Independent Evaluation of the Pacific Specialised Clinical Services and Health Workforce Improvement Program Phase 2 (PSCSHWIP II)

30 June 2026

Specialist Health Service

Strategic input on health to the Australian Government

Executive Summary

Australia remains the largest bilateral donor to the Pacific, with a long history of support for improving the health of people in the Pacific through strengthening health systems and service delivery. Pacific Island Countries (PICs) are diverse and face many challenges to delivering a quality and equitable health system; one of the key challenges has been to build a local clinical health workforce while providing specialised services not able to be provided by local health systems.

Since 1995, the Australian Government has funded six phases of support to assist PICs in the delivery of clinical services, including clinical workforce development. Approximately $40.8 million has been invested over the 30-year period. Each phase has been evaluated and evolved over time; however, many previous recommendations remain unaddressed. Current DFAT funding (2022-2026) for the Pacific Specialised Clinical Services and Health Workforce Improvement Program (PSCSHWIP) Phase 2 program is $10.4 million over four years (with an extension option) and covers 11 PICs. Most of the funding supports RACS' activities ($8.4 million), with SPC and FNU receiving a smaller share ($1 million each).

PSCSHWIP Phase 2 aims to achieve one overarching End-of-Program Outcome (EOPO): a strengthened Pacific health workforce and health systems capable of delivering higher-quality, more equitable, accessible and affordable specialised clinical services across the region. This EOPO is supported by three Intermediate Outcomes (IOs). IO1 focuses on improving the quality and accessibility of specialised clinical services, primarily through Visiting Medical Teams (VMTs). IO2 strengthens the specialised clinical services workforce, expanding skills, training pathways and professional support for clinicians across PICs. IO3 advances regionalisation, supporting shared standards, governance mechanisms, technical networks and coordinated approaches to specialist service delivery.

Partner roles are clear and complementary:

- **Royal Australasian College of Surgeons (RACS)** delivers specialist clinical services through VMTs and strengthens workforce skills via mentoring, on-the-job training and funding other regional clinical courses.
- **Pacific Community (SPC)** leads regional coordination and governance, supports technical networks and PICs with clinical systems strengthening, and houses the PSCSHWIP Program Coordination Unit (PCU).
- **Fiji National University (FNU)** provides formal health workforce training, postgraduate education and comprehensive support to regional students, and partners on specialist clinical training.

Evaluation Purpose and Methodology

This independent evaluation assesses program performance from late 2022 to early 2026. The evaluation has three objectives: 1) Assess the program's performance to date in terms of effectiveness, efficiency, gender equality, disability equity and social inclusion (GEDSI) and Monitoring, Evaluation and Learning (MEL) including reporting; 2) Recommend actions for DFAT to improve current program performance; and 3) Recommend if DFAT funding to RACS, SPC and FNU should continue beyond the current program, and if so whether the delivery model remains appropriate.

The evaluation draws on more than 120 documents, over 100 key informant interviews across 11 PICs, and in-country consultations in Fiji and Tonga. Time and resource constraints did not permit face-to-face in-country consultations in all 11 PICs.

Evaluative Summary: Effectiveness, Efficiency, MEL and GEDSI

Overall, the evaluation found that PSCSHWIP Phase 2 is effective, efficient, and highly valued by PIC governments, clinicians and DFAT posts. The program is making strong progress toward its IOs and EOPO, with clear evidence of strengthened clinical services, expanded workforce capability, and improved regional coordination. However, the evaluation also identified opportunities to enhance coherence, strengthen MEL, improve GEDSI integration, and shift toward a more Pacific-led and sustainable model for specialist clinical service strengthening.

Effectiveness

Strengthening specialised clinical services (Intermediate Outcome 1): RACS has delivered substantial specialist clinical services through VMTs, conducting a forecasted 5,000 consultations and 1,600 surgeries by the end of 2026 (Year 4), through 75 VMTs involving over 280 clinical volunteers. RACS VMTs remain important in addressing surgical backlogs, providing substitution in small island states, and enabling complex procedures in larger countries. They are highly valued by PIC clinicians.

However, VMT numbers are lower than in previous DFAT-funded phases; several PICs expressed a desire for more frequent and longer visits. They would also like more systematic capacity building and Continuing Professional Development (CPD) recognition. Communication gaps between RACS, PIC Ministries of Health (MOHs) and hospitals, and DFAT posts or health facilities/platforms have occasionally affected planning and coordination. End-of-Trip Reports provide valuable insights but are inconsistently utilised by MOHs and posts.

Strengthening the specialised clinical workforce (Intermediate Outcome 2): Between 2023-2025, more than 500 PIC clinicians received on-the-job training through VMTs, and 491 clinicians participated in formal training courses funded through RACS' PSCSHWIP allocation. The Pacific Islands Virtual Online Training in Surgery (PIVOTS) simulation-based surgical training program has emerged as a flagship regional training model, now embedded in the FNU Master of Surgery program and expanding across the region. The Australia New Zealand Gastroenterology International Training Association (ANZGITA) endoscopy training, Advanced Paediatric Life Support (APLS) and Early Management of Severe Trauma (EMST) courses also contribute to measurable skills development.

FNU's College of Medicine, Nursing and Health Sciences (CMNHS) provides critical academic, psychosocial and pastoral support to regional students through the PSCSHWIP-funded College Regional Office (CRO), contributing to strong retention and graduation outcomes. From 2022-2025, 4,153 students graduated, 22% of whom were regional.

Strengthening regional systems and coordination (Intermediate Outcome 3): SPC's Clinical Services Program (CSP) plays a central role in regional governance, coordination and technical leadership. SPC convenes Directors of Clinical Services, Pacific Heads of Health, and Pacific Heads of Nursing and Midwifery meetings, and supports 17 regional clinical and technical networks as its core business. These mechanisms are essential for advancing regional standards, sharing expertise and strengthening health systems.

SPC also supports National Surgical, Obstetrics and Anaesthesia Plan (NSOAP) development, clinical governance frameworks, biomedical engineering networks, and regional Infection Prevention and

Control (IPC) standards, relevant to PSCSHWIP outcomes. However, some planned PSCSHWIP deliverables, such as the 'clinical services strengthening data dashboard' and VMT calendar/coordination support, have not progressed and require renewed focus.

Efficiency

The delivery model is broadly efficient, with strong value for money generated through RACS' volunteer-based model and FNU's cost-effective student support systems. SPC delivers substantial regional coordination through core CSP activities with a relatively small PSCSHWIP budget. Efficiency is reduced by high shipping costs for RACS' VMT equipment, fragmented planning across VMT providers, and variable clarity around SPC's PSCSHWIP-funded versus core CSP activities. Staffing has been a concern, with a high turnover of 15 staff in RACS Global Health team, and delays in staffing at SPC (including a key position vacant) resulting in delays to Program Coordination Unit (PCU) deliverables. Coordination between regional and bilateral programs is improving but is inconsistent, and partners largely operate within their own mandates rather than through joint analysis and planning.

Monitoring, Evaluation and Learning (MEL)

The MEL system is partially fit-for-purpose. Partners produce annual plans and progress reports, and SPC consolidates these into joint reporting. However, indicator definitions have shifted between years, outcome-level analysis is limited, and disability and location-disaggregated data are often unavailable. MEL is not consistently used to drive learning, adaptation or collaboration.

Gender Equality, Disability Equity and Social Inclusion (GEDSI)

GEDSI integration has improved but remains uneven. A GEDSI Action Plan was developed in 2025, and partners now routinely report sex-disaggregated data. GEDSI training through FNU and SPC has reached more than 300 participants, and SPC has integrated GEDSI into NSOAP workshops and regional governance. However, disability-disaggregated data are limited, social inclusion is the least developed area, and VMTs do not consistently integrate GEDSI considerations into planning or service delivery. There is no reference to PIC Sexual and Gender-Based Violence (SGBV) clinical protocols despite their relevance to frontline clinicians.

Summary of High-Level Recommendations

This evaluation provides recommendations for strengthening specialist clinical services and workforce capability across the Pacific. The recommendations emphasise the need for a more coherent, better coordinated and more sustainably resourced model of support – one that is Pacific-led, outcomes-focused and aligned with national and regional priorities. Collectively, the recommendations fall into five interconnected domains: effectiveness, efficiency, delivery model, MEL and GEDSI.

Key Recommendations on Effectiveness

- **Recommendation 1:** SPC CSP to use its convening role to discuss at DCS meeting(s) support to PICs in developing Clinical Services Plans, including a timeline (as recommended in previous evaluations). These plans will strengthen VMT alignment to country needs.

- **Recommendation 2:** PCU to explore methods for providing individual performance metrics and CPD recognition during VMTs through on-the-job activities (at the request of many clinicians and MOHs who are reviewing performance systems for salary and promotion).
- **Recommendation 3:** RACS to confirm with SPC and MOHs who the End-of-Trip Reports should be sent to, in order to maximise the effectiveness of VMTs in supporting country priorities. This could be included as part of finalising MOUs with PICs.
- **Recommendation 4:** RACS to strengthen communication with DFAT posts, MOHs and hospitals (to ensure timely sharing of useful information before, during and after VMTs), through adherence to its existing communications plan.
- **Recommendation 5:** RACS to explore options for expanding regional training opportunities with partners in 2027 (e.g. MCS PIVOTS, Interplast, and ANZGITA), as their cost-effective trainings provide measurable skills transfer and recognition through certificates or as part of postgraduate qualifications.
- **Recommendation 6:** DFAT to continue support for the FNU CRO unit to the end of the current program, with a view to ensuring future sustainability in consultation with FNU.
- **Recommendation 7:** DFAT to explore options for a regional public health approach to Ear, Nose and Throat (ENT), beyond providing ENT VMTs, given the high number of ENT cases, lack of PIC specialists, and potential for prevention and screening models.

Key Recommendations on Efficiency

- **Recommendation 8:** PCU to review previous outstanding actions from Joint Annual Progress Reports and identify what actions are feasible to complete to the end of the current program.
- **Recommendation 9:** SPC CSP to discuss at DCS meeting(s) how to best support national calendars for all VMTs, drawing on examples where they exist. This could provide PICs with a standardised template that can be adapted to their specific health system contexts.
- **Recommendation 10:** RACS to consult with New Zealand Pasifika Medical Association (PMA) and Australian colleges, societies, associations and charities providing VMTs to the Pacific, to map out a coordination mechanism to avoid duplication and overlap.
- **Recommendation 11:** RACS to review current procurement costs and shipping methods for VMT surgical equipment and explore more cost-effective options, given the increasing costs.
- **Recommendation 12:** RACS to continue support for regional training partners – in particular PIVOTS to cover the remaining larger PICs – and identify which trainings can be sustainably transferred to FNU and other Pacific universities in the future.
- **Recommendation 13:** FNU CMNHS to report on progress and barriers to micro-credentialling 'stackable' courses, which provide a more modular and flexible pathway for upskilling formal qualifications.
- **Recommendation 14:** DFAT to explore options for supporting PIC procurement processes for basic, essential equipment, including for common surgeries.

Key Recommendations on Delivery Model

The evaluation finds that while the current delivery model is broadly fit-for-purpose, significant adjustments are required to ensure the program remains relevant, coherent and sustainable beyond 2027. Australian Government funding through DFAT has supported RACS for 30 years. The

healthcare workforce and burden of disease have changed over that period, but the model of surgical VMTs has remained largely the same. Many other donor countries now provide VMTs and longer-term clinical support to some PICs; RACS VMTs are only a small part of the VMTs currently in the Pacific, with two VMTs per year allocated to each of the 11 PICs through PSCSHWIP. Australia is at risk of being seen as a minor provider unless some major changes are made to how Australian VMTs are funded and delivered in line with broader PIC clinical services improvement planning.

- **Recommendation 15:** DFAT to identify how bilateral and regional health programs can jointly support specialty clinical services strengthening, including VMTs, where there is scope in the design phase. As noted in the DFAT Partnerships for Healthy Region (PHR) Strategic Investment Framework, there is a clear need for coordination and strategic alignment between regional and bilateral health programs.
- **Recommendation 16:** DFAT to consider future options for longer-term specialty capacity building placements (possibly through Australian Volunteers International (AVI) in collaboration with Australian colleges and NGOs).
- **Recommendation 17:** DFAT to consider linkages with Australian hospitals/health services. These linkages are highly valued but have decreased in recent phases of DFAT support.
- **Recommendation 18:** DFAT to explore regional Pacific-led models for specialist clinical service delivery, where Pacific clinicians and specialists provide services in other PICs, including mentorship of local clinicians. Consider drawing on Pacific clinician diaspora as volunteer advisers, educators and mentors.
- **Recommendation 19:** DFAT to explore opportunities for a hub-and-spoke model for clinical training, building on existing PIC university strengths.

Key Recommendations on MEL

- **Recommendation 20:** PCU to strengthen its MEL function by focusing more on improving specialist clinical services outcomes through collaboration, and less on routine activity and progress reporting.
- **Recommendation 21:** DFAT to ensure MEL and reporting for any future phase is simplified, harmonised and focused on outcomes and the collection and use of quality data; however, reporting should not change during the final year of the program as that would impact on meaningful comparison.

Key Recommendations on GEDSI

- **Recommendation 22:** SPC CSP, through regional health architecture meetings such as PHONM and PHOH, to advocate for specialist nurse positions (predominantly female) to be recognised by Public Service Commissions.
- **Recommendation 23:** RACS to review existing national SGBV Clinical Protocols and Interagency Guidelines and ensure that VMTs and local clinicians are aware of and following the protocols.
- **Recommendation 24:** PCU to map out existing gaps in disability-specific services, e.g. diabetic foot care, podiatry, physiotherapy, and prosthetics, and consider a plan to address these gaps.
- **Recommendation 25:** RACS to advocate for, and actively follow up on, dissemination of VMT information by MOHs to health centres and district hospitals in advance of visits, allowing time for local staff to identify and assess potential patients from remote communities for transfer to referral hospitals (where most surgical procedures are performed).

Recommendations emphasise the importance of **sustainability**, particularly through long-term workforce development, strengthened regional training pathways and Pacific-led models of service sharing. Supporting Pacific universities to adopt a greater role in training delivery and expanding regional partnerships will help to build a more resilient and self-sustaining specialist workforce. Strengthening SPC's convening role and improving alignment between DFAT's regional and bilateral programs will further reinforce a coherent and sustainable regional clinical services architecture. A future model should:

- Establish a coordinated regional mechanism for planning and sequencing all VMTs, led by SPC in partnership with DFAT posts and MOHs.
- Develop a regional Clinical Services Strengthening Framework linking VMTs, training pathways and national Clinical Services Plans.
- Support Pacific universities to expand postgraduate training and micro-credentialled pathways through a hub-and-spoke model.
- Strengthen bilateral-regional integration by embedding specialist clinical services within bilateral health programs' logics and budgets.
- Expand Pacific-led service-sharing and mentoring models, including structured use of Pacific clinician diaspora.
- Introduce longer-term specialist placements and exchanges to complement short-term VMTs, particularly in high-demand specialties.

These high-level recommendations provide a clear and actionable roadmap for enhancing coherence, effectiveness and long-term sustainability. They reinforce the importance of Pacific leadership, coordinated planning, strengthened workforce systems and a more robust evidence base to guide future investment, ensuring that specialist clinical services across the region become more accessible and equitable.

Contents

Executive Summary ..... **i**

Evaluation Purpose and Methodology i

Evaluative Summary: Effectiveness, Efficiency, MEL and GEDSI ii

Summary of High-Level Recommendations iii

Contents ..... **i**

Acronyms ..... **ii**

1. Introduction **1**

1.1. Background and Context 1

1.2. Program Overview 2

1.3. Purpose of Evaluation 2

2. Methodology **3**

2.1. Approach 3

2.2. Data Collection 3

3. Limitations and Constraints **4**

4. Findings and Recommendations **4**

4.1. Effectiveness 4

4.2. Efficiency 19

4.3. Monitoring, Evaluation and Learning (MEL) including reporting 31

4.4. Gender equality, disability equity, and social inclusion 33

5. Conclusion **38**

6. Acknowledgements **39**

7. Annexes **40**

7.1. Annex 1: Changes to the Pacific health workforce over time 40

7.2. Annex 2: Evaluation Terms of Reference (TOR) (Abridged Version) 45

7.3. Annex 3: Evaluation Plan 49

7.4. Annex 4: List of key informants 57

7.5. Annex 5: Summary of initial analysis of KEQs mapped to evaluation questions 61

7.6. Annex 6: Documents reviewed and references 68

7.7. Annex 7: Summary of RACS activity under PSCSHWIP and predecessor programs 72

7.8. Annex 8: Examples of Clinical Services Plans 74

Acronyms

Acronym	Description
ACCRM	Australian College of Rural and Remote Medicine
ACN	Australian College of Nursing
AI	Artificial Intelligence
AICG	Australian Institute of Clinical Governance
ANCP	Australian NGO Cooperation Program
ANZGITA	Australia and New Zealand Gastroenterology International Training Association
APLS	Advanced Paediatric Life Support
AVI	Australian Volunteers International
CCrISP	Care of the Critically Ill Surgical Patient
CMNHS	College of Medicine, Nursing and Health Sciences
CPD	Continuing Professional Development
CRO	College Regional Office
CSP	Clinical Services Program (within SPC)
CWM	Colonial War Memorial Hospital (Suva, Fiji)
DCS	Directors of Clinical Services (meetings)
DFAT	Australian Government Department of Foreign Affairs and Trade
EMST	Early Management of Severe Trauma
ENT	Ear, Nose and Throat
EOPO	End of Program Outcome
FNU	Fiji National University
GHD	Global Health and Education Division (within DFAT)
GEDSI	Gender Equality, Disability and Social Inclusion
HIS	Health Information System
ICU	Intensive Care Unit
IO	Intermediate Outcome
IPC	Infection Prevention and Control
KEQs	Key Evaluation Questions
KIIs	Key Informant Interviews
KRAs	Key Result Areas
MANA	Pacific Monitoring Alliance for NCD Action
MCS	Monash Children's Simulation
MEL	Monitoring, Evaluation and Learning
M&E	Monitoring and Evaluation
MFAT	New Zealand Ministry of Foreign Affairs and Trade
MOH	Ministry of Health
NCCTRC	National Critical Care and Trauma Response Centre
NCD	Non-Communicable Disease
NGO	Non-Government Organisation
NHSP	National Health Strategic Plan
NSOAP	National Surgical, Obstetrics and Anaesthesia Plan
NZMTS	New Zealand Medical Treatment Scheme
OMR	Overseas Medical Referral
OPD	Organisation of People with Disabilities

Acronym	Description
OT	Operating Theatre
PBEN	Pacific Biomedical Engineering Network
PENTAG	Pacific Ear, Nose and Throat Technical Advisory Group
PISA	Pacific Islands Surgeons Association
PSCSHWIP	Pacific Specialised Clinical Services and Health Workforce Improvement Program
PCU	Program Coordination Unit (for PSCSHWIP)
PCC	Program Coordination Committee (for PSCSHWIP)
PHC	Primary Health Care
PHD	Public Health Division (within SPC)
PHMM	Pacific Health Ministers Meeting
PHOHM	Pacific Heads of Health Meeting
PHONM	Pacific Heads of Nursing and Midwifery
PHR	Partnerships for a Healthy Region
PMA	Pasifika Medical Association
PICs	Pacific Island Countries
PIP	Pacific Island Program – RACS
PIVOTS	Pacific Islands Virtual Online Training in Surgery
PRCSHWIP	Pacific Regional Clinical Services and Health Workforce Improvement Program
RACS	Royal Australasian College of Surgeons
SSCSiP	Strengthening Specialised Clinical Services in the Pacific – FNU
SGBV	Sexual and Gender Based Violence
SIAHP	Solomon Islands-Australia Health Partnership (DFAT bilateral)
SINU	Solomon Islands National University
SPC	The Pacific Community
THSSP4	Tonga Health Systems Strengthening Program Phase 4
TOR	Terms of Reference
UPNG	University of Papua New Guinea
VCT	Visiting Clinical Team
VMT	Visiting Medical Team
WGO	World Gastroenterological Organisation
WHO	World Health Organization

1. Introduction

1.1. Background and Context

Australia remains the largest bilateral donor to Pacific Island Countries (PICs), with a long history of support to improving the health of people in the Pacific through strengthening health systems and service delivery. DFAT provides support to the health sector in PICs through bilateral, regional and global programs. PICs are diverse and face many challenges to delivering an equitable, quality health system; one of the key challenges has been to build a quality clinical health[1] workforce while providing specialised services that local health systems cannot provide. Recognising this gap, then AusAID funded the Royal Australasian College of Surgeons (RACS) from 1995-2010 to assist PICs in the delivery of specialist clinical services in the region and clinical workforce development[2]. At the heart of the RACS Visiting Medical Team (VMT) model were the volunteers, who generously donated weeks of their time to plan and deliver surgical services, carrying their own equipment and in many cases, self-funding their missions.

The next phase of DFAT support (2010-2015) funded RACS to implement the *Pacific Island Program (PIP)* and Fiji National University (FNU) to implement the *Strengthening Specialised Clinical Services in the Pacific* (SSCSiP) program. In 2015, an evaluation of RACS-PIP and FNU-SSCSiP was conducted to inform the design of the next program. In 2017, the *Pacific Regional Clinical Services and Health Workforce Improvement Program* (PRCSHWIP) was designed to bring together three implementing partners (RACS, SPC and FNU) for better coordination and achievements in clinical outcomes. DFAT provided $7.5 million in funding support for the period July 2016 to September 2022 to work across 11 PICs, including the period of COVID-19 lockdowns. This phase of support was evaluated in 2022.

The current *Pacific Specialised Clinical Services and Health Workforce Improvement Program Phase 2* (PSCSHWIP II, hereafter referred to as PSCSHWIP) (2022-2026, with an extension option) builds on Phase 1 of the investment. Current DFAT funding for PSCSHWIP is $10.4 million over four years and covers 11 PICs. Most of the funding supports RACS' activities ($8.4 million), with SPC and FNU receiving a smaller share ($1 million each). The original allocation to RACS was $4.9 million. However, in response to a significant increase in VMT deployment costs post-COVID, the program was topped up three times (in June 2024, March 2025, and May 2026) to reach the current $8.4 million. The Global Health and Education Division (GHD) in Canberra oversees the regional program as a whole and also manages the SPC and RACS components. Suva Post manages the FNU component and provides additional program support as needed. (Note: prior to May 2026, Suva Post managed the program as a whole and the SPC component.)

Since 1995, there have been significant changes in the Pacific health workforce, with more local nurses and doctors, including more specialists (see Annex 1 for longitudinal data). DFAT's evaluation of Pacific Health Programs (2008-2018)[3] noted the workforce changes, as well as the burden of disease shifting the focus of health services to addressing non-communicable diseases (NCDs) and strengthening primary health care (PHC) services. DFAT has also increased its funding to bilateral health programs, often with Managing Contractors engaged to provide flexible but targeted support to PIC Ministries of Health (MOHs) to address their health priorities and gaps.

[1] The term 'clinical services' refers to diagnosis, treatment/care and ongoing management of medical conditions by trained health professionals, including doctors, nurses and allied health professionals.
[2] Watters *D. A. K; H. Ewing;* E. McCaig Three phases of the Pacific Islands Project (1995-2010) *ANZ J Surg 82 (2012) 318–324*
[3] ODE (2019) Strengthening Pacific Health Systems: Evaluating ten years of Australia's support

1.2. Program Overview

End-of-Program Outcome

The End-of-Program Outcome (EOPO) is: *Strengthened health workforce and systems in the Pacific region for higher quality, more equitable, accessible and affordable specialised clinical health services*.

Intermediate Outcomes

The EOPO is supported by three Intermediate Outcomes (IOs).

- IO1: Quality specialised clinical services are strengthened and more accessible
- IO2: Specialised clinical services health workforce is developed and strengthened
- IO3: Regionalisation of organisations, guidance, tools, standards and services is strengthened.

Summary of key program activities, by partner:

- **Royal Australasian College of Surgeons (RACS)** sends volunteer Australian surgical teams to PICs to conduct consultations and surgeries on local patients and provide on-the-job training for local clinicians. RACS also supports formal regional surgical trainings through other organisations.
- **Fiji National University (FNU)** delivers clinical training and workforce strengthening through formal, short courses, continuing professional development (CPD) activities, and in-country training. FNU College of Medicine, Nursing and Health Sciences (CMNHS) provides counselling, psychosocial and other services to support regional students/trainees to graduation.
- **The Pacific Community (SPC)** coordinates overall program activity, primarily through the PSCSHWIP Program Coordination Unit (PCU) mechanism responsible for program-level monitoring, evaluation and learning, joint activity planning, partner coordination and communications, housed within SPC Public Health Division (PHD)'s Clinical Services Program (CSP). CSP also implements a range of key activities to improve clinical services in the Pacific, funded through other sources, which this evaluation considers.

1.3. Purpose of Evaluation

The purpose of this evaluation of PSCSHWIP is to assess the program's performance to date, and to inform whether DFAT should continue its funding support to RACS, SPC, and FNU beyond the current program (funded through Global Health and Education Division and bilateral health programs). The evaluation has three objectives:

1. Assess the program's performance to date in terms of effectiveness, efficiency, MEL (including reporting) and GEDSI,
2. Recommend actions for DFAT to improve current program performance, and
3. Recommend if DFAT funding to RACS, SPC and FNU should continue beyond the current program, and if so whether the delivery model remains appropriate.

2. Methodology

2.1. Approach

The overall evaluation approach aimed to ensure that the evaluation was evidence-based, relevant and useful for DFAT in future program design. The evaluation was primarily summative, with an additional focus on collating learnings for the design of any future programming. The evaluation used a mixed methods approach and tools, including structured document review, interviews and group discussions with key stakeholders, secondary data assessment, and observations in-country (Fiji and Tonga). This report presents a summative and formative evaluation of PSCSHWIP for the period from late 2022 to early 2026.

The evaluation process was multi-staged: the first stage involved a rapid desk review of literature and key documents provided by DFAT and sourced more widely. The documents were reviewed against a set of key evaluation questions (KEQs) included in the Terms of Reference (TOR) (Annex 2) and expanded in the Evaluation Plan (Annex 3). The KEQs were used to frame in-depth interview questions for key informants.

The second stage involved capturing views of key stakeholders from a total of 11 PICs. Virtual interviews were conducted with clinicians, MOH staff and DFAT posts (including bilateral health program managers where possible) from nine PICs: Federated States of Micronesia (FSM) (Kosrae), Kiribati, Nauru, Palau, Republic of Marshall Islands (RMI), Samoa, Solomon Islands, Tuvalu, and Vanuatu (see Annex 4 for full list). Most of the virtual interviews were fully transcribed by Artificial Intelligence (AI) with permission. Additional follow-up interviews/emails were used for clarification as required.

In-country face-to-face consultations were conducted in a further two PICs: Fiji and Tonga. The visits to these two countries involved in-depth individual and group interviews (SPC, FNU, DFAT posts and health facilities/platforms, MOH clinicians and trainees), observation of facilities, and observation of a RACS Urology VMT in Operating Theatre (OT).

Virtual interviews were also conducted with implementing partners (RACS, SPC and FNU), relevant Colleges and Associations, and training providers.

The final stage involved thematic data analysis, where quantitative and qualitative data were assessed against the KEQs (Annex 5). In Fiji, interviews were included as a trial for AI analysis, which generated recommendations including a Pacific hub-and-spoke model for capacity development (provided as a separate document to this report). The DFAT Investment Monitoring Report Ratings Matrix was used to assess against effectiveness, efficiency, GEDSI and MEL criteria.

2.2. Data Collection

2.2.1 Document review

The evaluation included a rapid review of the initial document set (40 documents) followed by a more in-depth systematic review of all documents collected during the evaluation process, including relevant literature. Over 120 documents were reviewed to support this evaluation (Annex 6 for list).

2.2.2 Program implementation data

Program implementation data were collected through individual partner and joint annual progress reporting. In-depth interviews were conducted with implementing partners (RACS, FNU, SPC) to clarify and triangulate data from reports.

2.2.3 Key Informant Interviews (KIIs)

Over 100 KIIs were conducted with stakeholders and beneficiaries from 11 PICs. Stakeholders included clinicians, MOH staff, DFAT posts, DFAT-funded health facilities/platforms, RACS Global Health staff and VMT volunteers, SPC PHD and CSP, FNU CMNHS, and former staff of RACS, SPC and MOHs as available. Most KIIs were conducted one-on-one, although in some PICs 2-4 staff gathered for a virtual interview. Beneficiaries included clinicians who had participated in VMTs, postgraduate courses and other training courses. Patients were not included. A full list of key informants is included in Annex 4. Follow-up and additional one-on-one interviews were conducted virtually as required and finalised in May-June 2026.

2.2.4 Observations of facilities

Facilities were observed in Tonga, including the OT facilities, oxygen plant, biomedical department, emergency department, outpatient clinics and wards. In Fiji, the OT facilities in Colonial War Memorial (CWM) Hospital were observed before and during the RACS Urology VMT procedures.

3. Limitations and Constraints

The evaluation team was aware of the extra workload of increasing the scope of countries from a sample of six (as suggested by DFAT) to 11, however considered it important to gain the views of as many stakeholders and beneficiaries as feasible. Due to time and resource constraints, apart from Fiji and Tonga, it was not possible to conduct in-country assessments in all 11 PICs. Fiji was chosen because it houses FNU and SPC CSP, and is a regional hub for some clinical services training. Tonga was chosen because its MOH staff have experienced decades of VMTs from RACS and many other organisations from multiple countries. Contacts for key informants were provided by RACS, FNU, SPC and DFAT, however additional interviews were conducted beyond those originally named. Some key informants who had been involved in VMTs or managing partner programs were unavailable.

4. Findings and Recommendations

This section describes the key findings and recommendations from the evaluation against the four areas of **effectiveness, efficiency, MEL and GEDSI** identified in the evaluation TOR. Many of the findings and recommendations from this evaluation echo those made in the 2015 and 2022 evaluations of the predecessor programs. Findings and recommendations are reported separately for each partner.

4.1. Effectiveness

KEQ 1: To what extent is each partner (RACS, SPC and FNU) achieving their Intermediate and End-of-Program Outcomes?

4.1.1 RACS Effectiveness

PSCSHWIP has one End-of-Program Outcome (EOPO): *Strengthened regional health workforce and systems for higher quality and more equitable, accessible and sustainable clinical services*. Aligned to this EOPO are three intermediate outcomes (IOs), with RACS contributing mainly to **IO1**: *Quality specialised clinical services are strengthened and more accessible* and **IO2**: *Specialised clinical services health workforce is developed and strengthened.*

The RACS component of PSCSHWIP focuses on direct clinical service delivery through the deployment of specialist surgical teams and the provision of a suite of clinical training, complemented by ongoing mentoring, to increase clinical capacity and strengthen health workforces and health systems in the 11 focus PICs. Data on ongoing mentoring and how clinical capacity strengthening is measured during VMTs was not routinely reported, so could not be assessed.

Table 1 summarises data on the number of VMT deployments, consultations and surgeries as evidence of specialist clinical services provided each year from 2023-2025. By the end of 2026 (year 4), the evaluation team estimates that 75 VMTs will have conducted a forecasted 5,000 consultations and 1,600 surgical procedures, involving over 280 clinical volunteers.

Table 1 below shows that over 500 PIC clinicians have received on-the-job training (which includes observation during surgical procedures and in some cases, hands-on training if appropriate, CPD sessions and grand ward rounds). RACS' Annual Progress Reports include participant numbers for various forms of training, but it was not clear how many local staff received CPD points from CPD sessions. It was also unclear what is involved for mentoring participants, although some qualitative evidence of mentoring is included in reports. Participation in formal courses is discussed later in this report.

Table 1: Key RACS program achievements against IOs

IO1: Specialised clinical services provided	2023	2024	2025	TOTAL	Est. 2026
Number of VMTs deployed	17	19	19	55	+20
Number of patient consultations conducted	1012	1484	1267	3,763	+1,250
Number of surgeries undertaken	321	512	411	1,244	+415
Number of RACS clinical volunteers engaged in surgical deployments	70	71	70	211	+70

IO2: Workforce strengthened (formal training is detailed in Table 2 below)	2023	2024	2025	TOTAL	Est. 2026
Number of PIC clinicians trained through on-the-job and other clinical training such as CPD sessions, grand rounds and post-operative checks (via RACS VMTs)	186	163	193	542	+180
Number of training and mentoring sessions conducted during VMTs	78	61	35	174	+58
Number of PIC clinicians mentored post VMT deployments (by RACS volunteers)	46	29	21	96	+32
Number of PIC clinicians who participated in formal training courses (online and face to face)	156	135	200	491	+163

Source: RACS Annual Progress Reports summary tables, 2022-23, 2024, 2025; 2026 estimates derived from average over previous years.

The evaluation lead observed local capacity building during RACS' Urology VMT in CWM Fiji, where a local Registrar was instructed by the visiting Consultant to perform 'hands-on' trans-urethral resection of the prostate. The visiting Anaesthetist also discussed various issues and scenarios with local staff, and the visiting nurses worked with local counterparts, as evidence of on-the-job training that builds skills and confidence of local staff. A minor post-operative complication overnight

provided an opportunity to highlight the importance of following post-operative nursing protocols to ensure patient safety.

VMTs are highly valued as part of supporting clinical services, ranging from providing substitution in smaller PICs (such as in FSM and Tuvalu), to teaching new techniques to local surgeons that they have not had the opportunity to perform, to performing complex surgeries with local clinicians in Fiji. All PIC key informants stated that they highly valued the VMTs, and no key informants stated VMTs should stop. Currently, VMTs generally include a surgeon, a scrub nurse and sometimes an additional perioperative nurse and anaesthetist. Most key informants appreciated that a team was sent in, as it relieved their own staff. Key informants also appreciated the training component of VMTs.

> I haven't received the final report from them, but they were seeing so many patients and because we don't have that specialty available locally, so it was a big help for us and also the bedside training and sharing the information with the surgeon, our operating theatre team as well too…And then we're very excited when they come, we're happy to have them because it's a huge, huge contribution, the support, the help. [PIC Director]

There is however a tension for RACS VMTs when there are no local surgeons to support skills improvement, and the visiting surgeon then provides substitute services rather than capacity building. That said, several informants mentioned key RACS Fellows who had promoted the development of PIC sub-speciality postgraduate training over decades and inspired the many young doctors who have now graduated from FNU, UPNG, Australia or New Zealand and returned home to practice. Again, because mentoring is a highly individual process, data on mentoring and impact are difficult to assess from RACS' progress reporting, unless extracted from each End-of-Trip Report.

Over 2023-2025, RACS also funded other colleges to provide VMTs: obstetrics and gynaecology through RANZCOG; plastics and reconstructive surgery through Interplast; gastroenterology through ANZGITA; ophthalmology teams comprising regional clinicians from PacEYES (a collaboration between RACS Global Health, the Fred Hollows Foundation in New Zealand and PacEYES). This collaboration demonstrates the regionalisation principle as outlined in RACS' Global Health program; however, these organisations did note that they are able to provide VMTs through their own governance structures. RACS' funding to other colleges is discussed in 4.2.1.

In addition to VMTs providing mentoring and on-the-job training, RACS allocates approximately $420,000 per year for other organisations to provide regional trainings (Table 2):

- Monash Children's Simulation (MCS) unit – to run the Pacific Islands Virtual Online Training in Surgery (PIVOTS) courses.
- Advanced Paediatric Life Support (APLS) Australia, currently reviewing its Pacific program.
- FNU – to run the Early Management of Severe Trauma (EMST) and Care of the Critically Ill Surgical Patient (CCrISP) trainings, currently on hold pending curriculum review.
- ANZGITA – to provide an annual 4-week endoscopy capacity development course in collaboration with FNU as part of the postgraduate gastroenterology module.
- Post Graduate Certificate in Perioperative Nursing mentoring program (originally through ACN, now delivered and funded through FNU).

In terms of strengthening Pacific institutions, two Fijian clinicians who participated in RACS' EMST Instructor Course in Melbourne in 2024 are now part of the FNU EMST and CCrISP Training Faculty. Most of the trainings are conducted in Fiji, although some regional participants are included. PIVOTS is the exception, with training hubs in Samoa, Solomon Islands and Vanuatu in addition to in Fiji.

Table 2: Number of Pacific clinicians trained by RACS, by course (2023-2025)

Course	Location	2023	2024	2025
PIVOTS (6-week core course)	Fiji	9	19	8
PIVOTS (6-week advanced course)	Fiji	N/A	10	17
PIVOTS (6-week core course)	Samoa	10	4	15
PIVOTS (6-week core course)	Vanuatu	N/A	11	N/A
PIVOTS (6-week core course)	Solomon Islands	N/A	N/A	17
PIVOTS (6-week nursing course)	Lautoka, Fiji	N/A	N/A	16
Postgraduate Certificate in peri-operative nursing; weekly mentoring sessions by RACS Nurse Educators	Online, regional	7 (ACN)	13	FNU*
Advanced Paediatric Life Support (APLS)	Fiji	22	19	18
Advanced Paediatric Life Support (APLS)	Fiji	24	21	24
Advanced Paediatric Life Support (APLS)	Fiji	16	20	43
Paediatric Life Support (PLS)	Labasa, Fiji (2)	24	20	32
Early Management of Severe Trauma (EMST)[4] Care of the Critically Ill Patient (CCrISP)	Suva, Fiji	32	2 (TOT)	32
World Gastroenterology Organisation Endoscopy Workshop (4-week course)	Suva, Fiji	18	18	10
TOTAL	**N/A**	**162**	**157**	**232**

*Source: Derived from RACS Annual Progress Reports (detailed tables), 2022-23, 2024, 2025 – not verified with partners. Note: total participant numbers differ slightly from the final row of Table 1, which was summary data. *RACS discontinued its support after FNU developed its own peri-operative nursing program in 2025, to avoid duplication.*

Case Study: PIVOTS training

The highly regarded PIVOTS course provides local trainees the opportunity to use simulation-based education (SBE) and virtual education methodology through novel portable learning simulators. The six-week course delivers structured surgical education, strengthening core technical skills (e.g. surgical preparation and operative documentation) alongside higher-order advanced competencies including clinical governance, problem-solving, clinical decision-making, and patient advocacy. Hand-eye coordination is critical for surgical procedures and the course provides measurable, objective assessment of skills. It provides participants access to the SurgTrac curriculum, which offers ascending modules that take novice learners from basic laparoscopic tasks through to advanced consultant level skills. SBE improves and accelerates healthcare worker training in PICs, while maximising patient safety.

Between 2022 and 2025, participants in PIVOTS Core and Advanced courses completed over 5,100 validated laparoscopic simulation tasks, demonstrating sustained engagement and measurable skills acquisition. Since program inception, 337 general surgery and obstetrics and gynaecology trainees and nurses have enrolled, with 292 participants on track to complete by 2026. In addition to the online learning courses (moodles), PIVOTS provided 48 live interactive webinars, real-time feedback, and a growing community of practice.

PIVOTS Core and Advanced courses are now mandatory components of the FNU Master of Surgery program, delivered under a Memorandum of Understanding with MCS, embedding PIVOTS within national training pathways and supporting local ownership and long-term sustainability. MCS staff support local facilitators to advance their skills in providing education using this technology, to

[4] EMST and CCrISP curricula are being revised and piloted; training will continue with the new Editions in 2026-27

ensure a sustainable educational system in the future. Training local educators encourages continuous, self-directed, in-country practice and reduces reliance on visiting teams of surgical educators. Two independently funded scholarships have been secured to support FNU in-country collaborators and PIVOTS program leads to complete the Graduate Certificate of Clinical Simulation at Monash University. This investment strengthens local educational leadership and supports the transition to a Pacific-led delivery model. MCS plans to expand the scholarship program in 2027, to further build regional capability and program sustainability.

Key informants reported growing confidence in their own surgical skills, as well as their facilitating competencies.

KEQ 1a: Are there any key areas of concern?

The data in Table 1 and Table 2 above indicate clear progress towards achieving outcomes, however the VMT numbers are lower than in previous phases funded by DFAT (Annex 7).

> We used to have lots of VMTs previously. Now it's only 1-2 a year... It's not as nice as it was, but we still appreciate it [VMTs]. Now we have to fight with MOH to get RACS. [PIC clinician]

While comparison over time presents challenges, it does provide evidence to support views expressed by all key informants that they preferred more VMTs and for longer periods so that CPD recognition could be gained through structured lectures and presentations. The perception of several informants was that the reduction in VMTs was due to a change in the funding model from the predecessor programs. While a stronger focus on capacity building was recommended in the 2022 evaluation and the RACS-PIP Learning Paper[5], there remain opportunities for a strengthened approach to documenting individual learnings from VMTs. For example, clinicians who participate in VMTs and on-the-job training generally do not gain recognition or CPD points, despite the intensive learning and skills development during these visits. Some suggested micro-credentialling[6] or using logbooks and other methods, mentioned in the RACS-PIP Learning Paper. Determining the appropriate capacity building model for each PIC is clearly a major issue to address in future.

Of note for this evaluation is that there have been recommendations in the RACS-PIP 2015 and 2022 evaluations that have not been addressed and remain as concerns for PSCSHWIP:

- 'DFAT should carefully examine the balance of effort that is devoted to building individual versus systems capacities and providing country-specific assistance versus strengthening regional mechanisms. Going further, DFAT should build into the design, mechanisms and incentives to ensure that the desired balance is more likely to be achieved (e.g. countries must first have a multi-year SCS human resources (HR) plan in place before submitting requests for individual training – ideally these would be part of broader HR planning, and not siloed to SCS).' (2015, p.10)

[5] Lessons from RACS Global Health's Pacific Islands Program, ND, 2022. 'Efforts to improve clinical monitoring and assessment could include support for the development of individual performance metrics for surgical competence; the building of data registries and clinical logs; and strengthening of formal (i.e. audit, review and evaluation of clinical practice) and informal (i.e. on the performance feedback and coaching) mechanisms to provide feedback on clinical performance. Feedback to surgeons and other health care workers on their performance is essential for fostering better surgical care and is strongly supported by Pacific clinicians and survey participants.

[6] Micro-credentials in health are short, targeted learning programs that allow professionals to upskill in specialised areas. They provide a fast, flexible alternative to full postgraduate degrees, focusing on practical clinical or administrative competencies that can be immediately applied in the workplace. Many health-related micro-credentials can be "stacked" (e.g., combining modules) to count as credit points toward a larger qualification, such as a Graduate Certificate or Masters.

- ‘DFAT may consider funding analysis which would allow countries, PIP/RACS and others to estimate surgical need by country, specialty and procedure so that met and unmet need can be better gauged.’ (2015, p.12)
- ‘For example, requests for SCS training should be linked to a SCS HR workforce plan. Therefore, in order for countries to access the training fund, they would first need to develop their SCS HR workforce plan, linked to a broader health HR plan, which, of course, would also be supported by the project.’ (2015, p.22)
- ‘RACS should change its approach to planning with country partners, which would be better facilitated through face-to-face planning with MoH and lead clinicians, in collaboration with other program partners where appropriate/feasible. This includes working with MoH to undertake advanced planning that is aligned with national strategic planning to build local capacity to provide SCS.’ (2022, p.ii)

Several key informants expressed concern about RACS’ communications, with both crucial staff in the MOHs and with DFAT posts/high commissions.

> I think it comes back to that communications piece with not only the ministry, also the high commission, and ensuring that the communication is with the appropriate people. I know that the RACS primary contact is Dr X, who is one of the chief surgeons, which is great, but ensuring you know that the director of hospital services, the Secretary, etc, are aware or across, because we can't make the assumption that internal coordination is happening. And I think that there's been some frustrations from the Ministry at more senior levels that they weren't aware of when certain visits were taking place. [DFAT Post]

There is an expectation that DFAT Pacific funding provides people-to-people outcomes, linked to public diplomacy through the VMTs deployed through the program, particularly at the country level. However, these expectations could have been more emphasised in the program design.

> I know from many, many years ago, before the VMTs come in country, we usually post up a press release to the public saying the service will be available during these days…But I haven't seen that happening for the past two years now, like us putting it out to the public. But that's an advantage of our other visiting team, the Chinese VMTs, like they always put it out to the public… we have the service, come to us... So in terms of our public diplomacy to our external people, maybe something to think about as well for the strategy going forward. [DFAT bilateral program local staff]

Each VMT returning from a RACS deployment provides an End-of-Trip Report that includes insights into the clinical aspects of the trip focused on planning, logistics, medical equipment and supplies, in-country capacity, local facilities and communications. End-of-Trip Reports are consolidated on a quarterly basis and analysed by RACS to identify capacity strengths and weaknesses for ongoing quality improvement. These reports provide valuable insights and suggestions for MOH to address and for future VMTs, although the evaluation team noted variability in the quality of the reports. Importantly, it is unclear if these important reports are being effectively utilised. In particular, does each report go to the right person in MOH who can act on it? Does it go to the DFAT post or health facility/platform? Do reports go to SPC CSP, who may have already addressed some issues or have budget to support the recommendations from the reports?

KEQ 1b: How well do RACS activities respond to the needs and priorities of Pacific Island countries?

As noted, previous evaluations have highlighted the need for RACS to respond better to PIC needs through a more systematic analysis of clinical services and gaps. The 2022 Nossal report for Interplast[7] suggested a useful schema where PICs can be broadly categorised into three groups based on the local capacity**: limited capacity** (countries reliant on VMTs for the delivery of most services), **foundational capacity** (countries with local surgical capacity to provide services, with VMTs providing support for capacity building and to perform more complex surgeries), and **established capacity** (countries with a local specialist(s) who can meet local demand for surgical services, but require ongoing mentoring and supervision). These categories can provide a basis for tailoring specialist clinical services provision in the Pacific, to align to the local context; however, individual PIC analysis would be optimal.

Some PICs have started this analysis through Clinical Services Plans (Fiji Clinical Services Improvement Plan as part of CWM Hospital Masterplan draft; Samoa Surgical Doctor Workforce Plan 2023; Vanuatu Clinical Services Plan 2019[8]) (Annex 8). However, just having a Plan does not necessarily mean there are actions and resources to support its implementation. For example, while Vanuatu has a Clinical Services Plan, the previous evaluation in 2022 found that Vanuatu was struggling to meet gaps in local capacity despite having an excellent Plan, largely due to individual clinician choices for specialist VMTs.

While RACS provides MOHs with the opportunity to identify needs and priorities on an annual basis, in reality there are many needs that are unable to be met with two VMTs per year, and there was little evidence that RACS has had the capacity to analyse National Health Strategic Plans (NHSPs), other Health Workforce Plans, or develop Clinical Service Plans to align VMT planning. Key informants noted that processes to identify country needs had changed over time; in predecessor programs, RACS would ask countries to fill in a survey to determine need. The default in some PICs has been to nominate VMTs that have been provided in the past to address backlogs and surgical waiting lists, without the analysis required to ensure effective planning.

> So what we found was that we would have departments going directly to the clinical teams and organising the visits, which is great that they have that relationship, but it was very ad hoc at times, and you'd have three or four teams at the referral hospital or out in the provinces at the same time. Now we only have one theatre, and we only have a handful of staff that can be released for training, and if you're running training sessions for three different clinical teams in one week. Well, the question is, who's looking after the patients? And then same with theatres. So if you've got a plastics team, a GI team, and also an X team in the same week well, and you've got 90 cases booked, and we can only provide capacity for 20, then we disappoint 70 people. [DFAT-funded health facility]

Key informants identified the need to meet changing health needs, specifically requesting: paediatric surgery; cardiac surgery; neurosurgery; oncology services (radiotherapy, chemotherapy); diabetes care including foot care, prosthetics; ultrasound skills; and prevention and treatments for non-

[7] Interplast, Nossal The State of Plastic and Reconstructive Surgery in the Pacific, 2022, p.7

[8] Vanuatu Clinical Services Plan 2019 'Clinical services are delivered throughout the health system, from dispensary to referral hospital. The range of services to be provided at each type of health facility is defined in the Role Delineation Policy (RDP). The RDP also defines the staffing, functional space and equipment required by those services. The Clinical Services Plan (CSP) aims to provide a 'road map' to guide clinical service development in Vanuatu over the next 5-10 years, progressively moving towards the standards set out in the RDP. It aims to improve the *overall functioning of clinical services within the health system*, to respond better to population health needs. This means getting the right balance of services between hospitals and primary health facilities and the providing right mix of specialist services within the hospital system.'

communicable diseases (NCDs) from primary health care (PHC) to tertiary services. In addition, two key informants requested specific skills training in endoscopy and laparoscopy, to improve surgical outcomes for patients; their request for ANZGITA training had been too late and places were filled.

One point raised by several key informants was that they wanted to nominate specific RACS volunteer surgeons for VMTs, rather than have RACS Global Health decide through an Expression of Interest process. One surgeon said: *'We are not here as a training for Australian doctors. We have built longstanding relationships with key clinicians, and we hope RACS respects that.'* Another noted that this choice should be included in the MOU with their MOH. In some countries, MOUs with RACS have not yet been finalised and signed (one waiting on Permanent Secretary approval).

Some key informants noted that Pacific specialists are now trained, but sometimes not able to maximise utilising their skills due to lack of OT time or equipment constraints or failures. For example, in Fiji, while there is a local Ear Nose Throat (ENT) specialist, OT time at CWM is highly constrained with no regular ENT slots available, only for emergencies and when ENT VMTs are scheduled.

Table 3 shows the range of VMT specialities provided over the first three years of the program, with the most common being Ear, Nose and Throat (ENT) (28), Urology (10), Paediatric (4), Vascular (3), Ophthalmology (3) and one each for Uro-gynaecology, General surgery, Neuro-spinal, Gastroenterology, Neurosurgery, and Orthopaedics. Nauru had the most VMTs (10) because Nauru Post provided additional funding to bridge key clinical gaps. As noted earlier, it may be the local surgeon who makes a case to the MOH that a particular VMT is needed, in the absence of a transparent decision-making process with RACS.

Table 3: Number of VMTs provided by RACS, by PIC and speciality (2023-2025)

Country	2023 VMTs	2024 VMTs	2025 VMTs	2023-2025 VMTs
Fiji	2 [Urology, ENT]	2 [ENT, Neuro-spinal]	2 [ENT, Neurosurgery]	6
FSM	1 [ENT]	2 [ENT]	1 [Urology]	4
Kiribati	2 [ENT, Urology]	1 [ENT]	2 [Urology, Orthopaedic]	5
Nauru	2 [Vascular, ENT]	4 [Ophthalmology, Vascular, General Surgery, Gastroenterology]	4 [ENT, Vascular, ENT, Ophthalmology]	10
RMI	1 [ENT]	1 [Ophthalmology]	2 [ENT]	4
Samoa	2 [Paediatric, Urology]	2 [Paediatric, Urology]	2 [Paediatric, Urology]	6
Solomons	2 [ENT]	2 [ENT]	1 [ENT]	5
Tonga	2 [Urology, ENT]	2 [ENT]	1 [ENT]	5
Tuvalu	1 [Paediatric]	2 [ENT, Urology]	2 [ENT]	5
Vanuatu	2 [ENT, O&G]	1 [Uro-gynaecology]	2 [ENT, Urology]	5
Palau*	0	0	0	0
TOTAL	**17**	**19**	**19**	**55**

*Source: RACS Annual Progress Reports 2023, 2024, 2025. *Palau only received RACS VMTs under PSCSHWIP in 2026.*

4.1.2 SPC CSP Effectiveness

SPC contributes mainly to achieving **IO3**: *Regionalisation of organisations, guidance, tools, standards and services is strengthened*, and also to **IO2**: *Specialised clinical services health workforce is developed and strengthened*.

Approximately 70% of the SPC PHD budget is funded by DFAT's Partnerships for a Healthy Region initiative. CSP is one program within the PHD, and in 2024 took over responsibility of the PSCSHWIP Program Coordination Unit (PCU), to function as the central coordination mechanism and work with the other two partners (RACS and FNU). The PCU was originally housed under the Office of the Director PHD. The CSP Annual Progress Reports 2024-20259 indicate that SPC substantially delivered the operational functions of the PCU through strong regional coordination, technical governance, MEL systems, workforce development and regionalisation across PICs.

While not funded directly by PSCSHWIP, the core functions of the CSP include the following critical activities for strengthening specialist clinical services, which contribute to PSCSHWIP IOs:

- **Provides a regional governance forum for clinical services**. SPC hosts regional Directors of Clinical Services (DCS) meetings. Directors of Clinical Services or their equivalent meet annually to discuss issues and explore regional solutions for clinical services. Key recommendations from the DCS are presented to the Pacific Heads of Health for discussions and endorsement. Critical clinical issues may be escalated to the Pacific Ministers of Health meeting.
  This is a key platform to raise issues that can be acted on by MOHs and integrated into Annual Workplans and Budgets. PSCSHWIP was presented on and well received by DCS at the 2024 meeting. SPC is currently working on a Regional Clinical Governance Framework, and Clinical Governance training has been developed by the Australian Institute of Clinical Governance (AICG), which has been contextualised for the Pacific and offers modules online. 26 participants from 12 PICs completed the training in 2025.
- **Hosts a regional help desk function to assist PICs with their clinical services queries**. This includes advertising clinical vacancies or locum positions, identifying clinical personnel, seeking collaborative opportunities, dissemination of information, and providing advice and solutions. As one key informant said: 'SPC is linked in with all the clinicians, and we all know each other, and who to ask if we need support for X [our specialty].'
- **Explores, develops and implements regional approaches and/or initiatives** that are cost-effective in delivery of clinical services including initiatives such as aligning internship programs to the recommended regional requirements; exploring regional Ear Nose Throat (ENT) solutions and developing a Regional ENT Plan; and implementing the Pacific perioperative practice standards. The 2024-2025 CSP Annual Progress Reports demonstrate that SPC improved cost-effective delivery of clinical services by using regional approaches such as shared technical networks, workforce training, biomedical support and digital health systems across Pacific countries. Activities include supporting National Surgical, Anaesthesia and Obstetrics Plans (NSOAPs) and helping countries share expertise, reducing duplication and strengthening specialised clinical services more efficiently across the region.
- **Supports commissioning and dissemination of research and analytical work** to support informed decision making by DCS and Heads of Health. Regional research and analytic work largely result from recommendations from DCS and technical meetings. This included operational research, NSOAP planning, digital health assessments, climate-health evidence

[9] SPC signed contract in early 2024, thus no Annual Report 2023

systems, program evaluations, dashboards for IPC, PBEN and regional data reporting that helped inform policy discussions, workforce planning and regional decision-making.

- **Strengthens Pacific Clinical Organisations' networks** to support continuing professional development and discuss regional discipline-specific issues and solutions. Key informants stated that a regional pool of clinicians can be mobilised under each network, for example a visiting team in Tuvalu comprised of clinicians from different PICs. They highlighted the importance of specialists based at SPC to respond to emergencies such as in RMI and Vanuatu. Since 2022, 17 Pacific clinical and technical networks were supported and strengthened to improve regional coordination, workforce development and specialised clinical services across PICs (Table 4).
- **Strengthens Pacific Health Systems**. SPC supports 20 Pacific MOHs to strengthen health systems, prevention, workforce capacity and clinical services development, including through PSCSHWIP. SPC provided technical support on sector-specific plans, clinical governance frameworks, workforce planning, and specialised health system strengthening initiatives. Examples include supporting NSOAPs for Tonga and Samoa to 2030, with Vanuatu to be completed soon.

Table 4: Pacific clinical and technical networks supported by SPC CSP since 2022

Network / Platform	Focus Area
Directors of Clinical Services (DCS)	Regional clinical governance and coordination
Pacific Heads of Health (PHOH)	Regional health leadership and policy dialogue
Pacific Heads of Nursing and Midwifery (PHONM)	Nursing and midwifery leadership
Pacific Islands Surgeons Association (PISA)	Surgical workforce and clinical support
Pacific Society of Anaesthesia (PSA)	Anaesthesia workforce development
Pacific Clinical and Nursing Networks (PCNNs)	Clinical workforce development and CPD
Pacific Biomedical Engineering Network (PBEN)	Biomedical engineering equipment support
Pacific Infection Control Network (PICNet)	Infection prevention and control
LabNet	Laboratory strengthening and diagnostics
PRATA Regional Rehabilitation Network	Rehabilitation and assistive technologies
Pacific Physio Rehab Network (PPReN)	Physiotherapy and rehabilitation services
Pacific Society for Reproductive Health (PSRH)	Reproductive health services
Pacific Network for Health and Climate Change (PNHCC)	Climate-health coordination
Health and Climate Change Technical Working Group	Climate resilience and technical coordination
Pacific Public Health Surveillance Network (PPHSN)	Disease surveillance and preparedness
Professional Clinical Associations (PCAs)	Professional standards and workforce support
Technical Working and Advisory Groups (TWAGs)	Technical advice and policy coordination

Source: SPC CSP Annual Progress Reports 2022-2025.

SPC remains highly valued as a regional coordination and convening platform for Pacific Health Ministers, Pacific Heads of Health, Directors of Clinical Services, and Pacific Heads of Nursing and Midwifery (PHONM) meetings. SPC also champions regional IPC, Nursing and Biomedical Engineering networks, which were acknowledged by key informants; however, informants identified the need to improve execution, systems integration, governance clarity and operational capability. Some key informants raised concerns that activities were being driven by available opportunities rather than structured country-led systems:

> 'Funding and country coordination need strengthening'.
>
> 'There is a need to better identify country priorities and use data to identify gaps'.
>
> 'Stronger country ownership and leadership are needed'.
>
> 'Some activities appear practical-driven rather than strategically aligned'.

Key informants raised that with increasing speciality demands, PIC health systems were not 'specialty-ready' when clinicians return from training, for example with the necessary specialist equipment. SPC has developed a concept paper for a Pooled Procurement Mechanism of critical and high-value health commodities that could be useful in future planning for specialty equipment.

Progress was observed in the formation and support for Pacific Clinical and Nursing Networks, but these require further strengthening across all levels of health care for accountability across the Pacific. Key informants noted that SPC's regional workforce planning role requires further strengthening, particularly in linking workforce planning, specialty mapping and training outputs to country needs. Greater use of workforce projections, regional human resource data and structured specialty planning would improve alignment between training, tailored VMTs and workforce capacity.

Key informants emphasised that SPC should accelerate development of a regional clinical services dashboard to better track progress, identify regional and country needs, and strengthen accountability across PICs. Harmonised dashboards, integrated datasets and feedback loops into planning processes would improve evidence-based decision-making and country-level use of data for clinical services planning and coordination. Only regional IPC and Biomedical Engineering have progressed in developing dashboards.

While SPC activities clearly respond to the needs and priorities of countries, some key informants raised concerns regarding Fiji-centric approaches, including fewer training opportunities for smaller PICs, as places for regional students are more limited than for Fijian students.

Key informants highlighted the need for stronger integration and coordination across DFAT-funded health investments and donor-supported clinical services. SPC was seen as best placed to facilitate regional investment mapping and alignment in relation to clinical services and workforce support.

4.1.3 FNU CMNHS Effectiveness

FNU CMNHS contributes to achieving **IO2**: *Specialised clinical services health workforce is developed and strengthened* mainly through its core academic programs but supports regional students through PSCSHWIP. FNU also contributes to **IO3**: *Regionalisation of organisations, guidance, tools, standards and services is strengthened* through PSCSHWIP. To note, FNU's MEL indicators for PSCSHWIP are specific, so broader FNU data was used to inform the assessment of FNU's contribution to the two IOs.

FNU is the key Pacific institution to train health workers and specialists. FNU College of Medicine, Nursing and Health Sciences (CMNHS) offers a range of Certificate, Diploma, Bachelor and Postgraduate higher education courses including specialised postgraduate medical, dental, and nursing clinical training. In support of **IO2**, PSCSHWIP funding has significantly assisted the institution to respond to the health training and research needs of the region. For example, CMNHS has been able to improve the quality of current academic programs and also offer new programs and short courses. FNU staff have been trained as facilitators for various PSCSHWIP programs such as MCS PIVOTS, ANZGITA, EMST and Perioperative Nursing.

FNU's PSCSHWIP Annual Progress Reports and CMNHS enrolment data from 2022-2025 (Table 5) show that FNU has maintained commitment to specialised clinical trainings, with a total of 11,204

enrolments (74% female on average). Undergraduate enrolments are the largest, averaging up to 73% of total enrolments. Postgraduate enrolments grew by 11.5%, highlighting an increased interest in specialisation by PIC students. FNU CMNHS is funded under the Fiji Ministry of Education, and policy mandates that at least 50% of enrolments must be Fijian nationals. Regional student enrolments remain well under 50%, however they have grown from 17.3% in 2022 to 20.5% in 2025. Detail on FNU CMNHS' suite of short courses is shown in Table 6.

FNU largely achieved IO2 through its strong regional role in clinical training, postgraduate education, specialist outreach, and continuing professional development. The 2024 and 2025 Annual Progress Reports and key informants highlighted FNU's contribution to strengthening Pacific clinical capacity through partnerships with SPC and RACS, trainee participation in VMTs and specialist programs, and growing focus on clinical leadership, workplace learning, governance, and operational research relevant to Pacific health systems.

Table 5: Number of FNU CMNHS enrolments, by region and gender (2022-2025)

Year	Fiji	Fiji	Fiji	Region	Region	Region	Int'l	Int'l	Int'l	All regions
N/A	Male	Female	Total	Male	Female	Total	Male	Female	Total	Total
2022	533	1744	2277	158	326	484	14	29	43	2804
2023	537	1792	2329	128	304	432	21	35	56	2817
2024	527	1722	2249	164	375	539	19	29	48	2836
2025	499	1624	2123	166	397	563	22	39	61	2747
Total	**2096**	**6882**	**8978**	**616**	**1402**	**2018**	**76**	**132**	**208**	**11204**

Source: FNU CMNHS enrolment records. Figures are head counts of enrolled students.

Table 6: FNU CMNHS short courses in 2026

School	No. courses	Courses
FIPHR – Fiji Institute of Pacific Health Research	3	Vaccinology and Applied Research for Immunisation Policy and Programs; Planetary Health in Pacific; International Health Regulation
SDOH – School of Dentistry & Oral Health	9	Certificate in Dental Assisting (Level 4) Quota Based; Manage Orofacial Pain Cases in Dental practice; Manage Oral Mucosal Diseases & Malignancies in Dental Practice; Manage Jaw Cysts, Tumours & Salivary Gland Disease Cases in Dental Practice; Digital Dental Photography; Aligner Orthodontics; Orthognathic Surgery Planning; Paediatric Orthodontics; Orthodontic Sleep Medicine
SHS – School of Health Sciences	14	Certificate in Clinical Laboratory Technology (Level 5) Quota Based; Certificate in Applied Phlebotomy (Level 5); Radiographic Image Interpretation and Reporting (Level 7); Medical Imaging Person Centred Care (Level 7); Radiographic Image Acquisition and Manipulation; Research Methods for Medical Imaging Technology; Principles of Medical Imaging Ethics; Strengthening Healthcare Associated Infection Prevention; Control Practices and Hand Hygiene; Implementing Transmission-Based Precautions with Correct PPE Application; Sharps Safety and Occupational Exposure; Improving Environmental Cleaning and Reprocessing of Patient Shared Equipment; Effective Waste and Linen Management for Healthcare Settings; Training in Aseptic Procedures for Healthcare Workers; Pharmacy Dispensing and Patient Safety
SMS – School of Medical Sciences	1	Certificate in Medical Certification of Cause of Death for PICT (Level 7)
SON – School of Nursing	4	Certificate in Enrolled Nursing; Certificate in Managing Diabetic Foot Disorders; Certificate in Substance Abuse Prevention; Basic Counselling Skills
SPHPC – School of Public Health & Primary Care	7	Certificate in Environmental Health; Certificate in Community Nutrition (Level 4) Quota Based; EDRP 8124 Environmental Health Disaster Risk Management: Preparedness; EDRP 8224 Environmental Health Disaster Risk Management Response; EDRP 8324 Environmental Health Disaster Risk Management: Recovery; Gender Equity, Disability and Social Inclusion; Implementing Healthy Settings in PIC
Unspecified	1	Certificate in Health Professions Foundation Studies (Level 4) Quota Based

Source: FNU CMNHS Administrative Data.

In support of **IO3**, PSCSHWIP funds staff positions at the College Regional Office (CRO), which functions like an Australian university international student office and supports regional students with their studies, to help improve retention and graduation rates. Key informants welcomed the assistance provided by the CRO to regional students, such as academic counselling, psychosocial support, accommodation support, study visas, English assistance, laptop loans, social and cultural activities, and engagement with PIC high commissions. This assistance is highly valued, and one student emphasised that: '*In CMNHS, only the CRO can help us regional students*', while a graduating

mother expressed gratitude for the CRO Project Manager's commitment to arranging a homestay for her daughter.

FNU's PSCSHWIP Annual Progress Reports also confirm continued investment in, and uptake of, FNU training programs for regional students, with students from nine PICs supported. A new course, Certificate in Health Professional Foundation Studies, was developed in 2023 to support regional students receive relevant industry-focused learning, enrolling 16 students. Key informants provided strong evidence that FNU contributes to regionalism through regional workforce training, in-country partnerships, telehealth, and Pacific-wide professional networks.

Key informants also emphasised that FNU's role extends beyond Fiji, through regional perioperative nursing, eye care, anaesthesia and surgical training; telehealth and online learning support in countries such as Vanuatu and Samoa; in-country midwifery training in the Cook Islands; and regional outreach and mentoring linked to VMTs and specialist attachments in their respective countries. This has already occurred in several PICs, and a Master of Anaesthesia trainee (from Vanuatu) will soon accompany a RACS VMT in Vanuatu. This collaboration enhances confidence for the trainee, creates trust from fellow nationals, and provides a 'cultural sensitivity bridge' for VMTs.

Separate to PSCSHWIP, DFAT provided 270 undergraduate and postgraduate scholarships to Pacific students between 2022-2025 (72% to females), and several informants described FNU as central to the Pacific regional workforce pipeline, including comments such as: *'Training people for your own people', 'Our region – preference for FNU to provide trainings undergrad, PG, re-skilling and upskilling'*, and *'Standardisation of practice – network of practitioners for different disciplines.'*

Overall, PSCSHWIP progress reporting and key informant views indicate that FNU substantially met the intent of both IOs by maintaining and expanding specialised clinical workforce training relevant to PIC needs beyond Fiji, including development/re-accreditation of specialised programs such as surgery, paediatrics, psychiatry, environmental health, nursing eye care and mental health nursing. Key informants also identified opportunities for further improvement, including more Pacific-focused short courses, expanded training for nurses and allied health workers serving rural and outer island communities, competency-based CPD programs, improved clinician career pathways and workforce retention planning. There was also strong support for regional accreditation and licensing systems, regional CPD harmonisation, and development of clinician databases through alumni and regional networks.

Finally, interviews also highlighted growing regional integration between SPC, RACS and FNU, including through regional specialist rotations, collaboration via DCS and professional clinical networks, and attachment of regional trainees to VMTs as mentioned above. However, key informants also identified weaknesses in regionalism, including perceptions that some training remained Fiji-centric, delays in admissions and offer letters for regional students, limited coordination with country planning cycles, and insufficient formalisation of scholarships and regional workforce planning aligned to PIC needs.

Case Study: Developing ENT specialty in the Pacific through partner collaboration

A positive example where RACS, SPC and FNU have collaborated well over the years is in ENT. Significant work has been done on ENT services since 2015 when Pacific Ear, Nose and Throat Technical Advisory Group (PENTAG) was formed, holding its 5th meeting in 2023. SPC has worked with its regional partners and donors to assist PICs in advancing this specialty and a Regional Plan was developed. Postgraduate courses in Otolaryngology are offered at UPNG and now at FNU, however there are still very few Pacific ENT specialists (two each in Fiji and Samoa, and one in Tonga; others are in training). PENTAG has encouraged the development and establishment of ENT services in each Pacific country's health system, comprising not just doctors and nurses but also audiologists, technicians, and speech therapists. Some nurses have been trained in audiometry skills, but there is

no postgraduate certificate in Ear Nursing. Over the past years, PENTAG has received donations of specialised equipment from partners such as RACS, ENT Surgeons from Auckland, the University of Auckland, and the Ernakulam Medical Centre in India. DFAT ANCP funded the Samoa Hearing Program.

RACS' ENT VMTs have provided support for backlog cases, in particular for children, however some surgeries could not be carried out as the children had suppurating otitis media that required pre-surgical treatments. This led to VMTs bringing audiologists, who provided essential diagnostic audiology tests crucial for pre-surgical evaluations and collaborative triage with the ENT surgeon, ensuring appropriate planning for future surgeries and hearing aid fittings. RACS Global Health recommended that a more preventive approach be taken to reduce the number of surgeries required, and in 2025 RACS' VMTs in Tuvalu worked with local nurses to conduct screening and hearing tests in schools and clinics. The audiology equipment was left behind with the nurse who had been trained; however, she was unable to continue with screening as she had other roles in the hospital, and she said she did not feel confident to conduct the screening on her own (KII).

On a subsequent visit in May 2026, an ENT VMT was able to observe the nurse and build her skills and confidence and ensure that a screening program is scheduled into her workload. During the VMT, 412 patients were seen by Ear Health Nurses and of these 49 were triaged to the surgical clinic, with 35% going on to receive surgery – significantly fewer cases were rejected due to active infection, because the nurse had been administering the correct ear drops prior to the VMT. This is an effective health system strengthening approach that included prevention and improved local primary clinical services to reduce the need for VMTs.

4.1.4 Summary of Key Findings on Effectiveness

RACS VMTs are highly regarded, with requests to continue the VMT model. However, changes are needed to embed VMTs into broader health system strengthening programs as has been recommended in previous evaluations. Sustainably strengthening specialist clinical services in PICs requires a country-by-country analysis of workforce and a Clinical Services Plan for 5-10 years, including for specialities and sub-specialities.

Australian Government funding has supported RACS Global Health for 30 years, over a period of time when there were very few local PIC doctors, nurses and allied health professionals. The healthcare workforce and burden of disease context have changed over that time, but the model of short-term VMTs remains largely the same. Most PICs preferred more and longer-term VMTs, or even in-country 3-12-month placements to better support building capacity of local doctors and nurses and outreach to more remote communities. Despite these challenges, the evaluation has identified strong evidence of high levels of satisfaction with RACS among stakeholders. Those interviewed often mentioned positive mentoring from RACS VMTs. Communications pre and post VMTs by RACS was a concern to some MOHs and DFAT posts.

The importance of micro-credentialling for local staff working with VMTs was raised by some key informants, as learnings during visits did not gain CPD recognition but were considered to provide more practical and important skills than completing an online course to 'tick-a-box' to gain CPD points.

Regional trainings – in particular PIVOTS courses – were very highly valued, as they provided objective, practical skills that could be used and also passed on to other PIC clinicians upon return by participants to their home countries. This component is critical to support in a next phase and to expand to other universities beyond Fiji for sustainability.

SPC CSP convening and networking has demonstrated its critical role in strengthening clinical services as the key regional partner. The 'clinical services strengthening data dashboard' concept

was presented at the 2024 DCS meeting, but there was no clear agreement on what the dashboard should include as the SPC staff member who proposed it left before it was developed.

The core function of **FNU CMNHS** is training of undergraduate and postgraduate health workforces. FNU has substantially met the intent of the IO2 and IO3 by expanding specialised clinical workforce training relevant to PIC needs beyond Fiji, strengthening regional student support systems, and participating in regional coordination functions under PSCSHWIP. FNU CRO is a highly valued resource for regional students and contributes to improving the Pacific health workforce through its support.

4.1.5 Key Recommendations on Effectiveness

- **Recommendation 1:** SPC CSP to use its convening role to discuss at DCS meeting(s) support to PICs in developing Clinical Services Plans, including a timeline (as recommended in previous evaluations). These plans will strengthen VMT alignment to country needs.
- **Recommendation 2:** PCU to explore methods for providing individual performance metrics and CPD recognition during VMTs through on-the-job activities (at the request of many clinicians and MOHs who are reviewing performance systems for salary and promotion).
- **Recommendation 3:** RACS to confirm with SPC and MOHs who the End-of-Trip Reports should be sent to, in order to maximise the effectiveness of VMTs in supporting country priorities. This could be included as part of finalising MOUs with PICs.
- **Recommendation 4:** RACS to strengthen communication with DFAT posts, MOHs and hospitals (to ensure timely sharing of useful information before, during and after VMTs), through adherence to its existing communications plan.
- **Recommendation 5:** RACS to explore options for expanding regional training opportunities with partners in 2027 (e.g. MCS PIVOTS, Interplast, and ANZGITA), as their cost-effective trainings provide measurable skills transfer and recognition through certificates or as part of postgraduate qualifications.
- **Recommendation 6:** DFAT to continue support for the FNU CRO unit to the end of the current program, with a view to ensuring future sustainability in consultation with FNU.
- **Recommendation 7:** DFAT to explore options for a regional public health approach to Ear, Nose and Throat (ENT), beyond providing ENT VMTs, given the high number of ENT cases, lack of PIC specialists, and potential for prevention and screening models.

4.2. Efficiency

KEQ 2: To what extent are the program's overall delivery model and partnership arrangements fit-for-purpose and supporting the achievement of Intermediate and End-of-Program Outcomes, now and for any future phases?

The role of each partner is well defined and aligned to the EOPO and IOs. Each partner is currently contributing to achieving IOs, however the Pacific health workforce is changing and the delivery model for any future support needs to evolve to more efficiently meet the needs of country health systems. Annex 1 shows the changes to health workforces over time, and the complexity of managing retention in PICs with attrition to Australia, Fiji and New Zealand. The evaluation found clear opportunities for increasing efficiency under the current model and in future support.

4.2.1 RACS Efficiency

RACS is the primary partner delivering on **IO1**: *Quality specialised clinical services are strengthened and more accessible*. The key niche for RACS is through the provision of surgical clinical services and the mentoring and training that takes place through VMTs. However, key informants also noted that several other countries provide similar VMTs (or VCTs/Visiting Clinical Teams), notably New Zealand through Pasifika Medical Association (PMA), China, Taiwan and the Philippines. In some cases, RACS VMTs did not have a viable surgical patient list as a previous longer-term clinician or team had completed most procedures. Some PICs have established longstanding relationships with clinicians in Australia and New Zealand outside of RACS, who have supported ongoing training, placements, mentoring, and have even responded to urgent equipment and medication requests.

A substantial budget is spent by RACS on shipping surgical equipment, trays and consumables for VMTs. Key informants suggested that each PIC should have its own basic surgical equipment that is of an acceptable standard for VMT surgeons; then only highly specialised equipment would need to be shipped. One local General Surgeon noted that it was *'embarrassing for us to have blunt scissors or not have different sized forceps. It is time for us to have our own simple, basic equipment.'* Local specialists suggested that they could be provided with basic speciality equipment at completion of their speciality training to ensure they can deliver procedures. In future, consideration might be given to more cost-effective pooled procurement of surgical equipment (for specific VMTs) that is pre-positioned (similar to the Pacific Humanitarian Warehousing Program). All equipment donated or procured needs to be entered in MOH Asset Registers, and Biomedical Engineers must be notified for the purposes of repairs and future routine maintenance.

IO2: *Specialised clinical services health workforce is developed and strengthened* is a focus of all three partners. RACS supports numerous regional clinical trainings, including the MCS PIVOTS Core and Advanced courses in Fiji, Samoa, Vanuatu, Solomon Islands and most recently Tonga. This is a relatively simple, low-cost program that has built strong foundations for surgery and key informants reported that it is a highly valued and successful program for strengthening surgical skills. It is now a mandatory course under the FNU Master of Surgery program. The Advanced course includes clinical decision-making and clinical governance, which is a gap in most PICs. Key informants who had participated in the ANZGITA endoscopy training found they gained measurable skills, and a certificate from WGO plus postgraduate academic recognition from FNU, however participant numbers for the endoscopy training are limited by space and not all requests for enrolment can be met.

As noted, RACS allocates approximately $420,000 per year for other organisations to provide regional trainings. Table 7 shows budget allocated and actual spend for these other training providers. While funding for regional training programs is currently channelled from RACS to partners, some key informants suggested that they could manage the trainings through their own management structures, reducing the load on RACS and providing more autonomy for partners. Training partners evaluate the effectiveness of their own trainings and can demonstrate improved skills and capacities. The relatively small amount of budget for regional trainings means they are a longer-term and more sustainable capacity building model.

Table 7: RACS expenditure on regional training partners (2023-2025)

Regional Trainings	Budget 2023	Actual 2023	Budget 2024	Actual 2024	Budget 2025	Actual 2025
Monash Children's Simulation for PIVOTS	$163,400	$186,740	$162,324	$162,324	$165,000	$162,324
Advanced Paediatric Life Support (APLS) Australia	$115,800	$86,024	$95,000	$85,515	$90,000	$46,719
FNU – EMST and CCrISP	$118,940	$29,345	$50,000	$407	$100,000	$21,644
ANZGITA	$121,200	$44,050	$40,129	$84,050	$45,000	$46,429
PG Certificate in Perioperative Nursing mentoring program	$12,960	$2,000	$12,000	$16,653	$65,000	$0
Total	**$532,300**	**$348,159**	**$359,453**	**$348,949**	**$465,000**	**$277,116**

Source: Email correspondence between evaluation team and RACS.

4.2.2 SPC CSP Efficiency

PSCSHWIP provides CSP with a small budget of $1m over four years to support it to deliver on PSCSHWIP-related activities. CSP's broader program of work to strengthen clinical services (described in 4.1.2) is funded through SPC PHD funds. PSCSHWIP funds were intended to support a program and communications officer position (never filled), an M&E and risk management adviser position, and program coordination work through the PCU. The M&E position took time to be filled and only commenced in January 2024 (originally reporting to the PHD Director, not to the CSP Team Leader). The adviser left after 12 months and the position was left vacant. From 2025, the CSP Team Leader provided PCU support in addition to her normal role within CSP. The resultant underspent funds were discussed with DFAT and will be used to support PIC attendance at regional trainings, conferences and meetings, including a pre-DCS workshop in July 2026. Funding will continue to support country requests for training and capacity building facilitated by FNU, e.g. endoscopy, ultrasound and burns training, as well as supporting capacity building for postgraduate trainees to be in-country when VMTs visit their countries, to learn and gain skills. All key informants noted that SPC had provided them with some technical support and funding to attend such activities and this was highly valued, as countries do not have budget for such capacity building activities. One key informant noted that with changes to staff in the PCU, there was a loss of continuity and information with 'no induction and no response when needed.'

SPC presented on PSCSHWIP at the 2024 DCS meeting, including on plans to develop a 'clinical services strengthening data dashboard' with regional scope that would help to:

- identify current strengths and guide national identification of priorities,
- support advocacy to policy makers, government ministers and key stakeholders, including funders, to engage with clinical services strengthening, and
- monitor and report progress on implementation of PSCSHWIP and similar programs.

The first action noted was to convene a dashboard coordination team comprising the PSCSHWIP implementing partners, PIC stakeholders and partner agencies to identify a set of indicators. This has not happened and is now a recommendation of this evaluation.

There also appeared to be some confusion around whether SPC was required to provide Annual Progress Reports on CSP core activities for PSCSHWIP. The 2023 Joint Annual Progress Report stated

that: *'Core functions of SPC's PHD-Clinical Services Programme (CSP) have been included in the PSCSHWIP2 MELF and work plan, however only PSCSHWIP2 functions, funded by DFAT for the PSCSHWIP2 program are to be included'.* DFAT clarified expectations with CSP ahead of 2025 reporting, however earlier clarity would have avoided confusion and meant progress reports were more consistent in the information they presented, and hence more comparable.

4.2.3 FNU CMNHS Efficiency

For a relatively small budget for staffing and student support, CMNHS has managed to provide a unit that is recognised as the go-to for student support. For regional (and Fijian) students, this support is critical for their health and wellbeing and allows them to focus on their studies. Staff go above and beyond their job descriptions to provide support to students. This is reflected in increasing numbers of regional students who continue with their studies to graduation, with most returning to work in their home country. From 2022-2025, 4,153 students graduated and of these 22% were regional students on average. In 2022 there were 194 regional student graduates (21.4% of all graduates), and in 2025 this had increased to 252 students (33.7% of all graduates). The higher percentage increase is partly due to a decline in Fijian student numbers.

KEQ 2a: To what extent does each partner have the right staff, management structures and budgeting arrangements in place?

Without a deep dive into each partner's organisation, it is difficult to provide a firm assessment of this KEQ, however some key findings are presented below. To note, there were a range of views on management structures and commitment.

RACS Global Health evolved from having a strong volunteer and philanthropic ethos in 1994 to establishing a Global Health program team, sitting under the Global Health Programs Steering Group (which reports to the International Engagement Committee of Council). RACS Global Health has numerous positions that are funded partly through PSCSHWIP (with budget just over $500,000 in 2025 and 2026), however it is difficult to confirm if they represent the right number and mix of staff. For example, there is no dedicated Communications position. During 2022-2025, four staff members were clinicians (nurses) and five staff had international health and development backgrounds. The Global Health team will soon merge with RACS' philanthropic arm, Foundations for Surgery, which raises funding for scholarships and grants, including for Pacific recipients. Currently, RACS is completing the ACFID Code of Conduct self-assessment and DFAT accreditation processes.

RACS has seen a high turnover of Global Health staff, with 15 staff leaving in the past three years. Three key informants stated that RACS as an organisation has '*little understanding about international development'* and two key informants stated that it does not seem that Global Health is taken seriously at Executive levels, rather it is being seen as a drain on the organisation's budget[10]. The Chief of Operations and Partnerships stated that the RACS Board and Council were both committed to Global Health. No interviews were conducted with the RACS Board or Council, so this could not be tested and verified. Conversely, one key informant noted that Global Health may not have a strong understanding of clinical services and the challenges clinicians face when working in limited resource health systems. Providing surgical VMTs requires coordination and managing relationships with volunteers, PIC clinicians and MOHs. However, it is unclear if Global Health staff based in Australia are able to analyse and integrate surgical VMTs into broader country health workforce planning and priorities, or indeed if it should be their role.

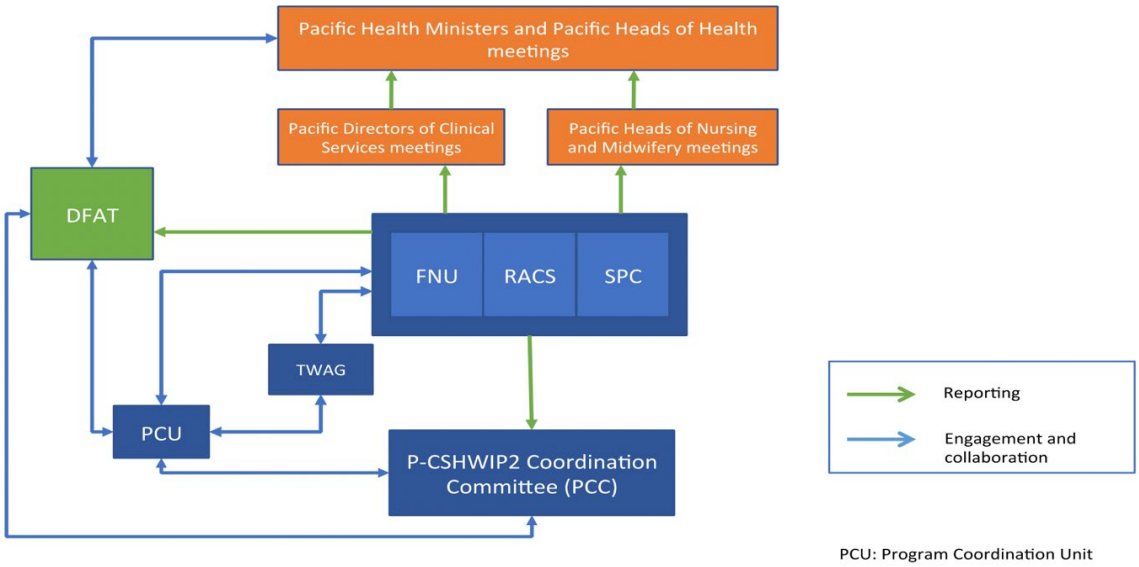
Management costs for both Phase 1 (2016-2022) and Phase 2 were 28% of the total RACS budget. These costs include the Global Health team salaries; PSCSHWIP allocation of office-related costs;

[10] 'I heard a Board member say, 'We do surgery not development work'. 'RACS GH don't have the support from leadership.'

depreciation on buildings, maintenance and repairs; required subscriptions; storage costs (for PSCSHWIP-related equipment); PSCSHWIP allocation of indemnity and liability costs; and PSCSHWIP allocation of risk management costs (CSI Watchdog for Counter-Terrorism Screening). Procurement and shipping costs for VMT equipment and consumables are a substantial budget item and could be reviewed to improve value-for-money.

SPC CSP is largely funded by PHD funds (70% funded by DFAT) and is the linchpin for a regional approach to clinical services planning and strengthening. CSP has eight staff positions, although not all are filled (noting that SPC positions take a long time to recruit and fill, and some are left vacant to reduce spending). PSCSHWIP funded an additional M&E and risk management adviser position, originally reporting to the Director of PHD but then shifting to the CSP Team Leader. In hindsight, more clarity on CSP's coordinating role and reporting channels for PSCSHWIP could have prevented misunderstandings. Budget for staffing positions versus supporting regional trainings has been discussed during a PCU meeting in 2026. It is not clear from PSCSHWIP's governance structure (Figure 1 below) what engagement, collaboration and reporting lines really mean for PCU functioning. As noted in the 2023 Joint Annual Progress Report: 'Functionality of the PSCSHWIP2 governance structure, especially through regional health meetings was not well formalised in this period. This is to be a priority in 2024'.

Figure 1: PSCSHWIP governance structure



Source: PSCSHWIP Phase 2 Investment Design Summary.

FNU CMNHS' core business is to train and build the Fijian and Pacific health workforce. PSCSHWIP funds five positions within the CMNHS College Regional Office (CRO): Project Manager, Regional Counsellor, Student Life Coordinator, and two Regional Student Relations Administrators. The funding also supports the provision of academic counselling and psychosocial support to regional students to enhance their retention and graduation, and support for a range of regional student activities. This investment appears to provide the right level of staffing for the CRO, which is well integrated within CMNHS and provides valued support services.

KEQ 2b: How well do the three partners collaborate with each other and other organisations to share resources and deliver outcomes?

The three partners meet twice a year through PCU and PCC meetings (the latter includes DFAT) and engage on an ad hoc basis outside of these meetings as needed. All partners report that these meetings are useful and cordial. They provide an opportunity for partners to share updates and

progress on activities and deliverables. However, there is much more that partners could do to prioritise and synergise, such as all focusing on what would be needed to support each PIC develop a Clinical Services Plan (including sub-specialties) and determining how each partner could contribute to country-level calendars for planning VMTs.

Joint Annual Progress Reports provided clear actions from 2023 that would have progressed coordination and improved program effectiveness and efficiency. However, at the time of this evaluation, these actions have not been reported on as completed and remain outstanding. A key question for the implementing partners and DFAT is: what are the barriers preventing action? For example, actions in the 2023 report included:

- Consult with local clinical teams to understand how patient lists for RACS VMTs are developed and how news of scheduled VMTs is communicated to potential patients living outside urban centres.
- Develop and support implementation of a VMT communication strategy to provide guidance on ways to improve community awareness of VMTs, especially among under-represented groups.
- Measure impact of formal and informal capacity building provided by clinical VMTs, including increased confidence to perform specialised surgeries.
- Develop a system to effectively record locality data (rural/urban) on key documents such as consultation and operation records.
- Engage disability and women's rights CSOs to identify barriers to awareness of, and access to VMTs for women, girls, and people with disabilities, and respond to allow more equitable access to VMTs.

During evaluation consultations, RACS staff asked about the status of the 'dashboard' that is a deliverable for SPC. It was unclear to the evaluation team what the dashboard was meant to capture, as partners appear to have differing views. The evaluation team's question for the PCU is: what data and indicators is the dashboard meant to provide? The Nossal Baseline Assessment suggested it was a dashboard for clinical service networks, guidance tools and standards by country, while RACS key informants suggested it is a regional calendar for all VMTs. For the latter, the question is: how realistic is it to develop a regional calendar for VMTs, given that PICs struggle to develop their own with limited resources? To note, it was later clarified with the evaluation team that there are indeed two 'dashboards' – one for clinical services strengthening, and one to serve as a calendar of VMT visits (most likely at the country rather than regional level).

One area where each partner could contribute to delivering on outcomes is through supporting the development of NSOAPs. To date, RACS specialists and FNU appear to have had limited involvement in supporting PICs and SPC. Both NSOAPs and Clinical Services Plans for countries are critical for strengthening specialist clinical services; more can be done by all partners to further what should have been a PSCSHWIP baseline activity.

EQ 2c: Is there merit in continuing to group the partners under a joint program?

Currently each partner appears focused on progressing against their own IOs and core business. It would be beneficial for the three partners to demonstrate what concrete deliverables they can jointly deliver until the end of the current program, but noting support to CSP ends in September 2026. For example, as mentioned above, there is scope for partners to work together on NSOAPs, Clinical Services Plans, VMT calendars, and Equipment Plans to reduce freighting costs.

Beyond 2027, there should be more of a focus on a Pacific-led delivery model, including bilateral health programs funding future VMTs as noted above, but not necessarily under a joint program with SPC and FNU. SPC should continue to play a major coordinating role through the CSP and

continue to collaborate with FNU and other Pacific universities on clinical health workforce development.

KEQ 2d: Should other Australian medical colleges and/or Pacific medical associations be more involved in delivering the RACS program?

Table 8 below shows the list of Pacific and Australian colleges, societies and associations that RACS is currently involved with. Relationships with Pacific societies and associations are key to the implementation of program activities in the Pacific. Meanwhile, RACS' engagement with Australian and New Zealand specialty colleges, societies and associations is key to the delivery of program activities in different specialty areas.

Table 8: Pacific and Australasian colleges, associations and societies engaged by RACS

Pacific Societies and Associations
Pacific Islands Surgeons Associations (PISA)
Pacific Society for Reproductive Health (PSRH)
Pacific Island Society for Pathology (PISP)
Pacific Ear, Nose, Throat & Audiology Group (PENTAG)
Pacific Society of Anaesthetists (PSA)
Fiji Obstetrics and Gynaecology Society (FOGS)
Pacific Perioperative Nurses Association (PIORNA)
Pacific Island Orthopaedic Association (PIOA)

Australian and New Zealand Colleges, Societies and Associations
Royal Australasian College of Physicians (RACP)
Royal Australian and New Zealand College of Psychiatrists (RANZCP)
Royal College of Pathologists of Australasia (RCPA)
Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
Interplast Australia and New Zealand
Australian and New Zealand Gastroenterology International Training Association (ANZGITA)
Open Heart International (OHI)
Australian College of Perioperative Nursing (ACORN)

Source: RACS Global Health Pacific Strategic Plan (2022-2027).

Some of those listed were consulted and considered the RACS relationship as 'transactional' and not a real partnership. Two key informants noted that their respective Australian colleges had been involved in productive and positive consultations for the design of PSCSHWIP, but after consultations they did not receive further information on outcomes from RACS or DFAT. Their involvement in this phase has been limited to requests to support specific VMTs, with RACS funding them $60,000 per VMT per country. It is unclear how much support RACS has provided to the Pacific associations and societies, beyond participating in and supporting attendance at some meetings and conferences. Pacific associations were recommended to be part of a regional Steering Committee for RACS, but this did not happen formally.

Beyond 2027, additional colleges, associations and societies should be more involved in delivering specialist clinical services to better meet PIC needs. For example, the Australian College of Rural and

Remote Medicine (ACCRM) and Rocketship are supporting SINU to run a postgraduate diploma in Rural Medicine. This program could expand to include training for other PICs that have remote populations and require clinicians with broad skills to respond to emergencies in rural settings (such as a caesarean section or appendectomy). Other NGOs and charities such as Radiology Across Borders provide training and services that are critical to improving diagnosis and subsequent treatment. It is unclear if RACS needs to be an intermediary for other colleges, especially if they have existing links with SPC and FNU that can be built on. Many of these organisations are charities or independently funded and do not require RACS or DFAT funding, however from a country perspective there is a need for better coordination.

RACS VMTs are only a small part of VMTs provided in the Pacific, and there is a risk that countries' expectations are not met, leading to potential reputational damage to DFAT's Pacific aid program. In a future phase, more needs to be done to coordinate individuals from other Australian colleges, associations, societies, charities and NGOs that provide VMTs/VCTs. A consortium of Australian colleges and associations providing VMTs in the Pacific could be convened to discuss improved coordination mechanisms, possibly through a managing contractor such as AVI or a DFAT online portal.

KEQ 2e: What support would SPC need to follow through and expand on its commitments under the current program?

SPC plays an important role in strengthening clinical services in PICs and all key informants value SPC's networking and support for regional meetings (e.g. DCS, Pacific Heads of Nursing and Midwifery, Pacific Heads of Health, and Pacific Health Ministers meetings). Discussions are needed at PCU and PCC meetings on what deliverable outcomes are feasible with existing staffing (as discussed: clinical services strengthening data dashboard, VMT country calendar support), and if additional staffing would be needed, e.g. through AVI.

KEQ 2f: Could FNU's short courses be better aligned to formal training pathways in the Pacific?

FNU CMNHS provides a major role in training future Pacific healthcare professionals, offering a wide range of undergraduate and postgraduate certificate, diploma and Masters courses. Students need flexibility to take courses that suit their circumstances and lives, in particular for female students with family commitments. FNU is looking at micro-credentialing 'stackable' courses, which provide a more modular, flexible pathway for upskilling for formal qualifications.

FNU academic staff currently teach in undergraduate and postgraduate programs, and short courses are perceived as an additional workload that is not valued in academic metrics. CMNHS staff were reported to be already overloaded with high teaching loads. Of note is that FNU is a national university, so the majority of students are Fijians, which creates some tensions with other PICs who can only access limited places in comparison. In addition, doctors in postgraduate programs who are training in Fiji are not paid while they work as Interns or Registrars in the Fijian public hospital system, which creates financial burdens. Some return to Fiji later, where doctors' salaries are significantly higher than in other PICs.

The largest and most comprehensive academic courses are in FNU and UPNG (as training hubs), however there are other Pacific universities that offer nursing, medical and other allied health training (NUS, TNU, SINU). Expanding courses in other PICs could reduce the burden on FNU and UPNG, as well as build 'spoke' capacity in other universities, such as Orthopaedics in Samoa and Tonga, and Family/Rural Medicine in Solomon Islands.

KEQ 2g: What strategies and/or activities could partners introduce to increase sustainability of the program (both to the end of the current program, and beyond if DFAT continues funding)?

PICs value VMTs, however all countries requested more focus on capacity building of local doctors, nurses, physiotherapists and other cadres (such as biomedical engineers, pharmacists, and prosthetists). This was noted in the RACS Global Health Regional Strategic Plan (2022-2027), which described how PSCSHWIP was integrated with other RACS projects and initiatives such as the Samoa Hearing Program, the Global Health scholarships and grants, and Timor-Leste programs. This Strategic Plan demonstrated careful consideration of the role for RACS VMTs and capacity building through a development lens. The conclusion presented a vision that is relevant to this evaluation:

> Where we can, RACS will always prefer localisation of skills and services, including supporting program systems that regionalise coordination. This includes successfully advocating for the DFAT funded PSCSHWIP (2022-2027) to include development and funding for a PSCSHWIP Regional Centre to coordinate the activities of the program, Fiji National University and the Pacific Community. This unit will be based at the Pacific Community in Fiji and DFAT funding goes toward funding human resource positions. This is with a view to encouraging the handover of coordination to the Region.

In terms of sustainability, RACS started 30 years ago with a strong volunteer ethos and commitment to supporting Pacific health systems by surgeons providing short-term visits. As one RACS Fellow described it, *'Philanthropic activity is the lifeblood of the Fellowship of Surgeons. Ask any surgeon.'* There is enormous goodwill from surgeons to build the capacity of local teams, and this was evidenced by interviews and observation of the Urology VMT. Some RACS Fellows provide self-funded voluntary support and even fly out on weekends where an urgent case is needed. Due to the pro-bono contributions of specialists, RACS offers a cost-effective program for DFAT to fund VMTs to deliver specialist clinical services and strengthen the workforce simultaneously. However, for PICs, RACS is only one of many organisations providing VMTs.

A PSCSHWIP Sustainability Plan was completed in 2025 and highlights that the program's sustainability pathway relies on: i) Pacific-led education and training systems (including accredited postgraduate and in-service pathways and structured CPD; ii) regional governance and common 'social goods' advanced through SPC-convened mechanisms; iii) strengthened models of clinical service delivery that shift from service substitution to mentoring and capability transfer (including digital case conferencing and tele-mentoring); and iv) progressive national uptake through domestic budgeting and policy recognition of specialist cadres and career pathways.'

This evaluation concurs with these focus areas for sustainability and agrees that SPC CSP should become the regional hub for coordination of specialist clinical services, while FNU and other PIC universities should lead on education and training for the specialised clinical services health workforce. The shift from service substitution to capability transfer will need to be staged for each PIC and requires SPC coordination and support. RACS can continue with identified VMTs that support this localisation, aligned with longer-term PIC Clinical Services Plans.

4.2.4 Key Recommendations on Efficiency

By the end of the current program, some clearer deliverables would demonstrate the value of future funding support. This will be more challenging for CSP because its PSCSHWIP funding finishes in September 2026. CSP should, however, remain in the PCU beyond that, as its core business is strengthening clinical services in the region. The coordination role will require partner agreement.

- **Recommendation 8:** PCU to review previous outstanding actions from Joint Annual Progress Reports and identify what actions are feasible to complete to the end of the current program.
- **Recommendation 9:** SPC CSP to discuss at DCS meeting(s) how to best support national calendars for all VMTs, drawing on examples where they exist. This could provide PICs with a standardised template that can be adapted to their specific health system contexts.

- **Recommendation 10:** RACS to consult with New Zealand Pasifika Medical Association (PMA) and Australian colleges, societies, associations and charities providing VMTs to the Pacific, to map out a coordination mechanism to avoid duplication and overlap.
- **Recommendation 11:** RACS to review current procurement costs and shipping methods for VMT surgical equipment and explore more cost-effective options, given the increasing costs.
- **Recommendation 12:** RACS to continue support for regional training partners – in particular PIVOTS to cover the remaining larger PICs – and identify which trainings can be sustainably transferred to FNU and other Pacific universities in the future.
- **Recommendation 13:** FNU CMNHS to report on progress and barriers to micro-credentialling 'stackable' courses, which provide a more modular and flexible pathway for upskilling formal qualifications.
- **Recommendation 14:** DFAT to explore options for supporting PIC procurement processes for basic, essential equipment, including for common surgeries.

KEQ 3: Are any changes to the program delivery model required if DFAT continues funding beyond the end of the current program?

Bilateral engagement

A recent change to program delivery is that DFAT posts now co-fund VMTs from their bilateral budgets, contributing $60,000 per VMT, effective for all posts from 2026. Note that Nauru Post already funded additional VMTs in 2024 and 2025, as specified in the original program design. Posts were positive about RACS VMTs, but some noted that bilateral funds were over-committed. Some posts had budgeted for a range of VMTs requested by MOH for 2026, not only for RACS VMTs. Some posts also noted that communication about RACS VMTs was inconsistent – some had little involvement with RACS VMTs, and in some instances, posts had not been notified until VMTs were in-country.

> We [Post] may miss meetings if RACS sets up a meeting directly with HOM. If RACS can make it more mandatory to provide a report from their visit, I would love to hear a brief report from their trip. You know, just really advising on cases, because it's really helpful, because our program could really contribute to provision of some of those issues. It would help inform our programming also. So we were not getting any reports from the team, from the last three teams that have visited…Try to make time to come and visit the office that would be sufficient for us to be across and aware of what the issues are. [DFAT Post]

DFAT bilateral programs in larger PICs fund human development programs including a range of health initiatives and activities through Managing Contractors (Fiji, Kiribati, Nauru, Samoa, Solomon Islands, Tonga and Vanuatu). Some bilateral health programs do not include a key EOPO or IO for clinical services, while others do. These programs have close working relationships with MOHs and provide flexible support to address National Health Strategic Plans (NHSPs). For example, in the Solomon Islands, the Solomon Islands-Australia Health Partnership (SIAHP) funded a volunteer Australian neurosurgical VMT (non-RACS) in 2025 that conducted 13 surgeries at the same cost of sending one patient overseas for treatment. In Fiji, the Australia-Fiji Health Platform has initiated a Clinical Services Improvement Plan (CSIP) linked to the CWM Hospital Masterplan. The Tonga Health System Support Program (THSSP4) works closely with health staff and executives, and the Team Leader developed a calendar for all visiting teams and individuals that is now mainstreamed as a weekly administrative task for the Medical Superintendent's Office to update.

> Our hope is that in the new [design] phase, all the programs within the region that are funded, regional or bilateral, all Australian funded programs, our hope is that we will be clear on what we're delivering in terms of in the health space... [DFAT Post]

In smaller PICs with no large bilateral health programs under managing contracts (FSM, Palau, RMI, Tuvalu), some posts play a hands-on role in supporting clinical services. For example, Palau Post assisted in conveying the National Hospital's interest in VMTs, connecting RACS team members with hospital staff, facilitating initial engagements, and fully funding these activities. Samoa Post supports quarterly off-island training for a local doctor at the National University of Samoa (NUS). Upon completion, this training will lead to a Master of Surgery in Orthopaedics. Palau Post has supported on-island training for Palau's Emergency Medical Team through the National Critical Care and Trauma Response Centre (NCCTRC). Palau Post has also supported the engagement of a Nurse Educator Curriculum Adviser to review the nursing curriculum at the local community college, with the goal of streamlining the program and better supporting students' transition from classroom learning to clinical practice. At the request of MOH since 2021, Palau Post has supported the locally known *Project Olangch*, which aims to digitise health services to streamline patient care and, critically, to improve data collection to enable hospital management to make informed, evidence-based decisions.

The missing piece for RACS and other VMTs is the linkage to broader clinical services planning, from primary health centres through to referral hospitals, where there is significant potential through bilateral health programs/facilities to improve those linkages. In some PICs, bilateral health programs/facilities have been allocating funding to support clinical services including essential equipment and consumables as part of their program logics. For example, in the Solomon Islands, clinical services strengthening is included as a service delivery outcome. In Fiji, the development of a Clinical Services Improvement Plan is part of the Masterplan for the new referral hospital. Vanuatu has a detailed Clinical Services Plan (2019), which has been updated. Such plans can include a focus on the role and coordination of VMTs, because otherwise VMTs are ad hoc and there is potential for clashes.

> It's explicitly built into our new program design that we take a more proactive role in helping to coordinate the totality of that clinical services delivery from Australia into X, and providing more of that wraparound support and thinking not just of each of these partners as individual partners, but as a collective contribution…SPC is well placed to support that. [DFAT Post]

One issue that emerged from country consultations was the confusion within MOH about what was funded or provided by DFAT versus other Australia organisations, as there were more VMTs than provided by RACS. As one Post suggested, it would be better to have a 'brand Australia' to cover all visits, including RACS:

> One of the things we're explicitly trying to do in our redesign is to strengthen that connection between the regional and the bilateral programs. I think the model for RACS moving forward is indeed that bilateral country programs contribute to the costs for RACS visit, so that that link and that strengthening of relationship is already being kind of monetised if you like, but we also want it to be more systematically linked up…From a public diplomacy perspective, and for the Ministry and Government, to see the work and support that is coming from RACS as being associated with just brand Australia. I think that's an important thing for Post… it's just part of Australia's support, and government see it in the context of our broader bilateral program, even though it's sort of a delivery of a regional initiative [DFAT Post]

Twinning and exchanges

Other suggestions from PICs for changes to the program included comments from nurses in smaller countries who suggested that they would greatly benefit from an exchange program with Australian hospitals, but that they could not be spared with such a small nursing workforce. They asked if it is possible to have volunteer Australian nurses replace them as an exchange while they gain practical learning opportunities in Australia.

Others commented that they used to be able to send complex cases to Australian hospitals, but the cost was now prohibitive. They suggested a return to a 'twinning' arrangement where PICs could send staff on exchanges to observe and learn skills in Australia, as well as refer some complex cases to Australia for treatment. For example, Tonga has had a longstanding relationship with St John of God Ballarat, which also receives some support from the bilateral program THSSP4.

Other delivery models

Key informants also noted that several other donor countries offer VMTs with longer-term clinical specialist placements. Taiwan, People's Republic of China, and more recently the Philippines have supported 3-12-month placements that have addressed backlogs, and in some cases worked in provinces and outer islands. This has been highly valued, albeit with some communication and cultural challenges, such as language barriers and understanding local societal norms.

> the good side [of Chinese specialists] is that they travel most times to the provinces, and they live with the local surgeon here, they train the local surgeon, and every operation that they did, local surgeon always be there with them, and they also travel together to the provinces. [DFAT bilateral program managing contractor]

Several countries highlighted the New Zealand Medical Treatment Scheme (NZMTS) as a positive model. This New Zealand Ministry of Foreign Affairs and Trade (MFAT)-funded VMT model has operated in the Pacific for over 30 years, *'providing life-saving medical interventions and specialist care in Tonga, Samoa, Fiji, Kiribati, Tuvalu and Vanuatu'*. A 2022-2024 report stated that NZMTS led to *'4,133 Pacific citizens accessing clinical services, including treatment at approved overseas institutions and in-country care provided by visiting specialists and medical teams. Of these, 14% were individuals from outer islands who received medical support through the scheme. Additionally, 638 Pacific health professionals have undergone training both overseas and in-country, strengthening local healthcare capacity'… 'Through the Visiting Medical Specialists component, 48 teams were deployed who provided support to 4,034 individuals and delivering 535 in-country surgical operations – dramatically increasing access to essential surgical care'*.

The NZMTS includes both VMTs as well as funding for Overseas Medical Referrals (OMRs), which provide Pacific patients with treatment overseas that is unavailable in their home countries. 53 patients received treatment from approved institutions during 2022-2024. The NZMTS is managed by PMA, which was formed in 1996 by a group of Pacific medical professionals and many of its visiting volunteers are originally from Pacific countries. There have been rich stories[11] written on the NZMTS VMTs, which provide excellent examples of communicating the value of VMTs.

[11] https://pmagroup.org.nz/updates/pacific-ent-capacity-strengthened-through-specialist-training-in-fiji; https://pmagroup.org.nz/updates/nzmts-building-cancer-care-capacity-vanuatu-clinicians-train-in-rotorua; https://pmagroup.org.nz/updates/nzmts-supporting-local-surgical-capacity-at-vaiola-hospital; https://pmagroup.org.nz/updates/nzmts-point-of-care-ultrasound-pocus-saves-lives-nzmts-investment-strengthens-emergency-care-in-tonga

Higher education hub-and-spoke model

FNU has been the premier institution to train Pacific doctors, nurses and increasingly allied health cadres. Several Pacific universities are now in a position to train some of their own health workforce. For example, SINU offers a postgraduate diploma in Rural Medicine (with the support of an AVI) and Rehabilitation courses that other PIC students could benefit from. Samoa and Tonga are also developing orthopaedic services.

Key informants suggested that SPC convene a meeting to discuss a hub-and-spoke capacity building and education model for the future. There is potential for all the Pacific universities to determine their specific strengths, to avoid costly competition for regional students and together provide a wider range of quality training options.

4.2.5 Key Recommendations on Delivery Model

DFAT should base its future regional capacity-building investments on joint analysis of needs, priorities and what could reasonably be expected to be achieved in each country context. Future changes to delivering specialist clinical services should include joint planning with DFAT posts and bilateral health programs/facilities, as well as a range of Australasian colleges, SPC, FNU and other Pacific universities (NUS, TNU, SINU, UPNG).

- **Recommendation 15:** DFAT to identify how bilateral and regional health programs can jointly support specialty clinical services strengthening, including VMTs, where there is scope in the design phase. As noted in the DFAT Partnerships for Healthy Region (PHR) Strategic Investment Framework, there is a clear need for coordination and strategic alignment between regional and bilateral health programs.
- **Recommendation 16:** DFAT to consider future options for longer-term specialty capacity building placements (possibly through Australian Volunteers International (AVI) in collaboration with Australian colleges and NGOs).
- **Recommendation 17:** DFAT to consider linkages with Australian hospitals/health services. These linkages are highly valued but have decreased in recent phases of DFAT support.
- **Recommendation 18:** DFAT to explore regional Pacific-led models for specialist clinical service delivery, where Pacific clinicians and specialists provide services in other PICs, including mentorship of local clinicians. Consider drawing on Pacific clinician diaspora as volunteer advisers, educators and mentors.
- **Recommendation 19:** DFAT to explore opportunities for a hub-and-spoke model for clinical training, building on existing PIC university strengths.

4.3. Monitoring, Evaluation and Learning (MEL) including reporting

KEQ 3a: To what extent is the program's MEL system fit for purpose and used to support learning, adaptation and accountability?

The PSCSHWIP MEL System is partially fit for purpose. The program has established important MEL foundations, including a shared program logic, MEL framework and baseline report in 2023, annual progress reporting, outcome tracking, and increasing use of sex-disaggregated data. However, there is opportunity to strengthen the approach to MEL. Currently, each partner provides an Annual Plan and Annual Progress Report. The individual partner Annual Progress Reports are consolidated by CSP into a Joint Annual Progress Report for PSCSHWIP as a whole. The value of the joint report should be to identify opportunities for collaboration and improve coordination, however there is limited

evidence that the joint reporting is used for this purpose. The focus on broader learning and being responsive and adaptive is also less evident.

Previous evaluations of earlier phases, in 2015 and 2022, provided similar findings to this evaluation and recommended areas for improvement, yet many of those lessons learned from previous phases remain unaddressed. Any future MEL should, as a first step, review recommendations from 2015 and 2022 evaluations and the RACS-PIP Learning Paper to clearly identify relevant indicators for each partner. PCU meetings could be more focused on learning and adaptation.

KEQ 3b: Do partners provide adequate data when reporting against the MEL Framework?

The evaluation found variability in the quality of MEL reporting between partners. RACS demonstrated strong routine operational reporting linked to VMT implementation, but less on how capacity building efforts are measured and reported on. SPC and FNU report on their core activities that, while they contribute to the EOPO and IOs, are not directly funded by PSCSHWIP. This creates confusion on what DFAT is supporting through PSCSHWIP versus other regional funding. For example, SPC demonstrated strong regional governance and systems reporting, but it was unclear what was funded under PSCSHWIP and what was core CSP business. FNU continued strengthening institutional MEL and research systems and reported on core as well PSCSHWIP-funded activities. Overall, partners provided sufficient data to support basic accountability and program monitoring, but reporting systems are not yet fully harmonised, outcome-focused, or consistently aligned with the broader MEL expectations outlined in the design. When reviewing Joint Annual Progress Reports, the evaluation team noted that some indicators changed from 2023 to 2024, and it is unclear why those changes were made and whether the current indicators are useful to assess PSCSHWIP progress.

KEQ 3c: Have partners satisfied DFAT's reporting requirements? i.e. were reports submitted on time and of acceptable quality?

The evaluation found limited direct evidence in the reports confirming whether all reports were formally submitted on time against DFAT schedules. However, PCC minutes and annual progress reporting records indicate that Joint Annual Progress Reports for 2023, 2024 (submitted late), and 2025 were produced and tabled through program governance processes, suggesting that reporting obligations were generally being met. PCC minutes from July 2024 also requested improvements to future reporting, including inclusion of MEL updates, risk management plans, partner workplans, and stronger harmonisation across reports, indicating that reporting quality was still evolving.

In terms of quality, the reports were generally considered acceptable and sufficiently detailed for operational accountability. However, the evaluation also identified recurring weaknesses, including incomplete disability and location-disaggregated data, inconsistent indicator reporting, uneven alignment between partner MEL systems and the overarching MEL framework, and limited outcome-level analysis. Several indicators were reported as 'off track', 'data unavailable', or 'not evidenced', particularly for GEDSI, governance, and systems-level outcomes, demonstrating that, while quality of reporting did improve over time, reporting systems are not yet fully harmonised or outcome-focused.

KEQ 3d: What should be considered in relation to MEL for any future reporting?

As noted, a revised MEL should, as a first step, review recommendations from 2015 and 2022 evaluations and RACS-PIP Learning Paper to clearly identify relevant indicators for each partner. PCU meetings could be more focused on learning and adaptation.

Any future phase should prioritise a simpler, more harmonised, Pacific-based, and outcome-focused MEL system across partners. Future reporting should include a smaller set of clear, shared indicators linked directly to the program logic and DFAT priorities, and include indicators focused on GEDSI,

workforce development, clinical performance and health systems strengthening. Partners should use common reporting templates and agreed indicator definitions to improve consistency and comparability across reporting.

Future MEL systems should also strengthen data quality, particularly for GEDSI, disability equity, rural access, workforce outcomes, and long-term clinical impact. Mandatory sex, disability, and location-disaggregated data should be built into all reporting systems, including VMTs, training, enrolments, mentoring, and patient access data. The MEL system and reporting should move beyond a focus on activities to a stronger focus on progress towards the achievement of outcomes, learning, sustainability, impact, and regional system changes. There is also a need for stronger MEL in relation to governance, partner capacity, and digital systems. Dedicated MEL resources, ongoing partner training, clearer reporting timelines, and stronger use of MEL findings for adaptive management and strategic decision-making would significantly improve accountability, learning and program effectiveness.

The PSCSHWIP Sustainability Plan also supports a shift from short-term activity reporting toward monitoring long-term workforce outcomes, regional clinical capacity, local ownership and health systems strengthening. Therefore, a future MEL system should be designed as a core sustainability mechanism that supports ongoing regional coordination, institutional memory, workforce planning, quality improvement, and evidence-informed policy development beyond the life of DFAT funding.

4.3.1 Key Recommendations on MEL

- **Recommendation 20:** PCU to strengthen its MEL function by focusing more on improving specialist clinical services outcomes through collaboration, and less on routine activity and progress reporting.
- **Recommendation 21:** DFAT to ensure MEL and reporting for any future phase is simplified, harmonised and focused on outcomes and the collection and use of quality data; however, reporting should not change during the final year of the program as that would impact on meaningful comparison.

4.4. Gender equality, disability equity, and social inclusion

The concept of GEDSI has been a challenging one to gain traction in the Pacific, where cultural and social norms are hard to change. For the purposes of this evaluation, there is a need to distinguish what a health program such as PSCSHWIP can feasibly deliver in terms of GEDSI outcomes, as compared to an ideal. For health workers, the relationship between *gender and health* is complex, and one that many health professionals struggle with. WHO has provided practical guidance on mainstreaming gender for health managers, using an evidence-informed analysis of gendered factors that impact on health seeking behaviour, diagnosis and treatment. As practical examples, men may not seek care for diabetic foot ulcers until it is too late and an amputation is necessary, and some women do not seek antenatal care until late in pregnancy, resulting in a complicated birth requiring surgical intervention. Why is there a much higher caesarean section rate in some PICs compared with others? Women are mostly the victim-survivors of violence, which is poorly recognised and responded to by health services. Prioritising women's health over men's is not evidence-based in terms of improving population health outcomes. Health workers need to analyse *gendered behaviours* and the *gendered response of health systems*.

For PSCSHWIP, this might mean finding a way to reach men through male workers or leaders to explore why they do not seek care earlier. It might mean talking with women about barriers to accessing antenatal care, and what factors affect doctors' decisions to perform a caesarean section.

It might mean healthcare staff seeing injuries and recognising them as potential signs of gender-based violence occurring and responding with care and compassion. More can also be done by MOHs to practically address gendered behaviours and norms and the response of health systems, but it is beyond the scope of partners to change social norms in countries through VMTs and training.

Promoting *gender equality* is a separate issue that requires highlighting women's disadvantage because gender norms perpetuate inequalities. For example, in the Pacific, nurses who complete postgraduate training in areas like perioperative nursing are mostly female but are not recognised or recompensed for this vital qualification. Pacific nurses who work in ear health, performing vital preventive and diagnostic roles, are not provided a career path that recognises their vital role in public and preventive health. Gender equality need not mean selecting a female surgeon for a VMT if a country has a preferred surgeon (who happens to be male) with a longstanding relationship with a local clinician or health service; however, sending female senior visiting clinicians does provide positive role models. For capacity building and training, regional advocacy should focus more on gender equality. In practical terms, it can be raised at regional meetings for countries to act on.

KEQ 4: To what extent has the program supported GEDSI outcomes as articulated in the Phase 2 design?

The PSCSHWIP design recommended a GEDSI strategic plan be developed in year 1, to advance gender equality and inclusion in the health workforce and supporting systems, and the provision of gender responsive and inclusive clinical services. A GEDSI Action Plan for PSCSHWIP was developed in June 2025, with actions against four priority areas: equity and access; inclusive workforce development; inclusive regional governance; and GEDSI evidence and learning. Based on the GEDSI Action Plan, SPC focuses on GEDSI within regional governance and standards, RACS strengthens equitable access through VMTs and inclusive clinical practice, and FNU addresses GEDSI within workforce development, training access, student support and digital learning. Monitoring is *'intentionally light, consistent and feasible'*.

Since June 2025 when the GEDSI Action Plan was developed, the key finding is that GEDSI is now visible across the program but not yet fully embedded across the program. The evaluation found moderate progress against the GEDSI commitments, but not full delivery. Reports demonstrated positive progress through disability inclusion training, engagement with gender and disability organisations, inclusive workforce development, GEDSI curriculum work at FNU, and strong female participation (73%) in training pathways, consistent with the investment design objectives. However, progress reporting and PCC discussions identified the need for stronger GEDSI mainstreaming, improved disability and location-disaggregated data, clearer GEDSI integration in the MEL, inclusive VMT planning, and stronger partner accountability across SPC, FNU, and RACS.

KEQ 4a: What gains and challenges were experienced by each partner when trying to incorporate and implement GEDSI into their programs?

Gender equality gains

Review of the investment design document, GEDSI Action Plan, and partner progress reporting documents found that PSCSHWIP has made moderate progress in implementing gender equality, particularly through gender-balanced participation, GEDSI training, improved GEDSI awareness, and inclusion of GEDSI in program governance and monitoring. FNU launched a GEDSI Strategy and delivered GEDSI training, RACS improved gender-responsive VMT activities, and SPC strengthened GEDSI integration through regional systems, trainings and recruitment of a SPC GEDSI Adviser.

All partners now report sex-disaggregated data for activities:

- **RACS** VMTs have achieved an overall gender balance for patient consultations and surgeries. VMT composition is generally balanced, with 57% female and 42% male clinicians on average (however, it should be noted that 95% of surgeons were male, 92% of nurses were female, and all audiologists were female).
- **SPC** collates sex-disaggregated data on participation in regional meetings and trainings.
- **FNU** reports sex-disaggregated data on participation in all its courses and trainings. Female students consistently represent around 73% of CMNHS enrolments. However, it is unclear how sex-disaggregated data is used to inform implementation and decision-making. A GEDSI Strategy and Action Plan, including training sessions, commenced in 2024.

RACS and SPC developed a GEDSI training, signing a Letter of Agreement in 2024 with Interplast to develop contextualised training on *Gender & Disability Inclusion in Healthcare Settings*, available at Praxhub (https://praxhub.com/) as a free online course. This online module takes approximately 40 minutes to complete, and the trainee receives a completion certificate that meets CPD requirements. In 2025, 62 participants from nine PICs completed the course. FNU's GEDSI short course training reached 185 participants in 2024 (106 students and 79 staff; 126 females and 50 males), and 152 participants in 2025 (150 students and two staff; 124 females and 28 males).

In 2025, CSP also integrated a number of gender-specific activities into trainings and core activities:

- Integrated GEDSI concepts into NSOAP workshops, and representatives from the community – women, people with disabilities (cancer, amputation patients) and youth – contributed during stakeholder meetings.
- Funded a gynaecologist to deliver gynaecological care for women in Kiribati, where there was an identified gap.
- Supported a female Director in Kiribati to undertake the RACMA course on leadership for clinicians, creating awareness and opportunities for female leadership in health.
- Presented the results of a nursing specialisation survey and GEDSI online education module at the PHONM meeting. PHONM recommendations were then presented at the PHOH meeting.
- Supported a leadership training facilitated by TAFE Queensland, with chief nursing and midwifery officers, prior to the 2025 PHONM meeting.
- Arranged for a presentation by Women in Surgery at the PISA meeting, highlighting the role of women in the surgical workforce.

Gender equality challenges

Despite these gains, there remains much to do, including in partnership with other organisations working on gender equality in the region (including DFAT-funded programs: Strengthening Health Workforce in the Pacific for Nursing & Midwifery, and Pacific Women Lead). Women remain underrepresented in senior leadership and decision-making roles within the health sector and more could be supported through PSCSHWIP partners. Despite nurses forming a significant proportion of the health workforce, and being predominantly female, many face systemic barriers that limit the recognition of speciality training and their progression into policymaking and leadership positions.

While ending violence against women and girls is one of the five priority areas in Australia's International Gender Equality Strategy, there was limited reference to this in PSCSHWIP partner progress reporting or key informant interviews, but given the high prevalence, clinicians are likely to see and treat victim-survivors. There is a clear role for all frontline healthcare workers to recognise and respond to domestic/sexual gender-based violence (SGBV). In many PICs, clinical guidelines and interagency protocols have been developed in the past five years, including SGBV guidance in frontline response, and VMTs should be familiar with local protocols.

Disability equity gains

PSCSHWIP partners have implemented a range of actions to address disability equity, including raising awareness within their organisations, as a baseline. In early 2023, CSP conducted a disability inclusion survey, completed by all 34 PHD staff. On average, the staff rated themselves as 1.83 out of 3 for their own knowledge and perception of disability inclusion, and noted that they required strengthened knowledge, established frameworks, and support structures to apply disability inclusion more effectively in their work practice. The average rating of only 1.26 out of 3 for the organisation's inclusive practices resulted in an updated PHD Action Plan matrix on Disability Inclusion.

SPC also strengthened disability equity and inclusion by supporting rehabilitation and disability inclusion training in Kiribati with Interplast, and presentations on GEDSI and disability (amputations and need for orthotics/prosthetics resulting from NCDs) at key sessions during the PISA meeting.

While not funded under PSCSHWIP, CSP's Performance Story12 demonstrated the beginnings of mainstreaming disability equity considerations into key regional meetings and trainings, with the delivery of a GEDSI workshop to representatives from 16 PICs as a precursor to the PHONM meeting in 2023. Facilitated by the Fiji Disabled Person's Federation (FDPF), the session covered types of impairment, barriers to inclusion, and considerations for a more inclusive delivery of health services. CSP has delivered similar trainings in collaboration with Interplast and FDPF for other healthcare groups in 2024 and beyond, fostering greater awareness of disability equity needs and promoting improved integration of disability considerations into health policy and practice throughout the region.

Many of the RACS VMTs prevent disabilities (e.g. inserting grommets for hearing disorders to prevent future hearing and learning disabilities) or reduce the impact of disabilities (e.g. vascular surgery to reduce the need for amputations). RACS could better articulate this contribution to improving disability outcomes.

FNU launched a GEDSI Strategy and Action Plan 2024-2026 to strengthen inclusion and equal academic opportunities. FNU also delivered a GEDSI short course training in 2024 involving nine sessions (face-to-face, blended, and virtual) with 185 participants – 106 students and 79 staff. In 2025, three virtual sessions were run for 152 participants – 150 students and two staff.

Disability equity challenges

People with disabilities continue to face compounded barriers: social exclusion, economic vulnerability, geographic isolation, physical inaccessibility, and disaster risk. Women with disabilities are especially disadvantaged in both access to services and economic opportunities. There is also a lack of inclusive health policies, services, and training frameworks for health workers with disabilities. The investment design document and GEDSI Action Plan require disability equity to be mainstreamed through accessible services, inclusive workforce development, engagement with Organisations of People with Disabilities (OPDs), collection of disability-disaggregated data, and disability-responsive MEL.

Progress reporting documents demonstrate early recognition of disability equity, but implementation remains weak: disability data were often unavailable, clinical disability-specific service gaps have not yet been mapped, and workforce needs of clinicians with disabilities were deferred to 2026-2027. This means disability equity is visible in planning but not yet consistently implemented in VMTs, training, workforce planning, service access, or reporting.

[12] 2023 CSP Performance Story, Disability

Social inclusion

Social inclusion is the least advanced in terms of GEDSI reporting. In healthcare, this is often translated into unmet need, such as needing medical treatment, mental health counselling or disability support, but facing long waitlists, long distances to travel with prohibitive costs, or a lack of local providers. For PSCSHWIP partners, there has been discussion on how to reach remote communities to access VMTs, yet data were still not available to report on how many patients came from remote communities. Anecdotally, ahead of a VMT a remote outer island nurse identified patients as needing assessment and treatment and also accompanied them to the referral hospital. RACS' End-of-Trip Reports do include some information about where patients are from (e.g. during a Fiji neurosurgery VMT, a 70-year-old male from Vanu Levu was successfully operated on for a cervical spinal stenosis), but this information is not collated and reported on systematically.

A more systematic approach to communicating with remote communities needs to be a stronger focus in future, and RACS and SPC could work with MOHs to identify how best to approach this. One key informant suggested that outer island medical officers or nurse practitioners should be informed about all upcoming VMTs and be guided on selection criteria for patients, to assess who might be eligible and need transport.

KEQ 4b: Are any changes needed to the GEDSI approach if DFAT continues funding beyond the end of the current program?

If DFAT continues funding beyond the current program, incorporation of GEDSI should shift from awareness raising and standalone activities to integration into the clinical aspects of health systems and workforces, supported by funding and PCU coordination. Efforts to improve GEDSI should include mandatory sex, disability and location-disaggregated data; OPD consultation in planning and monitoring; accessible VMT and training design; disability-inclusive CPD and workforce pathways; and clear GEDSI indicators, targets, budgets and accountability across SPC, FNU and RACS.

A future phase should retain the twin-track approach included in the GEDSI Action Plan, i.e. targeted disability and gender actions alongside mainstreaming across all clinical services, workforce and governance activities. Priority action areas could include practical disability access audits, patient referral and communication improvements, inclusive selection for training and mentoring, support for health workers with disabilities, and annual GEDSI learning reviews to show what changed, for whom, and why. In addition, careful consideration needs to be provided on how to expand the reach of VMTs and specialist clinical services to more remote and hard-to-reach communities in a future phase. This could be conducted with MOHs and bilateral health programs reviewing PHC linkages to referral services.

4.4.1 Key Recommendations on GEDSI

Despite early challenges, there has been progress on GEDSI with all partners meeting the requirement for collecting and reporting on basic sex-disaggregated data for their programs and activities. However, collection and use of disability data is far less progressed, and more can be done to reach more remote communities and address SGBV.

- **Recommendation 22:** SPC CSP, through regional health architecture meetings such as PHONM and PHOH, to advocate for specialist nurse positions (predominantly female) to be recognised by Public Service Commissions.
- **Recommendation 23:** RACS to review existing national SGBV Clinical Protocols and Interagency Guidelines and ensure that VMTs and local clinicians are aware of and following the protocols.
- **Recommendation 24:** PCU to map out existing gaps in disability-specific services, e.g. diabetic foot care, podiatry, physiotherapy, and prosthetics, and consider a plan to address these gaps.

- **Recommendation 25:** RACS to advocate for, and actively follow up on, dissemination of VMT information by MOHs to health centres and district hospitals in advance of visits, allowing time for local staff to identify and assess potential patients from remote communities for transfer to referral hospitals (where most surgical procedures are performed).

5. Conclusion

The evaluation team found strong evidence that PSCSHWIP is an effective and efficient program that is demonstrating good progress against the IOs and towards the EOPO. There was also strong evidence of high levels of satisfaction amongst stakeholders including PIC MOHs. However, the evaluation identified a range of key recommendations for strengthening delivery of the program until the end of its current phase, plus recommendations for any future phase of support – focused on improving overall effectiveness and efficiency of the investment, strengthening program MEL and reporting, and advancing GEDSI outcomes.

Recommendations from this evaluation highlight the need for a more coherent and strategically aligned approach to strengthening specialist clinical services across the Pacific. Central to this is improved regional and national coordination. Strengthening SPC's convening role, supporting PICs to develop Clinical Services Plans, and establishing national VMT calendars will provide a clearer basis for planning and prioritisation. Enhanced coordination between DFAT's regional and bilateral programs, and with New Zealand and Australian clinical partners, is required to reduce duplication, improve alignment with national priorities, and ensure that external inputs contribute to a more integrated regional clinical services architecture. Further investment in Pacific-led service delivery models, including stronger engagement with regional higher education institutions and Pacific clinician diaspora, will reinforce regional ownership and sustainability.

Improving the effectiveness of Visiting Medical Teams (VMTs) remains a priority. Strengthened communication between RACS, SPC, PIC Ministries of Health and hospitals, and DFAT posts will support more timely and coordinated planning. Standardising the distribution of End-of-Trip Reports and embedding performance metrics and CPD opportunities within VMTs will enhance their contribution to national clinical capacity and workforce development. In high-demand areas such as ENT, a more public health oriented regional approach may be required to complement specialist clinical services.

Long-term workforce development continues to be a critical enabler of sustainable specialist services. Expanding regional training opportunities with established partners, progressively transferring selected courses to Pacific universities, and maintaining support for the FNU College Regional Office will strengthen the regional training network. Advancing micro-credentialled, stackable qualifications will provide more flexible pathways for clinicians. Re-establishing linkages with Australian hospitals and exploring longer-term placements will further support clinical exposure and mentoring.

Efficiency and value for money can be improved through completion of outstanding actions from previous Joint Annual Progress Reports, review of procurement and shipping arrangements for RACS' VMT equipment, and targeted support to PICs to strengthen procurement processes for essential surgical equipment. These measures will help ensure that resources are used more strategically, and that program delivery remains cost-effective.

A more outcomes-focused approach to monitoring, evaluation and learning (MEL) is required to support continuous improvement. Future MEL systems should prioritise data quality, harmonised reporting templates, and agreed indicator definitions, enabling clearer assessment of progress and impact. Strengthening MEL will also support **more consistent integration of gender equality, disability and social inclusion (GEDSI) considerations across program activities.** This includes

ensuring equitable access to training and leadership opportunities, applying GEDSI analysis to planning processes, and improving the collection and use of disaggregated data to identify who is benefiting from specialist clinical services and workforce investments.

Collectively, these recommendations provide a pathway for DFAT and partners to strengthen the coherence, effectiveness and sustainability of specialist clinical services in the Pacific. They emphasise the importance of Pacific leadership, coordinated planning, strengthened workforce systems, and a more robust evidence base to guide future investment.

6. Acknowledgements

The evaluation team is grateful to all the participants from the Ministries of Health in Fiji and Tonga who took time out of their busy schedules to meet with the evaluation team. Clinical and Ministry of Health staff provided valuable contributions and insights essential to inform this evaluation. The team would like to thank DFAT Canberra, Suva Post, Tonga Post and Tonga Health Systems Support Program who helped to schedule and set up in-country interviews, as well as the Managing Contractor staff who provided critical information for the evaluation.

Special thanks go to the CWM Operating Theatre staff and RACS visiting urology team who generously allowed observation and questions during their busy operating schedule. Staff from SPC and FNU provided explanations of their work and roles and were patient in providing answers to the team's numerous questions after the interviews.

Thanks to the many busy clinical staff from FSM Kosrae, Kiribati, Nauru, Palau, RMI, Samoa, Solomon Islands, Tuvalu, and Vanuatu, who took time to offer their carefully considered views – which deeply shaped this evaluation. Staff from DFAT posts in FSM, Kiribati, Nauru, Palau, RMI, Samoa, Solomon Islands and Vanuatu provided thoughtful and knowledgeable insights into their country's needs and gaps.

RACS Global Health team and RACS Fellows and VMTs provided much needed and timely clarifications, and their deep commitment is acknowledged.

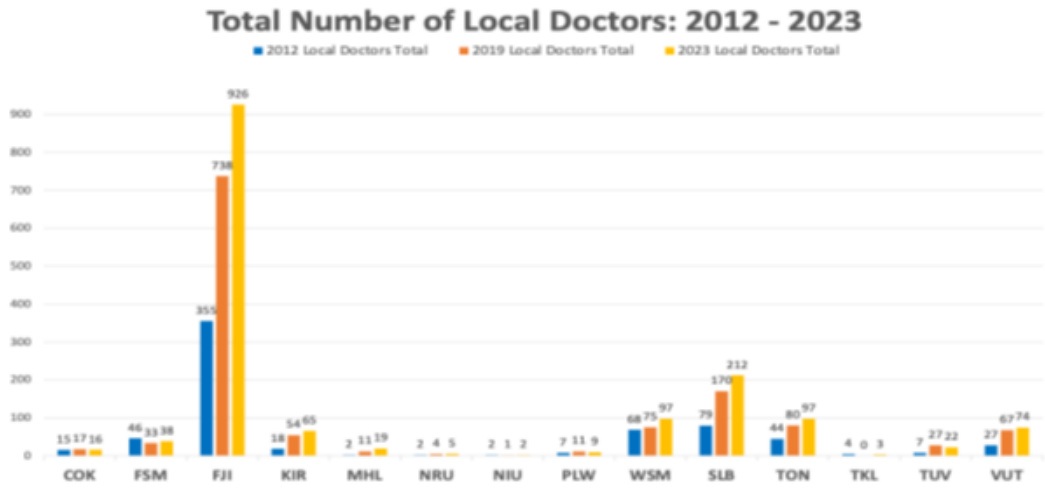
Dr Anna Klinken Whelan and Ms Vasiti Nawadra-Taylor

7. Annexes

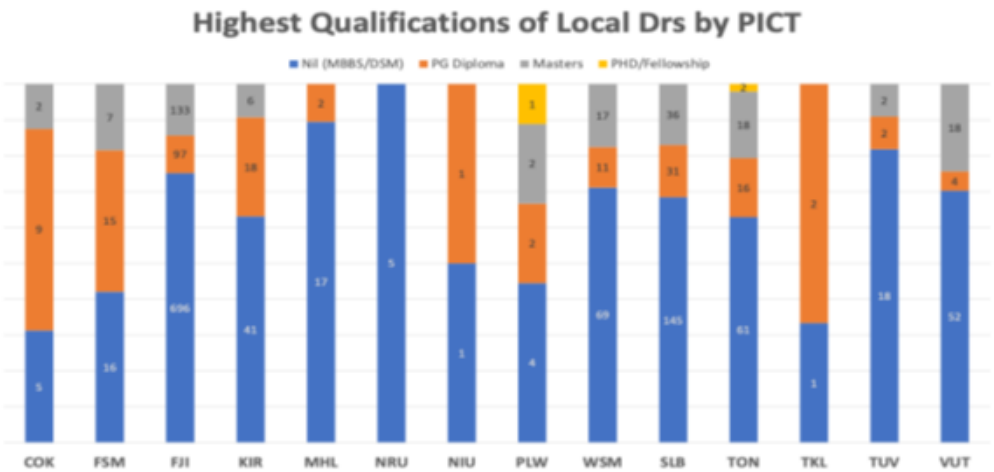
7.1. Annex 1: Changes to the Pacific health workforce over time

Source for below charts: SPC, Clinical Workforce Updates: Country participants to the DCS meetings, 2023.

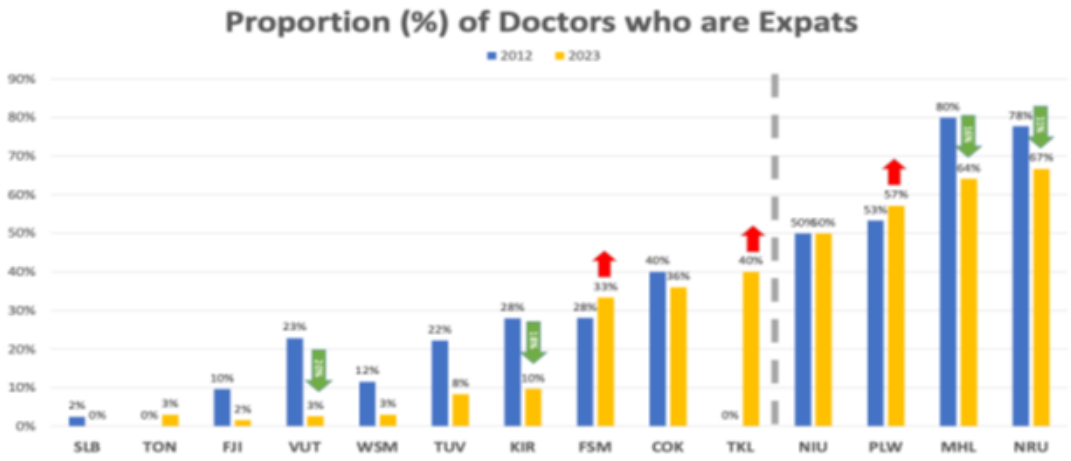
Total Number of Doctors, by PIC (2012-2023):



Highest Qualifications of Local Doctors, by PIC:



Proportion (%) of Doctors who are Expats, by PIC:



Source for below charts: WHO database; https://www.who.int/data/gho/data/themes/topics/health-workforce. Selected PICs: Fiji, Tonga, Kiribati, Samoa, Solomon Islands, Vanuatu.

Fiji Density of Physicians, Nurses and Midwifery Personnel:

In Fiji, the **density of physicians (per 10 000 population)** has **improved by ▲ 4.3 per 10 000 population** from 3.3 in 1999 to **7.5** in 2023.

1999 – 2023



In Fiji, the **density of nursing and midwifery personnel (per 10 000 population)** has **improved by ▲ 2.4 per 10 000 population** from 18.9 in 1999 to **21.3** in 2023.

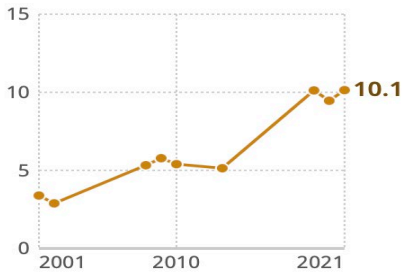
1999 – 2023



Tonga Density of Physicians, Nurses and Midwifery Personnel:

In Tonga, the **density of physicians (per 10 000 population)** has **improved by ▲ 6.8 per 10 000 population** from 3.4 in 2001 to **10.1** in 2021.

2001 – 2021



In Tonga, the **density of nursing and midwifery personnel (per 10 000 population)** has **improved by ▲ 9 per 10 000 population** from 33 in 2001 to **42** in 2021.

2001 – 2021



Kiribati Density of Physicians, Nurses and Midwifery Personnel:

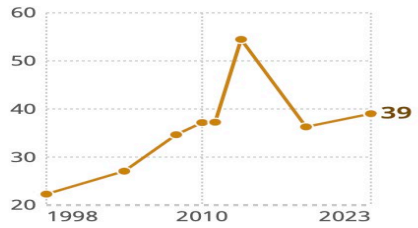
In Kiribati, the **density of physicians (per 10 000 population)** has **improved by ▲ 2.3 per 10 000 population** from 2.4 in 2008 to **4.7** in 2023.

2008 – 2023



In Kiribati, the **density of nursing and midwifery personnel (per 10 000 population)** has **improved by ▲ 16.7 per 10 000 population** from 22.3 in 1998 to **39** in 2023.

1998 – 2023



Samoa Density of Physicians, Nurses and Midwifery Personnel:

In Samoa, the **density of physicians (per 10 000 population)** has **worsened by ▼ 1 per 10 000 population** from 6.7 in 1999 to **5.6** in 2021.

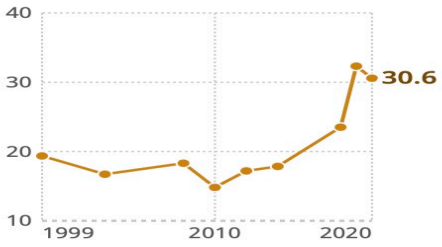
1999 – 2021



In Samoa, the **density of nursing and midwifery personnel (per 10 000 population)** has **improved by ▲ 11.2 per 10 000 population** from 19.4 in 1999 to **30.6** in 2020.

Samoa

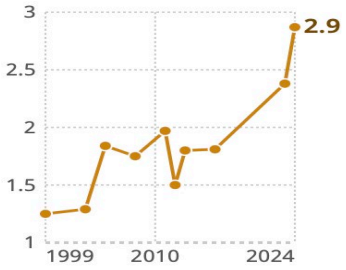
1999 – 2020



Solomon Islands Density of Physicians, Nurses and Midwifery Personnel:

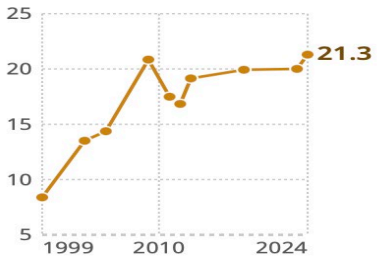
In the Solomon Islands, the **density of physicians (per 10 000 population)** has **improved by ▲ 1.6 per 10 000 population** from 1.3 in 1999 to **2.9** in 2024.

1999 – 2024



In the Solomon Islands, the **density of nursing and midwifery personnel (per 10 000 population)** has **improved by ▲ 12.9 per 10 000 population** from 8.4 in 1999 to **21.3** in 2024.

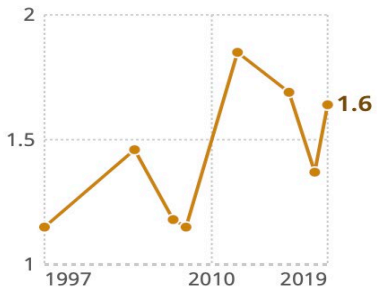
1999 – 2024



Vanuatu Density of Physicians, Nurses and Midwifery Personnel:

In Vanuatu, the **density of physicians (per 10 000 population)** has **improved by ▲ 0.5 per 10 000 population** from 1.1 in 1997 to **1.6** in 2019.

1997 – 2019



In Vanuatu, the **density of nursing and midwifery personnel (per 10 000 population)** has **worsened by ▼ 9.9 per 10 000 population** from 24.5 in 1997 to **14.6** in 2019.

1997 – 2019



7.2. Annex 2: Evaluation Terms of Reference (TOR) (Abridged Version)

Element	Detail
1. Title	Evaluation of the Pacific Specialised Clinical Services and Health Workforce Improvement Program Phase 2 (PSCSHWIP II)
2. Advisers	Evaluation Lead – up to 35 days National Health and GEDSI Adviser from the Pacific – up to 18 days
3. Program	Pacific Specialised Clinical Services and Health Workforce Improvement Program Phase 2 (PSCSHWIP II), jointly delivered by three partners: 1. The Royal Australasian College of Surgeons (RACS) 2. The Pacific Community Public Health Division (SPC PHD) 3. Fiji National University College of Medicine, Nursing and Health Sciences (FNU CMNHS)
4. Term	*9 March 2026 – mid June 2026*
5. Background	The Pacific Specialised Clinical Services and Health Workforce Improvement Program Phase 2 (PSCSHWIP II) (2022 – 2027) builds on the Phase 1 investment (2016/17 – 2021/22). The program aims to strengthen the Pacific region's health workforce and systems for higher quality, more equitable, accessible and affordable specialised clinical health services. This aim is supported by three intermediate outcomes: 1. Quality clinical services are strengthened and more accessible; 2. Health workforce is developed and strengthened; and 3. Regionalisation of organisations, guidance, tools, standards and services is strengthened. DFAT funding for the program is currently $9.3 million. The majority supports RACS' activities ($7.3 million), with SPC and FNU receiving a smaller share ($1.0 million each). Note, the original allocation to RACS was $4.5 million. In response to a significant rise in travel and training costs post-COVID, plus structural underfunding from the program's outset, the program was topped up twice (in June 2024 and March 2025) to now stand at $7.3 million. Summary of key program activities: • RACS sends volunteer Australian surgical teams to Pacific Island countries to conduct consultations and surgeries on local patients and provide on-the-job training for local clinicians. RACS also organises some formal regional surgical trainings. • SPC coordinates overall program activity, primarily through the PSCSHWIP II Coordination Unit (PCU) mechanism responsible for program-level monitoring, evaluation and learning, joint activity planning, partner coordination and communications. Whilst not in the original design, there are now plans for SPC to lead development of a dashboard to support coordination of visiting medical teams across

Element	Detail
	the region – both DFAT and non-DFAT funded – to improve alignment of demand/need and delivery of specialist medical services. • FNU delivers clinical training and workforce strengthening through formal courses, short courses, continuing professional development (CPD) activities, and in-country training. PSCSHWIP II funding is to support program activities over four years 2022 – 2026, with support for 2027 activities dependent on an independent mid-term evaluation and DFAT's budget position for the 2026/27 and 2027/28 financial years. A mid-term review of this program was originally scheduled for 2025, followed by an evaluation at the end of the program. However, the mid-term review was not completed as planned. Due to this delay, all three partners (RACS, SPC and FNU) have agreed that a single evaluation will be commissioned for completion in early-mid 2026, to both assess the performance of Phase 2, as well as to inform decisions regarding future support beyond the current program. *Suva Post oversees the program as a whole and also manages the SPC and FNU components. Global Health Division (GHD) manages the RACS component and provides additional program support as needed.*
6. Purpose and objectives	*The purpose of this evaluation of PSCSHWIP II is to help DFAT assess the program's performance to date, and to inform whether DFAT should continue its funding support to SPC, FNU and RACS beyond the current program. The evaluation findings will be used by the following people/areas at DFAT:* • Investment manager for PSCSHWIP II • Program managers for RACS, SPC and FNU programs • Director of Pacific Heath Section • Health Technical Hub (potentially) *The evaluation has three objectives:* 1. Assess the program's performance to date in terms of effectiveness, efficiency, and MEL including reporting, 2. Recommend actions for DFAT to improve current program performance, and 3. Recommend if DFAT funding to RACS, SPC and FNU should continue beyond the current program, and if so whether the delivery model remains appropriate.
7. Duty Statement	The evaluation should respond to the following key evaluation questions with a credible evidence base. The questions will be refined and prioritised with DFAT during evaluation planning. Priority questions are bolded. *Effectiveness* 1. To what extent is each partner (RACS, SPC and FNU) achieving their Intermediate and End-Of-Program Outcomes? Are there any key areas of concern?

Element	Detail
	2. To what extent are RACS, SPC and FNU activities meeting the needs of Pacific Island countries? Are any changes needed to support the achievement of Intermediate and End-Of-Program Outcomes by the end of the program? 3. To what extent is the overall program delivery model supporting the achievement of Intermediate and End-Of-Program Outcomes? Are any changes to the program delivery model required if DFAT continues funding beyond the end of the current program? a. Is there merit in continuing to group the partners under a joint program? b. Should other Australian and/or Pacific medical colleges be more involved in delivering the RACS program? c. What support would SPC need to follow through and expand on its commitments under the current program? d. Could FNU's short courses be better aligned to formal clinical training pathways in the Pacific? 4. What strategies and/or activities could partners introduce to increase sustainability of the program (both to the end of the current program, and beyond if DFAT continues funding)? *Efficiency* 5. To what extent does each partner have the right staff, management structures and budgeting arrangements in place? 6. How well do the three partners collaborate with each other and other organisations to share resources and deliver outcomes, in particular for the regional clinical trainings offered under PSCSHWIP II? *MEL including reporting* 7. To what extent is the program's MEL Framework fit for purpose? a. Do partners provide adequate data when reporting against the MEL Framework? b. Have partners satisfied DFAT's reporting requirements? I.e. were reports submitted on time and of acceptable quality? *Gender Equality, Disability Equity and Social Inclusion (GEDSI)* 8. To what extent has the program supported GEDSI outcomes as articulated in the Phase 2 design? 9. Are any changes needed to the GEDSI approach if DFAT continues funding beyond the end of the current program? The **Evaluation Lead** will be responsible for leading on all aspects of the evaluation, including: • Attending a DFAT briefing • Refining and confirming key evaluation questions and a consultation list with DFAT • Reviewing key documents provided by DFAT • Developing an evaluation plan that includes key evaluation questions, methodology and a stakeholder consultation list

Element	Detail	
	• Scheduling and leading consultations with stakeholders both in-country (in Fiji for 5 days; and in a second PIC (TBC) for 2 days) and remotely • Developing an evaluation report based on analysis from desktop review of key documents and consultation findings • Submitting the draft and final evaluation plan and evaluation report on time for SHS then DFAT review • Presenting the draft evaluation report to the three partners • Revising and finalising deliverables in response to feedback from SHS and DFAT that meet DFAT accessibility guidelines (see guidelines here) The **National Adviser** will be responsible for: • Managing in-country consultation logistics in Fiji including scheduling meetings and managing communications with relevant stakeholders • Liaising with all key partners in-country involved in the evaluation • Supporting the Evaluation Lead with contextual information relevant to the local operational context • Participating in and co-facilitating consultations and interviews with key stakeholders in-country • Assisting in drafting and revising the draft and final evaluation plan and reports, as directed by the Evaluation Lead **DFAT** will be responsible for: • Providing additional background and briefing, including helping to refine the key evaluation questions and develop a stakeholder consultation list • Providing key relevant documents • Connecting the adviser with stakeholders as required • Reviewing the evaluation plan and evaluation report, and providing timely, comprehensive feedback • Responding to any general questions and requests for information from the adviser in a timely manner	
8. Deliverable Published	*Yes* **Note:** It is the responsibility of the adviser to ensure that all deliverables that will be published are accessible, as per Microsoft's accessibility review function and DFAT guidance, available here: https://www.dfat.gov.au/about-us/about-this-website/accessible-documents/creating-documents-meet-accessibility-guidelines	☒ ☐

7.3. Annex 3: Evaluation Plan

Introduction

Background

Australia has an enduring interest in promoting the health of people in the Pacific and seeks to support and strengthen health systems and service delivery. DFAT provides support to the Pacific health sector through bilateral, Pacific regional and global programs. **One of the key challenges has been to build a Pacific quality clinical health workforce while providing specialised services not able to be provided by local health systems.**

DFAT has previously funded three distinct programs to assist Pacific Island Countries (PICs) in the delivery of clinical services in the region, including clinical workforce development. These programs were the: Royal Australasian College of Surgeons Pacific Islands Program (RACS-PIP); Strengthening Specialised Clinical Services in the Pacific (SSCSiP); and College of Medicine, Nursing and Health Science, Fiji National University (CMNHS, FNU). An Evaluation of RACS-PIP and SSCSiP was conducted in 2015, that informed the design of the next Program.

In 2017, the Pacific Regional Clinical Services & Health Workforce Improvement Program (PRCSHWIP) was designed to bring together all three implementing partners (RACS, SPC and FNU) for better coordination, and achievements in clinical outcomes. The Pacific Specialised Clinical Services and Health Workforce Improvement Program Phase 2 (PSCSHWIP II) (2022 – 2027) builds on Phase 1 of the investment (2016/17 – 2021/22). It initially covered 10 Pacific Island Countries (PICs), but now covers 11 PICs after Palau was included in the RACS component of the program in 2026.

The program's end-of-program outcome (EOPO) is *'strengthened health workforce and systems in the Pacific region for higher quality, more equitable, accessible and affordable specialised clinical health services*'. This EOPO is supported by three intermediate outcomes:

1. Quality specialised clinical services are strengthened and more accessible
2. Specialised clinical services health workforce is developed and strengthened
3. Regionalisation of organisations, guidance, tools, standards and services is strengthened.

Summary of key program activities, by partner:

- **Royal Australasian College of Surgeons (RACS)** sends volunteer Australian surgical teams to Pacific Island countries to conduct consultations and surgeries on local patients and provide on-the-job training for local clinicians. RACS also organises some formal regional surgical trainings.
- **Pacific Community (SPC)** coordinates overall program activity, primarily through the PSCSHWIP II Project Coordination Unit (PCU) mechanism responsible for program-level monitoring, evaluation and learning, joint activity planning, partner coordination and communications.
- **Fiji National University (FNU)** delivers clinical training and workforce strengthening through formal courses, short courses, continuing professional development (CPD) activities, and in-country training. FNU also provides counselling and psychosocial services assisting cohorts of professionals to achieve academic attainment.

DFAT funding for the program is **currently $9.3 million**. The majority of funding supports RACS' activities ($7.3 million), with SPC and FNU receiving a smaller share ($1.0 million each). The original allocation to RACS was $4.5 million; however, in response to a significant rise in Visiting Medical Team (VMT) deployment costs post-COVID (travel, accommodation, medical consumables), plus structural underfunding from the program's outset, the program was topped up twice (in June 2024 and March 2025) to now stand at $7.3 million. Suva Post oversees the program as a whole and also

manages the SPC and FNU components. The Global Health Division (GHD) in Canberra manages the RACS component and provides additional program support as needed.

PSCSHWIP II funding supports program activities over four years 2022-26, with support for 2027 activities dependent on the findings of an independent mid-term review and DFAT's budget position for the 2026/27 and 2027/28 financial years. However, the mid-term review was not completed as planned. Instead, all three partners (RACS, SPC and FNU) have agreed to this single evaluation, which combines the mid-term review and planned end-of-program evaluation, for completion in mid-2026. This independent evaluation will assess both the performance of Phase 2 to date and inform decisions regarding future support beyond the current program.

This independent evaluation has been commissioned through the Specialist Health Service (SHS).

Partner Activities in Clinical Capacity Development

While the focus of this evaluation is on the PSCSHWIP II, implementing partners also play a wider role in clinical capacity development. In summary:

Royal Australasian College of Surgeons (RACS)

RACS is a DFAT-accredited Australian Non-Government Organisation (NGO), responsible for training surgeons and maintaining surgical and quality standards in Australia and New Zealand (NZ). It supports capacity building and leadership development in the Asia-Pacific region, acting as a conduit for multi-speciality collaboration, delivering specialised clinical assistance and capacity development in surgery and associated clinical areas such as nursing and anaesthesia, obstetrics and gynaecology, pathology, gastroenterology, radiology and more. RACS has provided Visiting Medical Teams (VMTs) to the Pacific for 25 years.

The Pacific Community (SPC)

SPC coordinates overall program activity, primarily through the PSCSHWIP II Coordination Unit (PCU). This mechanism is responsible for program-level monitoring, evaluation and learning, joint activity planning, partner coordination and communications.

In addition, SPC Public Health Division (PHD) implements a range of activities related to improving clinical services in the Pacific:

1. Provides a regional governance forum for clinical services. SPC hosts the annual regional Directors of Clinical Services (DCS) meeting. Directors of Clinical Services or their equivalent meet annually to discuss issues and explore regional solutions for clinical services. Key recommendations from the DCS are presented to the Heads of Health for discussions and endorsement. Critical clinical issues may be escalated to the Pacific Ministers of Health meeting.

2. Hosts a regional help desk function to assist PICs with their clinical services queries. This includes advertising of clinical vacancies or locum positions, identifying clinical personnel, seeking collaborative opportunities, dissemination of information, and providing advice and solutions.

3. Explores, develops and implements regional approaches and/or initiatives that are cost-effective in delivery of clinical services including initiatives such as aligning internship programs to the recommended regional requirements; exploring regional Ear Nose Throat (ENT) solutions; and implementing the Pacific perioperative practice standards.

4. Supports commissioning and dissemination of research and analytical work as a means to support informed decision making by DCS and Heads of Health. SPC PHD partners with regional and international research institutes for research activities. Regional research and analytic work largely results from recommendations from DCS and technical meetings.

5. Strengthens Pacific Clinical Organisations' networks to support continuing professional development and discuss regional discipline-specific issues and solutions.

6. Strengthens Pacific Health Systems through networking and supporting continuing professional development on disease surveillance systems, laboratory and biomedical strengthening, Infection Prevention Control (IPC) and Non-Communicable Disease (NCD) prevention programs.

Fiji National University College of Medicine, Nursing and Health Sciences (FNU CMNHS)

Fiji National University (FNU) College of Medicine, Nursing and Health Sciences (CMNHS) is the main regional training institution for the 10 target Pacific Island Countries (PICs) that offers post-graduate specialised clinical medicine and nursing training and accreditation. CMNHS surveys and consults with PICs to identify areas of need, offer solutions, and also acts as a help desk for regional students at the College to support them while studying medicine, nursing and health in Fiji.

The CMNHS under FNU is the main health training institution serving the PICs targeted in PSCSHWIP II. Between 2016 and 2022, DFAT provided 73 scholarships for medical and nursing students in CMNHS. Of these, 65 students were from PICs outside Fiji, 29 undertook post-graduate studies, and 12 studied nursing.

Purpose and scope

Purpose

The purpose of this evaluation of PSCSHWIP II is to assess the program's performance to date, and to inform whether DFAT should continue its funding support to RACS, SPC, and FNU beyond the current program.

Objectives and Scope

The evaluation has three objectives:

1. Assess the program's performance to date in terms of effectiveness, efficiency, GEDSI and MEL including reporting
2. Recommend actions for DFAT to improve current program performance, and
3. Recommend if DFAT funding to RACS, SPC and FNU should continue beyond the current program, and if so whether the delivery model remains appropriate.

Essentially, the evaluation seeks to understand what has/has not worked well; what was achieved with these investments; what results are likely to be sustained; and what lessons learned and recommendations can support future programming.

The timeframe for Phase II covers 2022-27. The evaluation will examine partner plans for 2026-27 but will not be able to assess performance beyond 2025.

Key Users

The evaluation findings will be used by the following people/areas at DFAT:

- Investment manager for PSCSHWIP II
- Program managers for RACS, SPC and FNU programs
- Director of Pacific Heath Section
- Health Technical Hub (potentially)

Methodology

Overview

The evaluation will meet DFAT's Design and Monitoring, Evaluation and Learning Standards and DFAT's aid quality criteria with a focus on effectiveness, efficiency, gender equality, disability equity and social inclusion (GEDSI), and risks and safeguards. The approach will be participatory and consultative to ensure transparency and independence. Key stakeholders such as DFAT, RACS, SPC,

FNU CMNHS, relevant Advisers and other stakeholders will be engaged from the start and throughout the evaluation process to ensure findings and recommendations are accepted and owned by implementing partners and DFAT. A preliminary list of stakeholders and key informants is provided at Annex 1, awaiting confirmation by DFAT and implementing partners.

The evaluation will use a mixed-methods approach, involving a combination of qualitative and, where possible, quantitative methods. These will include document review, secondary analysis of program data and progress reports, review of key health and wellbeing indicators, key informant and stakeholder consultations, field visits and group discussions with beneficiaries if possible.

Key Evaluation Questions

The Evaluation will respond to the following key evaluation questions (KEQ) developed in the Terms of Reference (TOR) and further refined with DFAT. Priority questions are bolded.

Effectiveness

1. To what extent is each partner (RACS, SPC and FNU) achieving their Intermediate and End-Of-Program Outcomes?
    a. Are there any key areas of concern?
    b. How well do RACS, SPC and FNU activities respond to the needs and priorities of Pacific Island countries?

Efficiency

2. To what extent are the program's overall delivery model and partnership arrangements fit-for-purpose and supporting the achievement of Intermediate and End-Of-Program Outcomes, now and for any future phases?
    a. To what extent does each partner have the right staff, management structures and budgeting arrangements in place?
    b. How well do the three partners collaborate with each other and other organisations to share resources and deliver outcomes?
    c. Is there merit in continuing to group the partners under a joint program?
    d. Should other Australian and/or Pacific medical colleges be more involved in delivering the RACS program?
    e. What strategies and/or activities could partners introduce to increase sustainability of the program (both to the end of the current program, and beyond if DFAT continues funding)?

MEL including reporting

3. To what extent is the program's MEL system fit for purpose and used to support learning, adaptation and accountability?
    a. To what extent is the program's MEL Framework fit for purpose?
    b. Do partners provide adequate data when reporting against the MEL Framework?
    c. Have partners satisfied DFAT's reporting requirements? I.e. were reports submitted on time and of acceptable quality?
    d. What should be considered in relation to MEL for any future programming?

Gender Equality, Disability Equity and Social Inclusion (GEDSI)

4. To what extent has the program supported GEDSI outcomes as articulated in the Phase 2 design?
    a. What challenges and gains were experienced by each partner when trying to incorporate and implement GEDSI into their programs?

b. Are any changes needed to the GEDSI approach if DFAT continues funding beyond the end of the current program?

Specific questions will be tailored to each key implementing partner. Document review will further inform and refine the questions for each partner, and initial questions will be modified as necessary by the Evaluation Team during the consultations. Preliminary questions are listed at Annex 3.

Data Collection

Qualitative and quantitative data will be collected through a range of approaches including:

- A desk-based analysis of relevant partner reports, plans and presentations
- In-person consultations with key stakeholders involved in program implementation in Australia, Fiji and Vanuatu, through key informant interviews, meetings, and group discussions, including with beneficiaries
- Fieldwork and observations in Fiji and Vanuatu, including site visits to service delivery sites and training facilities
- Virtual consultations with key stakeholders involved in the RACS component of the program in PICs beyond Fiji and Vanuatu
- Collation, synthesis and analysis of relevant information and verification of data and information

Preparatory briefing

DFAT provided an initial briefing for the Evaluation Team on key issues and priority information prior to preparation of this Evaluation Plan. The briefing covered the background, purpose, objectives, key considerations and issues, key documents, stakeholders, and planning and logistics for deliverables and travel in-country for consultations.

Document review and analysis

The Evaluation Team has been provided with key documents for review (Annex 2) and has sourced additional materials. Documents will be reviewed and mapped against the KEQs and inform key informant interviews.

Field visits, interviews and meetings

A wide range of information sources will be used to gain a comprehensive understanding in a limited timeframe (see Annex 4 for proposed timeline) including a full five-day consultation program in Fiji and two days of consultations in Vanuatu. The methodology will be primarily qualitative with open-ended/semi-structured interviews with key informants and group discussions to address key questions and to explore and gain insight into the ‘why’ and ‘how’ questions.

Views, opinions and perceptions of a wide range of stakeholders are critical to assessing effectiveness and efficiency and future programs.

Group discussions with beneficiaries

Beneficiaries could include current or past CMNHS students (including regional students), and PIC clinicians (surgeons/nurses/anaesthetists) who have participated in VMTs, mentoring or training. If time permits, the team could also consult with in-country supervisors. VMT volunteer clinicians past and current, and other cadres in biomedical engineering, medical laboratory scientists and IPC practitioners.

Facility observations

Observation of facilities and equipment while discussing implementation and challenges with key informants and other health staff will provide further in-depth information. In Fiji, a VMT is planned for the week of the evaluation consultations, and it would be ideal to observe and interact with participants and volunteer clinicians during this time.

Flexibility will be maintained in the methodology and scheduling to refine the approach or consider new information or priorities that may emerge. Required and suggested refinements will be discussed with DFAT Investment Managers before proceeding.

Virtual consultations with key stakeholders

Stakeholders to be interviewed virtually include relevant staff within MoH and hospitals (including potentially some Pacific clinician beneficiaries too). Australian stakeholders include other medical colleges/organisations.

Data Analysis

Quantitative data, where available, will be analysed to assess progress towards outputs and outcomes. This will include but not be limited to indicators specified in the MEL Framework, where available: health worker density; percentage increase in utilisation of surgical, anaesthetic, and obstetric services; percentage change in number of PIC patients referred overseas; number of workforce strategies in place; percentage availability of critical biomedical equipment and health commodities to perform these updated skilled services. Data will be sourced from SPC PCU, program specific service records, and associated monitoring and review reports, to enable triangulation of findings with qualitative data. The evaluation will also draw upon data and analysis collected from other studies and assessments.

Qualitative information from interviews, group discussions, and facility observations will be analysed through thematic analysis. Time will be allocated for summarising and identifying themes among the Evaluation Team members (on a daily basis while in Fiji). This triangulation is an important element in synthesising and analysing data and information and identifying areas for follow-up.

In-depth analysis of consolidated data will be completed at the end of data collection to prepare preliminary findings. These findings and recommendations will be tested and discussed with DFAT Investment Managers. This process will verify and validate the accuracy of the findings and ensure that the recommendations are feasible, actionable and sustainable. Stakeholders will have the opportunity to review and provide feedback on draft findings and recommendations. Divergence of views will be noted, while still maintaining the independence of the Evaluation Team.

Reporting

The draft findings will be verbally presented during a debriefing to key DFAT Investment Managers. They will then also be verbally presented to the three program partners (RACS, SPC and FNU) for their awareness and any final input. A Draft Evaluation Report will be submitted for feedback and input from stakeholders. The Final Evaluation Report will reflect feedback and acknowledge any substantive variation of views or disagreements. It will also meet DFAT's Standard 10 for evaluation reports and meet DFAT's accessibility requirements (Standard 9.19).

Ethical considerations

The Evaluation Team will adhere to clear ethical standards during the course of the evaluation, namely DFAT's Ethical Research and Evaluation Guidance and the Australasian Evaluation Society's (AES) Guidelines for the Ethical Conduct of Evaluations. This Evaluation Plan is the initial step in meeting the requirements of those guidelines. The Evaluation Team will ensure that findings are discussed and presented in an accountable and transparent manner and ensure that all interactions with implementing partners, DFAT, Ministries of Health, beneficiaries and other key stakeholders are conducted in a professional and mutually respectful manner.

Ethical considerations (of respect for human beings, beneficence, research merit and integrity, and justice) are addressed in this Evaluation Plan and also through a number of concrete processes:

- All participants will have explained to them the purpose of the evaluation, how the information they provide will be used in the report, and whether they prefer to provide such information anonymously (if possible).
- Informed consent will be obtained verbally at the start of each interview and group discussion and recorded by the Team Leader.
- Participants will be asked if they would like to have their names recorded as having contributed to the evaluation and report.
- Participants will be asked if they would like to have comments attributed to them, or to remain confidential in the body of the report.

All participants will have explained to them that their relationship with DFAT and the implementing partners will not be affected by their participation (either positively or negatively), they are free to ask questions and can withdraw from the process at any stage with no consequence.

Management and Governance

The Evaluation Team will report to SHS, who will provide technical and operational support and quality assure all key deliverables. DFAT Investment Managers will review and provide feedback on key deliverables.

DFAT will be responsible for:

- Providing additional background and briefing, including helping to refine the key evaluation questions and developing a stakeholder consultation list
- Providing key relevant documents
- Connecting the adviser with stakeholders as required
- Reviewing the evaluation plan and evaluation report, and providing timely, comprehensive feedback
- Responding to any general questions and requests for information from the Evaluation Team in a timely manner.

The Evaluation Team consists of two independent consultants:

- Team Leader with expertise and experience in evaluation, health and Pacific contexts.
- National Adviser with expertise and experience in health and Pacific contexts.

The **Team Leader** will be responsible for:

- Attending a DFAT briefing
- Refining and confirming key evaluation questions and a consultation list with DFAT
- Reviewing key documents provided by DFAT
- Developing an evaluation plan that includes key evaluation questions, methodology and a stakeholder consultation list
- Scheduling and leading consultations with stakeholders both in-country (in Fiji for 5 days, and in Vanuatu for 2 days) and remotely
- Developing an evaluation report based on analysis from desktop review of key documents and consultation findings
- Submitting the draft and final evaluation plan and evaluation report on time for SHS then DFAT review
- Presenting the draft evaluation report to the three implementing partners
- Revising and finalising deliverables in response to feedback from SHS and DFAT that meet DFAT accessibility guidelines
- Overall quality of deliverables.

The **National Adviser** will be responsible for:

- Managing in-country consultation logistics in Fiji including scheduling meetings and managing communications with relevant stakeholders
- Liaising with all key partners in-country involved in the evaluation
- Supporting the Team Leader with contextual information relevant to the local operational context
- Participating in and co-facilitating consultations and interviews with key stakeholders in-country
- Assisting in drafting and revising the draft and final evaluation plan and reports, as directed by the Team Leader.

Limitations, Risks and Constraints

All evaluations have limitations. This table outlines potential or actual risks, limitations and constraints, and provides details on how we plan to manage these.

Table 1: Risks and mitigation

Risk/Limitations/Constraints	How this will be managed/mitigated
Key stakeholders not available for consultations during the evaluation timeframe	Seeking early scheduling of meetings and flexibility with scheduling. Meetings may have to be postponed or rescheduled, but there may be opportunity for further virtual follow-up. If not, this will be included as a limitation in the final report.
Key stakeholders unwilling to participate in the evaluation	Explanation of the importance of the evaluation so participants are well-informed. Ensure de-identified methods and attribution. DFAT to first introduce the evaluation and evaluation team to stakeholders.
Quality of data collected	Consider data quality when planning consultation approach. Ensure a feedback mechanism is in place to cross-check findings during reflections with RACS, SPC, FNU and with DFAT Investment Managers. Triangulation of sources and conflicting views will be assessed and cross-checked with key stakeholders.
Confidentiality of data	Participants will be asked for their consent and whether their views can be attributed to them or will be confidential. This will be noted and adhered to.
Delays in receiving feedback/input on draft deliverables lead to delayed finalisation of review	SHS will provide ongoing support for timely delivery of feedback/input on drafts and monitor and manage any delays with DFAT and the Evaluation Team including impact on contracting.
Conflict in the Middle East impacting air travel	If in-country visits are not possible due to flight cancellations, meetings will be virtual, and the National Advisor will lead in-country visits, interviews, discussions and observations, supported virtually by the Team Leader (noting the need for good connectivity).

7.4. Annex 4: List of key informants

Area	No.	Name	Role
DFAT – program management	1	Fiona Mulhearn	Director, Pacific Health Section, CHS, GHD
DFAT – program management	2	Sasha Lee	Assistant Director, Pacific Health Section; Investment Manager for PSCSHWIP, Program Manager for RACS
DFAT – program management	3	Frances Bingwor	Senior Program Manager, Suva Post; Program Manager for FNU, former Investment Manager for PSCSHWIP and Program Manager for SPC
RACS	4	A/Prof David McClure	Vascular Surgeon, Fellow and Chair RACS GH Scholarship Panel
RACS	5	Prof Suren Krishnan	University of Adelaide, RACS ENT Fellow
RACS	6	A/Prof Richard Grill	Urology Surgeon, RACS VMT
RACS	7	Dr James Muir	Anaesthetist, RACS VMT
RACS	8	Wendy Walpole	RN Theatre Nurse (Scrub Nurse educator VMT)
RACS	9	Sarah Howe	RN Ward Nurse (Perioperative educator VMT)
RACS	10	Vanessa Zulueta	Senior Program Advisor
RACS	11	Romy Soesanto	Finance and Grants Coordinator
RACS	12	Matt Pritchard	Senior Program and Engagement Advisor
RACS	13	Fiona McAllister	RACS Chief Operations and Partnerships Officer
RACS	14	Anita Delaney	Past Global Health General Manager
Fiji – SPC	15	Dr. Berlin Kafoa	Director, Public Health Division
Fiji – SPC	16	Dr. Silina Motofaga	Team Leader, Clinical Services Program
Fiji – SPC	17	Dr. Lamour Hansell	Clinical Services Adviser
Fiji – SPC	18	Emma Powan	GEDSI Adviser
Fiji – SPC	19	Margaret Leong	IPC Adviser
Fiji – SPC	20	Sunema Talapusi	Biomedical Engineer Adviser
Fiji – SPC	21	Dr. Clancy Read	Past M&E and Risk Advisor, CSP
Fiji – FNU	22	Dr. Amelia Turagabeci	Dean, College of Medicine, Nursing and Health
Fiji – FNU	23	Dr. Mai Ling Perman	Associate Professor Internal Medicine
Fiji – FNU	24	Vinau T Savau	CMNHS Regional Manager
Fiji – FNU	25	Dr. Toly Moali	PGD Oral Surgery Student (Solomon Islands)
Fiji – FNU	26	Dr. Phil Asial Temakon	PGD Anaesthesia Student (Vanuatu)
Fiji – FNU	27	Mrs. Fiona Pahuleu	Bachelor of Health Promotion (Kingdom of Tonga – Year 3)
Fiji – MHMS	28	Dr. Luisa Cikamatana-Rauto	Acting Permanent Secretary
Fiji – MHMS	29	Dr. Josese Turagava	Chief Surgeon Advisor
Fiji – MHMS	30	Mr. Jone	OMR and VMT Administrator
Fiji – MHMS	31	Dr. Fane Lord	ENT Consultant, CWMH
Fiji – MHMS	32	Dr. Semesa Matainacake	HoD Surgery CWMH/Consultant Plastic Surgeon
Fiji – MHMS	33	Dr. Alan Biribo	Chair Surgical CSN/Consultant Neurosurgeon, CWMH
Fiji – MHMS	34	Dr. Sela Koyamaitotoya	Consultant Vascular Surgeon
Fiji – MHMS	35	Sr. Maria Vucago	OT Manager, CWMH
Fiji – MHMS	36	Dr. Luke Nasedra	Medical Superintendent, CWMH
Fiji – MHMS	37	Dr. Delasau	Consultant Surgeon, CWMH

Area	No.	Name	Role
Fiji – MHMS	38	Dr. Mike Kama	Acting Deputy Secretary Hospital Services
Fiji – MHMS	39	Dr. Maloni Bulanauca	Former Chair Surgical CSN/Consultant Surgeon, Labasa Hosp (virtual)
Fiji – MHMS	40	A/Prof. Abhay Choudahri	Surgeon, Lautoka Hospital PIVOTS in-country lead (virtual)
Fiji – MHMS	41	Dr. Julia Singh	Head of Obstetrics and Gynaecology, FNU PIVOTS (virtual)
Fiji – DFAT	42	Emeline Cammack	Counsellor Human Development, Australian High Commission
Fiji – DFAT	43	Dr. Alipate Vakamoce	Standards, Clinical Governance Lead
Fiji – DFAT	44	Judy	Masterplan Team, Fiji Program Support Facility (FPSF)
Tonga – DFAT	45	Sineteke Tonga	Health Program Manager
Tonga – DFAT	46	Clare Whelan	Lead Adviser, Tonga Health System Support Program 3
Tonga – MoH	47	Dr. Siale Aka'uloa	(Former) CEO, Minister for Health
Tonga – MoH	48	Sr. Mele Sii Inukihaangana Filise	Chief Nursing Officer
Tonga – MoH	49	Dr. Sione Tomiki	Head of National Diabetes Centre
Tonga – MoH	50	Sr. Mele Inu Fifisa	Chief Nursing Officer
Tonga – MoH	51	Sr. Tilema Cama	Head of Tonga School of Nursing and Health Sciences
Tonga – MoH	52	Dr. Sisilia Fifita	Acting CEO
Tonga – MoH	53	Sr. Tangi Fine	Sister in charge, Operating Theatre
Tonga – MoH	54	Dr. Alamea Fulivai-Aholelei	General Surgeon
Tonga – MoH	55	Dr. Marina Tu'inukuafe	Medical Officer, Trainee Surgeon
Tonga – MoH	56	Dr. Sione Frisco Folau	ENT Medical Officer
Tonga – MoH	57	Loreta Mafi	Senior ENT Nurse
Tonga – MoH	58	Dr. Sifa Teumohenga	Medical Officer, ENT Training program UPNG **(virtual)**
Tonga – MoH	59	Dr. Maake Tupou	Medical Superintendent **(virtual)**
Tonga – MoH	60	Dr. Ana Aka'uloa	Former CEO, Medical Superintendent, Minister for Health **(virtual)**
FSM – DFAT	61	Roan Cabacungan	Senior Program Manager, Australian Embassy Pohnpei
FSM – MHMS	62	Dr. Tholman Alik	Director Kosrae State Hospital
FSM – MHMS	63	Dr. Judith Panapasa	Chief of Clinical Services, Kosrae State Hospital
FSM – MHMS	64	Dr. Tommy Joelle	General Surgeon, Kosrae State Hospital
Kiribati – DFAT	65	Ryan Kinder	First Secretary (Development) Australian High Commission
Kiribati – DFAT	66	Ka0kiateiti Erikate	Health Program Manager, DFAT
Kiribati – MHMS	67	Dr Kakaroa Kabiri	Head of Surgery
Kiribati – MHMS	68	Dr Tekeua Uriam	Director of Hospital Services
Nauru – DFAT	69	Eric Raymond	DFAT First Secretary (Policy) Australian High Commission
Nauru – DFAT	70	Dr. Susana Nakalevu	Former Director of Medical Services, RON Hospital; ISOS Advisor Raña Tsimorum health program
Nauru – Nauru Medical Centre	71	Roy Shaposhnik	Managing Director of GMSS

Area	No.	Name	Role
Nauru – Nauru Medical Centre	72	Dr. Angelique Makutu	Director of Medical Services, Nauru Medical Centre
Palau – DFAT	73	Camille Pesava	DFAT Second Secretary Development
Palau – DFAT	74	Axl Ungiltekoi Rdiall	Development and Admin Officer, Australian High Commission
Palau – MHMS	75	Dr. Myra Adelbai	Internal Medicine, Belau National Hospital
Palau – MHMS	76	Dr. Ngirachisau Mekoll	Chief of Hospital
RMI – MHMS	77	Dr. Robert Maddison	Chief of Staff, Majuro Hospital
RMI – MHMS	78	Elizabeth Holly	Administrator and Deputy Secretary Majuro Hospital
Samoa – DFAT	79	Shirley Vaafusuaga	Senior Program Manager, Australian High Commission
Samoa – DFAT	80	Kassandra Betham	PHR coordinator at post
Samoa – MoH	81	Dr Sione Pifeleti	ENT Specialist, PIVOTS Co-Ordinator
Samoa – MoH	82	Dr Junior Fa'asa'o Posini	Senior Surgical Registrar, General Surgery Department
Solomon Islands – DFAT	83	Zina Fefera	Senior Program Manager, Health
Solomon Islands – DFAT	84	Michael Samani	Assistant Program Manager (Health)
Solomon Islands – SIAHP	85	A/Prof. Arish Naresh	Interim Team Leader – Solomon Islands-Australia Health Partnership (SIAHP), Clinical Governance
Solomon Islands – SIAHP	86	Frank Kade	Health Partnership Coordinator, SIAHP
Solomon Islands – MHMS	87	Dr. Rooney Jagilly	General Surgeon, National Referral Hospital
Solomon Islands – MHMS	88	Dr. George Malefoasi	CEO, NRH
Tuvalu – MHSW	89	Dr. Nokis Simeona	Director of Health, Ministry of Health and Social Welfare
Tuvalu – MHSW	90	Dr. Pelenise Selota	Medical Superintendent, O&G specialist PM Hospital
Tuvalu – MHSW	91	Dr. Lolo	GP (Outer islands before)
Tuvalu – MHSW	92	Sr. Teveve	OT Nurse
Tuvalu – MHSW	93	Sr. Nuasi	ENT Nurse
Vanuatu – DFAT	94	Dominic Ransan-Cooper	First Secretary, DFAT Vanuatu
Vanuatu – DFAT	95	Patricia Fred	Program Manager, DFAT
Vanuatu – DFAT	96	Briscosley Kuah	Acting Program Manager, DFAT Vanuatu
Vanuatu – DFAT	97	Davina Iopa	Epidemiologist, DFAT Vanuatu
Vanuatu – MoH	98	Dr Margaret Tarere Lehi	PIVOTS Coordinator, Vanuatu Ministry of Health
Partners supported RACS	99	Prof. Ram Nataraja	Director Monash Children's Simulation (MCS)
Partners supported RACS	100	Noor Chaudhry	Coordinator MCS, PIVOTS
Partners supported RACS	101	Dr Claire Fotheringham	O&G Specialist (past MSF) Chair RANZCOG Global Health Committee

Area	No.	Name	Role
Partners supported RACS	102	Joelle Tan	Interim RANZCOG Global Health Lead
Partners supported RACS	103	A/Prof. Misha Coleman	Interplast CEO
Partners supported RACS	104	Dr. Robyn Nagel	ANZGITA Programs Coordinator
Partners supported RACS	105	Kirti Prasad	Pacific Eye Institute, Fiji Country Manager
Partners supported RACS	106	Debbie Sorenson	PMA Director of Regional Services

Note that meetings with Fijian and Tongan stakeholders were face-to-face, unless otherwise specified.

7.5. Annex 5: Summary of initial analysis of KEQs mapped to evaluation questions

This matrix summarises the evaluation team's initial analysis of the 19 Key Evaluation Questions (KEQs) set out in the Terms of Reference and expanded on in the Evaluation Plan, mapped against the evidence gathered through document review, Key Informant Interviews and in-country observations. It links each KEQ to the relevant evaluation measure (effectiveness, efficiency, MEL or GEDSI) and to the source documents and design elements (End-of-Program Outcome, Intermediate Outcomes, GEDSI Action Plan and Sustainability Plan) used to assess it. Full narrative findings and recommendations are presented in Section 4.

KEQ	Key Evaluation Question	Evaluation Measure	Summary of Initial Analysis / Evidence	Source/Link
KEQ 1	To what extent is each partner (RACS, SPC and FNU) achieving their Intermediate and End-of-Program Outcomes?	Effectiveness	▪ RACS: 55 VMTs delivered 2022-25 (est. 75 by end 2026), ~3,763 consultations and 1,244 surgeries (est. 5,000/1,600 by 2026); 542 clinicians trained on-the-job and 491 through formal courses (Tables 1-2). Highly valued. Capacity building during VMTs is occurring but not fully documented; CPD recognition lacking. Strong contribution to IO1 and IO2. Funding to other organisations for VMTs and regional training demonstrating stronger model for capacity building. ▪ PIVOTS is a stand-out success; as is endoscopy training by ANZGITA, however with limitations on numbers. ▪ SPC: CSP substantially delivered PCU coordination functions and role as regional coordinator; 17 regional clinical/technical networks supported since 2022. Strong contribution to IO3 and IO2, however not all PSCSHWIP funded. ▪ FNU: central to regional health workforce – 11,204 enrolments 2022-25 (74% female); regional enrolment share grew from 17.3% to 20.5%; 270 DFAT scholarships (72% female). Strong contribution to IO2 and IO3, however not all PSCSHWIP funded. ▪ Overall: clear evidence of progress against all three IOs and the EOPO, though mentoring/capacity-building impact is not routinely measured. ENT collaboration (RACS-SPC-FNU) demonstrated integrated system strengthening	Design EOPO and IO1-IO3; Investment Design logic; RACS/SPC/FNU Annual Progress Reports 2022-25; Joint Annual Progress Reports 2022-2025

KEQ	Key Evaluation Question	Evaluation Measure	Summary of Initial Analysis / Evidence	Source/Link
KEQ 1a	Are there any key areas of concern?	Effectiveness	▪ VMT numbers lower than previous program phases; all PIC informants requested more/longer VMTs and other specialties beyond surgery. ▪ Recommendations from 2015 and 2022 evaluations on linking VMTs to country HR/SCS plans and on RACS communications remain unaddressed. ▪ Limited systematic recognition (CPD/micro-credentialling) of skills gained by local clinicians during VMTs. ▪ Communication gaps between RACS and MOH senior management / DFAT posts on VMT scheduling and effective use of End-of-Trip reports. ▪ Clinical services strengthening data dashboard is overdue and clinical services plans are only present in a few PICs. These should be the basis for planning VMTs.	2015 and 2022 RACS-PIP evaluations; KIIs (PIC clinicians, DFAT posts); RACS-PIP Learning Paper
KEQ 1b	How well do RACS activities respond to the needs and priorities of Pacific Island countries?	Effectiveness	▪ In the absence of PIC Clinical Services Plans, RACS is only able to respond at a less strategic level; often to a local surgeon's request to MOH. ▪ Limited systematic analysis of National Health Strategic Plans / Clinical Services Plans to guide VMT planning; nomination of VMTs often based on historical patterns rather than needs analysis. ▪ Specific unmet needs identified: paediatric, cardiac and neurosurgery, oncology, NCD/diabetes care, ultrasound, endoscopy/laparoscopy. ▪ Tension between MOH/clinician preference for nominating specific volunteer surgeons and RACS Expression-of-Interest process; some MOUs not yet finalised. ▪ Trained local specialists sometimes unable to use skills fully due to OT time/equipment constraints (e.g. Fiji ENT).	Table 3 (VMTs by PIC/specialty 2023-25); 2022 Nossal/Interplast capacity schema; KIIs across 11 PICs

KEQ	Key Evaluation Question	Evaluation Measure	Summary of Initial Analysis / Evidence	Source/Link
KEQ 2	To what extent are the program's overall delivery model and partnership arrangements fit-for-purpose and supporting achievement of IOs/EOPO, now and for future phases?	Effectiveness / Efficiency	▪ Each partner's role is well defined and aligned to EOPO/IOs. ▪ Pacific health workforce context has changed substantially since the VMT model was first designed in 1995; delivery model has not evolved at the same pace. ▪ Clear opportunities identified for increasing efficiency in current and future delivery models (see Efficiency section below). ▪ RACS shipping costs high; basic equipment lacking in some PICs. ▪ Regional training partners under-utilised; budgets underspent.	Investment Design (program logic, partnership arrangements); Annex 1 (workforce change over time)
KEQ 2a	To what extent does each partner have the right staff, management structures and budgeting arrangements in place?	Efficiency	▪ RACS: Global Health team funded ~$500k (2025/26); high staff turnover (15 staff in 3 years); mixed views on organisational commitment to Global Health at Executive/Board level; management costs 28% of budget across Phase 1-2. ▪ Some tension between core business of RACS 'we do surgery' and a development model. ▪ SPC: CSP has 8 funded positions (not all filled); PSCSHWIP-funded M&E/risk adviser role had unclear reporting lines (to PHD Director, not CSP Team Leader) and position has been vacant, affecting continuity. Funds have been reallocated to support related clinical services activities. ▪ FNU: CRO funds 5 staff positions; staffing appears appropriately sized and well integrated, providing valued student support services. ▪ Program governance model needs review in any future phase.	Partner organisational charts; PCU/PCC meeting minutes; KIIs with RACS, SPC, FNU staff
KEQ 2b	How well do the three partners collaborate with each other and other organisations to share resources and deliver outcomes?	Efficiency	▪ PCU/PCC meetings held twice yearly and considered useful and cordial by all partners, but limited evidence of joint prioritisation and strategic decisions, beyond information sharing. ▪ Multiple agreed actions from 2023 Joint Annual Progress Report (patient list development, VMT communication strategy, measuring capacity-building impact, locality data) remain incomplete. ▪ Status and intended content of the SPC clinical services dashboard is unclear and contested between partners (clinical service mapping vs. VMT calendar). ▪ Limited partner involvement apart from SPC in supporting country NSOAPs to date.	Joint Annual Progress Reports 2023-2025; Nossal Baseline Assessment; PCU/PCC minutes

KEQ	Key Evaluation Question	Evaluation Measure	Summary of Initial Analysis / Evidence	Source/Link
KEQ 2c	Is there merit in continuing to group the partners under a joint program?	Efficiency	▪ Each partner currently focused on its own IOs/core business; scope exists for concrete joint deliverables (NSOAPs, Clinical Services Plans, VMT calendar, equipment planning) before end of current program. ▪ CSP support under PSCSHWIP ends September 2026, affecting joint program continuity. ▪ Evaluation suggests a more Pacific-led delivery model beyond 2027, with SPC continuing a coordinating role, not necessarily under a single joint program structure.	Investment Design partnership rationale; KIIs with implementing partners and DFAT
KEQ 2d	Should other Australian medical colleges and/or Pacific medical associations be more involved in delivering the RACS program?	Efficiency	▪ RACS partners with multiple Pacific medical associations and Australian/NZ specialty colleges (Table 8), but relationships described by some as 'transactional' rather than real partnerships. ▪ Pacific associations recommended for a regional RACS Steering Committee role, but this has not been formalised. ▪ Other organisations (e.g. ACRRM/Rocketship with SINU, Radiology Across Borders) offer relevant models for expanded involvement without necessarily requiring RACS as intermediary. ▪ Risk of fragmented/uncoordinated VMT provision and reputational risk to DFAT's Pacific Aid program if coordination is not improved.	Table 8 (RACS college/association partners); RACS Global Health Pacific Strategic Plan 2022-2027; KIIs with colleges/associations
KEQ 2e	What support would SPC need to follow through and expand on its commitments under the current program?	Efficiency	▪ SPC's convening/networking role for regional meetings (DCS, PHONM, PHOH, Pacific Health Ministers) is highly valued by all key informants. ▪ Clarity needed at PCU/PCC level on which deliverables (e.g. dashboard, VMT calendar) are feasible with existing staffing versus requiring additional resourcing (e.g. through AVI).	CSP Annual Progress Reports 2024-2025; PCU/PCC minutes
KEQ 2f	Could FNU's short courses be better aligned to formal training pathways in the Pacific?	Efficiency	▪ FNU exploring stackable micro-credentials for more flexible, modular upskilling pathways, particularly relevant for students with family/work commitments. ▪ Short courses currently perceived by academic staff as additional, undervalued workload alongside high teaching loads. ▪ Potential to expand specialty training capacity at other Pacific universities (NUS, TNU, SINU, UPNG) to reduce concentration of training at FNU.	FNU CMNHS course data; KIIs with FNU academic staff and PIC clinicians

KEQ	Key Evaluation Question	Evaluation Measure	Summary of Initial Analysis / Evidence	Source/Link
KEQ 2g	What strategies and/or activities could partners introduce to increase sustainability of the program (to the end of the current program, and beyond if DFAT continues funding)?	Efficiency / Sustainability	▪ 2025 PSCSHWIP Sustainability Plan identifies four pathways: Pacific-led education/training; SPC-convened regional governance; shift from service substitution to mentoring/capability transfer; and progressive domestic budgeting/policy recognition of specialist cadres. ▪ Evaluation concurs with and endorses these sustainability pathways as the basis for program design beyond the current phase. ▪ RACS Global Health Regional Strategic Plan (2022-2027) demonstrates organisational commitment to localisation, including the PSCSHWIP Regional Centre hosted at SPC.	PSCSHWIP Sustainability Plan 2025; RACS Global Health Pacific Strategic Plan 2022-2027
KEQ 3	Are any changes to the program delivery model required if DFAT continues funding beyond the end of the current program?	Efficiency / Delivery Model	▪ DFAT bilateral posts co-funding VMTs from 2026 ($60,000/VMT) offers a mechanism to strengthen regional-bilateral linkages, but communication with posts needs improvement (some posts not notified of in-country VMTs). ▪ Other donor VMT models (NZMTS/PMA, Taiwan, PRC, Philippines) offer comparative models, including longer in-country placements valued by PICs. ▪ A future model needs to be more Pacific-led delivery model, with SPC continuing a coordinating role; any future VMTs built on PIC Clinical Services Plans and analysis. ▪ Clear shift from substitution to capacity building, which may include developing specialist regional hubs, not just in Fiji or overseas in future. ▪ Potential hub-and-spoke model for higher education proposed by key informants, building on existing strengths at FNU and other Pacific universities :SINU, NUS, TNU. ▪ Twinning/exchange arrangements with Australian hospitals (e.g. Canberra hospital; Tonga – St John of God Ballarat) valued but have declined over time.	DFAT Partnerships for a Healthy Region Strategic Investment Framework; NZMTS reporting 2022-2024; KIIs with DFAT posts and bilateral programs
KEQ 3a	To what extent is the program's MEL system fit for purpose and used to support learning, adaptation and accountability?	MEL	▪ MEL system partially fit for purpose: shared program logic, MEL framework and 2023 baseline established; annual progress reporting occurring; increasing use of sex-disaggregated data. ▪ Joint Annual Progress Report not yet being used effectively to drive collaboration or adaptive management. ▪ 2015 and 2022 evaluation recommendations remain largely unaddressed; should have been addressed in MEL.	PSCSHWIP MEL Framework; 2023 Baseline Report; 2015 and 2022 evaluation reports

KEQ	Key Evaluation Question	Evaluation Measure	Summary of Initial Analysis / Evidence	Source/Link
KEQ 3b	Do partners provide adequate data when reporting against the MEL Framework?	MEL	▪ Variability across partners: RACS strong on operational VMT data, weaker on capacity-building measurement; SPC strong on governance/systems reporting but unclear PSCSHWIP vs core-CSP attribution; FNU reports on both core and PSCSHWIP funded activities. ▪ Indicators changed between 2023 and 2024 reporting without clear documented rationale, limiting trend analysis.	RACS/SPC/FNU Annual Progress Reports 2022-25; Joint Annual Progress Reports
KEQ 3c	Have partners satisfied DFAT's reporting requirements, i.e. were reports submitted on time and of acceptable quality?	MEL	▪ Limited direct evidence on timeliness; consolidated reports for 2023, 2024 (late) and 2025 were produced and tabled through governance processes. ▪ Quality generally acceptable for operational accountability, but recurring weaknesses in disability/location-disaggregated data, indicator consistency, and outcome-level analysis. ▪ PCC minutes (July 2024) requested improvements including MEL updates, risk plans and stronger harmonisation.	PCC minutes; consolidated Joint Annual Progress Reports 2023-2025
KEQ 3d	What should be considered in relation to MEL for any future reporting?	MEL	▪ Review 2015/2022 evaluation and PIP Learning Paper recommendations to define relevant indicators per partner. ▪ Adopt a simpler, harmonised, outcome-focused MEL system with common templates and agreed indicator definitions across partners. ▪ Mandate sex, disability and location-disaggregated data across all reporting (VMTs, training, enrolments, mentoring, patient access). ▪ Avoid changing indicators during the final program year to preserve comparability.	SPC Sustainability Plan; KIIs with MEL/program staff
KEQ 4	To what extent has the program supported GEDSI outcomes as articulated in the Phase 2 design?	GEDSI	▪ GEDSI Action Plan developed June 2025 with four priority areas (equity/access; inclusive workforce development; inclusive regional governance; GEDSI evidence/learning); partner roles allocated accordingly. ▪ Moderate progress since Plan development: disability inclusion training, engagement with gender/disability organisations, GEDSI curriculum work at FNU, 73% female training participation. ▪ GEDSI visible across the program but not yet fully embedded; mainstreaming, disaggregated data and MEL integration remain underdeveloped.	PSCSHWIP GEDSI Action Plan (June 2025); Investment Design GEDSI requirements

KEQ	Key Evaluation Question	Evaluation Measure	Summary of Initial Analysis / Evidence	Source/Link
KEQ 4a	What gains and challenges were experienced by each partner when trying to incorporate and implement GEDSI into their programs?	GEDSI	▪ Gains: all partners now report sex-disaggregated data; RACS VMT participation 57% female/42% male clinicians overall; FNU enrolments ~73% female; joint RACS/SPC/Interplast online GEDSI training reached 337 participants (2024-25); SPC integrated GEDSI into NSOAP workshops and PHONM/PISA activities. ▪ Challenges: women underrepresented in senior leadership/decision-making roles; limited attention to SGBV despite clinical relevance; disability data often unavailable; disability-specific service gaps not yet systematically mapped; social inclusion/remote-community access least developed and largely undocumented.	GEDSI Action Plan; CSP 2023 Performance Story (Disability); RACS/SPC/FNU GEDSI training data 2024-2025
KEQ 4b	Are any changes needed to the GEDSI approach if DFAT continues funding beyond the end of the current program?	GEDSI	▪ Shift from awareness/standalone activities to a funded, partner-wide implementation system coordinated by the PCU. ▪ Mandatory sex, disability-and location-disaggregated data; OPD consultation in planning/monitoring; accessible VMT/training design; disability-inclusive CPD and workforce pathways. ▪ Develop appropriate model to reach remote, outer island patients for VMTs and other specialist services not available. ▪ Retain twin-track approach (targeted action plus mainstreaming); introduce annual GEDSI learning reviews; strengthen outreach to remote/hard-to-reach communities.	GEDSI Action Plan; PSCSHWIP Sustainability Plan; KIIs

Note: This is a summary evidence matrix; it should be read alongside the full narrative analysis, tables and recommendations in Section 4 (Findings and Recommendations), which provides the detailed evidence base, direct quotations from key informants, and the complete numbered list of 26 recommendations.

7.6. Annex 6: Documents reviewed and references

DFAT documents (5):

- DFAT SmartyGrants 2025
- Partnerships for a Healthy Region Initiative, Strategic Investment Framework, 2023-2027
- Plowman B (2015) Independent Evaluation of PIP and SSCIP Joint Evaluation (2011-2016)
- DFAT Pacific SSCIP-PIP Joint Evaluation Management Response
- Strengthening Pacific Health Systems: Evaluating ten years of Australia's support, 2019

PSCSHWIP related documents (11):

- PSCSHWIP II Investment Design Document
- PSCSHWIP II Baseline Assessment (Nossal 2023)
- PSCSHWIP II Joint Annual Report 2023
- PSCSHWIP II Joint Annual Report 2024
- PSCSHWIP II Joint Annual Report 2025
- PSCSHWIP II Coordination Committee Meeting #3,4,5,6 minutes
- Presentation on PSCSHWIP II to DCS meeting August 2024
- PSCSHWIP II Draft Communications Plan (2026)
- PSCSHWIP II Sustainability Plan (2025)
- PSCSHWIP II GEDSI Plan (2025)
- Draft PSCSHWIP II Y4 Costed Workplan to DFAT V5 (2026)

Partner related documents (SPC 23; RACS 35; FNU 6):

- SPC PHD Annual Progress reports, 2024 2025
- SPC PHD Annual Overview reports 2024, 2025
- SPC PHD Business Plan 2022-2026
- SPC PHD DFAT Funding Budget Report 2025
- SPC CSP Comprehensive Narrative Progress Reports 2024, 2025
- CSP Report of Meeting Directors of Clinical Services, 2018
- CSP DCS Clinician Workforce Updates, 2023
- PHoNM Gender Equality and Disability Inclusion (GEDSI) Training: Online modules (Interplast)
- CSP PHoNM 2025 Nurses and Midwives Together: A force for global health
- SPC Technical Paper PSCSHWIP II to DCS, 2024
- SPC Information Paper, Mapping of Overseas Medical Referral Schemes and Visiting Specialist Medical Teams in the Pacific – a pathway for Regional Cooperation towards UHC to Pacific Heads of Health, 2019
- SPC Presentation Regional Internship Working Group (FTMG), March 2016
- SPC Standards for perioperative nursing in Pacific Island countries and territories: clinical standards: first edition 2022
- SPC Pacific Biomedical Engineering Workforces Data Summary 2023
- SHS, Evaluation of The Pacific Community (SPC) Public Health Division Investments, 2024
- National Surgical, Obstetrics and Anaesthesia Plans, Samoa 2026-2031
- National Surgical, Obstetrics and Anaesthesia Plans, Tonga 2023-2030
- NSOAP Situational Analysis Vanuatu (no date)
- National Surgical, Obstetrics and Anaesthesia Planning Manual, Harvard Medical School, GSF, UNITAR 2020
- SPC PENTAG Regional ENT Plan V2 at a glance
- RACS Annual Progress Report 2022-2023

- RACS Annual Progress Report 2024
- RACS mid-year Progress Report Jan-June 2025
- RACS Annual Report 2025
- RACS Annual Plans 2025, 2026
- RACS Global Health Pacific Islands Program phase 5.
- RACS Global Health Pacific Regional Strategic Plan, 2022-2027
- Example of RACS pre-deployment Information Sheet (ENT VMT Tonga 2025)
- RACS Briefing Paper to Pacific Heads of Nursing and Midwifery, 2022
- RACS presentation on PSCSHWIP II to DCS meeting August 2024
- RACS Briefing Paper to PHoNM Meeting 2022
- RACS 2025 Gratitude Report
- RACS TOR Global Health Program Steering Group
- RACS Global Health Deployment Guidebook
- RACS Lessons from RACS Global Health PIP 2022 Learning Paper
- RACS PIP Reflections Summary 2022
- RACS Financial Acquittal PIP 2016-2022
- RACS Pacific Island Program (PIP) End of Program Report 2022 (Nossal)
- RACS Tuvalu Ear Health Clinic and Audiometry Training Report, 2025
- RACS Neurosurgery VMT Fiji Report, 2025
- PEI Ophthalmology VMT RMI Report to RACS, 2026
- RACS ENT VMT Vanuatu End-of-Trip Report and Reflections, 2025
- ANZGITA End-of-Trip Report to RACS, 2025
- APLS Training Completion Report to RACS, 2025
- Interplast Annual Reports 2024-2025
- Interplast The State of Plastic and Reconstructive Surgery in the Pacific, 2022 (Nossal)
- Interplast Gender Equality and Diversity Inclusion and Specialist Clinical Services in Pacific Island Countries Meta Analysis 2022 (Nossal)
- MCS PIVOTS Progress Reports, 2024, 2025
- MCS PIVOTS Summary and Presentation DFAT 2026
- RANZCOG Global Health Unit Overview, 2026
- RANZCOG Global Health Action Plan 2025-2027
- RANZCOG Fetal Surveillance Education Program (FSEP) Training in the Pacific, 2025
- FNU mid-year Progress Report Jan-Jun 2025
- FNU Annual Progress Report 2024
- FNU Annual Progress Report 2025 (draft)
- FNU 6-monthly Progress Report Jan-Jun 2025
- FNU 6-monthly Progress Report Sep 2023 – Jan 2024
- FNU CMNHS Enrolment Statistics 2022-2026

Other related papers and documents (41):

- ACCRM Framework and Guideline for Telehealth Services, 2020
- Blick G, Smith J Evaluation of the New Zealand Medical Treatment Scheme, for NZMFAT, 2015
- Bornstein et al, Using a Partnership approach to strengthen acute care systems in the Pacific and Timor-Leste, Emergency Medicine Australasia, Vol 37(3):2025
- Boudville et al, Overseas Medical Referral: the health system challenges for Pacific Island Countries, Policy Brief Pacific Health, vol 4, 2021
- Center for Asia-Pacific Resilience and Innovation (CAPRI) Sustainability and Resilience in Pacific Island Health Systems Partnership for Health System Sustainability and Resilience 2024

- Chang AY,Hawkes S, Buse K, et al. 'Is gender equality in health' the right goal? Exploring issues of definition and measurement. BMJ Glob Health 2025;10:e017900.
- Guest GD, Scott DF, Xavier JP, Martins N, Vreede E, Chennal A, Moss D, Watters DA. Surgical capacity building in Timor-Leste: a review of the first 15 years of the Royal Australasian College of Surgeons-led Australian Aid programme. ANZ J Surg. 2017 Jun;87(6):436-440. doi: 10.1111/ans.13768. Epub 2016 Sep 20. PMID: 27647706.
- Health New Zealand | Te Whatu Ora. 2024. Pacific Health Workforce Strategic Plan 2022-2024. Wellington: Health New Zealand | Te Whatu Ora
- Kaspar A, Pifeleti S, Driscoll C. Knowledge and attitudes of university health students in the Pacific Islands towards childhood hearing loss and hearing services: a Samoan survey study protocol. BMJ Paediatrics Open 2021;5:e000998. doi:10.1136/bmjpo-2020-000998
- Lamine H, Markou-Pappas N, Buonamassa R, Ansaloni L, Alkarim T. Perceived impact of regular short-term medical missions: a qualitative study in Uganda. Academia Medicine and Health 2026;3. https://doi.org/10.20935/AcadMedHealth8152
- Lowy Institute Pacific Aid Map: 2024 Key Findings
- Manandhar M et al Gender, health and the 2030 agenda for sustainable development. Bull World Health Organ 2018;96:644–653
- Masterton JP, Moss D, Korin SJ, Watters DA. Evaluation of the medium-term outcomes and impact of the Rowan Nicks Scholarship Programme. ANZ J Surg. 2014 Mar;84(3):110-6. doi: 10.1111/ans.12493. Epub 2014 Jan 9. PMID: 24400956.
- Matoto V, Win Tin ST, et al. Measuring Diabetes Complications, Risk Factors and Capacity for Managing Diabetes: An Initial Step to Improve Diabetes Care at The Primary Health Centre in Tonga, Medical Research Archives, 2023
- McIver L, Manahan D, Jones S, 'Ulufonua L. Rocketship and the Rural Health Workforce Revolution in the Pacific: Growing Skilled Medical Generalists Across the "Blue Continent". Front Public Health. 2021 Feb 3;8:612531. doi: 10.3389/fpubh.2020.612531. PMID: 33614569; PMCID: PMC7887312.
- Nataraja R. et al (2020) Clinical Impact of the Introduction of Pediatric Intussusception Air Enema Reduction Technology in a Low- to Middle-Income Country Using Low-Cost Simulation-Based Medical Education, Society for Simulation in Healthcare
- New Zealand MFAT Pacific Regional Plan, 2025
- New Zealand Medical Treatment Scheme Guidelines, Pasifika Medical Association 2022
- Pacific Island Society for Emergency Care (PISEC) Framework 2025-2034
- Pacific Society of Anaesthetists (PSA) Strategic Plan 2025-2029
- Qin RX, Stankey M, Jayaram A, Fowler ZG, Yoon S, Watters D, Gelb AW, Park KB. Strategic partnerships to improve surgical care in the Asia-Pacific region: proceedings. BMC Proc. 2023 Jul 25;17(Suppl 5):11. doi: 10.1186/s12919-023-00257-y.
- Robinson SJA et al (2024) Simulation-based education in the Pacific Islands: educational experience, access, and perspectives of healthcare workers ANZ Journal of Surgery
- Rocketship Annual Report 2020, 2021 [Remote Opportunities for Clinical Knowledge, Education, Training and Support for Health in the Pacific https://rocket-ship.org/publications/
- Samoa Ministry of Health Surgical Doctor Workforce Development Plan 2023
- Singh, A., & Shute, K. (2026). Neurosurgical access in Fiji and Pacific. Journal of Clinical Neuroscience.
- South Pacific Chief Nursing and Midwifery Alliance Constitution (UTS)
- Tetra Tech Independent Evaluation of the Australian Volunteers Program. DFAT 2025
- The World Bank. Pacific Healthy Islands Transformation (PHIT) Project. Technical Note. N/D
- The Global Surgery Foundation Why Surgical Care? Closing the biggest neglected gap in global health to save lives, https://www.globalsurgeryfoundation.org/why

- Thorne P et al Provision of hearing care in the Pacific Island countries and territories Bull World Health Organ 2019;97:719–721
- Vanuatu Ministry of Health Clinical Services Plan, 2019
- Watters DA, McCaig E, Nagra S, Kevau I. Surgical training programmes in the South Pacific, Papua New Guinea and Timor Leste. Br J Surg. 2019 Jan;106(2):e53-e61.
- Watters DA, Ewing H, McCaig E. Three phases of the Pacific Islands Project (1995-2010). ANZ J Surg. 2012 May;82(5):318-24. doi: 10.1111/j.1445-2197.2012.06036.x. Epub 2012 Mar 23. PMID: 22507204.
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- WHO. Framework of Action for Revitalization of Healthy Islands in the Pacific
- WHO. Monitoring and Evaluation of Health Systems strengthening: an operational framework
- WHO WPRO. Outcomes of the Special Event of the Pacific Health Ministers in the Healthy Islands Vision. Yanuca Fiji, October 2025
- WHO WPRO. Regional Framework to Shape a Health Workforce for the Future of the Western Pacific, 2024
- WHO. Pacific Islands Meeting on Subregional Collaboration for Specialized Health-Care Services. Suva Fjij, 26-27 February 2019
- WHO, Policy Brief Overseas medical referral: the health system challenges for Pacific Island Countries, Jan. 1, 2020, pp. 1-17
- WHO. Guidelines for Safe Surgery, 2009

Guidelines and frameworks:

- https://www.dfat.gov.au/about-us/publications/dfat-design-monitoring-evaluation-learning-standards
- https://www.dfat.gov.au/development/new-international-development-policy
- https://www.dfat.gov.au/international-relations/themes/gender-equality/new-international-gender-equality-strategy
- https://www.dfat.gov.au/about-us/publications/disability-inclusive-development-guidance-note
- https://www.dfat.gov.au/about-us/publications/Pages/gender-equality-in-monitoring-and-evaluation-good-practice-note
- https://www.dfat.gov.au/about-us/publications/Pages/disaster-risk-reduction-and-climate-change-guidance-note
- https://www.dfat.gov.au/sites/default/files/international-development-programming-guide.pdf

7.7. Annex 7: Summary of RACS activity under PSCSHWIP and predecessor programs

RACS' activities under PSCSHWIP and predecessor programs (1995-2025):

Program	VMTs	Volunteers	Consultations	Procedures	DFAT funds
RACS* I, 1995-1998 (3yrs)	63 (avg, 21/yr)	255	13,401	2,633	N/A
RACS II, 1998-2001 (3yrs)	102 (avg. 34/yr)	483	14,379+	3,363	N/A
RACS III, 2001-2010 (9yrs)	367 (avg. 41/yr)	1,621	42,671	11,331	N/A
RACS total, 1995-2010[13] (15 yrs)	522 (avg. 34/yr)	2359	60,057+	15,955	$20.4m
RACS-PIP, 2010-2015[14] (5 yrs)	124 (avg. 25/yr)	552	13,333	3,559	$5.6m
PRCSHWIP, 2016-2022[15] (6 yrs)	115, plus 3 VMTs post-COVID	254	6,527	1,809	$7.5m
PSCSHWIP, 2022-**2025**[16] (3 yrs)	55 (avg. 18/yr)	211	3,763	1,244	$7.3m to end 2025

**AusAID funded RACS from 1995-2010 to assist PICs in the delivery of specialist clinical services in the region.*

RACS' clinical services activities under the Pacific Islands Project (1995-2010):

Phase	Years	Team Visits	Volunteers	Consultations	Operations
Phase I	1995-1998	63	255	3007+	1,261+
Phase II	1998-2001	102	483	14,379+	3,363+
Phase III	2001-2010	367	1612	42,671+	11,331+
Total	**1995-2010**	**522**	**2359**	**60,057+**	**15,955+**

Note that the numbers of consultations and operations are those recorded. There is likely to be some degree of under-reporting and certainly 3.5% of the teams failed to provide a report, hence the plus signs are the figures for consultations and operations. Psychiatry (to Samoa), diabetes and radiology visits consistently did not record their numbers of patient consults as happened with some cardiology visits.

[13] Derived from Tables 4 and 6: Watters *D. A. K; H. Ewing;* E.13 McCaig Three phases of the Pacific Islands Project (1995-2010) *ANZ Surg 82 (2012) 318–324*

[14] Plowman B, Independent Evaluation of the Tertiary Health Pacific Islands Program (PIP) and SSCiP, 2015 p.38

[15] Gilbert, K, End of Program Evaluation RACS-PIP 2022. Comparable data not provided in report.

[16] Data extracted from RACS Annual Reports 2022-23, 2024 and 2025

RACS' specialty visits and workload during the Pacific Islands Project Phase III (2001-2010):

Specialty Service	Persons	Weeks	Consultations	Operations
Cardiac Surgery	618	26	1600	359
Cardiology	23	13	1428	0
ENT surgery and audiology	213	113	12289	2271
Plastics & reconstructive Surgery	183	85	2958	1842
Neurosurgery	24	16	386	125
Ophthalmology surgery and optometry	167	78	12984	4000
Vitreoretinopathy	4	2	142	56
Orthopaedics surgery	135	62	3361	778
Paediatric surgery	60	24	533	401
Urology surgery	42	18	509	213
Laparoscopy	6	4	10	5
Oral & Maxillofacial	6	2	58	20
Gastroenterology	5	3	131	9
Psychiatry	6	11	NR	NR
Radiology	8	13	NR	NR
General Surgery	8	13	211	89
Gynaecology	4	3	50	1
Respiratory	2	1	63	0
Renal/vascular/nephrology	32	14	596	131
Neonatology	2	1	NR	0
Endocrinology	2	2	64	0
Diabetes	58	43	103	NR
Dermatology	1	1	94	NR
Oncology scoping	1	1	NR	NR
Cardiac scoping	1	1	NR	NR
Emergency medicine scoping	4	2	NR	NR
Mammography	6	5	676	NR
Total	**1621**	**557**	**38,246+**	**14,924+**

7.8. Annex 8: Examples of Clinical Services Plans

Excerpt from Vanuatu Ministry of Health Clinical Services Plan, 2019:

EXECUTIVE SUMMARY

Introduction

Clinical services are an integral part of the health system in Vanuatu. With public health services, they provide the balance of prevention and treatment required to support and improve population health.

Clinical services are delivered throughout the health system, from dispensary to referral hospital. The range of services to be provided at each type of health facility is defined in the Role Delineation Policy (RDP). The RDP also defines the staffing, functional/space and equipment required by those services.

Purpose

The Clinical Services Plan (CSP) aims to provide a 'road map' to guide clinical service development in Vanuatu over the next 5-10 years, progressively moving towards the standards set out in the RDP.

It aims to improve the overall functioning of clinical services within the health system, to respond better to population health needs. This means getting the right balance of services between hospitals and primary health facilities and providing the right mix of specialist services within the hospital system.

Process

This draft CSP has been developed through a process of consultation and analysis, workshop discussions and Working Group review. This process has identified both the main directions for clinical service development and the challenges that need to be tackled to achieve the desired outcomes.

Many of the challenges relate to shortfalls in workforce capacity and capability, and the human resource development required to address these issues. These are largely covered in the MOH Workforce Development Plan 2018-2030. The CSP complements this plan and seeks to provide a focus for future clinical workforce development, particularly in terms of specialist training and support.

Excerpt from Samoa Ministry of Health Surgical Doctor Workforce Development Plan, 2023:

The rest of registrar entering the department will do at least 2 years before do the PGD Surgery Locum – need locum for the next 5 years: 2 surgeons; 1 General surgery and 1 other sub-specialist surgeon (Urologist, Pediatric surgeon, Plastic surgeon, Neurosurgeon, Vascular surgeon, ENT, Orthopedic surgeon, Endocrine surgeon). At least at senior registrar/fellowship training or consultant level. This rotation can be 6 months or year or longer and this will assist in local capacity building. This will also assist with local registrar training and postgrad training supervision and assessment from FNU and also development of surgical training at SOM/NUS. The aim is development of sub-specialist training locally and the delivery of safe and affordable surgical services. These locum surgeons will also assist and support the delivery component of the MBBS program at NUS and also the Postgrad surgical training locally. This model of training of trainer and aim mainly on transfer of knowledge and skills and empower of local surgeons. Local surgeons can also be utilized. For example in utilizing Dr Dyxon Hansell can also be done to assistance as part-time and take some of the load is another solution.