Australian Government
AusAID

# Activity Completion Report

Tertiary Health Services to Pacific Islands Countries

AusAID Agreement No. 58814, Pacific Island Countries

Royal Australasian College of Surgeons

30 June 2012

## Table of Contents

## List of Acronyms

| | |
|---|---|
| ASC | Annual Scientific Congress |
| AusAID | Australian Agency for International Development |
| AVF | Arteriovenous Fistula |
| CCrISP | Care of the Critically Ill Surgical Patient |
| CWMH | Colonial War Memorial Hospital |
| EMC | Evaluation and Monitoring Committee |
| EMSB | Emergency Management of Severe Burns |
| EMST | Early Management of Severe Trauma |
| ENT | Ear Nose and Throat/Otolaryngology |
| EPM | Essential Pain Management Course |
| FSM | Federated States of Micronesia |
| FSMed | Fiji School of Medicine |
| HSL | Health Specialist Ltd. |
| IPMC | International Project Management Committee |
| M&E | Monitoring & Evaluation |
| MDG | Millennium Development Goal |
| MoH | Ministry of Health |
| MMED | Master of Medicine |
| NGO | Non-government Organisation |
| NZAID | New Zealand Agency for International Development |
| PEI | Pacific Eye Institute |
| PIP | Provision of a Range of Clinical Health Services to Pacific Island Countries (Pacific Islands Program) |
| PTC | Primary Trauma Care |
| RACS | Royal Australasian College of Surgeons |
| SSCSIP | Strengthening Specialised Clinical Services in the Pacific |

The Royal Australasian College of Surgeons certifies that this ACR has been completed in accordance with AusAID's AusGuideline 185.1 Complete an Activity Completion Report May 2010.

## Executive Summary

Many Pacific Island Countries (PICs) still face challenges in the provision of tertiary and some secondary health services to their populations. PICs are faced with a shortage of skilled health personnel; lack of necessary basic equipment and medical supplies; problems maintaining existing equipment and supplies; and of providing health services to communities in remote and isolated locations. Increased mobilisation, climate change and urbanisation have caused rapid lifestyle changes for many Pacific Islanders which has consequently resulted in a massive rise in non-communicable diseases such as diabetes and cardiac disease. In addition to this, the island nations find it financially difficult to provide and maintain highly specialised medical services for small and dispersed populations. The PIP aims to address these needs through the provision of services and capacity building activities as requested and/or in consultation with the Ministries of Health (MoHs) and relevant hospital medical personnel.

The development impact of the PIP falls into two categories: quality of life improvement for patients and increased number of clinicians who will continue to contribute to the development of more sustainable health services in the long term. Treatments not only reduced the burden on the government of the PICs but have in fact have enabled many patients to have increased access to education and work opportunities making them positive contributor to the society. While the capacity building of health systems in the Pacific remains a long term goal, the PIP has made gains and had continue to provide tangible impact on skills transfer and capacity development, particularly in the ability of local clinicians to effectively run outpatient clinics and screening services.

This phase of the PIP continued to provide effective service delivery and capacity building opportunities across the Pacific in support of national priorities and workforce plans for development. Clinical services delivered contributed to improving health outcomes for many people across 10 Pacific countries and supported the strengthening of capacity for Pacific clinicians to provide services themselves.

Delivery of all projected services and activities was achieved within budget and timeframes, with outcomes representing quality of life improvements for patients who received specialist healthcare and strengthened capacity of the regional health workforce to manage secondary and tertiary health demands of their people. In the short-term timeframe provided, the Program was able to generate benefits which will remain with individuals and communities beyond the confines of the contract period. Output delivery in support of these outcomes included:

- 56 specialist clinical service and teaching visits were delivered to 10 Pacific island countries (Fiji, Samoa, Tonga, Vanuatu, Solomon Islands, Tuvalu, Kiribati, Nauru, Federated States of Micronesia and the Cook Islands) wherein,
    - Approximately 5,962 people accessed specialist clinical consultations and almost all of these patients received diagnoses and non-surgical management and/or treatment options for their medical conditions.
    - 1,676 patients received life-changing and/or potentially life-saving surgical procedures.

- The Tonga MoH agreed to Tuvalu MoH request to have 2 cardiac patients attended to during the PIP-supported cardiac surgery visit (Operation Open Heart) in Tonga. Both patients had successful operations

- Documented involvement of the local surgeons in surgical procedures for 16 visits showed an average participation of 38 % as lead surgeon with assistance and 9 % as independent surgeon under supervision of visiting specialist.

- 50 training opportunities/activities were conducted and successfully completed by 647 local clinicians. These includes instructors courses to establish a cohort of qualified Pacific-based facilitators resulting into,

  - 3 additional Pacific clinicians successfully instructing in the EMST and CCrISP course in Fiji

  - 6 additional I-Kiribati clinicians instructing in the PTC course in Kiribati

  - 5 additional Ni-van clinicians instructing in the PTC course in Santo, Vanuatu

  - Cook Islands PTC courses delivered in 2011-2102 predominantly ran by Cook islands clinicians

  - 25 local clinicians conducting EPM workshops in Vanuatu and the Cook Islands

- In the spirit of regional cooperation, 4 clinicians from Fiji shared their skills and delivered the PTC Provider and Instructor workshop in Kiribati,

- 8 surgical/trainees registrars from the Pacific Island countries joined and worked with the visiting specialist team in their respective countries. These registrars are either pursuing post graduate programs in surgery and anaesthesia in Fiji and PNG or in Australia/New Zealand on scholarship program or work/training attachment.

- 30 Pacific islands surgeons, anaesthetists and registrars were supported to participate in Continuing Professional Development opportunities to foster regional cooperation and networking, and

- Formal workshop attendance, on-the-job training, mentoring and training attachments for surgeons, trainees and allied health professionals has generated new or improved knowledge and skills in specialist health, and enabled further training opportunities overseas.

All activities delivered during this contract phase were provided through in consultation with Pacific MoHs and other key stakeholders, including the SSCSiP. All activities were therefore planned for, budgeted and carried out to support and promote Pacific national health plans and contribute to the sustainability of health services and strengthen national ownership of health planning and management in the region.

The Program is realistic about the long-term impact of activities delivered in the region and sustainability of clinical and training achievements will need to be supported in the context of medium to longer-term donor support.

## Activity Summary

### 1. Summary Data

The goals of the Program under the funding contract period were: *to contribute to improving the clinical health outcomes of people in the Pacific; to strengthen local capacity to provide specialised medical services; and to promote national ownership of health planning and management.* These goals build on work conducted in previous phases of the Program and support the strategic development of clinical services in the region.

The Program involved a range of activities across four main objectives as follows:

a) visits by qualified Australian and New Zealand-based medical specialists and support To provide tertiary and secondary clinical services to the Pacific through a strategically planned program of staff;

b) To provide on-the-job, in-country training workshops and other educational development opportunities to Pacific clinicians to contribute to their ability to become more self-reliant in the provision of clinical services;

c) To respond to emerging health priorities in the Pacific, which had not been otherwise budgeted for under the proposal, as they arise;

d) To efficiently and effectively manage the logistical arrangements, services, disposable and equipment requirements, and training provisions of the program within the budget and agreed timeframe.

### 1.1 Map of The Pacific Islands[1]


[1] http://www.tropicalresortjobs.com/img/pacific-map.gif

## 1.2 Key Dates

Australian Government support for health development in the Pacific through the *Provision of a Range of Tertiary Health Services to Pacific Island Countries*, commonly referred to as the Pacific Islands Program (PIP) commenced in 1995.

Key dates for this funding agreement are as follows:

| | |
|---|---|
| Ratification: | 06 April 2011 |
| Amendment No. 1 Ratification: | 09 June 2011 |
| Commencement: | 01 April 2011 |
| Completion: | 30 June 2012 |

## 1.3 Funding

Funding in support of the PIP activities for the period April 2011 – December 2012 are shown in the following table:

| Source | Approximate Value ($A) | Purpose |
|---|---|---|
| Government of Australia through AusAID | $ 2,387,705 | Support for the delivery of clinical services and capacity building initiatives |
| PIP-Funded Volunteer Time | $ 1,321,000[2] | Provision of clinical services and training support |
| Self-funded Volunteer | $ 25,000 | Provision of clinical services and training support |
| Other Donors – NZAID, PIC MoH, Interplast, Orthopaedics Outreach, Suppliers and Service Providers | $ 600,000 | The provision of additional resources for teams such as disposables and equipment, equipment discounts, mobilisation cost of other non-PIP funded volunteers, excess baggage waiver/ concessions etc. |
| RACS Rowan Nicks Scholarship | $ 80,000 | Surgical training attachments in Australia and Nepal |
| RACS International Travel Grant | $ 14,000 | Overseas conference registration and masterclass workshops |
| Project Director | $ 30,000[3] | Leadership and clinical expertise and program direction |
| Evaluation and Monitoring Committee Members | $ 14,000[4] | Visit evaluation |
| Speciality Coordinators | $ 12,000[5] | Clinical expertise and volunteer recruitment and selection |

[2] Estimated using Australian pay scale (http://www.payscale.com/research/AU/Country=Australia/Salary) and the AusAID Short Term Adviser Remuneration Structure

[3] Based on pro-bono time at an average of 2 days per month over 15 months at AUD 1,000/day.

[4] The Evaluation and Monitoring Committee is comprised one chairperson (surgeon), 2 specialists (surgeon and anaesthetist) and an experienced nurse. The members are estimated to spend at least 1 day per quarter reviewing reports and attending committee meeting.

[5] Based on pro-bono time of 14 hours provided by each Speciality Coordinators (9)

## 1.4 Activity Governance Arrangements, Stakeholder Consultations and Coordination, and Collaboration

PIP Governance Arrangements through RACS

Through RACS, the PIP management team drew on the expertise of a number of specialists with considerable experience in the provision of health services in developing countries. A detailed outline of RACS governance arrangements can be found in Annex 1. Through these mechanisms, the PIP utilised the technical guidance and strategic oversight of health professionals to deliver the program.

As with the previous phases of the PIP, activities delivered through the program were independently reviewed and assessed by the PIP Evaluation and Monitoring Committee (EMC). The EMC comprises of two surgeons, an anaesthetist and a nurse; and meets a minimum of three times per year to assess PIP visit reports, appraise technical inputs and activity achievements including unexpected outcomes/adverse events. During the period under review, 3 Pacific clinicians namely Dr Dudley Ba'erodo (Head of Surgery, Solomon Islands); Dr Richard Leona (Senior Surgeon, Vanuatu); and Dr Alan Biribo (General Surgeon, Fiji) participated in the EMC meeting.

The RACS International Projects Management Committee (IPMC) meets annually to review the progress of RACS International Programs. In 2011, the IPMC met to specifically review the progress of the PIP. The PIP Review meeting was attended by the outgoing PIP Project Director, the incoming PIP Project Director, PIP Specialty Coordinators; and representatives from the Pacific, the SSCSiP, and AusAID.

The IPMC and the EMC report to the RACS International Committee which meets three times a year, and sets policies and guidelines for the RACS' International Program activities.

All RACS governance arrangements and inputs are honorary and provided on a *pro bono* basis.

Stakeholder Consultation & Coordination

All services delivered through the PIP were needs driven and were delivered as requested or in consultation with the MoH/Hospital clinicians. Due to the longstanding relationship with key Pacific MoH and hospital personnel, continuous dialogue was used to establish clinical and training priorities for each country. PIP volunteers also held regular debriefing meetings with Pacific representatives at the conclusion of each visit. Such debriefing session included MoH representatives, hospital management personnel and other key clinicians. Efforts were also made to ensure relevant AusAID representatives were also present. The debrief was an opportunity for all stakeholders to review the clinical and training performance and outcomes of the visit, discuss any issues arising, and consider lessons learned and/or strategies for continuous improvements of program activities. Feedback and recommendations that arose from these debriefing sessions was included in team visit reports.

The IPMC meeting in 2011 brought RACS/PIP management together with Pacific clinicians and volunteers to review the progress of the Program. The meeting discussed monitoring and evaluation (M&E) requirements and practicalities, visit coordination, equipment procurement and maintenance, and the importance of role modelling, leadership and supporting career pathways in the Pacific. This provided an opportunity for Pacific representatives to openly provide feedback to the Program.

The PIP management team also capitalised on meetings with relevant Pacific stakeholders at every given opportunity. This included stakeholder and clinical service meetings in Fiji organised by the SSCSiP, and surgical conferences in Australia and elsewhere in the Pacific.

The SSCSiP is an AusAID-funded initiative created to support Pacific countries plan for, access, host and evaluate specialised clinical services; and to strengthen health worker skills, capacity and capability to meet clinical service needs. The RACS continued to collaborate and consult with the SSCSiP to share information and ensure regional cooperation and coordination.

Collaboration

In addition to the Pacific MoH, Hospitals and the SSCSIP, the RACS also collaborated with other organisations to deliver the program activities. These include Interplast Australia and New Zealand, Australia and New Zealand Burns Association, Orthopaedic Outreach, Sydney Adventist Hospital, Royal Australian and New Zealand College of Ophthalmology, Australian and New Zealand College of Anaesthetists, Volunteer Ophthalmic Services Overseas, and Health Specialists Ltd (HSL).

Individual PIP volunteers also generated funds in support of the Program; self-funding additional team members and procurement and/or donation of additional medical supplies were common examples of valuable volunteer contributions. For example, one RACS Fellow and PIP volunteer has personally donated funds to support Micronesian surgical registrar, Dr Padwick Gallen, undertake his Postgraduate Diploma in Ophthalmology through the Pacific Eye Institute (PEI) in Fiji. Significant support was offered by the RACS through its scholarships and travel grants foundation programs. The RACS Rowan Nicks scholarships have provided funding support for both Richard Leona (Senior Surgeon, Vanuatu) and Dudley Ba'erodo (Head of Surgery, Solomon Islands) to spend 12 months training in Urology in Geelong and Melbourne respectively. The Rowan Nicks scholarships also provided funding support for Samoan ophthalmology trainee, Dr Lucilla Ah Ching-Sefo, to attend a six week training attachment in Nepal. In addition, the RACS funds the licensing subscription which provides Pacific trainees with access to online medical journals to support their continued learning. These journals would otherwise not be readily available to many Pacific personnel.

## 2. Activity Description

### 2.1 Background & Rationale

This PIP is the continuation of AusAID funding support to the Pacific, which has been managed by the RACS since 1995. The PIP has developed through three phases, Phase I (1995 - 1998); Phase II (1998 - 2001); and Phase III which originally operated 2001 – 2006 before a bridging/transition phase was extended on several occasions to 30 June 2012. This report details the implementation period of the Program which operated from 01 April 2011 to 30 June 2012.

For the period under review, the PIP provided specialised clinical support and capacity development activities in surgery as well as other clinical services (including nursing and anaesthesia) to 10 Pacific Island countries namely: Fiji, Samoa, Tonga, Vanuatu, Solomon Islands, Tuvalu, Kiribati, Nauru, Federated States of Micronesia and the Cook Islands.

The PIP represents a large proportion of the Australian government's investment in clinical service delivery across the Pacific region. This continuation of services supports Pacific MoHs provide secondary and tertiary health care services to their populations. Experience has shown that many Pacific countries face difficulties attracting and retaining doctors and other clinical personnel with appropriate training and experience in specialised tertiary and secondary care. Pacific countries also face challenges of inadequate hospital facilities; infrastructure and resource limitations; lack of necessary basic equipment and medical supplies; and problems maintaining existing buildings and servicing equipment. This is compounded by the challenge of providing health care services to remote and often isolated communities. These factors all make the provision of comprehensive health services problematic for many Pacific nations.

In close consultation with Pacific MoHs, the PIP has worked to support Pacific health systems deliver tertiary and secondary health services, which would otherwise be unavailable or very limited, to their populations. The PIP has also provided various capacity building activities for Pacific clinicians to contribute to their ability to provide improved health care services into the future. Despite the advances made by this valuable work over the past 17 years, there still remains a continued need for ongoing training support and service provision in the Pacific.

The PIP was independently reviewed in 2011 (see annex 9). The review recognised that the Program was having a positive impact on its goal and some of its activities, but that the monitoring and evaluation systems were unable to assess this. Since this review, the PIP has been working in collaboration with Pacific representatives and the SSCSiP to develop a suitable framework and model to address this concern. Further details regarding the Program's response to the review are outlined throughout this report.

## 3. Expenditure/Inputs

The overall budget from AusAID for the program covering the period April 2011 – 30 June 2012 totalled AUD 2,387,705 broken down as follows:

| Item | Budget (AUD) | Actual (AUD) |
|---|---|---|
| Clinical Visits | 1,422,849.00 | 1,316,161.00 |
| Training | 241,186.00 | 241,175.45 |
| Priority Health Fund | 55,000.00 | 52,770.78 |
| Disposables & Equipment | 491,150.00 | 491,061.09 |
| Management - Consultation Visit | 6,520.00 | 4,922.94 |
| Fixed Management Fees | 171,000.00 | 171,000.00 |
| **TOTAL** | **2,387,705.00** | **2,277,091.27** |

Key activity inputs included human resources, expertise and equipment. Volunteer human resources and expertise inputs were significant with more than 350 medical professionals providing more than 600 weeks of volunteer time delivering clinical service, mentoring, clinical teaching and education and training through formal workshops and academic support. In total, volunteer time contribution is conservatively estimated at AUD 1.321 million.

Disposable medical supplies and essential equipment were procured to support the self-sufficiency of clinical teams and the delivery of safe specialist procedures.

There were no expectations of contributions by partner governments or organisations in this contract. However, Pacific MoHs and hospitals take responsibility for a number of costs and they have done this over the reporting period. Human resources as well as clinical facilities and materials were provided by host hospitals and training institutions during clinical and training visits. Clinical visits could not effectively or safely function without the support, cooperation and contributions of local hospital staff. Contributions and cost-sharing has already been seen in the delivery of training courses and workshops which reflect the growing commitment of Pacific MoHs for the activities to be sustainable.

## 4. Approach/strategy adopted and key outputs received

The 2011 Review outlined that many Pacific countries suffer from low levels of 'home-grown' clinical specialists in the workforce. Gaps in service provision remain constant for Pacific Island countries. The review acknowledged that it is 'realistic to assume that many of the health systems will be unable to fund and deliver a full range of high-level secondary and tertiary services for the foreseeable future.'[6] Therefore, there remains a need for external clinical and training support to assist Pacific MoHs meet the health needs of their populations.

[6] J. Campbell, J. A. Braithwaite, J. Buchan & J. McKimm. 2011. PIP Phase III Review. AusAID, p. 3

This contract period continued to provide secondary and tertiary health care support to Pacific MoHs through three main activities: the delivery of clinical services; the delivery of training activities; and an allowance to respond to emerging priority health needs which were not otherwise budgeted for under the contract. These main components are considered in turn in the below.

## 4.1 Clinical Services

The Program provided a range of clinical services to Pacific countries to provide specialist consultation and treatment to Pacific people who would otherwise be unable to access services, or only able to do so at a high cost. The contract made provisions for disposable supplies and essential equipment to facilitate the safe delivery of quality services.

54 specialist visits were delivered during this contract period. In almost all countries, the Program delivered additional services than were proposed in the indicative schedule of the contract. Clinical visits of one to two weeks duration were delivered by volunteer medical teams of one to four persons. In response to the scope of medical conditions and disorders which cannot be managed by Pacific clinicians, RACS facilitated visits over a wide range of specialties, including Cardiac Surgery, Otolaryngology Head and Neck/ENT Surgery, Paediatric Surgery, Urology, Neurosurgery, Ophthalmology, Plastic & Reconstructive Surgery, Orthopaedic Surgery and Vascular surgery; as well as cardiology, nephrology, paediatric endocrinology and gastroenterology. Many of these specialties have assisted Pacific countries in managing the burden of conditions related to prevalent communicable and non-communicable diseases, injuries and congenital abnormalities. Surgery is an essential part of a comprehensive health system and can address many burdens of ill health, including serious acute and chronic conditions which can have a serious human and economic toll, and at times lead to acute, life-threatening complications.[7] For an overview of the quantitative outputs of clinical visits, please refer to Annex 2.

The 2011 Review highlighted the varying level of capacity in each Pacific country. The Review therefore concluded that different approaches to clinical service and capacity development delivery are warranted.[8] This highlights a key strength of the PIP in service delivery in the region, founded by long-standing relationships and understanding between Pacific clinicians and RACS. These strong relationships are utilised to ensure that service delivery is tailored to the needs of each country. For example, surgical visits in Tuvalu and Nauru are primarily service oriented due to limited or lack of appropriate local surgeons for training. In other countries where appropriate some human resource exists, visits were more accurately categorised as clinical service and training visits with the service delivery being used concurrently as a tool for mentoring and hands-on training. Within this framework, clinical services are delivered through the PIP to support the long-term goals of each country.

[7] H. T. Debas, R. Gosselin, C. McCord, and A. Thind, "Surgery." 2006. *Disease Control Priorities in Developing Countries (2nd Edition),ed.* , 1,245-1,260. New York: Oxford University Press. DOI: 10.1596/978-0-821-36179-5/Chpt-67.

[8] J. Campbell, J. A. Braithwaite, J. Buchan & J. McKimm. 2011. PIP Phase III Review. AusAID, p. 5

## 4.2 Capacity Building

In addition to clinical teaching and mentoring aspect of the clinical service visit, the program delivered a number of training opportunities to contribute to the capacity development of Pacific clinicians in the region and in support of Pacific MoH workforce development plans. Not all countries have the capacity to be self-reliant in the provision of services yet rather view long-term external service provision as a necessity. Therefore flexible approaches to capacity development in the Pacific were required.

The 2011 Review raised questions about the effectiveness of capacity development activities delivered on short-term timeframes.[9] Viewed as a single activity, the PIP recognises that individual training activities cannot ensure the sustainable transfer of skills in any environment. As stated in the 2011 Review, the PIP was primarily designed as a service provision program which has increasingly adapted to provide capacity development activities. Under the this changing scenario, RACS collaborated with Pacific MoHs and the Fiji School of Medicine (FSMed) to deliver and/or coordinate relevant training activities under PIP.

The PIP delivered capacity development opportunities to Pacific clinicians across the following areas: on-the-job training during clinical service visits and/or training attachments; the provision of regional or in-country training workshops; supporting PIC clinician participation in overseas training workshops and continuing professional development (CPD) programs; and through continued academic support to the FSMed. Summary is as follow:

| Training Initiative | PIC Clinician/ Beneficiaries |
|---|---|
| Regional/In-country Workshops (EMST, CCrISP, EMSB, PTC, EPM, ENT Nurse, Nurse Perioperative, Ultrasound, Ponseti) | 565 |
| Overseas Workshops (EMST Instructors Course, EMSB, DSTC) | 9 |
| Clinical Visit/Overseas Attachment | 11 |
| CPD (Australian Scientific Convention, PSA Conference) | 30 |
| FSMed Academic Support (MMED Surgical Pre-examination and External Examination) | 32 |

The benefits generated through capacity building activities of the Program also contributed towards strengthening the informal peer-support networks through the Program. The PIP 2011 review found that such relationships 'facilitate continuous professional development and life-long learning principles and present opportunities for Pacific clinicians to develop their competencies.'[10] Please refer to Annex 2 for an overview of quantitative capacity development outputs delivered through the Program.

[9] J. Campbell, J. A. Braithwaite, J. Buchan & J. McKimm. 2011. PIP Phase III Review. AusAID, p 7
[10] J. Campbell, J. A. Braithwaite, J. Buchan & J. McKimm. 2011. PIP Phase III Review. AusAID, p 7 & 8

### 4.3 Emerging Priority Health Needs

This funding component was included to allow the Program to respond to health service needs identified and requested by the Pacific Island countries which were not anticipated at the program proposal stage. During this contract period, six priority health needs were funded by the Program to include mobilisation of Vascular and ENT surgeon to Fiji to address urgent cases and/or clear surgical backlogs; emergency medicine scoping visit in Kiribati; radiology support during paediatric surgical visit to Fiji, supplementary optometry/opthalmology services to Samoa; and general surgery outreach visit to the Western province in the Solomon Islands.

The mobilisation of a Vascular surgeon to Fiji also provided mentoring opportunity in arteriovenous fistula (AVF) cases to Dr Josese Turagava who took over most of the surgical tasks at CWM Hospital when the Chief Surgeon, Dr. Waqainabete, accepted a short term work placement in New Zealand.

## 5. Key Outcomes

The overall goals of the PIP were to contribute to improving the clinical health outcomes of people in the Pacific; to strengthen the local capacity to provide specialised medical services; and to promote national ownership of health planning and management.

Underpinning the goals of the PIP was the purposeful desire to 'contribute' to achieving impact in the region. In articulating the goals as such, was recognition that the Program did not operate in isolation in the region and that multiple factors were responsible for achieving the goals. This does pose a challenge in assessing the 'contribution' of the Program to achieving goals. In this instance 'plausible association', where a reasonable person, knowing what has occurred in the Program agrees that the Program contributed to the outcome.[11] This logic will underpin the information provided below as evidence of the Program's contribution to achieving the stated goals.

### Expected Outcomes

| Expected Outcome | Outcome Achieved | Evidence |
|---|---|---|
| Clinical Services<br>- Improved health of people in the Pacific | - 5,962 Pacific islanders received specialist consultations, non-surgical treatment and/or referrals in a range of specialties | - 1,676 Pacific Islanders referred to and underwent surgical procedures in-country<br>- 4 breast screening patients referred to New Zealand for further investigation/treatment<br>- 2 Tuvaluan Cardiology patients referred for surgery during Operation Open Heart in Tonga |

[11] M. Hendricks. 1996. Performance Monitoring: How to Measure Effectively the Results of our Efforts. American Evaluation, Association Annual Conference. Atlanta USA

| Expected Outcome | Outcome Achieved | Evidence |
|---|---|---|
| | - 1,675 Pacific Islanders had successful surgical procedures | - 99.94 % surgical success rate (within 24 hours of surgery (only 1 pre-operative mortality reported)<br>- Patient post-surgical recovery outcome (after discharge) not quantified due to absence of in-country monitoring feedback and in most instance non-attendance of patients for follow-up review (especially when already feeling well or when travel cost is a concern for patients coming from the outer islands) |
| | - 4 Cook Is. women with potential breast cancer concerns had successful treatment regime in NZ | - According to Cook Islands resident physician, the 4 women are still alive but will need yearly breast screening |
| | | See Annex 3 for statements and other evidence of outcomes. |
| Strengthened local capacity to provide specialised medical services | Local surgeons able to conduct specialist surgical procedures | - 19 local surgeons/surgical registrars were directly involved in 88 surgical procedures as lead surgeons with assistance from the visiting specialist surgeons and in 19 surgical procedures as independent surgeon under supervision by the visiting specialist.<br>See Annex 4 for details. |
| | Cohorts of Pacific-based trainers are now qualified to facilitate PTC and EPM workshops to their peers in the Pacific. | 43 health professionals successfully completed instructor courses during this contract phase<br>- 12 new PTC instructors, Vanuatu<br>- 6 new PTC instructors, Kiribati<br>- 13 new EPM instructors, Cook Islands<br>- 12 new EPM instructors, Vanuatu |
| | Increased capacity to deliver PTC courses | Pacific clinicians accounted for 91% of facilitators for the PTC courses conducted during this contract phase (from 64% during the 2007 – 2010 period). |
| | Increased capacity to deliver EMST/CCrISP courses | Five (5) Pacific clinicians instructed during the EMST and CCrISP courses held at FSMed in Fiji during this contract period.<br><br>In addition 2 more Pacific clinicians successfully completed the EMST Instructor's course. |
| Increased national ownership of health planning and management | Pacific island countries able to plan for visits and organise and conduct appropriate preliminary screening of patients prior to visiting arrival | In 18 of the clinical service visits, local clinicians were reported to have conducted appropriate preliminary screening of patients totalling 1,159. |

See Annex 5 for some of the Pacific perspective/testimonies on the program's outcome and impact during this contract period.

## Unexpected Outcomes

There were 9 morbidities and 1 mortality (within 24 hrs. of surgery) reported during the period under review.

## 6. Expected long-term benefits and sustainability

Within the short-term timeframe of this funding period, the PIP was able to provide life changing and or saving clinical interventions to patients that will last beyond the contract completion date. Individuals are expected to enjoy improved levels of health following their treatment and are expected to be able to contribute and engage more fully in their communities as a result of treatment. The range of clinical activities undertaken generated significant benefits in improving child health outcomes; 28% of (recorded) operations performed during this phase were provided for neonates or paediatric patients.[12] Such outputs contribute to strengthening the Pacific's progress towards achieving the *Millennium Development Goal* (MDG) of improving child health and reducing mortality and morbidity.

As recognised in the 2011 Review, health benefits 'will largely remain with the individual…beyond the contract period of the AusAID funding.'[13] The review concluded that at 'this level the gains are clear'.[14] Sustainability of health improvements will depend on the follow-up health care services available to maintain clinical interventions (where required) in each country. The maintenance of long-term health outcomes will also rely on well-developed and implemented plans for health prevention in each country.

Capacity development activities have remained a key objective of the Program during this contract period. Activities have contributed to strengthening the health workforce for specialist service provision in the region. Increased availability of health care services in the Pacific contributes to the expected long-term improvements of the health status of Pacific populations. During this phase of the Program, mentoring support was offered in a range of specialties including Cardiac Surgery, ENT Surgery, Neurosurgery, ophthalmology, Orthopaedic Surgery, Paediatric Surgery, Plastic and Reconstructive Surgery, Urology Surgery and Vascular Surgery.

Long-term training benefits are not limited to surgery and/or surgical interventions. Doctors, anaesthetists, nurses and other allied health professionals across the Pacific have been formally trained in primary trauma and emergency trauma care, radiology, diabetes management, Ponseti club foot treatment techniques, essential pain management, and in the identification and management of primary ear diseases, to name a few. Trauma and injury, including road traffic accidents, violence and burns, are a leading cause of death and disability in many Pacific countries. Such injuries cause an estimated 1.2 million deaths per year in the region and predominantly affect individuals between five and 40 years of age.[15] With many countries experiencing rapid urbanisation and increased access to motor vehicles, the incidence of trauma

[12] NOTE: Paediatric patients defined as under 18 years of age
[13] J. Campbell, J. A. Braithwaite, J. Buchan & J. McKimm. 2011. PIP Phase III Review. AusAID, p. 11
[14] J. Campbell, J. A. Braithwaite, J. Buchan & J. McKimm. 2011. PIP Phase III Review. AusAID, p. 11
[15] World Health Organisations Western Pacific Region, Regional Framework for Action on Injury and Violence Prevention 2008-2013. Accessed at http://www.wpro.who.int/mnh/documents/docs/RegionalFrameworkforActionVIP200813.pdf, p 6

and injury is expected to continue to rise.[16] Access to training workshops such as EMST, PTC, and Emergency Management of Severe Burns (EMSB) courses will have significant long-term benefits in terms of improving health care workers' abilities to effectively and systematically manage trauma patients and this will improve outcomes for such patients.

As articulated in the 2011 Review, the risk to sustainability of skill levels in the region is largely dependent on a number of factors beyond the control of RACS.[17] Such issues include fluidity of staff in the region including 'brain drain' to neighbouring Australasian countries; limited national health budgets; poor infrastructure and limited resource availability; and underdeveloped career pathways for clinicians in the region. Many of these issues will require attention and strategy implementation by individual Pacific governments and/or action through wider regional planning mechanisms. The Program is aware of its limited ability to influence risks on these levels but has made all reasonable attempts to mitigate risks by working in close collaboration with individual Pacific governments and regional mechanisms such as the FSMed, the Pacific Surgeons Association and the SSCSiP to strengthen the potential for sustainable skills transfer. Please refer to Recommendations section for further information on this.

As already outlined in section 4.2, the Program supports the sustainability of skills transfer in the region through the establishment of peer-support networks with Pacific clinicians and volunteers from Australia and New Zealand. These relationships will last beyond any funding period as many long-lasting friendships have now been established through the Program. This was supported by the 2011 Review that noted 'it was evident that relationships with national counterparts had extended beyond professional engagement and peer-support networks into long-standing professional and personal support with mutual commitments to improving health.'[18] With some volunteers having relationships formed over 10 or more years, the review saw this support as 'likely to be of long-term, sustainable benefit beyond the duration of AusAID support.'[19]

## Overall Assessment

### 7. Relevance

The fundamental reason Australia supports work in the health sector in the Pacific is to obtain better health outcomes for people in Pacific countries.[20] Considered in light of this objective, the 2011 Review acknowledges that 'PIP's support to clinical service delivery and patient outcomes remains relevant.'[21] This conclusion follows the statement that RACS and the PIP 'is perceived as highly relevant to addressing the service challenges and gaps'[22] in the region. Throughout this contract period, the Program has delivered high quality specialised services and training in the Pacific.

[16] *Ibid.*
[17] J. Campbell, J. A. Braithwaite, J. Buchan & J. McKimm. 2011. PIP Phase III Review. AusAID, p. 11
[18] *Ibid.*
[19] *Ibid.*
[20] AusAID, Guidance Notes, p. 7
[21] World Health Organisations Western Pacific Region, Regional Framework for Action on Injury and Violence Prevention 2008-2013. Accessed at http://www.wpro.who.int/mnh/documents/docs/RegionalFrameworkforActionVIP200813.pdf, p. 4
[22] J. Campbell, J. A. Braithwaite, J. Buchan & J. McKimm. 2011. PIP Phase III Review. AusAID, p. 4

These services would otherwise be unavailable locally to populations. The high number of patients seeking consultations and requiring surgical interventions by visiting teams demonstrates the relevance and necessity of the activity.

Local Context, Need and Partner Government Priorities

Pacific countries face many challenges in the provision of health care services to their populations. Training and retention of qualified staff continues to be a significant challenge,[23] as is providing necessary secondary and tertiary health services, given infrastructure limitations and the often isolated and relatively small populations of many Pacific countries. Pacific countries are also relatively poor by world standards, largely categorised as low or lower/middle income economies.[24] This limits the economic resources available for the delivery of health care.

Tertiary and secondary health care services often fall outside the current predominant international health dialogue, which is heavily focused on primary preventative health. However it is important that such health care services are available to treat a range of disabling and potentially fatal health issues including congenital abnormalities in babies and children, rheumatic fever, trauma and injury and blindness or low vision for example.

For many Pacific countries, engaging external providers such as RACS to deliver specialist health services to their populations is an explicit input to longer-term strategic plans. Kiribati for example has outlined the need for support from RACS to assist in the long-term delivery of specialised services.[25] Vanuatu also acknowledges the importance of visiting specialist teams to deliver clinical services to their population in the medium- to longer-term. Given the high cost of establishing and maintaining some services, it would be unrealistic and inefficient to expect Vanuatu to develop a full range of specialised services. In some specialties however, plans are underway to up-skill and equip Vanuatu to deliver selected specialised services. This includes Urology, led by Richard Leona (Senior Surgeon, VCH); Paediatric Surgery, led by Basil Leodoro (surgical registrar, VCH); and eventually Plastics and Reconstructive Surgery through Samuel Kemuel (surgical registrar, VCH). In these situations, the flexibility of the program has enabled PIP to support each country at the varying level they require. This highlights the relevance of the Program in the Pacific and its value in supporting the long-term strategic goals of each country.

Country and Regional Strategy

The PIP was originally designed as a stand-alone program. As recognised in the 2011 Review, the Program is now part of a wider approach in the region and there are many overlaps in objectives and roles.[26] Since its establishment in 2010, RACS has worked in close collaboration with the SSCSiP to improve coordination of specialised services in the region and to identify and work towards improving monitoring and evaluation of programs. At the time of writing the program proposal, there was some uncertainty

[23] L. N. Henderson & J. Tulloch. 2008. Incentives for retaining and motivating health workers in Pacific and Asian countries. *Human Resources for Health*. 6:18

**[24]** Anonymous. 2009. United Nations Development Programme. *UNDP Human Development Report 2011: Overcoming Barriers: Human Mobility and Development*. Palgrave Macmillan. Washington, DC

[25] SSCSiP. 2011. Situational Analysis, Kiribati. AusAID

[26] J. Campbell, J. A. Braithwaite, J. Buchan & J. McKimm. 2011. PIP Phase III Review. AusAID, p 16

about the exact role of the SSCSiP and its organisational capacity to undertake activities. Throughout the duration of the contract, the working relationship between RACS and the SSCSiP assisted in clarifying the role of the SSCSiP and processes were put in place to ensure beneficial collaboration. RACS also continued to work directly with Pacific MoHs and hospital management to identify and respond to priorities in each country.

AusAID Strategy, Overarching Policy and Cross-Cutting Policy Objectives

As already outlined, Program activities are in line with AusAID's overarching goal to achieve better health outcomes for Pacific populations. The Program also supports AusAID's goal to develop a well-trained workforce to provide quality health services to women and children at all stages of their lives.[27]

AusAID's cross-cutting policy objectives continued to be supported and guided by RACS' strong policies during this contract phase. RACS maintains policies which address environmental concerns; disability inclusiveness; child protection; counter-terrorism; cultural awareness and development best practice; and gender equity. Examples of gender considerations can be found under 'Gender' in section 9.

Program Approach

The Program was designed and implemented taking 16 years of sound learning and extensive experience in delivering specialist health aid in the Pacific into account. As the managing contractor of PIP since 1995, RACS was well placed to implement this short-term contract cycle. RACS' productive working relationships and professional linkages with key stakeholders in the Pacific have facilitated collaborative learning and continuous improvement of PIP activities, ensuring that clinical and training inputs of this funding contract were demand drive and relevant in a context of changing needs and priorities.

## 8. Appropriateness of objectives and design

In the short-term period of the funding contract, and in the process of the SSCSiP establishing itself, the objectives of the Program remained clear, realistic and feasible. This provided a level of continuity in service provision which was required to support the service delivery priorities and longer-term national health workforce development plans of each Pacific country. The provision of funding budget for priority health needs also enabled the Program to offer timely support to requests for urgent services.

In relation to the actual benefits achieved, program funding were appropriate and delivered excellent value for money, particularly when considering the cost effectiveness of engaging specialist volunteers who provide *pro bono* services. Likewise, the program funding support was appropriate in relation to actual benefit of treating large numbers of patients given the costly alternative of offshore referrals for clinical treatment.

[27] AusAID. Saving Lives. Access via http://ausaid.gov.au/Publications/Documents/aidforwomenandchildren.pdf

## 9. Implementation issues

Contextual Issues

Staffing and workforce availability continued to be an issue for consideration during the delivery of this program. Research conducted by the SSCSiP indicates that 10 to 20 per cent of the specialist clinical workforce in the Pacific may be abroad for education at any given time.[28] The mobile nature of the Pacific workforce also meant that there was a high turnover of staff, either within hospital systems, between Pacific nations or to Australia or New Zealand. This presented challenges in coordinating and planning activities at times in some Pacific countries.

The Program is aware that many organisations provide support to Pacific MoHs to provide services and capacity building support to Pacific populations. Despite pro-active attempts by Program management to plan activities in advance and ensure that adequate notification was given of upcoming activities, a small number of incidences occurred where PIP activities either closely followed or clashed with the delivery of services by other providers. This is beyond the control of the Program and ultimately needs to be addressed by Pacific MoHs and hospitals. The scheduling assistance provided through the SSCSiP will also support better coordination of activities in the region going forward.

There are limited resources and access to technical support in the Pacific. This often meant that auxiliary services such as histopathology and radiology were either unavailable, available in a reduced capacity or would require significant lay times to receive results. This is not a new issue in the Pacific and it is one with which Pacific clinicians cope with remarkably well on a daily basis. Such restrictions are required to be taken into account by visiting specialists during planning stages of the visit. The budgetary allowances made through the priority health component of the contract enabled the Program to support these needs when requested. For example, through this component the Program was able to support a radiology specialist to join the Paediatrics visit to Fiji to provide training and support to staff at CWMH appropriate for dealing with paediatric cases.

Financial management and fund flows

The PIP is a regional program and aid during this phase was delivered through contracting arrangements between the Commonwealth through the Australian Agency for International Development (AusAID) and the Royal Australasian College of Surgeons (RACS). Subject to acquittal in accordance with the program funding proposal, Program funds were disbursed by AusAID in 3 tranches to cover activity costs and fees in accordance with the program design and budget. Considering the high volume of transactions involved with the program activity, this is deemed appropriate as it does not penalise RACS (by way providing funds advance) and at the same time greatly reduced the level of administrative work on the part of RACS and AusAID. No activity funds were channelled through partner government systems.

[28] J. Campbell, J. A. Braithwaite, J. Buchan & J. McKimm. 2011. PIP Phase III Review. AusAID,

Monitoring and evaluation (M&E)

The 2011 Review found that although the Program presented strong operational M&E, it was less able to explore the outcomes and impact of the Program. In response to this, the Program utilised this contract phase to build on its high quality operational M&E to explore strategies for monitoring and evaluating Program outcomes and impacts.

To effectively address these concerns, the Program consulted Pacific representatives, SSCSiP and other non-government organisations (NGOs) such as HSL, to identify what systems were already in place in the Pacific and how well they were functioning. To ensure the appropriateness and practicality of M&E plans, it was important to avoid duplicating existing systems and to capitalise on opportunities for collaboration where they existed. This approach was appropriate given the evolving capacity of the SSCSiP and to allow sufficient time to work on complementary plans. Although the fruits of these activities were limited during this contract phase, planning is well underway to have changes implemented in the next phase of the Program.

This contract saw the introduction of tracking surgical involvement levels of Pacific surgeons and/or surgical trainees during specialist visits. This was undertaken with the view of being able to measure changes in capacity over time. Owing to the short-term timeframe of this contract, the Program was only able to use this information as baseline data for future programs. Information collated from this data showed that Pacific surgeons (including trainees) when attached to a visiting team were largely engaged as either assisting surgeon (48 % of recorded procedures), lead surgeon with assistance (38 % of recorded procedures) and remarkably on their own under supervision of the visiting specialist (9 % of recorded procedures). When interpreting this data it is important to recognise that many Pacific surgeons are generalist by nature and may be capable of undertaking many surgeries independently. Nevertheless, surgical procedures undertaken with PIP teams are of a highly specialised nature and are those which are not usually able to be provided in respective Pacific countries.

The Program also benefitted from the establishment of more formalised feedback communication channels with Pacific representatives. Although strong communication channels have always existed with Program management, it was useful to implement standardised formats to request and receive recommendations and comments from Pacific representatives. This was conducted at the conclusion of each visit and feedback often included recommendations which could be included in future planning. See Annex 5 for a summary of feedback received through such channels.

As outlined in section 1.6, oversight of technical inputs, outputs and outcome of the Program and assessments of activities delivered, continued to be provided through the PIP EMC. As mentioned already, the committee benefitted from the inclusion of Pacific stakeholders in these meetings. Extended consultation was however limited by budgetary constraints of the contract structure.

## Gender

RACS maintains a policy on gender equity and the PIP is guided by its principles. The 2011 Review found 'several indicators [that] the PIP is taking a purposeful approach to understand and incorporate gender and gender equality in policy, clinical services and training.'[29] The review accurately recognised that the clinical services program is necessarily influenced by a number of factors outside of the control of the Program such as population health needs, national priorities and request, and quality/safety considerations prior to intervention/treatment. Similarly, access to capacity building opportunities is influenced by MoH strategic plans for national workforce development and availability of medical personnel at different times throughout the year.

Aggregate data collated from PIP clinical visits show that 43% of patients accessing consultations and receiving non-surgical treatment were males, compared to 47% females.[30] A similar even distribution was recorded in the break-down of data on patients receiving surgical treatment where 51% were males and 44% females.[31] It can be noted that there were services requested by the Pacific Island countries which were either exclusively for female (breast screening/mammography) or predominantly affects male (urology services concerning urinary problems and prostates).

While the medical specialist profession (surgeons and anaesthetists) in the Pacific remains to be predominantly males, the inclusion of more nurse orientated training activities in the program resulted into a more equitable access to training opportunities for male (43%) and female (57%).

## 10. Lessons learned

Lessons learned during the implementation of the PIP program under review are,

- PIP continued to be a cost-effective effective means of providing clinical treatment to the communities of the10 Pacific Island countries, and training to local medical personnel. Based on study conducted in Fiji[i][32] on cost comparison of cardiac treatment in Fiji showed that the extrapolated cost (exclusive of professional fees as services are provided pro bono) for visiting team in 2011 averaged FJD 11,676 (AUD 6,868) per patient. In comparison, this is 71% lower than the average MoH cost of sending a patient overseas (FJD 19,965 or AUD 11,744) and 228% less than the cost incurred by private insurance of sending patient to India. It is acknowledged however that the wide variance in cost could possibly be due to difference/complexity of cases.

- As the clinical needs and level of self-sufficiency in PICs vary across countries and specialties, any future regional program should have the latitude to acknowledge these variances and address them accordingly.

[29] J. Campbell, J. A. Braithwaite, J. Buchan & J. McKimm. 2011. PIP Phase III Review. AusAID, p 11
[30] NOTE: Approximately 10 per cent of data was unavailable at the time of reporting
[31] NOTE: Approximately 5 per cent of data was unavailable at the time of reporting
[32] Paper prepared by Dr Wayne Irava of The Centre for Health information Policy & Systems Research of the Fiji National University and presented at the SSCSIP Stakeholders Reference Group Meeting on 30 May 2012.

- The inclusion of local specialists to run training activities and lead visits is likely to promote more sustainable outcomes. Over the short period of the funding contract, there has been an increase in PIC clinicians assisting with clinical service provision and training. This was demonstrated as significant gains were made in the area of patient pre-screening and increased involvement (quantity and quality) of local clinicians in surgical procedures.

- While there are barriers in realising full regional cooperation and sharing of services and skills, these are not unsurmountable and limited cooperation can still be achieved. For the first time under PIP under this contract period, one Pacific Island country (Tonga) agreed to accept patients from another Pacific Island country (Tuvalu) for inclusion in cases to be attended to by PIP-supported specialist team. Likewise, a team of Fijian specialists delivered a training course in Kiribati. These instances of cooperation align with the recommendation of the Core Group Recommendation Report for a White Paper on Australian Aid that 'the future of the Pacific, including PNG, lies in integration.'[33]

- Objectives and indicators should be outcomes focused to ensure that over the project-life the appropriate quantitative and qualitative data is collected in order to report effectively on achievements (reflecting the Australian Government's new aid effectiveness agenda).

- Generally, the support for a program of clinical and training activities is enhanced by the engagement of volunteer services and the ensuing fostering of professional relationships. The Project's reliance on volunteer specialist resources, however, does result in a degree of variability in the quality of the reports and it has likewise been challenging at times to coordinate volunteer availability to suit country schedules. *Thus, more inputs from the local counterparts in providing feedback will greatly benefit any future program*.

- The design and objectives of a future program of support should continue to have strong focus on capacity building though this will need to be balanced with the support needed for ongoing provision of services.

- Long-standing issues require long-term commitments to invest in solutions. It is important to assure the Pacific MoHs of long term program support to induce long term planning, commitment and ownership.

- The inclusion of the priority health component was essential in providing timely responses to continually changing environments. This also supports Australia's vision to provide more responsible and less prescriptive aid that can be used wherever and at whatever pace it is needed.

- Staffs are often overworked in resource limited countries and Program activities can sometimes have negative impact on this workload. Open and honest consultation is important to communicate issues or concerns between the Program and Pacific clinicians to ensure the Program does not overburden hospital systems.

[33] AusAID Core Group Recommendation Report for a White Paper on Australian Aid, p.68.

- This funding period has enabled the Program to reflect on its M&E systems. As outlined in the 2011 Review, the Program lacks the ability to systematically track progress towards outcomes and impacts. In response to this, considerable effort has been made to develop a framework for the next phase of PIP which will clearly articulate progress towards achieving outcomes and impact.

## 11. Recommendations for further engagement

There will be a continuing need for clinical services and mentoring visits for better health outcomes and improved provision of secondary and tertiary health services in the Pacific Island countries. For long term sustainability and a more effective implementation in the region, consideration should be given to the following:

*Support for next generation of specialist leaders in the Pacific*

Through consultation meetings with RACS staff and volunteers and Pacific representatives, emphasis was placed on the importance of ensuring sufficient support is provided to future generations of surgical, anaesthetic and other specialist leaders in the Pacific. It is important that trainees are supported throughout their studies and that they know there is a job waiting for them on completion of their studies. This requires support from the Pacific MoH and various organisations including the SSCSiP, FSMed, RACS and other regional colleges and societies in the region. Supported career pathways and professional development opportunities will be important factors in influencing staff retention in the region.

*Need to improve and effectively coordinate M&E in the region*

Multiple programs operate in the Pacific and each has their own M&E system in place. It is important for organisations to share information. This would save on duplication across programs and possibly cut down onerous paperwork requirements. Information collated would also be more effective in addressing country and/or regional issues. As outlined in the monitoring and evaluation section, the PIP has utilised this contract period to hold discussions with the Pacific MoHs and representatives, SSCSiP, AusAID and other NGOs to identify existing systems in operation and the effectiveness of these systems. This has informed the plans for future PIP M&E systems and has been a highly beneficial exercise. This demonstrates the Programs understanding that it does not operate in isolation in the region and highlights the commitment of the RACS to investing in establishing appropriate systems.

*Continue working through SSCSiP to strengthen coordination in region*

As a central coordination body, the SSCSiP represents a good opportunity to address many regional issues. To ensure success, it is vital that all organisations make efforts to work with the SSCSiP as its success relies on its engagement with Pacific MoHs and NGOs alike. In saying this, it is also important for the SSCSiP to remain clear on its objectives and focus. Moving outside the defined scope of services presents a risk to overburdening the body and would threaten the efficiency with which the program can operate.

*Investing in research*

The Pacific region is unique and faces challenges which are not always present in other regions of the world. It is therefore important that the Pacific benefits from health policy agendas where appropriate. It is likewise important that the Pacific is able to recognise and set its own agenda in addressing health concerns. The development of strategic data collection and research in these areas would assist in the articulation and identification of key priorities in the region. This would support the principles of the *Cairns Compact on Strengthening Development Coordination in the Pacific* and the *Pacific Aid Effectiveness Principles*, to assist the Pacific countries build locally driven development.

## 12. Handover/Exit Arrangements

## People involved

| Name of person | Type of employee | Role | Time engaged | Contact details | Position post-activity |
|---|---|---|---|---|---|
| Prof. D. Watters | RACS | Project Director | 2001 | waters.david@gmail.com | Resigned |
| Mr K. Maoate | RACS | Project Director | 2012 | kiki@healthspecialists.co.nz | Continuing |
| A/Prof. H. Ewing | RACS | Chair, PIP EMC | 2001 | lewing@alphalink.com.au | Continuing |
| Daliah Moss | RACS | Director, External Affairs | 2001 | daliah.moss@surgeons.org | Continuing |
| Lito de Silva | RACS | Manager, Int'l. Projects | 2008 | lito.desilva@surgeons.org | Continuing |
| Kate Newall | RACS | Project Officer | 2009 | kate.newall@surgeons.org | Continuing |

**Documentation produced by activity**

| Name of Document | Type of document | Document owner | Date document produced | Location/s of document |
|---|---|---|---|---|
| Tertiary Health Services to Pacific Island Countries – AusAID Agreement No. 58814 | Grant Agreement | AusAID | 06 April 2011 | AusAID, RACS |
| AusAID Agreement No. 58814 Amendment No. 1 | Deed of Amendment | AusAID | 09 June 2011 | AusAID, RACS |

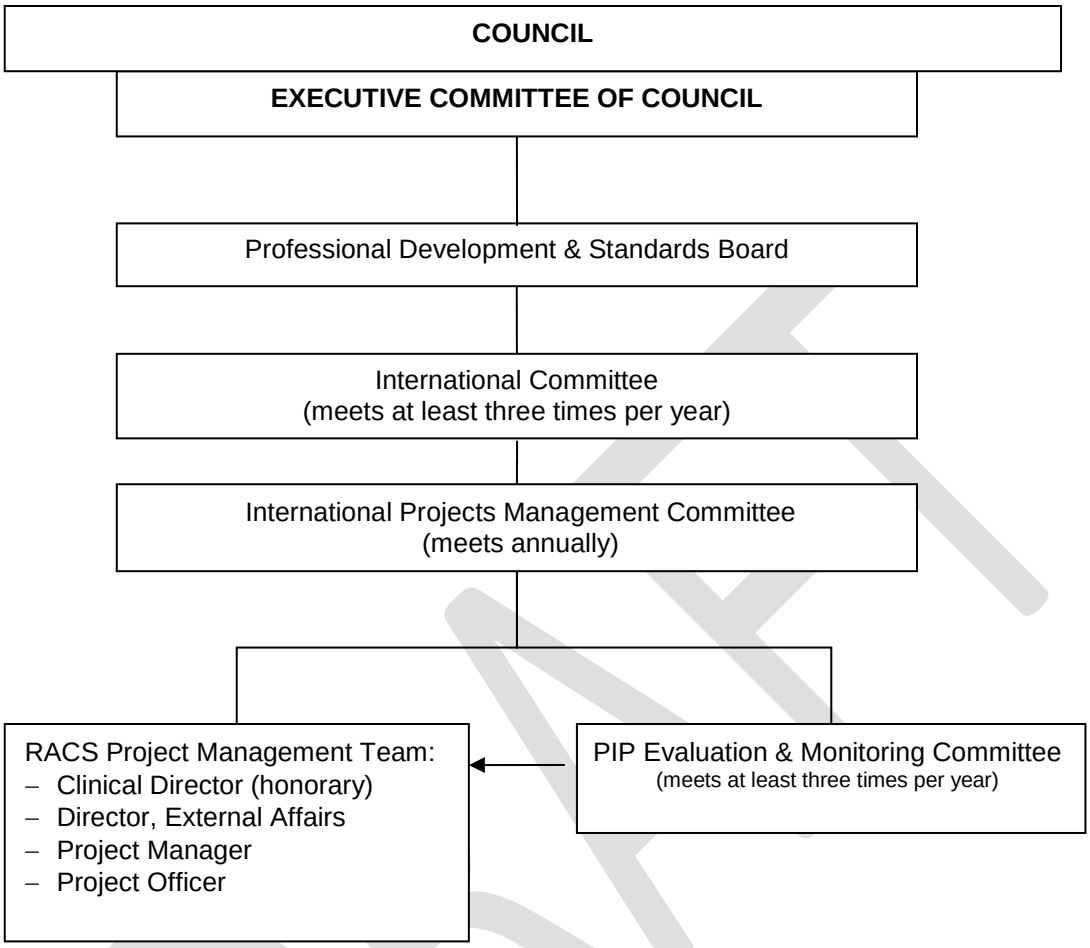
## Physical assets purchased with activity funds

In consultation with AusAID, all physical assets procured under the Program will be handed over to AusAID or its nominee at a mutually acceptable date.

## Contractual obligations/terms and status at end of activity

| Name of contract | Contract No. | Contractual obligations/terms | Status at the end of activity |
|---|---|---|---|
| Tertiary Health Services to Pacific Island Countries | 58814 | Provision of clinical services and training initiatives for the period April 2011 - June 2012 | Completed |

## Annex 1: RACS International Projects Management Structure



# Annex 2: Output Summary - PIP Clinical and Training Activities

## CLINICAL SERVICE OUTPUT SUMMARY

| CONSULTATIONS | | OPERATIONS | | SURGICAL OUTCOME | |
|---|---|---|---|---|---|
| Male | 2536 | Male | 858 | Successful | 1666 |
| Female | 2749 | Female | 739 | Morbidity | 9 |
| Gender Not Recorded | 677 | Gender Not Recorded | 79 | Mortality | 1 |
| **TOTAL** | **5962** | **TOTAL** | **1676** | | |

## TABLE A: CLINICAL OUTPUTS DATA

| No. | Country | Program | Dates | Year | Consultations | | | | Operations | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | M | F | ? | T | M | F | ? | T |
| 1 | Cook Is. | Mammography | 25 Jul - 05 Aug | 2011 | - | 365 | - | 365 | - | - | - | - |
| 2 | Cook Is. | ENT | 04 - 08 Jun | 2012 | 51 | 62 | - | 113 | 10 | 9 | - | 19 |
| 3 | Fiji | Cardiac Surgery | 12 - 27 Nov | 2011 | - | - | 73 | 73 | 15 | 34 | 3 | 52 |
| 4 | Fiji | Cardiac Surgery | 26 May - 10 Jun | 2012 | 24 | 13 | - | 37 | 24 | 13 | - | 37 |
| 5 | Fiji | Endocrinology | 13 - 17 Feb | 2012 | 23 | 31 | | 54 | - | - | - | - |
| 6 | Fiji | ENT | 06 - 13 Aug | 2011 | 40 | 39 | - | 79 | 13 | 6 | - | 19 |
| 7 | Fiji | ENT | 15 - 20 Apr | 2012 | 12 | 9 | - | 21 | 7 | 5 | - | 12 |
| 8 | Fiji | Neurosurgery | 16 - 28 Oct | 2011 | 71 | 38 | - | 109 | 13 | 4 | - | 17 |
| 9 | Fiji | Paediatric Oncology | 31 Jul - 06 Aug | 2011 | | | - | - | - | - | - | - |
| 10 | Fiji | Paediatric Surgery | 31 Jul - 06 Aug | 2011 | 21 | 8 | - | 29 | 18 | 5 | - | 23 |
| 11 | Fiji | Paediatric Surgery | 30 Mar - 06 Apr | 2012 | - | - | 54 | 54 | 2 | - | 33 | 35 |
| 12 | Fiji | Plastics & Reconstructive | 01 - 09 Oct | 2011 | 45 | 41 | 2 | 88 | 14 | 13 | 1 | 28 |
| 13 | Fiji | Radiology | 03 - 06 Apr | 2012 | - | - | 16 | 16 | - | - | - | - |
| 14 | Fiji | Urology | 31 Jul - 06 Aug | 2011 | - | - | 50 | 50 | - | - | 11 | 11 |
| 15 | Fiji | Vascular Surgery | 10 - 14 Apr | 2012 | 18 | 6 | - | 24 | 6 | 1 | - | 7 |
| 16 | Kiribati | Ophthalmology | 28 Dec - 03 Jan | 2011 | 255 | 245 | - | 500 | 74 | 61 | - | 135 |
| 17 | Kiribati | Orthopaedics | 21 Feb - 01 Mar | 2012 | 144 | 100 | | 244 | 13 | 10 | - | 23 |
| 18 | Kiribati | Plastics & Reconstructive | 17 - 30 Oct | 2011 | 53 | 59 | - | 112 | 37 | 49 | - | 86 |
| 19 | Micronesia | Ophthalmology | 16 - 26 Jan | 2012 | 198 | 271 | 57 | 526 | 33 | 51 | 28 | 112 |
| 20 | Micronesia | Orthopaedics | 21 Nov - 02 Dec | 2011 | 76 | 119 | - | 195 | 19 | 14 | - | 33 |
| 21 | Nauru | Cardiology | 10 - 18 Apr | 2011 | 51 | 60 | - | 111 | - | - | - | - |
| 22 | Nauru | Gastroenterology | 21 - 29 Aug | 2011 | 23 | 31 | - | 54 | - | - | - | - |
| 23 | Nauru | Vascular Surgery | 21 - 28 Mar | 2012 | 6 | 6 | - | 12 | 5 | 6 | - | 11 |
| 24 | Samoa | ENT | 17 - 27 Jul | 2011 | 61 | 45 | 13 | 119 | 14 | 11 | - | 25 |
| 25 | Samoa | Ophthalmology | 08 - 12 Aug | 2011 | 270 | 241 | - | 511 | 77 | 79 | - | 156 |
| 26 | Samoa | Ophthalmology | 11 - 17 Dec | 2011 | - | - | 200 | 200 | 48 | 53 | 1 | 102 |
| 27 | Samoa | Orthopaedics | 01 - 13 May | 2011 | - | - | 121 | 121 | 29 | 7 | - | 36 |
| 28 | Samoa | Orthopaedics | 13 - 23 Jun | 2012 | 70 | 24 | - | 94 | 20 | 6 | - | 26 |
| 29 | Samoa | Plastics & Reconstructive | 03 - 13 Aug | 2011 | 40 | 38 | - | 78 | 25 | 18 | - | 43 |
| 30 | Solomon Is. | ENT | 03 - 12 Oct | 2011 | 45 | 60 | - | 105 | 10 | 11 | - | 21 |
| 31 | Solomon Is. | General Surgery | 09 - 18 Apr | 2012 | 60 | 62 | - | 122 | 25 | 13 | - | 38 |
| 32 | Solomon Is. | Orthopaedics | 07 - 12 Aug | 2011 | 13 | 10 | - | 23 | 4 | 3 | - | 7 |
| 33 | Solomon Is. | Orthopaedics | 06 - 13 Nov | 2011 | 23 | 25 | - | 48 | 10 | 9 | - | 19 |
| 34 | Solomon Is. | Paediatric Surgery | 11 - 18 Nov | 2011 | 16 | 11 | 1 | 28 | 10 | 7 | - | 17 |
| 35 | Solomon Is. | Plastics & Reconstructive | 30 Jun - 14 Jul | 2011 | 47 | 24 | - | 71 | 29 | 14 | - | 43 |
| 36 | Solomon Is. | Plastics & Reconstructive | 07 - 21 Jun | 2012 | 32 | 27 | - | 59 | 21 | 23 | - | 44 |
| 37 | Solomon Is. | Radiology | 13 - 18 Nov | 2011 | 7 | 12 | 4 | 23 | - | - | - | - |
| 38 | Solomon Is. | Urology | 18 - 26 Feb | 2012 | 68 | 8 | - | 76 | 20 | 3 | - | 23 |
| 39 | Tonga | Cardiac Surgery | 16 Sept - 01 Oct | 2011 | - | - | 63 | 63 | 9 | 19 | - | 28 |
| 40 | Tonga | Ophthalmology | 23-30 June | 2012 | 22 | 26 | 1 | 49 | 15 | 20 | 2 | 37 |

| No. | Country | Program | Dates | Year | Consultations | | | | Operations | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | M | F | ? | T | M | F | ? | T |
| 41 | Tonga | Plastics & Reconstructive | 30 Oct - 05 Nov | 2011 | 49 | 53 | - | 102 | 37 | 31 | - | 68 |
| 42 | Tonga | Urology | 20 - 21 Oct | 2011 | 29 | 21 | - | 50 | 15 | 7 | - | 22 |
| 43 | Tuvalu | Cardiology | 15-24 Feb | 2012 | 45 | 58 | 4 | 107 | - | - | - | - |
| 44 | Tuvalu | Diabetes | 15 - 24 Aug | 2011 | 10 | 14 | - | 24 | - | - | - | - |
| 45 | Tuvalu | Diabetes | 28 May - 6 June | 2012 | 2 | 2 | - | 4 | - | - | - | - |
| 46 | Tuvalu | ENT | 06 - 13 Sept | 2011 | 99 | 108 | - | 207 | 4 | 2 | - | 6 |
| 47 | Tuvalu | Ophthalmology | 15 - 22 Sept | 2011 | 138 | 135 | 1 | 274 | 14 | 26 | - | 40 |
| 48 | Vanuatu | ENT | 07 - 18 Aug | 2011 | 73 | 71 | 15 | 159 | 27 | 37 | - | 64 |
| 49 | Vanuatu | ENT | 21 - 30 Jun | 2012 | 87 | 104 | - | 191 | 17 | 25 | - | 42 |
| 50 | Vanuatu | Orthopaedics | 10 - 22 Jul | 2011 | 40 | 29 | 1 | 70 | 15 | 14 | - | 29 |
| 51 | Vanuatu | Paediatric Surgery | 07 - 13 Aug | 2011 | 3 | 6 | - | 9 | 2 | 4 | - | 6 |
| 52 | Vanuatu | Plastics & Reconstructive | 15 - 29 Apr | 2012 | 23 | 10 | 1 | 34 | 17 | 10 | - | 27 |
| 53 | Vanuatu | Urology | 29 May - 08 Jun | 2011 | 28 | 4 | - | 32 | 22 | 4 | - | 26 |
| 54 | Vanuatu | Urology | 10 - 20 Jun | 2012 | 25 | 18 | - | 43 | 19 | 2 | - | 21 |
| **T O T A L** | | | | | **2,536** | **2,749** | **677** | **5,962** | **858** | **739** | **79** | **1,676** |

**TABLE B: PATIENT SUMMARY – AGE & GENDER DISAGGREGATED**

| COUNTRY | CONSULTATIONS | | | | | | | | OPERATIONS | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 - 18 Yrs | | | | ALL AGES | | | | 0 - 18 Yrs | | | | ALL AGES | | | |
| | M | F | ? | T | M | F | ? | T | M | F | ? | T | M | F | ? | T |
| COOK ISLANDS | 26 | 23 | - | **49** | 51 | 427 | - | **478** | 9 | 6 | - | **15** | 10 | 9 | - | **19** |
| FSM | 19 | 23 | - | **42** | 274 | 390 | 57 | **721** | 4 | 4 | - | **8** | 52 | 65 | 28 | **145** |
| FIJI | 99 | 87 | 132 | **318** | 254 | 185 | 195 | **634** | 40 | 41 | 35 | **116** | 112 | 81 | 48 | **241** |
| KIRIBATI | 55 | 62 | - | **117** | 452 | 404 | - | **856** | 14 | 26 | - | **40** | 124 | 120 | - | **244** |
| NAURU | 26 | 26 | - | **52** | 80 | 97 | - | **177** | - | 0 | - | **-** | 5 | 6 | - | **11** |
| SAMOA | 74 | 42 | 7 | **123** | 441 | 348 | 334 | **,123** | 23 | 20 | - | **43** | 213 | 174 | 1 | **388** |
| SOLOMON ISLANDS | 102 | 93 | 5 | **200** | 311 | 239 | 5 | **555** | 47 | 34 | - | **81** | 129 | 83 | - | **212** |
| TONGA | 19 | 18 | 32 | **69** | 100 | 100 | 64 | **264** | 15 | 22 | - | **37** | 76 | 77 | 2 | **155** |
| TUVALU | 72 | 65 | - | **137** | 294 | 317 | 5 | **616** | 3 | 1 | - | **4** | 18 | 28 | - | **46** |
| VANUATU | 116 | 110 | - | **226** | 279 | 242 | 17 | **538** | 44 | 52 | - | **96** | 119 | 96 | - | **215** |
| **TOTAL** | **563** | **503** | **176** | **1,333** | **2,211** | **1,932** | **620** | **5,962** | **186** | **196** | **35** | **440** | **796** | **665** | **51** | **1,676** |

## Implemented/Supported Capacity Building Activities
## PIP - April 2011 - 30 June 2012

## SUMMARY

| TYPE | PARTICIPANTS | | | |
|---|---|---|---|---|
| | M | F | ??? | TOTAL |
| PIP-Funded Regional & in-country Training Workshops | 231 | 334 | | 565 |
| Overseas Courses | 8 | 1 | - | 9 |
| PIP Clinical Visit Attachment (Surgical Trainees) | 6 | 2 | | 8 |
| Overseas Training Attachment | 1 | 2 | | 3 |
| CPD Activities | 28 | 2 | | 30 |
| FSMed Academic Support | 6 | 1 | 5 | 32 |
| **TOTAL** | **280** | **342** | 5 | **647** |

**NOTE: ON-THE-JOB TRAINING DATA NOT INCLUDED**

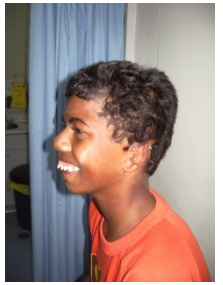
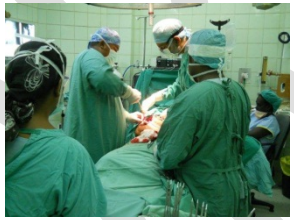
| TRAINING INITIATIVE | No. | PARTICIPANTS | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | FIJI | | SOLOMON | | VANUATU | | TUVALU | | KIRIBATI | | COOK IS. | | TONGA | | SAMOA | | FSM | | OTHERS | | TOTAL | | |
| | | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | T |
| **REGIONAL & IN-COUNTRY WORKSHOPS** | | | | | | | | | | | | | | | | | | | | | | | | |
| **EMST & CCrISP - FIJI** | | | | | | | | | | | | | | | | | | | | | | | | |
| CCrISP, 07 - 09 Aug 2011 (Suva) | 1 | 5 | 2 | 1 | | 1 | | | | | | | | 1 | | 1 | | 1 | | 1 | | **11** | **2** | **13** |
| EMST, 03 - 05 Aug 2011 (Suva) | 1 | 5 | 6 | 1 | | 1 | | | | | | | | 1 | | 1 | | 1 | | 1 | | **11** | **6** | **17** |
| Sub-Total | **2** | **10** | **8** | **2** | **-** | **2** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **2** | **-** | **2** | **-** | **2** | **-** | **2** | **-** | **22** | **8** | **30** |
| **EMSB** | | | | | | | | | | | | | | | | | | | | | | | | |
| Suva, 22 - 23 March 2012 | 1 | 14 | 2 | | | | | | | | | | | 1 | | 1 | | | | 2 | | **18** | **2** | **20** |
| Suva, 22 - 23 March 2012 (Nurse EMSB) | 1 | 2 | 22 | | | | | | | | | | | | | | | | | | | **2** | **22** | **24** |
| Sub-Total | **2** | **16** | **24** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **1** | **-** | **1** | **-** | **-** | **-** | **2** | **-** | **20** | **24** | **44** |
| **ENT Nurse Training** | | | | | | | | | | | | | | | | | | | | | | | | |
| Vanuatu, 12 - 18 Aug 2011 (Vila) | 1 | | | 1 | 1 | 1 | 6 | | | | | | | | | | | | | | | **2** | **7** | **9** |
| Vanuatu, 22 - 29 Aug 2012 (Santo) | 1 | | | 1 | 2 | 2 | 4 | | | | | | | | | | | | | | | **3** | **6** | **9** |
| Sub-Total | 2 | - | - | 2 | 3 | 3 | 10 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 5 | 13 | 18 |

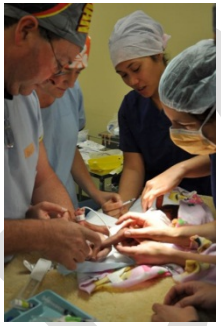
| TRAINING INITIATIVE | No. | PARTICIPANTS | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | FIJI | | SOLOMON | | VANUATU | | TUVALU | | KIRIBATI | | COOK IS. | | TONGA | | SAMOA | | FSM | | OTHERS | | TOTAL | | |
| | | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | T |
| **Essential Pain Management Course** | | | | | | | | | | | | | | | | | | | | | | | | |
| Cook Is., 14 Nov 2011 (Rarotonga) - Provider | 1 | | | | | | | | | | | 4 | 23 | | | | | | | | | **4** | **23** | **27** |
| Cook Is., 15 Nov 2011 (Rarotonga) - Instructors | 1 | | | | | | | | | | | 3 | 10 | | | | | | | | | **3** | **10** | **13** |
| Cook Is., 16 Nov 2011 (Aitutaki) - provider | 1 | | | | | | | | | | | 3 | 17 | | | | | | | | | **3** | **17** | **20** |
| Vanuatu, 13 Mar 2012 - Provider | 1 | | | | | 7 | 11 | | | | | | | | | | | | | | | **7** | **11** | **18** |
| Vanuatu, 14 Mar 2012 - Instructors | 1 | | | | | 7 | 5 | | | | | | | | | | | | | | | **7** | **5** | **12** |
| Vanuatu, 15 Mar 2012 -Provider | 1 | | | | | 5 | 16 | | | | | | | | | | | | | | | **5** | **16** | **21** |
| Vanuatu, 16 Mar 2012 - Provider | 1 | | | | | 8 | 14 | | | | | | | | | | | | | | | **8** | **14** | **22** |
| Sub-Total | **7** | **-** | **-** | **-** | **-** | **27** | **46** | **-** | **-** | **-** | **-** | **10** | **50** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **37** | **96** | **133** |
| **PRIMARY TRAUMA CARE** | | | | | | | | | | | | | | | | | | | | | | | | |
| Cook Islands, 11 - 12 July 2011 (Rarotonga) | 1 | | | | | | | | | | | 10 | 25 | | | | | | | | | **10** | **25** | **35** |
| Cook Islands, 18 July 2011 (Aitutaki) | 1 | | | | | | | | | | | 19 | 14 | | | | | | | | | **19** | **14** | **33** |
| Kiribati, 17 - 18 Nov 2011 | 1 | | | | | | | | | 11 | 13 | | | | | | | | | | | **11** | **13** | **24** |
| Kiribati, 19 Nov 2011 INSTRUCTOR | 1 | | | | | | | | | 3 | 3 | | | | | | | | | | | **3** | **3** | **6** |
| Kiribati, 20 - 21 Nov 2011 | 1 | | | | | | | | | 2 | 21 | | | | | | | | | | | **2** | **21** | **23** |
| Vanuatu, 30 Nov - 01 Dec 2011 (Santo) | 1 | | | | | 13 | 9 | | | | | | | | | | | | | | | **13** | **9** | **22** |
| Vanuatu, 02 Dec 2011 (Santo) INSTRUCTOR | 1 | | | | | 4 | 8 | | | | | | | | | | | | | | | **4** | **8** | **12** |
| Vanuatu, 03 - 05 Dec 2011 (Santo) | 1 | | | | | 11 | 11 | | | | | | | | | | | | | | | **11** | **11** | **22** |
| Cook Islands, 21 & 22 Jun 2012, Rarotonga | 1 | | | | | | | | | | | 7 | 21 | | | | | | | | | **7** | **21** | **28** |
| Cooks Islands, 25 Jun 2012, Aitutaki | 1 | | | | | | | | | | | 13 | 8 | | | | | | | | | **13** | **8** | **21** |
| Sub-Total | **10** | **-** | **-** | **-** | **-** | **28** | **28** | **-** | **-** | **16** | **37** | **49** | **68** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **93** | **133** | **226** |
| **PONSETI WORKSHOP** | | | | | | | | | | | | | | | | | | | | | | **11** | **7** | **18** |
| Solomon Is., May 2011 | 2 | | | 22 | 17 | | | | | | | | | | | | | | | | | **22** | **17** | **38** |
| Sub-Total | **2** | **-** | **-** | **22** | **17** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **33** | **27** | **60** |
| **PERIOPERATIVE NURSE WORKSHOP** | | | | | | | | | | | | | | | | | | | | | | | | |
| Solomon Isl., Mar 2012 | 1 | | | 7 | 23 | | | | | | | | | | | | | | | | | **7** | **23** | **30** |
| Sub-Total | **1** | **-** | **-** | **7** | **23** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **7** | **23** | **30** |
| **ULTRASOUNDS TRAINING WORKSHOP** | | | | | | | | | | | | | | | | | | | | | | | | |
| Solomon Isl., 23 - 27 Apr 2012 | 1 | | | 14 | 10 | | | | | | | | | | | | | | | | | **14** | **10** | **24** |
| Sub-Total | **1** | **-** | **-** | **14** | **10** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **14** | **10** | **24** |
| **REGIONAL & IN-COUNTRY WORKSHOPS TOTAL** | **27** | **26** | **32** | **47** | **53** | **60** | **84** | **-** | **-** | **16** | **37** | **59** | **118** | **3** | **-** | **3** | **-** | **2** | **-** | **4** | **-** | **231** | **334** | **565** |

| TRAINING INITIATIVE | No. | PARTICIPANTS | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | FIJI | | SOLOMON | | VANUATU | | TUVALU | | KIRIBATI | | COOK IS. | | TONGA | | SAMOA | | FSM | | OTHERS | | TOTAL | | |
| | | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | T |
| **OVERSEAS COURSES** | | | | | | | | | | | | | | | | | | | | | | | | |
| **DSTC** | | | | | | | | | | | | | | | | | | | | | | - | - | - |
| Auckland, 01 - 03 Aug 2011 | 1 | 2 | | | | | | | | | | | | 1 | | | | | | | | **3** | **-** | **3** |
| Melbourne, 14 - 15 Aug 2011 | 1 | 1 | | 1 | | | | | | | | | | | | | | | | | | **2** | **-** | **2** |
| Brisbane, 12 - 13 Mar 2012 | 1 | | | | | 1 | | | | | | | | | | | | | | | | **1** | **-** | **1** |
| Sub-Total | **3** | **3** | **-** | **1** | **-** | **1** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **1** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **6** | **-** | **6** |
| **EMSB** | | | | | | | | | | | | | | | | | | | | | | | - | - |
| PNG, 03 May 2011 | 1 | | | 1 | | | | | | | | | | | | | | | | | | **1** | **-** | **1** |
| Sub-Total | **1** | **-** | **-** | **1** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **1** | **-** | **1** |
| **EMST INSTRUCTORS COURSE** | | | | | | | | | | | | | | | | | | | | | | - | - | - |
| Melbourne, 02 - 04 Mar 2012 | 1 | 1 | 1 | | | | | | | | | | | | | | | | | | | **1** | **1** | **2** |
| Sub-Total | **1** | **1** | **1** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **1** | **1** | **2** |
| **OVERSEAS COURSES TOTAL** | **5** | **4** | **1** | **2** | **-** | **1** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **1** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **8** | **1** | **9** |
| **PIP CLINICAL VISIT ATTACHMENTS** | | | | | | | | | | | | | | | | | | | | | | | | |
| Dr R. Leona, Urology Visit, May 2011 Vanuatu | 1 | | | | | | | | | | | | | | | | | | | | | **1** | **-** | **1** |
| Dr R. Leona, Urology Visit, Jun 2012, Vanuatu | 1 | | | | | 1 | | | | | | | | | | | | | | | | - | - | - |
| Dr R. Leona, ENT Visit, Jun 2012, Vanuatu | 1 | | | | | | | | | | | | | | | | | | | | | - | - | - |
| Dr. A. Chang, ENT Visit, Aug 2011, Fiji | 1 | | 1 | | | | | | | | | | | | | | | | | | | - | **1** | **1** |
| Dr B. Leodoro,, Paediatrics Visit, Aug 2011, Vanuatu | 1 | | | | | 1 | | | | | | | | | | | | | | | | **1** | **-** | **1** |
| Dr S. Fifita, Cardiac Visit, Sept 2011, Tonga | 1 | | | | | | | | | | | | | | 1 | | | | | | | - | **1** | **1** |
| Dr L. Lagatiana, ENT Visit, Oct 2011 ,Solomon Is. | 1 | | | 1 | | | | | | | | | | | | | | | | | | **1** | **-** | **1** |
| Dr A, Biribo, Neurosurgery Visit Oct 2011, Fiji | 1 | 1 | | | | | | | | | | | | | | | | | | | | **1** | **-** | **1** |
| Dr D. Ba'erodo, Urology Visit, Feb 2012, Solomon | 1 | | | 1 | | | | | | | | | | | | | | | | | | **1** | **-** | **1** |
| Dr S. Kemuel, Plastics Visit, Apr 2012, Vanuatu | 1 | | | | | 1 | | | | | | | | | | | | | | | | **1** | **-** | **1** |
| **PIP CLINICAL VISIT ATTACHMENT TOTAL** | **10** | **1** | **1** | **2** | **-** | **3** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **1** | **-** | **-** | **-** | **-** | **-** | **-** | **6** | **2** | **8** |
| **OVERSEAS TRAINING ATTACHMENT** | | | | | | | | | | | | | | | | | | | | | | | | |
| Dr Lucilla Ah Ching-Sefo, Opthalmology Training, Hobart , 02 - 13 Apr 2012 | 1 | | | | | | | | | | | | | | | | 1 | | | | | - | **1** | **1** |
| Sua Mallei, Opthalmic Nurse Training, Hobart, Aug 2011 | 1 | | | | | | | | | | | | | | | 1 | | | | | | **1** | **-** | **1** |
| Caroline Liu, Opthalmic Nurse Training, Hobart, 02 - 13 Apr 2012 | 1 | | | | | | | | | | | | | | | | 1 | | | | | - | **1** | **1** |
| **OVERSEAS TRAINING ATTACHMENT TOTAL** | **3** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **1** | **2** | **-** | **-** | **-** | **-** | **1** | **2** | **3** |

| TRAINING INITIATIVE | No. | PARTICIPANTS | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | FIJI | | SOLOMON | | VANUATU | | TUVALU | | KIRIBATI | | COOK IS. | | TONGA | | SAMOA | | FSM | | OTHERS | | TOTAL | | |
| | | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | T |
| **CPD Activities** | | | | | | | | | | | | | | | | | | | | | | | | |
| ASC, 03 - 05 May 2011 (Adelaide) | 1 | 5 | | 1 | | 1 | | | | | | | | 1 | | | | | | | | **8** | **-** | **8** |
| ASC, 06 - 10 May 2012 (Kuala Lumpur) | 1 | | | 2 | | | | | | | | | | | | | | | | | | **2** | **-** | **2** |
| PSA Annual Refresher Course, 22 - 26 Aug 2011 | 1 | 11 | | 1 | | 1 | 1 | 1 | | 1 | | | 1 | 2 | | | | | | 1 | | **18** | **2** | **20** |
| **CPD TOTAL** | **3** | **16** | **-** | **4** | **-** | **2** | **1** | **1** | **-** | **1** | **-** | **-** | **1** | **3** | **-** | **-** | **-** | **-** | **-** | **1** | **-** | **28** | **2** | **30** |
| **ACADEMIC SUPPORT** | | | | | | | | | | | | | | | | | | | | | | | | |
| Exam Mentoring, FSMed, 09 - 14 Oct 2011 | 1 | 4 | 1 | | | 1 | | | | | | | | | | 1 | | | | | | **6** | **1** | **7** |
| External Examination, FSMed, 04 - 07 Nov 2011 | 1 | | | | | | | | | | | | | | | | | | | | | **-** | **-** | **25** |
| **ACADEMIC SUPPORT TOTAL** | **2** | **4** | **1** | **-** | **-** | **1** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **1** | **-** | **-** | **-** | **-** | **-** | **6** | **1** | **32** |
| **TOTAL PER COUNTRY (M/F)** | **50** | **51** | **35** | **55** | **53** | **67** | **85** | **1** | **-** | **17** | **37** | **59** | **119** | **7** | **1** | **5** | **2** | **2** | **-** | **5** | **-** | **280** | **342** | **647** |

## Annex 3: Evidence of Patient Outcomes

| PIP VISITDATE | COUNTRY | SPECIALTY | REPORTED PATIENT OUTCOME / IMPACT |
|---|---|---|---|
| April 2011 | Fiji | ENT |  Mateo (left with ENT surgeon, Mr Suren Krishnan and below showing ear) was born without developed ears and no hearing. After treatment by the ENT team in 2011he can now hear with bone anchored hearing aids.  |
| May 2011 | Kiribati | Orthopaedics | Five surgeries were carried out for bone and joint infection. Without these surgeries, the situations would have become chronic with further destruction of bone and joint tissue, and perhaps with the risk of developing sepsis leading to death.<br>Surgeries to optimise fracture fixation and to bone graft a non-union will improve function of the involved limbs. The surgeries and casting for congenital talipes eqinovarus have the goal of giving the children painless plantigrade feet. |
| November 2011 | Solomon Isl. | Orthopaedics |  A lady with a dislocated shoulder has had multiple painful dislocations requiring repeated closed reductions. She was very grateful for the visit.<br>Another girl with a foot drop will regain a normal walking pattern from her tibia post transfer. |
| February 2012 | Solomon Isl. | Urology | 40 male patients, presented with signs and symptoms of prostate disease of which 33 had Benign Prostatic Hyperplasia (BPH). The prostates were generally large. The next most common presentation was men with Urethral strictures, 13 patients in all. 24 patients (32% of the total) either had indwelling urinary catheters or supra-pubic catheters to relieve urinary obstruction from BPH or urethral strictures. Most of them had been living with catheters for more than six months, or even, years. Patients suffer from recurrent urinary tract infection due to poor hygiene and neglect. For most, the offensive odour from the urine bags they carry around, cause much embarrassment and loss of dignity in their community. A total of eight patients presented with stone disease. Generally, they had longer duration of illness, the longest being 10 years and frequently they present with recurrent pyelonephritis. |

| PIP VISITDATE | COUNTRY | SPECIALTY | REPORTED PATIENT OUTCOME / IMPACT |
|---|---|---|---|
| February 2012 | Solomon Isl. | Urology | Nine transurethral resection of the prostate (TURPs) were completed, two of which clinically had cancer of the prostate. Optical urethrotomy was done on seven patients with urethral stricture. A 25 year old male who had recurrence following reconstruction of posterior urethral stricture, was also operated on. Open prostatectomy was performed on a 54 year old male with enlarged prostate and bladder stone. An open right ureterolithotomy was performed to save the life of a 38 year old female who also had a non-functioning left kidney and was initially septic. Another 38 year old female had a large urethral diverticulum excised.<br>The surgery performed by the team improved quality of and/or save lives. For those who had lived with catheters, the surgery had enabled them to void (discharge urine) normally again. |
| February 2012 | Solomon Isl. | Urology | Such visits have helped to treat many chronic and acute conditions, thereby relieving the economic burden the diseases posed on the community. Furthermore, after treatment individuals will hopefully become active again in contributing positively to the country's economic growth. |
| October 2011 | Tonga | Cardiac Surgery |  Two premature babies who had large patent ductus arteriosus (PDA's) were diagnosed with the team's arrival and were failing to thrive. These were some of the smallest babies to date that an Operation Open Heart team have performed surgery on in an overseas country, being 1.3kgs and 1.5kgs at 28 days and 22 days of life. Both were born at 30 weeks gestation. At the end of the surgical visit both these babies were doing well and not requiring oxygen. The two premature infants are now gaining weight and will be discharge at the direction of the local paediatrician.  |
| June 2012 | Tonga | Ophthalmology |  One patient was diagnosed with bilateral cataract by the Pacific Eye Institute (PEI) in early June 2012. The PEI team performed surgery on her left eye. Instantly, the patient requested to have her right eye operated on, which was operated on by Dr Kearney. The following day of her second surgery the PIP team interviewed her on her progress. She explained that before the surgeries, she was 'very very depressed' and had to rely on her youngest son to assist her with all household duties. With a large smile on her face now, she exclaims that she finally has her independence back. Without the help of both medical teams, the patient's quality of life would not have Improved. |
| September 2011 | Tuvalu | ENT | These young patients all had hearing loss due to bilateral perforations or in one case from otitis media with effusion documented for more than a year. One child refused to attend school because of the hearing problems and another had been expelled from school due to his poor behaviour. It is anticipated that with better hearing they will have improved academic and social outcomes. |

| PIP VISITDATE | COUNTRY | SPECIALTY | REPORTED PATIENT OUTCOME / IMPACT |
|---|---|---|---|
| June 2011 | Vanuatu | Urology | Prostate surgery for bladder outlet obstructive symptoms is well known to have a very high impact on quality of life (QOL) indices. This is especially so in vanuatu.<br><br>Most patients present with severe lower urinary tract symptoms (LUTS) or in urinary retention with urethral catheter in situ, which have often been in place for months or even years! Although as a Surgeon I believe that all surgery is life changing, in Vanuatu prostate surgery makes significant improvements to the patients' quality of life.<br><br>In Vanuatu there is no medical therapy (pharmaceutical) or benign prostatic disease – i.e. no alpha blockade, the only treatment is surgical treatment. Rendering a patient catheter free, improving significant nocturia or poor urinary stream and lowering the impact of the sequelae of benign prostatic disease, such as urinary tract infections and chronic retention, makes a big difference. |
| June 2011 | Vanuatu | ENT | A ten year old girl had a radical mastoid cavity in the contralateral ear and a history of maggot infestation of the ears, developmental delay, mild nerve dysfunction and subsequent cholesteatoma formation with complete ossicular (middle ear) destruction. Mr Perry Burstin, team leader and surgeon on the visit, explained that the 'mastoid was rock hard and continued drilling to encounter an air cell system without the microscope resulted in canal exposure and injury at the second genu which was repaired with a nerve graft.' At the conclusion of the operation, the team was hopeful that the patient would make a full, however lengthy, recovery with the help of hearing aids and ongoing medical assistance.<br><br>Local Ni-van nurse Ms Andorin Aki assisted the team with the patient's surgery and ongoing recovery. Ms Aki has known the patient since she was six months old and was familiar with her serious condition. Ms Aki believes that the operation performed without a doubt saved the young patient's life. Ms Aki happily reported that the patient is now visiting the clinic on a weekly basis and completing regular physio exercises. With the support of her family, the patient can now close her eyes with ease, is headache free while her facial weakness is continuing to improve.<br><br>After a troubled start to her life, Ms Aki reports that the patient '…is now happily at school.' The patient's family is very appreciative of the complicated surgery performed by the team and the commitment of Ms Aki and the hospital staff post-surgery. |

## ANNEX 4: PACIFIC PERSPECTIVE - FEEDBACK AND TESTIMONIALS

| COUNTRY | SPECIALTY | COMMENT | BY |
|---|---|---|---|
| **Patient Accessibility** | | | |
| FSM | Orthopaedics | "Availability and provision of specialty orthopaedic consult and surgical services provided to treat inner lagoon and outer island patients." | Dr Julius Caesar "Jojo" Arsenal, Chief Surgeon, Chuuk State Hospital |
| FSM | Orthopaedics | "Medical personnel properly trained and skilled to do orthopaedic management came free to the Chuukese people. ☺ Thank you! Thank you for taking time to come to Chuuk, for training OR staff, and for taking time to be here rather than somewhere else…." | Rhea Migual, Anaesthetist, Chuuk State Hospital |
| Fiji | ENT | "Our poor patients do not have to pay their way to the main hospital in Suva. Especially for ENT, this is the first ENT team ever visit this side of the country. Never been a (ENT) team to Labasa." | Dr Jaoji Vulibeci, Medical Superintendent Labasa Hospital |
| Fiji | Neurosurgery | "Help the underprivileged by providing services they do not have access to…" | Alan Biribo, Neurosurgery Registrar, CWMH |
| **Improved Patient Health/Quality of Life** | | | |
| FSM | Ophthalmology | "The team screened and evaluated more than 120 people with eye problems, ranges from refractory to surgical conditions such as pterygium and cataract. …As we do not have any ophthalmologist, the services provided are very valuable." | Dr Kennedy Remit, Chief of Medical Services, Chuuk State Hospital |
| FSM | Ophthalmology | "On behalf of the staff and Department Heads, i would like to thank the RAC/PIP for the great assistances given to us for the specialist visiting teams, without which we may not able to assist them. In addition, it has a positive impact on the little funding for off-island referral for such cases which cannot be treated on island." | Dr Kennedy Remit, Chief of Medical Services, Chuuk State Hospital |
| Kiribati | Ophthalmology | "So many people who would otherwise be blind can now see." | Dr Rabebe Takeraoi, Ophthalmology Registrar, Tungaru Central Hospital |
| Samoa | Ophthalmology | "Samoa is currently without an ophthalmologist and there is a huge number of patients with poor quality of life owing to cataract, pterygiums, diabetic retinopathy etc. This PIP visit made a huge difference in the quality of life of many Samoans." | Dr Lucilla Ah Ching-Sefo, Ophthalmology Trainee, TTMH |
| Samoa | Ophthalmology | "There are many valuable things that Samoa has gained from this visit. Immediately or almost instantly, it has changed the quality of life of many of our people by removing their cataracts, pterygiums, altering the course of their diabetic retinopathy and improving their sights etc." | Dr Lucilla Ah Ching-Sefo, Ophthalmology Trainee, TTMH |
| Solomon Isl. | Urology | "With regards to the quality of life, 10 males who had been living with catheters are now able to void normally after the TURP procedures. A female was saved after open ureterolithotomy. These may be seen as part of statistics on paper, but they are real human beings who have benefitted from the visit." | Dudley Ba'erodo, Head of Surgery, National Referral Hospital |

| COUNTRY | SPECIALTY | COMMENT | BY |
|---|---|---|---|
| Vanuatu | ENT | "The most valuable thing about the PIP visit is that, to me as ENT Nurse in Santo that the team had visited, is that they have saved more of my patients' life, and help many to recover from their prolonged ENT problems, as we don't have any ENT specialist doctor in Vanuatu to do the ENT problems." | Mrs Leisale Rovette, ENT Nurse, Northern Provincial Hospital, Santo |
| Vanuatu | ENT | "The most valuable thing about the PIP visit is we local nurses are trained to become ENT practitioners diagnosing and treating ENT conditions. The training is very valuable for the betterment of our people in Vanuatu where these ENT clinics have never been established. All ENT conditions were treated in normal outpatients until the PIP visited us." | Naumu Stephens, ENT Nurse, Lenakel Hospital |
| **Professional Learning/Development** | | | |
| Fiji | ENT | "[Working with the PIP team] provided opportunity to learn from an experienced surgeon & wonderful teacher not only at CWM Hospital, but also in a new setting (Labasa Hospital)." | Annette Chang, Surgical Registrar, CWMH |
| Fiji | ENT | "[While working with the PIP team I] revised in theatre<br>i. Neck dissection<br>ii. Thyroidectomy<br>iii. Hemiglossectomy + buccinators flap<br>iv. Septorhinoplasty<br>v. Nasal polypectomy<br>vi. Tonsillectomy<br>Revision in class of neck lumps and had a brief session on robot technology in surgery." | Annette Chang, Surgical Registrar, CWMH |
| Fiji | Paediatrics | "I think the comrade or collegial support provided by one of my previous bosses to come and support or to assist me with some complex surgeries was the most valuable." | Jitoko Cama, then Paediatric Surgeon CWMH |
| Fiji | Neurosurgery | "Great opportunity to take a trainee like myself back for some hands-on experience and test the skills we have acquired abroad; strengthen existing inter-hospital and inter-agency ties." | Alan Biribo, Neurosurgery Registrar, CWMH |
| Kiribati | Orthopaedics | "Increased confidence with assessing some conditions and operating experience." | Dr Kaberi Tunet, Orthopaedic Trainee, Tungaru Central Hospital |
| Samoa | Ophthalmology | "This visit is also a blessing to our staff as we often feel helpless that we do not have the skills to help our patients, so these visits offer a service that is lacking in Samoa and greatly improves knowledge and practice of the local staff so that we are able to help our people." | Dr Lucilla Ah Ching-Sefo, Ophthalmology Trainee, TTMH |
| Tonga | Anaesthesia | "[The main benefits of working with the PIP team were that I am] more confident in inserting arterial lines and central venous lines; more confident in dealing with cardiac patients; gained more knowledge and skills on anaesthetising patients with cardiac abnormalities; attached to a Specialised Team from a different environment and seeing, learning new principles in cardiac anaesthesia." | Selesia Fifita, Anaesthetic Trainee, Vaiola Hospital |

| COUNTRY | SPECIALTY | COMMENT | BY |
|---|---|---|---|
| Samoa | Ophthalmology | "The main benefit of this attachment for me was that it put me in contact with people like Dr Nitn Verma and Dr Thomas Bonnelame who have a wealth of knowledge and experience and who are willing and able to teach trainees like myself who have no consultants to learn from. I find it easier and quicker to learn in clinical setting than to just study the textbooks alone. As Dr Bonnelame often mentions in the clinic, "if you're not trained to see it, you won't look for it". Attachments like this is very helpful and encouraging as I often feel overwhelmed by the huge task I have back home, being a young doctor training to be the only ophthalmologist; and to have this much support gives me great confidence and much hope for the future." | Lucilla Ah Ching-Sefo, Ophthalmology Trainee, TTMH |
| Solomon Isl. | ENT | "Dr.Brian Costello is a fantastic teacher and a mentor. I am privileged to work with him during this very short time. With his huge experience and knowledge in treating ENT conditions, he taught me how to perform clinical examinations and to diagnose some difficult conditions. He also taught me how to perform nasal polypectomy using co-phenylcaine spray to pack the nostrils to minimize nasal bleeding. I was taught how to performed tonsillectomy .Overall this a very beneficial and hands on training for me.<br>The skills I have acquired and learned from this visits include;<br>- performing nasal polypectomy<br>- doing an underlay technique of myringoplasty<br>- combined approached Canal wall down tympanomastoidectomy<br>- how to infiltrate the ear canal with local anaesthetic drugs during myringoplasty<br>- how to perform Tonsillectomy by using the tonsillectomy dissector. And also how to identify the tonsillar capsule." | Larry Lagatiana, ENT Trainee Registrar, National Referral Hospital |
| Solomon Isl. | Ponseti Workshop | "This is the first [Ponseti workshop] to be held here…All the participants enjoyed the course and now we see talipes with the knowledge and skill we acquire as a condition that can be managed well in our setting here. I have talipes publicity posters and pamphlets etc. (abduction splints) in our 2012 operational plans and a centre for excellence here at the National referral hospital. We are looking at a course for the nurses at the periphery next year as well, to be run by the local Ponseti panel. We are well aware that things do not take off smoothly initially here for reasons, but the condition is here and needs to be managed…." | Patrick Houasia, Orthopaedic Surgical Registrar, National Referral Hospital |
| Vanuatu | ENT | "The most valuable thing about the PIP visit is the transferring of knowledge to local participants." | Andorin Aki, ENT Nurse In Charge, Vila Central Hospital |
| Vanuatu | ENT | "I like to thank the PIP team, as ENT Nurse in Santo, cos of the enormous job they done. Especially my ENT patients in Santo. I'd like to thank Sarah (Speech Therapist) for supplying us more information and exercise on helping clients with speech difficulties, thanks for the information passing on to the disability students and their care takers." | Mrs Leisale Rovette, ENT Nurse, Northern Provincial Hospital, Santo |

| COUNTRY | SPECIALTY | COMMENT | BY |
|---|---|---|---|
| Vanuatu | ENT | "On behalf of Lolowai Hospital I would like to convey our deepest gratitude for your support to developing the clinic (ENT) in Penama Province. You have been the only team that equipped ENT in Penama holistically through equipments (we could not afford to buy) trainings and treatments of our patients. We thank you. Please convey this message to the AusAID." | Beverley Tosiro, ENT & Mental Health Nurse In Charge, Lolowai Hsopital |
| Vanuatu | Paediatrics | "[Skills revised while working with the team were] surgical skills – diathermy technique, approach to the paediatric patient, Management skills – bowel obstruction, redo CDH repairs" | Basil Leodoro, Surgical Trainee, VCH |
| Vanuatu | Paediatrics | "Exposure to Consultant experience and teaching, learning new techniques, forming networks and establishing a working relationship for ease of case referral and discussions." | Basil Leodoro, Surgical Trainee, VCH |
| **Mentoring/Network Support** | | | |
| FSM | Ophthalmology | "[The PIP visit] assisted Dr Gallen in stimulating his interest in taking up ophthalmology field as a Career!" | Dr John Hedson, Chief, Division of Medical Services/Surgeon, Pohnpei State Hospital |
| Fiji | ENT | "It was a wonderful visiting team to be attached to. Professor Krishnan does actively encouraged networking and continuation of work relationships. This was evident both at Labasa Hospital and at CWM Hospital, not only with the registrars but also at the consultant level." | Annette Chang, Surgical Registrar, CWMH |
| Fiji | Neurosurgery | "This was a good team with good group dynamics and good leadership. I will be happy if this team was retained for as long as possible." | Alan Biribo, Neurosurgery Registrar, CWMH |
| Nauru | Gastroenterology | "We are currently [communicating] if we have cases that we need expert opinion with regards to their management. We tend to contact these specialists for advice on our overseas referral and also our inpatients." | Alani Tangitau, Secretary of Health, Nauru |
| Nauru | Gastroenterology | "[I would contact] the nurse for advice on purchasing forceps or chemicals for the scopes etc. and also for education tools." | Gano Mwareow, Director of Nursing, Republic of Nauru Hospital |
| Samoa | Ophthalmology | "The PIP team members have been generous in sharing their knowledge and skills in helping our local staff help our own people when the visiting teams leave again. We very much appreciate and cherish this relationship for this reason amongst many others." | Dr Lucilla Ah Ching-Sefo, Ophthalmology Trainee, TTMH |
| Tonga | Anaesthetics | "Excellent team dynamics. Very good working relationship. Good networks established. I felt privileged to join the team and work with them." | Selesia Fifita, Anaesthtic Trainee, Vaiola Hospital |

## Annex 5: Local Surgeon Involvement in PIP Visit Surgical Procedures (April 2011 – June 2012)

| Country | Local Surgeon/ Registrar | Surgical Visit | | | Local Surgeon Direct Involvement - No. of Patients/Cases | | |
|---|---|---|---|---|---|---|---|
| | | Specialty | Dates | Total Surgical Patients/Cases | Assisting | Lead Surgeon w/ Assistance [1/] | Independent Surgeon [2/] |
| Fiji | Alan Biribo | Neurosurgery | 2011 19 - 27 Oct | 17 | 8 | 5 | 0 |
| Fiji | Sonal Nagra | Cardiac | 2012 15 - 20 April | 52 | 0 | 0 | 1 |
| Fiji | Josese Turagava | Vascular | 2012 10 - 14 April | 7 | 0 | 5 | 2 |
| Fiji | Annette Chang | ENT | 2011 06 - 13 Aug | 19 | 10 | 1 | 1 |
| Fiji | Jitoko Cama | Paediatrics | 2011 31 Jul - 06 Aug | 23 | 11 | 11 | 1 |
| Fiji | Su Hong | ENT | 2012 15 - 20 Apr | 12 | 12 | 0 | 0 |
| Solomon Isl. | George Kabwere | Orthopaedics | 2011 08 - 12 Aug | 7 | 0 | 2 | 0 |
| Solomon Isl. | Peter Nukuro | | | | 0 | 1 | 0 |
| Solomon Isl. | Alex Munamua | | | | 0 | 1 | 0 |
| Solomon Isl. | Patrick Houasia | | | | 0 | 3 | 0 |
| Solomon Isl. | Alex Munamua | Orthopaedics | 2011 06 - 13 Nov | 19 | 0 | 8 | 0 |
| Solomon Isl. | Patrick Housia | | | | 0 | 8 | 0 |
| Solomon Isl. | Larry Lagatiana | ENT | 2011 03 - 12 Oct | 21 | 8 | 12 | 1 |
| Solomon Isl. | Dudley Ba'erodo | Urology | 2012 18 - 26 Feb | 23 | 13 | 6 | 4 |
| Vanuatu | Trevor Cullwick | Paediatrics | 2011 06 - 13 Aug | 6 | 5 | 0 | 0 |
| Vanuatu | Samule Kemuel | | | | 1 | 0 | 0 |
| Vanuatu | Richard Leona | Urology | 2012 11 - 20 Jun | 21 | 11 | 1 | 1 |
| Samoa | Loudeen Lam | ENT | 2011 17 - 27 July | 25 | 15 | 2 | 8 |
| Samoa | Tala Ta'avao | Orthopaedics | 2012 13 - 23 Jun | 23 | 0 | 10 | 0 |
| Kiribati | Kabiri Tuneti | Orthopaedics | 2012 21 Feb - 01 Mar | 23 | 10 | 6 | 0 |
| Tonga | Saia Piukala | Urology | 2011 21 - 30 Oct | 22 | 15 | 6 | 0 |
| **TOTAL** | | | | **320** | **119** | **88** | **19** |

[1/] With assistance from PIP visiting specialist/surgeon
[2/] Under supervision of the PIP visiting specialist/surgeon