REPORT

MEETING OF MINISTERS OF HEALTH
FOR THE PACIFIC ISLAND COUNTRIES

Nuku'alofa, Tonga
9-13 March 2003

Manila, Philippines
July 2003
REPORT

MEETING OF MINISTERS OF HEALTH FOR THE PACIFIC ISLAND COUNTRIES

Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

Co-organized by:

SECRETARIAT OF THE PACIFIC COMMUNITY

Nuku'alofa, Tonga
9-13 March 2003
NOTE

The views expressed in this report are those of the participants, consultant, and observers in the Meeting and do not necessarily reflect the policy of the World Health Organization.

This report has been prepared by the Regional Office for the Western Pacific of the World Health Organization for governments of Member States in the Region and for the participants, consultant and observers in the Meeting of Ministers of Health for the Pacific Island Countries held in Nuku'Alofa, Tonga, from 9 to 13 March 2003.
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1. INTRODUCTION

1. Background to the Meeting of Ministers of Health for the Pacific Island Countries

This Meeting of Ministers of Health for the Pacific Island Countries in Tonga was preceded by four similar meetings (Yanuca, Fiji, 1995; Rarotonga, Cook Islands, 1997; Koror, Palau, 1999; and Madang, Papua New Guinea, 2001). During the Yanuca meeting, the concept of Healthy Islands as the unifying theme for health promotion and health protection was adopted. The Rarotonga meeting further advanced the core elements in the Healthy Islands concept. It was during the Palau meeting that the Secretariat for the Pacific Community (SPC) joined hands with WHO and the Healthy Islands concept progressed to an action plan, while the overall focus remained on Healthy Islands as the unifying theme for health promotion and protection. A number of topics related to the basic principle of Healthy Islands were discussed during these meetings.

At Madang, a commitment to action was made and ‘Healthy Islands’ gained specificity with emphasis on action.

A follow up to the Madang Commitment found that national capacity was improving and the use of the settings approach was expanding to a range of programmes including health promotion, water and sanitation, nutrition, communicable and noncommunicable disease control, etc. Cooperation among the Pacific island countries expanded considerably. Human resource development programmes, including in the areas of health leadership and management, were underway.

It was observed that these meetings covered diverse areas and good progress was reported. It is important to note that even though the Madang Commitment Towards Healthy Islands was action-oriented, it is difficult to assess progress in individual countries. However, it is clear that the ‘Healthy Islands’ concept continues to expand.

2. Tonga 2003

With the progress observed to date, it was decided that the March 2003 meeting of Health Ministers in the Pacific should have one unifying theme of ‘Healthy Lifestyles’ (which is a priority for the Pacific) while building upon the 2002 World Health Report on Risks to Health and the Healthy Island vision.

A new format was also adopted by having the meeting of Ministers and Directors of Health combined with working group sessions to develop strategic approaches and target outcomes and indicators wherever feasible.

2.1 The meeting

The opening ceremony of the Meeting of Ministers of Health for the Pacific Island Countries was held on 9 March 2003 at the Queen Salote Memorial Hall. His Majesty the King of Tonga graced the occasion.

Dr Shigeru Omi, Regional Director of WHO, in his opening remarks (see Annex 1) expressed his sincere thanks to the Government of Tonga for hosting the meeting. The presence of His Majesty the King of Tonga added regal dignity to the important gathering. Dr Omi emphasized that an
important outcome of the meeting would be an action plan to address priority public health issues for countries in the Pacific such as lifestyle and related diseases, mental health, and environmental health.

Mr Y. Corbel, Deputy Director-General of the SPC, spoke of the ‘Healthy Islands’ approach as a unifying theme for public health action in the Region and the SPC’s commitment to work together with WHO and other partners to achieve the goal of ‘Healthy Islands’ (see Annex 2).

The opening address by His Majesty the King of Tonga is attached as Annex 3.

On 10 March 2003 the conference was convened at the International Dateline Hotel. Dr Omi welcomed all the participants and the following were elected as officers of the meeting:

- **Chairperson**
  - Honourable Viliami Ta’u Tangi
  - Minister of Health, Tonga

- **Vice-Chairperson**
  - Madame Armelle Merceron
  - Ministre de la Sante’ de la Polynésie Française

- **English Rapporteur**
  - Dr Eti Enosa
  - Director-General of Health, Samoa

- **French Rapporteur**
  - Ms Myriam Abel
  - Director-General of Health, Vanuatu

The agenda of the meeting was approved (attached as Annex 4).

The list of participants is attached as Annex 5.

Please refer to Annex 6 for the schedule of the meeting. The programme for the field visits is attached as Annex 7 and the background of the recommendations of working groups 1 and 2 as Annexes 8 and 9.

### 3. HEALTHY LIFESTYLES

#### 3.1 General

**Situation analysis**

The epidemiological picture is shifting considerably in the Pacific island countries. Traditional practices are changing due to a number of factors, including foreign-influenced urbanization. Dietary practices are changing, particularly in urban settings. Physical activity is decreasing, alcohol and drug abuse are increasing, and mental health is severely affected as evidenced by the increasing rate of suicide.

Environmental degradation and tobacco use further complicate issues and increase risks to noncommunicable diseases (NCDs) and deplorable lifestyles.
The resultant epidemiological picture is alarming. Obesity is over 20% in most countries of the Pacific, and NCDs are the principal causes of mortality and morbidity as well as health expenditure. Diabetes ranks as the number one NCD in the area, outnumbering cardiovascular disease, hypertension and cancer.

Possible actions

Fortunately, it is possible to prevent further progress along this epidemiological paradigm.

Reversing this trend requires that sound policies and legislation banning unhealthy practices relating to food, drink, and tobacco use are in place. This must be coupled with sound health education and health promoting activities at different sites such as schools and markets, and securing support form the media for these policies and programmes.

Improving water and sanitation, limiting imports of unhealthy food stuffs, regulating marketing practices including advertising, labeling nutrient contents, and increasing taxes for cigarettes are efforts that are feasible.

A sound national policy must be backed by a strong political will. Governments need to realize that economic development cannot be achieved without adequate investment in health.

Principal concern

The principal concern for the Tonga meeting delegates was to develop strategies for preventing chronic diseases and stopping the deplorable downward trend in the epidemiological picture. The focus of attention was therefore on the following:

- Diet, physical activity and other risk factors
- Obesity, diabetes and other NCDs
- Tobacco and alcohol use
- Mental health
- Environmental health
- Sociocultural factors and sexual behaviour.

Preventing risks and taking action

- It should be noted that focusing on prevention means focusing on risks.
- Effective and affordable preventive measures are available which can easily be adapted to individual country situations.
- The key to risk reduction is population-wide prevention strategies, although vulnerable groups should be targeted initially.
- Reducing risks will result in promoting a healthy lifestyle, which is a goal of the meeting.
3.2 Diabetes and other NCDs

The estimated burden of NCDs in the Western Pacific Region highlights the prominence of diabetes. Diabetes and obesity are among the complex NCD and risk factors that have related causation and consequences. Despite the large burden, little timely comparable data is available on NCDs and risk factors in the Pacific. This hampers planning as well as quantification of the impact of interventions.

The WHO STEPwise approach for NCD surveillance (STEPS) was introduced as a tried and tested tool to obtain these data in a timely and standardized fashion. It has been implemented in Fiji, the Federated States of Micronesia, Marshall Islands and Samoa, which completed baseline surveys in 2002. Nine other countries or areas have started planning their baseline surveys or have expressed strong interest in doing so.

Diabetes can be considered a central component of wider NCD prevention and control. Evidence on diabetes control and prevention is now available to demonstrate that the following outcomes are possible:

1. It is possible to achieve dietary change to some extent through changes in national policy, legislation and education.

2. Education and individual counselling can lead to weight reduction that can be sustained over time.

3. Clinical preventive approaches can reduce the incidence of diabetes in people at high risk.

4. Good control of blood glucose and blood pressure in diabetes can result in significant reductions of complications and mortality.

5. A large proportion of diabetes in the Western Pacific Region is undiagnosed but can be screened with simple methods, however this burden of new cases detected will present a significant unmet demand for treatment.

Diabetes and other NCD control activities can be put in place in the Pacific island countries. It would entail a surveillance activity (ideally based on STEPS), the promotion of healthy diet and physical activity, and clinical management guidelines coupled with a high-risk intervention. The high-risk intervention would in many cases first be developed in demonstration communities before scaling up to the national level.

Evaluation should document and analyse interventions at three levels. Process evaluation records the activities that are carried out. Impact evaluation measures changes in NCD determinants. Outcome evaluation measures the incidence and prevalence of end-points (e.g. diabetes or its complications).

During the discussion, a number of points were emphasized:

- Political will is central to the whole process of NCD control. Too often, sectors outside health value other aspects of socio-economic development above health. Such political will can be expressed in various ways: through making diabetes a priority disease in national planning, and through innovative legislation such as banning mutton flap importation and tobacco control through legislation. Politicians themselves have to be role models to promote healthy behaviours.
• Comprehensive approaches and demonstration projects on NCD prevention and control were presented by representatives from a number of countries and areas. The examples described included: the National Diabetes Programme (Tonga), ‘Putting Prevention into Practice’ (American Samoa), and the ‘Pacific Islands Project on Diabetes’ (Tuvalu and others).

• Several delegations commented on the issue of political commitment, individual will, and the changing social environment of the Pacific today. This environment is changing rapidly. The individual decision is the final common pathway for health behaviour but needs to be supported by family health programmes and by supportive environments.

3.3 Diet, physical activity and health

Traditional Pacific diets have been based on root crops, fish, fruits, coconuts and vegetables for thousands of years. This healthy balanced diet was changed by foreign influence and ‘modern lifestyles’. Now there is decreased physical activity particularly among the urban dwellers. Much of the food now available is high in fat, and much of it is imported. Obesity and imported foods are both found more in urban than in rural areas. In some islands, it is more difficult for urban families to grow or buy the traditional staples (root crops) and to use traditional cooking methods, like fat-free cooking in earthen ovens. For urban families it is easier to buy food from stores, food which is easier to prepare and is in many cases less expensive than traditional foods. Consumption of imported food seems to have been added to, rather than replaced, the intake of local foods. As a result, energy intake has increased greatly.

Pacific island countries today have some of the highest prevalence rates of obesity in the world and have reached epidemic proportions. This has important implications both for health and development. Obesity is one of the main causes of NCDs, which are the main causes of mortality in the Pacific; obesity is thus also one of the main determinants of the high health expenditures for treatment of NCDs in Pacific island countries (estimated at about 50% of total health expenditure). The ‘Consultation on food safety and quality in the Pacific’ held in Nadi in November 2002 suggested that to control increasing obesity rates in the Pacific, it is necessary to achieve better control over the food supply and distribution through appropriate food policies and legislation. Efficient, aggressive promotion and marketing of the local food supply can increase the availability of local foods in the market, and induce consumers to choose them. Cultural factors that favour overeating, such as feasting, need to be addressed. For a healthier diet in the Pacific, it is necessary to reduce portion size; eat less fat overall (choosing low-fat foods and using fat-free and low-fat cooking methods), and less saturated fat in particular; reduce the intake of added sugar and salt; and eat more fish, fruit, and vegetables, giving preference to root crops and non-refined cereals over white rice and white flour.

Physical activity also needs to be increased in all aspects of daily life. One suggestion is to ensure that there is at least one hour of physical activity per day in schools (including sports, dance, martial arts, whatever is culturally appropriate and appeals to boys and girls). Environments should be created that encourage and promote physical activity, with suitable physical and car-free areas for recreation and exercise such as parks, footpaths, and bicycle lanes. Programmes should be introduced as well, such as car-free days of the week.

During the discussion, many good examples of creative interventions were provided. Issues raised included how WHO could help to ensure that public health concerns prevail when discussing food trade, to ensure the availability of healthy food for all. The importance of role models was emphasized, as was the need to work more through schools for health promotion; and the need to reduce salt intake, as well as fat and sugar, in promoting healthy diets. The WHO delegates explained that WHO is developing a global strategy on diet, physical activity and health, to help improve diets and lifestyles.
3.4 Tobacco-free initiative

While the international Framework Convention for Tobacco Control (FCTC) provides a global framework for controlling the tobacco epidemic, its success will rely on the ability of individual countries to implement the obligations laid out in the treaty. Successful tobacco control within the Western Pacific Region requires a two-pronged parallel approach: ensuring the adoption and entry into force of the FCTC on the multi-national level, while already putting in place national infrastructure and capacity to carry out evidence-based tobacco control interventions. At the sixth and last session of the Intergovernmental Negotiating Body (INB-6), Member States negotiated and agreed upon a final text for the FCTC. WHO appreciates the leadership role displayed by the Pacific islands communities in ensuring a strong and comprehensive FCTC text. The next steps in the FCTC process were highlighted, including its adoption at the World Health Assembly in May 2003, the need for ratification within each country prior to its entry into force, and protocol development. Necessary actions from ministries of health in this regard were outlined. The key areas of work under national capacity building were discussed and ongoing efforts reported. Three priorities were outlined: ensuring the FCTC's entry into force, enhancing national capacity to implement the FCTC, and harmonizing efforts across the Pacific islands community to ensure that tobacco consumption is effectively reduced and the risks from tobacco use minimized.

Cook Islands, Federated States of Micronesia, Fiji, Palau, Tonga, and Tuvalu led the other Pacific island countries in expressing their commitment to support the adoption and entry into force of the FCTC. Palau emphasized that the strong voice of the Pacific islands did not waver throughout the negotiations process because the Pacific island countries stood together in partnership for a strong FCTC. The role of partnerships in ensuring successful tobacco control, particularly in relation to cross-border issues such as trade and smuggling, was echoed by Fiji and Tuvalu. Papua New Guinea described the difficulties encountered by countries where revenues were derived in part from the production and/or manufacturing of tobacco. Samoa reported that the Government recently approved the establishment of a cigarette manufacturing company from China, and mentioned the impact of Samoa’s membership in the World Trade Organization which involves opening up its market to foreign tobacco manufacturers. The efforts of the tobacco industry to engage governments in collaborative partnerships, with the alleged purpose of conducting tobacco control campaigns, was brought up. Samoa mentioned that political will was critical when this occurred. The vital role of legislation and tax increases on tobacco products was also deliberated. Tonga was able to successfully pass a comprehensive Tobacco Act in September 2001, and recently increased its tobacco tax. Cook Islands, Papua New Guinea and Tuvalu were also working on revising or drafting tobacco control legislation, and implementation of Fiji’s Tobacco Control Act began in November 2000. In the area of surveillance, Cook Islands and Fiji had recently participated in tobacco use surveys such as the Global Youth Tobacco Survey (GYTS). Other countries requested assistance from WHO to initiate national surveys on tobacco consumption. In addition to technical assistance for surveillance, the need for support for the implementation of the various tobacco control interventions in the FCTC was requested by several countries.

In response, it was indicated that the FCTC’s entry into force was critical as the first step to strengthening countries’ ability to stem the tobacco epidemic. WHO acknowledges that tobacco control can be challenging when countries derive revenue from engaging in tobacco production, manufacturing and trade. The involvement of key decision-makers who act as champions for tobacco control can influence political decisions in these cases. The evidence indicates that the long-term costs of ignoring the tobacco epidemic out of economic concerns far outweigh the short-term benefits the tobacco industry may provide. WHO is working with the other international organizations on this complex issue. In addition, WHO is actively collaborating with Pacific island Member States to ensure that countries are prepared and able to address tobacco control and meet their obligations under the FCTC when the treaty enters into force. The SPC will be positioned to also make a significant contribution to this effort, through its new tobacco and alcohol initiative.
3.5 Mental health and healthy islands

Mental health is more than the absence of mental disorders. Mental health is fundamentally linked to an individual's personal achievement and contribution to society, to overall wellbeing of societies, and to physical health. Mental health programmes should go beyond dealing with the treatment and rehabilitation of mental disorders. There are at least three interrelated objectives of a mental health programme: prevention, treatment and rehabilitation of mental disorders; promotion of mental health; and improving the quality of health care through the use of mental health skills and knowledge in general health care. The concept of Healthy Islands clearly indicate that mental health is indispensable and contributes to various aspects of the Healthy Islands movement.

In Pacific island countries and areas suicide, alcohol and drug use, and other mental health and behavioural problems are becoming an increasing source of concern. Only a few have adequate mental health resources, while others have almost no resources in terms of manpower, health budget allocated for mental health and mental health policy, legislation and programmes. These, combined with the challenges of urbanization, changing family structures, poverty, and unemployment, create a veritable challenge for the largely weak mental health services in the Pacific.

The Regional Strategy for Mental Health, endorsed by the WHO Regional Committee meeting in 2001, has been prepared to provide general principles and guidance for countries and areas in responding to the challenges posed by mental health problems and in formulating policies and programmes on mental health. Key approaches proposed in the strategy are: advocacy, service provision, mental health promotion, policy and legislation, encouraging research and suicide prevention. Recommendations for effective suicide prevention were given: the early recognition and treatment of depression, schizophrenia and alcohol dependence; training of general practitioners and primary health care personnel; detoxification of domestic gases; and life skills education in schools.

- Mental disorders, substance abuse, and suicide are increasing concerns in the sub-region. It is noted that although the suicide rate is not high in some countries, the impact and increasing trend should not be ignored.

- The regional strategy has provided a useful framework to guide mental health programme and policy development and reform. In several countries, policies and legislation are being developed or reformed. There is experience in the sub-region with the development of community-based mental health service and suicide prevention strategies. Churches and nongovernmental organizations (NGOs) have been actively involved in mental health programmes.

- The major points of concern raised during the discussion include the lack of human resources for planning and implementing mental health programmes; the urgent need to develop or update mental health policy and legislation; the need to better understand the relationship between mental health and social change; and the need for technical assistance for the development of suicide prevention programmes.

- In response to comments and requests, a small working group for further discussion on mental health capacity building was proposed. Ongoing projects of WHO such as the mental health policy and legislation project, the suicide prevention project and related resources were introduced. Continued technical support through consultants, organization of training workshops, and delivery of resource materials were proposed.

In response to the general concern about the lack of human resources in the Pacific island countries and areas expressed during the discussion session on mental health, a small group was formed to further discuss the various needs of the Pacific island countries in this regard.
A review of mental health education at undergraduate and postgraduate levels and training for mental health workers revealed the following:

- In Fiji and Papua New Guinea, teaching of psychiatry for nursing and medical students follow similar curricula to those in other parts around the world. The curricula of psychiatric care are reviewed regularly. For example, James Cook University helps the curriculum review process for the Fiji School of Nursing.

- Papua New Guinea started a diploma course in mental health five years ago, which offers a bachelor of nursing degree in mental health.

- Postgraduate training in mental health is available in Papua New Guinea. There have been 12 graduates so far.

- There are no special psychiatric programmes for nurses in either Fiji or Tonga.

- There are short-term courses for nurses and general practitioners conducted on an irregular basis in Fiji and Papua New Guinea.

- No systematic training or curricula is available for mental health workers in any country represented at the meeting.

Who should be trained for what?

- From a long-term perspective, diploma courses for psychiatrists and psychiatric nurses should be developed. The participating schools expressed willingness to explore the possibility in this regard.

- To meet urgent needs, it is proposed to train an existing professional category in mental health, expanding their expertise through short-term courses. Candidates for training will depend on the situation in each country. For example, there is a great shortage of nurses in Palau and they would therefore not be an appropriate group to target for mental health training.

- It is suggested to train someone to work in the community and focus on specific sub-areas of mental health, e.g. substance abuse.

- The community-based rehabilitation model can provide a framework for developing a training plan. Priority areas mentioned are human resources for management of substance abuse and management of suicidal behaviour.

Summaries:

1. Needs assessments should be continued, with more detailed research in selected countries and areas.

2. Training should respond to the country's specific needs. Both format and content of training could be flexible and innovative as long as the programme fits the mental health needs of a given country.

3. Donors indicated that human resource development has been part of existing programmes in a couple of the countries. Further support will depend on the extent to which the proposed programme matches the country's needs and priorities of the donor.
4. Ideally, training would be organized to take place in the Pacific area.

5. Developing staff to provide community-based mental health services and services targeted to rural areas should be considered a priority.

3.6 Environmental health

WHO and the SPC gave a joint presentation on environmental health. It covered the targets and indicators set on water and sanitation in the United Nations Millennium Development Goals (MDGs), the emphasis placed on water resource management in the Johannesburg Plan of Implementation, and WHO’s new global Water Quality Initiative to respond to these worldwide commitments to water management. In the Pacific region, WHO convened a workshop on drinking water quality surveillance and safety in October 2001, which recommended protecting water sources from contamination; training technical staff in water quality monitoring, surveillance and control, and community mobilization; establishing a national committee and standards on water quality; and developing a regional network for further collaboration. Another major regional event was the Pacific Consultation on Water in Small Island Countries organized by the Asian Development Bank (ADB) and the South Pacific Applied Geosciences Commission (SOPAC) in Fiji in July 2002. The Pacific Regional Action Plan for Sustainable Water Management, adopted at the Consultation, recognized the health sector as an important partner in ensuring the safety of drinking water and adequacy of sanitation. The most recent data collected under the joint monitoring programme of the United Nations Children’s Fund (UNICEF) and WHO indicate that some countries in the Pacific require substantial improvement in access to water supply and sanitation, although the quality of the data collected requires verification.

The SPC plans to support the strengthening of national capacity in environmental health, working with a more comprehensive set of environmental health determinants. The proposed SPC approach is to assist the Pacific island countries and areas to develop national action plans that support establishing (or strengthening) environmental health steering committees; review perceived environmental health risks, environmental health services, and the nature and arrangement of environmental health workforce, legislative tools and guidelines; and analyses the information obtained and prioritizes the risks and actions. A document on the status of environmental health, a workforce development plan, and a database of environmental health projects are expected. The establishment of an environmental health programme will allow the SPC to respond to the requests for assistance in this complex area and satisfies the requests of the 1999 meeting of Health Ministers in Palau.

A more specific framework for action on water and sanitation involves the establishment of a multi-sectoral mechanism to coordinate action among the water authority, public works, health and environment. A national strategy is needed to achieve the MDG targets on water and sanitation and should include a realistic timetable for achievement of these targets and a review of the national database on water and sanitation. The particular role of the health sector is to ensure the safety of water and adequacy of sanitation. As such, the health sector should set standards for drinking water quality and sanitation facilities, and establish monitoring and surveillance programmes. The health sector’s role in sanitation is advocacy and awareness raising. Community-based health protection and promotion approaches would be useful. Strengthening national capacity to meet the MDG targets on water and sanitation is essential.

Issues faced by Pacific island countries and areas were presented. Safe water is not an abundant resource in most countries, particularly in atoll islands. Therefore, water sources must be protected from contamination. Strengthening capacity in water quality monitoring and surveillance, including the provision of field-test kits and training relevant officers, was observed to be relevant. The increase in water demand from the tourism industry, which affects the water use of local communities, was noted. There was strong support from Member States for the collaborative
approach taken with environmental health by the SPC and WHO with other regional partner agencies and for the proposed future work in this area as presented in Annex 10.

3.7 HIV/AIDS

The trends prevailing in the Pacific island countries with respect to HIV/AIDS is not yet alarming, the exception being only Papua New Guinea where the rise is continuing. The prevalence rate for HIV as of 2002 is under 0.1% (Cook Islands, Niue and Tokelau are still free of cases). There are many factors which explain under-reporting such as limited testing and surveillance facilities, poor accessibility of people at risk, improper diagnosis and migration overseas.

Low condom use, teenage pregnancy and migrant workers, all pose risks for the spread of sexually-transmitted infections (STIs), including HIV. However, a number of recent or soon to commence initiatives in the Western Pacific Region will significantly strengthen capacity to prevent these infections in the Pacific. For example, the WHO plan of action for 1998-2000 to strengthen STI services was an important step towards enhanced prevention. HIV/AIDS STI surveillance is being strengthened through a number of new programmes: the SPC, supported by the Australian Agency for International Development (AusAID), is soon to embark on the cooperative development of a new regional HIV/AIDS/STI strategy; the NGO sector is being strengthened through such programmes as the establishment of the Pacific Islands AIDS Foundation; and 11 Pacific island countries, with the support of the SPC, the Joint United Nations Programme on AIDS (UNAIDS) and WHO, were successful in obtaining funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) for a major new regional programme for 2003-2007, with the SPC to act as the principal programme recipient. This initiative will cover such areas as strengthening surveillance to better support future prevention, advocacy programmes, further supporting the work of NGOs, and strengthening clinical service and prevention programmes.

3.8 Three working groups were constituted during the meeting:

Group 1 Stewardship and the role of the Ministry of Health

Group 2 Enabling environments for healthy lifestyles

Group 3 Surveillance and the management of diabetes and other NCDs

3.9 Recommendations

The recommendations made by the working groups were read during the plenary of 13 March 2003 and were approved. They are the following:

Group 1 Stewardship and the role of the Ministry of Health

1. The STEPwise framework for NCD prevention and control (Annex 8) is recommended as the fundamental basis for risk reduction for the priority NCDs in the Pacific island countries and areas.

2. Governments, through the Ministries of Health:

   • should develop a national NCD plan based on this template;

   • should set up intersectoral mechanisms (including with other government ministries, NGOs, and the private sector) for informing society of these commitments and involving them in implementing the plan;
should assess the potential health impact of proposed public policies as an integral part of public decision making; and

will report on progress at the next Ministers and Directors of Health Meeting in 2005.

3. Appropriate financial resources should be re-allocated for NCD control according to the framework of the STEPwise approach to NCD prevention and control.

4. Member States should adopt a regional approach to specific elements of the response to NCDs which would cover such areas as research, laboratory testing, surveillance, evaluation, and cross-border issues.

Progress indicators:

- Number of countries that have endorsed a national NCD plan with an inter-sectoral mechanism for implementation of the NCD plan.

- Number of countries that have published a health impact assessment of at least one area of public policy.

- Number of countries that have demonstration communities with projects that address NCD risk reduction (such as provision of infrastructure for physical activity, promotion of healthy diets, tobacco use, and alcohol misuse) and published a report on the process and impact of at least one such demonstration project.

- Number of countries that have endorsed a national policy framework for health promotion.

- Number of countries that have mechanisms for sustainable national financing mechanism for promoting healthy lifestyles.

Group 2  Enabling environments for healthy lifestyles

The group focused on three desired outcomes:

1. Healthy diets

2. Increased physical activity

3. Tobacco-free lifestyles

The group decided on priority interventions which are feasible for countries to accomplish within the next two years, with the goal of reporting back on progress achieved at the next Ministerial Meeting:

- Countries should collaborate in the development and implementation of the Global Strategy on Diet, Physical Activity and Health, with particular attention paid over the next two years on the following areas:

  o Healthy diets

    - National and community-level awareness-raising and advocacy for intervention
• Assessment of the nutritional value of local foods leading to the promotion of healthy traditional food use and cooking methods

• Development/updating and implementation of existing national food and nutrition policies and legislation that encompass food security, safety, marketing practices, labelling, and nutritional standards

Progress indicators:

1. Number of countries with national and country-level advocacy programmes to promote healthy diets.

2. Number of countries which have begun initiatives for assessment of local foods.

3. Number of countries with food and nutrition policies and legislation in place.

   o Increased physical activity

   • National and community-level awareness-raising and advocacy for intervention

   • Development and implementation of evidence-based national physical activity guidelines related to NCD policies

   • Public communication using culturally appropriate messages

Progress indicators:

1. Number of countries with national and country-level advocacy programmes to promote increased physical activity.

2. Number of countries implementing physical activity guidelines.

3. Number of countries with culturally appropriate communications campaigns to promote greater physical activity.

• Countries need to achieve tobacco-free lifestyles through:

   o Mobilization of political and public support for the adoption and ratification of the FCTC.

   o Development and implementation of comprehensive policy and legislation consistent with the FCTC.

Progress indicators:

1. Number of Pacific countries who have adopted and ratified the FCTC.

2. Number of countries developing or improving national tobacco control legislation.

• Countries need to initiate discussion on mechanisms to ensure sustainable financing for healthy lifestyle programmes.

Progress indicator: Number of countries with a sustainable national financing mechanism for promoting healthy lifestyles.
Communities should be consulted and encouraged to take the lead in developing and implementing strategies for healthy lifestyles; these strategies should take into consideration cultural norms and traditional approaches.

Group 3  Surveillance and the management of diabetes and other NCDs

This group looked at the role of the Ministry of Health concerning surveillance, screening and management of chronic diseases, especially diabetes.

1. Surveillance: risk and NCDs

- Defining indicators, determining data use and methods for disseminating information, and plans for provision of feedback to end-users (including data collectors) should be the first step in preparation for surveillance. Training should be implemented to strengthen these aspects.

- Simple and efficient in-country surveillance systems (including the upgrading of information technology systems) should be strengthened.

- STEPS should be adopted as the regional standard tool for NCD surveillance with the aim to improve and simplify information collection to assess trends in risk factors and NCDs.

- Aspects of NCD surveillance should be incorporated into the Pacific Public Health Surveillance Network (PPHSN).

  **Progress indicators:**

  1. Number of countries with NCD surveillance systems integrating data collection with data use.

  2. Number of countries having undertaken STEPS surveillance activities, allowing by 2005 to set long-term population targets in risk factor reduction.

2. NCD and risk factor screening

- Screening programmes for risk factors and NCDs should only be conducted after consideration of the availability of resources for primary and secondary interventions, including proper counselling.

- Guidelines for screening should be established which specify target groups, cut-off levels, referral systems and follow-up.

- Screening programmes should address several key risk factors at the same time to improve their cost-effectiveness.
Progress indicator: Number of countries having guideline-based screening programmes for diabetes and hypertension.

3. Management of diabetes and reducing complications

- Strengthening the capacity of community health care for diabetes and other NCDs should be done through the development and implementation of protocols and standards for care and patient education and training.

- An integrated approach should be introduced to manage diabetes together with other NCDs such as cardiovascular disease and hypertension.

- Mechanisms of quality assurance, such as process and impact evaluation, should be integrated into NCD management.

- Tertiary care services should be provided according to protocols and guidelines.

- Coordination and criteria for tertiary care components such as overseas referrals, visiting specialists, and training of local specialists should be established.

Progress indicators:

1. Number of countries using comprehensive NCD management guidelines.

2. Number of countries showing a reduction in diabetes-related amputations.

4. COMMUNICABLE DISEASE AND SURVEILLANCE

While outside of the theme of ‘Healthy Lifestyles’, the issue of the surveillance of communicable diseases was also explicitly discussed at the meeting. More specifically, the meeting emphasized the continuing importance of effective communicable disease surveillance, and the crucial role played by the PPHSN and its Coordinating Body Focal Point at the SPC.

It was acknowledged that the PPHSN continues to play an essential public health role in the Region. The importance of strengthening the capacity of the PPHSN through strengthening the Coordinating Body Focal Point was recognized. The meeting strongly supported the SPC’s efforts to identify funding to achieve this strengthened capacity to assist countries in responding rapidly to significant communicable diseases outbreaks.
ANNEX 1

OPENING SPEECH BY DR SHIGERU OMI,
REGIONAL DIRECTOR, WHO REGIONAL OFFICE FOR THE WESTERN PACIFIC,
AT THE MEETING OF MINISTERS OF HEALTH
FOR THE PACIFIC ISLAND COUNTRIES

NUKU’ALOFA, KINGDOM OF TONGA
9 MARCH 2003


I would like to thank the Government of Tonga for hosting us in this beautiful country. I am delighted to be joined in this welcome by His Majesty the King of Tonga, my old friend the Honourable Minister Tangi and WHO’s co-hosts for this meeting, the Secretariat of the Pacific Community. The presence of His Majesty gives a regal dignity and importance to our gathering. We are grateful for his presence, as we are also grateful for the tireless work of Minister Tangi and his staff who have over the past year worked ceaselessly to ensure that this meeting takes place, and does so smoothly. Your work is warmly appreciated by all of us, as are your efforts to promote the health of the people of Tonga and of the Region as a whole.

This is the fifth in this series of meetings of Ministers and Directors of Health of the Pacific Island Countries. Each of these meetings has had excellent results, has led to innovations, introduced solid frameworks for action, and been followed up actively by its Members States and its partner agencies.

This time we are meeting to plan action in the areas of lifestyle and related diseases, in mental health, and in environmental health, areas of tremendous importance for public health in these islands.

We know that much progress has already been made in meeting these formidable challenges. For example, Pacific island countries are setting up surveillance systems and taking action on diabetes and related diseases. They are establishing or strengthening national nutrition policies, physical activity campaigns, and obesity prevention and control programmes. Pacific island countries have been a vital force during the development and negotiations for a strong Framework Convention on Tobacco Control.

However, we also know that formidable challenges remain. In the Pacific islands, most countries report that cardiovascular diseases are the leading cause of death. We have recorded prevalence rates for diabetes of 10% to 15% of adults and the rate exceeds 20% in some populations. Obesity and overweight are so common that they seem normal in some populations. Chronic diseases are draining the health budget and, in some instances, as much as 60% of the health budget is taken up by overseas referrals, particularly for diabetes.
Annex 1

Why are these risk factors growing so fast in the Pacific? We know that modern environments are conducive to sedentary behaviours. People in the Pacific are rapidly moving to the cities and to office-based jobs, changing their leisure habits to more inactive choices, and altering their diets so they consume more processed and high-fat foods. These changes are not taking place by accident. Yes, people do choose their diets based on personal preferences, but culture, price, and food availability are also very important determinants. People do not simply choose to leave their rural homes or their land. They leave them because they aspire to a better life in cities. In effect, sectors outside health strongly influence the physical and political environments that determine health: agriculture, trade, education, transport, labour, police, churches, urban planners, and others.

We all met to discuss these issues at the Ministerial Round Table in the Kyoto Regional Committee Meeting and then the International Conference on Health Promotion last year. At that meeting we also discussed the barriers to be overcome, and we agreed on the need to change values, to set up role models for effective communication, to support environmental change, and to strengthen preventive health services. To be frank, we already know what needs to be done.

Now is the time to act.

We need to overcome the knowledge/behaviour paradox. We need to motivate people to value health and to adopt healthy behaviour. We need to motivate policy-makers to assess the impact of their policies on health and to maximize supportive policies. We need to bring the media on board and to sustain effective communication campaigns. We need to bring all health workers together and to use both clinical and public health workers in unified efforts for prevention and control of lifestyle-related diseases.

Now I urge that this meeting takes us into a new era of the evolution of Healthy Islands. We should now agree on concrete actions to be taken. We need to identify specific milestones that will allow us to measure progress objectively.

The fundamental question that we need to address this week is whether we can really make a difference to the mental health, environmental health and lifestyle-related disease burden in the Pacific before the next meeting. Can we set ourselves an agenda of work that will allow us to meet again in two years and say: our actions have reduced risk or improved health in some measurable manner?

Let me close by first of all thanking His Royal Highness for his gracious presence and support for this meeting. I know that he has a personal commitment to improving the health of his people and I hope that our meeting this week will live up to his expectations. I would like to once again thank Minister Tangi and his team for the hard work that they have put into this meeting.

Looking around the people in this room and the commitment they have shown in tackling many other difficult health issues, I am completely confident that we will make great progress this week, just as we have done in the past.

Thank you very much.
OPENING ADDRESS BY MR YVES CORBEL,
DEPUTY DIRECTOR-GENERAL,
SECRETARIAT OF THE PACIFIC COMMUNITY,
ON BEHALF OF MS LOURDES PANGELINAN,
DIRECTOR GENERAL,
AT THE WHO/SPC MEETING OF HEALTH MINISTERS

NUKU’ALOFA, KINGDOM OF TONGA
9 MARCH 2003

- Your Majesty, King Taaofa’aa Tupou the IVth
- Her Royal Highness Princess Salote Mafile’o Pilolevu and the Captain Honourable Ma’ulupekotofoa Tuita and members of the Royal Family
- The Prime Minister, His Royal Highness Prince ‘Ulukalala Lavaka Ata and Princess Nanasi Pau’u Tuku’aho
- Dr Shigeru Omi, the Regional Director of the World Health Organization for the Western Pacific
- Members of the diplomatic corps
- Honourable Ministers of Health from around the Pacific island countries
- Honourable Ministers of the Crown
- Nobles of the Realm
- Speaker of the Legislative Assembly, Honourable Tu’ivakano and Robyn and the Honourable Members of Parliament
- Honorary consuls and diplomatic staff
- Denominational leaders
- Directors of Health from the Region
- Members of the observing representatives and secretariats
- Distinguished guests
- Ladies and Gentlemen

On behalf of the Director-General of the SPC, Lourdes Pangelinan, I take great pleasure in joining with my colleague Dr Omi in welcoming you to this meeting of Pacific Island Health Ministers, jointly organized by WHO and the SPC, and hosted by the Kingdom of Tonga.

Since the meeting of Health Ministers in Fiji Islands in 1995, the concept of ‘Healthy Islands’ has been established as a unifying theme for public health action in the Region. The meeting held two years ago in Papua New Guinea reaffirmed, through the ‘Madang Commitment Towards Healthy Islands’, that Pacific countries and areas intended to further institutionalize and sustain this approach across the continuum of public health practice.

The SPC has been, and continues to be, committed to working with Pacific island countries and areas, WHO and other partners to achieve the goal of ‘healthy islands’.

Not only has the SPC clearly established ‘Healthy Islands’, along with the suitably adapted United Nations Millennium Development Goals, as pillars of the new SPC Corporate Plan, but we have also undertaken a wide variety of work and built new capacities as part of our commitment since the Madang meeting.

An example of which we have been very proud has been the Pacific Health Leadership and Management Development Programme.

This Programme, identified as a priority by the Madang meeting, with the support of the New Zealand Agency for International Development (NZAID), WHO, and the members of the Project Coordinating Committee, was able to establish a curriculum for training of mid-level managers in the health sector.
Annex 2

Importantly, we have put in place an innovative model of delivery that is now being run by the consortium of the National University of Samoa and the University of Guam. I look forward to this programme being a very useful resource for years to come.

The SPC has also played a central role in the surveillance of communicable diseases, as the Coordinating Body Focal Point for the Pacific Public Health Surveillance Network, or PPHSN.

Through our role in the PPHSN, we have worked actively with countries and with partners such as WHO to establish and maintain systems to support disease surveillance and response, through focussing on key aspects, such as the sharing of information and the strengthening of laboratory and outbreak response capacity.

We see this as being a key component of our ongoing commitment to ‘Healthy Islands’, but as you will hear during the course of the meeting, the SPC is facing some significant challenges in terms of the future availability of resources to support this work.

Within the context of the new Public Health Programme Strategic Plan, the SPC has already commenced or will soon commence an even wider range of initiatives to contribute to the achievement of ‘Healthy Islands’. For example, as an organization we have recently decided to address the challenges of HIV/AIDS as a major strategic priority.

HIV/AIDS is not only a key issue for ‘Healthy Islands’, the threat it poses to health and development globally is emphasized through its explicit inclusion in the Millennium Development Goals.

Leaders directed the (Forum) Secretariat to encourage, through other regional and international organizations and stakeholders, the development of a Pacific Regional Plan of Action against HIV/AIDS, including an effective resourcing mechanism.

Responding to these requests, the SPC has endeavoured to play a central role in the protection of the Region against the pandemic.

We were recently delighted to hear that the regional submission to the second round of the Global Fund to Fight AIDS, Tuberculosis and Malaria, for which the SPC had provided logistic assistance, along with WHO, had been successful. The SPC is to play a key role in the implementation of this project as the Principal Recipient of funding.

Key initiatives and activities that the SPC plans to commence in the coming months include:

- working with countries and regional partners to develop a new regional HIV/AIDS/STI strategy;
- strengthening regional HIV/AIDS/STI surveillance;
- supporting the development and implementation of national HIV/AIDS/STI policies and programmes
- supporting prevention in priority groups;
- improving coordination in the Region; and
- supporting the nongovernmental sector.

I am particularly happy about the technical and financial support that the SPC has been able to provide to the Pacific Islands AIDS Foundation, a recently born nongovernmental organization, to help it through its inception phase.
A key initiative to enable this work to be undertaken is the establishment of a new HIV/AIDS/STI Adviser position, using SPC core funding. This position will be filled shortly.

Finally, some of the work referred to above will be supported by the Australian Agency for International Development (AusAID) and the French Government through their new regional initiatives which are soon to be finalized, with the SPC being responsible for the implementation of one of the two major components of the AusAID initiative.

Another area that is fundamental to ‘Healthy Islands’ and in which the SPC has recently begun to work is environmental health.

Our new Environmental Health Adviser has already had discussions with public health staff from a number of countries to gain their views on how best the SPC can make a contribution in this area, and these discussions will continue, prior to the development of concrete proposals to discuss with our donor partners, including France which has agreed to provide seed funding for this position.

The SPC continues to work very actively in the area of the prevention of noncommunicable diseases through our Lifestyle Health and Pacific Action for Health initiatives.

Two important initiatives soon to commence are a new project on NCD prevention in schools, supported by NZAID, that you will hear more about during in the meeting, and the appointment of a Health Promotion Adviser on Tobacco and Alcohol at the SPC. This new position, created with the assistance of AusAID, will substantially increase our capacity to assist countries to address these major NCD risk factors, and to work with WHO to help countries implement the commitments of the Framework Convention on Tobacco Control.

We will also continue to work in active partnership with WHO to assist countries in their tuberculosis control efforts, and in particular their implementation of DOTS strategies.

In conclusion, the concept of ‘Healthy Islands’ has certainly been a fundamental guide to the work of the SPC over recent years, and I am excited about the range of upcoming new initiatives that, with the help of our donor partners and the dynamic leadership of our new director of the Public Health Programme, Dr Mark Jacobs, will substantially strengthen our contribution to the achievement of ‘Healthy Islands’ into the future.

These Ministers and Directors of Health meetings, jointly organized biannually by WHO and the SPC, provide a unique opportunity for the 22 countries and areas of the Pacific to debate public health issues and guide the work of our regional organization.

We believe that the agenda that has been submitted to you reflects the most challenging public health issues faced by the Pacific island countries, and the Regional Director of WHO reminded us of these challenges during his opening speech.

I hope that open and fruitful discussions will take place during this meeting and that its outcomes will reflect your aspirations and your priorities.

Finally, I wish to express to his Majesty the King of Tonga, my sincere gratitude for honouring this ceremony by his presence, and thus demonstrating once again his commitment toward the Healthy Island concept.

My gratitude goes also to the Minister of Health the Honourable Viliami Ta’u Tangi, and to his staff, for hosting this meeting, and for all the work that they have already undertaken.

Malo ‘aupito, thank you, merci.
OPENING SPEECH BY HIS EXCELLENCY TAUFA'AHAU TUPOU IV,
THE KING OF TONGA, AT THE MEETING OF MINISTERS OF HEALTH
FOR THE PACIFIC ISLAND COUNTRIES

NUKU'ALOFA, KINGDOM OF TONGA
9 MARCH 2003

HONOURABLE MINISTERS OF HEALTH, MEMBERS OF THE DIPLOMATIC CORPS,
HONOURABLE PRIME MINISTER OF TONGA, MEMBERS OF THE CABINET OF TONGA,
DISTINGUISHED VISITORS, LADIES AND GENTLEMEN.

I have very much pleasure in declaring this meeting open on behalf of Tonga and all the hosts
in Tonga, we welcome you all to this meeting sponsored by the World Health Organization and I hope
that your short stay in Tonga will be fruitful and pleasant for you all. We regard this a great privilege
to be the host of the meeting this year and I hope that your meeting will be successful and will
promote good health for the people of the Pacific Region.

Thank you very much.
PROVISIONAL AGENDA

1. Opening ceremony

2. Election of Chairman and Rapporteur

3. Adoption of the agenda

4. Progress in implementation of the Madang Commitment Towards Healthy Islands

5. Diabetes and other noncommunicable diseases

6. Diet, physical activity and health

7. Tobacco-Free Initiative

8. Mental health
Annex 4

9. Environmental health

WPR/ICP/ECP/7.2/001/DPM(1)/2003/6

10. Presentation of reports of working groups

11. Update on HIV/AIDS in the Pacific

WPR/ICP/ECP/7.2/001/DPM(1)/2003/8

12. Closure
INFORMATION BULLETIN NO. 2

PROVISIONAL LIST OF PARTICIPANTS, CONSULTANT, OBSERVERS AND REPRESENTATIVES OF INTERGOVERNMENTAL ORGANIZATIONS, NONGOVERNMENTAL ORGANIZATIONS AND PARTNER AGENCIES AND SECRETARIAT

1. PARTICIPANTS

AMERICAN SAMOA
Dr Joseph Tufa, Director of Health, Department of Health
Pago pago, Tutuila, Fax: (684) 633 5379,
Tel: (684) 633 4606, E-mail: jtufa@rocketmail.com

COOK ISLANDS
Honourable Vaevae Pare, Minister of Health
Ministry of Health, P.O. Box 109, Rarotonga
Fax: (682) 20261, Tel: (682) 20262
E-mail: peri@matavera.gov.ck

Mr Vaine Teokotai, Acting Secretary of Health
Ministry of Health, P.O. Box 109, Rarotonga
Fax: (828) 23 109, Tel: (682) 29 664, E-mail: sohl@health.gov.ck

FIJI
Honourable Solomoni Naivalu, Minister of Health
Ministry of Health, Dinem House, 33 Amy St., Toorak
Box 2223, Govt. Buildings, Suva, Fax: (679) 3306163
Tel: (679) 3306177, E-mail: info@health.gov.fj

Dr Lepani Waqatakirewa, Director of Public Health
Ministry of Health, Dinem House, 33 Amy St., Toorak
Box 2223, Govt. Buildings, Suva, Fax: (679) 3306163
Tel: (679) 3306177, E-mail: info@health.gov.fj
Annex 5

FRENCH POLYNESIA

Madame Armelle Merceron, Ministre de la Santé de la Polynésie, B.P. 2551, Papeete – Tahiti,
Fax: (689) 43 39 42, Tel: (689) 46 00 99,
E-mail: dircab.msa@sante.gov.pf

Dr Jules Ien Fa, Directeur Adjoint de la Sante en Polynésie, B.P. 2551, Papeete – Tahiti,
Fax: (689) 43 39 42, Tel: (689) 46 00 99,
E-mail: dircab.msa@sante.gov.pf

KIRIBATI

Dr Airam Metai, Director of Public Health, Ministry of Health and Family Planning, P.O. Box 268, Bikenibeu Tarawa, Fax: (686) 28152, Tel: (686) 28100
E-mail: mhfp@tskl.net.ki

MARSHALL ISLANDS,
REPUBLIC OF

Ms Justina R. Langidrik, Secretary of Health, Ministry of Health, P.O. Box 16, Majuro 96960, Fax: 011 692 625 3432, Tel.: 011 692 625 5660,
E-mail: rmimohe@ntamar.com

MICRONESIA,
FEDERATED STATES OF

Dr Jefferson Benjamin, Assistant Secretary of Health Division of Health, Department of Health, Education and Social Affairs, P.O. Box PS 70, FSM National Government, Palikir, Pohnpei 96941,
Fax: (691) 320-5263, Tel: (691) 320-2619/2643/2872
E-mail: fsmhealth@mail.fm

NEW CALEDONIA

Honourable Leopold Joredie, Minister for Education and Society Matters, In-charge of the Prevention, Sector of the Public Health, B.P. N4 98851 Noumea-Cedex
Fax: (687) 24 37 02

Dr Jean Paul Grangeon, Médecin inspecteur de la santé Direction des affaires sanitaires et sociales de la Nouvelle-Calédonie, B.P. N498851, Noumea,
Fax: (687) 24 37 02, Tel: (687) 24-37 04/ 24 37 10,
E-mail: dass@gouv.nc

NIUE

Honourable Fisa Pihigia, Minister of Health, Ministry of Health, P.O. Box 33, Alofi, Fax: (683) 4265,
Tel: (683) 4100, E-mail: health@mail.gov.nu

Dr Hare Paka, Director of Health, Ministry of Health P.O. Box 33, Alofi, Fax: (683) 4265, Tel: (683) 4100
E-mail: health@mail.gov.nu

PALAU, REPUBLIC OF

Dr Caleb Otto, Director, Bureau of Public Health Services, Ministry of Health, P.O. Box 100, Koror
Fax: (680) 488-1211/488-1725, Tel: (680) 488-2813
E-mail: PHPAL@palaunet.com
<table>
<thead>
<tr>
<th>Country</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papua New Guinea</td>
<td>Honourable Melchior Pep, Minister for Health, Department of Health, P.O. Box 807, Waigani, National Capital District, Fax: (675) 301 3604, Tel: (675) 301 3601, E-mail: <a href="mailto:healthsec@health.gov.pg">healthsec@health.gov.pg</a></td>
</tr>
<tr>
<td></td>
<td>Dr Nicholas Mann, Secretary for Health, Department of Health, P.O. Box 807, Waigani, National Capital District Fax: (675) 301 3604, Tel: (675) 301 3601</td>
</tr>
<tr>
<td>Samoa</td>
<td>Honourable Mulitalo Siafausa Vui, Minister of Health Department of Health, Office of the Director-General Private Mail Bag, Apia, Fax: (685) 26 553 Tel: (685) 23 330/21 212</td>
</tr>
<tr>
<td></td>
<td>Dr Eti Enosa, Director-General of Health, Department of Health, Office of the Director-General, Private Mail Bag Motoootua, Apia, Fax: (685) 26 553 Tel: (685) 23 330/21 212</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>Honourable Benjamin Patrick Una, Minister of Health and Medical Services, Ministry of Health and Medical Services, P.O. Box 349, Honiara, Fax: (677) 20085 Tel: (677) 23402/20830</td>
</tr>
<tr>
<td></td>
<td>Dr George Manimu, Permanent Secretary, Ministry of Health and Medical Services, P.O. Box 349, Honiara, Fax: (677) 20085, Tel: (677) 23402/20830</td>
</tr>
<tr>
<td>Tokelau</td>
<td>Honourable Pio Tuia, Minister of Health, c/o Tokelau Apia Liaison Office, P.O. Box 865, Apia, Samoa Fax: (685) 21 761, Tel: (685) 20 822</td>
</tr>
<tr>
<td></td>
<td>Dr Tekie Iosefa, Director of Health, c/o Tokelau Apia Liaison Office, P.O. Box 865, Apia, Samoa Fax: (685) 21 761, Tel: (685) 20 822</td>
</tr>
<tr>
<td>Tonga</td>
<td>Honourable Viliami Ta'u Tangi, Minister of Health Ministry of Health, P.O. Box 59, Nuku'alofa Fax: (676) 24291, Tel: (676) 23200 E-mail: <a href="mailto:mohtonga@kalianet.to">mohtonga@kalianet.to</a></td>
</tr>
<tr>
<td></td>
<td>Dr Litili Ofanoa, Director of Health, Ministry of Health P.O. Box 59, Nuku'alofa, Fax: (00676) 24291 Tel: (00676) 23200, E-mail: <a href="mailto:mohtonga@kalianet.to">mohtonga@kalianet.to</a></td>
</tr>
<tr>
<td>Tuvalu</td>
<td>Honourable Alesana Kleis Seluka, Minister for Health Ministry of Health, Women and, Community Affairs Private Mail Bag, Funafuti, Fax: (688) 20 404 Tel: (688) 20 832, E-mail: <a href="mailto:minhes@tuvalu.tv">minhes@tuvalu.tv</a></td>
</tr>
<tr>
<td></td>
<td>Dr Tekaai Nelesone, Acting Director of Health, Ministry of Health, Women and, Community Affairs, Private Mail Bag, Funafuti, Fax: (688) 20 404, Tel: (688) 20 832</td>
</tr>
</tbody>
</table>
**Annex 5**

**VANUATU**

Honourable Donald Kalpokas Masikevanua, Minister of Health, Ministry of Health, Private Mail Bag 0042
Port Vila, Fax: (678) 26113, Tel: (678) 22545

Ms Myriam Abel, Director General of Health, Ministry of Health, Private Mail Bag 0042, Port Vila,
Fax: (678) 26113, Tel: (678) 22545

Mr Obed Masingiow, Second Political Advisor, Ministry of Health, Private Mail Bag 0042, Port Vila,
Fax: (678) 26113, Tel.: (678) 22545

**WALLIS AND FUTUNA**

Dr Laurent Morisse, Service de Medecine Interne Hopital de Sia, BP 600 Mara’utu – UNEA, 98600 Wallis
Tel.: 681 720707, Fax: 681 722399
E-mail: lmorrisse@wallis.co.nc

**2. CONSULTANT**

Dr N.V.K. Nair, 9/1501, Rathapurakunnu,
Sasthamangalam, Trivandrum, Kerala 695010, India,
Tel: 91 (471) 2721815, E-mail: nvknair@satyam.net.in

**3. OBSERVERS**

**ASIAN DEVELOPMENT BANK**

Dr Maryse Dugue, Health Specialist, Pacific Department
6 ADB Avenue, Mandaluyong City 1501, Metro Manila
Philippines, Fax: (632) 636-2404, Tel: (632) 632 2444
E-mail: mdugue@adb.org

**AUSTRALIAN AGENCY FOR INTERNATIONAL DEVELOPMENT (AUSAID)**

Mr Sinna Sinnappurajar, Health and Social Services
Program Manager, Pacific Section III, GPO Box 887,
Canberra ACT 2601, Australia, Tel: 61 2 62064909
Fax: 61 2 62064720
E-mail: sinna_sinnappurajar@ausaid.gov.au

Ms Heather Macdonald, Public Health Adviser, Sectors
Group, GPO Box 887, Canberra ACT 2601, Australia
Tel: 61 2 62064909, Fax: 61 2 62064720
E-mail: heather_macdonald@ausaid.gov.au
AUSTRALIAN AGENCY FOR INTERNATIONAL DEVELOPMENT (AUSAID)
(cont'd.)

Mr Rick Nicholls, First Secretary (Development Cooperation), Australian High Commission, Salote Road Nuku'alofa, Tonga, Tel: 676 232 44, Fax: 676 232 43

EMBASSY OF THE PEOPLE’S REPUBLIC OF CHINA IN TONGA

His Excellency Ambassador Gao Shanhai, Vuna Road Nuku'alofa, Tonga, Tel.: (676) 24 544, Fax: (676) 24 595, Email: Chinatown@kalianet.to

INTERNATIONAL DIABETES FEDERATION

Ms Ruth Colagiuri, Centre for Diabetes Strategies, Sydney, Australia, c/o Faculty of Medicine, The Chinese University of Hong Kong, Prince of Wales Hospital, Shatin, N.T., Hong Kong, Tel: (852) 2632 3137, Fax: (852) 2637 3852 E-mail: colaguiriR@sesahs.nws.GOV.AU

FIJI SCHOOL OF MEDICINE

Mr Wame Baravilala, Dean, Private Mail Bag, Suva Fiji, Tel.: (679) 311 700, Fax: (679) 305 781 Email: fsm.ac.fj

Mr Rodney Yee, Private Mail Bag, Suva Phone: (679) 311 700, Fax: (679) 305 781 Email: fsm.ac.fj

FIJI SCHOOL OF NURSING

Mrs Iloi Rabuka, Principal, Private Mail Bag, G.P.O Suva Fiji, Tel.: (679) 3321499, Fax: (679) 3321013 E-mail: irabuka@healthfiji.gov.fij

MINISTRY OF HEALTH, LABOUR AND WELFARE, GOVERNMENT OF JAPAN

Dr Koji Okamoto, Director, International Cooperation Office, International Affairs Division, Minister's Secretariat, 1-2-2, Kasumigaseki, Chiyoda-ku, Tokyo, Japan, Tel.: 81 3 3595 2403, Fax: 81 3 3501 2532 E-mail: okamoto-kouji@mhlw.go.jp

Dr Masami Sakoi, Deputy Director, International Cooperation Office, International Affairs Division Minister's Secretariat, 1-2-2, Kasumigaseki, Chiyoda-ku Tokyo, Japan, Tel.: 81 3 3595 2403, Fax: 81 3 3501 2532

Ms Kazuko Kurata, Assistant Director for International Organizations, International Affairs Division, Minister's Secretariat, 1-2-2, Kasumigaseki, Chiyoda-ku, Tokyo Japan, Tel.: 81 3 3595 2403, Fax: 81 3 3501 2532

Mr Tesuo Ogawa, Unit Chief for Budget, International Affairs Division, Minister's Secretariat, 1-2-2, Kasumigaseki, Chiyoda-ku, Tokyo, Japan Tel.: 81 3 3595 2403, Fax: 81 3 3501 2532
Annex 5

MINISTRY OF HEALTH OF NEW ZEALAND

Dr Colin Tukuitonga, Director of Public Health, P.O. Box 5013, Wellington, New Zealand, Tel: 64 4 495 4434 Fax: 64 4 495 4401 E-mail: Colin-Tukuitonga@moh.govt.nz

NEW ZEALAND AGENCY FOR INTERNATIONAL DEVELOPMENT (NZAID)

Ms Ruth Holland, Programme Manager, Pacific Regional Health & Education, Ministry of Foreign Affairs and Trade, 195 Lamton Quay, Private Bag 18-901, Wellington, New Zealand, Tel.: 64-4 439 8143, Fax: 64-4 439 8513, E-mail: ruth.Holland@mfat.govt.nz

Ms Sarah-Jane Marriott, Health Advisor, Strategy, Advisory and Evaluation Group, Ministry of Foreign Affairs and Trade, 195 Lambton Quay, Private Bag 18-901, Wellington, New Zealand, Tel.: 64-4 439 8167 Fax: 64-4 439 8513 E-mail: sarah-jane.marriott@mfat.govt.nz

PACIFIC ISLANDS AIDS FOUNDATION

Ms Maire Bopp Dupont, Chief Executive Officer, c/o CI Red Cross Society, P.O. Box 888, Rarotonga, Cook Islands, Tel. (+682) 50750 (cell), E-mail: piaf@oyster.net.ck

PACIFIC ISLANDS FORUM SECRETARIAT

Dr Helen Tavola, Social Policy Adviser, Private Mail Bag, Suva, Fiji, Tel.: (679) 330 0314 Fax: (679) 330 1102/330 5573 E-mail: helent@forumsec.org.fj

UNITED NATIONS CHILDREN’S FUNDS

Dr Ajesh Ishri, Assistant Health and Nutrition Officer UNICEF Pacific, 3rd Floor, Fiji Development Bank Bldg. 360 Victoria Parade, Suva, Fiji, Tel: (679) 330 0439 Fax: (679) 330 1667, E-mail: suva@unicef.org

UNITED NATIONS POPULATION FUND

Ms Urmila Singh, UNFPA Assistant Representative UNFPA Office for the Pacific, Private Mail Bag, Suva Fiji, Tel.: 679 330 8022, Fax: 679 331 2785 E-mail: usingh@unfpa.org.fj

UNIVERSITY OF PAPUA NEW GUINEA

Professor Mathias Sapuri, Executive Dean, School of Medicine and Health Sciences, P.O. Box 5623, Boroko, NCD, Papua New Guinea, Fax: (675) 323 0809 Tel: (675) 311-2304

WORLD BANK

Mr Vincent Turbat, Senior Economist, 1818 H Street, N.W., Washington, D.C. 20043, Tel.: (202) 473 2529 Fax: (202) 522 3394, E-mail: vturbat@worldbank.org

Ms Naoko Ohno, Consultant, 1818 H Street, N.W. Washington, D.C. 20043, Tel.: (202) 473 2529 Fax: (202) 522 3394, E-mail: nohno@worldbank.org
4. SECRETARIAT

SECRETARIAT OF THE PACIFIC COMMUNITY

Mr Yves Corbel, Deputy Director-General, B.P. D5
8848 Noumea Cedex, New Caledonia,
Fax: (687) 263 818, Tel: (687) 262 000

Dr Mark Jacobs, Manager, Public Health Program
B.P. D5, 8848 Noumea Cedex, New Caledonia
Fax: (687) 263 818, Tel: (687) 262 000

Mr Jim Dodds, Environmental Health Adviser, B.P. D5
98848 Noumea Cedex, New Caledonia,
Fax: (687) 263 818, Tel: (687) 262 000

Dr Tom Kiedrznski, Notifiable Diseases Specialist, B.P. D5
98848 Noumea Cedex, New Caledonia,
Fax: (687) 263 818, Tel: (687) 262 000

Dr Tony Lower, Team Leader, Pacific Action for Health
B.P. D5, 98848 Noumea Cedex, New Caledonia
Fax: (687) 263 818, Tel: (687) 262 000

Ms Odile Rolland, Secretary to the Manager of Public Health Program, B.P. D5, 98848 Noumea Cedex
New Caledonia, Fax: (687) 263 818, Tel: (687) 262 000

Ms Jimaima Tuniau-Schultz, Lifestyle Health Adviser
B.P. D5, 98848 Noumea Cedex, New Caledonia
Fax: (687) 263 818, Tel: (687) 262 000

Dr Janet O'Connor, Tuberculosis Specialist, Pacific Regional Tuberculosis Control Project, B.P. D5
98848 Noumea Cedex, New Caledonia
Fax: (687) 263 818, Tel: (687) 262 000

Ms Marie Francoise Bourgoin, Translator, B.P. D5
98848 Noumea Cedex, New Caledonia,
Fax: (687) 263 818, Tel: (687) 262 000

Ms Marie Odile Bayle, Interpreter/Translator, B.P. D5
98848 Noumea Cedex, New Caledonia,
Fax: (687) 263 818, Tel: (687) 262 000

Mr Gerard de Haro, Interpreter/Translator, B.P. D5
98848 Noumea Cedex, New Caledonia,
Fax: (687) 263 818, Tel: (687) 262 000

Mr Roy Benyon, Interpreter/Translator, B.P. D5
98848 Noumea Cedex, New Caledonia,
Fax: (687) 263 818, Tel: (687) 262 000
Annex 5

SECRETARIAT OF THE PACIFIC COMMUNITY (cont'd)

Ms Anne Dubois, Clerical Officer, Translation and Interpretation Section, B.P. D5, 98848 Noumea Cedex, New Caledonia, Fax: (687) 263 818, Tel: (687) 262 000

Mr Phil Hardstaff, Senior Support Engineer Information Technology and Communications Section B.P. D5, 98848 Noumea Cedex, New Caledonia Fax: (687) 263 818, Tel: (687) 262 000

Mr Shekhar Balralm, Information Technology and Computer Systems Assistant, B.P. D5 98848, Noumea Cedex, New Caledonia, Fax: (687) 263 818 Tel: (687) 262 000

WORLD HEALTH ORGANIZATION

Dr Shigeru Omi, Regional Director, Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines, Tel: (632) 528 9903; 528-9904, Fax: (632) 521 1036, E-mail: omis@wpro.who.int

Dr Richard Nesbit (Responsible Officer), Director, Programme Management, Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines, Tel: (632) 528 9921; 528-9923, Fax: (632) 521 1036, E-mail: nesbitr@wpro.who.int

Dr Linda Milan, Director, Building Healthy Communities and Populations, Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines, Tel.: (632) 528 9981, Fax: (632) 521 1036 E-mail: milanl@wpro.who.int

Mr Wu Guogao (Focal Point), External Relations Officer Regional Office for the Western Pacific, P.O. Box 2932 1000 Manila, Philippines, Tel: (632) 528-9930 Fax: (632) 521-1036, E-mail: wug@wpro.who.int

Dr Hisashi Ogawa, Regional Adviser in Environmental Health, Regional Office for the Western Pacific P.O. Box 2932, 1000 Manila, Philippines Tel: (632) 528-9885, Fax: (632) 521-1036 E-mail: ogawah@wpro.who.int

Dr Gauden Galea, Regional Adviser, Noncommunicable Diseases, Regional Office for the Western Pacific P.O. Box 2932, 1000 Manila, Philippines Tel: (632) 528-9860, Fax: (632) 521-1036 E-mail: galeag@wpro.who.int
Dr Wang Xiangdong, Acting Regional Adviser Mental Health, Regional Office for the Western Pacific
P.O. Box 2932, 1000 Manila, Philippines
Tel.: (632) 528 9858, Fax: (632) 521 1036
E-mail: wangx@wpro.who.int

Dr Luca-Tommaso Cavalli-Sforza, Regional Adviser Nutrition and Food Safety, Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines, Tel.: (632) 528 9864, Fax: (632) 521 1036
E-mail: cavalli-sforzat@wpro.who.int

Dr Bernard Fabre-Teste, Regional Adviser Sexually Transmitted Infections, including HIV/AIDS Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines, Tel.: (632) 528 9714
Fax: (632) 528 1036, E-mail: fabretesteb@wpro.who.int

Dr Chen Ken, Regional Adviser in Traditional Medicine, Laboratories and Research, Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines, Tel.: (632) 528 9844, Fax: (632) 521 1036
E-mail: chenk@wpro.who.int

Dr Marie Paz Annette M. David, Acting Regional Focal Point, Tobacco-Free Initiative, Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines, Tel.: (632) 528 9893, Fax: (632) 528 1036, E-mail: davida@wpro.who.int

Dr Harley Stanton, Scientist, Tobacco-Free Initiative Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines, Tel.: (632) 528 9894
Fax: (632) 528 1036, E-mail: stantonh@wpro.who.int

Dr Li Shichuo, WHO Representative, Level 4 Provident Plaza One, Downtown Boulevard, 33 Ellery Street Suva, Fiji, Tel: (679) 3304600; 300727
Fax: (679) 3300462, E-mail: lis@fij.wpro.who.int

Dr Han Tieru, WHO Representative, Ioane Viliamu Building, Beach Road, Apia, Western Samoa
Tel: (685) 24-976; 23-756; 23-757, Fax: (685) 23-765
E-mail: hantieru@sma.wpro.who.int

Dr Yves Renault, WHO Representative, 4th Floor, AOPI Centre, Waigani Drive, Papua New Guinea
Tel.: (675) 325 7827, Fax: (675) 325 9568
E-mail: renaultv@png.wpro.who.int
<table>
<thead>
<tr>
<th>Annex 5</th>
<th>WORLD HEALTH ORGANIZATION (cont’d.)</th>
<th>WHO HEADQUARTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Salesi Katoanga, Country Liaison Officer, Ministry of Health Bldg., Chinatown, Honiara, Solomon Islands</td>
<td>Dr Ruth Bonita, Director, Noncommunicable Disease Surveillance, Geneva, Switzerland</td>
<td></td>
</tr>
<tr>
<td>Tel.: (677) 24001, Fax: (677) 23406</td>
<td>Tel.: 4122 791 2111, Fax: 4122 791 4769</td>
<td></td>
</tr>
<tr>
<td>E-mail: <a href="mailto:katoangas@who.org.sb">katoangas@who.org.sb</a></td>
<td>E-mail: <a href="mailto:bonitar@who.int">bonitar@who.int</a></td>
<td></td>
</tr>
<tr>
<td>Dr Niklas P. Danielsson, Country Liaison Officer Ministry of Health, Nuku'alofa, Tonga</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tel.: (676) 23 217, Fax: (676) 23 938</td>
<td></td>
<td></td>
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<tr>
<td>E-mail: cloton@kalianeto</td>
<td></td>
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<tr>
<td>Dr Corrine Capuano, Country Liaison Officer, George Pompidou Bldg., Port Vila, Vanuatu, Tel.: (678) 27 683 Fax.: (678) 22 691,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E-mail: <a href="mailto:capaunoc@van.wpro.who.int">capaunoc@van.wpro.who.int</a></td>
<td></td>
<td></td>
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<tr>
<td>Dr Kwang Soo Park, Country Liaison Officer, World Health Organization, Bikenibeu, Tarawa, Kiribati</td>
<td></td>
<td></td>
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<tr>
<td>Tel.: (686) 28 231, Fax: (686) 29 188</td>
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<td></td>
</tr>
<tr>
<td>E-mail: <a href="mailto:who@kir.wpro.who.int">who@kir.wpro.who.int</a></td>
<td></td>
<td></td>
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<tr>
<td>Dr Maximillian De Courten, Medical Officer, WHO Representative’s Office, Level 4 Provident Plaza One Downtown Boulevard, 33 Ellery Street, Suva, Fiji</td>
<td></td>
<td></td>
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<tr>
<td>Tel: (679) 304600; 300727, Fax: (679) 300462</td>
<td></td>
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<td>E-mail: <a href="mailto:decourtenmg@fij.wpro.who.int">decourtenmg@fij.wpro.who.int</a></td>
<td></td>
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<tr>
<td>Ms Ma Lourdes Rodriguez, Administrative Officer Regional Director’s Office, Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines, Tel: (632) 528-9902, Fax: (632) 521-1036</td>
<td></td>
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<tr>
<td>E-mail: <a href="mailto:rodriguezm@wpro.who.int">rodriguezm@wpro.who.int</a></td>
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</tbody>
</table>
## SCHEDULE FOR THE MEETING OF MINISTERS OF HEALTH FOR THE PACIFIC ISLAND COUNTRIES

**Nuku'alofa, Kingdom of Tonga, 9 to 13 March 2003**

**6 March 2003**

**For Participants**

<table>
<thead>
<tr>
<th>Time</th>
<th>Sunday, 9 March</th>
<th>Time</th>
<th>Monday, 10 March</th>
<th>Time</th>
<th>Tuesday, 11 March</th>
<th>Time</th>
<th>Wednesday, 12 March</th>
<th>Thursday, 13 March</th>
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<tbody>
<tr>
<td>0830-1000</td>
<td>Item 2</td>
<td>0830-1000</td>
<td>Item 8</td>
<td>0630-1000</td>
<td>Introduction to group work</td>
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<td></td>
<td>Election of Chairman and Rapporteur</td>
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<td>Mental health</td>
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<td>Group work</td>
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<td></td>
<td>Item 3</td>
<td>1000-1030</td>
<td>Coffee break</td>
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<td>1000-1030</td>
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<td>Adoption of the agenda</td>
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<td></td>
<td>Item 4</td>
<td>1030-1200</td>
<td>Item 5</td>
<td>1030-1200</td>
<td>Group Work (continued)</td>
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<td></td>
<td>Progress in implementation of the Madang Commitment Towards Healthy Islands</td>
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<td>Diabetes and other noncommunicable diseases</td>
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<td></td>
<td>1000-1030 Photo session/Coffee break</td>
<td>1200-1330 Lunch</td>
<td>Item 6</td>
<td>1200-1330 Lunch</td>
<td>1200-1330 Lunch</td>
<td>1330-1500 Group Work (continued)</td>
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<td></td>
<td>1200-1330 Lunch</td>
<td>1200-1330 Lunch</td>
<td>1330-1700 Field Trip</td>
<td>1500-1530 Coffee break</td>
<td>1500-1530 Coffee break</td>
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<td></td>
<td>1330-1500 Item 6</td>
<td>1330-1700 Field Trip</td>
<td>1330-1500 Group Work (continued)</td>
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<td></td>
<td>Diet, physical activity and health</td>
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<td>1500-1530 Coffee break</td>
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<tr>
<td>1600-1700</td>
<td>Registration (International Dateline Hotel)</td>
<td>1530-1700 Item 7</td>
<td>Tobacco Free Initiative</td>
<td>1530-1700 Group work (continued)</td>
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<td>1800-2030</td>
<td>Item 1</td>
<td>1530-1700</td>
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<td></td>
<td>Opening ceremony (Queen Salote Memorial Hall)</td>
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<tr>
<td>Dinner</td>
<td>Dinner hosted by the Government of Tonga</td>
<td></td>
<td>Dinner hosted by the Regional Director, WPRO</td>
<td>Dinner hosted by the SPC</td>
<td></td>
<td>Dinner hosted by MHLW, Japan</td>
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</tr>
</tbody>
</table>
Community Visits

1. **Kolovai:** Theme: Healthy village
   - Clean environment
   - People with healthy lifestyle

   1. Tour of district; start from Ha'atafu (clean environment)
   2. Kolovia Health Centre (healthy lifestyle)
      (a) Aerobic display (youths and youths at heart)
      (c) Display of health status for whole district and individual villages

2. **Nukunuk:** Theme: Healthy village
   - Healthy health centre
   - Clean environment

   1. Tour of district from Lakepa to Matahu
   2. Display of routine activities at health centre level, type of services available from health office and public health nurse

3. **Fahefa Primary School** Theme: Health Promoting School

   1. Display of:
      - Clean environment/flower garden
      - Healthy facilities
      - Playground
      - Clean water supply
      - Clean toilet facilities
      - Shady areas
      - Safety fence
      - Vegetable garden

4. **Houma** Theme: Healthy village is a community approach

   - Healthy health centre
   - Clean environment
   - Adequate, clean water supply
   - Clean beach
   - Healthy lifestyle
Annex 7

Activities:

(i) Tour of the district

(ii) Display of a Healthy Island approach at the health centre to address:

- Health status by health officer/public health nurse
- Healthy food/vegetable garden
- Children's playground
- Adult resting place

(iii) Visit to community water supply office

(iv) Walk for health to the beach

(v) Aerobic and traditional dancing
Group 1  Stewardship and the role of the Ministry of Health

Table 1: STEPwise approach to noncommunicable disease (NCD) intervention

- The burden of NCDs (including diabetes) is high.

- Type 2 Diabetes appears in Pacific island countries at levels that exceed most other countries in the world. Rates in countries with repeat surveys have shown as much as a doubling in as short a span as two decades.

- Cardiovascular disease is the predominant cause of death in most Pacific island countries.

- Obesity is so common in Pacific societies as to appear normal. Overweight and obesity have been recorded at levels that exceed 80% (males) and 90% (females) of the adult population, and is being increasingly recorded in children.

- Tobacco use is high across the Pacific and is recorded at levels as high as 70% of the adult male population.

- Up to 60% of the health budget in some countries of the Pacific is spent on overseas referral of patients, often with chronic disease, particularly diabetes.

The evidence for prevention is now overwhelming:

Lifestyle interventions can reduce the incidence of Type 2 Diabetes in high-risk populations by up to 58% in four to six years.

- Effective tobacco legislation can reduce tobacco use within one year and subsequently coronary mortality within the same period.

- Weight reduction through a combination of dietary and physical activity interventions can reduce obesity in high-risk populations within one year.

- Experience in the Pacific (Tonga) indicates that leg amputations can be reduced by 50% in six years and the control of chronic disease has thus the potential to make significant savings on overseas referrals.
Annex 8

As a long-term goal: the Ministries of Health of the Pacific island countries and areas aim to reduce the burden of avoidable NCD through comprehensive national NCD programmes as detailed below. They will report on progress on these actions during their next meeting in 2005.

National NCD plans will be reviewed or developed in the light of the framework below. Such plans will be endorsed by the government and should define long-range goals and strategies. A mechanism for NCD surveillance, programme implementation, and regular evaluation will be provided for in the national plan.

Table 1: STEPwise framework for NCD intervention

<table>
<thead>
<tr>
<th>Resource level</th>
<th>Population approach</th>
<th>Individual high-risk approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core</td>
<td></td>
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</tr>
<tr>
<td>FCTC is ratified in the country.</td>
<td>Local infrastructure plans include the provision and maintenance of accessible and safe sites for physical activity (such as parks, and pedestrian-only areas).</td>
<td>A standard set of management guidelines for priority NCDs (such as diabetes and hypertension) have been adopted and used in health care centres, outpatient clinics, and hospitals.</td>
</tr>
<tr>
<td>Tobacco control legislation consistent with the elements of the FCTC is enacted and enforced.</td>
<td>Health-promoting community projects include participatory actions to audit and address the environmental factors that predispose to NCD risk: inactivity, unhealthy diet, tobacco use, alcohol misuse, etc.</td>
<td>A sustainable accessible supply is assured (in the Essential Drug List) for appropriate medication for priority NCDs.</td>
</tr>
<tr>
<td>A national nutrition policy consistent with the Global Strategy has been developed and endorsed at Cabinet level; sustained multisectoral action is evident to reduce fat intake, reduce salt (with attention to iodized salt where appropriate), and promote fruit and vegetable consumption.</td>
<td>Active Healthy Islands programmes addressing NCDs are implemented in different settings: villages, schools, and workplaces.</td>
<td>A system for consistent, high-quality application of clinical guidelines, and for the clinical audit of services offered.</td>
</tr>
<tr>
<td>Health impact assessment of public policy is carried out (for instance: transportation, urban planning, taxation, pollution, and others).</td>
<td>A health impact assessment of public health impact assessment of public policy is carried out (for instance: transportation, urban planning, taxation, pollution, and others).</td>
<td>A system for call and recall of patients with diabetes and hypertension in operation.</td>
</tr>
</tbody>
</table>

Expanded

| Tobacco legislation provides for incremental increases in tax on tobacco, and to earmark a proportion of the revenue for health promotion. | Sustained, well-designed, programmes are in place to promote: | Systems are in place for selective and targeted prevention aimed at high-risk populations (e.g. tobacco cessation, reduction of overweight, identification and treatment of co-morbidities of obesity, follow up of gestational diabetes). |
| Food standards legislation is enacted and enforced. It includes capacity to monitor standards. It also includes provisions for nutrition labeling and for the taxation of less healthy foods (e.g. high fat foods, soft drinks) and the subsidy of fruits and vegetables. | • Tobacco-free lifestyles, e.g. tobacco-free youth, smoke-free public places, smoke-free sports. | |
| Sustained, well-designed, national programmes (counter-advertising) are in place to promote non-smoking lifestyles, e.g. tobacco-free youth, smoke-free sports. | • Healthy diet, e.g. cooking skills, promotion of low-cost low-fat foods, water as opposed to sodas, dietary diversity (e.g. "five-a-day" or "five plus" fresh fruit and vegetables, promotion of local foods). | |
| • Physical activity, e.g.: "movement" promoted in different domains (occupational and leisure); movement as opportunity; cumulative daily movement standards are set; promotion of cultural activities such as dancing. | • "movement" promoted in different domains (occupational and leisure); movement as opportunity; cumulative daily movement standards are set; promotion of cultural activities such as dancing. | |

Table 1: STEPwise framework for NCD intervention
Optimal

Country standards are established that address marketing of unhealthy food (particularly those high in energy, saturated fat, salt and sugar, and poor in essential nutrients) to children. Legislation is enacted to control or ban sales of foods that do not meet national standards of nutrient content. Capacity for health research is built within the Pacific by encouraging studies on NCDs.

Recreational and fitness centers are available for community use (possibly set up as a local initiative by communities).

Opportunistic screening and case-finding programmes for diabetes, hypertension and overweight are implemented. An information system for registration of patients with cancer, diabetes and hypertension is operating. Support groups for tobacco cessation and overweight people and breastfeeding are fostered. Appropriate tertiary diagnostic and therapeutic interventions are implemented (e.g. chemotherapy and radiotherapy for cancer). Overseas referral for diagnostic and therapeutic interventions.

Table 2: Indicators for core action within the STEPwise approach to NCD intervention

Overarching indicator:

- Number of countries that have endorsed a national NCD plan with an intersectoral mechanism for implementation of the NCD plan

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Population approach</th>
<th>Community approach (micro level)</th>
<th>Individual high-risk approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of countries that have ratified the FCTC.</td>
<td>Number of countries that have demonstration communities with projects that address NCD risk reduction (such as provision of infrastructure for physical activity, promotion of healthy diets, tobacco use, and alcohol misuse). Published report on the process and impact of at least one such demonstration project.</td>
<td>Number of countries that have adopted guidelines for the management of diabetes and hypertension. Number of countries that have trained health care workers in the use of these guidelines, and number of workers trained. Number of countries that have carried out at least one audit of the control of diabetes and hypertension. Number of countries that have an active palliative care programme for terminally ill patients.</td>
<td></td>
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<tr>
<td>Number of countries that have adopted a tobacco control act.</td>
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<tr>
<td>Number of countries that have endorsed a national nutrition policy with provision for control of fat, sugar, and salt, and promotion of fruits and vegetables.</td>
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</table>
### Annex 9

**Group 2 Enabling environments for healthy lifestyles**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Population approach</th>
<th>Community level (specifying setting)</th>
<th>High risk approach (individual, clinical)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National level</td>
<td>Community level</td>
<td>Help overweight children and adults understand the essentials of a healthy diet and eating behaviour, for behaviour change. Setting: Obesity counselling centres, weight loss clinics. <strong>Milestone:</strong> Programmes on counselling overweight individuals on healthy diets and eating behaviour established. <strong>Progress indicator:</strong> Number of centres with these programmes in place.</td>
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<td>1. Healthy diets</td>
<td>Review the information on the nutrient content of local foods, and research the feasibility of growing locally imported plants high in micronutrients. Example: Samoan pêle for Vitamin A. <strong>Supporting Institutions:</strong> SPC, University of the South Pacific (Suva), Technical University of Papua New Guinea (food technology department), FAO, Pacific Health Research Council (Fiji SM) <strong>Milestone:</strong> Results communicated to Pacific island communities and reported back to next PI Health Ministers' Meeting. <strong>Progress indicator:</strong> Updates of completed analysis of local foods published and distributed to countries within two years.</td>
<td>Promote social marketing to encourage communities to grow and consume nutritious local foods. Setting: Churches, schools, villages, community councils, mass media. <strong>Milestone:</strong> Improvement in obesity statistics. <strong>Progress indicator:</strong> Obesity prevalence after one year improved over baseline</td>
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<td>Annex 9</td>
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| **Reduce cost and increase availability and or accessibility of local foods and increase cost of less healthy foods through mechanisms such as levies and taxes, licensing, with consideration for economics of food and urbanization.**  
Setting: Ministry of Trade in collaboration with Ministry of Health.  
Milestone: Legislation in place to achieve these.  
Progress indicator: Number of countries with legislation in place. | Help children and adults understand the basics of a healthy diet and eating behaviour for prevention of obesity.  
Setting: Schools.  
Milestone: Introduction of analysis of determinants of a healthy diet and eating behaviour in school curricula.  
Progress indicator: Number of communities where schools address healthy diets and eating behaviour in their curricula. |
| **Consider possibility of taxation of less healthy foods, based on fat, salt and sugar content, consistent with international trade agreements.**  
Setting: Ministry of Trade and Ministry of Health.  
Milestone: Taxation levels established.  
Progress indicator: Number of countries where such taxes are in effect. | Work with community and school leaders and nutritionists to train canteen staff to prepare healthy meals for school children, to include nutritious locally grown foods.  
Setting: Schools.  
Milestone: Nutritious school lunches regularly served.  
Progress indicator: Number of schools collaborating with nutritionists/dieticians for healthy menus. |
| **Facilitate trade exchanges among countries for nutritious locally grown foods.**  
Milestone: New nutritious plants introduced from regional sources.  
Progress indicator: Number of countries with healthy food exchange programmes. |  |

- Consider possibility of taxation of less healthy foods, based on fat, salt and sugar content, consistent with international trade agreements.

- Facilitate trade exchanges among countries for nutritious locally grown foods.
To ensure adequate micronutrient status in countries where it is difficult to grow vegetables and fruits (e.g. atoll countries), consider feasibility of fortification of staple foods (e.g. wheat, rice) with the help of UNICEF, WHO, FAO.

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### 2. Increased physical activity

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<th>National level</th>
<th>Community level (specify setting)</th>
<th>High risk approach (individual, clinical)</th>
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| **NOTE:** Distinguish between sports and physical activity. Also consider traditional dances, alternative types of activities such as rowing and swimming, particularly for island countries. | **Political championship by the highest-level officials of the land.**

*Example:* Championship of increased physical activity and sports by the King of Tonga.

**Progress indicators:** Number of countries with an identified high-level champion. | **Evidence-based workplace and school policies to encourage increased physical activity.**

*Examples:* designated sports days (Papua New Guinea), regular health walks for health care staff and patients (FRP), at least one hour of physical activity per day in schools.

**Setting:** Workplaces, health care centres, schools.

**Progress indicator:** Number of settings with evidence-based policies in effect. |

| **National weight loss programmes** including ongoing comprehensive mass media and educational campaigns, periodic height and weight measurement and competitions (e.g. use of meaningful messages and formulas which people readily understand and remember).

**Milestone:** National weight loss programme under implementation.

**Progress indicator:** Number of countries with national weight loss programmes. | **Establishing appropriate and safe facilities and protected space for physical activities, and alternative activities in areas with limited space.**

*Examples:* playgrounds, footpaths, athletic courts, parks, bicycle lanes, car-free days and car-free areas.

**Setting:** Villages, through church groups, women's groups, sports groups and youth groups. |

| **Develop national policy for physical activity**

**Milestone:** National policy for physical activity endorsed by government.

**Progress indicator:** Number of countries with an official national policy for physical activity. | **Establish weighing centres in village centres for periodic weight monitoring.**

**Setting:** Village health centres and clinics.

**Progress indicator:** Number of village health centres with height and weight scales. |

### 3. Tobacco-free lifestyle

<table>
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<th>National level</th>
<th>Community level (specify setting)</th>
<th>High risk approach (individual, clinical)</th>
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| **Sub-regional support and consensus on tobacco control goals needed to harmonize interventions that involve cross-** | **Adopt and ratify the FCTC**

**Setting:** World Health Assembly (adoption), individual countries' Parliaments or Senates (ratification).

**Milestone:** Entry into force.

**Progress indicator:** Number of countries that ratify the FCTC. | **Life skills development and promoting positive adult role models.**

*Examples:* Papua New Guinea school clubs and decision card programmes; non-smokers empowered for social change through women's associations, churches.

**Setting:** Youth groups, sports groups, church groups, schools, family settings. |

| Tobacco use cessation for tobacco users who want to quit | **Setting:** Health care centres, workplaces. **Milestone:** Clinical cessation services and |
Annex 9

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<tr>
<th>border issues.</th>
<th>Pacific countries who have adopted and ratified the FCTC.</th>
<th>Progress indicator: Number of communities with life skills programmes.</th>
<th>support groups present in each Pacific island country. Progress indicator: Proportion of health professionals trained in cessation.</th>
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<tr>
<td>NOTE: For small island countries that do not grow tobacco, consider feasibility of prohibiting all forms of tobacco. For tobacco-growing countries, strategies to move from tobacco agriculture to other forms of agriculture will need to be investigated.</td>
<td>Develop comprehensive policy and legislation consistent with the FCTC: 1. taxation 2. control of smuggling 3. comprehensive advertising bans 4. advocacy 5. supply issues, such as imports</td>
<td>Targeted campaigns: 1. children and young people 2. pregnant women 3. families 4. non-smokers 5. counter-advertising</td>
<td>Examples: Tokelau ban on smoking in health buildings Setting: Schools, daycare centres, health care centres, homes, workplace, other public places, media, public transport. Milestone: Smoke-free public places, smoke-free homes. Progress indicator: Number of anti-tobacco events, media events, and school programmes involved in tobacco control campaigns.</td>
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<td>4. Sustainable financing for healthy lifestyles</td>
<td>National level</td>
<td>Community level (specify setting)</td>
<td>High risk approach (individual, clinical)</td>
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<td>Ensure sustainable financing for healthy lifestyle programmes through: 1. taxation of unhealthy products (ex: FRP-taxes on sugar and beer used to fund prevention through a public body). 2. contributions into health promotion and/or prevention funds from private groups, such as churches. 3. allocation of funds from national budgets for prevention and health promotion consistent with stated national priorities (i.e. ADB's participatory budget preparation in some countries). Milestone: Earmarked taxes for healthy lifestyles promotion. Progress indicator: Number of countries with a sustainable national financing mechanism for promoting healthy lifestyles.</td>
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* NOTE: For all these interventions, communities should be consulted and encouraged to take the lead in developing and implementing strategies for healthy lifestyles; these strategies should take into consideration cultural norms and traditional approaches.
**STEPwise approach to strategic environmental health interventions**

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<th>Resource level</th>
<th>National level</th>
<th>Community level</th>
<th>Individual level</th>
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| Essential      | - WHO drinking water quality (DWQ) guidelines adopted as tentative standards.  
- DWQ monitoring programme established with necessary equipment and supplies and training of personnel.  
- National Environmental Health Action Plans (NEHAPS) developed.  
- National training needs assessment for environmental health completed and training plan developed.  | - Water and sanitation integrated into healthy settings (e.g. schools, villages, markets).  
- Community health workers trained in water quality management and sanitation survey.  
- Water sources vulnerable to contamination identified, and protection plan developed and implemented.  | - Information, education, and communication (IEC) materials on water conservation and good hygiene practices produced and disseminated. |
| Expanded        | - National DWQ standards and sanitation standards established.  
- National database on water and sanitation developed.  
- Strategy or guidelines for the protection of water and sanitation developed.  
- National environmental health legislation reviewed and revised where necessary.  
- National training courses for environmental health organized.  
- Database of environmental health services established.  | - Local Environmental Health Action Plans (LEHAPS) developed.  
- Training courses offered to community environmental health workers.  | - Increased knowledge of environmental health and individual actions that can be taken to manage these.  |