Australian Government
Department of Foreign Affairs and Trade

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

## EVALUATION OVERVIEW

The Pacific Specialised Clinical Services and Health Workforce Improvement Program Phase 2 (PSCSHWIP II) is a four-year regional investment (2022-2026, with an extension option) supporting specialist clinical service delivery and health workforce development across 11 Pacific island countries. DFAT funding for PSCSHWIP II totals approximately AUD 10.4 million (at the time of this evaluation) and builds on three decades of Australian Government support to the Pacific in this space.

The program is delivered through three implementing partners: the Royal Australasian College of Surgeons (RACS), the Pacific Community (SPC), and Fiji National University (FNU). Its overarching aim is to strengthen Pacific health workforces and health systems to deliver more equitable, higher quality, accessible and affordable specialised clinical services. This is supported by three Intermediate Outcomes focused on: strengthening specialised clinical services; strengthening the specialised clinical workforce; and strengthening regional coordination, governance and systems for clinical service delivery.

In 2026, DFAT commissioned an independent evaluation of PSCSHWIP II through the Specialist Health Service (SHS) to:

- Assess the program's performance to date in relation to effectiveness; efficiency; monitoring, evaluation and learning (MEL); and gender equality, disability equity and social inclusion (GEDSI).
- Recommend actions to strengthen current program performance.
- Inform DFAT's consideration of future support to RACS, SPC and FNU beyond the current program period, including the suitability of the existing delivery model.

A mixed-methods approach was used to answer a set of key evaluation questions. The evaluation team reviewed more than 120 documents and interviewed over 100 key informants across the 11 participating Pacific island countries, including in-country interviews and observations in Fiji and Tonga. Key informants included Pacific clinicians, Pacific health ministry staff, regional organisations, training providers, DFAT posts, the three implementing partners, Visiting Medical Team (VMT) volunteers, and program beneficiaries.

The evaluation findings and recommendations are presented in an Evaluation Report. Responses from DFAT, RACS, SPC and FNU to the report's 25 recommendations are listed in the table below.

## EVALUATION KEY FINDINGS

The evaluation found that PSCSHWIP II is overall an effective, efficient and highly valued regional investment that is making strong progress towards its intended outcomes. The program continues to provide important specialist clinical services across the Pacific while strengthening workforce capability, supporting regional coordination, and contributing to improved health systems. The evaluation also identified opportunities to strengthen sustainability, coordination, monitoring and learning, and GEDSI integration as the program evolves.

### Effectiveness

The evaluation found that PSCSHWIP II is delivering strong results and is highly valued by Pacific governments, clinicians and DFAT posts. RACS VMTs continue to provide important specialist services. The regional clinical trainings, particularly the PIVOTS (Pacific Islands Virtual Online Training in Surgery) training, were highlighted as successful and are increasingly embedded within Pacific training pathways. SPC has strengthened regional coordination and technical networks, while FNU has contributed to specialist workforce development and regional student support.

The report also outlines numerous recommended areas for improvement. Many countries requested more frequent and longer-term VMTs with a stronger focus on capacity development (on-the-job learning during VMTs is not recognised in a formal or consistent way) and increased Pacific involvement and leadership during VMTs. Communication between RACS, health ministries, hospitals and DFAT posts was sometimes fragmented. PSCSHWIP II support could better align with national priorities if countries developed clinical services plans.

### Efficiency

The program was assessed as broadly efficient and providing good value for money. RACS' volunteer model leverages significant specialist expertise, SPC provides extensive regional coordination with relatively modest resources, and FNU's support to regional students contributes to strong retention and graduation outcomes. The three partners' roles are generally complementary and aligned with program objectives.

However, numerous efficiency gains are possible. The high cost of procurement and shipping of VMT equipment reduces value for money, and staffing vacancies and turnover within SPC delayed delivery of planned activities under the regional coordination component. The evaluation also found that some opportunities for collaboration between partners had not been fully realised, with several recommended actions from predecessor evaluations remaining incomplete.

### Delivery Model

The evaluation found that the current delivery model is broadly fit-for-purpose as it has contributed to stronger specialist clinical services, workforce development and regional collaboration. Stakeholders consistently supported continued investment in specialist clinical services and recognised the value of the complementary roles played by RACS, SPC and FNU.

At the same time, the model will need to evolve beyond 2027 for stronger integration between regional and bilateral health programs, greater emphasis on long-term capacity building rather than clinical service substitution, and a more streamlined model for specialist training across Pacific institutions.

### Monitoring, Evaluation and Learning (MEL)

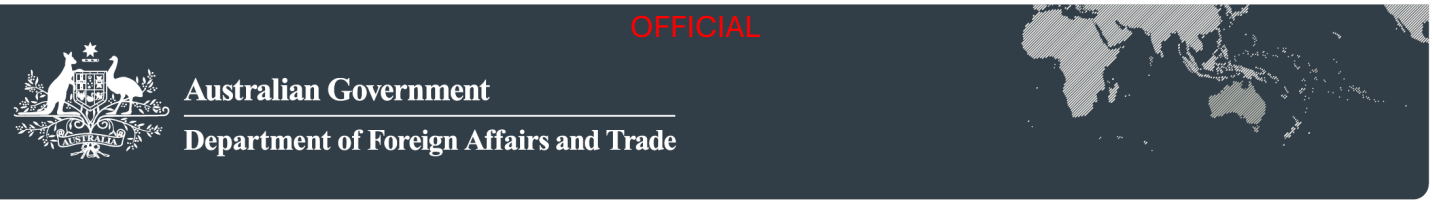
The program established a solid MEL foundation, including a shared program logic, and routine reporting processes for both individual partners and at the joint PSCSHWIP II investment level. Reporting generally provides sufficient information for accountability and monitoring.

However, the MEL system remains only partially fit-for-purpose. Reporting focuses heavily on activities rather than outcomes and impact, indicators have changed over time, and important data gaps remain. The evaluation recommends a simpler, more harmonised and outcome-focused MEL approach that better supports learning, adaptation and evidence-based decision-making.

### GEDSI

The evaluation found some progress in GEDSI integration, including the development of a GEDSI Action Plan, routine reporting of sex-disaggregated data, and stronger consideration of gender and disability issues in training and regional governance. Female participation in training remains strong.

Despite this progress, GEDSI is not yet well embedded. Disability data remains limited, disability-specific service gaps have not been systematically mapped, access for remote and underserved populations remains a challenge, and gender-based violence receives insufficient attention. Therefore, there are tangible opportunities to strengthen GEDSI integration across service delivery, workforce planning and monitoring systems.




# MANAGEMENT RESPONSE TO EVALUATION RECOMMENDATIONS

| Recommendation | Response | Action Plan | Timeframe |
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| 1: SPC Clinical Services Program (CSP) to use its convening role to discuss at DCS meeting(s) support to Pacific island countries (PICs) in developing Clinical Services Plans, including a timeline (as recommended in previous evaluations). These plans will strengthen VMT alignment to country needs. | Accepted | In July 2026, SPC convened a VMT workshop with six PICs (Fiji, Kiribati, Samoa, Tonga, Tuvalu and Vanuatu), ahead of the hybrid 16th Directors of Clinical Services (DCS) meeting. The VMT workshop discussed how PICs can best support VMTs, identifying challenges and opportunities for improvement. Recommendations included providing regional support for national VMT planning, aligned with National Surgical, Obstetric and Anaesthesia Plans (NSOAPs) and/or clinical plans available at the national level; and sharing of VMT schedules. As a follow-up, SPC will continue to reach out to PICs for their VMT calendars and any clinical services plans available.<br>CSP will aim to visit two PICs per year, to provide support in developing or reviewing NSOAPs and/or national clinical services plans, pending funding support. | Preparation discussion(s) with PICs in Q3-Q4 2026<br>Visits to PICs starting in Q1-Q2 2027, pending funding support |
| 2: PCU to explore methods for providing individual performance metrics and Continuing Professional Development (CPD) recognition during VMTs through on-the-job activities (at the request of many clinicians and Ministries of Health (MOHs) who are reviewing performance systems for salary and promotion). | Accepted | SPC will explore methods for providing individual performance metrics and CPD recognition during VMTs.<br>This work will align with the World Bank's *Pacific Healthy Islands Transformation (PHIT)* project (2025-2030), for which country scoping missions were conducted in Fiji, Tonga and Tuvalu during Q2-Q4 2026 as part of the inception phase. PICs will decide the training types most relevant for CPD recognition, which may or may not include VMTs. | Starting Q1-Q4 2027<br>This work will take time and continue beyond the PSCSHWIP period |
| 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 Memorandums of Understanding (MOUs) with PICs. | Accepted | RACS will liaise with SPC to obtain an agreed list of recommended reception points for all End of Trip Reports across all partner countries. RACS will also liaise with key MOH contacts to seek confirmation of distribution for End of Trip Reports.<br>Timely delivery of the End of Trip Reports will rely on SPC and MOHs providing their inputs.<br>In addition, RACS will share End of Trip Reports with DFAT posts following visits. | Reach out to MOHs during the remainder of 2026, aiming for an agreed list for every partner country by the start of 2027 |

| Recommendation | Response | Action Plan | Timeframe |
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| 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. | Accepted | RACS endeavours to have a finalised VMT Deployment Calendar (including locations, dates and specialties) confirmed by October/November in the preceding year. The complexity of meeting partner specialty preferences, theatre capacity/availability in partner hospitals, and logistical timeframes for sequencing of freighting/sterilising/re-freighting surgical equipment, means that finalisation of all deployments can sometimes take longer.<br>In developing the calendar, RACS will include MOH, hospital and DFAT post contacts in all planning emails. When the calendar is finalised, the deployment locations/dates/specialties will be circulated to relevant MOHs, hospitals and DFAT posts, along with the DFAT program manager.<br>Once the calendar year commences, regular contact with partner-country clinicians, administrators, MOH staff, and DFAT posts will be maintained, with particular focus on streamlining the Clinical Planning process. RACS will send an Information Sheet to DFAT posts/high commissions 4-6 weeks before each deployment, try to meet whilst in-country, and share key statistics as soon as possible (ideally less than one week) after deployments. | Starting in September 2026 and ongoing throughout 2027 |
| 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. | Accepted | RACS will deliver regional training as planned for 2027, with budget for these trainings included in the 2027 costed workplan for DFAT's approval.<br>• RACS will discuss internally the development of CCrISP and EMST (ATLS) online platforms, the availability of instructors, and the proposed training plans with in-country partners / stakeholders.<br>• RACS will consider next steps for PIVOTS with Monash. RACS will work with Monash to draw up a proposal for 2027 PIVOTS trainings with options for scaling. These options will be discussed with DFAT.<br>• RACS will discuss with ANZGITA the plan for gastroenterology training in 2027.<br>• RACS will discuss with APLS Australia the plan for delivering APLS, PLS and GIC courses in PICs in 2027. | Discussions from late 2026<br>Training delivery in 2027 |

| Recommendation | Response | Action Plan | Timeframe |
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| | | RACS is open to participating in future sector discussions with partners on training amplification across the region, to explore options for region-wide micro-credentialling. | |
| 6: DFAT to continue support for the FNU College Regional Office (CRO) unit to the end of the current program, with a view to ensuring future sustainability in consultation with FNU. | Accepted | DFAT will continue to support the FNU CRO unit to the end of the current program period, while working with FNU to consider practical options for a sustainable financing model beyond the current program. This will include discussing the CRO unit's ongoing role, resourcing needs and integration within FNU systems. | Initial DFAT-FNU meeting in late 2026<br>Until the end of PSCSHWIP, and beyond |
| 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. | Accepted | DFAT recognises the high demand for ENT services and the potential value of prevention through screening initiatives. DFAT will explore whether there are feasible opportunities to support a more regional approach to prevention and treatment of ENT conditions, with SPC involvement. The Ear Health Clinic that RACS established in Tuvalu is a good demonstration of a prevention model.<br>Any future support will need to be considered alongside broader health priorities, available resources and partner country demand, noting that PSCSHWIP's current ENT support is primarily delivered through VMTs. | From 2028 |
| 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. | Accepted | SPC will collate previous outstanding actions from Joint Annual Progress Reports and prioritise actions for completion by the end of PSCSHWIP.<br>This will be shared with the DFAT investment manager during the next Program Coordination Committee (PCC) meeting in Q4 2026. | From Q4 2026 until the end of PSCSHWIP |
| 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. | Accepted | National VMT calendars were discussed during a VMT workshop that SPC convened with six PICs (Fiji, Kiribati, Samoa, Tonga, Tuvalu and Vanuatu) in July 2026. A summary of workshop discussions was presented at the subsequent 16th Directors of Clinical Services (DCS) meeting.<br>For PICs with existing, established VMT calendars that they are willing to share, SPC will request a copy of these calendars on a 6-monthly basis. SPC may develop a regional database for PICs to view, pending consent. | Starting in Q3 2026 and ongoing |

| Recommendation | Response | Action Plan | Timeframe |
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| | | For PICs without well-developed VMT calendars, SPC will provide support for developing calendars, drawing on existing good examples from other PICs. | |
| 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. | Accepted | RACS will engage with PMA leadership to establish two-way sharing of deployment information, particularly planned dates, to support coordination for forthcoming calendar years wherever possible.<br>RACS will continue to request full calendar year scheduling information from partner countries, to avoid duplication and augment information sharing where possible.<br>Note: A region-wide calendar has not previously been available, and developing and maintaining one would be challenging. | December 2026 |
| 11: RACS to review current procurement costs and shipping methods for VMT surgical equipment and explore more cost-effective options, given the increasing costs. | Accepted | RACS will:<br>1. reduce packing lists where possible to reduce freight costs.<br>2. for consumables that are commonly used across multiple deployments of different specialties, explore procuring in half-yearly blocks – to save money, time and de-risk.<br>3. continue to explore strengthening donation partnerships with suppliers, for newer equipment model acquisition – to save money on purchases and servicing (newer models, cheaper to service, fewer issues).<br>4. explore the feasibility of implementing a resource/stock management system to track, order, and accurately cost code consumables to each deployment – to save money, time and reduce the risk of backorders.<br>5. offer 'double-deployments' (two-week deployments) to partner countries – creates efficiencies including reduced shipping costs. | 1. 2027 program delivery<br>2. 2027 program delivery<br>3. Ongoing<br>4. By end of 2027<br>5. 2027 program delivery |
| 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. | Partially accepted (see 5) | RACS will continue its support for regional clinical trainings in 2027. PIVOTS could be scaled with additional funding, pending discussions with all partners including Monash (as noted in item 5 above).<br>In terms of identifying trainings that could be sustainably transferred to FNU, RACS commits to an initial conversation with FNU to ensure a country-led approach and to | 2027 program delivery |

| Recommendation | Response | Action Plan | Timeframe |
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| | | support an initial needs assessment, based on strategic aims, capacity, and existing faculty. | |
| **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. | Accepted | FNU plans to offer more stackable short courses in 2027, following recent approval of the *Standard Operating Procedure (SOP) for Short Course Cross Crediting and Mapping to Award programmes* at FNU in July 2026.<br>FNU is already delivering a short course series on Oral Medicine & Oral Pathology (OMOP; 2024-27) for dentists in PICs, where a postgraduate diploma in OMOP is granted upon completion of all four courses. Some other disciplines have identified existing or new courses with potential for stacking, but a delay in the university's approval process has affected the progress of these. The SOP might help to expedite this.<br>To improve regional health workforce enrolment in newly developed short courses at FNU, CMNHS plans to conduct in-country training sessions to market these short courses among PICs. | Three OMOP short courses available by December 2026; fourth and final course available in 2027<br>Approve at least three other short course series in 2026 |
| **14**: DFAT to explore options for supporting PIC procurement processes for basic, essential equipment, including for common surgeries. | Partially accepted | DFAT will explore whether future regional or bilateral health investments can support partner country procurement processes or better coordinate equipment needs with planned clinical services.<br>DFAT will not establish a standalone procurement mechanism, but will consider how equipment constraints can be identified earlier and addressed through existing country-led planning and procurement processes, where feasible. DFAT may draw on RACS to understand equipment needs, and the Pacific Biomedical Engineering Network (PBEN) to provide PICs with technical advice on procurement. | From 2028 |
| **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 | Accepted | DFAT will actively consider how regional and bilateral health programs can better align to support specialist clinical services strengthening, including VMTs, during future design and planning processes.<br>Future regional health investment design will include consultations with DFAT posts that manage bilateral health programs to support alignment on clinical services. | Ongoing |

| Recommendation | Response | Action Plan | Timeframe |
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| strategic alignment between regional and bilateral health programs. | | | |
| 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). | Accepted | DFAT will consider options for longer-term specialty capacity building placements as part of future programming support. This may include exploring models that draw on the Australian Volunteers Program, Australian specialist colleges, NGOs and other partners.<br>For the remaining program period, DFAT will work with RACS to offer more Pacific countries the option of hosting 2-week VMTs, rather than the standard 1-week VMTs, to allow more time for relationship building and training during visits. | In 2027, and beyond |
| 17: DFAT to consider linkages with Australian hospitals/health services. These linkages are highly valued but have decreased in recent phases of DFAT support. | Accepted | DFAT will consider how future support can link Pacific clinicians with Australian hospitals or health services, where these linkages are feasible and aligned with partner country priorities. This may include partnerships that support clinical attachments, training and mentoring. | From 2027 |
| 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. | Accepted | DFAT will explore opportunities to support more Pacific-led models of specialist clinical service delivery in future programming. This will include considering how Pacific clinicians and specialists could provide more services, mentoring and training, while balancing workforce needs across the region. | From 2027 |
| 19: DFAT to explore opportunities for a hub-and-spoke model for clinical training, building on existing PIC university strengths. | Accepted | DFAT will explore whether a hub-and-spoke approach to specialist clinical training could be supported in future program design, building on existing faculties in Pacific universities and training institutions where there is capacity to scale up training pathways. | From 2027 |
| 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. | Accepted | A MEL Adviser position within SPC PHD has been advertised. Once recruited, the MEL Adviser will provide MEL support for PSCSHWIP as well, including a focus on where the three implementing partners can better work together to improve specialist | From recruitment of MEL Adviser (by the end of 2026) |

| Recommendation | Response | Action Plan | Timeframe |
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| | | clinical services outcomes in the remaining program period, and ensuring alignment with SPC PHD MEL indicators also. | until the end of PSCSHWIP |
| 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. | Accepted | DFAT will ensure that MEL and reporting requirements for any future phase are simpler, more harmonised and more clearly focused on outcomes, learning and the use of quality data.<br>DFAT agrees that reporting requirements should not be materially changed during the final year of the current program, to preserve consistency and enable comparison of performance over time. | From 2028, if applicable |
| 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. | Accepted | SPC advocated for the need for specialist nurse positions to be recognised by governments through the 6th Pacific Heads of Nursing and Midwifery (PHONM) regional governance meetings in 2026, as well as in PHONM meetings over previous years. The Pacific Heads of Health (PHOH) meeting in August 2026 included a PHONM information paper on nursing workforce that incorporates this issue.<br>This is work in progress. | Work will continue as part of PHONM |
| 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. | Partially accepted | RACS will obtain existing SGBV Clinical Guidelines from all relevant partner MOHs, in digestible format, for circulation to VMTs. Once obtained, RACS will ensure this information is included in briefing packs and communications for all visiting teams. This will rely on MOHs providing the relevant protocols/guidelines.<br>It is important to note that ensuring local clinicians are aware of and compliant with SGBV national protocols remains the function of national MOHs and relevant local authorities. RACS will be cautious not to overstep its authority in this regard. RACS will continue to ensure all VMT members are provided with RACS' PSEAH and Child Safeguarding policies and undertake requisite online training modules. | 2027 program delivery |
| 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. | Partially accepted | This recommendation is beyond the scope of PSCSHWIP, but mapping out of current gaps in disability-specific services in the Pacific will be done through SPC's broader work carried out by its Non-Communicable Disease (NCD), CSP and GESI teams. | n/a |

| Recommendation | Response | Action Plan | Timeframe |
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| | | This work will also align with the World Bank's *Pacific Healthy Islands Transformation (PHIT)* project (2025-2030). | |
| **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). | Partially accepted | RACS is committed to sharing information, and will provide information in relation to all VMT and training deployments to the relevant MOH and hospitals. RACS will also work with MOH counterparts to ensure information is relevant and in the right format for broader dissemination (e.g. to Community Health Centres). However, this dissemination task remains the role and responsibility of MOHs. | 2027 program delivery |