Contents
Meeting Report ........................................................................................................................................................................... 3
Day 1: 18 February 2015 ............................................................................................................................................................ 3
 ITEM 1: Opening ceremony ....................................................................................................................................................... 3
 ITEM 2: The Healthy Islands journey (1995–2015); Achievements and challenges, and way forward .................. 4
 ITEM 3: Review of outcomes, PHMM and Joint FEM and PHMM on NCDs, Honiara, 2014; Directives and progress .................................................................................................................................................. 10
 ITEM 4: Review of SIDS 2014 Health-related outcomes and next steps [Samoa] ......................................................... 14
 ITEM 5: 5.1 Strengthening leadership, governance and accountability [SPC/WHO] ..................................................... 14
Day 2: 19 February 2015 .......................................................................................................................................................... 22
 ITEM 6: Monitoring and implementation of the Healthy Islands Vision [WHO/SPC] .............................................................. 27
 ITEM 7: Pacific Health Agenda post 2015 [Fiji/SPC/WHO] ................................................................................................. 31
 ITEM 8: Key decision points [Secretariat] .......................................................................................................................... 32
 ITEM 9: Closing ......................................................................................................................................................................... 32
Key decision points ..................................................................................................................................................................... 34
3rd Heads of Health Meeting, February 2015: List of participants, partner agencies, observers and secretariat .... 38
ITEM 1: Opening ceremony

Welcome and remarks by the Chair and introduction of speakers

1. The Chair welcomed leaders, donors, partners and all other participants and observers on behalf of the Fiji Government and the Fiji Prime Minister. And on behalf of SPC/WHO who have organised the meeting. The Chair summarised the main objectives of the meeting, which were to:
   a) Review, discuss and make recommendations to the Pacific Health Ministers Meeting (PHMM) in April 2015, about:
      • the Yanuca Island Declaration review;
      • strengthening leadership, governance and accountability;
      • reducing avoidable disease burden and premature deaths;
      • nurturing children in body and mind; and
      • promoting ecological balance.
   b) Agree on the main themes for Heads of Health (HoH) to brief ministers in preparation for the 11th PHMM, including country review of 20 years of Healthy Islands.

Remarks from SPC, Dr Paula Vivili

2. Dr Vivili acknowledged all participants, countries, representatives, partners and observers. He brought greetings from SPC's Director General. SPC was very pleased to host and contribute to the forum, which was set up three years ago to ensure that Pacific Island countries and territories (PICTs) are empowered to contribute to decisions and regional policy on health. The heads of Health forum has proved useful, and has met many of its intended purposes. The link between the HoH meeting and Pacific ministers will only be strengthened into the future. The HoH is a forum for presenting your views and contributions, to build on the Yanuca Review. The discussions and outputs of this meeting, as well as the follow-up work from the Pacific Health Ministers’ Meeting, will contribute to the way forward from the review of the Yanuca Declaration. Dr Vivili acknowledged the strong working relationship between countries, partners and other agencies. SPC remains committed to working with all partners and agencies to continue to improve health in the Pacific.

Remarks from WHO, Dr Yunguo Liu

3. Dr Liu was very pleased to welcome all to the Third HoH meeting, which has special significance this year, on the 20th anniversary of the Yanuca Declaration. 2015 is also the end date to meet all Millennium Development Goal (MDG) targets. This meeting is an excellent opportunity to review progress in last 20 years. It would help us prepare for the Pacific Health Ministers’ Meeting in April, and to work for the health agenda for the next 20 years.
4. Dr Liu reviewed existing and new challenges. The rise of non-communicable diseases (NCDs) is of far greater magnitude in the Pacific than in other areas of the world. Climate change is having serious impacts on health. Access to health benefits is a significant issue, in light of old and new health threats.

5. The Healthy Islands vision has guided policy and progress. The extent to which Healthy Islands has been operationalised varies across PICTs. As we know, timelines or monitoring and evaluation (M&E) mechanisms to monitor progress were lacking in the Healthy Islands vision. The Healthy Islands vision fits well with the sustainable development goals as well as with the universal health care (UHC) objectives. WHO is committed to working closely with all to achieve the meeting’s objectives.

Guest of Honour remarks, Hon Mr Jone Usamate, Minister of Health and Medical Services, Fiji Islands

6. It’s an honour for us in Fiji to be able to host you. It’s been a week full of health here in Fiji – a ‘healthy week’. We will be working towards the Health Ministers’ meeting – and trying to understand ‘how we will get there’ and ‘when we will get there’ – which were missing from the last declaration. For our small island states it’s not just about development – it’s about sustainable development. Health is required for sustainable development, and is also an outcome of sustainable development. The threat of NCDs is serious. It requires treatment, care and education. Sustainable development requires us to help our populations reach overall wellbeing. The NCD crisis continues to be a burden on all of us in the Pacific – it’s a tsunami that has already engulfed us. You are the specialists in health in the Pacific – ministers will rely on your expertise, guidance and advice about policy to address regional health issues.

7. The Hon Jone Usamate thanked all country partners and agencies for supporting the Pacific region in their health programmes. We in the Pacific need to ensure two things:
   a) The Pacific voice heard in global health issues.
   b) That we work well with our development partners so they focus on our needs, not just their own needs and agendas.

8. Small countries in the Pacific need to work together to achieve these two things. The Healthy Islands vision will provide vital feedback to ministers. We need a good, strong health vision for our Pacific Island nations, to ensure our visions become realty; that we have strong programmes to make them a reality. We need to put in place strong all-of-government and multi-sector policies and strategies; strengthen our health systems; include all people in health care; ensure that people have access to drugs and medicines; and ensure that our people are aware of and educated about health. You will discuss these issues and make recommendations to ministers, to bring about a healthier Pacific.

ITEM 2: The Healthy Islands journey (1995–2015); Achievements and challenges, and way forward

Professor Donald Matheson [SPC/WHO]:

9. Healthy Islands was an idea that came up in 1995 in Yanuca. Professors Matheson highlighted the Healthy Islands logo – three happy people: Melanesian; Polynesian; Micronesian. The declaration coined some words that are novel and important:
   a) Children are nurtured in body and mind – an aspirational vision of overall wellness
   b) Environments invite learning and leisure – environments are important
   c) People work and age with dignity – not just work and age, but acknowledging dignity
   d) Ecological balance is a source of pride
   e) The oceans that protect us is sustained – the view of oceans is not only food, but as connection, protection
10. These are profound visions – set for a century. This is the challenge before us now. The review’s core team had great help from 79 people from around the Pacific. What stood out with these 79 people was their passion and their depth of knowledge.

11. The objectives of the review were to:

- assess the overall achievement of the Healthy Islands vision and the Yanuca declaration in the Pacific Islands, including identifying success stories and lessons learnt;
- identify both remaining challenges and opportunities in realising the Healthy Islands vision in the Pacific; and
- propose a renewed Healthy Islands vision for consideration at the PHMM in April 2015, including scaling up action and introducing new areas, while considering the post 2015 development agenda and universal health coverage.

12. The methodology included both quantitative and qualitative methods: 79 interviews with health ministers, health officials, health workers, development partners and community members; and an in-depth exploration of Healthy Islands in Fiji, Samoa and Vanuatu.

13. Some of the perceptions of the achievements of HI:

- Health ministers on Healthy Islands: The vision is still valid. It highlighted the need for PICs to work together... an example of PICs working together.
- Senior health officials: Healthy Islands reflects Pacific wisdom in context.
- The overall achievement of the HI vision/ Yanuca Declaration: Great concept, high-level leadership, then it cooled down. The name remains, health promotion branch, healthy islands branch, but there is no real structure.
- Pacific health ministers helped put NCDs on the global agenda.

14. Current understandings of Healthy Islands:

- An overall vision of health development that belongs to the Pacific.
- A settings approach to health development.
- A platform for progressing NCDs, inter-sectoral approaches.
- A subset of, and sometimes synonymous with, Primary Health Care, Health Promotion.

15. Conclusions from country visits:

- All had inspiring examples of HI in some places, in some settings, at some times.
- Seldom were the initiatives brought to scale or sustained.
- The district health systems are in decline.

16. The outcomes for each of the main goals of HI:

<table>
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<tr>
<th>Outcomes for the main goals of the HI vision:</th>
<th>The last 20 years has seen improvement in child survival, as measured by reduction of the under-five mortality rate, but not as fast as the rest of the world average; and many PICs are unlikely to meet the MDGs for children.</th>
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<tbody>
<tr>
<td>a) Children are nurtured in body and mind</td>
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<tr>
<td>The last 20 years has seen improvement in child survival, as measured by reduction of the under-five mortality rate, but not as fast as the rest of the world average; and many PICs are unlikely to meet the MDGs for children.</td>
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**Third Heads of Health Meeting**

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<tr>
<th>b) Environments invite learning and leisure</th>
<th>Most PICs are on track to achieve the MDG target of universal primary education, for both girls and boys. However, there are challenges in the quality of education.</th>
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<tr>
<td>c) People work and age with dignity</td>
<td>The last 20 years have seen improvements in life expectancy. However, life expectancy in the Pacific is lower than the global average, and the gap in this case is not closing. Life expectancy is influenced by deaths throughout the life course. The advances in life expectancy from reduced deaths in children are being offset by the increase in premature deaths occurring through the NCD epidemic.</td>
</tr>
<tr>
<td>d) Ecological balance is a source of pride</td>
<td>The last 20 years have seen improvements in the proportion of the population using improved water sources. However, this is lower for the Pacific than the rest of the world, and the gap is not closing. A similar pattern is seen for the percentage of the population with improved sanitation facilities, and this gap is also increasing.</td>
</tr>
<tr>
<td>e) The ocean that protects us is sustained</td>
<td>Unfortunately, the fishing stock in the Pacific for some species is under threat from over-fishing.</td>
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17. Questions to think about:
- We have made progress; thinking about ‘why’ is important. Thinking about why we are slipping behind is also important. Is it money? Yes in many cases, but money is not a simple issue.
- The value for money: that is, the money you do have, have you spent it well, or has it been diverted to other areas?
- Did we have enough health workers during this period? The WHO minimum threshold of health workers/population ratio in order to reach the MDGs (2.3/1000). Many PICTs are below that threshold.
- The impact of broader determinants of poverty – many are deteriorating rather than improving.
- Inequalities: we see very big differences between rural/urban; rich/poor; isolated islands/capital.

18. The indicators show that:
- Pacific health is improving.
- Progress is slower than the rest of the world and the gap is increasing.
- Health MDGs are not going to be met.
- Health Financing is a major issue.
- More effective use of existing resources is possible.
- NCD disease burden is intensifying, especially diabetes.
- The double burden persists for the bulk of the population.
Inequalities are an issue – between and within countries.

Implementation barriers include: lack of timeframes and targets out of PHMMs; and consistent ministerial attendance for only 14 PICTs. Most respondents felt that the HI vision was great, but that implementation was poor. Lessons were learned in the following areas:

- Governance
- Management
- Information and indicators
- Prioritisation and scope
- Global policy and framework overload
- Vertical programmes that undermine comprehensive local approaches
- Piecemeal decisions around resource allocation, especially operating budgets
- Donor funds are not predictable; some countries are chronically under-aided as the crowds focus elsewhere; and fragmentation of sources

Challenges:

- Contextual differences between PICTs
- External changes impacting Pacific health:
  - Climate change and adaptation
  - Geopolitical interests of the rest of the world are increasing
  - Significant new donor partners
  - Reduced health assistance from NZ, Aus, GFATM
  - PNG experiencing dynamic economic growth, while weak regional growth
  - MDGs becoming SDGs – SDGs are seen as one of 17 goals – many of the other goals have impacts on health
- Changing relationships within the PHMMs

There is an untapped potential in the HI vision. Ideas for a renewed HI vision include:

- Healthy Islands, as an overall vision for Health Development in the Pacific, still has currency. It is the Pacific Health Vision for the century.
- Countries should be encouraged to develop their own interpretations related to the overall vision: e.g.: Healthy Samoa; Islands of Wellness (Fiji); Healthy Lifestyles (Tonga); Healthy Blue Continent (PIHOA).
- The HI vision needs better connection and ‘buy in’ within the clinical workforce.
- A continuous cycle of action and reflection to support implementation of the vision.

Conclusions arising from the review of the HI vision:

- Healthy Islands is a strong vision but implementation has fallen short.
- ‘Business as usual’ for health development in the Pacific is insufficient to meet the increasing gap between the Pacific region and the rest of the world.
- The 20th anniversary – an opportunity to re-commit to the vision, while at the same time address the implementation challenges that have weakened progress to date.
- Ministers, officials, donors and technical agencies all need to come to the PHMM at Yanuca prepared for a fresh approach for the decades ahead.
23. Proposed recommendations for HI vision:

| Proposed recommendations – from review of Healthy Islands vision:

| For Pacific health ministers: | • Build on the vision, as a unifying brand, across stakeholders and through all levels of Pacific health systems.  
| | • Use the SDGs as a basis for indicators in support of the HI vision.  
| | • Support the continuation of PHMMs, and commission a work programme that develops detailed proposals concerning:  
| | o Membership  
| | o Formalising the relationship with the PIF, the WHO’s Regional Committee  
| | o Sustainable funding arrangements  
| | o Meeting format  
| | o Priorities and Indicators  
| | o Monitoring and evaluation  
| | o Tailored approach to differing contexts (size, disease burden, economy, rural issues, population growth)  
| For heads of health: | Lead the operational and reporting functions of the PHMM:  
| | • Meet before each biennial PHMM and prepare options papers for the PHMM to consider.  
| | • Establish draft criteria for the inclusion of agenda items based on the priorities set by ministers, and focus on issues for which collective deliberation and decision-making will add value. Manageable number of items and supporting documents.  
| | • Operationalise the monitoring, reporting and evaluation mechanisms of HI/SDGs/UHC, with the support of technical agencies, and deliver a biennial progress report to the PHMM.  
| | • Develop the ‘Healthy Islands’ brand.  
| | • Take advantage of existing regional and global meetings (RCM, WHA) to meet regularly throughout the year, to operationalise PHMM findings, and to lay the groundwork for the next biennial meeting.  
| | • Consult with technical agencies, development partners and other stakeholders, including multidisciplinary clinical leadership and other sector groups in HoH deliberations on the agenda for PHMMs.  
| | • Incorporate ‘systems thinking’ into the way the HoH meeting operates.  
| For development partners: | • Report their deliberations, policy and funding intentions directly to the biennial PHMM.  
| | • The quintilateral group should remain open for other partners active in the region to join and to report its deliberations.  
| | • The development partners collectively report to PHMM on progress they are making in moving towards an aid effectiveness approach to the PHMM.  
| | • For small states, (populations less than 100,000), develop a single development cooperation plan that is part of the Island government’s own implementation plan.  
| | • Consider shifting from a focus on public health issues to a general health systems approach, and support governments
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<th>For technical agencies:</th>
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| - Develop an approach for the provision of technical support to Pacific Island countries with populations of less than 100,000 that recognises their ongoing need for national level policy support.  
| - Establish the actual cost of realising the right to health for Pacific peoples, and develop novel funding options for consideration by ministers for the period 2015–2035, and to 2100.  
| - Support the process of the HoH meetings and the PHMM. This is primarily a facilitation role, and should be distinct from the role of providing particular technical agendas.  
| - Produce a combined programme of work and present it to the PHMM (via the HoH meeting) for their approval.  
| - Invite PIHOA as a third agency to directly support the PHMM and the HoH meetings. |

**Discussion:**

24. **Tonga:** Systems thinking principle – there are existing tools for how you look at UHC, and monitor the progress of different pillars of health systems. It should not be difficult to operationalise the HI vision – we have existing tools, within WHO and other agencies. We fully support the recommendations.

25. **Cook Islands:** We support the recommendations. HI brand – suggested that there should be a move from Healthy Islands to Healthy People – where are the people? We need to recapture that. HoH meetings: we have evolved. We agree that we need to be more systematic in this meeting. We need to take key things and focus on those. Systems thinking from a country level, we bring to this meeting. Regional public goods – we need to identify what those are. We need to focus on those.

26. **Chair:** We have all agreed with the recommendations. Noting additions from Cook Islands.

27. **New Caledonia:** Conclusions are relevant but: (a) Health issues of overseas territories were not presented here. (b) We should not forget about French overseas countries and territories. (c) We should insist on a multi-sectoral approach to operationalise the HI vision.

28. **Chair:** We note that – it is important to include French countries and territories in discussions and in recommendations.

29. **Palau:** We want to promote that directors of health in countries and territories need to be engaged in the HoH meeting. We need to promote a multi-sectoral approach.

30. **Chair:** We note that it is important to do both of those things in the recommendations.

31. **FSM:** We support the general recommendations and the way forward discussed. Benchmarks: how will we assess the situation in 20 years? We need to be mindful that if the aspiration of HI is to be realised, the
aspirations within countries should not be compromised. The funding issue is critical – it needs to be further fleshed out.

32. Chair: These points are taken: Identifying what we want to achieve is important.

33. Professor Matheson: Sincerely acknowledged New Caledonia’s issues. Explained that the French countries and territories data was received too late to be included in the body of work.

34. SPC, Dr Vivili: Acknowledged the New Caledonian points.

35. FSM: Hopes that the regional emphasis does not take the focus away from interventions in countries.

36. Chair: Yes, this is fundamental – interventions must add to countries’ capacities and local experience.

37. Professor Matheson: Funding: existing regional relationships – partnering provides them with levels of health expenditure above the rest of the Pacific. Also, the dynamic growth of PNG – this represents a different sort of problem – spending money can also be a problem if there is more money available than countries are used to having. So, for a smaller group of countries that do not have economic growth and can get to this base level of funding, government expenditure in health is a primary way of growth. There needs to be an emphasis on what governments are spending. Also, there should be consideration of novel funding mechanisms – need to think about how the Pacific progresses, especially those countries with insufficient resources to guarantee a right to health. What is the cost of running a health system with an advanced NCD epidemic? We don't know that. What does it cost to provide effective chronic care management to a large population with diabetes? We need to think about the consequences of an advanced NCD epidemic.

38. Chair: We take these comments on very gladly and note them in the final documents for PHMM.

39. SPC, Dr Vivili: Process: Smaller groups to work on all recommendations from all papers to refine, for presentation to PHMM.

ITEM 3: Review of outcomes, PHMM and Joint FEM and PHMM on NCDs, Honiara, 2014; Directives and progress

Item 3.1: NCD Roadmap: Tobacco control, Sugar sweetened beverages, PEN and pharmaceutical costs [SPC/WHO]

SPC: Dr Vivili:

40. PHMM decisions from Honiara:
   - Pacific Health Development Framework.
   - Pacific Mana (Monitoring Alliance for NCD Action) Framework.
   - Surveillance and Outbreak Response.
   - Pacific Sexual Health and Wellbeing Shared Agenda.
   - SIDS meeting.

41. Joint FEM and PHMM agreed actions:
   - Strengthen tobacco control.
• Consider an increase in taxation of alcohol products.
• Consider policies that reduce consumption of local and imported food and drinks that are high in sugar, salt and fat content.
• Improving the efficiency and impact of the existing health budget by reallocating scarce health resources to target primary and secondary prevention of cardiovascular disease and diabetes, including through the Package of Essential Non Communicable Disease Interventions (WHO PEN) of ‘best buys’; adapting WHO PEN in the Pacific; pharmaceutical costs.
• Strengthening the evidence base for better investment planning: assessing costs and impacts of NCDs; data sources.

**Item 3.2 Country Updates [Country Reps – (Solomon Islands, Cook Islands)]**

**Cook Islands: Ms Elizabeth Iro:**

**WHO PEN project in Cook Islands:**

42. Cook Islands was a late entrant to this programme – PEN was introduced in October 2012. Goals around strengthening primary health care (PHC) Services for NCD prevention and control. Purpose: Improve the health of the Cook Islands population by strengthening the health system approach to NCD prevention and control through PHC. Objective and anticipated outcomes: Strengthen the Cook Islands health system and capacity through four specific approaches to address NCDs.

43. Projected outputs were: (a) Improve early detection and management of NCDs. (b) Improve health workforce capacity to prevent and control NCDs. (c) Increase integration between community health services and HHS. (d) Improve existing HIS to ensure accurate reporting of data on NCDs.

44. Project impact or outcomes were: (a) Systemised NCD and cardiovascular risk assessment programme. (b) Reduction in NCD complications; e.g. kidney disease. (c) Reduction in premature deaths from NCDs. (d) Improved recording and reporting of NCD data and information.

45. Programme location – five clinics were identified: Rarotonga (4); outer island of Aitutaki (second-most populated).

46. A progress report was delivered in the areas of: (a) Building health worker capacity; (b) Health systems; (c) Resources; (d) Projected impact or outcomes.

**Discussion:**

47. **Tuvalu:** The presentation mentioned the problem of support for outer islands: Call and recall for non-compliance in outer islands?

48. **Cook Islands:** Response: The outer islands do a better job in meeting the PEN goals than on Rarotonga.

**Solomon Islands:** [Not presenting today]

**Item 3.3 Pacific MANA [WHO/SPC]**

**WHO (Dr Wendy Snowdon):**
49. **Background:** The rate of NCD-related disability and premature death is at crisis point for countries in the Pacific, creating huge and wide ranging social and economic costs. Monitoring data is critical for understanding and tracking the burden, informing action and measuring the progress of programmes and policies. The Pacific Monitoring Alliance for NCD Action (MANA) was established to provide a mechanism for coordinating and strengthening NCD monitoring by improving national and regional monitoring data and reporting, demonstrating progress and stimulating innovation and accountability for actions to control and prevent NCDs.

50. **Progress in developing MANA:**
   - Consultations and discussions: activity and agency mapping: Several consultation meetings have taken place over the past year, to discuss, clarify and map the existing NCD monitoring activities around the region.
   - Dynamic master proposal: The mapping exercise informed the latest iteration of the master proposal document, discussed at the 2nd MANA Technical Meeting in Suva in August 2014. Subsequent meetings with donors and partners confirmed support for three MANA strategic objectives and clarified potential funding mechanisms.
   - Funding support approaches for the three MANA strategic objectives:
     - In-country monitoring priorities
     - Regional public goods
     - Innovation and accountability
   - A MANA coordination team has been established.

51. **Scope of MANA:** Raising support for technical capacity building within countries and across the region is a key priority of the MANA Strategic Framework. Monitoring progress in policies addressing NCDs is critical to the accountability role that MANA aims to develop – have developed the Pacific MANA Dashboard for NCD Action.

52. **Operational description:** Need a governance mechanism – will be looking to heads of health to be involved in that role. Will work closely with the coordination team, which will provide secretariat functions and other actions. Reports will be provided to annual HoH and biennial PHMM.

53. **Discussion point 1: Governance mechanism**
   - Three options proposed: (a) Existing HoH sub-committee; (b) A new sub-group of HoH; (c) The Pacific Public Health Surveillance Network (PPHSN).
   - Role: to provide leadership in identifying priorities, guide decision-making and encourage greater collaboration and coordination.

54. **Discussion point 2: Coordination team role and composition**
   - Not a decision-making body. Roles:
     - Communication flows
     - Discuss member activities and country needs
     - Ensure available support provided to meet country needs
     - Act as monitoring body – preparation of MANA dashboard/similar NCD actions
   - Current composition: In-kind representation from WHO SPC, C-POND and UoA (until end of year 1)
   - HoH are asked to consider the involvement of another organisation, e.g. PIHOA, to be included in the coordination team.

55. **Discussion point 3: MANA Dashboard for NCD action**
   - Should the dashboard approach be developed further?
56. **Chair:** Discussion points are:
   a) Preferred option for a MANA steering/governance mechanism.
   b) Additional partner to nominate representation to MANA coordination team.
   c) Should the MANA dashboard be adopted as the approach and developed further?

a) **Discussion:** Preferred option for a MANA steering/governance mechanism

57. **Australia:** We don’t express a view right now about which option to go with, but we need a direct line of sight between reporting of the steering group and the ministers’ meeting – we need a seamless and straightforward mechanism.

58. **FSM:** Option 3 seeking guidance: How easily can this body take on this responsibility?

59. **SPC:** PPHSN are CD specialists. PPHSN people – it has been suggested that we have a separate group of NCD people, or escalate the group so they are senior enough to cover both CD and NCD.

60. **NZ:** How will MANA and the dashboard relate to core indicators for Healthy Islands to be established?

61. **WHO:** We presented the dashboard in that style, but the indicators can be changed – they can be aligned with HI indicators as well.

62. **Guam:** (subcommittee member from Micronesia): If we align with the CD and syndromic surveillance, we can do the syndromic surveillance approach that way. Keeping existing subcommittee structure and adding PIHOA would be a good option.

63. **Tonga:** There needs to be a subsection in the dashboard to show the impact on population – how does it impact on people’s health in general?

64. **WHO:** We are very happy to discuss what’s included in the dashboard with a wider governance group.

65. **Chair:** The meeting agrees on option A: The existing HoH sub-committee assumes the MANA governance role.

b) **Discussion:** Additional partner to nominate representation to MANA coordination team

66. **Guam:** Supported the composition expansion options presented by the paper.

67. No other comments from the meeting and the Chair confirmed agreement to the proposal to expand the composition of the coordination team.

68. **Chair:** All agreed to support the expansion of the composition of the coordination team to include an additional member from the northern Pacific; and the involvement of another organisation, such as PIHOA, in the coordination team.

c) **Discussion:** Should MANA dashboard be adopted as the approach and developed further?

69. **Chair:** Invited comment, and confirmed general agreement to the proposal: All agreed to support the MANA Dashboard for NCD Action as an approach to develop further.
70. **Chair:** Item to be sent forward to PHMM.

**Item 3.5 CRVS update (Paper Only)**

71. **Chair:** Item to be sent forward to PHMM.

**ITEM 4: Review of SIDS 2014 Health-related outcomes and next steps [Samoa]**

*Ministry of Health Samoa (Ms Delphina Taaoa Kerslake):*

**Samoa Pathway – Health and NCDs:**

72. Commitments include:
   1. Develop multi-sectoral policies and strategies for disease prevention and management.
   2. Strengthen health systems for UHC.
   3. Establish 10-year targets to reverse NCDs.
   4. Implement interventions that strengthen health promotion, primary health care and monitoring of NCDs.
   5. Enable cooperation among SIDS to convene meetings to respond to NCDs.
   6. Achieve universal access to HIV prevention/treatment and strengthen the fight against malaria, TB and neglected tropical diseases.
   7. Improve maternal newborn and child health, and reduce mortality.

73. Related outcomes: Food security and nutrition commitments; and Water and sanitation commitments

74. Apia challenge document – the outcome document of the SIDS side event on NCDs, health and development (September 2014, Samoa) – Challenges: (a) UN Member States and development partners to support SIDS by taking greater responsibility for their international trading practices – reducing trade in unhealthy products (food and drink high in salt, sugar and fat). (b) SIDS to strengthen their regulations on trade, taxation and excise to encourage healthy food and drink consumption. (c) UN Member States to ensure the Non-communicable Disease goals and targets are central to the Post-2015 Development Agenda.

75. **SPC/WHO:** Noted the summary of the Samoa Pathway; Apia Challenge; and Pacific NCD Partnership.

76. **SPC (Dr Paula Vivili):** Pacific NCD Partnership: This is a work in progress, and we will get an update on how this relates to all of the other NCDs.

**ITEM 5: 5.1 Strengthening leadership, governance and accountability [SPC/WHO]**

*WHO (Dr Ezekiel Nukuro):*

77. Noted that the paper is a draft, and WHO would appreciate inputs of HoH into this paper. We need more concrete actions and directions for health ministers to make firm decisions. Effective leadership, governance and accountability, particularly at country level, is more critical now than ever in the Pacific, due to, among other things, an increasing population’s health needs and demands, emerging health challenges, and rising
health care costs against a backdrop of limited and decreasing health resources. While progress and achievements have been made, such as in sustaining political commitment to health, an enduring vision of Healthy Islands, development of regulations, policies and action plans, and in services organisation and delivery, more efforts are needed for equitable access to quality care and better health outcomes.

78. Leadership and governance involves:
- Ensuring strategic policy frameworks are combined with effective oversight.
- Coalition building.
- The provision of appropriate regulations and incentives.
- Attention to system design and accountability.

79. Leaders: set the strategic vision and direction, and mobilise efforts and resources for their realisation. Managers: ensure effective organisation, implementation and utilisation of resources to achieve results. Each country’s specific context and history shapes the way leadership and governance is exercised.

80. A well-functioning health system responds in a balanced way to a population’s health needs and expectations. The principle of ‘leave no-one behind’ is key in a well-functioning health system, and should be a key principle in Pacific health.

81. The urgency of effective leadership, governance and accountability: Health systems under pressure to cope with: Multiple burdens of disease, injuries and disability, and emerging challenges; Increasing population demands for quality care and protection; Crowded partners with fragmented approaches; and Rising health care costs against the backdrop of limited resources that are primarily for curative care.

82. Progress and achievements include:
- 14 countries have NHPSP – links with national development plans
- Sub-national, institutional and programmatic annual or short-term action plans developed based on NHPSP
- National health summits to review, track progress and set future directions and priorities
- Some form of partnership/coordination mechanisms

83. Issues and challenges include:
- Pacific contexts/settings.
- Ageing populations.
- New health technologies.
- Provider-driven.
- The social determinants of health.
- Gaps – data and evidence, service organisation and delivery, tracking progress and accountability, engagement of communities/individuals, etc.
- Imbalance in resource allocations.
- Government leadership in setting strategic directions/approaches, lead change and ensure sustainability of services.

84. Future directions:
- Refocus and strategic.
- Evidence-based targets and indicators – monitor, track, report.
- Supportive mechanisms, peer learning and innovations.
- Need to rebalance health priorities.
• Improve and sustain national leadership capacity, working across sectors and ensuring coherence and integration of plans.
• Making aid effectiveness and principles a reality.

Discussion:

85. Tonga: Tonga is implementing most of what was said – a very useful presentation.

86. NZ: Key learning from NZ – around clinical leadership and governance: it is very important to have clinical governance and leadership in the mix of what we do. Clinicians are being held accountable for quality outcomes of care in the service they are delivering, so it is important that they have control over outcomes.

87. PNG: Leadership and accountability: must have the public, not self-interest, at heart. Leaders must practise and observe leadership, with accountability. We fully support the presentation.

88. Palau: Question about accountability/primary prevention: do we include intervention? Is that part of the plan – that we are accountable from primary to secondary prevention? It is still in the preventive measures?

89. Samoa: Reiterated PNG’s comments about political leadership. Political will is crucial.

90. Tonga: Evidence-based: it is important for policy decision-makers to identify the tool we use to identify the basic health needs. One of the side effects of using mortality rates is that some of the other needs do not come out. We must not overlook other health needs/health burdens that are not shown by certain indicators/tools.

91. Australia: We are drawing together discussion points for ministers, from different perspectives. Let’s find a way of bringing recommendations and reviews so that ministers have the best opportunity to hear what we are saying in a coordinated way.

92. Cook Islands: What is the position of civil society/NGOs: For small islands like us, small organisations take a lead in key areas, such as disability and mental health? We need to urge ministries to take the lead on those issues. But we should not miss the role of key agencies in health.

93. WHO, Dr Nukuro: NZ issue raised the role of hospitals and health centres. Management of hospitals attracts resources. These issues are important. The NZ model may be a good one to look at. The role of civil society and individuals, communities, faith-based organisations. This is very important – we could emphasise this area.

94. Chair: All agreed that we need very strong leadership, governance and accountability to achieve positive outcomes for the Pacific. We need to have a robust and efficient health system/strengthening: clinical governance. Health needs should be visualised in policy and planning. We need to provide information for political decision-makers. We need buy-in from other organisations: NGOs, FBOs etc.

Item 5.2a: Reducing avoidable disease burden and premature deaths [WHO/SPC]

WHO (Dr Wendy Snowdon):

95. Pacific Island countries and territories have shown a consistent increase in life expectancy over the last 20 years. Remarkable contributions to this have come from improvements in immunisation, child health and communicable disease control. At the same time, NCDs have reached crisis levels in many PICTs, and so, despite improvements in CDs, many countries now face a double burden of disease. Countries face many challenges in
tackling this double burden. For example, many key drivers of NCDs in particular lie beyond the health sector. Another key challenge is sustainability – changing donor priorities can put at risk the gains that have been achieved.

96. Achievements include: A consistent increase in life expectancy; TB control – on track to achieve MDG; Malaria morbidity and mortality has been reduced; Pacific Lymphatic Filariasis Elimination Programme (PacELF); Polio, measles, HepB elimination is on track; NCDs have been raised as a national priority; Tobacco tax increase in 11 PICs; 12 PICs have raised taxes on sugar sweetened beverages (SSBs); PEN demonstration in 15 PICs; STEPs survey in 17 PICs.

97. Challenges include:
   - Determinants of health and risk factors are beyond the health ministries – tobacco, food, water/sanitation, trade, rapid, unplanned urbanisation
   - Fragmented health services – too many vertical programmes, sustainability
   - Inequitable service delivery – service provision not meeting the population needs in an equitable manner
   - Not enough timely information – multiple surveys, but information is not complete, reliable and timely

98. Approaches include: Multisectoral action and 'health in all policies'; Health promotion; Integrated people-centred service delivery; Reliable and timely data.

Discussion:

99. FSM: Some surveys and tools that we use take years to return the data – there is a very long-term return of information. Query the usefulness of this for preventative actions or interventions. Is there any thought to using a data set that is useful but has a shorter turnaround time for decision-making?

100. WHO: This remains an ongoing challenge – we can emphasise that more in the paper.

101. NZ: Noted the rise in life expectancy in last 20 years in the paper. But there is lots of work to be done in the Pacific to close the gap with the rest of the world. We need to hear more of what will make a difference for Pacific nations.

102. Chair: NZ’s points are noted: We agree about the importance of what is happening at the country level to be visible to bring to PHMM to make tough decisions going forward.

Item 5.2b: Health Promotion Foundations [SPC/WHO/WB]

Updated through paper – no discussion.

Item 5.2c: Global Fund update [PIRMCCM]

Ms Siula Bulu (acting chair PIRMCCM):

103. The Pacific nations of Cook Islands, Federated States of Micronesia, Kiribati, Marshall Islands, Nauru, Niue, Palau, Samoa, Tonga, Tuvalu and Vanuatu are the 11 PICTs that are recipients of the Global Fund grants under the Multi-Country Western Pacific (MWP) arrangement. Global Fund (GF) currently supports three grants:
HIV/AIDS, Tuberculosis and Malaria (for Vanuatu only). GF support in the Pacific commenced in 2004 and GF remains a major donor in the region. The Pacific Islands Regional Multi-Country Coordinating Mechanism (PIRMCCM) is the oldest governing body that still exists in the Pacific. There are lots of lessons learned from that, and lots of challenges. Global Fund funding is part of the bigger health funding picture in the Pacific – it’s a good thing for heads of health to see how everything fits together. 11 PICs are members of PIRMCCM.

104. Under the coordination of the Pacific Islands Regional Multi-Country Coordinating Mechanism (PIRMCCM), the Pacific has submitted grant applications for the newly introduced Global Fund New Funding Model (NFM). Introduced in 2011, the NFM set parameters for eligibility for funding, using the following criteria:

- Income Level based on World Bank (Altas Method) Income Classifications
- Disease burden (for upper-middle income countries only)
- G–20 membership (for upper-middle income countries only)
- OECF-DAC list of Official Development Assistance (ODA) recipients (for upper-middle income countries)

105. Based on the assessment under these criteria, four of 11 PICTs are not eligible for funding. Cook Islands, Nauru, Niue and Palau are classified as upper-middle income countries, with low disease burden. However, they were included in the MWP applications, as the remaining seen countries qualified for funding, thus achieving the ‘at least 51% threshold for inclusion’ – a criteria set by GF.

106. The NFM is premised on investing more strategically through targeting resources to maximise the impact of its grants. Concerning the MWP NFM grant applications, a greater focus is to seek the support of national governments to increase cost sharing arrangements, specifically with respect to human resource and service delivery. With respect to sustaining donor investment, PIRMCCM would like to bring to the attention of the Ministries of Health, through the forum of the Heads of Health, this important issue for individual countries to plan for. We would like to see how we could collaborate better so we do not go backwards. We would ask that HoH keep this in mind, in an environment where donor support is falling due to global economic circumstances. PIRMCCM offers to be part of planning, to support, to be part of ongoing work. We would like to see more work together between PIRMCCM and HoH. PIRMCCM also acknowledges the need to sustain the TB and HIV programme in countries having a low burden of disease to facilitate their prevention and TB elimination.

Recommendations:

107. HoH are invited to:
   a) Consider the issues and opportunities for cost sharing approaches in the implementation of the NFM grants
   b) Include on the agenda of the ministers of health of individual countries a plan to action to support this
   c) Advocate with the PHMM on the broader issue of sustaining the gains of investments for HIV, TB and Malaria programmes.

Discussion:

108. Cook Islands: Cook Islands is one of four countries that did not technically qualify for this programme, but went to the table and these four countries were included. Importance of civil society – important funding has come in through civil society/NGOs – HIV, STI funding. We are very supportive of the work that needs to be done. Countries need to be smart about what needs to be done. There is not a lot of money around. We need to find a way to put this issue on our agenda.
109. **Tonga:** The paper is interesting in respect of project management-related costs – 60% – which is one of the highest in terms of budget costs. Data was presented about the percentage of GDP used on general health expenditure. Most countries are less than 4% – the benchmark is 5%. How did you measure project management-related costs?

110. **PIRMCCM:** Four PICs are deemed not eligible for GF funding based on disease burden. The other seven Pacific countries were consulted and made a unanimous decision to include the additional four – these four countries would share what was allocated to the seven countries. Regarding Tonga’s comment: Costing is a tricky issue. This is what the region is asking the GF to fund in terms of HR positions – based on our applications to the GF. GF argues we are spending too much money paying people.

111. **Tuvalu:** Tuvalu benefits from the GF for HIV and TB. The costs issue is important to be noted (Tonga’s point). Cook Islands’ point about civil society should be noted – it is not clear why these organisations were not funded.

112. **PNG:** PNG receives funding for three diseases: HIV, TB, Malaria. These are big burdens in PNG. Malaria has been reduced from 18% to 2%. PNG has been focusing on control; now looking at eradication. You must put more money in if you want to see results.

113. **FSM:** Questions: 1. Has this grant been awarded? 2. Cost sharing: what are the conditions? Is it a condition for receiving funding? 3. Does each country know how much it will get from this package? 4. We need leeway for planning purposes – two years ahead for budgeting to pay for staff that are not covered by GF funding is too far out.

114. **PIRMCCM response:** 1. Yes. The new round of funding is for 2015-2017. We have funds from the earlier period. 2. Not specifically – GF encourages all countries receiving GF funding to plan ahead. 3. Each country is asked to make a proposal/wish list. PIRMCCM trimmed it down to match what GF would give us. All countries were advised what they were to be allocated for the three diseases. 4. HoH are the people that are in the best position to influence government decisions about planning. Eventually GF funding will not pay for people in countries.

115. **SPC, Dr Vivili:** Who decides is eligible/what criteria?

116. **PIRMCCM:** It includes the disease burden, and compares the applicant country with group of countries. We do not get more information back from GF about why the funding decisions were made.

117. **FSM:** What happens with our comments from here? How will it be presented to the PHMM?

118. **SPC, Dr Vivili:** We’ll discuss that in working groups.

119. **FSM:** We do not want to compromise service at the country level. We understand the need to absorb positions for cohesion to take forward to PHMM, but at the administrative level I’m conscious about how it moves forward so that service at the country level is not compromised.

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**Item 5.2d: Preparedness and capacity building: PPHSN, SHIP, and enhanced surveillance for mass gatherings [SPC/WHO]**

**SPC (Dr Damian Hoy):**
The presentation gave a brief overview of the epidemiological situation in the region, and discussed a selection of the many initiatives that are currently under way to address this situation. These include some of the core PPHSN functions, capacity building through the Strengthening Health Interventions in the Pacific (SHIP) program, and utilising mass gatherings for reducing the transmission of communicable disease as well as strengthening the durability of surveillance systems.

Regional epidemiological update:

121. Communicable diseases: The frequency, range and causes of viral mosquito-borne outbreaks in the Pacific have increased at alarming rates since 2012. For as long as there has been data from the region (i.e. 40 years), this epidemic wave of mosquito-borne viruses is unprecedented, and is placing a huge burden on Pacific people and their health care systems.

122. Non-Communicable diseases: The recently released Global Burden of Disease (GBD) study estimates that diabetes, ischaemic heart disease and asthma are in the top 10 causes of burden in the Pacific. Depression and low back pain are estimated to be the top two causes of disability. In 2010, a substantially larger proportion of the overall disease burden in the Pacific was estimated to be due to NCDs compared to 1990 (48% compared with 33%). The top three of all risk factors in the Pacific in 2010 were reported to be high fasting plasma glucose, high body mass index and tobacco smoking, suggesting that the burden from NCDs is likely to further increase over coming years.

123. Progress on some of the initiatives responding to the situation: Mitigation and control of NCDs and CDs, and of public health emergencies, require a shared a number of core capacities; e.g. surveillance, operational research, monitoring and evaluation, planning and policymaking, health promotion, and strategic health communication. In resource-constrained Pacific Islands, building national and regional capacity for core public health functions (CPHFs) is important for the efficiency of public health investments.

124. PPHSN core functions and services: The PICT-governed Pacific Public Health Surveillance Network (PPHSN) has undertaken considerable work over the last decades to improve the health of Pacific people. Key allied members are WHO, FNU, PIHOA, CDC and SPC. Operational steps of the PPHSN include outbreak detection through syndromic and event-based surveillance; regional alert and communication through the PacNet email list; verification and identification through the LabNet network; investigation and response; and infection control. At the most recent IHR meeting, WHO, SPC and partners were requested to support PICs to implement formal event-based surveillance as a complement to the existing indicator-based Pacific Syndromic Surveillance System. PPHSN has recently updated the Pacific Outbreak Manual. Capacity building is also a key initiative of PPHSN.

125. National and regional capacity building of core public health functions (SHIP program):
   - Earlier PHMMs emphasised the limited capacity of staff in many PICTs to analyse, interpret and use health data effectively as an evidence base for informing and evaluating policies, actions and programmes. In response, the PPHSN Coordinating Body approved SPC to commission a study for assessing the feasibility of establishing a training and capacity development programme in the Pacific. The study proposed a programme for Strengthening Health Interventions in the Pacific (SHIP), with the overall goal of improving population health outcomes in PICTs by increasing the effectiveness of core public health services. The SHIP program was endorsed at the HoH meeting in 2014.
   - Adaptation of FETP: The SHIP program will establish a regional entity that will integrate training with capacity development in a way similar to that used in the FETP models that have been adopted in over 50 countries and regions around the globe. The SHIP program builds on the principle ‘from work, at work, for work’, and will incorporate existing initiatives for capacity building in essential public health functions.
• There are three qualification levels within SHIP: the Masters in Field Epidemiology; Diploma in Field Epidemiology; and Certificate in Field Epidemiology. The Masters level is done full-time and trainees will be enrolled to study and work full-time in their home country over a period of two years. The diploma level is done part-time over one to two years, and the certificate level is done part-time over one year.
• Progress: Currently applying to FNU for accreditation of SHIP. Funding needs to be sought. Excellent progress and interest in DDM.

126. Enhanced surveillance for mass gatherings:
• One of the downsides of mass gatherings is the potential for communicable diseases to spread efficiently and rapidly. Enhanced syndromic surveillance (ESS) is increasingly being used for mass gatherings, and is an important opportunity to strengthen existing syndromic surveillance systems. Since 2012 SPC has been providing support to PICTs in mass gatherings. The objectives have been: 1) To provide a simple surveillance system for detecting and responding to disease outbreaks quickly and efficiently; 2) To ensure durable surveillance system improvements beyond the mass gathering; and 3) To disseminate epidemiological information through the region to assist with preparedness.

127. Recommendations to HoH:
• Discuss and acknowledge the current epidemiological situation in the Pacific Islands region.
• Discuss and continue to support the work of PPHSN members and partners in preparedness and capacity building.
• Discuss and continue to support the SHIP program and advise the most appropriate approach for selecting candidates and projects for Certificate level, Diploma level, Master level.
• Discuss and continue to support the ES of mass gatherings and commit to providing notification at least 12 months in advance of seeking technical assistance.

128. Chair: 1. We acknowledge the work and efforts going into these programmes. 2. We note and acknowledge the work of PPHSN. 3. Called for discussion in respect of the SHIP program:

129. Australia: How is it delivered? And how is it funded?

130. Dr Hoy: Funding is next on the agenda.

131. Chair: 3. We support the SHIP program and preparedness in Pacific islands. 4. Called for discussion in respect of ES for mass gatherings:

132. Tuvalu: Duration for asking for TA – 12 months in advance. Sometimes we do not know that far in advance.

133. Dr Hoy: For anything over 1000 people it would be worth having ES. If you don’t know in advance then of course we are flexible.

134. Chair: 4. The definition of mass gatherings – we need to be clear on: 1000 people. Agree with all of the recommendations.

135. FSM: What is the turnaround with the John Hopkins research?

136. Dr Hoy: We are looking at various developments – this will be an ongoing thing. We will keep HoH informed.
137. **Tuvalu:** What is the turnaround time for results? When we get the results the epidemic is post-peak. How can we deal with this issue?

138. **Dr Hoy:** It is an issue with specific labs. Dr Hoy offered to put this to SPC’s lab specialist, who would raise it with specific labs.

139. **Tuvalu:** Dengue outbreak: the Tuvalu Health Department is keen to give the community the right information.

140. **Dr Hoy:** Indicated that SPC is happy to do whatever it can. SPC will follow up the lab issue. We are keen to hear thoughts on what the specific problem is: specific labs, transport of samples, etc.

141. **Palau:** PNG has mass gatherings once a week.

142. **Dr Hoy:** Mass gatherings are a good opportunity to build capacity in a sustainable way in the systems. It is a flexible thing.

143. **Chair:** Closed the day

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**Day 2: 19 February 2015**

**Item 5.3a: Nurturing children in body and mind [WHO/SPC]**

**WHO (Dr Jayaprakash Valiakolleri):**

144. Protecting children and their development is a critical issue for the Pacific region. Substantial gains have been made in the last 20 years in improving child health, through improvements in maternal care, immunisations and other programmes. Substantial challenges remain, with ongoing threats from outbreaks, insufficient emergency obstetric and new-born care and family planning services, and poor nutrition, along with developing problems associated with issues of food security, societal change and environmental changes. These include growing obesity problems, STIs in teenagers and child abuse. Tackling these issues, in resource-constrained settings with fragile health systems, requires multi-sectoral and multi-faceted responses.

145. Future directions:
   a) **Strengthen service provision**
      i. Assess current issues with MNCH service: need continuum of care, equity
      ii. Target STIs pre-pregnancy
      iii. Immunisation programme
      iv. RHD programmes needed in all PICTs
      v. Ensure mental health integrated in MNCH
   b) **Build on success stories:** E.g. IMCI, RHD screening, BFJI, immunisation, TBAs, supplementation
      i. Review and document best practice from within the PICTs and share experience
      ii. Scale up successful programmes nationally
      iii. Revitalise BFHI – target full accreditation
      iv. Develop strong partnerships with MoE
   c) **Strengthen IMCI and early child development monitoring – first 1000 days are critical**
      i. Review existing child development monitoring and strengthen it
      ii. Incorporate monitoring milestones in patient information systems
      iii. Incorporate IMCI fundamentals in PHC
iv. BMI monitoring system for school/pre-school children
v. Raise profile of nutrition
vi. Review and reorient programmes for breastfeeding and complementary feeding
d) Holistic child-centred approach
   i. Child-centred approach across national strategy

Discussion:

a) Strengthen service provision:

146. Samoa: Very interested in the natural immunity of the human system to diseases. Do you have any epidemiological data on human exposure to diseases – e.g. the percentage of people who will catch diseases? In terms of immunising the population, how many people are you planning to immunise?

147. WHO: For vaccine-preventable diseases, it depends on the disease. E.g. for measles, herd immunity needs to be at least 95%; polio needs to be 90%.

148. Tonga: From the table in the presentation, under-5 mortality, the leading causes of mortality have remained the same over the last 20 years. Clearly most of these diseases can be prevented. What is the progress in getting the vaccines utilised in the Pacific region?

149. WHO: Immunococcal vaccine: the cost is the most important factor hindering countries introducing the vaccine. E.g. rotavirus vaccine. Also, the sustainability needs to be addressed, before the vaccine is introduced – for example, the case of measles.

150. Fiji: Assessing current issues needs to be done within the Pacific Island countries. Do you have a tool to use? Does each country have to fund their own assessment?

151. WHO: Continuum of care is the deciding factor. Tools are available that can be adapted to the country context. What are the practices that are happening in each country - minimal funding will be required for that.

152. Marshall Islands: Vitamin A programmes. Only three PICs using it. In Marshall Is, women are routinely given Vitamin A in delivery room. Tour Vitamin A programme is very effective in RMI. HPV vaccines – the issue of getting them to girls, since cervical cancer rates are high in RMI in Marshall Islands. The issue is one of consent. Is there a way that our ministers can incorporate these vaccines that do not require consent? Do any other countries have comments on that – incorporating within an exception law – can we have a recommendation to ministers to include HPV along with other childhood immunisation?

153. WHO: RMI is quite successful. We are advising countries to learn from other countries to learn from experiences in countries such as Marshall Islands. Needs to be considered at the country level.

154. Fiji: We did a lot of education in places where there were many concerns about these vaccinations.

155. Samoa: Marshall Islands needs to be careful to specify the age group that needs this vaccine.

156. NZ: NZ has had a HPV vaccine programme in place for the last 3-4 years. There was a campaign around awareness. We were aware that it would not be well received particularly in our Pacific communities, so we engaged in an education and information programme. We followed the track of the uptake, especially in Pacific communities and young women; it’s delivered at intermediate school age – it must be delivered before first sexual contact – so it was intermediate, which is the around the age of 11-12. There is an informed
consent process. Information goes out to parents, and it is translated. Information is made available at schools. The campaign has been quite successful in NZ.

157. Marshall Islands: HPV has also been found to be transmitted through clothing. Family planning and Child Protection Act – we want to prevent unwanted teenage pregnancy. The law requires consent from parents before family planning methods are administered to children. Can we use the Child Protection Act to administer these vaccination methods when requested by these younger-age/non-adults?

158. UNICEF:
- Childhood deaths are interlinked. On the issue of herd immunity it is not just looking at one particular vaccine, but we are looking at an overall package of vaccines – addressing U5 deaths in the population.
- For example, vitamin A has been proven to have very good impacts across various diseases.
- Tools: there are tools that are available. E.g. Botanic analysis – they have been costed, we’ve looked at various scenarios. UNICEF is involved in a joint programme providing support to countries.
- HPV vaccine and family planning: Some countries have introduced laws whereby children, once assessed, along with confirmed mental capacity, are provided with these services, such as family planning (and abortion in some countries). Pacific Island countries may need to consider how to protect these young girls. How can we introduce family planning? An entry point in schools has proven to be very effective in some countries.
- The availability of vaccines: most countries have moved from low to medium income. This means you no longer qualify for some of the benefits that other countries are receiving. So, interventions need to come from governments or other donors. So we need to see how to increase access, other funding, etc.

159. New Caledonia:
- The experience of NC, when it comes to HPV: we started vaccination in NC several years ago, not compulsory. We believe you should not confuse HPV immunisation and protection against that type of cervical cancer. We should not make people believe that once they have been immunised they don’t need to have a smear test regularly. So we insist that a pap test should be done on regular basis, even if vaccinated.
- For the time being, we cannot say how efficient the vaccine is in the long term; it’s pretty new, so we will reassess in a few years.
- Family planning – all people can have access to that service. We also have a compulsory visit to a social worker/doctor, etc. Because we want to ensure the young person knows all the relevant parameters in making a decision, so these visits to professionals are compulsory.

160. Cook Islands:
- We do not go down the track of regulating immunisation. We have found advocacy is the key for the Cook Islands. And providing the right information to parents. Coverage: we find that people that come from outside of Cook Islands are resistant to immunisation, and become a challenge for us. E.g. measles recently: it helps to get information out there and raise awareness, and therefore to convince people to accept immunisation for their children. Cook Islands will continue on this line and will not go with legislation.

161. Chair: Ultimately, parents remain responsible for their children. We must make them aware of the options available to protect their children. We endorse a) Strengthen service provision.

c) Strengthen IMCI and early child development

162. Fiji: Mothers welcome the interaction that comes with IMCI.
163. **Chair:** We endorse c) Strengthen IMCI and early child development.

164. **Palau:** ‘The first 1000 days are critical’. This year we had two cases of deaths, 2 and 4 months breast-fed. Autopsy revealed chest filled with milk. Future directions: breast feeding is good but there are things you need to do after breast feeding so the children won’t aspirate/die.

165. **Chair:** Yes, this is covered under the proposals: Review and reorient programmes for breastfeeding and complementary feeding.

166. **Tuvalu:** How do we ‘raise the profile of nutrition’?

167. **WHO:** Nutrition is always underfunded. Good to can encourage countries to focus on funding. Not a lot of success in raising awareness of nutrition. We need to consider the means for raising the profile of nutrition.

168. **Samoa:** Looking at ways to raise awareness of nutrition. Link it to NCDs, food security, Apia programme.

169. **Palau:** Are there programmes that can help us to prevent aspiration from breast feeding?

170. **WHO:** The baby-friendly hospital initiative is a way to look at it. This ensures that once they leave the hospital support is still there.

d) **Holistic child-centred approach**

171. **Tuvalu:** Holistic approach: does it include water and sanitation?

172. **WHO:** Yes, it takes into account all areas – all have roles to play.

173. **Chair:** We emphasise it needs to be a child-centred approach.

174. **Tuvalu:** If we can recommend for ministers the problem with water and sanitation.

175. **Chair:** Yes, we will consider this in the working group.

**Discussion points:**
- Priority actions
- Targets and indicators

**Item 5.4: Promoting ecological balance [WHO/SPC]**

**WHO (Dr Padmasiri Eswara Aratchige):**

176. Paper is in a draft stage, to be modified after input. Balanced ecosystems are a key contributor to health, well-being and resilience. Pacific island countries and areas are vulnerable to the impacts of climate change, natural disasters and environmental risks. Some PICTs will fail to meet MDG targets on water and sanitation coverage. Most countries developed national action plans on climate change and health (NCCHAP) based on vulnerability assessment, and the Pacific collaboration on disaster risk management for health has improved in the past 20 years.
177. Challenges of promoting ecological balance for health gains in the Pacific include: ecological fragility and vulnerability; limited knowledge, attitude and practice based on the linkages of ecosystem and health; and difficulties in influencing non-health sectors. Future directions for considerations are to: commit to post-2015 agenda relevant to health and the environment; adopt a multi-sectoral approach to universal access to water and sanitation; build resilience of health systems to climate, disaster and environmental risks; and mobilise resources from global climate finance mechanisms. Climate change has many facets and impacts, including impacts on health.

178. Promoting ecological balance – key areas:
   - Water, sanitation and hygiene (WASH)
   - Climate change adaptation
   - Disaster risk management

179. Priorities: Commit to the post-2015 agenda relevant to health and the environment:
   - Take urgent action to combat climate change and its impacts
   - Ensure availability and sustainable management of WASH for all
   - Build resilient infrastructure
   - Conserve and sustainably use the oceans, seas and marine resources for sustainable development

180. Approaches:
   - Preparation and implementation of drinking water safety plans (DWSPs), including rural water supplies of remote outer islands
   - Address water security, along with water safety, to adapt to droughts and dry seasons aggravated by climate change
   - Coordination to ensure addressing the root causes of health risks championing ‘Health-in-All Policies’ approach
   - Utilising integrated water resources management approaches for long-term sustainability of fresh water resources
   - Building resilience of health systems to climate, disaster and environmental risks:
     - Work with and lead actors outside of the health sector to ensure coordination and synergies
     - Committing to resilience by reducing vulnerability and improving the capacity of the overall health system

Discussion:

181. Chair: Ecological balance is very important in the Pacific.

182. Tokelau: Queried why Tokelau data is not presented – is the data not coming to you, or we are not being asked? With a multi-sectoral approach, some of the water and sanitation targets sit under the economics and environment area.

183. WHO: Will follow that up.

184. Cook Islands: Interested in the compost toilet. Will discuss these issues with the minister.

185. WHO: The secret is to make it an aspirational item.
186. **Tonga:** We are looking at compost toilets. People are vulnerable to weather events leading to contaminated water supply. We try to strengthen water committees who are supposed to collect fees and maintain the pump, but only around 20% of water committees have the capacity to do that job.

187. **WHO:** Yes, maintenance is a big issue — the greater the technology the greater the maintenance issue.

188. **Tokelau:** Desalinators are used during drought, but outside of emergencies the equipment falls into disuse and maintenance is an issue.

189. **Fiji:** Health waste management — is a challenging area for Fiji — especially segregating waste, and incinerator pollution. We need a system that is more eco-friendly.

190. **Australia:** We’ve talked about some of the countries that have adopted climate-resistant health systems and planning — how much do these address long-term change, and susceptibility to climate shocks and intermittent natural disasters.

191. **WHO:** There is a framework for countries to follow and they constitute long-term planning for systems.

192. **Tuvalu:** Building resilience of health systems to environmental risk. We really don’t have anywhere to run to or anywhere to build – Tuvalu is only 5 metres above sea level.

193. **Chair:** That concludes the five thematic areas of the review of the Healthy Islands journey. Group work will follow, to discuss recommendations for the PHMM.

**ITEM 6: Monitoring and implementation of the Healthy Islands Vision [WHO/SPC]**

**Item 6.1: Data review – targets and indicators for healthy islands, including data review [WHO/SPC]**

*WHO (Dr Manju Rani):*

*Presentation: Reviewing the progress in the last 20 years in the Pacific: data availability, accessibility and quality*

194. Purpose of the review: To seek data to show, over the last 20 years:
   - Is the performance of health systems getting better?
   - Are children better nourished and better protected from diseases?
   - Do people get sick less often and live healthier lives?

195. Data issues:
   - Data is often not consistent across databases
   - Reaching different conclusions using different data from different sources
   - Substantial variation in:
     - Content
     - Integration of data from different sources
     - Public accessibility of reports
     - Variability in ease of retrieving information on different key issues
     - Accessibility of data varies widely across countries
196. Produced:
   - First draft Country Profiles and regional indicator sheets
   - Attempt to customise the profiles to reflect country priorities

197. Lessons:
   - Invest in efforts to translate all the collected raw data into usable form and develop an accessible dissemination system
   - Commit to producing regular and timely reports
   - Making the reports easily accessible – online
   - Only use actual/estimated data from countries rather than the global/regional estimates
   - Make efforts to harmonise data collection efforts of partner agencies, and aim for consistency across their databases

*Item 6.2: Group work on indicators and mechanism for monitoring and implementation [WHO/SPC]*

**SPC/Centres for Disease Control (Dr Damian Hoy; Dr Hayley Cash):**

**Presentation: Training for communicable and non-communicable disease**

**Why do we need data?**

198. Given the current scenario with over-strained and under-resourced systems, data is essential for health leaders to:
   - Plan: To understand the health status of our populations in order to prioritise health programs so that limited resources are able to be used to the best possible effect.
   - Implement, monitor and evaluate:
     - ‘If we don’t know where we are going, chances are we won’t get there.’ Anon.
     - Assessing the effect and efficiency of health programmes.

199. As we further develop the DDM curriculum and plan other initiatives, we’d like to hear from you about data for decision-making in your country/territory.

**Group work to discuss ideas about data for decision-making in countries/territories:**

200. **Questions for groups to consider:**
   1a. What do you think of data availability in your country?
   1b. In what format are data available to you?
   1c. Are the data available in a state/format that is adequate to serve your decision-making needs?
   1d. What recommendations do you have to improve this?
   2a. What are the key issues faced in getting and using the data to inform your decision-making needs?
   2b. How do you recommend these be overcome?
   3a. Are the goals and targets at regional and global level (and the consequent global and regional data reporting needs) aligned with your own national goal and targets and data needs?
   3b. If yes, how is this done?
   3c. If no, how do you think this can be improved?
4a. How can partners and countries/territories work together to minimize your data reporting burden (if you consider this high at present)?
4b. How can data collection be made more efficient?
4c. How can data be made more accessible to all stakeholders?
4d. For your decision-making, what are the most useful information products for presenting health data (e.g., annual health reports, posters, papers, etc)?

5. What recommendations do you have for partners in assisting to strengthen data for decision-making in your country/territory?

201. Chair: It is very important to present donors with objective and reliable data, in progressing the Healthy Islands vision.

Item 6.3: Group presentations

202. Presentation: Group 1 – Cook Islands; Nauru; Niue; Palau; Tokelau; Tuvalu.

203. Need to discuss data within the framework of the HI vision. HI is very broad, so we need to define better: what are our goals? How do we access this?

<table>
<thead>
<tr>
<th>Questions 1–4 considered in the group discussion, summarised as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Do we have data available in our countries?</td>
</tr>
<tr>
<td>• Yes, but in various formats</td>
</tr>
<tr>
<td>• Need to review availability and access to PH data management systems</td>
</tr>
<tr>
<td>• Often have two different systems, e.g.:</td>
</tr>
<tr>
<td>o  Patient information systems</td>
</tr>
<tr>
<td>o  PH IS</td>
</tr>
<tr>
<td>➢  Need to integrate</td>
</tr>
<tr>
<td>• Most data is already available to inform the review of HI, but we need to clarify the format, where that information/data is sourced, and in what format it is available in country</td>
</tr>
<tr>
<td>• Need to build a good system in the first place, that is appropriate to the country needs</td>
</tr>
<tr>
<td>o  Data entry</td>
</tr>
<tr>
<td>o  Analysis</td>
</tr>
<tr>
<td>o  Advocacy</td>
</tr>
<tr>
<td>➢  Consistent loop</td>
</tr>
<tr>
<td>• Need consistent and clear practice and protocols in place for data collection, analysis and response (e.g. patient management)</td>
</tr>
<tr>
<td>• It is critical to agree on own country indicators – core indicators that are consistently used at ministerial level – that could feed into a HI co-monitoring framework; that could feed into ministerial discussion, which could be utilised for monitoring funds</td>
</tr>
<tr>
<td>• Need consistent monitoring and tracking of high-risk patients over time (e.g. in reference to NCDs)</td>
</tr>
<tr>
<td>• Use data to influence funding</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question 5. Recommendations to partners:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Do not overburden countries with the expectation for collecting and reporting on data – we take data from what we already have. Some do it in an annual report; some do it with periodic reporting within health departments</td>
</tr>
<tr>
<td>• Ministers to advocate for a simple template that is used for technical and other development partners – we have been talking about this for many years, and do not have a standard template, as it is difficult with different partners</td>
</tr>
<tr>
<td>• National indicators for HI monitoring to feed into the HI framework</td>
</tr>
</tbody>
</table>
| • Need help with capacity development, and assistance through DDM training. Some countries
need help with data systems within country
• Need support to develop solutions with development partners
• Some scoping missions do not have action oriented for approaching member countries – we would like to see that in future
• Additional human resources for data analysis

204. Presentation: Group 2 – American Samoa; Federated States of Micronesia; Marshall Islands; Northern Marianna Islands; Kiribati; Tonga.

205. All countries have a data system in place, and data available: Varies between different countries – different systems; Northern PI/ Southern PI – different data systems. So when leaders come in and talk about policy data we all have different data – we cannot be uniform in a common reference point for our discussions.

<table>
<thead>
<tr>
<th>Group 2: Responses to questions 1–5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 1. Data availability:</td>
</tr>
<tr>
<td>• Use what is working at each level in country</td>
</tr>
<tr>
<td>• Data is available, but getting the data is difficult</td>
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<tr>
<td>• Should be a single reporting system or form – donors should become a partner and request one single indicator to be reported from each country</td>
</tr>
<tr>
<td>• Challenges: producing or reading data</td>
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<tr>
<td>o Epidemiologist</td>
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<tr>
<td>o Strengthen career pathways, from a data recorder up to Epidemiologist</td>
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<tr>
<td>▪ Need regional support</td>
</tr>
<tr>
<td>▪ If we want good data everything must come together</td>
</tr>
<tr>
<td>Question 2. Issues in using data:</td>
</tr>
<tr>
<td>• Need proper planning in setting up a system – need a single reporting system or format</td>
</tr>
<tr>
<td>• When we present data to ministers, it should be possible to report on MDGs that are required to be reported in each country</td>
</tr>
<tr>
<td>Question 3. Goals and targets:</td>
</tr>
<tr>
<td>• Develop partners between the provider and the country on the indicators needed</td>
</tr>
<tr>
<td>Question 4. Data accessibility:</td>
</tr>
<tr>
<td>• Funders come up with one effective system for data reporting – i.e. TB, HD</td>
</tr>
<tr>
<td>• Depends on different data in each country – one system would help, rather than making multiple demands/burden</td>
</tr>
<tr>
<td>Question 5. Recommendations to partners:</td>
</tr>
<tr>
<td>• Same recommendation that came out of questions 1-4: single data reporting – all partners need to work together</td>
</tr>
<tr>
<td>• Use the data and systems that are already available – develop those, in country</td>
</tr>
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</table>

206. Presentation: Group 3 – Fiji, Guam, Samoa, New Caledonia, PNG, Solomon Islands, Vanuatu.

<table>
<thead>
<tr>
<th>Group 3: Responses to questions 1–5</th>
</tr>
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<tbody>
<tr>
<td>Question 1a:</td>
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<tr>
<td>• There is a lot of data available but no uniform data set</td>
</tr>
<tr>
<td>Question 1b. Data is available in:</td>
</tr>
<tr>
<td>• Annual Reports, Corporate Plans/Reports</td>
</tr>
<tr>
<td>• General Reports</td>
</tr>
<tr>
<td>• Electronic databases (Excel sheet) e.g. Public health, patient information</td>
</tr>
<tr>
<td>Question 1c. Data facilitates DM?</td>
</tr>
<tr>
<td>• Yes, but not on a timely basis</td>
</tr>
<tr>
<td>Question 1d. Recommendations to improve:</td>
</tr>
<tr>
<td>• Look at inventory of data – reviewing the type of data and prioritising data system</td>
</tr>
<tr>
<td>• Tool for collection of data in a more effective manner. E.g. data to be transmitted through IT system(s), paper forms</td>
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<tr>
<td>• Prioritise the indicators of the type of data to collect; e.g. Malaria</td>
</tr>
<tr>
<td>• Data dictionary</td>
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<tr>
<td>• Review types of data sources so data is of good quality</td>
</tr>
</tbody>
</table>
**Question 2a. Key issues:**
- Getting the data in time to make effective decisions, otherwise delayed decisions are made and therefore not effective
- Little trust in the data sets (too much information/data)
- Not enough trained personnel in data collection level
- Capacity for analysis of information and interpretation

**Question 2b. How overcome?**
- A simple system to be able to extract information on a timely basis
- Build capacity of personnel and health information system

**Question 3a. Goals and targets aligned?**
- Some national priorities are aligned to global reporting, such as MDGs
- Different data reporting and requirements by different agencies
- Targets set at global/regional level are not always feasible in local jurisdictions – too ambitious.

**Question 3b. How is alignment achieved?**
- Through national strategies/plans

**Question 3c. Improvement?**
- Look at having standardised formats for data collection to save time
- Harmonise all of the formats on common information/indicators
- Informatics who may do the analysis for national and global projection. Training of people in informatics.

**Question 4a. Working together:**
- Look at country data source that has authority. Point partners to website where information is available.
- Build capacity on using data and informing partners
- More resourcing and funding

**Question 4b. Better efficiency?**
- Use of IT and mobile communication

**Question 4c. Data accessibility?**
- Available on websites

**Question 4d. Useful info products:**
- For immediate information – websites, databases, bulletins on timely basis
- For long term decisions – Annual reports, Corporate plans, National plans

**Question 5. Recommendations to partners:**
- Capacity building of HR – training in the area of Informatics
- Countries have core data sets to meet national reporting requirements which can also be used at regional and global level (to avoid vertical reporting)

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**207. Chair:** We recognise the need for a standardised reporting system for countries.

**208. Chair:** Invited OBSERVERS’ comments about meeting: There were no observer comments – the Chair thanked the observers for their important role.

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**PICT allotment into the five HI thematic areas for developing recommendations for the PHMM:**

<table>
<thead>
<tr>
<th>Thematic Area</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Island Journey, achievements, challenges and way forward</td>
<td>Cook Islands; FSM; Nauru; Solomon Islands</td>
</tr>
<tr>
<td>Strengthening, leadership, governance and accountability</td>
<td>Australia; Cook Islands; New Caledonia; CNMI; PNG; Samoa; Tokelau; USA</td>
</tr>
<tr>
<td>Reducing avoidable disease burden and premature death</td>
<td>Fiji; Guam; Palau; Tuvalu</td>
</tr>
<tr>
<td>Nurturing children in body and mind</td>
<td>Marshall Islands; New Zealand</td>
</tr>
<tr>
<td>Promoting ecological balance</td>
<td>Tonga; Vanuatu</td>
</tr>
</tbody>
</table>

**ITEM 7: Pacific Health Agenda post 2015 [Fiji/SPC/WHO]**

**209. Fiji:** Outlined arrangements and logistics for the 11th PHMM, 15-17 April 2015.
WHO: Dr Liu:

**Draft agenda for the 11th PHMM:**

210. As the secretariat to the PHMM, the Fiji Government has organised a strong team to work towards the PHMM.

211. Some more points about preparation:
   1. Invitations have been sent to ministers. Please urge and facilitate nomination of attendance
   2. As we discussed this is a good meeting to prepare for the ministers meeting – it is critical to organise a country-level 20 years review of your achievements and progress. Your experience at country level review will be critical to formulate the post-2015 agenda
   3. Please brief your health minister on the programme and purpose of the next meeting and prepare them for their participation and brief in respect of interventions. We can do much better than the last two decades. We can put in place evaluation mechanisms and have clear targets in place – if we continue to adhere to the HI vision
   4. After this meeting we need a group of directors to lead the outcome of the next ministers meeting. We put in the programme the post-2015 agenda – we can change it to make it more relevant to the Pacific context. SPC and partners can assist the group to get something drafted. Prepare something before PHMM.

ITEM 8: Key decision points [Secretariat]

212. Guam – HoH sub-committee: Presented draft Key decision points for comment.

213. NZ: NZ supports this HoH meeting. There have been some valuable opportunities to discuss important topics. Constructive feedback on the process on this meeting. Small groups meeting – this was the most interaction, during that group work. We support the need to have more group opportunities, to better engage with each other.

214. Chair: We note and take on board those issues raised.

215. FSM: How do you see the smaller entities – thematic groups – working before PHMM?

216. SPC, Dr Vivili: Groups should work with the Secretariat to refine all papers before PHMM. Looking at the detail, how we can operationalise these issues, so that these details are in place before PHMM (e.g. indicators, systems for monitoring), so ministers can endorse tangible issues.

217. SPC: The Secretariat will circulate the final recommendations.

ITEM 9: Closing

WHO:
218. This is a very important event that will lead to a successful PHMM. Many issues have been discussed and agreed at this meeting. I appreciate your passion and your wisdom at this meeting. I appreciate the leadership of Fiji’s Minister of Health, to give guidance and note important points: 1. To get the Pacific voice heard at the global and regional level; and 2. We need to decide our priorities and implement them at the country level.

219. You need to implement the health agenda in your country. I appreciate all partners’ contributions to discussions. Thank you to the Chair for the successful carriage of this meeting.

220. Chair:
   1. After the session, the five HI thematic groups will meet briefly to pick a team leader from PICs
   2. SPC will be in contact about the working groups’ work before the 11th PHMM
   3. Fiji members will sing a traditional farewell

221. The HI concept was born here 20 years ago. We have noted the journey with all of its challenges and gaps. As leaders, the onus is on us now as we further dissect the five HI thematic areas, and advise our ministers on decision-making. We have noted the report by Dr Don Matheson and his team. We have noted the Samoa Pathway and outcome of the SIDS meeting. We have noted the UN post-2015 development agenda. And we have noted your own country assessments of your HI journey.

222. Let’s all perform to our very best as we head to the 11th PHMM, for the betterment of health for Pacific people, not only nationally but also globally. Let’s commit ourselves to make the Pacific’s people not only the friendliest, but the healthiest, people worldwide. This can only be achieved by strong leadership, governance and policymaking, from us and our policymakers.

223. As experts in health, our role becomes more and more important in providing evidence-based data in the decision-making process for our leaders. On that note I acknowledge SPC and WHO for organising this meeting.

224. I wish everyone a safe journey back home, and indeed it is an honour for me to declare the Third Heads of Health meeting closed. God bless us all and safe travels back to your different Pacific Island countries.

-- Devotion and close --
Key decision points


Purpose: To review progress made towards achieving the vision of Healthy Islands and craft a way forward.

- The meeting endorsed the findings of the Healthy Islands Review and the formation of a subcommittee(s) to further refine its recommendations for presentation to the Pacific Health Ministers Meeting (PHMM) for approval.

Review of outcomes of PHMM and First Joint Meeting of PHMM and Forum Economic Ministers, Honiara, 2014: Directives and Progress

Purpose: Review of outcomes of the meetings, and progress on implementing recommendations, particularly in relation to the NCD Roadmap.

The meeting

- noted the progress being made and achievements at the political level in several countries in implementing PEN and the recommendations of the NCD Roadmap;
- agreed that the existing HOH subcommittee should assume the role of governance of MANA, that PIHOA should be included in the Coordination Team (pending the endorsement of the PIHOA Board), and the team should further develop the ‘MANA dashboard for NCD action’ as a monitoring and evaluation tool.

Review of SIDS 2014 Health Related Outcomes and next steps

Purpose: To consider the health and NCD related commitments made in the SAMOA Pathway and Apia Challenge.

The meeting

- endorsed the health commitments made in the SAMOA Pathway and Apia Challenge;
- endorsed the aims of the Pacific NCD Partnership, which was launched at SIDS 2014, noting the meeting’s focus on effective partnerships.

Strengthening leadership, governance and accountability
Purpose: To consider the future strategic leadership, governance and accountability of the Heads of Health mechanism.

The meeting endorsed the points made in the paper, which is to be presented to PHMM, and in particular agreed on the importance of:

- strong leadership and political will in effective implementation of health measures;
- the role of clinical governance in accountability;
- the contribution of civil society, including NGOs and faith-based organisations, particularly in areas such as mental health;
- provision of information and evidence to guide decision-makers.

Reducing avoidable disease burden and premature deaths

Purpose: To review the challenge of tackling the double burden of communicable and non-communicable diseases and propose future directions.

The meeting agreed on:

- the importance of timely data for decision-makers and need to avoid delay in releasing reports, results and analyses;
- the value of country-level experience in assessing the effectiveness of interventions;
- the importance of multi-sectoral action and ‘Health in All Policies’ to promote health across the life course;
- the role of legislative, regulatory and fiscal interventions in provision of health services;
- the need for integrated, people-centred service delivery with emphasis on primary health care that addresses health needs equitably;
- the potential to adapt indicators capable of measuring health outcomes in the Pacific from existing globally agreed targets and indicators.

Global Fund Update

Purpose: To explore the concept of cost sharing between countries and the Global Fund in implementing NFM (new funding model) grants, and potential links between HOH and the Pacific Islands Regional Multi-Country Coordinating Mechanism.

The meeting:

- noted that the level of Global Fund grants was likely to decrease and that countries therefore need to explore the issues and opportunities for cost sharing approaches in implementing NFM grants;
- agreed to include on the agenda of the Ministers of Health of individual countries a plan of action to support this;
- agreed to advocate with Pacific Ministers of Health on the issue of sustaining the gains made by investments in HIV, TB and malaria programmes;
- also expressed concern at the high cost of project management of Global Fund grants.
Preparedness and capacity building: PPHSN, SHIP, and enhanced surveillance for mass gatherings

Purpose: To present an overview of the current epidemiological situation in the Pacific and surveillance and prevention measures.

The meeting:
- acknowledged the current epidemiological situation in the Pacific Islands region;
- acknowledged the work of PPHSN members and partners in preparedness and capacity building;
- supported the Strengthening Health Interventions in the Pacific (SHIP) Program, and agreed to establish criteria for selecting candidates and projects for:
  - Certificate-level (epi-techs)
  - Diploma-level (senior epi-techs)
  - Masters-level (epidemiologists)
- noted that retention plans should be in place for staff who gain new qualifications;
- supported enhanced syndromic surveillance for mass gatherings (over 1000 people), and committed to providing notification at least 12 months in advance when possible if seeking technical assistance.

Nurturing children in body and mind

Purpose: To consider challenges for child health and child protection and their links to maternal and adolescent health.

The meeting agreed on the importance of:
- strengthening service provision to ensure child health, including equitable provision of prenatal and maternal care;
- building on success stories regarding programme implementation and outcomes in some countries;
- strengthening IMCI (Integrated Management of Childhood Illness) and early child development monitoring, including raising the profile and awareness of nutrition and water and sanitation issues;
- ensuring a holistic child-centred approach to protecting and nurturing children.

Promoting ecological balance

Purpose: To consider the contribution of ecosystems to health, well-being and resilience, noting the role of water and sanitation, and the vulnerability of Pacific Island countries and territories to the impacts of climate change, natural disasters and environmental risks.

The meeting agreed on the need for political leadership in
- committing to the post-2015 agenda relevant to health and the environment;
- adopting multi-sectoral approaches to universal access to water and sanitation;
- building the resilience of health systems to climate, disaster and environmental risks;
- mobilising resources from global climate finance mechanisms.
Reviewing progress in the last 20 years in the Pacific: data availability, accessibility and quality

Purpose: To consider how data can be used to evaluate the performance of health systems and which indicators are most useful for countries.

The meeting heard the feedback from the three working groups, noting consensus on the

- need for HR capacity building in epidemiology
- the burden of data collection for countries
- the need to develop standardised reporting systems for countries; and
- the request for feedback on the draft country profiles that were presented.

11th Pacific Health Ministers Meeting

The meeting noted information on preparations for the 11th PHMM, which will be held from 15 to 17 April 2015 at Yanuca Island, Fiji.
# Third Heads of Health Meeting

## 3rd Heads of Health Meeting, February 2015:
List of participants, partner agencies, observers and secretariat

<table>
<thead>
<tr>
<th>List of participants, partner agencies, observers and secretariat</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AMERICAN SAMOA</strong></td>
</tr>
</tbody>
</table>
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Chief Advisor Pacific Health
Pacific Health Improvement Team
Sector Capability and Implementation
Ministry of Health
<table>
<thead>
<tr>
<th>Country</th>
<th>Participant</th>
<th>Position and Details</th>
</tr>
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<tbody>
<tr>
<td>NIUE</td>
<td>UNABLE TO ATTEND</td>
<td></td>
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<tr>
<td>NORTHERN MARIANA ISLANDS</td>
<td>Ms Janet C. GUERRERO</td>
<td>Special Assistant to the CEO</td>
</tr>
<tr>
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<td>Commonwealth Healthcare Corporation</td>
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<td></td>
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<td>Email: <a href="mailto:janet.guerrero@dph.gov.mp">janet.guerrero@dph.gov.mp</a></td>
</tr>
<tr>
<td>PALAU</td>
<td>Dr Kathy NGEMAES-MADISON</td>
<td>Director, Bureau of Hospital and Clinical Services</td>
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<td>Ministry of Health</td>
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