PASIFIKA MEDICAL ASSOCIATION GROUP

NEW ZEALAND FOREIGN AFFAIRS & TRADE
Manatū Aorere

Guidelines for New Zealand Medical Treatment Scheme (NZMTS)

1. Introduction to the New Zealand Medical Treatment Scheme

The New Zealand Medical Treatment Scheme (NZMTS) has provided access to life saving medical treatment for target Pacific countries for over 30 years. This includes receiving overseas medical referrals in New Zealand, Australia, Fiji and sending visiting medical specialists to undertake medical and surgical procedures in partner Pacific countries and supporting investment in local health system capability and sustainability.

The Ministry of Foreign Affairs and Trade (MFAT)'s purpose is to act in the world to build a safer, more prosperous and more sustainable future for New Zealanders.

The NZMTS operates within the wider context of the New Zealand Aid Programme Pacific health goal of strengthened and resilient health systems that can withstand health security threats and deliver sustainable and inclusive services. This context recognises that good health is both a means to achieving inclusive and sustainable development, and a critical Sustainable Development Goal (SDG3) in its own right. It also acknowledges that societies and economies cannot thrive without healthy populations, nor can they develop sustainably when there is inequality in health care delivery. Investing in health is therefore a critical component of building long-term resilience in the Pacific. While the New Zealand Aid Programme focus is on strengthening primary health care, there is recognition of the need for targeted support for medical and surgical treatment – to helps countries to meet their SDG 3 target of Universal Health Coverage.

2. Guidelines for the New Zealand Medical Treatment Scheme

The following guidelines define the criteria for provision of services under the NZMTS, the processes for referral and the roles and responsibilities of different stakeholders in the scheme. These guidelines are intended to provide guidance to Pacific countries involved in this scheme and similar schemes (Niue and Cook Islands), New Zealand Aid Programme Managers and the Pasifika Medical Association Limited (PMA).

2.1 Goal of the NZMTS

The goal of the NZMTS is that Pacific people are able to live healthy productive lives through the provision of overseas medical treatment and in-country health care services.

2.2 Components of the NZMTS:

The NZMTS has three components:

a) The Overseas Referral Scheme (ORS)
The objective of the ORS is to improve health outcomes for men, women and children (who cannot afford it) by giving them access to specialised treatment not normally available in their home country. The Overseas Referrals component provides medical treatment predominantly in New Zealand or Fiji, for people from partner countries with a life threatening or seriously debilitating medical condition but with a good prognosis, and who have a prognosis of at least five (5) years of life after their treatment. Some conditions will not be considered for referral and countries have their own criteria.

The programme covers the costs of treatment from arrival until departure in the country where treatment is to be provided. Support costs for accommodation, transport and a small living allowance is available following approval from the in-country Overseas Referral Committee (ORC). For children it may be necessary to include the costs of a caregiver.

b) Visiting Medical Teams (VMT) Teams
The objectives of VMT are:

1. To assess and, where appropriate, provide health services that are not otherwise available in alignment with the strategic goals of partner countries and according to identified need.
2. To maximise opportunities for capability building through activities such as structured training (e.g. seminars for relevant health professionals) and/or on-the-job training of medical, nursing and allied health staff.

The VMT component enables teams to be sent to countries to provide medical consultation, assessment and/or treatment. The visits provide opportunities for local medical staff to improve their skills and knowledge. This component also includes specialist via telehealth as necessary.

c) Strengthening In-country Capacity (SCC)
The objectives of the SCC are:

1. To strengthen the specialist public health service system to expand the provision or increase the quality of in-country specialist health services.
2. To develop clinical guidelines and provide mentoring and ongoing workforce support for doctors and nurses and telemedicine or twinning approaches.

The SCC component supports and strengthens health workforce capacity in countries through training, the development of systems and protocols, and support for equipment and supplies. The SCC component is supporting sustainable health system improvements.

2.3 Partner Countries
The following countries participate in the NZMTS: Fiji, Kiribati, Samoa, Tonga, Tuvalu, and Vanuatu. The Cook Islands, Niue, and Tokelau operate similar schemes through a different process.

2.4 Roles and responsibilities of stakeholders in the management and administration of the NZMTS
There are a wide range of stakeholders involved in the management and administration of the NZMTS. These include:

2.5 Role of the Overseas Referral Committee (ORC)

Each partner country operates an ORC. The ORC provides an important means of ensuring appropriate decisions about treatment are made taking into account competing priorities and the likely treatment and post treatment costs.
The ORC must include (but not necessarily be limited to) senior clinicians and relevant health sector officials. The ORC must have a recognised chairperson whose signature must authorise each overseas referral. For some countries approval is required by Ministers of Health and/or the Secretary of Health as part of internal country approval processes.

The ORC is responsible for in-country management of the scheme, including both the ORS and the VMT components. Specific tasks should be carried out in partnership with PMA including:

- Determining the allocations of services between ORS and VMT annually.
- Determining which patients should be referred for treatment and that all referrals meet the NZMTS referral criteria.
- Ensuring that ORS equity criteria, as set out in clause 3.3, are met.
- Deciding levels of patient support costs including a living allowance, transport and accommodation.
- Managing all aspects of the referral until the patient arrives overseas.
- To ensure that all patients on return to their country are followed up appropriately including in accordance with discharge recommendations and that the clinician responsible for on-going care is identified on the referral form.
- Maintaining a patient registry and good records of discharge summaries and follow up appointments.
- Ensuring all returning patients to make contact on arrival back in country.
- Requesting specific VMT visits that are possible within financial resources and carrying out the management tasks set out in clause 4.3.1.
- Undertaking annual reporting of patient outcomes for both ORS and VMT to PMA who will report annually to MFAT.

Annually, the ORC must formally notify PMA of the membership of the ORC and the identity of the Chairperson as well as the approval processes of the partner country. Whenever the composition of the ORC changes; the Chairperson will notify PMA. Some ORCs employ a NZMTS Co-ordinator to manage the in-country aspects of the scheme. All ORCs should be supported by an in-country coordinator.

2.6 Role of PMA

The NZMTS for Fiji, Kiribati, Samoa, Tonga, Tuvalu, and Vanuatu is managed and administered by PMA as the MSC contracted by MFAT.

PMA's role is to ensure that the scheme operates according to the approved guidelines and monitors all activities and the use of resources. PMA approves and organises treatment for all patients referred for treatment by the ORCs and also organises and approves visiting specialist's visits when countries

request this form of assistance. In addition, PMA also provides specific capacity and capability building to countries with regard to building the capacity of clinical, non-clinical and allied support staff.

2.7 Country visits
PMA will visit Fiji, Kiribati, Samoa, Tonga, Tuvalu, and Vanuatu at least annually. During these visits PMA will:

- Ensure the in-country ORC continues to function effectively and that there is an identified chairperson;
- With the ORC, review the previous year's programme of activities and use of funds;
- Develop a work plan for the coming year;
- Identify opportunities for VMT including capacity building opportunities for staff that can be integrated with visits;
- Ensure the NZMTS guidelines and criteria are widely known and complied with; and
- Contribute where requested to any specialist workforce planning and capacity building activities, as part of SCC.

3. Criteria and Procedures for the ORS (Component One)

3.1 Funding of Overseas Referrals
The NZMTS pays for the cost of agreed treatment from arrival in New Zealand (or Fiji) until departure. This can include diagnostic services, treatment and post-operative care. In some cases (where this is agreed between PMA and the referring country) the NZMTS can make contributions towards living expenses for the patient and/or their companion whilst in the country of treatment.

The partner country funds airfares for the patient (and for a companion or medical escort where necessary and determined by the in-country ORC), internal travel and any pre-departure costs (such as passports, visas etc.). In hardship cases NZMTS can contribute to cost of passports and/or visas on request and approval by ORC.

In some cases these costs may be borne by the patient or their family. Access to the scheme however must not be determined by a patient's ability to contribute to airfare and pre departure costs. In some cases the patient's family or relatives may provide support in the form of accommodation and living expenses while overseas.

3.2 Overseas Referrals: Patient Eligibility
Individuals being referred for treatment under the ORS should be citizens of the referring country and normally resident in the country. Dual citizens (i.e. those with New Zealand or Australian passports) will not be eligible for treatment under the ORS. The criteria specifically excludes those citizens who: are usually resident in another country (e.g. citizen of Fiji living in Tonga) and who have not become citizens of the partner country and those who have not made provision for medical costs to be funded by insurance whilst living outside of their own country.

3.3 Overseas Referrals: Equity Criteria
The NZMTS should be accessible (within the funds available in each country) to men, women and children who meet the equity and medical criteria regardless of ethnicity, age, gender, ability to fund airfares or support costs or location. It is particularly important that people from outer islands and rural areas are aware of and have access to the ORS and the opportunities it provides. Those being referred should demonstrate lack of access to alternative means of accessing the necessary treatment. This includes (but is not necessarily limited to) personal funds, government or private insurance schemes, church or voluntary agency funds. It is the role of the ORC to assess eligibility prior to application to PMA.

3.4 Overseas Referrals: Referral Procedures
All people referred must be normally resident in the partner country and must be referred by the partner country ORC. Procedures for partner country referrals to an ORC are the responsibility of each country but countries should ensure that NZMTS equity and clinical criteria are maintained.

3.5 Overseas Referrals: Clinical Criteria
All patients referred must meet the clinical criteria as assessed firstly by the partner country ORC and secondly as approved by PMA following its own clinical assessment processes.

The following clinical criteria will be applied to all referrals:

- Appropriate skills, expertise or facilities to treat the condition are not available in the referring country. This may include seeking referral for diagnostic purposes to determine a patient's condition and prognosis.
- Consideration has been given to whether the condition can be treated in-country by a planned visit of a clinical specialist team within a timeframe unlikely to jeopardise clinical outcomes and the well-being of the patient. This may include sending a visiting team or specialist to treat the patient in the partner country if this is cost effective.
- The referral has been made on appropriate specialist advice and supported by the partner country's ORC.
- There is good prognosis for the patient living and improved quality of life for at least five (5) years after treatment according to clinical evidence and advice.

The following conditions are excluded for treatment under the ORS:

- chronic cardiac failure, chronic renal failure, chronic lung conditions, chronic neurological conditions and conditions requiring heart, renal or bone marrow transplants with the exception of Hodgkins and non-Hodgkins lymphoma in children;
- secondary cancer;
- patients who have significant medical conditions other than that for which they are being referred (e.g. co-existing renal disease); and/or
- medical conditions that will incur on-going costs that are unable to be met by partner government health funds.

Note: Referrals made directly to PMA or New Zealand Government will be forwarded to the in-country ORC to be processed through normal channels.

3.6 Overseas Referrals: Partner Country Medical Treatment Scheme Committee

All referrals for treatment under the ORS must be made by the ORC using an ORS referral form including a clinical referral letter, which should be emailed (with scanned authorised signatories) to PMA for consideration and referral to an appropriate specialist, prior to approval for funding and treatment being approved.

The following documentation is required:

a) The Overseas Medical Treatment Referral Form must:

- indicate the referral is made on the basis of appropriate clinical advice supported by advice from the partner country ORC. This means that all patients referred must have undergone a clinical assessment by a senior clinician. The ORC then reviews the clinical assessment as part of the committee assessment process;
- prove that the condition is unable to be treated in-country due to lack of available clinical expertise and/or facilities and that consideration has been given to whether the patient could be treated in-country by a planned VMT;
- show the referral meets all equity and clinical criteria for the ORS;
- indicate that the ORC and referring clinician authorises and appoints a medical escort where this is considered necessary;
- indicate that the patient support costs are authorised[1]
- include all patient details: name, date of birth, occupation, gender, address (including outer island and village);
- identify the clinician responsible for follow up in-country;
- be signed by the Chairperson of the ORC; and
- appropriately address privacy issues.

b) Clinical referral letter complete by a senior clinician and following the accepted standard format:

- Patient details; name, address, date of birth, hospital identification number/file number, gender, weight;
- provisional diagnosis;
- other medical conditions;
- current medication;
- presenting symptoms and history;
- clinical history and treatment; and
- tests undertaken.

c) Patient details form including requests for accommodation, transport, living allowance and interpreter requirements.

d) Copy of passport.

[1] Patient support costs are all costs not directly related to treatment. i.e. accommodation, living allowance and transport costs. All other costs e.g. all medicines, approved companion costs, translation services, physiotherapy and wheelchairs are part of treatment costs. Financial reporting should be based on these categories.

e) Patient registration form.

All documentation must be received by PMA and formal written approval notified prior to patients being organised for transfer.

Once a decision agreeing to treatment has been received from PMA, the ORC ensures the timely submission of recommendations to the appropriate authority to enable the patient to be referred and treated as soon as possible. The ORC ensures that the patient (or his/her family) is able to meet any travel documentation costs (such as passports/visas) and if not arranges for these costs to be met by the government or in cases of hardship with PMA.

The ORC also ensures that appropriate records are maintained of all referrals made under the ORS (including patient contact details, referral form and pre and post-operative reports) in order for any future review or impact assessment of the scheme to be carried out.

3.7 New Zealand-based Management of Overseas Referrals

This is the responsibility of PMA. Following receipt of a referral PMA will:

- acknowledge receipt of referral within 24 hours;
- provide an acceptance letter subject to provisional treatment costs and funding availability within 48 hours of a specialist acceptance and costings;
- ensure funds are available within the bilateral NZMTS allocation;
- ensure all referrals meet ORS eligibility, equity and clinical criteria and seek relevant specialised medical opinion on the treatment requested where required;
- ensure the referral forms are accurately and fully completed (returning the form for completion if any information is omitted);
- ensure arrangements for appropriate support are in place in the receiving country;
- ensure that any support costs to be paid by MFAT conform to the MFAT policy;
- request any specialist recommendations be confirmed in writing to enable peer review at a later stage as part of the accountability process;
- seek estimates from treatment hospitals, select the appropriate one and arrange for admission of the patient at the earliest possible date (for some procedures only one provider may be available e.g. paediatric cardiac surgery is only available in New Zealand in one hospital);
- provide a provisional approval letter within 48 hours to the preferred provider including the funding limit approved;
- notify the ORC in the partner country within 48 hours of receipt of the request of progress on the referral and the proposed next steps;
- as soon as possible notify the ORC whether the treatment can be provided, at which hospital, the likely dates and the approximate cost of the treatment;
- coordinate all patient appointments, accommodation, transport, interpreter, living allowance and pastoral care;
- ensure all patient consents for follow up, photographs and sharing of clinical information are completed;
- maintain records of all referrals including details of the estimated price and the indicated upper risk limit for the cost of treatment;

- monitor management of the agreed course of treatment by the hospital and the medical specialist providing the treatment;
- maintain a record of any proposal by the treatment hospital to extend or alter the treatment including the estimate of costs and approve these changes before they treatment is carried out;
- review the service provided including the price and advise MFAT and/or the partner country (in regular reports) of any policy matter that may require addressing;
- review the discharge report and account rendered and if satisfied submit invoices to MFAT for approval and reimbursement on a regular basis; and
- provide a copy of the discharge summary to referring clinician for follow up in country.

<u>When the patient arrives</u>:
It is expected that all patients arriving are met by transport (or by relatives if previous arrangements have been made). Patients will be contacted within 24 hours to complete consent forms, have passports sighted and copies taken and support needs assessed and organised. Weekly contact, or as required contact, with patients is necessary to check progress and deal with any on-going needs.

<u>When patients are discharged</u>:
When the clinical team advises of patient discharge, PMA advises the partner ORC that the patient is cleared for travel. The ORC arranges for return travel and a clinical appointment with the patients partner country referral clinician.

4. Guidelines for VMT (Component Two)

4.1 Background

Treating patients in New Zealand is an expensive approach and severely limits the number of patients able to be treated from limited bilateral NZMTS allocations. Treating patients in New Zealand also provides few opportunities for the NZMTS to contribute to capacity building of local medical, nursing and other support staff. There are many situations where consultations, clinical assessments and operations can be carried out more cost effectively by VMT teams. These teams can also support capacity building of local medical and nursing staff. The previous NZMTS (2017-2022) saw an increased allocation of funds in VMT type activities in most partner countries. To ensure the efficient and effective use of resources, the VMT have included doctors, nurses, anaesthetists and any other specialists that may be required.

VMT can comprise of any type of registered health professional including medical and nurse specialists and other technical health personnel e.g. anaesthetic technicians. It is important to view VMT in its broadest context to allow for the opportunity to support the development of capacity building in-country as well as providing capacity supplementation where necessary, e.g. through provision of locums. In addition, the programme may also be utilised for providing locum relief cover where a country may suddenly be without a particular type of health professional. For example, where a sole surgeon in a country is unavailable to work a locum surgeon may be funded under the programme. VMT can also include specialist support via telehealth as necessary.

4.2 Objectives for VMT

The objectives for the VMT are:

- to assess and, where appropriate, provide treatment for identified individuals where not normally available in-country; and
- to maximize opportunities for capacity building through a range of modalities from mentoring and on- the-job-training to structured training such as seminars for groups such as medical, nursing and allied health staff.

The intention of Component Two is to ensure maximum flexibility so that countries may utilise this mechanism for on-going capacity development as well as the provision of expert clinical services.

The VMT fund may be used for the provision of specialist medical supplies and consumables for the patient, where necessary for patients' treatment where this becomes more cost effective than referring a patient overseas and/or sending a specialist to the country. Examples of this include but are not limited to the provision of shunts, PIC lines etc. It may be utilised to support new skills acquired by clinicians through capacity building activities. It does not include the acquisition of permanent assets for the hospital such as a dialysis machine.

4.3 NZMTS Stakeholders: roles and responsibilities of stakeholders in the organisation of VMT visits

4.3.1 Partner Country ORC

The ORC will:

- identify needs for VMT visits taking into account the programmes of other agencies and donors providing assistance for secondary and tertiary health care;
- consult with PMA to develop an annual programme of VMT visits;
- provide a written request signed by the Chairperson of the ORC for the programme of visits, or alternatively for each visit, to PMA for approval;
- agree a Terms of Reference (TOR) with PMA for each team including the purpose, scope, expected outputs and outcomes, risks and how they will be managed, resources, timing and team membership;
- determine the dates for the visit;
- identify the country contribution e.g. transport for teams, availability of staff, facilities and equipment etc;
- identify a clinical point of contact for the team. This will most likely be the clinical head of the services under which the visit will be operating;
- prepare for the visit ensuring attention is given to availability of staff, facilities and equipment, ensuring information about the visit is communicated throughout the health system (including in outer islands and rural areas);
- undertake pre-assessments and patient selection;
- where necessary, ensure appropriate follow-up care is available;
- ensure relevant staff are available to participate in structured and/or on-the job training provided by the VMT;

- participate in a debriefing with the VMT at the end of each visit; and
- ensure systems/procedures are in place to maintain records of patients treated by VMT teams and report annually on patient outcomes.

4.3.2 Role of VMT

The VMT Teams will:

- in consultation with PMA and relevant local medical and nursing staff, ensure that necessary pre-assessments have been carried out and facilities and equipment are adequate and appropriate to undertake the treatment required;
- ensure that follow-up care and medication will be available;
- arrange provision of any specialised equipment/materials required for treatment not available in-country;
- assess patients identified in pre-assessments to ensure they are able to be treated in-country safely (including the provision of appropriate after-care);
- prioritise and undertake treatment of patients within the time and resources available;
- advise local medical/nursing staff on follow-up care of patients treated and future medical options/care of those patients unable to be treated;
- in consultation with the relevant local medical, nursing and Ministry of Health (MOH) staff, identify relevant staff to be involved in both structured training and on-the-job training. This could include placements in New Zealand or the region (e.g. Fiji);
- plan and undertake seminars/workshops for identified staff. These should be available for the broadest range of health staff possible;
- involve relevant medical and nursing staff to as great an extent as possible in on-the job training in out-patient clinics, consultations, surgical procedures, post-operative care etc; and
- where appropriate, identify key individuals who might benefit from additional training/mentoring/professional development and suggest how this might be addressed. Recommendations regarding capacity development or training must be discussed with PMA and ORC. No undertaking should be given to trainees prior to a discussion being held.

4.3.3 VMT Reporting

The VMT Team leader will:

- ensure that data on patients treated, activities undertaken, and immediate patient outcomes including any adverse outcomes are collected to enable completion of a team visit report;
- at the completion of the visit, undertake a debriefing meeting with members of the ORC and other relevant MOH, medical and other health sector specialists and MFAT Post (if relevant) to discuss outcomes of the visit, any issues arising and recommendations for future visits dedicate a half day for debriefing and planning;

- provide a report on PMA's template (to PMA within one (1) month of completion of the assignment) and PMA to provide Medical superintendent (or similar) with a copy of the VMT report within 1 week of receipt; and
- provide any feedback and comments to PMA that would assist in future visits.

4.4 Procedures for review of any adverse event or outcome resulting from NZMTS activities.
If there is any adverse event or outcome resulting immediately from any ORS referral or VMT visit, countries may request MFAT�Ÿs financial assistance to conduct an independent review.

- The request should be made to MFAT by the partner country ORC via PMA
- The review should commence within 1 month after the adverse event.
- The request should set out the estimated costs of the review, the scope, and the proposed reviewer(s). A copy of the report and recommendations will be sent to MFAT on completion within three (3) months of the event.

MFAT will consider each request on its merits and according to the circumstances.

5. Guidelines for Strengthening In-Country Capability (SCC) (Component Three)

This Activity includes strengthening in-country provision of medical services, in each partner country. PMA will ensure that this Output is tailored to the needs of each partner country. PMA will undertake a high-level training needs assessment in each partner country and identify (in collaboration with each partner country's Ministry of Health or equivalent) those areas of need or focus for strengthening services.

5.1 Objectives for SCC Teams
The intention of Component Three is to work with countries to identify areas that may utilise this mechanism for on-going capacity development that over time contributes to improving health services as well as building capability.

The SCC funds may be used for the provision of consumables for training purposes where necessary. It may be utilised to support new skills acquired by clinicians and allied health staff through capacity building activities in agreed areas of need. It does not include the acquisition of permanent assets for the hospital such as a dialysis machine.

The objectives for SCC teams are:

- to maximize opportunities for capacity building through a range of modalities from mentoring and on- the-job-training to structured training such as seminars for groups such as medical, nursing and allied health staff and conferences where appropriate;
- Supporting the development of guidelines, processes and protocols to improve in-country quality of care;
- Facilitation e-health opportunities to provide clinical advice; and
- Provision of ongoing mentoring and support either face to face or online.

MFAT will provide PMA with details of MFAT-funded health-related activities in each partner country, to be updated regularly. Where MFAT is aware of the work of other development partners, this will also be shared with PMA.

5.2 NZMTS Stakeholders: roles and responsibilities of stakeholders in the organisation of SCC visits

5.2.1 Overseas Referral Committees & MOH

- Provide a terms of reference to PMA that outline the need and the outcomes of the planned activities and identify suitable personnel to participate in SCC activities;
- ensure all members of visiting teams:
    - have current practicing certificates that meet country requirements. These must be sighted and copied by the MSC. It is the responsibility of PMA to ensure this requirement is met;
    - have annual letters of good standing from professional bodies of which they are members; and
    - have professional indemnity cover and have appropriate arrangements in place for accident compensation cover.
- make appropriate arrangements for visits (or training attachments) in consultation with the relevant country official(s). This includes organising flights, payment of per diems etc;
- ensure that the partner country host organisation is ready and organised to receive the SCC team and that the local organisation is in place;
- provide MFAT and the relevant MFAT Post with information on of proposed SCC visit about three months in advance. Cooperate with any reasonable requests from MFAT Posts for publicity for the visit;
- provide visiting SCC teams with the agreed TOR detailing what is expected from the visit in relation to scope, formal and on-the-job training, the budget available and reporting required;
- brief SCC teams on 'in country' facilities and conditions and any cultural constraints or sensitivities;
- provide a letter of engagement for each member of the team outlining the TOR including requirements for reporting, providing documentation and what is included for the visit;
- provide cash per diems to SCC where credit cards are not used for accommodation and food and other expenses related to the activity or otherwise reimburse SCC teams, in accordance with agreed payment schedules, on completion of their assignment and receipt of a satisfactory report;
- analyse any recommendation in SCC team reports and decide on the appropriate response for each recommendation (note the need to be cost-neutral and 'reasonable' in the country context;
- report annually on outcomes, trends, issues relating to the SCC.

5.3 Role of SCC Teams

The SCC Teams will:

- in consultation with PMA and relevant local medical and nursing staff, ensure that necessary pre-assessments have been carried out and facilities and equipment are adequate and appropriate to undertake the any scoping or training required.
- arrange provision of any specialised equipment/materials required for training not available in-country;
- in consultation with the relevant local medical, nursing and Ministry of Health (MOH) staff, identify relevant staff to be involved in both structured training and on-the-job training. This could include placements in New Zealand, Fiji (region) and Australia;
- plan and undertake seminars/workshops for identified staff. These should be available for the broadest range of health staff possible; and
- where appropriate, identify key individuals who might benefit from additional training/mentoring/professional development and suggest how this might be addressed. Recommendations regarding capacity development or training must be discussed with PMA and the partner countries. No undertaking should be given to trainees prior to a discussion being held.

5.3.1 SCC Team Reporting

The SCC team leader will:

- at the completion of the visit, undertake a debriefing meeting with members of the Medical Superintendent or equivalent and other relevant MOH, medical and other health sector specialists to discuss outcomes of the visit, any issues arising and recommendations for future visits dedicate a half day for debriefing and planning;
- provide a report (to PMA within (1) month of completion of the assignment) and to the Medical Superintendent or equivalent within a further week; and
- provide any feedback and comments to PMA that would assist in future visits.

NOTE: SCC team costs are payable on production of all required receipts and documentation including completed reports in the template required.

5.4 Procedures for review of any adverse event or outcome resulting from NZMTS activities.

If there is any adverse event or outcome resulting immediately from any SCC visit, countries may request MFAT; financial assistance to conduct an independent review.

- The request should be made to MFAT by the partner country ORC via PMA.
- The review should commence within 1 month after the adverse event.
- The request should set out the estimated costs of the review, the scope, and the proposed reviewer(s). A copy of the report and recommendations will be sent to MFAT on completion within three (3) months of the event.

MFAT will consider each request on its merits and according to the circumstances.