee Meeting (RCM)), the PHoHM will be held no less than four months before the PHMM. This is to enable PHoH to help shape the agenda for the PHMM and assist in the preparation for the meeting.

A template for the meeting agenda is attached as Annex 1.

11. Secretariat arrangements

The country chairing the PHoH will lead the preparation for the PHoH meeting, with secretariat support provided by the Pacific Community (SPC), WHO and the Pacific Islands Health Officers Association (PIHOA) with linkage to the Pacific Islands Forum Secretariat (PIFS). PHoH retains the right to review and modify those arrangements.

12. Linkages to the broader Pacific Islands Forum and regional health architecture

The relationship between PHoH, PHM, the PIF architecture and country level arrangements for development cooperation in health are set out in Annex 2.

13. Review of Terms of Reference

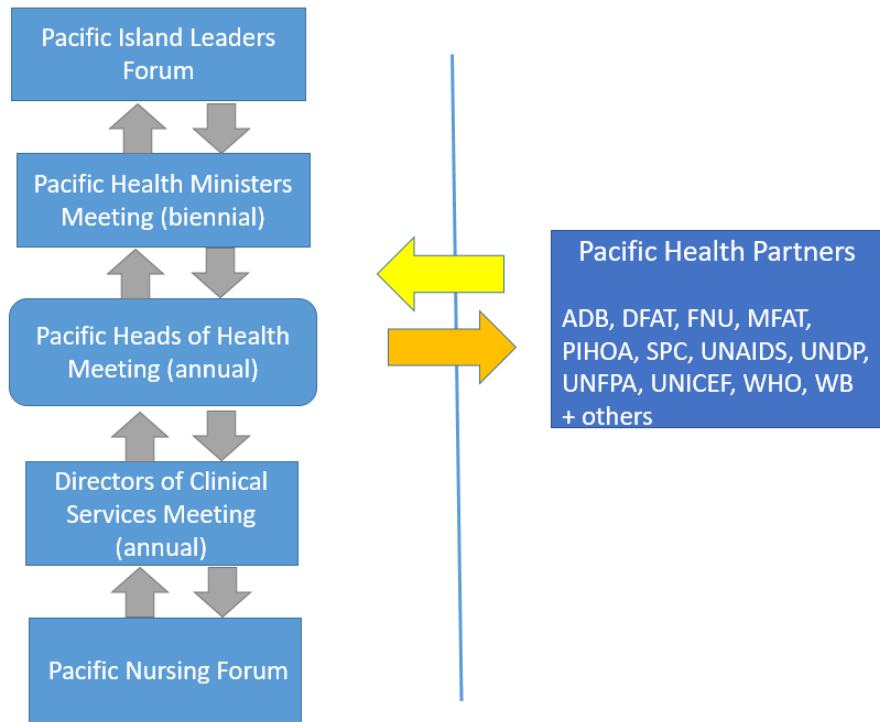
The PHoH shall retain the right to review and amend the Terms of Reference every two years.

19/04/2018

Annex 1 – Proposed template for meeting agenda

1. Opening ceremony
2. Review of progress of PHoH and PHMM directives
3. Closed session for PHoH
4. UHC / PHC
5. Monitoring, evaluation and learning (HIMF)
6. Human resources for health
7. Update from Directors of Clinical Services Meeting
8. Non communicable diseases
9. Health security
10. Reproductive, maternal, newborn, child, adolescent health (RMNCAH)
11. Climate change and health
12. Planning for PHMM, WHA, RCM
13. Other matters
14. Next meeting

Annex 2 – Pacific regional health architecture



Annex 3 – Abbreviations

ADB	Asian Development Bank
CNMI	Commonwealth of the Northern Mariana Islands
DFAT	(Australia) Department of Foreign Affairs and Trade
FNU	Fiji National University
FSM	Federated States of Micronesia
FPR	Framework for Pacific Regionalism
HIMF	Healthy Islands Monitoring Framework
HoH	Heads of Health
MFAT	(New Zealand) Ministry of Foreign Affairs and Trade
MIF	Micronesian Islands Forum
PHC	Primary Health Care
PHoH	Pacific Heads of Health
PHoHM	Pacific Heads of Health Meeting
PHM	Pacific Health Ministers
PHMM	Pacific Health Ministers Meeting
PIFS	Pacific Islands Forum Secretariat
PIHOA	Pacific Islands Health Officers' Association
PPHSN	Pacific Public Health Surveillance Network
RMI	Republic of the Marshall Islands
SPC	Pacific Community
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Fund
WB	World Bank
WHO	World Health Organization

Provision of education and training**The meeting:**

- i. acknowledged the services, training and support offered through the Fiji National University College of Medicine, Nursing and Health Sciences, the New Zealand Medical Treatment Scheme, the Royal Australasian College of Physicians, and the Royal Australasian College of Surgeons – Pacific Islands Program;
- ii. acknowledged the establishment of the post of Associate Dean Regional as a means to accommodate the health training needs of Pacific Island countries, and to support regional students enrolled for studies at FNU College of Medicine, Nursing and Health Sciences;

Regional Cancer Registry

- iii. endorsed the proposal to establish the Pacific Cancer Registry Hub through the Global Initiative for Cancer Registry Development, facilitated by the International Agency for Research on Cancer, and supported by partners including Australia, New Zealand, SPC and WHO;
- iv. agreed that further consideration should be given to the necessary investments for implementation of the Pacific Cancer Registry;
- v. agreed the proposal should be tabled at the Heads of Health meeting for endorsement;

Country needs

- vi. noted requirements for capacity building in areas including mental health, rheumatic heart disease programmes, cancer care pathways, emergency medicine, radiology and biomedical services, and in other areas, such as TB, that are specific to the needs of individual countries;
- vii. acknowledged the need for a regional mechanism for nursing and midwifery to provide continuing capacity building for training, protocols and standards development;
- viii. emphasised the need to include allied medical disciplines in capacity building;
- ix. welcomed Radiology across Borders' plans to deliver an online curriculum combined with face-to-face training to build radiology capacity in the Asia-Pacific region;
- x. agreed on the urgent need for training pathways in rural medicine as part of providing Universal Health Coverage, and noted that programmes are available in Papua New Guinea, Australia and New Zealand;
- xi. requested facilitation of better networks and access to countries such as Australia and New Zealand for professional development and attachments;
- xii. acknowledged the contribution of visiting medical teams and stressed that visits should ideally be a minimum of a week long and integrate ongoing training of country clinicians and nurses;
- xiii. requested support for strengthening health systems, especially clinical governance and protocols, e.g. for patient safety and infection control;
- xiv. noted that health systems in all Pacific Island countries need to plan for the impacts of disasters and climate change;

- xv. noted the need for a regional referral pathway for care of critically ill non-residents;
- xvi. expressed interest in the results of a feasibility study of providing haemodialysis in Tuvalu, noting the analysis factored in other care needs of dialysis patients, and that the study methodology is available for replication in other countries;
- xvii. further noted that similar studies have been done in the North Pacific with support from the Pacific Island Health Officers' Association (PIHOA);
- xviii. endorsed the efforts of the Royal Australasian College of Physicians in supporting the development of the clinical workforce and services in Pacific Island countries.
- xix. recognised the opportunities offered for efficient purchase of medical supplies and pharmaceuticals through the UNFPA and UNICEF procurement mechanisms;
- xx. noted the update from WHO on forming a Network of Health Workforce Regulators and the request to countries to nominate focal points;
- xxi. endorsed the recommendations made by the Pacific Island country consultation on ENT and audiology services (held in Nadi, Fiji, on 27–28 November) to the Pacific Regional Clinical Services and Workforce Improvement Programme, through SPC, as follows:
 1. To revise the ENT Regional Plan based on discussions at this consultation and subsequent discussions with external technical experts
 2. To compile submissions to the 2018 DCS and HOH meetings, incorporating the updated ENT Regional Plan and the principal findings of this meeting report
 3. To convene a regional working meeting on ENT-related TOT and national accreditation to ensure alignment and convergence of the various national training programs and curricula, with a strong initial focus on senior ENT nurse practitioners and nurses working at the PHC level
 4. To explore the feasibility of forming a regional ENT and Audiology Hub; the Hub would potentially have multiple functions, but an early priority should be to establish a communication network with country ENT focal points and ensure access to biomedical and equipment databases and catalogues to advise and support equipment purchase and maintenance
 5. To reconvene and reinvigorate PENTAG, aiming for a regional meeting around October 2018 to:
 - a. endorse an overall monitoring and evaluation framework for the revised Regional Plan;
 - b. collate and compare data from countries (where available), to start to build a more accurate picture of the burden of ENT-related disease in the region;
 - c. review national drug and equipment lists, with a view to developing a regional standard or set of recommendations to guide updating of national EDLs;
 - d. subject to feedback from the HOH meeting, prepare a submission to the 2019 Pacific Health Ministers' Meeting.

Frequency of meetings

- xvii. agreed that the meeting of Directors of Clinical Services should continue to be held annually.

Conclusions and Recommendations

Regulatory frameworks

The meeting:

- i. acknowledged that Pacific Island countries face common challenges in development and/or revision of national regulatory frameworks and processes for registration of health practitioners;
- ii. agreed that patient safety and protection of the public are the main objectives of such regulations;

Regional mechanism

- iii. acknowledged that Pacific Island countries face common challenges in development and/or revision of national regulatory frameworks and processes for registration of health practitioners;
- iv. agreed that patient safety and protection of the public are the main objectives of such regulations;
- v. agreed on the establishment of a regional mechanism to support national frameworks for registration of health practitioners;
- vi. further agreed that a regional mechanism
 - could provide advice on technical aspects of accreditation of training providers, especially providers new to the region;
 - assist in defining qualifications, standards and competencies for specialist and sub-specialist categories of health practitioners;
 - provide advice on mutual recognition of qualifications;
 - assist practitioners to access professional development;
 - provide a potential home or register for continuing professional development (CPD);

Australian Health Practitioner Regulation Agency and New Zealand Medical Council

- vii. expressed interest in the frameworks, standards and procedures of the Australian Health Practitioner Regulation Agency (AHPRA) and the relevance of these to Pacific Island countries;
- viii. noted that AHPRA and the New Zealand Medical Council, among others, have worked to make training and professional development more accessible for Pacific practitioners;

Pacific Island Medical Councils and Boards

- ix. acknowledged the information presented on the Medical Councils or Boards of Cook Islands, Fiji, Kiribati, Samoa and Solomon Islands;
- x. noted all shared challenges in appraising qualifications, performance and competency, resolving complaints and ensuring continuing professional development;

- xi. noted some countries expressed the need to update or strengthen the legislation for the establishment of their councils;
- xii. noted the benefits of including community members on councils;

Nursing and midwifery

- xiii. recognised the urgent need for
 - revision of legislation and regulations relating to nursing and midwifery services;
 - establishment of standards for educational quality, accreditation and continuing professional development;
 - establishment of a regional registration framework for nurse practitioners and other specialist programmes;
 - a regional meeting of Pacific nursing and midwifery leaders to develop minimum standards in line with global standards.

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