Directors of Clinical Services (DCS) Annual Meeting

(Novotel Hotel, Lami, Fiji, 24 April 2017)

Hosted by:
The Pacific Community (SPC)

Meeting Report

Prepared by the Pacific Community, 2017

ITEM 1: Opening

1. Opening remarks were made by former Chair, Dr Eddie McCaig, Fiji National University (FNU), and new Chair, Dr Yin May, Chief Medical and Clinical Officer, Ministry of Health – Cook Islands. The meeting was attended by Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, Nauru, New Zealand, Niue, Palau, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu. Partners in attendance included Australian Department of Foreign Affairs and Trade (DFAT), FNU College of Medicine, Nursing & Health Sciences (CMNHS), New Zealand Aid Programme, Royal Australasian College of Surgeons (RACS), World Health Organization (WHO). The meeting was also attended by representatives of the Pacific Community (SPC) Secretariat and staff (see Annex 1).

The meeting:

2. noted that Strengthening Specialised Clinical Services in the Pacific (SSCSiP), which was established in 2011 and reached the end of its term in March 2017, has been replaced by Pacific Regional Clinical Services and Workforce Improvement Programme (PRCSWIP);

3. noted that PRCSWIP brings together a number of activities and implementing partners that were present in SSCSiP, and that through ownership of the new programme and taking into account country priorities, Directors of Clinical Services (DCS) can support Heads of Health (HOH) to make informed decisions in providing sustainable, specialised clinical services that will result in better health outcomes for Pacific people.

ITEM 2: Transition from SSCSiP to PRCSWIP

2.1: SSCSiP journey

The Secretariat:

4. noted that PRCSWIP represents the next phase of the SSCSiP journey;

5. noted that the objectives of SSCSiP were to: 1) work with Pacific Island countries and territories (PICTs) to improve the planning, delivery, monitoring and evaluation of specialised clinical services and the systems that support these at country level; 2) to facilitate skill development and career enhancement for health workers by strengthening country level human resources for health (HRH) planning and inter-country coordination, and by facilitating and maintaining linkages with academic and health training institutions; and 3) to promote coordination, alignment and quality of specialised clinical services (SCS) support for the Pacific;

6. noted that SSCSiP generated discussion around clinical services around the region;

7. noted that some of the lessons learned from SSCSiP include the importance of solutions at different levels and a health systems approach (e.g. workforce planning, biomedical, resources, continuing professional development [CPD] and research and analysis) and the need for leadership training;

8. noted some of the outputs and achievements of the SSCSiP: better workforce planning (SSCSiP regional database) and better resourcing of HR development (training, leadership, CPD) for SCS; 645 capacity building activities (attachments, workshops, formal training etc) and 42 postgraduate studies; development of the biomedical workforce (technician, engineer) and nursing specialisation (e.g. Midwifery, Ophthalmology);

9. noted growing interest in other cadres of work – cardiology, ear nose and throat;

10. noted that SSCSiP provided biomedical support at the national, sub-regional and regional levels through provision of: biomedical regional test equipment, user trainer manual, biomedical technician course, technical advice, and generic standards and policies;

11. noted that SSCSiP worked closely with Pacific clinical organisations (PCOs) to strengthen: technical advisory, CPD, SCS workforce, and links with colleges and associations;

12. noted that countries should send the Secretariat their vacancies to facilitate short-term workforce relief; and

13. noted the transition of SSCSiP hosted by FNU to PRCWSIP, now housed within SPC.

The meeting:

14. noted that the role of the Secretariat is to facilitate connections when short-term workforce relief is needed, and that they do so by distributing announcements to relevant parties, but that it's between the country and interested individuals to coordinate, and only in rare cases would SSCIP fund emergency relief;

15. noted that government policies can be a hindrance to workforce relief (e.g. in Fiji clinicians must use their own annual leave); and

16. noted the importance of countries submitting requests for workforce relief as early as possible.

2.2: PRCSWIP overview

The Secretariat:

17. noted their gratitude for DFAT's support;

18. invited FNU to share experiences of emergency requests from countries, who noted the progress made over the years with regard to countries

19. building contingencies into budgets to cover locum needs, and the importance of regional organisations;

20. noted that PRCSWIP brings together a number of DFAT-funded activities and implementing partners with the aim of leveraging the contributions of each implementing partner (FNU-CMNHS, RACS, SPC) to ensure the programme is following its objectives;

21. noted that the PRCSWIP design recognises the value of PICT ownership and that the governance and strategic direction of the programme will therefore be provided by DCS;

22. noted that the role of the DCS forum is to keep the HOH informed, especially on policy issues and key recommendations;

23. noted that the key principles guiding the programme are: demand driven – responding to service and training needs, as well as the need for regional approaches/standards, as identified by PICTs; accountability – implementing partners working together to use scare resources efficiently, based on the evidence of what is needed; relationship building – open, fluid and trusting relationships so that information can flow between all stakeholders;

24. noted that two of the implementing partners have been contracted and that they are in discussions with FNU;

25. noted that the vision for PRCSWIP is to ensure health care in PICTs is affordable, appropriate to local needs, of good quality and accessible, and that the partners will contribute to this vision through the following outcomes: 1) FNU to ensure FNU-CMNHS post graduate students are representative of the region and graduate with relevant competencies to practice in the Pacific; 2) SPC to ensure PICTs value and actively engage in regional fora on relevant clinical services and health workforce issues; and 3) RACS to ensure PICTs receive quality Visiting Medical Teams (VMTs) that meet their priority clinical and training needs; and

26. noted that SPC component will achieve its outcome through six key activities: 1) hosting the DCS Secretariat; 2) hosting a regional helpdesk function; 3) providing an information-sharing platform; supporting the commissioning and dissemination of research and analysis; strengthening networks of clinical professionals and institutions; and 4) developing regional approaches and/or standards.

The Royal Australasian College of Surgeons:

27. noted that 11 countries will be covered under their component of the programme: Cook Islands, Fiji, Kiribati, Republic of Marshall Islands, Federated States of Micronesia, Nauru and Samoa;

28. noted that their component comprises four outcomes focused around capacity building and service delivery at the individual and systems level: 1) prioritised Pacific SCS professionals have improved competencies; 2) PICTs receive quality VMTs that meet their priority clinical and training needs; 3) Pacific ministries of health (MOHs) better identify and prioritise SCS and training/CPD needs, to inform MOH planning; 4) Pacific specialised clinical educational institutions and PCOs have better educational resources;

29. noted that the last two outcomes tie in closely with the work of regional partners;

30. noted that VMT model has moved from service delivery to mentoring, training, confidence building, protocols, management, and integration;

31. in relation to SCS, noted that project activities are not just limited to surgery, anaesthesia, and nursing, but could include cardiology, psychiatry, emergency medicine, gastroenterology, etc., and that RACS will work with other specialist colleges and associations in Australia, New Zealand, and across the Pacific to deliver education and training needs as required by Ministries of Health; and

32. noted there are four core indicators for the regional programme set by DFAT, and that RACS has its own indicators;

2.3 Discussion

The meeting:

33. noted that the selection of countries for the RACS programme was determined during a design process undertaken with DFAT, and that requests for inclusion should be addressed to DFAT and key decision makers;

34. noted that Niue and other countries may be included under SPC under RACS outcomes 3 and 4, however the way of working with RACS may be slightly different than the 11 countries selected;

35. noted an interest in seeing more clinical outcomes;

36. noted that the issue of post graduate training gaps in some countries is something SPC rather than RACS would look into; and

37. noted that PICTs have different challenges and needs based on differing contexts.

Recommendations

The meeting:

38. recommends that the regional focus of PRCWSIP be leveraged, including as follows:

    i. clinical issues be included on the regional agenda;
    ii. a closer working relationship is established between donors (RACs, SPC, FNU); and
    iii. continued assistance to in-country clinical coordinators.

DCS Draft Terms of Reference

The Secretariat:

39. noted the responsibilities of the DCS forum (a) through to (f) as outlined in the Terms of Reference – Director of Clinical Services (DCS) Forum:

    i. Make recommendations on technical and policy issues, and strategic directions for clinical services and workforce development in the region to the HoH,
    ii. Provide and encourage a mechanism for networking between PICTs, development partners and service providers,
    iii. Support efforts geared at pooling of resources to meet shared needs,
    iv. Provide a mechanism for information sharing and transfer of best practises between countries,
    v. Review and approve the recommendations of Technical Advisory Committees and research groups commissioned by the Directors of Clinical Services,
    vi. Review the progress of implementation and ensure full accountability to PICs review and approve work plans, budgets and reports.

The meeting:

40. requested clarity around the transition from SSCSiP to PRCSWIP;

41. indicated that from a structural perspective the programme will do most of the things that were done before; that SPC, along with WHO, would continue to contribute to regional issues; that training issues would continue to be done by FNU; and that by continuing RACS by bringing it together is a useful move to consolidate the service;

42. noted that there is no mention in the TOR of research and data being required to support requests and proposed that there should be a recommendation from this meeting that requires policy issue recommendations to be supported by facts and figures;

43. queried how the technical advisory committee would be selected and noted that the committee needs to be quite strong around the scope of the role it will undertake; and

44. in relation to the TOR regarding technical advisory committees, noted that the TOR refers to committees that need to be set up in response to a need – e.g. Ear, Nose and Throat (ENT) was brought up as a need, and a committee was established; a scientific and advisory group had formerly provided advice to SSCSiP, but is no longer active, and has been superseded by two groups: Project Coordinating Committee (PCC) and the existing SPC PHD Scientific and Technical Expert Group (STEG).

Recommendations

The meeting:

45. recommends that, in respect of responsibility (a) of the TOR, strategic directions and technical and policy issues be supported by research and data analysis.

ITEM 3: Key issues affecting clinical services and health workforce in the region

3.1 A snapshot of clinical workforce in the PICTs

The Secretariat:

46. thanked all who had provided information for the survey undertaken to determine what has changed since 2012 in terms of local capacity to deliver clinical services, and noted that the response rate was 95%, and SPC received survey forms back from 13 countries;

47. noted that some of the key findings from the survey were as follows:

    i. There was an increase in the number of doctors employed by MOHs.
    ii. There was a 50% increase in the number of local doctors.
    iii. In many PICTs the proportion of expat doctors has declined.
    iv. In most countries the number of female doctors has increased, exceeding male doctor numbers in six PICTs.
    v. The Pacific has a very young medical workforce (majority < 40yrs in most PICTs, especially in the South Pacific). There is an ageing medical workforce in the northern Pacific.
    vi. Two thirds of the Pacific medical workforce do not have a PG qualification
    vii. For the mainstream clinical disciplines, paediatrics has the lowest numbers with PG qualification.
    viii. Over the last five years, the number of doctors with postgraduate qualifications in sub-speciality areas has increased.

The meeting:

48. queried whether it was possible to separate local doctors and expat doctors/those funded by donors and noted that it was useful to see gender statistics;

49. advised that if a specific doctor is practising outside-country they are considered an expat, though a further survey may be able to drill deeper;

50. noted that there has been an upskilling of nurse practitioners, which has tended to replace doctor roles in the health workforce; and

51. noted the need to look at an appropriate and sustainable way of training, especially with regard to losing workforce when they go out of country to train.

3.2 Health workforce training programmes

FNU-CMNHS:

52. noted that FNU-CMNHS comprises five schools and four campuses: Public Health, Oral Health, Medical Sciences, Health Sciences, Nursing;

53. provided an overview of undergraduate training sites: Fiji: Bachelor of Medicine and Bachelor of Surgery (MBBS), Dentistry, Bachelors of Medical Imaging Science (BMIS), Bachelor of Medical Laboratory Science (BMLS), Bachelor of Physiotherapy, and Bachelor of Pharmacology; Solomon Island Campus; James Cook University (JCU) rotation –TI; Vava'u Hospital Public Health; Savai'i Samoa Public Health;

54. provided an overview of post-graduate training sites: Fiji, Kiribati, Solomon Islands, Samoa, Vanuatu, and Tonga, and noted that they had not yet visited Vanuatu;

55. noted that there has been a big increase in enrolment over the last 4–5 years;

56. noted that gender ratios are consistent with the workforce – 70% female as average;

57. noted that local (Fiji) enrolment is around 80%, and regional enrolment is around 20%, lead by Solomon Islands, Tonga, Vanuatu, Samoa, and Kiribati, with a rise from FSM and surge in 2015 by Palau;

58. noted that the average number graduates over the last seven years was 560, and is representative of geographic enrolment;

59. noted that regional representation in postgraduate enrolment is higher than among undergraduates (38% in 2015), though this declined in 2016;

60. noted they are trying to transition from diploma to degree programmes;

61. noted other trends, including popularity of bachelor of environmental health, and bachelor of dietetics and nutrition, and Master of Public Health, and less popular programmes such as Master of Health Service Management and Master of Applied Epidemiology;

62. noted that the bachelor of public health is attracting students from the region as well as the bachelor of nursing, while the postgraduate nursing programme is struggling, which needs further analysis and support from MOHs;

63. noted that enrolment numbers for most of the Health Sciences degree programmes are climbing;

64. noted some troubling attrition trends and the need for support;

65. noted that data on countries that have not produced doctors are consistent with workforce data;

66. noted a dip in paediatrics;

67. noted that Fiji produces approximately 60% of graduates;

68. noted new programmes for 2017: Masters in Oral Surgery – Targeting Semester II 2017; MBBS Graduate Entry – Targeting Semester II 2017; Bachelor in Nursing Bridging (Diploma to Bachelor) – Targeting Semester II 2017; and

69. invited requests from countries to send in requests to CMNHS for 2017 in-country career expo.

Recommendations

The meeting:

70. recommends that training providers be more responsive to the specialised clinical training needs of PICTs, through:

    i. standardisation of internship programmes in the region given the influx of foreign trained medical graduates in PICTs;
    ii. taking account of specific country needs;
    iii. undertaking clinical research;
    iv. utilising local specialists; and
    v. taking into account disease profiles that impact demand for specialist services;

71. recommends that training providers consider that formal postgraduate clinical training be undertaken in-country;

72. recommends that training providers offer postgraduate radiology training in the Pacific;

73. recommends that training providers make the entry requirements more realistic and make their training programmes more appealing;

74. recommends strengthening the pipeline from elementary school to high school so students can meet the requirements to undertake tertiary health education;

75. recommends providing a bridging programme for Pacific health workers entering into formal training, including:

    i. high school: diploma training; and
    ii. from diploma: bachelor;

76. recommends that wherever possible WHO deliver an offline mode for POLHN and include clinical training in POLHN;

77. recommends the strengthening of primary health care (PHC) training;

78. recommends that short-term clinical attachments for PICT clinicians and nurses is made available with various providers;

79. recommends that PRCSWIP keep PICTs informed on the scheduling of clinical courses and workshops;

80. recommends continuing in-country training and mentoring through visiting teams;

81. recommends that PICTs strengthen mentoring programmes for clinical services;

82. recommends that countries continue reviewing and updating clinical services HR plans annually; and

83. recommends that PICTs develop contingency plans for the absence of specialists.

3.3 Leadership and CPD

The Secretariat:

84. noted that a leadership development pathway was identified as a need as more clinicians find themselves in leadership roles, and that they wished to hear from DCS participants what they think should be included in a leadership development pathway;

85. noted that while many PICTs encourage/require their clinicians to engage in some sort of CPD, many do not have specific CPD framework for the various clinical disciplines; and

86. noted that the SSCSiP programme worked with Pacific clinical organisations to develop CPD framework for the various clinical disciplines, which could be used to guide their decisions when providing annual practicing licensing for clinicians in the various specialities, acknowledging it was a generic template countries could adapt/change.

The meeting:

87. noted the challenges in implementing CPD due to lack of political will and government support in some countries, and that these issues should be brought forward to HOH and the Pacific Health Ministers Meeting.

Recommendations

The meeting:

88. recommends that leadership and management training be required for all leaders, tailored according to role, including clinical governance, planning, management and finance concepts, and that this training is ongoing;

89. recommends that regional CPD frameworks are provided at the national level for countries to adapt to their specific needs, should there be a need;

90. recommends that minimum CPD units of training in the specific area of specialty be required for certificate renewal; and

91. recommends assistance to help to strengthen medical councils.

3.4 Overview of Nursing in PICTs

WHO Collaborating Centre, University of Technology, Sydney, South Pacific Chief Nursing and Midwifery Officers Alliance (SPCNMOA):

92. noted that the SPCNMOA secretariat is the bridge to provide national, regional and global policy to strengthen health systems for isolated colleagues in the Pacific;

93. noted that the Alliance meets every two years on a self-funded basis, which provide an opportunity to liaise with regional global colleagues and look at global standards;

94. noted the priorities of their regional health system strengthening agenda:

    i. Transforming health workforce education in support of UHC.
    ii. Strengthening regional governmental networks to improve communication, strategic planning for improved health system strengthening – including regulation and education.
    iii. Regional emergency and disaster preparedness in the face of public threats, climate change.
    iv. Maternal and child health.
    v. Non-communicable disease.
    vi. Antimicrobial resistance;

95. noted that the following recommendation from their 2016 meeting in Solomon Islands have been prioritised by SPCNMOA: 1) opportunities to aligning regional regulatory frameworks ; and 2) post-graduate education requirements in line with health workforce needs;

96. noted the development of a leadership programme in collaboration with SPCNMOA partners to strengthen health systems in the Pacific;

97. noted that the Australian Leadership Fellowship includes: mentoring from national SPCNMOA members; access to some of Australia's leading health experts; provision of workbooks; pre-programme support – 2-week programme in Sydney; and post-programme follow-up research – confidence, planning, evidence, referral and decision making;

98. noted a few key elements for success: genuine partnership; local leaders with power (or supported); reference group; relevant tools; and communication, support and safe environment;

99. provided an overview of major health challenges in the Pacific;

100. discussed the critical HRH threshold, and noted that WHO recommends that 4.5 doctors, nurses and midwives per 1,000 will be needed to meet SDG population needs by 2030;

101. noted significant health workforce shortages across the region, offering midwifery as one example, which will be further impacted by a large number of midwives retiring over next five years;

102. based on extensive research undertaken across the Pacific, noted gaps across several areas:

    i. Education:
        a. Curriculum reviews (many 20 + years old)
        b. Coordination of specialisation programs across region
        c. Need for highly qualified educators
        d. Need for continuing professional development
        e. Conducting and using research
        f. Regular institutional accreditation
        g. Resources – human, infrastructure, teaching
    ii. Associations:
        a. Health professional support
        b. Interface between profession, health service and governance
        c. Providing continuing professional development
    iii. Regulation:
        a. Registration legislation
        b. Strong registration processes

c. Country competences
d. Regular institutional accreditation
e. Career pathways recognised across the region
f. Scope of practice

iv. Governance:
a. Coordination of HRH training requirements
b. Coordination of regular multi-sectoral meetings
c. National policy communicated and owned
d. Regional HRH coordination;

103. queried where SPCNMOA can speak around some of these urgent issues and how the gaps can be addressed strategically.

Recommendations

The meeting:

104. recommends that training providers respond to strengthening specialised clinical nursing at the national level through:

i. the provision of specialised nursing programmes, such as paediatrics, surgical, medical perioperative and ENT, learning from successful programmes, such as ophthalmology and midwifery;

105. recommends using existing regional nursing forums such as the South Pacific Chief Nursing and Midwives Officers Alliance (SPCNMOA) to be an integral part of the DCS forum;

106. requests that PRCSWIP provide clarity on specialised nursing components in the various programmes;

107. requests that a curriculum review and baseline be undertaken for nursing;

108. recommends that PICTs provide clinical nursing career pathways; and

109. recommends that with regard to specialised clinical nursing services, a regional survey be undertaken to identify high (e.g. top three) priorities to inform resource and funding allocation decision-making for nursing.

3.5 Perioperative nursing

The Secretariat:

110. noted that SSCSiP took two main approaches to supporting nursing specialisation: clinical training attachments and addressing specific clinical need within a discipline, and that in the case of perioperative nursing in the PICTs, the latter approach was used;

111. noted the collaborative approach undertaken between a team of perioperative nurses representing 14 PICTs and education consultants in Australia, to establish optimum standards of perioperative nursing care;

112. noted that SSCSiP in response to reports from RACS- Pacific Islands Program (PIP) VMTs, saw the need for improvement in standards of practice within operating theatres (OTs) across the South Pacific;

113. noted that with the assistance of RACS, and the Australian College of Perioperative Nurses (ACORN), SSCSiP contracted consultants to develop standards, which were rolled out in two stages – development of standards and implementation of standards, which took place at a workshop conducted over three days in August 2016 in Suva;

114. noted that the latest ACORN Standards were used as the foundation for the project;

115. noted the limitations of these standards in limited resource settings, and the need to refine the minimum practice standards for perioperative nurses in the 14 PICTs;

116. noted that a bundle of six individual standards was produced:

    i. Hand hygiene
    ii. Perioperative attire
    iii. Aseptic technique
    iv. Protective apparel
    v. Scrubbing, gowning and gloving
    vi. Skin preparation and draping;

117. noted that the standards comprise core elements of infection prevention commonly used in OTs and are applicable to other health care environments;

118. noted that it's mandatory for all OT staff to read and sign off on the standards;

119. noted that the collaboration resulted in a greater sense of community and momentum; and

120. noted that the whole implementation process was documented in two articles published in ACORN.

Recommendations

121. recommends the implementation of minimum standards of practice in operating theatres, and audit tools to monitor compliance, for all operating room users at a country level to ensure safe surgeries and improve surgical patient outcomes.

3.6 Offshore medical evacuation/referrals

Palau:

122. provided an overview and history of the Palau Medical Referral Program (MRP), Medical Referral Committee (MRC), Healthcare Fund (HCF), and National Health Insurance (NHI);

123. noted that the HCF and NHI provide a pooled fund to cover in-patient and off-island referral costs;

124. noted that the MRP:

    i. Manages the referral process of approved cases.
    ii. Coordinates patient care at off island facilities, MRP Manager and staff (Palau Based) coordinating with MRP Coordinators stationed at Philippines, Taiwan, and Hawaii
    iii. Ensures financial agreements are secured
    iv. Arranges and coordinates airline tickets for patients and advise family escorts, work with HCF office.
    v. Goes over policies with patients and escorts.

vi. Coordinates per MRC on need of Medical and or Nurse escorts and other needs on airlines: i.e. stretcher case and/or oxygen use on transport;

125. noted that the MRP and MRC advise on the need for particular specialties so more patients can benefit and facilitate teams' visits, and work closely with clinical staff so that all patients who will benefit have the opportunity to see a specialist;

126. noted that visiting teams are an opportunity for local providers to participate in visits, gain skills and learn to use new equipment that are donated by teams or proposed for us to obtain to eliminate sending people offshore when treatment can be given locally;

127. noted that the MRC makes decisions on who gets to go offshore to get help based on guidelines provided by the programme, and that patients are sent to three places: Philippines, Taipei, Hawai'i;

128. noted that the programme will only cover what the patient was referred for;

129. noted that there is a fine of 5000 for anyone who interferes with decisions made by the MRC;

130. noted that both locals and expats contribute to the NHI and are eligible to receive services provided by MRP; and

131. noted some challenges and ways forward:

i. Reducing use of expensive off-island care by building local capacity (upgrading medical equipment, machinery and facilities, training for local physicians, expanding scope of services offered); and
ii. Increasing use of visiting specialists when cost-effective.

Recommendations

The meeting:

132. recommends that national offshore referral systems be strengthened through:

i. developing and maintaining strong legal frameworks to guide overseas referral policies;
ii. producing data on health outcomes for patients referred under different country referral systems; and
iii. cost sharing with patients, or though the health insurance system; and

133. recommends bringing in specialists and equipment to provide service in-country as an alternative to overseas referrals (reverse referral).

Item 4: Group work

4.1 Country priority issues

The Secretariat:

134. provided the following guiding questions for group work:

i. 3.2 Health workforce training programmes

a. How can the training providers be more responsive to the specialized clinical training needs of Pacific Island Countries?

ii. 3.3 Leadership and CPD
   a. Now that you are in this role, is there a need for leadership training for the health sector?
   b. If so, what components should be included or strengthened
   c. Should PICs use the CPD frameworks as an integral part of the annual licencing process?

iii. 3.4 Overview of nursing in PICTs
   a. How can specialised clinical nursing be strengthened at a national level?
   b. What can be done at a regional level to develop clinical nursing specialisation?

iv. 3.5 Offshore medical evacuation/referrals
   a. What aspects of the national offshore referrals systems should be strengthened?
   b. What resources are needed to strengthen offshore referrals systems?

4.2 Group feedback

In relation to health workforce training programmes, the meeting:

135. noted that each country has specific requirements and needs;

136. noted the need for standardisation of internship programme;

137. noted the need for postgraduate programmes and clinical research;

138. noted the importance of utilising local specialists;

139. noted that consideration needs to be given to disease profiles that impact on specialist services – i.e. NCDs – and developing programmes around primary health care (PHC) training;

140. noted the need for planning for short-term clinical attachment for PITC clinicians/nurses;

141. identified that countries need a back-filling mechanism when clinicians are away for trainings, etc.;

142. noted there should be a component of formal training done in-country;

143. noted the issue of course scheduling;

144. called for continued in-country training capacity from visiting teams an continuation of mentoring programmes;

145. noted the need for offline mode of Pacific Open Learning Health Network (POLHN);

146. noted the need for a bridging programme for Pacific health workers entering into formal training;

147. noted the need for training providers to get to know countries better and spend more time in counties before coming up with recommendations;

148. noted the need for countries to have their own HR plans for clinical services to better guide training providers;

149. noted the need for better definitions of specialised services;

150. noted the need to make programmes more appealing and in some cases easier to pass – e.g. paediatrics at FNU; and

151. noted the need to spark greater interest in careers in health care and medicine and strengthen math and science courses at the primary level.

In relation to leadership and CPD, the meeting:

152. noted that leadership and management trainings should be required for all leaders depending on their role – i.e. planning, management, finance concepts;

153. noted the need for strong meaningful/consistent CPD frameworks that should be adapted to country contexts and needs;

154. noted the need for specific training related to field of speciality; and

155. noted that before CPD can be linked to registration in a number of countries, there is a need to strengthen medical councils.

In relation to nursing in PICTs, the meeting:

156. noted the need for specialised nursing programmes, such as ophthalmology, midwifery, OT nurses;

157. noted the need for clear nursing pathways and review of curriculum and competencies at the regional level; and

158. queried the best way to have the voices of regional nurses heard at higher levels.

In relation to offshore medical evacuation/referrals, the meeting:

159. noted the great need to produce data on health outcomes for patients referred under different country schemes; and

160. noted that cost sharing with patients is a good model, or, alternatively, having health insurance for the country.

In relation to an additional area considered by Group 2 – Transition from SSCSiP to PRCWSIP, the meeting:

161. noted the need to look deeper into why we transition and what lessons can be learned from SSCSiP, and recognised the benefits of now being able to address clinical issues at a very high level and in a strategic way.

To close the group work session, FNU:

162. noted some lack of clarity amongst the nursing fraternity regarding where they fit within the present programme; and

163. requested clarity regarding the resources available through the programme and how they will be distributed amongst the 14 countries.

Item 5: Other business

The meeting:

164. noted that countries require a share of the resources available through the regional mechanism, and through the support of partners in order to address the challenges they face in trying to address clinical growth and development.

Item 6: Review of key decision points

Recommendations

The meeting:

165. requests that PICTs cover medical indemnity of volunteers for the period they spend in-country.

Item 7: Close of meeting

166. The meeting thanked outgoing Chair, Dr Eddie McCaig, and shared the hope of achieving productive outcomes at HOH.

Annex 1: Participant list

DIRECTOR OF CLINICAL SERVICES (DCS) – ANNUAL MEETING
(Novotel Hotel, Lami, Suva Fiji, 24 April 2017)

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24/04/2017