Ministry of Health
Government of the Republic of Vanuatu



VANUATU NATIONAL TELEMEDICINE POLICY

2026–2030

Vanuatu Telemedicine Policy 2026-2030

MINISTRY OF HEALTH
VANUATU GOVERNMENT

World Health Organization
Vanuatu

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This Policy was developed by HIS & Digital Health Advisor, World Health Organization (WHO), in close collaboration with Manager of the Health Information Systems Unit at the Ministry of Health.

Acknowledgment

The Ministry of Health (MOH), of Vanuatu, wishes to acknowledge and express its sincere appreciation to everyone who contributed to the development of the Vanuatu National Telemedicine Policy 2026–2030.

Special appreciation is extended to HIS & Digital Health Advisor from World Health Organization (WHO) in Vanuatu, for leading the drafting and providing technical guidance in the development of this Policy, in close collaboration with the Digital Health Unit of the Ministry of Health. Their collaboration and commitment have been instrumental in shaping a national policy framework that reflects Vanuatu's health priorities, digital health aspirations and the need to improve access to quality healthcare services across the country's dispersed islands.

The Ministry also wishes to acknowledge the Ministry of Health Executive Committee for its endorsement and approval of this Policy, and for its continued leadership and commitment to advancing digital health in Vanuatu. In particular, appreciation is extended to the Executive Committee for its strong encouragement and push to ensure that telemedicine moves beyond planning and policy development into practical implementation and actual use within the health service delivery system.

This leadership and commitment demonstrate the Ministry's determination to embrace appropriate digital technologies to strengthen healthcare delivery, improve access to specialist services, support health workers and bring essential healthcare services closer to communities, particularly those in remote and underserved areas.

The Vanuatu National Telemedicine Policy 2026–2030 is also an important component of the Vanuatu Digital Health Strategy 2025–2030, supporting the Strategy's vision of a connected, accessible, resilient and people-centred health system. Its development reinforces the Ministry's commitment to translating the strategic priorities of the Digital Health Strategy into practical action.

Finally, the Ministry acknowledges the continued support and collaboration of WHO, development partners, health professionals and all stakeholders who share the vision of strengthening healthcare delivery through the responsible and sustainable use of digital health technologies.

Together, we look forward to translating this Policy into action and making telemedicine an integral part of healthcare delivery in Vanuatu.

Minister's Foreword



It is my pleasure to present the **Vanuatu National Telemedicine Policy 2026–2030**, a significant step forward in our commitment to ensuring that every person in Vanuatu can access quality health services, regardless of where they live.

As a nation of dispersed islands, Vanuatu faces Many challenges in delivering timely and equitable healthcare. Geographic isolation, limited specialist availability, high transportation costs, and the increasing impact of natural disasters can make access to essential health services difficult for many of our communities. At the same time, advances in digital technology present new opportunities to overcome these barriers and bring healthcare closer to our people.

This Policy provides the national framework for the safe, secure and sustainable use of telemedicine across the health sector. It recognizes telemedicine not as a separate health system, but as an important model of care that strengthens existing health services, supports our health workforce, and improves access to specialist expertise and clinical support when and where it is needed most.

The Policy aligns with the Vanuatu Digital Health Strategy 2025–2030 and reflects the Government's commitment to universal health coverage, primary health care strengthening, patient safety, and digital transformation. It establishes clear governance arrangements, clinical standards, privacy and security requirements, workforce expectations, and implementation pathways to ensure that telemedicine services are introduced responsibly and deliver meaningful benefits to patients and communities.

Telemedicine has the potential to transform healthcare delivery in Vanuatu. It can reduce unnecessary travel for patients and health workers, strengthen referral pathways, support the management of non-communicable diseases, improve maternal and child health services, expand access to diagnostic expertise, and maintain continuity of care during emergencies and disasters. Importantly, it can also support the development of our national and provincial health workforce through clinical mentoring, collaboration, and knowledge sharing.

This Policy emphasizes a phased and evidence-based approach. New telemedicine services will be introduced progressively, tested carefully, and expanded only where they demonstrate safety, effectiveness, affordability, and sustainability. In doing so, we will ensure that investments in digital health contribute to long-term improvements in health outcomes and strengthen the resilience of our health system.

The successful implementation of this Policy will require strong collaboration between the Ministry of Health, Provincial Health Services, healthcare workers, communities, development partners, regional institutions, and technology providers. Together, we can harness innovation to improve access to care while maintaining the highest standards of clinical quality, patient protection, and public trust.

I wish to acknowledge the contributions of health professionals, technical experts, development partners, and stakeholders whose expertise and commitment have informed the development of this Policy. Your support will continue to be vital as we move from policy to implementation.

On behalf of the Government of the Republic of Vanuatu and the Ministry of Health, I commend this Policy as a framework for improving health service delivery and ensuring that more ni-Vanuatu can access the care they need, when they need it, wherever they live.

Hon. Robert Murray Bohn
Minister of Health
Government of Vanuatu

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Document Control

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Executive Policy Statement

The Ministry of Health will use telemedicine to improve equitable access to safe, timely and appropriate health services, particularly for people living in remote, rural and underserved communities.

Telemedicine will strengthen, not replace, Vanuatu's existing health service delivery and referral system. It will connect patients and health workers progressively through community and primary care services, Provincial Hospitals, Vanuatu National Hospital and, where required, approved regional and international specialist services.
Telemedicine is a **model of care, not a separate health system**. Services must be clinically governed, integrated into existing patient pathways, documented in the patient's official health record, and supported by secure, resilient and appropriate digital infrastructure.

The Ministry will introduce telemedicine progressively as **clinical, workforce, facility and technology readiness** is established. New or materially changed services must be evaluated through controlled implementation and scaled only where they demonstrate clinical benefit, patient safety, operational feasibility, security, affordability and sustainability.

1. Background

Vanuatu's dispersed island geography, limited specialist workforce, high inter-island travel costs, uneven connectivity and exposure to cyclones, earthquakes, volcanic events and other emergencies create significant barriers to timely access to health services.

The Vanuatu Digital Health Strategy 2025–2030 identifies telemedicine as a means of strengthening primary health care and improving access and continuity of care. It calls for a national telemedicine service model, clear patient pathways, regulatory guidance, teleconsultation capability, controlled proof-of-concept implementation, use of shared infrastructure where appropriate, and progressive integration with the wider digital health ecosystem.

This Policy provides the national governance framework for implementing telemedicine coherently rather than through isolated, donor-driven or technology-specific projects.

2. Purpose

The purpose of this Policy is to establish the national framework for the safe, equitable, clinically governed, secure and sustainable use of telemedicine in Vanuatu. It defines the national service model, governance and accountability arrangements, patient protections, workforce and clinical requirements, information and technology requirements, external-partner arrangements, and the conditions for approving, piloting and scaling telemedicine services.

3. Scope

This Policy applies to **all telemedicine services delivered, commissioned, funded, supported or endorsed by the Ministry of Health**, regardless of whether the service, technology or infrastructure is Ministry-funded, donated, grant-funded, subsidised, externally hosted or externally supported.

It applies to participating **h**ealth facilities, Provincial Hospitals, Vanuatu National Hospital, community and outreach services, public health programmes, Ministry and provincial health workers, contracted providers, visiting medical teams, development partners, regional and international specialists, technology providers and other organisations delivering telemedicine on behalf of or in partnership with the Ministry.

4. Definitions

Term	Definition
Asynchronous telemedicine	Store-and-forward transmission of information for later clinical review.
Disaster telehealth	Telemedicine and related digital health services used during emergencies or disruption to normal health services.
National ID	The national identity identifier used to uniquely identify an individual and progressively link health information across approved national systems.

Term	Definition
Remote patient monitoring	Collection and transmission of patient measurements outside a health facility for clinical review.
Synchronous telemedicine	Real-time interaction, such as telephone or video consultation.
Tele-MCH	Telemedicine supporting maternal, newborn, child and adolescent health.
Teleconsultation	Remote patient-to-clinician or clinician-to-clinician consultation.
Telehealth	Broader use of digital communications for clinical and non-clinical health services, including education and workforce support.
Telemedicine	Provision of clinical health services at a distance using information and communication technologies.
Telepathology	Remote review and interpretation of pathology images and associated clinical or laboratory information.
Teleradiology	Remote transmission and interpretation of diagnostic imaging.

5. Policy Objectives

The Ministry will use telemedicine to:

1. **Improve equitable access** to safe clinical services for remote, rural and underserved communities;
2. **Strengthen primary health care and the national tiered referral and escalation system**, including the role of Provincial Hospitals and Vanuatu National Hospital;
3. Improve **continuity, follow-up and access to specialist and diagnostic expertise**, while reducing unnecessary travel and avoidable referrals;
4. Strengthen priority services, including **NCD, maternal, newborn, child and adolescent health, and continuity of care during disasters and emergencies**;
5. Ensure telemedicine encounters contribute to the patient's **longitudinal health record** and progressively integrate with national digital health systems;
6. Strengthen **clinical collaboration, mentoring, knowledge transfer and national and provincial workforce capability**;
7. Ensure telemedicine is **safe, secure, interoperable, resilient and appropriate to Vanuatu's infrastructure and resource constraints**; and
8. Scale services only where they are **clinically beneficial, operationally feasible, affordable and sustainable**, while reducing unnecessary dependence on individual donors, vendors or external clinicians.

6. Guiding Principles

1. **Patient safety first.** Telemedicine must only be used where it can provide safe and clinically appropriate care. It must never delay necessary physical examination, treatment, transfer or evacuation.
2. **Equity and universal access.** Priority should be given to communities disadvantaged by geography, disability, mobility, cost, or lack of specialist access.
3. **Integrated care.** Telemedicine must support existing health services, clinical programs, referrals and patient pathways rather than create parallel health systems.
4. **Appropriate technology.** The simplest safe and effective modality should be used. Video should not be mandatory where telephone, secure messaging, or store-and-forward services can safely achieve the clinical objective.
5. **Government ownership.** The Ministry remains accountable for Ministry-approved telemedicine services even when technology, funding or clinical expertise is provided externally.
6. **Privacy and security by design.** Privacy, cybersecurity, identity management, access controls, encryption and auditability must be considered from the beginning of every service.
7. **Interoperability.** Telemedicine must progressively integrate with national health information systems and avoid creating additional information silos.
8. **Sustainability.** Technology must be affordable, maintainable, and proportionate to Vanuatu's workforce and infrastructure capacity.
9. **Resilience.** Services must anticipate power failures, network outages, disasters and other disruptions.
10. **Continuous improvement.** Telemedicine services will be evaluated and improved using clinical, patient, operational, technical and financial evidence.

7. Governance and Accountability

Telemedicine will operate under existing Ministry digital health and clinical governance structures.

Governance Levels	Main Responsibilities
Director General / Digital Health Steering Committee	Strategic direction, major investment and national scale-up decisions, and acceptance of significant risks.
Curative Services Subcommittee, once established[1]	Coordinate, prioritize and oversee digital health and health information initiatives across Vanuatu's hospitals to ensure they support safe, efficient, integrated and data-driven clinical service delivery.
Medical Superintendents and facility managers	Local implementation, staffing, readiness, adoption and operational oversight.

[1] At the time of Policy preparation, the Curative Services Subcommittee for Digital Health was being established. Its governance responsibilities under this Policy will take effect once formally established by the Ministry of Health.

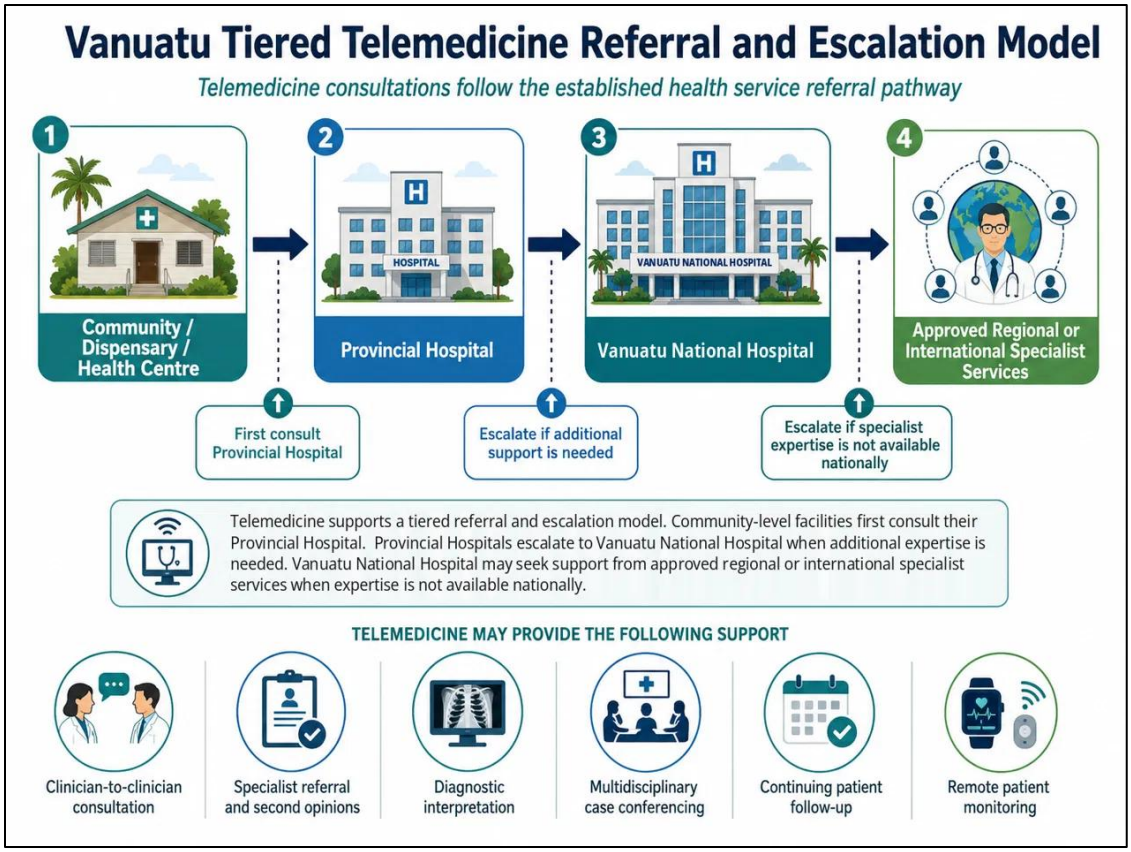
Governance Levels	Main Responsibilities
Health Information and Digital Health Unit	Policy stewardship, program coordination, architecture, technology deployment, interoperability, data governance and monitoring.
Clinical Programmes and Hospital Services	Clinical ownership, clinical pathways, standards of care, escalation, workforce and clinical quality.
Technical Management governance / DCDT	Infrastructure, networking, hosting, cybersecurity, identity and access management, technical standards and operational arrangements.
Service-specific technical working groups	Service design, requirements, SOPs, validation, implementation and quality assurance.
Development partners and vendors	Delivery within approved Government requirements and contracts.

Development partners and vendors shall not independently determine national clinical standards, architecture, hosting arrangements, data ownership or patient information governance.

8. National Telemedicine Service Model

Vanuatu will operate a **tiered telemedicine referral and escalation model** aligned with the existing health service delivery and referral structure.

Telemedicine consultations will normally follow this pathway:



8.1 Tiered Referral and Escalation

Community-level facilities will use telemedicine as part of Vanuatu's existing referral system, with clinical support provided progressively through the appropriate level of care. This approach ensures that cases are managed as close to the patient as safely possible, while enabling timely escalation when higher-level expertise is required.

- Community-level facilities, dispensaries and health centers will **first seek clinical advice and support from their respective Provincial Hospital**.
- The Provincial Hospital will provide the first level of remote clinical support, including advice on diagnosis, treatment, referral, investigations, patient management and whether further specialist input is required.
- Where the Provincial Hospital determines that additional clinical expertise, diagnostic support or specialist input is required, the case will be escalated to the appropriate clinician or service at **Vanuatu National Hospital**.
- Where the required expertise or service is not available nationally, Vanuatu National Hospital may seek assistance from an **approved regional or international specialist service**.

Telemedicine will therefore support the **progressive escalation of clinical expertise** through the health system rather than creating parallel or routine direct referral pathways that bypass Provincial Hospitals.

8.2 Role of Provincial Hospitals

Provincial Hospitals are a critical part of the national telemedicine model. The model is intended to:

- Preserve and strengthen the role of Provincial Hospitals as the primary clinical referral and support point for facilities within their province;
- Strengthen provincial clinical capability through regular interaction, consultation and knowledge transfer;
- Ensure that cases are managed at the most appropriate level of the health system;
- Reduce unnecessary escalation of routine cases to Vanuatu National Hospital;
- Allow Vanuatu National Hospital clinicians to concentrate on cases requiring higher-level or specialist expertise; and
- Establish a clear and operationally manageable escalation pathway across the health system.

This approach supports both **service delivery and capacity building**, as Provincial Hospital clinicians progressively strengthen their ability to manage cases locally with support from Vanuatu National Hospital when required.

8.3 Types of Telemedicine Support

Within this tiered model, telemedicine may support:

- Clinician-to-clinician consultation and case discussion;
- Specialist referral and second opinions;
- Diagnostic interpretation, including teleradiology and telepathology;
- Multidisciplinary case conferencing;
- Continuing patient follow-up;
- Maternal, newborn and child health consultation;
- NCD management and remote patient monitoring;
- Clinical support during disasters and emergencies; and
- Patient-to-clinician consultation where authorized under an approved service model.

8.4 Clinical Education, Mentoring and Capacity Building

Telemedicine may also be used to strengthen the capability of Vanuatu's health workforce through case-based learning, clinical mentoring, peer consultation, multidisciplinary case review, quality assurance and continuing professional development. These activities should complement clinical service delivery and progressively strengthen the ability of health workers and facilities to manage appropriate cases locally.

8.5 Modes of Telemedicine

Both **synchronous** and **asynchronous** telemedicine may be used.

Synchronous services may include telephone or video consultation. Asynchronous services may include secure store-and-forward transmission of clinical information, diagnostic images, photographs, laboratory information or other approved clinical data.

The model must be capable of operating in **low-bandwidth and intermittent-connectivity environments** and must not depend exclusively on continuous video connectivity.

8.6 Integration with Existing Health Services

Telemedicine does not create a separate referral system. It is a digital mechanism for strengthening the existing clinical referral, consultation and escalation pathways.

Telemedicine referrals and consultations must therefore be integrated with:

- Existing provincial referral arrangements;
- Vanuatu National Hospital clinical services;
- Approved patient referral pathways;
- Clinical documentation and patient records; and
- Relevant national and regional specialist networks.

9. Priority Telemedicine Services

9.1 Teleconsultation and Tele-referral

May include:

- Primary care support;
- Specialist consultation;
- Second opinions;
- Referral decision support;
- NCD patient counselling;
- Clinical case conferencing; and
- Follow-up consultations.

Teleconsultation should be the initial national primary care telemedicine capability and should be introduced through controlled implementation before scale-up.

9.2 Teleradiology

Teleradiology may support remote interpretation of:

- X-rays;

- CT;
- Ultrasound;
- Case review, peer consultation, quality assurance, mentoring and continuing professional development of clinicians and imaging staff; and
- Other approved diagnostic imaging.

Services must use diagnostic-quality images, appropriately qualified interpreters, secure and reliable transmission, clear turnaround targets and processes for urgent and critical findings. Where available, teleradiology should integrate with PACS and the patient's national health record using the National ID.

9.3 Telepathology

Telepathology may support:

- Primary diagnosis where clinically validated;
- Specialist consultation;
- Second opinions;
- Quality assurance; and
- Training, mentoring and continuing professional development of laboratory and clinical staff.

Before use for routine diagnosis, the Ministry must validate imaging equipment, image quality, specimen-to-patient identification, diagnostic workflow, remote specialist access and clinical quality assurance. Telepathology should be designed for eventual integration with national laboratory information systems (NLIMS) and the national electronic health record (NEHR).

9.4 Tele-MCH

Telemedicine may support maternal, newborn, child and adolescent health services, including:

- Antenatal consultation;
- Remote-supported antenatal screening and risk assessment;
- Midwifery and obstetric specialist advice;
- Tele-ultrasound and remote sonography support;
- Remote interpretation and consultation on maternal and fetal ultrasound findings;
- Doppler-supported fetal assessment where clinically appropriate;
- Remote clinical support for point-of-care maternal diagnostic testing;
- Postnatal follow-up;
- Newborn care;
- Child health;
- Immunization follow-up;
- Paediatric consultation;
- Remote case conferencing;
- Mobile and outreach-enabled telemedicine for maternal and child health services in remote communities;
- Remote clinical mentoring and skills development for physicians, nurses, midwives and sonographers; and
- Remote maternal health counselling, prenatal education and support for improved uptake of antenatal care.

Tele-MCH services, including tele-ultrasound and remote diagnostic support, should follow the national tiered referral and escalation model wherever clinically appropriate, with Provincial Hospitals serving as the first referral and clinical support level before escalation to Vanuatu National Hospital.

Tele-MCH services may be delivered from fixed health facilities or through approved outreach arrangements, including mobile clinics, vehicles or vessels, where these are used to extend services to geographically isolated communities.

Telemedicine must not substitute for required physical examination, emergency obstetric or neonatal care, or timely referral and transfer of high-risk mothers, newborns or children.

9.5 NCD Telemedicine and Remote Patient Monitoring

Telemedicine may support management of:

- Hypertension;
- Diabetes;
- Cardiovascular disease;
- Chronic respiratory disease; and
- Other appropriate chronic conditions.

Remote monitoring may include approved measurements such as blood pressure, glucose, weight, pulse, oxygen saturation and other clinically approved measurements. Each program must define patient eligibility, device requirements, measurement frequency, monitoring responsibility, alert thresholds, expected response time and escalation arrangements.

Where remote patient monitoring occurs in the patient's home or another location without a health worker present, the service must operate under a Ministry-approved SOP defining patient eligibility, responsibilities, monitoring frequency, alert thresholds, response times, escalation and emergency instructions.

9.6 Disaster Telehealth

During cyclones, earthquakes, volcanic events, disease outbreaks and other emergencies, telehealth may support:

- Remote triage;
- Clinical consultation;
- Specialist advice;
- Continuity of NCD care;
- Support to isolated facilities;
- Emergency coordination; and
- Re-establishment of clinical communications.

Emergency procedures may temporarily use alternative communication methods when approved telemedicine platforms are unavailable. Any emergency exception must be necessary, proportionate, documented where practical, limited to the emergency period, and followed by appropriate transfer of clinical information into the official health record.

Where an emergency makes completion of the standard written Telemedicine Patient Consent Form impracticable, or where requiring completion would delay urgently required care, the service may follow an approved emergency consent procedure where permitted by applicable law. Wherever practicable, the patient or authorized representative should still be informed about the telemedicine consultation and their agreement sought. The reason for using the emergency exception and the consent process followed must be documented in the patient's official health record as soon as practicable.

9.7 Additional Services

As Vanuatu's telemedicine capability matures, the Ministry may progressively introduce **other telemedicine services where there is a demonstrated clinical need, appropriate workforce capacity, suitable technology and a sustainable service model**. These services may include, but are not limited to, the following:

- **Tele-dermatology:** Remote assessment of skin conditions using clinical information and appropriately captured images to support diagnosis, treatment advice, referral and follow-up.
- **Tele-ophthalmology:** Remote assessment of eye conditions using clinical information and digital eye images or other approved diagnostic information to support screening, specialist review and referral.
- **Tele-mental health:** Remote delivery of mental health assessment, counseling, follow-up and specialist consultation for patients who may otherwise have limited access to mental health services.
- **Tele-rehabilitation:** Remote provision of rehabilitation assessment, therapy guidance, exercise programs and follow-up by physiotherapists, occupational therapists or other rehabilitation professionals.
- **Tele-pharmacy:** Remote pharmacist support for medication review, medicine counseling, adherence support, medicines management and advice to patients and health workers.
- **Remote ECG interpretation:** Secure transmission of electrocardiogram results for remote clinical interpretation and advice to support diagnosis and management of cardiovascular conditions.
- **Remote ultrasound support:** Remote clinical or technical support for ultrasound examinations, including guidance during image acquisition and specialist review of ultrasound findings where appropriate.
- **Oral health consultation:** Remote dental and oral health assessment, advice, triage and referral using clinical information and appropriate images where a face-to-face dental assessment is not immediately available.
- **Multidisciplinary tumour boards:** Virtual meetings that bring together clinicians from different specialties to review cancer cases and agree on diagnosis, treatment and referral plans.
- **Infectious disease consultation:** Remote specialist advice to support the diagnosis, treatment, infection prevention and management of complex or unusual infectious diseases.
- **Other clinically appropriate telemedicine services:** The Ministry may introduce additional services where evidence demonstrates that telemedicine can safely improve access, quality, continuity or efficiency of care.

Any additional telemedicine service must follow the **national tiered referral and escalation model** where applicable and must meet the clinical governance, patient safety, privacy, cybersecurity, interoperability, facility readiness and sustainability requirements established under this Policy.

10. Clinical Governance and Patient Safety

Patient safety and quality of care shall be the primary consideration in all telemedicine services. Telemedicine must be delivered within approved clinical pathways and must not be used where remote care would create an unacceptable risk to the patient or delay necessary face-to-face assessment, treatment, referral or emergency transfer.

10.1 Clinical Governance Requirements

Every telemedicine service must have:

- An accountable clinical owner responsible for clinical quality and patient safety;
- An approved patient pathway and service workflow;
- Clearly defined roles and responsibilities for the referring and consulting health workers;
- Patient inclusion and exclusion criteria;
- Referral and escalation criteria;
- Requirements for patient identification and consent;
- Clinical documentation requirements;
- Arrangements for communicating clinical advice, results and treatment plans;
- Follow-up responsibilities and timeframes;
- Arrangements for urgent and critical findings;
- Emergency referral and evacuation procedures;
- Incident reporting and clinical quality review arrangements; and
- Downtime and contingency procedures for connectivity, power or technology failure.

10.2 Health Worker Presence with the Patient

For patient-facing telemedicine encounters delivered from a health facility or approved outreach location, the **patient must be physically accompanied by an appropriately trained health worker**.

The accompanying health worker is responsible for supporting the safe conduct of the consultation, including:

- Confirming the patient's identity;
- Explaining the telemedicine process and supporting the consent process;
- Providing relevant clinical history and information to the remote clinician;
- Obtaining and communicating vital signs and other clinical observations where required;
- Assisting with physical examination or use of diagnostic equipment under the direction of the consulting clinician and within their scope of practice;
- Ensuring that images, measurements, specimens and other clinical information relate to the correct patient;
- Facilitating communication where language, hearing, disability or other barriers exist;
- Implementing or coordinating immediate clinical actions advised during the consultation;
- Recognizing deterioration or emergency conditions and initiating the appropriate escalation pathway;
- Ensuring the consultation and resulting clinical plan are documented in the patient's health record; and
- Arranging follow-up, referral or transfer as required.

The accompanying health worker remains responsible for care delivered locally within their authorized scope of practice. The remote clinician remains responsible for the clinical advice, interpretation or treatment recommendations they provide within their authorized scope of practice.

This requirement does not apply to clinician-to-clinician case discussions where the patient is not participating in the encounter. Ministry-approved direct-to-patient telemedicine and home-based remote patient monitoring services may operate without a health worker physically present where the service-specific SOP defines appropriate patient eligibility, identification, consent, clinical responsibility, monitoring, escalation, emergency and technology-failure arrangements. **This exception does not remove the clinical documentation requirements in Section 13** where the discussion contributes to patient care.

10.3 Standard of Care

Telemedicine does not reduce the standard of clinical care expected from health workers. Clinical decisions must be based on sufficient and reliable information. Clinicians must recognize the limitations of remote assessment, including circumstances where physical examination, diagnostic testing or direct observation cannot be adequately performed remotely.

Where sufficient clinical information cannot be obtained through telemedicine, the patient must be referred for appropriate face-to-face assessment.

A telemedicine consultation must not delay:

- Emergency treatment;
- Referral to a higher level of care;
- Patient transfer or medical evacuation;
- Required diagnostic investigation; or
- Other time-critical clinical intervention.

10.4 Patient Identification and Clinical Information

Before providing patient-specific clinical advice, the participating health workers must confirm that the correct patient and the correct clinical information are being used. **Where available and applicable, the National ID must be used as the primary patient identifier.** Where the National ID is unavailable or not applicable, Ministry-approved patient identification procedures must be used.

Particular attention must be given to matching patients correctly with:

- Diagnostic images;
- Pathology specimens and images;
- Laboratory results;
- Ultrasound examinations;
- ECG recordings;
- Remote patient monitoring measurements; and
- Other clinical information transmitted for remote interpretation.

10.5 Clinical Responsibility and Handover

Each telemedicine service must clearly identify who is responsible for the patient **before, during and after the consultation**.

The remote clinician's recommendations must be communicated clearly to the accompanying health worker and documented in the patient's health record.

The clinical plan must identify, where applicable:

- Actions to be taken;
- Who is responsible for each action;
- Required timeframe;
- Follow-up arrangements;
- Criteria for further escalation; and
- The level of care to which the patient should be referred if their condition deteriorates.

Responsibility must not become unclear simply because care is being provided across different facilities or jurisdictions.

10.6 Critical and Urgent Findings

Critical or urgent clinical findings identified through telemedicine, including teleradiology, telepathology, tele-ultrasound or other remote diagnostic services, must use a **closed-loop communication process**. The responsible clinician or health worker must:

1. Receive the critical finding;
2. Acknowledge receipt;
3. Understand the required action;
4. Initiate the appropriate clinical response; and
5. Ensure the action is documented.

Sending a report, message or electronic notification alone is **not sufficient** where an urgent finding requires immediate clinical action.

10.7 Technology Failure and Clinical Safety

Every telemedicine service must have a defined procedure for technology failure.

Where video, connectivity, diagnostic equipment or other technology fails during a consultation, the responsible health worker and remote clinician, or the remote clinician with the patient in an approved direct-to-patient service, must determine whether the encounter can safely:

- Continue using an alternative approved communication method;
- Be rescheduled;
- Proceed through an asynchronous consultation;
- Require face-to-face assessment; or
- Require immediate referral or transfer.

Technology failure must never prevent a patient from receiving necessary clinical care.

10.8 Clinical Incidents and Quality Improvement

Clinical incidents, near misses and patient safety concerns associated with telemedicine must be reported and reviewed through approved Ministry clinical governance processes.

Where an incident involves technology, connectivity, cybersecurity or system failure, it should be treated as both a **clinical safety incident and a digital/technical incident**, where appropriate.

Lessons from incidents, complaints, patient feedback and health worker experience should be used to improve clinical protocols, training, technology and patient pathways.

11. Patient Identification and Consent

Patients must be correctly identified before patient-specific information is exchanged.

Patient identification **must follow the requirements set out in Section 10.4**.

Patients should be informed:

- That telemedicine is being used;
- Who will participate;
- The purpose of the consultation;
- Benefits and limitations;
- What information will be shared;
- Any significant privacy considerations;
- Available alternatives; and
- What to do if patient's condition deteriorates.

Before participating in a patient-facing telemedicine service, the patient must provide written informed consent by signing a Ministry-approved Telemedicine Patient Consent Form. Where the patient is a child, lacks capacity, or is otherwise unable to provide consent, the form must be signed by the parent, legal guardian, or other authorized representative, as permitted under applicable law and Ministry policy. The signed consent form must be retained as part of the patient's official health record.

The consent process must explain, in clear and understandable language, the purpose of the telemedicine service, who may participate, how the consultation will be conducted, what health information may be shared, the material limitations and risks of remote care, available alternatives, and how the patient's information will be protected.

Additional protections must apply to children and vulnerable people.[2]

Emergency exceptions to the standard written consent requirement are governed by Section 9.6, Disaster Telehealth. Such exceptions may only be used where permitted by applicable law and an approved Ministry emergency protocol.

12. Health Workforce, Credentialing and External Specialists

Telemedicine does not extend a healthcare worker's authorized scope of practice. All health workers participating in telemedicine must be appropriately qualified, trained and authorized for the services they provide.

[2] Additional protections required under applicable Vanuatu law and Ministry policy must apply to children and vulnerable people.

Clinicians providing patient-specific diagnosis, interpretation, clinical advice or treatment remotely must be appropriately credentialed. For clinicians not already credentialed by the Ministry of Health, the Ministry-approved process must verify, as applicable:

- Identity and professional qualifications;
- Current professional registration or licence;
- Relevant specialist qualifications and experience;
- Scope of service;
- Professional standing; and
- Appropriate indemnity or liability arrangements.

Vanuatu may use approved regional and international specialists where the required expertise is not available nationally. Such services should follow the national tiered referral and escalation model and operate through Ministry-approved arrangements that define clinical responsibilities, documentation, confidentiality, escalation, complaints, adverse events and other applicable professional and legal requirements.

Where specialist support is provided through an approved hospital, university, professional body or partner institution, the Ministry may establish an institutional arrangement that defines approved services, participating clinicians, credentialing responsibilities, service standards and quality assurance requirements.

Health workers participating in telemedicine must receive appropriate training for their role, including the use of technology, patient identification and consent, clinical documentation, privacy, cybersecurity, referral and escalation, and management of technology failure.

External specialist involvement should, where practicable, also support **clinical mentoring, knowledge transfer, quality improvement and continuing professional development** to strengthen Vanuatu's national and provincial health workforce.

13. Clinical Documentation

Every telemedicine encounter that contributes to the diagnosis, treatment, referral or ongoing care of an identifiable patient, including patient-facing and clinician-to-clinician consultations, must be documented in the patient's official health record. Where available and applicable, the record **must be linked to the patient's National ID.**

At minimum, the record must include:

- Patient identification;
- Date, time and participating health workers or clinicians;
- Consultation modality and reason for consultation;
- Relevant clinical information, findings, diagnosis or advice;
- Investigations and treatment;
- Consent status and documentation, as applicable under Sections 9.6 and 11, including confirmation of the signed Telemedicine Patient Consent Form for patient-facing encounters where required;
- Referral or escalation decisions; and

- Follow-up plan.

Where the National Electronic Health Record is available, telemedicine information should be integrated into it. Until integration is available, an approved minimum clinical dataset must be retained and capable of subsequent transfer or synchronization.

For clinician-to-clinician consultations, the locally responsible or referring clinician must ensure that the relevant advice, recommendations and resulting clinical plan are recorded in the patient's official health record.

General education, mentoring, peer discussion or continuing professional development that does not involve patient-specific clinical advice does not require documentation in an individual patient record.

Audio or video recording of telemedicine encounters must not occur unless specifically authorized by the Ministry and separately consented to by the patient.

14. Data Governance, Privacy and Confidentiality

Identifiable health information is sensitive information and must be collected, accessed, used, shared, retained and disposed of only for authorized purposes and in accordance with applicable Vanuatu requirements and Government security policies. Health information must be handled in accordance with applicable Vanuatu data protection and privacy legislation and any associated regulations or Government requirements.

The Ministry of Health remains accountable for patient information processed through telemedicine, including information handled by external clinicians, vendors, donors and development partners. Access must be limited to authorized users and to the minimum information necessary for their role.

Patient information must only be transmitted or stored using **Ministry or Government-approved systems and communication channels**. Personal email, personal cloud storage, personal social media accounts and unapproved consumer messaging platforms must not be used for routine transmission of identifiable patient information.

Cross-border access, remote support and external processing must comply with the requirements of **Section 16, Hosting and Cross-Border Services**. Use of patient information for research, commercial purposes, AI development or other secondary purposes requires separate Ministry approval and is not authorized solely by the patient's consent to participate in telemedicine.

15. Cybersecurity

Telemedicine systems, devices and services must comply with applicable Government cybersecurity policies, security standards and DCDT requirements. Security controls must be proportionate to the sensitivity of patient information, clinical risk and criticality of the service.

Minimum requirements include:

- Government-approved platforms, accounts and devices;
- individual user accounts, role-based access and least-privilege access;

- multi-factor authentication for privileged and remote administrative access, and for other users where required by Government standards or assessed risk;
- encryption of identifiable patient information in transit and at rest in accordance with Government requirements;
- audit logging and monitoring of security-relevant activity;
- supported software, security patching and endpoint protection;
- secure backup, recovery and tested business continuity arrangements; and
- approved, controlled and auditable remote access for vendors, external specialists and technical support personnel.

Cybersecurity incidents involving telemedicine or patient information must be reported promptly through Ministry and DCDT/CERT incident management processes. Any incident must be assessed for both **technical impact and patient safety impact**, with continuity of essential clinical services maintained wherever possible.

16. Hosting and Cross-Border Services

Telemedicine systems and services must comply with applicable Vanuatu data classification, privacy, cybersecurity, hosting and digital infrastructure requirements. Hosting decisions must be risk-based and take account of the sensitivity of identifiable health information, clinical criticality, service resilience and continuity of care.

Any cloud-based, externally hosted or cross-border telemedicine service must have approved arrangements that clearly define:

- Data location, ownership and authorized access;
- Security, encryption, backup, recovery and audit requirements;
- Subcontractors, remote support and cross-border access;
- Service levels and incident reporting; and
- Data portability, exit and data-repatriation arrangements.

Cross-border processing or access to patient information must comply with applicable Vanuatu data protection, privacy and data-transfer requirements.

Donated, grant-funded, vendor-hosted or externally supported systems are not exempt from Government requirements for privacy, cybersecurity, hosting, sovereignty, audit or exit.

Where required, hosting and cross-border arrangements must receive appropriate **Ministry of Health and DCDT approval before implementation**.

17. Digital Architecture and Interoperability

Telemedicine systems must align with the **national digital health architecture** and avoid creating standalone applications, duplicate patient records or isolated data silos.

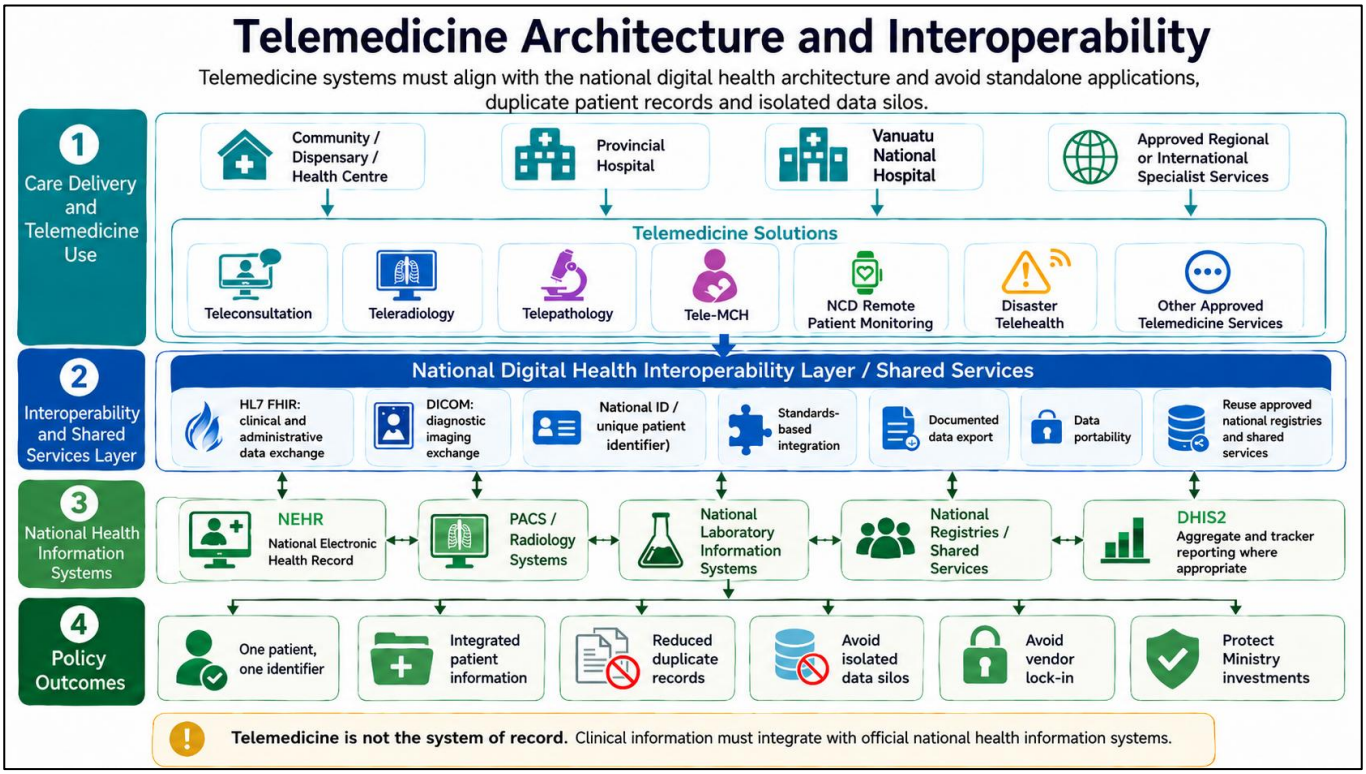
Where applicable:

- Telemedicine systems that create, store or exchange structured clinical or administrative data must support nationally approved interoperability standards, including HL7 FHIR where

applicable. Systems that create, store or exchange diagnostic images must support DICOM where applicable;

- Government-approved enterprise communication or collaboration platforms used solely as an interim consultation channel are not required to natively support HL7 FHIR or DICOM, provided the telemedicine encounter is documented in the patient's official health record and the platform is not used as the permanent clinical record or an unapproved repository of patient information;
- Telemedicine systems must support the National ID as the national unique patient identifier where available and applicable;
- Telemedicine information must progressively integrate with the **NEHR** and relevant national systems, including radiology/PACS and laboratory information systems;
- Approved national registries, shared services and interoperability mechanisms should be reused rather than duplicated; and

The diagram illustrates how telemedicine services should connect through Vanuatu's national digital health architecture rather than operate as standalone systems. It shows the use of shared interoperability standards, the National ID, and integration with core national health information systems to support continuity of care, reduce duplication, and avoid isolated data silos.



Telemedicine systems that create, store or exchange clinical information must support appropriate standards-based integration, documented data export and data portability to protect Ministry investments and avoid unnecessary vendor lock-in. This requirement does not apply to an approved interim communication platform used solely as the consultation channel.

18. Technology and Platform Requirements

The Ministry will remain **technology-neutral** and will select platforms based on clinical need, security, privacy, usability, reliability, affordability and sustainability.

A dedicated telemedicine platform is **not required to commence telemedicine services**. Government-managed or Government-approved enterprise communication and collaboration platforms may be used as an **interim telemedicine solution**, provided they are approved by the Ministry of Health and DCDT and configured and operated in accordance with applicable Government security and privacy requirements.

Interim platforms must:

- Use approved Government accounts and access controls;
- Protect patient confidentiality and provide a private consultation environment;
- Meet applicable authentication, encryption, audit and cybersecurity requirements;
- Ensure that the telemedicine encounter is documented in the patient's official health record; and
- Not be used as the permanent clinical record or create an unapproved repository of patient information.

Interim solutions may operate without full integration with national health information systems where integration is not technically available, provided clinical information is captured in the official patient record and future transition or integration is not unnecessarily restricted.

The Ministry may progressively transition to a dedicated national telemedicine platform where this provides greater clinical, technical, interoperability or operational benefit.

19. Facility and Service Location Readiness

Before activation, each participating health facility or approved outreach/service location must complete a readiness assessment appropriate to the telemedicine service being provided.

The assessment must confirm:

- A trained health worker is available to accompany the patient where required by the approved service model;
- Connectivity is adequate for the intended modality, with an approved lower-bandwidth or downtime alternative where required;
- Reliable power or appropriate backup power is available;
- Approved devices, accounts and telemedicine platforms are available and operational;
- Required clinical and diagnostic equipment is available and fit for purpose;
- A private environment is available to protect patient confidentiality;
- Clinical workflow, documentation, referral and escalation arrangements are established; and
- Technical support and downtime procedures are in place.

Shared Government or Area Council infrastructure may be used where approved, provided patient privacy, secure device access, authorized user access and protection of identifiable health information can be maintained.

20. Training and Change Management

Telemedicine must be implemented as a **clinical service transformation program**, not simply as an ICT deployment.

Health workers and other users must complete **role-based training and demonstrate appropriate competency before participating in a telemedicine service**. Training must cover, as applicable:

- Clinical workflows, patient selection and the tiered referral and escalation pathway;
- Patient identification, informed consent and the role of the accompanying health worker;
- Use of approved platforms, devices and clinical equipment;
- Clinical documentation and the official patient record;
- Privacy, confidentiality and cybersecurity;
- Management of urgent patients, technology failure and downtime procedures; and
- Service-specific requirements relevant to the user's role.

Implementation must be supported by **local champions, practical workflow coaching, user support and hypercare during initial deployment**. Refresher training must be provided when systems, workflows, clinical protocols or security requirements materially change.

User feedback, service performance and clinical incidents should inform continuous improvement of training, workflows and telemedicine services.

21. Development Partners and Vendors

Development partner and vendor support for telemedicine is encouraged where it aligns with Ministry priorities and strengthens national capability.

Donated, grant-funded, subsidized, concessional, vendor-hosted or externally supported systems and services must meet the same Ministry and Government requirements as Ministry-funded solutions.

Relevant clinical, digital health, architecture, cybersecurity, hosting and procurement approvals must be obtained before implementation.

Agreements must define, as applicable:

- Ministry governance and data ownership;
- Clinical standards and responsibilities;
- Cybersecurity, hosting and cross-border access;
- Interoperability, data export and portability;
- Service levels, support and maintenance;
- Training and knowledge transfer;
- Recurrent costs and sustainability; and
- Exit, handover, data repatriation and transition arrangements.

External support should strengthen local capability and avoid unnecessary vendor or donor dependency. Pilot or externally funded services should transition to routine operation only following an approved sustainability and scale-up decision.

22. Monitoring, Evaluation and Quality Improvement

The Ministry will maintain a **simple national telemedicine monitoring framework** to assess whether services are safe, accessible, effective, equitable, reliable, used appropriately and sustainable.

Core monitoring domains should include:

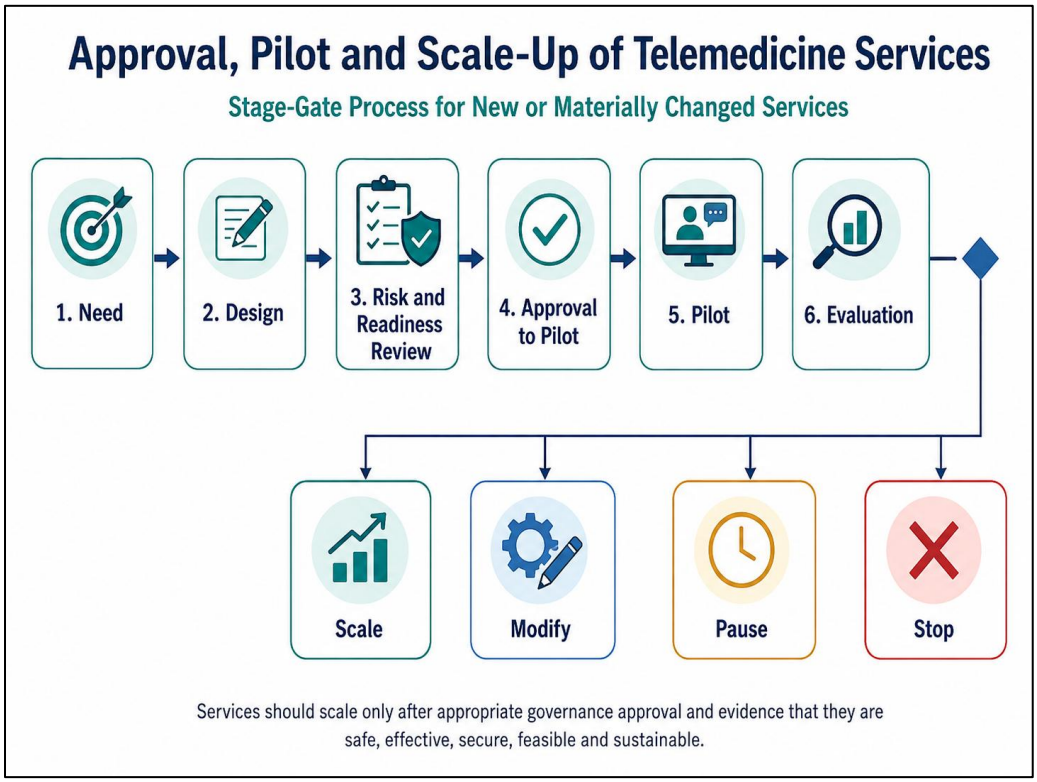
Domain	Example measures
Access and Equity	Use by province, facility, service type and remote or underserved population
Referral and Timeliness	Referral-to-consultation time, escalation patterns, specialist response and diagnostic turnaround
Clinical Quality and Safety	Appropriate referrals avoided or escalated, critical-result follow-up, clinical incidents and adverse events
Continuity and Data Quality	Follow-up completion, encounters documented in the official patient record, completeness and accuracy of required data
Adoption and User Experience	Health worker use, patient/provider experience, training or competency gaps
Technology and Security	Successful sessions, service availability, connectivity failures, privacy and cybersecurity incidents
Efficiency and Sustainability	Patient travel avoided, operating cost, specialist/support costs and affordability

Service-specific indicators may be established for teleconsultation, teleradiology, telepathology, Tele-MCH, NCD remote patient monitoring and other approved services.

The **Health Information and Digital Health Unit** will consolidate national performance information. Service owners must review findings and implement corrective actions. Significant clinical safety, privacy or cybersecurity concerns must be escalated promptly through the appropriate Ministry and DCDT governance processes.

23. Approval, Pilot and Scale-Up of Telemedicine Services

New or materially changed telemedicine services must follow a **proportionate, evidence-based stage-gate process**:



Before pilot implementation, the service must meet the applicable requirements of this Policy, including clinical governance, workforce readiness, patient safety, privacy, cybersecurity, hosting, interoperability, facility readiness and sustainability.

National scale-up must receive the appropriate Ministry governance approval and must occur only where evaluation demonstrates that the service is:

- Clinically safe and effective;
- Usable and acceptable to patients and health workers;
- Technically reliable and secure;
- Operationally feasible;
- Affordable and sustainable; and
- Aligned with the national digital health architecture.

Pilot findings must inform any required changes before wider implementation. Emergency arrangements are governed separately under the Disaster Telehealth provisions.

24. Financing and Sustainability

Telemedicine must be financed and managed as an **ongoing health service**, not as a stand-alone technology project. Before national scale-up, each service must identify its full recurrent and lifecycle costs, responsible budget holder and a realistic source of funding.

Planning must include, as applicable:

- Connectivity, licences, hosting and cybersecurity;
- Maintenance, technical support and equipment replacement;
- Training and clinical specialist costs;

- Backup, consumables and programme management.

Where practical, connectivity, infrastructure and support should be shared across digital health services rather than funded separately.
Donor- or vendor-supported services must include knowledge transfer, transition, exit and post-funding arrangements from the outset, while progressively strengthening Ministry and provincial capacity for routine support.

National scale-up must not proceed where long-term operating costs are unaffordable or depend on an unreliable external subsidy.

25. Exceptions, Complaints and Incident Management

Exceptions to this Policy must be **justified, risk-assessed, documented, approved by the appropriate authority, time-limited and reviewed**. Emergency exceptions must follow the Disaster Telehealth provisions.

Patients and health workers must have accessible mechanisms to report:

- Complaints and patient safety concerns;
- Clinical incidents and near misses;
- Technology or connectivity failures;
- Privacy or confidentiality concerns; and
- Cybersecurity incidents.

Reports must be assessed and managed through the appropriate clinical, digital health, privacy or cybersecurity governance process. Where an incident crosses more than one domain, the relevant processes must be coordinated.

Where technology, connectivity or cybersecurity contributes to clinical harm or patient safety risk, the event must be treated as both a clinical safety incident and a digital/technical incident.

Lessons from complaints and incidents must inform corrective action, training, workflows and service improvement.

26. Implementation Priorities 2026–2030

Implementation will be **phased and adaptive**, with annual priorities confirmed through Ministry workplans according to clinical need, readiness, evidence, funding and national digital health dependencies.

Period	Priority
2026	Approve the Policy and supporting SOP framework; establish governance; commence controlled teleconsultation using an approved interim solution where appropriate; validate telepathology; formalize teleradiology arrangements; complete priority site readiness assessments; and establish baseline indicators.

2027–2028	Evaluate services through the stage-gate process and expand those demonstrating benefit and sustainability; progressively integrate with NEHR, PACS and laboratory systems, and progressively use the National ID as it becomes available and applicable; introduce or expand Tele-MCH, NCD remote monitoring and other priority specialist services where readiness and funding permit.
2029–2030	Consolidate equitable national coverage; strengthen provincial and regional specialist networks; optimize interoperability and workforce capability; and review quality, access, cost-effectiveness, affordability and sustainability.

National expansion must remain subject to the **approval, pilot and scale-up requirements in Section 23** and the **financing and sustainability requirements in Section 24**.

27. Policy Review

This Policy must be reviewed:

- after the first **12 months of implementation**;
- at least every **two years thereafter**; or
- earlier following significant changes in legislation, cybersecurity or hosting requirements, national digital health architecture, technology, service models or clinical practice.

Reviews should consider monitoring and evaluation findings, clinical and cybersecurity incidents, patient and health worker feedback, implementation experience, equity, affordability and sustainability.

Supporting standards and service-specific SOPs may be updated more frequently without reopening the national Policy, provided changes remain consistent with this Policy and are approved through the appropriate clinical and digital health governance process.

Annex 1. Minimum Telemedicine Service Readiness Checklist

A telemedicine service must not proceed to pilot or scale-up until the applicable readiness requirements below have been addressed.

Requirement	Minimum Gate
Clinical need and accountable clinical/service owner defined	Before pilot
Patient pathway, inclusion/exclusion criteria, referral and escalation arrangements approved	Before pilot
Clinical roles and responsibilities defined	Before pilot
Participating clinicians appropriately credentialed	Before pilot
Appropriately trained accompanying health worker available where required by the approved service model	Before pilot
Patient identification process established	Before pilot
Ministry-approved written consent process and form established, including an emergency consent procedure where applicable	Before pilot
Clinical documentation and official-record workflow established for patient-facing and clinician-to-clinician care	Before pilot
Privacy and data-handling assessment completed	Before pilot
Cybersecurity and access-control assessment completed	Before pilot
Hosting and cross-border arrangements approved	Before pilot, where applicable
Approved platform, accounts, devices and required clinical equipment available	Before pilot
Interoperability and data-export requirements defined	Before pilot
Connectivity, power/backup and private consultation environment assessed	Before pilot
Downtime, failed-connection and emergency escalation procedures tested	Before pilot
Role-based training completed and competency confirmed; user support established	Before pilot
Pilot indicators, baseline and evaluation plan approved	Before pilot
Evaluation demonstrates safety, effectiveness, usability, reliability and acceptability	Before scale-up
Recurrent and lifecycle costs, budget holder and funding source identified	Before scale-up
Exit, transition and data-repatriation arrangements documented	Before scale-up, where applicable to external/vendor-supported services.

Annex 2. Telemedicine Policy and Operational Framework

The National Telemedicine Policy is the **umbrella governance instrument**. Detailed operational requirements will be maintained in supporting standards, SOPs and operating arrangements so they can be updated as services, technology and Government requirements evolve.

Level	Instrument	Purpose
1	**National Telemedicine Policy**	National governance, service model, mandatory principles, patient protections and requirements for approval and scale-up.
2	**National Telemedicine Standards and Operating Framework**	Common requirements for consent, credentialing, documentation, privacy, cybersecurity, hosting, interoperability, service readiness, training, incident management and M&E.
3	**Service-Specific SOPs and Operating Arrangements**	Detailed clinical workflows, roles, referral and escalation procedures, platform use, downtime arrangements, service levels and service-specific requirements for teleconsultation, telepathology, teleradiology, NCD remote monitoring, Tele-MCH, Disaster Telehealth and other approved services.

The National Policy must remain **platform-neutral**. Specific technologies, including approved interim platforms, may be authorised through Level 3 SOPs or operating arrangements, subject to the requirements of Levels 1 and 2 and appropriate Ministry and DCDT approval.

Supporting standards, SOPs and operating arrangements may be updated through the approved governance process without reopening the National Policy, provided they remain consistent with it.

