



**The Australian Government's
Fiji Program Support Facility**

STRATEGIC REVIEW OF THE FIJI HEALTH PROGRAM

FINAL REPORT

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STRATEGIC REVIEW OF THE FIJI HEALTH PROGRAM (FHP): KEY FINDINGS AND RECOMMENDATIONS

Acronyms

AHC	Australian High Commission, Suva
AIFFP	Australian Infrastructure Financing Facility for the Pacific
CSO	Civil Society Organisation
CCDR	Climate Change and Disaster Risk Reduction
DFAT	Department of Foreign Affairs and Trade
FHP	Fiji Health Project
GEDSI	Gender Equality, Disability and Social Inclusion
IPC	Infection Prevention Control
MERLA	Monitoring, Evaluation, Research, Learning and Adaptation.
MHMS	Ministry for Health and Medical Services
NHSP	National Health Strategic Plan
NCDs	Non-communicable diseases (diabetes, heart disease, cancer etc)
NGOs	Nongovernmental organisations
PSH	Permanent Secretary for Health
PCC	Project Coordinating Committee
PRF	Preparedness and Response Fund
RACS	Royal Australian College of Surgeons
TA	Technical Assistance
UORs	Unusual occurrence reports

Currencies

All \$ are current Australian dollars. Fiji dollars are shown as FJD.



Executive Summary

Section 1: the strategic context.

Fiji faces a number of public health, and public financing challenges. Fiji achieved notable success in terms of the main health (and other) Millennium Development Goals: see Annex 1. However, Fiji is facing a particular challenge in terms of the rapid rise of often expensive to treat non-communicable diseases (NCDs) including especially diabetes, heart disease and cancers. Fiji also faces some important public financing challenges. For example, per capita expenditure on health, and total expenditure on health as a share of GDP, has been noticeably, and consistently, lower than the average for upper-middle income countries globally. The population is ageing, which is likely to increase the incidence of expensive to treat NCDs. Further details are in Annex 1. Also, in terms of the strategic context it is worth noting that both Australia and Fiji are scheduled to have national elections this year. Either or both elections may result in changed in policies and priorities for the health sector in Fiji. Section 1 elaborates on the Strategic Context.

Section 2: background to the Fiji Program Support Facility and the Fiji Health Program (FHP).

The Fiji Health Program (FHP) is an integral part of the broader Fiji Program Support Facility (“the Facility”). The FHP works in partnership with the Ministry of Health and Medical Services (MHMS) to address strategies in the Fiji National Health Strategic Plan (NHSP). FHP usually invests about \$ 5 million per year (pre COVID 19) aimed at strengthening health services through a range of activities and projects. The assistance is delivered through modalities including technical advice, procurement of services and goods, capacity building and training support, and grants to civil society organisations. COVID 19 required FHP to undertake major, quick and nimble scaling up of a surge response, and adjustments to programs. Section 2 elaborates.

Section 3: objective, methods, strengths and limitations of the Review.

The Review had an overarching objective. As set out in the Terms of Reference, this was “To review the scope of Australia’s current bilateral health assistance to Fiji and provide advice on FHP’s Phase 2 assistance (2022-2024) based on lessons learnt during Phase 1 (2017-2021) and evidence of what is, or is not, working well and suggest policy and program focus areas for the remaining period of the program. It is therefore a review and “refresh” of the design, not a “redesign”. The Strategic Review involved a combination of qualitative and quantitative methods, including in-country consultations with over 50 key stakeholders during April 2022. The Review involved six screening criteria to assess possible future areas and priorities up until the end of Phase 2 in December 2024. There were a number of strengths, and limitations, to the Review process. Section 3 elaborates.

Section 4: key findings

Leadership and Management

The FHP has clearly been well-managed during the challenging COVID 19 emergency period as demonstrated by the outputs and outcomes, but there has been some noticeable turnover of staff over the years. The Facility, and FHP, have both experienced several changes in management teams in Phase 1 and emergency Phase 2021/2022. In addition, frequent changes in senior health leadership in the MHMS have also affected programme progress and implementation: there have been four changes in the Permanent Secretary for Health in the last 5 years.

The Facility itself

There are some direct and important synergies between the various components of Facility. This includes for example health services for children under the FHP and the corresponding school-based education programs under the Facility. The Fiji Health Program (FHP) itself: “what is working well” and “not working well”.

The TORs tasked the Review to assess what is working well; not working well, lessons from Phase 1 and recommendations”: Annex 2 provides a detailed, activity by activity, summary addressing each of those issues.

Six things are clearly “working well” in the FHP:

- FHP has a demonstrably effective, efficient, accountable and above all timely and “nimble” response to the COVID 19 emergency.
- The overall structure is appropriate and conducive to partnerships. FHP is physically embedded with MHMS which facilitates collaboration between MHMS and FHP in many areas. FHP also makes good use of local expertise.
- Individual programs and activities have a direct, clear and measurable output / outcomes focus but are also linked to broader, longer-term, overall institutional strengthening (although more could and should be done in terms of capturing and thinking about the actual *financial and broader economic costs* of particular interventions so as to maximise the effectiveness, efficiency, equity and sustainability of not just FHP investments but the priorities and resource allocation of MHMS, and its development partners as well.
- There are direct, significant, and tangible benefits for affected communities in terms of gender equality, disability, and social inclusion (GEDSI)¹, and FHP resources give GEDSI issues priority (although more still needs to be done: see third bullet point in the next separate paragraph)
- There is coherence and complementarities within the FHP itself. For example, initiatives on supply chain reform improve the effectiveness, efficiency and equity of disease specific programs also being supported by FHP. Also, increasing the prevention and early treatment of NCDs, including diabetes, will reduce the currently very high rate of diabetic related amputations – one of the highest rates per capita in the world – which feeds a pipeline of people with otherwise preventable causes of living with a physical disability.
- Value for Money, including good use of the Monitoring Evaluation and Learning (MEL) to learn lessons and provide an evidence base for improving the program outcomes, outputs and risk management.

There are some things within the direct span of control of FHP that are not working as well as they could be and should be addressed in the remaining period of Phase 2. These include:

- Some strategies requested by MHMS and funded / supported by FHP do not get traction within MHMS after the strategies are completed, resulting in loss of impact by FHP - and within MHMS - therefore potentially undermining the overall effectiveness, efficiency and value for money of the FHP program unless addressed.
- FHP is good at systematically capturing inputs, outputs and outcomes, but there are important missed opportunities to then also capture the financial and other resource costs

¹ Gender, disability, and lack of social inclusion are not, of course, necessarily separate domains. Indeed, they can often overlap: referred to as “intersectionality”. For example, an elderly widow, living with a disability, in a poor and remote area and / or from a marginalised ethnic group may experience hardship as a combined result of gender, disability and lack of opportunities for social inclusion.

involved in implementing an FHP – and more importantly an MHMS - activity. This is important because having accurate, up to date, information on the true financial and broader resource costs (including health worker time) is central to improving the overall effectiveness, efficiency, equity and sustainability of the public health system; the all-important trade-offs between competing priorities; and the potential cost-effectiveness – even *cost-saving* – opportunities of certain interventions. The Permanent Secretary of the Ministry himself referred to the potential cost-effectiveness and *cost-saving* interventions of secondary prevention ².

- As noted in the preceding paragraph, one of the things that is “working well” is the ability of FHP to deliver direct, significant, and tangible benefits to affected communities in terms of gender equality, disability, and social inclusion (GEDSI). Nevertheless, there is scope to assessing, and then addressing, the extent to which GEDSI initiatives supported by FHP are then being institutionalised and sustained within MHMS, and are then meeting the needs of women and girls, people living with disabilities, or the poor and marginalised. See separate reports on GEDSI. Note also that FHP has said that it will be undertaking a more detailed GEDSI analysis later in 2022.

There are also some issues that are not working particularly well that are beyond the direct span of control of FHP itself. These will require attention in terms of the overall governance arrangements. They include:

- **Donor coordination is weak**, thereby making it difficult to determine if Australian aid funding through the FHP is being used to best effect. This is ultimately a governance issue requiring discussion between the Australian High Commission and the Secretary of MHMS.
- **The FHP may now be becoming a victim of its own success as a result of its effective, quick and nimble response to COVID 19:** there is now a risk that some within MHMS may see the FHP as the “go to” agency when any problem arises so as to avoid and bypass using Fiji’s own procedures which are often slow.
- **The primary goal of the FHP.** It is *because* the FHP is now starting to be seen as the “go to agency” to get things done quickly that a question now arises: is – or should – the FHP essentially meant to focus on an agreed set of strategic objectives, while retaining a quick response mechanism in emergency and non-emergency times, or is – and should – the focus of the FHP to be essentially a quick response mechanism, with strategic objectives and goals a more secondary objective. The Review firmly supports the former approach. The FHP should continue to have strategic focus, directly aligned with the strategic priorities of MHMS, and consistent with Australian Government and DFAT priorities at its core: for example around 80% of total program expenditure. But, because FHP is a “facility” and not a traditional project, it should *also* be able to consider and respond promptly to priority and urgent requests from MHMS in exceptional – eg emergency – circumstances.

² There is an important distinction in public health, and public finance, between primary prevention and secondary prevention. Primary prevention is generally defined as interventions that prevent or delay the *onset* of a disease. However, secondary prevention is generally defined as interventions that prevent or delay the development or progression of a disease. Because people have already acquired a disease - for example diabetes – the pool of people affected is (somewhat) narrower than the total population (depending upon the effectiveness of initial population screening). That in turn means it is potentially easier and less expensive in terms of scarce financial and human resources to target that group and provide services that can reduce the progression of that disease to more medically complex and more expensive interventions.

Section 4: conclusions and summary of recommendations

It is for MHMS, DFAT, and the FHP to decide what existing activities should be retained and / or expanded and what activities could be phased out or transferred across to MHMS. This Report and Annex 2 provides detailed assessments that forms an important part of the evidence base to inform that discussion. The following is a summary of the key findings and recommendations. Details are in Annex 2.

The Review identifies a series of **programs to retain / strengthen**. These include:

- **Digital and health information.** The Permanent Secretary for MHMS explained this is a top priority because it is “the backbone” of the whole of the health system, generating data and evidence that then drives priorities and resource allocations.
- **Digital and health information with respect to NCD prevention and control** would be an obvious strategic area for scaling up given the high and growing burden of NCDs in Fiji. A stronger, digitally based, health information system could provide the evidence base for identifying what works, when, why, for whom at what cost in terms of prevention and treatment of NCDs (as well as other health challenges), thereby improving the effectiveness, efficiency, equity and sustainability of the Fiji health system.
- **Supply chain reforms** is another particularly strong area of FHP engagement to date. This directly and visibly improves overall health services because drugs and equipment can be released on time and with minimum delay, reducing the risk of stock outs and out of date drugs. Supply chain reform is of course linked to digital and health information (see preceding bullet point). And as with digital and health information, supply chain reform can directly and substantively improve the overall effectiveness, efficiency, equity, and sustainability of the health system. It can also directly contribute to patient safety (eg minimising risk of out of date drugs) and can be a sound investment in disaster preparedness (eg rational pre-positioning of essential drugs and equipment)
- **Clinical governance** at the hospital level is a potentially important area because of its direct effects on improving patient safety. It also has the advantage that by tracking, and averting, otherwise preventable mistakes it directly improves the the effectiveness and efficiency of the hospital system and reduces otherwise avoidable costs such as treating complex hospital acquired infections, requiring patients to undergo additional surgery or stay at the hospital longer than was necessary.
- **Disability and rehabilitation** is a recommended area because it is an area of particular priority and comparative advantage for DFAT. Among other things, this is also a growing area in Fiji: Fiji now has an average of 3 diabetic-related amputations per day as a result of the rise of NCDs, one of the highest rates per capita in the world. This, in turn, generates an otherwise preventable source of people living with a disability.
- The **expanded program of immunisation (EPI)** continues to be a useful activity to support at this stage, as it has broader impacts and benefits than procurement of vaccines. Having said that, immunisation is such a basic and fundamental part of any public health system, especially for an upper-middle income country like Fiji, that it is timely and appropriate to now have a longer term (eg if necessary beyond December 2024) for FHP to progressively transition and transfer that program across to full ownership and responsibility to MHMS.

There are some areas to possibly phase down. COVID-19 is one area that can transition away from an emergency response program, while incorporating and mainstreaming the many lessons learned about COVID 19 into the normal programs of FHP and MHMS. Public financial management is unquestionably an important part of health system strengthening and ultimately achieving progress in terms of Universal Health Coverage. However, the World Bank and / or WHO financing and economics area in Geneva have a stronger comparative advantage in this area than DFAT. If requested by MHMS, it always remains possible, of course, for DFAT to help finance specific analytical work the World Bank and / or WHO to undertake public expenditure reviews of health expenditure or specific costing scenarios required for increasing progress on Universal Health Coverage.

There are some possible new areas to invest in. During the review period, the Permanent Secretary for Health identified Divisional Command Centres as a priority under the MHMS Remodelling Strategy. Further details in Annex 2. There was not sufficient time during the review period itself to assess this suggestion, so FHP and DFAT will need to continue to have discussions with MHMS about what, specifically, might be involved and what is Australia's / FHP's specific contribution and value added in being involved.

There are currently some areas which, while unquestionably important, are not recommended for major investment. Activities that may well fall into this category is providing significant support for mental health¹⁰ or for climate change¹¹. Small scale, basic routine infrastructure, including rehabilitation, is eligible where it is demonstrably value for money and / or urgent.

There are some areas where this Review recommends FHP transition existing programs across to MHMS over the longer term (eg beyond December 2024). Midwifery training is something that Fiji, as an upper-middle income country with good educational facilities and staff, is capable of managing and financing by itself. That is particularly the case given that midwifery training is a basic and central part of the health workforce system. Similarly, given that immunisation is such a basic and fundamental part of a public health program in any country, and Fiji is already an upper-middle income country, there should be an agreed, longer-term (even beyond December 2024 if necessary) strategy and roadmap for FHP to transition support for the Expanded Program of Immunisation (EPI) across to MHMS.

FHP does not currently invest in large infrastructure, but if requested to do so would need to carefully balance the relative advantages but also disadvantages. FHP has invested in health facility infrastructure to good effect: the quick infrastructure upgrades at the Nadi Border Health Protection Unit including major renovations, installation of generators and IT as part of the urgent COVID 19 response is just one example. However, FHP should be cautious if requested itself to fund very large infrastructure – eg hospitals – as the “opportunity cost” (that is, what those funds could have achieved instead in terms of technical assistance and institutional strengthening) is likely to be very high. Importantly, if FHP is required to fund large and expensive infrastructure there should first be a clear and agreed MHMS protocol – and budget – for preventive maintenance. There may well be better and more appropriate funding windows than FHP to fund large infrastructure, including the recently expanded Australian Infrastructure Financing Facility for the Pacific. That would thereby enable the FHP to focus its resources on what it does best, including demonstrating new and more effective, efficient and equitable approaches to public health that can then be scaled up by MHMS itself.

There is not a sufficiently strong evidence base for the Review to make a specific recommendation on future financing for the FHP. However, MHMS did indicate likely future priority areas where it would like Australian support. More specifically, the Permanent Secretary of MHMS explained that digital technology and communications should be the central “backbone and spine” of the health system. The Permanent Secretary for Health identified Divisional Command Centres as a priority under the MHMS Remodeling Strategy.

1. The strategic context to the Fiji Health Program

Fiji faces a number of public health challenges. Fiji achieved notable success in terms of the main health (and other) Millennium Development Goals: see Annex 1. However, Fiji is facing a particular challenge in terms of the rapid rise of non-communicable diseases (NCDs) including especially diabetes, heart disease and cancers. NCDs now account for 8 of the top 10 leading causes of death in Fiji and the incidence is increasing (1). Many of the NCD related deaths and disabilities occur in the working age population with consequential implications for national economic growth. There are an average of 3 diabetic related amputations every day in Fiji: the highest rate per capita in the world. NCDs, including diabetes, and the risk factors for NCDs, including obesity, magnify or complicate health outcomes and health expenditure when combined with COVID 19. Further details in Annex 1.

Fiji also faces some important public financing challenges. For example, per capita expenditure on health, and total expenditure on health as a share of GDP, has been noticeably, and consistently, lower than the average for upper-middle income countries globally. The population is ageing, which is likely to increase the incidence of expensive to treat NCDs such as diabetes and cancer, while at the same time reducing the share of the workforce able to generate tax revenues for government.

As an island country, Fiji is vulnerable to external economic shocks and natural disasters: the growth in GDP per capita is noticeably lower – and more volatile – in Fiji than in upper middle-income countries globally. The World Bank concludes due to COVID-19 that “Fiji’s economic growth contracted by 19 percent in 2020; one of the worst downturns in growth in the world, and the most severe in the country’s history”. Estimates based on modelling suggest that health spending per person in Fiji could increase from \$US 195 per capita in 2019 to \$US 304 per capita by 2050 (in current 2020 \$US), still well below the estimated per capita spending of upper middle income countries globally of \$US 1001 per capita (2). Further details are in Annex 1.

Both Australia and Fiji are scheduled to have national elections this year. Either or both elections may result in changed in policies and priorities for the health sector in Fiji.

2. Background to the Fiji Program Support Facility and Fiji Health Program.

An aid program “facility” has a different purpose and structure to a traditional project. A “facility” can be defined as “an aid delivery mechanism that provides flexible (adaptive and responsive) services managed in an integrated way. Objectives (or end-of-facility outcomes) are specified, but the pathways to deliver them are left unspecified”(3). DFAT management has noted that facilities can be a particularly appropriate, effective and efficient form of development assistance³ in the right circumstances and if well designed and well managed (4).

The Fiji Program Support Facility (“the Facility”) was established in 2017 to support and implement Australia’s aid programs such as health, education, emergency preparedness and response and governance in Fiji. More specifically, as described in the Facility’s own website⁴:

³ The DFAT Management response to the Review of Facilities noted, among other things, that “The review found facilities are a highly relevant model for effectively delivering Australian aid. Facilities enable a flexible, adaptive, and responsive link between technical and political engagement to optimise the impact of aid. The review found that facilities are achieving results on the ground in a range of countries where we have larger aid programs (from Indonesia to Timor Leste and Solomon Islands). The review noted that there have been administrative savings. Efficiencies have been achieved by reducing overhead costs, vehicle fleets and project transaction costs. Some facilities have consolidated smaller aid projects, which has helped to meet the aid program’s strategic target to reduce the number of individual aid investments by 20 per cent.”

⁴ Available at <https://www.tetrattech.com/en/projects/fiji-program-support-facility>

The facility, managed by Tetra Tech on behalf of the Australian government, implements Australia's aid programs in the health, governance, civil society engagement, and emergency preparedness and response sectors in Fiji, and the Australia Awards and education programs in both Fiji and Tuvalu. These programs will represent one third of Australia's annual bilateral aid to Fiji, amounting to AUD\$66 million from 2017 to 2021.

The Facility integrates cross-cutting themes, including gender equality, disability and social inclusion, and Climate Change and Disaster Risk Reduction (CCDR), across sectoral programs. The Fiji Health Program (FHP) is an integral part of the Facility, and accounts for 27 per cent of the Facility's total overall budget. The FHP works in partnership with the Ministry of Health and Medical Services (MHMS) to address strategies in the Fiji National Health Strategic Plan (NHSP). Phase 1 of the FHP was aligned to the NHSP 2017-2020 and for 2021-2022, the FHP Work Plans sought to address the new NHSP 2020-2025 three strategic pillars outlined below:

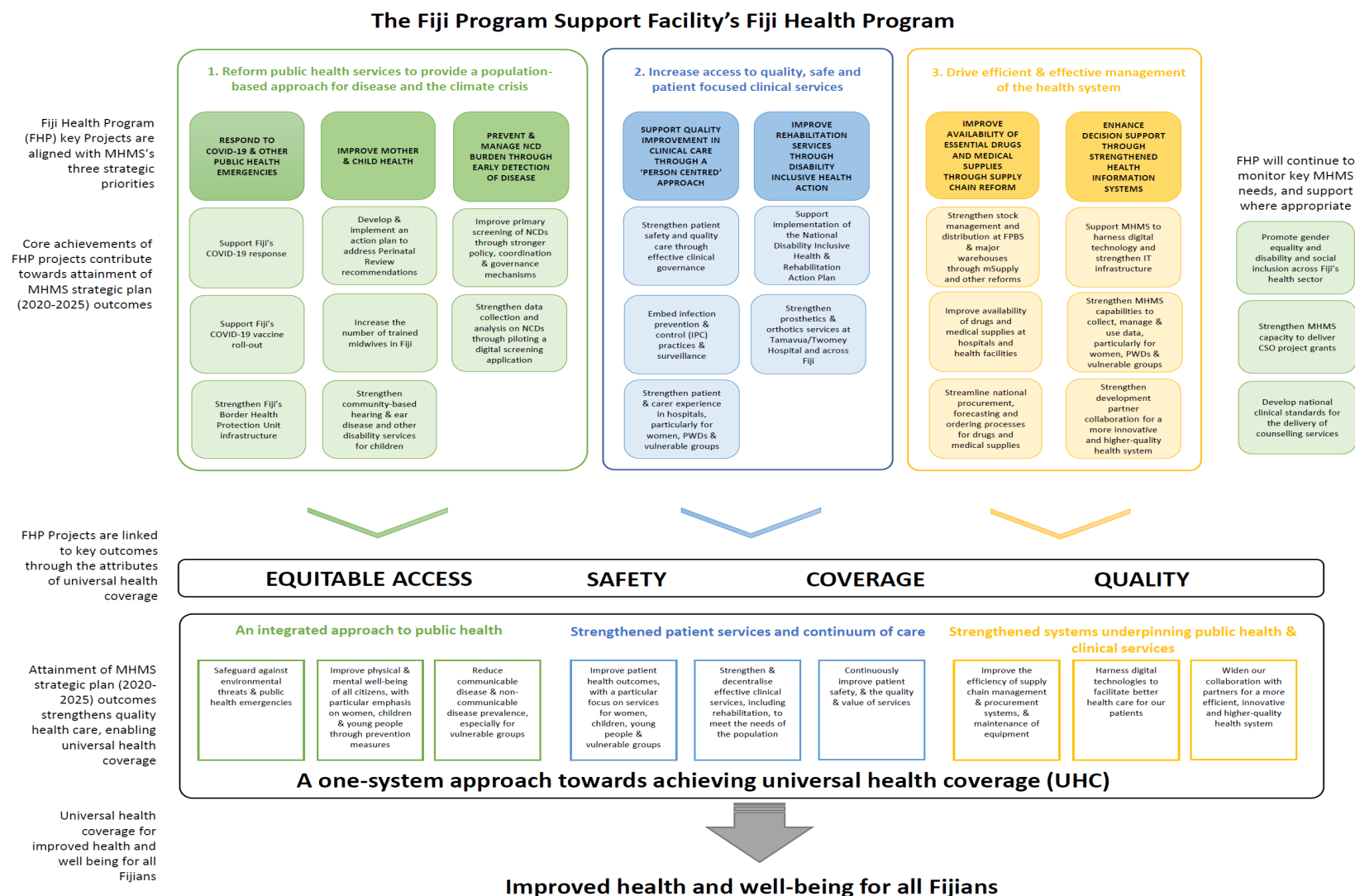
1. Reform public health services to provide a population-based approach for disease and the climate crisis;
2. Increase access to quality, safe and patient focused clinical services; and
3. Drive efficient & effective management of the health system.

FHP invests about \$ 5-6 million per year⁵ aimed at strengthening health services through a range of activities and projects. The assistance is delivered through modalities including technical advice, procurement of services and goods, capacity building and training support, and grants to civil society organisations. FHP aims across all projects and areas of support to identify ways to support MHMS to improve gender equality and disability and social inclusion in health services, making them more accessible and higher quality to those who need these services the most. A separate report on FHP and GEDSI was commissioned as part of this Review and is available separately.

Because it is part of a “facility”, FHP supports a range of activities and investments requested by MHMS and DFAT. In Phase 1 of the investment, FHP supported and implemented 35 activities under the 5 strategic objectives of the NHSP 2016-2020. There were 15 Technical Assistants (international and local) and five administrative staff engaged in the programme. In 2021/2022 there are at least 19 projects or programme activities supported by the FHP aligned to the three strategic pillars of the NHSP 2020-2025. The rapid emergence and significant health and economic impact of Covid-19 required a significant resource commitment and allocation. For the financial year, FHP provided \$2.4M or 46% of its \$5.2M budget to Covid-19 activities. Diagram 1 provides a summary of current FHP investments.

⁵ Pre-COVID-19. Expenditure did increase significantly as part of the surge response to COVID-19

Diagram of Fiji Health Program current activities.



3. Objective, methods, strengths, and limitations of the Review.

The TORs for this Strategic Review state that the overarching objective is “To review the scope of Australia’s current bilateral health assistance to Fiji and provide advice on FHP’s Phase 2 assistance (2022-2024) based on lessons learnt during Phase 1 (2017-2021) and evidence of what is, or is not, working well and suggest policy and program focus areas for the remaining period of the program. It is therefore a review and “refresh” of the design, not a “redesign”. The Strategic Review, which was conducted in-country in Fiji over the period 14-24 March 2022, is timely. That is because the disruptions to MHMS, and FHP, programs caused by COVID 19 are now starting to ease. Attention can now move from an emergency response phase and return to a more focused program of strategic and coherent interventions to be supported up until 31 December 2024 when the current FHP Phase 2 ends.

The strategic review methodology involved a combination of qualitative and quantitative methods. These included:

- A desk-based review of relevant documents.
- Development of the evaluation plan for FHP / DFAT information and endorsement.
- Consultations with DFAT, Fiji Health Facility, Fiji Health Programme staff, and key stakeholders involved in implementation of the programme in Fiji through informant interviews, meetings and focus group discussions.
- Site visits to the Colonial War Memorial Hospital (CWMH), Tamavua Twomey Hospital (TTH) and Fiji Centre of Disease Control (FCDC).
- Consultation with a key UN partner of the World Health Organization.
- Collation, synthesis and analysis of relevant information including health statistics and data, when available.

The Review used five criteria to “screen” past, current and possible future programs against the TORs direction to identify “a more focused program”. Those five screening criteria were as follows:

- All FHP activities need to be **clearly and directly aligned to MHMS stated priorities** as outlined in the national health strategic plan 2020-2025.
- Assessing the root cause of **why MHMS itself cannot do this activity themselves?** Fiji is an upper-middle income country ⁶, with many well-trained and competent officials. Investigating *why* MHMS is requesting a particular type of support from FHP then gives an insight into the *potential* value-added and justification for Australian development assistance. There is then a likely strong business case for when MHMS is requesting technical or financial assistance to scale up a *new intervention*. This could include for example new forms of cancer screening and / or building institutional capacity in key areas such as digital technology and use. Conversely, requests for FHP assistance where MHMS clearly has the capacity – including routine maintenance of buildings – would need a much stronger justification and explanation for support from FHP.
- Matches **DFAT’s priorities** (for example disability and rehabilitation) and Australia’s comparative advantage.

⁶ The World Bank classifies a country as Upper Middle Income if the Gross National Income per capita in 2020 was between \$US 4096 - \$US 12,695. For further details see: <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519>

- The FHP makes a **visible and direct** contribution to extending or improving the quality of essential health services while simultaneously helping to **transform** the health system and offering the ability, over time, for FHP to **transfer and transition** its activities across to MHMS. This requires realistic – and in some cases modest – expectations as to what is achievable and realistic given the resource and time available.
- What is the “**real**” **purpose and value added of FHP**? This emerged as a key issue during the course of the Review, particularly given the experience of the emergency response to COVID 19. Is the “real” purpose of FHP to be *essentially* a quick response mechanism, with strategic focus a welcome but secondary consideration? Or is the real purpose of FHP to have a level of strategic focus and outcome, but to also be responsive to a wide range of requests even in a non-emergency situation? Section 4 below provides the findings of the Review team on this issue.

In addition, the Review then used the DFAT four aid tests⁷ that it applies to the designs of all aid programs in all countries as a final screening device. This did not change the substance of the findings or recommendations. It did, however, serve as an important reminder that Australia’s development assistance programs do need to *explicitly* explain the contribution to “promoting growth and reducing poverty” (italics added for emphasis). Poverty is clearly a multi-dimensional situation, not simply related to income levels. Poverty and hardship also includes having access to essential health services, and avoidance of significant diseases that can limit or destroy individual and household opportunities for employment and income. There are some missed opportunities for FHP to make the case that it is contributing not only to improved health outcomes but reduced poverty as well.

Strengths and limitations of the Strategic Review

There are a number of strengths to the Review process. The three-person Review team⁸ was well-balanced in terms of skills and experience, including a previous Permanent Secretary of MHMS, and a GEDSI expert, both being Fiji nationals. The Review team was able to have a wide range of in-country interviews⁹. The Review team had site visits to two hospitals being supported by FHP as well as the Fiji Center for Disease Control. Another strength of the Review is that virtually all ¹⁰ activities are clearly and directly linked to MHMS Strategic Plan, making it quick and easy to confirm all activities were MHMS priorities. Importantly, the FHP, and the Facility more generally, has a strong Monitoring Evaluation and Learning (MEL) program. More specifically, the program currently allocates \$399,000 or 6.4% of the \$6.2 million budget (increased recently in response to COVID 19). That 6.4% allocation to MEL sits comfortably within the 4%-7% range now recommended by DFAT for investing in MEL (5). The 6.4% is also appropriate given the range of activities requested of FHP, and the potential for generating lessons and insights from that range that can inform and influence MHMS’ own programs. Importantly, the strong MEL has been able to generate data relevant for this Review (albeit not as much as originally intended due to program disruptions caused by COVID 19: see next paragraph).

But there are limitations to the review. COVID 19 caused extensive delays, disruptions, and postponement of virtually all FHP (and MHMS) activities for many months at a time. That means it is hard to assess FHP against original goals due to COVID-19 induced delays and postponements. It is also hard to track FHP contributions and impact against MHMS’ own M&E framework or MHMS budget priorities due to significant gaps and weaknesses in those systems.¹¹ Finally, the Review is focused on

⁷ The four aid tests are: (1) pursuing national interest and extending Australia’s influence (ii) impact on promoting growth and reducing poverty (iii) Australia’s value-add and leverage (reflects Australia’s relative advantages and (iv) making performance count (stronger focus on results and value for money, drawing on previous sector performance, including other donor experience).

⁸ Ian Anderson PhD, Team Leader; Dr Lepani Waqatakirewa, Public Health Specialist; Ms Aliti Vunisea, GEDSI Specialist

⁹ This includes the Secretary of MHMS and Chief Medical Adviser; 8 heads of units and 2 medical superintendents; 7 development partners (WHO, Doherty Institute, Beyond Essentials, Project Heaven, mpower Pacific, Frank Hilton, Motivation Australia, Health Informatics; and more than 50 officials and individuals; the majority of whom were female).

¹⁰ The MHMS Strategic Plan did not, of course, anticipate COVID 19.

¹¹ The MHMS Monitoring and Evaluation Framework has not been endorsed by MHMS. The Budget for the health sector is organised more along the lines of cost centres (eg amounts spent by individual hospitals) rather than program budgeting against key public health challenges.

possible adjustments to the program over the coming 33 months from April 2022 to end December 2024: a *relatively* short period that limits the scope for any major change, if that was considered necessary.

4. Key findings

Leadership and Management

The management of the COVID 19 response was particularly effective, efficient, “nimble” and accountable, however Facility and FHP Programmes have both experienced several changes in management teams in Phase 1 and emergency Phase 2021/2022. Frequent changes in Team Leaders during the first five years of the programme posed challenges to management. This was compounded by a relatively frequent turnover of TA and international staff engaged across the various programme areas. Changes of Team Leaders and TA can incur time delays in programme decision-making and implementation as international engagement processes could take up to 3 months to complete.

In addition, frequent changes in senior health leadership in the MHMS have also affected programme progress and implementation. Over the past five years since the FHP commencement, appointments to the Permanent Secretary for Health (PSH) position changed four times with each PSH identifying and prioritising different aspects of health care services and delivery. Furthermore, in 2018 the Fiji Government implemented an organisational and management reform across the public sector. For the MHMS, the restructure resulted in several key changes including the removal of positions for the Director Public Health and Director Hospital Services for the creation of one Chief Medical Adviser post. The impact of these changes in relation to the health service and health system including FHP is yet to be fully evaluated and known.

The Facility itself

The Fiji Program Support Facility (“The Facility”), of which FHP is part, is not part of the Review process but some general comments are still relevant. The Review found there are some direct and important synergies between the various components of Facility. For example, the FHP is screening and treating hearing and ear care, including among school children. This provides complementarities and coherence to the similarly important “education” component of the Facility. The Facility also has a comprehensive “GEDSI tracker” that systematically collects and analyses data on gender equality, disability inclusion, and social inclusion (see separate report on GEDSI undertaken as part of this Review for details). The Facility itself provides an overarching Monitoring Evaluation and Learning (MEL) framework. The Facility is finalising an overarching policy on achieving value for money. The Facility was able to utilise an unallocated, emergency fund and redeploy funds to FHP during the COVID 19 emergency. The Facility provides a series of “back office” support to both the FHP and other parts of the Facility, thereby achieving economies of scale.

The Fiji Health Program (FHP) itself: “what is working well”.

The TORs tasked the Review to assess what is working well, not working well, lessons from Phase 1 and recommendations: Annex 2 provides a detailed, activity by activity, summary addressing each of those issues. The following therefore provides a summary overview.

Six things are clearly “working well” in the FHP. Annex 2 provides details, but the issues can be summarised as follows:

1. The FHP was demonstrably effective, efficient, accountable and above all timely and “nimble” response to the COVID 19 emergency. FHP enabled MHMS to maintain – and quickly expand – essential health services during the pandemic emergency. Among other things, FHP quickly engaged 120 surge positions (75% female) to support the COVID 19 vaccine roll out; quickly supported major and essential infrastructure upgrade of Fiji’s border health protection unit near the main international gateway to Fiji and Nadi airport; supported deployment of the Australian Medical Assistance Team (AUSMAT); active communication and outreach to the community about COVID 19 awareness; and

provided more than \$2 million in emergency procurement and logistics support to enable essential needs to be met.

2.The overall structure of the FHP is appropriate in terms of working closely with MHMS and making a clear effort to use local expertise. The FHP is physically located within the MHMS building, thereby ensuring close and regular daily contact with MHMS staff. The FHP has made a conscious effort to transition to using local Fijian expertise rather than use external long term advisors. Of the 47 FHP staff ¹², 5 are international staff (and of those, only 2 – the Team Leader and the MEL officer – are full time) with the 42 other staff Fijian nationals. 70% of the total FHP staff are female. Interviews confirm there is a culture of close collaboration; partnerships; and, where required, “shared decision making” between MHMS and FHP staff. Specific examples cited by those interviewed included close collaboration between MHM and FHP on the development of the NCD primary screening steering group as well as the development of the cervical cancer screening video

3.There is a clear outcomes focus in terms of direct service delivery, but this is also linked to overall institutional strengthening: FHP makes a concerted effort to align all activities to the MHMS Strategic Plan. But it also does seek to then track how inputs, outputs, and outcomes contribute to that Plan. For example, FHP’s documents note that Fiji has a shortage of 263 midwives, including a shortage of 85 midwives at the main hospital in Fiji. FHP supported 115 nurses to complete Diploma of Midwifery. This has a potentially direct, long term, sustainable, impact on MNCH outcomes. FHP tracked and reported that 63% of midwifery training recipients are now located in hospitals that deliver 87% of Fiji’s babies.

Similarly, FHP investments in clinical governance improve health outcomes and safety for individual patients but also improve the operations of the health system. The Clinical Governance component of FHP tracked the extent to which Unusual Occurrence Reports (UORs) - reports on patients’ safety and outcomes that were preventable and should not have occurred - were actually being used in hospitals to then improve clinical outcomes. At the end of one year, UORs had reduced from an average of 130 per month to 56 per month.

Senior officials in MHMS said the rural health facility report was particularly useful and helpful in prioritising and reallocating scarce financial and other resources. That was because it was systematic (as opposed to the usual one-off and opportunistic assessment of needs at a health facility) and independent / disinterested: not subject to ‘gaming’ the systems.

The work on supply chain management also had direct benefits in terms of improving the availability of COVID-19 drugs and equipment but also has the capacity to improve effectiveness, efficiency and equity of the MHMS public health system. More specifically, the latest Annual Report of the FHP notes that “Fiji is ready to ‘go-live’ with mSupply (a logistics management information system developed by Beyond Essentials Systems (BES)), which is expected to improve availability of medicines and medical supplies at primary health facilities and reduce wastage of expired stock. This in turn is expected to deliver improved patient care, cost reductions of 30 to 40 per cent and environmental benefits. Most importantly, the system will improve stocks of essential medicines at health centres serving remote communities as well as for women, people with disabilities and people living with HIV.”(6) Furthermore, the work on supply chain management had enabled accurate visibility of stock levels available and coming in and out of all of the major health warehouses. This has improved the ability of Fiji Pharmaceutical and Biomedical Services centre to deliver on orders from hospitals and health facilities, which was a key weakness during the COVID response in 2021.

4.GEDSI. The GEDSI specialist working with the Review team is submitting a separate, stand-alone report, on GEDSI. FHP also intend to undertake a more detailed GEDSI analysis, expected to be undertaken later in 2022 with a particular aim of seeing where further improvements can be made in terms of GEDSI outcomes. However, in the interim the following can be noted. The FHP has a major component on improving mother and child health. FHP supported 115 nurses to complete a Diploma of Midwifery over the period 2019-2021, thereby helping to reduce the shortage of 263 midwives in Fiji.

¹² There are also 20 health inspectors, 6 oxygen coordinators/biomed techs and 4 call centre nurses but these are managed under MHMS contracts rather than by FHP.

FHP also supported a major procurement exercise ¹³that helped address critical gaps in diagnostic and treatment for mothers and infants, particularly in rural and more remote areas. FHP was, through its investments, also able to identify data quality gaps that undermined the accuracy and reliability of Fiji's Patient Information System (PATIS): particularly relevant for maternal and neonatal health given the volume of services provided for that cohort. FHP has specifically nominated "gender champions" in the FHP office to provide accountability for gender and GESDI issues. FHP also has a major component focused on improved rehabilitation for people living with disabilities including a strengthening prosthetics and orthotics services at Tamavua / Twomey hospital and across Fiji. The rural health facility assessment, and the improvements in supply chain management directly improve access to services for women, people living with disabilities, and the poor given the focus on improving conditions in rural and remote areas. Work on gender equality disability engagement and social inclusion has progressed through the implementation of the GESDI strategy; outreach work on disability work and rehabilitation; and the use of the GESDI tracker in the last year. Future work is to include a twin approach where current GESDI mainstreaming work is continued both at the level of community and population engagement, but also at the policy level. Targeted gender and social inclusion activities and specific interventions on disability and social inclusion to be strengthened and continued through continued partnerships with CSOs and nongovernmental organisations (NGOs).

5.Coherence and complementarities within the program. As just one example, the NCD screening project will, to the extent that it identifies and refers NCD patients, including those with diabetes, help reduce the high rate of diabetic related amputations in Fiji: the highest rates in the world per capita. A Royal Australian College of Surgeons (RACS) analysis of ways to improve infection prevention and control identified supply chain weaknesses as a key constraint: FHP then worked to improve the effectiveness and efficiency of the supply chain. Improvements in the supply chain directly improve the ultimate effectiveness, efficiency and equity of supply drugs and equipment to Fiji's health system, including to more remote rural areas and islands.

6.Value for money. The FHP allocated \$399,000 to Monitoring Evaluation and Learning (MEL) in 2021/22. This equates to 6.4% of the overall \$6.2 million budget for that year (increased because of COVID 19). This is comfortably within the 4%-7% range recently recommended by DFAT for programs to allocate to MEL. Allocating such an amount generates an evidence base that can produce lessons, inform priority setting and decision making, and manage risk, all of which contributes to achieving value for money. There are several examples of this at the activity level. An FHP supported report on the relative costs and outcomes of Meningococcal vaccines provided the evidence base for resolving a number of longstanding questions about the cost-effectiveness and value for money of various vaccines. Furthermore, FHP supported work on supply chain management are estimated to result in a possible 30%-40% reduction in costs due to reduced wastage, and overall availability of essential drugs (6). The FHP also makes a conscious effort to use and leverage different modalities, taking into account their respective financial costs weighed up against their potential for adding value to the FHP program and MHMS institutional strengthening. Examples include using Civil Society Organisations such as Project Heaven to undertake community based screening and awareness training for hearing and ear disease health. But FHP also partners with world-class institutions to improve clinical governance in hospitals, including the Melbourne based Doherty Institute for Infection and Immunity.

The FHP itself: "what is not working well" including issues and challenges to think about – only some of which are within the span of control of the FHP to address.

Within the direct span of control of FHP

Some **strategies requested by MHMS and funded / supported by FHP do not get traction after the strategies are completed.** Examples of such strategies include Health Workforce, and Monitoring, Evaluation and Learning (MEL) strategies. Some of those problems are beyond the span of control of FHP itself to control. The lack of traction of strategies rests more within the span of control of MHMS itself and include issues such as weaknesses in the overall strategic policy development; key operational positions within the Ministry being vacant; and / or lack of routine budget allocation to implement the strategy.

¹³ The procurement included four ultra scanners, six infant warmers, eight transport incubators and ten foetal monitors

There are some things within the span of control of FHP to at least reduce the likelihood of strategies failing to get traction within the Ministry. To increase the likelihood that FHP efforts get traction with MHMS in practice, FHP and MHMS should seriously consider only commissioning new strategies in future if all of the following conditions are met:

- There is an MHMS officer of appropriate level and experience attached as a member of the team doing the Strategy (to ensure recommendations are appropriate and practical in the MHMS context as the strategy is being developed)
- That those drafting a new Strategy are required to show that they have investigated and taken into account the lessons to be learned why *previous strategies* did not get endorsed, implemented or get traction.
- That prior to the Strategy being developed, that MHMS make clear what the realistic scope is for increasing the budget / personnel to implement any recommendations.
- There is to be a multi-year commitment within both FHP, and MHMS, to resource and follow up agreed recommendations of a Strategy.

FHP is good at systematically capturing inputs, outputs and outcomes, but there are important missed opportunities to then also capture the financial and other resource costs involved in implementing an FHP activity. This is important because no country, including Fiji, can afford to waste scarce financial and human resources on programs that are not particularly effective, efficient (including value for money) equitable, affordable or sustainable. FHP projects can be particularly informative and helpful in this regard. That is because FHP projects often involve pilots and trial where capturing of benefits *and costs* can then provide the evidence base for MHMS scaling up at a national level. Done well and in a sophisticated, tailored, manner the capturing of financial and human resource costs, and examined in terms of outputs and outcomes, can contribute to a more substantive and compelling public diplomacy and “story telling”.

Governance issues largely beyond the span of control of FHP itself.

Donor coordination is weak, thereby making it difficult to determine if Australian aid funding through the FHP is being used to best effect. More specifically, there is no real “donor mapping” that maps where the strategic financing gaps are in the public health budget of Fiji, and which bilateral or multilateral development agencies are best placed to respond. It is not possible to know if FHP programs are complementing - or competing with - other development partners. The longstanding convention and agreed principle is that donor coordination is the responsibility of the partner government (in this case MHMS) which is to be “in the driver’s seat” (7-10).

FHP can be helpful in terms of strengthening donor coordination, but this is ultimately a governance issue requiring discussion between the Australian High Commission and the Secretary of MHMS. FHP is, for example, already considering the possibility of providing support to the Ministry, (possibly part time) to enable MHMS to actively chair and manage donor coordination. But the current absence of donor coordination direction and information needs to be elevated as part of overall governance arrangements by the AHC, explaining that effective, transparent, donor coordination is reassuring to DFAT that its investments are well targeted, strategic and do not duplicate others. Conversely, absence of adequate donor coordination is a strategic risk factor and generates hesitancy to be involved in new activities.

One potentially damaging weakness is that the FHP may now be becoming a victim of its own success as a result of its effective, quick and nimble response to COVID 19: there is now a risk that some within MHMS may see the FHP as the “go to” agency when *any problem arises* so as to avoid and bypass using Fiji’s own procedures which are often slow. It is clear that Fiji’s rules on procurement, construction of infrastructure, and appointment of new staff are slow and cumbersome. Interviews confirm a real risk that MHMS officials understandably then see FHP as a quicker, more effective, more predictable solution to delivering not just essential health services *during a pandemic or an emergency but also in more routine times*. It is certainly not the role of the FHP to displace or bypass MHMS’ own procedures.

This leads to a separate but related issue: is – or should – the FHP essentially meant to focus on an agreed set of strategic objectives, while retaining a quick response mechanism in emergency and non-emergency times or is – and should – the focus of the FHP to be essentially a quick response mechanism, with strategic objectives and goals a more secondary objective. As the COVID 19 experience shows, it is not necessarily easy to distinguish what is the primary role, as focus *and responsiveness* were necessarily combined. The Review concludes that it is in MHMS, and Australian, interests for the FHP to be primarily designed to generate strategic interventions that deliver priority services to Fiji that would not have happened in the absence of the Facility, and to help strengthen MHMS institutions and systems. Having said that, the FHP, being part of a “facility” and not a traditional “project” also does have the responsibility to be able to respond quickly to urgent requests from MHMS, provided that in non-emergency situations such requests are not simply being forwarded to bypass MHMS’ own systems.

This is fundamentally also a “governance” issue: the Review therefore recommends that the AHC, MHMS and FHP consider and agree on a framework involving possibly three attributes to preserve the strategic focus of the FHP while retaining responsiveness. Those three attributes might be based on the following:

- (i) That the primary goal of the FHP is to support strategic investments that contribute to key priorities of the MHMS Strategic Plans and help strengthen MHMS policies, programs, and institutional capacity. Around 80% of program funds will be allocated to these core, medium to longer term, priorities. 20% of FHP program funds can be used for quick response needs in a non-emergency situation, provided such requests are not being used to bypass or substitute for activities that MHMS could and should be able to do itself.
- (ii) FHP resume meetings with the MHMS budget group to ensure priorities are aligned and likely to get downstream implementation and traction, and that FHP displacing MHMS expenditure effort is also therefore minimised
- (iii) At that regular meeting between FHP and the MHMS budget group, agreement would be reached on a plan and a budget for how staff currently funded by the FHP would phase out and transition across to the MHMS budget (iv) have a

Future financing

There is not a sufficiently strong evidence base for the Review to make a specific recommendation on future financing for the FHP. The TORs for the Review asks “What is an appropriate and sustainable level of funding for DFAT to allocate for Phase 2 of the program on an annual basis?” The Review finds that, unsurprisingly, there are significant health financing needs in Fiji, as there are across the Pacific. However, the Review also finds that the evidence base for making even rough estimates of plausible *ranges* of possible future financing is lacking. That is because, among other things:

- MHMS itself concedes that it does not currently have the capacity to identify specific strategic priority requests that can be presented to development partners like Australia;
- The health budget does not readily identify specific financing gaps, particularly financing gaps against particular program outcomes. Even if financing gaps were able to be clearly identified, there is no “donor mapping”. As a result, it is not possible to know which agency (multilateral or bilateral) or country is best placed to fill particular financing gaps;
- The MHMS MEL has not been endorsed, so it is difficult to know with any confidence what MHMS programs “work, when, why, how, for whom, and at what cost.” Nor is it then possible to identify with confidence what programs could / should be scaled up, and which ones scaled down, with support from development partners.

There are, however, some things that can be said with confidence, with respect to Government of Fiji financing in general and MHMS financing in particular. These issues are captured in Annex

1. However, key points include that fact that while public expenditure on health by the government has been increasing, Fiji's per capita expenditure on health, and total expenditure on health as a share of GDP, has been noticeably, and consistently, lower than the average for upper-middle income countries globally before COVID 19 for many years. Fiji scores well on a number of the World Bank's Country Policy and Institutional Assessment (CPIA ratings) including for equity of public resource use, as well as gender equality rating (Fiji gets a score of 4 where the lowest rating is 1 and the highest is 6 for both attributes). However, Fiji does less well on the "quality of budgetary and financial management" with a score of 2.5 out of a possible score of 6. This is also lower than the global average of 3.5 for upper middle-income countries globally (11).

There are also some things that can be said with confidence with respect to the level and nature of Australian development assistance financing to the health sector of Fiji. Importantly, Australian development assistance to Fiji is a 100% grant. This is the most valuable form of aid as it does not expose Fiji or similar countries to debt distress. Furthermore, the Australian Government has made it clear that the Pacific is a particular priority for Australian aid, including as part of the "Pacific Step Up" program. Having said that, it needs to be also acknowledged that the FHP itself is a *relatively* small part of the overall public expenditure on health in Fiji. The average (pre COVID 19) \$ 5 million allocated to FHP currently represents around 1.94% of the MHMS budget.¹⁴ The average pre COVID 19 budget to FHP of around \$5 million per year is also the equivalent of expenditure of just \$5.55 per person per year in Fiji. That \$5.5 million average per year has been kept roughly constant at least since 2011,. That means the program has been decreasing each year in real (adjusted for inflation) as well as per capita terms¹⁵.

In short, while there is not enough robust evidence to make a specific recommendation about funding levels, MHMS did indicate likely future priority areas where it would like Australian support. More specifically, the Permanent Secretary of MHMS explained that digital technology and communications should be the central "backbone and spine" of the health system. He explained better, more timely, and more accessible online data would be able to improve effectiveness, efficiency, equity and sustainability of the overall health system. FHP is already working in this area, including the NCD screening program, which may be a good foundation for an expanded investment in that area.

The Permanent Secretary also highlighted the need for MHMS, and development partners, to focus on secondary prevention¹⁶ as a particularly cost-effective, even cost-saving intervention. In his view, the focus and funding has hitherto been on primary prevention and care at a public level and also tertiary care at the hospital level. There had been inadequate focus of funding on secondary prevention.

The Permanent Secretary for Health identified Divisional Command Centres as a priority under the MHMS Remodelling Strategy. While FHP may not be best positioned to support the governance of these centres, FHP could explore options on supporting improved reporting and health information for these groups. The work on the Consolidated Monthly Return Information System (CMRIS), MHMS core indicator framework, disease registries, and the Logistics Management Information System (mSupply) may present entry points and build on existing investments.

¹⁴ The MHMS budget for 2021/2022 is FJD 403.3 million, or approximately AUD 257 million. The average pre COVID 19 expenditure for FHP is around AUD 5 million.

¹⁵ To give an order of magnitude, the Fiji Health Systems Support Program (FHSSP) was valued at \$33 million (current Australian dollars) over the two phases (2011 – 2014 and 2014 – 2016). That implies an average expenditure of \$5.5 million per year. The GDP deflator available in the World Bank *World Development Indicators* states that the GDP deflator was 75.7 in 2010 in Fiji and 109.17 in 2020. $109.17/75.7 = 1.442$. This implies that annual funding would need to be closer to \$ 7.9 million per year to maintain the purchasing power in real (adjusted for inflation) terms. Over that period the population of Fiji has also increased from an estimated 859 816 people in 2020 to 896,444 in 2020. The nominal (not taking into account inflation) expenditure has therefore decreased from an average \$6.39 per capita in 2010 to \$6.13 per capita in 2020.

¹⁶ In essence, primary prevention seeks to avert the occurrence of a disease in the first place. Secondary prevention seeks to prevent the disease from progressing to a more advanced (and therefore often more severe and expensive) stage.

5. Conclusions and recommendations

Areas to retain / expand or phase down in period up to December 2024.

It is for MHMS, DFAT, and the FHP to decide what existing activities should be retained and / or expanded and what activities could be phased out or transferred across to MHMS. Annex 2 provides a detailed assessment and rationale for the recommendations of the Review team. Annex 2 also provides suggested Key Result Areas of the recommendations (based on lessons learned hitherto) and, where possible, time-lines for achieving those Key Result Areas. Annex 2 also includes some specific recommendations that would apply to all programs supported by FHP (and ideally MHMS itself) including the need to better capture the financial and broader economic costs (eg health workforce time) of programs. This, in turn, would provide the evidence base for improving the effectiveness, efficiency, equity and sustainability of FHP and MHMS priority setting and resource allocation decisions.

The following provides a short summary of the key conclusions and recommendations (details in Attachment 2):

The Review identifies a series of **programs to retain / strengthen**. These include:

To retain / strengthen

- **Digital and health information.** The Permanent Secretary for MHMS explained this is a top priority because it is “the backbone” of the whole of the health system, generating data and evidence that then drives priorities and resource allocations.
- **Digital and health information with respect to NCD prevention and control** would be an obvious strategic area for scaling up given the high and growing burden of NCDs in Fiji. A stronger, digitally based, health information system could provide the evidence base for identifying what works, when, why, for whom at what cost in terms of prevention and treatment of NCDs (as well as other health challenges), thereby improving the effectiveness, efficiency, equity and sustainability of the Fiji health system.
- **Supply chain reforms** is another particularly strong area of FHP engagement to date. This directly and visibly improves overall health services because drugs and equipment can be released on time and with minimum delay, reducing the risk of stock outs and out of date drugs. Supply chain reform is of course linked to digital and health information (see preceding bullet point). And as with digital and health information, supply chain reform can directly and substantively improve the overall effectiveness, efficiency, equity, and sustainability of the health system. It can also directly contribute to patient safety (eg minimising risk of out of date drugs) and can be a sound investment in disaster preparedness (eg rational pre-positioning of essential drugs and equipment)
- **Clinical governance** at the hospital level is a potentially important area because of its direct effects on improving patient safety. It also has the advantage that by tracking, and averting, otherwise preventable mistakes it directly improves the the effectiveness and efficiency of the hospital system and reduces otherwise avoidable costs such as treating complex hospital acquired infections, requiring patients to undergo additional surgery or stay at the hospital longer than was necessary.
- **Disability and rehabilitation** is a recommended area because it is an area of particular priority and comparative advantage for DFAT. Among other things, this is also a growing area in Fiji: Fiji now has an average of 3 diabetic-related amputations per day as a result of the rise of NCDs, one of the highest rates per capita in the world. This, in turn, generates an otherwise preventable source of people living with a disability.
- The **expanded program of immunisation (EPI)** continues to be a useful activity to support at this stage, as it has broader impacts and benefits than procurement of vaccines. Having said that, immunisation is such a basic and fundamental part of any public health system, especially for an

upper-middle income country like Fiji, that it is timely and appropriate to now have a longer term (eg if necessary beyond December 2024) for FHP to progressively transition and transfer that program across to full ownership and responsibility to MHMS.

To possibly phase down

There are some areas to possibly phase down. COVID-19 is one area that can transition away from an emergency response program, while incorporating and mainstreaming the many lessons learned about COVID 19 into the normal programs of FHP and MHMS. . Public financial management is unquestionably an important part of health system strengthening and ultimately achieving progress in terms of Universal Health Coverage. However, the World Bank and / or WHO financing and economics area in Geneva have a stronger comparative advantage in this area than DFAT. If requested by MHMS, it always remains possible, of course, for DFAT to help finance specific analytical work the World Bank and / or WHO to undertake public expenditure reviews of health expenditure or specific costing scenarios required for increasing progress on Universal Health Coverage.

Possible new areas to invest in.

There are some possible new areas to invest in. During the review period, the Permanent Secretary for Health identified Divisional Command Centres as a priority under the MHMS Remodelling Strategy. Further details in Annex 2. There was not sufficient time during the review period itself to assess this suggestion, so FHP and DFAT will need to continue to have discussions with MHMS about what, specifically, might be involved and what is Australia's / FHP's specific contribution and value added in being involved.

Areas that are unquestionably important but are not recommended for major investment in the remaining period of Phase 2.

There are currently some areas which, while unquestionably important, are not recommended for major investment. Activities that may well fall into this category is providing significant support for mental health ¹⁷ or for climate change¹⁸. Furthermore, small scale, basic routine infrastructure, including rehabilitation, is eligible where it is demonstrably value for money and / or urgent.

There are some areas where this Review recommends FHP transition existing programs across to MHMS over the longer term (eg beyond December 2024).

Midwifery training is something that Fiji, as an upper-middle income country with good educational facilities and staff, is capable of managing and financing by itself. That is particularly the case given that midwifery training is a basic and central part of the health workforce system. Similarly, given that immunisation is such a basic and fundamental part of a public health program in any country, and Fiji

¹⁷ The FHP did provide assistance to support mental health challenges of front line health workers returning to work during COVID-19. Such support - while sensible and needed - was done on a largely opportunistic basis and at the margins of the FHP response to COVID-19.

¹⁸ The interviews did not receive any requests or discussions from MHMS staff about climate change. Again, it is, however, possible to be helpful to MHMS by doing some activities on climate change and disaster risk reduction at the margin, without it being a core priority. For example, in terms of mitigation, any infrastructure investments could give priority to solar powered electricity generation and / or designing and locating buildings to be energy efficient. In terms of mitigation, FHP could make sure the location, design and construction of health facility buildings are adapted to the risks of cyclones in Fiji.

is already an upper-middle income country, there should be an agreed, longer-term (even beyond December 2024 if necessary) strategy and roadmap for FHP to transition support for the Expanded Program of Immunisation (EPI) across to MHMS.

There is not a sufficiently strong evidence base for the Review to make a specific recommendation on future financing for the FHP. However, MHMS did indicate likely future priority areas where it would like Australian support. More specifically, the Permanent Secretary of MHMS explained that digital technology and communications should be the central “backbone and spine” of the health system. The Permanent Secretary for Health identified Divisional Command Centres as a priority under the MHMS Remodeling Strategy.

Other issues to consider as part of the recommendations.

The advantages – and disadvantages – of FHP funding large infrastructure.

The FHP does not currently fund large infrastructure eg building new hospitals, but it is conceivable it could be asked to do so: in that event FHP and DFAT would need to consider the advantages but also the disadvantages of funding “large infrastructure.”¹⁹ There are good reasons for the FHP to respond to MHMS request for investing in new infrastructure / rehabilitating old infrastructure. These include the need for basic infrastructure, its “visibility” in terms of outputs and outcomes, and – potentially – the duration and sustainability of infrastructure.

FHP has invested in health facility infrastructure to good effect to date. The quick infrastructure upgrades at the Nadi Border Health Protection Unit including major renovations, installation of generators and IT as part of the urgent COVID 19 response is just one example.

There are also good reasons to be cautious about investing in large infrastructure using FHP program funds. It is expensive and “lumpy” which means the “opportunity cost” (that is, would that amount of money had a higher impact and ‘bang for the buck’ had it been allocated to another priority) is high. Importantly, there are alternative – and larger - sources of finance to support large infrastructure expenditure if that is a key binding constraint to expanding access to health care, especially for the poor and vulnerable. For example, Fiji and Australia may decide that it is better to access the Australian Infrastructure Financing Facility for the Pacific (AIFFP), the funding limit which has recently been increased from \$1.5 billion to \$3 billion in the latest Australian budget, rather than use the FHP. Alternatively, MHMS, and DFAT, could consider cofinancing concessional loans from the Asian Development Bank and / or World Bank, with Australian funding used to help further improve the concessionality of such financing. That would then enable the FHP to focus its resources on what it does best, including demonstrating new and more effective, efficient and equitable approaches to public health that can then be scaled up by MHMS itself.

Based on lessons learned in Fiji and elsewhere in the Pacific, *and outside of the emergency context* such as a cyclone; a pandemic; or an imminent public health threat,²⁰ it would be prudent to only accept requests to fund infrastructure, particularly using FHP funds, that met the following principles:

- The request is a clear high priority for MHMS

¹⁹The budget threshold limit of “large infrastructure” would need to be defined and agreed by FHP, DFAT and MHMS as part of ongoing governance arrangements.

²⁰ There is a balance to be struck here. In emergency situations where a quick and effective response is the overriding priority, there should be capacity for FHP managers to make decisions quickly and then be accountable for their decisions. Based on interviews, the FHP response to COVID-19 would appear to have been particularly effective, efficient, equitable, particularly fast and “nimble”, but also accountable without being overly bureaucratic. In non-emergency situations it is reasonable for FHP to expect additional justifications and checking.

- There is some specific reason why MHMS cannot undertake the investment itself
- The investment in infrastructure by the FHP is demonstrably additional to, and not a substitute for, MHMS' own expenditure effort.
- There is a clear, agreed, budget line in the MHMS for that infrastructure which allocates an appropriate level of "preventive maintenance" to preserve the technical and economic life of the building or equipment

The FHP will seek to ensure that the design and construction methods used for infrastructure investments it funds maximise energy-efficient and climate change and disaster risk reduction (CCDR) friendly approaches. Where possible the FHP will seek to capture the predicted cost savings of energy efficient designs, and the benefits of CCDR approaches, and disseminate such findings to MHMS and other development partners, and then assess if that has influenced the way they design and build infrastructure. The Review Team takes this opportunity to thank all the staff at MHMS, DFAT, WHO, and FHP itself, who gave their time to provide thoughtful and constructive advice and input to this review.

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Annex A: Alternate text for Diagram of health Program current activities (accessible)

The Fiji Health Program (FHP) key Projects are aligned with MHMS's three strategic priorities:

1. Reform public health services to provide a population-based approach for disease and the climate crisis
 - a. Respond to COVID-19 & other public health emergencies
 - i. Support for Fiji's COVID-19 response
 - ii. Support for Fiji's COVID-19 vaccine roll-out
 - iii. Strengthen Fiji's Border Health Protection Unit Infrastructure
 - b. Improve Mother & Child Health
 - i. Develop and implementation and action plan to address Perinatal Review recommendations
 - ii. Increase the number of trained midwives in Fiji
 - iii. Strengthen community-based hearing & ear disease and other disability services for children
 - c. Prevent & manage NCD burden through early detection of disease
 - i. Improve primary screening of NCDs through stronger policy, coordination & governance mechanisms
 - ii. Strengthen data collection and analysis on NCDs through piloting a digital screening application
2. Increase access to quality, safe and patient focused clinical services
 - a. Support quality improvement in clinical care through a 'Person Centered Approach'
 - i. Strengthen patient safety and quality care through effective clinical governance
 - ii. Embed infection prevention & control (IPC) practices & surveillance
 - iii. Strengthen patient & carer experience in hospitals, particularly for women, PWDs & vulnerability groups
 - b. Improve rehabilitation services through disability inclusive health action
 - i. Support implementation of the National Disability Inclusive health & Rehabilitation Action Plan
 - ii. Strengthen prosthetics & orthotics services at Tamavua/Twomey Hospital and across Fiji
3. Drive efficient & effective management of the health system
 - a. Improve availability of essential drugs and medical supplies through supply chain reform
 - i. Strengthen stock management and distribution at FBPS & major warehouses through mSupply and other reforms
 - ii. Improve availability of drugs and medical supplies at hospitals and health facilities
 - iii. Streamline national procurement, forecasting and ordering processes for drugs and medical supplies
 - b. Enhance decision support through strengthened information systems

- i. Support MHMS to harness digital technology and strengthen IT infrastructure
- ii. Strengthen MHMS capabilities to collect, manage & use data, particularly for women, PWDs & vulnerable groups
- iii. Strengthen development partner collaboration for a more innovative and higher quality health system

FHP will continue to monitor key MHMS needs, and support where appropriate:

- 1. Promote gender equality and disability and social inclusion across Fiji's health sector
- 2. Strengthen MHMS capacity to deliver CSO project grants
- 3. Develop national clinical standards for the delivery of counselling services

FHP Projects are linked to key outcomes through the attributes of universal health coverage:

- 1. Equitable access – An integrated approach to public health
 - a. Safeguard against environmental threats and public health emergencies
 - b. Improve physical & mental well being of all children, with particular emphasis on women, children & young people through prevention measures
 - c. Reduce communicable disease & non-communicable disease prevalence, especially for vulnerable groups
- 2. Safety & Coverage – Strengthened patient services and continuum of care
 - a. Improve patient health outcomes, with a particular focus on services for women, children, young people & vulnerable groups
 - b. Strengthen & decentralise effective clinical services, including rehabilitation, to meet the needs of the population
 - c. Continuously improve patient safety & the quality & value of services
- 3. Quality – Strengthened systems underpinning public health & clinical services
 - a. Improve the efficiency of supply chain management & procurement systems, & maintenance of equipment
 - b. Harness digital technologies too facilitate better health care for our patients
 - c. Widen our collaboration with partners for a more efficient, innovative and higher-quality health options

A one-system approach towards achieving universal health coverage (UHS)

Leading to

Improved health and well-being for all Fijians