2ND Heads of Health Meeting

29-30 April 2014

Summary Report

Second Pacific Directors of Health Meeting

Sheraton Fiji Resort, Denarau, Nadi, Fiji
29-30 April 2014

Contents

Introduction and objectives

1. The Heads of Health meeting was held on 29-30 April 2014 at the Sheraton Fiji Resort in Denarau, Nadi, Fiji. The meeting was held in conjunction with two other meetings: a Strengthening Specialised Clinical Services in the Pacific (SSCSiP) Stakeholder Reference Group (SRG) meeting (the day before) and a UNFPA meeting titled 'Achieving Universal Access to Reproductive Health, including Family Planning Services and Commodities in the Pacific' (the two following days). The results of the Heads of Health meeting, which included Pacific Chief Executive Officers of Health, Directors of Health and Permanent Secretaries of Health, would feed into the joint Forum Economic Ministers Meeting (FEMM) and Pacific Health Ministers Meeting (PHMM) to be held in Honiara, Solomon Islands during 9-11 July 2014.

2. As discussed at the 2013 Pacific Health Ministers Meeting in Samoa, the main objectives of the 2014 Heads of Health meeting would be to:
   a. Review the way forward for the regional architecture for health, including regional functions and governance arrangements, and in this context to approve Terms of Reference for the Heads of Health Meeting.
   b. Finalise the Pacific Health Development Framework and recommend it to the Pacific Health Ministers for endorsement in their meeting in July 2014.
   c. Make recommendations to health and economic Ministers on critical health issues and initiatives for the Pacific region including 'A Roadmap for Responding to the NCD Crisis in the Pacific', for their joint meeting in July 2014.

TUESDAY, 29 APRIL 2014

Agenda 1. Opening

Led by: Dr Siale 'Akau'ola, Director of Health, Tonga

3. The acting Chair, Dr Siale 'Akau'ola, Director of Health, Tonga, began the meeting by requesting Dr Ismeili Tukana, National Advisor, NCD Prevention and Control, Fiji Ministry of Health, to give the opening prayer. Dr 'Akau'ola then welcomed the participants, including the Directors and the Ministers of Health present, and the Representative from WHO.

4. Following the prayer, Dr Colin Tukuitonga, SPC Director-General, introduced the meeting. He welcomed the participants and thanked the donors for their support. He also acknowledged the work of SPC's partners in the sector. Dr Tukuitonga introduced the meeting by stressing the importance of directors of health to lead and set the agenda for health in the region. Sector leaders and directors must make the key decisions and only by exception will political leaders make the decisions on the region's health agenda. For this reason, directors must get closer to regional organisations; SPC is pleased to facilitate these discussions. Directors of Health must think strategically about the issues faced by the sectors and act together.

5. Dr Tukuitonga also touched on some key health themes. Representatives must be clear about the directive of having a smoke free pacific by 2025. He expressed hope that the representatives would support the Roadmap for Responding to the NCD Crisis in the Pacific. Dr Tukuitonga

concluded his remarks by thanking the participants for their time and anticipated that the meeting of Heads of Health becomes a regular occurrence for the sector.

6. Dr Liu Yunguo, World Health Organization (WHO) Representative to the South Pacific and Director of Pacific Technical Support, also thanked the participants and acknowledged the partners whose assistance made the meeting possible. He stated that WHO is undergoing a reorganisation. Concluding his remarks, Dr Yunguo anticipated a positive meeting and outcomes that would enable WHO to better assist the Pacific region in fulfilling its health needs.

7. The guest of honour, Dr Neil Sharma, Honourable Minister of Health, Fiji, gave the keynote address. He highlighted several key initiatives in the region, including the Pacific Health Development Framework (PHDF) and the Pacific Monitoring Alliance for NCD Action (Pacific MANA). He stated that Ministers trust that the participants will produce an outcomes document that assists the region in driving the way forward for health. Continuing, Dr Sharma strongly recommended that participants build on the successful Healthy Islands Initiative, outlined in the 1995 Yanuca Declaration and reinforced several times since.

8. Dr Sharma concluded the address by highlighting several issues related to surveillance and epidemic response. The region should anticipate making improvements in both areas. Also, sexual health and wellbeing services should be integrated into general health services, resulting in health services being more horizontally integrated instead of segregated into vertical silos.

Agenda 2. WHO Framework Convention on Tobacco Control (FCTC) Secretariat Update

Led by: Dr Haik Nikogosian, Head of the Convention Secretariat, WHO Framework Convention on Tobacco Control (FCTC)

9. Dr Haik Nikogosian, Head of the Convention Secretariat, WHO Framework Convention on Tobacco Control (FCTC), presented an update. The FCTC is the world's first modern global public health treaty and a milestone development in public health. The FCTC was adopted in 2003 and entered into force in 2005. Within less than ten years, 95% of all countries ratified the FCTC. The convention has almost universal acceptance and is one of the most widely accepted instruments in the history of the UN. More than 90% of countries adopted new or strengthened tobacco laws after ratification of the FCTC.

10. The main problems related to tobacco include sales to minors and illicit trade. The *Protocol to Eliminate Illicit Trade in Tobacco* is essentially the second public health treaty, as international protocols often eventually become formal treaties. An estimated nearly 10% of tobacco trade is illegal; this statistic is close to 50% in developing countries. Among the 54 countries that signed the Protocol, the only Pacific country to ratify it was Fiji. WHO understands that Fiji is close to adopting the Protocol, following its ratification. However, WHO is unaware of any other Pacific countries' efforts to ratify the Protocol. Illicit trade in tobacco is a trans-national and cross-border issue, as well as an important inter-sectoral issue, including health, customs, law enforcement, foreign affairs, and justice. The Protocol is primarily a health protocol and if the health sector does not drive it, other sectors in the Pacific region will. SPC is an official supporter of the protocol and its work will be important to the protocol. Dr Nikogosian concluded his remarks by requesting that the Heads of Health support the *Protocol to Eliminate Illicit Trade in Tobacco*.

Agenda 3. Review of outcomes of Apia PHMM: Directives and Progress

Led by: Dr Siale 'Akau'ola, Director of Health, Tonga

11. Dr 'Akau'ola presented the actions of the First Heads of Health Meeting in 2013. The Heads of Health approved five actions in 2013. Activities have occurred regarding each of the five actions.

12. Regarding a review of the Pacific Plan, in 2013 Heads of Health (HoH) recognised the weaknesses of the current Pacific Plan but agreed on the potential value of 'more health' content in the revised plan. Heads of Health agreed to prepare a submission to the Pacific Plan Review Team on behalf of the group. This review has been completed.

13. Regarding regional public goods (RPGs), in 2013 HoH appreciated the discussion of RPGs and agreed on the need for clarity on what constitutes RPGs and how they can support and add value to country level work. The group agreed on the supremacy of national developments and that an 'inclusion/exclusion list' of RPGs was not appropriate. Rather, a process for deciding what should be regarded as an RPG was needed. The group recognised the need for further discussion on this topic. This information was noted and incorporated where appropriate into relevant documents, such as the NCD Roadmap, the draft Pacific Framework for Health Development, and the Pacific MANA plan. These would be discussed during the 2014 HoH meeting.

14. Regarding the regional health architecture, HoH agreed in 2013 that the current architecture for regional health could be improved and the decision-making processes could be streamlined. No rationale exists for the arrangements currently in place, resulting in duplication of effort and inefficiencies. The group agreed on the need to strengthen links with Pacific Islands Forum Leaders. Several models were discussed at the 2013 meeting but no decision was made on the architecture. Decisions on the optimum architecture were considered as part of the development of the Pacific Framework for Health Development and incorporated into the draft framework.

15. Regarding holding a Heads of Health meeting, in 2013 all Heads of Health agreed on the need to hold HoH meetings on an annual basis. Annual meetings would enable HoH to discuss matters of mutual and strategic interest to health in the region. The group requested SPC to draft Terms of Reference (ToR) for the annual HoH meeting, outlining the purpose and conduct of the meetings. As a result, SPC developed a draft ToR, which would be discussed during the 2014 HoH meeting.

16. Regarding the Pacific Framework for Health Development, in 2013 HoH discussed the lack of a planned approach and agreed strategy to guide regional health development in the Pacific region. The group recognised the inefficiencies, as well as the financial and opportunity costs inherent in the absence of guidance. References were made to the benefits of an agreed framework in the education sector. The group agreed to develop the Framework based on the background paper presented in 2013, including the process for progressing this issue. As a result, a draft Framework was developed and would be discussed during the 2014 HoH meeting.

Discussion:

17. Following the presentation, Dr Tukuitonga, SPC, noted that all the items are on the agenda except for the Pacific Plan. It is unfortunate that there will be no additional inclusion of health in the Framework, the updated Pacific Plan. Because the process of funding projects is at a more strategic level, individual projects no longer need to be listed in that document. The Leaders may decide in Palau, in July 2014, that they are interested in keeping NCDs on their agenda. SPC believes the Framework is an important document; it will guide future Pacific development.

Agenda 4. Terms of reference for the Directors of Health meeting

Led by: Dr Dr Siale 'Akau'ola, Director of Health, Tonga

18. Dr 'Akau'ola presented the Terms of Reference for the Heads of Health Meeting, which had been discussed extensively at the 2013 HoH Meeting. He began by stating that the name of the meeting is a concern; the group must decide if it is the 'Heads of Health' or the 'Directors of Health'. 'Heads' is the terminology used in other sectors under the Forum architecture to describe the secretaries and directors general of a sector. Standard terminology in other sectors is also to use the term 'Forum' to describe ministerial level groupings and 'Heads' of sector to describe official level groupings (for example, the Heads of Statistics).

19. The role of the HoH is to ensure that Health Ministers are provided with clear guidance, advice and support from their senior officials to enable them to make informed decisions on policy options to address regional health issues of strategic importance. The HoH meet as a 'policy advisory' and technical group, providing a governance oversight role for regional functions, including RPGs in health. The group has four core values: accountability, efficiency, aid effectiveness, and to ensure a clear focus.

20. The meeting chairperson will be from the country that hosted the last Pacific Health Ministers Meeting and the deputy chairperson will be the country hosting the next Pacific Health Ministers Meeting. This will ensure maintenance of a strong link with the Pacific Health Ministers Meeting and continuity in sharing institutional knowledge from outgoing to incumbent chairperson.

21. The HoH meeting has seven main responsibilities. It should:
    a. Advise Pacific Health Ministers, and through them Forum processes, on health issues of strategic importance to the region, including the development of a collective view on global health developments relevant to the Pacific region.
    b. Oversee the development and regular updating of the Pacific Framework for Health Development (PFHD) for approval by Pacific Health Ministers and the Pacific Island Forum (PIF) Leaders, as appropriate, and ensure it complements and adds value to National Health and Development Plans.
    c. Advise the Pacific Island Forum Secretariat (PIFS) on implementation of both the PFHD and the revised Pacific Plan as it relates to health, within and outside the health sector.
    d. Provide advice and commission analysis to inform policy development by Ministers in relation to regional services and the delivery of RPGs.
    e. Oversee implementation and ensure efficient mechanisms for cooperation on policy and technical health issues. This would provide regional bodies, such as the Pacific Islands Regional Multi-Country Coordinating Mechanism (PIRMCCM), with stronger links to the regional architecture of the Pacific Health Ministers and PIF Leaders.
    f. Direct the Secretariat to commission analysis to inform decisions or evaluate performance of agreed functions or activities (working with other bodies as appropriate).
    g. And assist the Pacific Plan Advisory Committee (PPAC) and the Committee of Regional Governments and Administrations (CRGA) to guide and monitor the work of regional partners and the United Nations, which are responsible for delivering regional services agreed in the Pacific Plan and the Pacific Framework for Health Development, noting that agencies have their own processes, systems and accountabilities.

22. The Heads of Health may establish sub-committees, standing committees and working groups to assist its operations. Standing committees are time limited, operate under similar Terms of Reference, and are subordinate to the HoH.

23. The HoH should meet annually. The meetings should occur outside the period of May to August, when Ministries are preparing their annual plans and budgets. During years when Pacific Health Ministers hold their biennial meeting, the HoH Meeting will be held no less than six months before the Ministers meeting. This will help shape the agenda for the Ministers meeting and assist in its preparation.

24. For the first instance of the HoH meeting, the secretariat services for the committee will be provided by SPC, with support from WHO and strong links to PIFS. HoH retain the right to review and modify the secretariat arrangements.

25. Prior to concluding, Dr 'Akau'ola displayed a chart showing that the Pacific region's critical guiding documents are linked to the designated health authorities in the regional health architecture. Development partners and technical agencies assist with these linkages. The interim chair then concluded the presentation of the Terms of Reference by requesting a nomination for the formal chairperson of the Heads of Health Meeting.

Discussion:

26. Mrs Elizabeth Iro, Secretary of Health, Cook Islands, requested that the interim chair continue until the ToR are approved. With approval of the ToR, the new chair would be automatically selected.

27. Dr Tukuitonga, SPC, stated that the ToR are meant to guide the group's work. Heads of Health and colleagues already extensively discussed and refined them. The ToR, however, are not 'black and white'. The document guides the work of the HoH and can be amended; elements can be added or deleted. The question at hand is whether it captures the essence of what the HoH want to do and whether there are elements that are significant enough to require immediate change.

28. Mrs Sylvie Andre, Director of Health, French Polynesia, stated that the Pacific Island Territories represented at the meeting do not have representation in the Forum ministers meetings and this could pose a problem. Dr Tukuitonga responded that the HoH must decide whether or not it operates 'under the auspices' of the Pacific Island Forum Leaders. Dr Eloni Tora, Permenant Secretary for Health, Fiji, responded that if the meeting makes health its key objective, it should go beyond borders. The group should include every director of health in the Pacific region. He concluded his comments by stating Fiji's support that the meeting opens its membership and that the issue of health be at the head of the agenda, as opposed to membership.

29. Mr Darius Everett, Director, International Relationship and Coordination Section, Australia Department of Health, stated Australia's support of the group. He stated that the ToR should include an element on membership and rules for governance.

30. Leausa Tole'afoa Dr Take Naseri, Director General of Health, Samoa, proposed that mention of the Forum should be dropped from the background portions of the ToR.

31. Mrs Iro, Cook Islands, motioned that the ToR be adopted, subject to the recommended changes being made. The motion was seconded by Mr Manila Nosa, Dorector of Health, Niue, and the ToR were adopted.

32. The interim chair suggested that, following the ToR, the chairmanship be given to Samoa, the host of the last HoH Meeting. The deputy chairmanship should be given to Fiji. Dr Naseri, Samoa, and Dr Tora, Fiji, then assumed their positions as chair and deputy chair.

Agenda 5. Review of Outcomes of Apia PHMM: Directives and Progress

Led by: Dr Temo Waqanivalu, Coordinator, Non Communicable Diseases, Office of the WHO Representative in the South Pacific

33. Dr Waqanivalu introduced the presentation reviewing the outcomes of the Apia Pacific Health Ministers Meeting (PHMM) by stating that the presentation would focus mainly on the NCD and the mental health components of the outcomes. He began with the NCD component.

34. The Apia meeting agreed to adopt NDC targets. The tobacco target was easy for Ministers to agree on; the meeting forged a goal for a *Tobacco Free Pacific by 2025*, with an adult smoking prevalence of less than 5% in each country. FCTC compliant legislation should be enacted and enforced. Tobacco taxes should be raised, with multi-year tax plans making taxes 70% of tobacco's retail price. Every school and town should become a tobacco free setting. Smoking cessation support services would be integrated into the Package of Essential NCD Services (PEN). Also, networking and advocacy on tobacco would be reinforced.

35. Regarding the *Tobacco Free Pacific by 2025*, HoH should support, advocate, and budget for the establishment of a tobacco control enforcement unit or a designated coordinator. Ministers of Health should be encouraged to collaborate with Attorneys General and Ministers of Justice to draft legislation on tobacco control and strengthen enforcement. HoH should support and budget for continued NCD surveillance, which includes tobacco-related survey items. HoH should also support and budget for the development of appropriate tobacco cessation services as well as capacity building for skill development of the cessation services workforce.

36. Targets should also be developed for recommended levels of fat, sugar and salt in food and beverages for the Pacific region. This would enable the creation of legislative and regulatory measures for locally produced and imported processed foods and beverages as well as to protect children from marketing of products high in salt, fat and sugar. It would facilitate achievement of the *Political Commitment to Resilient Action* made at the Fifth Pacific NCD Forum in September 2013; this involves the three key pillars of tobacco control, healthy diet and physical activity (including salt reduction), and cardio-vascular disease (CVD) management and counselling, implementing PEN. It would also include regulation of marketing of foods to children.

37. Regarding salt, the goal would be to have a 30% reduction in salt intake by 2025. Lower salt intake leads to lower blood pressure, which leads to lower incidences of CVD. Some options for implementing lower salt levels include food standards, taxation, labelling standards, and voluntary compliance. Monitoring and enforcement can be achieved through national food control systems strengthening, including food import control, shop surveys, and development of databases on sodium content in foods. Strong monitoring and enforcement require structured and risk-based approaches as well as robust methodology to ensure consistency over time.

38. The Pacific should undergo a phased implementation of the Package of Essential NCD Services. The PEN helps close the gap between what is needed and what is currently available for improved coverage. It uses the primary health care facility as a setting for healthy living and facilitating people-centred and integrated NCD services focussed on reducing or delaying major NCD outcomes. It integrates public health and clinical approaches for NCD at the most important levels: the people and their communities. This approach integrates public health and clinical approaches. Implementation would include model laws and discussions at the regional level, legislation and enforced regulations at the national level, and health promotion in schools at the local level. PEN is the entry point for strengthening the health system, including the pharmaceutical system and the health information system.

39. Dr Waqanivalu concluded the presentation by highlighting the mental health outcomes, which were well aligned with the WHO Action Plan 2013-2020. As a result, the Pacific region's efforts on mental health are well aligned with global health efforts. Another major point to consider is that there are only 15 psychiatrists in the Pacific region. Efforts include revitalising the Pacific Islands Mental Health Network (PIMHN), which was launched in 2007. A Mental Health Officer was added to the WHO Pacific Office. The Ministers' outcomes included seven recommendations:
    a. Strengthen national and regional leadership to drive the mental health agenda, support legislation and policy, and combat stigma.
    b. Strengthen the evidence base on the burden of mental disorders, utilizing tools and methodologies that are appropriate for the Pacific context and tailored to country needs.
    c. Develop and strengthen comprehensive education and training for human resources in the region for a full range of mental health care services, responding to the levels of need.
    d. Integrate mental health into general health and community-based services.
    e. Strengthen the existing network and multi-sectoral partnership mechanisms to promote capacity-building and coordination
    f. Expand mental health service delivery, utilizing existing infrastructure and tailored services to meet diverse population needs.
    g. Address prevention, social determinants and risk factors, and promote mental health as part of holistic well-being.

40. The way forward on mental health in the Pacific region includes establishment of a Mental Health Programme and designation of a mental health post within each Ministry of Health. Mental health policies and laws should also be revised to make them rights-based. Mental health must be integrated into primary health care and communities, including annual monitoring of core indicators. WHO offered to provide support to achieve these activities.

<u>Presentation: Civil Registration and Vital Statistics (CRVS) and the Pacific Vital Statistics Action Plan (PVSAP) 2011-2014</u>
Led by: Ms Audrey Amua, Health Information Systems Knowledge Hub (HisHUB) Manager, University of Queensland

41. Ms Amua, University of Queensland, began the presentation on the CRVS component of the 10th Pacific Ministers of Health Meeting by providing background on the importance of CRVS. Accurate data on births, deaths, and cause-of-death are essential for monitoring population health, identifying health priorities, evaluating health and program impacts, providing context for a broad range of social and development investments, and providing up-to-date data for the

calculation of population-based indicators for tracking development progress (such as for the Millennium Development Goals and the National Minimum Development Indicators).

42. CRVS provides real data for real decisions. While estimates of fertility and mortality serve an important function in highlighting the potential scale of a problem or calling attention to issues that may otherwise go unnoticed, they are not a substitute for real data. Also, CRVS facilitates registration, which protects rights. Civil registration delivers an important legal function through the provision of legal identity. Children without a legal identity are at greater risk of trafficking, statelessness, and arguably violence.

43. At the Apia Pacific Health Ministers Meeting, Ministers recognised the importance of:
    a. Health information systems (HIS) and civil registration and vital statistics (CRVS) for setting health priorities and the effective use of resources to address these health priorities, and in evaluating health system responses and performance.
    b. HIS and CRVS systems for monitoring and accountability.
    c. Cause of death and mortality level data in monitoring health outcomes.
    d. Encouraging a culture of information use and planning based on evidence.
    e. A multi-sectoral approach to HIS and CRVS.
    f. And the importance of integrating data from surveillance systems into the broader HIS.

44. In 2010 the HISHub at the University of Queensland convened a meeting of several agencies concerned with improving vital statistics in the Pacific region. The Brisbane Accord Group (BAG) was established at this meeting, with the aim of providing strategic and technical support to countries around vital statistics improvements, and providing a more coordinated response from partner agencies. Following the BAG's establishment, the *Pacific Vital Statistics Action Plan (2011-2014)*, or PVSAP, was developed, becoming the mechanism through which partners coordinate technical assistance. The overarching aim of the plan is to assist Pacific countries to improve their statistics on birth, death, and cause-of-death through routine collections and thereby provide decision-makers with evidence needed for effective planning. The plan is under the *Ten Year Pacific Statistics Strategy (TYPSS) 2011-2020* and is a regional statistical priority.

45. In 2013, both the Heads of Planning and Statistics and the Pacific Health Ministers meetings encouraged countries to formalise their CRVS committees, conduct assessments of CRVS systems, develop national CRVS improvement plans, obtain high-level endorsement and support for the improvement plans, ensure CRVS is embedded in countries' National Statistics Strategies, and ensure vital statistics are routinely updated in the National Minimum Development Indicators (NMDI) database. For the second phase of TYPPS, BAG partners re-conformed their commitment to a second round of the PVSAP for 2015 onwards. In 2014, Pacific countries will be invited to participate in the broader Asia-Pacific Regional Action Framework for CRVS, led by UNESCAP. A Ministerial meeting will be held in November in relation to this action framework.

Discussion:

46. Dr 'Akau'ola, Tonga, asked if any update was performed on marketing of fast food in the Pacific. This had been initially presented in a in a paper at the Pacific Health Ministers Meeting. Dr Waqanivalu, WHO, responded that marketing of foods and non-alcoholic beverages is rampant in the Pacific, specifically to youth. Fiji is making efforts to have a blanket ban on fast food marketing but this is struggling. Childhood obesity is an important problem in the Pacific region and WHO looks forward to increased participation by HoH on this issue.

47. Mr Russell Edwards, Acting Secretary of Health, Marshall Islands, stated that the region has seen many public education campaigns but needs to capitalise on legislation backed by data. Marshall Islands has a high prevalence of cancer but the amount of cancer related to tobacco use is unknown because of a lack of data. Ms Amua, University of Queensland, responded that the HISHub is making efforts to define the scope of the tobacco problem in the Pacific region. It is researching what people are dying from and where were they living. The HISHub needs to be sure that countries' death certificates are being used correctly and that doctors are completing them correctly. This kind of data quality will help decision makers form their policy decisions.

48. Dr Ian Rouse, Dean of the College of Medicine, Nursing and Health Sciences, Fiji National University, stated that tobacco is the most significant contributor to NCDs. If HoH do not share the resolve against NCDs the region may loose a generation of Pacific Islanders. Dr Waqanivalu responded that enacting and enforcing legislation are the best ways to combat NCDs caused by tobacco. Fiji is embarking on an effort to put this portion of its NCD plan into law.

49. Mr Tuileama Toatala Nua, Director of Health, American Samoa, stated that tobacco companies today are working hand-in-hand with e-cigarette manufacturers. The United States Centers for Disease Control and Prevention (CDC) are performing research to make decisions related to e-cigarettes. American political appointees and doctors are puzzled with how to handle the issue of e-cigarettes. Mr Nua concluded his comments by requesting that HoH be provided information for addressing the media on e-cigarettes.

50. Dr Nikogosian, WHO Framework Convention on Tobacco Control, stated that e-cigarettes have several features. They are promoted as a smoking cessation product; no evidence has come to light to support this claim. E-cigarettes could contribute to re-normalization of smoking and, through that, promotion of cigarette smoking. A political debate is underway on whether e-cigarettes are a tobacco product or not; some countries categorise e-cigarettes as tobacco, some as medicinal, and some ban the product entirely. The Conference of the Parties (COP) will formally address the e-cigarette issue in October 2014; countries should closely monitor the COP process before making their legislative and regulatory decisions. WHO also published a paper on e-cigarettes for the last COP (November 2012), which is available to countries from WHO.

51. Following-up, the Chair requested that Dr Waqanivalu provide an information paper on e-cigarettes and options to countries.

52. Mr Nua, American Samoa, concluded the discussion by stating that if Pacific region governments do not take a collective stand on e-cigarettes, each country will take its own position. HoH must educate Pacific populations about this issue.

Agenda 6. Heads of Health Closed Session

Led by: Leausa Tole'afoa Dr Take Naseri, Director General of Health, Samoa

53. Following the review of the outcomes from the Apia Pacific Health Ministers Meeting. Country representatives met in a closed session. The group agreed that the representatives from Australia and New Zealand should participate in the closed session. Representatives discussed topics that were not explicitly included on the agenda and formal minutes of the discussion were requested not to be taken.

Agenda 7. Feedback from Heads of Health closed session

Led by: Dr Eloni Tora, Permenant Secretary for Health, Fiji

54. The deputy chair presented a summary of the points discussed during the closed meeting of the Heads of Health Closed Session. He began by congratulating the Ministers of Health for making health an important issue on the regional agenda. The resolutions of the Ministers of Health Meeting should guide discussions for implementation and sharing of experiences. Interventions should be linked to the World Health Assembly (WHA) Global Action Plan for the Prevention and Control of NCDs (GAP). Since NCD will continue as a main issue, Ministries of Health must involve other ministries, such as finance, education, and justice, as well as legislators.

55. The HoH expressed appreciation for the important role of the HoH Meeting in setting the agenda and implementation plans for a healthier Pacific. Participants discussed the importance of a bottom-up approach to ensure interventions are implemented at the local level. Regarding evaluation of interventions, HoH requested assistance from development partners to do surveys to determine whether interventions are working (for example, on behaviour change in health).

56. Regarding donor coordination, HoH proposed that SPC work on strengthening coordination amongst donors. Donors often have their own indicators that are difficult to change. An example of an area where improved donor coordination was needed is Kiribati, where the largest support goes to TB and HIV but the least goes to NCDs, is the country's major public health problem.

57. HoH acknowledged that individual countries might have differing priorities. Some examples of this include tobacco not being a major priority for Palau, infectious diseases not being a major priority for Nauru, and the increased priority of rheumatic heart diseases (RHD), present in 34 per 1000 people in Tuvalu (which requested assistance from SPC and WHO on NCDs and RHD).

58. HoH discussed that countries should examine strategies that are practical for their interventions. Regarding reforming health services, Vanuatu is focusing on decentralising services, for example.

59. HoH discussed the importance of innovative ways to address health, especially the NCD problem. Other topics of similarly high importance include CRVS and the integration of services from hospitals to public health facilities (and vice versa).

60. Concluding, HoH acknowledged the importance of advisors in the Ministries of Health, such as the advice TB and NCD managers should provide on technical issues. HoH also stressed the importance of having interventions and strategies that are sustainable. Development partners should be encouraged to support interventions that can be sustainable at all levels. Finally, Heads of Health should be mindful of their own health and evidence of this mindfulness should be present at HoH Meetings.

Discussion:

61. Mr Everett, Australia, expressed appreciation for the discussion, adding that it was beneficial to have a frank and open dialogue about problems facing the region. Australia supported the involvement of finance ministries, whose participation presents a unique opportunity.

62. Ms Anna Pasikale, Deputy Director, Human Development, New Zealand Ministry of Foreign Affairs and Trade, stated that the closed session provided a useful opportunity for countries to

discuss issues of importance both at the country and regional levels. She expressed New Zealand's support for the discussion, which proved useful to highlight common issues.

63. Dr Tukuitonga, SPC, stated that the Pacific region is grateful that the Global Fund committed resources to fight HIV/AIDS and STIs. Even though the Pacific still has a low prevalence of HIV/AIDS, STIs are a different story. SPC does not have resources to provide a similar level of assistance on NCDs. The resources available in the region fall very short of what is needed. The Global Fund represents issues that are not priorities for the region and HoH must express this. The Pacific region should have a regional fund for STIs but it is important to protect what the region receives from the Global Fund. The region has nowhere near the resources needed to influence CVD, diabetes, gout and other NCDs.

64. Dr Tukuitonga continued, regarding donor coordination, stating that SPC does not have a mandate to coordinate anybody else. SPC would consider it, if this mandate were given to the organisation. All of SPC's work affects countries at the ground level. Coordination involving work on regional priorities is something SPC could do. Concluding his statement, Dr Tukuitonga noted that he sees HoH shaping the donor coordination process and charging SPC or WHO with executing it. The issue should potentially be explored and discussed more among HoH.

65. Dr Waqanivalu, WHO, commented that secretaries and directors of health are the front line for achieving grant change. Specifically, after seven years of efforts behind RHD, it continues to be only a research issue. Hopefully upcoming meetings can forge advancements on RHD.

66. Dr Tora, Fiji, stated that regarding donor coordination, HoH should go to the highest level to accomplish grant coordination. Fiji organised a donor coordinating unit within the Ministry of Health and also has regular meetings with donor partners. Countries cannot change donor-funded programs while they are running. The government of Australia expressed interest to hear about Fiji's experiences. Countries hold the key to development funds entering their borders.

67. Dr Rouse, Fiji National University, agreed with the problem of prioritisation and stated that often donors do not seem to work together. He was not convinced that Pacific populations understand the gravity of the NCD problem; for example, American Samoa recently closed a hospital ward to build another dialysis centre. In some countries, the cost of offshore referrals is 40% of their health budget; these referrals are not for TB and STIs. Countries should examine what would work best for each of them, with their individual restricted levels of resources. Pacific-wide, the amount of resources for combating NCDs is much too small for the size of the problem.

68. Mr Terieta Mwemwenikeaki, Secretary of Health, Kiribati, expressed agreement that the resources available are much smaller than the demand. He stated that Kiribati is also seeking donors outside the common donor circle and that the country should make greater efforts to collaborate with PIFS on donor coordination.

69. Mr Filipe Jitoko, Social Policy Advisor, PIFS, stated that the Forum made considerable efforts on the Cairns Compact on Strengthening Development Coordination (2009). This included peer reviews by all the Forum member countries involving participation of ministries of national planning and the ministries coordinating donor funding. Another activity involved peer learning to determine what development projects work best in each country.

70. Mr Edwards, Marshall Islands, expressed the importance of performing pre-diabetic work. He stated that not enough efforts are being made after diabetic testing. The Chair responded that this issue should be raised at the SSCSiP meeting, which would make a recommendation to HoH. Dr Tora, Fiji, also responded that kidney dialysis is outsourced in Fiji. He expressed appreciation for the idea from Marshall Islands and expected to discuss it more.

71. Upon request, the Chair received unanimous approval of the outcomes of the closed session.

72. Dr Waqanivalu, WHO, concluded the discussion by stating that the topics of risk profiling and counselling should be included in the HoH Meeting. HoH should also be champions of the battle against NCDs.

Agenda 8. Joint Forum Economic and Health Ministers Meeting

Led by: Dr Paula Vivili, Deputy-Director, Public Health Division, SPC

Presentation: Roadmap for Responding to the NCD Crisis in the Pacific

73. Dr Vivili began the presentation by presenting the World Bank report titled 'The Economic Costs of Non-Communicable Diseases in the Pacific Islands' (November 2012). The report was a rapid stocktake of the situation in Samoa, Tonga, and Vanuatu. The report had three key messages:
    a. NCDs can impose large health, financial and economic costs on countries.
    b. Risk factors in the Pacific are feeding a pipeline of potentially expensive to treat NCDs, including diabetes and heart disease.
    c. From a public health and public finance perspective, many NCDs are avoidable or their health and financial costs can be postponed through primary and secondary prevention.

74. Dr Vivili then presented some country examples of the economic costs of NCDs. These included drug costs alone, in one PICT, for treating one diabetic patient equals the drug budget for 76.4 other patients. Dialysis in another PICT costed $38,686 per patient per year in 2010-2011: more than 12 times GNI per capita. Dr Vivili then displayed several charts showing prevalence of obesity, diabetes, and proportional mortality attributable to NCDs in PICTs.

75. In the 2013 Forum Economic Ministers Meeting (FEMM) Action Plan, Ministers made three decisions relating to NCDs in the Pacific region. These included the Ministers agreeing 'to include NCDs as a standing agenda item for future FEMMs' and requesting SPC 'to provide updates on the development of the NCD roadmap'. Ministers also requested SPC 'to present the finalised NCD roadmap to Economic Ministers in 2014, outlining the specific role and contribution of Economic Ministers in strengthening NCD prevention and control in the Pacific region.' Related to the Joint Economic and Health Ministers Meeting, PIFS and SPC should 'explore options for a joint meeting of Economic and Health Ministers to promote greater collaboration to tackle the epidemic rate of NCDs in the region.' As a result, the Roadmap has political commitment, involving concern from both Ministries of Health and Ministries of Finance. It therefore presents an opportunity to address a joint meeting of Ministers of Finance and Ministers of Health. The inclusion of 'social determinants of health' means a multi-sectoral approach is required.

76. Dr Vivili then provided the roadmap's scope. It has a special focus on accountable offices, such as the Prime Minister's Department, Finance and Economic Ministries, and Health Ministries. It also includes other line ministries involved in combating NCDs, such as Justice, Trade, Education,

National Statistics, and Police. Other stakeholders include development partners, civil society and regional organisations.

77. Some of the roadmap's key messages include that NCDs are already causing a health crisis in the Pacific, with most of the trends and risk factors pointing to a substantial worsening of the situation unless action is taken immediately. Several NCD-related programs are already financially unaffordable and unsustainable. Growing NCD burdens, combined with modest economic growth, will inevitably further squeeze budgets of ministries of health and ministries of national development unless urgent action is taken. Fortunately, many NCDs are preventable or their health and financial burdens can at least be postponed.

78. The roadmap contains four key recommended actions all countries in the Pacific can take: take tobacco control measures, reduce unhealthy food and drink, improve the efficiency of existing health funds, and strengthen the evidence base to ensure resources are well used. Each of the four key recommendations has a 2014-2017 timeline. In addition, it includes a menu of over 30 multi-sectoral interventions that countries can choose to use.

79. Tobacco is a key driver of the NCD crisis. The product kills one-half to two-thirds of its users. Tobacco causes or worsens all NCDs. Countries should raise their excise taxes on tobacco to 70% of its retail price. Countries should implement tobacco control, including on advertising and restricting single-stick sales of tobacco products.

80. Regarding food and drink, obesity in PICTs has become the highest in world. Lowering salt intake reduces high blood pressure. Consumption of sugary drinks raises the risk of diabetes. Alcohol consumption contributes to traffic accidents and domestic violence. The availability of other processed and junk food can be regulated. Increased taxes and restricting marketing to children are ways to implement change.

81. Regarding improved efficiency of use for existing health funds, the Package of Essential NCD interventions should be scaled up as part of broader health sector reforms. The Pacific region has a wide variation in drug prices (such as the ten-fold difference in price of the drug simvastatin between the countries of Nauru, Cook Islands and Kiribati). Sometimes difficult decisions must be made such as whether dialysis is effective, equitable, and affordable for populations.

82. For improving the evidence base for decision making, research must be performed on who treats NCDs well and at an efficient cost. The cost for scaling up PEN, including recurrent costs, must be determined. The most cost-effective way of strengthening health promotion and awareness must also be determined.

83. Dr Vivili concluded the presentation on the roadmap by highlighting its two desired outcomes. The region should endorse the four key recommendations. Also, PICTs should commit to developing their own country roadmaps, combining actions on the four recommendations and feasible options from the menu of over 30 multi-sectoral interventions.

Discussion:

84. Mr Everett, Australia, began the discussion by expressing Australia's strong endorsement of the roadmap. He added that advocating for additional resources might be necessary.

85. In response to comments that other recommended actions should be added as priorities, Dr Vivili, SPC, noted that the key recommendations were based on evidence and established priorities from the Pacific region. Different countries may have different priorities, which can be addressed by implementing actions from the menu of multi-sectoral interventions.

86. Dr Xiaohui Hou, Senior Health Economist, World Bank, stated that the World Bank performed selected in-country consultations of the NCD Roadmap. The World Bank is interested to hear if the roadmap is relevant for the region and how to make it more relevant to countries. Dr Hou also asked how the roadmap could be made more persuasive for the Economic Ministers. Dr Tukuitonga, SPC, added that it would be helpful to hear from HoH regarding whether the proposal would be supported by individual Ministers of Health and if they can convince the Ministers of Finance of the roadmap's feasibility.

87. Dr Anne Pfannenstiel, Doctor in Charge of Public Health Programs, *Direction des Affaires Sanitaires et Sociales* (DASS), New Caledonia, requested that SPC update its charts on NCD prevalence in PICTs to include New Caledonia. Dr Vivili responded that SPC is collaborating with New Caledonia to include data from all the francophone PICTs in the NCD roadmap.

88. Dr Tenneth Dalipanda, Under Secretary Health Improvement, Solomon Islands, noted that the language on the roadmap seems soft and that including strengthening of legislation might improve it. Usually monitoring is a way to implement these sorts of changes and formulation of legislation often takes several years.

89. Dr Samuela Korovou, Acting Director Medical Services and Assistant Director Public Health, Nauru, expressed Nauru's support for the four key recommendations but noted a concern: Nauru is a tax-free country. The government of Nauru is, however, considering introducing taxes. Reducing unhealthy foods in Nauru will be difficult because the country does not grow most of its own food; it is almost all imported. The Ministry of Health will need to collaborate with customs to accomplish this.

90. Dr Tora, Fiji, expressed support for the two recommendations on tobacco control and reducing unhealthy food and drink. The recommendations on improving efficiency of funds and strengthening the evidence base may cause problems for Fiji's Minister of Health. Fiji is making efforts to increase its health funding rather than increasing efficiency. Dr Vivili, SPC, responded that the intention of the recommendation to increase efficiency of funding was in addition to looking for additional funding resources.

91. Mrs Iro, Cook Islands, stated that some information in the presentation on Cook Islands is incorrect. As a result of Cook Islands tobacco taxation, the country accesses additional monies for a health promotion fund. Related to the initiatives described in the roadmap, the challenge is to implement activities for longer than a one-week period; often health activities 'fizzle out' and ministries should emphasise such important agenda items throughout the year.

92. Representatives from the following countries endorsed the roadmap recommendations: Cook Islands, Federated States of Micronesia (FSM), Kiribati, Palau, Samoa, Tokelau, and Tonga. Dr Vita Skilling, Secretary of Health and Social Affairs, FSM, added that two of FSM's four states declared NCDs to have an emergency status. Following these statements of support, the Chair noted the group's consensus to endorse the recommendations from SPC.

Presentation: Update on the Joint Economic Health Ministers Meeting

93. Dr Vivili continued the presentation by providing an update on the upcoming Joint Economic and Health Ministers Meeting. The meeting will occur on 11 July 2014. The agenda for the meeting will be composed of the NCD Roadmap. The Joint Meeting will be preceded by a two-day Pacific Health Ministers Meeting (9-10 July). The desired outcomes of the Joint Meeting are the approval of the NCD Roadmap and viewing examples of NCD Country Roadmaps from some PICTs. The meeting will be held in Honiara, Solomon Islands. Concluding the presentation, Dr Vivili displayed an outline of the provisional agenda for the Joint Meeting, including a session when three or four PICTs would present their roadmaps to the meeting.

Discussion:

94. Mr Everett, Australia, praised the initiative and recommended forging early interventions between Health and Finance Ministers.

95. Noting no further comments, Dr Vivili concluded the discussion, stating that SPC can provide additional feedback upon request. SPC and PIFS are relying on HoH to discuss the meeting with finance counterparts. The World Bank has also collaborated on this. He also noted that more opportunities would be available in the future for countries that have not yet had consultations.

Agenda 9. Specialized tertiary care and clinical services

Led by: Dr Siale 'Akau'ola, Director of Health, Tonga

96. Dr 'Akau'ola presented on the Strengthening Specialised Clinical Services in the Pacific (SSCSiP) initiative. The initiative was funded by the Government of Australia and began in 2005. It ends in 2014. SSCSiP's vision is that all PICTs, irrespective of socio-economic or geographic status, have access to quality clinical care. Its aim is to achieve stronger planning and clinical services with the aspiration of having improved coordinated alignment of quality clinical support in the Pacific region. Dr 'Akau'ola then proceeded to present the meeting recommendations.

97. Regarding specialised clinical services (SCS), a regional statement from Pacific leaders is needed to acknowledge the important role of SCS. Also SCS should be incorporated into the Pacific Plan through the Pacific Islands Forum and implemented by SPC.

98. Regarding governance, a regional support program for SCS, like SSCSiP, should continue and be absorbed by SPC, preferably with Suva as its location. A change is needed in the mode of delivery from project-oriented to program-oriented. Pacific directors of clinical services must provide an independent governance mechanism for SCS in the Pacific region. SSCSiP has a preference of being a program in transition, for about one year, to a regional organisation.

99. Dr 'Akau'ola laid out several specific clinical support categories and their recommended functions. Clinical service delivery should be composed of a visiting team program for the Pacific region and the capacity building functions that accompany it. Biomedical support should include standards, maintenance support, capacity development, regional procurement, management systems, guidelines and policy support. Human resources for SCS should include HR planning, capacity building, continuing medical education, mentoring, accreditation and registration, in addition to HR information systems for SCS, research and data analysis. Country planning and management systems for SCS should include support for referral systems, management systems for visiting teams, standards, research and data analysis, HIS for SCS, planning and monitoring

and evaluation. Governance and coordination for regional support programs should be performed through a mechanism composed of Pacific senior ministry of health representatives and development partners.

100. Regarding sub-regional SCS activities, the Kiribati internship training program in Cuba (KITP) should continue; it currently caters for applicants from Kiribati, Nauru and Tuvalu. Also a visiting team and specialists should be shared between Pacific Island Countries.

Discussion:

101. Dr Tukuitonga, SPC, stated that the issue is to determine the best way so support this low-volume high-cost service for the region; this is not SPC's forte and further discussions should occur on the issue. For example, human resources for health have been a specialty of WHO for many years. Discussions should occur on whether SPC is the best organisation to house this facility over the long-term.

102. Ms Kerry Flanagan, Deputy Secretary of Health, Australia, noted that Australia was entering its budget process, when it would review its health processes more broadly. Further support for SCS will be guided by this review and by Australia's new regional health strategy. Although Australia funded this program in the past, it cannot provide support beyond December 2014.

103. Mrs Andre, French Polynesia, requested additional details on KITP in Cuba. Dr 'Akau'ola, Tonga, responded that Cuba developed a curriculum and a capacity building program on SCS. This training is being made available to applicants outside Cuba.

104. Dr Rouse, Fiji National University, stated that FNU is committed to help with the future of the program. SSCSiP is a consulting project housed within the Fiji Medical School Dean's Office. Such a consulting program is traditionally out of place in a university context.

105. Dr Tukuitonga, SPC, responded that regardless of sub-committees, the HoH meeting is the best forum for discussions about the important topics on public health in the region, including this topic. Before December 2014, HoH should discuss the next steps for SSCSiP; he extended SPC's offer to hold a meeting for this discussion.

106. Dr Rouse, Fiji National University, concluded the discussion by expressing enthusiasm about Dr Tukuitonga's comments. He anticipated collaborating with SPC in the next several months before the SSCSiP program closes.

WEDNESDAY, 30 APRIL 2014

Agenda 10. Summary of previous day and Revision of ToR

Led by: Dr Paula Vivili, Deputy-Director, Public Health Division, SPC

107. Dr Vivili, SPC, gave an overview of the previous day's proceedings. Afterward, Dr Tukuitonga noted his appreciation for the summary and emphasised that more discussions must occur on many topics. The Chair, noticing no additional comments, noted the adoption of the summary.

108. Dr Vivili then presented the changes to the ToR that were agreed to by the participants the day before. The proposed revisions were distributed to the participants the day before via e-mail.

109. The Chair asked if funding was available for the HoH meeting. Dr Tukuitonga responded that SPC could not fund it but would search for funding due to the meeting's importance. He acknowledged funding by Australia and the New Zealand Aid Programme for the 2014 meeting.

110. Mrs Iro, Cook Islands, asked if membership should be clarified or identified. She noted that proposed language on membership could be: Membership will consist of 'Heads of Health (including CEOs, Directors, Director Generals, Permanent Secretaries, and Secretaries)' of PICTs, and include Australia and New Zealand. Dr Tukuitonga responded that the meeting is for health colleagues. Participants would expect that health colleagues from Australia and New Zealand would be those countries' representatives.

111. The Chair stated that attendance should be included in the ToR and proposed language: 'Member countries and territories are encouraged to send their Head of Health to the annual HoH meetings.'

112. Ms Pasikale, New Zealand, asked if participants agreed to hold the meeting on an annual basis, noting that the meeting frequency has funding implications. Dr Tukuitonga responded that the meeting frequency had been discussed extensively the past year and an annual event was highly desirable. That frequency had been endorsed as part of the ToR submitted to the Ministers. He stated that the meeting should be held annually until a rhythm is found.

113. Mrs Andre, French Polynesia, noted that her concerns had been addressed in the revision and the Chair noted that all the participants agreed with the ToR. As a result, the document was approved unanimously.

Agenda 11. Regional health architecture

Led by: Dr Paula Vivili, Deputy-Director, Public Health Division, SPC

114. Dr Vivili, SPC, presented the Pacific Health Development Framework 2014-2018. Its theme is 'towards healthy islands, healthy people'. Dr Vivili emphasised that it is not a regional strategy; it is a regional framework for use by Pacific ministries of health. In 2012, Pacific Leaders called for clarification of the strategic direction for the health sector in PICTs. In 2013 Pacific Health Ministers and Heads of Health also supported the Framework's development.

115. The Framework is a comprehensive multi-sectoral approach for addressing PICTs' health needs. It emphasises social determinants, universal health coverage and efficient utilisation of available resources. There are six key principles underpinning the Framework: the Healthy Islands Vision (as articulated in the 1995 Yanuca Island Declaration), health in all policies, health as a resource for development, aid effectiveness, cooperation with a unified Pacific regional voice, and a life course approach. At the national level the Framework will facilitate development and implementation of national plans that reflect country realities and priorities. It will also be used to underpin national health budgets and secure outside investment.

116. The Framework does not have a direct link to the Pacific Plan; it provides strategic guidance to ensure a coordinated regional approach to health. The Framework's strategic goals are:

a. To guide action on the social determinants of health, addressing health promotion, protection and prevention;
b. To strengthen health services in order to achieve universal health coverage and primary health care, and improved health outcomes in PICTs; and
c. To provide a system for ensuring clinical (including training and support) services are efficient and effective in serving the PICTs' needs.

117. The Framework will send an explicit message to development partners of the primacy of country leadership, the need to work with PICTs to identify needed support, and the importance of collaboration to improve the effectiveness of technical and financial support. In light of resource constraints, PICTs are encouraged to make assessments of their respective health sectors to identify priority areas for national budgets and outside investment.

118. The Framework is intended to be a living document and will adapt over time to respond to the changing needs of PICTs.

Discussion:

119. Several representatives commented positively or noted their support for the Framework, including: FSM, Fiji, New Zealand, and Samoa. They noted that PICTs would need to integrate the Framework into their already existing strategic and sector plans but they could integrate only the sections that would be useful for them. Although funding implementation of the full Framework could be problematic, filling gaps would be an opportunity for donors and partners. The Framework complements the NCD Roadmap.

120. Dr 'Akau'ola, Tonga, expressed support for the Framework's mission and vision. He noted, however, that service delivery should cover primary, secondary and tertiary care, and that WHO has expressed interest in including tertiary care in similar efforts. Dr Ezekiel Nukuro, Technical Officer Human Resources and Health Systems, WHO, responded that all components of health systems, HIS, pharmaceuticals and supplies, and human resources should be considered part of the Framework. The Framework should cut across levels of care, even to the tertiary level; its goal is to cut across the social determinants of health. The degree that PICTs implement the Framework at the different levels of care would depend on the country. Dr Vivili, SPC, agreed that it is important to include all the components of care.

121. Ms Pasikale, New Zealand, noted that the operational details in the document are distracting and that it should be a high-level document. She continued that New Zealand would provide SPC with specific formatting and presentation recommendations for the Framework.

122. Dr Liu, WHO, stated that the Framework would guide collective efforts in the future, across the Pacific region. He mentioned that MDGs should be considered for inclusion in the Framework since its timeline is 2014-2018. He also mentioned that a summary statement on the commitment of the region toward the Framework should be included. Dr 'Akau'ola, Tonga, agreed that regionalism and aid effectiveness should be emphasised more.

123. Dr Colin Tukuitonga, SPC, emphasised that the Framework is for strengthening health at the country level and country programs should not need to be adapted to fit it. The fundamental question is how the Framework will assist countries to reach the next level of desired health outcomes.

124. The Chair noted that the Framework is very NCD heavy. Surveillance and response to other diseases should also be emphasised.

125. Mr Everett, Australia, stressed the importance on not rushing the Framework's development, requesting additional opportunities to collaborate further on it. He expressed support for SPC's efforts and the process of the Framework's development thus far.

126. Dr Vivili, SPC, stated that SPC would continue to work with PICTs on improving the Framework and would present an updated version to the Ministers. He commented that SPC truly appreciates comments and feedback from its members.

127. The Chair noted that the majority of the HoH had endorsed the Framework.

Agenda 12. Pacific Monitoring Alliance for NCD Action (MANA)

Led by: Dr Temo Waqanivalu, Coordinator, Non Communicable Diseases, Office of the WHO Representative in the South Pacific

128. Dr Waqanivalu began the presentation on Pacific MANA by noting the mandate given by the Tenth Pacific Ministers of Health meeting: 'Development of regional and national NCD accountability mechanisms which will monitor, review and propose remedial action to ensure progress towards the NCD goals and targets. Accountability mechanisms will build on existing monitoring and surveillance input, including the proposed platform for coordinated support.'

129. The Pacific Monitoring Alliance for NCD Action, also known as Pacific MANA, is a PICT-led and owned alliance of collaborating PICTs and partners for supporting effective monitoring of progress towards NCD targets within a mutual accountability system. It strives for effective action to reduce the NCD crisis in the Pacific region. A priority of Pacific MANA is to strengthen national NCD monitoring systems by identifying data and capacity gaps and supporting remedial actions through collaborative multi-level assistance.

130. The proposed members of Pacific MANA are all the PICTs as well as other partners working within the field of NCDs. These partners include regional and international agencies, Pacific health associations and networks, academic institutions, and development partners.

131. The benefits of Pacific MANA are that it contributes to a platform of mutual accountability on NCD action. It provides opportunities for strengthening the coordination of support for remedial action on NCD monitoring in PICTs. It supports PICTs in their collection of good quality monitoring data to guide resource allocation, inform which actions are making a difference, and translate data into strong messages that can drive legislative and policy decisions. It also facilitates opportunities for networking and mobilisation of the Pacific community to address the NCD crisis in a more collaborative way.

132. Pacific MANA's accountability framework has four core parts: evaluation, improvement, communication and enforcement. Evaluation, to include collection, analysis and benchmarking of available evidence against the agreed NCD targets (such as Tobacco Free Pacific 2025), would be implemented through in-country support to strengthen the quality and integration of monitoring mechanisms for NCD priorities. Improvement, including in-country and regional actions to strengthen policies, practises and monitoring actions, would include developing a strong regional

network of expertise and data systems on RPGs and creating a regional platform to share innovations in NCD monitoring. Communication and enforcement, including sharing evidence with vested stakeholders through participatory processes and appraisal of contributions of PICTs and stakeholders at appropriate fora, would be carried out at regional and national levels.

133. Pacific MANA would expand existing support for national NCD monitoring, as opposed to being duplicative. It would seek support and investment for those already making valuable contributions to capacity development for NCD monitoring. Its efforts would identify important gaps in available expertise and services and find ways to address them. It would share new approaches to monitoring and build an accountability mechanism across the Pacific region.

134. PICTs and development partners would have roles and responsibilities in Pacific MANA. PICTs would need to provide local political leadership, mobilise resources for NCD monitoring and coordination, and commit to an agreed accountability framework. Partners would need to strengthen coordinated support for NCD monitoring, provide regional strategic leadership, host and coordinate regional public goods, and contribute to accountability systems.

135. Health Ministers and Secretaries would provide steering and some governance. SPC, WHO, or another organisation would provide coordination efforts. The first five years (2015-2020) of Pacific MANA are fully costed, based on working with selected countries. Support funding will be sought from key bilateral and multi-lateral donors and other funding bodies. Alliance partners will continue with existing activities but stronger and more sustainable systems will be built through improved coordination and collaboration.

Discussion:

136. Representatives from several PICTs made positive comments and expressed support for the MANA initiative. HoH from the following PICTs expressed support and requested the initiative's accelerated implementation: Cook Islands, Fiji, Nauru and Tonga.

137. Dr Waqanivalu, WHO, added that new developments in m-health are being studied. Giving doctors a tablet computer may produce positive developments; doctors are more used to pushing buttons than writing. This could be even more useful if the tablet computer is linked to a central database in a cloud since patient health information frequently does not follow patients during their health lifecycles.

138. Dr Skilling, FSM, asked who Pacific MANA reports to, if PICTs are reporting to it. He also stated that data ownership must be clearly defined. Dr Waqanivalu, WHO, responded that Pacific MANA is not another structure; it is an alliance of Pacific communities collaborating on health. PICTs would be mutually accountable under Pacific MANA. The organisation would not produce an additional burden for PICTs; it would reinforce efforts that many PICTs are already making. Pacific MANA would help PICTs better report on their existing reporting requirements.

139. Dr Debbie Ngemaes-Madison, Director of Hospital and Clinical Services, Palau, asked if WHO could provide support for implementing Pacific MANA projects in PICTs who use cloud computing. Dr Waqanivalu responded that WHO would examine the infrastructure already in place in each PICT and ask each one how the organisation could help implement Pacific MANA.

140. Dr Tora, Fiji, stated that the Pacific region is at the epicentre of NCDs and the Ministers declared a Pacific NCD crisis. NCDs are killing more people than communicable diseases. Pacific

MANA is a step forward from the Framework and it provides an innovative Pacific way of looking at NCDs. He also proposed adding the following language to the Pacific MANA document at the appropriate location: 'support the monitoring of the effective implementation of NCDs'.

141. Dr Tukuitonga, SPC, stated that SPC supports the implementation of Pacific MANA and added that SPC is not organised to perform donor coordination, as opposed to coordination at different levels. SPC supports the process of donor coordination.

142. Dr Korovou, Nauru, expressed concerns related to the location and funding of Pacific MANA. She stated that funding intended for countries should not go to a university to operationalize the Pacific MANA facility.

143. Dr Tukana, Fiji, suggested that Pacific MANA be included in the NCD Roadmap, under the recommendation of strengthening the evidence base to ensure resources are used well. Dr Waqanivalu, WHO, responded that Pacific MANA is linked with and related to the NCD Roadmap. Mentioning it in the presentation to the Ministers in this context could be an option.

Agenda 13. Sexual Health and Wellbeing Shared Agenda

Led by: Ms Michelle O'Connor, SPC, and Dr Dennie Iniakwala, SPC

144. Ms O'Connor, SPC began the presentation on the Sexual Health and Wellbeing Shared Agenda by providing some background on the Shared Agenda. It has its origins in several Pacific declarations and commitments, including the MDGs, CEDAW, the Suva Declaration of Commitment on HIV/AIDS 2004, the Outcome Statement of Pacific Parliamentarians for Population and Development 2013, the Outcome statement of the 12th Triennial Conference of Pacific Women and Ministerial Meeting 2013, and the Outcome statement of the Pacific Youth Ministerial Meeting 2013. WHO identifies five domains which play a crucial role in determining sexual health and wellbeing: laws, policies and human rights; education; society and culture; economics; and health systems.

145. The Pacific Regional Strategy on HIV Implementation Plan (PRSIP) expired at the end of 2013. Consultations then occurred on the next steps, focusing on: sexual and reproductive health needs of PICTs, lessons learnt from PRSIP II, whether there is a need for a further collective approach, and the scope of that next collective approach.

146. The outcome from consultations produced the rationale for the Shared Agenda. The Shared Agenda should be a strategic document to guide PICTs in responding to sexual health issues in the region. The document should not prescribe a one 'size fits all' approach for all PICTs but should be an overarching guiding document. Integration between HIV/STI and sexual and reproductive health issues is needed and should be featured in the document. A comprehensive approach should be developed addressing the complexities of sexual health. More focus should be placed on the most-at-risk and vulnerable populations.

147. The purpose of the Shared Agenda is three-fold. It should set and build a vision for integrating HIV and STIs into a broader sexual health agenda around priority needs in the region. It should facilitate the delivery of accessible and equitable sexual and reproductive health services and programmes. It should add value to country-level programmes and initiatives strategically working towards integrated and coordinated actions by regional and development partners. The

goal of the Shared Agenda is that the highest attainable standards of sexual health and wellbeing are achieved and sexual and reproductive rights are realised for all people in the Pacific region.

148. The Shared Agenda uses five key approaches:
   a. Strengthen generation of strategic information to inform policy, planning, and programming.
   b. Establish, strengthen and expand integration between STIs/HIV, sexual and reproductive health and support services.
   c. Strengthen and roll out strategic health communications and comprehensive sexuality education.
   d. Empower key stakeholders to create inclusive environments through legal, social, structural and policy reform.
   e. Tailor services and programmes to meet the needs and rights of key populations.

149. The Shared Agenda has three expected outcomes:
   a. Inclusive and comprehensive sexual health services are integrated at all levels of health services (prevention, treatment, care and support) and are accessible to and meet the needs of all people in the Pacific region, with an emphasis on key populations.
   b. All people in the Pacific region, emphasising key populations, have the knowledge, skills, and tools to protect and promote their sexual health, wellbeing, and human rights.
   c. All PICTs have an enabling and empowering social and legal environment that promotes and protects good sexual health, wellbeing and rights, free from discrimination.

150. Dr Iniakwala, SPC, continued the presentation by providing details of options for the Shared Agenda's governance and coordination mechanisms. Governance could be provided by several existing organisations: HoH, PIRMCCM, a CROP working group, a working group of the Pacific AIDS Team, or a multi-disciplinary working group from the regional academic institutions. However, the proposed governance mechanism would be composed of the HoH as the governing body and PIRMCCM as the coordinating body.

151. Implementation of the Shared Agenda would be the responsibility of governments, civil society organisations and development partners. National multi-sectoral costed implementation plans would be developed or activities would be integrated into existing plans tailored to the Agenda's five key approaches. Development partners would provide technical support and capacity building to countries to implement the Shared Agenda. Regional development partners also play the role of delivering regional public goods. A regional development partners' division of labour framework would be developed and regional organisations would align their work plans with the Agenda's the five key approaches.

152. Dr Iniakwala, SPC, concluded the presentation by presenting resourcing options. Funding and resourcing of the Shared Agenda would come from national budgets, bilateral and multi-lateral organisations (such as donors and UN agencies), global entities (such as the Global Fund) and public-private partnerships.

Discussion:

153. Dr Korovou, Nauru, stated that there are no recorded cases of HIV in Nauru. The proposed approach of combining STIs and HIV would be more inclusive.

154. Dr Tora, Fiji, praised the initiative and requested that WHO re-examine Pacific MANA from the perspective of the Shared Agenda. He also noted that the Shared Agenda acknowledges the differing views of PICTs regarding same-sex marriage and abortion. Fiji would continue to endorse the Shared Agenda as long as these considerations are met.

155. Mr Everett, Australia, requested clarification on the governing body for the Shared Agenda. Ms O'Connor, SPC, responded that the governing body would be the HoH and the coordinating body would be PIRMCCM.

156. Dr Ngemaes-Madison, Palau, requested clarification on how the Shared Agenda differs from other similar programs already in place. She also asked what innovative approaches the Shared Agenda would introduce to provide more data. Dr Iniakwala, SPC, responded by stating that currently most HIV and STI policies are separate and also separated from sexual and reproductive health. The Shared Agenda helps assure that HIV/STI programs are integrated into maternal health. The Shared Agenda would also encourage greater integration to provide improved data.

157. Ms Pasikale, New Zealand, noted that other organisations are already working on efforts to integrate sexual and maternal health. Ms O'Connor responded that SPC consulted with small and large non-governmental organisations as well as civil society organisations; they are in favour of the initiative. SPC established a task force of these organisations to consult on the Shared Agenda and assist in establishing the proper direction for it.

158. Mr Nua, Director of Health, American Samoa, echoed the comments by Palau and stated that the Shared Agenda may not meet the level of concern of the HoH. Some PICTs have HIV and others do not; each should control its own policies on sexual and reproductive health until the initiative reaches the level of concern of the HoH. Ms O'Connor, SPC, responded that the Shared Agenda covers more than HIV; it also covers syphilis, other STIs and juvenile pregnancies, for example. The Shared Agenda is broader than just HIV but does not neglect that important issue.

159. Dr Skilling, FSM, echoed the sentiments of American Samoa, New Zealand and Palau. He stated that the Shared Agenda is a good action plan and it may be possible to incorporate it into FSM's existing systems. FSM does not have specific sexual and reproductive health policies due to the country's politics; the government does not want to be seen as promoting youth pregnancy or same sex partnership, especially due to the political concerns of parents and church leaders. Men and parents would need to understand the problem before the Shared Agenda could be fully implemented in FSM.

160. Dr Rouse, Fiji National University, praised the Shared Agenda and its efforts to change the focus to sexual and reproductive health. He stated that the Shared Agenda could potentially be used to get key players to collaborate on sexual and reproductive health.

161. Dr Tukana also expressed Fiji's support for the Shared Agenda. Governments cannot stop youth from having intercourse. He praised the initiative's lack of silo approach and stated that sexual and reproductive health should also be treated as a social issue to assist with planning.

162. Dr Ngemaes-Madison, Palau, requested that the Shared Agenda monitoring and evaluation framework equally seek data for man and women (males and females) everywhere gender is disaggregated. Ms O'Connor, SPC, noted that SPC would try to integrate the request.

163. Mr Everett, Australia, asked if funds from the Global Fund grant would support the Shared Agenda. Dr Iniakwala, SPC, replied that the Shared Agenda responds to Global Fund criteria. If funds from the Global Fund are used, they would only contribute to the total as opposed to funding the entire initiative.

164. Mrs Iro, Cook Islands, praised the initiative but requested that its title be changed to reflect its being an HIV/STI strategy. There are no cases of HIV in Cook Islands but STIs are more significant there. She also praised the multi-mechanism funding, using the Global Fund. Ms O'Connor, SPC, stated that the Shared Agenda is broader than just HIV and STIs; it addresses a multitude of issues, including maternal health for example.

165. Dr Tim Rwabuhemba, Country Director for Pacific Island Countries, UNAIDS, emphasised that the Shared Agenda goes far beyond the silo approach; it is broader and does not silo HIV and STIs. Because it is broader, several other plans may grow from it. He stated that the Shared Agenda embraces the vision of the Pacific and represented Post-2015 and post-MDG ways of thinking. Regarding the issue of using funds from the Global Fund to implement the Shared Agenda, Dr Rwabuhemba stated that the Shared Agenda would be a resource mobilisation tool, not only for the Global Fund but also for other donors and potential partners. He concluded by asserting that HoH should commend SPC on the Shared Agenda and that HoH should endorse it.

166. The Chair stated that often men are not represented in sexual health and wellbeing policies, which are sometimes too focused on women. PICTs need to address the sexual problems of men as well as women. He stated that the Sexual Health and Wellbeing Shared Agenda document can evolve as it progresses and that the HoH would endorse it in principle.

Agenda 14. Surveillance and outbreak response

Led by: Dr Yvan Souarès, Deputy-Director, Public Health Division, SPC

167. Dr Souarès, SPC, began the update on outbreak surveillance and response by presenting a map of the Pacific region showing recent Dengue, Chikungunya and Zika virus outbreaks. There were 14 Dengue epidemics, four Chikungunya outbreaks, and four Zika outbreaks. Four serio-types of Dengue circulated within the Pacific region during in the last year. No immunity to these viruses (Dengue, Chikungunya and Zika) exists in the region. There are, however, few competent vectors; most are two distinct species of mosquito. The spread of these viruses is due to the intense population mobility in the Pacific region. Fiji is working its way towards the end of its worst epidemic since the 1970s, Dengue-2 virus, in addition to circulation of Dengue-3 virus. During the summer in the northern hemisphere, the intensity of the epidemics should diminish in the southern hemisphere and shift to the north; these viruses will then appear more prevalently in the north and less in the south. In March and April 2014, some PICTs encountered epidemics of Pink Eye (viral conjunctivitis). Occurrences of diarrheal diseases also appear periodically.

168. Although known before then, Chikungunya first emerged in the region in New Caledonia, in 2011. Zika has been known since the mid-1950s (it was known in Africa and Southeast Asia without epidemic) but first appeared in the region with a case in Yap, in 2007. The virus remained quiet for several years and then re-emerged. During one week in French Polynesia, the intensive care unit counted seven Zika patients; it could not handle any more. The region must closely monitor this virus.

169. Dengue, Chikungunya and Zika virus are only one direct flight away from most PICTs and governments should make appropriate plans for outbreaks. There are immediate risks, like epidemics, and long-term risks, like climate change and sea-level rise, which would affect these plans. Both national and regional planning for surveillance and outbreak response must occur and be improved. There is also an acute need for vector control in PICTs. Few resources exist for this at the national level and harmonisation of support is not present at the regional level. SPC is re-organising its Public Health Division around the disease categories and Core Public Health Functions; this is the core of SPC's strategy for 2013-2022.

170. In 2011, the Pacific Ministers of Health called for training around the Core Public Health Functions. The Data for decision-making (DDM) course was revitalised for deliverance to epi-net teams. That led to accreditation of Fiji National University's course and to a Pacific Operational Research (OR) course. The DDM course is an accredited curriculum of four one-week modules. Module-1 was delivered to six PICTs in 2013 and module-2 will commence delivery in the North Pacific in May 2014, and later in the South Pacific. The OR course should improve the capacity of national health programme staff to plan, conduct and publish operational research and to influence policy and practices with their results. It is a curriculum of three modules given over a one-year period. The OR course already yielded 11 studies accepted for publication.

171. The Strengthening Health Intervention in the Pacific (SHIP) programme came from a call by Health Ministers in 2011 for development partners to support training programs for all levels of the health workforce. The training should address: core capacities in the Asia Pacific Strategy for Emerging Diseases (APSED) and International Health Regulations (IHR), strengthen communicable disease control, and NCD surveillance and control. It should also accelerate progress towards achieving Millennium Development Goal Four (child health) and Five (maternal health). SHIP should improve population health outcomes in PICTs by increasing the effectiveness of core public health services. It would develop and implement a training program integrated with capacity development initiatives, addressing immediate and long-term needs and bridging national and regional planning. SHIP would also build on the achievements of the Pacific Public Health Surveillance Network (PPHSN).

172. Dr Souarès, SPC, concluded the presentation by highlighting the strengthening of regional capacity with the PPHSN new service network. A new network of vector control and entomology services is being established, under PPHSN, to face current and future mosquito-borne disease threats. It would network existing regional expertise in the wider Pacific region and take stock of current vector control research initiatives while fostering increased networking of projects, outputs and experts. It would explore possible networking opportunities and *ad hoc* support from specialists and field operators from the Indian and Caribbean Oceans.

Discussion:

173. Mrs Andre, French Polynesia, summarised the difficulties French Polynesia experienced with Zika virus. The population is resisting using vector control products and the government needs to find vector control products that the population finds acceptable. Hospitals have also had difficulty coping with the neurological problems caused by the virus. Relatedly, hospitals did not have enough beds to handle the outbreak. The government is working on an analysis of lessons learnt from Zika virus and collaborating with a specialist from Reunion in the Indian Ocean.

174. Mr Edwards, Marshall Islands, endorsed the presentation and noted that Marshall Islands had an outbreak of Dengue but was able to contain it. Military assistance helped the government control the outbreak. The region should develop improved vector control methods.

175. Dr 'Akau'ola, stated that Tonga's Chikungunya outbreak was a shocking experience for the country, which is anticipating receiving the related recommendations from SPC. He complemented the vector control use in New Caledonia and expressed a desire to share and learn from their successes. Tonga's internal surveillance system was not able to handle the epidemic and many false positives were diagnosed. Initially many of the diagnosis kits tested positive for Dengue but came back negative from the lab in Tahiti. Concluding his comments, Dr 'Akau'ola expressed support for the recommendations.

176. A participant from WHO stated that Tonga's experience with Chikungunya was an exception. He congratulated the Pacific region on its rollout of its surveillance system, as requested by the Health Ministers, but the region's response systems are not as well developed as its surveillance. In September, WHO plans to hold a joint meeting with SPC. The planning for that meeting is still evolving but early plans will focus discussion around arborvirus (arthropod-borne) outbreaks (such as West Nile virus). The meeting will provide regional recommendations for action.

177. Mr Nosa, Niue, asked if the DDM and OR courses would be available online. Although Niue checks all incoming visitors, better chemicals for vector control may be available.

178. Mr Nua, American Samoa, stated that the region is not responding well to outbreaks. PICTs were shocked by the Pink Eye outbreak because surveillance was not strong enough. Concluding his comment, Mr Nua expressed optimism about being part of the surveillance network.

179. The Chair stated that many PICTs do not have surveillance divisions, which should be a necessary element for Ministries of Health.

180. Dr Souarès, SPC, responded to the question from Niue by stating that a program is providing several surveillance and related courses online through WHO. He added that the American Samoa epi-net team was online to share information on the Pink Eye epidemic.

Agenda 15. Planning for the 11th Pacific Health Ministers Meeting in Fiji (2015)

Led by: Dr Eloni Tora, Permenant Secretary for Health, Fiji

181. Dr Tora stated that the 11th Pacific Health Ministers Meeting would be in Fiji in 2015. It would be jointly hosted by WHO and the government of Fiji. Planners are considering holding the meeting on Yanuca Island, in honour of the 20th anniversary of the Yanuca Declaration. Additional planning for this meeting has not yet begun.

Agenda 16. Direction for future meetings (funding sustainability)

Discussion led by: Dr Eloni Tora, Permenant Secretary for Health, Fiji

182. Dr Tora, Fiji, requested recommendations regarding direction and funding of future HoH meetings.

183. Cook Islands, stated that it may be good to hold the HoH meeting at the same time as the Regional RCM (or the WHA) meeting. This could help with funding sustainability. The Chair responded that it would be good for costing the meeting but US territories do not attend RCM.

184. A representative from UNICEF stated that the regional meeting for education ministers works with UNESCO on its annual meetings. Countries can apply to UNESCO for funds to have travel and other expenses paid. This could be an example for HoH meetings.

185. Ms Pasikale, New Zealand, emphasised that the HoH meeting is a platform for the voices of PICTs to be heard. Relatedly, the agenda for HoH meetings should be set by PICTs, as opposed to being set by SPC or WHO.

186. Dr Souarès expressed SPC's thanks to development partners for helping to fund and organise the meeting. SPC would support taking the lead in organising a meeting where the HoH set the agenda. SPC would rely on the generosity of partners to fund the meetings. SPC would also support continuing the model of having the HoH meeting during the same week as the SSCSiP and UNFPA meetings.

187. Mrs Jane Wallace, Senior Health Advisor, WHO, expressed her organisation's satisfaction to be a part of the HoH forum and would be interested in continuing to take part in organising it. The HoH meeting also feeds well into the Pacific Health Ministers Meeting.

188. Mr Everett, Australia, stated that the HoH meeting is one of only a few opportunities that Australia gets to participate in regional meetings of leading health professionals. The agenda and the meeting must be owned and driven by PICTs. A good cost-saving measure would be to align the meeting with others that occur around the same time.

189. Regarding the question of where to meet in 2015, the Chair suggested that it might be easier to have the meeting in a central location rather than rotating the hosting of the meeting.

190. Dr Korovou, Nauru, stated that holding the HoH meeting around the same time as the meeting for another agency would require coordinating the location with that agency. He suggested considering keeping the venue in Fiji since other agencies would likely meet there.

191. Mrs Iro, Cook Islands, agreed that having multiple meetings scheduled together would be beneficial. If similar arrangements can be made for 2015, the meeting could be coordinated with other agencies. She recommended adopting a similar approach for the 2015 HoH meeting.

192. Dr Souarès agreed, stating that SPC supports the approach mentioned by Cook Islands. SPC could coordinate with partners on the location and exact date, working alongside other agencies' meetings. SPC would then consult with PICTs on the options.

193. Dr Tora, Fiji, summarised that the HoH meeting agenda will be set by PICTs, making sure organisers consult them on details. A key purpose of the meeting is to guide the Health Ministers Meeting. In coordinating the next meeting, SPC will try having the same combined approach, considering cost effective options; SPC will report back to PICTs on this. The 2015 Health Ministers Meeting would usually be scheduled for July, although a date will be set in conjunction with the Fiji Ministry of Health.

Agenda 17. Other business – Update on the SIDS Meeting

Led by: Leausa Tole'afoa Dr Take Naseri, Director General of Health, Samoa

194. Dr Naseri, Samoa, presented the importance of addressing NCDs at the UN Conference on SIDS. The SIDS meeting will be held in Apia during the first week of September 2014. There will be a health side event on NCDs during the meeting, titled 'Health and NCDs based on Healthy Island vision for all SIDS countries'.

195. NCDs are relevant to SIDS because the drivers of NCDs are the globalisation of marketing and trade, increasing urbanisation, and aging populations. The impact is that governments are unable to meet the needs of their populations. Health systems are unable to respond effectively and equitably to the needs of the increasing amount of patients with NCDs. Legislation and regulatory frameworks need to be implemented to protect SIDS populations from risk factors for NCDs.

196. Dr Naseri presented a timeline showing 28 August as the date when preparations for the NCD side event (activities related to the SIDS Conference) should be complete. A side event to the World Health Assembly is also being planned for May 2014 in Geneva. All Pacific Health Ministers are being invited to the World Health Assembly side event. This side event will promote the SIDS conference as an avenue of opportunity to address health and NCDs. A separate World Health Assembly side event hosted by the NCD Coalition and New Zealand is on a different date.

197. Dr Naseri also presented information related to the SIDS Conference preparatory process, the zero-draft outcomes document, and the SIDS Conference organisational structure.

198. Dr 'Akau'ola, Tonga, congratulated Samoa on the presentation and for hosting the SIDS Conference. He also thanked Samoa for alerting the HoH regarding the side event and the important topic chosen. He stated that Samoa would receive support from the HoH.

Agenda 18. Key decision points

Led by: Mr Taniela Sunia Soakai, Senior Advisor, Public Health Division, SPC

199. Mr Soakai, SPC, presented the key decision items (Annex A), point by point. No major changes to the outlined decision items were requested by the participants during the presentation.

Discussion:

200. Dr Korovou, Nauru, motioned to endorse the decision points and that the HoH should prepare their respective ministers. The motion was seconded by Mrs Iro, Cook Islands, and was adopted unanimously.

201. Mrs Wallace, WHO, thanked the participants for sharing information with the development partners, and regional and international organisations, which now have additional clear direction for the future. She stated that the World Health Assembly is approaching and participating countries' lists of participants, hotel and contact details should be sent to Francis Loloma at WHO.

202. Dr Vivili, SPC, stated that the organisers are grateful for the feedback provided on all the papers that were presented, as well as the participation of the members and development partners. Updated documents will be sent to the HoH before the upcoming Joint Ministers

Meeting. He concluded his statement by requesting any comments that participants might have on the organisation of the meeting.

Agenda 19. Closing

Led by: Leausa Tole'afoa Dr Take Naseri, Director General of Health, Samoa

203. The Chair acknowledged the efforts of SPC for hosting and organising the meeting and extended thanks from the HoH to the entire SPC team. He also expressed appreciation to all the Heads of Health who attended this second meeting, as well as the development partners, Australia and New Zealand. He concluded his remarks by wishing all the participants safe travels and invited Dr Tukana, Fiji, to give the closing prayer.

ANNEX A: Key Decision Points

1. Terms of Reference for the Heads of Health Meeting
   Purpose: To document the objectives, processes, membership and responsibilities of parties involved in the Heads of Health Meeting. Participants provided and suggested changes and gave feedback on the draft document.
   a. Approved the Terms of Reference, with changes agreed upon during the meeting.

2. Roadmap for Responding to the NCD Crisis in the Pacific
   Purpose: To provide economic analysis of the costs of NCDs and targeted, very cost effective interventions.
   a. Endorsed the Roadmap, and the recommendations therein, for submission to the Joint Economic and Health Ministers Meeting for approval.

3. Pacific Health Development Framework
   Purpose: To provide a structure that guides health development in the Pacific region, at both the national and regional levels.
   a. Endorsed by the majority of members with comments and an understanding that SPC will continue to collaborate with PICTs and development partners on its improvement.
      i. SPC will present an updated version of the framework to the Pacific Health Ministers Meeting.

4. Pacific Monitoring Alliance for NCD Action (MANA)
   Purpose: To provide an apparatus for coordinating and strengthening PICTs' capacity, regional expertise and resources, and innovation and accountability systems to improve NCD monitoring for action.
   a. Endorsed, in principle, by participants for submission to the Pacific Health Ministers Meeting for approval.

5. Sexual Health and Wellbeing Shared Agenda
   Purpose: To integrate HIV and STIs into a broader sexual health agenda. To facilitate delivery of accessible and equitable sexual and reproductive health services. To add value to country level initiatives, while working towards integration and coordination of action of regional and development partners.
   a. Endorsed, in principle, by participants for submission to the Pacific Health Ministers Meeting for approval.
   b. Endorsed, in principle, the recommended governance and coordination mechanism.
   c. Noted the request for Heads of Health to be advocates of the Shared Agenda with Ministers of Health.

6. Surveillance and Outbreak Response
   Purpose: To receive an update on the Pacific region epidemic situation, challenges and initiatives.
   a. Participants discussed and acknowledged:
      i. The current epidemic situation in PICTs.
      ii. The constraints and opportunities related to planning and responding to current and future outbreak surveillance and response needed in the region.

b. Participants supported the initiatives and programs for the national and regional capacity building of core public health functions proposed and/or implemented by the SPC PHD and PPHSN partners.

7. Future Direction and Funding Sustainability of Heads of Health Meetings
   Purpose: To propose options for funding and location of future Heads of Health Meetings.
   a. Participants agreed to have Heads of Health actively participate in determining future meeting agendas, noting that a key purpose of the meeting is to inform the agenda for the Ministers of Health Meeting.
   b. Participants agreed to adopt the same combined approach for scheduling and location of the meetings, considering cost effective options.
   c. Participants agreed to instruct SPC to explore funding, venue, and timing options and report back to Heads of Health for a decision.

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