REPORT

MEETING OF MINISTERS OF HEALTH FOR THE PACIFIC ISLAND COUNTRIES

Port Vila, Vanuatu
12-15 March 2007

Manila, Philippines
13 August 2007
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MEETING OF MINISTERS OF HEALTH FOR THE PACIFIC ISLAND COUNTRIES

Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

Co-organized by:

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12-15 March 2007

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NOTE

The views expressed in this report are those of the participants, consultant, and observers in the Meeting and do not necessarily reflect the policy of the World Health Organization.

This report has been prepared by the Regional Office for the Western Pacific of the World Health Organization for governments of Member States in the Region and for the participants, consultant and observers in the Meeting of Ministers of Health for the Pacific Island Countries held in Port Vila, Vanuatu, from 12 to 15 March 2007.
1. BACKGROUND

A ministerial conference on health for Pacific Islands was convened in Fiji 6–10 March 1995. The conference adopted the Yanuca Island Declaration, in which three priority issues were identified: human resources development; health promotion and health protection; and the supply and management of pharmaceuticals and other medical supplies.

A follow-up meeting of Ministers of Health for the Pacific Island Countries was held at Rarotonga, Cook Islands, 6–7 August 1997. The meeting of the Ministers adopted the Rarotonga Agreement: Towards Healthy Islands.

Another follow-up meeting of Ministers of Health for the Pacific Island Countries was convened in Koror, Palau, 17–19 March 1999. The meeting reviewed progress made in implementation of the Healthy Islands concept and unanimously adopted the Palau Action Statement. The statement summarizes conclusions and recommendations of the meeting. It was agreed to convene the next meeting to be organized jointly by the World Health Organization (WHO) and the Secretariat of the Pacific Community (SPC) in 2001, and the Government of Papua New Guinea offered to host the meeting.

The meeting in Madang, Papua New Guinea, was convened 12–15 March 2001. The meeting reviewed progress in implementing the Palau Action Statement and ways to strengthen collaboration using the Healthy Islands approach in the following areas: communicable diseases with special reference to control of tuberculosis and filariasis, and surveillance; noncommunicable diseases, in particular diabetes; and human resource development in such areas as distance learning and primary health management. The meeting adopted the Madang Commitment Towards Healthy Islands. It was agreed during the meeting to convene the next joint WHO/SPC meeting in 2003 and the Government of Tonga offered to host the meeting.

The meeting in Tonga was convened 10–13 March 2003. The main theme of the meeting was Healthy lifestyles and supportive environment. The subjects covered at the meeting included diabetes and other noncommunicable diseases; diet, physical activity and health; the Tobacco Free Initiative; mental health; environmental health; and HIV/AIDS in the Pacific. The meeting adopted the Tonga Commitment to Promote Healthy Lifestyles and Supportive Environment which contains recommendations, with clear objectives and indicators to measure progress. It was agreed during the meeting to convene the next joint WHO/SPC meeting in 2005. The Government of Samoa offered to host the meeting to be held 14–17 March 2005.

The meeting in Samoa was convened 14–17 March 2005. The main topics of the meeting included progress in implementation of the Tonga Commitment; HIV/AIDS and sexually transmitted infections; migration of health personnel; surveillance and outbreak response capacity-building; dengue; the Pacific Open Learning Health Network (POLHN); and the expanded programme on immunization (EPI). The meeting adopted the Samoa Commitment Towards Achieving Healthy Islands. It was agreed during the meeting to convene the Seventh WHO/SPC meeting in 2007. The Government of Vanuatu offered to host the meeting to be held 12–15 March 2007.
2. OBJECTIVES

The objectives of the meeting were:

(1) to review and decide on future strategic directions for health in the Pacific;

(2) to discuss priority technical health programmes, regional and country plans, and identify actions; and

(3) to follow up progress made since the Tonga and Samoa Commitments.

3. MEETING

This meeting followed the format adopted by the previous two meetings held in Tonga and Samoa, having the meetings of Ministers and Directors of Health combined with both plenary and group work sessions.

The opening ceremony of the Seventh Meeting of Ministers of Health for the Pacific Island Countries was held Monday morning, 12 March 2007, at the Le Lagon Resort, Port Vila. Honourable Ham Lini Vanuaroroa, Prime Minister of Vanuatu, attended the occasion.

Dr Shigeru Omi, WHO Regional Director for the Western Pacific, in his opening remarks expressed his sincere thanks to the Government of Vanuatu for hosting the meeting and the hospitality extended. He added that this meeting marks the seventh time that we have gathered to take stock of the health situation in the Pacific and to set future directions in our continuing efforts to ensure good health for the nearly 9 million people who inhabit the Pacific Island Countries and Areas. (See Annex 1)

Dr Jimmie Rodgers, Director-General of the Secretariat of the Pacific Community, expressed sincere appreciation to the Government and the people of Vanuatu for hosting the meeting and for the excellent arrangements. He stated that 12 years on from the first ministerial meeting, this meeting offers an opportunity to take stock of what we have achieved as individual countries and territories, or collectively as a region, in attaining better health outcomes for Pacific people. (See Annex 2).

Honourable Ham Lini Vanuaroroa, the Prime Minister of Vanuatu, in his official opening address, extended his warm welcome on behalf of the Government. He wished that the work and discussion during the meeting would effectively contribute in the process initiated in 1995 and marked by important declarations and commitments: Yanuca, Rarotonga, Palau, Madang, Tonga and Samoa. He expressed hope that actions following this meeting will also have an impact on the policy-makers and health and development stakeholders concerned about the well-being and the future of the Pacific Communities. (See Annex 3).

The plenary session of the meeting was convened at the Pacific Room, Le Lagon Resort, after the opening ceremony.
The following were elected as officers of the meeting:

Chairperson
Honourable Morking Stevens Iatika
Minister of Health, Vanuatu

Vice-Chairperson
Honourable Gatoloaifaana Amataga Alesana Gidlow
Minister of Health, Samoa

English Rapporteur
Honourable Terepai Maoate
Deputy Prime Minister and Minister of Health,
Cook Islands

French Rapporteur
Dr Mareva Tourneux
Directrice de la Santé en Polynésie française
Ministère de la Santé

The provisional agenda of the meeting was approved (attached as Annex 4).

The draft conclusions and recommendations of the meeting of Ministers of Health for the Pacific Island Countries were adopted unanimously as the Vanuatu Commitment.

The meeting took note of the willingness of the Government of Papua New Guinea to host the next Meeting of Ministers of Health for the Pacific Island Countries in March 2009.

The meeting was formally closed by the Honourable Morking Stevens Iatika, Minister of Health, Vanuatu. Dr Omi expressed satisfaction and gratitude to the Government of Vanuatu for the wonderful arrangements. Dr Rodgers also thanked the host Government and all participants for a successful meeting.

The list of participants is attached as Annex 5.

4. DISCUSSION AND RECOMMENDATIONS

4.1 A Health Strategy for the Pacific and

4.2 The Pacific Health Fund

The Ministers note with appreciation the work undertaken by the Secretariats of SPC and WHO on the request of the Pacific Islands Forum Leaders to examine the possibility of a Pacific Health Fund and note the subsequent work on a proposed Pacific Health Framework/Strategy.

The Ministers however expressed concerns with the process to date, in particular the lack of consultation and the subsequent impression of a lack of ownership by the Pacific Island Countries, a feeling that the process had been rushed, that there are already too many strategies and a concern that this work must not duplicate existing work.

The Ministers note the principles of the Pacific Plan to strengthen regional cooperation and the Pacific Islands Forum Leaders Communiqué regarding a Pacific Health Fund. The
benefits of regional cooperation, as well as the need to develop regional and nationally appropriate responses to Pacific health needs, were also noted.

The Ministers therefore request the Secretariat to:

(1) start the process again with greater consultations with Ministers and Directors of Health in the Pacific Island Countries, to develop possible mechanisms that will strengthen regional cooperation in health without duplicating work already undertaken, and noting the many concerns raised;

(2) continue work on possible mechanisms that will facilitate additional funding of regional and national health priorities and/or gaps in the Pacific through a Pacific Health Fund that will not detract from existing relationships; and

(3) request the Secretariat to prepare a report which the Ministers of Health of Pacific Island Countries can discuss in Korea in September 2007.

4.3 Review of Progress on Tonga and Samoa Commitments

Significant progress has been made on implementing the recommendations from the Tonga and Samoa Commitments.

The Pacific remains polio free and nearly all countries have embarked on measles elimination. Coverage rates for the first rounds of measles immunization have been high: approaching 95% and above, but there are still problems in the remote areas of Papua New Guinea and in some of the remote island groups elsewhere in the Pacific. Even faced with these obstacles, measles elimination is feasible by 2012.

In Fiji, high coverage with its measles immunization together with the efficient dissemination of information by the Pacific Public Health Surveillance Network (PPHSN) was credited with quickly containing a major epidemic in 2006 and preventing its spread to neighbouring countries.

Thirteen countries and areas will be deciding whether to include Hepatitis B vaccinations as part of their regular EPI programme over the few next years.

Countries are making some progress in implementing mental health activities. Samoa already has a national mental health policy and supporting legislation. Cook Islands has established a new mental health division; the Marshall Islands has established a mental health programme targeting suicide prevention and substance abuse, and French Polynesia is particularly concerned about mental health problems among children and teenagers. Other countries expressed the need to further develop capacity for mental health.

The POLHN is recognized as a valuable contribution to capacity-building in the region. A number of countries have already set up POLHN centres and look forward to an expanded selection of courses.

All countries expressed the need to give greater priority to environmental health issues. These include safe water supply, sanitation, and consequences of climate change, together with clinical and solid waste disposal. A number of countries reported having implemented activities for medical waste disposal. Samoa provided an example of a strengthened safe water programme, and Tuvalu has started a programme on regular water testing.
Dengue was identified as a major communicable disease problem in the region resulting in significant morbidity and severe economic losses, particularly for tourism. But since the last meeting in Samoa, the proposed regional dengue initiative has not materialized. The need for effective surveillance systems was recognized as a key issue related to dengue as well as other new and emerging diseases.

There has been some success in implementing vector control for dengue. French Polynesia reported a successful programme of vector surveillance and control that significantly reduced the impact of a recent outbreak. Australia pointed out its successes in controlling dengue in Northern Queensland that could have similar characteristics to the situation in Pacific Island countries. Australia encouraged the submission of a regional dengue initiative and offered to share its dengue management plan.

Although it was recognized that significant progress is being made, it is important that countries evaluate the success of the various regional programmes and strategies. A trigger mechanism was suggested as a way to alert countries to the need to measure the performance and progress of their health programmes.

4.4 Prevention and Control of Noncommunicable Diseases

4.4.1 Background

Noncommunicable diseases (NCD) are the leading causes of death and morbidity in Pacific Island Countries. By 2020, it is estimated that 70% of the global burden of disease will relate to NCD. However, NCD in the Pacific already exceeds this level (75%) and is continuing to rise. Left unabated, the increasing noncommunicable disease burden will not only lead to premature death and disability for thousands of people, but also will threaten to overwhelm health resources and services already stretched thin.

In an effort to strengthen the global response to the growing threat of noncommunicable diseases, WHO together with Member States developed the Global Strategy on Diet, Physical Activity and Health (DPAS), endorsed by the World Health Assembly in 2004. DPAS presents an evidence-based approach for concrete action promoting healthy lifestyles and is supported by multiple stakeholders, including key United Nations organizations. The Food and Agriculture Organization of the United Nations (FAO), the United Nations Children's Fund (UNICEF) and SPC have collaborated with WHO in translating DPAS recommendations into action in the Pacific. SPC has supported this by introducing the Healthy Pacific Lifestyles Strategy (HPLS) in 2007. The WHO STEPwise (STEPS) framework for noncommunicable disease intervention was developed in 2001 and endorsed at the Meeting of the Ministers of Health for the Pacific Island Countries in Tonga in 2003. DPAS and HPLS are ideal strategies and STEPS an ideal mechanism for translating the Healthy Islands vision into appropriately designed, results-oriented action and programmes.

As a follow-up to the Samoa Commitment, the Vanuatu Commitment builds on Healthy Lifestyles and Supportive Environments and provides structure to the Healthy Islands vision. The Vanuatu meeting confirmed that many social and economic influences on the health of Pacific people are beyond the control of national governments. Trade, especially food, tobacco and alcohol imports, and commercial and international communication media influences are of particular concern. However, there has been much progress since the Samoa meeting in 2005.
4.4.2 Discussions

The current status of the NCD situation in the Pacific was presented by WHO and SPC representatives and Ministers of Health from several countries responded with comments.

People frequently asked whether health has improved in the Pacific. STEPS survey data should show the latest NCD situations. Some Ministers did not know the extent of the NCD problem in their country until the results of the STEPS survey were presented to them. Now that the evidence is available, it will provide the basis for grant proposals. For others, the STEPS surveys showed an alarming increase in NCD. Some Ministers inquired about how to assess the effects of their programmes. More information and training on monitoring and evaluation are needed.

In general, many countries have made significant progress in NCD programme delivery. The budgets of most countries dedicated to fighting NCD have improved. One country increased from US$60 000 in 2004 to US$ 400 000 in 2007 and has a specific budget line for NCD activities. Many countries have intersectoral committees, some are undertaking mini STEPS, some are strengthening clinical NCD services and at least one has an oral health strategy.

Another key issue is the best way for Ministers to inform the general public about the NCD problem. One Minister was specifically concerned about messages on diet, physical activity and tobacco use. He tries to promote the consumption of local foods, but the costs of local foods exceed the cost of imported foods. It was agreed that more attention should be given to social marketing, and delegates said they needed more information on the issue.

A key theme was that of health Ministers and staff as role models. Health and education are the top priorities for many countries. Reductions in NCD must start with the Ministers and health staff. “We must be role models,” one Minister said. One Pacific Island government allows 45 minutes for public servants for physical activity each week. Existing models from other Pacific governments also should be considered.

It was agreed that donors should not dictate health priorities for countries. For at least one major donor, the national and regional priority now is NCD prevention and control. Another key issue was an apparent lack of funds for programmes on physical activity, National Plans of Action for Nutrition, tobacco control strategies, and the establishment of health promotion foundations. Most Ministers found that multisectoral approaches to NCD to be the most cost-effective.

Current resources are inadequate and the balance of resources for specific health priorities should be addressed. Resource and information sharing was suggested as an alternative.

Overweight and obesity is still a sensitive issue for Pacific Island Countries, especially among women and schoolchildren. Foods import companies often are controlled by influential people in the Pacific. Governments have difficulty in controlling the flow of unhealthy food into their countries.

There was general support for the whole-of-government approach, but some Ministers asked that activities be country-specific. Many expressed concern that they did not have the capacity to deliver adequate health services to the people and of unequal resources for NCD. The value of planning cannot be underestimated. One Minister said he would like to see the NCD figures for New Zealand and Australia, as he is sure that they may not be much better.
All Pacific Island Countries now have many national action plans, strategies and policies and are reluctant to develop more.

Fourteen countries have undertaken STEPS surveys and some have already undertaken follow-up, community-based NCD interventions. Eight Pacific Island Countries now have the most up-to-date and valid data on the prevalence of NCD risk factors. However, many countries are having difficulty in implementing action. A few have undertaken evaluations of existing NCD activities with suitable indicators to monitor progress.

Delegates stated that governments, in particular Ministers and Ministries of Health, should be the role models for healthy lifestyles. Many NCD interventions can use existing models provided by WHO and SPC adapted to suit particular countries.

The concern of imported unhealthy commodities (e.g. food, tobacco and alcohol) and their effects on the health of Pacific Island people remain an issue for Ministers. They requested that WHO and SPC help them control food imports.

The economic costs of NCD for most countries is huge, including reduced quality of life and workforce productivity. Noncommunicable diseases are diseases of poverty and have great influence in determining the wealth of a nation. WHO, SPC and individual countries should increase their budget allocations for NCD.

4.4.3 Conclusions and Recommendations

(1) With the exception of a few, most Pacific Island Countries reported that they do not have the capacity to deal with the NCD epidemic. Funding is not the major issue. Some countries cannot allocate the funds either because they lack the experience and knowledge or do not have the personnel to carry out NCD prevention and control activities.

(2) Countries delegates stated that governments, in particular Ministers and Ministries of Health, should be the role models for healthy lifestyles. Many NCD interventions can use existing models provided by WHO and SPC adapted to suit particular countries.

(3) Most countries requested that forms of social marketing be undertaken to inform the general public of the issues and consequences of unhealthy diet, physical inactivity, and tobacco and alcohol use.

(4) Imported food and its effect on the health of Pacific Island people remain an issue for Ministers. They requested that WHO and SPC help them facilitate/initiate engagement with the trade sector to ensure that the health impact of trade agreements on diet is minimized.

(5) The economic costs of NCD for most countries is huge, including reduced quality of life for the workforce. NCD are diseases of poverty and have great influence in determining the wealth of a nation. WHO, SPC and individual countries should increase their budget allocation for NCD.

(6) WHO should provide experts to explain and interpret the STEPS results and develop country-specific activities.

(7) WHO and SPC should stress the importance of oral health.
(8) WHO and/or SPC will supply video footage on no-tobacco advertisements appearing on Australian TV.

(9) WHO and SPC should support healthy lifestyle approaches.

(10) A whole-of-society approach is strongly recommended for NCD interventions, in addition to a whole-of-government approach.

(11) A joint team approach including all stakeholders should be undertaken for NCD interventions. Groups reported that most countries have limited capacity to deal with the NCD epidemic.

(12) Convening of a Food Summit should be further explored involving broad representation from all sectors.

(13) NCD programmes must include a combination of population approaches (environmental interventions that include legislative measures and advocacy) and individual approaches (which include lifestyle interventions), harnessing the synergistic effect of combined approaches for effective NCD prevention and control programmes.

4.5 The Asia Pacific Strategy for Emerging Diseases, including International Health Regulations (2005) and Pandemic Preparedness

4.5.1 Background

International Health Regulations (IHR)

The IHR (2005) are a global legal framework for preventing and responding to the international spread of diseases while avoiding unnecessary interference with international traffic and trade. Under IHR (2005), all countries are required to assess, by June 2009, the ability of existing national structures and resources, and based on that assessment develop and implement plans of action to ensure these core capacities are present and functioning. The minimum core capacities required for surveillance and response are summarized as follows:

1. at the community or primary public health level, to detect, report and respond to events involving unexpected diseases or deaths;

2. at the intermediate public health levels, to verify, assess, report and respond to urgent events; and

3. at the national level, to assess, notify the World Health Organization (WHO), and provide a coordinated public health response to urgent events, in particular those events that may constitute a public health emergency of international concern (PHEIC).

Asia Pacific Strategy for Emerging Diseases (APSED)

APSED provides the countries of the WHO Western Pacific Region with strategic directions for enhancing capacities required for effective preparedness, prevention, early detection of and rapid response to emerging diseases. The WHO Regional Committee for the Western Pacific urged Member States in the Western Pacific Region to use the Strategy as a framework to guide national capacity-building programmes for emerging diseases and as a stepping stone towards the effective implementation of IHR (2005).
In September 2006, the Regional Committee for the Western Pacific urged each Member State to develop a country APSED workplan. The country plan should be able to meet the surveillance and response capacity development obligations required under IHR (2005). The country plan will be considered as a national plan of action required under Annex 1 of the IHR (2005).

**Pandemic influenza preparedness**

The meeting of Ministers of Health for the Pacific Island Countries in Samoa in March 2005, recognized the importance of improving national pandemic influenza preparedness. With the support of donor agencies, SPC has been working closely with WHO to initiate the Pacific Regional Influenza Pandemic Preparedness Project (PRIPPP), involving animal and human health services. The project aims to further improve the capacity of the Pacific Island Countries to effectively and efficiently respond to emerging diseases, in particular highly pathogenic avian influenza (HPAI) and pandemic influenza.

**Pacific Public Health Surveillance Network**

The Pacific Public Health Surveillance Network was created in December 1996, and the three networking services (PacNet, LabNet and EpiNet) that were established under PPHSN have played an important role in strengthening public health surveillance and response systems. In addition, the Pacific Infection Control Network (PICNet) is now being created to be used as a tool for reinforcing infection control in the Pacific.

While feasible and practical arrangements in line with the IHR (2005) requirements need to be further discussed, it has been recommended that the PPHSN should be utilized to facilitate the IHR implementation, whenever possible. Although the IHR (2005) has designated WHO as the primary agency for receipt of notifications of public health events of international concern and the verification of these events, the PPHSN can play an important role in the dissemination and sharing of related information among Pacific Island Countries and for mobilizing resources for public health response.

As it will take time to ensure that national and local core capacities for early warning and rapid response are in place, the Samoa Commitment recommended that the Regional EpiNet Team (RET) be established by creating a pool of experts among the countries in the Pacific in order to support national teams in the event of outbreaks and to build immediate capacity. To facilitate this process, a directory of PPHSN resources has been developed and is regularly updated, and the framework of the RET is being established.

**Discussion**

All countries expressed strong support for using APSED as a tool for implementing IHR (2005) and for planning for avian and pandemic influenza. Appreciation was expressed for the assistance provided by WHO, SPC, Australia, New Zealand and other partners for these activities.

Countries shared the progress of their pandemic influenza preparedness activities. Most countries emphasized the need for strengthening capacities to detect and respond to outbreaks.

Other areas of support requested by countries were for:

1. technical and financial assistance for testing exercises of pandemic influenza preparedness plans;
(2) technical assistance for legislative reform to support implementation of the IHR (2005);

(3) technical assistance to integrate the pandemic influenza plans of different sectors within their country; and

(4) financial assistance for drugs and supplies to respond to avian and pandemic influenza.

Pacific Island Countries were concerned that as small island states, they have limited capacity to respond to outbreaks including avian influenza. However, they were encouraged not to underestimate their ability to mount an initial response through risk communication and basic containment methods.

Countries noted the need for integration at country level of activities related to IHR (2005), APSED and pandemic preparedness and encouraged WHO and SPC to continue their collaborative approach, especially within the framework of the PPHSN.

4.5.3 Conclusions and Recommendations

(1) National and local core capacities for surveillance and response required under IHR (2005) should be strengthened through implementation of APSED:

a. awareness about IHR (2005) and APSED should be increased;

b. existing capacities, using APSED-based checklists adapted to the Pacific Island situation should be assessed;

c. plans of action (APSED workplan or equivalent) should be developed;

d. PPHSN and other existing mechanisms to supplement country capacity-building should be utilized; and

e. encouraging the active participation by Pacific Island Countries to enhance the role of the Pacific Regional Influenza Pandemic Preparedness Project (PRIPPP) in helping Pacific Island Countries to be better prepared for pandemic influenza and other emerging diseases.

(2) Effective communication channels and operational links should be established and practical arrangements should be made to comply with IHR (2005) in the Pacific:

a. operationalize National IHR Focal Points and practical arrangements with relevant Member States;

b. enable notification to WHO within 24 hours of assessment;

c. verify events when WHO so requests;

d. share information, through PPHSN when practical;

e. coordinate response with WHO, SPC and other partners; and

f. build core capacity through existing mechanisms (e.g. PPHSN).
Further recognition needs to be given to the importance of pandemic preparedness and need for active participation by Pacific Island Countries and the role of PRIPPP in helping Pacific Island Countries to be better prepared for pandemic influenza.


4.6.1 Background

The shortage of health workers is a chronic problem for Pacific Island Countries due mainly to inadequate numbers being trained and losses through migration and early retirement. Health worker density is below 2 per 1000 population in several countries, and the average health worker density of 3 per 1000 population for all Pacific Island Countries is at least three times lower than that of developed countries such as Australia and New Zealand with more than 10 per 1000 population.

The other common health workforce challenges in Pacific Island Countries include: imbalances in the skill-mix and distribution of health workers; limited capacity in effective human resources for health planning and management compounded by unreliable and limited health workforce data and information management system; low salaries and wages and limited incentives (both monetary and non-monetary); poor working environment; and limited opportunities for continuing education and professional development, especially for workers in remote areas. Most Pacific Island Countries with national health workforce strategies and plans do not sufficiently implement them and effective coordination among partners and stakeholders is lacking.

Information on the extent of the movement of skilled health workers within and from the region is incomplete, and there is no systematic way of collecting relevant data. Information on the impact of migration of workers on health care provision is even more difficult to obtain. Thus, the true extent of the impact is difficult to measure. It is now recognized that traditional measures designed to restrict the movement of skilled workers across borders are ineffective and may infringe upon human rights. Therefore, alternative arrangements are needed, such as partnerships to encourage managed migration and encourage the rotation of skilled workers within and out of the region. The main destination countries for Pacific Island Countries skilled workers should also be encouraged to train sufficient numbers of workers to meet their own needs and avoid or restrict recruitment from Pacific Island Countries, especially those with critical shortages.

Although the majority of the health workers are nurses (more than 50% in most countries and areas), their numbers are not great enough to meet the primary health care needs of the majority of the people, who are rural dwellers. Besides, the unique situations of Pacific Island Countries such as small population sizes; limited health technology, equipment and supplies; and lack of support services for delivery of clinical specialized care in many areas, mean that nurses and mid-level practitioners are also trained to provide basic diagnostic and curative services that would normally be done by doctors. This reliance on nurses and mid-level practitioners as frontline workers responsible for the delivery of most of the basic and primary care services, supported by a clinical referral system for secondary and tertiary care by doctors and specialists who are mostly based in hospitals in urban areas, appears to be suitable and appropriate for most Pacific Island Countries.

In view of the above-mentioned situation and challenges, of Pacific Island Countries, the Ministers of Health agreed on specific actions for managing the migration of health workers, including the development of a Code of Practice and a strengthening of health workforce
capacity in the 2005 Samoa Commitment. Member States from the Pacific also strongly supported the Regional Strategy on Human Resources for Health (2006-2015) at the fifty-seventh session of the Regional Committee for the Western Pacific in September 2006.

4.6.2 Discussions

Delegates stressed the shortage of health workers as a major constraint and threat to the achievement of their health goals and the successful and effective implementation of health programmes. The shortage is very critical in some countries such as Nauru, Papua New Guinea and Solomon Islands. In some provinces of Papua New Guinea, there was only 1 doctor per 50,000 population. The meeting recognized that the main causes for the shortages of skilled workers included, among others, limited numbers of workers being trained and the loss of highly skilled and experienced health professionals through out-migration.

With regards to the education and training of health workers, the education system in some Pacific Island Countries does not equip school-leavers with the basic sciences, mathematics and English levels needed for entry into health professional education and training courses. To overcome this gap, the Federated States of Micronesia, Nauru and Palau have conducted bridging courses for school-leavers that would enable them to qualify for enrollment in various health courses delivered by training institutions in the region. Training the types of health workers (like nurse practitioners and non-physician practitioners) that are most suitable for country needs, increasing the capacity of existing training institutions or setting up new ones (such as the Divine Word University in Papua New Guinea) and strengthening the continuing education of health workers through flexible/open learning were some of the steps being taken by Pacific Island Countries to increase the number of health workers. The Pacific Open Learning Health Network has an important role in the continuing education of workers. Kiribati and Solomon Islands have signed agreements with Cuba for the recruitment of Cuban doctors to serve in their national health services and the training of their doctors in Cuba.

Although there were serious concerns about the out-migration of highly skilled health professionals from the Pacific Island Countries, the meeting recognized that there were also benefits from migrants, who have gained technical skills and expertise abroad that could benefit the country upon their return, that should be tapped. In Cook Islands, several highly trained migrant doctors were providing their services free of charge when they were on holidays or called upon for assistance. Other measures being taken to manage migration of health workers included: enforcement of obligatory periods of service (bonding) for scholars whose education has been paid from public funds; restricting the employment of workers from Pacific Island Countries (New Caledonia); training to meet local needs (such as in Samoa and Papua New Guinea); and supporting/encouraging those health professionals who are unlikely to migrate, to remain (Tonga). The meeting endorsed the Pacific Code of Practice for Recruitment of Health Workers and its compendium as a guide that contributes towards better management of the migration of workers.

Despite these measures, the meeting recognized that multisectoral and partnership approaches would be needed to address the fundamental social, financial and structural factors that are beyond the jurisdiction of the health sector that influence the migration of health workers.

Apart from efforts to scale up the education and training of more health workers, which is a continuing and long-term undertaking, many, if not all Pacific Island Countries were recruiting foreign health workers from within and outside the Pacific as stop-gap measure to meet the shortage of national workers. To strengthen the capacity of Pacific Island Countries in effective planning, development and management of human resources for health, the meeting stressed the
need for improving the quality of the health workforce database, information and management system, as well as the number of trained and skilled planners and managers. The meeting found the range of policy options and strategic actions of the *Regional Strategy on Human Resources for Health (2006-2015)* to be a very useful guide for the development of their country-specific policies and strategies.

### 4.6.3 Conclusions and Recommendations

The meeting recognized the importance of human resources for health for the successful implementation of health programmes and for achieving national and regional health goals. The shortage of health workers was seen as a major constraint and threat in this regard. The shortage was mainly a result of the limited number of health workers being trained due to a variety of reasons, the out-migration of skilled health professionals, and the lack of capacity in human resources for health planning and management, and the poor quality of health workforce data, information and evidence.

The meeting further recognized an urgent need to address the skill mix imbalances within and between occupational groups in the Pacific region and that there were certain aspects of human resources for health (sharing of information, expertise, highly trained specialists and use of regional training institutions), in which a regional approach may be beneficial in view of the unique circumstances of Pacific Island Countries. The meeting endorsed the *Pacific Code of Practice for the Recruitment of Health Workers*, and found the *Regional Strategy on Human Resources for Health (2006-2015)* to be a useful guide for the development of country-specific policies and strategies.

The following recommendations were made:

1. The *Pacific Code of Practice for the Recruitment of Health Workers* should be submitted to the Pacific Islands Forum to give it more significance and wider recognition within and outside the Pacific region;

2. Ministers take necessary action for their governments to support the *Pacific Code of Practice for the Recruitment of Health Workers*, its application and use in their countries, and provide support for the monitoring and evaluation at a regional level of the implementation of Code in Pacific Island Countries.

3. Ministers commit to take necessary action as stipulated in the relevant operative paragraphs in resolution WPR/RC57.R7 of the fifty-seventh session of the WHO Regional Committee for the Western Pacific as follows: to establish or strengthen national governance and management mechanisms to develop reliable workforce data and evidence for policy-making, planning, monitoring and evaluation purposes, and ensure that health workforce planning and development are integral parts of national development and health sector planning; and to use the *Regional Strategy on Human Resources for Health (2006-2015)* as a framework for developing and strengthening country-specific human resources for health policies, approaches and strategic actions where appropriate.

4. To increase the number of well-trained health professionals to meet population health needs, it is recommended that attention be given to the following aspects:

   a. Political leaders, governments and partners must view the workforce as an investment to be nurtured and not as a cost to be minimized.
b. Along with strong leadership, there must be a commitment to devote the necessary funds and resources to support the training of health professionals.

c. Develop and implement country-specific strategies with short, medium and long-term goals.

d. Development partners and donors should consider continued investment in the education and training of health workers, as well as salary support to establishing key posts and incentives for retention of health professionals.

To explore establishment of regional mechanisms for addressing common health workforce challenges in Pacific Island Countries such as a system for collecting, collating and sharing information about human resources for health in the Pacific region, a regional inventory of skilled health workers (Human Resources Bank) for sharing of highly skilled health personnel among Pacific Island Countries, and strengthening or establishing of regional training institutions.

4.7 A Review of the Pacific Regional HIV Strategy and Progress Towards Universal Access to Prevention, Treatment, Care and Support

4.7.1 Background

In August 2004 the Pacific Islands Forum and the Secretariat of the Pacific Community endorsed the Pacific Regional Strategy on HIV/AIDS (2004–2008) and called for the development of a comprehensive implementation plan, which was subsequently endorsed as a "living document" in 2005. The Strategy is intended to be the central mechanism to support prevention and care in relation to HIV/AIDS at the regional level and to strengthen regional and country coordination, collaboration and partnerships. It identifies eight Pacific themes that ensure that the traditional, cultural and religious values of the Pacific are acknowledged; that the protection and promotion of human rights are affirmed; that the Strategy is based on partnerships and a multisectoral approach; and that its approach is sensitive to gender and vulnerable groups.

In Apia, Samoa, 2005, at the Meeting of Ministers of Health for the Pacific Island Countries, the ministers noted significant progress in addressing HIV and other sexually-transmitted infections (STI) at both national and regional levels. However, there was still much to be done to prevent an HIV epidemic comparable to those experienced in other regions of the world. There was a call for continued commitment at all levels; maintaining prevention as a key strategy; strengthening HIV and STI surveillance; refining policies, strategies and plans for care and treatment; and strengthening coordination at both regional and national levels.

In 2006, two major reviews were conducted. One was led by the Joint United Nations Programme on HIV/AIDS (UNAIDS) on the scaling-up towards universal access in the Pacific whose findings contributed to a regional consultation for Asia and the Pacific, held in Pattaya, Thailand in February 2006. This in turn provided for the development of a global Report on Universal Access presented by UNAIDS to the United Nations General Assembly Special Session and the G8 Summit. The second was a mid-term review of the Regional Strategy on HIV/AIDS (2004–2008) by SPC. The reviews provided further insight into addressing HIV and other STI in the Pacific.

Finally, in October 2006, Fiji representatives joined the First Asia-Pacific Regional Conference on Universal Access for HIV Prevention, Treatment, Care and Support in Low-Prevalence Countries held in Ulaanbaatar, Mongolia, which resulted in the Ulaanbaatar 2006 Call for Action.
4.7.2 Discussions

The Minister from Papua New Guinea and Dr Banare Bun from the Papua New Guinea delegation reported on the efforts made by their government to reduce the transmission of HIV and provide effective care for people living with HIV. Leadership is crucial for Papua New Guinea and more advocacy and effective communication are required to support the work that is being carried out there.

Ministers and representatives from Fiji, the Marshall Islands, Samoa, Solomon Islands, Tonga and Vanuatu spoke on the issue and all endorsed the framework of action outlined by SPC and WHO.

Vanuatu noted the progress that has been made both at regional and national levels, but asked that emphasis be placed on a shift from awareness to behaviour change communication, better coordination, and donor flexibility in implementing national programmes.

The Ministers also acknowledged the financial support from other regional agencies and development partners in support of their national efforts.

4.7.3 Conclusions and Recommendations

1. Support and consolidate leadership advocacy programmes in relation to HIV and other STI.

2. In accordance with human rights principles and equity values, review and update legislation and policies in relation to HIV.

3. Continue ensuring gender balance, equity of HIV and STI services, and the involvement of people living with HIV.

4. Strengthen primary prevention, aiming at adolescent and youth population groups at higher risk of transmission through targeted and sustained behaviour change interventions and condom promotion.

5. Expand availability and access to HIV testing and counselling services.

6. Building on the progress achieved in implementing second-generation surveillance surveys, strengthen capacities for strategic information on HIV and STI.

7. Improve effectiveness in planning and monitoring of and resource mobilization for programme interventions that are evidence based and guided by strategic information.

8. Enhance existing coordination mechanisms and collaboration to:
   a. facilitate operational links between reproductive health, adolescent health, TB control, blood safety, and HIV and STI services; and
   b. promote long-term and sustainable capacity development, including through the development programmes of other sectors.

9. Renew efforts for STI prevention with a focus on updated strategies for effective interventions.
(10) Support and expand affordable comprehensive services for care, treatment and support for people living with HIV.

(11) Continue strengthening health systems, in particular human resources development, laboratory support, health infrastructures, procurement and supply management, and health information systems.

4.8 Food Fortification in the Pacific

4.8.1 Background

Two recent reviews of information available on micronutrient deficiencies in the Western Pacific Region, conducted by WHO and UNICEF, concluded that vitamin and mineral deficiencies (VMD) are a public health problem in many Pacific Island Countries. VMD can co-exist in populations that are overweight or undernourished. In particular:

(1) Nutritional anaemia is the most prevalent VMD disorder, found in most Pacific Island Countries. Anaemia affects the cognitive development of children, reduces adult productivity, increases the risk of pregnancy complications and maternal mortality, and impairs immune response. Although specific information on the causes of anaemia in the Pacific is limited, the main causes are considered deficiencies of iron, folic acid and other B vitamins and, in some cases, vitamin A and other micronutrient deficiencies. In many countries, parasite infections, such as hookworm and malaria, are significant causes.

(2) Iodine deficiency disorders can occur in Pacific Island Countries and have been documented in Fiji, Papua New Guinea and Vanuatu, while this deficiency is clinically suspected in Samoa and Solomon Islands. Iodine deficiency seriously constrains mental and physical development and productivity. Meta-analyses of IQ studies show losses of 10 to 15 IQ points in populations with moderate to severe iodine deficiency.

(3) Vitamin A deficiency has been reported as a public health problem in the Federated States of Micronesia, Kiribati, Papua New Guinea, and the Marshall Islands.

A WHO review in 2002 on VMD and opportunities for food fortification in the Western Pacific Region and two WHO-supported studies in 2006 identified wheat flour, rice and their products, and possibly salt and oil, as good vehicles for food fortification in the Pacific and determined the regulatory and legislative requirements for fortification. In March 2006, a workshop in Fiji organized by WHO, SPC, UNICEF and the United States Centers for Disease Control and Prevention recognized that VMD is a public health problem for the Pacific Island Countries and recommended various interventions, including fortification.

Programmes for the prevention and control of anaemia rely on four main strategies; dietary improvement; supplementation; fortification; and helminths and parasite control. Usually, no single programme component is sufficient to prevent and control anaemia in isolation. Fortification is an important component, which has the major advantage of improving nutritional status without requiring changes in diet by putting back into staple foods such as wheat and rice, those essential minerals and vitamins, such as iron, folate, zinc and other vitamins and minerals, 90% of which are usually removed by refining cereals, removing the outer layers of the grains.

For decades, fortified flour has put additional iron into the diets of the United States of America and Canada, providing about a quarter of daily iron intake. At present 52 countries add iron and folic acid to flour, representing about 26% of output from the world's flour mills. A
regional fortification programme has been established in Central America, and similar initiatives are developing in central and southern Africa and the Middle East. Fiji legislated fortification in 2004, and the flour exported from the Fiji mills to other Pacific nations is also fortified. Flour imported from Australia and New Zealand is generally not fortified while that from the United States of America is. Ministers of Health of Australian states and territories and New Zealand have asked the Food Standards Authority of Australia and New Zealand to make flour fortification with folic acid mandatory.

Inexpensive technologies are now available to fortify rice with iron, zinc, vitamin A, folic acid and other B vitamins. Cooking oil is increasingly being fortified with vitamin A. In China and Viet Nam condiments such as soy and fish sauce are being fortified with iron on a large scale. Universal salt iodization has been legislated in over 120 countries, and it is the single most successful fortification programme globally. In the Pacific, universal salt iodization has been adopted in Fiji and Papua New Guinea and could easily be adopted by other Pacific Island Countries.

Fortification is not the only solution to iron and other deficiencies, as adding iron and other micronutrients to widely consumed foods can only provide a proportion of daily requirements. Improving nutrition from locally available foods remains a major component of the strategy for the Pacific Island Countries. However, fortification of staple foods like flour and rice for populations known to have VMD should become a matter of routine milling practice.

4.8.2 Discussion

The representatives of several countries spoke in support of the Pacific Food Fortification Initiative.

The Director of Public Health of Vanuatu referred to the current nutrition problems in Vanuatu as including undernutrition and micronutrient deficiencies, as well as overweight and obesity in the more affluent urban population. Some foods are already fortified, and food importers are interested in introducing fortified salt and other fortified foods. He reported the main findings of a recent survey on IDD conducted in Tanna, in collaboration with the Institute of Clinical Pathology and Medical Research, Westmead Hospital, Sydney, which showed that 51% of primary school children have mild to moderate iodine deficiencies and 20% have severe iodine deficiency (based on urinary iodine). He considered these findings extremely worrying and said there is a need to quickly establish universal salt iodization. He thanked UNICEF, WHO, SPC and other partners who have helped to address VMD and encouraged all Pacific Island Countries to join forces to improve the situation. He noted that his department is working with UNICEF in drafting a bill for food fortification on iodized salt and wheat flour products.

The representative of Fiji reported a high prevalence of anaemia in women and children, as well as vitamin A and iodine deficiencies. She reported that salt iodization has been in place in Fiji since 1996 and wheat flour fortification since 2004. She pointed out that the challenge is enforcing and monitoring legislation. She endorsed the regional framework.

The representative of Kiribati proposed that vitamin A fortification should be included in the fortification initiative. The consumption of local foods that are very high in Vitamin A, such as pandanus fruit and some types of cooking bananas available in Micronesia and elsewhere, should also be further promoted.

The representative of New Zealand stated the need to ensure that there are no negative effects of fortification, particularly in young men who may not need additional iron. A response to this concern came from other participants who pointed out that while in New Zealand the
prevalence of anaemia is less than 5%, adult males in Fiji have a prevalence of 10% and adult males in Papua New Guinea are also affected by anaemia. Very little data on anaemia prevalence is available for men from the other Pacific Island Countries. However, fortification programmes usually contribute to satisfy only part of the iron requirements of adults, often around 25%, so it is very unlikely that they would lead to excessive iron intake. The representative from New Zealand also emphasized the importance of monitoring and evaluating the fortification programme to determine if the objectives are achieved.

The representative from Nauru stated that fortification is a good way to make healthy choices easy, as it does not require changes in eating patterns. He referred to this initiative as a good example of a regional approach to the solution of common problems. In relation to the proposal of a food summit for the prevention of NCD, he suggested that there should be a food summit for the Pacific Island Countries addressing both NCD and micronutrient deficiency prevention.

The representative from Papua New Guinea, in endorsing the initiative, proposed that the programme be added to the ones included in the Pacific Health Strategy. He pointed out that both rice and salt have been fortified in Papua New Guinea for many years and fortification of wheat flour was recently agreed upon. While the government promotes the consumption of whole grain rice, he thought that the fortification of refined grains should remain mandatory.

The representative from the Marshall Islands supported the initiative, as his country has a considerable VMD problem, attributed to the preference of most people for white flour and white rice. Although vitamin A supplements are provided to children and mothers, he proposed that wheat flour, rice and instant noodles should be fortified with other micronutrients.

The representative from Niue fully supported the initiative and referred to the need to better determine the causes of anaemia in women. She also raised the question of increased cost of fortified foods as a concern for ensuring their affordability by the poor. It was pointed out that the food fortification involves a minimal increase in cost and there have been discussions with the Wheat Board of Australia to absorb this cost for wheat exported to Pacific Island Countries.

The representative of New Caledonia asked that also fluoride be considered as part of fortification programmes, aiming to contribute to the improvement of oral health through the prevention of dental caries, especially in children, in addition to promoting a reduced consumption of sugary foods and drinks. It was pointed out that WHO is exploring the double fortification of salt with iodine and fluorine for some countries where both nutrients are deficient, based on successful experience with this approach in France and elsewhere.

The representative of French Polynesia referred to the iron deficiency problem being addressed through iron supplements for pregnant women and mentioned the use of prescription fluoride for the prevention of dental caries. She supported food fortification.

4.8.3 Conclusions and Recommendations

(1) Recognize that nutritional anaemia and iron, iodine, vitamin A and folate deficiencies are public health problems in many Pacific Island Countries.

(2) Support in principle the establishment of a regional fortification programme for the Pacific Island Countries to help alleviate VMD.

(3) Agree to the creation of a formal Pacific Fortification Partners Group (membership to be confirmed) and call for nominations from Ministers to lead the group.
(4) Favour the development of a workplan by the Pacific Fortification Partners Group, the first step of which is the establishment of regional fortification standards for selected foods considering not only iron and folate, but also iodine, vitamin A and fluorine deficiencies.

(5) As an intermediate step towards a Pacific Food Summit, Ministry of Health staff from the Pacific Island Countries should present information on the Pacific Food Fortification Programme at meetings of Ministers of Agriculture and Trade.
OPENING REMARKS BY DR SHIGERU OMI, REGIONAL DIRECTOR
WHO REGIONAL OFFICE FOR THE WESTERN PACIFIC

Honourable Prime Minister, Mr Ham Lini Vanuaroroa,
Pastor Shem Temar, Secretary, Christian Council of Churches,
Honourable Minister of Health, Mr Stevens Morking Iatika,
Honourable Ministers of Health from the Pacific Island Countries,
Honourable Ministers and senior officials of the Government of Vanuatu,
Dr Jimmie Rodgers, Director-General, Secretariat of the Pacific Community,
Chief Representative of Malvatumauri,
Members of the Diplomatic Corps,
Representative of Vanuatu Council of Women
Distinguished Guests,
Ladies and gentlemen

Gud moning long evriwan, Mi hapi tumas blong stap long ples ia long bioutifoul kantri blong you.

I would like to thank the Government of Vanuatu for hosting this meeting of the Ministers of Health of the Pacific Island Countries. For me personally, it's always a pleasure to return to Vanuatu. The archipelago's unspoiled beaches, pristine waters and active volcanoes offer an environment a first-time visitor won't soon forget. The country's diverse ethnic and cultural make-up – more than 100 languages are spoken here – add to its allure. We are grateful for the hospitality that has been extended to us since our arrival, and despite our busy agenda I hope everyone gets to spend some time getting acquainted with these beautiful islands.

This meeting marks the seventh time that we have gathered to take stock of the health situation in the Pacific and to set future directions in our continuing efforts to ensure good health for the nearly 9 million people who inhabit the Pacific Island Countries and Areas. We are a diverse group, including ministers and directors of health from across the Pacific, officials and technical experts from the World Health Organization and the Secretariat of the Pacific Community, colleagues from partner agencies and donors, representatives from nongovernmental organizations, and other stakeholders. But we all share that singular vision of "Healthy Islands" that we first mapped out at our inaugural meeting in Fiji in 1995.

The issues we have been tackling these past 12 years are those that have been articulated by the people of the Pacific and their governments: the alarming increase in noncommunicable diseases, which are the leading cause of death and illnesses in the Pacific; the continuing threat from emerging and re-emerging diseases, including HIV/AIDS; the need to ensure that we have sufficient numbers and the proper skill mix of health workers despite the lure of higher-paying jobs abroad.

We have a full agenda this week that will tackle all of these issues and more. And I'm certain that our discussions and decisions here in Port Vila will lead to great progress, as did our initial meeting in Fiji in 1995, our gathering in Cook Islands in 1997, in Palau in 1999, in Papua New Guinea in 2001, in Tonga in 2003 and in Samoa in 2005.

We'll begin our deliberations later this morning with an update on the Tonga Commitment to Promote Healthy Lifestyles and a Supportive Environment and the Samoa Commitment to Achieve Healthy Islands. We will also tackle noncommunicable diseases, which account for
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more than 75% of the disease burden in the Pacific. Left unchecked, these diseases will not only lead to premature death and disability for tens of thousands of people, but also will threaten to overwhelm Pacific health resources and services already stretched thin.

Today we'll consider a discussion paper on a Health Strategy for the Pacific. The Strategy has been proposed as an overarching framework to link and coordinate existing regional health strategies and programmes. It can prove to be an important additional tool for improving health in Pacific Island Countries by complementing and strengthening national health plans and strategies. If you agree to its development, it will be led by the Pacific Island Countries themselves and involve their full participation. The discussion paper is intended to inform Ministers of Health on the development of the Health Strategy for the Pacific and to seek their guidance.

While the Pacific Island Countries have been fortunate enough – thus far –to have escaped the ravages of SARS and avian influenza, we are all smart enough to realize we can't become complacent. Therefore, we'll take time to review WHO's Asia Pacific Strategy for Emerging Diseases, with a special emphasis on pandemic preparedness and the revised International Health Regulations, which enter into force in less than three months. The regulations set out many new obligations and provide opportunities for Member States to strengthen their public health systems and capacities. Our goal is to ensure that all the countries and areas of the Asia Pacific Region have at least the minimum capacity for epidemic alert and response by 2010.

We'll also revisit a vital issue for the Pacific: human resources for health. We all know there is a strong correlation between the density of health care providers and the reach of essential health interventions. Countries with fewer than 2.3 doctors, nurses and midwives per 1000 people simply aren't able to consistently provide basic, life-saving services. With this in mind, we'll look at the Pacific Code of Practice for the Recruitment of Health Workers and the Regional Strategy on Human Resources for Health.

In addition, we'll be reviewing the Pacific Regional HIV Strategy, with an eye towards universal access to prevention, treatment, care and support. We'll also consider a paper that looks at food fortification as a means of fighting iron deficiency anaemia in Pacific populations.

As I look around this room and see the people that have gathered here, I am confident that together we can make great progress on the agenda that lies before us.

It is a pleasure to co-organize this meeting with the Secretariat of the Pacific Community and I extend my sincere appreciation to Dr Jimmie Rodgers, Director-General of the Secretariat of the Pacific Community. And once again, I would like to thank His Excellency, the Right Honourable Prime Minister and the people of Vanuatu, for kindly hosting us here in this beautiful country. Enjoy the meeting – and Vanuatu.
OPENING REMARKS BY DR JIMMIE RODGERS, DIRECTOR GENERAL,
SECRETARIAT OF THE PACIFIC COMMUNITY

The Honourable Prime Minister of Vanuatu, Mr. Ham Lini Vanuaroroa
Pastor Shem Temar, Secretary Christian Council of Churches of Vanuatu
Honourable Minister of Health and host for this year’s meeting of Ministers of Health,
Mr Morking Stevens Iatika
Honourable Ministers and heads of delegations from Pacific island Countries & territories and Australia and New Zealand
Honourable Ministers of the Government of Vanuatu
Dr Shigeru Omi, Regional Director for the WHO Western Pacific Regional Office
Chief Representative of Malvatumauri
Members of the Diplomatic Corps
Senior Officials of the Government of Vanuatu
Representative from the Vanuatu Council of Women
Organizing Committee of the 7th Pacific Health Ministers Meeting
Representatives from our Development Partners, Regional and International organisations
Representatives from Nongovernmental Organisations
Members of the Media, Staff of WHO and SPC, Invited guests, Ladies and gentlemen

I bring warm greetings to you from the Secretariat of the Pacific Community and I join Dr Omi in welcoming you all to Vanuatu for this, the seventh meeting of Ministers of Health from the Pacific. 2007 is a special year for SPC as we commemorate its 60th years of service to the region across a range of sectors.

At the outset I wish to convey our sincere appreciation to our host for this meeting, the honourable Minister of Health of Vanuatu and your team for the excellent reception and hospitality we have received since our arrival to your beautiful country and the excellent arrangements for the meeting at this beautiful hotel located next to paradise. I would also like to convey on behalf of SPC our sincere appreciation to our co-organizer, Dr Omi and your team from WHO for the excellent cooperation between our two organisations leading up to and during this meeting. I also wish to register our appreciation to delegations from all participating countries and territories and other stakeholders at this meeting. Without you this meeting would not take place.

This is my first WHO-SPC jointly organised meeting of Pacific Ministers of Health since taking up the position to head the SPC a year ago. However, I was one of the rapportuers at the inaugural 1995 ministerial conference at Yanuca Island, Fiji from which the ‘Yanuca Island Declaration on Healthy Islands’ emerged. If my memory serves me correctly, I believe Sir Peter Barter, the Minister of Health for Papua New Guinea was also at the 1995 ministerial conference.

Twelve years on from the first ministerial meeting, this meeting offers us an opportunity to take stock of what we have achieved as individual countries and territories or collectively as a region in attaining better health outcomes for Pacific people. It offers you Ministers the opportunity to address questions such as ‘is this august body working to its full potential in helping shape the health agenda for our countries & territories and our region?’

Can our region demonstrate best practice examples in ‘effectively addressing health challenges’ using innovative approaches that binds our respective strengths which could become
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models for other regions of the world? Are there other or better ways of addressing health challenges at national, regional and international levels?

Are we positioning our health services at the national and regional level to engage strategically internationally, regionally and nationally for better health outcomes taking into account the changing population dynamics and emerging challenges to health?

I am very pleased to see that the agenda for this ministerial meeting has a strategic focus as well as the usual programmatic focus. This meeting more than any of the previous ones provides the opportunity for ministers to consider national health issues, challenges and priorities within the context of the broader Pacific region and the international environment. It provides an opportunity for all countries and territories to embark on a process that could ultimately result in a much clearer identification of the totality of challenges facing the health sectors in the region, many of which do not fall within the purview of health ministries / departments yet impact on the ability of the health sector to deliver effective health services. For the challenges facing the health sector in the region, the process could delineate more clearly between those priorities that are best addressed nationally, and those where regional or international support would add value to achieving national health outcomes. I can not emphasize enough the importance of the paper on discussing a possible ‘health strategy for the Pacific’ or a possible ‘framework for health priorities in the Pacific’.

It is my hope that in discussing this issue, which has the potential to shape the region’s approach to health into the future, that honourable Ministers would have the opportunity to think outside the box, with the view to exploring mechanisms that would best help you add value to your efforts to achieve greater health outcomes for your respective countries and territories.

The responsibility of finding effective and sustainable solutions for the current challenges facing the Pacific health sector has come under our watch. It is not something that we can delay for those coming after us. The choice to take a more strategic approach to addressing current challenges facing the region’s health sector and more importantly to position our respective countries and territories and our region in such a way that they can effectively respond to future challenges, is for us to make.

The question for all of us, the leaders and decision-makers dealing with health in today’s Pacific is, ‘what legacy do we wish to leave behind in the health sector for our children and their children?’ I am sure you will agree with me that we would wish to be remembered as that generation that had made the choices to explore and grasp the opportunities aimed at enhancing better health outcomes for our people; the generation that had worked toward improving the foundation upon which the health and wellbeing of our future generations throughout the Pacific region could be further enhanced. It is my sincere hope that this meeting will provide the impetus for us to meet this challenge.

May God guide and bless us all as we collectively embark on a journey in the next few days to reach outcomes that would benefit the health and the future of Pacific island people – a future that is in keeping with the Vision of Pacific Leaders in the Pacific Plan – where our people live free and worthwhile lives.

Thank you for your attention.
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SPEECH BY THE HONOURABLE HAM LINI VANUAROROA, PRIME MINISTER OF VANUATU AT THE OPENING CEREMONY

Leader of Opposition, Honourable Serge Vohor Rialut,
Honourable Minister of Health,
Honourable Ministers of Health of Pacific Island Countries
Heads of Delegations,
Honourable Ministers of the Government of Vanuatu,
Dr Shigeru Omi, Regional Director WHO Western Pacific Region,
Dr Jimmie Rodgers, Director General of the Secretariat of the Pacific Community,
Pastor Shem Temar, Secretary, Vanuatu Christian Council of Churches,
Members of the Diplomatic Corps – Police Commissioner, Political Advisors, Directors General, Directors of Government Departments,
Representatives, National Council of Chiefs,
Representative, National Council of Women,
Representative, National Council of Youth,
Organizing Committee of the 7th Pacific Health Ministers Meeting,
Representatives of Nongovernmental Organizations,
Distinguished guests,
Ladies and gentlemen,

The present meeting in Vanuatu is now the seventh in a series of consultations between the Ministers of Health of the Pacific Island Countries with the Secretariat of the Pacific Community and the World Health Organization.

Discussions during these consultations are related to those in other forums on health and development with our loyal partners like Australia, New Zealand, Japan, France, the Asian Development Bank, the World Bank, and United Nations agencies. Since the first meeting held in 1995 in Yauca, Fiji, these discussions have given rise to a structure and a common vision but have also pinpointed the health needs of our Pacific communities that are also targeted by the millennium development goals.

However, despite the efforts of everyone involved, the governments, partners and communities, considerable problems persist or even worsen and others appear in the area of public health, jeopardizing the achievement of the millennium development goals and the reduction of poverty in many countries, including those in the Pacific sub-region.

All these changes require and will require even more effort and motivation, political and financial commitment from every one of us, governments, partners and communities.

I do not wish to draw up a gloomy litany that could sap your dynamism and morale at the start of this meeting, but the majority of crucial issues are the following:

How to prevent and control non-communicable diseases such as diabetes, obesity and cardiovascular diseases?

What to make of the fact that among the “top ten obese countries” we find eight small Pacific island countries, the top six of which have an obesity rate of more than 80%. The Daily Telegraph of Sydney recently wrote an article on the subject of the
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obesity epidemics in the South Pacific. Unfortunately, this is the reality and a real tragedy for our populations.

How can we keep a low or even a very low HIV infection incidence and prevalence level while stopping and reversing the dramatic evolution of the HIV/AIDS epidemics in our neighbour, Papua New Guinea.

How, with the prevailing structural difficulties in human resources, can we increase efforts and improve our deficient health systems so that they would be able to better respond to the numerous risks that never cease to threaten us: natural disasters and infectious pandemics.

How can we guarantee equal access to health, in particular for the most vulnerable, the women and children, but also for the marginalized population in our societies.

How can we effectively and continuously fight all forms of discrimination in our communities and even in our own health systems, how can we fight domestic violence and all forms of human trafficking, particularly that involving children.

All these questions should not cease to push us to take action and each one of us should feel a sense of responsibility. It is sad and regrettable that there are usually possible and efficient solutions to most of these issues, but unfortunately, very often, it is only the lack of any real motivation that prevents these solutions from being put into action.

Everybody’s motivation

Motivation and courage on the part of politicians and decision-makers to change the social and legislative environment and framework, motivation of the partners to provide a little more technical and financial support but also motivation on the part of the population itself when it comes to adopting a healthier lifestyle.

The Government of Vanuatu, who is very proud and happy to welcome you to Port Vila, is aware of and actually experiences the intensity of these problems.

In your work programme, one session is dedicated to the development of “A Health Strategy for the Region” and of a “Pacific Health Fund”. The Government of Vanuatu looks forward to these two initiatives and from today on, commits itself totally to their realization. I also really appreciate that, following a recommendation from Vanuatu, another working session will be dedicated to the “food fortification” issues.

We are sure that your work and discussions will also effectively contribute in this process committed to since 1995 and marked by important declarations and commitments: Yanuca, Rarotonga, Palau, Madang, Tonga, Samoa…I do not know yet how you will call the fruit of this meeting in Port Vila but I sincerely wish that the actions following it will also make an impact on this difficult road we are all on, policy makers and health and development stakeholders, for the well being and the future of our Pacific Communities.

On behalf of the Government of Vanuatu, I wish you all a warm welcome.
My colleagues, the Ministers of Health, will have the chance to visit Tanna tomorrow. I wish them a pleasant and a dynamic stay on this island guided by their host, the Honourable Minister Stevens Iatika.

I now solemnly declare the 7th meeting of the Ministers of Health of Pacific Island Countries with the Secretariat of the Pacific Community and the World Health Organization open.
AGENDA

1. Opening ceremony
2. Election of Chairperson and Rapporteurs
3. Adoption of the agenda
4. Strategic items
   4.1. A Health Strategy for the Region: discussion paper
   4.2. Pacific Health Fund
5. Technical items
   5.1. Follow-up to the Samoa and Tonga Commitments, including mental health and other items not covered in the agenda
   5.2. Prevention and control of noncommunicable diseases
   5.3. The Asia Pacific Strategy for Emerging Diseases, including the International Health Regulations (2005) and pandemic preparedness
   5.5. HIV/AIDS: a review of the Regional Strategy and universal access
   5.6. Food Fortification Plan
6. Closure
ANNEX 5

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