REPORT OF MEETING

22nd Meeting of the Pacific Public Health Surveillance Network (PPHSN) Coordinating Body (CB)

14 April 2018, Westin Resort and Spa**,** Denarau, Nadi, Fiji

With financial support from the Agence française de développement (AFD),
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Acronyms

AFD	Agence Française de Développement (French Development Agency)
ANU	Australian National University
CB	Coordinating Body
CDC	Centers for Disease Control and Prevention
DDM	Data for Decision-Making
EMT	Emergency management Team
FETP	Field Epidemioloy Training Programmes
FNU	Fiji National University
GOARN	Global Outbreak Alert and Response Network
JEE	Joint external evaluation
HOH	Head of Health
IHR	International Health Regulations
ILM	Institut Louis Malardé (Louis Malardé Institute)
IPNC	Institut Pasteur de Nouvelle-Calédonie (Pasteur Institute of New Caledonia)
MEF	Monitoring and Evaluation Framework
MOH	Ministry of Health
PPHSN	Pacific Public Health Surveillance Network
PHD	Public Health Division
PHSWG	Public Health Security Coordination Plan Working Group
PICT	Pacific Island countries and territories
PIHOA	Pacific Islands Health Officers' Association
PahSeC	Pacific Health Security Coordination
SHIP	Strengthening Health Interventions in the Pacific
SPC	The Pacific Community
STWG	Surveillance Technical Working Group
TOR	Term of Reference
WHO	World Health Organization

Executive summary

The 22nd Meeting of the Pacific Public Health Surveillance Network (PPHSN) Coordinating Body (CB) was held at Denarau, Fiji, on 14 April 2018, chaired by Dr Eric Rafai of Fiji. Important points of discussion included:

- agreement that the Pacific Island Health Officers' Association (PIHOA), will become a permanent allied member of the CB (pending the completion of the current review of PPHSN);
- the role of the Global Outbreak Alert and Response Network (GOARN), and possible opportunities for Pacific health professionals and institutions to take part in its missions and training;
- the criteria and process for selecting the first seven members of the new Surveillance Technical Working Group;
- the draft Pacific Health Security Coordination Plan (PaHSeC), which was developed to provide countries and partners with more coordinated support for implementing the International Health Regulations (IHR), and the adoption of the IHR monitoring and evaluation framework. The meeting acknowledged the need to adapt the framework to fit conditions in small island states;
- the results of the first meeting of the Project Steering Committee for the project, *Strengthening the services of the PPHSN*. Its objectives include increasing the capacity of country laboratories, with support for accreditation where appropriate;
- the outcome of an external evaluation of the delivery of the Data for Decision Making (DDM) programme in Federated States of Micronesia, which saluted the success of the programme in building surveillance skills;
- an update from Fiji National University (FNU) on the content and delivery of both the DDM programme and Strengthening Health Interventions in the Pacific (SHIP), which will now allow progression to a masters in applied epidemiology.

Introduction

1. Participants were welcomed to the meeting and Dr Eric Rafai, Fiji, was elected Chairperson of the 22nd PPHSN-CB Meeting.

2. The meeting adopted its agenda.

Overview of PPHSN-CB terms of reference (TOR)

3. The Pacific Community (SPC), as focal point for the PPHSN, presented the TOR for the Coordinating Body. The TOR include the CB's major roles and function, structure, membership and renewal of membership. The core members of PPHSN are representatives of the Ministries of Health (MOH) of the 22 PICT[1] members of SPC. Allied members include academic and training institutions and development partners. SPC provides the secretariat.

[1] Pacific Island countries and territories.

4. The PPHSN-CB has seven members and five allied members (three are permanent and two rotate). Country membership of the CB has rotated since 2007. An allied member can apply to become a permanent member of the CB if they meet the criteria set.

Comments

5. The Director of SPC's Public Health Division (PHD), Dr Paula Vivili, noted that a review of the PPHSN is taking place. He said PIHOA[2] has been a temporary rotating member of the CB and suggested it become a permanent member as a key implementing partner. This would be an interim arrangement pending the completion of the review.

6. The Chair noted the meeting's consensus that PIHOA should become a permanent allied member of the CB pending the completion of the PPHSN review.

Decisions

7. The meeting:

i. acknowledged the three outgoing members of PPHSN-CB: French Polynesia, Kiribati and Samoa (terms ending December 2017);

ii. noted that the incoming members of PPHSN-CB in 2018 are Guam, Niue and Wallis and Futuna;

iii. noted the current membership of PPHSN CB: seven core members (Northern Marianas, Fiji, Tokelau, Marshall Islands and the three outgoing members), three permanent allied members (Fiji National University, Pacific Community and World Health Organization), and two non-permanent allied members (Centers for Disease Control and Prevention (CDC) and Institut Pasteur, New Caledonia).

iv. agreed that PIHOA (the Pacific Island Health Officers' Association) will become a permanent allied member of the PPHSN-CB in the interim, pending the completion of the review of the PPHSN.

Update on Regional EpiNet Team based on the Global Outbreak Alert and Response Network concept

8. Dr Angela Merianos (WHO) said the Global Outbreak Alert and Response Network (GOARN) was established in 2000 with the aim of providing rapid, multidisciplinary, technical support for outbreak response. This support has now expanded into longer-term capacity building in countries. GOARN has 500 partners, with the Western Pacific well represented. It has credibility in terms of its ability to provide support and also training, including through using realistic scenarios for outbreak response. GOARN response requires a formal request from a WHO member state. The question of 'who pays' (e.g. for evacuation) is important, as are the logistics of responding, including safety. Technical institutions in the Pacific region can apply to become members of GOARN. (SPC and PPHSN are members.)

[2] Pacific Island Health Officers' Association.

Comments

9. Representatives asked (a) whether GOARN has already provided support for PICTs, and (b) how can appropriately qualified PICT staff participate in GOARN missions. The representative of the Centers for Disease Control and Prevention (CDC) asked if there are ways to strengthen Pacific involvement in GOARN, including for training.

10. WHO suggested representatives talk to their own Ministries of Health. Countries must agree to release staff to participate in GOARN deployments, with the full understanding that they have to cover salary and insurance requirements. WHO covers travel and per diem costs associated with deployment. GOARN/WHO are planning a regional workshop (possibly in September 2018) to 'give a taste' of GOARN. It is likely to include a desktop-based scenario exercise, and a focus on disaster risk management for health.

11. There were two GOARN missions to Fiji after Tropical Cyclone Winston in response to requests from Fiji. The first mission set up an early warning response system. Epidemiologists were mobilized over six months to provide training for sentinel sites in Fiji and capacity building. The second mission deployed an infection control team in response to an outbreak of hospital-acquired infection.

12. Tokelau asked if PPHSN could provide a coordinating mechanism for accessing GOARN support.

13. WHO said that PPHSN and SPC are both members of GOARN and thus receive its alerts. At that point, suitable CVs could be submitted to provide support, as long as ministries agreed to the release of the staff concerned.

14. PIHOA asked if outbreak management could be built into the SHIP[3] programme at masters level to provide a permanent regional response capability.

15. Fiji National University (FNU) noted that a revised curriculum for the SHIP masters programme would be presented to the meeting. It was important to strengthen in-country capacity for outbreak response and also to provide mentorship for students.

16. WHO said several larger Field Epidemiology Training Programmes (FETP) around the world are GOARN partners and have provided mentorship and supervision.

17. The Chair said Fiji was planning to register its emergency management team (EMT) under the WHO system. He asked if it was feasible to merge GOARN, EpiNet and EMT teams.

18. WHO agrees these teams should work together, possibly in modular approaches with sequenced deployment depending on requirements. The teams should know each other and train together.

[3] Strengthening Health Interventions in the Pacific programme.

19. CDC suggested PPHSN could facilitate deployment of Pacific expertise through submission of suitable CVs to GOARN, and could advocate GOARN training of Pacific students. PPHSN could play a role in facilitating access to GOARN expertise.

20. The Chair said the first step was the need to build a list of CVs. At the moment Fiji is selecting members of its EMT. The aim is to develop a quality-assured registered EMT. He noted that after a disaster, many teams (health and humanitarian) want to assist. Fiji has learned lessons about screening these offers of assistance and is establishing a process to determine which teams should come in after a disaster. These guidelines may be useful for other PICTs.

21. Dr Berlin Kafoa (SPC) said PHD has a database of clinicians/expertise. In disasters, clinicians can be deployed straight to hospitals, with country approval. Emergency medicine is a growing discipline in the region and capacity is increasing, especially for Papua New Guinea and Fiji. It would be useful to build true competency by being able to post staff for longer periods to an organisation such as GOARN rather than only for short-term responses.

22. WHO said PPHSN could coordinate collation and submission of CVs if countries agree to their staff participating in GOARN deployments, with full understanding of the salary and insurance requirements.

23. Dr Saketa said that as the focal point, SPC will work with WHO to see how PICT participants can access the GOARN framework. This may require partners' support.

Decisions

24. The meeting:

i. noted that PPHSN is a member of the Global Outbreak Alert and Response Network (GOARN) and could assist countries to access its services, which include training in addition to emergency response;

ii. agreed that SPC, as the PPHSN focal point, will be the umbrella organisation for submitting Pacific CVs when there is a request for international assistance through GOARN.

Update on PPHSN review

25. Dr Vivili (SPC) said the TOR for the PPHSN review had been shared with the CB. Some aspects of PPHSN have already been evaluated (e.g. SHIP). Another priority for assessment is LabNet.

26. In response to a suggestion from CDC that the review should consider the alignment of the PPHSN with the IHR (International Health Regulations) and other global frameworks, Dr Vivili agreed to circulate the TOR again to CB members to give them an opportunity for further comments. The review of PPHSN will be completed over the next 12 months.

Decisions

27. The meeting noted:

i. the focal point's intention to carry out the review of PPHSN within the next 12 months;

ii. agreed that the focal point will recirculate the terms of reference for the review (TOR) to CB members to give them an opportunity (two weeks) for further comments before finalising the TOR;

iii. agreed that the review will take into account PPHSN's alignment with the IHR and other global frameworks.

Surveillance Technical Working Group (STWG) – Update

28. The STWG's aim is to provide more proactive leadership of surveillance in the region, with members required to have excellent technical knowledge of surveillance systems, methodology and capacity building. The STWG will report to the CB. It will have seven members, who will come from the core group and allied members. The meeting agreed that the following nominating panel will appoint the STWG members: Dr Silivia Tavite (Tokelau); Dr Mark Durand (PIHOA); and Dr Sala Saketa (SPC).

29. STWG will meet face to face once a year, with the meeting to be convened by the PPHSN-CB.

30. Some revisions of the TOR for the STWG were also presented, including a proposal that PPHSN adopt the IHR-Monitoring and Evaluation Framework as a guide for monitoring and evaluation of national surveillance systems. It was also proposed that STWG members serve for an initial term of two years.

31. The Chair noted there were no objections to the proposed amendments and said the focal point would work on implementing the relevant procedures. He encouraged applications for membership of the STWG.

Decisions

32. The meeting:

i. agreed to the following revisions (in red) of the TOR for the STWG:

Roles and Functions

- Establishing and/or adopting existing systems (e.g. IHR-Monitoring and Evaluation Framework) to serve as a guide for monitoring and evaluation of national surveillance systems.

Membership and Structure

- Members of the STWG shall be appointed to serve for an initial term of up to two years.

(deleted: for an initial term of up to three years, renewable once, for up to an additional three years).

Ii agreed that Tokelau, PIHOA (Mark Durand) and the focal point (SPC) will comprise the selection panel for the seven members of the STWG.

Update on PPHSN website

33. SPC presented the draft design of the new PPHSN website, noting it had been agreed that a Healthy Islands website would be established, with the PPHSN website to link to it directly. The website includes space for country surveillance reports, meeting reports, sharing activities, etc. There had been some discussion of country pages, but the preference was for this information to be on the Healthy Islands website, or on PICT's own MOH websites.

Comments

34. Participants congratulated the team on the development of the website and suggested the addition of content, including IHR focal points, issues of Inform'Action (the PPHSN information bulletin), articles and success stories.

35. SPC said EpiNet details are on the website. Past issues of Inform'Action will be available in searchable digital format.

36. CDC requested that Inform'Action be revived.

37. SPC said there were limited resources for producing the Inform'Action bulletin so the request would have to come from the whole PPHSN body. There was difficulty in attracting articles from PICTs when requested; however, SPC was considering publishing SHIP/DDM (Data for Decision-Making) papers on the website.

38. The Chair supported this suggestion as a means of disseminating research findings. As part of DDM requirements, candidates could be asked to forward papers for publication. The comments function on the website will also be useful. He noted that Fiji has a Journal of Public Health and could share articles.

39. Dr Vivili said getting feedback from PICTs was a common difficulty and they needed support sometimes. He asked if partners could provide this support, in terms of both writing and editing.

40. PIHOA suggested publishing SHIP/DDM papers in a journal supplement. PIHOA already provides dedicated support for graduates to publish their papers. This has been effective.

41. FNU said the ability to write papers is part of capacity building. For sustainability, there needs to be training at country level in developing publishable content. Health professionals in operational research in the region are publishing papers. Each PICT should have its own ethics committee. If every country also has a position to support publishing, a regional network could be established.

42. Guam suggested providing a template for articles. Rather than re-publishing, the website could provide links or references to articles published in other journals.

43. The Chair asked SPC to explore the question of providing publishing support for PICT personnel.

Decisions

44. The meeting:

i. thanked the focal point for the work in developing the new website, noting its benefits for PPHSN awareness and communication, and for sharing country activities and successes;

ii. asked the focal point to explore opportunities for publishing or providing links to regional research reports, e.g. by postgraduate students, noting the need to respect ethics and copyright standards.

Update on Pacific Health Security Coordination (PaHSeC) Plan 2017–2022

45. Dr Angela Merianos (WHO) said the draft Pacific Health Security Coordination Plan was developed in response to a need identified by countries and regional partners for more coordinated support in implementing the IHR through APSED III and meeting IHR monitoring requirements.

46. PaHSeC areas of action include coordinated in-country support for IHR implementation; strengthening national responses to outbreaks and health emergencies; improving regional preparedness, alert and response; and implementing the IHR monitoring and evaluation framework.

47. The Ebola outbreak highlighted gaps in countries' implementation of the IHR. As a result, more peer review is now included in assessing IHR implementation. The assessment has four parts: an annual report; after-action review; simulation exercise; and joint external evaluation (JEE),[4] which includes collating relevant information and identifying gaps. Countries are encouraged to complete the JEE, which has considerable partner support. To date, FSM is the only PICT to have completed the JEE.

48. The Pacific Health Security Coordination Plan Working Group (PHSWG) has been formed to improve coordination between the partners and other agencies on health security and to support strengthening of core public health capacities in PICTs.

49. As the next steps, the PPHSN-CB was asked to support four recommendations relating to adoption of the IHR MEF (see decisions below).

[4] JEE (joint external evaluation) is a tool for monitoring the capacities that countries have in place in relation to the IHR framework.

Comments

50. PIHOA said the IHR MEF would need to be adapted to fit PPHSN requirements and noted that the US has already submitted its JEE, which in theory included the Pacific US territories (but in fact did not). Could PPHSN help address this situation for the US territories.

51. Tokelau said such tools tended to be too complex for small island states to implement and asked for support from WHO.

52. Wallis and Futuna said approval would be needed from the French Ministry of Health for application of the tool, even though it would be useful. He asked if there was an agreement between WHO on the issue for territories.

53. SPC said countries have support at the regional or international level for accessing capacity where they lack their own, e.g. though LabNet or the International Atomic Energy Agency (on radiation).

54. CDC said PICTs could use the tool to look at their own capacity and identify gaps. The partners could support these evaluations.

55. WHO agreed that the JEE is a complex tool. However, even though PICTs may have very low risk of some events, such as chemical exposure, the tool allowed them to identify the level of risk and their ability to respond at the appropriate scale. PPHSN may need to agree on how the JEE is applied to small island states. She emphasised that partners are prepared to provide support to countries.

56. The Chair asked the meeting to approve the proposed resolutions and noted there was consensus.

Decisions

57. The meeting agreed:

i. to adopt the International Health Regulations monitoring and evaluation framework (IHR MEF) as a monitoring mechanism to support PPHSN's goal of strengthening Pacific regional surveillance and response and preparedness in a sustainable way;

ii. to undertake high-level advocacy for all four components of the IHR MEF (State Party annual report; after-action review; simulation exercises; and joint external evaluation), noting that territories may need the agreement of relevant authorities;

iii. that all partners should support and encourage countries to undertake at least one after-action review and be involved in at least one simulation exercise annually, and to report and publish the results;

iv. that the PaHSeC working group will undertake joint planning for support of national and regional IHR implementation and monitoring.

AFD/SPC project – Strengthening the services of the PPHSN

58. SPC presented a summary of the First Meeting of the Project Steering Committee for the SPC/AFD[5] project, Strengthening the services of the PPHSN. The project has three components:

1. Enhancing the epidemiological surveillance network at regional and national levels.
2. Developing vector control skills, including adaptation to climate change effects.
3. Preparing the PPHSN strategy to address emerging risks.

The project will include capacity development in epidemiology through supporting the expansion of SHIP; a laboratory mentorship programme aimed at achieving accreditation of at least three PICT labs; and vector control training based on adaptation of the existing WHO malarial module. Materials will be translated into French to allow extension of SHIP and other training to Francophone countries. The project will facilitate updating of the PPHSN strategic plan in a consultative process.

59. AFD is contributing partial funding of Euro 3 million to the project. Other funding is being contributed by partners. The committee approved the budget for year one of the programme, and the procurement and contracting plan.

60. The CB was requested to endorse the following resolutions of the steering committee to be presented to the meeting of Heads of Health (HOH):

i. Endorse the three key components of the AFD-supported project on strengthening the services of the PPHSN and the required actions for full implementation;
ii. Note the need to communicate and collaborate with other non-health sectors such as animal health, environment and biosecurity in fully addressing emerging public health threats such as zoonotic diseases and antimicrobial resistance.

Comments

61. SPC noted that once a lab receives accreditation, this status has to be maintained. There are costs in letting accreditation lapse. HOH must recognise the need to provide sustained resources for accredited labs. Only five labs are accredited in the whole of the Pacific at present.

62. WHO said PICTs need a clear plan of intent in seeking and sustaining accreditation. PICTs can choose to seek accreditation for specific tests, which may be a solution for some.

[5] Agence Française de Développement/French Development Agency.

63. In response to FNU's request for membership of the steering committee, given its role in capacity development, SPC as focal point said the request would be discussed with FNU.

Project Steering Committee terms of reference (TOR)

64. SPC noted that the TOR for the Steering Committee will be circulated with the amendments made during the first meeting. It is hoped that the Project Steering Committee and CB can be merged into one body following the PPHSN review, given that the membership is largely the same.

65. CDC requested that it retain observer status on the Steering Committee in the event of a merger.

Decisions

66. The meeting:

i. endorsed the resolutions of the First Meeting of the AFD/SPC Project Steering Committee and agreed they could be presented to HOH;

ii. agreed that while the project will build laboratory capacity, countries should have a clear plan for their intent in seeking laboratory accreditation, stressing that HOH must recognise the need to provide continued resources to maintain such accreditation;

iii. noted that countries can request accreditation of specific tests rather than accreditation of the whole laboratory, which may better suit the needs and resources of some countries.

Resolutions and recommendations of the One Health Consultative Workshop

67. SPC presented the conclusions and decisions of the One Health Consultative Workshop.

Decision

68. The meeting endorsed the recommendations of the One Health Workshop and agreed they could be presented to HOH.

LabNet Technical Working Group report

69. SPC presented an update on relevant resolutions from the 21st CB meeting and laboratory capacity issues.

- LabNet was established in 2000 as an overarching network for the 22 PICTs. It involves Level 1, 2 and 3 laboratories in the region (the levels define capacity). PIHOA also supports a LabNet for the six US affiliated PICTs. The two LabNet collaborate well and coordinate their activities.

- SPC again stressed the need for the availability of long-term resources to maintain lab accreditation. Regardless of whether PICTs are working towards accreditation of their labs, all labs should undertake training in lab quality management systems (LQMS) to provide a benchmark for their work. It is also important that all countries have national lab policies in place for all labs (human, animal or private).

- There are opportunities for laboratories to introduce new technologies and diagnostic tests to improve the accuracy of results and turnaround times. For example, GeneXpert, which was introduced to labs for TB testing, can be used for other targets. However, PICTs need partner support to evaluate and expand their capacity in this regard.

- Shipping of samples is expensive, but there is no funding for the public health surveillance activities of labs. Instead samples are stored. Funding is needed to support the public health functions of labs and associated testing requirements.

- Reference labs provide diagnostic testing and confirmation. LabNet hopes to expand these roles to mentorship by putting in place MOUs to strengthen links and collaboration, including on issues such as biosafety, which is a current gap for PICT labs.

Comments

70. PIHOA has funding for a lab mentorship programme that involves support from labs within the region with appropriate expertise, e.g. under a cost-sharing arrangement, LBJ Tropical Medical Center in American Samoa provides training in diagnostic microbiology for the Yap lab. PIHOA asked if it was possible to set up a regional body to set appropriate accreditation standards for Pacific labs.

71. SPC said the option of regional accreditation had been discussed. All partners had stressed that accreditation must be external.

72. In response to a question on costs, SPC said the cost of maintaining accreditation is at least $10,000 per year. This does not include the costs of gaining accreditation. SPC and PIHOA provide free support to labs to undertake the steps towards accreditation. PIHOA added that accredited labs have to take part in proficiency assessments per year, which would take costs to over USD 20,000 a year.

73. Dr Vivili (SPC) said only 5 of 22 Pacific labs are accredited, which is not ideal. He suggested the Technical Working Group should give countries information on the standing of their labs and the steps they need to take to increase this standing. This would give them a realistic perspective for their decisions on accreditation.

74. The Chair noted the focal point's suggestion that mentorship can be provided by reference labs. Fiji is in the process of gaining accreditation for vaccine-preventable diseases.

75. PIHOA noted the shortage of biomedical engineers in the region. Shortage of supplies and equipment breakdown are chronic problems for Pacific labs. PIHOA suggests leasing equipment, as is now done in some North Pacific labs, with maintenance provided by the vendor.

76. The Chair said equipment maintenance is part of good lab management. This may be an aspect to consider under the AFD/SPC project.

Decisions

77. The meeting:

i. recognized the work of PIHOA in strengthening laboratories in the North Pacific;

ii. noted the specialised competencies provided by Level 2 laboratories (such as Institut Pasteur de Nouvelle Caledonie for leptospirosis and Institut Louis Malardé for arboviruses);

iii. encouraged all countries to develop national laboratory policies that apply to all laboratories – human or animal, and also private.

Data for Decision Making (DDM) – external evaluation of delivery in FSM

78. Dr Mohammed Patel (Australian National University) and Dr Mark Durand (PIHOA) evaluated the delivery of the DDM programme in FSM.

79. Dr Durand briefly described the development of the DDM programme and lessons learned in its delivery, including problems in retaining candidates. Before delivery of the programme in FSM, there were senior-level consultations, including discussions of candidate selection and sharing of costs. As part of cost sharing, the country provided in-kind support (e.g. the venue).

80. Dr Patel (via video) said the evaluation focused on training impact – What difference did it make? Did changes occur to health polices, programmes or practices as a result of the training? Was the competency of trainees improved in their normal work? Did others besides the trainees benefit?

81. The evaluation showed DDM resulted in positive changes for trainees and systems. Trainees who completed their projects made impressive changes to systems including in implementation of useful databases/health information systems and patient treatment schedules.

Lessons learned from the evaluation

- It is important that trainees are allowed protected time to complete their projects.
- The quality of the DDM faculty is very important, especially the delivery leader.
- Experience in the Pacific context, including in health information systems, is also important for the faculty.
- Candidates need an appropriate academic background to successfully complete the course. Those who did not complete the course lacked this background.
- The timing of DDM programme delivery requires considerable flexibility from FNU in relation to its enrolment requirements. FNU's efforts in this regard are acknowledged.
- Finally, in-country delivery of DDM, and the resulting benefits for surveillance, are an achievement for the PPHSN network. PPHSN should capitalise on this success and momentum, including seeking extra resources.

Decisions

82. The meeting:

i. acknowledged the findings of the DDM evaluation conducted by Dr Mohammed Patel (ANU) and Dr Mark Durand (PIHOA), including lessons learned;

ii. recognised the outstanding success of the DDM programme in developing skills and improving workplace performance.

Update from Fiji National University (FNU) on the training programmes, Data for Decision Making (DDM) and Strengthening Health Interventions in the Pacific (SHIP)

83. The FNU Director presented an update on the DDM and SHIP programmes. He described the revised requirements for the masters-level programme in applied epidemiology, and for DDM, and the expected competencies of graduates. One aim is to meet TEPHINET[6] requirements for accreditation of competency-based training in epidemiology (meaning graduates would meet the criteria for GOARN deployment). One-on-one mentorship of students is necessary to meet these requirements and FNU needs more resources for this approach.

[6] Training Programs in Epidemiology and Public Health Interventions Network.

84. An increasing challenge for FNU is that countries enrolling DDM students do not follow FNU enrolment requirements or semester timing. This means that the Director has to request 'retrospective enrolment', which creates difficulties. A possible solution is to annualize the courses. Another solution is for PHHSN-CB to make the following recommendation to HOH:

- 'PPHSN-CB recommends to HOH that a special request be made to FNU, via communication from the Ministry of Health to the Ministry of Education, that the logistical challenges of DDM delivery be recognised and for some flexibility to be granted to SPC and PIHOA in terms of enrolments, especially retrospective enrolments.'

85. PIHOA said that funding award cycles and logistical difficulties (release of candidates, trainer availability, etc.) made it almost impossible to match the timing of FNU semesters and enrolment requirements. She expressed appreciation for FNU's flexibility to date and supported the recommendation.

86. Dr Vivili (SPC) suggested going ahead with the above recommendation to HOH. He said DDM was bringing benefits to the region and was an initiative that PPHSN and FNU could be proud of.

87. After some discussion of who should present the recommendation, the Chair said the focal point would present the recommendation to HOH on behalf of PPHSN-CB.

Decisions

88. The meeting:

i. expressed appreciation for FNU's delivery of the DDM and SHIP programmes, and the efforts made to overcome the difficulties arising from differences in the timing of university semesters, partner funding cycles and student availability;

ii. agreed to recommend to HOH that a special request be made to FNU, via communication between the Ministries of Health and Education, that the logistical challenges of DDM delivery be recognised and for some flexibility to be granted to SPC and PIHOA in terms of enrolments, especially retrospective enrolments;

iii. further agreed the PPHSN-CB focal point will present the recommendation to HOH;

iv. noted with interest the proposed progression of SHIP to a diploma and masters in applied epidemiology.

Other business/Close of meeting

89. Dr Vivili (SPC) thanked the Chair for his excellent conduct of the meeting. He asked countries to provide feedback to the focal point and to raise issues they wanted PPHSN to address.

90. FNU confirmed that translation of DDM documents into French had been approved and asked that the work be done through SPC to ensure the quality of the result.

91. PIHOA said it had been with PPHSN since Day 1 and expressed appreciation for the opportunity to become a permanent allied member of the CB.

92. The Chair thanked everyone for their contribution to the discussions and declared the meeting closed.

Decision Points

Introduction

1. The meeting:

    i. introduced the members of the Pacific Public Health Surveillance Network Coordinating Body (PPHSN-CB);
    ii. nominated Fiji as Chair of the 22nd PPHSN-CB Meeting;
    iii. adopted the agenda.

Coordinating Body Membership

2. The meeting:

    i. acknowledged the three outgoing members of PPHSN-CB: French Polynesia, Kiribati and Samoa (terms ending December 2017);
    ii. noted that the incoming members of PPHSN-CB in 2018 will be Guam, Niue and Wallis and Futuna;
    iii. noted the current membership of PPHSN CB: seven core members (Commonwealth of the Northern Mariana Islands, Fiji, Tokelau, Republic of Marshall Islands and the three outgoing members), three permanent allied members (FNU, SPC and WHO), and two non-permanent allied members (CDC and Institut Pasteur, New Caledonia).

    iv. agreed that PIHOA (Pacific Island Health Officers' Association) will become a permanent allied member of the PPHSN-CB in the interim, pending the completion of the review of the PPHSN.

Update on Regional EpiNet Team

3. The meeting:

   i. noted that PPHSN is a member of the Global Outbreak Alert and Response Network (GOARN) and could assist countries to access its services, which include training in addition to emergency response;

   ii. agreed that SPC, as the PPHSN focal point, would be the umbrella for submitting Pacific CVs when there is a request for international assistance through GOARN.

Update on PPHSN Review

4. The meeting noted:

   i. the focal point's intent to carry out the review of PPHSN within the next 12 months;

   ii. agreed that the focal point will recirculate the TOR to CB members to give them an opportunity (two weeks) for further comments before finalising the TOR;

   iii. agreed that the review will take into account PPHSN's alignment with the IHR and other global frameworks.

Update on establishing Surveillance Technical Working Group

5. The meeting:

   i. agreed to the following revisions (in red) of the TOR for the STWG:

   Roles and Functions

   - Establishing and/or adopting existing systems (e.g. IHR-Monitoring and Evaluation Framework) to serve as a guide for monitoring and evaluation of national surveillance systems.

   Membership and Structure

   - Members of the STWG shall be appointed to serve for an initial term of up to two years.
   - (deleted: for an initial term of up to three years, renewable once, for up to an additional three years).

   ii. agreed that Tokelau, PIHOA (Mark Durand) and the focal point (SPC) will comprise the selection panel for the seven members of the STWG.

Update on PPHSN Website

6. The meeting:

   i. thanked the focal point for the work in developing the new website, noting its benefits for PPHSN awareness and communication, and for sharing country activities and successes;

   ii. asked the focal point to explore opportunities for publishing or providing links to regional research reports, e.g. by postgraduate students, noting the need to respect ethics and copyright standards.

Update on Pacific Health Security Coordination Plan (PaHSeC) 2017–2022

7. The meeting agreed:

   i. to adopt the International Health Regulations monitoring and evaluation framework (IHR MEF) as a monitoring mechanism to support PPHSN's goal of strengthening Pacific regional surveillance and response and preparedness in a sustainable way;

   ii. to undertake high-level advocacy for all four components of the IHR MEF (State Party annual report; after action review; simulation exercises; and joint external evaluation), noting that territories may need the agreement of relevant authorities;

   iii. that all partners should support and encourage countries to undertake at least one after action review and be involved in at least one simulation exercise annually, and to report and publish the results;

   iv. that the PaHSeC working group will undertake joint planning for support of national and regional IHR implementation and monitoring.

AFD/SPC project – Strengthening of the services of PPHSN

8. The meeting:

   i. endorsed the resolutions of the First Meeting of the AFD/SPC Project Steering Committee and agreed they could be presented to HOH;

   ii. agreed that while the project will build laboratory capacity, countries should have a clear plan for their intent in seeking laboratory accreditation, stressing that HOH must recognise the need to provide continued resources to maintain such accreditation;

   iii. noted that countries can request accreditation of specific tests rather than accreditation of the whole laboratory, which may better suit the needs and resources of some countries.

Conclusions and recommendations of the One Health Consultative Workshop

9. The meeting endorsed the recommendations of the One Health Workshop and agreed they could be presented to HOH.

LabNet TWG report

10. The meeting:

    i. recognised the work of PIHOA in strengthening laboratories in the North Pacific;

    ii. noted the specialised competencies provided by Level 2 laboratories (such as IPNC for leptospirosis and ILM for arboviruses);

    iii. encouraged all countries to develop national laboratory policies that apply to all laboratories – human or animal.

Data for Decision Making (DDM) – external evaluation for internal delivery in FSM

11. The meeting:

    i. acknowledged the findings of the evaluation conducted by Dr Mohammed Patel (ANU) and Mark Durand (PIHOA), including lessons learned;

    ii. recognised the outstanding success of the DDM programme in developing skills and improving workplace performance.

Update from Fiji National University (FNU) on the training programmes, Data for Decision Making (DDM) and Strengthening Health Interventions in the Pacific (SHIP)

12. The meeting:

    i. expressed appreciation for FNU's delivery of the DDM and SHIP programmes, and the efforts made to overcome the difficulties arising from differences in timing of semesters, partner funding cycles and student availability;

    ii. agreed to recommend to HOH that a special request be made to FNU, via communication between the Ministries of Health and Education, that the logistical challenges of DDM delivery be recognised and for some flexibility to be granted to SPC and PIHOA in terms of enrolments, especially retrospective enrolments;

    iii. further agreed the PPHSN-CB focal point will present the recommendation to HOH;

    iv. noted with interest the proposed progression of SHIP to a diploma and masters in applied epidemiology.

Annex I: Agenda

Time	Activity	Facilitator/Presenter
Saturday 14 April 2018		
8.00 - 8.10am	Registration	Béryl Fulilagi/ Elise Benyon
8.10 - 9.10am	**Introduction** • Opening prayer • Self-introduction of PPHSN-CB members • Nomination of chairperson of the 22nd PPHSN-CB Meeting • Adoption of the agenda • Introduction of rapporteur • Overview of PPHSN-CB TOR, process of nomination of members, PPHSN-CB list and communication • Discussion	Focal Point
9.10 – 10.30am	Matters Arising from 21st PPHSN-CB Meeting-Selected items • Update on Regional EpiNet Team based on GOARN concept-WHO • Update on PPHSN Review-Focal Point • Update on Surveillance TWG – Focal Point • Update on PPHSN Website- Focal Point	Chairperson
10.30 - 11.00am	Tea break and group photo	
11.00am - 12.00pm	Matters Arising from 21st PPHSN-CB Meeting-cont'd • Update on Pacific Health Security Coordination Plan 2017-2022-WHO • Discussion	Chairperson
12.00 - 1.00pm	New items • AFD/SPC project on Strengthening of the services PPHSN-Focal Point • Project Steering Committee TOR-Focal Point • Resolutions and recommendations of the One Health Consultative Workshop • Discussion	Chairperson
1.00 - 2.00pm	Lunch	
2.00 - 3.00pm	Ongoing items • LabNet TWG report-Focal Point • DDM/SHIP update –FNU • DDM/SHIP Evaluation Northern Pacific- PIHOA • Discussion	Chairperson
3.00-3.30pm	Tea break	
3.30 – 4.00pm	Other Business • Any issues to be raised by country representatives	Chairperson
END OF MEETING		

Annex II: List of participants

CORE MEMBERS REPRESENTATIVES

Fiji *Fidji*	Dr Eric Rafai Deputy Secretary of Public Health Dinem House 88 Amy Street, Toorak Suva Telephone: (679) 3215 707 Fax.: (679) 3312 381 Cell: (679) 9904145 Email: Eric.rafac@govnet.gov.fj
Guam	Ms Annette Aguon CDC Coordinator Supervisor Dept. of Public Health & Social Services/ Immunization Program #123 Chalan Kareta Mangilao, Guam 96913-6304 Telephone: (671)-735-7143/ (671) 734 1337 Facsimile: (671)-734-2104 Email: annette.aguon@dphss.guam.gov
Marshall Islands *Îles Marshall*	Dr Helentina Garstang Medical Director Public health Ministry of Health P.O. Box 16 Majuro, RMI 96960 Telephone: (692) 625-3632 Facsimile: (692) 625-3432 Email: aina.garstang@gmail.com
Niue	Not represented / non représenté
Norther Mariana Islands (Commonwealth of) *Îles Marianne du Nord (Commonwealth des)*	Not represented / Non représenté

Tokelau

Dr Siliva Tavite
Director of Health
Health Department
Nukunonu,
Telephone: (690) 24211 / 24212
Facsimile: (690)
Email: stdrtavite@gmail.com

Wallis & Futuna

Mr Patrick Lambruschini
Directeur Adjoint
de l'Agence de Santé du Territoire
des îles Wallis et Futuna
BP 4G - 98600 Mata'utu
Telephone: (681) 72 07 12
Mobile: (681) 82 42 15
Email: patrick.lambruschini@adswf.fr

PPHSN ALLIED MEMBERS REPRESENTATIVES

Centers for Disease Control

Dr Bill Galo
Senior Advisor, Pacific Islands
Office of Insular Affairs (Proposed)
Center for State, Tribal, Local, and Territorial Support (Proposed)
Centers for Disease Control and Prevention
300 Ala Moana Blvd. Room 8-125
Honolulu HI, 96850 - USA
Tel: : 808 541 3760
Mob: 404 319 9996
Email: bgallo@cdc.gov

W. Thane Hancock MD MPH
LCDR U.S. Public Health Service
Pacific Lead: CDC Zika Response
Office of Public Health Preparedness and Response
Centers for Disease Control and Prevention
Pacific Islands Health Officers Association
GCIC Building Ste 800
14 W. Soledad Ave. , Hagatna, GU 96910
Telephone: (671)-735-3339
Cell: (671)-864-1981
Email: vie1@cdc.gov

Institut Pasteur de Nouvelle-Calédonie

Dr Cyrille Goarant
Responsable URE Leptospirose
Institut Pasteur
B.P. 61

	Noumea Cedex Telephone: (687) Email : cgoarant@pasteur.nc
Fiji National University (FNU)	Dr Donald Wilson College of Medicine, Nursing & Health Sciences, FNU Tamavua Campus Kings Road, Nasinu, Suva Telephone: (679) 339 4000 Facsimile: (679) Email: donald.wilson@fnu.ac.fj Dr Ramneek Goundar, Programme Co-ordinator, Epidemiology & Biostatistics, College of Medicine, Nursing & Health Sciences, Tamavua Campus Kings Road, Nasinu, Suva Telephone: (679) 339 4000 Cell: 5679) 9252568) Email: ramneek.goundar@fnu.ac.fj
Pacific Islands Health Officer Association (PIHOA)	Ms Emi Chutaro Executive Director 737 Bishop St., Suite 2075 Honolulu, HI 96813 Hawaii, USA Tel: +1 808 537 3131 Fax: +1 808 537 6868 Email: emic@pihoa.org Dr Mark Durand Regional Coordinator for Health Information Management Systems and Quality &Performance Management 345 Queen Street, Suite 604, Honolulu HI 96813 Hawaii, USA Telephone: (1) 808 537 3131 Mobile: (1) 808 687 0285 Facsimile: (1) 808 537 6858 Email:durand@pihoa.org

Ms Vasiti Uluiviti
Regional Laboratory Coordinator
Pacific Island Health Officers Association (PIHOA)
c/o Guam Public Health Laboratory
P.O. Box 5314, UOG Station, Mangilao
GUAM 96923
Telephone: (671) 734 3338
Cell: (671) 488 8234
Email: vasitiu@pihoa.org

World Health Organization
Organisation Mondiale De La Sante

Dr Angela Merianos
Public Health Physician
Emerging Disease Surveillance & Response Unit
Division of Pacific Technical Support
World Health Organization
Level 4 Provident Plaza One, Downtown Boulevard
33 Ellery Street, Suva, Fiji
Telephone: (679) 3 323 4100
Facsimile: (679) 3 323 4177
E-mail: merianosa@wpro.who.int

SECRETARIAT & PPHSN-CB Focal Point

The Pacific Community
La Communauté du Pacifique

Dr Paula Vivili
Director
SPC Public Health Division
BP D5, 98848 Noumea Cedex
New Caledonia
Telephone: (687) 26 20 00
Facsimile: (687) 26 38 18
Email: paulav@spc.int

Dr Salanieta Saketa
Acting Deputy Director, Public Health Division
Research, Evidence and Information Programme
Focal Point PPHSN Coordinating Body
Suva Office, Fiji
Telephone: (679) 3370733
Facsimile: (679) 3370021
E-mail: salanietas@spc.int

Ms Salanieta Duituturaga
Team Leader
Laboratory Strengthening Team
Research, Evidence and Information Programme,
Public Health Division
Private Mail Bag
Suva, Fiji
Tel: +679 3370 733
Fax: +679 337 0021
E-mail: salanietad@spc.int

Mr Jojo Merilles
Epidemiologist
Research, Evidence and Information Programme
Public Health Division
B.P. D5 - 98848 Noumea CEDEX
New Caledonia
Telephone: (687) 262000
Facsimile: (687) 263818
E-mail: jojom@spc.int

Ms Christelle Lepers
Surveillance Information and Communication Officer
Research, Evidence and Information Programme
Public Health Division
B.P. D5 - 98848 Noumea CEDEX
New Caledonia
Telephone: (687) 262000
Facsimile: (687) 263818
E-mail: christellel@spc.int

Mr Vijesh Lal
PPHSN Laboratory Coordinator
Fiji Centre for Communicable Disease Control
Mataika House, Building 30, P.O. Box 16436
Tamavua, Suva, Fiji
Telephone: (679) 3320066
Facsimile: (679) 3378101
E-mail: vijeshl@spc.int

Mr Tebuka Toatu
PPHSN Laboratory Coordinator
Research, Evidence and Information Programme
Focal Point PPHSN Coordinating Body
Public Health Division
Private Mail Bag
Suva, Fiji
Telephone: (679) 3370733
Facsimile: (679) 3370021
E-mail: tebukat@spc.int

Ms Béryl Fulilagi
Programme Administrator - Finance
Research, Evidence and Information Programme
Public Health Division
B.P. D5 - 98848 Noumea CEDEX
New Caledonia
Telephone: (687) 262000 ext. 31255
Facsimile: (687) 263818
E-mail: berylf@spc.int

Mrs Elise Benyon
Programme Administrator – Data Management
Surveillance & Operational Research Team
Research, Evidence and Information Programme
Public Health Division
B.P. D5 - 98848 Noumea CEDEX
New Caledonia
Telephone: (687) 260164 (Direct) and 262000
Facsimile: (687) 263818
E-mail: eliseb@spc.int

Mrs Angela Templeton
Consultant Rapporteur
32 A Bryndwr Road
Christchurch, New Zealand
Tel.: (+64) 3 351 4104
Mobile (+64) 21 235 8411
Email: templetona@gmail.com

SPC INTERPRETATION TEAM

Mr Roy Benyon
Interpreter
Interpretation – Translation section
B.P. D5 - 98848 Noumea CEDEX
New Caledonia
Telephone: (687) 26 20 00 Ext 31 129
Facsimile: (687) 263818
Email: royb@spc.int

Ms Christelle Petite
Interpreter
Interpretation – Translation section
B.P. D5 - 98848 Noumea CEDEX
New Caledonia
Telephone: (687) 26 20 00 Ext 31 185
Facsimile: (687) 263818
Email: christellep@spc.int

Ms Valérie Hassan
Interpreter
Interpretation – Translation section
B.P. D5 - 98848 Noumea CEDEX
New Caledonia
Telephone: (687) 26 20 00 Ext 31 308
Facsimile: (687) 263818
Email: valerie@spc.int

Mr Endar Singh
IT Technician
Level 2, Lotus Building, Ratu Mara Rd, Nabua
Private Mail Bag
Suva,
Telephone: (679) 3370733
Facsimile: (679) 337 0021
Email: endars@spc.int

Mr Lovoti Nasaroa
IT Technician
Level 2, Lotus Building, Ratu Mara Rd, Nabua
Private Mail Bag, Suva,
Telephone: (679) 3370733
Facsimile: (679) 337 0021
Email: lovotin@spc.int