Health Resource Facility
for Australia's Aid Program

Australian Health Portfolio Review, Vanuatu

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On 13 March 2015 – between the draft and final versions of this report – Tropical Cyclone Pam hit Vanuatu and did enormous damage. This report was not able to consider the implications of the cyclone, though we realise of course that they are massive.

On a personal level we wish the best possible recovery to Vanuatu in general and in particular to the people mentioned in the above Acknowledgements.

Abbreviations

ABER	Annual blood examination rate (malaria)
AFD	Agence Française de Développement
AICEM	Australian Initiative for the Control and Elimination of Malaria
AIU	Assets and Infrastructure Unit
API	Annual Parasite Incidence (malaria)
AUD	Australian Dollar
AusAID	Australian Agency for International Development
DFA	Direct Funding Agreement
DFAT	Department of Foreign Affairs and Trade
DHIS2	District Health Information System 2
DHS	Demographic and Health Survey
EPI	Expanded Programme on Immunisation
GDP	Gross Domestic Product
GoV	Government of Vanuatu
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HR	Human Resources
HSL	Health Specialists Ltd
HSS	Health Sector Strategy
IMR	Infant Mortality Rate
MDGs	Millennium Development Goals
MFEM	Ministry of Finance and Economic management
MoH	Ministry of Health
NCDs	Non-Communicable Diseases
NDH	Northern District Hospital
NGO	Non-governmental Organisation
PACTAM	Pacific Technical Assistance Mechanism
PLAS	*Planning Long - Acting Short*
PMO	Prime Minister's Office
SCA	Save the Children Australia
STI	Sexually transmitted Infection
SWAp	Sector Wide Approach
TA	Technical assistance
UN	United Nations
UNDP	United Nations Development Programme

VCH	Vila Central Hospital
VCNE	Vanuatu College for Nursing Education
VHRM	Vanuatu Health Resource Mechanism
VHW	Village Health Worker
WHO	World Health Organisation

Executive Summary

Main Observations

- DFAT's health sector support is fragmented and would benefit from clearer focus and sense of direction.
- The balance of funding is too skewed towards hospital care. Primary care offers more potential for cost-effectiveness and equity.
- There is no overall focus on results. Some parts of the program have clear targets and performance frameworks; others lack even basic documentation.
- Vanuatu exhibits many characteristics of a chronically under-performing fragile state, with poor governance, weak demands for performance and accountability and limited capacity. There is no coherent response to this for the sector as a whole.
- Whilst the number of separate agreements needs to be reduced, now is not the time for a major change in modalities.
- Development partners should be more harmonized; it is difficult for Australia to lead the way in this amongst development partners when its own portfolio is so fragmented.
- Programme management concentrates by necessity on numerous administrative tasks, making it difficult to focus on important issues related to strategy and performance.

Key Features of this proposed strategy

- One Vanuatu Health Support Program with three main components – primary care; leadership and management; and hospitals.
- Sustained, robust dialogue between Government of Vanuatu (GoV) and development partners, with Australia in a leading role from the development partners' side. Consistent focus on levels of GoV financial commitment to health and on responsible stewardship of finances and HR.
- A strong focus on strengthening results, mutual accountability and awareness of performance, complemented by problem-solving support related to the delivery of core services.
- Capacity development for leadership and management at the highest levels.
- Flexible TA with as much of a focus on mentoring and change management as on technical issues.
- No large-scale funding for vertical programs, except in extreme circumstances.
- Good co-ordination between the Vanuatu Health Support Program and other DFAT-funded activities within and beyond the health sector.

Australia's investment in health in Vanuatu consists of a number of separate aid agreements including support for hospital services; the village health worker, malaria and immunization programs; and systems strengthening activities related to financial and asset management, procurement and health information. Support is provided through a combination of modalities, including a Direct Funding Agreement (DFA) which uses government systems; contracts for third parties to provide services; technical assistance; and projects directly managed by contractors. In addition to this bilateral program of support, there is a regional program, plus funding for scholarships and non-governmental organisation (NGO) grants.

Whilst some individual investments have been reviewed in the past, the overall health program has not. The objective of this report is to assess Australia's bilateral and regional health investments in Vanuatu over the period 2010-2014 and, based on the findings, to make recommendations for a strategic re-focus in the period 2015-2018. The assessment is timely because of recent developments both in Australia (the integration of Department of Foreign Affairs and Trade [DFAT] and the

Australian Agency for International Development [AusAID]) and in Vanuatu (where governance weaknesses were particularly acute in 2013).

The assignment included a review of relevant documentation, as well as a large number of interviews and site visits to facilities in Shefa and Malampa Provinces.

Situation analysis

The findings of the 2013 Demographic and Health Survey have recently been published and have produced some interesting findings. They show an infant mortality rate of 28, and an under-5 mortality rate of 31. Vanuatu is performing much more poorly than had generally been thought and it will not meet Millennium Development Goal (MDG) 4 (child mortality).

The 2013 DHS also states that only 33% of children aged 12-23 months were fully vaccinated and 20% of children had received no vaccinations at all. Measles coverage for 1 year olds was 53%, compared with 66% in 1990. Other indicators are more positive: for example, 89% of births were attended by a trained birth attendant in 2012 and annual parasite incidence for malaria fell from 73/1,000 in 2003 to 13/1,000 in 2012.

Almost 30% of children are stunted, but at the same time 19% of women are obese, and 31% are overweight. This illustrates the 'double burden' of disease which Vanuatu faces: whilst some 'traditional' indicators are static or getting worse, non-communicable diseases are rising and now account for 70% of deaths.

Several policy, strategic and operational plans have been produced in recent years which could guide the health sector and improve performance. Unfortunately, whilst there is no shortage of plans, very little implementation follows them. Many plans are very broad in scope and aspirational, with limited cohesion and alignment between them, and they are rarely linked to budgets. Indicators are not routinely monitored.

Total health expenditure is around 5% of Gross Domestic Product (GDP). For every 1,000 Vatu spent on health, about 570 Vatu comes from central government, 340 Vatu from development partners (mostly Government of Australia and the Global Fund) and about 90 Vatu comes from private sources. Since 2004, the proportion of government expenditure spent on health has decreased and is now less than 10%. Donor financing appears to be substituting for Government's own expenditure efforts.

Increasing proportions of expenditure go to salaries and hospitals. Hospitals account for about 50% of government expenditure; the budget for Vila Central Hospital is higher than the total budget for government primary health care facilities.

Financial management is a major problem. Expenditure routinely exceeds approved budgets, requiring emergency supplementary appropriations. The central problem is over-spending on salaries and allowances, leading to operating budgets for primary care being cut by almost 60% in 2013. There is a huge backlog of financial arrears and liabilities.

Since mid-2014 the Ministry of Health (MoH) has, with support, made concerted efforts to control spending, and the 2015 MoH budget submission to the Ministry of Finance and Economic management (MFEM) was seen by many as credible. These may be tentative signs of an understanding of the need to address the deep-seated financial problems.

Even though overall staff numbers in the MoH grew by 26% between 2009 and 2013, there are important gaps in terms of senior managers and clinical staff. Vanuatu has a lower ratio of doctors per 1,000 (0.18/1,000) than other similar sized countries. The number of professional health workers is 1.73 per 1000 people. World Health Organization (WHO) states that 2.3 professionals doctors per 1,000 people is the

minimum threshold needed to adequately provide essential health services and to achieve the MDGs.

MoH management is dogged by frequent changes in key appointments, and the uncertainty around key positions is a persistent problem. Ministerial changes have also been frequent, often accompanied by sweeping programmatic changes.

The formal health sector is made up of a three-tier structure for service delivery: hospitals, health centres and dispensaries. Aid posts make up the informal component of the health service and are staffed by village health workers (who are not on the Ministry of Health payroll). In addition to facility-based services, some programs – notably immunization and vector-borne disease control – are organized vertically. Churches and NGOs also provide health services, but quantitative information about their coverage is lacking.

Vanuatu's chronically under-performing health sector has its roots in desperately weak governance. Rules are not enforced, and functions are not carried out. Ministerial disputes cause leadership crises. Human Resources (HR) allocation and performance are poor, contributing to lack of clarity about roles and responsibilities. All of this contributes ultimately to poor health outcomes.

DFAT's Health Investments 2010-14

DFAT's support to Vanuatu's health sector is very fragmented. Approximately AUD$4.4 million per year is spent on the bilateral programme through at least 12 separate budgets. Seven of these are combined into the DFA, although they still all have separate budget lines. The Regional Programme involves over 15 separate agreements of varying degrees of direct relevance to Vanuatu. In addition DFAT funds scholarships, NGO grants and some multilateral work (notably by the World Bank) in the health sector in Vanuatu. Overall, we estimate that DFAT provides about $8 million to the health sector in Vanuatu per year through over 30 financing channels. The bilateral and regional programmes are discussed in detail in Chapter 4 of this report.

Aid modalities

In terms of aid modalities, DFAT uses a hybrid of program-based approaches and projects, with significant technical assistance inputs. Within this overall hybrid, there are four specific (though overlapping) modalities in use in the bilateral program: the DFA – 22%; contracts for third parties to provide services (18%); technical assistance (TA) (29%) and a project managed by contractor (31%).

The DFA has proved durable and effective as a way of keeping funds flowing, with appropriate checks and balances.

The main third party contract is with Save the Children Australia to run the village health worker program. Over the years, monitoring of outputs has been extremely poor, though the new contract attempts to rectify this. Key issues include limited MoH contract management capacity and questions related to longer term sustainability.

TA is playing a beneficial role in supporting Vanuatu's health systems, and there are good examples of well-targeted and well-implemented TA in the current health portfolio. However a greater variety of ways of organizing TA could be deployed and more innovative approaches are needed to address governance challenges.

Support for clinical staff in hospitals is provided through a direct contract. In Vanuatu's current circumstances it would not be appropriate to jeopardise this important work by using a more risky modality.

With some exceptions, these modalities do not build capacity to run efficient government support systems by directly using them. Most strengthening is in the form of somewhat piecemeal TA. Other aspects of the program largely bypass government management systems so that important inputs to the health system (health workers) can have their capacity developed. However, modalities have contributed to achieving the stated goals of DFAT support in a reasonably sensible, pragmatic way. Government systems, particularly for finances and human resources, are weak, meaning that budget support or a light-touch programmatic approach would be highly risky for DFAT. Nevertheless, the modalities used mean that the Ministry has a strong say in how DFA funds are disbursed and could potentially exert a strong influence over the village health worker (VHW) contract.

However the modalities need to give greater attention to addressing weak governance and fragility. Modalities will need to be more innovative, adaptive and able to take risks; identify, create and grasp windows of opportunity; and help facilitate local problem solving and collective action. International experience could be drawn on to help design and shape more effective modalities geared to addressing deeply rooted governance challenges.

Assessing the health program as whole

Chapter 6 assesses DFAT's health program as whole, using four different 'lenses': value for money, aid effectiveness, good governance and seven 'tests' related to the quality of aid (DFAT's four tests, plus gender, private sector and output-based aid).

In terms of value for money, funding in the bilateral program is generally for appropriate areas, although the level of spending on hospitals is high. Lessons for future support include:

- The most cost-effective interventions for Vanuatu would be a good-quality primary health care package and health promotion/prevention activities related to public health priorities, notably non-communicable diseases (NCDs). Neither of these is currently supported under the bilateral program.
- The VHW program is *potentially* a highly cost-effective element, although too little is known about how effective it is in practice.
- Some support for hospitals is appropriate but this has to be proportionate, as access to hospitals is limited for many ni-Vanuatu.
- Important health priorities do not need to be funded through vertical programs, which tend to be expensive.
- In terms of aid effectiveness, the main message is that Government of Vanuatu is not 'leading from the front' in terms of setting and following clear priorities, implementing plans or assessing its own performance. The key question now, is: how can aid actively address the domestic governance issues which impinge so drastically on service delivery? Aid effectiveness principles cannot provide solutions when there are serious governance constraints. There has to be an additional focus on the *types of activities* supported by donors.
- However the aid effectiveness principles *do* point towards some useful things which could be done in Vanuatu. For example, a health sector pooled fund built around the procedures of the DFA could help in terms of harmonising and simplifying aid management procedures: the main UN agencies working in health, for example, could contribute to such a fund. (There are many examples of pooled funds from other countries which could inform this.) Development partners could sign a Joint Funding Arrangement that specified standardized financial management procedures, even if funds were not actually pooled.

Pooled funds and Joint Funding Arrangements are well-established mechanisms for delivering aid: development partners obviously need to ensure that appropriate financial management standards are maintained in the joint arrangements.

- International experience suggests that there are clear lessons for good practice in improving governance in chronically under-performing states. These include adopting more effective 'all of government' approaches; exploiting presumed political commitments (e.g. as expressed in policies and plans); considering supporting reforms with tangible political pay-offs; strengthening incentives around performance and accountability, and adopting more innovative, adaptive approaches, particularly at provincial and facility levels. There is considerable potential to build more of these practices into DFAT's support.

The portfolio performs reasonably well against the DFAT's aid quality tests. Programs such as malaria, immunization and village health workers have benefitted the poor. DFAT support has improved value for money in terms of how some resources are used, notably in relation to procurement and asset management. Funding for malaria has complemented funding from the Global Fund in important ways, and DFAT has encouraged valuable engagement by the World Bank. Information disaggregated by gender is available, but there is little evidence that it is used for planning and resource information. DFAT's health investments have not explicitly supported the private health sector and it is important that the private sector is not supported just for the sake of it: it is only appropriate if it is in the context of cost-effective, priority health interventions. Output-based aid has not been used, though the 2014 VHW contract is an interesting step in the right direction.

Recommendations for future strategic focus

The final chapter describes our proposals for the future strategic direction of support to the health sector. The objective of the support should be to increase the capacity of the Ministry of Health – and other organizations where appropriate – to lead and manage the provision of effective and equitable health services.

Key features of this proposed strategy are:

- One Vanuatu Health Support Program with three main components – primary care (about 60% of the portfolio); leadership and management (20%); and hospitals (20%). These three components are all necessary for the health system to function and are inter-connected.
- Sustained, robust dialogue between Government of Vanuatu and development partners, with Australia in a leading role from the development partners' side. Consistent focus on levels of Government of Vanuatu (GoV) financial commitment to health and on responsible stewardship of finances and HR.
- A strong focus on results, increasing demand for performance and mutual accountability, complemented by problem-solving support related to the delivery of core services.
- Capacity development for leadership and management at the highest levels.
- No large-scale funding for vertical programs, except in extreme circumstances.
- Good co-ordination between the Vanuatu Health Support Program and other DFAT-funded activities within and beyond the health sector (regional programs, scholarships, NGO grants, links with Ministry of Finance and Economic Management etc.).

The objective of the primary care would be to strengthen the provincial health care system so that primary health services are more effective and equitable. The component would support provincial health teams to plan, deliver and monitor basic service provision across their province. It would include TA and operational funding against an agreed plan. There would be a strong focus on problem-solving and on-the-job learning, with regular communication amongst teams from different provinces.

The hospital component would focus on developing the leadership, management and appropriate clinical skills of doctors and nurses, as well as providing gradually decreasing funding for 'gap-filling' specialists. Its objective would be to improve the clinical staffing in hospitals so that hospitals could provide a more appropriate and equitable service. The work should clearly place hospital care within the context of the wider health system – information about patient numbers, their places of residence and diagnoses should be analysed regularly. Given the absolute shortage of health workers, this component should also include support for nurse and midwifery training, no matter whether the graduates end up working in primary or secondary care. Numbers of trainees need to be established as part of a wider Human Resources plan which includes realistic projections of nursing and midwifery posts and the likelihood of appropriate funding being available.

The leadership and management component should include both high-level leadership capacity building and support for specific systems, including financial management, procurement, health information and human resources. The objective of this component would be to equip leaders and managers (including politicians) with relevant stewardship skills to ensure that effective and efficient health services are delivered in Vanuatu.

The report describes various ways in which the support as a whole can be adapted to suit the governance situation in Vanuatu: for example DFAT could also promote – and join - a high level 'Task Force' (involving the Office of the Prime Minister) to agree and push through the necessary changes in the MoH; a 'roadmap approach' could be adopted to generate top-down demands for better performance, accountability and responsiveness; and senior management could be supported with mentoring and organisational change management approaches to strengthen internal systems and processes, provided by 'draw-down' technical assistance.

The report then discusses various issues for the stage of transition towards the new strategy. These include possible support to the Ministry to develop the next Health Sector Strategy; the integration of malaria; careful management of the VHW contract; and new programs in medical workforce development and through the UN Joint Program (to support women and children's health). The final point is about the importance of having senior technical staff within DFAT to oversee the challenging work envisaged in the new strategy.

Australia's national interests

There are four main reasons why supporting the health sector in Vanuatu is in Australia's interests:

1. Good health is a necessary (although not sufficient) condition for **poverty reduction and economic growth**. Healthy families are better able to take advantage of economic and educational opportunities. It is in Australia's national interest for countries in the Pacific to have growing economies and reducing levels of poverty.
2. A well-managed health sector is one important element of a **stable, well-governed** country. Moreover there is better value for money for Australia's aid

dollars when there is a strong focus on governance and **performance**. Australia benefits when its neighbours are stable, well-governed and able to spend aid money effectively and efficiently.

3. Malaria is a **health threat** to Australia and Australians. It is important that malaria is kept under control in Vanuatu, a country which receives large numbers of Australian tourists.
4. The **empowerment of women** is an important element of development in the Pacific region. The health sector is important to women – as users, as carers for sick family members and as a source of employment. The health sector provides valuable opportunities for women to fill senior leadership posts.

The recommendations for the future strategic focus of Australian support to the health sector suggest important ways in which Australia's national interest could be enhanced, notably by focussing on good governance and performance, the control of malaria, and the development of a more efficient and equitable health service.

1. Rationale, recurring themes and structure of the report

1.1. Rationale for the portfolio review

Australia's investment in health in Vanuatu is broadly guided by a ten year strategy, the Vanuatu Health Delivery Strategy (2010). This strategy was updated in 2012 and serves as an umbrella for a number of separate aid agreements including support for hospital services; the village health worker, malaria and immunization programs; and systems strengthening activities related to financial and asset management, procurement and health information. Support is provided through a combination of modalities, including a Direct Funding Agreement (DFA) which uses government systems; contracts for third parties to provide services; technical assistance and projects directly managed by contractors.

Whilst some individual investments have been reviewed in the past, the overall health program has not. The recent integration of the Department of Foreign Affairs and Trade (DFAT) and the Australian Agency for International Development (AusAID) presents an opportunity to take stock of Australia's overall health portfolio with a view to informing future investment in the sector between 2015 and 2018. This is part of wider changes: the review coincides with the development of an Aid Investment Plan for Vanuatu and the negotiation of a new Partnership for Development between Vanuatu and Australia.

The review is also timely because in practice it has been difficult to monitor the portfolio against the outcomes specified in the Partnership for Development between Vanuatu and Australia. This is because of weak and unstable conditions in the Ministry of Health, with extremely frequent changes in senior management posts and chronic over-spending. The 2014 *Quality at Implementation Report* notes that in 2012 'discussions between DFAT and the Ministry of Health shifted immediate focus away from high-level MDG targets and onto government-led change in key areas of weakness'. Then the following year: 'Given the current political instability within Ministry of Health Executive, targets for 2013 were revised to reflect practical, realistic, outcomes'.

1.2. Objective of the portfolio review

The objective of the assignment is to review DFAT's overall health program in Vanuatu and provide guidance to help DFAT refocus its investments. More specifically, the review seeks to assess Australia's bilateral and regional health investments in Vanuatu over the period 2010-2014 and, based on the findings, to make recommendations for a strategic re-focus in the period 2015-2018. Health investments were reviewed collectively to gauge the performance of the entire portfolio rather than individual programs (i.e. a cluster review). This is a qualitative review rather than an evaluation, intended to assist DFAT make judgements about the future.

The full terms of reference are given in Annex 1.

1.3. Recurring themes in the report

Before explaining the structure of the report, it is worth describing in brief what the main recurrent themes are. The report by necessity includes a lot of detail about individual projects and modalities. It is hoped that a clear understanding of the main themes from the start will help the reader not to get lost in the details. The overall messages of the report are summarized in the rest of this section.

The review was commissioned because of recognition that DFAT support to the health sector is very fragmented. This fragmentation has a number of consequences:

- The **balance of funding** is too skewed towards hospital care, whereas primary care offers more potential for cost-effectiveness and equity.
- There is no overall focus on **results**. Some parts of the program have clear targets and performance frameworks; others lack even basic documentation.
- The support operates in a fragile and **difficult governance context** but there is no coherent response to this for the sector as a whole. This dilutes the focus on mutual accountability.
- The **modalities** used to deliver aid are broadly fit for purpose. Whilst the number of separate agreements needs to be reduced, now is not the time for a major change in modalities.
- Development partners should be more **harmonized**: it is difficult for Australia to lead the way in this amongst development partners when its own portfolio is so fragmented.
- **Programme management** concentrates by necessity on numerous administrative tasks, making it difficult to focus on important issues related to strategy and performance.

A proposed new strategy is outlined, informed by the above points. For this strategy to be successful, DFAT will need to be involved in ongoing dialogue with the Government of Vanuatu about its stewardship of the health sector. This will be difficult – but the only alternative to this developmental approach is to support straightforward service delivery.

1.4. Structure of the report

This report is structured as follows:

Chapter 2 – **Scope, methodology and limitations** - comments on the overall scope of the review, describes the way the work was undertaken and identifies some of the limitations.

Chapter 3 provides a **situation analysis** of the health sector in Vanuatu. This includes health indicators, key health sector documents, the financing, organization and management of the health system and a brief comment on the fragility of the sector.

Chapter 4 - **DFAT's health investments in Vanuatu -** describes the investments, starting with an overview of spending and then looking at each bilateral agreement separately. Selected regional programs are also discussed.

Chapter 5 - **Aid modalities used by DFAT -** describes *how* DFAT channels its support, focussing mostly on the bilateral program. It discusses how the modalities used have contributed to the overall goal of the support.

Up to this point the report looks at DFAT support to the health sector in a piecemeal way, dealing with each component and each modality separately. Chapter 6 - **Assessing the health program as whole** - brings the analysis together, using four different 'lenses':

- A value for money lens: are the right things being funded?
- An aid effectiveness lens: are the Paris principles being adhered to?

- A governance lens: is this the right way to support a chronically under-performing country?
- The lens of DFAT's aid policy framework.

The insights from Chapter 6 are used to inform Chapter 7, **Recommendations for strategic focus of future health investments.** This chapter describes technical areas which could be supported, modalities and appropriate ways of working in the chronically under-performing environment of the health sector. The chapter ends with a discussion of practical considerations about the transition to a new strategy.

2. Scope, methodology and limitations of the review

2.1. Scope

The scope of the review is clearly set out in the terms of reference (ToRs) (see Annex 1). The review was guided by aid quality criteria and aid effectiveness principles, as well as considerations of value-for-money and how to respond to the governance weaknesses in Vanuatu.

Aid quality is assessed using the 'four tests' in the new Australian aid policy framework. The tests question whether aid: (1) pursues Australia's national interest and extends its influence; (2) impacts on promoting growth and reducing poverty; (3) reflects Australia's value-added and leverage; and (4) makes performance count. In order to respond to specific requests in the ToR and from DFAT officials, we added three more tests: does the support promote gender equality and the empowerment of women and girls; does it support the private sector; and does it encourage mutual accountability and output-based aid?

Aid effectiveness principles were used to address the question of whether appropriate aid modalities are being used. The five principles are country ownership, alignment, harmonization, managing for results and mutual accountability.

The analysis of the current portfolio was then used to inform recommendations about re-focussing the portfolio to maximise strategic impact in the context of reduced resources.

2.2. Methodology

The review team had two members – Catriona Waddington (team leader and health economist) and Jack Eldon (governance specialist). A timetable for the review is given below. We were joined by Rebecca Dodd, a Canberra-based DFAT Senior Health Adviser, for the last week of the visit. Elena Fontaine, Health Sector Senior Programme Manager, joined us for many of the interviews and visits.

Table 1: Review schedule

Activity	Dates
Document review and draft review plan	Week of 27 October 2014
Arrive Vanuatu	5 November 2014
Briefing with DFAT Vanuatu	6 November 2014
Interviews in Port Vila	6-11 November 2014
Interviews in Malakula Island, Malampa Province	11-13 November 2014
Interviews in Port Vila	13-21 November 2014
Brainstorm meeting with key stakeholders to discuss initial findings	20 November 2014

Activity	Dates
Presentation to High Commissioner and DFAT team	21 November 2014
Aide Memoire for Government of Vanuatu finalized and submitted to DFAT	22 November 2014
Depart Vanuatu	22 November 2014
Presentation/meeting in Canberra (Jack Eldon only)	24 November 2014
Travel to UK	25 November 2014
Submission of Draft Report	15 December 2014

A Review Plan was written prior to travelling to Vanuatu and formally agreed at the start of the visit. The Review Plan included a suggested table of contents for this final report. We have adapted this slightly, as in practice it proved to be unduly repetitive, but we do not believe that this has removed any of the planned content.

The assignment was undertaken as a partly descriptive, partly analytical review, using two main methodologies:

1. A review of narrative and, where available, quantitative **documentation**, made available from a wide range of stakeholders including Ministry of Health (MoH) and other Government of Vanuatu (GoV) departments, DFAT, other bilateral and multilateral development partners, implementing partners, contractors, technical advisers, UN agencies, non-governmental organisations (NGOs) and health practitioners. In addition the review team members consulted their own resources relevant to the review, e.g. on health financing and economics, aid effectiveness and governance in fragile and difficult environments. A full list of documents consulted is provided in Annex 2.
2. Individual and group **interviews** with a wide range of key stakeholders, including face-to-face meetings in Shefa and Malampa Provinces, Vanuatu; and telephone interviews with stakeholders in Australia and Suva. A full list of interviewees is provided in Annex 3. (N.B. This annex is not included in the first draft.) We believe that we met with a good range of stakeholders – however it is notable that many of the key senior Ministry of Health posts were either vacant, newly appointed or only filled in an acting capacity. This meant that we inevitably had less interaction than we would have liked with senior management at the Ministry.

Before each interview the review team identified key questions to be asked and issues to be explored. Interviews allowed the team to build on information and insights from the documentation and from earlier interviews, and to triangulate, cross-check and validate findings and conclusions as they took shape.

In addition to the interviews, site visits were made to a number of aid posts and dispensaries in Shefa and Malampa provinces and time was spent with members of the Malampa Provincial Health Team. Tours were taken of the Vila Central Hospital (VCH) and Norsup Hospitals and the Vanuatu College for Nursing Education.

In order to ensure a systematic approach, the team members regularly collated and discussed information. Frequent meetings were held with the DFAT post throughout the mission during which the team verified and ‘tested’ their emerging findings and ideas.

2.3. Limitations

The following limitations were experienced:

- Time available before the country visit. There was only a very short time between the contract signing, the receipt of documents and the start of the country visit. This meant that the advance review of documents was incomplete. However this time was generally made up as the review progressed.
- The review questions are broad and cover a wide range of issues. Therefore by necessity the review had to rely on existing evaluations and other documentation about individual programs – this was patchy, with some programs very comprehensively documented (e.g. malaria) and others with very little documentation (e.g. nurse training).
- Availability of good, consistent information data. Data limitations within the Vanuatu health sector are well known: indeed one of DFAT's investments is geared precisely at improving the health information system. A particular limitation was that the final analysis of the 2013 Demographic and Health Survey had not been published.

Having stated the limitations, we wish to acknowledge that the number of days provided for this assignment was fair. In addition, Elena's Fontaine's practical help with arranging interviews and accessing documents was of a very high standard.

3. Situation analysis: health, financing and governance

3.1. Health status in Vanuatu

The findings of the 2013 Demographic and Health Survey (DHS) include some interesting results.

Table 2: Infant and child mortality, Vanuatu

	1989	1999	2013
Infant mortality rate (under 1 year old/1,000)	42	28	28
Child mortality rate (under 5 years old/1,000)	58	31	31

Source: DHS 2013

Table 2 shows rates of **infant and child mortality** over time, as given in the DHS. The infant mortality rate (IMR) is very different from the rate quoted by global data sources such as UNICEF (which stated that Vanuatu's IMR was 15 in 2013) and the US World Factbook 2014 (which quoted an IMR of 16).

Table 3 compares the range of estimates for IMR in Vanuatu with data from other countries. The countries have been selected because they are adjacent to Vanuatu in the global Human Development Index rankings – in other words they are broadly at the same level of social development. The wide range in estimates for Vanuatu means it is difficult to make meaningful comparisons, except it is clear that IMR in Vanuatu is considerably lower than in the relatively nearby countries of Timor-Leste and Kiribati (though of course the small-number problem also applies to Kiribati).

If the DHS is right about infant and child mortality rates, **Vanuatu is performing much more poorly than had generally been thought and it will not meet MDG 4 (child mortality).**

Table 3: Infant mortality rates, various countries

Country (ranking for Human development Index out of 187 countries, where 1 is the best)	Infant mortality rate, 2013
Timor Leste (128th/187 countries)	46
Morocco (joint 129th)	26
Honduras (joint 129th)	19
Vanuatu (131st)	15 (UNICEF) 28 (DHS)
Nicaragua (132nd)	20
Kiribati (133rd)	45

Source: Human Development Report 2014 (UNDP) and State of the World's Children 2014 (UNICEF)

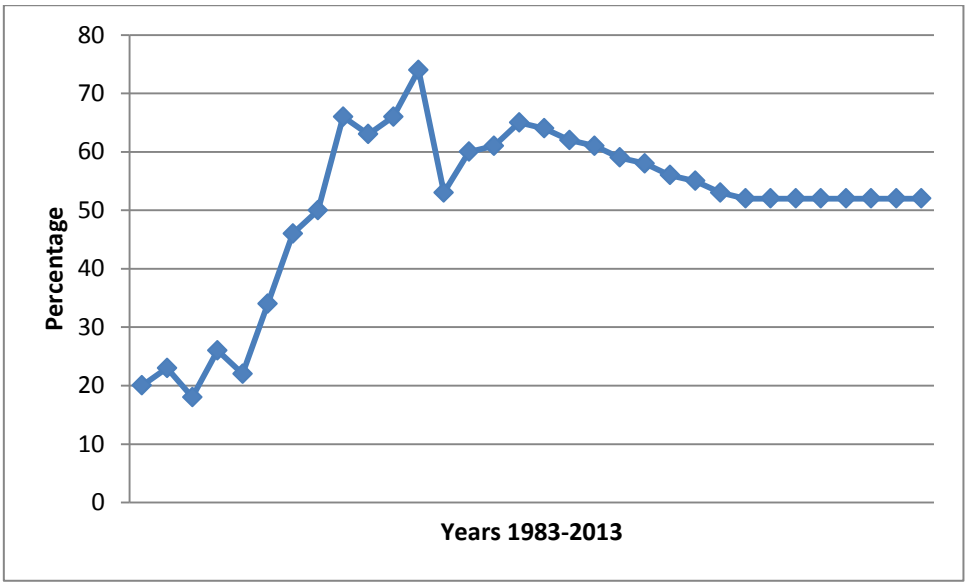
According to the 2013 DHS the total **fertility** rate is 4.2, with the rural rate (4.7 births) considerably higher than the urban (3.3 births). There has been a slight decline from 4.4 births per woman during the period 2007-2009.

For **immunization**, the 2013 DHS states that:

- 33% of children aged 12-23 months were fully vaccinated with BCG, measles and three doses of DPT/PENTA and polio.
- 20% of children have received no vaccinations at all.
- Measles coverage for 1 year olds was 53% (compared with 66% in 1990).

The measles data quoted in the DHS is a reasonable match to the information on measles immunization coverage amongst 1-year olds reported by the Global Health Observatory Data Repository[1]. The Repository gives a long time-series of data which shows that coverage declined gradually for about a decade after 1998, and has since remained static (Figure 1). Coverage was at its highest in the mid-1990s.

Figure 1: Time series of measles immunization coverage amongst 1-year olds, Vanuatu



Source: Global Health Observatory Data Repository

[1] http://apps.who.int/gho/data/node.main.A826

The situation appears to be slightly better for measles than for most other vaccinations - between 2007 and 2014 coverage dropped for all other vaccinations. The DHS reported rate of 33% fully immunized children is extremely low.

Some other health indicators are more positive, including for attended births and malaria:

- The DHS reported that 89% of **births** were **attended by a trained birth attendant**. (With only about 8,000 live births per year, the maternal mortality rate is very volatile, so absolute numbers are used. The MoH target is to have no more than 3 maternal deaths per year: the annual figure is usually slightly above that.)
- For **malaria**, the annual parasite incidence fell from 74/1,000 in 2003 to 13/1,000 in 2012. Malaria-related deaths have, for the time being, 'virtually disappeared'. (National Malaria Strategic Plan)

In terms of **nutrition**, 29% of children are stunted, but at the same time 19% of women are obese, and 31% are overweight. (DHS 2013, STEPS 2013, Vanuatu Nutrition Survey 2013) This illustrates the 'double burden' of disease which Vanuatu faces. Whilst diseases of poverty are still a problem, there is also a high rate of non-communicable diseases, which are regarded as diseases of lifestyle.

The situation with respect to non-communicable diseases (NCDs) is well described in the 2013 Vanuatu National NCD STEPS report[2]. NCDs are responsible for 70% of deaths and are the leading cause of disability. However, the survey found that ni-Vanuatu tend to be ill-informed about NCD risk factors and possible complications. The report flags tobacco use among men, hypertension, high blood glucose and cholesterol as areas for priority action. Behavioural risks to public health start at a young age, presenting a need for effective health promotion and disease prevention activities among younger people, particularly to prevent diabetes reaching higher levels.

In conclusion, there is much to be concerned about. Many 'traditional' indicators are static or worsening, whilst at the same time rates of NCDs are rising.

3.2. Guiding documents in the health sector

There are two high level multi-sectoral policy documents that set out a strategic framework for the development of health in Vanuatu. The 2006 *Priorities and Action Agenda 2006-15* sets out a vision for national social and economic development. It includes 5 broad health strategies and indicators linked to the MDGs. *Planning Long - Acting Short* (PLAS) sets out the Government's Policy Priorities for 2009-12. PLAS includes a health agenda with 4 strategic priorities: strengthening the capacity of the Ministry of Health; strengthening the delivery of basic health services; controlling and progressively eliminating malaria from Vanuatu; and investing in training the health workforce. Neither of these policy documents appears to have been used to guide the development of annual plans and investments, nor has implementation been routinely monitored.

The Government's *Health Sector Strategy 2010-2016* (HSS) could reasonably be expected to guide health sector development. However it is too broad and generalized for that purpose. The HSS does however recognise the need for deep reforms in the organizational structure and ways of working of the MoH, to bring about improvements in management and oversight, to improve efficiencies and use available resources more effectively, and to enable line managers and staff to be

[2] WHO, 2013, Vanuatu NCD Risk Factors STEPS Report. WHO Western Pacific Region

more effective through skills development and performance management. In this regard the HSS is a step forward. However, it is not clear that it has been used to guide annual operational planning, and budget analysis suggests that actual spending is not aligned to HSS priorities.

The *National Policy and Strategy for Healthy Islands, 2011-15* is intended to translate the HSS into 'practical and achievable activities that can bring results and differences in health outcomes'. Other relevant plans include the *MoH Three Year Corporate Plan* and *Annual Business Plans*. In recent years Corporate Plans have not been updated during annual planning and budget preparations; annual budgets have been prepared in the absence of a business plan, and business plans have been prepared without the involvement of MoH divisions[3]. MoH annual planning is usually ad hoc and rarely aligned with other planning processes or plans. Different plans contain different indicators, often in long lists, making monitoring difficult.

Whilst there is no shortage of written plans, implementation tends not to follow them. Most are aspirational, with limited cohesion and alignment between them. Indicators are not routinely monitored and provide little information for managers or service providers. Budgets are often developed in isolation from annual business plans. At one extreme, strategic plans are very broad in scope and do not provide practical frameworks for implementation; at the other extreme, annual business plans are sometimes impractically detailed[4].

3.3. Health financing

This section summarises the key points about health financing in Vanuatu. It draws heavily on Anderson's 2013 *Health financing in Vanuatu: challenges and options.* There is little other published information about health financing: the latest National Health Accounts were for 2007.

Total health expenditure was about 5% of Gross Domestic Product (GDP) in 2010. Government spending plays a dominant role in health expenditure. In broad terms, for every 1,000 Vatu spent on health, about 570 Vatu comes from central government, 340 Vatu from development partners (mostly Government of Australia and the Global Fund) and about 90 Vatu comes from private sources, including out of pocket expenses. The private insurance market is small, accounting for no more than 3% of total health expenditure[5].

In terms of absolute amounts of Vatu, central government budgets and expenditure both rose between 2006 and 2009, spiked in 2010, and have since remained relatively constant. Budget management is poor, with disproportionate amounts spent in the first part of the financial year and over-spends a frequent occurrence. There are however, tentative indications that the situation was improving in 2014. (This is discussed at greater length in the next section.)

Per capita, real (i.e. inflation-adjusted) health budgets have not increased since 2007. The share of total government expenditure spent on health has also not increased since 2004 and is now under 10% of the total government budget. At the same time, the share of financing coming from development partners has risen. According to Anderson, 'It could just as well be argued that donor funding has substituted for Government's own expenditure efforts'.

[3] Cate Keane, 2013, Strategic budget advisor, Ministry of Health Vanuatu, Final Report, 30 June 2013. HRF, Canberra.

[4] Keane 2013 op cit

[5] Assessment of the health sector PFM systems, Vanuatu. Unpublished Draft Report, July 2013

Increasing proportions of expenditure go to salaries and hospitals. For example the share of government health funds going to community health centres fell from 22% in 2006 to 18% in 2010. The funding of non-salary recurrent items, including drugs and transport, is particularly threatened because even when an amount is budgeted, overspends on salaries tend to mean that the money is not available in practice.[6]

Hospitals account for about 50% of government expenditure. Half of hospital expenditure is for VCH. VCH's budget is higher than the total budget for government primary health care facilities.

The MoH raises some revenue from user fees. Keane (2012) estimates that outpatient fees collected were in the region of VT 27.4 million in 2013 (less than 2% of total recurrent expenditure). The financial management procedures and systems for collection, utilizing and reporting on outpatient fees are unclear and lack transparency.

3.4. Budgeting and financial management

In the past 5 years (if not longer) health sector planning, budgeting and financial management have been highly problematic areas for the Ministry of Health. MoH expenditure routinely exceeds approved budgets, requiring emergency supplementary appropriations. The money that is spent is not well aligned with the Ministry's own priorities as stated in plans and budgets[7].

The central problem is over-spending on salaries and allowances. Between 2010 and 2012 the MoH budget did not grow and there was no budgetary provision for recruitment. However during these 2 years the MoH workforce increased by 23.4%, growing from 800 employees to 1012. Overall, between 2009 and 2013 the MoH workforce increased by 26.5%, with some staff receiving higher levels of allowances than their legal entitlements, adding to the build-up of arrears and payroll liabilities. This caused a decline in the operating budgets required to deliver services: in 2013 operating budgets for primary care were effectively cut by almost 60%.[8]

MoH officials have also placed unofficial orders with suppliers in the absence of approved budgets, bypassing GoV commitment controls and increasing the level of arrears. By December 2013 outstanding MoH debts stood at VT 125 million, as well as having over VT 600 million in outstanding severance/retirement payments, and VT 53 million of unretired imprest accounts[9]. In 2014, the situation appeared to be not quite as drastic: by June, six months into the budget year, the cost centres of Corporate Services and Hospital Referral of Patients were both somewhat over budget, having spent 64.7% per cent and 61.8% of their annual budgets respectively.

Since mid-2014 the Ministry of Health has, with support from the Ministry of Finance and Economic Management (MFEM), the Prime Minister's Office and development partners (notably the World Bank), made concerted efforts to control spending, and the 2015 MoH budget submission to MFEM was seen by many as credible. There was also acknowledgement from the Minister of Health that financial and staff challenges were the result of poor MoH management, weak internal controls and poor accountability, made worse by the chaotic implementation of the 'decentralized' structure in 2013. There are thus tentative indications of a determination in the Ministry of Health to address the deep seated financial problems. However there are

[6] Whimp 2010 Report on support to financial management in Ministry of Health, September 2010

[7] Ian Anderson 2013

[8] Information provided by World Bank officials, verbally and by reference to PowerPoint presentations.

[9] ibid

massive accumulated liabilities and the situation will require careful monitoring in the coming years.

3.5. Leadership and senior management

Ministry of Health management is dogged by frequent changes in key appointments. For example, during the second half of 2012 four different Director Generals were appointed, and the Finance Manager and Head of Planning were both temporarily removed from their positions (which stalled the financial management reform program). The uncertainty around key positions is a persistent problem. During the present assignment in November 2014 there was no substantive Director-General in post and no Director of Human Resources (HR), despite the HR challenges facing the Ministry.

Ministerial changes have also been frequent in recent years, often accompanied by sweeping programmatic changes and reshuffling of ongoing tasks and priorities. This can have serious consequences for overall stability and for key reforms.

3.6. Health services and staffing in Vanuatu

The MoH has overall responsibility for the GoV health system. It develops health policy, operates Vanuatu's public health services and provides public health promotion and preventative services. Most health services in Vanuatu are provided by the government sector. NGOs and churches provide some services, and there are a small number of private practitioners and private pharmacies in urban areas. Little is known about the relative size of NGO and church services and what they contribute to the health system as a whole. Certainly they appear to fill important gaps in service provision, including in peri-urban and remote rural areas.

The formal health sector is made up of a three-tier structure for service delivery: hospitals, health centres and dispensaries. There are five main hospitals in Vanuatu. VCH in Port Vila and the Northern District Hospital in Luganville are the main referral hospitals for Vanuatu's Southern and Northern Health Care Directorates respectively. Provincial hospitals are found at Norsup, Lolowai and Lenakel and Torba, though in practice they have limited capacity to provide appropriate services.

Rural health care is provided through a network of health centres and dispensaries. Health centres are responsible for supervising dispensaries and aid posts in their catchment areas, including receiving referrals and conducting supervisory, public health program and clinical outreach visits.

Aid posts make up the informal, or community owned, component of the health service and are staffed by village health workers who have received up to three months of basic training in primary and preventive care. Aid posts receive supplies and (in theory at least) outreach supervision from the nearest health facility. The village health workers receive a small stipend but are not on the Ministry of Health payroll.

The urban areas of Port Vila and Luganville are served by dispensaries governed by the municipal administrations of Port Vila (five dispensaries) and Luganville (three). These are staffed by a nurse or nurse practitioner and provide primary curative and limited preventive services.

In addition to facility-based services, some programs – notably immunization and vector-borne diseases – are organized vertically.

Table 4 shows the distribution of health facilities across Vanuatu's six provinces. Although it is beyond the scope of this report, it would be an interesting exercise to map this facility information against data from the recent Socio-Economic Report

provided by the Vanuatu National Statistics Office[10]. For example, data provided by the Household Wellbeing Study would allow correlation between population densities, the distribution of poor households in Area Councils, access to health facilities and levels of inequity.

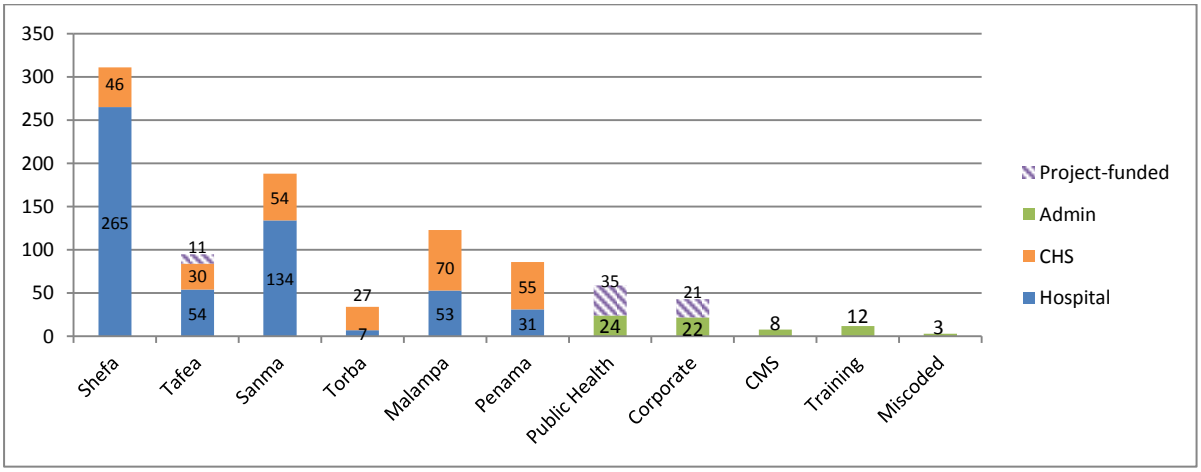
Table 4: Health facility distribution by Province of Vanuatu, 2014

Province	Aid-posts	Dispensaries	Health Centres	Hospitals	MCH Teams	Total Health Facilities
Torba	20	7	3	0	1	31
Sanma	34	22	6	1	2	65
Malampa	38	19	9	1	2	69
Penama	33	22	6	1	2	64
Shefa	42	19	4	1	3	69
Tafea	33	12	1	1	2	49
Total	**200**	**101**	**29**	**5**	**12**	**347**

Sources: SCA VHW Aid Post Mapping Report 2014 (open aid posts only); and MFEM, 2012, Public Expenditure Review Health Sector 2011.

The MoH **staffing** situation in 2014 is summarized in Figure 2. The numbers of professional staff are shown in Table 5. Despite the increasing wages bill referred to above, there are important gaps in terms of senior managers and front line workers. Vanuatu has a lower ratio of doctors per 1,000 (0.18/ 1,000) than other similar sized countries. As shown in Table 5 the number of professional health workers (excluding nurse aides and village health workers) is 1.73 per 1000 people. Nurse aides have basic nursing skills; they are not appropriately qualified to head a health centre which provides a reasonable range of primary care interventions.[11] The 2006 World Health Report[12] states that 2.3 doctors, nurses, and midwives per 1,000 people is the *minimum* threshold needed to adequately provide essential health services. Unless countries meet this threshold – and Vanuatu does not - they are unlikely to achieve the Millennium Development Goals.

Figure 2: Ministry of Health staff, October 2014



Source: MoH Monthly Financial Report: October 2014

[10] http://www.vnso.gov.vu/index.php/special-report/socio-economic-atlas#socio-economic-report

[11] WHO and University of New South wales (2013) *Human Resources for Health Country Profile: Republic of Vanuatu.*

[12] WHO, 2006, Working together for health to highlight the global health workforce crisis. Geneva.

Table 5: Clinical staff in the Ministry of Health

Staff category	Total	Per/1,000 population
Professional staff [Doctors (46), advance practice nurse (56), registered nurses (279) and midwives (62)]	443	1.73
Professional staff (443) + nurse aides (152)	595	2.33
Professional staff + nurse aides + VHWs (206)	801	3.13

Source: Ministri Blong Helt (July 2014) PMO and Finance Briefing, PowerPoint slides.

3.7. Weak governance and health sector fragility

'Chronic under-performance' is formally recognised as a category of country, within the wider term 'fragile states'.[13] The findings of this brief overview suggest that the health sector in Vanuatu suffers from chronic under-performance, characterized by:

- Non-existence of the top-down discipline needed in bureaucratic organizations, compounded by lack of bottom-up accountability, resulting in rules that are not developed or enforced, and instructions that are not followed and functions that are not carried out.
- Generalized policies that are often poorly aligned with budgets and institutional capacity, and poor frameworks for delivery.
- Poor fiscal management of budgets and overspending.
- Ministerial disputes, leadership crises, confusion over mandates and lack of clarity about roles and responsibilities within government departments.
- Poor HR allocation and performance.
- A disconnect between the centre and provinces and facilities, in terms of financing, support and supervision, leading to poor morale and undermining the scope of local health actors to work productively together for problem solving. This in turn contributes to poor delivery, under-utilization of services and failure to develop and maintain the health infrastructure.

Chronic under-performers are recognised as the hardest countries of all to help, given (a) the lack of political will for change, (b) the costs associated with the long term investments needed to strengthen capacity and leadership while supporting service delivery, and (c) because they can carry significant risks for development partners in terms of achieving results and because of the risks of corruption. Health in Vanuatu is recognised by many as a particularly challenging sector and was referred to in various discussions with senior stakeholders as 'a disaster', a 'basket case' and as one of the worst performing sectors.

There is, however, growing international experience providing good practice lessons for development partners and practitioners, to help improve the effectiveness of

[13] See, for example: WHO & Alliance for Health Policy and Systems Research(2008) *Neglected Health Systems Research: Health Policy and Systems Research in Conflict-Affected Fragile States*; Management Sciences for Health (2007) *Rebuilding Health Systems and Providing Health Services in Fragile States;* USAID (2007) *Arrested development in fragile states: opportunities and guidance for USAID programming;* Chapman N and Vaillant C (2010) *Synthesis of country programme evaluations conducted in fragile states*. ITAD. (DFID Evaluation Report EV709); OECD (2007) *Principles for Good International Engagement in Fragile States and Situations*.

support to chronically under-performing states and sectors. This is explored in Chapter 6 of this report, while Chapter 7 makes suggestions about how to apply these ideas to DFAT's new health strategy in Vanuatu.

4. DFAT's health investments in Vanuatu

This chapter describes DFAT's health investments in Vanuatu, starting with an overview of spending and then looking at each agreement separately.

4.1. Overview of DFAT support to the health sector in Vanuatu

DFAT's support to the health sector in Vanuatu is very fragmented. An average of about AUD$4.4 million per year is spent on the bilateral program through at least 12 separate budgets: although seven of these are combined into the DFA, they still all have separate budget lines.

The Pacific regional program involves over 15 separate agreements of varying degrees of direct relevance to Vanuatu. It is difficult (and not entirely appropriate) to gauge Vanuatu's share of this spend, but a crude estimate suggests that this perhaps peaked at about $3 million per year when the large Regional HIV and STI Response Fund was active.[14]

In addition to the bilateral and regional programs, DFAT also funds scholarships, NGO grants and some multilateral work (notably by the World Bank) in the health sector in Vanuatu. The value of this combined support is not known.

Although exact numbers are not known, a fair summary seems to be that **DFAT provides up to about $8 million to the health sector in Vanuatu per year through over 30 financing channels.**

Table 6: DFAT bilateral health budget

DFAT Agreement	Average annual budget 2013/14 – 2014/15 (AUD$)	Percentage
Clinical – hospitals	1,370,000	31
Malaria Technical Assistance	600,000	14
DFA*: malaria/dengue	281,500	6
DFA: Village health workers	533,500	12
Vanuatu Health Resource Mechanism	437,500	10
DFA: procurement, assets and infrastructure	362,500	8
Health information system, WHO	250,000	6
DFA: Health information system	37,000	1
Immunization -UNICEF	250,000	6
DFA: nurse education	202,500	5
DFA Central Medical Stores	87,500	2
TOTAL	4,412,000	100

**DFA = Direct Funding Agreement*

[14] This was calculated using the annual spend of recent relevant regional programs. 15% was taken to be Vanuatu's share. The 15% is admittedly somewhat arbitrary, but the percentage was discussed with Vanuatu Post and it was agreed that this was an acceptable 'guestimate'.

Figure 3: DFAT bilateral health budget

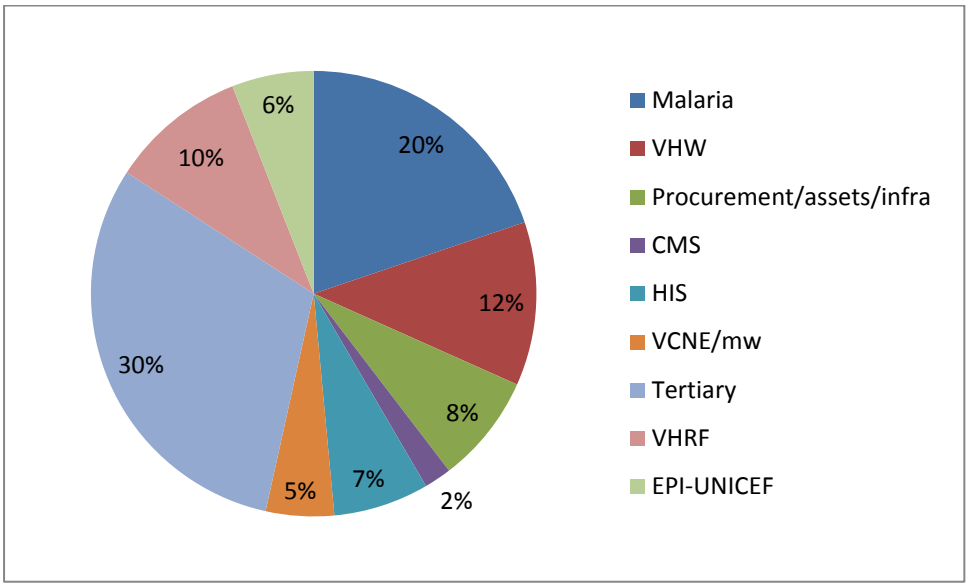


Table 6 and Figure 3 show the breakdown of expenditure on the bilateral program by DFAT agreement. An average over the two years 2013/14 and 2014/15 has been used.

These agreements vary considerably in the extent to which there is documentation about their expected results and actual performance. At the one extreme the malaria support is extremely thoroughly reviewed. At the other extreme there is remarkably little documentation about the support to the Vanuatu College for Nursing Education.

As highlighted in Chapter 1, the fragmented nature of the overall program has a number of consequences:

The balance of funding is skewed towards hospital care, whereas primary care offers more potential for cost-effectiveness and equity.

There are gaps in the overall portfolio that reduce its value for money. The absence of support for primary care represents a 'missing middle', as this is where the burden of disease can be tackled most cost-effectively.

There is no overall focus on results. Some parts of the program have clear targets and performance frameworks, others lack even basic documentation.

The support operates in a fragile and difficult governance context but there is no coherent response to this for the sector as a whole. This dilutes any focus on local ownership, sustainability and mutual accountability.

The chapter now moves on to briefly describe each of the DFAT agreements and to review what is known about their performance. This is done in order of value, starting with the largest. Where appropriate, agreements are dealt with together when they are clearly closely linked – for example, 'Health information system, WHO' (the TA) is clearly linked to 'DFA: Health information system' (the operational budget).

4.2. Performance of DFAT bilateral investments

4.2.1. Clinical support to hospitals ($1.2 million/year: 31% of bilateral budget)

For over a decade until 2012 AusAID funded internationally recruited specialist clinicians to fill posts in Vanuatu, predominantly at the VCH. In recent years, five

specialist positions have been funded – a surgeon, anaesthetist, physician, paediatrician and obstetrician/gynaecologist, along with a pharmacist and bio-medical engineer. The average cost of funding a consultant per year was estimated in 2010 to be over $230,000.

This support was reviewed by Hurly in 2010[15]. The main conclusion was that the support had succeeded in filling gaps in the clinical workforce (with some caveats about recruitment procedures and clinical governance risks), but that it had not been an effective way to develop specialist clinical capacity in Vanuatu.

In 2012 it was decided to contract a specialist organization to develop recommendations for the future of Specialist Clinical Support to Vanuatu – this resulted in the 2013 *Evaluation of the Specialist Clinical Support Programme provided through the Pacific Technical Assistance Mechanism (PACTAM).*

The 2013 Evaluation notes that the clinical support mechanism was intended to be for capacity *supplementation* (i.e. gap-filling) rather than capacity *development*. Capacity development for ni-Vanuatu staff was in practice patchy – sometimes excellent and sometimes very poor. Nevertheless, the Clinical Support Programme did play an important role in the development of the country's clinical workforce by providing senior clinicians who could act as mentors to ni-Vanuatu doctors. Certainly the number of local specialists is growing – in 2002 there were no consultant or Masters-level ni-Vanuatu doctors; there were 5 in 2013, plus 7 Diploma-level doctors. By 2025 there will be a projected 59 Masters level ni-Vanuatu specialists. Unlike some other Pacific countries, most national clinicians return to work in Vanuatu. However this should not be taken for granted in the longer term, particularly given the dissatisfaction amongst doctors about their salaries.[16]

The 2013 Evaluation also made the following point about the mechanism: "The program lacked any formal program design….. According to our interview data the program was not 'traditionally defined' and instead could be described as 'ad hoc responses to requests submitted by the Ministry of Health on behalf of the hospital for medical specialists". Because of this, an evaluation against expected performance was not possible. In effect almost nothing is known about the effectiveness of the PACTAM Mechanism in terms of health outcomes or value for money.

In 2013 an interim arrangement began with Health Specialists Ltd (HSL). This will last until mid-2015. This interim program has more of a focus on the leadership and management skills of clinicians. The heads of the major clinical departments in the hospital are now all ni-Vanuatu doctors and they are receiving support for these new roles. The program is also working to develop an internship program for newly qualified doctors returning from Cuba and elsewhere: over 30 graduates will return from Cuba in the next few years.

This greater focus on leadership and on internships seems entirely appropriate as more ni-Vanuatu doctors are trained. What is much less clear is whether the program provides value for money – this is important, because it accounts for 31% of bilateral spending. In terms of numbers of patients reached, the location of these patients and the likely health outcomes, very little is known about what the clinical support program achieves.

Plans for a new Medical Workforce program have been developed – this is discussed in Chapter 7. An important issue for this new program is that it needs to be seen as part of support for the wider health system, not just as a stand-alone project.

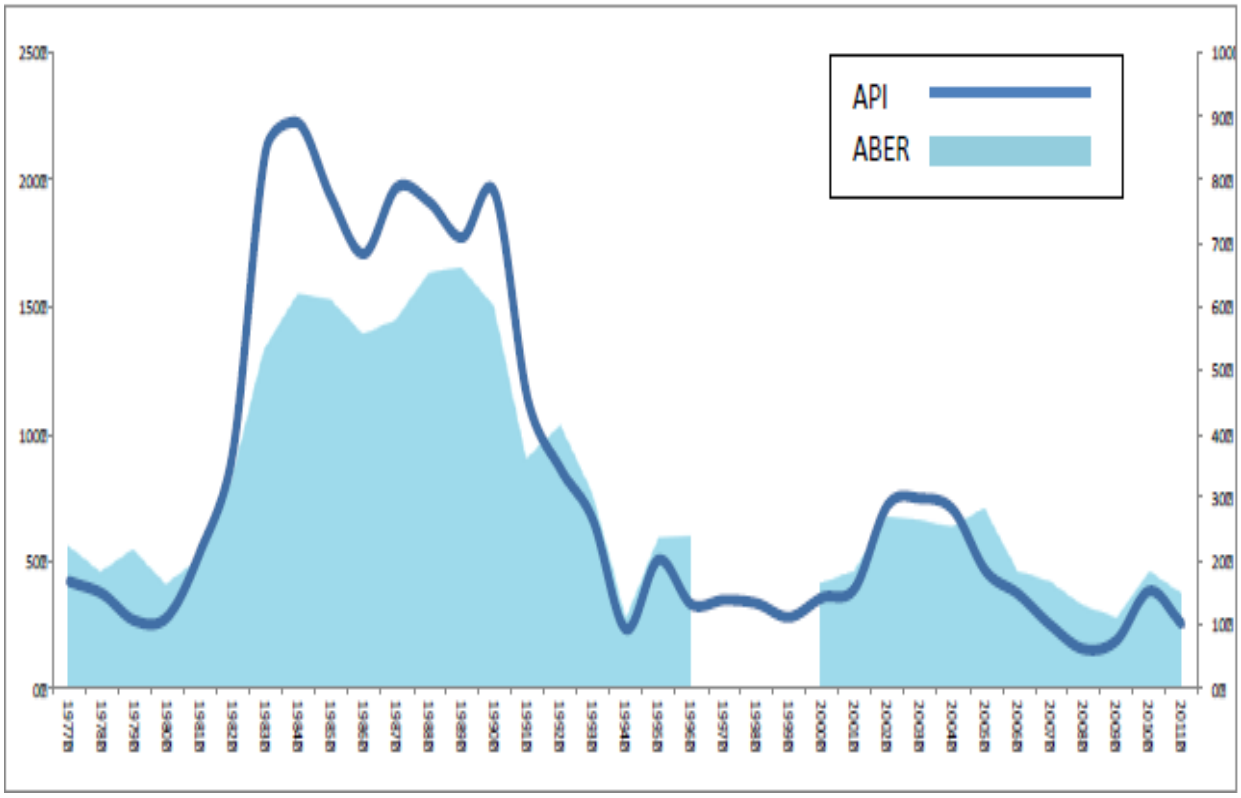
[15] Hurly D (2010) *The Vanuatu Medical Workforce – current situation and future development.*
[16] Biscoe G et al (2014) *Medical Workforce Support Program (Vanuatu): Investment Design.*

4.2.2. Malaria: AICEM ($600k/year) and DFA funding ($281,500/year). Total 20% of bilateral budget.

The bilateral program has funded malaria in two main ways – through technical assistance from the Australian Initiative for the Control and Elimination of Malaria (AICEM) and with recurrent costs through the Direct Funding Agreement. Australian funding has been part of a period of exceptionally high external donor support in recent years, with significant contributions from Global Fund to Fight AIDS, Tuberculosis and Malaria.

The nationwide vertically implemented Malaria Programme has been thoroughly evaluated[17] and has achieved impressive results. Figure 4 shows the reduction in the national malaria burden from 73/1,000 annual parasite incidence (API) in 2003 down to 23.3/1,000 in 2007; in 2012 the rate was 13/1,000. The province of Tafea, which was the focus of the first provincial elimination strategy (later followed by Torba), reached almost zero indigenous cases in 2013. Confirmed malaria-related deaths have, in the phrase of the National Malaria Strategic Plan 'virtually disappeared'.

Figure 4: Trends in annual parasite incidence (API, line, Y1 axis) and annual blood examination rate (ABER, shaded, Y2 axis) 1977-2011, Vanuatu



Source: National Malaria Strategic Plan, Vanuatu, 2015-20

Australia's inputs have complemented higher values of support from the Global Fund, with mutual benefits. Australian technical assistance has helped to deal with the often-complex procedures of the Fund; the combined funding has meant that, at least in the short term, a very comprehensive vertical program has been able to produce positive results. From the perspective of December 2014, DFAT investments in malaria appear to have provided good value for money.

[17] See the National Malaria Strategic Plan Vanuatu 2015-20; the Ministry of Health Vanuatu Malaria Programme Review, 2013; and the Vector Borne Disease Control Program: Thematic Desk Review Report: Vanuatu Malaria Program Review. All from 2013.

However malaria control faces considerable challenges in the next few years if recent gains are to be maintained. Less external funding will be available over the next decade and working methods will have to become more integrated if they are to be affordable. This is a fairly typical situation for vertical programs which receive boosts in funding: in the short-term they produce impressive results and provide good value for money, but these are difficult to maintain in the longer term.

4.2.3. Village health worker program ($533,500/year; 12% of bilateral health spend)

The Village Health Worker (VHW) Programme in Vanuatu began in the 1970s. From 1998–2013 Save the Children Australia (SCA) worked with the Ministry of Health to implement the program with funding from AusAID totalling approximately AUD$3.7 million over the first 14 years. Phase II of the support – the Strengthening Village Health Worker and Community Based Health Management Project (2006-2012) - aimed to improve health in rural communities by improving the performance of VHWs and strengthening program management.

An independent evaluation of the program reported in March 2013. Its conclusion about the lack of information available about the program is worth quoting in full:

'It is widely acknowledged that despite its 30 year history, there has been no effective monitoring and evaluation framework in place for the VHW program, and the collection of data has been sporadic. In the absence of a sound results framework and evidence base, it is only possible to draw some tentative conclusions about the extent to which the program has contributed to achieving health outcomes; whether it has alleviated pressures on the formal health system; or whether it has been effective and delivered value for money. A continuation of the program will only be justified if a robust monitoring and evaluation framework is in place which collects, analyses, reports and uses information to support decision making and review resource allocations.'

Despite this lack of hard evidence, the evaluation was able to come to the following conclusions:

- It is appropriate to have a VHW program in Vanuatu: 'it can reasonably be concluded that without VHWs, communities in some areas of Vanuatu would not have access to any health services at all'.
- The lack of capacity and resources at provincial level meant that the support for VHWs was inadequate.
- Capacity of the Ministry of Health to take over the program was weak, despite this being a priority for the Phase II support.
- VHWs spent most time on minor curative work; prevention, promotion and referrals were all found to be weak.
- Management costs of the program were high: over 50% of the DFAT budget.
- Although the Ministry stated it was committed to the program, there was little capacity to take over managerial and financial responsibility for it. Ownership of the program was limited: after so many years it tended to be seen as an SCA program.

The evaluation concluded that the VHW program was potentially an important part of the health system in Vanuatu (and one that enhanced equity), but that it was operating sub-optimally. A greater focus on prevention, promotion and timely, appropriate referrals could potentially increase the health impact of the program.

Amongst the ten recommendations was one to develop a systematic approach to monitoring future progress.

Following on from the evaluation, a request for proposals for a new VHW contract was issued in 2013. This resulted in SCA again winning the contract, which was signed in January 2014. However the nature of the contract changed, with a much more business-like focus on payment-by-deliverables. The first important deliverable was an inception report – at the time of writing, this had been delayed by several months, but is due in December 2014.

Looked at very crudely, the VHW program supports about 200 VHWs at a cost of about AUD$500k per year: this is $2,500 per VHW per year. The problem is that there is very little information about what a VHW actually does – but at only $7 each per day, it is reasonable to think that VHWs could provide a cost-effective basic service.

4.2.4. DFA: Vanuatu Health Resource Mechanism ($437,500/year; 10% of bilateral budget)

The Vanuatu Health Resource Mechanism (VHRM) was established in January 2014. It is managed by a local firm, Consulting Vanuatu, and acts as a technical assistance (TA) recruitment and management agency, providing expertise to support the Vanuatu health sector. VHRM provides long and short term consultants across a range of technical areas, ad-hoc TA and some in-line 'gap filling'. Examples include an Assets, Infrastructure and Procurement TA; audit of the management of DFAT funds expended by the MoH; an Audit and Finance Officer; and ad hoc support to the MoH Internal Audit Unit.

The VHRM is flexible, responsive and seems able to provide good quality expertise at short notice. It is currently developing a database of quality-assured national, regional and international consultants. Consulting Vanuatu contracts, employs and manages the consultants, shouldering a load that would otherwise need to be managed by MoH or DFAT.

VHRM has not been formally reviewed. On the basis of brief fieldwork undertaken in November 2014 the review team concluded that it seems reasonably efficient, effective and appears to provide reasonable value for money. However there are some areas which could be improved. For example, VHRM provides a range of TA 'types', from senior experts providing high level advice to in-line staff effectively filling gaps. Whilst there is confidence around the ability of senior experts to deliver against their terms of reference, there is less clarity around performance management of some of the in-line positions. Contractually in-line positions are employed by Consulting Vanuatu, yet the firm pays limited attention to the on-the-job performance, which is left to the MoH. This would make sense if the MoH had a performance management culture and framework, but it does not. In practice much of the supervision is undertaken by the VHRM Procurement Manager, an expatriate in-line position, raising questions about longer term institutional capacity strengthening of the MoH.

One other observation relates to the appropriateness of the TA, given the fragile context of Vanuatu's health sector. TA provided by VHRM is demand-driven and focused on key technical weaknesses. This is good in itself. However, many of these weaknesses have their roots in entrenched institutional issues. Experience from elsewhere shows that more innovative TA approaches could help to address these root causes, however this is not being requested or provided. There is a need for much more thought around how to engage with these complex institutional issues. This is discussed in more detail in the following chapters of this report.

4.2.5. DFA: procurement, assets and infrastructure ($437,500/year; 10% of bilateral budget)

DFAT support to procurement, asset management and infrastructure is funded through the Direct Funding Agreement. Technical support is provided by the Procurement Manager employed by Beacon, a company sub-contracted by Consulting Vanuatu which runs the VHRM.

This support has a clearly stated long term objective – to provide facilities and equipment that are fit for purpose and supported through established maintenance and replacement programs. Initial assets and infrastructure work focused on creating baselines for asset management reform. At the time there were few MoH personnel focusing on asset management, little or no asset management in practice, no focus on strengthening procurement, and several cases of fraud involving procurement had been reported. Maintenance budgets had declined to a record low, and actual maintenance spending was lower that the budgets.

A provincial resource review was undertaken to assess assets in every facility across the country. This reviewed infrastructure provided by MoH, WHO and other programs, details of which at the time were recorded in different 'silos'. The malaria program had also undertaken a review of assets, and SCA had completed an assessment of community health posts. However knowledge of assets and equipment was fragmented and different assessments (e.g. malaria, SCA) had produced different results. There was no coherent, validated 'big picture'. The attempt in 2011 was to pull all this together, starting by using the malaria program as a framework for broader overarching asset management, to understand what actually existed across the country and assess its current state.

A health facility assessment was undertaken of buildings, equipment and staffing in all provinces. A contract for $700,000 was awarded to a separate company to assist with the survey and produce survey reports. The intention now is to get provinces to validate the results, and ensure that health facilities report on assets and inventory every six months through 'dynamic surveys'. MoH will also be expected to do spot checks using inspection templates developed by the new MoH Assets and Infrastructure Unit.

This work has helped to develop a strong MoH Assets and Infrastructure Unit involving a national Asset Manager and national Infrastructure Officer, led by the international technical expert as Procurement Manager. It also provides a good basis to achieve added value, leverage efficiencies and achieve results, insofar as more cost-effective procurement will free up resources. These need to be quantified for GoV, which then could be asked to re-direct the savings to other health sector investments.

Future work to be undertaken by the Assets and Infrastructure Unit includes a stronger focus on zone level (to plan and cost refurbishment by facility); finalising all asset management capital plans by March 2015; helping to establish good management of the biomedical fleet and assets; improving the cold chain and bringing its assets within the biomedical section; strengthening the internal procurement system; and agreeing standard facility designs. Some of the planned work requires close co-ordination with technical programs, notably clarifying the roles of different types of health facilities and their staff and standardizing the NCD equipment list.

Support to assets management has helped strengthen core systems and gives the Ministry a valuable opportunity to improve management of its resources. It has also helped strengthen internal capacity and confidence considerably, by providing high quality technical leadership and by demonstrating what can be achieved in practice

by good planning and teamwork. Internal training has been provided in inspection frameworks, preventative maintenance, cyclical routine maintenance and reactive maintenance and rehabilitation, showing the financial implications of each. The challenges facing infrastructure and equipment were analysed and an asset management reform planning guide developed. Details of equipment, HR and infrastructure surveys were developed. Following the surveys, key findings were reviewed by the team and a maintenance plan developed and costed.

Whilst all of this is extremely valuable, and provides an excellent basis to build on (both in terms of the baseline asset work itself and its value as a demonstration project), a key question is the extent to which the deeply rooted management (dis)incentives within the MoH will enable these initiatives to continue once external support is withdrawn. In other words, will the MoH take the leadership and responsibility needed to take asset management forward and build upon work to date? In the absence of clear and effective incentives to ensure systemic institutional performance and accountability, the answer may be 'probably not'.

This support has been expensive, largely because of the detailed fieldwork required for the facilities review. It is important in future to ensure that systems development is proportionate to the likelihood that it will be sustained: sometimes a 'good enough' product is more cost-effective than a deluxe one.

A de-facto Project Management Unit?

The VHRM Procurement Manager performs a second role within the MoH, involving staff management and oversight of all of the money going through the MoH via the DFA. This financial oversight clearly provides confidence to DFAT around fiduciary risk issues.

In discussions with the VHRM managers about how the performance of the staff they place in the MoH is undertaken, it became clear that the Procurement Manager plays a key role in keeping staff focused on their terms of reference and outputs, on behalf of VHRM and the MoH. This may be understandable given the acute human resource management weaknesses within the MoH, however there needs to be a clear strategy to strengthen the HR department to play this role once a Director of HR is in place.

4.2.6. Health Information system (TA + DFA: total $287,000/year; 7% of budget)

According to research[18] in 2009 Vanuatu had some of the foundational building blocks for a successful health information system (HIS) in place, but suffered from a number of chronic problems. These included:

- Persistent staffing issues and HIS governance weakness within the Ministry of Health and provincial offices.
- Data collection methods that were overly complicated and created a burden on clinical staff, affecting timeliness of reporting and reducing incentives for completing reports.
- Lack of national health information standards, standard definitions and methods for collection.

[18] Miriam Lum On, Vicki Bennett and Maxine Whittaker, 2009, Health information systems in the Pacific: a case study of Vanuatu, University of Queensland.

- Absence of a clear HIS action plan that defined, prioritized and aligned future HIS activities into the wider policies of the MoH.

In addition, while there has been significant support for improvements to the national health information system from international donors, support has been irregular and has contributed to a disjointed system.

DFAT has been providing TA to address these issues and strengthen health information systems through a direct agreement with WHO since May 2013. This is complemented by modest operational funding provided through the DFA to support national office administration, provincial officer support, supervisory visits, training, and maintenance of the new District Health Information System 2 (DHIS2), a web-based platform.

The contracted specialist found a HIS system in place, but it was very dysfunctional and took him some time to properly understand. He has been effective in expanding the use of simplified HIS forms, providing relevant training and improving the forms' reliability. The next step is to expand use of DHIS2.

The technical specialist disseminates National Health Information Unit bulletins which provide data on the use of information reporting systems, as well as progress against specific indicators (service delivery, Maternal Neo-natal and Child Health, malaria etc.). Bulletins also provide up to date information on reporting rates and health data.

In July 2014 the HIS Bulletin reported some improvements, suggesting that the new system was becoming more active and familiar to HIS officers. However, reporting rates remained low and inconsistent, partly due to transport and internet shortages. The most significant challenge at that time was the persistent lack of human resources: the National HIS unit had been without MoH-funded staff for four out of the first seven months of 2014.

By September reporting rates were improving slowly, although timeliness remained a challenge in some provinces, because of lack of transport, poor internet connectivity and access, and unmet IT infrastructure needs (e.g. computers requiring repairs or delivery). These challenges were compounded by the continued absence of a national HIS manager.

In October 2014 the HIS Bulletin reported that the National HIS Unit had achieved a significant milestone: the successful migration of data from the old database to the new DHIS2. This will improve the Unit's ability to process and manage data and assist in its dissemination. The Unit now plans to improve the functionality of the system by creating indicators and information templates, and by enhancing the way data is stored and managed in the database.

During discussion in November it was reported that there was a growing demand for health information and that the strengthened HIS infrastructure was beginning to deliver results. In some provinces reporting rates were up to 80%.

Overall, support to HIS is effective and probably represents good value for money. It is also necessary as part of strengthening core central health systems. The single long term major constraint remains staffing. When the TA specialist started work in 2013 he had a counterpart – the HIS manager. However that was just as 'decentralization' was implemented and when the HIS manager resigned. Since then the position has been vacant. This brings serious challenges for future sustainability. In the words of the technical expert, 'there is no one to work with, so there is a long term sustainability problem. If I leave they are stranded. It's scary'. For the moment there is no commitment from GoV to address the staffing problem, and in practice the National Unit accounts to the donors. While this is better than no accountability at all,

it is not a basis for successful, locally owned development. Innovative approaches to address these deep-seated institutional constraints are discussed in Chapter 7.

4.2.7. Immunization, UNICEF ($250,000/year; 6% of bilateral budget)

In May 2014 UNICEF Vanuatu developed a Concept Note for DFAT funding to strengthen immunization in Vanuatu. The Note was largely in response to the findings of the 2013 DHS, which showed that only 33% of children were fully immunized, with 53% coverage for measles. Then in July an outbreak of measles in the Solomon Islands provided another reason to support immunization. The short turn-around time for this funding decision suggests an atmosphere of mini-crisis – it was felt to be urgent and important to provide this funding.

As with malaria, the Expanded Programme on Immunization (EPI) is a vertical program within the Ministry of Health. However in stark contrast with malaria, EPI has seen a decline in external funding in recent years. Because of its relatively high per capita gross national income, Vanuatu is not eligible for support from GAVI, the Vaccine Alliance which is the immunization-equivalent of the role played by the Global Fund in malaria. Over recent years EPI has faced a number of challenges, many of which are linked to the wider financial and HR problems within the Ministry of Health. Moreover because monitoring was weak the decline in coverage did not appear to receive much attention.

Funding of $250k/year for two years was agreed for UNICEF. There are clear targets, including at least 80% coverage in two provinces in two years. The support is provided in two main ways – detailed support for micro-planning and implementation of EPI activities with provincial and health facility staff, and the organization of six-monthly Mother and Child Health weeks with extended outreach activities.

It is likely that this very targeted support will produce good results and provide reasonable value for money in the short term. Indeed the claim is already being made – with at least some justification - that the rapid response has helped to avoid a measles outbreak in Vanuatu. As for malaria, the challenge is to maximise the sustainability and long-term impact of this support. This is discussed in Chapter 7.

4.2.8. Support for nurse and midwifery training ($202,500/year; 5% of bilateral budget)

Although DFAT provides about $200k/year to support nurse training, there is remarkably little documentation about this support. Despite extensive searching by the Senior Programme Manager, no recent documentation could be located. This makes it difficult to discuss the effectiveness of the support.

The Vanuatu College for Nursing Education (VCNE) trains nurses who then serve a two-year placement in a hospital. After that, they can be assigned to either community or hospital work providing there is a vacant position. For at least a decade (and probably longer), the VCNE has suffered from the instability caused by the poor HR management in the Ministry of Health. Nurse aide training ended in 2004 when there were no Ministry jobs for the trained aides; there is a long-standing problem that graduating nurses cannot find a job because of the backlog of nurse retirements.

Between 2007 and 2009 the Agence Française de Développement (AFD) supported the VCNE in terms of buildings, educational materials, curriculum development, in-service training for nurse-educators and technical assistance. Since the AFD funding ended, DFAT has supported the College in a number of ways, both by funding TA in the form of nurse educators, and by providing students with allowances and opportunities for placements outside Port Vila. New legislation related to

qualifications (the Vanuatu Qualifications Authority Act) requires nurse trainers to be qualified at degree level. This has increased dependence on Australian-funded trainers, because most of the ni-Vanuatu trainers are not qualified to this new standard. The College relies on DFAT-funded posts to keep the training program running.

It is a pity that more structured information is not available about the support for the College, because nurses are a vital part of the health system in Vanuatu, fulfilling crucial roles in both primary health care facilities and hospitals. The most senior clinical staff in many provincial hospitals are nurses. Moreover, as we saw in Chapter 3, there is an absolute shortage of skilled health workers in Vanuatu.

Assuming that 25 nurses graduate per year, DFAT funding amounts to $8,000 per graduate. It is not possible to say whether this provides value for money without more information about the numbers of graduates and their subsequent employment.

In addition to its support for nurse training, DFAT has stated that it is willing to fund the training of midwives. The availability of midwives is expected to drop sharply, as a number of Solomon Island midwives return home and as retirement arrangements are made for the ageing workforce. To illustrate the gravity of the situation, Vila Central Hospital (where 40% of ni-Vanuatu births take place) may well soon move from having three midwives per shift to only one. The midwifery training program has met with numerous delays, including disagreements about the benefits to be paid to the students and the need for formal recognition of the course.

4.2.9 Central Medical Stores ($87,500/year; 2% of bilateral budget)

DFAT funds an electronic pharmaceutical supply stock program for Central Medical Stores, including server costs, database updates and consumables. This program is widely used in the Pacific. Although we did not look in depth at this area of work, based on experience from elsewhere and the potential to make savings through improved drug management, it is reasonable to assume that the program pays for itself in terms of wastage avoided.

4.3. Performance of selected DFAT regional investments

DFAT's *Pacific Regional Aid Program Performance Report 2012-13* acknowledged that the Pacific regional health program lacked an overarching strategy and had become highly fragmented, consisting of 12 regional initiatives with 30 funding arrangements across 8 agencies and working in 14 countries. Concerns with the program included 'variable impact at country level, poor sustainability, limited country ownership and high transaction costs'.

Looking at the (pre-reform) regional program from the Vanuatu country perspective confirms these concerns. As described in Section 4.1, the regional program involves over 15 separate agreements of varying degrees of direct relevance to Vanuatu.

Much the largest regional health program in recent years was the Pacific Islands Response Fund for HIV and STIs, which disbursed over AUD$26 million between 2009 and 2014. In some ways Vanuatu did disproportionately well out of the Fund, because its nominated Capacity Development Organization, Wan Smolbag, managed the available Community Action Grants exceptionally well.[19] This meant that Vanuatu received 58 out of the 123 grants disbursed (47%), with the remaining 53% of grants shared amongst nine other countries. However the Response Fund as a whole was weak in terms of grant management and monitoring/evaluation and,

[19] Secretariat of the Pacific Community, Public Health Division (2014). Pacific Islands Response Fund for HIV and STIs. Completion Report, 2009-14.

according to the 2012/3 Regional Program Performance Report 'struggled to meet its objective of providing an efficient funding mechanism'. It is reasonable to question, therefore, whether the regional nature of the program benefitted Vanuatu, or whether the funds could have been passed in a much less costly way to Wan Smolbag. Moreover there are serious questions of sustainability – for a time Vanuatu gained disproportionately, but this was not matched by local commitment to sustain the funding.

Since 2013 fragmentation in the regional health portfolio has been reduced, so that there are now 6 regional initiatives with 6 funding agreements across 6 partners. The regional health program now aims to focus on activities which require a regional or multi-country approach and for these activities to contribute to cost-effective, quality and equitable health services in countries.

Three of these programs are of particular relevance to Vanuatu: core support to the College of Medicine, Nursing and Health Sciences at the Fiji National University; addressing non-communicable diseases; and providing specialist clinical services (actually provided through two separate agreements).

4.3.1. Core support to the College of Medicine, Nursing and Health Sciences at the Fiji National University

Australia's core support contributes to the provision of medical and nursing education and to the development of new courses such as paediatric and diabetic nursing. There is no doubt that the existence of this regional education facility for health workers benefits Vanuatu. However the multiple ways in which Australia financially supports the training means that information about the cost of educating a skilled ni-Vanuatu health workforce is fragmented and not brought sufficiently to the Government of Vanuatu's attention. McKimm et al estimated that during the period 2008-12, 33 ni-Vanuatu students graduated from the Fiji School of Medicine at an average cost of $9,000 per graduate. This meant 'almost $300,000 in subsidy to the country's health care education'.[20] However this sum excludes scholarships for fees and subsistence, which are also often funded by the Government of Australia. Even if Australia continues to subsidise regional education, it is important that these costs are acknowledged in Vanuatu, with a view to increasing co-financing over time.

4.3.2. Addressing non-communicable diseases (NCDs)

The 2014 Joint Forum of Economic and Pacific Health Ministers unanimously endorsed an 'NCD Roadmap'. The Roadmap synthesizes global evidence about tackling NCDs and offers practical guidance about interventions which offer good value for money. The importance of effective NCD management in primary health care settings is emphasised. One potentially relevant idea for Vanuatu is to link NCD interventions to maternal care in primary health care settings as a way of strengthening the health system more broadly and avoiding a 'vertical' disease approach.

The Roadmap is highly relevant to Vanuatu and is a potentially valuable resource, including to inform the development of the next five-year strategic health plan. It is also relevant to the proposed future DFAT strategy, which we describe in Chapter 7. NCD prevention and management at the primary care level would be an important part of this strategy.

[20] McKimm J et al (2011) AusAID support program to Fiji School of Medicine. Independent Progress Report.

4.3.3. Providing specialist clinical services

There are two agreements related to tertiary visits – Tertiary Health Services to Pacific Island Countries and the Strengthening Specialized Clinical Services in Pacific Project (SSCSiP). The latter aims to assist countries to improve the planning, co-ordination and delivery of specialized clinical services.

In 2013 there were five clinical visits to Vanuatu that provided non-surgical services to 635 people and surgery for 66. SSCSiP also conducted 10 training activities for 38 people (21 women, 17 men) – four of these activities took place in Vanuatu.

The visits to Vanuatu are certainly appreciated by ni-Vanuatu doctors and patients. For the doctors, the visits are opportunities to provide continuity of care to complex clinical cases and to learn new skills. SSCSiP inputs appear to be appreciated in terms of organizing the visits, though the time is approaching when this should be done in-country.

An SSCSiP-sponsored study has been conducted of the costs of visiting cardiac services in Fiji.[21] Although the country context is different, the findings probably hold true for Vanuatu – cardiac treatment from a visiting health team was found to be cheaper than overseas evacuation, whether the evacuation was paid for by a government or by a private health insurer. That said, the costs per patient of receiving visiting specialist care are clearly very high – as medicine develops in Vanuatu, it will be important to be aware of the relative costs of visiting services compared with developing local skills to deal with a relatively small number of patients with a particular medical need.

The report now moves on to look at the aid modalities through which support is provided (Chapter 5). Chapter 6 then assesses the support as a whole in terms of value for money, appropriate governance, aid effectiveness and compatibility with the Australian aid framework.

5. Aid modalities used by DFAT

Chapter 4 described what DFAT funds in the health sector; this chapter describes how DFAT channels the support.

5.1. What are aid modalities?

An aid modality (or aid instrument) is a way of delivering aid resources. Modalities are about how funds are managed, rather than about the content of the support.

The somewhat simplified conventional wisdom states that there are four broad types of aid modality. Within each broad modality there is great variety about exactly how it is operationalized: for example a project could be delivered completely without government, or it could be very closely linked to government policies and work through government staff. The four broad types of modality are:

- **Budget support (including sector budget support**): funds are channelled through the national government budget to support implementation of a strategic plan. Budget support is appropriate when there are reasonably robust prioritisation processes and financial management systems.
- **Program-based approaches:** assistance is provided in support of a sectoral or thematic strategy, with a structured process for increasing use of country

[21] Irava W (undated, presumed to be 2012). Comparing costs of cardiac treatment between government, private insurance and visiting cardiac teams. SSCSiP/Fiji National University.

systems. (When development partners collaborate in this approach it is called a SWAp, or Sector-wide Approach.) A program-based approach is appropriate when there is a strategic document with clear prioritisation and identification of the main operational tasks.

- **Projects:** aid is delivered through dedicated management structures and arrangements. Projects are often the 'modality of last resort' when the conditions for budget or programmatic support are not present. However projects are also suitable for particular situations such as emergencies and when testing out innovations.
- **Technical assistance (TA):** aims to transfer knowledge and skills in a sustainable manner. TA tends to be in addition, rather than an alternative, to the above approaches.

It is easy to say what the DFAT bilateral health support in Vanuatu is not: it is not budget support, sector budget support or a SWAp. However it is more difficult to say what it is: in effect it is a hybrid of a program-based approach and projects, with significant TA inputs.

5.2. Aid modalities in the bilateral health program

Within this overall hybrid, there are four specific modalities currently in use in the bilateral health program, with some overlaps amongst the four categories. These are:

- DFA
- Contracts for third parties to provide services
- Technical assistance
- Projects managed by a contractor.

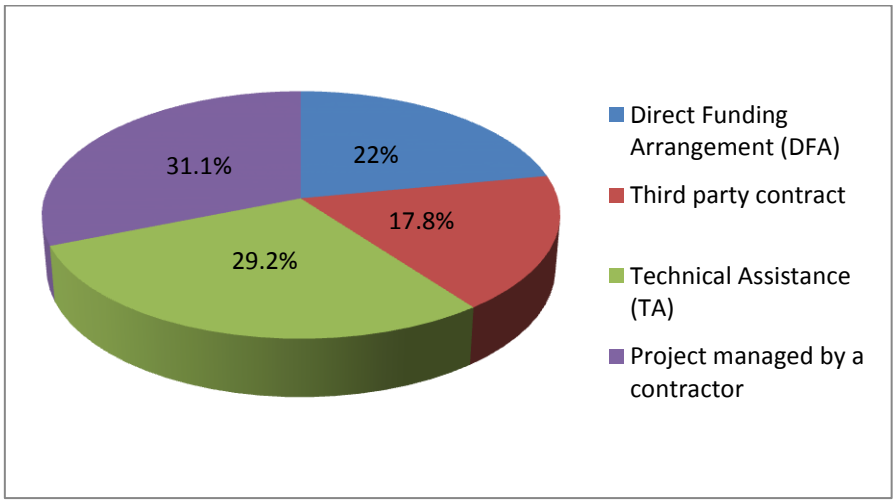
Table 7 shows the average annual budget by modality, aggregated for the two years 2013/14 and 2014/15. Any way of categorising the bilateral budget according to modality will have weaknesses, because there are such a large number of separate managerial arrangements within the health program. For example, the VHW work has been classified as a 'third party contract' here even though it is also part of the DFA, and the DFA includes some funding for TA in addition to the separate TA category. Nevertheless the table and accompanying pie-chart give a reasonable impression of the overall mix of modalities.

Table 7: Average annual budget by modality, aggregated 2013/14 - 2014/15 [22]

Modality	AUD$	Percentage
Direct Funding Agreement (DFA)	971,000	22.0
Third party contract	783,500	17.8
Technical Assistance (TA)	1,287,500	29.2
Project managed by a contractor	1,370,000	31.1
Total	**4,412,000**	**100**

[22] All the DFA expenditures except the SCA Village Health Worker contract are included under DFA. The 'third party contracts' are with SCA and UNICEF (immunization). TA includes the support provided through the Vanuatu Health Resource Mechanism, plus the advisers for malaria (AICEM) and health information (WHO). The one project is the clinical support to hospitals.

Figure 5: DFAT funding by modality, health sector Vanuatu



5.3. The four aid modalities

This section discusses each modality separately. The chapter then moves on to discuss how the modalities contribute to the overall goals of the support. The final section is a reminder that the bilateral program is only one part of Australian support – other channels include scholarships, regional agreements and NGO grants.

5.3.1. Direct Funding Agreement

The Direct Funding Agreement works through government systems and is on-budget. Crucially, government officials sign off DFA expenditure. In 2012 the DFA was temporarily suspended 'following concern by the Post and DFAT central agencies that the Ministry was spending funds in a reckless fashion'. Since then more stringent controls have been introduced, with each payment needing to be approved in advance by a DFAT-funded member of staff hired through the Vanuatu Health Resource Mechanism.

As described in earlier chapters, there are very significant problems with public financial management in the health sector in Vanuatu: the Ministry regularly overspends and both the immunization and malaria programs are currently subject to fraud investigations, with some activities suspended as a result. These problems have a serious effect on front-line services because they reduce the amount of money available for vital recurrent items such as fuel and utility bills.

In this difficult environment, the DFA – with its unusual mix of government 'ownership' and donor controls – has proved durable and effective as a way of keeping funds flowing, with appropriate checks and balances. It is notable that nobody we spoke to stated that they wanted the system to change: the recent additional controls were generally regarded as an appropriate and welcome safeguard against abuse and the consequent freezing of funds.

5.3.2. Contracts for third parties to provide services

The main third-party contract is to manage the VHW program. As described in Chapter 4, SCA is contracted through the DFA to run the VHW program. The Ministry of Health is the client for this contract, with 100% of the funding coming from DFAT.

The various phases of 'contracting' SCA over time to run the VHW program have served the program well in some respects: the VHW program has enjoyed considerably more continuity and stability than programs run directly by government.

Following the evaluation in 2013, the contract was re-let and a tighter contract was signed, with clearer links between inputs and outputs.

Contracting to a third party makes sense if:

- It frees up the client to focus on more strategic issues, rather than the details of providing services.
- The contractor is able to provide a better service in terms of value-for-money because of its superior technical capacity and/or lower cost.

The first argument – reduced workload – is valid for both DFAT and the Ministry of Health. Both have limited managerial resources and it potentially makes sense to contract out the management of a relatively large and complex program such as the VHWs.

Issues relevant to the second argument – that the contractor may be able to provide a better service – were discussed in the previous chapter. Despite the evaluation of the program in 2013, it is difficult to say anything definitive about either the cost or the quality of SCA's work. The program is not expensive, but that is because the VHWs are volunteers: the evaluation did express concern that about 50% of the program's costs were on 'management'. In terms of quality, the absence of any systematic monitoring has been a major problem. In reality, however, there are few competitors for the work and SCA won the new contract, which was awarded following due process.

The potential gains from contracting out require sound contract management of both financial and technical matters by the client. This is particularly true in a relatively uncompetitive market such as the health sector in Vanuatu. This good contract management by core Ministry of Health staff is currently lacking. There has been more engagement with the technical aspects of the program in the past, but this has been largely lost recently because of the extreme instability of staffing in the Public Health Division of the Ministry.

The financial aspects of the contract are, however, being carefully monitored by the expatriate Procurement Manager in the Assets and Infrastructure Unit (AIU). As discussed in Chapter 4, the distinction between the Ministry and DFAT is in practice somewhat blurred here. The financial monitoring is entirely within the scope of the adviser's role within the Ministry, but the assurance to DFAT is stronger because DFAT is also directly supporting the AIU. One the other hand, this level of financial oversight is unlikely to be sustained once the Procurement Manager leaves.

In practice the VHW program operates like a third-party-managed project which is nominally contracted through the Ministry's books but more actively managed by DFAT/DFAT-funded TA. This may be a pragmatic approach, but after more than 15 years, it is time to begin to tackle the lack of sustainability.

The other contracted-out work is to UNICEF to support immunization services (although in practice it is clear that contracted out TA and project management overlap as categories). UNICEF has acknowledged expertise in immunization and was able to respond quickly when an agreement needed to be signed. Although not the cheapest alternative, this was an appropriate choice of provider in the circumstances.

5.3.3. Technical assistance

There are three key TA initiatives funded by DFAT: the AICEM, the Vanuatu Health Resource Mechanisms (VHRM) and TA to strengthen Health Information Systems provided through bilateral support to WHO. These were described in Chapter 4.

As this report has already discussed, TA in the public sector in Vanuatu is working in an environment of chronic under-performance where there are serious institutional weaknesses. Individuals providing TA will inevitably find themselves having to balance 'advising' against 'doing', because in most cases the area in which they are working will be under-staffed. This can be difficult, especially when there is a strong focus on short-term results. TA can certainly prove frustrating: we heard about fraudulent activity related to HR allowances, lack of government ownership and oversight, and weak accountability for results. One person stated that TA is fostering 'a culture of learned helplessness', with GoV simply waiting passively for someone else to solve its problems while any vestiges of government ownership and responsibility are at risk of withering. Other individuals were more positive, though of course all were very aware of the financial and staffing problems within the Ministry.

TA can play a beneficial role in supporting health systems if appropriate approaches are taken. Lessons from international experience are presented in section 6.3 of this report. Table 10 assesses the extent to which these principles are being operationalised in Vanuatu, and demonstrates mixed experiences; closer attention to the lessons of experience could bring benefits. Section 7.5 provides some specific examples for the implementation of more innovative approaches, e.g. a governance Task Force with high level leadership; whole of government approaches; and devolved health grants to stimulate local action around which support could be mobilized to facilitate local pressures for performance and accountability.

There are examples of well-targeted and well-implemented TA in the current health portfolio. However a greater variety of ways of organizing TA could be deployed. The key is to be very clear about the objectives of the TA: the problems to be addressed and the best way to approach the problems. For example, in Vanuatu, as in many other under-performing situations, there are challenges with respect to commitment to change, capacity to bring about improvements, and the mandate or authority to do so. Each of these things requires different thinking and approaches. In practice TA tends to focus on the capacity components of under-performance – usually through training. This can be very helpful in strengthening skills and knowledge but does not always address institutional dimensions of under-performance (e.g. organizational structures, processes and cultures). A focus on these can help to improve the organizational frameworks in which people operate and the incentives that shape the way they work. Equally important, TA often fails to address issues of political will or those related to mandates and authority (room to manoeuvre). Working to improve commitment and 'political will' need different, more innovative approaches, e.g. a 'roadmap approach'[23] – aimed at generating demands from the very top of government for better sector performance and accountability; and change management approaches[24], based on process consultation and aimed at pulling together and supporting those who support change to counter the negative effects of those supporting the status quo.

TA can also help widen the 'room to manoeuvre' – particularly where decentralization is a policy objective - by advising on key technical issues related to fiscal decentralization and devolved HR management and by helping to shape the distribution of functions. TA can also help widen the scope for local institutional and community action by facilitating joint analysis of problems and solutions, as well as supporting bottom-up demands for greater accountability. Figure 6 attempts to show

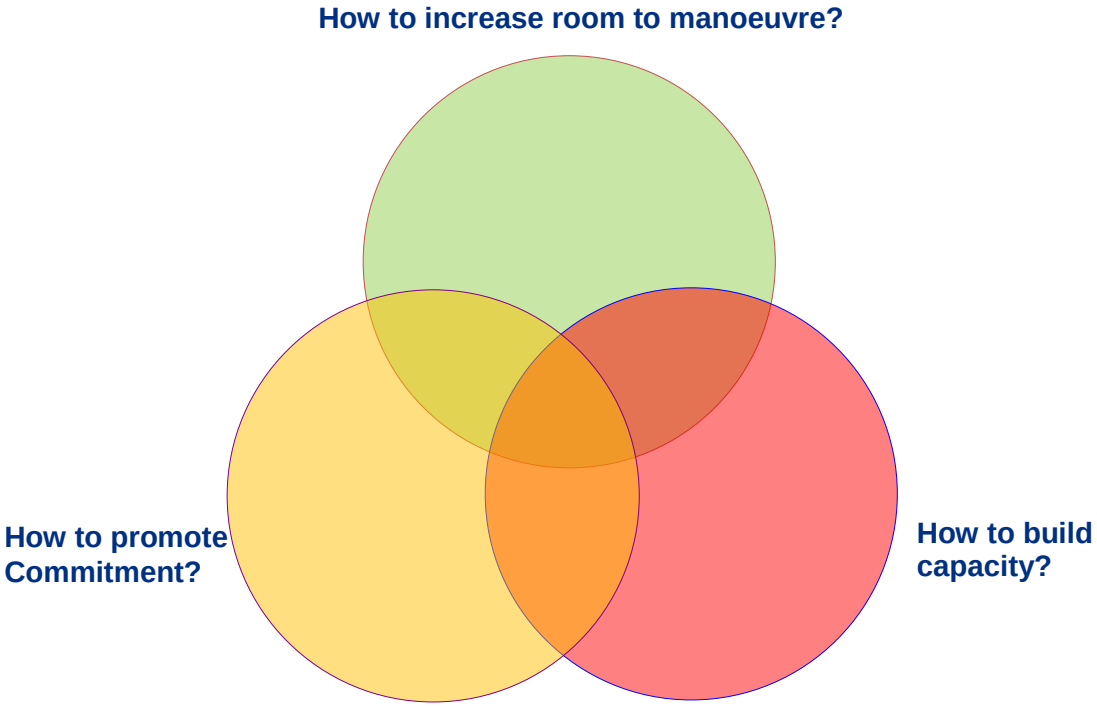
[23] See e.g. Todd R et al (2014) Delivery Units: can they catalyse sustained improvements in education service delivery? Cambridge Education, Cambridge.

[24] E.g. see Paton R et al (2008) Change management: a guide to its effective implementation, Sage Publications, UK.

this graphically. Strategically the attempt should be to expand each of the circles and make them as congruent (overlapping) as possible.

There is considerable experience of these types of TA approaches in under-performing and decentralized contexts, and there are many potential lessons for Vanuatu, not least in how to improve governance and strengthen incentives at all levels for better performance and accountability.

Figure 6: Technical assistance



5.3.4. Project managed by a contractor

The largest component of the bilateral program – support for clinical staff in hospitals – is a project. As described in Chapter 4, the contract is currently held on a short-term basis by HSL. If government systems were stronger, much of this work could be funded through these systems (as happens, for example, in Tonga). Apart from its relatively high component of off-shore costs, there is nothing particular about this project which calls for a project – it is not a pilot, nor is it operating in emergency circumstances. However in the current circumstances it makes sense to continue with the project-style modality. The work on leadership development and internships for newly graduated doctors is a vital stage in Vanuatu's progress towards having a reasonable number of ni-Vanuatu clinicians. It would not be appropriate to jeopardise this work by using a more risky modality.

5.4. How have the modalities contributed to achieving the stated goal of the support?

The stated goal of DFAT support is 'to improve health systems and build capacity within the Government of Vanuatu'. Except for some aspects of financial and asset management, the modalities do not build capacity to run efficient government support systems by directly using them – the support does not rely on government plans or HR procedures, for example. Most strengthening is in the form of somewhat piecemeal TA. The aspects of the program which deal more directly with service

delivery (training doctors, managing VHWs) in practice largely bypass government management systems so that health workers' capacity can be developed.

To return to the overall question of how the modalities have contributed to achieving the stated goals of the support, the answer can be summarized as 'a reasonably sensible, pragmatic mix of modalities that facilitates an appropriate flow of resources'. Government systems, particularly for finances and human resources, are weak, meaning that budget support or a light-touch programmatic approach would be highly risky for DFAT. Nevertheless, the modalities used mean that the Ministry has a strong say in how DFA funds are disbursed and can potentially exert a strong influence over the VHW contract.

That said, the modalities which are used could be better adapted to the realities of an under-performing sector. There is little if any explicit attention to shaping modalities to try and address weak governance and fragility. This brings significant long-term risks in terms of government ownership, leadership and sustainability. There is a need going forward for support to have a clear focus on three key governance issues:

a) the disconnects between policy objectives and institutional frameworks;

b) weak mechanisms for ensuring performance and accountability (top-down and bottom-up); and

c) the absence of an environment conducive to health actors engaging at the local (provincial) level to solve problems and improve public service delivery.

Modalities will need to include approaches (probably with TA support) that are more innovative, adaptive and able to take risks; that can identify, create and grasp windows of opportunity; and that facilitate local problem solving and collective action, most likely through process-consultation approaches. As described in the section on TA above, there are a wide range of aid-funded practical experiences and lessons that could be drawn on to help design and shape more effective modalities geared to addressing deeply rooted governance challenges.

5.5. Beyond the bilateral program of support to the health sector

This section so far has only discussed the bilateral health program. The issue is further complicated when other sources of funding from the Government of Australia are considered: these include regional programs, scholarships, in-country activities by multilaterals and grants for NGOs. Highly fragmented support can undermine aid effectiveness because it means that there is no consistent message about expectations in terms of government responsibilities and results. For example the bilateral support for medical and nurse training needs to be clear about the responsibilities of government to budget appropriately for health worker training and to enforce reasonable rules about allowances for trainees. It is important that the scholarships program does not undermine these messages.

The way Australian support is currently organized means that decisions about different strands of funding are not automatically co-ordinated. This is unhelpful in the difficult context of strengthening institutions in a fragile environment. Moreover it is difficult for Australia to lead sectoral harmonization and alignment amongst development partners when its own support to the sector is somewhat unharmonized.

6. Assessing the health program as whole

So far this report has looked at DFAT support to the health sector in a piecemeal way, dealing with each component and each modality separately. This chapter assesses the bilateral program as a whole, using four different 'lenses':

- A **value for money lens:** are the right things being funded?
- An **aid effectiveness lens**: are the Paris principles being adhered to?
- A **governance lens**: is this the right way to support a chronically under-performing sector?
- The **lens of DFAT's aid policy framework** ('the four tests'). Three additional tests have been added to respond to specific requests from DFAT officials.

It is generally acknowledged that the bilateral health program is too fragmented and that it is does not work as a consistent, coherent whole. But it is nevertheless worthwhile to think about the support to the sector in its entirety, as this provides useful lessons and insights for future funding.

6.1. The value for money lens: are the right things being funded?

Although this is clearly over-simplifying a complex body of knowledge, it is reasonable to say that a cost-effective health system includes the following:

- Effective health promotion and preventive activities tackling major public health priorities (e.g. smoking);
- A national network of primary care facilities providing access to a cost-effective package of preventive and curative interventions;
- Hospital care that focuses on activities which are cost-effective and appropriate to be dealt with in a secondary care facility (including emergency obstetric care);
- Public health programs which ensure that major health issues are dealt with to a high standard, but which do not necessarily employ large numbers of staff;
- Effective management and support systems; and
- Appropriate health workforce training facilities and opportunities for newly qualified technical staff to work with others and learn from their seniors.

Given this list, plus our knowledge about the 'double burden' of disease in Vanuatu (NCDs as well as diseases of poverty), is the bilateral program supporting the right type of activities? Table 8 addresses this question.

Table 8 suggests that the funding in the bilateral program is generally for appropriate areas; nothing stands out as a particularly 'bad buy', though the level of spending on hospitals is high. However some lessons can be drawn for future support:

- Two of the most cost-effective interventions for Vanuatu would be a good-quality primary health care package and health promotion/prevention activities related to public health priorities, notably NCDs. Neither of these is currently supported under the bilateral program.
- The VHW program is potentially a highly cost-effective element in the ni-Vanuatu health system, but, as we saw in Chapter 4, too little is known about how effective it is in practice.
- Some support for hospitals is appropriate but this has to be proportionate, as access to hospitals is limited for many ni-Vanuatu.

- Important health priorities do not need to be funded through vertical programs, which tend to be expensive.

It could be argued that external aid should not be used for funding the most cost-effective interventions, such as primary health care –funding for the highest priorities should come from the Government of Vanuatu. In the long-term this is correct. But in the shorter-term, there is a need to invest in the current run-down primary health care system and to promote good practice.

Table 8: Are the right things being funded?

DFAT-supported area	Cost effective? A good buy?
Clinical support in hospitals	√ Appropriate to an extent, but costs have a tendency to escalate. Needs to focus on equipping clinical staff with the skills to deal with secondary care priorities.
Malaria	√√ The package of malaria interventions is cost-effective, but there are rapidly diminishing returns as the incidence of malaria decreases (unless elimination is a realistic goal). The vertical organization of the program adds to costs.
Village health workers	√√ Has the potential to be highly cost-effective; appropriate for Vanuatu's geography.
Health systems (health information, procurement, asset management etc.)	√√ Necessary means to an end. Technical interventions cannot perform efficiently without effective support services such as financial management and health information. However support for HR/workforce planning is a crucial gap in support.
Immunization	√√ One of the most cost-effective of all health interventions, particularly when provided routinely through facilities and outreach.
Nurse training	√√ Nurses are integral to many cost-effective health interventions; good quality nurse training is a sound investment.
But some of the best buys of all are NOT being supported, notably primary health care as a whole and health promotion activities related to NCDs.	

6.2. The aid effectiveness lens: does DFAT's support adhere to the principles of aid effectiveness?

The principles of aid effectiveness, as articulated in the Paris Declaration, are:

- Ownership: The host government sets the agenda in terms of priorities.
- Alignment: Donors support local priorities and use local systems.
- Harmonization: Donors co-ordinate, simplify procedures and share information to avoid duplication.

- Results: There is a focus on results and how they are managed, rather than on processes and procedures (output-based aid)
- Mutual accountability: Governments and donors are accountable to each other for results.

Table 9 explores these principles in terms of the four modalities used in the bilateral health program. The main message emerging from the table is one that has already been thoroughly discussed in this report – Government of Vanuatu is not 'leading from the front' in terms of setting and following clear priorities, implementing plans or assessing its own performance.

In general Table 9 shows that the bilateral health program does not perform strongly in terms of aid effectiveness. However this is a somewhat unsatisfactory conclusion because the aid effectiveness principles used here focus on how donors can prevent aid from exacerbating governance problems in recipient countries. This is certainly relevant in Vanuatu, and more could be done in this regard (see the last paragraph in this section for more on this). However the main concern in Vanuatu is different from the focus of aid effectiveness: the key question is how can aid actively address the domestic governance issues which impinge so drastically on service delivery?

Circumstances such as those in Vanuatu are covered in the 2013 Overseas Development Institute publication *Unblocking Results*[25], which discusses 'effective aid' in situations with serious governance constraints. The focus is on factors that 'enable aid-funded activities to obtain traction and nudge forward institutional change that is conducive to the improved delivery of results.' The six factors identified are:

- Identifying and seizing windows of opportunity
- Focusing on reformers with tangible political pay-offs
- Building on what exists to implement legal mandates
- Moving beyond reliance on policy dialogue
- Facilitating problem solving and local collective action solutions by bearing the transaction costs
- Adaptation by learning.

The point here is that the aid effectiveness principles cannot provide solutions when there are serious governance constraints. In addition to aid effectiveness, there has to be a focus on the types of activities supported by donors. These activities should focus on minimising the gap between policy and practice in the public sector, so as to strengthen the processes of managing, delivering and accounting for services. This point is picked up again in Chapter 7, when we discuss possible future strategies for support to the health sector.

Having said that aid effectiveness principles do not provide all the answers, they do point towards some useful things which could be done in Vanuatu. One area where there could be improvement is in terms of harmonising and simplifying aid management procedures related to planning, budgeting, financial management and reporting. An obvious area where donors cause additional work is in financial management, where the hard-pressed finance office in the Ministry has to manage funds from different donors according to different procedures. A pooled fund built around the procedures of the DFA, for example, would be one positive development: partners could include the UN agencies. Another option would be for development

[25] Tavakoli H et al (2013) *Unblocking Results: Using aid to address governance constraints in public service delivery*, ODI, London.

partners to sign a Joint Funding Arrangement that specified standardized financial management procedures, even if funds were not actually pooled.

Pooled funds and Joint Funding Arrangements are established mechanisms for the delivery of aid. Development partners agree to use a uniform set of financial procedures to reduce the transaction costs for the host government: obviously each partner satisfies itself that the procedures are robust and will meet the required standards of that partner agency. Development partners are generally not confined to using one inflexible financial management system: there *is* flexibility to work with partners, as long as basic standards are adhered to. (More information about pooled funds can be found online in, for example Commins S et al (2013) *Pooled Funding to Support Service Delivery: Lessons of Experience from Fragile and Conflict-Affected States* and *Ethiopia's health sector: excellent returns on your development funding* by the Ethiopian Federal Ministry of Health.)

Table 9: Aid effectiveness principles and modalities used in the bilateral health program

	Direct Funding Agreement	Third party contract	Technical Assistance	Project managed by contractor
Government ownership	Reasonable. Funding is broadly earmarked, categories having been discussed with MoH. Government can initiate and veto expenditures within the earmarked categories.	In theory yes for SCA contract (contract is with MoH); in practice no, largely because lack of continuity in senior management.	Mixed/low-ish, varies between different TA positions. Relatively high level of TA, including expatriate TA, decreases local ownership.	Partial. Project developed and managed in collaborative way, but financial details etc. not controlled by government.
Alignment	Alignment (i.e. donors support local priorities and use local systems) Supporting local priorities: passive alignment. Local priorities are not clearly stated - strategic documents are very general. None of the funding appears to go against these very general priority areas. Little support for the stated priority of NCDs. Using local systems: partial, using some financial management and procurement systems but in a carefully controlled way.			
Harmonization	Limited: whilst there is regular communication & information-sharing amongst most of the main partners, there is little 'hard' harmonization in terms of simplifying procedures. E.g. no pooled fund and a variety of financial management procedures.			
Focus on Results	No, most focus is on procedures. Very fragmented earmarking, not all of which has clearly stated targets in terms of outcomes.	Potentially yes, with the new SCA contract, though it is too early for this focus, and government is in any case not actively engaged.	Relatively clear focus on results, defined in TORs that can be evaluated and verified. There is a challenge for TA working on institutional strengthening in that success is often determined not by ***what*** results are to be achieved, but ***how*** TA goes about it.	Limited. Intermediate outputs are assessed, but outcomes are not reported on.
Mutual accountability	Some, in that both parties have to agree to expenditures. But not mutual accountability in terms of *results*.	In theory yes, but government is not actively engaged in the payment-for-deliverables discussions.	Not mutual: advisers are monitored for performance and held accountable by the counterpart/MoH manager, but not vice versa.	Not as a whole, though there may be some mutual accountability in terms of support for individuals.

6.3. The governance lens: are things being done in the right way?

International experience suggests that there are clear lessons for good practice in supporting chronically under-performing states with severe governance constraints[26]. A common message is that there are no blueprints. Evidence points to the need for robust analysis to understand the local context before attempting to transfer any practices that were effective in a different context. There is also a need for robust political analysis to understand the motivations of policy-makers and practitioners, the opportunities and power those actors have to act on the basis of those motivations, and the decisions that result. There is also likely to be a need for grounded, flexible and innovative service-delivery frameworks.

The list of lessons below is quite long, but this is because it describes possible ways of working, rather than each bullet specifying a 'must-do'.

For development partners, good practice includes:

- Develop a ***shared understanding amongst development partners*** of the root problems and agree a joint strategy to address these.
- ***Adopt 'all of government' approaches.*** There are two dimensions to this. First, target higher level recipient government institutions – including the Prime Minister's Office, ministries of finance, public service departments, parliamentary committees and internal audit departments – to help leverage better sector performance. Getting the Prime Minister 'on-side' can be pivotal in pushing strong demands for improved performance and accountability down through the bureaucracy. Second, development partner engagement can be more effective by making use of their own government's involvement in other areas, such as governance and security, trade and diplomatic channels.
- ***Adopt long term approaches*** that strengthen the state at all levels. This can include helping to resolve conflicting mandates which impinge on implementation and supporting senior officials in prioritization efforts, with particular focus on addressing implementation gaps.
- ***Focus on core functions, but lighten the load*** where possible. In health this could include the contracting out of ancillary services and strengthening capacity of MoH to manage contracts.
- ***Exploit a presumed political commitment*** for activities and functions based on their articulation in formal documentation such as the Constitution, laws and policies. Start with what exists and build on this to implement legal mandates. Work 'with the political grain' by building on existing mandates and supporting existing systems to do so, even if these mandates are imperfect or poorly implemented.
- ***Consider support that has tangible political pay-offs***, e.g. seek to deliver tangible goods and services (as long as these are reasonable) that politicians could capitalise on in their campaigns***.*** This can have short-term benefits in terms of political popularity, and demonstrate a longer-term government commitment to the population.
- ***Help to operationalise policies.*** Move beyond reliance on policy dialogue into the 'nuts and bolts' of service delivery to make existing systems deliver better, rather than simply trying to create better policies and strategic frameworks. This can be effective where there is a weak relationship between stated commitments on paper and actual practices.

[26] See e.g. Tavakoli H et al (2013) *Unblocking Results* Op cit; Booth D (2014) *Aiding Institutional Reform in Developing Countries: Lessons from the Philippines and what works, what doesn't and why*. Asia Foundation and ODI, USA and London; Wild L et al (2012) *Common constraints and incentive problems in service delivery*, ODI, London.

- ***Exploit entry points to generate expectations and incentives around performance and accountability*** and to amplify bottom-up voice. Support the combination of incentives and information, providing managers with more information with which to hold their subordinate department or individuals to account. Facilitate local stakeholders to recognise their collective power to create pressure for change and exercise their oversight responsibilities in a practical way.
- ***Consider performance based support.*** This could include graduated support and incentives, linking support to governance trends.
- ***Strengthen ability to respond opportunistically*** when conditions are right. This requires the ability to recognise appropriate opportunities, to create them where feasible, and to respond to them quickly and flexibly.
- ***Innovate, experiment, take risks.*** For example, provide facilitators, coaches, mentors or brokers and use 'objective outsider status' to encourage stakeholders to meet, discuss and resolve common problems. Provide support and/or coaching to facilitate a greater degree of local problem solving. Encourage actors to come together to find solutions to problems they face in a more sustainable way. Encouraging those who previously were less inclined to act collectively to work to achieve a common good. Consider process-learning approaches, innovation and adaptation through on-the-job learning.

Readers will notice that there are significant overlaps between this governance-led view of good practice and the good practice for effective aid described in the previous section. The overall message is the same: support needs to be designed not only in terms of technical content and formal modalities, but also in terms of a style of working which is innovative and flexible enough to respond to governance opportunities.

To what extent have DFAT investments in health been aligned to these lessons of good practice? Table 10 assesses DFAT support to the health sector against the above lessons about good governance practice in chronically under-performing states. The table shows that, whilst there are already examples of good practice, there is considerable potential to build more of these practices into DFAT's support: practice which explicitly respond to the governance weaknesses in Vanuatu.

Table 10: Good governance lessons and DFAT's health sector support

Good practice	DFAT support: experience in Vanuatu
Shared understanding between development partners of root problems; agree a joint strategy	Reasonable communication amongst partners, but not a strongly shared analysis or joint strategy.
'All of government' approaches	No consciously co-ordinated 'all of government' approach, though there is scope to achieve this.
Long term approaches	Long term engagement in health by DFAT over many years is positive and has achieved some excellent results. However there is not long-term thinking about institutional capacity-building and some parts of government are strengthened, collapse and are then supported again.
Support core functions, but lighten the load	Mixed success with developing capacity of core health sector support systems. Insufficient attention to strengthening leadership and senior management, though this is understandable given the rapid turnover of staff and the gaps in senior management. With the exception of the VHW contract (which is not for a core government responsibility), little explicit consideration of lightening the load e.g. through contracting out.

Exploit presumed political commitment	This has not been consciously attempted. Mandates and responsibilities are clearly stated, policy documents chart a general way forward and state commitment. These provide scope to hold government to account. Although this is difficult, it has to be done to show that development partners require some technical continuity when politicians change.
Support appropriate improvements in infrastructure and services which politicians can capitalise on.	Not attempted. Could be a valuable approach at provincial level, e.g. by improving health facility maintenance and rehabilitation, equipment and services. Activities such as these enhance the visibility of politicians and can demonstrate that the state *can* be responsive. Clearly funding should only be granted where the activity improves equity and/or efficiency and where the politicians have demonstrated responsible attitudes.
Help to operationalise policies	Some success, e.g. with malaria, immunization and VHWs, although health policies stress integrated primary health care, which has largely been neglected.
Incentives around performance and accountability	There has been no real attention to strengthening demand, incentives for performance, accountability or responsiveness. Senior doctors are evolving a sense of professional leadership which could potentially be translated into demands for better oversight and leadership.
Performance based support	Not yet applied. Could be considered in the context of support to provinces.
Respond opportunistically	There has been a degree of responding to opportunities, but this has not been guided by a clear framework of strategic objectives which could provide a sense of direction in deciding when and how to respond.
Innovate, experiment, take risks	Scope for innovation not really exploited though considerable potential for this, particularly at provincial and facility levels.

6.4. Alignment of investments with Australia's aid policy framework

Australia's aid policy framework has four tests to guide strategic choices across the aid program. Australian aid should:

1. Pursue Australia's national interest and extend Australia's influence
2. Impact on promoting growth and reducing poverty
3. Reflect Australia's value-added and leverage
4. Make performance count.

The table below discusses health sector support in Vanuatu in the context of these tests. In addition to the 4 tests, there are other issues which are priorities for DFAT and which we were asked to consider in this review. To respond to this we have added three more tests;

5. Promote gender equality and the empowerment of women and girls
6. Support the private sector
7. Promote mutual accountability and output-based aid.

Table 11: Applying 'tests` derived from the aid policy framework

Aid policy 'tests'	Contribution of DFAT's health investments in Vanuatu
1. Pursue Australia's national interest and extend its influence	Overall stability: Vanuatu has many of the characteristics of a type of fragile state known as chronic under-performers, where there is the potential for prolonged political instability. Without support there are risks of increased instability and insecurity, including financial, humanitarian, political and health-related risks, with implications for the region as a whole. DFAT investment in Vanuatu is helping to address these challenges and reduce these risks (though more could be done with a less fragmented approach). Communicable diseases: Australia was certified as malaria-free by WHO in 1981. However, several hundred imported cases of malaria are recorded in Australia each year, including carriers travelling from Vanuatu. DFAT investment in combatting malaria in Vanuatu is of direct benefit to Australians. Public expenditure: Health is an important component of the public sector and its management affects the stability of the system as a whole.
2. Impact on promoting growth and reducing poverty	Economic growth: Better health leads to improved earning potential and income for individuals and households. Poverty reduction and equity: DFAT funds programs such as malaria, immunization and village health workers which aim to reach *all* ni-Vanuatu. VHWs and the virtual disappearance of malaria deaths have particularly benefitted the poor. DFAT support contributes to economic stability by helping to finance public goods not adequately supplied by the private sector, such as disease surveillance and vector control of communicable diseases.
3. Reflect Australia's value-added and leverage	The health portfolio has *not* stimulated an increase in domestic resource mobilization for health – health as a percentage of government spending has declined in the last decade. DFAT support *does* contribute to better value for money in terms of how some resources are used, notably in relation to procurement and asset management. DFAT support has complemented funding from the Global Fund in important ways. DFAT-funded TA has been important for accessing and managing significant amounts of Global Fund money. DFAT lobbying and support have led to active engagement by the World Bank in Vanuatu; UN in-country representation has improved. Support in the health sector has become very fragmented: this is partly why this review was commissioned and is extensively discussed in this report. A more consolidated portfolio, plus more across-government co-ordination, should give Australia more effective influence in the health sector.
4. Make performance count	The extent to which performance is measured varies across the portfolio: malaria and immunization provide the best examples. The new VHW contract is a positive step forwards in terms of actively managing contracts to improve value for money.
5.Promote	The Demographic and Health Survey and the NCD STEPS report provide

gender equality and the empowerment of women and girls	a lot of health information disaggregated by gender, but there is little evidence that such information is used for planning and resource information. Support for reproductive and maternal health is a necessary part of empowering women and girls.
6.Support the private sector	DFAT's health investments have helped connect Australian private sector individuals and institutions to markets and improved the flow of goods and services between the two countries. Within Vanuatu the VHRM is operated by a private sector company (Consulting Vanuatu). The not-for-profit private sector in Vanuatu is important, and churches and NGOs have received support (e.g. Wan Smolbag and the Vanuatu Family Health Association). DFAT's health investments have not explicitly supported the Vanuatu private health sector. It is important that the private sector is not supported just for the sake of it: it is only appropriate if it is in the context of cost-effective, priority health interventions. For example support to a private ambulance service is often mentioned, but it is not clear that this is an appropriate priority just now.
7. Promote mutual accountability and output-based aid.	The portfolio has been too fragmented to have a systematic approach to mutual accountability. Funding through the DFA was suspended for a time when government's use of it was felt to be reckless. Output-based aid has not been used, though the 2014 VHW contract is an interesting step in the right direction.

This chapter has provided some insights to inform a new health support strategy. We have seen that better value-for-money could be obtained through a greater focus on primary health care and that the modalities used are broadly appropriate, although they could be less fragmented and more harmonized with other development partners. The governance lens revealed that more could be done to adapt working practices to suit support to a chronically under-performing sector. Assessing the portfolio against the aid policy framework raised some concerns – perhaps the most significant is the declining percentage of government expenditure going to health. This needs to be a standing item in policy discussions between the Government of Vanuatu and development partners.

7. Recommendations for strategic focus of future health investments

7.1. Key messages from the review so far

The 'lenses' used in Chapter 6 provide some clear messages to inform the future direction of DFAT support to the health sector in Vanuatu.

7.1.1. Value for money

The value for money provided by all investments in the health sector is seriously compromised by the weak management of government finances and HR. Confronting this problem is an absolute priority.

Government's primary health care facilities have been relatively neglected in recent years. The facilities have the potential to provide a cost-effective package of basic services, including for immunization, malaria, NCDs and maternal, child and reproductive health.

7.1.2. Aid effectiveness

The situation in Vanuatu is not currently appropriate for budget support or a program-based approach using government systems. There needs to be more stability in the management of finances and HR before the modalities currently used by DFAT should be radically changed.

7.1.3. Governance

The resources of the Ministry of Health are sometimes used for entirely political reasons, without heed of the health consequences. There is little or no systematic performance management or accountability within the Ministry, and few if any demands for improvement, either from above or below. This has led to poor organizational discipline, policies that are not implemented, weak financial management and over-spending, poor HR performance, and a disconnect between the MoH, provinces and facilities. The consequence of this is poor delivery, under-utilization of services and failure to maintain health infrastructure and equipment.

These are complex issues but they need to be tackled head-on. There are no simple answers or 'quick fixes' – however there are lessons from elsewhere to guide thinking and this chapter makes suggestions about possible approaches.

7.1.4. The aid policy framework

A number of issues arose from the analysis of the aid framework which can be incorporated into a future strategy. These include ongoing dialogue about Government of Vanuatu's prioritization of health within the overall budget; enhancing Australia's influence in the health sector through a less fragmented portfolio and with stronger links to other parts of government, including the Office of the Prime Minister; more awareness of gender issues; and developing incentives for performance (output-based aid).

7.2. Objective and key features of the future strategy

The considerations summarized above inform our proposals for the future strategic direction of the Australian Aid Program's support to the health sector. **The objective of the support should be to improve the performance of the Ministry of Health – and other organizations where appropriate –in leading and managing the provision of effective and equitable health services.**

Key features of this proposed strategy are:

- One Vanuatu Health Support Program with three main components – primary care; leadership and management; and hospitals. These three components are all necessary for the health system to function and are inter-connected.
- Sustained, robust dialogue between Government of Vanuatu and development partners, with Australia in a leading role from the development partners' side. Consistent focus on levels of GoV financial commitment to health and on responsible stewardship of finances and HR.
- A strong focus on results and mutual accountability, complemented by problem-solving support related to the delivery of core services.
- Capacity development for leadership and management at the highest levels.
- No large-scale funding for vertical programs, except in extreme circumstances.

- Good co-ordination between the Vanuatu Health Support Program and other DFAT-funded activities within and beyond the health sector (regional programs, scholarships, NGO grants, links with Ministry of Finance and Economic Management etc.).

7.3. Technical areas to be supported in a future strategy

The recommendation is to develop one Vanuatu Health Support Program with three main components – primary care; leadership and management; and hospitals. Broadly speaking, spending on the three components should be approximately 60% for primary care and 20% each for hospitals and leadership/management. Figure 7 illustrates this simplification of the health portfolio. The consolidation of the portfolio needs to be done gradually, using every opportunity when it is time to renew, end or alter a contract or agreement to move towards a program with fewer separate components.

The objective of the **primary care** component would be to **strengthen the provincial health care system so that primary health services are more effective and equitable**. The component would support provincial health teams to plan, deliver and monitor basic service provision across their province. It would include TA and operational funding against an agreed plan. There would be a strong focus on problem-solving and on-the-job learning, with regular communication amongst teams from different provinces.

There are various ways in which the overall support could be organized: for example provinces could compete to be included (there are lessons here from the Vanuatu technical and vocational education and training sector) and/or well-performing provinces could be rewarded with additional resources. Provincial outposts of the MFEM – the Financial Service Bureaus – could play a role in disbursement, accounting and reporting, thereby strengthening horizontal accountability within provinces.

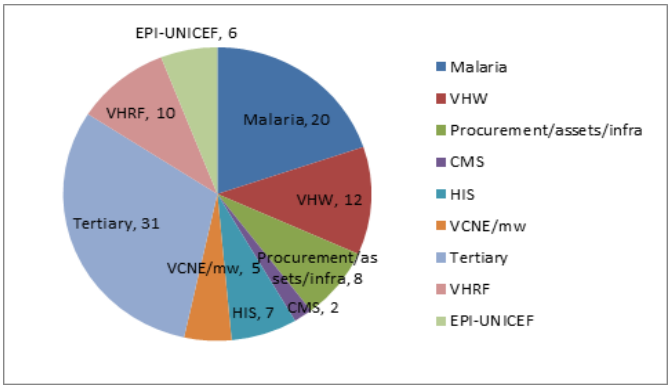
Radically improving primary health care will not be easy. Part of the program will be to follow up practical problems, including with MoH headquarters and, when appropriate, with other central ministries (such as the Office of the Prime Minister) and politicians. The idea is to develop demands from the provincial level for effective management from above.

Malaria would be included as part of the primary health care package – the transition towards this integration is discussed briefly below. Funding for the VHW program could also come under this component to encourage co-ordinated planning and implementation.

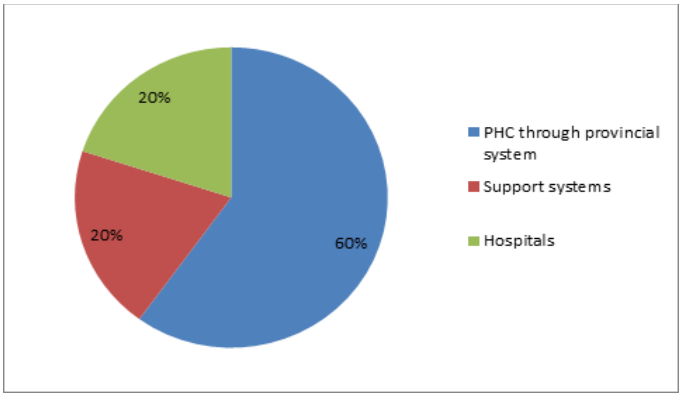
The **hospital** component would focus on developing the leadership, management and appropriate clinical skills of doctors and nurses, as well as providing gradually decreasing funding for ‘gap-filling’ specialists. Its objective would be to **improve the clinical staffing in hospitals so that hospitals could provide a more appropriate and equitable service.** The work should clearly place hospital care within the context of the wider health system – information about patient numbers, their places of residence and diagnoses should be analysed regularly. Equity should be an important part of this component – this can be achieved by working more in hospitals other than VCH, by providing more clinical visits outside Port Vila and/or by improving transportation and other arrangements for referred patients. Given the absolute shortage of health workers, this component should also include support for nurse and midwifery training, no matter whether the graduates end up working in primary or secondary care. Numbers of trainees need to be established as part of a wider Human Resources plan which includes realistic projections of nursing and midwifery posts and the likelihood of appropriate funding being available.

Figure 7: Moving from a fragmented to a more coherently structured portfolio

Moving from the existing portfolio …



… to a more coherent one



The **leadership and management** component should include both high-level leadership capacity-building and support for specific systems, including financial management, procurement, health information and human resources/workforce planning. The support for leaders should include work on motivation (both their own and their employees'): it is important to understand the extent to which motivation can be improved in the prevailing circumstances. Work could also be done with leaders about their expectations in terms of performance, and the tools available to improve performance (comparisons with other, better-performing sectors could be used). The systems support should be as much as possible about capacity-building, whilst realising that at times there will also be a need to actually do some of the tasks on which the health system depends. The demonstration effect of a well-functioning system should not be under-estimated: once health centre in-charges and community leaders have become used to receiving reliable drug supplies, for example, they are much more likely to complain about stock-outs than if supplies had always been unreliable. The objective of this component would be **to equip leaders and managers (including politicians) with relevant stewardship skills to ensure that effective and efficient health services are delivered in Vanuatu.**

Note that the proposed Vanuatu Health Support Program is not a comprehensive package of support for the sector. A significant but deliberate omission is support for health promotion and behaviour change activities, particularly in relation to NCDs. This technical area is important and has the potential to provide value for money. However it is risky, and requires high-level political support for areas such as import policies and tobacco control. DFAT

cannot support all parts of the Ministry of Health and the proposed portfolio will at least develop important primary care services related to NCDs.

7.4. Modalities for the future strategy

No radical changes in modalities are recommended. The one exception to this is that there should be more harmonization amongst development partners, particularly with respect to financial management. As well as causing extra work and distracting from core tasks, poor harmonization makes it difficult for MoH staff to see 'the big picture' in terms of planning and allocating resources. The DFA has worked well in difficult circumstances and at a time when malaria and immunization funding have been suspended. More harmonized, preferably pooled, financial arrangements could be developed around the structure of the DFA: partners could include the main UN agencies working in health in Vanuatu. There is considerable international experience on pooled funding for health in difficult environments, e.g. Liberia and South Sudan. The pooled funding could start with money that is spent in Vanuatu on recurrent items for the Ministry: this could include expenditure on immunisation outreach, malaria activities and stationery for the Health Information System, for example.

7.5. A tentative framework for addressing weak governance

We have referred to the desperately poor governance, leadership and management of the health sector, and the consequences for health financing, the health workforce and service delivery throughout this report. If these root causes of under-performance are not tackled as a priority, health sector performance will remain constrained and the impact of DFAT's investment will be seriously compromised. International experience provides useful lessons for how DFAT could support improved governance and management in Vanuatu.

We suggest below a tentative series of strategic actions that we believe could help 'unblock' some of the causes of under-performance and provide a basis for longer-term systems strengthening. The ideas presented here are not intended to be a definitive program of action but rather suggest potential approaches, based on principles of good practice, that could guide the implementation of DFAT support. They should also be based on a clear analysis of the current governance context, particularly on the incentives and motivations that shape current performance and the potential for any realistic drivers of change.

Step 1: We know from our discussions with the Office of the Prime Minister, the Public Service Commission and the Ministry of Finance and Economic Management, that they are all keenly aware of the dysfunctions within the MoH and would support a concerted approach, led from the very top of the Government of Vanuatu, to confront and address them. This presents an opportunity for Australia as the major donor in the sector to stress at the highest levels that health sector management requires strong leadership, both within the MoH and also from other core ministries. DFAT could promote the formation of a high level 'Task Force' to define and help push through the changes needed. DFAT could increase its influence and impact here by consciously employing 'whole of government approaches', using the full resources of its wide-ranging engagement in Vanuatu.

Step 2: Once a high level, concerted approach has been agreed, it would be worth considering a 'roadmap approach' to stimulate more effective leadership. This approach is used in Tanzania and Pakistan, working with top leaders in government to strengthen political commitment to change and develop a results-oriented culture in the health and education sectors. Emerging evidence suggests that the approach can strengthen political will at central and decentralised levels of government, and support key leaders as champions of change if the circumstances are right. A key requirement is that the approach relies on a real willingness from the very top of government to push improvements through. Given the concerns expressed to us by the Office of the Prime Minister, there could well be scope to support a roadmap approach as part of a wider strategy.

Step 3: Once MoH senior managers demonstrate willingness to resolve deep-seated governance issues it will be important to help them to implement agreed changes. In Pakistan this is being achieved through technical support to strengthen service delivery through better planning and management, and mentoring and change management approaches to strengthen organisational processes and accountabilities. This combination is proving to be effective in helping senior managers understand what is not working and what needs to be fixed, and what can be done to provide the fix. In Vanuatu, this could also be connected to performance-based support, such as linking continued financing to tangible governance and institutional improvements. If progress stalls, support could be scaled back.

Technical support also needs to be continued to improve core health systems strengthening, with a strong focus on workforce planning. Improvements in these areas would contribute directly to overall improvements in MoH performance.

Funding primary health care via decentralized provincial health grants (through the DFA) should stimulate local action and responsibility around health planning and budgeting, and prioritization of services. Finances could be managed in each province by the Financial Service Bureau, with oversight from MFEM. Provincial health plans could be developed with community/zone participation and approved by Provincial Councils and Provincial Health Committees. Performance-based support could also be linked to provincial service delivery, e.g. achieving agreed targets could result in additional resources for service delivery or facility maintenance. From a governance perspective the intention would be to strengthen capacity, accountability and responsiveness by facilitating local responsibility for delivery, and involving service users in health service planning and monitoring, to stimulate a sense of expectations around delivery. TA could be provided to support a bottom up health planning process, strengthen facility monitoring committees and so forth. TA would also need to provide on-the-job support to provincial health planners and managers to strengthen capacity to respond. TA need not involve full time support, for example one TA adviser should be 'shared' between 2 provinces. TA would need to be innovative and adaptive, using a range of facilitative approaches. The aim would be to move towards more client-driven (as opposed to consultant-driven) TA/facilitation.

7.6. The transition towards a new strategy

Because health sector support is currently very fragmented, there is no one single time when the current program ends and implementation of a new strategy can neatly begin. Some individual agreements are due to end soon, others are about to be signed. It would be advantageous to agree on the broad outline of a new strategy as soon as possible, so that decisions about individual agreements can at least all be moving in the same general direction.

This section briefly discusses the main issues which will have to be addressed during a period of transition.

7.6.1. Overall stewardship of the health sector

Stewardship of the health sector has been very weak in recent years – over-spending on staff has compromised the ability to deliver services. There are tentative signs of a willingness to tackle the chronic financial and HR problems, although it will probably take many years to deal with the backlog of debt and HR issues. The World Bank is actively supporting work in this area. Dealing with these issues needs to involve not only the MoH, but also the Office of the Prime Minister, the Public Service Commission and the Ministry of Finance and Economic Management. As the major donor in the sector, Australia needs to consistently stress at the highest levels that health sector management requires strong leadership, both within the MoH and also from other core ministries. This work can be complemented by the carrots and sticks of output-based aid and sanctions such as reduced

funding when a basic element of good practice is not met, e.g. sound financial management. (See box below.)

Output-based aid: some possibilities

Output-based aid can be effective: however it does not work in all contexts and it requires careful design. Possibilities for out-based aid in Vanuatu include:

- Additional funding for individual provinces (or facilities) which meet agreed health targets (immunisation, ante-natal care, treatment of pneumonia etc.).
- Reduced DFAT funding if the Ministry exceeds thresholds for spending or staffing.
- Performance payments to the contractor to spend as they wish on the Village Health Worker Program if targets for enhanced supervision and improved health information are met.
- Incentives for hospital doctors who act as effective Heads of Department, for example by organising high-quality internship programs for newly qualified doctors.

7.6.2. Sectoral strategies and plans

The national Health Sector Strategy and the National Policy and Strategy for Healthy Islands cover the periods 2010-2016 and 2011-15 respectively. It is time to begin to think about their successors: development partners should collectively make clear that they would like to see good-quality documents developed and that they are willing to support this process.

As stated in Section 6.3, work on strategies and plans is not, in itself, sufficient: it needs to be complemented by support for service delivery to make existing systems deliver better. However there *is* a role for supporting strategy development, particularly when the support continues into the implementation phase.

7.6.3. Existing agreements: Village health workers

As we have seen, there is currently very little information available about what VHWs do and what they achieve. It is important that this situation is rectified so that informed decisions can be made about resource allocation to the VHW program. Discussions about co-financing from the Ministry of Health need to start.

More information about VHWs should become available because of changes in the SCA VHW contract and because of improvements in the health information system. The 'inception report' from SCA is a crucial document that will give an idea of how the program's performance will be monitored in future. This report is long over-due, but is expected imminently. The report should receive a thorough technical critique which can contribute to DFAT's overall management response.

7.6.4. Existing agreements: malaria

The next few years are crucial for malaria, as external funding declines. The realities of integrating the program will really kick in when there are no additional funds for staff allowances. Integration needs to be carefully planned, including who will be responsible for distributing new bednets.

7.6.5. New program: medical workforce

A new agreement about the medical workforce is due to be signed soon. The following are key considerations:

- The greater focus on leadership and management development for senior doctors is very appropriate.

- The budget is large and would account for about one-third of the bilateral spend. This is too large a proportion, when there are more cost-effective parts of the system which could benefit from funds.
- This funding should be used to ensure that priority secondary care interventions (e.g. emergency obstetric care, basic surgical services) are provided to a good standard in appropriate settings in Vanuatu. The monitoring framework should reflect this and include appropriate information about patient workload.

7.6.6. New regional program: Improving health outcomes for women and children in the Pacific

A new regional program is due to start soon which plans to support reproductive, maternal, newborn, child and adolescent health in Vanuatu. This is part of a three-country program. The program's focus on the provincial level is appropriate and to be welcomed. However attention needs to be paid to the following concerns:

- The focus on 'reproductive, maternal, newborn, child and adolescent' health is wide: in reality all that is left is adult non-reproductive health. What Vanuatu needs is support for a well-balanced, integrated package of primary care: it would be beneficial if this program supported, as much as possible, primary health care for all members of the community.
- There is a risk that Australian funds will be used to set up new project management systems, including for finance. The support should build on existing management systems. This could mean channelling the money through the DFA, or at least using the same financial management arrangements as the DFA.

7.6.7. Portfolio management

DFAT supports a health portfolio which accounts for a significant percentage of health spending in Vanuatu. Moreover Vanuatu is fragile in governance terms. It is not possible to manage a health portfolio in these circumstances without senior in-house technical expertise and active support from top management. This is emphatically not a criticism of the current program management, which deals with a huge workload in a commendable way. The point is that if DFAT wants to try to break through the vicious circle of re-build/collapse/re-build in the health sector it has to provide appropriately skilled senior staff to oversee this challenging and complex work. This holds true even though the new strategy should include fewer formal agreements and be simpler in purely administrative terms.

7.7. Australia's national interests

There are four main reasons why supporting the health sector in Vanuatu is in Australia's interests:

1. Good health is a necessary (although not sufficient) condition for **poverty reduction and economic growth**. Healthy families are better able to take advantage of economic and educational opportunities. It is in Australia's national interest for countries in the Pacific to have growing economies and reducing levels of poverty.
2. A well-managed health sector is one important element of a **stable, well-governed** country. Moreover there is better value for money for Australia's aid dollars when there is a strong focus on governance and **performance**. Australia benefits when its neighbours are stable, well-governed and able to spend aid money effectively and efficiently.
3. Malaria is a **health threat** to Australia and Australians. It is important that malaria is kept under control in Vanuatu, a country which receives large numbers of Australian tourists.

4. The **empowerment of women** is an important element of development in the Pacific region. The health sector is important to women – as users, as carers for sick family members and as a source of employment. The health sector provides valuable opportunities for women to fill senior leadership posts.

The recommendations for the future strategic focus of Australian support to the health sector suggest important ways in which Australia's national interest could be enhanced, notably by focussing on good governance and performance, the control of malaria, and the development of a more efficient and equitable health service.

Annex 1: Terms of reference: Australian Health Portfolio Review, Vanuatu

Background

Vanuatu is a lower middle-income country with a total estimated population of 240,000, of which 70% live in rural areas spread over 69 inhabited islands. The Vanuatu Ministry of Health (MoH) has identified the provision of an efficient, equitable and effective health service as a priority[27], with a particular focus on Community Health[28]. However, constraints imposed by geography, limited fiscal space and inadequate human resources have resulted in chronic underperformance, particularly in terms of community health.

Vanuatu has one of the lowest ratios of health workers per head of population in the Pacific, exacerbated by significant inequalities in distribution of workforce; it is likely that only 30% of the health workforce is targeted at community health. Access to these services is further hampered by transport costs and geography. At the national government level a lack of basic health services has been identified as a 'major cause of hardship and poverty in the country'.

Australia's investment in health in Vanuatu is guided by a ten year strategy - the Vanuatu Health Delivery Strategy (2010) - which was updated in 2012/13. Following the strategy, Australia will address major health service delivery challenges by strengthening Government's planning and budgeting systems, assisting develop an evidence-based, affordable health workforce, increasing service delivery to the provinces and providing direct support to tackle priority diseases, notably malaria. Australia will continue to work with and through government systems, and to align behind government policies and plans. The totality of Australia's health investments in Vanuatu have not been reviewed or evaluated – although individual programs (such as the Village Health Worker program) have been.

The Australian Government's new Aid Policy (Australian aid: promoting prosperity, reducing poverty, enhancing stability) highlights the issue of health as critical to improving livelihoods, enabling poor people to participate in the economy and lifting living standards.[29]

Australia's investments in education and health will primarily focus on supporting changes to the systems and policies that deliver better education and health in our regions. This focus on systematic change requires our aid investments to be catalytic, leveraging other sources of financing for development, particularly the domestic tax revenues of our partner countries and private sources of funding. Australia's diplomats will advocate for reforms to health and education and more effective spending by partner governments and multilateral organizations.

The Australian aid program intends to invest in health – particularly health systems – so that women, men and children can achieve better health and live healthy and productive lives.[30]

In Vanuatu's context, the new aid paradigm is relevant for both Vanuatu's health systems and health outcomes. Focussing on health systems alone will not deliver the desired health outcomes unless there is motivation for organizational and individual behaviour change.

[27] Health Sector Strategy 2010-2016

[28] PLAS Agenda 2011 and MoH Health Sector Strategy 2010 – 2016

[29] Australian aid: promoting prosperity, reducing poverty, enhancing stability p19

[30] Australian aid: promoting prosperity, reducing poverty, enhancing stability p21

Purpose

The purpose is two-fold:

1. To review the health sector context and performance of Australia's regional and bilateral health investments in Vanuatu over the period 2010-2014 and;
2. Based on the review and synthesis of findings, to make recommendations for the strategic focus of health investments in the period 2014 to 2018.

DFAT investments in the health sector will be reviewed collectively, with the intention of looking at the performance of the entire portfolio rather than individual programs (i.e., a cluster review). This will include looking at a sample of health investments funded by the DFAT Regional Program, to assess the extent to which these meet the aid quality criteria and are in line with the objectives of the bilateral program.

The review is carried out in the context of a continually evolving and changing environment for health service delivery in Vanuatu; a key review question is whether DFAT's investment in the Vanuatu Health Sector between 2010 and 2015 have been able to respond efficiency, effectively and sustainably to this changing context.

Context and Key Issues of the Australian Health Portfolio

The recent integration of DFAT and AusAID and the changing health sector context in Vanuatu presents an opportunity to review Australia's investments in the health sector since 2010 with a view to informing how Australia will contribute to health outcomes in Vanuatu between 2015 and 2018. Australia needs to adjust its programming to respond to both changing priorities within its own aid portfolio, the shifting Vanuatu political context and the newly decentralised service delivery model being implemented by the MoH.

This DFAT Health portfolio review coincides with related processes, notably the development of an Aid Investment Plan for Vanuatu and the negotiation of a new Partnership for Development between Vanuatu and Australia. The Aid Investment Plan will set the broad parameters for sectoral investments, but a review is required to help determine the focus of investments within those broad parameters, as well as the best modalities for support.

In addition there has been:

- a Public Financial Management review of the MoH (2013);
- a Demographic Health Survey (2013);
- a provincial stocktake and mapping of village health services (2014);
- a provincial stocktake and mapping of MoH assets and resources (2014) and
- the development of a proposal for improved collaboration between UN agencies in Vanuatu to support better maternal and child health outcomes.

There is also recent information on poverty (World Bank, 2014), Pacific health performance (SPC and WHO, 2014) and other World Bank development indicator data which can be drawn on in the review process.

Scope and Key Evaluation Questions

The review will focus on the key evaluation questions below. The review team will develop a detailed review plan to determine how each of these questions will be assessed. The plan will meet DFAT M&E Standard 5.

1. Context / Situation Analysis

What is the health and health system context that DFAT is operating in? This will be answered through a *situation analysis* of health sector needs and constraints in Vanuatu, based on existing literature and supplemented by key informant interviews in country. This should include decadal trends in incidence of key indicator diseases and infant and maternal mortality); changes to institutional and financing arrangements for health service delivery (decadal trends in recurrent budget allocation to health as % state budget and % GDP; human resources in MoH, MoH management and governance); and a brief examination, based on existing literature of factors (positive & negative) that drive the observed trends.?

2. DFAT's performance and role
   How have DFAT health investments performed in relation to their original intention to improve health systems and build capacity within GoV?
   What practical things could Government of Vanuatu and MoH do to strengthen the performance of health systems and service delivery in Vanuatu?
   How can DFAT use bilateral and regional investments to support this change, i.e. to strengthen the MOH's leadership and stewardship of the health sector?

3. Modality of investment
   How effective and appropriate has the modality of investing through GOV's system been?
   How could mutual accountability and output-based aid be practically applied in the Vanuatu health sector context in future?

4. Alignment with the Aid Policy Framework
   Is the current suite of health investments aligned with the priorities of the new government, i.e. does it meet the 'four tests' in the Australian government's new aid policy framework.

Recommendations

Based on the outcomes of the review, the team will **make recommendations on how Australia's portfolio of health investments should be refocussed** to ensure maximum strategic impact given reduced resources available for health in the coming period. This should include:

- Setting out proposed objectives for Australia's health investments 2014-18;
- Based on these, the proposed suite of priority investment areas and the broad parameters for each;
- Recommendations for the modality to be used for each investment
- Identification of programs / initiatives that require substantial refocussing and therefore re-design
- Identification of programs / initiatives that may need to be closed
- Recommendations for improvements, if any, to the management of the health portfolio (e.g. strengthening monitoring and evaluation, better access to TA);
- Recommendations, if any, to improve the harmonisation and alignment of the health portfolio in line with aid effectiveness criteria.

Team Composition

The review team will consist of:

- Team leader /health systems specialist, ideally with experience of working in fragile/unstable environments – responsible for coordinating team inputs and finalising written reports
- Governance Specialist (fragile environments) – with expertise in governance/management of the health sector. *especially in fragile environments*;
- DFAT Health Specialist (to join the latter half of the review including discussions with government).

Person Specifications

The **Team Leader / performance management specialist / evaluator specialist** will have the following skills and experience:

- At least 10 years' experience in thematic and sector reviews at country-program level, ideally including developing country health systems, particularly financing, health workforce, health information systems.
- Experience in leading review or evaluation teams.
- Strong knowledge of service delivery issues in resource constrained environments, with ideally experience in decentralised service delivery relating to maternal and child health and communicable disease control (e.g. Malaria).
- Experience in reviewing decentralised service delivery workforces and related organizational systems.
- Expertise in review and evaluation.
- Skilled in quantitative and qualitative data analysis, synthesis and reporting for evaluation.
- Extensive experience in the Pacific region, particularly in Melanesia, would be desirable.
- A thorough understanding of Australia's Aid program, or similar bilateral programs.
- High level analysis and writing skills in English.
- Excellent interpersonal and communication skills, including a proven ability to liaise and communicate effectively with multi-cultural colleagues.

The **governance specialist** will have the following skills and experience:

- Strong expertise in health sector governance, including decentralised management and administration in fragile and unstable environments.
- Experience in quantitative and qualitative analysis, synthesis and reporting for evaluation.
- Excellent knowledge of models of health service delivery. Good knowledge of governance issues related to decentralisation reforms.

The **DFAT Health Specialist** will have the following skills and experience:

- Significant health strategy and policy development experience, preferably gained during overseas assignments.
- Significant program development and implementation experience.
- Understanding of DFAT's Pacific regional health investments.
- High level analysis and writing skills in English.

- Excellent interpersonal and communication skills, including a proven ability to liaise and communicate effectively with colleagues from different cultures.

Team Responsibilities

The **Team Leader / performance management specialist / evaluator specialist** will:

- Plan, guide and develop the overall approach and methodology for the Review.
- Produce a review plan that meets DFAT M&E Standard 5.
- Manage and direct review activities, representing the team and lead consultations with government officials and other donor agencies.
- Write the Review plan, the aide memoire, the draft and final report.
- Lead quantitative and qualitative analysis, synthesis and reporting for the review.
- Manage, compile and edit inputs from other team members to ensure the report meets DFAT M&E Standard 6.
- Produce an aide memoire, synthesise review material into a clear draft and final report that meets DFAT M&E Standard 6.
- Provide timely delivery of high-quality written reports.
- Represent the review team in peer reviews.
- Assess the performance and quality of the Australian Health portfolio's monitoring and evaluation, including utilisation of lessons learned.

The **Governance specialist** will:

- Work with the Team Leader in the management of team inputs, liaison and production of a review plan, an Aide Memoire and Review report.
- Look particularly at the appropriateness of the DFAT health investments in the context of the Vanuatu environment of instability and volatility, and make recommendations which ensure future investments and modalities are appropriate given this context.
- Support quantitative and qualitative analysis, synthesis and reporting for the review.
- Make recommendations on future areas of DFAT support related to strengthening management and governance of the sector.
- Contribute to production of a review plan, an Aide Memoire and Review report.
- Undertake any other tasks as requested by the Team Leader.

The **DFAT health specialist** will:

- Provide advice, context and an understanding of DFAT processes and program management, including regional context.
- Produce technical inputs to and provide comments on the TOR, Review plan, the aide memoire, the draft and final report.
- Participate in working and drafting sessions in the second half of the mission during which recommendations are formulated.
- Participate in debriefing sessions with government and partners.

Timing and Duration

The program review will commence on 20th October 2014 and be completed no later than 20th January 2015. An indicative table of input ceilings is set out below. Timing and duration for the scope of services will be negotiated with the team.

Key Task	Working Days Team Leader (up to)	Working Days – Health Governance Specialist (up to)	Dates (2014)
Review Plan	4	1	October
Document Review	Up to 5	Up to 3	October
National Consultations (including at least 1 provincial visit), and Aide Memoire Presentation	13	13	5-21 November
Presentations in Canberra including preparation	0	2	23-24 November
International travel	4	4	November
Draft report	Up to 8	Up to 5	18 December
Final report	3	2	20 January
Final report following peer review	**2**	**1**	TBC
Sub-total	**39**	**31**	

Duration

The expected period for the review process is from 20th October 2014 to 20th January 2015 with 17 days in country from 5th to 21st November 2014. This review period includes time for Desk review, preparation of the review plan, debrief and presentations in Canberra and preparation of reports.

Outputs and reporting requirements

The following outputs are to be provided in line with the **DFAT Monitoring and Evaluation Standards 2014 Version. Department of Foreign Affairs and Trade, Canberra, Australia** (See: http://aid.dfat.gov.au/publications/Pages/dfat-monitoring-evaluation-standards.aspx):

1. **A review plan (DFAT Standard 5)** – summary of review questions, methodology and report outline, no more than 10 pages in length, to be submitted for agreement with the Australian Aid Program and GoV prior to mission. This should include a description of the approach to the focussed situation analysis, including the questions to be addressed and the information sources.

2. **Aide memoire (DFAT Standard 6)** – summary of key findings and recommendations, to be presented at workshop with key stakeholders in Port Vila, including Vanuatu and Australian Government agencies. This will be towards the end of the week beginning 17th November. Consultants should be prepared to submit data collection and analysis upon request. No more than 5 pages in length.
3. **First draft report and annexes (DFAT Standard 6)** – overall report detailing key findings and recommendations, no more than 30 pages in length (excluding executive summary and annexes). An executive Summary or 4-6 pages should be provided.; The draft will be delivered to the program manager, the Australian Aid Program in Port Vila and the Senior Health Specialist Canberra, by 18 December 2014. (It will be sent to HRF by 15th December.) Feedback from the Aid Program and other stakeholders will be provided by 9th January 2014, and again following a peer review.

4. **Second and final draft report/annexes** – as above, revised to incorporate stakeholder feedback. The Final draft of the report will be due to HRF by 16 January 2015 and to DFAT by Tuesday 20 January.

Each Report should be:

- Of the highest standard of quality, including report content, format, spelling and grammar.
- Prepared in accordance with DFAT Monitoring and Evaluation Standards 2014 Version.
- Provided in electronic format in Microsoft Word.
- Delivered by the required date.

Annex A - Documents for Review

The Australian Aid Program will provide hyperlinks/electronic copies of documents prior to the evaluation commencing. The Australian Aid Program appreciates the documentation is extensive although not exhaustive.

It should be noted that some of these are sensitive, unofficial publications that should not be shared outside the Program Preparation Team. They will be provided for context and reference only. Please consult with the Australian Aid Vanuatu Program Manager before sharing any review documentation outside the team.

Government of Vanuatu documents:

- Vanuatu Priority Action Agenda
- Planning Long Acting Short 2009-2012
- MoH Health Sector Strategy 2010 – 2016
- MoH Healthy Islands Policy
- GoV Public Service terms and conditions manual
- Proposed work-force structure

Government of Australia documents:

- Partnership for Development between the GoA and the GoV (2009)
- Australian aid: promoting prosperity, reducing poverty, enhancing stability (2014)
- Draft Aid Investment Plan (Vanuatu) (2014)
- Quality at Implementation Report for Vanuatu Health Sector (2013)
- Medical Workforce Support Program (Vanuatu) (2014)
- Annual Review of Aid Effectiveness 2012-2013
- Annual Program Performance Report (2013)
- Village Health Worker Program – 2012 Evaluation
- Village Health Worker Aid Post Mapping Report (2014)
- Provincial Health Resource and Asset Review (2014)
- Reproductive, Maternal, Neonatal, Child and Adolescent Health Proposal (2014)

Other documents:

- Public Financial Management review of the MoH (2013)
- Demographic Health Survey (2013)
- Vanuatu Poverty Mapping (World Bank, 2013)

Websites:

- http://aid.dfat.gov.au/publications/Pages/dfat-monitoring-evaluation-standards.aspx
- Government of Vanuatu: http://gov.vu/
- Vanuatu National Statistics Office http://www.vnso.gov.vu
- Australian Government. Department of Foreign Affairs and Trade. Australian Aid website

Annex 2: Documents reviewed

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AusAID	2012	Helping the World's Poor through Effective Aid: Australia's Comprehensive Aid Policy Framework to 2015–16
AusAID	December 2012	2011–12 Annual Review of Aid Effectiveness
AusAID	February 2013	Quality at Implementation Report – Vanuatu Health Sector 2010-2014 (INJ438).
AusAID	July 2013	Assessment of the health sector public financial management systems, Vanuatu (draft report).
AusAID	June 2009	Australian Aid To Health Service Delivery in Papua New Guinea, Solomon Islands and Vanuatu. Evaluation Report.
AusAID	June 2012	Pacific Regional Program Annual Program Performance Report 2011
AusAID	May 2013	Vanuatu Health Sector Delivery Strategy Update
AusAID	ND	Delivery Strategy: Vanuatu Health Sector
Cate Keane	June 2013	Final Report (Draft), Strategic budget advisor – Ministry of Health Vanuatu
Cate Keane	November 2012	Final Trip Report (Draft), Strategic budget advisor – Ministry of Health Vanuatu
Cate Keane	November 2012	Medium Term Expenditure Framework Analysis Report, MoH Vanuatu
Dawson et al.	2011	Human resources for health in maternal, neonatal and reproductive health at community level: A profile of Vanuatu.
DFAT	December 2013	Pacific Regional Health Program Delivery Strategy 2013-2017
DFAT	February 2014	Annual Review of Aid Effectiveness 2012-201
DFAT	January 2014	Aid Program Performance Report 2012−13 Vanuatu
DFAT	March 2014	Quality at Implementation Report – Vanuatu Health Sector 2010-2015 (INJ438)
DFAT	June 2014	Australian aid: promoting prosperity, reducing poverty, enhancing stability
DFAT	May 2014	Direct Funding Agreement between Government of Australia and the Government of Vanuatu in relation to Health Sector Support Grant.
Gillian Biscoe et al	September 2014	Medical Workforce Support Program (Vanuatu): Investment Design.
Glenn Lavarack and Linda Westberg	March 2013	Independent Evaluation of the Village Health Worker Program, Vanuatu. Final report.
Global Health Workforce Alliance	ND	Re-energizing the HRH agenda for a post 2015 world – responding to the needs of fragile states.
GoV	2009	Planning Long, Acting Short: The Government's Policy Priorities for 2009-12

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GoV, MFEM	June 2006	Priorities and Action Agenda 2006 – 2015
GoV/MFEM	2013	Government of Vanuatu Budget 2014
GoV/MoH	2010	Health Sector Strategy 2010-2016
GoV/MoH	2011	National Policy and Strategy for Healthy Islands – 2011-2015
GoV/MoH	June 2004	Vanuatu Master Health Services Plan 2004-2009
Governments of Australia and New Zealand	ND	Australia - New Zealand Partnership for Development Cooperation in the Pacific
Governments of Australia and Vanuatu	May 2009	Partnership for development between the Government of Australia and the Government of Vanuatu
Heidi Tavakoli et al	May 2013	Using aid to address governance constraints in public service delivery
HIS Unit	July 2014	Health Information Unit Bulletin No 2, MoH.
HIS Unit	October 2014	Health Information Unit Bulletin No 4, MoH.
HIS Unit	September 2014	Health Information Unit Bulletin No 3, MoH.
Ian Anderson for World Bank	June 2013	Health Financing in Vanuatu: Challenges and Options
Kathy Whimp	May 2012	Vanuatu Nursing Support Concept Note
Kathy Whimp,	September 2010	Report on support to financial management in Ministry of Health July 2010
Linda Westberg	July 2013	Vanuatu Village Health Worker Program 2014-2016: Program description
M. Harradine	July 2008	Analytical notes – review of financial management of aid donor funding
Marcus Cox et al.	April 2007	The unfinished state: Drivers of change in Vanuatu
MFEM	January 2012	Public Expenditure Review, Health Sector 2011
Miriam Lum On et al.	November 2009	Health information systems in the Pacific: a case study of Vanuatu
MoH	2014	Malaria Action Plan: Vector borne disease control program.
MoH	2014	National malaria strategic plan, Vanuatu 2015-2020
MoH	July 2015	Finalising the 2015 Budget Estimates
MoH	October 2013	Vanuatu Malaria Programme Performance Review 2013
MoH	October 2014	Ministry of Health Monthly Financial Report

Author	Date	Title
MoH Assets and Infrastructure Unit	August 2014	MOH Provincial Resource Review
Pacific Islands Forum Secretariat	August 2012	2012 Pacific Islands MDG Tracking Report
Prime Minister's Office, GoV	September 2010	MDG 2010 Report for Vanuatu
Public Service Commission, GoV	2008	Public Service Staff Manual
Raul Schneider	September 2014	Tanna Helti Komuniti Project: End of Project Evaluation
Rebecca Dodd, DFAT.	September 2014	Health Sector Mission to Vanuatu Back to Office Report
Rob Condon	July 2013	Health Workforce Development in the Pacific: Presentation at 10th Meeting of Pacific Health Ministers, Apia, Samoa.
SCA	September 2014	Vanuatu Village Health Worker Program Inception Report: January – August 2014
UNFPA, UNICEF, WHO.	July 2014	Improving health outcomes for women and children in the Pacific. UN Joint Programme on reproductive, maternal, newborn, child and adolescent health (Kiribati, Solomon Islands, and Vanuatu)
UNICEF	January 2012	Pacific Immunization Programme, 2011–2012 Strengthening Immunization in The Context of Multi-Donor, Multi-Country, Multi-Year Programming. Final Report
UNICEF	May 2014	Project Concept Note - UNICEF Vanuatu EPI proposal
Vanuatu National Statistics Office	February 2013	Vanuatu Demographic and Health Survey 2013: Preliminary Report
Vanuatu National Statistics Office	November 2014	Vanuatu Socio economic report
WHO	May 2013	Vanuatu NCD Risk Factors STEPS Report
World Bank	June 2014	Vanuatu Health Sector Record of Mission: World Bank Health Team Visit 19 to 30 May 2014
World Bank	March 2014	Vanuatu Health Sector Record of Mission: World Bank Health Team Visit 17 to 28 February 2014
World Bank	October 2014	Update for Health Development Partners Meeting, Thursday, 30 October, 2014.
World Bank	September 2014	Vanuatu Health Sector Record of Mission: World Bank Health Team Visit 18 to 29 August 2014

Annex 3: People consulted

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Hilton, Caroline. National VHW Program Co-ordinator, SCA.

Ivatts, Susan. World Bank.

Jackson, Christine. Maternal & Child Health Consultant

Lakaleo, Henry. Budget and Accounts Officer, MoH

Latu, Rufina. Medical Officer/Health Systems Development, WHO Vanuatu

Leona, Richard. Clinician, Port Vila Central.

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