Tertiary Health Services (Pacific Island Countries)

Agreement 63683

Year 1 Annual Report

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AN INITIATIVE FUNDED BY

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AND MANAGED BY THE

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Table of Contents

Tables

Acronyms

ANZBA	Australian and New Zealand Burns Association
ANZCA	Australian and New Zealand College of Anaesthetists
CCrISP	Care of the Critically Ill Surgical Patient
CPD	Continuing Professional Development
CVA	Cerebrovascular Accident
EMSB	Essential Management of Severe Burns
EMST	Emergency Management of Severe Trauma
ENT	Ear, Nose & Throat Surgery
EPM	Essential Pain Management
FSMed	Fiji School of Medicine
M&E	Monitoring & Evaluation
MDGs	Millennium Development Goals
MEF	Monitoring & Evaluation Framework
MoH	Ministry of Health
O&G	Obstetrics & Gynaecology
PEmOC	Pacific Emergency Obstetric Care
PIP	Pacific Islands Program
PTC	Primary Trauma Care
RACS	Royal Australasian College of Surgeons
RANZCOG	Royal Australian and New Zealand College of Obstetrics and Gynaecologists
RANZCR	Royal Australian and New Zealand College of Radiologists
SSCSiP	Strengthening Specialised Clinical Services in the Pacific

1. Executive Summary

1.1. Program

The Royal Australasian College of Surgeons (RACS) has continued to work with Pacific Ministries of Health (MoHs) to provide essential clinical service and capacity development support to Pacific Island nations through the Pacific Islands Program (PIP) during the period 01 July 2012 to 30 June 2013. This contract phase, which will run until the end of December 2014, is a continuation of support the Australian Government has been providing through the RACS since 1995 in line with the Australian Government's long-standing commitment to provide a high standard of clinical service support and medical education in the Asia-Pacific region.

The PIP delivers specialised secondary and tertiary health care services and training to the Cook Islands, Fiji, Federated States of Micronesia, Kiribati, and Republic of the Marshall Islands, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu and Nauru.

Since 2010, PIP activities have been implemented in close collaboration with the Strengthening Specialised Clinical Services in the Pacific (SSCSiP) program which assists MoHs to improve the planning, delivery, and monitoring and evaluation of specialised clinical services and the systems that support them. This relationship underpins RACS' strong support for local ownership of health services and the vision for health system development in the region.

1.2. Implementation

The following outlines the implementation results of clinical/mentoring visits and capacity development initiatives during this reporting period.

Clinical/Mentoring Visits

- A total of 42 clinical service and mentoring visits were delivered to nine Pacific Island countries during this period. As a result:
    - 4,194 individuals received specialist consultations and non-surgical advice and/or treatment
    - 1,132 individuals underwent quality of life improving surgical procedures
    - 99.65% (1,128) of surgical patients were reported to have satisfactorily recovered post-operation
- These statistics demonstrate the high number of services delivered in this period, facilitating the access of thousands of Pacific people to specialist treatment and advice that would otherwise not be available to them. The very high post-operative results highlight the quality of the outcomes achieved to date
- 26 Pacific doctors were directly involved in 323 surgical procedures. Pacific doctors performed in the lead surgeon role, with or without assistance from PIP surgeons, in half of the recorded operations. This demonstrates the capability of Pacific doctors to assist or lead surgical procedures and the value of the continued mentoring provided by the PIP in support of surgical capacity development

Micronesian Dr Padwick Gallen, conducting ophthalmic surgery under supervision of PIP surgeon *(Ophthalmology visit, Micronesia, Jan 2013)*

- The first PIP Obstetrics and Gynaecology visits were delivered in the Solomon Islands in March and May 2013. These visits enabled specialised mentoring of the country's only Obstetrician Gynaecologist and facilitated medical consultations and life-changing procedures for complex cases that would have otherwise not received treatment in-country

Capacity Development

- 57 new Pacific clinicians completed Primary Trauma Care (PTC), Essential Pain Management (EPM), Emergency Management of Severe Burns (EMSB), Emergency Management of Severe Trauma (EMST) and Care of the Critically Ill Surgical Patient (CCrISP) Instructor courses during this period. This presents investments made in training new instructor candidates who will be able to facilitate capacity development workshops in the future
- 25 out of 67 instructors (37%) delivering 30 in-country workshops during this period were Pacific clinicians. These workshops were attended by 505 participants
- 3 PTC workshops delivered in Nauru and 1 PTC workshop delivered in Tonga, attended by 75 Pacific participants, were entirely instructed by Pacific clinicians

  The foregoing is a substantial achievement. It should be noted that Nauru PTC instructors were trained under previous phases of the PIP and we are now seeing them lead training activities in their home countries and increasingly across the region. Importantly, this illustrates the investment in developing capacity and ownership over time in these small nations

This report highlights the value of the new MEF and the data collection tools developed by the Program (see section 6.3 for further information on this). This information now provides baseline data from which evidence of change can be assessed and reported on in Year 2 of the Program's implementation.

1.3 Progress Assessment

The Program assists Pacific MoHs provide essential medical services to their populations and supports the longer-term development of specialist capacity in Pacific countries. The three end-of-program outcome areas (defined under section 3.2) aim to contribute to improving health outcomes of individuals in Pacific countries and assisting develop the capacity of Pacific medical personnel. The Program recognises that each Pacific country has its own unique challenges and priorities and therefore all activities continue to be delivered in consultation with individual MoHs in each country.

Information obtained during this period suggests that activity implementation is on track to deliver Program workplans within budget over the life of the contract. Pleasingly, the number and quality of activities delivered during this period also suggest that the Program is on track to achieve its three end-of-program outcomes. Already evidence illustrates that the health of Pacific Islanders has been positively affected based on the 99.65% post-operative success rate of surgical patients treated in this period. Furthermore the active involvement of Pacific clinicians, both as participants and as instructors in a range of training courses is indicative of the Program's success in contributing to the development of local capacity.

The Program's design facilitates maximum flexibility in providing responsiveness to Pacific MoH needs. Several exceptions to implementation success must be noted at this time. Specifically, no services have been delivered in the Marshall Islands during this period as requests for support have not been received. Likewise, there were limited activities delivered to the Cook Islands during this period as the MoH was able to source alternative funding (from NZAID) for most of their tertiary services and training needs.

During this 12 month period, expenditure was under budget in the capacity development and priority health components. This was due to program start-up which generally takes some time for Pacific MoHs to assess their needs and is also due to savings realised in some activities. This however does not reflect expectations for the coming period and the remainder of the contract.

The continued support and engagement of Pacific MoHs is a key strength of the Program and will support the achievement of end-of-program outcomes. This strength is underpinned by long-standing relationships based on mutual respect, confidence and trust which have been developed and consolidated over many years. These long-term relationships and the increased strength of the Program's operating systems and processes will support the achievement of end-of-program outcomes.

In addition, the ability of the Program to successfully deliver on its workplans during this period can in part be attributed to the Program flow-on from the previous funding contract without a confusing or unnecessary break. This ensured optimal continuation of planning and avoided major delays.

There were some inhibiting factors to the delivery of activities during this period such as disease outbreaks and natural disasters in the Solomon Islands and accommodation shortages due to increased activity in Nauru. This has meant that some visits have had to be postponed to ensure the convenience of visit timing for local hospitals and the safety of volunteers. The responsive management style of the Program has accommodated such factors and these incidents are not expected to have a significant negative impact on the ability of the Program to deliver end-of-program outcomes.

2. Relevance

Although significant improvements have been made in in the standards of living across the Pacific in recent decades, evidence suggests that the Pacific is not on track to meet many of its Millennium Development Goals (MDGs).[1] This is despite large investments in service delivery and public spending.[2] Given the limited resources of governments within the Pacific, aid organisations play a crucial role in filling some of the gaps which exist in the alleviation of poverty and disease.[3] Therefore PIP continues to play a contributing role in building the capabilities of Pacific personnel as well as providing much needed specialist services to improve health outcomes in the Pacific.

The Australian Government is committed to the implementation of the MDGs by 2015 and in turn helps support developing countries work towards these goals. As a main economic partner, security partner and aid donor in the region, twenty per cent of the aid budget administered through the Australian Government is directed to the Pacific.[4]

[1] 2012 Pacific Regional MDGs Tracking Report. http://www.forumsec.org/resources/uploads/attachments/documents/MDG%20Track%20Rpt%20web%2020122.pdf
[2] Ibid.
[3] Ibid.
[4] http://aid.dfat.gov.au/countries/pacific/Pages/home.aspx

RACS manages the PIP, servicing 11 Pacific countries on behalf of the Australian Government. The Program provides a breadth and range of secondary and tertiary specialist services and training that Pacific countries are presently unable to provide. The Program works closely with Pacific MoHs and hospitals to contribute to improving the quality of health care in Pacific hospitals as well as building capacity of its personnel. Experience has shown that many Pacific Island nations struggle to attract and retain specialist medical personnel and for some smaller nations, the reliance on external support for specialist medical services forms part of an expressed long-term plan for meeting population health needs. This is particularly true for smaller Pacific nations which find it difficult and financially unviable to train and maintain highly specialised medical services for often small and dispersed populations. Therefore, the PIP objectives continue to be relevant as their purpose is to:

a. contribute to improving the clinical health outcomes of individuals in targeted Pacific Island populations through the provision of specialist services as prioritised and identified by Pacific MoHs
b. strengthen the capabilities of Pacific clinicians to provide specialised medical and health support services through skills upgrading of local personnel and continuing professional development opportunities.

Furthermore, the RACS has the advantage of 18 years' experience in delivering the Program and has demonstrated a continued commitment to delivering specialised clinical services and training opportunities in the region. Open communication between the PIP and Pacific MoHs is facilitated through the confidence and trust that underpins these long-standing relationships. This ensures that services continue to be delivered in line with MoH priorities and plans for workforce development. The PIP also works and collaborates with the SSCSiP, the Fiji School of Medicine (FSMed) and other key stakeholders and service providers in the region to achieve these objectives, and with whom strong relationships also exist.

3. Effectiveness

3.1. Overview

The Program engaged external consultants during this reporting period to work with the PIP team to develop the **Program's MEF.** The MEF now articulates an outcomes-based model for monitoring the Program's progress. Three end-of-program outcomes are defined against the Program's two key objectives (see section 2). Progress for these outcomes is outlined in section 3.2. As the MEF was defined to monitor and evaluate outcomes based on a two and a half year program, this report is only able to provide an assessment of the baseline information collected to date. Analysis of comparative data will become available in subsequent reports.

This period has seen Pacific countries continue to benefit from PIP activities. The PIP has contributed to increasing access to essential specialised clinical care and medical advice for 4,194 individuals and provided valuable training and mentoring to 692 Pacific clinicians to strengthen their capability to provide specialised medical services into the future. These activities have been provided through close consultation with Pacific MoHs and other key stakeholders, including the SSCSiP and FSMed. All activities are planned for, budgeted and carried out to support and promote Pacific national health plans which will contribute to the sustainable development of health services and strengthen national ownership of health planning and management.

Overall, in the first year of this contract's operation, Program activities are on track to contribute to end-of-program outcomes and objectives. A number of individual outcomes have already been achieved and are expected to extend beyond the lifetime of the Program in relation to: individual health outcomes; and capability of Pacific clinicians to perform specialist surgeries and instruct educational workshops and courses.

3.2. Program Outcomes Progress

The Program's three outcome areas are reported against the measures of success defined in the PIP's MEF. The Program has developed a number of new methods and tools to capture evidence of progress, challenges and lessons learned. Volunteer teams have been guided and supported to accurately capture key data requirements. The majority of volunteers have found these tools useful and relatively easy to complete. The Program believes the quality of data being captured has significantly improved based on these new tools.

It should be noted that the tool for beneficiary studies (one of the measure of success for outcome 1) has been developed in Year 1 and will be implemented and reported on in Year 2. For outcome 2.1, the tool for measuring the capability of Pacific clinicians to undertake pre-screening was developed in Year 1 and will be implemented and reported on in Year 2. Challenges have been experienced in obtaining feedback from Pacific clinicians three months after participating in PIP training activities (as defined as a measure of success for outcome 2.1). This is due to the multiple countries and specialties covered by the PIP's training activities. The Program is looking at methods for reporting against this indicator in a practical and timely manner. In the interim, immediate post-training feedback from participants has been captured and reported for Year 1 (see Annex 5). The Program is still developing a suitable, practical tool to capture intermediate training outcomes.

The following is a summary analysis of progress towards achieving end-of-program outcomes using measures of success set out in the MEF.

Outcome 1: PIP contributed to improved health outcomes of the target populations

A total of 1,132 patients received surgical intervention and treatment during this period. Immediate successful outcomes for surgical interventions were recorded for 97.88% (1,108) of patients post-operation. This reflects an excellent result for a large number of people who received surgical intervention for medical conditions that were unable to be managed locally. Left untreated, many of these conditions would have resulted in prolonged disability, sub-optimal quality of life and potential reduction of life expectancy.

Only twenty of 1,132 patients (1.77%) experienced some form of post-operation morbidity from which a successful recovery was later recorded.

- 15 patients (1.32%) suffered minor morbidity which did not prolong their hospital stay and had little impact on their well-being.
- Five patients (0.44%) experienced a prolonged stay in hospital but experienced a full recovery.

This brings the total of individuals who successfully benefited from surgical treatment to 1,128. Although no beneficiary studies were conducted during this period to measure the intermediate health change/s experienced by these individuals, it can reasonably be assumed that most, if not all, of these individuals now enjoy improved levels of health.

There were four (0.35%) unexpected outcomes/mortalities reported during this period, as follows:

- One patient died after an ENT surgical procedure in Fiji from a suspected Cerebrovascular Accident (CVA) or stroke post-operation while recovering in the Intensive Care Unit. A post-mortem was not conducted at the wishes of the family, and therefore supporting records are unable to definitively confirm the cause of death.
- Two patients died after undergoing surgical procedures during the Urology visit to Vanuatu. Both patients died of suspected acute myocardial events (heart attacks) while recovering post-operatively. Anaemia was suspected to be a contributing factor in one of the patients.
- One patient died after receiving treatment during the Cardiac surgery visit to Fiji. Several days after the procedure the patient developed severe sepsis and poor left ventricle function was identified. A cardiac arrest ensued and the patient could not be resuscitated.

All cases of mortality were discussed with the host-hospital and reports given back to the directing staff for comment and/or action as required.

Outcome 2.1: Increased capability of Pacific clinicians to diagnose and undertake medical procedures independently

26 Pacific doctors were involved in surgical procedures with PIP teams during this period. Pacific doctors were involved in a total of 323 operations either as assisting surgeon or primary surgeon with or without assistance from a PIP surgeon (see Table 1 over page). Pacific doctors were involved in surgeries in a wide range of specialties as outlined in Table 2. This highlights the capacity development model engaged by PIP visiting teams.

Ni-Van Dr Basil Leodoro (second from left) being assisted to conduct procedure by visiting specialist *(Paediatrics Visit, Vanuatu, Sept 2012)*

Feedback from Pacific clinicians highlights the benefits of training and mentoring provided through the PIP. For example:

> *"Training wise, I have been able to do 3 pyeloplasties/nephrolithotomy on my own since [the visit in] April and I am more confident exploring the paediatric kidney/ureter/bladder/urethra and hypospadias repair as a result of this visit or capacity building exercise." (Dr Josese Turagava, after working with PIP Paediatrics team in Fiji, Apr 2013)*

> *"[The] opportunity for our nursing students and teachers to participate in updating their knowledge and skills form visiting specialists is gratefully received and benefit all in the healthcare system to ensure best practice based care for our patients." (Carlene Allport, Nurse Educator, Orthopaedics visit, Vanuatu, July 2012)*

Such feedback (see Annex 5 for full details) highlights the value of PIP training activities. For training participants, PIP teams assist develop skills which will remain

with the Pacific clinician and the wider health system beyond the individual activity and are expected to extend beyond the period of this contract.

TABLE 1: Pacific Doctors Surgical Involvement – By Level

LEVEL OF INVOLVEMENT[5]	SURGICAL PROCEDURES					
	Semester 1 (Jul – Dec 2012)		Semester 2 (Jan – Jun 2013)		YEAR 1 (Jul 2012 – Jun 2013)	
	No.	%	No.	%	No.	%
Assisting Surgeon	78	56.52	81	43.78	**159**	**49.23**
Primary Surgeon with Assistance	42	30.43	88	47.57	**130**	**40.25**
Primary Surgeon under Supervision	18	13.05	16	8.65	**34**	**10.53**
T O T A L	**138**		**185**		**323**	

TABLE 2: Pacific Doctors Surgical Involvement – By Specialty

LEVEL OF INVOLVEMENT	SURGICAL PROCEDURES					
	Semester 1 (Jul – Dec 2012)		Semester 2 (Jan – Jun 2013)		YEAR 1 (Jul 2012 – Jun 2013)	
	No.	%	No.	%	No.	%
ENT Surgery	29	21.02	-	-	**29**	**8.98**
General Surgery	18	13.04	-	-	**18**	**5.57**
Neurosurgery	32	23.19	14	7.57	**46**	**14.24**
Obstetrics & Gynaecology	-	-	35	18.92	**35**	**10.84**
Oral Maxillofacial Surgery	-	-	15	8.11	**15**	**4.64**
Ophthalmology	-	-	48	25.94	**48**	**14.86**
Orthopaedics	9	6.52	11	5.94	**20**	**6.19**
Paediatric Surgery	11	7.97	17	9.19	**28**	**8.67**
Plastic & Reconstructive Surgery	-	-	10	5.41	**10**	**3.1**
Urology	29	21.01	35	18.92	**64**	**19.81**
Vascular Surgery	10	7.25	-	-	**10**	**3.1**
T O T A L	**138**		**185**		**323**	

This information presents baseline data against which future progress can be measured. Current trends show Pacific doctors performing in the lead surgeon role, either with or without assistance from a PIP surgeon, in about 15% of all recorded operations. Urology, Neurosurgery and Obstetrics and Gynaecology represent the specialties where Pacific doctors are most actively involved. This reflects the PIP's ability to support mentor identified Pacific doctors to develop specific surgical skills. Notably, this includes for Richard Leona (Vanuatu) and Dudley Ba'erodo (Solomon Islands) who are working to develop their Urology sub-specialist skills; Alan Biribo who has recently returned to Fiji after completing Neurosurgical sub-specialist training in Australia; and Leeanne Panisi who is the only qualified Obstetrician Gynaecologist in the Solomon Islands and is looking to expand her surgical skillset. The PIP is working with these and many other doctors in the region to develop their generalist and sub-specialist surgical skills. These are not only significant contributions made towards end-

[5] Pacific doctors from Fiji, Kiribati, Nauru, Samoa, Solomon Islands, Tonga and Vanuatu

of-program outcomes but are also outcomes that will remain with Pacific clinicians and their health systems beyond the lifetime of this contract.

Outcome 2.2: Increased capability of Pacific clinicians to teach and lead educational programs

25 out of 67 instructors (37%) who delivered 30 in-country workshops and courses to 505 participants were recorded as being Pacific clinicians (see Table 3). Pacific clinicians were reported as having equal input with specialists from Australia or New Zealand in leading and instructing CCrISP and EMST courses. It is important to note that the training courses delivered were identified and requested as priorities by Pacific MoHs. The PIP has been responsive in meeting these identified needs and has worked with Pacific clinicians to ensure a capacity development model is applied to these activities.

TABLE 3: No. and Type of Instructors – By Workshop/Course

TYPE	INSTRUCTORS		
	PACIFIC	AUS/NZ/OTHER	TOTAL
EMSB	-	17	**17**
EMST/CCrISP	6	4	**10**
Essential Pain Management	3	10	**13**
Ponseti[6]	-	2	**2**
Primary Trauma Care	15	1	**16**
Others[7]	1	8	**9**
T O T A L	**25**	**42**	**67**

Furthermore, the large majority of instructors for PTC workshops delivered in this period were Pacific clinicians (93.75%) with two thirds of workshops delivered (run in Tonga and Nauru) operating entirely under the instruction of Pacific clinicians. This is a substantial achievement and it should be noted that these Pacific instructors were trained under previous phases of the PIP and we are now seeing evidence of the value of this capacity development approach being applied on a regional level.

A Tongan instructor demonstrates a log roll in a trauma situation *(PTC, Tonga, Mar 2013)*

This presents a positive trend of capacity development in the region and progress towards achieving outcomes that will last beyond the end of this contract period. Most promising is the early indication of the willingness of Pacific clinicians to assist deliver training in countries other than their own, as experienced with the PTC workshops delivered in Nauru. This positively shows the benefits of training on a regional level and that benefits are not confined to individual countries and/or health systems.

[6] Ponseti is a manipulative technique that corrects congenital clubfoot without invasive surgery
[7] Including Endoscopy, Peri-Operative Nursing, Intrapartum Care and Ultrasound workshops

3.3. Immediate Results by Country

Clinical Services

4,194 individuals received specialist medical consultations and non-surgical treatment on PIP visits during this period. Consultations included the provision of: specialist advice from speech therapists, physiotherapists and image specialists; hearing and vision assessments; and many other non-surgical treatments and advice.

A child receiving a hearing test from local ENT nurse *(ENT visit, Solomon Isl., Feb 2013)*

Overall, a total of 42 visits were delivered to nine countries across the Pacific. As a result 4,194 individuals received specialist advice, non-surgical or surgical treatment. Of that total, 1,132 individuals received surgical treatment by PIP teams and their Pacific counterparts (see Tables 4 and 5 for full details).

Given the wide range of countries and specialties, these activities represent good value for money given the cost that would be incurred for these medical services overseas.

TABLE 4: Clinical Service Statistics – By Country

Country	Number of Visits			Number of Patients					
				Consultation			Operations		
	Jul-Dec 2012	Jan-Jun 2013	Year 1 Total	Jul-Dec 2012	Jan-Jun 2013	Year 1 Total	Jul-Dec 2012	Jan-Jun 2013	Year 1 Total
Fiji	5	6	11	293	512	**805**	86	125	**211**
Kiribati	1	3	4	73	843	**916**	55	156	**211**
Micronesia	-	1	1	-	330	**330**	-	42	**42**
Nauru	5	-	5	360	-	**360**	36	-	**36**
Samoa	2	2	4	418	54	**472**	125	83	**208**
Solomon Is.	3	4	7	136	228	**364**	59	102	**161**
Tonga	2	1	3	158	45	**203**	73	25	**98**
Tuvalu	1	2	3	439	136	**575**	50	-	**50**
Vanuatu	2	2	4	88	81	**169**	45	70	**115**
TOTAL	**21**	**21**	**42**	**1,965**	**2,229**	**4,194**	**529**	**603**	**1,132**

TABLE 5: Clinical Service Statistics – By Specialty

Speciality	Number of Visits			Number of Patients					
				Consultation			Operations		
	Jul-Dec 2012	Jan-Jun 2013	Year 1 Total	Jul-Dec 2012	Jan-Jun 2013	Year 1 Total	Jul-Dec 2012	Jan-Jun 2013	Year 1 Total
Cardiac Surgery	-	1	**1**	-	225	**225**	-	43	**43**
ENT Surgery	2	2	**4**	444	351	**795**	88	50	**138**
General Surgery	1	-	**1**	107	-	**107**	34	-	**34**
Neurosurgery	1	1	**2**	105	57	**162**	22	11	**33**
Obstetrics & Gynaecology	-	2	**2**	-	44	**44**	-	35	**35**
Ophthalmology	1	4	**5**	439	728	**1167**	50	227	**277**
Oral Maxillofacial	-	1	**1**	-	35	**35**	-	15	**15**
Orthopaedics	2	1	**3**	83	253	**336**	45	34	**79**
Paediatrics	2	1	**3**	51	73	**124**	46	17	**63**
Plastics & Reconstructive	3	3	**6**	249	215	**464**	159	113	**272**
Urology	2	2	**4**	77	80	**157**	37	58	**95**
Vascular Surgery	2	-	**2**	39	-	**39**	28	-	**28**
Gastroenterology	1	-	**1**	30	-	**30**	20	-	**20**
Audiology	1	-	**1**	123	-	**123**	-	-	**-**
Diabetes	-	1	**1**	-	5	**5**	-	-	**-**
Cardiology	1	1	**2**	100	131	**231**	-	-	**-**
Endocrinology	-	1	**1**	-	32	**32**	-	-	**-**
Nephrology	2	-	**2**	118	-	**118**	-	-	**-**
TOTAL	21	21	**42**	1,965	2,229	**4,194**	529	603	**1,132**

In June 2013 PIP delivered a Urology specialist visit to Tonga from which Mr Palu Kanongataa, a 48 year old Tongan man, underwent a surgical procedure. This treatment saw Mr Kanongataa have kidney stones measuring 5.6cm removed. Four days later, Mr Kanongataa wrote to the team surgeons, Mr Alex Cato and Mr Phil McCahy, with the following:

"To the team of surgical specialists from Australia. I would like to take this opportunity to say thank you very much to all of you for the excellent job that you have done for my behalf regarding the kidney stones which were in my right kidney. I do not have any appropriate words to express my sincere appreciation for your hard work and you loving care. Your smiling faces and your approachability made me feel encouraged to accept the operation for the first time in my life. May God bless you all for your hard work. Palu Kanongataa. One of your faithful patients." (PIP Urology visit to Tonga, June 2013.

The above testimony is an example of the types of feedback received from patients who recognise that they would not have been able to receive this treatment without the PIP.

It is important to note that no clinical visits were delivered to the Marshall Islands and the Cook Islands during this period. No specific request was received from the Marshall Islands and the Cook Islands confirmed that their clinical service needs during the period were being met by NZAID-funded programs. This highlights the responsive nature of the Program.

Refer to Annex 1 for details of clinical activities delivered/supported.

Capacity Development

A total of 692 Pacific clinicians attended/completed or were involved in 50 capacity development opportunities delivered/supported by the Program during the reporting period.[8] These figures demonstrate the substantial number of Pacific clinicians participating in the Program and the reach and breadth of PIP's capacity development activities. Participants came from countries served by the PIP and also included clinicians from the wider Asia-Pacific region including Timor Leste, Papua New Guinea, Palau and Niue. This can be seen as contributing to regional networking and peer-to-peer learning opportunities. Experience has shown that many Pacific clinicians experience professional isolation in their own countries with few, if any, having colleagues practicing in their sub-specialist field. It can therefore be expected that many Pacific clinicians benefit from establishing and maintaining regional professional networks through such training activities.

Nauru hosted two PTC Provider workshops and one PTC Instructor workshop during this period. These workshops were entirely facilitated by Pacific clinicians from Tonga, the Solomon Islands and Vanuatu. One PTC Provider workshop held in Tonga during this period was delivered entirely under the instruction of Tongan clinicians. This was the first time such activities are recorded as having been delivered by Pacific clinicians in each country. This demonstrates the increasing capability and ownership of Pacific personnel to deliver these activities. Positively, Nauru's case demonstrates the inter-country cooperation that exists for delivering training. This suggests that the benefits of training activities are not confined to specific countries or health systems and extend to a regional level.

2013 saw the first two Obstetrics and Gynaecology visits delivered in the Solomon Islands at the request of the MoH. These visits were delivered as part of a planned series of four visits aimed at mentoring and up-skilling the country's only qualified Obstetrician Gynaecologist, Dr Leeanne Panisi. This plan was developed in consultation with the Solomon Islands MoH, Dr Leeanne Panisi and personnel from the Royal Australian and New Zealand College of Obstetrics and Gynaecologists (RANZCOG). Dr Panisi specifically requested assistance to develop her surgical skills in hysterectomy and complicated hysterectomy. Dr Panisi believes the visits have been of great value to her as per feedback provided:

Dr Panisi working with PIP specialist *(O&G visit, Solomon Isl., Feb 2013)*

[8] This does not reflect the real number of clinicians trained as many clinicians were involved in multiple training activities.

"This is the first ever PIP/Gynaecology visit and I am so happy that you have started the PIP/Gynaecology visit to Solomon Islands…These visits are seen as golden opportunity for me to up skill my surgical skills, work on my protocols and assist in training of my registrars and interns. Especially since I am working alone here as the only Specialist Gynaecologist/Obstetrician for the country. The level of skills passed on is for all levels of medical officers in the department and our nursing staffs as well. I would like these visits to continue in the years to come. I am glad that there will be four visits this year. I am very much looking forward to these visits and planning for these visits. Thank you very much." (Dr Leeanne Panisi, Obstetrician Gynaecologist, Solomon Islands)

The successful delivery of these first two visits highlights the responsive nature of the Program and its ability to meet specific requests for support where priority needs are identified by Pacific MoHs. It should be noted that ability of the Program to effectively respond to such requests is underpinned by the high levels of communication and collaboration maintained by the Program and the RACS with its partners in the region.

Refer to Annex 2 for details of capacity development initiatives delivered/supported during this period.

4. Cross cutting Issues

4.1. Pro-Poor Considerations

The PIP recognises that ill health can be a key driver of poverty and that poor and disadvantaged people are often disproportionately affected by the results of ill health. Conservative figures estimate that one third of people living in the Pacific Islands live below national poverty lines.[9] The rationale for providing ongoing specialist medical support, training and education to the countries the PIP works in is that their patients continue to require access to specialist care for a range of treatable illnesses and disabilities, which local governments require support in providing adequately.

Services are provided free of charge by PIP teams which removes access barriers due to financial costs. Many Pacific MoHs also assist individuals from outer islands or districts access services through reimbursement of travel costs. This further increases the accessibility of services for Pacific people who may not have the financial resources to otherwise access such medical services.

[9] AusAID (2009) *Tracking Development and Governance in the Pacific*, available at http://www.ausaid.gov.au/publications/pdf/track_devgov09.pdf; ADB (2004) 'Hardship and Poverty in the Pacific', available at http://www.adb.org/Documents/Reports/Hardship-Poverty-Pacific/hardship-poverty.pdf

4.2. Gender

The PIP supports gender equality in the selection of patients for diagnosis and treatment. Disaggregated data from this period (see Table 6) shows a relative balance between the number of women and men accessing services and receiving surgical treatment.

Table 6: Clinical Service Patient Statistics – By Gender

Clinical Activity	Number of Patients						
	Gender						Total
	M	%	F	%	NR	%	
Consultations							
Jul – Dec 2012	800	40.71	698	35.52	467	23.77	1,965
Jan – Jun 2013	945	42.40	874	39.21	410	18.39	2,229
T O T A L	**1,745**	**41.61**	**1572**	**37.48**	**877**	**20.91**	**4,194**
Operations							
Jul – Dec 2012	268	50.66	261	49.34	-	-	529
Jan – Jun 2013	325	53.9	261	43.28	17	2.82	603
T O T A L	**593**	**52.39**	**522**	**46.11**	**17**	**1.5**	**1,132**

5. Efficiency

5.1. Value for money

The PIP's ability to engage highly qualified specialist medical personnel to volunteer their time and skills to deliver Program activities presents excellent value for money. During this reporting period, a total of 180 volunteers were engaged to deliver both clinical and training activities, with approximately 52 weeks of volunteer time contributed in total.

Various providers were also generous enough to donate consumables and equipment to PIP.

- Lifehealthcare and Designs for Vision extended substantial discounts on instruments and equipment for ENT and Ophthalmology visits
- Johnson and Johnson donated $40,000 worth of sutures to the RACS International Development Program
- Alcon donated 60 Phaco kits for the January 2013 Ophthalmology mentoring and clinical service visit to Samoa
- Matrix donated grommets and micro-suckers for ENT specialist visits
- Micromed loaned a microscope head to convert the ENT microscope to Eyes for the Ophthalmology visit to Kiribati in January 2013
- $250,000 worth of urology equipment was donated to the International Development Program by the Storz Foundation in April 2013

In addition, Qantas, Solomon Airlines and Air Vanuatu, generously provided excess baggage waivers for the visiting teams.

5.2. Collaboration

Wherever possible the PIP collaborates with relevant service providers in the region. In this reporting period, the PIP collaborated with RANZCOG in the delivery of the Intrapartum Care workshop series in Fiji, as well as the Obstetrics and Gynaecology service and mentoring visits to the Solomon Islands. The Australian and New Zealand College of Anaesthetists (ANZCA) Fellows and the Australian and New Zealand Burns Association (ANZBA) collaborated in the running of the EPM workshop in Tonga and the EMSB Course/Burns Workshop in Fiji respectively. The PTC Foundation members and Pacific instructors ran the PTC workshops in Nauru and the Royal Australian and New Zealand College of Radiologists (RANZCR) collaborated with the PIP to run an ultrasound workshop in Fiji in June 2013.

6. Sustainability & Learning

6.1. Issues

The lack of **human resources available** in the Pacific is a factor that can have adverse effects on the sustainable development of specialised medical services in the region. The mobility of the Pacific workforce means that investments made in training may not always convert to the long-term strengthening of Pacific health systems. This is an ongoing and much discussed issue but it is one which is outside the control of the Program. The Program does, and will continue to respond to requests for training from Pacific MoHs to support their plans for workforce development.

In many Pacific countries, some **medical equipment remains** unused through lack of user training or is in such a state of disrepair that it becomes unusable. Several teams have noted this as an issue during this period. In some cases this can affect the quality and speed of service delivery and training. Maintaining contact with the Medical Equipment Coordinators run through the Australian Volunteers International in the lead up to visits means that, where possible, equipment can be serviced as required. The communication between programs, often facilitated by the SSCSiP, means that the Program is able to assist alert Medical Equipment Coordinators to some issues they may be unaware of.

6.2. Sustainability of Results

The Program presents opportunities for sustainability of expected long-term benefits to patient health. 1,128 individuals are expected to enjoy improved levels of quality of life as a result of PIP visits during this period. These results are expected to continue beyond this reporting period and the operational period of this contract.

As highlighted under section 3.2, 25 out of 67 instructors (37%) for 30 in-country workshops delivered during this period were Pacific clinicians. Notably, this included the PTC workshops in Nauru which were wholly instructed by clinicians from Vanuatu, the Solomon Islands and Tonga. Tonga also recorded one workshop as having been wholly instructed by national clinicians. This is evidence of the development of long-term knowledge and skills in the region.

6.3. Lesson Learnt

A number of **monitoring and evaluation data collection tools** and methods have been developed by the Program during this period. The data provided in this report is illustrative of the value of many of these new tools. It should be noted that some delays and challenges have been experienced in the development of some tools. Specific details of this are outlined in section 3.2. The Program will continue to critically assess the effectiveness of data collection tools to improve the quality of the evidence it collects and its progressive reporting on end-of-program outcomes.

The **benefit of capacity development activities on a regional level** has been demonstrated in this period. Promisingly, the ability of trained Pacific clinicians to lead and instruct training activities in countries other than their own has displayed (as per PTC workshop in Nauru). This is in addition to the continuation of several regional training activities delivered in various Pacific countries which have been attended by personnel from across the Pacific. With the resource limitations present in the Pacific, this presents a good model for sharing resources to maximise benefits.

A number of changes and adaptions to original Program workplans have been implemented in this period (e.g. the addition of Obstetrics and Gynaecology visits to the Solomon Islands and a Vascular Access surgical visit to Fiji). The Program maintains **flexible planning mechanisms** to accommodate unexpected and emerging priorities. This extends to both program management mechanisms and budgeting. This illustrates the need for continued flexibility in Program budgets allowing resource allocation over the lifetime of the Program and not confining portions of funding to fixed periods.

7. Management

7.1. Program Management Activities

The PIP continues to be managed through the RACS office in Melbourne under the direction of Project Director, Mr Kiki Maoate, FRACS. Eight specialty coordinators and the Evaluation and Monitoring Committee (EMC) continue to provide specialist advice and guidance to the Program. The EMC met on three occasions during this reporting period. The Committee benefited from having a range of Pacific clinicians participate in the meetings. Pacific surgeons or surgical trainees in attendance at one or more of these meetings included: Colin Brook, Alan Biribo and Semesa Matanaicake from Fiji; Richard Leona from Vanuatu and the Hon. V. T. Tangi, FRACS from Tonga. The Program benefitted from the input of these Pacific clinicians in finalising the tools and data collection methods for the MEF and their guidance and feedback on Program activities. This consultation is highly encouraged by the Program is something that will continue in the coming year.

As outlined in various sections above, this reporting period saw the development of the **Program's MEF**. The Program engaged two highly qualified specialists, Jan Cossar and Meg Alston, to assist in this process which extended over several months. Wide consultation was held internally and with external stakeholders to draft the framework. The MEF now articulates an outcomes-based model for assessing the Program's achievements. The last 12 months have seen the development, trial and implementation of several new tools for data collection and the Program is now satisfied that suitable information is being collected. At this point, the Program is collecting a wide range of baseline data and looks forward to collating comparative data to measure levels of change under the Program's three outcome areas in the coming periods.

In addition to collaboration activities stated in section 5.2, management and relationship activities implemented/participated in during the period are outlined below. This demonstrates the collaborative nature of the Program and highlights the regular consultation which occurs with Program stakeholders ranging from partner MoHs and hospitals, individual Pacific clinicians, external organisations/institutes operating in the region and Program funders. It is the strength of these relationships that ensures the continued success of Program delivery.

- Through RACS, Pacific personnel participated in the **Global Burden of Surgical Disease Symposium in Melbourne**, September 2012. This was delivered in association with the Australian Society of Anaesthetists, International Society for Surgery and the Alliance for Surgery and Anaesthesia Presence. The Symposium was aimed at surgeons, anaesthetist and other specialists, donors and policy makers and provided a platform to discuss the challenges facing surgery and anaesthesia in the Asia-Pacific region.

Tongan surgeon, Hon. V. T. Tangi, FRACS presenting at the Symposium on aid effectiveness in the Pacific, Sept 2012

- The Program convened a **PIP Stakeholders Meeting**, September 2012, attended by a number of key Pacific stakeholders including: Australian Government aid program representatives, the SSCSiP and PIP Speciality Coordinators and management staff. The group discussed the philosophical shift in PIP's objectives from a high volume clinical output delivery model to one highly focused on capacity development.

- RACS and PIP management staff attended the **Pacific Islands Surgeons Association (PISA) conference**, 07 – 10 August 2012 in Tonga. The meeting highlighted the continuing need for educational support of Pacific clinicians. The RACS currently provides access to an online database which includes journals and educational material to assist Pacific clinicians' access resources they need.

- PIP management staff participated in **SSCSIP's Stakeholders Reference Group (SRG) meeting** held in Fiji last April 2013.

7.2. Risks

Risk management has been a key to the Program's ability to provide prompt responses to emerging issues in this reporting period. The following key incidents were noted as having an effect on the Program during this period and the Program's Risk Management Matrix has been updated where required (Annex 4).

The **Dengue Fever outbreak in the Solomon Islands in April 2013** prevented the PIP Paediatrics team from visiting the Solomon Islands as scheduled. This visit has since been rescheduled to take place 25-29 November 2013. The outbreak affected the local staff as well as prospective visiting teams. Dr David Simon's Obstetrics and Gynaecology visit in May was only endorsed to proceed at the last minute due to the uncertainty associated with the outbreak. The Plastics and Reconstructive team also

noted how the outbreak affected their trip with reduced consultation numbers (due to reduced resources and capacity available at the local hospital). This demonstrates the ongoing need for high levels of communication between PIP management and Pacific MoHs. This also demonstrates the importance of flexible and responsive management strategies to ensure that the Program can successfully accommodate late changes in circumstance and adequately assess any risks posed to the Program, the volunteers and potential patients prior to proceeding.

An **earthquake** measuring eight on the Richter scale struck the **Solomon Islands on 06 February 2013** while the visiting PIP ENT team was in-country. The team was not affected; however this did impacted on the local ENT nurses which were quite shaken by the experience. The PIP aims to ensure that it manages natural disasters and their risks according to the impending gravity of the situation. Safety remains paramount to the Program and volunteers are briefed on safety and security procedures and protocols before travelling in-country. In cases where the risk appears too large, clinical visits have been postponed and if necessary, processes are in place to ensure that volunteers can be safely evacuated.

Given the recent decision taken by the Australian Government to process asylum seekers in **Nauru**, there have been **increasing shortages in accommodation** options available for travelling teams. As a result accommodation has to be booked months ahead of proposed visits. The PIP's policy of liaising with the MoH also ensures that visits are confirmed well ahead of time to facilitate advanced arrangements. The PIP remains flexible and forward planning is paramount to ensure that all the logistical issues are addressed.

8. Financial Summary (A$) – As at 30 June 2013

8.1. Actual Amount[10] vis-a-vis Contract Budget

BUDGET LINE ITEM	TOTAL CONTRACT BUDGET (A$)	ACTUAL AMOUNT CLAIMED (A$)	PERCENTAGE OF BUDGET UTILISED (%)
Clinical Visit	2,334,570	821,605	35.2
Training	1,324,000	301,344	22.8
Priority Health Fund	55,000	-	-
Disposables & Equipment	1,149,500	325,664	28.3
Fixed Management Fees [11]	516,000	206,400	40.4
Management - Consultation Visit	21,200	2,889	13.6
Monitoring and Evaluation	182,930	9,900	5.4
TOTAL	**5,583,200**	**1,667,802**	**29.9**

While linear analysis over the life of the Program (30 months) showed slightly lower expenditure vis-à-vis the budget, it is not a reflection of the true state of Program implementation. The initial stage of Program implementation is generally associated with a slower phase of activity, primarily due to start-up planning and identification/re-confirmation of needs and volunteer availability. The Program's activity implementation has always been on the basis of responding to identified needs as requested by, and in consultation with, Pacific MoHs and relevant Pacific medical personnel. While Pacific

[10] Ex-GST
[11] Acquitted at A$17,200 per month

countries are encouraged to set the agenda for the Program, the PIP is likewise committed to ensuring that supported activities represent value for money and that budget funds are frugally spent. Except for some areas where alternative funding sources have been identified for other providers/volunteers to deliver capacity development initiatives which would have been otherwise funded through PIP, the PIP expects to maximise the utilisation of the clinical visit, training and disposable and equipment budget in the remaining life of the Program.

Expenditure for stakeholder consultation to date is not a manifestation of the lack of wider consultation by PIP management but more of other funding sources being used to support different activities. The PIP management has participated, and was actively involved in, the SSCSiP initiated consultation meetings with relevant Pacific stakeholders. In most of these meetings, if not all, the SSCSiP has provided the funding for all attendees, including the RACS & PIP staff. The RACS also funded relevant PIP management staff to enable participation in regional and Pacific Islands' surgical conferences during the year under review (see section 7.1 for full details). These conferences provided a forum for PIP management staff to consult and exchange ideas with medical personnel in the region.

As of the end of the review period, a minimal amount of the M&E budget has been used. Again, this is not an indication of the minimal, or lack of activity but a streamlining of processes and procedures in recognition that patient outcomes are best measured and assessed after some period of time. Now that the MEF has been developed, and required information and data established, vigorous field activities will be pursued during the remaining life of the Program to document and analyse outcomes.

During the period under review, the Priority Health Fund budget remained untouched due to absence of specific requests which cannot be supported under the clinical and training budgets.

8.2 Acquittal Summary vis-a-vis Funds Advance[12]

ITEM	AMOUNT (A$)
GRANT FUNDS ADVANCE	
Tranche No. 1 – September 2012	1,956,800
Tranche No. 2 – June 2013	43,200
TOTAL FUNDS ADVANCE	**2,000,000**
ACTUAL EXPENDITURE/ACQUITTED AMOUNT	
Clinical Visit	821,605
Training	301,344
Priority Health Fund	-
Disposables & Equipment	325,664
Fixed Management Fees [13]	206,400
Management - Consultation Visit	2,889
Monitoring and Evaluation	9,900
TOTAL EXPENDITURE/ACQUITTED AMOUNT	**1,667,802**
GRANT FUNDS BALANCE (DEFICIT) – AS AT 30 JUNE 2013	**332,198**

[12] Ex-GST
[13] Acquitted at A$17,200 per month

Annex 1: Activity Plan (July 2013 – December 2014)

Indicative activities[14] for the period July 2013 – July 2014 are as follows:

A. Clinical Service and Mentoring Visit

PACIFIC ISLAND COUNTRIES	SPECIALITY	INDICATIVE DATE
Cook Islands	ENT surgery	30 Sep - 04 Oct 2013
	ENT surgery	Oct 2014 - TBC
Micronesia	ENT Surgery	25 Oct - 02 Nov 2013
	Opthalmology	04 - 18 Jan 2014
	Orthopaedics	13 - 27 Feb 2014
Fiji	ENT Surgery	06 - 14 Aug 2013
	Paediatrics	31 Aug - 06 Sep 2013
	Neurosurgery	Mar 2014 - TBC
	Paediatrics	Apr/May 2014 - TBC
	Cardiac surgery	24 May - 08 Jun 2014
	Neurosurgery	Oct 2014 - TBC
	Plastics & reconstructive	Oct 2014 - TBC
	Paediatrics	2014 - TBA
	OMF	2014 - TBA
	ENT Surgery	2014 - TBA
	Nephrology	2014 - TBA
Kiribati	Opthalmology	02 - 10 Jan 2014
	Orthopaedics	27 Apr - 8 May 2014
	Plastics & reconstructive	Apr 2014 - TBC
	ENT Surgery	TBA
Nauru	Vascular Surgery	03 - 12 Jul 2013
	Gastroenterology	18 - 29 Aug 2013
	Cardiology	10 - 17 Oct 2013
	ENT Surgery	28 Nov - 05 Dec 2013
	Renal/Nephrology	23 - 30 Jan 2014
	Vascular Surgery	23 - 30 Jan 2014
	Vascular Surgery	June 2014 - TBC
	Gastroenterology	TBA
Samoa	Orthopaedics	11 - 22 Sep 2013
	ENT Surgery	07 - 18 Oct 2013
	Plastics & reconstructive	28 Sep - 05 Oct 2013
	ENT Surgery	07 - 18 Oct 2013
	Opthalmology	Apr/May 2014 - TBC
	Orthopaedics	June 2014 - TBC
	Plastics & reconstructive	Sep 2014 - TBC
	ENT Surgery	Sep/Oct 2014 - TBC

[14] Subject to confirmation by the Pacific Island Ministry of Health or relevant Hospital authorities and volunteer availability

PACIFIC ISLAND COUNTRIES	SPECIALITY	INDICATIVE DATE
Solomon Islands	General Surgery	25 Sep - 06 Oct 2013
	Obstetrics & Gynaecology	11 - 16 Nov 2013
	Paediatrics	25 - 29 Nov 2013
	ENT surgery	Feb/Mar 2014 - TBC
	Plastics & reconstructive	June 2014 - TBC
	General Surgery (Western Province)	Apr-14
	Paediatrics	TBA
	Urology	TBA
Tonga	Opthalmology	14 - 22 Aug 2013
	ENT Surgery	Aug/Sep 2013
	Cardiac surgery	09 - 20 Sep 2013
	Plastics & reconstructive	30 Oct - 07 Nov
	Urology	18 - 28 Nov 2013
	Opthalmology	Aug 2014 - TBC
	Plastics & reconstructive	Oct 2014 - TBC
	Urology	TBA
Tuvalu	Opthalmology	11 - 18 Jul 2013
	ENT surgery	29 Jul - 06 Aug 2013
	Cardiology	TBA
	ENT surgery	TBA
	Opthalmology	TBA
	Diabetes	TBA
Vanuatu	Orthopaedics	22 - 30 Jul 2013
	ENT Surgery	27 Aug - 05 Sep 2013
	Paediatrics	Sep/Oct 2013
	Urology	05 - 13 May 2014
	Orthopaedics	06 - 24 July 2014
	Plastics & reconstructive	Jun/Jul 2014 - TBC
	ENT Surgery	Jul/Aug 2014 - TBC
	Paediatrics	Sep/Oct 2014

B. Capacity Building and Professional Development Initiatives

ACTIVITY	COUNTRY/LOCATION	INDICATIVE DATE
In-country Workshops		
Ponseti	Vanuatu	23 – 24 July 2013 Jul 2014 - TBC
EPM	Samoa, Nauru, Micronesia, Kiribati, Tuvalu, Fiji	Fiji & Tuvalu – Oct 2013 2014 - TBA
Nurse Peri-operative	Fiji[15], Solomon Is., Northern Pacific	Fiji – Nov 2013 2014 - TBA
PTC	Vanuatu, Tonga, Samoa, Cook Is., Tuvalu, Kiribati	Cook Is. – Jul 2013 Jul 2014 - TBA
ENT Nurse	Vanuatu[15]	27 Aug – 05 Sep 2013 Aug 2014 - TBC

[15] With regional participants

ACTIVITY	COUNTRY/LOCATION	INDICATIVE DATE
EMST	Fiji[15]	21 – 23 Aug 2013 2014 - TBA
CCrISP	Fiji[15]	25 – 27 Aug 2013 2014 - TBA
EMSB	Fiji[15]	Mar/Apr 2014 - TBC
Gastroenterology/Endoscopy	Fiji[16]	01 – 26 July 2013 2014 - TBA
O&G - PEmOC	Samoa	06 – 08 Jul 2013
O&G - Intrapartum Care	Fiji, Solomon Is., Vanuatu, Micronesia	Fiji – early 2014 Others – 2014 TBA
Ultrasound Workshop	Fiji or any other Pacific countries	2014 - TBA
Overseas Courses		
EMST Instructors	Melbourne - 2 Pacific Trainees	June 2014
DSTC Course	SYD/BNE/MEL/AKL - 6 Trainees	TBA
Management of Surgical Emergencies Course	Sydney – 1 Pacific Surgeon	24 – 29 Sep 2013
AUSMAT	Darwin – 1 or 2 Pacific Specialists	2014 - TBA
CPD Activities		
PSA Conference/Anaesthetist Refresher	2013 – Tonga 2014 - TBA	Tonga (16 – 19 Jul 2013) 2014 - TBA
PISA Conference	Fiji – Regional Representatives	Aug 2014 - TBC
RANZCO Conference	Australia – Regional Representative	2014 – TBA
General Surgeons Australia Conference	Australia – Regional Representative	Sep 2013 2014 - TBA
MMED Pre-Exam Mentoring	Fiji	07 – 09 Oct 2013 2014 - TBA
Specialist Society Conferences (TBA)	Australia – Regional Representative	2014 - TBA
Clinical Visit Attachments[17]		

[16] With regional participation and delivered through the WGO Training Centre in Suva.

[17] Surgical trainees in overseas training or work placements

Annex 2: Clinical and Mentoring Visits

CONSULTATIONS	
MALE	1,745
FEMALE	1,572
SEX NOT RECORDED	877
TOTAL	**4,194**

OPERATIONS	
MALE	593
FEMALE	522
SEX NOT RECORDED	17
TOTAL	**1,132**

SURGICAL OUTCOME	No.	%
SUCCESSFUL	1108	97.88
MORBIDITIES	20	1.77
MORTALITIES	4	0.35

VOLUNTEER TOTAL	
SURGEONS	54
ANAESTHETISTS	33
NURSES	68
OTHER[18]	49
TOTAL	**204**

No.	Year	Specialty	Country	Dates	No. of Volunteers	No. of Weeks	VISIT STATISTICS								M1	M2
							Consultations				Operations					
							M	F	?	T	M	F	?	T		
1	2012	Nephrology	Fiji	08 - 14 July	1	1	21	10	-	31	-	-	-	-	-	-
2	2012	Paediatrics	Fiji	29 July - 04 Aug	4	1	13	12	8	33	17	16	-	33	-	-
3	2012	Renal Access[19]	Fiji	05 - 07 Sept	1	1	9	10	-	19	6	6	-	12	-	-
4	2012	Neurosurgery	Fiji	22 Oct - 02 Nov	4	1	63	42	-	105	8	14	-	22	-	-
5	2012	ENT	Fiji	08 - 15 Dec	3	1	51	54	-	105	9	10	-	19	-	1
6	2013	Plastics & Reconstructive	Fiji	16 - 24 Feb	6	1	51	39	-	90	24	15	-	39	-	-
7	2013	Oral Maxillofacial Surgery	Fiji	09 - 17 Mar	2	1	23	12	-	35	11	4	-	15	-	-
				03 – 17 Mar	1	2										
8	2013	Neurosurgery	Fiji	18 - 27 Mar	5	1	36	21	-	57	4	7	-	11	-	-
9	2013	Paediatrics	Fiji	12 - 20 Apr	5	1	-	-	73	73	-	-	17	17	-	-
10	2013	Endocrinology[20]	Fiji	14 - 20 Apr	1	1	9	20	3	32	-	-	-	-	-	-

[18] Includes Nephrologists, Cardiologist, Rheumatologist, Gastroenterologist, Sonographer, Audiologist, Perfusionists, Pathologists, Intensivists, and Occupational Therapist etc.
[19] Funded under the Priority Health Funding budget
[20] Primarily a training visit and hence funded under the training budget

No.	Year	Specialty	Country	Dates	No. of Volunteers	No. of Weeks	VISIT STATISTICS								M1	M2
							Consultations				Operations					
							M	F	?	T	M	F	?	T		
11	2013	Cardiac Surgery	Fiji	11 - 26 May	51	2	108	117	-	225	18	25	-	43	-	1
12	2012	Plastics & Reconstructive	Kiribati	02 - 13 Dec	6[21]	2	28	45	-	73	18	37	-	55	-	-
13	2013	Ophthalmology	Kiribati	30 Dec - 07 Jan	7[22]	1	179	165	-	344	61	41	-	102	1	-
14	2013	ENT	Kiribati	11 - 18 Feb	3	1	117	129	-	246	11	9	-	20	-	-
15	2013	Orthopaedics	Kiribati	05 - 20 May	5	2	142	111	-	253	24	10	-	34	-	-
16	2013	Ophthalmology	Micronesia	03 - 18 Jan	3	2	-	-	330	330	21	21	-	42	-	-
17	2012	Cardiology	Nauru	15 - 23 July	2	1	47	53	-	100	-	-	-	-	-	-
18	2012	Gastroenterology	Nauru	24 Sept - 02 Oct	2	1	14	16	-	30	6	14	-	20	-	-
19	2012	Vascular	Nauru	11 - 19 Nov	3	1	14	6	-	20	12	4	-	16	1	-
20	2012	Nephrology	Nauru	11 - 19 Nov	1	1	50	37	-	87	-	-	-	-	-	-
21	2012	Audiology	Nauru	18 - 26 Nov	1	1	61	62	-	123	-	-	-	-	-	-
22	2012	Plastics & Reconstructive	Samoa	12 - 23 Aug	5	2	46	33	-	79	31	25	-	56	-	-
23	2012	ENT	Samoa	16 - 29 Sept	4	2	148	172	19	339	26	43	-	69	3	-
24	2013	Ophthalmology	Samoa	25 Jan - 02 Feb	4	1	-	-	-	-	30	32	-	62	5	-
25	2013	Ophthalmology	Samoa	01 - 16 Jun	1	2	32	22	-	54	16	5	-	21	-	-
26	2012	General Surgery	Solomon Isl.	28 Sept - 07 Oct	3	1	52	55	-	107	15	19	-	34	-	-
27	2012	Urology	Solomon Isl.	21 - 27 Oct	3	1	16	-	-	16	12	-	-	12	-	-
28	2012	Orthopaedics	Solomon Isl.	24 Nov - 02 Dec	3	1	8	5	-	13	8	5	-	13	-	-
29	2013	ENT	Solomon Isl.	03 - 13 Feb	4	1	60	45	-	105	19	11	-	30	-	-
30	2013	Obstetrics & Gynaecology[23]	Solomon Isl.	03 - 09 Mar	1	1	-	21	-	21	-	17	-	17	-	-

[21] Includes 1 Interplast-funded team member
[22] Includes 3 self-funded team members
[23] Primarily a mentoring visit, hence funded under the training budget

No.	Year	Specialty	Country	Dates	No. of Volunteers	No. of Weeks	VISIT STATISTICS								M1	M2
							Consultations				Operations					
							M	F	?	T	M	F	?	T		
31	2013	Obstetrics & Gynaecology[24]	Solomon Isl.	05 - 12 May	1	1	-	23	-	23	-	18	-	18	-	-
32	2013	Plastics & Reconstructive	Solomon Isl.	6 - 20 June	5[25]	2	39	37	3	79	14	23	-	37	3	-
33	2012	Plastics & Reconstructive	Tonga	25 Oct - 05 Nov	5	1	49	48	-	97	25	23	-	48	-	-
34	2012	Urology	Tonga	23 - 30 Nov	4	1	49	12	-	61	24	1	-	25	2	-
35	2013	Urology	Tonga	05 - 15 June	6	1	37	8	-	45	20	5	-	25	-	-
36	2012	Ophthalmology	Tuvalu	01 - 08 Nov	3	1	-	-	439	439	25	25	-	50	-	-
37	2013	Cardiology	Tuvalu	03 - 12 Apr	2	1	57	73	1	131	-	-	-	-	-	-
38	2013	Diabetes	Tuvalu	20 - 29 May	2	1	2	3	-	5	-	-	-	-	-	-
39	2012	Orthopaedics	Vanuatu	08-18 July	5	1	49	21	-	70	18	14	-	32	-	-
40	2012	Paediatrics	Vanuatu	29 Sept - 05 Oct	3	1	12	5	1	18	8	5	-	13	-	-
41	2013	Urology	Vanuatu	14 - 25 Apr	4	1	34	1	-	35	33	-	-	33	5	2
42	2013	Plastics & Reconstructive	Vanuatu	10 - 21 Jun	5	1	19	27	-	46	19	18	-	37	-	-
T O T A L					**180**	**52**	**1,745**	**1,572**	**877**	**4,194**	**593**	**522**	**17**	**1,132**	**20**	**4**

[24] Primarily a mentoring visit, hence funded under the training budget

[25] Includes 1 Interplast-funded team member

Annex 3: Capacity Development/Training

SUMMARY

TYPE OF TRAINING	NO.	TRAINEES	INSTRUCTORS		
			PACIFIC ISLANDERS	AUS/NZ	TOTAL
IN-COUNTRY - WORKSHOPS	30	505	25	42	67
- CLINICAL ATTACHMENTS	8[26]	6	-	-	-
REGIONAL TRAINING WORKSHOPS	5	115	-	16	16
OVERSEAS TRAINING ACTIVITIES	3	9	-	-	-
CPD ACTIVITIES	4	57	-	-	-
T O T A L	**50**	**692**	**25**	**58**	**83**

3.1 In-Country Training Activities

Location	Training Activity	No.	Participants			Instructors		
			M	F	T	Pacific	Aust/NZ	T
WORKSHOPS								
Fiji	EMST Course, 29 – 31 Aug 2012 (Suva)	1	13	3	16	2	4	10
Fiji	CCrISP Course, 02 – 04 Sept 2012 (Suva)	1	10	2	12	4		
Fiji	EPM Workshop, 21 – 22 Nov 2012 (Labasa)	2	11	31	42	-	4	4
Vanuatu	EPM workshop, 26 & 28 Nov 2012 (Santo)	2	9	12	21	2	1	3
Vanuatu	EPM Instructors workshop, 27 Nov 2012 (Santo)	1	3	5	8			
Samoa	EPM Workshop, 15, 17 & 18 Apr 2013 (Apia)	3	20	55	75	-	3	3

[26] Some trainees were included on multiple attachments

Samoa	EPM Instructors Workshop, 16 Apr 2013 (Apia)	1	7	18	25			
Tonga	EPM Workshop, 15 May 2013 (Nuku'alofa)	1	7	25	32	1	2	3
Tonga	EPM Instructors Workshop, 16 May 2013 (Nuku'alofa)	1	6	14	20			
Vanuatu	Ponseti Workshop, 09 – 13 Jul 2012 (Port Vila)	1	4	6	10	-	2	2
Vanuatu	Ponseti Workshop, 27 – 30 Jan 2013 (Port Vila)	1	1	2	3			
Tonga	PTC Workshop, 4-5 & 7 – 8 Mar 2013 (Nuku'alofa)	2	N/A	N/A	30	11	1	12
Tonga	PTC Instructor Workshop, 6 Mar 2013 (Nuku'alofa)	1	N/A	N/A	10			
Nauru	PTC Workshop, 13 – 14 & 17 – 18 Jun 2013 (Yaren)	2	7	20	27	4	-	4
Nauru	PTC Instructor Workshop, 19 Jun 2013 (Yaren)	1	1	7	8			
Fiji	EMSB Workshop, 25 May 2013 (Suva)	1	15	2	17	-	11	11
Fiji	EMSB Instructors Workshop, 24 May 2013 (Suva)	1	9	1	10			
Fiji	Nurses Burns Workshop, 22 - 23 May 2013 (Suva)	1	1	22	26	-	6	6
Fiji	Intrapartum Care Workshop, 09 – 11 Apr 2013 (Suva)	3	6	51	57	-	3	3
Fiji	Future Leaders Workshop, 13 – 14 Apr 2013 (Suva)	1	10	8	26	-	1	1
Vanuatu	Nurse Peri-operative Workshop, 11 – 14 Mar 2013 (Port Vila)	1	3	16	19	1	3	4
Fiji	Ultrasound Workshop, 24 – 29 Jun 2013 (Suva)	1	5	6	11	-	1	1
VISIT ATTACHMENTS/MENTORING								
Fiji	S. Nagra, Cardiac Surgery, 15 – 20 Sept 2012 (Suva)	1	1	-	1	-	1	1
Vanuatu	B. Leodoro, Paediatric Surgery, 29 Sept – 10 Oct 2012 (Port Vila)	1	1	-	1	-	1	1
Fiji	A. Biribo, Neurosurgery, 22 Oct – 04 Nov 2012 (Suva)	1	1	-	1	-	1	1
Fiji	A. Biribo, Neurosurgery, 18 - 27 Mar 2013 (Suva)	1				-	1	1
Micronesia	P. Gallen, Ophthalmology, 07 - 12 Jan 2013 (Kosrae)	1	1	-	1	-	1	1
Vanuatu	S. Kemuel, Plastics & Reconstructive, 10 – 21 Jun 2013 (Port Vila)	1	1	-	1	-	2	2
Solomon Is.	L. Panisi, Obstetrics & Gynaecology, 03 – 09 Mar 2013 (Honiara)	1	-	1	1	-	1	1
Solomon Is.	L. Panisi, Obstetrics & Gynaecology, 05 -12 May 2013 (Honiara)	1				-	1	1
T O T A L		**38**	**80+**	**181+**	**312+**	**25**	**51**	**75**

3.2 Regional Training Workshops

Location	Training Activity	Participants				Instructors		
		From	M	F	Total	Pacific	Aust/NZ	Total
Fiji	Endoscopy Workshop, 02 – 27 Jul 2012 (Suva)	Fiji	6	6	12	-	7	7
		Kiribati	2	-	2			
		Micronesia	2	-	2			
		Solomon Isl.	2	-	2			
		Tonga	-	1	1			
Fiji	Peri-operative Nurse Workshop, 12 – 15 Nov 2012 (Suva)	Cook Isl.	-	2	2	-	6	6
		Fiji	2	12	14			
		Kiribati	-	2	2			
		Nauru	-	1	1			
		Samoa	1	1	2			
		Tonga	-	2	2			
		Tuvalu	-	2	2			
Fiji	Intrapartum Care Workshop, 09 – 14 Apr 2013 (Suva) x 3	Fiji	9	54	63	-	3	3
		Solomon Isl.	2	-	2			
		Vanuatu	1	1	2			
		Kiribati	-	1	1			
		Tonga	1	-	1			
		Samoa	1	1	2			
T O T A L			**29**	**86**	**115**	**-**	**16**	**16**

3.3 Overseas Training Activities

Location	Training Activity	Participants			
		From	M	F	T
WORKSHOPS					
Australia	Definitive Surgical Trauma Care (DSTC) Course, 20 Nov – 01 Dec 2012 (Melbourne)	Kiribati	1	-	1
		Tonga	1	-	1
		Vanuatu	1	-	1
Australia	Urology Nurse Training Attachment, 17 Feb – 02 Mar 2012 (Geelong)	Vanuatu	1	2	3
Australia	Emergency Management of Severe Trauma Course, 14 – 16 Jun 2013 (Melbourne)	Kiribati	1	-	1
		Tonga	1	-	1
		Vanuatu	1	-	1
T O T A L			**7**	**2**	**9**
CONTINUING PROFESSIONAL DEVELOPMENT (CPD) OPPORTUNITIES					
Fiji	Surgical Exam Preparation Course, 08 – 10 Oct 2012	Fiji	3	1	4
Tonga	Pacific Island Surgeons Association (PISA), 06 – 10 Aug 2012 (Nuku'alofa)	Solomon Isl.	2	-	2
Fiji	Pacific Society of Anaesthesia Annual Refresher Course, 27 - 31 Aug 2012 (Suva)	Cook Isl.	1	1	2
		Fiji	10	5	15
		Kiribati	2	2	4
		Micronesia	2	-	2
		Nauru	2	1	3
		Samoa	1	3	4
		Solomon Isl.	2	1	3
		Tonga	1	3	4
		Tuvalu	2	1	3
		Vanuatu	3	1	4
		Other[27]	4	2	6
Australia	Practical Ophthalmic Course, 27 Nov – 15 Dec 2012 (Sydney)	Samoa	-	1	1
T O T A L			**35**	**22**	**57**

[27] From PNG, Palau and Niue

Annex 4: Risk Management Matrix

Risk	Probability	Impact	Risk Assessment	Mitigation	Responsibility
Program Design Risks					
MoH unable to fund positions for Pacific medical personnel once trained	Low	High	Medium	Careful ongoing dialogue with MoHs during selection process for trainees; continued program engagement with evolving health workforce planning process and providing assistance to specialist workforce planning, where requested.	RACS Pacific MoHs
Program Implementation Risks					
Lack of adequate post-operative aftercare for patients	Medium	High	High	All PIP teams are instructed to avoid conducting procedures that require post-operative care beyond the skills and resources of the Pacific host-nation. Appropriate patients are selected by PIP teams in collaboration with the local clinicians. Pacific medical personnel are provided with appropriate post-operative care training and/or instruction as required, which they can deliver after PIP teams have departed Post-operative morbidity and/or mortality are documented through specific report templates. All reports are reviewed by the PIP EMC and the Project Directors. Recommendations are provided and then fed back to local medical personnel and the visiting specialists as appropriate	RACS Volunteer Team/ Specialists Pacific MoHs/hospital authorities/medical staff/counterparts
Lack of necessary equipment and support facilities such as x-ray and pathology	High	Medium	High	Teams are advised to undertake procedures that can be safely delivered using materials and supplies available locally or brought by the visiting team	RACS PIP Volunteers Pacific MoHs/ medical personnel

Risk	Probability	Impact	Risk Assessment	Mitigation	Responsibility
Lack of adequate pre-screening of patients by Pacific clinicians in advance of visits	Medium	Medium-High	High	A communication link between visiting teams and relevant Pacific clinicians is established prior to each visit. This serves to discuss preliminary screening of patients/cases waiting. The team will also dedicate time for pre-operative assessments and conduct clinics in between procedures. Pre-screening visits by an Australian or New Zealand specialist will be arranged as required. PIP will monitor team reports for comment on screening and take action to remedy shortcomings when necessary	RACS Pacific MoHs/Hospital authorities/medical Staff/counterparts
Disruption of normal Pacific hospital routine by visiting clinical teams	Medium	Medium	Medium	Careful consultation of PIP management team with Pacific MoH and hospitals on timing and logistics for team visits	RACS Pacific MoHs/hospital authorities
Lack of Pacific MoH and/or hospital budget to provide counterpart contribution in support of clinical visit and training initiatives	High	Low	Medium	To minimise the cost burdens of visits, teams are provided with appropriate medical equipment and disposable supplies for the provision of services. . Under the Program budget, funds are allocated for training initiatives to maximise opportunities for capacity development for Pacific clinicians	RACS Pacific MoH/Hospital Authorities
Poor infrastructure outside major centres limits delivery of clinical services to hospitals in major centres thereby limiting access to visiting teams' services for some communities (e.g. for people from outer islands or remote locations)	High	Low	Medium	In partnership with Pacific MoHs, information regarding approved visits is disseminated widely. Subject to availability and Pacific MoH/hospitals requests, clinical visits to the outer islands or outlying districts will be considered in lieu of or in combination with trip to main centre/hospital. It should be recognised that teams' limited time in-country may make it impractical for some specialities to provide services at more than one location. This will be conducted under the guidance and discretion of Pacific MoHs	RACS Pacific MoHs/hospital authorities/medical staff/counterparts
Failure to document clinical visit and/or training outcomes, including receiving relevant feedback reports from Pacific clinicians	Low-Medium	Medium	Medium	The responsibility of monitoring and auditing surgical patient outcome lies primarily with Pacific clinicians as there is no program management staff on the ground. Visiting teams are directed to collect immediate information but Pacific clinicians will be engaged for further information and/or follow-up.	RACS PIP Volunteers Pacific medical personnel

Risk	Probability	Impact	Risk Assessment	Mitigation	Responsibility
Failure to gain the cooperation and participation of Pacific clinicians in activity implementation	Low	Medium	Low	The Program will encourage a collaborative approach to program implementation through continuous dialogue and consultation with Pacific MoHs. Pacific clinician participation is encouraged and monitored and dialogue between Pacific clinicians, PIP staff and volunteer team/specialists is maintained. Teams are advised to be aware and sensitive to cultural differences and additional demands they will be placing on hospital personnel and resources	RACS Pacific MoHs/Hospitals/ Medical Personnel/ Counterparts PIP Volunteers
Failure to identify appropriately qualified and experienced team members to deliver program activities	Low	High	Medium	The Program maintains a database of potential volunteers. Visits are planned well in advance and program administration maintains a flexible approach enabling it to amend schedules as necessary in response to Pacific MoH/hospital requests and availability of volunteers. The RACS/PIP also maintains strong relationships with a large number of specialist organisations and associations. This facilitates access to a wide range of specialists to provide program activities. In the event that the RACS and its partners are unable to deliver requested services, this would be clearly communicated to Pacific MoHs.	RACS
Failure of Pacific MoH/hospitals to act on the recommendations of visiting teams	Medium - High	Low - Medium	Medium	The Program will provide Pacific MoHs and medical personnel with the recommendations for them to implement at their discretion. The Program will provide support and advice where appropriate to support their development, as required.	RACS Pacific MoHs/Hospital authorities
Duplication or clash (timing) of activities provided by other donors NGOs and/or church based organisations	Low	Low - Medium	Low	The Program will monitor health projects in the Pacific through liaison with Pacific MoHs, the SSCSIP and the Australian Government. In addition, timing of activity implementation shall be finalised in consultation with the recipient/host country MoH/Hospital	RACS Pacific MoHs/Hospital authorities SSCSiP
Pacific MoHs are unable or unwilling to approach PIP management staff with key issues requiring attention	Low	Medium	Low	The Program actively promotes Pacific MoH involvement by maintaining regular contact with MoH staff and other key medical personnel. Face-to-face discussions are important for maintaining such relationships and are budgeted for through regional workshops and consultation meetings	RACS Pacific MoHs/medical personnel SSCSIP

Risk	Probability	Impact	Risk Assessment	Mitigation	Responsibility
Equipment and disposable supplies provided to PIP teams will be inadequate to address local needs, including equipment being maintained at the required level	Low	Medium	Low	Equipment and supplies lists for specialist visits and training regularly updated in accordance with recommendations from previous visits and in consultation with Pacific medical personnel requirements	RACS Pacific MoH/medical personnel
Delay in contracting arrangements/ program implementation	Low	Medium	Low	Timely submission of proposal and contract finalisation.	RACS Australian Government
Sustainability Risks					
Pacific surgeons leave the public health system or the country	Medium	High	High	Where appropriate, providing Postgraduate training and support for continuing professional development (e.g. attendance to international conferences to interact with overseas colleagues which mitigates isolation) may encourage Pacific clinicians to continue working within with the public health system. Overseas training components can be an important part of personnel development and therefore personnel may decide to train overseas for several months and/or years before returning to their country	Pacific MoHs
Pacific health budget is unable to meet recurring expenditures to maintain acceptable standards of tertiary health care services and workforce development	Medium	High	High	Program to monitor access to and condition of facilities in Pacific hospitals and explore options to assist Pacific MoH/hospitals, as necessary. As requested and as approved by the Australian Government, the Priority Health Fund component can be used to respond to suitable requests	Pacific MoHs RACS/PIP
Training delivered to Pacific clinicians will not be utilised in the future and/or training could be compromised by multiple mentors/ instructors providing conflicting advice	Medium	Medium	Medium	PIP volunteers are advised to provide contextually appropriate advice to Pacific clinicians and encourage them to utilise equipment and supplies readily available in-country, provide regular training opportunities to concrete lessons learned and ensuring training activities are aligned with Pacific MoH national plans for workforce development	RACS/PIP Pacific MoHs
Patients requiring follow-up do not present for post-op review.	High	Low	Medium	Patient information records are taken that note place of residence and mobile phone number. These can be used to follow-up with patients who do not return for scheduled treatment and review	RACS/PIP Pacific MoH/medical personnel

Risk	Probability	Impact	Risk Assessment	Mitigation	Responsibility
Pacific clinicians use team visit as locum services and take leave during visit.	Low	Low	Low	Communicate and emphasise to the Pacific MoH/ Hospital counterpart/clinicians the objective of the program and the need for Pacific clinicians to participate in the activities and take advantage of training opportunity	RACS/PIP Pacific MoHs/medical personnel
Failure to gain release of identified medical personnel from regular duties to enable training	Low	Low	Low	The program will maintain close liaison with key counterparts to allow planning for the release of medical personnel to participate in training opportunities	RACS/PIP Pacific MoHs/Hospital Authorities
External Risks					
Emergence of epidemic, pandemic or natural disaster at a national or regional level	Medium	High	High	Program management will monitor DFAT travel advice and information received from in-country contacts regarding such developments. Any action taken will consider the safety of the volunteers and the requirements of each Pacific country.	RACS/PIP Pacific MoHs/medical personnel Australian Government
Activity implementation is disrupted due to emerging national or regional issues and priorities	Medium	Medium	Medium	Program management ensures flexibility in the forward planning and delivery of activities. This enables the program to effectively respond to emerging issues and priorities to ensure the smooth delivery of quality activities.	RACS/PIP MoH/medical personnel
Activity implementation is disrupted due to political or civil unrest in the Pacific countries	Low	Low	Low	The program monitors DFAT travel advice and will temporarily suspend activities in affected countries, if necessary. The schedule will be amended accordingly and if necessary respond with changes to planned activities if agreed by the SSCSiP and the Australian Government. Where appropriate security plans will be developed to enhance the safety of program volunteers and personnel.	RACS/PIP Pacific MoHs/medical personnel Australian Government

Annex 5: Pacific Perspective & Feedback

Year	Sem	Country	Specialty	Comment	By
SERVICES PROVIDED & VISIT OUTCOME/S					
2012	2	Fiji	Cardiac Surgery	I was an assistant Surgeon on this trip…assisting 2 Cardiac Surgeons. I was also involved in the ward assessing admissions and scheduling patients for operations. Apart from this, I was also involved in the logistics of patient care, organisational issues and acting as a liaison between the team and our Fiji medical team. I personally gained from the experience and over the last 7 years with the team have increased my contribution. Over time, I have increased by understanding the basic principles of cardiac surgery and dealing with emergencies such as tamponades…the Medical Registrar gained enormously from the experience being actively involved. Apart from the role of a Cardiac Registrar, I also managed to provide some services to the local team with supervising surgery with trainees, being involved in registrar training and setting up a database for review of cardiac cases done at Lautoka hospital.	Sonal Nagra, General Surgeon, CWMH, Suva, Fiji
2012	2	Fiji	Neurosurgery	I was able to learn how to perform a non-instrumented anterior cervical fusion using autologous bone graft without the use of an operating microscope and without proper cervical retraction systems. This has great scope for the vast majority of cervical myelopathy patients that cannot afford instrumented fusion abroad. It also has a role in traumatic cervical disc ruptures. It is something that can be offered locally while we await proper instrumentation.	Alan Biribo, General Surgeon/ Neurosurgical Trainee, CWMH, Suva, Fiji
2013	1	Fiji	Paediatrics	All children have done well and recovered completely with no morbidity/ mortality. I have reviewed them in surgical clinics in 6 weeks and all have healed well	Josese Turagava, Medical Superintendent, CWMH, Suva, Fiji
2013	1	Fiji	Paediatrics	Training wise, I have been able to do 3 pyeloplasties/nephrolithotomy on my own since April and I am more confident exploring the paediatric kidney/ureter/bladder/urethra and hypospadias repair as a result of this visit or capacity building exercise.	Josese Turagava, General Surgeon, CWMH, Suva, Fiji

Year	Sem	Country	Specialty	Comment	By
2013	1	Fiji	Paediatrics	Russell Metcalfe's contribution to this visit was very valuable as to how he used imaging to better define anatomy for us to plan surgery. He took the radiology registrars for numerous lectures and discussed cases by cases and improved techniques for better care for the patients. Russell Metcalfe may organise a fellow job for Komal for further radiology attachment for work experience. Ngaire Murray –charge nurse from Auckland Starship Hospital brought consumables and supplies donated by Johnson and Johnson in Auckland to replenish my supply of PDS sutures and consumables for paediatrics. She has also brought in case list of equipment to help us set up paediatric trays for future cases. In addition, she took a few lectures for the theatre nurses on basic topics and a keen teacher. Shonagh Dunning – our recovery nurse was excellent as she taught the recovery nurse of the important things that people take for granted. She also gave good lecture notes for the nurses and they have her as a mentor overseas for answering nursing issues. Ian had taken a keen interest in teaching our 2 local anaesthetists Mara Vukivukiseru and Lamour Hansell. He was impressed with their commitment and hopefully may organise further attachment overseas for work experience.	Josese Turagava, Medical Superintendent, CWMH, Suva, Fiji
2013	1	Samoa	Ophthalmology	59 patients underwent cataract surgery with the PIP team. 40 patients had phacoemulsification plus 19 extracapsular cataract (ECCE) surgeries. After 1 week follow-up (follow-up rate 80.7%) 83.3% of patients had good outcome with best corrected vision of 6/18 or better in their operated eye. There was a complication rate of 13.5%. Vitreous loss was most commonly encountered and mainly with ECCE technique. 7% of patients had poor outcome of which a ¼ was due to patient selection and the remainder a result of surgery complications. Last year PIP/RACS donated a fundus camera for the TTM hospital eye clinic which was not being used until the arrival of the team. Dr Haybittel and Dr Basil set up the camera and demonstrated how to operate it. The camera has since been used regularly for the screening, diagnosis and counselling of many diabetic patients.	Lucilla Ah Ching-Sefo, Ophthalmology Trainee, TTMH, Apia, Western Samoa
2013	1	Vanuatu	Urology	As a result of the attachment, we expect • Patients will get the same, best possible care, so that recovery from a big operation is made easy; and to relieve the pain and suffering of the patient. • We will do more in-service training in order to up skill staff and pass on information and skills. • It will help us a lot to manage our ward, and relieve us from frustrations within the workplace. • As a long term plan - we hope to have a separate unit for urology patients. • Include in our curriculum and train new intake specialised in this unit	Roger Jelpao, Nurse, Vila Central Hospital, Port Vila, Vanuatu

Year	Sem	Country	Specialty	Comment	By
MAIN BENEFITS OF THE VISIT/ACTIVITY					
2012	2	Fiji	Cardiac Surgery	a) The main benefits is to maintain my skills and knowledge of cardiac surgery so as to have the confidence of managing patients particularly once teams leave b) Having more networking with the team specialists and having their contact for future cases for advice and management c) Up skilling of local staff which has had a great impact on Lautoka hospital	Sonal Nagra, General Surgeon, CWMH, Suva, Fiji
2012	2	Fiji	ENT	We were exposed to specialised surgical cases and were able to familiarise ourselves with the special considerations in anaesthetising these patients.	Kartik Mudliar, Anaesthesia Registrar, Lautoka Hospital, Lautoka, Fiji
2012	2	Fiji	ENT	a) Specialised ENT advice given to out-patients b) Major surgeries carried out c) Teaching to local staff.	Arun Murari, Consultant Surgeon, Lautoka Hospital, Lautoka, Fiji
2012	2	Fiji	Nephrology	a) Strengthen networks b) Assess and make recommendations for children diagnosed with renal diseases requiring specialist evaluation, who otherwise do not have the means to travel abroad to see a paediatric nephrologist c) Review Nephrotic Protocol d) Share resources – reference texts, journal articles etc.	Rigamoto Taito, Consultant Paediatrician, Lautoka Hospital, Lautoka, Fiji
2012	2	Fiji	Neurosurgery	a) Practising acquired surgical skills b) Teaching sessions with my colleagues benefitted me as well as them c) Strengthening old networks and making new acquaintances within the medical and administerial fraternity. Very important so that I do not return as a complete stranger next year! d) Giving back to the people of Fiji without whose blessings I would not have made it this far.	Alan Biribo, Neurosurgical Trainee, CWMH, Suva, Fiji
2013	1	Fiji	Neurosurgery	Continuing medical education - radiology teaching tutorials, MRI reporting; lectures to orthopaedic/surgical registrars; clinical presentation at Tuesday lunch our meeting. Reduce the volume of workload particularly on MRI reporting. A chance to establish contacts for future reference.	Paula Nakabea, Radiologist, CWMH, Suva, Fiji

Year	Sem	Country	Specialty	Comment	By
2013	1	Fiji	Neurosurgery	Benefit tremendous. Currently Fiji does not have a Neurosurgical Services. Patients are referred overseas for treatment. The team's visit saved a lot of overseas referrals. Secondly, benefit also noted in the training of a surgical registrar (Dr Alan Biribo) who would be providing some neurosurgical services in future.	Gyaneshwar Rao, Consultant Physician, CWMH, Suva, Fiji
2013	1	Fiji	Neurosurgery	Operative skills transfer from visiting surgeon; teaching local counterparts; following up previously treated patients and assessing outcomes of earlier visits; and being able to expedite work for the visiting team	Alan Biribo, General Surgeon, CWMH, Suva, Fiji
2013	1	Fiji	Paediatrics	We were able to sort out all the complex cases from Fiji and from the Pacific – particularly, Kiribati. They were surgical teaching sessions and now I am confident to do hypospadias repairs, pyeloplasties, nephrolithotomy, cystoscopies, valve ablations, vesicostomies, PSARP and orchidopexies. Our radiology registrars are now more confident in interpreting urology images and further techniques to answer pertinent surgical questions. Surgical registrars have revised important topics in paediatric urology. I have a replenished supply of consumables for paediatric surgery patients.	Josese Turagava, General Surgeon, CWMH, Suva, Fiji
2013	1	Kiribati	ENT	a) Workforce support b) Mentoring c) Treatment and advice provided	Bwabwa Oten, Director of Hospital Services/ Consultant Surgeon, Tungaru Central Hospital, Tarawa
2012	2	Nauru	Audiology	a) attended to 70 outpatients. b) school classes at i) boe infant school (4) classes; ii) kayser school (2) classes; and iii) disabled school.	June-Rose Bill, Nurse Aide, RON Hospital, Nauru
2012	2	Nauru	Cardiology	Be able to identify and categorize the heart diseases of the people. Be able to identify the problem of the patient's heart that needs further surgeries.	Elizabeth Giouba, Supervisor - Out-patient Department, RON Hospital, Nauru
2012	2	Nauru	Cardiology	Reviewing of our RHD priority patients list from the last visit; reviewing new referral RHD and other cardiac cases booked for the visit; reviewing all post operation cardiac cases missed out last visit; compiled new patients list for overseas referral for assessment or treatment as they cannot be managed locally; case discussions and at the same asking expert advices how to deal with problem cases training for local staff	Gano Mwareow, Director of Nursing, RON Hospital, Nauru

Year	Sem	Country	Specialty	Comment	By
2012	2	Nauru	Cardiology	Radiographer learns how to do echocardiography, orientation and how to set the scan machine into echo and Doppler mode	Sulueti Bauleka-Vuanivono, Senior Radiographer, RON Hospital, Nauru
2012	2	Nauru	Vascular	For patients - reducing morbidity and mortality rate. For staffs - motivation and continuous medical education	Htet Naing, Anaesthetist, RON Hospital, Nauru
2012	2	Nauru	Vascular	a) creation of permanent haemodialysis access by skilled and experienced surgeon. b) invaluable training to local staff (surgeon). c) assisted in management of other surgical patients	Ako Milan, General Surgeon, RON Hospital
2013	2	Nauru	Vascular	Patients are comfortable and positive about their fistula being created, knowing they don't need to go through the procedure of inserting the vas-cath. Patients were educated about the fistula creation & understanding the advantages of their well-being.	Elizabeth Giouba, Supervisor - Out-patient Department, RON Hospital, Nauru
2012	2	Samoa	ENT	Being able to diagnose ENT cases and manage them accordingly.	Shaun Mailiu, Surgical Registrar, TTMH Apia, Western Samoa
2012	2	Samoa	ENT	Being able to identify and assess then appropriately manage the ENT cases in Samoa. Performed some major and minor operation procedures. Follow up of cases. To help if ENT cases look overdue for surgical procedure	Sione Pifeleti, Surgical Registrar, TTMH Apia, Western Samoa
2013	1	Samoa	Ophthalmology	a) At the moment, Dr Mau Imo is the only operating eye doctor on island and the PIP team helps relieve much of the cataract case load put on the eye clinic and its staff. b) In-country training was offered for improvement of my surgical skills to deal with patients with cataract so that the demand for cataract surgery can be fully satisfied by the local staff. c) The PIP team provide their own medical supplies for the cataract operations and this offers great relief on the local health care budget.	Lucilla Ah Ching-Sefo, Ophthalmology Trainee, TTMH, Apia, Western Samoa
2012	1	Solomon Islands	Endoscopy Workshop	I have done gastroscopies for a few years already…so I have had some experience. However I just learned from other colleagues- with no proper training. From this course I actually learned from experienced gastroenterologist so it helped me improved my techniques a lot. I learned to be more thorough and look for specific pathologies I don't know I should look for before; the new techniques enable me to	Dr Rooney Jagilly, Consultant Surgeon, National Referral Hospital, Honiara, Solomon Islands

Year	Sem	Country	Specialty	Comment	By
				do a faster and easier gastroscopy.	
2012	2	Tuvalu	Ophthalmology	a) provide eye services to the people of Tuvalu. b) people with cataracts are able to get operated and get visions back. c) get training for the local health workers.	Filoiala Sakaio, Matron, Princess Margaret Hospital, Funafuti, Tuvalu
2012	2	Vanuatu	Orthopaedics	The visit helped the staff to up skill their knowledge at preparing of equipment to use in orthopaedics surgery	Dorothy Namel, Sister in-charge, Vila Central Hospital, Port Vila, Vanuatu
2012	2	Vanuatu	Orthopaedics	Opportunity for our nursing students and teachers to participate in updating their knowledge and skills form visiting specialists is gratefully received and benefit all in the healthcare system to ensure best practice based care for our patients.	Carlene Allport, Nurse Educator, Vanuatu College of Nursing Education (VCNE) Port Vila, Vanuatu
2012	2	Vanuatu	Orthopaedics	Getting local staff together from different health facilities and islands, enabling networking. Group of people together being taught the same thing allowing uniformity of treatment (hopefully). Having 2 physiotherapists included in this visit	Leitare Raubani, Rehabilitation Manager (Physiotherapist), Vila Central Hospital, Port Vila, Vanuatu
2012	2	Vanuatu	Paediatric	Learn from specialist. Able to discuss and liaise with families in local language what can be done, what should be done and what will be done. Learning directly, one-to-one operating was an honour and privilege. Discussing outreach and plans for future. Working with donors for your patients. Developing research.	Basil Leodoro General Surgeon Vila Central Hospital, Port Vila, Vanuatu
MOST VALUABLE THING ABOUT THE VISIT					
2012	2	Fiji	ENT	Exposure to specialised cases and supervision of an experienced anaesthetist.	Kartik Mudliar, Anaesthesia Registrar, Lautoka Hospital Lautoka, Fiji
2012	2	Fiji	ENT	a) Training to local staff b) Major operations done	Arun Murari, Consultant Surgeon, Lautoka Hospital Lautoka, Fiji

Year	Sem	Country	Specialty	Comment	By
2013	1	Fiji	Neurosurgery	From our side - radiology teaching sessions	Paula Nakabea, Radiologist, CWMH, Suva, Fiji
2013	1	Fiji	Neurosurgery	To me, the operation done locally was most valuable.	Gyaneshwar Rao, Consultant Physician, CWMH. Suva, Fiji
2013	1	Fiji	Paediatrics	The teaching and surgical skills transfer over all the painstaking hours in surgery. I am thankful for the patients to teach me and Save, and the confidence built on this week long of surgery.	Josese Turagava, General Surgeon, CWMH, Suva, Fiji
2013	1	Kiribati	ENT	Operative treatment of polyps and tympanoplsty	Bwabwa Oten, Director of Hospital Services/ Consultant Surgeon, Tungaru Central Hospital, Tarawa
2012	2	Nauru	Audiology	a) found patients who needed treatment for ENT team. b) hearing aids provided. c) perforated ear drum, referred to ear, nose & throat team	June-Rose Bill, Nurse Aide, RON Hospital
2012	2	Nauru	Cardiology	a) Giving the patients the opportunity to examine their heart & be able to recognize the condition of their heart; b) Giving the opportunity to the Health Staff to learn how to identify a bad/sickly heart by using the ultra-scan on the heart; c) Providing an ECG machine which is very easy to use and operate and prevent time consuming.	Elizabeth Giouba, Supervisor - Out-patient Department, RON Hospital
2012	2	Nauru	Cardiology	Providing clinical services that cannot be offered by our local doctors at the hospital skills transfer and training for local staff Prioritizing patients and treat those that can be treated during the visit and recommend those which needs treatment abroad	Gano Mwareow, Director of Nursing, RON Hospital
2012	2	Nauru	Cardiology	The service they provided to the people of Nauru	Sulueti Bauleka-Vuanivono, Senior Radiographer, RON Hospital
2012	2	Nauru	Vascular	Cost effectiveness of patient health care	Htet Naing, Anaesthetist, RON Hospital

Year	Sem	Country	Specialty	Comment	By
2012	2	Nauru	Vascular	Provided expert specialised treatment of patients - life AVF creation	Ako Milan, General Surgeon, RON Hospital
2013	2	Nauru	Vascular	a) The trust and comfort of the patients after the doctor and the nurse explained about their condition, about the procedure and the advantage of the fistula being created; b) The patients willing to have the procedure done to them; they understood their sickness and knew that this is their chance which means they will not experience the insertion of the vascath or need to wait for the next team visit which could be too late for them ; c) Feel relieved to have the vascath inserted on standby and knowing that, that arm can still be used normally.	Elizabeth Giouba, Supervisor - Out-patient Department, RON Hospital
2012	2	Samoa	ENT	Being able to do a thyroidectomy.	Shaun Mailiu, Surgical Registrar, TTMH, Apia
2012	2	Samoa	ENT	Enhance the confidence and ability for us local doctors in dealing with ENT cases, emergency/elective. Able to do plenty of surgical operation for most of ENT cases in Samoa.	Sione Pifeleti, Surgical Registrar, TTMH, Apia
2013	1	Samoa	Ophthalmology	The most valuable thing about the PIP visit is the sharing of knowledge and skills to the local staff so that there will come a time where the local staff will be able to satisfy the eye health demands of the Samoan people and not be so reliant on visiting teams.	Lucilla Ah Ching-Sefo, Ophthalmology Trainee, TTMH, Apia, Western Samoa
2012	1	Tuvalu	Ophthalmology	a) the blind are able to see again. b) provide spectacles for reading and for distance. c) the local people are able to get better services from the specialists.	Filoiala Sakaio, Matron, Princess Margaret Hospital, Funafuti
2012	2	Vanuatu	Orthopaedics	The most valuable thing about the PIP visit is to provide services for patients who cannot travel overseas for further treatment	Dorothy Namel, Sister in-charge, Vila Central Hospital, Port Vila
2012	2	Vanuatu	Orthopaedics	The important of early identification end referral of patients born with club foot. Awareness of the occurrence of club foot in Vanuatu and the availability of (15 trained staff) around the islands who can treat this using the minimally invasive Ponseti program.	Carlene Allport, Nurse Educator, Vanuatu College of Nursing Education (VCNE)

Year	Sem	Country	Specialty	Comment	By
2012	2	Vanuatu	Orthopaedics	The Ponseti method teaching. Getting local staff together.	Leitare Raubani, Rehabilitation Manager (Physiotherapist), Vila Central Hospital, Port Vila
PROTOCOLS/PROCESSES ADOPTED AS A RESULT OF VISIT					
2012	2	Fiji	ENT	Will be starting to do tonsillectomies and some more cancer surgeries	Arun Murari, Consultant Surgeon, Lautoka Hospital
2012	2	Fiji	Nephrology	The revised Nephrotic Protocol has included the use of levimasole in frequent relapsing, steroid dependent nephrotic syndromes. 4 patients meet this criteria. A submission has been forwarded to our National Therapeutic and Medicines Committee for funding consideration which is now approved.	Rigamoto Taito, Consultant Paediatrician, Lautoka Hospital
2013	1	Fiji	Neurosurgery	Particularly with MRI. An opportunity to review some of the established protocols with MRI-introduction of some new MR sequence to better demonstrate pathologies and anatomy. This was possible with assistance from MRI tech Kylie Walters and neuro-radiologist Dr Trevor Watkins	Paula Nakabea, Radiologist, CWMH
2013	1	Fiji	Neurosurgery	In the long term, the development of a Neurosurgical Unit at CWM Hospital is envisaged. The Medical Unit is setting up an EEG Service soon, a doctor has been trained. A Neurology Registrar will be identified in due course to be a part of staffing in the development of a Neuro Surgical Unit.	Gyaneshwar Rao, Consultant Physician, CWMH
2012	2	Nauru	Cardiology	We try to adjust/adopt to any practice we learned or experience from any visiting specialists if it needs to and if it is approved by the Directors / Head of Department.	Elizabeth Giouba, Supervisor - Out-patient Department, RON Hospital
2012	2	Nauru	Cardiology	We are evaluating our program and had targeted one of our priority weakness especially our poor compliances rate -have commenced one on one patient approach and a good outcome since the visit. Re- arranged other community activities that transport is available for RHD outreach activities. Injection card developed with a Nauruan version on the importance of the Benthazine Inj done and forwarded to Menzies University for printing last week.	Gano Mwareow, Director of Nursing, RON Hospital

Year	Sem	Country	Specialty	Comment	By
2012	2	Nauru	Cardiology	Now that we know how to do echo, we will have to include this in the departmental scan protocol	Sulueti Bauleka-Vuanivono, Senior Radiographer, RON Hospital
2012	2	Samoa	ENT	Learn a lot on how to perform thyroidectomy, Mr Ghali showed a simple method in doing neck dissections and performing thyroidectomy on complicated cases	Shaun Mailiu, Surgical Registrar, TTMH, Apia
2013	1	Samoa	Ophthalmology	As a result of advice by Nurse Andrea, we have actually changed the process for sterilizing our operating theatre. We will not be using formalin as we did in the past.	Lucilla Ah Ching-Sefo, Ophthalmology Trainee, TTMH, Apia
2012	2	Tuvalu	Ophthalmology	The local team should have assessed all the cases prior the teams arrival instead of giving a list of all those who wants an eye check and as a result, the most priority cases would not have a chance to be an operation.	Filoiala Sakaio, Matron, Princess Margaret Hospital, Funafuti
2012	2	Vanuatu	Orthopaedics	All participants of the Ponseti training presentation given by Helen Burgan (VCNE students and staff) are now aware of this management and will increase awareness in the communities for early identification and referral.	Carlene Allport, Nurse Educator, Vanuatu College of Nursing Education (VCNE)
2012	2	Vanuatu	Orthopaedics	Awareness to health works of Ponseti method as the treatment of clubfoot. Setting up Ponseti Network Vanuatu, its vision, objectives and strategies. Having contact focal people in the islands/provincial hospitals and the 2 main hospitals to improve referral and follow-up treatments.	Leitare Raubani, Rehabilitation Manager (Physiotherapist), Vila Central Hospital, Port Vila
2013	1	Vanuatu	Urology	These are some of the procedures that will be done at home in Vanuatu. We observed and learnt 'best practice' in regard to patient care and maintenance of instruments. We scrubbed with the Australian Registered Nurses for the procedures (to comply with Australian Standards), to improve our skills and knowledge so we are able to teach others at home.	Leisong Lagoiala & Yolande Maltahial, Nurses, Vila Central Hospital, Port Vila
NATIONAL TEAM FEELING COMFORTABLE CONTACTING TEAM FOR FUTURE ADVICE					
2012	2	Fiji	ENT	Yes – contacting Dr Krishnan for complex ENT cases.	Arun Murari, Consultant Surgeon,

Year	Sem	Country	Specialty	Comment	By
					Lautoka Hospital
2012	2	Fiji	Nephrology	Yes - Dr Wong has been guiding our clinical care of children with kidney diseases through e-mail and occasionally phone calls on urgent advice, even before his first visit in 2006. The actual visits further strengthened that relationship.	Rigamoto Taito, Consultant Paediatrician, Lautoka Hospital
2013	1	Fiji	Neurosurgery	Yes, certainly - our resource people MRI tech Kylie Walters and Dr Trevor Watkins have agreed to assist us in future as regards queries on MRI protocols etc. and Dr Watkins for second opinion on MRI/CT as regards difficult/interesting cases.	Paula Nakabea, Radiologist, CWMH
2013	1	Fiji	Neurosurgery	I would like to contact Dr Kevin Seex for advice in the Management of patients, particularly with brain tumour	Gyaneshwar Rao, Consultant Physician, CWMH
2013	1	Fiji	Paediatrics	Yes, I always contact Dr Vipul for complex paediatric urology cases as well as the other known surgeons in NZ. Russell helps interpret our complex radiology.	Josese Turagava, Surgeon, CWMH, Suva
2012	2	Nauru	Cardiology	Yes, this is an ongoing practice contacting the cardiologist /assistant regarding clarifications of patients status in their report and for new updated information on management & treatment of RHD.D14	Gano Mwareow, Director of Nursing, RON Hospital
2012	2	Nauru	Cardiology	Yes - Dr Walsh advice on echocardiography where we send videos of scan by email for his opinion.	Sulueti Bauleka-Vuanivono, Senior Radiographer, RON Hospital
2012	2	Nauru	Vascular	Yes - Dr Alan Saunder (Dr John Graham) for advice on management of complications in patients operated on during the visit. Also for second opinion on the management of other patients with vascular problems e.g. PVD and diabetic foot.	Ako Milan, General Surgeon, RON Hospital
2012	2	Samoa	ENT	Yes, most certainly especially with our oropharyngeal cancer patients and contacting Mr Ghali on further treatment and management.	Shaun Mailiu, Surgical Registrar, TTMH, Apia
2012	2	Samoa	ENT	Yes, thanks for the contact and very useful for further references and opinion.	Sione Pifeleti, Surgical Registrar, TTMH, Apia
2013	1	Samoa	Ophthalmology	I have been in contact with Dr Haybittel concerning our patients and he has been very helpful.	Lucilla Ah Ching-Sefo, Ophthalmology Trainee, TTMH, Apia

Year	Sem	Country	Specialty	Comment	By
2012	2	Tuvalu	Ophthalmology	Yes, our doctors were contacting Dr Richard Rawson if they have cases that need a specialist advice and for further management.	Filoiala Sakaio, Matron, Princess Margaret Hospital, Funafuti
2012	2	Vanuatu	Orthopaedics	The staff would feel confident to ask for advice on how to care for instruments and how to use the instruments.	Dorothy Namel, Sister in-charge, Vila Central Hospital, Port Vila
2012	2	Vanuatu	Orthopaedics	Yes - any teaching resources/advice/forms/best practice updates/suppliers (already do)	Carlene Allport, Nurse Educator, Vanuatu College of Nursing Education (VCNE)
2012	2	Vanuatu	Orthopaedics	Yes. Helen Burgan & Keryn Parkes for advice on orthopaedic paediatric cases and paediatric development issues.	Leitare Raubani, Rehabilitation Manager (Physiotherapist), Vila Central Hospital, Port Vila