12th BIENNIAL CONFERENCE
15-18 July, 2017
PORT VILA, VANUATU

CONFERENCE REPORT

ISBN 978-1-927201-04-6

PSRH Press
PSRH Secretariat
525 Remuera Rd, Remuera, Auckland
New Zealand 1050
# Table of Contents

1. **EXECUTIVE SUMMARY** ................................................................. 4  
2. **RECOMMENDATIONS FROM THE CONFERENCE** ................................. 6  
3. **ACKNOWLEDGEMENT** ...................................................................... 8  
4. **BACKGROUND** ............................................................................... 9  
5. **PRE-CONFERENCE WORKSHOPS** ..................................................... 11  
6. **CONFERENCE PROCEEDINGS** ......................................................... 12  
   Objectives ............................................................................................ 12  
   Abstracts ............................................................................................. 12  
   Conference Programme ....................................................................... 12  
   Opening Ceremony ............................................................................... 13  
   Brian Spurret Oration ......................................................................... 13  
   PSRH Awards ..................................................................................... 13  
7. **CONFERENCE PROGRAMME** ........................................................ 14  
   Local Organising Committee ............................................................. 14  
   Participants, Speakers and Resource Persons ..................................... 14  
8. **BIENNIAL GENERAL MEETING** ...................................................... 15  
9. **APPENDICES** ................................................................................ 16  
   Appendix 1: Conference Abstracts ...................................................... 16  
   Appendix 2 – Citations of PSRH Awardees ......................................... 36  
   Appendix 3 – Conference Programme ................................................. 39  
   Appendix 4 – Conference Evaluation .................................................. 47  
   Appendix 5 – The President’s Report ................................................. 59  
   Appendix 4 – Statement of Financial Position ................................... 63
1. EXECUTIVE SUMMARY

The Pacific Society for Reproductive Health (PSRH) is a Charitable Trust, not-for-profit organisation designed to contribute to the improvement of reproductive, maternal and newborn health in the Pacific Region.

The PSRH 12th biennial conference was held in Port Vila, Vanuatu during 15-18th July 2017. More than 300 health professionals participated. The theme of the conference was: “Reproductive Health and the Sustainable Development Goals – catalysts for accelerating progress.” The theme was selected in line with the global agenda of the Sustainable Development Goals (SDGs), a blueprint to improve health and development in the 15-year period, 2016 to 2030.

The conference was preceded by six technical skills workshops, namely: Pacific Emergency Maternal and Newborn Training (PEMNeT) including Early Essential Newborn Care (EENC); Family Planning; Research and Clinical Audit; Repair of Obstetric Tears; Ultrasound in maternity care; and Colposcopy. The workshops were conducted in parallel sessions.

The conference discussed a number of areas including: best practices in maternal and newborn health; health workforce development in obstetrics and gynaecology; midwifery; maternal death surveillance and response; family planning and the unmet needs; prevention of cervical cancer; gender-based violence; adolescent sexual and reproductive health; and leadership in the workplace. In addition to the conference sessions, a side session on “Practice Improvement Marketplace Stalls” was set up which allowed midwives to showcase best practices and innovative methods for improving maternal and newborn health in their own settings.

The PSRH also conducted its biennial general meeting and elected members of its Board. Dr Pushpa Nusair from Fiji was elected as the new President, taking over from Ms Kathy Gapirongo from Solomon Islands. The election added five new members, two midwives and three doctors.

The conference made four key recommendations which will guide the work of the Society in the next biennium. The four recommendations are:

a) That PSRH collaborates with governments, organisations and partners to establish a Comprehensive Cervical Cancer Prevention and Control Programme appropriate for the Pacific context;

b) That PSRH collaborates with governments, organisations and partners to support Health Workforce Development in Obstetrics and Gynaecology to address the shortage of skilled manpower against the increasing demands for quality care in maternal-newborn care;

c) That PSRH collaborates with governments, organisations and partners to strengthen the capacity of midwifery training institutions in the Pacific in order to respond more efficiently to the growing need for more midwives in the region; and
d) PSRH collaborates with governments, organisations and partners to support increased contraceptive uptake and reduce the unmet needs for family planning in the Region.

PSRH is grateful to the main donors – UNFPA and the Pacific Community (SPC) – for the generous support and contribution made towards the success of the conference. The support of other organisations, development partners and individuals is also acknowledged with sincere appreciation. Special acknowledgement goes to the Government of Vanuatu for its immense support in hosting the conference.
2. RECOMMENDATIONS FROM THE CONFERENCE

Based on the conference discussions, consultations and the post-conference strategy meeting by the PSRH Board, four key recommendations were identified. They form the basis for developing actions that the Society will support, working in collaboration with governments, institutions and other partners in health.

The recommendations are:

Recommmendation 1
Establish a Comprehensive Cervical Cancer Prevention and Control Programme

1.1 Cervical Cancer is the most common female cancer in the Pacific, contributing to disease burden and causing more than 1,500 premature deaths per year in the region. These deaths can be prevented if pre-cancer status is detected and treated early. Primary and secondary prevention that are effective and practical for Pacific island settings should be pursued.

1.2 The Society made strong commitments to develop a Pacific-oriented guideline on Comprehensive Cervical Cancer Prevention to help countries address this problem. PSRH will embark on collaborating with governments and key partners in the region to pursue this agenda.

1.3 A multi-country Technical Working Group on Cervical Cancer Prevention will be coordinated by PSRH to oversee the development of this programme and facilitate its progress.

Recommendation 2
Support Health Workforce Development in Obstetrics and Gynaecology

2.1 The shortage of health workforce in midwifery and obstetrics is a long-standing problem in the Pacific and affects the quality of service delivery in maternal-newborn care. The issue needs to be positioned high in the agenda of development and in the discussions among governments and development partners.

2.2 PSRH is well-positioned to engage in advocacy dialogue with donors and development partners to leverage resources and sponsorship for strengthening health institutions (midwifery schools, Fiji National University and UPNG) to produce adequate health workforce for the region.

Recommendation 3
Strengthen the Capacity of Midwifery Training Institutions to produce increased numbers of Midwives to meet national targets

3.1 Shortage of midwives has been a long-standing problem that hinder the provision of essential maternal-newborn care at all levels of the health care system. Increasing the numbers of midwives to fill in the large numbers of vacancies is critical to make progress in quality of care especially at primary care level.

3.2 The Midwifery segment of PSRH Board will work with governments and development partners to reassess the situation in the Pacific and develop strategic plans that are practical and affordable in addressing the issues.
Recommendation 4

Increase Contraceptive uptake and Reduce the Unmet Need for family planning in the Region

4.1 Family planning is an effective intervention for reducing maternal deaths and should be strongly promoted to couples and individuals as an essential component of essential maternal health package.

4.2 PSRH will collaborate with countries, donors and development partners on innovative ways to reach more people with effective contraception, with a focus on long-acting methods of contraception.

Other important Recommendations

In addition to the above, the conference discussed other recommendations relevant to the needs of the region. The PSRH Secretariat will endeavor to mobilise partnerships with relevant institutions to partner in these areas. These include:

a) Mainstream the prevention of gender-based violence as part of existing services for women and children. More specifically, screening for GBV using simple practical screening tools can be introduced in clinical settings at all levels of the health care system.

b) Strengthen the practice of functional and effective maternal death reviews as an effective intervention for improving quality of care. PSRH can work with other partners to expand the application of standard methods and templates that can be modified, as appropriate.

c) Explore the establishment of a “surgical skills laboratory” at the two main medical training institutions – Fiji National University and University of Papua New Guinea. The aim is to ensure that graduating doctors are well skilled in conducting operations and perineal repairs.

d) Work in partnership with Ministries of Education in selected countries to support the development of a position statement on the need to incorporate Adolescent Sexual and Reproductive Health Education as a compulsory subject in the school system.
3. ACKNOWLEDGEMENT

The Pacific Society for Reproductive Health wishes to thank the main sponsors of the conference, namely the Pacific Community (SPC) and the United Nations Population Fund (UNFPA) for their generous support and contribution that made the conference possible.

Much appreciation goes to the Vanuatu government for the overall support in hosting the conference and for the hospitality offered to the visitors. PSRH was honoured to have both the Prime Minister and the Minister of Health officiating at the conference.

PSRH acknowledges with gratitude the support of the Australian Society for Cytology and Cervical Pathology (ASCCP), Fiji National University (FNU), the University of Papua New Guinea (UPNG), World Health Organization (WHO), United Nations Children Education Fund (UNICEF), Royal Australian and New Zealand College of Obstetricians and Gynecologists (RANZCOG), Fiji O&G Society, Papua New Guinea Society of O&G, Australian College of Midwives (ACM), New Zealand Midwifery Council (NZMC), Midwifery Societies from Fiji, Solomon Islands and Papua New Guinea, and the assistance from the governments of Australian and New Zealand.

A special thank-you goes to the Director General of Health and his staff for supporting in great numbers. The local organising committee (LOC) deserves special recognition with appreciation for their tireless efforts in coordinating the many tasks on ground.

PSRH is grateful to the governments of the Pacific island countries and member countries who supported the participation of respective country delegates.

To all conference speakers, facilitators, chairs and managers of market stalls – PSRH is most grateful for your active engagement and contribution to make the conference a success. To the other organisations, groups and individuals who, in one way or another, supported the conference, PSRH is greatly appreciative.

Last but not the least, PSRH acknowledges the dedication and commitment of volunteers and the Secretariat working tirelessly well before the conference, during and after the conference.
4. BACKGROUND

The Pacific Society for Reproductive Health (PSRH) is a Charitable Trust which is as a not-for-profit non-government organisation designed to contribute to the improvement of reproductive health and related services in the Pacific Region. The Society was conceived in 1993 and held its first conference in 1995 in Vanuatu. Its membership comprise of health professionals from 15 Pacific island countries and encompassing New Zealand, Australia and England. The membership include academic, health and political leaders, clinical specialists, maternal-newborn experts, midwives and nurses, public health specialists, programme analysts, researchers, educators and community health workers – all with vested interest for improved reproductive, maternal-newborn, child and adolescent health (RMNCAH) by building the capacity and capability of the Pacific workforce.

The Society's mandate is to supplement and add value to the work of existing RMNCAH stakeholders and players, positioning itself where it has comparative advantages, and ensuring complementarity and synergy to the efforts and investment of other partners. PSRH is committed to supporting innovative approaches for interventions that contribute to long-lasting impact in improving maternal and newborn health outcomes.

Unique Features of PSRH

PSRH has developed and evolved in the last 20 years and now stands the test of time as a regional organisation that aims to contribute to ongoing efforts in the RMNCAH Agenda in the Pacific. A unique feature of PSRH lies in its organizational culture of volunteerism, sharing and learning through engagement of a wide network of professions, bringing together a rich mix of expertise, knowledge, experience and skills to deliberate on the RMNCAH agenda. A distinctive comparative advantage of PSRH is its ability to plan, organize and carry out a scientific conference every two years with a strategic theme that guides the agenda and discussions. The conference is preceded by several technical skills workshops running in parallel – this provides participants the option of selecting which workshops to attend based on their interests. PSRH draws from within its members and networks highly distinguished speakers, facilitators and resource persons who voluntarily dedicate professional time and effort to share expertise and experience, and facilitate the conferences and workshops. These events are attended by hundreds of health professionals from the Pacific and beyond.

PSRH has uniquely developed its capacity to be able to address RMNCAH from different perspectives. This is because of the wide professional diversity in the membership and network that the organisation has inherited. RMNCAH can be discussed from the viewpoints of clinical obstetric and gynaecological care, midwifery, maternal-newborn care, public health, programme management, research, advocacy, education and community engagement. PSRH links health workers in obstetrics and midwifery with other health professionals, bringing about a cross-pollination of rich mix of skills that enhance the delivery of maternal and newborn care in the Pacific.
Between its standard biennial conferences and workshops, PSRH supports countries in a range of activities including in-service training, practice visits, research and attachment programmes. For example, PSRH has developed a training manual on the “Pacific Emergency Maternal and Newborn Training (PEMNeT)” as a tool to help doctors and midwives facilitate in-service training on this subject.

Located in Auckland, New Zealand, the PSRH Secretariat is run by volunteers. Many of them are in full-time employment but use off-hours to support the business of PSRH. They strongly believe that PSRH has a unique role to supplement the RMNCAH agenda in the Pacific. The PSRH governing body is the Executive Board whose members are located in various Pacific island countries. The Board regularly holds electronic meetings several times a year and a face-to-face meeting at least once a year.

PSRH promotes equal participation among its members and embraces interested peers to join the organisation. Its inclusiveness of engagement “leaves no one behind” in the joint venture improved well-being for women and children.

The PSRH Board

The Board provides governance – strategy, policy decision and overseas operations. There are nine members of the Executive Board: seven are elected every two years. The other two comprise the immediate past president as an ex-officio member and a representative of RANZCOG appointed by its President.

Since its inception meeting in 1993, PSRH has organized biennial conferences held in different countries of the region. The numbers of health professionals participating in these meetings have increased from 25 in 1993 to more than 300 in 2015.

<table>
<thead>
<tr>
<th>Year held</th>
<th>Host town &amp; country</th>
<th>No of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>Port Vila, Vanuatu</td>
<td>323</td>
</tr>
<tr>
<td>2015</td>
<td>Suva Fiji</td>
<td>336</td>
</tr>
<tr>
<td>2013</td>
<td>Apia, Samoa</td>
<td>280</td>
</tr>
<tr>
<td>2011</td>
<td>Honiara, Solomon Islands</td>
<td>280</td>
</tr>
<tr>
<td>2009</td>
<td>Auckland, New Zealand</td>
<td>170</td>
</tr>
<tr>
<td>2007</td>
<td>Apia, Samoa</td>
<td>130</td>
</tr>
<tr>
<td>2005</td>
<td>Nadi, Fiji</td>
<td>110</td>
</tr>
<tr>
<td>2003</td>
<td>Nadi, Fiji</td>
<td>100</td>
</tr>
<tr>
<td>2001</td>
<td>Madang, Papua New Guinea</td>
<td>90</td>
</tr>
<tr>
<td>1999</td>
<td>Suva, Fiji</td>
<td>80</td>
</tr>
<tr>
<td>1997</td>
<td>Apia, Samoa</td>
<td>70</td>
</tr>
<tr>
<td>1995</td>
<td>Port Vila, Vanuatu</td>
<td>50</td>
</tr>
<tr>
<td>1993</td>
<td>Suva, Fiji (Inception)</td>
<td>25</td>
</tr>
</tbody>
</table>
5. PRE-CONFERENCE WORKSHOPS

Six (6) skills building workshops were conducted over 2-3 days during 13-15 July, prior to the conference. The workshops aimed at building specific skills in various areas of RMNCAH, including the following:

<table>
<thead>
<tr>
<th>Workshop title</th>
<th>Facilitators</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pacific Emergency Maternal and Newborn Training (PEMNeT), including Early Essential Newborn Care (EENC).</td>
<td>Sharron Bolitho, Martin Sowter, Paula Puawe, Aliote Galuvakadua, Tim Draycott</td>
<td>80</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Pushpa Nusair, Moape Bavou, Pulane Tlebere, Nina Bavou, Rufina Latu, Glen Mola</td>
<td>40</td>
</tr>
<tr>
<td>Research and Clinical Audit</td>
<td>Alec Ekeroma, Caroline Homer, Courtney Choy, Alysa Pomer, Kara Okesene-Gafa</td>
<td>50</td>
</tr>
<tr>
<td>Repair of Obstetric Tears</td>
<td>Jackie Smalldridge, Judith Goh, Mairi Wallace</td>
<td></td>
</tr>
<tr>
<td>Ultrasound in maternity care</td>
<td>Renuka Bhatt, Bronwyn Andrew</td>
<td>20</td>
</tr>
<tr>
<td>Colposcopy</td>
<td>Jeffrey Tan, Annabelle Farnsworth</td>
<td>15</td>
</tr>
</tbody>
</table>

Workshop team leaders were briefed on their roles and they took the initiative to design their own workshops, formed a team of facilitators and prepared their own workshop materials. Substantial coordination and consultation with the Secretariat and the local organizing committee was critical in making the workshops successful, particularly those that required real patients for demonstration of skills (Ultrasound and Colposcopy).

All the six workshops were conducted either at Vila Central Hospital or at the School of Nursing. They were conducted over two to three days. Summaries of the Workshops have been uploaded on the PSRH website. Participants expressed the relevance and usefulness of the workshops.
6. CONFERENCE PROCEEDINGS

The 12th Biennial Conference was hosted by the Government of the Republic of Vanuatu and was held at the National Convention Centre in Port Vila during 13th to 18th July 2017, twenty-two years following the first inaugural meeting of the Society in 1995 which was historically held in Vanuatu.

Theme

The theme of the conference endorsed by the PSRH Board was: “Reproductive Health and the Sustainable Development Goals – catalysts for accelerating progress.” The theme was selected to fall in line with the global agenda of the SDGs, a blueprint to improve health and development in the next 15 years, 2016 to 2030. It was noted that in the SDG era, health needs to be addressed from a wider development agenda taking into consideration the social determinants of health, such as gender-based violence, access to health services and the unmet needs for contraceptive use and family planning.

Objectives

The conference established the following objectives which guided the development of the conference programme.

- To discuss issues of reproductive, maternal-newborn, child and adolescent health and identify catalysts for improving programmes and services.
- To support and promote best practices and innovative interventions which improve maternal-newborn and the wider RMNCAH agenda, this contributing to sustainable and better health outcomes for Pacific peoples.
- To share knowledge, skills, expertise and research findings across health professionals in the Pacific – O&G specialists, midwives, nurses, doctors, researchers and public health specialists – as a way for enhancing professional networking and continuing professional development among Pacific health workers.

Abstracts

An invitation for abstracts along the conference theme was sent out to members and was also posted on the PSRH website. This encouraged health professionals of various categories to send original pieces of work seeking for places during the conference to make presentations. It was encouraging to see midwives submitting abstracts. More than 50 abstracts were received; however, only two-thirds of these were included. Space and time within the 3-day programme was a determining factor in the inclusion. Accepted Abstracts were published in the Pacific Journal of Reproductive Health June 2017 issue and are appended as Appendix 1.

Conference Programme

A conference programme committee was endorsed by the Secretariat and the members included: Dr Rufina Latu (Chair, Papua New Guinea), Dr Alec Ekeroma (NZ), Professor Glen Mola (Papua New Guinea) and Professor Caroline Homer (Australia). The role of the
committee was to review the abstracts, incorporate the successful ones into the 3-day programme, and coordinate the preparation and organisation of the pre-conference workshops.

**Opening Ceremony**

The 2017 PSRH Conference was graced with high level political figures officiating at the opening ceremony on Iririki Island in Port Vila. The Minister of Health, Honourable Jerome Ludvaune officially welcomed the delegates to the Conference. He delivered an inspiring speech which set the tone for the rest of the meeting.

The next day, the Prime Minister of Vanuatu, Honourable Charlot Salwai Tabimasmas opened the conference with a keynote address entitled: *Investing in Women’s Health – Vanuatu’s Experience.*

**Brian Spurret Oration**

The Brian Spurret Oration is a special occasion of PSRH conferences where a tribute is made to honour work of the late Dr Brian Spurret who was instrumental in the early formation of the Society. The oration was delivered by Prof Glen Mola who spoke on the historical development of obstetrics and gynaecology, a session entitled *Integrated O&G Services – Knowing Where You Are and Having a Sense of History.*

**PSRH Awards**

A number of awards were presented to acknowledge outstanding work of professionals in the Pacific. The President's Medals were presented to Professor Peter Stone (New Zealand) for his services to PSRH and dissemination of ultrasound scanning training in the Pacific, and to Salausa Dr John Ah Ching (Samoa) for his dedicated services to PSRH where he served for two years as President.

The Distinguished Service Awards were presented to two midwives: Midwife Judith Seke (Solomon Islands) on the nomination of the Solomon Islands Midwifery Society, and to Midwife Alumita Bulickokoko (Fiji) on the nomination of the Fiji Midwifery Association. These two members have served the profession and the health service in their respective countries with dedication for more than 30 years.

The citations for the Awards can be found in Appendix 2.
7. CONFERENCE PROGRAMME

The main areas of discussion covered in the Conference included the following. Experienced and distinguished speakers spoke on the topics with great passion while emerging Pacific researchers had the opportunity to showcase their studies. The full conference programme is attached as Appendix 3.

1. Leadership in Reproductive Health and maternal-newborn health
2. Best practices to improve maternal and newborn outcomes
3. Family Planning and the unmet needs
4. Adolescent sexual and reproductive health
5. Gender-based Violence
6. Cervical Cancer – Prevention and Management
7. Maternal death surveillance and response (MDSR)
8. Midwifery Development and the role of Midwifery Societies
9. Continuing Professional Development
10. Health workforce development in obstetrics and gynaecology in the Pacific

In addition to the conference sessions, a side session on “Practice Improvement Marketplace Stalls” was set up. This allowed midwives to showcase best practices and innovative methods for improving maternal and newborn health in their own settings. The list of best practice topics and presenters at the Marketplace Stalls can be found at the end of Appendix 3 (conference programme).

Local Organising Committee

In preparation for the conference, a local organizing committee was formed 10 months before the event. The role of the local organising committee was to plan, organize and coordinate the preparations required to host a fairly large gathering. The contribution of this committee played a critical role in the smooth running of the workshops and the conference. Dr Errollyn Tungu, O&G Consultant at Vila Central Hospital was the Team Leader of the committee which worked tirelessly to put together the ground work and logistics of the event, in particular the organisation of the venue, transport, workshop arrangements and the official opening ceremony. The committee was the link between PSRH and the Government of Vanuatu. PSRH is appreciative of the work undertaken by the local organizing committee to help make the conference a successful one.

Participants, Speakers and Resource Persons

Three hundred thirty-two (332) participants took part in both the workshops and the conference. Twelve (12) countries were represented at this event and included: American Samoa, Australia, Cook Islands, Fiji, Kiribati, New Zealand, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu. The largest contingent came from the Solomon Islands.

Visiting experts also came from England and the United States – they funded their travel and volunteered as facilitators. Key speakers, facilitators and resources persons came from the bigger countries of Australia, New Zealand, Papua New Guinea and Fiji. The Royal
Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) was represented by Dr Roy Watson.

Being the major funder of the conference, there was a large turn-up from UNFPA. Staff of UNFPA Offices in Fiji, Papua New Guinea, Solomon Islands and Vanuatu participated actively both the workshops and the conference, showing their engagement and support for a worthy cause. UNFPA was a major sponsor of a number of participants who attended both the workshops and the conference.

**Conference Evaluation**

A written feedback at the conclusion of the conference allowed the Secretariat to assess Participants reaction about the workshops and conference. In general, the feedback was very positive *(Appendix 4).*

**8. PSRH BIENNIAL GENERAL MEETING (BGM)**

The business meeting of the PSRH Trust was conducted on 17th July and was opened by the President, Kathy Gapirongo. Minutes of the 2015 meeting were approved and the President reported on the accomplishments of the previous two years which included forming a PSRH Branch in Samoa. Her report was endorsed by the meeting, and is listed in *Appendix 5.*

The Hon Treasurer’s report was presented and followed and a surplus was made in the previous two years. The full financial report is listed as *Appendix 6.*

Election of Office holders followed and the new Board for the period 2017-2019 are as follows:

- **President** Dr Pushpa Nusair (Fiji)
- **Vice Presidents**
  - Dr Kara Okesene-Gafa (Medical, New Zealand)
  - Paula Puawe (Midwifery, Papua New Guinea)
- **Hon Treasurer** Dr Roy Watson (Australia, RANZCOG Representative)
- **Hon Secretary** Dr Gunzee Gawin (PNG)
- **Past President** Kathy Gapirongo (Solomon Islands, ex-officio member)
- **General Members**
  - Nancy Pego (Solomon Islands)
  - Tagiyaco Vakaloloma (Fiji)
  - Dr Errollyn Tungu (Vanuatu)

The BGM brought in four new members: two midwives and two doctors.

The following abstracts were accepted for presentation at the 2017 PSRH Conference, 15-18 July 2017, Port Vila, Vanuatu. Disclaimer: this has been prepared using the author-supplied copy with a review process independent of the PJRH peer-review process. Editing has been restricted to some corrections of spelling and style, where appropriate. No responsibility is assumed for any methods or claims contained in the abstracts. The theme of the conference was “Reproductive Health and the Sustainable Development Goals – catalysts for accelerating progress”.

MATERNAL HEALTH

A retrospective study of Births before Arrival (BBA) at the Colonial War Memorial Hospital (CWMH), Suva

Aliote GALUVAKADUA

Anderson Maternity Unit, CWM Hospital, Suva Fiji. aliote.galuvakadua@govnet.gov.fj

Birth before arrival (BBA) refers to childbirth taking place either at home or en route to a health facility. A baby delivered before arrival (BBA) places both mother and newborn at risk of immediate postpartum complications. Hence, they need extra care upon reaching the health facility so that a quick assessment is made and to ensure their conditions are stabilised.

This hospital delivers more than 8,000 babies per annum. During 2013, there were 62 BBAs out of 8,717 total births. A small study was undertaken to review data of BBA cases admitted to CWM Hospital during a 12-month period, January to December 2013. The study aimed at identifying the factors associated with Birth Before Arrival (BBAs) at the maternity unit of the Colonial War Memorial Hospital and to describe maternal-newborn outcomes.

Establishing a maternal death review system – keeping it functional effective

Rajat GYANESHWAR

Professor of Obstetrics and Gynaecology, Fiji National University. Rajat.gyaneshwar@gmail.com

Many of the Pacific Island countries have small populations and the numbers of maternal deaths are few and often occur far between. Despite this it is good to have an efficient, effective and functional maternal death review system. Review of such catastrophic events can inform policy and practice. They often identify gaps in service, clinical skills, resources and other health systems issues.

The review system must not be resource intensive. It must be responsive to local needs but at the same time be comprehensive enough to be reliable. Adverse events can be very distressing for the clinicians involved and can be associated with the public and administrators trying to find a scapegoat.

In this presentation, some observations will be made about the existing maternal death review systems and recommendations made for consideration for a more functional and effective system. It is important that any system should be able to prompt the health team to respond to the findings and recommendations of each case reviewed. A case study will be presented for consideration as a model for a simple, effective review system.
How to avoid obstetric sphincter injuries

Judith GOH

Consultant Urogynaecologist, Greenslopes Private Hospital, Brisbane; Griffith University, Queensland, Australia. jtwgoh@hotmail.com

The rates of obstetric anal sphincter injuries (OASIS) range from 1-9% of all vaginal deliveries. Improved training and awareness are associated with higher rates of identification of injuries. Repair of OASIS should be performed by or supervised by appropriately trained health workers, under appropriate conditions (anaesthesia, lighting, instruments etc.). Risk factors for OASIS include primigravida, higher birth weight (over 4 kg), Asian ethnicity, occipito-posterior position, prolonged second stage of labour, shoulder dystocia and instrumental deliveries. However, recognition of risk factors does not currently allow for accurate prediction or total prevention of injuries.

There are modifiable second stage interventions that may reduce the risk of OASIS. The evidence for protective effect of episiotomies is conflicting. However, if an episiotomy is performed, a mediolateral not midline episiotomy is recommended. In addition, due to the crowning of the head causing perineal distension, an episiotomy angle of 60 degrees from the midline is recommended. A mediolateral episiotomy performed at time of instrumental delivery lowers OASIS.

Continuous application of warm compress during the second stage of labour has been shown to reduce OASIS (Cochrane). Perineal massage antenatally or in labour has not been shown to reduce perineal tears. Perineal protection (‘hands-on’ perineum, slowing delivery of the head) may be protective. Ideally, women who have had OASIS should be followed up in a multi-disciplinary perineal clinic. Obstetric anal sphincter injury is not considered substandard care but failure to recognise the injury may be considered substandard care.

Screening, diagnosis and management of gestational diabetes in New Zealand: A clinical practice guideline

Karaponi OKESENE-GAFA

Obstetrician and lead clinician for the diabetes in pregnancy services, Counties Manukau Health, South Auckland, New Zealand. kokesene-gafa@auckland.ac.nz

Increasing rates of gestational diabetes (GDM) globally as a consequence of the obesity pandemic affecting developed and developing countries is concerning. In December 2014, the New Zealand Ministry of Heath published the “Screening, Diagnosis and Management of Gestational Diabetes in New Zealand: a clinical practice guideline”, with the aim of standardising diagnosis and management of GDM whilst awaiting research outcomes to review the guidelines.

The guideline recommended HBA1c be included with antenatal booking bloods. This helps identify pregnant women with undiagnosed type 2 diabetes (HBA1c ≥ 50 mmol/mol) for prompt referral to a diabetes in pregnancy (DiP) specialised service. Prediabetes HBA1c in the range 41-49 mmol/mol are to be offered dietary and lifestyle advice and a 75g oral glucose tolerance test between 24-28 weeks gestation. If positive, these women are to be referred to DiP services. All others with HBA1c of ≤ 40mmol/mol are offered a non-fasting polycose test at 24-28 weeks gestation and if positive are offered the 75g OGTT test and then if positive, are referred to the DiP services for management. If the OGTT is negative and the practitioner is still concerned the mother may have developed GDM, the OGTT is repeated later in pregnancy.

There are controversies around the implementation of the guideline in New Zealand. In Middlemore Hospital in South Auckland, we have decided to implement the guidelines and be involved with research, the: “Gestational diabetes study in the detection of thresholds (GEMS)”; the "Optimal Glycaemic targets for gestational diabetes (TARGET)" and the “Healthy Mums and Babies study (HUMBA)".

Perinatal depression

Amanda NOOVAO-HILL

A/Professor in Obstetrics and Gynaecology, Lautoka Hospital and College of Medicine, Nursing and Health Sciences, Fiji National University. amanda.hill@fnu.ac.fj
Perinatal depression is prevalent, under-diagnosed and can have serious long-term effects on the wellbeing of women, their infants, their partners and families. The WHO statistics show, that worldwide, 10% of pregnant women and 13% of women who have just given birth experience a mental disorder, primarily depression. In developing countries this is higher, i.e. 15.6% during pregnancy and 19.8% after childbirth. In severe cases this had led to suicide. WHO defines mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. In 2012–14, 25% of all maternal deaths in the UK between 6 weeks and 1 year after childbirth were related to mental health problems, with suicide the leading cause of direct maternal death.

The MDG5 addressed improving maternal health. Integral to maternal health is maternal mental health. World leaders recognize the need for promotion of mental health and well-being, and the prevention and treatment of substance abuse, as health priorities within the global development agenda. The inclusion of mental health and substance abuse in the Sustainable Development Agenda, which was adopted at the United Nations General Assembly in September 2015, is likely to have a positive impact on communities and countries.

The gaps that exist in perinatal mental health care would be unacceptable in any other area of maternal and child health, and must be addressed. This presentation will cover perinatal depression. **Conclusion:**

PND is a significant contributor to maternal morbidity and mortality and we in Fiji and the Pacific have limited information about the magnitude of this problem.

**Prevalence of overweight and obesity among pregnant women attending antenatal clinic at Colonial War Memorial Hospital (CWMH), Suva, Fiji**

Pushpa NUSAIR, James FONG, S PRAKASH, Ian ROUSE

**Consultant Obstetrician and Gynaecologist, CWM Hospital; Fiji National University.  Pushpa.nusair@fnu.ac.fj**

Overweight and Obesity are considered major public health issues in both developed and developing countries. This study aims to understand the prevalence of overweight and obesity among pregnant women attending the antenatal clinic at the CWM Hospital, in Suva, Fiji during 2014-2015.

A cross-sectional study was conducted among 2203 mothers who met the inclusion criteria to participate in this study between 1st May 2014 and 31st December 2015. A purposive sampling was used to select the participants. The study participants were informed about the objectives of the study using an information sheet and a consent form was completed before any data was collected. Research assistants assisted in collecting the data through questionnaires. The participants’ body mass index (BMI) was measured and data were analysed using descriptive analytical techniques. Statistical significance was declared when p<0.05. The study highlighted overweight and obesity as an urgent health issue among pregnant women in Fiji.

**Metformin for gestational diabetes – a cause for concern?**

Bill HAGUE

Robinson Research Institute, University of Adelaide; Women’s and Children’s Hospital, Adelaide. bill.hague@adelaide.edu.au

Metformin is a first line agent around the world for the management of type 2 diabetes. It is an oral medication that is widely available, cheap and effective, with a low side effect profile.

Concerns have been expressed about the safety of metformin in pregnancy as it crosses the placenta. The Metformin in Gestational diabetes (MiG) trial, conducted in New Zealand and Australia, demonstrated that metformin is as effective as insulin in the management of women with GDM, with no major safety concerns. Subsequent follow-up of the offspring up to age 13 years has not identified any significant issues with their growth or development beyond those associated with the maternal diabetes and its associated hyperglycaemia.

Despite the evidence and the inclusion of metformin in many national and regional guidelines for the management of gestational diabetes, some senior physicians are still questioning its use in pregnancy. Perhaps it is time to turn to evidence-based, rather than “eminence-based”, medicine?! There are particular benefits to be considered for using metformin in pregnancy among Pacific Island nations.
Working with women experiencing postpartum haemorrhage in Santo, Vanuatu
Anna-Maria Salmamkan, Catherine Wright
Northern Provincial Hospital, Santo, Vanuatu: annasalmamkan@gmail.com or catherine.wright@acu.edu.au

Postpartum haemorrhage [PPH] is life threatening, particularly in the absence of trained health care professionals, or when the woman is situated in a remote part of the island. At Northern Provincial Hospital, several women per year experience life threatening PPH. In this presentation, Anna-Maria will share her experience in caring for these women – the diagnosis, treatment and care will be explored in detail. This presentation is intended for other midwives and those caring for birthing women. Women and babies need skilled attendants, with adequate resources and medications during birth.

Outcomes of high risk obstetrics transfer in Kavieng General Hospital
Saberina Silas
Kavieng General Hospital: saberina.silas@gmail.com

This presentation aims to identify the reasons for high risks obstetrics transfers to Kavieng General Hospital and determine the maternal and perinatal outcomes of these high risk obstetric transfers. A study of 80 cases of high risk obstetrics transfers to Kavieng General Hospital was undertaken over a six-month period from March to August 2016.

The study found that the most common reasons for transfer were: prolonged labour, transverse lie, postterm, antepartum haemorrhage, and pre-eclampsia. Of the transfers, 33/80 were referrals antenatally, 40/80 in labour and 4/80 postnatally. Mode of delivery outcomes: 44/80 had normal vaginal deliveries, 18/80 had caesarean sections, 11/80 had assisted deliveries and 4/80 had breech deliveries. Neonatal outcomes: 47/80 born alive and well, 19/80 babies admitted to SCN, 10/80 still born babies and 1/80 had an early neonatal death. Grand multiparty was associated with more post-partum complications. 32/80 had 4-7 days length of stay, > 1 week 25/80, 2-3 days 13/80 and 1/80 > 1 month.

The study showed that transferred cases largely result in successful outcomes for both mothers and babies. Early recognition and timely transfer of high risk obstetrics transfers affects the maternal and perinatal outcomes. Emphasis should therefore be put into addressing the three delays in order to reduce the likelihood of maternal and newborn deaths.

Update on PRE-EMPT
Wame Baravilala
Consultant in Reproductive Health, Navava Estate, Savusavu, Fiji. wrbaravilala@gmail.com

The perinatal mortality rate from eclampsia in the USA and the United Kingdom ranges from 5.6% to 11.8%. The maternal mortality rate is as high as 14% in some developing countries. Since the beginning of this decade PRE-EMPT, a Bill Gates Foundation funded initiative, has been looking at the monitoring, prevention and treatment of pre-eclampsia and eclampsia in low and middle incoming countries. This presentation will cover some of the significant developments and findings of PRE-EMPT, to date.

The Impact of Maternal Trauma on Bonding
Sara Weeks: sweeks@adhb.govt.nz

Psychiatrist at Lotofale Pacific Island Mental Health Service, Auckland, New Zealand

Trauma has a profound and pervasive impact on neurological functioning. Both historical and acute trauma have effects on the brain which can reduce empathy, numb the experience of emotions, and impair executive functioning. Even basic functions like eating, sleeping and breathing can be affected which further compounds subjective distress and dysfunction. A traumatized mother will find it difficult to engage with her baby – both in utero and out – and the trauma may be transmitted to the next generation.

An overview of the biological impact of trauma will be presented along with some case vignettes. Some strategies for reducing the impact of trauma on both mother and baby will be presented, with a focus on those which are available in the Pacific context. Discussion and questions are encouraged. Trauma is
unfortunately very common and could be considered a hidden cause of transgenerationally transmitted morbidity. While it is of paramount importance to deal with the causes of the trauma, it is nonetheless also important to ameliorate its impact.

School of Medical and Health Sciences, University of Papua New Guinea, glenmola@dg.com.pg

The traditional time to initiate postpartum contraception is after the 6 weeks postpartum check. Many women in Papua New Guinea (PNG) do not have access to a postpartum check. Reliable family planning is used by only about 25% of women in PNG, and Demographic Health Surveys indicate that the unmet need is more than 40%.

Most women who have just delivered a baby are keen not to get pregnant for at least several years. Many family planning (FP) methods are not unsuitable for immediate postpartum use. Mini-pills and depo provera can safely be used in the immediate postpartum period. But if a woman is exclusively breast feeding, they do not add anything to lactational amenorrhoea for at least the first 3 months. Recently, there has been a considerable tranche of research on the immediate postpartum insertion of FP Implants. WHO has also declared that their postpartum use is not contraindicated for breast feeding women.

A number of large hospitals in PNG have set up programs to make immediate postpartum Implant insertion available to women before they are discharged. At the Port Moresby General Hospital, 15-20 out of the 45 women who give birth every day accept the offer of an immediate postpartum Implant insertion. A further 5-7 women request immediate postpartum tubal ligation. This means that nowadays more than 50% of women giving birth go home with an effective method of contraception. Implants are also popular when offered on mobile clinics outreach to rural villages.

SEXUAL AND REPRODUCTIVE HEALTH

Management of family and sexual violence in Papua New Guinea health facilities

Lara ANDREWS

Psychologist and Doctorate of Public Health, Flinders University; Department of Foreign Affairs, Australia. Lara.andrews@dfat.gov.au

This presentation will discuss the results of a study, which sought to explore the underlying factors that influence how nurses ask patients about family and sexual violence (FSV) and how they respond to survivors in Papua New Guinean (PNG) health facilities.

Fifty-four nurses completed the Domestic Violence Healthcare Provider Survey Scales (DVHPSS), which measured their self-perceived knowledge, attitudes, beliefs and practices towards identification of FSV. In-depth interviews with eighteen postgraduate midwifery nursing students helped explore social, cultural and organisational factors that affect nurses’ identification and management of FSV.

The combined results demonstrate that nurses regularly deal with cases of FSV but often lack the training, support and security to provide appropriate treatment and care. Cultural constructions of gender in PNG, the operating environment, as well as professional training and, interact and converge to shape the individual behaviour of nurses in different ways.

These findings show nuances of health care provision in PNG but also demonstrate that PNG nurses face similar challenges to nurses in other parts of the world, particularly those working in resource-constrained environments and with high levels of gender inequality. Nurses face multiple barriers when trying to provide care but also demonstrate deep commitment to improving health outcomes for their patients and this is a source of great opportunity. This study provides contextually specific evidence relevant for improving service delivery for survivors in PNG.

Family planning in Lautoka Hospital, Fiji

Luisa GAVIDI, Veena MUDALIAR, Felicity COPELAND

Family planning clinic, Lautoka Hospital, Fiji. gavidiluisa1@gmail.com

Lautoka Hospital in the Western Division of Viti Levu in Fiji, serves approximately 370 000 people, which is 40% of Fiji’s population. It is the Division’s only referral tertiary level hospital and provides both
primary and secondary health care. The maternity unit facilitates the birth of over 4000 babies per annum.

Of specific importance to the health of women are family planning options. The Lautoka nurses and midwives are well trained to provide counselling and are committed to deliver safe and effective birth control methods for women. This paper describes the experience of midwives and nurses working in this area of maternity care and explores the ways in which culturally appropriate care is delivered to women who seek reliable family spacing options.

Using videoed interviews and images, we see first-hand the interactions between health care professionals and the women in their care. The challenges, rewards and results of this important service are examined in relation to the World Health Organization’s declaration... ‘that family planning can play a vital role in the reduction of infant, child and maternal morbidity and mortality and can lead to higher education and employment opportunities and empowerment for women...’(WHO 2013).

This paper illustrates the importance of a dedicated evidence-based approach to family planning services and highlights the benefits to the health and well-being of the families and communities in this area. This presentation is appropriate for all health care professionals working in maternal, child and family health.

Successful initiatives in advancing sexual and reproductive health in Kiribati

Tamoa MOANNATA
Healthy Families Project Manager, Kiribati Family Health Association, Teoraereke, Tarawa, Kiribati. tamoamoannata@gmail.com

The Republic of Kiribati is a remote island nation in the equatorial Pacific Ocean, consisting of 32 coral atolls and two raised coral islands spread over an area of 3.5 million square kilometers. With a current population of around 110 000, the Kiribati National Statistics Office and Secretariat of the Pacific Community have estimated that population could exceed 200 000 by 2050. Data from the 2009 Demographic and Health Survey in Kiribati highlight a significant unmet need for family planning, with total fertility of 3.8 children per woman exceeding the desired family size of 2.7 children.

The Kiribati Family Health Association (KFHA) is an International Planned Parenthood Federation member that works to improve access to sexual and reproductive health services and information in Kiribati. KFHA has adopted a holistic approach to its work, and recognises the needs to engage and work closely with central and local government, churches and community leaders. Its approach is tailored to the needs of diverse clients including sex workers, MSM, Catholic women, youth and people living in urban centers and outer islands. KFHA's approach has proved successful and has seen substantial increases in the number of clients accessing SRHR services in Kiribati.

Tamoa Moannata, Healthy Families Project Manager at KFHA will share lessons from KFHA's successful initiatives, including; the development and implementation of island strategy plans to enhance strong partnerships between community leaders, facilitating community grant programmes, the establishment of volunteer groups, and engaging with Catholic communities and heads of households.

Barriers to adolescent use of contraception in Pacific Island countries: sexual and reproductive health workers’ perspectives

Renee MONTGOMERY
Master of Public Health Programme, University of Queensland. renee.e.m@gmail.com

Modern contraception has a profound impact on global health, including maternal and child survival and health outcomes, and socio-economic benefits from women controlling the timing and number of their pregnancies. By reducing unintended pregnancies, modern methods of contraception offer an important solution, especially for sexually active adolescents, for whom unintended pregnancies carry higher risk of complications and greater opportunity costs. The majority of the Pacific region's population is under 25 years, adding to the importance of modern contraception for this group.
The Sustainable Development Goals - health, education and gender in particular - renew focus on adolescent contraception, yet there is limited research of adolescents’ use of contraception across the Pacific. Both available data and local understandings however, indicate that adolescent sexual activity and unintended pregnancy are common. Twelve key informants (SRH workers) were interviewed, focusing on major impediments to adolescent access to contraceptives in the Pacific and the socio-cultural contexts in which they occur.

Findings are of relevance to policymakers, service providers and advocates of adolescent sexual and reproductive health. Preliminary findings suggest that in light of gendered reproductive expectations and stigma surrounding pre-marital sex, adolescents must navigate a dynamic and contentious context, relating to knowledge and power within communities, families, and relationships, resulting in reduced agency and increased ambivalence attitude towards using contraception. This suggests that there is a need for greater engagement and consultation, and wider consideration of cultural factors to improve adolescent use of contraception in the Pacific.

**Family planning among rural women in Fiji**

Swaran L NAIDU  
A/Professor of Obstetrics and Gynaecology, Fiji National University; Medical Director Viseisei Sai Health Centre, Lautoka, Fiji. Swaran.naidu108@gmail.com

The contraceptive coverage rate in Fiji is reported as 45%. Adolescent pregnancy rates are high at 35 per 1000 females in the age group 15-19. SRH information and services are a fundamental human right. Rural women are generally disadvantaged for many reasons - 40% of the rural population live below the poverty line, they often have difficulty in accessing accurate information and clinical service.

In this paper, we share some findings of our baseline survey on the Knowledge, Attitude, Practice & Barriers (KAPB) to safe sex practices, contraceptive use as well as our experience of taking outreach health promotion and family planning services to the rural women.

There was a significant knowledge-practice gap surrounding contraceptives and safe sex. Forty percent of women were unable to articulate a barrier to contraceptive use and said they did not know whereas 21% said ‘fear’, 15% said ‘partner objecting’ and 5% said ‘religion’ were barriers. When women with children were asked how many of their pregnancies were planned 18.2% had not planned any of their pregnancies and 37% of all pregnancies were reported to be unplanned.

**Conclusion:** Review of reproductive health programs is necessary to ensure misinformation and false perceptions do not act as barriers. For those in rural areas, outreach health promotion and clinical services is required to reach those with difficulty in accessing these services.

**Health sector response to sexual violence and gender-based violence in PNG**

Jessica YAIPUPU  
Technical Officer, Women’s Health/Gender Equity Human Rights and Violence Injury Prevention, World Health Organisation, PNG. yaipupuj@who.int

The rates of violence against Women (VAW), girls and children in PNG are thought to be some of the highest in the Western Pacific Region. Gender-based violence and sexual violence against women and girls is a human rights violation and a major public health concern, with wide ranging health consequences for women, families and communities.

The health sector has a critical role to play, as part of the multi-sectoral response in addressing violence. Health systems can and must provide access to quality, comprehensive services for survivors. They have an important role to play in improving data collection and evidence to inform policies and programmes for prevention and response. Papua New Guinea over the last three years has taken drastic steps to strengthen the health systems response to addressing gender-based violence, and to work towards ensuring that survivors have access to quality health services.
**Contraceptive methods according to age group—analysing medical records of pregnant women who visited the clinic of Vanuatu Family Health Association**

Minami KAWAMATA, Julianne ARU

*Vanuatu Family Health Association, Japan International Cooperative Agency.* kwmt8257@gmail.com

The Contraceptive Prevalence Rate in Vanuatu is 37.7%, while 28.9% use a modern method. The estimated population growth rate is 2.4% and Total Fertility Rate is 4.2. This research was conducted to elucidate the current situation of contraceptive used among pregnant women who visited our clinic in Port-Vila.

107 antenatal medical records were classified into the following five categories and each category is cross-examined: Age, number of children, education level, contraceptive history, and planned or un-planned pregnancy. From the cross-examination three trends were identified (p<0.05).

1) Age<19 women (N=12) didn’t use any contraceptives and 77% of them are un-planned.
2) Age between 25 to 40 women (N=61) increase in using contraceptives. This age group woman has 2 or more children.
3) 77% of the women who have more than 4 children (N=10), whose contraceptives were not successful and had un-planned pregnancy.

**Conclusion:** The results indicated that the following points are recommended:
1) Continue sexual education and provide contraception among teenage girls for preventing un-planned pregnancy.
2) Motivate mothers to use family planning methods effectively and persuade to use Long Acting Reversible Contraceptive.
3) Motivate for all un-planned pregnant mothers who are over 40 years or with more than four children to be encouraged to choose permanent method.
4) Further research is needed to find out the reason why contraceptive users are still ended up with un-planned pregnancy.

---

**Determinants and consequences of unsafe abortion in Solomon Islands**

Rebecca MANEHANITALI, Paula LORGELLY, Katherine GILBERT, Divi OGAOGA, Jane FISHER, Elissa KENNEDY

*Solomon Islands Nurses Association (SINA).* Bettyrmane@gmail.com

Unsafe abortion is one leading causes of maternal mortality and morbidity, accounting for a yearly estimated 47,000 deaths globally. Majority of deaths occur in lower-middle income countries, like SI, where use of modern contraception is low and access to safe abortion services is legally restricted.

This project is one of the first studies in the region to examine the multifactorial determinants and consequences of unsafe abortion.

Interviews with health workers and focus group discussions with young women and men were conducted in Honiara and Guadalcanal in 2015. Also, inpatient records were extracted from the National Referral Hospital. Ethics approval was obtained from Solomon Islands National Health Training and Research Institute and Monash University.

Unwanted pregnancy occurs to both unmarried and married women for many reasons. Lack of use of contraception is an after-thought. Abortion is often considered in situations where pregnancy is not planned and is not wanted. However, abortion is illegal in Solomon Islands. Hence, abortion may take the form of kastom medicine, self-harm or accessing misoprostol. The complications are common and may lead to incomplete abortion presenting with bleeding, anaemia and infection. Stigmatization of women is common in communities. Post-abortion care at health facilities is limited. Post-abortion complications account for 2.4% of admissions at an average cost of SBD 10 000 per admission, representing a preventable burden on the health system.

Findings from the study can be used to inform policy and programs to reduce unwanted pregnancy through effective family planning services, and therefore present unsafe abortion; and improve access to quality care for post-abortion complications.
Contraceptives uptake in the Pacific: Impact of Long-acting Reversible Contraceptives (LARCs) in Couple Years of Protection (CYP)

Pulane TIEBERE

United Nations Population Fund, Suva, Fiji. tiebere@unfpa.org

Access to modern methods of family planning is essential to strengthening gender equality and women’s and girl’s economic empowerment. Women and girls who have access to FP typically have higher levels of education, greater wealth, and healthier families. In the Pacific, against the global trend, access to, and the use of FP has been stagnant for a decade, and alarmingly, in some countries is beginning to decline. A new approach is required to reverse this trend and position the Pacific to achieve Agenda 2030 goals on SRHR, particularly universal access to FP (target 3.7).

For all countries in the Pacific, at least three types of contraception are available at all central levels including emergency contraception, and male and female condoms. Changes in the method mix in recent times (2014-2016), mostly due to the popularity of contraceptive implants, has seen a significant increase in the Couple Years of Protection (CYP) in the Pacific Island Countries and Territories (PICTS).

This significant change in the CYP indicators reflects the programmatic efforts led by Solomon Islands, Fiji and Vanuatu in introducing and offering subdermal implants, mainly Jadelle, which contributed to boost demand of Family Planning services. However, these recent changes have also increased the cost of provision of contraceptives and challenged the financial sustainability of the FP programmes, coinciding with a decrease of funding support from the main regional donors in recent years.

CANCER OF CERVIX

An overview of cervical cancer at the Port Moresby General Hospital, PNG

Mary R BAGITA, Bediako AMOA

Obstetrician and Gynaecologist at the Port Moresby General Hospital, Papua New Guinea. mbvangana@yahoo.com

Cancer of the cervix is the commonest gynaecological cancer in Papua New Guinea (PNG). More than 1500 women die from cervical cancer in PNG every year and therefore, the burden of cervical cancer is amongst the highest in the world.

Cervical cancer accounts for more than 50% of all admissions for gynaecological malignancies (54% in 2016, PMGH). However, only 12.5% of these women were eligible for a Wertheim’s hysterectomy in 2016. A smaller proportion was able to receive radiation therapy. Port Moresby General Hospital (PMGH) is the national referral hospital receiving patient referrals from across the country. Cervical cancer is a common reason for referral to PMGH.

The challenges faced in managing cervical cancer in PNG are numerous ranging from late presentation (usually beyond stage 2A) to difficulties obtaining histopathological confirmation, to challenges in surgery and radiation treatment. This paper highlights the challenges and an attempt to look at ways to improve the cervical cancer burden in the country.

Introduction of HPV vaccination in PNG

Julia V STINSHOFF, Edward WARAMIN, Lutty AMOS, Mary R Bagita*

National Department of Health; National Capital District Health Services; University of PNG School of Medicine and Health Sciences; Port Moresby General Hospital, PNG. mbvangana@yahoo.com

Cervical cancer is the most common cancer amongst women in PNG, accounting for approximately 1500 deaths each year. PNG has amongst the highest estimated burdens of cervical cancer globally (6.3 times higher incidence than Australia and New Zealand, with a 13.5 times higher mortality rate).

Both lower HPV infection prevalence and properly implemented screening programmes contribute to the low mortality in some countries; and higher mortality in some countries is at least due in part to co-infection with HIV and STIs. In one PNG study of 1173 women attending ANC, SRH, and WWC, nearly 50% of women had HPV infection, three quarters being infected with high risk HPV.
PNG commenced its first cervical cancer vaccination programme in May 2017, using the vaccine GARDASIL. The vaccination will be given in 2 doses, 6 months apart to girls aged 9-14 and in grades 3-8 at a public and private schools in the National Capital District. It is planned that in 2018, girls in other provinces and out-of-school girls will be offered the vaccination. This paper is a preliminary presentation on the HPV vaccine roll-out in PNG.

**Follow-up challenges in cervical cancer prevention**

Catherine MCGOWAN, Sera TOALIU

*Family Planning Australia and Vila Central Hospital, Vanuatu. catherinem@fpnsw.org.au*

**Objective:** Preventing deaths from cervical cancer in Pacific Island nations has been recognised as a priority for the region. While screening activities are increasing in several countries, we acknowledge that screening alone will not prevent cervical cancer. We provide a review of the challenges faced in providing follow-up treatment for women who screen positive and strategies appropriate for local health systems.

**Discussion:** The importance of each component of the screening, treatment and follow-up pathway is discussed, and challenges described from a client, screening provider and gynaecology service perspective. While exploring factors that contribute to high lost to follow-up rates, we focus on strategies that mitigate this risk to a screening programs success and the health of individual women. Pacific specific strategies are presented, including the provision of adequate information regarding follow-up at the time of screening, sustainable methods of communicating and documenting results at each stage of the pathway, improved access to diagnostic and treatment services, commitment of resources, vigilant monitoring and evaluation of services.

**Conclusion:** It is essential that Pacific Island nations aiming to prevent deaths from cervical cancer, implement robust treatment and follow-up processes to support screening activities. Strategies are provided for consideration by those involved in implementing new cervical screening programs and strengthening existing cervical cancer prevention activities.

**Alec EKEROMA, Peter SYKES Cervical cancer treatment in Small Island Development States (SIDS) - a narrative synthesis**

, Glen MOLA, James FONG, Sandeep NAiK, Jeffrey TAN

*Pacific Women’s Health Research Unit, Department of Obstetrics and Gynaecology, University of Auckland. alec.ekeroma@auckland.ac.nz*

**Background:** Cervical cancer incidence and mortality in the Pacific region range from 8.2-50.7/100,000 and 2.7-23.9/100,000 respectively which translates to 800 new cases and 500 preventable deaths per year. Prevention strategies in HPV vaccination and screening programmes are lacking in most Pacific Island countries. The aim of systematic review and narrative synthesis were to identify effective cancer treatments provided in the Small Island Developing States. The aim of the PICCCS is to determine the availability of a policy framework, infrastructure, diagnostic and treatment options available in the Pacific Islands.

**Methods:** Systematic review of the literature on cervical cancer treatments in 34 SIDS countries. A survey of identified O&G specialists recruited by email and administered a questionnaire using Qualtrics.

**Results:** One of the seven papers, describing services, was from the Pacific. Four (13%) and six (19%) of respondents were aware of local policies and clinical guidelines respectively that support and guide the treatment of women with cervical cancer. Computed tomography imaging was available in the country of 29 (85%) respondents and 21 (66%) knew of a doctor who can perform radical surgery. Chemotherapy was available in the country of 14 (44%) and there is one radiotherapy unit in Papua New Guinea. Most respondents saw an average of 13 women with cervical cancer in the last 12 months. Most respondents preferred to spend limited resources on HPV vaccination and community palliative services than on building treatment capability.

**Conclusion:** The findings stress the need for widely disseminated policies and guidelines for the management of women with cervical cancer, from prevention to palliation.
Gynaecological diagnosis at the primary care level

Glen MOLA

School of Medical and Health Sciences, University of Papua New Guinea, glenmola@dg.com.pg

Gynaecological problems are often counted as the most difficult to work out and manage at the primary care level. However, a few simple rules and guidelines can help primary care workers work out most presentations.

Sexually transmitted infections are common all around the Pacific; this means that a woman in the fertile age group who has a partner and not using family planning, and who is unable to get pregnant probably has PID. Endometriosis is a less common diagnosis and some simple history can usually help point to the diagnosis. Women over the age of 30, with abnormal uterine bleeding must have a speculum examination to exclude cancer of the cervix. Becoming adept at speculum examination is also important so that the primary care worker can tell the difference between the common causes of vaginal discharge (vaginitis).

Because of the obesity epidemic in urban areas of most Pacific island countries, dysfunctional uterine bleeding (DUB) is also very common and can usually be worked out from the history. The androgenisation of women with polycystic ovarian syndrome (PCOS) associated with DUB is genetically quite variable, and health workers in various parts of the Pacific need to become familiar with its usual local manifestations.

Although ultrasound can assist in the diagnosis and management of miscarriage and ectopic pregnancy, it is not essential. The simple technique of culdocentesis is very helpful when the diagnosis of ectopic pregnancy is suspected. Incomplete miscarriage can now be effectively managed medically with misoprostol, making referral for surgical evacuation unnecessary for most cases.

State of the midwifery workforce in the Pacific

Caroline HOMER, Sabera TURKMANI, Michele RUMSEY

Centre for Midwifery, Child and Family Health and the WHO Collaborating Centre for Nursing, Midwifery and Health Development; Faculty of Health, University of Technology Sydney. Caroline.homer@uts.edu.au

Background: Strengthening midwifery is a global priority. Little is known about the education, regulation and professional associations for midwives in the small island nations of the South Pacific. Only Papua New Guinea and the Solomon Islands were included in the State of the World’s Midwifery Report in 2014.

Aim: To explore the current situation of the education, regulation and association of midwives in 12 small island nations of the South Pacific and determine the gaps in these areas.

Methods: A descriptive study was undertaken. Data were collected through a survey completed by key representatives (usually the Chief Nursing and Midwifery Officer) from each of the 12 countries. Ethical approval was received from UTS prior to commencement.

Findings: Many of the small island nations had few midwives, in some instances, only two midwives for the whole country. Midwifery education programs included post-graduate diploma, certificates and bachelor degrees. Midwives were required to be registered nurses in all countries. Regulation and licensing also varied - most countries did not have a separate licensing system for midwives. Only three countries have a specific professional association for midwives. Midwifery is invisible in much of the regulation and therefore in the acknowledgement of the contribution of midwives.

Conclusion: The variation and the small number of midwives poses challenges for workforce planning. Consideration could be given to developing regional standards and potentially a shared curriculum framework. Ongoing collaboration and networking between countries is a critical part of future developments.
Evaluation of community health workers’ upskilling training in maternal-newborn care

Jolly KULIMBUA, Mary SITAING
Mt. Hagen General Hospital, Western Highlands Province, Papua New Guinea. jollykulimbua@yahoo.com or msitaing@hotmail.com

Background: Community Health Workers (CHWs) in Western Highlands Province were given a 6-month CHW upskilling training to enable them to provide essential maternal-newborn care and refer emergencies to hospital. Five sets of trainings were conducted and 47 CHWs completed over a 5-year period.

Aim: To evaluate the effectiveness of the CHW Upskilling Training during 2012-2016.

Methods: A post-training assessment was conducted by direct observations of the CHWs in their workplaces. Assessors observed the application of knowledge and skills and determined if there were improvements in the health facilities. Purposeful discussions were carried out to elicit qualitative feedback from CHWs.

Findings: The findings were impressive. The organisation of health facilities improved with specific schedules made for priority reproductive and maternal health services. The recording of maternal and newborn care services indicated great improvement. The ANC, family planning and labour ward registers indicated the kinds of services provided including management of life-threatening conditions. Records show reduced maternal and newborn deaths, and referrals.

Conclusions: The CHW Upskilling Training Program is an effective intervention to improve reproductive health and maternal-newborn services in remote areas of PNG, particularly where there are no midwives, or higher category health providers. It has contributed to improved maternal-newborn survival.

Recommendations: The evaluation recommends that the CHW Upskilling Training should reach more CHWs to fill in gaps in health facilities where there are no midwives or doctors. In PNG, the CHWs upskilling program in maternal and newborn care is recommended for all CHWs.

Midwifery training in Papua New Guinea – the past, present and future – where do we go from here?

Paula PUAWE
School of Midwifery, University of Goroka, Eastern Highlands Province, PNG. Puawep3@gmail.com

Midwifery education until the 1990s was offered within schools of nursing until the University of Papua New Guinea (UPNG) offered a Certificate and then a Diploma in Midwifery. In the early years of the 2000s it became obvious that the midwifery workforce was declining and midwifery education needed a review. The 2006 Demographic Health Survey Maternal Mortality Ratio of 733 maternal deaths per 100 000 live births was released in 2009. This number was shocking to many and around the same time the Ministerial Task Force on Maternal Health in Papua New Guinea was convened. A number of international and local consultants, and the National Department of Health worked on revitalizing midwifery education and by 2009 a new national midwifery curriculum framework was approved.

The curriculum was implemented at five universities and have experienced great opportunities and challenges. Current midwifery students are taught evidence-based practice but this is difficult to implement in clinical settings due to lack of this knowledge by other clinical staff. There is also a lack of quality supervision of midwifery students by clinical staff who lack evidence-based knowledge. Midwifery graduates have problems maintaining their level of practice when they return to their own context for this reason.

Midwives who are well educated and regulated to international standards can provide 87 percent of the essential care needed for women and newborns. This presentation explains how the educators are addressing the challenges to sustain the midwifery training.

Developing a midwifery training programme in Vanuatu

Renata BULEBAN
Registered Nurse-Midwife, Vanuatu College of Nursing Education (VCNE). rbuleban@vanuatu.gov.vu
Midwives are the single most important cadre of health workers for preventing maternal, neonatal deaths, and stillbirths, but the number of midwives falls far short of the need. (HNN 2017).

Since Independence in 1980, Vanuatu has had numerous midwifery training programmes, delivered by the Nursing School in the capital and an independent institution in the Northern Province, and some have been trained in Fiji. The worsening maternal and newborn health statistics and the unchanged numbers of preventable maternal deaths prompted the Ministry of Health to address the root cause – not enough midwives!

Although there was some resistance, many challenges and the usual funding constraints the midwifery workforce was scrutinised and recommendations made for the way forward in Vanuatu. Addressing the low numbers of midwives and the impact of poor quality service delivery assured the process would have a positive influence on changing the data. Internationally the data has shown that midwives are the single most important profession that can make a difference to mothers and their newborn and that “midwifery is not just a vertical service….. but, midwifery services are a core part of universal health coverage.” (Lancet, 2014).

This session will describe our journey in developing a quality, accredited Midwifery training program in Vanuatu. What was needed, the support which was required, the lessons learned along the way, and the true measure of success.

**Midwifery leadership training in Australia**

Toonga TIEEI  
*Senior Nursing Officer, Obstetric Ward Tungaru Central Hospital, Nawerewere South Tarawa, Kiribati.*  
tjaylau71@gmail.com or pier.malavisi@gmail.com

In 2015, I attended Midwifery Leadership Training in Sydney, Australia. During that training, I identified my project “To establish Perinatal Morbidity and Mortality meetings”. Since then I have included quality improvement. I prepared a database for data collection on the Obstetric Ward and secured a laptop from UNICEF and recently secured a desktop community with funds provided by Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH). RMNCAH have funded a ward clerk position for the collection of our obstetric data. He really helps by assisting in the collecting of missing and/or incomplete data from our birth register book.

We are now using the data from our improved data collection for our Maternal Perinatal Death Systems Report (MPDSR) meetings. I believe this is a good example of how we can actually improve things here in the Pacific so I am keen to share our achievement with our Pacific neighbours. We really have improved data collection and I believe that this has helped raise awareness and improve our work practices. My presentation will focus on providing more detail on what we have achieved here in Kiribati.

**Review of the RANZCOG Pacific Midwifery Leadership Fellowship Programme, 2004-2016**

Carmel WALKER  
*The Royal Australian and New Zealand College of Obstetricians and Gynaecologists.*  
cwalker@ranzcog.edu.au

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Brian Spurrett Foundation has offered training and leadership fellowships to doctors and midwives since 2004. As a result of the success of the Brian Spurrett Fellowship program, RANZCOG has attracted support from the Australian Government’s Department of Foreign Affairs and Trade (DFAT) Australia Awards program between 2010 and 2017 to offer more midwifery leadership fellowships at participating Sydney hospitals. To date 101 midwifery leadership fellowships have been provided at Liverpool and Nepean Hospitals Sydney, and Middlemore Hospital, Auckland New Zealand.

This presentation will give an overview of the participation of senior Pacific midwives in a RANZCOG Midwifery Leadership Fellowship and outcomes arising from the program through leadership activities, perceived benefits to the midwives’ hospitals and health services, promotions gained and subsequent study achievements of past Fellows. The presentation will be relevant to midwives and those interested in pathways to personal growth, development of leadership capacity and the benefits of learning and networking between colleagues across the Pacific Islands, Australia and New Zealand.
Leadership in Multiple Disciplines – Adapting to the Changing roles of Pacific Clinical Specialists
Gunzee GAWIN
Hela Provincial Health Authority. Gawin.gunzee@gmail.com

Delivering effective health care in the Pacific has its own challenges where the rubber meets the road – at the point of patient/healthcare provider interaction. The irony is that the decision to effectively deliver health care is made at the executive level. The link between the executives of health care organizations/ agencies and the professionals providing health care to the patient is LEADERSHIP. Managers and executives are leaders; clinical specialists are also leaders. In Pacific settings, our local Specialists based on their professional capacity, are expected to take on multiple roles – one of them is to lead the clinical team and ensure that optimum care is provided to achieve the best outcome for women and infants.

In many situations due to human resource constraints, the same clinical specialist has to take on added roles and perform in multiple disciplines. This is the reality. How do we adapt and respond to the demands of changing roles? In this presentation, I wish to share my experience of assuming expanding leadership roles in multiple disciplines, from a clinical leader to the position of executive leadership.

Review of research projects by MMEd (O&G) for the last five years (2012-2016) at College of Medicine, Nursing and Health Science, Fiji National University
Pushpa NUSAIR
Fiji National University. Pushpa.nusair@fnu.ac.fj

Research projects are part of the requirements for the student to graduate with the Master in Medicine (Obstetrics and Gynaecology). The Master in Medicine degree course at the Fiji School of Medicine had their first graduates in year 2001 and each student completed a research project as part course for the degree.

This presentation captures the last five years (2012 to 2016) list of topics of the research projects, the review process, research clearance, challenges and success of these research projects. The list illustrates the growing interest among our post-graduate students in selecting a range of research subjects to carry out.

Incorporating research as a core activity for the MMEd students will greatly enhance the critical thinking and evidence based practice. Research helps to accelerate the progress towards achieving better maternal health outcomes and ultimately towards the achievement of the Sustainability Development Goals.

Fiji Midwifery Society – development and progress
Aliote GALUVAKADUA
Fiji Midwifery Society. aliote.galuvakadua@govnet.gov.fj

The main presentation will cover background, where the Society is now and the Society’s future.

Society background

Fiji Midwifery Society was formed in 1999 after Mrs. Alumita Bulicokocoko who was also the founder and the first President of the Society returned from an ICM conference that was held in India. Members of the Society included midwives practicing in Fiji and student midwives were also encouraged to join. There are challenges in running the Society in the last 18 years since 1999.

There was a pause in Society activities in 2008 when the midwives’ retirement age was reduced to 55years from 60years. All Society executives had to retire and only a few executives remained to run the Society. Bank account need to be renewed with new trustees. The Society was then managed by an interim committee until 2011 when an annual general meeting was held and the Society executive was elected. Society constitution was reviewed and endorsed in 2015 AGM. Membership drive for the Society was top priority to ensure that all Midwives in Fiji are members.

Where the Society is now
Membership for the society has really grown from 118 in 2015 to 250 in 2017. The Society Constitution had been reviewed and endorsed and been used to guide the society in all its activities. The bank account open and activated with new Trusties elected by the society BGM. Society now has its own logo. International midwifery day celebration and annual society scientific conference are two main activities organized by the Society to support its members in terms of up-skilling and capacity building. Scope of Practicing Midwives is now in place to guide midwifery practice in Fiji and annual licensing for practicing midwives established at $70.00 fees.

**Society's future**
Competency-based practice and competency standards for annual assessment are required by FNC. FMWS to be well presented at FNC. All Midwives in Fiji to be Society members. Joint effort with other stakeholders in mapping out the way forward for Midwifery practice in Fiji. Collaboration with other Midwifery Society regionally and internationally (PSRH/ICM). The Society aims to create and support Midwifery in terms of scope of practice, Legislation and Safety of midwifery practice.

This presentation aims to assist other PIC Midwives in developing their own Midwifery Society.

---

**Partnership between mothers and midwives in the Quality of Care Model - a success Story (Solomon Islands)**

Relmah HARRINGTON  
*School of Health Science, Pacific Adventist University (Atoifi Campus), Solomon Islands. Relmah.Harrington@atoifi.org.sb*

The Bachelor of Nursing took on the 2nd cohort of eleven students in 2015. The course currently runs for 18 months and has been upgraded from the advanced Diploma program. Whilst midwifery care in Solomon Islands delivers optimal care, there are gaps in providing continuity of care with mutual partnership that can enable women to actively participate in their care. There is substantial evidence in literature that supports better birth outcomes and experiences for women who receive continuity of care by partnering with the midwife.

During the course of study, student midwives are assigned to follow through ten (10) women during pregnancy, birth and postnatal. There have been positive feedback and experiences both from women and midwives, regarding the care offered and received, respectively. Women and families satisfactorily experience better birth outcome and a sense of control over their care. Midwives testify rewarding experiences of what working in partnership with women meant.

There may be challenges adapting this model as midwives in Solomon Islands are seen as more knowledgeable and superior by community women seeking specialized services like midwifery care. However, women express a feeling of assurance receiving care from midwives on a one-on-one basis. This has helped to avoid potential complications and to facilitate quick recovery after confinement. This success story encourages midwives and nurses to apply this midwifery model of care that builds a partnership between health care providers with mothers. In the Pacific, this is a catalyst for accelerating progress towards improved maternal-newborn care and reproductive health in this era of the Sustainable Development Goals.

---

**Training of midwives in basic ultrasound scan (USS)**

John AH CHING  
*Ministry of Health, Samoa. johnahching@gmail.com*

The Basic Level Ultrasound Training in Obstetrics for Rural Midwives is a new initiative that Samoa has embarked on.

We aim to train key midwives in all the district hospitals in Samoa. The training is designed to equip midwives with the skills to help them diagnose common antenatal problems such as placenta praevia and malpresentation. Similar initiatives in capacity building midwives in ultrasound techniques have been tried in other parts of the world such as African states and Asian countries. The rationale is to build capacity and skills in non-doctor health professionals in order to access USS services to greater populations. Samoa’s experience is the first in the Pacific.
Developing leaders or leadership development – what is the difference and why does it matter?

Alana KILLEN
Chief Executive Officer, The Royal Australian and New Zealand College of Obstetricians and Gynaecologists.
ceo@ranzcoh.edu.au

Multiple theories abound within the scholarly literature regarding the traits and attributes of effective leaders and the most appropriate way to develop and enhance leadership capacity and effectiveness. Whilst the focus has historically been on the individual as a leader, more recent research has focused on the nature of leadership within the social context and the critical nature of team-based approaches to leadership.

This presentation will identify the difference between intrapersonal factors (relating to the individual) and interpersonal factors (relating to leadership development) and the emerging theories of leadership relevant to the healthcare sector.

The presentation will be of relevance to those with an interest in leadership and leadership development. The presentation will also be of interest to those working in team-based environments, particularly regarding the challenges that these environments may engender.

The power of an inclusive approach that creates ownership and sustainability

Ireen MANUEL
Directorate of Population Health, Strategy and Investments; Pacific Health Development
iren.manuel@middlemore.co.nz

The Pacific has high maternal and child health service constraints. We have moved from MDGs to the inclusive SDGs where duty bearers, civil society and others are joining hands to address our maternal and child health issues in the Pacific. The common themes replicate in the Pacific on lack of partnership, spreading donor support too thin, the sector plans not aligning to availability of correct skillset and insufficient human resourcing, lack of sufficient funds, and the concern for deteriorating continuum of care for mothers and children.

After having a presence in the Pacific for over a decade, Counties Manukau Health has used different approaches to grow and strengthen services which are informed by thematic priorities. These approaches within a programme allows for flexibility to meet the needs of each island nation. The programme has identified how to strengthen the capability of nurses across disciplines as nurses are the forefront of our health services. As the demand for growing and strengthening services increases, so too does the need for our responses to be more effective, efficient and accountable collectively.

The success is in empowering, emancipating, prioritising, co-designing, being risk informed, and building a resilient workforce who take ownership of their development.

Working together to improve midwifery care in Papua New Guinea: The role of collaborative partnerships

Karen CHEER, Rachael TOMMBE and Lalen SIMEON
James Cook University Australia; Pacific Adventist University Papua New Guinea karen.cheer@my.jcu.edu.au

Annually, there are over three million stillbirths worldwide and 98% occur in developing countries. However, stillbirth remains unrecognised on national health agendas and by international organisations including the United Nations (UN), which omits targets for stillbirth reduction in the Sustainable Development Goals. The stillbirth rate of 15 per 1000 births in Papua New Guinea (PNG) is one of the highest in the Pacific. Midwives are often the frontline providers of maternity care to women following stillbirth, yet the mental and emotional impact of stillbirth for midwifery staff in Pacific nations such as PNG is an unexplored area of research. This presentation highlights the culturally informed and collaborative process used in a postgraduate study by researchers from James Cook University Australia and Pacific Adventist University PNG that explores the experiences of a cohort of PNG midwifery students in their provision of care to women following stillbirth. Students enrolled in PNG midwifery programs are typically registered nurses with prior experience in women's health care.
For Australian researchers, undertaking sensitive research in PNG requires careful consideration of diverse socio-cultural and spiritual beliefs and customs, as well as an understanding of historical political issues. In this presentation, we discuss how decolonizing methodologies provide an enabling environment for research, aid in the development of research capabilities for staff and students, help to forge friendships and strengthen institutional relationships. The benefit is a robust regional partnership that may inform midwifery education and practice in PNG, Australia and the wider Pacific region.

Regional clinical services recommendations
Berlin KAFOA
The Pacific Community (SPC), Fiji. berlink@spc.int

The Pacific Regional Clinical Services Workforce Improvement Program (PRCSWIP) is a regional collaborative program between the RACS, FNU and SPC focusing on Specialised Clinical Services in the region. Annually the Directors of Clinical Services (DCS) and Heads of Health (HOH) from the Pacific Island Countries meet to discuss Clinical Services and Other important regional health matters. The recent meeting was held in April 2017

This year the recommendations for clinical services cover health workforce training programs, leadership, continuing professional development, specialist nursing and indemnity for volunteers. The presentation will also cover the important role of Regional Clinical Organisations such as PSRH in assisting with these recommendations.

Conclusion: PSRH plays an important role in assisting with the DCS/HOH regional recommendations for Clinical Services.

Mapping the Obstetrics and Gynaecology Workforce in the Pacific Islands
Alec EKEROMA, Tim KENEALY, Glen MOLA, William MAY, Theresa MITTERMEIER, Savannah GILHEANY-BLACK, Rajat GYANESHWAR
Pacific Society for Reproductive Health, Department of Obstetrics and Gynaecology, University of Auckland. alec.ekeroma@psrh.org.nz

Background: The shortage of surgeons, obstetricians and anaesthetists has been associated with an increase in maternal mortality rates. Core indicators include the need for at least 20 surgical, anaesthetic and obstetric specialists per 100 000 population by 2030. The PSRH is concerned with the shortage of midwives and obstetricians in the Pacific. The study aimed to map the number, work conditions and training of obstetricians and gynaecologists (O&G) in the Pacific region.

Method: Identified O&G specialists were recruited by email and administered a questionnaire using Qualtrics.

Findings: There are 96 O&G specialists working in 16 Pacific countries and territories. The ratio of specialists to adult women populations was lowest in Papua New Guinea, Kiribati and the Solomon Islands whereas it was highest in the Cook Islands, Palau and Tonga. Of 52 invited specialists, 46 (89%) completed some or all of the survey. Most were employed by government (39, 87%), subscribed to a continuous professional development programme (29, 66%) and could perform staging surgery for ovarian cancer with confidence (23, 52%). Most worked an average of 46 hours a week, on call three times a week and called in four times. All respondents felt the workload was heavy and stressful and that more O&G specialists were needed for their service. The most common tasks shared with either other doctors or midwives/nurses were Jadelle and Intrauterine Contraceptive insertions although caesarean sections, instrumental deliveries and manual removal of placenta were also performed by some. The University of Papua New Guinea and the Fiji National University trained an average of six specialists per year in the last 15 years with 16/37 (43%) having done of their training in either Australia or New Zealand. Salaries ranged between countries (NZ$17 - 137,000) and within countries with the highest paid working in the territories of either New Zealand or the United States.

Conclusion: There is a need for increased capacity in training and professional support for the O&G specialist workforce.
SERVICE IMPROVEMENT

Customer-focused care – ethics and professionalism in the workplace

Rajat GYANESHWAR
Professor of Obstetrics and Gynaecology, Fiji National University. Rajat.gyaneshwar@gmail.com

When we are customers we know how we want to be treated. We want courtesy and respect. We want expert advice and information. We want to be advised accurately. We want a timely and efficient response. Our patients are our customers. Their expectations are similar to ours.

Unfortunately, when we review patient complaints we find a consistent theme. Health professionals are not compassionate, they keep patients waiting, they are disrespectful, they seem unprofessional, they don’t know what they are doing. They do not know how to maintain confidentiality.

The health workforce has some codes of practice to guide us. Medical ethics has evolved over the ages. We need to respect our patients’ views helping them decide on their management based on information and advice. We must aim to do the best for our patients advising them about what management options would be most beneficial. We must never do any harm. We must treat all our patients equally, not making any distinction based on ability to pay, race, religion, gender or any other prejudice.

Professionalism is about our dress and conduct as a health worker. As health professionals we must be competent, know our limitations, and communicate with courtesy. We must be responsible for our work and take pride in it. We must treat everyone with respect. We must not be arrogant. We must maintain good personal hygiene. The presentation will encourage discussion on these issues and seek consensus on some minimum standards.

Youth-friendly Health Services Assessment in Five Pacific Countries

Marija VASILEVA-BLAZEV, Adriu NADUVA
United Nations Population Fund, Suva, Fiji. vasileva-blazev@unfpa.org or naduva@unfpa.org

Youth-friendly health services (YFHS) are central to improving young people’s health and wellbeing. Globally, millions of people, especially women, youth and people from marginalized groups, face a range of barriers to obtaining basic health information and services and also encounter difficulties that prevent them from making educated and informed choices. This prevents them from exercising their SRHR, which can result in ill health and social consequences for themselves, their families and communities.

YFHS assessments were carried out in Vanuatu, Kiribati, Tonga, Solomon Islands, and Samoa to look at availability, accessibility, acceptability and equity. The YFHS Programs are supported by the New Zealand Aid Programme, in collaboration with UNFPA Sub Regional Office Suva and the respective Ministries of Health in Vanuatu, Kiribati, Tonga, Solomon Islands, and Samoa.

The results of the five country assessments provide current evidence and information to support and guide each country YFHS Program, as government ministries and other regional partners including UNFPA, work collaboratively to strengthen and expand.

The country assessments, generally found the gaps in YFHS programs to be similar in nature and consistent with global and regional research. This is accordingly reflected in the similarities of the recommendations made for each country, which are provided in an effort to improve systems that respond to young people’s needs. The session will present the findings of these assessments as well as the latest technical guidance and evidence for delivering adolescent sexual and reproductive health (ASRH) services.

Linking the national health monitoring framework with regional SDG priorities, with a focus on reproductive health

Sandra PAREDEZ
United Nations Population Fund, Suva, Fiji. paredez@unfpa.org

The Sustainable Development Goals call for “leaving no one behind” which creates the demand for disaggregated data at the national level and makes the call to the national statistical systems (NSS) to respond with the data required to develop evidence-based targeted plans and programs that will help countries to move toward the goals, and measure progress on the way to 2030. Given that Pacific Island Countries and Territories (PICTS) are in various stages of developing and implementing their health
sector policies, strategies and programs, it is important that SDGs are localised and a national health sector monitoring framework is developed which will satisfy the various national data needs. Furthermore, ensuring alignment between national, regional and international frameworks will help to minimise the reporting burden on the NSS and ensure that national priorities are not lost in the bigger pictures.

How can countries prioritise which health indicators need to be monitored to address needs across various health sector frameworks, while ensuring that they are able to report on national commitments made at the regional and international level? This paper seeks to share information with health sector personnel on some of the on-going SDG processes in the region and internationally, focusing on the health sector indicators, particularly sexual and reproductive health, so that countries can be fully engaged in the data arena. The presentation will also share some methodologies developed to help the NSS identify and address capacity gaps to ensure reporting comparability across the national, regional and international data domains.

**Maternal Death Surveillance and Response Systems: Improvements in measurement and quality of care**

Pulane TIEBERE, Mosese QASENIVALU

*United Nations Population Fund, Suva, Fiji. tlebere@unfpa.org, qasenivalu@unfpa.org*

Most countries in the Pacific made notable progress towards the Millennium Development Goals (MDGs) with a significant number of them achieving MDG 5 target A of reducing the maternal mortality ratio (MMR) by three quarters by 2015 from the 1990s level. According to the 2015 Pacific Regional MDG Tracking Report, half of the Pacific Forum Island Countries achieved MDG 5A on improving maternal health with only the Federated States of Micronesia and Papua New Guinea failing to achieve the goal. The same report highlights weak data management systems and lack of a standardised definition for maternal deaths in the region may affect completeness of data and lead to under estimation of maternal deaths in the region.

These challenges can be overcome by implementation of Maternal Death Surveillance and Response (MDSR) which enables routine identification, notification, quantification, mapping, and determination of causes and avoidability of all maternal deaths. MDSR links health information system and quality of care improvement processes.

The presentation will share findings of a MDSR assessment conducted in 6 Pacific countries. The assessment identified initiatives/programmes in place, gaps and needs to transition from Maternal Death Reviews (MDRs) to MDSR. This forms a baseline on steps already in place, capacity building and country supports needs for transitioning from MDR to a more robust MDSR system. The existing MDR programmes in the six countries assessed provide a foundation for easy transition to MDSR. Countries are urged to adopt this more robust and action oriented system for improved measurement and quality of care.

---

**MATERNAL HEALTH IN DISASTER SITUATION**

**Post Tropical Cyclone Winston Family Health Outreaches: Fiji Retired Midwives Experience**

Penina DRUAVESI

*Manager for Community Nursing, Central Division of Fiji Ministry of Health; Fiji Midwifery Society. penina.druavesi@govnet.gov.fj*

Tropical Cyclone Winston was a destructive category 5 TC that struck Fiji on the 20th February 2016. Without mercy, it roared into our islands and left behind vast trails of severe devastation affecting the health and survival of people. It blew away houses and ripped our infrastructure, something that has never before been seen in our country.

But alas, we must respond to survive. The Ministry of Health and Medical Services set up the Family Health Outreach Mobile clinic as the post TC Winston recovery initiative as the third phase; this followed
the initial 1st trauma response and 2nd public health response – rapid responses to the affected population.

The main purpose of the project was to make the health services available to all affected populations thus reducing the risk of complications that may arise. The outreach clinic encompassed all services to be delivered in a health facility including maternal and child health, antenatal clinic, general and special outpatient, counseling, health promotion and gender-based violence.

This presentation will focus on the roles and responsibilities of the midwife as part of the medical teams. Each team comprises a doctor, midwife, dietician, peer educator, and a psychosocial support officer. About eleven retired midwives participated in this six weeks project in which they focused mainly on maternal, child health, antenatal clinic, family planning, cervical cancer screening and gender-based violence. Despite the many challenges faced by the outreach team in terms of accommodation, basic needs such as water, sanitation and food supply, the project successfully achieved its objectives.
Appendix 2 – Citations of PSRH Awardees

A. PSRH Distinguished Service Award

1. Judith Seke
   By Kathleen Gapirongo

Sr Judith Seke began her working career in the labour ward at Kilufi Hospital in Malaita Province as a registered nurse in 1980 to 1983 then transferred on to the Labour Ward at the National Referral Hospital as the Sister in Charge from 1983 to 1990.

Her stronghold and commitment in Maternal and Child health has begun to increase and develop when she moved in to become the National Maternal and Child Health Coordinator at the Reproductive Health Unit at the Ministry of Health and Medical Services in 1990. Not long she became the Program Manager for Reproductive Health from the year 2000 to 2007. Leading to that she was promoted to become the Supervising Director for Reproductive Health from 2008 - 2012. From her vast experience, Judith was appointed to be the Local Consultant for the Reproductive Health Assessment in Solomon Islands collaborated by the Fiji National University and Solomon Islands government under the Ministry of Health in Jan - Dec.2013.

Sr. Judith has a Solid background in Programme Management in Reproductive Health and Child Health as well as Family Planning in Solomon Islands since 1990 and coordination particularly in the areas of reproductive health, family planning, child health and its linkages to evidence based information with strong emphasis on related development frameworks such as the National Health Strategic Plan and the Millennium Development Goals. Experienced in organization and coordination of national and provincial trainings, workshop and conferences as well as stakeholders meetings with partners engaged in reproductive health, child health and family planning services at national level. She is proficient in developing and implementing the Solomon Islands Obstetrics and Gynaecology manual, Solomon Islands Evidence Based Family Planning Manuals, Solomon Islands Reproductive Health Strategic Plan and Policy formulation which is still currently in draft.

Currently, from Oct 2014 to present, she is the Local Consultant and Coordinator for Jadelle Implant Programming in the Solomon Islands. Judith has a great passion for Reproductive Health in the Solomon Islands and the Region. A great role model for midwives and nurses in the Solomon Islands and the Pacific.

2. Alumita Bulicokocoko
   By Aliote Galuvakadua

Alumita worked both in the public and private sectors as a clinician and a Midwifery Tutor. She had been the coordinator for Midwifery Training in Fiji in 1997 and for many years, Alumita trained not only locals nurses but also regional nurses to become Midwives. She was the Founder of our Midwifery Society in Fiji and the first Society President in 1999. She was also the President of the Fiji Nurses Association (FNA) in which she championed Nurses/Midwives working condition and welfare.
While Alumita was President of the FNA she was elected regional representative of the International College of Midwives for the Commonwealth which included NZ, Australia and the Pacific Islands. Alumita was awarded Best Practical Midwife at the Midwifery Conference in India.

In 2005, Alumita started working with the World Health Organization as a Project Officer for Maternal Health. After her work there, she decided to return as a lecturer to the Fiji School of Medicine as a lecturer in child health and obstetric nursing.

Prior to her retirement, Alumita was the co-coordinator of the Reproductive Health Program at the Fiji National University (FNU) where she trained nurses from all over the Pacific.

B. President’s Medal

1. Peter Richard Stone
   By Kara Okesene-Gafa

Peter has a passion for TEACHING. Peter has been teaching USS skills in the Pacific especially during PSRH meetings for a number of years. He loves to impart the knowledge he has to students, and other health professionals with the desire to see health professionals in the Pacific acquire the skills that will help improve health outcomes of mothers and babies in the region.

Peter is very culturally sensitive and has a heart for women and children in the Pacific. Personal note from one of his students – now an MFM specialist: He is nurturing like a dad. It is an honour to work with him. He has so much energy like a teenager who plays football. He has taught me a lot. I would not be here doing what I am doing now if it wasn’t for him as my training supervisor and under his guidance I have come this far in building on the knowledge I have gained from him. He has helped students over and beyond what was expected of him.

Peter is very approachable. You would not think he is a professor. He is very down to earth, very practical, non-threatening and friendly. He has been teaching us ultrasound for many years. All the ultrasound I have learnt in the work I am now doing in Samoa was from Peter. I am very grateful for the knowledge he has imparted. His passion to teach us ultrasound skills is contagious and we have had some fun times. We are grateful to have USS taught to us by one of the best. We all know that the skills we acquire is to try and improve outcomes for our mothers and babies.

Peter has been doing research for as long as he has been practicing O&G. Has numerous research interests in maternal fetal medicine and has published numerous journal articles. He has also been successful in writing a number of grants as a principal investigator and obtaining funding to carry out research and also to securing funding for teaching resources including a RANZCOG $5,000 Grant for the development of ultrasound teaching course for the Pacific. Peter has spoken in many clinical conferences, scientific meetings as an invited speaker, refereed many journal articles and has written chapters in several clinical books. Thank you Peter. Very grateful for all the work you have done.
2. Salausa John Ah-Ching
By Salote Vaai

Dr. Ah Ching graduated from the Fiji School of Medicine and spent his early years working in the rural areas of Upolu and Savaii, until he was recruited into the Obstetrics & Gynaecology Department. This was later followed by postgraduate training and his long and distinguished career in the area of Women's Health. He later moved onto American Samoa and served as Consultant Obstetrician and Gynaecologist in the LBJ Medical Centre for 20 years. He returned to Apia in 2010 and began his work as Rural Visiting Obstetrician. His work has made him a household name in the rural villages where he visits weekly and provides Antenatal Care and ultrasound scanning. Always creative and compassionate, he approached the former General Manager of NHS in 2015 and discussed the issues his patients were experiencing with walking several kilometers to reach the rural hospitals. This resulted in NHS initiative of picking up patients from their villages on the way to the Clinic and returning them to their homes before nightfall. His work in the remote clinics has often seen him work right up to 6-7pm at times, in order to have every patient seen before returning to Apia.

Dr Ah Ching admits his first love was always Public Health and he is happy to return to this work in Primary Health care, even whilst carrying out his duties as Associate Minister of Health. He is also an Associate Member with the Royal Australian and New Zealand College of Obstetrics & Gynaecology (RANZCOG). Dr Ah Ching presented an Audit Paper at the PSRH Conference, about his work with rural ultrasound scanning as well as the ultrasound training for midwives. This presentation sparked great interest from colleagues around the Pacific, especially midwives who are keen to have similar training implemented in their countries.

He isn’t all serious and work-oriented though – Salausa is also an avid golfer, a karaoke champion, and proud grandfather to Sienna and Christian. He and his ever-supportive wife Mrs. La Ah-Ching have six children, and he attributes his many achievements to his family. He is also a proud member of the Marist Old Boys Association and still runs on the rugby field for a game of touch rugby with former classmates. Well-respected by his patients and colleagues both young and old, he is recognized by many as a trusted physician, a patient mentor and a genuine friend.
**SATURDAY 15TH JULY 2017**

**OFFICIAL OPENING CEREMONY**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REGISTRATION</strong></td>
<td><strong>VENUE: NATIONAL CONFERENCE CENTRE</strong></td>
</tr>
</tbody>
</table>
| 9.00AM – 2.00PM | Conference Registration  
Registration will be open from 9.00am to allow participants ample time to register and to meet up with friends and colleagues. |
| **OFFICIAL OPENING CEREMONY** | **VENUE: IRIRIKI ISLAND**                                                                                                                          |
| 2.30PM          | Participants are seated                                                                                                                             |
| 3.00PM          | Arrival of Chief Guest: Hon. Minister of Health, Jerome Ludvaune                                                                                  |
| 3.05PM          | Dedication Prayer: Reverend Javen Kovan                                               |
| 3.20PM          | Welcome Speech – Kathleen Gapirongo, President of PSRH                                      |
| 3.30PM          | Introduction of Chief Guest – George Taleo, Director General of Health                                                                          |
| 3.35PM          | **Keynote Address by the Hon. Minister of Health:**  
The SDGs – an opportunity for strengthening health and development in Pacific island countries |
| 4.00PM          | **The Brian Spurret Oration:**  
Integrated approach to delivering effective Reproductive Health care in Pacific settings  
Glen Mola, former PSRH President                                                        |
| 4.40PM          | **Vote of Thanks – Aliote Galuvakadua**                                                     |
| 4.45PM          | Group Photo                                                                              |
| 5.00PM – 8.00PM | **Welcome Reception – hosted by the Hon Minister of Health,**  
**Government of Vanuatu**  
**Venue:** Iririki Island, Port Vila                                                    |
## DAY ONE
SUNDAY 16TH JULY 2017
VENUE: NATIONAL CONVENTION CENTRE

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.00AM - 8.10AM</td>
<td>Sunday dedication service - Rev. Joven Kovanai</td>
</tr>
<tr>
<td>8.10AM - 8.45AM</td>
<td><strong>Investing in Women’s Health – Vanuatu’s Experience</strong>&lt;br&gt;<strong>Keynote Speaker:</strong> Hon. Prime Minister of Vanuatu Charlot Salwai&lt;br&gt;<strong>Group Photo with Prime Minister</strong></td>
</tr>
<tr>
<td>8.45AM - 10.00AM</td>
<td><strong>Health and Development: Presentation by Development Partners</strong></td>
</tr>
<tr>
<td>8.45AM - 9.00AM</td>
<td><strong>The Power of an Inclusive Approach that creates Ownership and Sustainability</strong>&lt;br&gt;<strong>Ireen Manuel, Programme Manager, Regional Pacific Development, Counties Manukau</strong></td>
</tr>
<tr>
<td>9.00AM - 9.15AM</td>
<td><strong>Reflecting on the changing donor landscape in Papua New Guinea</strong>&lt;br&gt;<strong>Lara Andrews, Development Cooperation, Australian High Commission, Port Moresby</strong></td>
</tr>
<tr>
<td>9.15AM - 9.30AM</td>
<td><strong>Regional Clinical Services Recommendations</strong>&lt;br&gt;<strong>Berin Kafao, The Secretariat of the Pacific Community (SPC)</strong></td>
</tr>
<tr>
<td>9.45AM - 10.00AM</td>
<td>Discussion</td>
</tr>
<tr>
<td>10.00AM - 10.30AM</td>
<td>Morning Tea</td>
</tr>
<tr>
<td>10.30AM - 12.30PM</td>
<td><strong>Panel 1: Leadership in maternal and reproductive health - a catalyst for accelerating progress in the Pacific</strong>&lt;br&gt;<strong>Chair:</strong> Rajat Gyaneshwar / Len Tariwonda</td>
</tr>
<tr>
<td>10.30AM - 10.50AM</td>
<td><strong>Leadership in multiple disciplines – adapting to the changing roles of Pacific Clinical Specialists</strong>&lt;br&gt;<strong>Gunzee Gawiin, Obstetrician Specialist and CEO, Hela Provincial Health Authority, PNG</strong></td>
</tr>
<tr>
<td>10.50AM - 11.10AM</td>
<td><strong>Working with Leaders in Maternal and Neonatal Health</strong>&lt;br&gt;<strong>Alana Killen, CEO, Royal Aust and NZ College of Obstetricians &amp; Gynaecologists, RANZCOG</strong></td>
</tr>
<tr>
<td>11.10AM - 11.30AM</td>
<td><strong>Nurturing emerging leaders in maternity care – the role of Midwifery</strong>&lt;br&gt;<strong>Judith McCara-Couper, Chairwoman, NZ Midwifery Council, Auckland University of Technology</strong></td>
</tr>
<tr>
<td>11.30AM - 11.50AM</td>
<td><strong>Pacific Midwifery Leadership program – experience from an awardee</strong>&lt;br&gt;<strong>Kathy Gaprongo &amp; Carmel Walker</strong></td>
</tr>
<tr>
<td>11.50AM - 12.10PM</td>
<td><strong>Linking the monitoring framework of national health sector priorities with the regional SDG priorities with a focus on reproductive health</strong>&lt;br&gt;<strong>Sandra Paredes</strong></td>
</tr>
<tr>
<td>12.10PM - 12.30PM</td>
<td>Discussion</td>
</tr>
<tr>
<td>12.30PM - 1.30PM</td>
<td>Lunch</td>
</tr>
<tr>
<td>Time</td>
<td>Parallel Sessions</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------------------</td>
</tr>
</tbody>
</table>
| 1.30PM - 1.45PM | Partnership between mothers and midwives in the Quality of Care Model - a success story  
Relmah Harrington | Session 1  
Kathy Gapirongo/Tony Harry |
|              | Challenges in an obese pregnant mother  
Janet Taikave | Session 2  
Paula Puawe/Errollyn Tungu |
| 1.45PM - 2.00PM | Working together to improve midwifery care in Papua New Guinea: the role of collaborative partnerships  
Karen Cheer, Rachael Tommbe and Laleni Simeon | Session 3  
Toonga Tieei |
|              | Screening, Diagnosis and Management of Gestational Diabetes in New Zealand: A clinical practice guideline  
Karaponi Okesene-Gafa | Session 4  
Amado Noovao-Hill |
| 2.00PM - 2.15PM | Midwifery leadership training in Australia  
Toonga Tieei | Session 3  
Moape Bavou/Jennifer Pyakalya |
|              | Prevalence of overweight and obesity among pregnant women attending antenatal clinic at CWMH, Suva, Fiji  
Pushpa Nusair | Session 4  
Nga Masters/Amado Noovao-Hill |
| 2.15PM - 2.30PM | Post cyclone Winston in Fiji: responses from retired midwives  
Penina Druavesi | Session 3  
Moape Bavou/Jennifer Pyakalya |
|              | Dietary patterns are associated with child, maternal, and household-level characteristics and overweight/obesity among young Samoan children  
Courtney C. Choy et al | Session 4  
Amado Noovao-Hill |
| 2.30PM - 2.45PM | Evaluation of Community Health Workers' Upskilling Training in Maternal and Newborn Care  
Jolly Kulimba and Mary Sitaing | Session 3  
Moape Bavou/Jennifer Pyakalya |
|              | Perinatal Depression  
Amanda Noovao-Hill | Session 4  
Amado Noovao-Hill |
| 2.45PM - 3.00PM | Discussion | Session 3  
Moape Bavou/Jennifer Pyakalya |
|              | Dengue in Pregnancy  
Nikita Ram/Moape Bavou | Session 4  
Amado Noovao-Hill |
| 3.00PM - 3.30PM | Afternoon Tea | Session 3  
Moape Bavou/Jennifer Pyakalya |
| 3.30PM - 5.00PM | Parallel Sessions                              | Session 3  
Moape Bavou/Jennifer Pyakalya |
|              | Session 4  
Nga Masters/Amado Noovao-Hill | Session 4  
Amado Noovao-Hill |
| 3.30PM - 3.45PM | Basic Ultrasound Training in Obstetrics for Rural Midwives in Samoa  
Salusasa Dr John Ah Ching | Session 3  
Moape Bavou/Jennifer Pyakalya |
|              | Case on Intimate Partner Violence  
Margaret Tarere | Session 4  
Amado Noovao-Hill |
| 3.45PM - 4.00PM | A retrospective study of Births Before Arrival (BBA) in Fiji  
Aliote Galuvakadua | Session 3  
Moape Bavou/Jennifer Pyakalya |
|              | Family Planning in Lautoka Hospital, Fiji  
Luisa Gavidi | Session 4  
Amado Noovao-Hill |
| 5.00PM - 5.15PM | Discussion | Session 3  
Moape Bavou/Jennifer Pyakalya |
## DAY TWO
**MONDAY 17TH JULY 2017**
**VENUE: NATIONAL CONVENTION CENTRE**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.30AM - 8.30AM</td>
<td>Debate with the Experts – interactive session</td>
</tr>
<tr>
<td>7.30AM - 8.00AM</td>
<td>How to avoid obstetric sphincter injuries</td>
</tr>
<tr>
<td></td>
<td><em>Judith Goh</em></td>
</tr>
<tr>
<td>8.00AM - 8.30AM</td>
<td>Gynaecological diagnosis and management at the primary care level</td>
</tr>
<tr>
<td></td>
<td><em>Glen Mola</em></td>
</tr>
<tr>
<td><strong>PANEL 3:</strong></td>
<td>Gender-based Violence (GBV) in the Pacific and its impact on women’s health and family well-being</td>
</tr>
<tr>
<td>CHAIRS</td>
<td>Rufina Latu and Swaran Naidu</td>
</tr>
<tr>
<td>8.30AM - 8.50AM</td>
<td>Gender-based violence in Vanuatu – magnitude of the problem and national responses</td>
</tr>
<tr>
<td></td>
<td><em>Merelyn Tahi</em></td>
</tr>
<tr>
<td>8.50AM - 9.10AM</td>
<td>A study of GBV among health providers in Port Moresby</td>
</tr>
<tr>
<td></td>
<td><em>Lara Andrews</em></td>
</tr>
<tr>
<td>9.10AM - 9.30AM</td>
<td>Health sector response to GBV – the PNG experience.</td>
</tr>
<tr>
<td></td>
<td><em>Jessica Yaipupu</em></td>
</tr>
<tr>
<td>9.30AM - 9.50AM</td>
<td>The impact of maternal trauma on bonding</td>
</tr>
<tr>
<td></td>
<td><em>Sara Weeks</em></td>
</tr>
<tr>
<td>9.50AM - 10.10AM</td>
<td>An analysis of the determinants and consequences of unsafe abortion in Solomon Islands</td>
</tr>
<tr>
<td></td>
<td><em>Rebecca Manehanitai</em></td>
</tr>
<tr>
<td>10.10AM - 10.30AM</td>
<td>Morning Tea</td>
</tr>
<tr>
<td><strong>PANEL 4:</strong></td>
<td>Family planning - its role in maternal-neonatal health</td>
</tr>
<tr>
<td>CHAIRS</td>
<td>Pushpa Nusair/Kiribati Midwife</td>
</tr>
<tr>
<td>10.30AM - 10.50AM</td>
<td>Contraceptive Uptake in the Pacific – impact of long-acting reversible contraceptives in CYP</td>
</tr>
<tr>
<td></td>
<td><em>Pulane Tiebere</em></td>
</tr>
<tr>
<td>10.50AM - 11.10AM</td>
<td>Reaching rural women with family planning services</td>
</tr>
<tr>
<td></td>
<td><em>Swaran Naidu</em></td>
</tr>
<tr>
<td>11.10AM - 11.30AM</td>
<td>Vasectomy in Solomon Islands – reaching urban and rural areas</td>
</tr>
<tr>
<td></td>
<td><em>Jack Siwanao</em></td>
</tr>
<tr>
<td>11.30AM - 11.50AM</td>
<td>Post-partum and community-based Implant programs</td>
</tr>
<tr>
<td></td>
<td><em>Glen Mola</em></td>
</tr>
<tr>
<td>11.50AM - 12.10PM</td>
<td>Barriers to adolescent use of contraception in Pacific Island Countries: sexual and reproductive health workers’ perspectives</td>
</tr>
<tr>
<td></td>
<td><em>Renee Montgomery</em></td>
</tr>
<tr>
<td>12.10PM - 12.30PM</td>
<td>Discussion</td>
</tr>
<tr>
<td>12.30PM - 1.30PM</td>
<td>Lunch - announcement about practice improvement marketplace for midwives</td>
</tr>
<tr>
<td>Time</td>
<td>Session 1</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>1.30PM - 1.45PM</td>
<td>Establishing a maternal death review system – keeping it functional and effective &lt;br&gt; Rajat Gyaneshwar</td>
</tr>
<tr>
<td>1.45PM - 2.00PM</td>
<td>Maternal Death Surveillance and Response Systems: improvement in measurement and quality of care. &lt;br&gt; Pulane Tierebe</td>
</tr>
<tr>
<td>2.00PM - 2.30PM</td>
<td>Diabetes in pregnancy – management in low resource settings &lt;br&gt; Bill Hague</td>
</tr>
<tr>
<td>2.30PM - 3.00PM</td>
<td><strong>PARALLEL SESSIONS</strong>&lt;br&gt; Session 1&lt;br&gt; Falahola Fuka/Kevin Bisili</td>
</tr>
<tr>
<td>2.30PM - 2.45PM</td>
<td>Update on PRE-EMPT &lt;br&gt; Wame Baravilala</td>
</tr>
<tr>
<td>2.45PM - 3.00PM</td>
<td>Working with women who experience postpartum haemorrhage in Santo, Vanuatu &lt;br&gt; Anna-Maria Salanmanak</td>
</tr>
<tr>
<td>3.00PM - 3.15PM</td>
<td>Successful initiatives in advancing sexual and reproductive health in Kiribati &lt;br&gt; Tamaa Moannata</td>
</tr>
<tr>
<td>3.15PM - 3.30PM</td>
<td>A menstrual health and endometriosis education in secondary schools &lt;br&gt; Deborah Bush</td>
</tr>
<tr>
<td>3.30PM - 3.45PM</td>
<td>Sexual and Reproductive Health and Rights in Vanuatu &lt;br&gt; Jayline Malverus &amp; Kate Burry</td>
</tr>
<tr>
<td>3.45PM - 4.00PM</td>
<td>Afternoon Break</td>
</tr>
</tbody>
</table>

**PSRH BIENNIAL GENERAL MEETING, BGM (SEPARATE AGENDA)**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session 1</th>
<th>Session 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.00PM - 5.30PM</td>
<td>BGM - business meeting of PSRH &lt;br&gt; Board and members</td>
<td></td>
</tr>
<tr>
<td>6.00PM - 11.00PM</td>
<td>PSRH Cultural Night – Convention Centre &lt;br&gt; MC: Salausa Dr John Ah Ching</td>
<td></td>
</tr>
</tbody>
</table>
**DAY THREE**
**TUESDAY 18TH JULY 2017**
**VENUE: NATIONAL CONVENTION CENTRE**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.30AM - 8.30AM</td>
<td><strong>Debate with the Experts</strong>&lt;br&gt;Case presentation of near-misses and maternal deaths.&lt;br&gt;<em>Vanuatu Clinical Team, Rajat Gyaneshwar, Caroline Homer, Glen Mola and Midwives</em></td>
</tr>
<tr>
<td>8.30AM - 8.50AM</td>
<td><strong>Cervical Cancer: Screening, treatment and prevention options appropriate for Pacific Island countries</strong>&lt;br&gt;<em>Alec Ekeroma, Peter Sykes, James Fong, Sandeep Naik, Jeffrey Tan, Glen Mola</em></td>
</tr>
<tr>
<td>8.50AM - 9.10AM</td>
<td><strong>An overview of cervical cancer at the Port Moresby General Hospital, Papua New Guinea</strong>&lt;br&gt;<em>Mary Bagita, Bediako Armoa</em></td>
</tr>
<tr>
<td>9.10AM - 9.30AM</td>
<td><strong>Introduction of HPV vaccination in PNG</strong>&lt;br&gt;<em>Glen Mola &amp; PNG Team</em></td>
</tr>
<tr>
<td>9.30AM - 9.50AM</td>
<td><strong>Cervical Cancer and HPV vaccination in Vanuatu</strong>&lt;br&gt;<em>Tony Harry, Apisai Tokon and Margaret McAdam</em></td>
</tr>
<tr>
<td>9.50AM - 10.10AM</td>
<td><strong>The challenges in follow up of cervical cancer screening</strong>&lt;br&gt;<em>Catherine McGowan and Sera Toalii</em></td>
</tr>
<tr>
<td>10.10AM - 10.30AM</td>
<td><strong>Morning Tea</strong></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>PANEL 2:</strong> Pacific Workforce Development in maternity care</td>
</tr>
<tr>
<td>CHAIRS</td>
<td>Jessie Larul/ Arthur Elijah</td>
</tr>
<tr>
<td>10.30AM - 11.00AM</td>
<td><strong>State of the midwifery workforce in the Pacific</strong>&lt;br&gt;<em>Caroline Homer, Professor of Midwifery, University of Technology, Sydney</em></td>
</tr>
<tr>
<td>11.00AM - 11.30AM</td>
<td><strong>Mapping the Pacific O&amp;G specialist workforce</strong>&lt;br&gt;<em>Alec Ekeroma, Tim Kenealy, Glen Mola, William May, Savannah Gilheany-Black, Theresa Mittermeier, Rajat Gyaneshwar</em></td>
</tr>
<tr>
<td>11.30AM - 12.00PM</td>
<td><strong>Customer-focused care – ethics and professionalism in the workplace</strong>&lt;br&gt;<em>Rajat Gyaneshwar</em></td>
</tr>
<tr>
<td>12.00PM - 12.30PM</td>
<td>Discussion</td>
</tr>
<tr>
<td>12.30PM - 1.30PM</td>
<td>Lunch</td>
</tr>
<tr>
<td>Time</td>
<td>Session 1</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1.30PM - 3.00PM</td>
<td><strong>PARALLEL SESSIONS</strong></td>
</tr>
<tr>
<td>THEMES</td>
<td>Pacific Workforce Development Midwifery</td>
</tr>
<tr>
<td>CHAIRS</td>
<td>Judith McCara-Couper/Paula Puawe</td>
</tr>
<tr>
<td>1.30PM - 1.45PM</td>
<td>Developing a Vanuatu midwifery training programme</td>
</tr>
<tr>
<td></td>
<td>Renata Buleban</td>
</tr>
<tr>
<td>1.45PM - 2.00PM</td>
<td>Solomon Islands Midwifery Society - development and progress</td>
</tr>
<tr>
<td></td>
<td>Jessie Larui</td>
</tr>
<tr>
<td>2.15PM - 2.30PM</td>
<td>Fiji Midwifery Society – development and progress</td>
</tr>
<tr>
<td></td>
<td>Aliote Galuvakadua</td>
</tr>
<tr>
<td></td>
<td>Fiji midwifery at the cross-roads</td>
</tr>
<tr>
<td></td>
<td>Senimelia Hataongo</td>
</tr>
<tr>
<td>2.30PM - 2.45PM</td>
<td>PNG Midwifery Society - development and progress</td>
</tr>
<tr>
<td></td>
<td>Jennifer Pyakolyia</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>2.45PM - 3.00PM</td>
<td>Midwifery training in PNG – past, present and future</td>
</tr>
<tr>
<td></td>
<td>Paula Puawe</td>
</tr>
<tr>
<td>3.00PM - 3.30PM</td>
<td>Afternoon Tea</td>
</tr>
<tr>
<td>3.30PM - 4.00PM</td>
<td><strong>DISCUSSION</strong></td>
</tr>
<tr>
<td>4.00PM - 4.30PM</td>
<td>Summary: Catalysts for Accelerating Progress Agreement for PSRH key action areas for next biennium</td>
</tr>
<tr>
<td>4.30PM</td>
<td><strong>Official Closing</strong></td>
</tr>
</tbody>
</table>
# Practice Improvement - Marketplace Stalls

## VANUATU

<table>
<thead>
<tr>
<th>Name</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosita Aru</td>
<td>Quality Improvement on Hand Hygiene “Clean Hands Stops Bugs, Penama Provincial Hospital</td>
</tr>
<tr>
<td>Serah Malwerssets</td>
<td>Addressing Perineal Infection</td>
</tr>
<tr>
<td>Angela Mento</td>
<td>Strengthening sexual and reproductive health services at the Vila Central Hospital, Vanuatu.</td>
</tr>
<tr>
<td>Vanuatu Family Health Association - Minami Kawamata &amp; Julianne Aru</td>
<td>Contraceptive methods by age group–analyzing medical records of pregnant women who visited the Vanuatu Family Health Association clinic</td>
</tr>
<tr>
<td>UNFPA</td>
<td>Showcasing Regional Programs</td>
</tr>
</tbody>
</table>

## SOLOMON ISLANDS

<table>
<thead>
<tr>
<th>Name</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rebecca Manehanetai</td>
<td>Emergency Maternal and Neonatal Obstetric Care coaching package and use of MDSR form</td>
</tr>
<tr>
<td>Anna Jatobatu</td>
<td>Early essential newborn care in Solomon Islands</td>
</tr>
<tr>
<td>Nancy Pego</td>
<td>Improving contraceptive use for adolescents at White River clinic, Honiara City Council, Solomon Islands</td>
</tr>
<tr>
<td>Mabel Numo</td>
<td>Improving Anaemia in pregnancy (Poster /pamphlet)</td>
</tr>
<tr>
<td>Ethel Koavi &amp; Edna Titulu</td>
<td>Improving First Trimester Pregnancy visits at Good Samaritan Health Facility, Guadalcanal Province, Solomon Islands</td>
</tr>
<tr>
<td>Marilyn Iro</td>
<td>Thermo regulation at Kilu’ufi Hospital</td>
</tr>
<tr>
<td>Henrietta Jagily &amp; Dynise Abuito</td>
<td>Dry cord care – Gizo Hospital</td>
</tr>
<tr>
<td>Solomon Island</td>
<td>Family Planning Programs</td>
</tr>
</tbody>
</table>

## FIJI

<table>
<thead>
<tr>
<th>Name</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tagi Vakaloloma</td>
<td>The Red Flag - An assessment tool to assist midwives and nurses to escalate patients to another level of care</td>
</tr>
<tr>
<td>Virisila Carasobu</td>
<td>Oral health Card for pregnant women- wellness concept</td>
</tr>
<tr>
<td>Penina Druavesi</td>
<td>Post-cyclone Winston – Outreach Response from Retired Midwives in Fiji</td>
</tr>
</tbody>
</table>

## PAPUA NEW GUINEA

<table>
<thead>
<tr>
<th>Name</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jolly Kulimbua</td>
<td>Evaluation of Community Health Workers’ Upskilling Training in Maternal and Newborn Care in Western Highlands, PNG</td>
</tr>
<tr>
<td>Primrose Homiehombo</td>
<td>Exploring Grand Multiparity and unmet need for family planning, analysis from East New Britain Province</td>
</tr>
</tbody>
</table>

## KIRIBATI

<table>
<thead>
<tr>
<th>Name</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toata Titaake &amp; Monica Tarabo</td>
<td>Improving the referral system between traditional birth attendants (TBAs) and the Tungara Hospital,</td>
</tr>
</tbody>
</table>
# Appendix 4 – Conference Evaluation Form

## PSRH Conference Evaluation Form

13 - 18 July 2017, Port Vila, Vanuatu

Please complete this evaluation form so we can improve our future conferences.

<table>
<thead>
<tr>
<th>Scientific Program</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The topics in the program were relevant to me.</td>
<td>45</td>
<td>36</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The information was presented in a way that was interesting and engaging.</td>
<td>23</td>
<td>51</td>
<td>10</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Overall, adequate time was allowed for the sessions.</td>
<td>8</td>
<td>50</td>
<td>14</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>There was adequate time allowed for questions.</td>
<td>8</td>
<td>42</td>
<td>14</td>
<td>17</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Speakers</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall the presenters were of a high standard.</td>
<td>30</td>
<td>43</td>
<td>13</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>The material presented by the speakers was informative and easy to understand.</td>
<td>20</td>
<td>45</td>
<td>13</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>The speakers addressed questions well.</td>
<td>18</td>
<td>50</td>
<td>17</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Logistics</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The conference set up and layout was satisfactory.</td>
<td>31</td>
<td>36</td>
<td>10</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>The catering was appropriate for the conference.</td>
<td>13</td>
<td>19</td>
<td>18</td>
<td>25</td>
<td>11</td>
</tr>
<tr>
<td>The starting and ending times each day were appropriate.</td>
<td>13</td>
<td>18</td>
<td>17</td>
<td>31</td>
<td>4</td>
</tr>
<tr>
<td>Transport and accommodation were satisfactory.</td>
<td>16</td>
<td>20</td>
<td>18</td>
<td>20</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Program</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The social events were well organised and engaging.</td>
<td>21</td>
<td>24</td>
<td>13</td>
<td>10</td>
<td>2</td>
</tr>
</tbody>
</table>

Which three (3) topics in the conference program were the **most** valuable for you?
1. Challenges in Cervical Cancer and HPV (32)
2. Customer focused care, ethics and professionalism in the workforce (25)
3. Family planning: it’s role in maternal and neonatal health

Other topics of most value:
- Gender based violence and it’s impact on women’s health and family wellbeing (24)
- Gynaecological diagnosis and management at the primary care level (12)
- Nurturing emerging leaders in maternity care (10)
- The impact of maternal trauma on bonding (10)
- Clinical leadership (8)
- How to avoid obstetric sphincter injuries (8)
- Diabetes (8)

Which three (3) topics in the conference program were the **least** valuable for you?
1. Every topic was useful (6)
2. Gender based violence topics (6)
3. Diabetes in pregnancy (4)

Other topics of least value:
- Basic ultrasound training (3)
- How to avoid obstetric sphincter injuries
- Family planning (3)
- Reflecting on the donor landscape (3)
- Responses from retired midwives (post cyclone Winston in Fiji) (3)
• Pacific leadership in multiple disciplines (3)
• The impact of maternal trauma on bonding (2)

After this conference, what skills or knowledge will you be able to apply or introduce back in your workplace?

• Audit & Research skills (10)
• Applying customer focused care/ethics and professionalism in the workplace (7)
• PEMNeT (2)
• How to avoid obstetric sphincter injuries by putting the message across to colleagues @ workplace, add into the training unit and run training on suturing (2)
• Leadership in midwifery (2)
• Approaching customer in a holistic manner as a receiver by being in their shoes
• The skills/knowledge as midwife when I go back I will promote contraception, change my attitude to be a loving compassionate nurse and do Quality of care model. Lastly research presentation has taught me a lot on how to present in future PSRH conferences.
• Pacific empowerment
• Hope to carry out small audits/research (as practice) at own workplace to inform evidence-based practice
• Ultrasound programme
• Aligning regional maternal provincial indicators (monitoring)
• To follow up the lost client for high grade lesions
• To inform midwife in the province concerning midwifery association that was set up during PSRH conference
• To continue with the profession of good care to mothers and babies
• Utilising the availability of donor agencies to support staff up-skilling and development
• To improve more on documentation, proper recordings of all necessary information of patients
• Leadership in the workplace
• Also improve documentation in the workplace
• Improve on audits - maternal health/ NND/ still births
• Include IPV in antenatal screening
• Try and do small research at the provisional hospital I'm working at
• How to work in partnership with women
• Unmet needs; friendly clinic set up; Challenging behaviours
• The role of midwifery in reproductive health
• Liaising with our supervising DON if we can adapt Dr Gawin's model of leadership and management
• Do feedback loops with my nurses on areas of their responsibilities
• Upskilling in obstetric care to meet unmet need and accredit and remunerate midwives post their formal overseas in-service training
• Understanding PICs specific needs/contexts
• Teach the health staff all of the above
• Being more client centred - have time for our clients
• Improve knowledge on PPH & shoulder dystocia
• Passion on working place to clients e.g. important to improve in workplace
• Upskilling of nurse and midwives
• Doing community awareness
• To promote youth friendly services
• Advocate for safe motherhood
• Promote contraceptive through counselling
• Plans of care for high risk mothers
• After attended the pre-workshop on suturing perineal - I will improve myself on the suturing of perineal tears and will be asked to present perineal tears when doing delivery of the basis head on the 2nd stage labour
• LARC insertion (x2)
• Do more research on reproductive health issues
• Cervical cancer
• Strategies to improve maternal health services the unmet needs for reproductive health (FP)
• Catalysts for accelerating progress in maternal / reproductive health
• Family planning
• Do proper vaginal examination after delivery to make good perineal repair and to identity the unmet need, meet them for the betterment of our women and girls to control child birth
Approaches to cervical cancer screening
Leadership development
Audit of clinical issues especially newborns
Conduct of weekly in house training on maternal/neonatal care at the labour
Management to clients as part of quality of care
Cervical cancer procedures and management
Pathways and avenues of where reproductive health services are carried out
After this conference I will be able to diagnose and manage the gynaecological problems based off the knowledge and skills gained from this conference (2)
Actively advocate and counselling and involve others in Family planning/ contraceptives as the way forward from my country
Multi-sector approaches
Provide maternal and neonatal continuity of care effectively
Establishing a maternal research nurse for labour ward staff to recognise the causing factor and be able to improve on it
Making sure the mother and neonatal care safe from trauma
A lot of the things touched on in this conference, are done back in my homeland. I just need to strengthen it and in this conference, it has given me ideas on how to improve on the service delivery back home
Medical ethics - obstetric ultrasonography and proper data recording
More on how to avoid obstetric sphincter injury
Awareness of what is happening with PIC in terms of women’s healthcare
Ensure maximum care and compassion to clients
Outreach programme to reduce death and FPC coverage
Technical knowledge on maternal and reproductive health issues
I would like to introduce FP and postnatal clinic separately from antenatal and care in order to give a good education and counselling to mothers and their spouse on FP
Colposcopy
Capacity development
SDGs in my workplace
Broad, Pacific relevance improved my understanding about access, barriers to LARC. Ideas, skills, passion from others, pragmatic approach to advocacy
To providing new information/knowledge to my work colleague and applied quality of care to my clients. To improve the gaps/issues that are lacking and influence management for improvement
More gynaecology issues and how to address the women with their problems and complaints
Perineal repair; research; support women and educating about GBV
How to improve and strengthen the cervical cancer (screening, treatment, prevention strategies - awareness)
Education, training, skills on clinical application

What other topics do you suggest should be covered in a future PSRH conference or workshop?
**Men as partners:**
- Men as partners programme (7)
- I believe most topics covered in this PSRH conference were relevant in our work place. For future it is good to allow enough time for incoming participants to have time for sightseeing. This is out of programme but it’s good to have sometime and one last thing, men as partner should be emphasised more as men are block for most of our women in the Pacific.
- To operate men’s clinic; what part do men perform when his wife is pregnant in labour/delivery
- Men as partners should be focus more and be involved in our PSRH conference. Not only NSV and male condoms use but other aspects that also relate to men in terms of man as the boss and decision makers in reproductive health for the family and country at large
- Men’s reproductive health

**Research:**
- More presentations on evidence based research including scientific team and health researchers
- PSRH should gather all SRH Audit and research from PSRH member countries by PSRH financial members then select winners (MW; O&G doctor) then only these should be presented in the official formal forum.
- Other research materials should be displayed outside in the marketplace
- Research and audit to benefit the midwifery workforce; analysing their proposal project in order for them
to present and to know how to present during big conferences like this one

- Research and audit skills
- Clinical topics; registrar research topics
- Audit on clinical and documentation. It is identified as poor in the Pacific. More practical research presentations please.
- How to do research and auditing: More on reproductive health issues and how to diagnose.
- More clinical audits
- Maternal audit and neonatal audits of nurses
- How to do research/ write abstracts

All other topics:

- How effective is the baby friendly/ breastfeeding policy (2)
- Advocacy for family planning and GBV issues (3)
- Customer focused care
- Policy making to be included as often (stakeholders)
- Sexual health and rights e.g. HIV vaccines/ rules of paediatric HIV and government sustainability
- Any opportunities for O & G registrars for attachment abroad in terms of USS
- Qualitative presentations
- Workforce planning - best practice (success stories)
- Sexual health and rights (sexual reproductive health rights)
- Youth friendly services
- Education of young age to prevent them from teenage pregnancy (girls) and abuse of drugs, alcohol and tobacco (both genders)
- Sexual transmitted together in adolescence group of people
- Early Neonatal care should be included
- EENC in workshops
- If possible can put 3 - 5 presentations from each country in each workshop apart from 1st priority to the hosting country because looking back not many of the hosting country participate in workshops
- Resuscitation on neonate and mothers
- Emergency drug review
- We could also add in a bit more topics on neonatal care. Some more case presentations from each country on emergency cases they dealt with that can be discussed and everyone can learn from.
- Emergency obstetric management experiences
- Need more topics on complications with NCDs in relation to maternal death and death in mothers
- Ultrasound
- More practical pre-workshops that meant limited topics were chosen. Increase the number of participants for the most important topics in health in the Pacific
- Hypertension in pregnancy as well as diabetes. These 2 lifestyle diseases are on the rise in the Pacific and also more on cervical cancer + breast cancer.
- Leadership skills
- Mechanism to combat the influence of decision makers
- NCD burden on the obstetrics and gynaecological services
- Neonatal care
- Midwifery development
- To develop strategies to meet unmet need for family planning
- SOPs for clinical procedures & cervical cancer
- Communicable diseases impact in reproductive health
- More on case studies
- I suggest in future PSRH conferences or workshops should be centred more on emergencies in obstetrics
- Early recognition of ectopic pregnancy
- Vaccinations - short term and long term effects
- Maternal, perinatal deaths, surveillance and response in the Pacific
- TB positive patient in pregnancy "Antenatally, postnatally, what further steps need to be done"
- Management in obstetrics services
- The first pregnancy
- Role of radiotherapy in the Pacific
- Place of surgery in the Pacific
• Antenatal care
• Antenatal care; mother friendly hospitals; breastfeeding
• Written materials/programmes not enough: I came late and was not able to get any
• STI and HIV
• Environmental issues affecting our PICs
• Tour or visits and cultural night was too long (timing was late)
• The overall organisation was good however it would be good to stick to the programme so as to allow time for discussion sessions
• How to recognise the early signs and symptoms of cervical cancer in small island countries and how to do pap smear in rural clinic and how to send the specimen over to the countries like Australia to analyse
• Laparoscopic surgery in the Pacific
• Vasectomy and ultrasound
• Obstetric emergencies
• Especially with cervical cancer - need to do awareness to women to come early for screening for early detection in health facilities
• Importance of having males undergo circumcision to reduce the cervical cancer rate;
• More on family planning; concerns with logistics and supplies, more discussion from attendees
• Services in remote, rural community in East coast NZ

If you have any other general comments or need more space, please write on the back of this form.

• Strict time limits for presentations because too tired at the end of the day
• Some presentations were of poor quality with too much content
• Please consider large amounts of rubbish from plastic bottles, could we drink water from a filter (climate change and plastic in mother earth) thank you for a great conference
• Please give some time (1/2 day) to tour the place/do shopping; every country has its own beauty to appreciate
• Conference was too long
• Some country presenting at same time during parallel sessions
• Catering was hopeless; long line, waste of time; food wasn’t enough
• Poor technical systems
• Tangiu tumas PSRH - most empowering and educational
• Some presenters should talk to main points not read presentation word for word
• Had more local foods, taro, yam, pana, cassava
• Improve the PA system
• The PSRH was amazing, challenging and very interesting
• Pre-workshops should be compulsory for all participants
• Need more local nurses in attendance that are motivated and link them to midwifery associations as well as male support nurses
• I want to say thank you for everything!
• LOC needs to improve next time e.g. PSRH formal programme was too fast, photocopy not a hardcopy like the rest (some received a photocopy one)
• Very poor technical - same country presenters presenting at the same during parallel sessions
• Name tag and booklet were not enough for all nurses attending this conference. President’s report as well as financial report of the executive could have been better if printed and included at the back of the programme booklet. We did pay our membership fee and we have the right to have such documents. Most of us did buy our own fares and all internal fees of full conference. For future conferences it would have been better if accommodation fees are faced or paid for by the PSRH LOC and even negotiate airfares with airlines if they can slightly drop them as we all come for such conferences to discuss issues regarding the better health outcomes for our countries and the overall Pacific countries that we each represent.
• The meals served especially lunch and dinners were not enough that most participants did complain that they felt hungry. Also the pork provided was not cooked properly. All presenters were all done in lectures and no group work to really establish understanding.

51
• More poor technical maintenance - no staff! Poor toilets, no paper; need at least 4 food setups - queues too long
• Policy makers, politicians and church leaders should be involved to sit and participate in the future of PSRH conferences. Because some of these people are barriers to development of health funding and reproductive health services to young people in terms of family planning services, condom distribution, injection, implant etc.
• Would like to thank the host and the LOC for their hard work and the hospitality during my 10 days here in Port Vila
• Maternal care and antenatal
  When midwives presented there were less doctors attending on Day but when doctors presented, they forced everyone to attend.
• Tour to general hospital to see the facts
• Programme officer to have a coverage on development of effective workplaces
• Men as partners programme should also be included.
• Without midwives or clinical nurses whom are front liners there will be no success whatsoever, we tried to improve on the health of mothers and babies
• An hours visit of the province
• If presenters can only be experts on clinical work updates, procedures or presentation from research not progress
• How to do counselling on GBV mothers
• Poorly prepared presentations - too much content; talking to slides was not engaging and wanted to know more about case studies and personal experiences
• Most deaths of women in rural communities are later diagnosed with death with ectopic but not reported
• The outlines and programme for the conference should be given to the participants on the day they arrive at the airport or accommodate registration should be done as soon as participants arrive.
• Registration fee should be transparent and should covered for all cost rather than few money for each items like fees for cultural night etc.
• Teaching students on updated skills & practice
• Implement tips on leadership skills
• The conference was interesting, discussing all interesting issues around midwifery, obstetrics and gynaec. Time is too short and if it is possible to put next conference in working days (not in Saturday and Sunday)
• To change my attitude - more caring for women
• More topics on maternal - fetal near miss case presentations for discussion - this is a great opportunity
• Catering needs improvement, should include more local food and increase the amount
• Projector board size is too small for the size of the rooms. Hence speakers should be informed to stick to 7 lines for slides so they can be seen properly
• Venue is nice, the convention centre is perfect
• Vanuatu is a lovely place to visit
• Most of seminars and speakers did not stick to schedule. Seminars went late and speakers need to stick to their allocated time.
• Organise the conference in a hotel that has a venue for both the conference and catering so that food is of a regional conference standard
• More success stories or obstetric cases by midwives and doctors
• The workshops should also include PICs input e.g. facilitators on certain topics to enhance capacity building
### Please complete this evaluation form so we can improve our future workshops

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have a greater appreciation of the role and use of ultrasound in reproductive health care.</td>
<td>8</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have a better understanding of the interpretation of scans to identify clinical problems.</td>
<td>2</td>
<td>8</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The course has improved my knowledge and skills in O&amp;G ultrasound.</td>
<td>8</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The course has improved my confidence in this area.</td>
<td>7</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sessions featured relevant and practical clinical scenarios.</td>
<td>7</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The course was relevant to my practice.</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall, my learning needs were met.</td>
<td>4</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After the course, I would consider implementing or participating in a review of this area in my workplace.</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall the length of each session was appropriate.</td>
<td>5</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There was adequate time for questions and discussion.</td>
<td>6</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The meeting facilities provided a satisfactory environment for learning.</td>
<td>5</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate information regarding the course (including pre-reading, venue etc.) was provided prior to the session.</td>
<td>2</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The presenter’s style enhanced my learning experience.</td>
<td>5</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As part of the quality improvement process within your facility, list how you think you would apply what you have learnt from this workshop to improve services to women’s health in your facility/hospital.

- Keep practising with my sonographer when I go back
- Scan pregnant mothers during antenatal clinic
- Scan pregnant mothers in the absence of a sonographer/doctor or during emergencies to confirm diagnosis e.g. abnormal presentations
- It’s a good refresher course on basic ultrasound to assist with basic obstetric use for all pregnant women in early and late pregnancy
- Happy to have learned some studies which I now can do with babies
- Educating antenatal mothers on the importance of early antenatal scanning
- As a midwife I will work closely with the radiologist and do more practice and interpretation of scans to identify problems
- Provide better assessment of fetal growth
- Provide better estimation/assessment of total gestation
- Care in handling a USS machines
- The purpose of using scan to each trimester
- I could understand results of scan from HP
- I want to have scan in my workplace
I want to go to Australia or NZ to have training on scanning
Will be useful in medication education
More accurate scans
USS screening of high risk patients
To improve the identification of high-risk problems in our antenatal clinics before labour or if not to be reviewed.
To improve identification of the high risk mothers
To improve high risk QIs and refer them before her condition becomes worse

What other topics do you suggest should be covered in a future workshop?

- How to operate the scan machine (2)
- How to calculate BPD, HC, FL etc.
- How to calculate fetal heart rate, measure volume (2)
- How to detect other gynaecological problems using the scanner
- Would be nice to have more studies on abnormal ultrasound findings e.g. fetal anomalies, gastroenesis, hernia etc.
- We should learn how to turn on and off or even operate the machine e.g. doing the measurement of the fetus length and head circumference etc. according to weeks of gestation
- More practical
- More picture
- Measuring CRL etc.
- Screening may not be relevant in Vanuatu
- Management of abnormal results
- More of Doppler topics (for doctors)
- Other obstetric emergency scans e.g. placenta abruption
- Antenatal care all through
- Antenatal with obstetric labour

What advice would you give to the course organisers in their preparation for the next workshop?

- All participants were not at the same level because some were midwives, medical students and gynaecologists so next workshop there should be a facilitator for each category of participants especially during practical sessions
- Step procedures and pictures to follow along
- Excellent workshop
- All the workshops should be in one area where tea breaks, lunch and facilities under one roof to avoid too much movement that will drag out the times for lessons
- Participants should receive certificates at the end of the workshop
- More hands on for Doppler measurements
- This workshop is well created
- Was very good, difficult to manage varying levels of knowledge
- Separate participants if possible e.g. midwives/medical officer etc.
- We need big space to move around and more practice
- It’s good to do the workshops in a big place
- It’s good for the workshops to be held for more than 2 days
Please complete this evaluation form so we can improve our future workshops

<table>
<thead>
<tr>
<th>The objectives of the workshop were clear</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The objectives of the workshop were achieved</td>
<td>14</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>The workshop addressed my research needs</td>
<td>13</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>I have a greater appreciation of the role and use of research in clinical practice.</td>
<td>18</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>The workshop improved my knowledge of research</td>
<td>16</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>The workshop improved my knowledge of audit</td>
<td>14</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>The workshop was relevant to my clinical practice.</td>
<td>11</td>
<td>12</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>I intend performing research as a result of participating in the workshop</td>
<td>16</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>I intend performing audit as a result of participating in the workshop</td>
<td>16</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>The length of the workshop was adequate</td>
<td>8</td>
<td>10</td>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>There was adequate time for questions and discussion.</td>
<td>13</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>The facility and catering provided a satisfactory environment for learning.</td>
<td>9</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>The presenter’s style enhanced my learning experience.</td>
<td>14</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

As part of the quality improvement process within your facility, list how you think you would apply what you have learnt from this workshop to improve services in your facility/hospital.

- prepare research questions
- awareness of the necessary people to seek advice or help from
- encourage other members of my ward to create a group and start doing research
- start doing audits regularly
- build capacity for nurses, collaborate with other stakeholders to build and support research
- to share what I’ve learned here with colleagues
- assist in improving Data collection and analysis
- conduct audits on the daily program practices
- conduct research on DOT compliance in TB treatments
- develop clinical guidelines specific to my hospital
- conduct audit
- teach research to other colleagues and co-partner with clinicians
- Data collection and entry

What other topics do you suggest should be covered in a future Advanced Research workshop?

- Power off a study and how to determine a study population size
- Chance to perform a brief mock research in groups
- right actual practical research postal and submit right graphics committee
- need hard copies of presentations
- please invite tomorrow participants from Pacific countries
- copies all five reading materials and presentations, Flash drives
- more practical exercises
- more time on the electronic data analysis
- Report writing, Data reporting and write up for publications
- writing a research proposal
- more time on analysis
- who to approach to stunt our research
- without be online with the researcher and how we can send out research work
- research proposal needs more time

<table>
<thead>
<tr>
<th>What advice would you give to the course organisers in their preparation for the next workshop?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- More time- an extra half day would give facilitators more time so that topics are not rushed.</td>
</tr>
<tr>
<td>- More interactions with the participants to identify where help on research use needed the most</td>
</tr>
<tr>
<td>- provide manuals for training to be distributed to participants</td>
</tr>
<tr>
<td>- classify participants into level of research capacity to suit presentations</td>
</tr>
<tr>
<td>- have a bigger venue</td>
</tr>
<tr>
<td>- find a good comfortable conference room</td>
</tr>
<tr>
<td>- facilitators to slow the speech on presentations</td>
</tr>
<tr>
<td>- statistics session should be in the mornings</td>
</tr>
<tr>
<td>- Prior needs assessment; communication with potential participants; needs assessment; choose the participants before hand</td>
</tr>
<tr>
<td>- fantastic workshop - got rejuvenated, keep it up</td>
</tr>
<tr>
<td>- improved catering, better venue, the rest rooms were not so private and no toilet papers</td>
</tr>
<tr>
<td>- inconsistency off information at country level creating confusion upon arrival</td>
</tr>
<tr>
<td>- Better for participants to have a laptop and teach us how to use Excel for data collection</td>
</tr>
<tr>
<td>- Help countries to setup research Center</td>
</tr>
</tbody>
</table>
Please complete this evaluation form so we can improve our future workshops

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>8</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>9</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>7</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As part of the quality improvement process within your facility, list how you think you would apply what you have learnt from this workshop to improve services to women’s health in your facility/hospital.

- Teach other midwives and registered nurses on the new suturing technique (2)
- Apply the technique or practice regularly in order to improve practice
- Always do proper and thorough examination for tears with every delivery
- Teach my working colleague
- Learn how to always do perennial examination after all deliveries
- Always ask others for any help
- Sterile technique
- Timing of loop/knot
- Stitching technique of third and fourth degree tears
- Always do hand washing when doing delivery
- Good hygiene must emphasise
- Do rectal check after delivery
- Inspect well all perennial tear
- Request for more instrument to be used
- More careful and use sterile techniques
- Teach other types of the suturing technique
- Assist midwives in suturing patients
• Educate staff of sterile technique in suturing is important (2)
• Early detection of perennial tears OASIS and early treatment to prevent complications
• Encourage proper support of head and perennial body during crowning and delivery of head
• Right timing for clear episiotomy
• Pass on information to the staff of my hospital
• On the job training with the suturing skill technique one on one
• Collaborate with our pharmacy to order instruments and suturing materials
• More reading and practice with dummy
• Go back to the workplace and share information gained in the workshop
• Embed what I’ve learned by showing my colleagues and practising (2)
• Use skills in perennial suturing to improve my suturing skills
• Educate junior colleagues in the skills learned
• Teach my colleagues about the skills
• I need to have more equipment in order to do the procedures
• I need to leave an assistant in my clinic in order to do suturing of 3rd and 4th degree tears
• I need to apply this suture technique to improve the health of the mother
• All mothers to be properly checked before discharge (2)
• Encourage good personal hygiene
• Give 6 weeks postnatal education counselling on sexual intercourse

What other topics do you suggest should be covered in a future workshop?

• Other obstetric emergencies cases which are life threatening
• Ultrasound scanning
• Postnatal care to mothers after delivery
• Importance of suturing to internal and sphincter
• Give handouts to participants
• Needs more practice in suturing to be confident
• Haematoma and cervical tears (4)

What advice would you give to the course organisers in their preparation for the next workshop?

• Proper preparations prior to workshop to avoid confusion between participants and instructors
• Allow more time for each workshops
• Allow enough time of asking questions
• This is just perfect, I hope next time will be far more better
• Just a big thank to the facilitators for their presentation as it was very simple and very easy to understand especially the anatomy and how to suture OASIS – great job
• Overall it is excellent however coming from a low resourced country it would be good to give some information on where to order the kind of materials/instruments that you use in the session.
• Provide the presentation to each participant by providing a flash drive
• More videos and more practical exercises
• The workshop is well prepared for so well done and thank you
• Over 2 days (2)
• Provide notes to participants
Appendix 5 – The President’s Report

PSRH Presidents Report 2015-2017

Welcome to you all our financial members and Pacific greetings.

It is my pleasure to present this report to this 12th Biennial General Meeting of the Pacific Society for Reproductive Health Charitable Trust. The 2015–2017 period has been a busy and productive 2 years for the PSRH Board and Secretariat.

1. The 11th Biennial Conference

The 11th Workshops, Conference and BGM in Suva in July 2015 was a huge success with the largest number of participants at 336 with a 140 from within Fiji. There were nine workshops all run concurrently for three days followed by a three-day conference with a packed programme with multiple concurrent sessions. The workshop saw the launch of the Family Planning Workshop led by A/Prof Pushpa Nusair, the PEMNeT Manual authored by 33 clinicians with Pacific experience, the Pacific Journal of Reproductive Health founded by Alec Ekeroma. Our huge gratitude goes out to Prof Rajat Gyaneshwar and his team comprised mainly of Masters trainees for a job well. We are also grateful to our partners in UNFPA, WHO, SCCIPS and many other donors who made the conference possible. It was a memorable conference for me as I was elected President of PSRH – the first woman and midwife.

2. PEMNeT TOT Workshop

The first PEMNeT Workshop to train the trainers was conducted in Auckland NZ in July 2016 where the PEMNeT Facilitators Guide, that was edited by Bronwyn Robinson of RANZCOG and Alec Ekeroma was launched. The workshop was made possible by funding from NZAID, WHO, Counties Manukau and Pacific governments. There were 31 participants at the programme training from all member countries of PSRH.
Since that first training, workshops have been conducted in 7 Pacific countries and more than 200 health workers have been trained. The aim of the PEMNeT programme is to have the training embedded in sustainable continuous professional development activity at the health centre and hospital level. We aim to disseminate and embed the workshop in all Pacific countries by the end of next year made possible with promised funding from Counties Manukau. We have appointed Dr Sharron Bolitho to lead the PSRH PEMNeT workshop and we are grateful to her and her team which include midwives and O&G specialists from the United Kingdom, Australia and NZ.

3. PSRH/TAHA conference
A 2-day conference was held in Auckland NZ post PEMNeT training as a collaborative project with TAHA – a Pacific provider of antenatal education. The theme of the conference was: Catalysts for change – achieving the SDGs for women, children and families. There was excellent feedback from the more than 200 participants. The conference was opened by the Prime Minister of Samoa.

4. Networks

The Society has three Networks – Gynae-oncology, Medical and Midwifery –led by A/Prof Peter Sykes, A/Prof Pushpa Nusair and Matron Aliote Galuvakadua respectively. The Gynae-Oncology Network has performed a survey of O&G specialists in the Pacific and are supporting a training of the first gynae-oncology specialist in the Pacific based at the Colonial Memorial Hospital in Suva and Christchurch New Zealand starting from next year under the auspices of PSRH and the International Gynecologic Cancer Society (IGCS) with the support of Drs Michael Quinn of Melbourne and Ailing Tan of Auckland.

5. The Pacific Journal of Reproductive Health

The Pacific Journal of Reproductive Health published its 5th issue last month where the accepted abstracts of this conference are published. Our Open Access Journal provides a vehicle to assist our clinicians and researchers to cultivate a research culture at the workplace and to disseminate our research evidence to the region and the world. We encourage all those speakers at this conference to submit papers to our Journal. Our Newsletter is now published in the Journal so all the more reasons for sending your stories and news in.

6. Workshops

Besides the PEMNeT we now have five other flagship workshops. The Ultrasound Scanning workshop is led by Drs Bronwyn Andrew from New South Wales and Renuka Bhatt from Auckland. The Family Planning Workshops are led by Drs Pushpa Nusair and Moape Bavou. The Colposcopy workshop is led by Dr Jeffrey Tan from Melbourne. The Perineal Suturing/OASIS workshop is led by Dr Jackie Smalldridge from Auckland. The Research and Audit workshops are led by Dr Alec Ekeroma from Auckland and Prof Caroline Homer from Sydney. In addition, we have the Market Place, a creation of Carmel Walker, which encourages Pacific nurses and midwives to exchange project ideas.

At this conference, we have 34 overseas faculty training 230 participants from 13 countries. On behalf of the PSRH Board, we cannot thank you enough for utilising your own resources and time to train Pacific clinicians and researchers.

Four of our six workshops have accreditation and we aim to accredit the rest by the end of the year.

7. Awards
In honour of a loved Board Member who passed in office, we created the PSRH Mary Magabe Award that is open to all nurses and midwives to pursue further training in any field or skill of their choice. The first Mary Magabe award of NZ$5,000 last year was to Kini Bolalevu of Fiji. There have been no applicants this year and the Board will consider late applications. We also have ten Research/Audit Awards annually to the total of NZ$5,000 and three were awarded last year to clinicians in Fiji and PNG. The Board will accept late applications to this year’s $500 per project award.

8. The Trust Deed

The Board had seen it important to make amendments to the Trust Deed to keep up with developments in the Society’s growth. For example, we have seen the need to create incorporated PSRH branches as Charities in the Pacific Islands. This provides flexibility in funding applications and administration arrangements, acknowledge country-level priorities and promotes participation in PSRH activities. The first branch has been formally incorporated in Samoa under the leadership of a former President of PSRH, Dr John Ah Ching. We are planning to have a branch in Fiji and the Solomon Islands in the next 12 months.

9. This 12th Conference

It is good to have you all here in Port Vila. Our 12th conference has been made possible by the three major sponsors in the Vanuatu government, the United Nations Population Fund, the Secretariat of the Pacific Community. There were also a host of other sponsors who will be acknowledged accordingly. On behalf of the PSRH members and Board, we say Vinaka, Faafetai, Fakafetai, Tenk yu tumas and from our many languages of the Pacific.

The Board would also like to thank the Local Organising Committee under the leadership of Dr Errollyn Tungu and Midwife Apisai Tokon. Without your efforts on the ground, this much needed gathering of Pacific clinicians would not have been possible.

10. The Secretariat

The Secretariat has operated from Auckland New Zealand since 2006 under the leadership of Dr Alec Ekeroma. After the departure of Frances Turrall 18 months ago, he was assisted by Programme Coordinators in Sheetal Naidu and very briefly by Donelle Thompson. It has been a challenge to appoint an Executive Officer given the remuneration offered for the skills required. Since 3 weeks ago, Siobhan Patia, who is seated here, was engaged as the Acting Executive Officer until such time a permanent appointment is made.

The Secretariat has assisted the Board with policy decisions and supported the President and the Board in their governance role. The Secretariat organises annual face to face meetings of the Board and has recently used Zoom meetings to complement email discussions.
Most of the work is performed in volunteer time and by volunteers. An active recruitment programme for volunteers and an executive officer are ongoing. The Secretariat encourages the membership to engage by contributing to the Pacific Journal of Reproductive Health, the Newsletter, Facebook and email discussions.

11. The Future

The future of PSRH is in good hands and we will continue to grow in strength to meet the educational needs of our members in order to improve the reproductive health of our communities. We aim to continue to be flexible, to be relevant and to be sustainable. For example, tomorrow night we are holding a meeting to discuss strategy. Those deliberations will continue to shape our work going forward.

I thank you all for listening and that concludes my report

Yours sincerely

Kathy Gapirongo
### Pacific Society for Reproductive Health

**Statement of Financial Position**

**As at 31 March 2017**

<table>
<thead>
<tr>
<th>Note</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

**CURRENT ASSETS**

<table>
<thead>
<tr>
<th>Item</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANZ -00 account</td>
<td>9,283</td>
<td>2,391</td>
</tr>
<tr>
<td>Accounts Receivable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-46 deposit</td>
<td>68,583</td>
<td>64,355</td>
</tr>
<tr>
<td>Term Deposits</td>
<td>169,578</td>
<td>164,205</td>
</tr>
<tr>
<td>Prepayments</td>
<td>954</td>
<td>15,634</td>
</tr>
<tr>
<td>Conference LOC Float</td>
<td>700</td>
<td>700</td>
</tr>
<tr>
<td>GST Receivable</td>
<td>-</td>
<td>160</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>249,098</td>
<td>247,445</td>
</tr>
</tbody>
</table>

**FIXED ASSETS**

<table>
<thead>
<tr>
<th>Item</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less Prov for Depreciation</td>
<td>(1,146)</td>
<td>(687)</td>
</tr>
<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>-</td>
<td>459</td>
</tr>
</tbody>
</table>

**CURRENT LIABILITIES**

<table>
<thead>
<tr>
<th>Item</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts Payable</td>
<td>577</td>
<td>416</td>
</tr>
<tr>
<td>GST Payable</td>
<td>5,503</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td>6,080</td>
<td>416</td>
</tr>
</tbody>
</table>

**NET ASSETS**

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>243,018</td>
<td>247,488</td>
</tr>
</tbody>
</table>

Represented by:

<table>
<thead>
<tr>
<th>TRUSTEES FUNDS</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>243,018</td>
<td>247,488</td>
</tr>
</tbody>
</table>