ÉVALUATION DU

DÉPARTEMENT SANTÉ PUBLIQUE DU SECRÉTARIAT GÉNÉRAL DE LA COMMUNAUTÉ DU PACIFIQUE

REVIEW OF THE

PUBLIC HEALTH PROGRAMME SECRETARIAT OF THE PACIFIC COMMUNITY

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ACRONYMS AND ABBREVIATIONS

ADRA	Adventist Development and Relief Agency
AusAID	Australian Agency for International Development
BCC	behaviour change communication
CDC	Centers for Disease Control (United States)
CROP	Council of Regional Organisations in the Pacific
DOTS	Directly Observed Treatment – Short Course
FCTC	Framework Convention on Tobacco Control
FSM	Fiji School of Medicine
GFATM	Global Fund to fight Aids, Tuberculosis and Malaria
GDP	gross domestic product
HCW	health-care worker
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
IHR	International Health Regulations
IMR	infant mortality rate
JCS	Joint Country Strategy
JICA	Japanese International Cooperation Agency
LDC	least developed country
MDG	Millennium Development Goal
MOH	Ministry of Health
NCD	noncommunicable disease
NGO	non-governmental organisation
NZAID	New Zealand Agency for International Development
PHP	Public Health Programme
PICTA	Pacific Island Countries Trade Agreement
PICTs	Pacific Island countries and territories
PNG	Papua New Guinea
PPA	Pacific Platform for Action
PPHSN	Pacific Public Health Surveillance Network
PRIPPP	Pacific Regional Influenza Pandemic Preparedness Project
PRISM	Pacific Regional Information System
SARS	severe acute respiratory syndrome
SOPAC	Pacific Islands Applied Geoscience Commission
SPC	Secretariat of the Pacific Community
SPREP	South Pacific Regional Environment Programme
STEPS	(WHO) STEPwise approach to surveillance
STI	sexually transmitted infection
TB	tuberculosis
UN	United Nations
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WPRO	(WHO) Western Pacific Regional Office

1.0 RÉSUMÉ

L'évaluation des résultats du Département Santé publique du Secrétariat général de la Communauté du Pacifique (CPS) pour la période allant de 2003 à 2005 a permis de recueillir des opinions très différentes. Selon d'influentes personnes interrogées dans les pays membres, les relations entre la CPS et les agents des services de santé nationaux sont excellentes lorsque des programmes techniques bénéficiant du soutien de la CPS sont conduits dans un pays. Cependant, les avis des responsables de la santé publique de certains États et Territoires insulaires du Pacifique sont plus nuancés. Parmi les sujets évoqués, on citera le manque de visibilité des agents de la CPS dans les pays, le caractère ponctuel du soutien de l'Organisation envers les politiques et les programmes de santé publique, et la formation dans ce secteur, ainsi que la nécessité pour la CPS d'assumer plus pleinement son rôle de chef de file et de promoteur de la santé publique dans la région. En outre, il s'est avéré difficile d'évaluer les résultats du Département Santé publique objectivement en l'absence d'un système de suivi et d'indicateurs fiables. Force est de constater que le Département Santé publique ne dispose pas de moyens fiables qui lui permettraient d'évaluer les effets de ses propres programmes et les améliorations apportées à la santé publique dans les États et Territoires insulaires du Pacifique.

Pendant la période de référence, certaines Sections du Département Santé publique ont été bien soutenues par les partenaires de développement (par exemple, la Section lutte contre le VIH/SIDA et les infections sexuellement transmissibles (IST), et le Projet régional océanien de préparation à une pandémie de grippe), cependant que d'autres Sections dont les travaux sont considérés prioritaires par la CPS, qui n'ont pas réussi à obtenir les ressources nécessaires, n'ont pu mettre en œuvre concrètement que quelques activités. Les principales faiblesses relevées concernent l'incapacité du Département Santé publique à apporter des ressources et un soutien technique aux États et Territoires océaniens dans les domaines de la salubrité de l'environnement, de la prévention et la lutte contre les maladies non transmissibles (MNT) chroniques, et à répertorier les capacités en santé publique essentielles des pays et de la CPS à la lumière des objectifs fixés pour la période allant de 2003 à 2005. Le manque de progrès en matière de renforcement des capacités en santé publique revêt d'autant plus d'importance que les besoins des services de santé de la région augmentent alors même qu'ils doivent faire face à des défis de santé publique d'une complexité croissante avec, pour la plupart d'entre eux, des capacités limitées. Les services de santé océaniens sont fragiles et leurs capacités en santé publique sont mises à rude épreuve par suite de la pénurie de personnel qualifié dont souffrent de nombreux États et Territoires.

Il semble que le financement des Sections de la CPS concorde avec les préoccupations de la communauté internationale et les priorités des bailleurs de fonds, plutôt qu'avec les menaces pour la santé publique qui sont effectivement à l'origine d'un lourd fardeau de mortalité, de morbidité et d'incapacité dans la région. Par ailleurs, le fait que certaines Sections sont bien financées entraîne des distorsions des priorités de santé publique dans les États et Territoires océaniens, notamment dans les petits États insulaires dont les capacités en santé publique sont limitées. Le Département Santé publique et les partenaires en développement devraient appliquer de manière plus cohérente des méthodes d'évaluation, de dépistage, de gestion et de prévention des risques favorables à la mise en œuvre d'une approche plus équilibrée et équitable du financement axée sur les priorités de santé publique de la région. La CPS et les pouvoirs publics des États et Territoires insulaires du Pacifique devraient cibler en priorité les maladies entraînant un lourd fardeau de morbidité, telles les MNT et les principaux facteurs de risque, lorsqu'elles affectent les ressources, que celles-ci proviennent de l'aide au développement ou d'affectations récurrentes du budget national.

L'équipe chargée de l'évaluation constate également qu'il est nécessaire de mieux intégrer le Département Santé publique et les autres sections de la Division Ressources sociales (Bureau des

femmes du Pacifique, Bureau de la Jeunesse du Pacifique et Section Affaires culturelles) ainsi qu'avec d'autres Sections notamment celles compétentes en matière d'agriculture et de santé animale. La Section Santé génésique et développement des adolescents n'est pas bien intégrée avec les autres Sections du Département Santé publique. Il est plus important encore d'améliorer les relations de travail avec les pays membres et de leur apporter un soutien. La CPS doit également clarifier la relation entre le rôle qu'elle est appelée à jouer dans le domaine de la santé publique et ses fonctions essentielles de renforcement et de supplémentation des capacités, et de coordination des questions transnationales. Plusieurs personnes interrogées ont signalé le rôle de la CPS dans l'élaboration de la Stratégie régionale océanienne de lutte contre le VIH/SIDA et les IST, considérant que c'est un modèle à suivre par l'Organisation pour coordonner les activités de santé publique dans la région, faciliter le consensus et harmoniser les contributions des diverses parties prenantes aux fins d'améliorer la santé publique.

Les modalités actuelles de planification et de financement du Département Santé publique ne sont pas aptes à appuyer des interventions de santé publique efficaces. Les activités du Département sont principalement financées à court terme, et cette situation ne lui permet pas d'adopter l'approche à plus long terme essentielle aux investissements en santé publique. Pérenniser les activités du Département Santé publique est une gageure, et ses méthodes de planification et de financement doivent évoluer. En outre, le positionnement actuel du Département au sein de la Division Ressources sociales ne correspond ni à l'orientation, ni à l'autorité, ni à la visibilité dont il a besoin pour assumer pleinement son rôle de chef de file en matière de santé publique dans la région. Par ailleurs, son budget de fonctionnement a baissé de 2005 à 2006, et le soutien administratif actuellement disponible n'est pas également réparti entre ses diverses activités. L'actuelle structure de gestion doit être révisée et alignée sur les priorités (révisées) proposées dans cette évaluation, pour lui permettre d'être mieux à même d'atteindre ses objectifs. Nombre des recommandations du rapport d'évaluation du Secrétariat général de la Communauté du Pacifique visant la gestion et l'administration des divisions, départements et sections, s'appliquent également au Département Santé publique.

En ce qui concerne l'avenir, un certain nombre d'accords régionaux et internationaux continueront à influencer la nature et le rôle de la CPS, ainsi que les priorités de santé publique de l'Océanie. La mise en œuvre des recommandations du rapport d'évaluation du Secrétariat général de la Communauté du Pacifique, la réalisation des ODM, le Plan de renforcement de la coopération et de l'intégration régionale pour le Pacifique (Plan pour le Pacifique), et l'élaboration de la Stratégie océanienne en faveur de la santé, joueront un rôle particulièrement important. Aligner les activités de la CPS sur les priorités des États et Territoires océaniens, et influencer la mise en œuvre de la Déclaration de Rome sur l'harmonisation et de la Déclaration de Paris sur l'efficacité de l'aide au développement, constituent des activités cruciales pour l'avenir de la région. La bonne santé des populations est essentielle au bien-être des personnes et au développement national. Il importe que la CPS veille à ce qu'une meilleure santé publique contribue aux activités de développement à caractère plus général dans la région, et puisse en bénéficier. Ces attentes ont été incorporées dans les recommandations de la présente évaluation.

1.0 EXECUTIVE SUMMARY

The review of the performance of the Public Health Programme (PHP) of the Secretariat of the Pacific Community (SPC) during 2003–2005 showed variable results. Feedback from key informants in member states showed very good relationships between SPC and country staff where SPC-supported technical programmes were being implemented in the country. However, feedback from the health leadership in some Pacific Island countries and territories (PICTs) was variable. Common themes were the lack of visibility of SPC staff in country, the ad hoc nature of its support for public health policy, programmes and training, and the need for greater SPC leadership and advocacy roles in public health for the region. Furthermore, objective assessment

of PHP performance was problematic because of the lack of a monitoring system and reliable indicators. It was apparent that PHP had no reliable way of assessing the impact of its own programme and the improvements made in public health in PICTs across PHP.

During the period under review, some PHP programmes received good development partner support, e.g. HIV/AIDS and sexually transmitted infections (STI) and the Pacific Regional Influenza Pandemic Preparedness Project (PRIPPP), while other programmes that were stated to be priorities for SPC failed to attract the necessary resources and few effective actions were implemented. The most important gaps were: the inability of PHP to provide resources and technical support to PICTs in environmental health and prevention and control of chronic noncommunicable diseases (NCDs); and the identification of core national and SPC public health capacities in the light of the 2003–2005 objectives. Failure to make progress on building public health capacity was particularly important in view of the increasing need and complexity of public health challenges in the region and the limited capacity in most PICTs. Health systems in the region are weak and public health capacity is under strain due in part to the shortage of skilled health-care workers (HCWs) in many PICTs.

It appeared that SPC programmes that were funded were consistent with international community concerns and donor priorities rather than with public health threats that were actually causing a high burden of death, disease and disability in the region. Moreover, well-funded programmes distort public health priorities in PICTs, especially in small island states where the public health capacity is limited. Better risk assessment, detection, management and prevention methodologies should be more consistently applied by PHP and development partners in order to establish a more balanced and shared approach to funding decisions on public health priorities in the region. SPC and PICT governments should also elevate the priority ranking of high burden conditions, such as NCDs and their major risk factors, when making resource allocation decisions, either from development funds or from recurrent national budgets.

The review also found that better integration between PHP and other Social Resources Division activities (women, youth and culture) is needed, as well as between PHP and other SPC programmes such as agriculture and animal health. The Adolescent Health Development Section is not well integrated with other PHP activities. Of even greater importance is the need to improve working relationships with and provide support to member states. SPC also needs to clarify its primary role in public health in relation to its core functions of capacity building, capacity supplementation and coordinating transboundary issues. The role played by SPC in the development of the Pacific Regional Strategy on HIV/AIDS 2004–2008 was highlighted by various respondents as a model for SPC in coordinating public health activities in the region, developing consensus and harmonising contributions from various stakeholders for the purposes of improving public health.

Current planning and funding arrangements for PHP are not conducive to supporting effective public health interventions. PHP activities are funded mainly on a short-term basis and this situation does not enable PHP to adopt the longer-term view that is essential for public health investments. The sustainability of PHP activities is a major challenge, and the way PHP plans and funds its activities needs to be modified. Similarly, the current location of PHP within the Social Resources Division does not provide PHP with the focus, authority and visibility needed to provide greater public health leadership in the region. In addition, funding for management support for PHP declined between 2005 and 2006 and the current administrative support is not evenly allocated within the programme. The current management structure needs to be revised to better support the (revised) PHP priorities proposed by this review. Many of the recommendations made in the SPC Corporate Review (2005) regarding management and administration of its programmes are relevant to PHP.

In preparing for the future, a number of regional and international agreements will continue to shape the nature and role of SPC and public health priorities in the region. The recommendations of the SPC Corporate Review, the achievement of health-related Millennium Development Goals (MDGs), the Pacific Plan and the development of the Health Strategy for the Pacific are particularly important. Aligning SPC activities with the priorities of PICTs and influencing the implementation of the Rome Declaration on Aid Harmonisation and the Paris Declaration on Aid Effectiveness are important activities for the region in future. Good health is essential for personal well-being and national development. It is important for SPC to ensure that improved public health contributes to and benefits from wider development activities in the region. These expectations are incorporated into the recommendations of this review.

2.0 RECOMMANDATIONS

L'équipe d'évaluation soumet les recommandations suivantes à l'attention de la CPS :

1. Renforcer les rôles de la CPS en tant qu'organisme dirigeant, gestionnaire et promoteur de la santé publique en Océanie, et pour ce faire :
    - faciliter l'identification des besoins prioritaires de santé publique dans la région,
    - élaborer et mettre en œuvre des politiques et des stratégies de santé publique en partenariat avec d'autres partenaires du développement et organisations régionales et internationales, et
    - réviser la structure du Département Santé publique au sein la CPS en vue de le renforcer (Recommandation 7).

2. Adopter un horizon de planification à plus long terme et élaborer pour ses programmes de santé publique une déclaration de principe identifiant clairement son orientation stratégique, ses priorités, résultats escomptés, modalités de financement, rôles et responsabilités, ainsi que ses relations avec d'autres parties prenantes. Cette déclaration de principe envisagerait une période de dix à douze ans et sa mise en œuvre se ferait sur la base de cycles de planification et de budgétisation de trois ans, selon la pratique actuelle.

3. Adopter les priorités suivantes et veiller à ce que les ressources et le soutien politique nécessaires soient disponibles pendant la période allant de 2006 à 2009 :
    - renforcement des capacités en santé publique,
    - prévention et lutte contre les MNT et les principaux facteurs de risque,
    - renforcement de la salubrité de l'environnement.

4. Faciliter un processus de renforcement des capacités et des moyens en santé publique dans les États et Territoires insulaires du Pacifique en association avec les établissements de formation compétents, les partenaires en développement et les pays membres. Favoriser une collaboration plus étroite avec l'Organisation mondiale de la santé (OMS) et les partenaires en développement actifs dans le domaine des ressources humaines des services de santé, pour assurer le renforcement des capacités et des compétences en santé publique.

5. Renforcer la présence de la CPS dans les pays et envisager d'augmenter les effectifs dans des pays (ou groupes de pays) sélectionnés, pour aider à la planification, à la mise en œuvre et au suivi de toutes les activités de la CPS, notamment celles du Département Santé publique.

6. Améliorer les liaisons et la communication avec les hautes Directions des ministères de la santé des pays océaniens et, outre les correspondants officiels, avec les acteurs de la mise en œuvre, y compris les organisations non gouvernementales.

7. Rehausser le profil, l'orientation stratégique, l'autorité et la visibilité du Département Santé publique pour lui permettre de jouer un rôle prépondérant dans le monde océanien de la santé publique et, pour ce faire :
   - créer une Division de la Santé publique de même rang que d'autres divisions de la CPS, telle les Divisions Ressources terrestres et Ressources marines ;
   - créer un poste de Directeur de la Division Santé publique en remplacement de l'actuel poste de Directeur du Département Santé publique ;
   - créer un poste de Chef de la Section Mode de vie sains en Océanie, veiller à l'adoption d'une approche intégrée en regroupant en son sein toutes les activités concernant le tabagisme, la consommation excessive d'alcool et l'usage d'autres stupéfiants, la nutrition et l'activité physique, et réaliser une meilleure harmonisation avec le Département Développement humain. Il est essentiel que cette Section puisse bénéficier d'un soutien spécialisé pour pouvoir agir sur les facteurs systémiques causes de maladies chroniques. Il faudra privilégier la réduction des différences modifiables entre les sexes pour ce qui concerne les origines de ces maladies, l'accès aux services de prévention et de traitement des maladies et les résultats avérés.

8. À moyen terme, remettre en place une Section Salubrité de l'environnement et créer un poste de Directeur de cette Section.

9. Veiller à ce que la CPS dispose des compétences et des capacités lui permettant de fournir des conseils techniques crédibles, notamment en matière de salubrité de l'environnement, de droit sanitaire, d'épidémiologie des maladies chroniques, de gestion des données et des connaissances, d'économie de la santé et de politique commerciale, pour contribuer à la prévention des problèmes de santé publique prioritaires. Veiller à la bonne intégration des spécificités des hommes et des femmes, et de la jeunesse, ainsi que des facteurs culturels dans toutes les activités du Département Santé publique.

10. Systématiquement renforcer une approche de la promotion de la santé fondée sur les faits observés dans toutes les activités du Département Santé publique.

11. Concevoir un système de suivi et d'évaluation systématique permettant d'apprécier l'efficacité de toutes les activités de santé publique de la CPS.

12. Étudier la faisabilité de fournir aux États et Territoires insulaires du Pacifique un système coordonné et intégré de surveillance des maladies transmissibles et non-transmissibles et des facteurs de risque communs. Le système de surveillance des facteurs de risque communs des MNT devrait être basé sur l'approche par étapes (approche STEPS) mise au point par l'OMS.

13. Soutenir activement le développement de la recherche médicale et appuyer la recherche dans les domaines prioritaires en collaboration avec le Conseil océanien de recherche en santé (*Pacific Health Research Council*), le Conseil néo-zélandais de recherche en santé (*Pacific Health Research Council*), l'Institut national australien de la Santé et de la Recherche médicale (*Australian National Health and Medical Research Council*), l'Institut de recherche pour le développement (IRD), et les établissements de formation en santé publique, ainsi que les organisations internationales d'aide au développement.

2.0 RECOMMENDATIONS

The review team recommends that SPC should:

1. strengthen its leadership, stewardship and advocacy roles in public health in the Pacific region by:
    - facilitating the identification of regional public health priority needs;
    - developing and implementing regional public health policies and strategies in partnership with other development partners and regional and international organisations;
    - revising the organisational structure to strengthen PHP within SPC (recommendation 7).
2. adopt a longer-term planning horizon, and develop a policy statement for its public health programmes, clearly identifying the strategic direction, priorities, expected outcomes, funding arrangements, roles and responsibilities, and relationships with other stakeholders. The policy statement would span 10–12 years and be implemented through a series of two- to three-year planning and budget cycles as per current practice.
3. adopt the following priorities and ensure the availability of additional resources and political support during 2006–2009:
    - building public health capacity;
    - preventing and controlling NCDs and major risk factors;
    - strengthening environmental health.
4. facilitate a process for building public health capacity and capability in PICTs in association with relevant training institutions, development partners and member states; and facilitate closer collaboration with the World Health Organization (WHO) and development partners working in human resources for health to ensure that public health capacity and skills are enhanced.
5. strengthen SPC's country presence and consider enhancing representation in (selected) PICTs or groups of PICTs to assist with planning, implementation and monitoring of all SPC activities, including PHP.
6. enhance PHP's communication links with PICTs at senior Ministry of Health (MOH) and implementation levels (inclusive of non-governmental organisations, NGOs) in addition to official communication channels.
7. strengthen PHP's status, focus, visibility and authority to provide regional leadership in public health by:
    - establishing a Division of Public Health in line with other SPC work programmes such as Land and Marine Resources;
    - creating a post of Director of Public Health to replace the current post of Manager, PHP;
    - establishing a post of Section Head for Healthy Pacific Lifestyles and ensuring an integrated approach through the inclusion of all activities related to tobacco, alcohol and misuse of other drugs, nutrition and physical activity and better alignment with the Human Development Programme. It is essential that this section receives adequate specialist support to address the wider

systemic determinants of chronic diseases. Particular attention should be given to reducing modifiable gender differences in the origins of these conditions, improving access to preventive and treatment services and maximising outcomes achieved.

8. re-establish an Environmental Health Section and create the post of Section Head for Environmental Health in the medium term
9. ensure that SPC has the necessary skills and competencies to provide credible technical advice for the prevention of priority public health problems, including environmental health, public health law, chronic disease epidemiology, data and knowledge management, health economics and trade policy; and ensure that gender, youth and cultural perspectives are well integrated into all PHP activities.
10. systematically strengthen the adoption of evidence-based health promotion approaches in all PHP activities.
11. develop a systematic monitoring and evaluation system to document the effectiveness of all SPC public health activities.
12. investigate the feasibility of providing a coordinated and integrated surveillance system for communicable diseases, NCDs and common risk factors for PICTs. Surveillance of NCD risk factors should build on the STEPwise approach to surveillance (STEPS) framework developed by WHO.
13. actively support the development of regional health research capacity and support research activities in priority areas, in collaboration with the Pacific Health Research Council, New Zealand Health Research Council, Australian National Health and Medical Research Council, WHO, French Institute for Research and Development, public health training institutions, and international aid and development agencies.

3.0 BUT ET OBJECTIFS DE L'ÉVALUATION

L'évaluation du Département Santé publique s'inscrit dans le programme d'évaluation ordinaire de la CPS et témoigne de l'engagement de l'Organisation à « mettre l'accent sur les résultats et la reddition de comptes », « viser l'excellence », « mettre l'accent sur la transparence des activités » pour améliorer le bien-être des peuples océaniens.

L'évaluation du Département Santé publique a pour but d'aider le Département Santé publique à élaborer :

- un programme de santé publique plus efficace répondant aux besoins et aux attentes des États et Territoires insulaires du Pacifique, et
- une structure opérationnelle qui guidera la gestion du Département au cours des cinq années à venir, conformément aux orientations de son plan stratégique et dans le respect des meilleures pratiques, et lui permettra de continuer à améliorer ses prestations de services en faveur des pays et de leurs populations.

Les principaux objectifs de l'évaluation sont les suivants :

a. apprécier l'efficacité des résultats et des prestations de services du Département Santé publique au cours des quatre dernières années,
b. évaluer et apprécier les priorités, objectifs, et résultats escomptés actuellement inscrits au plan stratégique pour la période allant de 2006 à 2009 à la lumières des besoins et des attentes des pays membres de la CPS et des partenaires dans le développement en matière de santé publique,

c. Sur la base des conclusions b) ci-dessus, recommander des modifications appropriées à l'actuel plan stratégique du Département Santé publique pour la période allant de 2006 à 2009, et
d. évaluer et recommander des modifications à apporter à la structure de gestion et d'administration du Département Santé publique pour lui donner les moyens d'atteindre les objectifs (révisés) inscrits à son plan stratégique.

3.0 PURPOSE AND OBJECTIVES

The review of PHP is part of the regular SPC programme of reviews and reflects the organisation's corporate commitment to an "emphasis on results and accountability" as a means of providing "excellence of service", and its "commitment to transparency of operations" in order to improve the well-being of Pacific Island people.

The purpose of the review is to assist PHP to develop:

- a more effective public health programme that reflects the needs and expectations of PICTs; and
- an operational framework to guide the management of PHP for the next five years in accordance with its Strategic Programme Plan in order to further improve the delivery of services to countries and communities according to best practice criteria.

The main objectives of the review are to:

a. gauge the effectiveness of PHP over the past four years in relation to performance and service delivery;
b. review and critique the current priorities, objectives and outputs as reflected in the Strategic Programme Plan 2006–2009 according to public health needs and expectations of SPC member countries and territories, and requirements of development partners;
c. as a result of (b) above, recommend changes to the current PHP Strategic Programme Plan 2006–2009 as appropriate;
d. assess and recommend changes to the PHP management and administrative structure in relation to its capacity to achieve (revised) Strategic Programme Plan outputs.

4.0 METHODOLOGY

The review was undertaken during August and September 2006. A three-member independent review team, supported by SPC planning personnel, consulted extensively with staff (Noumea- and Suva-based), and with a range of PICT representatives during the French Hospital Federation Meeting (28–30 August 2006) and the WHO Regional Committee Meeting held in Auckland, New Zealand (20–22 September 2006). Field visits were made to Fiji, New Caledonia, Samoa, Cook Islands, Solomon Islands and Marshall Islands and short reports of country visits are attached (Appendix 1). A list of the individuals consulted is attached as Appendix 2.

In preparing the report, the team reviewed a large number of documents generated by SPC, WHO, and government and donor agencies engaged in the provision of public health services in the region. The list of documents reviewed is attached as Appendix 3.

At the conclusion of the country visits, the team presented preliminary findings to an SPC Public Health Reference Group consisting of Heads of Health Services from most PICTs, representatives of regional and international organisations, NGOs and development agencies at a meeting held in

Noumea (11–13 October 2006). Feedback from the Reference Group has been incorporated into the draft report.

The review team acknowledges the professionalism of David Gowty, Tracey McMartin and Adeline Patissou in the planning and organisation of the review and their assistance with the country visits. Their assistance ensured that the review was completed effectively and efficiently.

5.0 BACKGROUND

The SPC region includes 22 PICTs, whose membership of other regional and international institutions varies considerably. Traditionally, island states are aggregated into three major indigenous groupings: Polynesia, Micronesia and Melanesia. These three groupings are characterised by distinct cultural, demographic and epidemiological features, as well as by their own particular health-care provision arrangements. The United Nations has designated five countries as least developed countries (LDCs): Kiribati, Samoa, Tuvalu, Vanuatu and Solomon Islands.

Remoteness from each other and from major trading partners, high transportation costs and scattered populations all raise the cost of services in PICTs. The communications infrastructure is improving but the cost remains high and air links to many places remain unreliable. Poverty and lack of critical mass to drive change are important features. The region is heavily dependent on foreign development aid; as a proportion of GNP, official development assistance ranges from 48 per cent in the Marshall Islands to 1.8 per cent in Fiji. The region is threatened by pollution due to poor waste management practices and people in some PICTs do not have access to safe water or basic sanitation facilities. Much morbidity and mortality result from lack of safe water and sanitation, especially in Melanesian and some Micronesian countries.

Until recently, the Pacific region was politically stable but instability is now common in many PICTs and security problems are causing concern. The situation is particularly problematic in Fiji and some other Melanesian countries. Increasing demands for a greater level of democracy in Tonga have created additional challenges at the political level there. Economic problems in Nauru have required political support from members of the Pacific Forum. At the same time, the adoption of the Pacific Plan provides a golden opportunity to achieve tangible outcomes for Pacific peoples through its implementation. Improvements in public health through health sector investment and development are important aspects of strategic objective 6 of the Pacific Plan. Furthermore, strategic objective 8 requires that improved gender equality is measured by the contributions from other objectives such as improved health, and improved education and training. The interwoven nature of these outcomes is part of the justification for recommending special expertise in this area in SPC if it takes on a lead role in the priority areas identified by the review.

5.1 Pacific Island populations

The population of Pacific Island countries and territories is estimated at 8.5 million, with 88 per cent of this population concentrated in the three Melanesian countries of Papua New Guinea, Fiji and Solomon Islands. Table 1 shows key population data for selected PICTs. In most PICTs, the majority of the population lives in rural areas. Provision of health care to rural residents is difficult and expensive, and rural areas suffer most from the shortage of HCWs. Most PICTs have high levels of population growth due mainly to high fertility rates. In some PICTs, such as Samoa, population growth has been contained by high levels of emigration. In other PICTs, such as the Cook Islands and Niue, emigration has resulted in significant population decline. Emigration has been described as a "safety valve" for many states that have high population growth along with limited natural resources and employment opportunities.

Overall, the situation in most PICTs is characterised by persistently high population growth rates, with the proportion of youth reaching sometimes more than 40 per cent of the total population. Low prospects for employment and erosion of traditional values and lifestyles have put new demands on governments for better services. These trends are also causing concern about possible social pressures for small island states and the need for appropriate policies in education, health and development.

Table 1: Populations of selected Pacific Island countries and territories

PICT	Mid-2006 population (thousands)	Population growth rate	Urban population (%)
American Samoa	67	2.0	91
Cook Islands	17	–1.3	68
Fiji	851	0.8	54
Kiribati	97	2.3	51
Marshall Islands	60	2.3	67
Micronesia (Federated States)	115	1.2	30
New Caledonia	246	1.9	62
Niue	2	–1.5	37
Palau	21	1.3	70
PNG	6,001	1.9	13
Samoa	186	0.9	22
Solomon Islands	490	2.4	17
Tonga	103	0.3	34
Tuvalu	10	0.4	58
Vanuatu	215	1.9	24
Total	***8,481***		

Source: United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) 2006

5.2 Socio-economic indicators

The economies of most PICTs are heavily dependent on aid and remittances; in some PICTs, remittances are more financially significant than development assistance and direct foreign investment. With the exception of a few PICTs, most island economies are stagnating or in decline. Disparities in economic development and welfare between PICTs and Pacific rim metropolitan countries have contributed to substantial migration and increased pressure for further international migration. Concern has been raised that remittances have been used mainly for consumption rather than for national development and investment.

5.3 Health indicators

Mortality indicators in Melanesian countries (PNG, Vanuatu and Solomon Islands) are the worst in the region; slightly better health indicators are reported from Polynesian countries. Data show considerable differences in life expectancy between PICTs and Australia and New Zealand. Average life expectancy at birth for those born in PICTs is 66 years for Pacific males and 69 years for females. These figures show life expectancy for males to be 11.5 years shorter than for males in Australia and New Zealand and 13.5 years lower for females. There was no improvement in life expectancy in Nauru from 1980 to 2000. Marked differences in life expectancies suggest that considerable improvement in the quality of life is not only desirable but

possible in many PICTs. Gender differences in health indicators suggest that more work needs to be done to improve gender inequalities in health in the region.

The infant mortality rate (IMR) is generally regarded as a reliable indicator of the socio-economic circumstances under which children live. It also reflects, in part, the availability and quality of health-care services. Mortality rates of children under five years of age are also commonly used as indicators. Decline in IMR and childhood mortality has been seen in all PICTs in recent years, except for reversals in trends in Nauru and Solomon Islands in the late 1990s. IMRs in the Pacific Island region vary widely, with rates in Melanesia and Micronesia worse than those reported from Polynesian countries. Table 2 shows life expectancy and mortality indicators from selected PICTs, along with comparison data from Australia and New Zealand.

Table 2: Basic health indicators in selected PICTs

PICT	Life expectancy at birth (males)	Life expectancy at birth (females)	Infant mortality rate (per 1000)	Mortality rate under age 5 years (per 1000)	Mortality rate under age 5 years #	Maternal mortality rate (per 1000)
American Samoa	69	76	15	–		
Cook Islands	68	74	17	–	21	
Fiji	66	71	20	25	20	75
Kiribati	61	67	44	–	65	
Marshall Islands	68	72	28		59	
Micronesia (Federated States)	67	68	35	44	23	
New Caledonia	70	78	7	9		10
Niue	69	71	29		36	
Palau	67	74	14		27	
PNG	56	57	66	91	93	300
Samoa	72	74	19	23	30	130
Solomon Islands	62	64	32	54	56	130
Tonga	71	74	20	23	25	
Tuvalu	62	65	35	–	51	
Vanuatu	68	72	30	36	40	130
Average for these Pacific Islands	66.4	70.5				
Australia	*78*	*83*	*5*	*6*	*5*	*8*
New Zealand	*76*	*81*	*6*	*7*	*6*	*7*

Source: UNESCAP 2006
Source: World Health Report 2006; these figures are provided to supplement the UNESCAP data.

5.4 Public health needs and priorities

Chronic diseases are the leading causes of death, disease and disability in the region. Major risk factors for chronic diseases, such as tobacco use, unhealthy diets and physical inactivity, are also rising in all PICTs. Injuries are becoming other major causes of death and disability.

Communicable diseases remain important causes of death and disease, resulting in a double burden of disease in some PICTs and representing the main causes of death in PNG and Solomon

Islands. The prevalence of tuberculosis (TB) is highest in PNG. A significant proportion of the morbidity and mortality associated with communicable diseases is due to gaps in environmental health services, including lack of universal access to safe water and basic sanitation, poor waste disposal and ineffective vector control. Moreover, the underlying determinants of poor health, such as income, employment and education levels, and lack of social cohesion, are being increasingly recognised as important factors that need attention.

Table 3 shows the major causes of death and selected diseases in PICTs.

Table 3: Selected major causes of death and disease prevalence in selected PICTs

PICT	NCD mortality per 100,000	YLL* due to communicable diseases (%)	YLL* due to NCDs (%)	YLL* due to injuries (%)	Deaths <5 years diarrhoea (%)	TB prevalence per 100,000
Cook Islands	616.2 (2002)	29.5 (2002)	57.1 (2002)	13.4 (2002)	0.7 (2000)	51.3 (2004)
Fiji	825.2 (2002)	27.1 (2002)	62.8 (2002)	10.1 (2002)	10.6 (2000)	40.8 (2004)
Kiribati	773.3 (2002)	44.9 (2002)	52.2 (2002)	2.8 (2002)	21.9 (2000)	58.9 (2004)
Marshall Islands	997.5 (2002)	30.6 (2002)	59.0 (2002)	10.4 (2002)	14.1 (2000)	58.9 (2004)
Micronesia (Federated States)	781.6 (2002)	40.4 (2002)	50.9 (2002)	8.7 (2002)	8.0 (2000)	58.9 (2004)
Nauru	1136.7 (2002)	19.4 (2002)	67.6 (2002)	13.0 (2002)	37.8 (2000)	34.9 (2004)
Niue	636.8 (2002)	32.7 (2002)	55.3 (2002)	12.0 (2002)	n/a	56.9 (2004)
Palau	774.3 (2002)	27.8 (2002)	62.5 (2002)	9.7 (2002)	9.7 (2000)	91.3 (2004)
PNG	814.9 (2002)	64.4 (2002)	24.7 (2002)	10.9 (2002)	15.3 (2000)	448.4 (2004)
Samoa	781.8 (2002)	31.3 (2002)	57.9 (2002)	10.8 (2002)	9.7 (2000)	42.6 (2004)
Solomon Islands	785.7 (2002)	49.2 (2002)	44.0 (2002)	6.8 (2002)	8.8 (2000)	58.9 (2004)
Tonga	683.9 (2002)	29.2 (2002)	61.8 (2002)	9.0 (2002)	10.0 (2000)	41.8 (2004)
Tuvalu	1045.8 (2002)	33.6 (2002)	55.5 (2002)	10.9 (2002)	13.9 (2000)	56.9 (2004)
Vanuatu	772.4 (2002)	39.3 (2002)	51.5 (2002)	9.3 (2002)	11.5 (2000)	64.3 (2004)

* YLL = Years of life lost

Source: WHO (year indicated in brackets)

Data from the SPC AIDS Section show that the cumulative HIV incidence rates were 143, 53 and 44.5 per 100,000 population in Melanesian, Micronesian and Polynesian PICTs, respectively. The highest rates were reported in PNG, New Caledonia, Guam and French Polynesia.

5.5 Health services funding and provision

Health-care systems in the Pacific Island region are biased towards curative services, which are expensive and rely heavily on the availability of skilled HCWs. Public health functions and preventive services are poorly funded and many PICTs fail to benefit from investments in population-wide interventions with proven benefit. For example, despite repeated political pledges to support health promotion and disease prevention, such as the Yanuca Declaration on Healthy Islands, most PICTs do not have effective health promotion capabilities. Prevailing problems due to chronic NCDs are strongly determined by low levels of physical activity and unhealthy diets, but most PICTs have not addressed NCD determinants and risk factors effectively. Furthermore, cost-effective interventions in primary care have not been adequately implemented. For example, giving aspirin to people with established heart disease has been shown to reduce the risk of subsequent heart attacks by up to 50 per cent, yet aspirin is not routinely used in the Pacific Island region.

It is clear that governments are the major funders of health services in the Pacific Island region, with only Samoa, Fiji and Vanuatu showing some contributions from the private sector. In Solomon Islands and Vanuatu, a large proportion of health resources is derived from external sources. The proportion of gross domestic product (GDP) spent on health care in PICTs is low by global standards and varies widely within the region. The three countries with the largest populations (Papua New Guinea, Fiji and Solomon Islands) spend proportionately lower amounts of GDP on health (3.4. 3.7 and 4.8 per cent, respectively) compared with other PICTs, Australia and New Zealand. PICTs in Micronesia and Polynesia generally spend a higher proportion of GDP on health compared with Melanesian PICTs, Cook Islands and Fiji. The proportion of GDP spent on health is an important consideration because low spending on health compromises health system performance and contributes to the problems of the shortage of HCWs. Given that the relatively poor economic environment of these PICTs is unlikely to improve, the financial limitations on health spending will remain a dominant factor affecting the health of populations in the region. However, better service planning linked to the budget process, monitoring and review, and the adoption of a sector-wide approach covering all aspects of human resource development (training; infrastructure; service delivery; institutional issues; data and information) should lead to improvements in many PICTs. SPC and other partners should encourage and support PICTs in these processes to get serious commitment to human development issues on national development agendas.

5.6 Regional and international agreements influencing public health

SPC PHP activities were, and continue to be, influenced by a number of significant international and regional developments during the period under review. The most important developments are outlined below.

i. SPC Corporate Review

An independent corporate review of SPC in 2005 found that it was close to achieving its vision of a "highly professional bilingual organisation working in partnership with other international and regional organisations and its donor partners to serve its island members". A number of recommendations were made that are relevant to the current PHP review and helped shape the recommendations of the review. These include recommendations that SPC should:

- play a greater leadership role in identifying and advocating for regional priority needs and in developing and implementing regional policies and strategies;
- strengthen planning, implementation and monitoring of SPC activities through country-specific engagement strategies;
- decentralise SPC services beyond the two main current locations;

- clarify and document the scope of SPC's role in human resource development in the Pacific;
- prioritise the development of the organisation's ability to monitor and document the impact and outcomes of SPC activities.

ii. SPC Community Health Programme Review
PHP was last reviewed in 2000 (when it was known as the Community Health Programme), which helped determine the strategic direction, priorities and organisational structure for 2003–2005. Many of the recommendations from that review were included in the subsequent PHP Strategic Programme Plan 2003–2005.

iii. United Nations Millennium Development Goals
The achievement of the United Nations MDGs is a central theme in the development agendas of all PICTs. Pacific Island leaders have made the prevention and control of NCDs an important component of goal 6 for the region. Achievement of health-related MDGs will continue to influence public health agendas in the region. It will determine the priorities for action at national level and help shape the regional agenda as well.

A progress report on the achievement of MDGs in 2004 showed variable progress in the Pacific Island region. In some sectors – in particular health – there was a real risk that some of the gains may be reversed. This threat poses a serious challenge for public health programmes within SPC and at country level. Gender is a factor in all MDGs and features specifically in four of them, three of which are health-related goals. Its inclusion affirms the global recognition of the importance of equality issues in development and of the important role that women play in both reproductive and productive processes in ensuring that these gains are not reversed.

iv. Pacific Plan
The Pacific Plan is an important policy statement for the region, agreed to by Pacific leaders in 2005. Its goal is to "enhance and stimulate economic growth, sustainable development, good governance and security for Pacific countries through regionalism".

Strategic objective 6 (improved health) seeks to harmonise approaches in the health sector under the Samoa Commitment. Achieving this objective includes implementing the Pacific Regional Strategy on HIV/AIDS; focusing more strongly on noncommunicable diseases; and establishing an agreement on health worker recruitment. The Pacific Plan includes a wide range of public health priorities for action, including specific gender expectations in strategic objective 8. It notes the need to improve harmonisation of all development aid, and of public health activities in the region by regional and international organisations.

v. A Health Strategy for the Pacific and the Pacific Health Fund
SPC has been given the mandate to coordinate discussions with development agencies and regional and international organisations on the need for the Pacific Health Fund, and the manner in which it could contribute to improving public health in the region. The fund is part of wider discussions on public health, as it is only the funding mechanism of a Health Strategy for the Pacific. The strategy would not only identify the public health priorities for the region, but also enable clarification of the roles of various organisations involved in public health. Development of the Health Strategy for the Pacific and the Pacific Health Fund is an opportunity to ensure that planning, funding and delivery of public health programmes in the region are better coordinated and aligned with the priorities of PICTs.

vi. Rome and Paris Declarations on Aid Effectiveness
Donor agencies will continue to play influential roles in policy development, priority setting and provision of public health services, and in training and education of health-care workers in the Pacific Island region. However, it is important that all donor activities are coordinated, harmonised and communicated in a systematic manner and are designed to support priority public

health needs, interventions and expectations identified by PICTs. Implementing the relevant expectations of the Rome Declaration on Aid Harmonisation and the Paris Declaration on Aid Effectiveness in the region is a promising avenue for improving coordination and harmonisation of all activities, and aligning the plans and activities of regional and international organisations with those of PICTs.

SPC has an important role to play in coordinating donor support and ensuring that duplication of effort is avoided and limited development resources are utilised effectively. The role of SPC in facilitating and coordinating the development of the Pacific Regional Strategy on HIV/AIDS is a good model for the coordination role that SPC could play in other public health programmes. The revised Pacific Platform for Action (PPA) on Advancement of Women and Gender Equality 2005–2015, "A Regional Charter", reflects gender equality in health for the region, and the SPC Women's Bureau plays a key role in coordinating this process. In terms of international commitments, 2008 will see a donor focus on international financing for gender equality, and SPC needs to be positioned to take advantage of this in relation to national and regional development frameworks that are about improving longer-term, sustainable health outcomes for all Pacific Island people.

6.0 SPC PUBLIC HEALTH PROGRAMME

PHP is a component of the Social Resources Division within SPC. The mission of the Social Resources Division is:

> *To maximise the development potential of Pacific Island people in health, culture and information and enhance the empowerment of women and young people.*

The PHP Strategic Programme Plan 2003–2005 provided detailed planned activities and expected outputs for all SPC public health activities. Achieving the health-related United Nations MDGs is a key objective of the SPC Corporate Plan and the PHP Strategic Programme Plan for the Pacific Island region.

The primary aims of PHP are to promote healthy lifestyles and to improve and protect the health of Pacific Island populations and communities. The ability to improve population health and prevent illness is already influenced by a number of regional and international organisations and agreements, in addition to existing national health plans and strategies. International aid and development agencies have also been extremely influential with regard to funding decisions in the region in view of the significant support received by SPC and health sectors in some PICTs.

Public health priorities identified in the SPC Corporate Plan and the PHP Strategic Programme Plan 2003–2005 are:

- environmental health
- NCD prevention
- HIV/AIDS and STIs
- surveillance and control of priority communicable diseases
- identification of core national and SPC public health capacities

In order to coordinate its work for the purpose of achieving its objectives, PHP operated two (virtual) functional units, each comprising a number of sections, as identified below. The current structure of PHP generally still reflects the public health priorities identified in the previous (2003–2005) PHP Strategic Programme Plan.

Health protection

- Public health surveillance and communicable disease control

- Tuberculosis control
- HIV/AIDS and STI control
- Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)

Health promotion

- Healthy Pacific Lifestyles (alcohol and tobacco control, promotion of physical activity and nutrition)
- Adolescent Health and Development – Suva (previously known as Adolescent Reproductive Health)

7.0 REVIEW FINDINGS

7.1 Performance and service delivery

In assessing the effectiveness of PHP over the past four years, progress can be measured against the PHP Strategic Programme Plan 2003–2005, with its stated goal of 'Healthier Pacific Island communities'. To attain this goal, PHP had two broad objectives:

1. strengthened public health capacity in PICTs; and
2. enhanced public health action at the regional level.

Performance in attaining these goals and the related objectives was difficult to assess as progress varied at country level, with lack of substantive information on which to base an objective response. This shortage of information was recognised in the Pacific Islands regional MDG report (2004), which highlighted "... the need for more accurate, relevant and up-to-date data and particularly time-series data from which trends can be derived". Notwithstanding these data limits, the report illustrated significant variation in progress over time within individual PICTs and between PICTs on the health indicators assessed. Furthermore, anecdotal reports provided to the review team by in-country representatives repeatedly suggested that health status was improving in some areas yet declining in others as a result of a range of factors, some within the health sector (e.g. workforce) and others outside (e.g. erosion of traditional value systems and trade impacts). Better policy development, budgeting, monitoring and effective multi-sectoral approaches in addressing public health problems are needed.

SPC's own performance during the 2003–2005 period received mixed responses. Staff in PICTs that are involved in SPC public health projects reported favourably on their relationships with SPC technical staff. However, at the political and management leadership levels, the responses were mixed. Several country representatives reported a lack of SPC presence in country and failure to "market" their services effectively to some member states. A common response was "SPC needs to inform us what they can and cannot do". Inevitably, SPC is compared to WHO in terms of the availability and quality of technical support provided to member states. Many member states reported that WHO is their preferred technical agency for public health, mainly because of its presence in country and availability of country budgets, with WHO and the member state jointly developing and agreeing on a work plan reflecting country priorities prior to implementation. There have been no such opportunities with SPC, whose support is perceived to be ad hoc and lacking a structure and framework for ongoing interactions. Most member countries and territories had not been informed of the PHP Strategic Programme Plan 2006–2009 prior to its finalisation, and reportedly would have wanted to contribute to the plan during its development.

7.1.1 Priority areas

While PHP work incorporates a range of public health fields, particularly public health policy and communicable and noncommunicable diseases, a subset of key priorities was listed in the Strategic Programme Plan 2003–2005, as outlined above.

In broad terms, progress in addressing these priorities during this period was variable within SPC (PHP) and at the country level. SPC was able to secure funding for some activities, such as HIV/AIDS and STIs and PRIPPP, which enabled good progress to be made. Other priority areas – including NCD prevention and control, and human resources for health – could not be progressed due to lack of resources and commitment from development partners and PICTs, despite the Tonga and Samoa recommendations. It appeared that programmes that were funded were consistent with international community and donor priorities. However, some priority programmes failed to attract the necessary funding, even though these priorities caused a much greater burden of disease in the region. Moreover, the well-funded programmes distort public health priorities in PICTs, especially in small island states where public health capacity is limited.

A better balance and a programmatic approach to the work to be undertaken are needed in the region to ensure that regional and country needs are correctly prioritised and that sufficient resources are received to implement programmes that address them. Application of more reliable tools and priority-setting methods and criteria in regard to risk assessment detection, prevention and management may establish a different set of priorities in the region. Opportunities for truly effective multi-sectoral programmes for health improvement exist in all PICTs and should form an integral component of the public health approach in the region.

i. Environmental health

Despite the establishment of an environmental health position within PHP, only limited progress was made in this priority area. The main reason for the limited progress was the inability of SPC and the structure of this programme to attract additional development partner funds to address these issues.

Environmental health challenges are significant in the Pacific Island region, given the fragile nature of small islands, rapid population growth in some PICTs and limited public health capacity in many PICTs. Some PICTs lack basic public health services and high levels of morbidity and mortality result from the lack of clean water, basic sanitation and waste disposal. Several Pacific regional organisations, such as the Pacific Islands Applied Geoscience Commission (SOPAC) and South Pacific Regional Environmental Programme (SPREP), and global ones such as WHO, are involved in the provision of environmental health and conservation in the region, but most, including SPC, have not adequately addressed basic environmental health needs in some PICTs. Provision of safe water, basic sanitation and waste disposal is a fundamental public health requirement that should be met in all PICTs. SPC has a central role in coordinating this process.

ii. NCD prevention, including an enhanced focus on major risk factors such as tobacco and physical activity

This work was a core responsibility of the Healthy Lifestyle advisers and the Pacific Action for Health project (now renamed the Healthy Pacific Lifestyles Section). Considerable work was undertaken in enhancing integrated and systematic approaches to NCD prevention, with the development of NCD strategies addressing the four key risk factors (alcohol, nutrition, physical activity and tobacco) and national plans of action on nutrition being updated in many PICTs. All eligible PICTs have signed the Framework Convention on Tobacco Control (FCTC), with nine countries ratifying, and an increasing number have adopted comprehensive tobacco-control actions. As a result of the internal reviews undertaken, a new position of Physical Activity Adviser was created within SPC in 2005 and preliminary work to establish a framework for effective action on alcohol involving a great diversity of partners was completed. SPC also played a central role in assisting Tonga and Kiribati in working towards the development of sustainable funding sources to establish Health Promotion Foundations (drawing on tobacco and/or alcohol excise). However, the impact of these interventions on NCD prevalence in the region is not yet established and a lot more needs to be done to address the issues in an effective, sustainable way.

Adolescent Reproductive Health (now renamed Adolescent Health and Development) established good relationships with country staff in eight PICTs. Interviews with staff in country showed good progress on the implementation of reproductive health information and advocacy in those PICTs. However, the project needs to be better integrated with other PHP activities (HIV and Healthy Pacific Lifestyles) and those of the SPC Human Development Programme through joint work plans and activities addressing all relevant adolescent health issues.

iii. HIV/AIDS

The HIV/AIDS and STI Section was re-established in 2003 and embarked on developing a new Pacific Regional Strategy on HIV/AIDS 2004–2008. The strategy was endorsed by Pacific leaders in 2004 and the pace of its implementation has progressively increased. The HIV/AIDS strategy provides a useful model for development partner collaboration, with funding inputs derived from a range of sources (Asian Development Bank, Australia, France, GFATM, New Zealand). Some other key areas of action undertaken by SPC, in addition to the development and management of the strategy, include: assisting Kiribati, Marshall Islands, Solomon Islands and Tuvalu to update/develop national HIV/AIDS strategic plans; providing technical support; training in and applying behaviour change communication (BCC); supporting a regional treatment and care programme for practitioners and people living with HIV/AIDS from five PICTs; strengthening surveillance systems for HIV/AIDS and STIs and conducting a second-generation surveillance survey in six PICTs; and providing input to the development of voluntary confidential counselling and testing procedures.

A mid-term review of the Pacific Regional Strategy on HIV/AIDS was recently completed. The review found good progress had been made in the level of political leadership and coordination of HIV/AIDS activities in the region, but several areas needed further improvement; for example, action on STIs was poor in most PICTs. The review team also noted that the activities of the Adolescent Health and Development Section have successfully augmented some HIV/AIDS and STI activities, while also covering a broader scope inclusive of youth life skills and family support.

iv. Surveillance and control of priority communicable diseases

Two sections within PHP involved with surveillance and control of priority communicable diseases are Communicable Disease/Surveillance and Tuberculosis. The Pacific Public Health Surveillance Network (PPHSN) has continued to expand its role as the lead agency in surveillance by strengthening field epidemiology and outbreak response capability. This work has included strengthening the two initiatives to establish and maintain effective case detection (LabNet) and outbreak response (EpiNet), in addition to the PacNet information system. Feedback to the review team indicated that this network was highly regarded and valued by PICTs.

The TB Section has consolidated its functions in conjunction with WHO and the United States Centers for Disease Control and Prevention (CDC) in implementing the Directly Observed Treatment – Short Course (DOTS) strategy on a regional basis. SPC has also played a central role in enhancing and coordinating TB surveillance and reporting. Additionally, collaboration across sections in areas such as surveillance of TB–HIV co-infection has expanded. In relation to emerging diseases, the severe acute respiratory syndrome (SARS) outbreak, potential for a Pacific regional influenza pandemic, and adoption of the International Health Regulations (IHR) have resulted in SPC fast-tracking assistance to PICTs to enhance emergency preparedness and response systems at country and regional levels, in conjunction with its partners.

v. Identification of core public health capacities

The review team found that during the period 2003–2005, SPC had made no progress on identifying its core public health functions (capacities) as expected in the PHP Strategic Programme Plan. This is a significant omission given the limited capacity of most PICTs to

provide essential public health functions. This project would have helped PICTs to better define priority public health functions and to build capacity within individual countries and territories. PICTs need to build strong public health capacity if public health programmes are to be implemented effectively at national and regional levels.

7.1.2 Progress against objectives

The Strategic Programme Plan 2003–2005 identified several key outputs for each of the objectives. These are briefly described below.

Objective 1: Strengthened public health capacity in PICTs
Indicator: Clear improvements in at least three significant capacities against agreed capacity inventory.
Progress: As no baseline measure of capacity was completed, there are no objective measures to assess overall completion. Training provided by SPC on a range of public health topics partly contributes to strengthening capacity, but the information was not collected in a systematic way. However, feedback from PICTs suggests that this objective was not achieved. In view of the capacity limitations within many PICTs, there is a desire to make progress on building public health capacity in the region, building on the WHO experience (Output 1.1) and working with development partners and regional training institutions.

Output 1.1: Set of essential public health capacities agreed and consequent capacity gaps in PICTs identified
Indicators: PICT agreement to a set of essential national capacities and completion of national assessments. PICT agreement to identify national capacity gaps and essential PHP capacities.
Progress: SPC participated in a WHO forum that resulted in PICTs agreeing on establishing capacities for the Pacific Island region (December 2003). However, action beyond this meeting was delayed, with WHO subsequently piloting assessments of public health capacity in two PICTs in early 2006. Consequently, none of the indicators has been achieved. While not specifically identifying all essential public health capacities, SPC continues to play an integral part at the country level in assessing core capacities relating to the International Health Regulations. In addition, GFATM funded national laboratory capacity assessments in six PICTs plus capacity assessments for two Level 2 laboratories in the region.

Output 1.2: Higher-skilled health workforce
Indicator: Number of people trained in priority areas in PICTs.
Progress: There have been a considerable number of country-level training initiatives leading to observable improvements in surveillance capacity and laboratory skills through PPHSN, TB, HIV/AIDS and GFATM initiatives. These actions have been complemented by further upskilling of staff in clinical case management for TB, HIV/AIDS and STIs. Additionally, workforce training sessions in BCC for HIV/AIDS and STIs, and broad NCD (alcohol, nutrition, physical activity and tobacco) initiatives have expanded skill sets. Regrettably, the development of skills in the workforce is countered by a number of factors, not the least being migration of skilled health professionals.

Output 1.3: More comprehensive, timely and accessible information
Indicator: At least three relevant new topics (including environmental health, tobacco and physical activity) covered by information that PHP generates or distributes.
Progress: A comprehensive approach to addressing environmental health did not eventuate over this period. In relation to tobacco and alcohol, SPC played a leading role in coordinating the compilation and distribution of information to defer the decision to include alcohol and tobacco in the Pacific Island Countries Trade Agreement (PICTA). This decision would have removed excise taxes from these products, potentially increasing consumption. A new physical activity position was established and a manual and training on promoting physical activity in Pacific communities were completed. Other new developments over this period included: new and

innovative distribution lists for HIV/AIDS (AIDSTOK) and GFATM (Country Coordinating Mechanism – HIV/AIDS, malaria and TB); a substantive role in establishing the Pacific chapter of the Global Alcohol Policy Alliance list server; and a new information platform in conjunction with the Pacific Regional Information System (PRISM) project (SPC Statistics Programme), allowing access to key health data for TB at the country level.

Output 1.4: Improved policy and legislative frameworks
Indicator: At least four new pieces of legislation enacted, or significant plans and policies developed and implemented, that incorporate PHP advice.
Progress: Most national youth policies now feature adolescent reproductive health issues. All eligible countries have signed FCTC and nine have ratified, with legislative amendments relating to tobacco completed in some countries (e.g. Fiji, Tonga). Finally, reviews of alcohol and/or tobacco legislation have been completed or are underway in several PICTs (e.g. Kiribati, Tonga and Vanuatu).

Objective 2: Enhanced public health action at the regional level
Indicator: At least two new or expanded regional initiatives that successfully address priority public health issues.
Progress: Five new actions include the development of: the Pacific Regional Strategy on HIV/AIDS 2004–2008, LabNet and EpiNet, preparedness plans for SARS and pandemic influenza, GFATM and physical activity. Expanded actions include extension of the adolescent reproductive health project and upgraded inputs in respect to TB prevention in high-risk PICTs (e.g. Kiribati).

Output 2.1: Increased public health response capacity
Indicators: LabNet (case detection) and EpiNet (outbreak response) set up and operational.
Progress: Both LabNet and EpiNet were strengthened to support response capacity. Surveillance systems and response capacity to address HIV/AIDS, STIs and TB were developed and/or substantially improved, and regional procurement mechanisms for HIV/AIDS medications were established.

Output 2.2: Regional-level research undertaken
Indicators: Research to establish TB prevalence in PICTs and essential public health capacities and capacity gaps undertaken (see also Output 1.1). Subject to resources becoming available, at least two regional research projects completed in HIV/STI and environmental health.
Progress: HIV–TB co-infection was assessed for the first time in the Pacific Island region in 2006 but, as previously indicated, SPC did not assess essential public health capacities. Research was completed on the burden of disease from tobacco in Fiji and on the economic costs associated with in-patient admissions for NCDs in Kiribati, Tonga and Vanuatu. Second-generation surveillance on HIV/AIDS and STIs in high-risk populations was completed in six PICTs in 2005. Although no environmental health research was undertaken on core issues relating to water, sanitation and waste, the Communicable Disease Section did complete an assessment of the impact of leptospirosis on PICTs.

Output 2.3: Stronger and/or more sustained partnerships with PICTs and international and regional organisations
Indicators: At least two new or expanded partnerships operating successfully, PICTs increase contributions to partnerships and a Memorandum of Understanding signed with New Caledonia.
Progress: Expanded partnerships were illustrated through the formation of the Country Coordinating Mechanism overseeing GFATM, development of a conjoint TB information system and joint approaches in 2006 with the United States CDC and WHO. Senior parliamentarians were represented on national HIV/AIDS committees and agreed to the Suva Declaration on HIV/AIDS at a regional level. No progress was made in developing a Memorandum of Understanding with New Caledonia, but letters were exchanged in 2006.

Output 2.4: Policy frameworks developed for SPC region
Indicator: Development of regional policies targeting priority public health issues, including the environmental health initiative, HIV/STI and likely tobacco control.
Progress: The Pacific Regional Strategy on HIV/AIDS 2004–2008 was developed and endorsed and implementation commenced. Agreement was reached with the Pacific Trade Ministers to defer the inclusion of alcohol and tobacco in PICTA. A regional strategic framework was developed for PPHSN, and DOTS was endorsed as the regional tool to be used for TB control. As indicated above, while a formative meeting to examine the potential for a regional environmental health framework was convened by SPC, no further progress was made. In all of the above, gender dimensions are being highlighted in one way or another as a result of a lack of suitable data.

Highlights throughout the triennium include: development and implementation of the Pacific Regional Strategy on HIV/AIDS 2004–2008; implementation of GFATM; strengthening of PPHSN, especially LabNet (network of public health laboratories to diagnose outbreaks) and EpiNet (network of "virtual" multidisciplinary outbreak response teams); expansion of the Adolescent Reproductive Health programme; ratification of FCTC; and the development and implementation of national NCD strategies in several PICTs.

7.1.3 Public health needs of member states and sustainability

SPC currently uses a variety of mechanisms in working with member states to ascertain needs. At a macro level, there is input into the biennial Meeting of Pacific Health Ministers and collaboration to meet international obligations and/or approaches, such as IHR, DOTS and FCTC. At the level of PHP sections, there are frequent interactions with counterparts in member states to identify needs and integrate actions into national health plans. More recently, SPC has provided assistance to the in-country MDG Taskforce in Tuvalu and for the development of a joint country strategy (JCS) in Kiribati. Both these activities support key health targets identified in national plans. It is regrettable that the planned assessment of core public health capacities at the country level, as identified in the PHP Strategic Programme Plan 2003–2005, did not eventuate, as this would have assisted PICTs in systematically identifying their priority needs. The evolution of JCS is an opportunity to improve coordination within SPC and with partners, and to increase the visibility of SPC's presence in PICTs.

In some instances, the regional priorities funded appear to be predominantly driven by development partner priorities and the availability of funding, rather than by PICT or SPC priorities. For example, environmental health, NCDs and mental health have been repeatedly identified as high-priority needs, yet resources to address these issues are insufficient for a consolidated response. Consequently, there appears to be a degree of mismatch in the sustainability of programmes that meet direct country-level needs. SPC needs to take a stronger leadership role in advocating for resources to address the priority health needs identified by its members. It should also take a greater role in coordinating identification of regional priorities and harmonising contributions from development agencies and other stakeholders to the development of public health policy and strategies in the region. Moreover, there is universal agreement from PICTs and within SPC that further strengthening and localisation of action at the country level is vital to address the array of public health issues that require attention. Many of these issues are reflected in the updated PHP Strategic Programme Plan 2006–2009. SPC has a central role in providing technical support to PICTs as well as in leading and coordinating approaches to public health threats that are best managed at regional level.

The coordination and delivery of PHP activities by SPC are constrained by several issues, not the least being workforce capacity at the country level. The pressure on workforce capacity was consistently identified by PICTs as a major barrier. While there is much debate around the issues underpinning workforce capacity, the solutions are far less obvious. Although SPC provides

considerable training of staff in the region, if the number and mix of professional staff at a country level are inadequate, the benefits derived from training will not be commensurate with the inputs. Workforce capacity will remain a crucial issue. SPC needs to work with larger players in this area (specifically WHO and other development partners) to ensure it enhances positive developments in capacity by supporting and adopting mechanisms that may be evolving to address this issue. However, the approach taken by SPC to training and capacity building in public health is criticised as being ad hoc and lacking structure. Staff from PICTs are often invited to SPC workshops and training sessions without an underlying framework to guide the longer-term expectations and expected outcomes. Coordination across sections within PHP and with other SPC sections, such as culture, women and youth, continues to improve. However, further progress in this area is required to ensure that SPC optimises its return on investment, and does not duplicate existing initiatives or exacerbate pressure on local staff.

Community and government networks in the areas of gender, youth and culture often overlap. Governments frequently use the same focal point; many of the reporting and monitoring procedures cover the same data and information; and there are common information gaps. The role of the Statistics and Demography Programme is critical, but often these perspectives are not mainstreamed into sector planning.

7.2 PHP strategic directions (2006–2009 priorities, objectives and outputs)

The PHP Strategic Programme Plan 2006–2009 provides the direction and priorities for PHP activities for the next four years. The plan generally outlines continuation of many of the activities from 2003–2005 based on the resources available at the time of its development, rather than addressing the priority public health needs of PICTs. The proposed priorities are: improved information and evidence for decision-making; HIV/AIDS and TB; NCD prevention across all four key risk factors – alcohol, nutrition, physical activity and tobacco; and emergency preparedness and response.

7.2.1 Revised strategic directions

After a review of the PHP Strategic Programme Plan and consultation with stakeholders, the review team proposes a revision of the proposed PHP objectives, priorities and expected outputs for 2006–2009. The revised objectives are to:

1. enhance public health systems in PICTs, including management and infrastructure;
2. contribute to the prevention, control and management of priority communicable and noncommunicable diseases

Promoting and protecting population health and preventing illness and injury are likely to receive greater regional recognition in future as both governments and donor agencies recognise the importance of investing in health as part of national development agendas. Failing to act to improve population health has clear implications for Pacific governments, individuals, families and communities and for development agencies. For Pacific governments, the social and economic costs of treating and caring for people with poor health will not be sustainable. For individuals and their families, poor health is a barrier to employment, and both a major cause and major consequence of poverty. For development agencies, improving aid effectiveness and increased transparency and accountability in using donor resources will remain important considerations.

7.2.2 SPC roles

Within its current mandate, SPC should assume a greater leadership and facilitation role and increase its influence on public health policy and strategic developments in the region. It is ideally placed to be a major regional public health agency, and to lead efforts to improve population health, reduce inequalities in health between and within PICTs, and contribute to each national development agenda. It demonstrated during the development of the Pacific Regional

Strategy on HIV/AIDS that it can play a vital role in coordinating the activities of development partners, international organisations and NGOs. It needs to develop this role further and seek to influence the development of all regional public health policies, advocate on behalf of PICTs in international forums, and moderate discussions with development partners to ensure that appropriate public health priorities are resourced in the region. However, it must also preserve its fundamental role of supporting member countries and territories and align its priorities with those of PICTs. It should also facilitate harmonisation of the public health activities of all development partners and regional and international organisations in the region, as envisaged in strategic objective 6 of the Pacific Plan.

Appropriate roles and responsibilities in public health for SPC may include:

- providing regional leadership and stewardship for public health;
- coordinating and harmonising regional public health activities;
- developing and providing ethical, evidence-based policies;
- collecting, collating, managing and disseminating information;
- providing technical support through capacity building, capacity supplementation and transboundary functions;
- implementing and evaluating public health programmes.

SPC should also bring to the attention of all stakeholders health issues specific to vulnerable and marginalised groups (women, youth, young men), such as reproductive cancers, abortion, and access to emergency reproductive health services. There is a need to develop a pathway to deal with issues around special situations such as mental health, making links with rape, domestic violence, child abuse, and cultural practices, by facilitating appropriate research and policy development.

7.2.3 Greater leadership role in public health in the region

The SPC Corporate Review 2005 recommended that the organisation take a stronger and more open role in regard to policy and leadership in all the sectors in which it is involved in the region. We agree with this recommendation. SPC is well placed to assume greater leadership in the development of public health policies and strategies for the region. It has a track record of successful implementation of public health programmes and the advantage of being the only regional organisation with a clear mandate to act across the entire public health spectrum. Furthermore, SPC has technical expertise in many areas that could be applied to the prevention and control of several other public health problems, such as surveillance of public health risks and development of regional strategies.

SPC can and should assume a central leadership, facilitation and stewardship role in public health consistent with its core functions. In this regard, its relationship with international and other regional organisations involved in public health should be clarified. The relationship between SPC and WHO is particularly important, and their Memorandum of Understanding should be revised following the endorsement of the Regional Health Strategy for the Pacific (currently being developed). Better clarification of roles would be beneficial for both organisations.

7.2.4 Revised public health priorities (2006–2009)

Based on the review of the PHP Strategic Programme Plan 2003–2005, the current and future burden of death, disease and disability, underlying determinants of health, projected population growth, and the capacity and performance of health systems in the region, the priorities of the latest (2006–2009) plan must be modified. Furthermore, in view of the limited public health capacity of PICTs and the resource limitations of both PICTs and SPC, it is essential that the organisation focuses on a few priority areas and ensures optimal impact from its investments. Working closely with partner agencies will enhance the effectiveness of its public health programmes. It must align its priorities with those of PICTs and ensure effective implementation of stated priorities.

SPC should tailor its assistance to member countries and territories based on prevailing public health problems in each PICT and adopt multi-country approaches based on common needs, where required – for example, malaria control in PNG, Vanuatu and Solomon Islands, and access to clean water and sanitation in Tuvalu, Kiribati, Marshall Islands and Fiji. There should be clarity on which public health activities are best provided at regional level and which at national level.

Therefore, the review team proposes that SPC categorise its PHP priorities into three areas:

i. Areas for further development and increased funding
ii. Areas for consolidation
iii. Areas for advocacy

i. Areas for development and increased funding

The following priorities should be further developed and should receive additional funding and political support during 2006–2009:

- NCD and risk factor prevention and control (including surveillance)
- Environmental health
- Public health capacity building

Prevention and control of NCDs and major risk factors

NCDs and their major risk factors are the leading causes of death and disability in the region. Despite various political commitments that have been made, the incidence of these conditions continues to escalate rapidly in all PICTs. Failure to act decisively will result in major social and economic costs to individuals, families and communities and pose considerable barriers to development in the region.

The level of investment in NCD prevention and control should be commensurate with the level of risk posed by NCDs and their major risk factors in the region. Future NCD prevention and control activities should focus on supporting PICTs to develop and implement realistic national policies, plans and programmes and on addressing underlying structural issues such as trade, marketing and advertising of processed foods. Transport policy options, urban planning and programmes to promote increased levels of physical activity in Pacific populations are important. Implementing such initiatives requires better information and education across all sectors, giving attention to the critical role of women in social, recreational and cultural arenas in the region. Better surveillance of NCD risk factors is urgently needed, perhaps as part of an integrated surveillance system building on the experience of PPHSN and subject to the needs and experiences of PICTs. The WHO STEPS framework is in use in all PICTs. SPC, in association with the Fiji School of Medicine (FSM), should take the main responsibility for providing technical support for WHO's leadership in the region. The planned work programme for the Healthy Pacific Lifestyles Section provides direction and priority actions for the prevention and control of NCDs and common risk factors.

Environmental health

Environmental health was identified as a priority for SPC in the PHP Strategic Programme Plan 2003–2005, but no progress was made in this area. Several PICTs have failed to provide access to clean water and basic sanitation for their citizens, and disposal of waste is becoming a major challenge in many small island states. Lack of basic sanitation is the underlying cause of significant morbidity and mortality in some PICTs. Core elements of goal 7 of the MDGs, to ensure environmental sustainability, include access to safe water, improved sanitation and environmental management to enhance vector control. SPC should ensure that measurable progress is made in the provision of clean water and basic sanitation in priority PICTs within the next five years. Current re-organisation of agencies in the Council of Regional Organisations in the Pacific (CROP) provides an opportunity to strengthen activities in environmental health at

regional, subregional and national levels. SPC is well placed to coordinate these activities, but it will need additional resources for this purpose.

Public health capacity building in PICTs
Improved information and evidence for decision-making are essential requirements for the provision of effective programmes in NCD prevention and control, environmental health and other priority public health programmes in the region. Furthermore, strengthened public health capacity in PICTs was identified in the previous PHP Strategic Programme Plan, although no effective action towards it was taken. SPC needs to secure adequate resources and substantially increase investment in public health capacity in the region. Training a suitable public health workforce, promoting a regional research agenda, and investing in the public health infrastructure are important aspects of building capacity in PICTs. Human resource development activities at SPC need to be captured accurately and reported as a consolidated contribution to capacity building in public health. Consideration should also be given to establishing a database of experts in the Pacific Island region who are available to provide technical support to member countries and territories. As part of human resource development, an SPC fellowship programme could be designed and implemented to enable short-term attachments of public health staff to various SPC programmes or similar institutions in the Pacific rim. The experience of the Statistics and Demography Programme could greatly assist in this development.

ii. Areas for consolidation
The range and complexity of public health problems in the region are such that the sum total of public health investment by all agencies is not meeting regional needs. The public health activities of all international and regional organisations are yet to make a positive impact on the health of Pacific Island populations. Public health functions, including health promotion and disease prevention, are weak and poorly funded in most jurisdictions. Furthermore, some strategically important SPC public health programmes recently started without the full complement of staff, which has delayed their full implementation and consequently has made it difficult to judge their impact. Therefore, the review team recommends a period of consolidation of some public health programmes, such as the implementation of the Pacific Regional Strategy on HIV/AIDS, PRIPPP and the TB-DOTS programme. Aspects of the TB control programme may require additional resources. Adolescent Health and Development needs to include suicide prevention and to better integrate its activities with those of SPC's Pacific Youth Bureau and other PHP sections such as Healthy Pacific Lifestyles and HIV/AIDS and STIs.

However, it is important for SPC to contribute effectively to regional and international emergency preparedness and response activities, and to provide support for PICTs as needed. For example, SPC can assist with the development of policy and legislative options for PICTs in association with WHO. Implementation of the requirements of the International Health Regulations, as addressed in PRIPPP, is another important activity.

iii. Areas for advocacy
SPC's limited capacity and expertise in certain areas, and uncertain funding streams, mean that it will not be able to provide services in all the areas of public health requested by member countries and territories. A recurring theme is the provision of mental health services, including suicide prevention programmes. SPC should advocate for improved provision of mental health services in the region by appropriate agencies and integrate mental health issues into its current programmes as far as possible. However, in view of the complexity of mental health issues and lack of existing capability within SPC, active involvement by SPC in mental health is not recommended at this time.

Improving maternal and child health is essential for achieving the MDGs. SPC's appropriate role is to work closely with WHO, the United Nations Children's Fund (UNICEF) and other agencies to ensure progress is made.

7.3 PHP programme management and capacity

7.3.1 Funding and planning

The nature of funding for organisations such as SPC makes long-term planning difficult. This situation is particularly problematic for PHP where outcomes from health promotion and disease prevention investments take a long time, often decades, to materialise. While the overall funding arrangements for SPC are subject to several factors beyond the control of the organisation, the review team is of the view that a longer-term planning and funding horizon would be beneficial for effective implementation of its public health programmes in the Pacific Island region. Adopting a longer-term planning and funding horizon for PHP would also signal the direction and priorities of SPC, give guidance to donor agencies and partners, and reduce the incidence of "stop–start" programmes, some of which have been evident in SPC in recent years.

A long-term (strategic) SPC PHP policy statement, say over 10–12 years, supported by a three-year (operational) public health programme and budget plan, would provide the stability and focus required for effective implementation of public health programmes in the region. This would in turn provide a platform from which to approach donors for longer-term contributions based on identified priorities agreed among SPC, member PICTs, development partners, international and regional organisations, and civil society groups.

7.3.2 PHP management and resources

PHP has grown significantly recently and is expected to grow substantially more in the next few years. Management capacity, however, has not grown to reflect this. On the contrary, the core budgetary allocation for management was reduced from USD266,700 in 2005 to USD249,700 in 2006. Programme funding from AusAID, NZAID and France is USD1,225,000 in 2006 compared with USD1,040,000 in 2005. Project funding from donors for 2006 is USD3,708,000 compared with USD3,471,500 in 2005.

To provide good leadership and respond effectively to PICT public health needs and SPC priorities, PHP must be structured appropriately. The proposed structure takes into account the need to utilise limited resources as effectively and efficiently as possible and to integrate PHP activities as far as possible. Proposed options for the management structure of PHP are attached as Appendix 4. The creation of a Public Health Division will have implications for the remaining components of the Social Resources Division. The SPC Corporate Review recommended strengthening the programmes of the Pacific Women's Bureau, Pacific Youth Bureau and Cultural Affairs Programme. This strengthening may be best achieved through locating these three components within the (proposed) expanded Planning Unit because their resources are of value across all SPC programmes, including PHP. Furthermore, in view of the revised public health priorities for SPC, it is essential that the organisation acquires the skills and expertise needed to provide credible technical advice in areas such as data and knowledge management and epidemiology, public health law, health economics, and trade policy. These competencies could be co-located in the Planning Unit.

The current administrative structure provides a core group of support staff who are well educated and enthusiastic. However, there appears to be mismatch between the size of sections and administrative support in some areas. In addition, there are opportunities to expand the role of administrators to include some functions that technical staff currently perform. The nature of this expansion will be specific to each section, but the result could be more efficient use of administrators' skills. Managers of sections require specific management training and support. Most managers have previously been in technical roles and may or may not have the skills and training needed to undertake staff management, budgetary reporting, planning and performance-based assessment.

7.3.3 Responding better to country needs

An important barrier to attracting resources to better respond to country needs is the low visibility of SPC and specifically PHP in member countries and territories. Historically, the manner of working has been to develop plans in isolation without adequate country consultation; for example, most member countries and territories visited had no or limited knowledge of the existence of the PHP Strategic Programme Plan 2006–2009. The JCS approach being developed by SPC is an important opportunity to improve working relationships with PICTs and enhance SPC's visibility. Further decentralisation of SPC activities beyond the two main locations in Fiji and New Caledonia would assist in this process.

To give their support to PHP activities and the proposed Pacific Health Fund, PICTs would need to be convinced of the benefits. They would also need to be assured that the additional step between donors and PICTs would not attract increased overhead costs and that SPC could deliver on the processes required to manage such a fund. The process for GFATM funding, in terms of the resources required to develop a proposal or bid and the very demanding reporting requirements, means that PICTs would not welcome a requirement of following the same burdensome and expensive process. It is also a shared view that all stakeholders must take into account the lessons learnt from the GFATM experience and ensure that a simpler mechanism is adopted, if required.

7.3.4 Improving integration within SPC programmes

There appears to be little interaction between PHP and other work programmes across SPC, or even within its own sections, such as between the Adolescent Health and Development programme and the HIV/AIDS and STI Section, and programmes relating to women, youth and culture. Strategies to assist with integration of activities need to be developed to include both structural and functional measures, such as:

- allocation of specific public health liaison responsibilities in other divisions, with staff members given the specific role of ensuring integration between groups;
- development of working groups to focus on comprehensive JCS that include a specific public health component;
- development of working groups to focus on specific issues-based activities. that is, a public health environment within the Land and Marine Resources Divisions would develop strategies and provide input into work programmes.

This review suggests two options for restructuring PHP (see Appendix 4). As indicated above, the establishment of the Division of Public Health will have implications for the remaining components of the Social Resources Division. It will therefore be necessary to review the structure and role of the Social Resources Division and ensure that integration is supported by appropriate administrative, management and policy measures. In support of the SPC Corporate Review recommendation that the Women's Bureau, Youth Bureau and Cultural Affairs Programme be strengthened, the proposed changes to the PHP structure under option 1 provide an opportunity to reposition these sections as a resource for the whole organisation.

Option 2 is designed to encourage better integration of PHP activities across all sections and to improve coordination between individuals and teams. It highlights functions that are common to all sections, such as information management, capacity building and monitoring and evaluation. This option requires major changes in the way sections function and represents a major shift in the way staff are expected to work. In this option, the "programmes" section will have most of the PHP staff. Skills and competencies needed to support the future activities of PHP, such as data management, public health law and health economics, are located within the (proposed) expanded Corporate Planning Unit. Other skills and competencies may be needed from time to time, depending on PHP and PICT priorities.

7.3.5 Improving gender equality

The revised Pacific Platform for Action on Advancement of Women and Gender Equality 2005–2015, "A Regional Charter", provides SPC with a policy platform and guidelines for the implementation of gender-focused activities. The PPA recommends the following objectives:

- national health policy and programmes that meet the different needs of women and men and promote gender equity in access to services, training and employment;
- improvements in the quality of and access to medical services and reproductive health services;
- prevention of the spread of HIV/AIDS and STIs;
- improved basic services accessible to all women and men.

PHP has a role to play in all these areas. There are two clear areas of focus – the external PHP focus and the internal PHP arrangements.

i. External public health programmes

The current PHP Strategic Programme Plan contains no indicators related to gender. There is no commentary within the plan regarding gender-based considerations, perspectives and activities. There is limited technical gender-based knowledge within the group and a limited interface with the Pacific Women's Bureau. The addition of a Gender Specialist, either within the PHP group or as an addition to the Pacific Women's Bureau with specific responsibility for public health, would assist greatly in building capacity within PHP. Collaboration is needed on areas such as the development of health, education and other indicators that could contribute to improved monitoring of women's health within the framework of PHP and other regional and international frameworks. There is also a need to identify relevant research, develop policy positions for use across the full range of SPC programmes, and develop a corporate and sectoral focus on the benefits of addressing the gender dimensions of public health and increasing the participation of women in health-care management.

Work in all these areas would enable the group to develop a policy paper to provide a context for gender-based considerations in PHP based on evidence, and could assist programmes to develop performance-based gender outcome indicators.

ii. Within the new Public Health Division

The new Public Health Division would benefit from the development of a specific programme to ensure gender equity was evident in the recruitment and development of staff. A monitoring role could be developed to ensure gender equity in the numbers of people trained through PHP. SPC is currently working with PICTs to develop gender programmes and policy and could lead by role-modelling best practice in this area, such as by supporting the promotion of women to senior management positions within public health programmes in the region.

The long-term benefits of investing in women's education and increased participation in all aspects of development can no longer be debated. SPC needs to ensure that gender dimensions are incorporated in all of its technical programmes, including PHP.

8.0 CONCLUSIONS

SPC's Public Health Programme has grown dramatically in recent years and the organisation is re-establishing itself as an important player in the coordination and delivery of public health services in the region. For the most part, member countries and territories reported favourably on SPC activities at the technical level, but feedback from the health leadership in PICTs was mixed. Clearly, SPC needs to raise its profile and presence in member PICTs and ensure better communication at all levels, in addition to its interaction through existing agreed channels. The failure to interact and communicate effectively on the development of the PHP Strategic

Programme Plan 2006–2009 illustrates this problem. PHP cannot rely solely on established, official communication channels with member countries and territories.

The growth in PHP activities has been a reflection of the concerns of the international community, rather than a reflection of PICT priorities and needs based on the current burden of death, disease and disability in the region. This situation has meant that public health priorities causing significant morbidity and mortality in the region have not attracted the necessary resources. As a consequence, the limited public health capacity of small island states may have been diverted from more urgent public health threats such as gaps in environmental health services and prevention of chronic diseases such as diabetes, heart disease and some cancers.

Funding and planning arrangements at SPC also mean that the organisation lacks a longer-term view of its goals and objectives for public health. In public health terms, this is unacceptable because investments in public health must be long term to obtain the desired results. The review team strongly recommends that SPC develops a long-term view for public health with its member countries and territories, including strategic direction, public health priorities and resource requirements, and that it clarifies its specific roles and expected partnership arrangements. This development will signal the views of SPC to development partners and other stakeholders. It will also serve as the basis for resource mobilisation for the organisation, thus reducing its reliance on short-term project and programme-based funding. It may also enable SPC to enter into structured relationships with its member states.

SPC has positioned itself as a potential leader in public health in the region. By working closely with its development partners and international organisations, it could achieve even more. Leadership, stewardship, coordination and advocacy are important roles that fit with SPC's mandate to nurture the development of Pacific peoples. Good health is a resource to be promoted and protected, and it is a central requirement for the development of individuals, communities, societies and the region of the Pacific Islands.

APPENDICES

Appendix 1 – Country visit reports

- Cook Islands
- Fiji
- Marshall Islands
- New Caledonia
- Samoa
- Solomon Islands

1. COOK ISLANDS COUNTRY VISIT: 3–7 October 2006 by Debbie Sorensen

Performance and service delivery

- There is little relationship between the MOH and SPC
- Supportive of a recent visit by the Director-General of SPC; however, no other visits have been undertaken by senior staff recently
- Excellent support regarding surveillance
- Excellent support for pandemic planning
- Not really aware of what SPC has to offer
- Would welcome annual discussions on how SPC could assist the Cook Islands
- Not aware of the country contribution and unable to gauge if the Cook Islands gets value for money from SPC
- Would like to know what they can expect from SPC
- Contact WHO in the first instance for technical advice

Strategic directions

- No discussion at country level with regard to SPC Strategic Planning for Public Health
- Have not seen the plan and were not aware it existed
- Believe that SPC priorities should support countries, rather than countries supporting SPC work

PHP programme management and capacity

- Perception that SPC provided better service to the French territories and Northern Pacific
- Felt there was benefit in SPC being based in Suva as when staff travelled to Fiji, they could also visit SPC
- Would like a closer relationship with senior public health people
- Felt SPC was not really based in the Pacific region
- SPC supported people to attend workshops, but that was not seen as building capacity or developing new public health capacity

2. FIJI COUNTRY VISIT: 24–28 September 2006 by Debbie Sorensen and Tracey McMartin

2.1 Donor partners and UN agencies

Performance and service delivery

- There is little collaboration with other agency-identified country needs; however, where there is a common agenda, i.e. UNFPA, then they do work closely together
- There is a gap in environmental health and a perceived lack of resourcing for NCDs in the broadest sense, including mental health and cancer
- Human resource development has focused on raising skills, rather than developing new human resources in the public health area
- The same people attend all the workshops that are being held, so capacity is not extended across a sector but focused on an existing small number of in-country staff

Strategic directions

- Donors and UN partners see NCDs, environmental health and adolescent health as priorities. There was concern voiced from UNICEF regarding the low priority for children
- Donors and UN agencies were not aware of the PHP Strategic Plan nor were they involved in its development
- They expressed interest in being involved in the process

PHP programme management and capacity

- Perception from donors that Noumea as a base for public health was problematic. They stated that it cost 50% more to fund a position in Noumea as opposed to a position based in Fiji
- There was general discussion about the value of being based in Suva with more opportunities for collaboration with other agencies
- Felt an increased in-country presence was necessary
- Good support for the Pacific Health Fund concept
- Poor integration with other SPC activities; felt there could be greater liaison between other SPC programmes and UN agencies

2.2 Fiji country

Performance and service delivery

- Excellent technical support from surveillance section
- Felt that Fiji helped SPC with "SPC work" but that SPC did not help Fiji with public health work
- Fiji has a very well developed and extensive Strategic Public Health Plan; did not feel that SPC has added any value to the development of public health priorities and planning in Fiji due to good public health capacity in Fiji
- SPC provides skill-based workshops, but does not build new capacity. Access to public health training scholarships would be helpful
- Poor relationship between SPC and Ministry of Health and senior officials; needs a more strategic approach and a feeling of working together

Strategic directions of PHP

- Unaware of a Public Health Strategic Plan; were not involved in its development
- Agreed with the priorities, but felt that environmental health and NCDs required a higher priority
- Would be interested in working with SPC to develop strategic priorities to guide SPC work
- Do not see that SPC has built significant public health capacity as the same people are doing the same jobs

Programme management and capacity

- Felt PHP should be based in Suva
- Saw WHO as the first point of call for technical advice
- Would like to see a stronger in-country profile
- Support for the Pacific Health Fund as a concept, but concern around allocation of funding; felt the HIV model required too much administration for accessing funding

3. MARSHALL ISLANDS COUNTRY VISIT: 15–20 September 2006 by Tony Lower

Performance and service delivery

- MOH is generally happy with SPC's input – but better communication with SPC would assist as often not aware of activities arising
- Excellent technical support particularly from the PPHSN and TB sections
- Current NCD inputs are solely education based at the country level; they would welcome direct assistance in developing/implementing NCD plan and use of more evidence-based approaches

Strategic directions of PHP

- No knowledge of the Public Health Strategic Plan
- Future inputs: assistance with general planning and coordinating efforts – major issues continue to be diabetes, HIV, teen pregnancy, alcohol, youth suicide
- Assistance with environmental health – once sanitation/food safety come back to MOH domain would be welcomed
- Data coverage and utilisation is poor; collation would assist with developing interventions

Programme management and capacity

- There is a need and willingness for broadly based assistance to re-structure the system to be more PH based, perhaps by a long-term advisory (in-country) role (even 3–6 months or longer). Health system strengthening and reorientation of the system are key concerns for the MOH
- No workforce development strategy – a major barrier to progress
- Coordination of efforts between donors would help – SPC should investigate how it can link with the UN office that is being established in Majuro

4. NEW CALEDONIA: 26 August – 2 September by Tony Lower, Debbie Sorensen and Colin Tukuitonga

Performance and service delivery

- Excellent technical support and working relationships with PPHSN, TB, HIV/AIDS/STI
- Good support for dengue surveillance
- Recent improvements in interactions with SPC PHP
- Would like more involvement with SPC activities and can offer more from New Caledonia to other Pacific Islands
- New Caledonia has enough capacity, skills and technology to offer – no real need for SPC assistance
- Communication can be a problem because of the language; not all materials are translated into French
- Material often too simplistic for French-speaking population

Strategic directions of PHP

- Unaware of a Public Health Strategic Plan; were not involved in its development
- Better surveillance to comply with IHR
- NCD surveillance

Programme management and capacity

- Lack of visibility of regional programmes, from the perspective of the country (accessing funding) and SPC gaining recognition for the work it does in New Caledonia
- Would like to see a stronger SPC in-country profile
- Better planning and notification of meetings
- SPC should take greater leadership role in public health in the region
- Better communication with countries; some repetition of information sent to WHO

5. SAMOA COUNTRY VISIT: 26–29 September 2006 by Colin Tukuitonga and Tracey McMartin

Performance and service delivery

- Excellent technical support and working relationships with TB, NCDs, PPHSN and Adolescent Reproductive Health
- Little involvement and support for environmental health in Samoa
- IEC materials for nutrition and NCDs proved very popular in Samoa
- Political and health leadership felt SPC was not visible enough and should promote what it offers to Samoa
- SPC provides skill-based workshops, but does not build new capacity. Assistance unstructured and ad hoc
- SPC is reactive, not proactive enough
- Need a more strategic approach and stronger working relationships; WHO is preferred technical agency at present for Samoa (in-country presence is part of this)
- SOPAC approach welcomed by Samoa
- No real need for Pacific Health Fund since Samoa has existing mechanism in place
- Problems with communication; just through agreed CRGA process, but need additional avenues

Strategic directions of PHP

- Unaware of a Public Health Strategic Plan; were not involved in its development
- Agreed with the proposed priorities but felt that environmental health (including food safety) and NCDs required a higher priority
- Mental health is a priority area that needs support and SPC involvement
- Adolescent reproductive health and reproductive health are priority areas (population pressure is currently relieved by overseas migration), but better coordination is needed
- Health promotion extremely important and needs support
- Protect and promote nutrition role at SPC and continue with production of IEC materials, including PacNut – real need for evidence-based advice from a respectable source
- SPC needs to demonstrate its comparative advantage in health

Programme management and capacity

- Lack of visibility of regional programmes, from the perspective of the country (accessing funding) and SPC gaining recognition for the work it does in Samoa
- WHO is the first point of call for technical advice, not SPC. A large factor is WHO's in-country presence
- Would like to see a stronger SPC in-country profile
- SPC should take greater leadership role in public health in the region
- Better communication with countries, not just through CRGA

South Pacific Regional Environmental Programme (SPREP)

Performance and service delivery

- Excellent relationships with SPC (SPREP used to be a programme within SPC), with the main links occurring through working groups, national government coordination mechanisms and networks of technical staff
- Respective roles and responsibilities well defined and working well
- SPREP relies on SPC technical advice for health-related matters
- More interactions with SPC Agriculture and Coastal Fisheries, not PHP. An environmental waste management officer in PHP would facilitate collaboration. Current interaction with SPC includes livestock waste, pesticide use, aquaculture, land management, and forestry
- Keen end user of SPC advice
- SPC presence in country can enhance SPREP activities and vice versa
- SPC and other regional organisations need to develop a much stronger role in advising and advocating on issues with member governments

Strategic directions for SPREP

- Awaiting CROP reorganisation discussions and SPREP 2007 Corporate Review
- SPREP priority areas: pollution/waste management, climate change and natural resource management/biodiversity
- Need to strengthen environmental programmes (environment always the last consideration in development)
- Better coordination in country highly desirable

PHP programme management and capacity

- Limited capacity and high turnover of SPREP staff in country

6. SOLOMON ISLANDS COUNTRY VISIT: 23–28 September 2006 by Tony Lower and David Gowty

Performance and service delivery

- Given the range of donors and technical agencies providing services, the MOH finds it is often difficult to know what SPC is directly funding/managing and what comes from other sources – this makes comments on performance problematic
- However, there was general acknowledgement that SPC is well perceived, particularly in relation to the PPHSN and in some of the malaria-related actions. SPC inputs into NCDs were perceived to be not well coordinated (tobacco), with significant amounts of information provided but little actual progress or technical guidance
- Interaction at grass roots is basis of success – however, most programmes are not filtering through to this level.
- Save the Children the only impartial agency without political or church affiliations that will enable them to access communities relatively broadly (in particular, provision of condoms)

Strategic directions of PHP

- Little to no knowledge of the PHP Strategic Plan at the country level
- Long standing health issues around MCH, RH/FP and malaria remain. Growing issues are NCDs and HIV
- National level water/sanitation programmes are very disjointed and require coordination and investment. If SPC can assist with this it would be welcome
- A more regular in-country presence by SPC (however managed) is needed
- The SWAp will dominate thinking in the MOH and should be used as a basis for SPC inputs
- SPC must be strongly represented on all SWAp preparations

Programme management and capacity

- SPC has increased pressure on PICTs to perform (particularly through GFATM) – this is good and should be maintained. It is not business as usual given the many confronting health issues
- A lack of coordination by partners at national level is a major issue
- Capacity has not been developed at national level and this is even more so in the provinces. Approaches to assist with this are required

Appendix 2 – Individuals interviewed

Name	Title/Role	Organisation
1. Cook Islands		
Hon. Dr Terepai Maoate	Minister of Health	Cook Islands Government
Roro Daniel	Secretary for Health	Ministry of Health
Ngapoko Short	Director of Public Health	Ministry of Health
Miriama Pierre	Director of Dentistry	Ministry of Health
Neti Tamarua	Director of Nursing	Ministry of Health
Henry Tikaka	Director of Clinical Services	Ministry of Health
Stephanie Wright	Deputy NZ High Commissioner	NZ High Commission
Garth Henderson	AIDS Management	Ministry of Health
Helen Sinclair	Project Manager	Ministry of Health
Edwina Tangaroa	Health Education	Ministry of Health
Karen Tairea	Nutritionist/Dietician	Ministry of Health
2. Fiji		
Lepani Waqatakirewa	Chief Executive Officer	Ministry of Health
Joe Koroivueta	Acting Director of Public Health	Ministry of Health
Jope Davetanivalu	Environmental Health	Ministry of Health
Timoci Young	Public Health	Ministry of Health
David Brewster	Dean	Fiji School of Medicine
Jan Pryor	Director of Research	Fiji School of Medicine
Urmila Singh	Assistant Representative	UNFPA
Najib Assifi	Representative	UNFPA
Wame Baravilala	Clinical Advisor	UNFPA
Tamara Kwateng	Manager	Pacific Regional HIV/AIDS Project
Manish Pant	Representative	Fiji Red Cross
Kamrul Islam	Director	UNICEF
Robyn McIntyre	Clinical Advisor	UNICEF
Rosalina Saaga-Banuve	Youth Programmes	UNICEF
Richelle Tickle	First Secretary	AusAID
Ilisapeci Neitoga	Program Manager	AusAID
Vicki Bennet	Health Information Fiji Health Sector Improvement Project	Ministry of Health
Helen Tavola	Social Policy Adviser	Forum Secretariat
Tracey McMartin	Planning Adviser	SPC

Name	Title/Role	Organisation
3. Marshall Islands		
Kennar Briand	Director of Public Health	MOH
Ione deBrum	Director of Health Promotion	MOH
Russell Edwards	Assistant Secretary Public Health	MOH
Allan Fowler	COMPACT Grants Manager	US Embassy
Ben Graham	Consultant	
Carl Hacker	Director	National Planning Officer
Justina Langdrik	Secretary for Health	MOH
Janet Nemra	Diabetes Health Educator	MOH
Charles Paul	Chief, Performance Monitoring & Evaluation	National Planning Office
Helen Reed-Rowe	Chargé d'Affaires	US Embassy
Godfrey Wadibu	Dept of Human Services & Health Promotion Manager	MOH
Zacharias Zacharias	Public Health Physician	MOH

4. New Caledonia		
Jimmie Rodgers	Director-General	SPC
Richard Mann	Director, Corporate Planning	SPC
Louni Hanipale Mose	Director, Corporate Services	SPC
PHP Administrative Staff		SPC
David Gowty	Planning Adviser	SPC
Thierry Jubeau	PHP Manager	SPC
Tom Kiedrzynski	PHS&CDC Section Head	SPC
Bill Parr	GFATM Section Head	SPC
Dennie Iniakwala	HIV/AIDS/STI Section Head	SPC
Viliami Puloka	HPL Section Physical Activity Adviser	SPC
Jeanie McKenzie	HPL Section Tobacco and Alcohol Adviser	SPC
Karen Fukofuka	HPL Section Nutrition Adviser	SPC
Jennifer Corigliano	HPL Section Project Assistant	SPC
Janet O'Connor	TB Programme Section Head	SPC
Mark Lambert	TB Programme Adviser	SPC
Rhonda Griffiths	Cultural Affairs Bureau	SPC
Linda Petersen	Pacific Women's Bureau	SPC
Tangata Vainerere (by phone)	Pacific Youth Bureau	SPC
Graeme Brown	Statistics and Demography	SPC
Gerald Haberkorn	Statistics and Demography	SPC
Rufina Latu	Adolescent Health and Development	SPC, Fiji
Jacques Buguet	French Delegation	New Caledonia
Sophie Lagueny	EU Delegation	New Caledonia
Pierre Georges	CEO Health	Wallis & Futuna
Jean-François Yvon	Medical Officer	Wallis & Futuna
Bernard Rouchon	Agence de Sanitaire	New Caledonia
Jean-Paul Grangeon	Médecin Inspecteur	New Caledonia
Erica Mansel	Head of Opthalmology, NC General Hospital	New Caledonia

Name	Title/Role	Organisation
5. Samoa		
Palanatina Toelupe	Chief Executive Officer	Ministry of Health
Frances Brebner	Assistant CEO (Planning)	Ministry of Health
Christine Quested	Chief Nutritionist	Ministry of Health
Terenia Simanu	Acting Assistant CEO (Public Health)	Ministry of Health
Pelenatete Stowers	Director of Nursing	Ministry of Health
Robert Thomsen	Clinical Director	Ministry of Health
Serafi Moa	Clinical Nurse Specialist	Ministry of Health
Pisa, Diane, Malilelei, Tupou	Mental Health Team	Ministry of Health
Ma'atasesa Samuelu-Mathers	Integrated Community Health Services	Ministry of Health
Stephan Terras	Officer in Charge	WHO
Asaua Faasino	Medical Officer	WHO
Nuufou Petaia		Ministry of Education
Vitolio Lui	Deputy Director-General	SPREP
Mark Ricketts	Solid Waste Officer	SPREP
Noumea Simi	Head, Aid Coordination	Treasury Department
Fa'alua Mata'afa	Chief Nursing Officer	Samoa Family Health Association
Phillip Hewitt	NZAID Manager/First Secretary	NZAID
Christine Saaga	Development Programme Coordinator	NZAID
Amanda Roberts	First Secretary	AusAID

6. Solomon Islands		
Vicki Assenheim	Senior Management & Planning Adviser	Health Institutional Strengthening Project
Glenn Bond	Acting Country Program Director	Save the Children
Damien Brosnan	In-country Project Manager	Health Institutional Strengthening Project
Christine Evans	Data Manager	Health Institutional Strengthening Project
Katherine Gilbert	Country Manager	UNICEF
Steven Harries	Country Program Manager	World Vision
Jeffrey Hii	Malaria Program Officer	WHO
Lesley Hoatson	Program Officer	Church of Melanesia
John Kelleher	Country Representative	Oxfam
Charles Kelley	Executive Officer	Red Cross
George Maleofosi	Under-Secretary	MOH
Karen McPhail-Ball	Volunteer	ADRA
Rhona McPhee	Second Secretary	AusAID
Tony Maelasi	Program Officer	Church of Melanesia
Kimio Miura	Resident Representative	JICA
Robertson Natei	Program Manager (Health)	AusAID
Yoshihiko Nishimura	Project Formulation Adviser	JICA
Divi Ogaoga	Under-Secretary Health Improvement	MOH
Julie-ann Oge	Executive Officer	ADRA
Cyril Pitakaka	Permanent Secretary	MOH
Ollie Pokana	Project Director	Church of Melanesia

Solomon Islands (continued)		
Name	**Title/Role**	**Organisation**
Anne Saenamua	Executive Officer	International Women's Development Agency
Sam Sahu	Canon	Church of Melanesia
George Slama	Acting Country Liaison Officer	WHO
Rebecca Spratt	First Secretary	NZAID
Leigh Trevillian	Health Sector Adviser	AusAID

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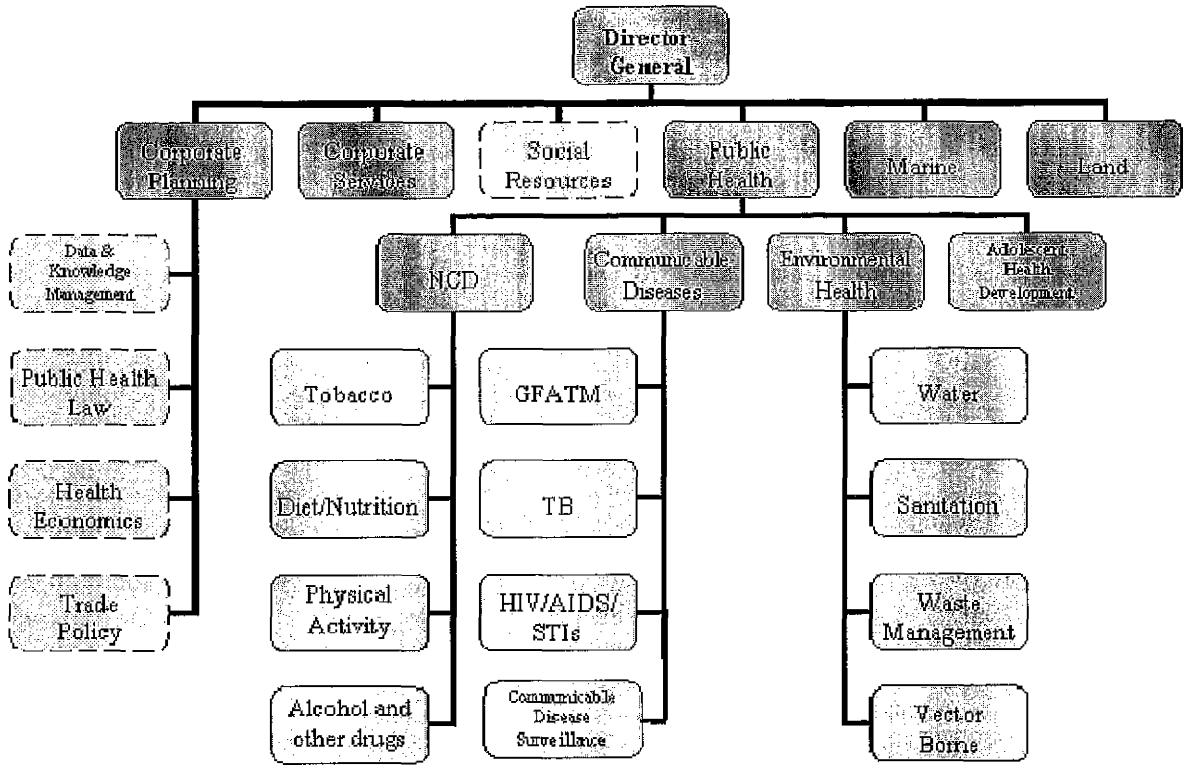
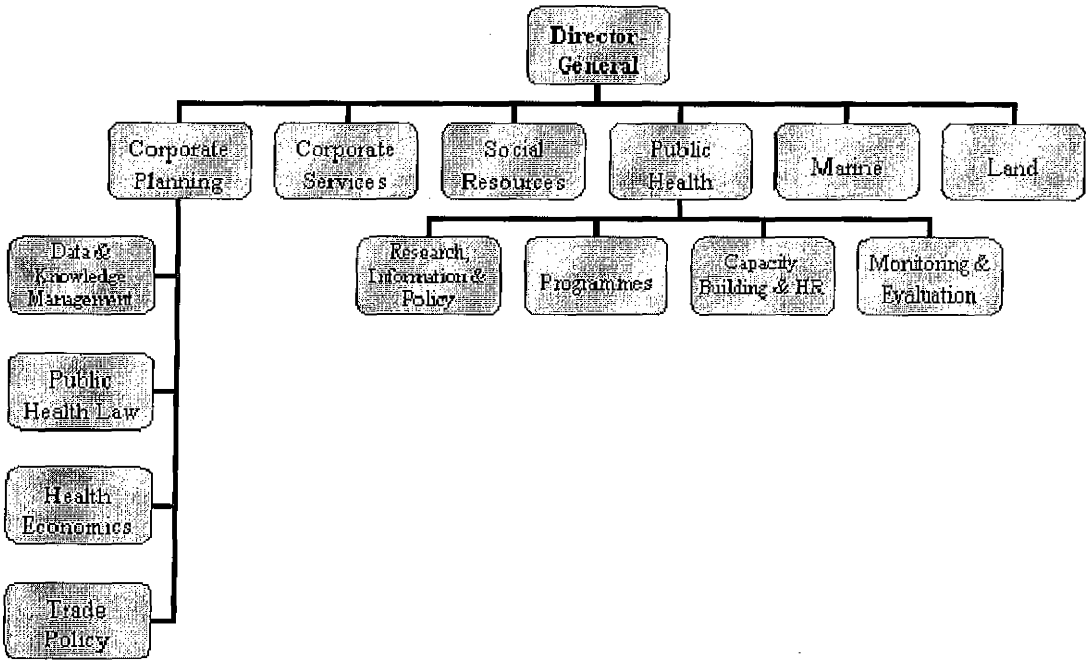
Appendix 4 – Options for the PHP Organisational Structure

OPTION 1



The establishment of the Division of Public Health will have implications for the remaining components of the Social Resources Division. The SPC Corporate Review recommended that the Pacific Women's Bureau, Pacific Youth Bureau and Cultural Affairs Section be strengthened. Proposed changes to PHP provide an opportunity to reposition these sections as a resource across the whole organisation.

OPTION 2



Option 2 is designed to encourage better integration of PHP activities across all sections and improve coordination between individuals and teams. It highlights functions that are common to all sections, such as information management, capacity building and monitoring and evaluation. This option requires major changes in the way sections function and represents a major shift in the way staff are expected to work. In this option, the "programmes" section will contain most of the PHP staff.

Skills and competencies needed to support the future activities of PHP, such as data management, public health law and health economics, are located within the (proposed) expanded Corporate Planning Unit. Other skills and competencies may be needed from time to time depending on PHP and PICT priorities.