



**Fiji Health Sector Support Program
End of Program Evaluation
Final Report**



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Acronyms and Abbreviations

ANC	Antenatal Care
APLS	Advanced Paediatric Life Support
AusAID	Australian Agency for International Development (now DFAT)
AUD	Australian Dollar
AVID	Australian Volunteers for International Development
CD	Capacity Development
CHW	Community Health Worker
CSN	Clinical Service Networks
CWMH	Colonial War Memorial Hospital
DAC	Development Assistance Committee (of the OECD)
DFAT	Department of Foreign Affairs and Trade (Australia)
EmONC	Emergency Obstetric and Neonatal Care
EOP	End of Program
EPE	End of Program Evaluation
EPI	Expanded Program on Immunisation
FCDP	Fiji Community Development Program
FHSIP	Fiji Health Sector Improvement Program
FHSRP	Fiji Health Sector Reform Program
FHSSP	Fiji Health Sector Support Program
FJD	Fiji Dollar
FNU	Fiji National University
GDP	Gross Domestic Product
GoF	Government of Fiji
HIS	Health Information System
HIU	Health Information Unit
HPV	Human Papilloma Virus
IMCI	Integrated Management of Childhood Illness
JICA	Japan International Cooperation Agency
LTA	Long-Term Adviser
MC	Managing Contractor
MCH	Maternal and Child Health
MCRI	Murdoch Children's Research Institute
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MEP	Monitoring and Evaluation Plan

METT	Monitoring and Evaluation Technical Team
MoH	Ministry of Health (Fiji)
MoHMS	Ministry of Health and Medical Services (Fiji)
MSHI	Mother Safe Hospital Initiative
MSHIS	Mother Safe Hospital Initiative Standard
MTR	Mid-Term Review
MVA	Manual Vacuum Aspirator
MWCPA	Ministry of Women, Children and Poverty Alleviation
NCD	Noncommunicable Disease
NGO	Non-Government Organisation
NVEP	New Vaccine Evaluation Project
OECD	Organisation for Economic Cooperation and Development
PATIS	Patient Information System
PCC	Program Coordinating Committee
PCV	Pneumococcal Conjugate Vaccine
PDD	Program design document
PHIS	Public Health Information System
PLS	Paediatric Life Support
RACS	Royal Australian College of Surgeons
RV	Rotavirus
SDH	Sub-Divisional Hospital
SDG	Sustainable Development Goal
SOPD	Specialist Outpatient Department
SPA	Senior Program Administrator
STA	Short-Term Adviser
TA	Technical Assistance
ToR	Terms of Reference
ToT	Training of Trainers
TAG	Technical Advisory Group
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
VfM	Value for money
VIA	Visual Inspection through Acetic Acid
WHO	World Health Organization

Map of Fiji Showing the Four Divisions



Source: <http://www.decorationsmem.tk/fiji-map/>

Executive Summary

This Draft Report presents the findings and recommendations of an End of Program Evaluation (EPE) of the Fiji Health Systems Support Program (FHSSP). The Program, valued at \$A33 million, has been implemented in two Phases (2011 – 2014 and 2014 – 2016), both of which have been managed by Abt-JTA, as had two previous health projects.

Effectiveness: FHSSP has performed well against its planned activities but it is not possible to assess the impact of the Program.

Objective 1, Safe motherhood: The late starting pilot of a community based communications campaign to increase antenatal attendance has yet to report so long term program impact will depend on uptake by MOH beyond the life of the program. The Mother Safe Hospital Initiative Standard (MSHIS) audit approach has improved availability of staff equipment and supplies and encouraged more services to be delivered against standards, in facilities where most deliveries take place. Field work suggested that staff have been motivated by the approach. However the program has not gathered evidence on whether quality of care and outcomes for mothers and babies have improved, so it is difficult to say conclusively that this has been an effective approach, although anecdotal evidence gathered from the field is positive. Similarly data on the impact of training on improving safe and effective post-miscarriage services is not being gathered consistently across all facilities where it is in use.

Objective 2, Healthy child: provision of pneumococcal and rotavirus vaccines, through a cost-sharing arrangement, has been very successful – Ministry of Health and Medical Services (MoHMS) has now taken on 100 per cent of funding for vaccine procurement. Program support has helped to maintain high immunisation rates. Sustaining improvements in surveillance will be challenging beyond the end of the program and the team notes the high proportion of Program funding allocated to the New Vaccine Evaluation Project. Improving the quality of child health care has been tackled primarily through training. The program has performed well in terms of numbers of people trained but the impact of that training has not been measured in terms of quality of care and patient outcomes, although staff interviewed reported improved competence and confidence.

Objective 3: Noncommunicable diseases (NCD): this has been a more modest intervention than originally planned largely due to challenges in establishing quality diabetes centres. However FHSSP has helped MoHMS increase its diabetes screening coverage, and training on diabetic foot care is reported to be having an impact in preventing amputations, although again data has not been gathered to demonstrate this. HPV vaccine coverage is on target and effectively supports the implementation of the cervical cancer screening policy.

Objective 4: Community Health Workers (CHWs): Although this has been a successful intervention by the Program in terms of numbers trained, its scope has been more limited than originally planned, and several factors, including lack of remuneration, weak links with the health system in some areas, and the future

recurrent costs of training, supervising and monitoring CHWs make it a fragile investment. With release of the CHW Policy in November 2015, MoHMS is nearer to institutionalising CHWs, but funding remains an issue. Moreover although the training was reported by the program to have been warmly received by participants, no evidence has been gathered of the impact upon CHWs' practice or service uptake.

Objective 5, Health system strengthening: This has been an effective intervention. Support to the Health Information Unit has enabled significant improvements to be made in the availability of better quality and more health information. Support to monitoring and evaluation (M&E) has helped to improve the coherence and quality of indicators being used in the corporate planning process. Support to workforce planning and development has also been effective with some important policies and plans now in place, and data being used to successfully justify the need for new posts.

Social inclusion: The program was able to contribute to an increased interest in MoHMS in gender awareness and inclusion by delivering gender training in early 2015. Targeting the needs of people with **disability** has not been prioritised to date, although FHSSP can be seen to have contributed to reducing and preventing disability through its NCD and healthy child objectives.

Capacity development (CD): The Evaluation Team noted a lack of a specific focus on CD in the Program design, even though CD is inherent in each of the five objectives. However, the long-term adviser (LTA) Workforce Development and several other Team members invested time in improving the quality of training. Many respondents in the evaluation believed their practice had improved as a result of training. The lack of a dedicated CD specialist was a missed opportunity.

Program governance has been effective, with a well functioning Program Coordinating Committee (PCC) and Finance and Audit Committee (FAC). Governance arrangements have evolved since the predecessor Fiji Health System Improvement Program to offer MoHMS more autonomy, responsibility and ownership. **Contracting arrangements** have been effective. **Program management** has also been effective in terms of delivering results, but there has been little investment in staff professional development and higher turnover of staff than the Team would have expected. **Alignment with MoHMS systems** is good and the Program has enjoyed effective relationships with MoHMS at both central and divisional levels. The Divisional and Divisional Plus meetings have been important for building wide ownership of the Program and fostering two-way communication. The Program manages **risks** well. Internal Program **monitoring and evaluation** has evolved. It is now rigorous and largely based on MoHMS's own monitoring framework. However, there is a lack of outcome data for specific Program interventions and scope to add some targeted impact studies.

The Program is highly **relevant** to global, and GoF priorities, and aligns well with the current Government of Australia Investment Plan for Fiji. FHSSP has been able to contribute directly to health service delivery (bottom-up approach) as well as support national strategy in health systems in Suva headquarters (top-down approach). FHSSP complies well with **aid effectiveness principles**.

Observations on **value for money** show how resources have been redirected towards different objectives as the Program has evolved. Investment in vaccine evaluation has been significant. The Team wonders about the opportunity cost of this, particularly when the Program appears to have under-invested in other impact evaluation. Program scale-up enabled employment of long-term advisers who have made a significant contribution to Program effectiveness and impact, suggesting that the original budget was underfunded.

As discussed above the Program generally lacks outcome and **impact** data on most of its interventions so it is not possible to assess program impact. However, the EPE Team heard many accounts of successful outcomes, such as fewer maternal and child emergencies being referred upwards, and better staff capacity to cope with them. Although not measured, long-term impact from the Program can be expected from several interventions including the three new vaccines, investments in health information, and continued support to the clinical service networks. The Program has taken a strategic approach to **sustainability**, with development and implementation of an exit strategy. The EPE Team has concerns about the sustainability of some interventions, CHWs in particular.

Success factors include a more strategic and coherent approach to Programming, in Phase 2, high quality long-term and short-term technical assistance and, perversely, financial pressures, which encouraged a focus on priorities and impact. **Challenges** have included the absorptive capacity of MoHMS, staff turnover in MoHMS and FHSSP, and managing the implications of major fluctuations in Australian aid funding (scale-up in 2012 and scale-down in 2013).

Future Australian support to the Fiji health sector should be aligned to the new Sustainable Development Goals and the forthcoming Fiji health sector Strategic Plan. In terms of continuity from FHSSP there should be continued support to health information and a focus on hard to reach women linked to efforts to reduce maternal mortality. A more strategic multi-sectoral view of NCDs is needed as is a more explicit focus on capacity development and a more coordinated and evidence-based approach to planning and evaluating aid Program activities to ensure MoHMS can sustain investments. The EPE recommends replicating the model of cost sharing and some selective investment in community health workers. New areas to support could include helping MoHMS improve its evidence-based results focused planning and budgeting. There is a need to target vulnerable groups and reduce the high and growing birth rate among teenagers. Gender equality should be promoted. Rational and cost-effective provision of services needs to be addressed, alongside support to forthcoming civil service reform.

1. Introduction

This report presents the findings and recommendations of a two-person Team¹ commissioned by the Department of Foreign Affairs and Trade (DFAT) in Suva to undertake an End of Program Evaluation (EPE) of the *Fiji Health Systems Support Program (FHSSP)*. The EPE fieldwork was undertaken in November 2015, well before the Program's scheduled close in June 2016. This timing will enable the Report to be used to inform the design of a future DFAT health investment in Fiji.

2. Background

2.1 Australian Support to the Health Sector

FHSSP has been delivering Australia's bilateral support to the Fiji health sector since July 2011, continuing from the predecessor *Fiji Health Sector Improvement Program (FHSIP)* from 2003 to 2010, and the *Fiji Health Sector Reform Program (FHSRP)* from 2000 to 2003. Following completion of FHSIP, there was an interim transition Program managed by the Fiji National University (FNU).

FHSSP is due to be completed on 30 June 2016, with a final total value expected to be \$A33 million (\$F50 million). FHSSP aims to support delivery of effective health services to the people of Fiji and to strengthen health systems. The Program has five key focus areas: maternal health; child health; noncommunicable diseases (NCDs) – specifically diabetes and cervical cancer; primary health care revitalisation; and, health systems strengthening; plus an Unallocated Fund to allow it to meet emergent and emergency health needs.

DFAT also supports health initiatives in other bilateral Programs such as: non-government organisation (NGO) activities through the *Fiji Community Development Program*² (FCDP); placements of *Australian Volunteers for International Development (AVID)* in health-related positions; and scholarships for academic long-term training. In addition to support through the Fiji bilateral Program, DFAT funds Pacific regional Programs. Relevant regional Programs referred to by interviewees were the:

- *Strengthening Specialised Clinical Services Improvement Program*, through FNU;
- *Support to the Fiji School of Medicine*, also through FNU;
- *Pacific Regional Blindness Prevention Program – Phase 3*, run by the Pacific Eye Institute; and
- *Pacific Islands Project*, Royal Australian College of Surgeons (RACS).

2.2 Overall Health Context in Fiji

Fiji has a relatively young population with a median age of 25 years. Over half of the population (53 per cent) now lives in towns and cities. A high rate of rural-urban

¹ Team Leader/Health Specialist, Adrienne Chattoe-Brown and Evaluation Specialist, Susan Majid.

² An FCDP brochure indicates that in its first three years, 56 per cent (\$F4.1 million) of the \$F7.3 million value of grants disbursed under FCDP were for health activities, including WASH. Appendix 6 of the *Fiji Health Sector Situational Analysis 2014* listed 37 Fijian health-related organisations which benefitted from these FCDP grants.

migration has resulted in rapid growth of peri-urban settlements with attendant health and sanitation challenges. The multicultural society includes approximately 57 per cent indigenous Fijians (i-Taukei), 37 per cent Indo-Fijians and six per cent other ethnic groups. Both demographic trends and disease incidence differ by ethnic group. For example, the i-Taukei population has higher fertility and mortality rates, whereas Indo-Fijians have lower fertility and mortality rates, and higher emigration, resulting in negative population growth.

Like many countries, Fiji experiences the “triple burden of disease” – the “unfinished business” of communicable disease and reproductive health; an increasingly severe burden of NCDs (particularly diabetes, hypertension and cancer), some of which are exacerbating and increasing communicable diseases (for example tuberculosis in diabetes patients); and emerging risks from new diseases and environmental change. Particular challenges include:

- Fiji has been unable to reach the United Nations’ 2015 targets for reduced child mortality and maternal mortality set out in Millennium Development Goals (MDGs) four and five respectively;
- high prevalence of obesity leading to diabetes and diabetes-related amputations;
- conversely, malnutrition and child stunting are also problematic in some communities due both to poverty and to poor understanding of nutritional requirements of infants;
- threat of importation by travellers of emerging infectious diseases like ebola, Middle East respiratory syndrome coronavirus (MERS-CoV), and avian influenza;
- climate change has led to salt water inundation, increased disease in affected communities, and the need to move some local health facilities to higher locations.

In the Fiji health system, primary care is delivered by Nursing Stations and Health Centres, which refer cases up to three levels of hospitals culminating in national referral hospitals, and even overseas referrals for complicated cases. Community Health Workers (CHW) support Zone Nurses as a link to the community, but are not a paid workforce. Public health services are provided free of charge to patients.



Ba Mission Hospital, Western Division

Table 1 below shows the numbers of public health facilities at various levels, distributed across the four administrative divisions³. The map on page iii shows the locations of the Divisions and major towns.

³ In addition there are four private hospitals and private sector practitioners in urban areas.

Table 1: Health Facility Hierarchy

Division	Nursing Station	Health Centre	Sub-Divisional Hospital	Divisional Hospital	National Referral Hospital	Population Served
Northern	21	20	3	1	0	140,323
Eastern	31	15	5	0	0	38,418
Central	21	21	4	1	2	370,543
Western	25	23	5	1	0	365,379
Total	98	79	17	3	2	914,663

Source: Adapted from data in Tables 7 and 8 in O'Mahony (2015), which in turn were sourced from the *MoH Annual Report 2013*.

Policy-making, human resource management, pharmaceutical supply and health system management is centred in Ministry of Health and Medical Services (MoHMS) Suva, led by the Permanent Secretary and three Deputy Secretaries with support from National Advisers, Directors, Divisional Medical Officers and networks of practitioners in specialist Clinical Service Networks (CSN). The CSNs report to a national CSN which has an overall coordination role.

The health budget has increased significantly in nominal terms in recent years, with expenditure almost doubling from \$F137.4 million in 2011 to an estimated \$F268.8 million in 2015⁴. Table 2 sets out planned expenditure in the Fiji budgets for selected years. It shows increases in the health portfolio relative to both total Government of Fiji (GoF) expenditure, and to nominal Gross Domestic Product (GDP).

Table 2: Fiji's Health Expenditure for Selected Years

Year	Fiji National Budgeted Expenditure	MoHMS Budgeted Expenditure	Health / Total	Fiji's Nominal GDP	Health / GDP
	(FJD '000)	(FJD '000)	(%)	(FJD '000)	(%)
2012	2,077,929	153,074	7.4	7,223,737	2.1
2014	2,883,261	222,477	7.7	8,283,429	2.7
2016	3,414,537	280,084	8.2	9,691,109	2.9

Source: Expenditure and GDP forecasts extracted from the *Fiji Budget Estimates* for 2012, 2014 and 2016.

Further information about the health context in Fiji is set out comprehensively in another recent document funded by DFAT - the *Fiji Health Sector Situational Analysis 2014*⁵.

⁴ Data from the 2012 and 2016 Budget papers.

⁵ See Annex 2 for the full reference to this report which was finalised in March 2015.

3. Purpose, Objectives and Scope of the EPE

3.1 Purpose and objectives

The purpose and objectives of the EPE are set out in the Terms of Reference (ToR) attached as Annex 1. Specifically, the evaluation has been designed to:

‘independently assess relevance, efficiency, effectiveness, accountability, impact and sustainability of the FHSSP activities, with specific focus on:

- i. capacity building approaches*
- ii. management effectiveness*
- iii. stakeholder cohesion and cooperation*
- iv. monitoring and evaluation*
- v. analysis and learning*
- vi. cross-sectoral issues like gender and disability*
- vii. relevant applicability of the project design document’.*⁶

3.2 Scope

The Team was mindful that this EPE follows several other reviews commissioned by DFAT during the life of FHSSP, in addition to the Program Annual Reports and regular progress reports produced by the FHSSP Team⁷. Independent reviews of FHSSP and the health sector more generally have included⁸:

- *Review of Mobilisation Phase and Appraisal of QAI Report*, by the FHSSP Technical Advisory Group (TAG) in March 2012;
- *Mid-Term Review (MTR)*, by the TAG in May 2013
- *High Level Strategic Review: Fiji Health Sector Support Program*, in May 2014;
- *Fiji Health Sector Situational Analysis 2014*, in March 2015.

This EPE aims to add value to previous analyses. The EPE covers the life of the Program to date (i.e. from July 2011 to November 2015), with a particular focus on the period since the MTR, given that there has been less independent review of the most recent period. FHSSP was tendered as a “three plus two” year Program, which has resulted in two phases, both managed by AbtJTA.

The ToR identified a significant number of questions for evaluation. In response, the Team identified 13 focus questions in its *Evaluation Plan*, and subsidiary questions (see Annex 3, section A3.6) which further defined them. These were agreed with DFAT prior to the in-country mission. As can be seen in Table 3 below, the 13 evaluation questions are organised under the six DAC criteria⁹.

⁶ ToR p3

⁷ These were initially quarterly, and since 2014 written reports have been produced on a six-monthly basis. With verbal reports quarterly.

⁸ Details of these reviews are included in the list of references at Annex 2.

⁹ The Development Assistance Committee (DAC) of the Organisation for Economic Cooperation and Development evaluation criteria are defined in the Glossary of Evaluation and Results Based Management Terms, OECD (2000)

Table 3: Key Evaluation Questions

DAC criteria	Focus Questions
Effectiveness	1. Did the Program achieve its objectives?
	2. What was the contribution of analysis and learning?
	3. How well have gender and disability been addressed?
	4. How effective have the Program's capacity building strategies been?
Accountability	5. Were the Program governance arrangements appropriate?
	6. How well was the Program run?
	7. Were risks managed appropriately?
	8. How effective was stakeholder cooperation and engagement?
	9. What was quality of monitoring and evaluation?
Relevance	10. How consistent was the Program with beneficiary requirements, country needs, global priorities and partner and donor policies?
Efficiency	11. Did the Program provide good value for money?
Impact	12. What long term outcomes are likely to result from the Program?
Sustainability	13. Are Program benefits likely to last beyond the life of the Program?

These key evaluation questions and subsidiary questions guided the methodology described below in Annex 3.

3.3 Limitations

Team inputs into this EPE were limited to two weeks of in-country work and one week prior to review documents and prepare the *Evaluation Plan*. The Team has worked hard within these constraints to analyse results and formulate its views, as set out in this Report.

As noted in the evaluation plan (see Annex 3), it has not been possible to do a systematic analysis of Program impact within the scope of the assignment. Very few baselines were available except for EOP outcomes developed under phase two of the program and time did not permit data collection independent of that supplied by the Program/MoHMS, the limitations of which are described under 5.2.5 and 5.5.

4. Methodology

The EPE Team has followed a four-stage methodology to develop this Report: i) document review and analysis at home office; ii) data collection; iii) data analysis; and, iv) debriefing and report writing.

4.1 Document Analysis

The EPE Team read and analysed relevant documents, held Team meetings by Skype and developed an *Evaluation Plan* submitted to DFAT prior to starting fieldwork. A list of documents reviewed prior to the field mission and other selected

references collected during the fieldwork is attached in Annex 2. These latter materials were an important supplement to the documents received prior to travel.

4.2 Data Collection

DFAT and FHSSP developed a comprehensive Program for the Team in Suva, Western Division and Northern Division. The final Program is attached as Annex 4.

The Team collected information through a mix of interviews, briefings and site visits using formats that had been developed in the Evaluation Plan. Site visits and interviewees were identified by DFAT and FHSSP taking into account access to facilities within the time available, locations where the Team could see most activities at one time, and interviewee availability. Whilst the fieldwork was in progress the team requested some additional meetings to ensure that at least two people from each level of service delivery was interviewed. The purpose of the interviews was not to gather original information based on a representative sample of respondents but rather to focus on validating claims made by the Program in its reporting as far as was feasible within the time available.

A list of the 63 people (44 women, 19 men) interviewed is included as Annex 5. Table 4 below provides a summary of the 33 data collection events, broken down by method and location. The *Interview Schedule* and *Facility Observation Checklist* are attached as Annexes 6 and 7 respectively. When walking around health facilities, the Team spoke to many staff to learn about their work and how they had benefitted from FHSSP activities. These interlocutors are additional to the 63 in Annex 5. The Team was accompanied by a DFAT representative and for some site visits, by a Team member from FHSSP's local Divisional office.

Table 4: Data Collection Methods

Data Collection Event	Suva	Western Division	Northern Division	Skype	Total
Interviews/Meetings	17	1	1	1	20
Site Visits	0	6	6		12
Divisional Meeting	1				1
Total	18	6	8	1	33

4.3 Data Analysis

Information collected from the 63 respondents was collated using a large grid matrix so that data from multiple meetings / events was organised under themes, which in turn relate to the evaluation questions in the ToR. The grid has helped identify trends and patterns across the various meetings to provide evidence for this Report. Data analysis commenced in Fiji and has continued at home office and through Skype conversations, contributing to completion of this Report.

The Team has also invested time following the field trip in examining the many documents provided by the FHSSP Team and analysing information.

4.4 Debriefing and Report Writing

The Team prepared an Aide Memoire PowerPoint presentation and had meetings with FHSSP, DFAT and MoHMS and other stakeholders on 27 November 2015 at the end of the field mission. These meetings provided an opportunity to test the findings and validate the direction taken by this Report. The first version of this Report has been prepared for submission on 18 December 2015, and the final version, following feedback, is due in January 2016.

5. Findings

5.1 Effectiveness

5.1.1 Achievement of Objectives

An assessment of whether the Program achieved its objectives relies on understanding what those objectives were. The Program has not always consistently defined its objectives. While the themes of safe motherhood, healthy child, NCDs, CHW and health systems strengthening have remained, there have been variations in how these have been interpreted and approached, and therefore the focus of each objective has varied over time (see Annex 8, Evolution of FHSSP Objectives). Nor has the Program always had well-defined, measurable indicators. It is therefore not possible to track Program performance against the original planned outcomes. However these have been noted below as this section attempts to assess performance against the evolving objectives and indicators at different points of the Program with a stronger focus on Phase 2.

Annex 9 presents the latest results available from the Program against current Phase 2 indicators. The annex illustrates that the program has generally performed well against its activity indicators. However, as discussed at the end of each objective and in section 5.5 impact, the Program lacks impact data which makes it difficult to assess effectiveness.

5.1.1.1 Objective 1: Safe Motherhood (to institutionalise a safe motherhood Program throughout Fiji)

The original Program objective as stated in the design document was to institutionalise a safe motherhood Program at decentralised levels, i.e. at Sub-Divisional level and below. The original outcomes were: an increasing number of women routinely presenting for first antenatal (ANC) check-up in the first trimester (increased by 10 per cent per annum); at least 8 of the 16 Sub-Divisional hospitals classified as “baby safe”; high proportion of deliveries being carried out in Sub-Divisional hospitals or higher level institutions (increased by 10 per cent per annum); increased contraceptive prevalence rate and reduced unmet need for family planning (increased by 10 per cent per annum)¹⁰.

By the end of 2012 the Program had provided few inputs in **family planning**. There had been brief support to family planning training and outreach services in the Qarani medical area which helped raise family planning service coverage in the area from 20

¹⁰ 23 Nov 2010, Fiji Health Sector Support Program 2011-2015: Design Document – Final, D. Wilkinson, L. Evans, R.Sutton, p24

per cent to 22 per cent¹¹. There had also been some limited activity around training nurses to use contraceptive implants and some promotion of family planning awareness and contraceptive use and a media campaign aimed at teenagers. In the course of 2013, the focus of MoHMS was on revising family planning policy and guidelines with the United Nations Population Fund (UNFPA) which delayed FHSSP training, so no further activity took place, and the outcome was dropped in Phase 2. Two strategic areas have remained throughout the Program: safe pregnancy, motherhood and childbirth; and, early and adequate ANC. Safe and effective post-miscarriage services became a strategic area in Phase 2, although there had been some limited activity in Phase 1.

Improvements in **safe pregnancy, motherhood and childbirth** have been driven by implementation of the Mother Safe Hospital Initiative Standard (MSHIS). Guidelines and an audit tool were developed and subsequently revised by the Obstetrics and Gynaecological CSN with FHSSP support and MoHMS endorsement. Seventeen divisional and Sub-Divisional hospitals (SDH) were audited initially and the Program then targeted nine SDHs, supporting them to try to meet service delivery standards, staff capacity, and equipment and supplies, in line with the Program's objective of strengthening services at decentralised levels.

By the end of 2013, the Program had encountered a variety of challenges including the unavailability of tetracycline eye ointment (still not available), and high rotation of staff which eroded the benefits of training to the audited facilities. As a result, although four SDHs had improved functionality from their baseline audit of 2012, three had merely maintained their baseline functionality and two had lost functionality¹².



Two babies benefit from equipment procured with FHSSP funds, neonatal ICU, Labasa Hospital

The Program design document (PDD) plus the additional financing from scale-up in 2012, had allowed for a limited infrastructure Program. MoHMS, however, directed FHSSP towards assisting with the scoping of a new birthing unit at Makoi which according to the MTR "significantly delayed"¹³ the original work of the Short Term Adviser (STA) Infrastructure and meant the planned upgrades were unlikely to be completed by the end of the Program. Neither the birthing unit nor the upgrades went ahead and infrastructure funds were distributed across the Program objectives.

This strategic area was refocused at the direction of the High-Level Strategic Review of FHSSP in 2014 which recommended that under Phase 2 the Program re-prioritise its support to include three divisional hospitals and drop three Sub-Divisional ones, in order to prioritise those six facilities where a very high proportion of babies are born. This was a sensible approach in the light of the need to reduce perinatal mortality.

¹¹ 2013 Fiji Health Sector Support Program 2012 Annual Report, p7

¹² March 2014 Fiji Health Sector Support Program 2013 Annual Progress Report, FHSSP, p13

¹³ May 2013 Fiji Health Sector Support Program Technical Advisory Group: Mid-term Review, p22

MoHMS staff and hospital management Teams are engaged with the process, and results of the audits have been used to develop facility level “follow-up action plans”. FHSSP has continued to supply training (e.g. in Emergency Obstetric and Neonatal Care (EmONC) and some equipment in line with these plans (including delivery beds, incubators, and scales to weigh infants). Although many challenges remain, the approach has evidently had an impact, as illustrated by Table 5 below.

Table 5 Progress towards achievement of the MSHIS in FHSSP targeted facilities

	Sigatoka (SDH)	Nadi (SDH)	Nausori (SDH)	CWMH	Labasa	Lautoka
Percentage functional in Q2 2012 (baseline)	50%	33%	42%			
Percentage functional in Q2, 2014	50%	50%	58%	33%	42%	0%
Percentage functional in Q2, 2015	67%	83%	58%	58%	67%	58%

Sources: 23 Sept 2015, Fiji Health Sector Support Program progress report: January – June 2015 (draft), p19, (2014 and 2015 data); March 2014 Fiji Health Sector Support Program 2013 Annual Progress Report, FHSSP, p13 (2012 data).

The evaluation Team interviewed staff at Labasa and Lautoka hospitals, who were able to explain the results of their latest audits and what they needed to do to improve their scores. There was a consensus among those interviewed that the audit process was a motivating and useful process. A recurring theme was that nursing practices had been appropriate but that failure to prepare adequate documentation had contributed to low audit scores initially. An increased understanding of the importance of documentation, and prioritisation of time to make this happen, had seen scores lift. Furthermore, staff were motivated by the audit process and set targets for future audits. Despite this, however, the Team learned that hospitals are still missing key low-tech equipment. For example, in Ba Hospital staff said that the delivery room had no simple equipment such as measuring jugs to estimate blood loss or special scissors to cut the umbilical cord.



Mother and child at check-up in Savusavu Health Centre

The Program has also supported a number of much smaller scale but useful interventions, for example providing technical assistance (TA) to carry out a maternal health services review, training nurses at Fiji National University (FNU), and development of a strategic action plan.

Program activities to promote **early and adequate antenatal care** started out rather unfocused with the intention to conduct a national level mass media campaign. FHSSP also revised the ANC brochure, and trialled early booking kits in some Health Centres. This strategic area became more focused in 2014, however, when the Program provided support to the Health Information Unit (HIU) to enable PATISPlus to

gather data about the scale of late visits. The Program then carried out behavioural research to develop an evidence-based community-based communications campaign. This is being piloted in the second half of 2015, so results are not yet available. The *High Level Strategic Review: FHSSP* in 2014 had previously concluded “*indications are that early antenatal visits have increased in some areas in response to FHSSP supported initiatives*”¹⁴.

Box 1 Empower Pacific

Empower Pacific is the only provider of counselling in the Fiji public health system. Beneficiaries include patients in "stress wards", diabetics at risk of amputation, new mothers, patients at risk (e.g. STIs and AIDS), and bereaved families. Counsellors identify "bottleneck factors" – for example, reasons why ANC patients or new mothers may not come back after their first visit. In addition, in the aftermath of emergencies, Empower Pacific counsellors went to the emergency shelters to support those displaced by the floods. In 2014 the NGO counselled 13,386 women and their partners, exceeding their target of 10,000.

Source: 2014, Quarterly Performance Reports for the Provision of Hospital Based Psychosocial Support Services, Quarters 1-4, Empower Pacific

Local NGO, Empower Pacific (See Box 1 above), received core funding from FHSSP in 2013 and 2014 to allow it to continue its work when other funding (Global Fund, Secretariat of the Pacific Community) ceased. Although this was a useful intervention, the inclusion of Empower Pacific within the Program was primarily about ensuring continued support to the NGO rather than contributing to FHSSP delivering against its objectives. In 2015, DFAT funded the NGO directly. At the time of the Team's meeting with them in November 2015, Empower Pacific had no guarantee of ongoing funding for 2016.

Improving **safe and effective post-miscarriage services** has been a small but important focus of the Program. Manual vacuum aspirators (MVA) had been procured in 2012 and training given, through a training of trainers (ToT) approach, to doctors and nurses in 2014. The procedure is now being carried out in outpatients at some divisional hospitals. The 2014 annual progress report stated that in Colonial War Memorial Hospital (CWMH), “*fewer women are attending the operating theatre to have retained products of conception evacuated, as was the usual practice in the past.*”

Effectiveness summary

Late program work on ANC may have the potential to be effective but its impact beyond the pilot will depend on uptake by MOH beyond the life of the program. The audit approach has improved availability of staff equipment and supplies and encouraged more services to be delivered against standards, in facilities where most deliveries take place. However the program has not gathered evidence on whether quality of care and outcomes for mothers and babies have improved, so it is difficult to say conclusively that this has been an effective approach, although anecdotal evidence gathered from the field is positive. Similarly evidence on the impact of

¹⁴ 9 May 2014 High Level Strategic Review: Fiji Health Sector Support Program - Final Report, p10

training in the use of MVA is not being gathered consistently across all facilities where it is in use.

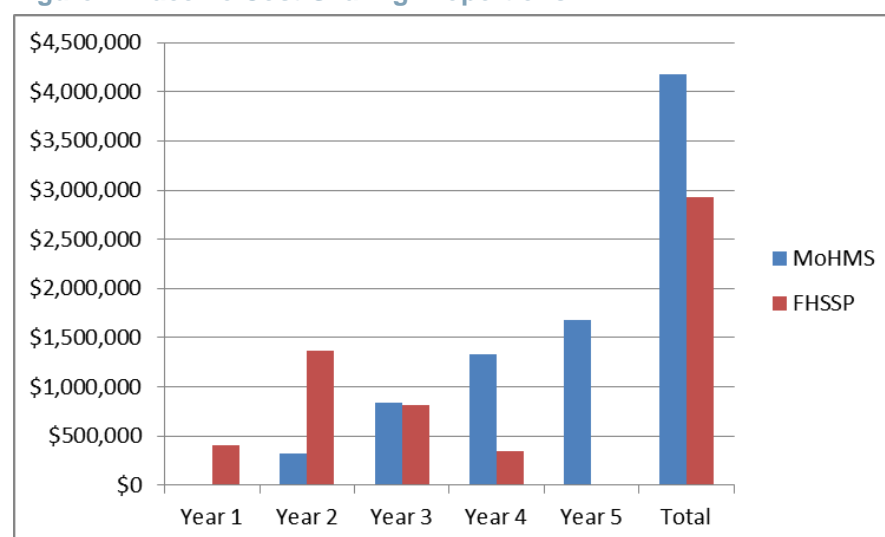
5.1.1.2 Objective 2: Healthy Child

This Objective aims to strengthen infant immunisation and care and the management of childhood illnesses and thus institutionalise a “healthy child” Program throughout Fiji.

Throughout its life, the Program has focused on three key areas: provision of vaccines, ensuring systems are in place to maintain Expanded Program on Immunisation (EPI) rates, and improving the quality of child health care. In the PDD, the original outcomes were: systems in place to maintain EPI rates >90 per cent; and comprehensive training in Integrated Management of Childhood Illness (IMCI) leading to at least 10 per cent increase in secondary level paediatric care being safely carried out at Sub-Divisional hospital level or below¹⁵.

A key pillar of the support to EPI has been the **provision of the pneumococcal (PCV), and rotavirus (RV) vaccines**, delivered through a cost-sharing arrangement whereby MoHMS has gradually taken on 100 per cent funding for vaccine procurement. This has been a highly successful approach. Figure 1 below illustrates the changing proportion of the cost of all three vaccines (the third vaccine is against Human Papilloma Virus (HPV); see section 5.1.1.3) funded by MoHMS and FHSSP, and also illustrates the power of FHSSP funding to lever higher counterpart funding. It should also be noted that MoHMS was sufficiently committed to this approach that in early 2013 it agreed to bring forward its 19 per cent payment for the vaccines to offset the changed Australian aid Program funding environment.¹⁶

Figure 1: Vaccine Cost-Sharing Proportions



Source: Based on data provided by FHSSP (estimated status)

¹⁵ 23 Nov 2010, Fiji Health Sector Support Program 2011-2015: Design Document – Final, D. Wilkinson, L. Evans, R. Sutton, p26

¹⁶ March 2014, Fiji Health Sector Support Program 2013 Annual Progress Report, p20



Support to the EPI Program has included assistance with the vaccine procurement process, revision, printing, distribution and training in a new child health record, funding events during Child Health Week and funding training of nurses new to EPI. These activities have contributed to the EPI Program as a whole and specifically to MoHMS being on target to achieve agreed coverage rates for RV and PCV1 immunisation (see Table 6). There has also been a significant body of support directed through Murdoch Children's Research Institute's (MCRI) *New Vaccine Evaluation Project (NVEP)*, which operates as a sub-project within FHSSP. Its purpose is to carry out RV, PCV and HPV vaccine evaluation and establish surveillance systems. It was beyond the scope of this evaluation to assess in any detail the effectiveness of this project, but a report from MCRI identifies improvements in capacity of specific MoHMS staff to carry out surveillance in a range of diseases and to undertake epidemiological analysis¹⁷.

Table 6: Immunisation coverage (RV and PCV 1)

Indicator and target	Baseline (date)	Target (date)	2014 results
Percent (%) coverage for RV immunisation	0% (2012)	95% (2015)	87% (quarter 4, 2014)
Percent (%) coverage for PCV one immunisation	0% (2012)	95% (2015)	87% (quarter 4, 2014)

Source: 2015, Fiji health sector support Program, Progress report: July – December 2014

Improving the quality of child health care level has been tackled primarily through training in IMCI, Paediatric Life Support (PLS), Advanced Paediatric Life Support (APLS) and the World Health Organization (WHO) Pocket Book on Hospital Care for Children. There has also been some provision of equipment. Initially, the focus was on Sub-Divisional hospital level or below but in 2013 the Program expanded its activities to address perinatal care at the three divisional hospitals, in order to reflect the very high proportion of births that occurs at that level of facility. The High-Level Strategic Review prepared for Phase 2 then recommended that IMCI should be shifted down to health centres given the level of postnatal / other care they provide to children under five years. Data is not yet available for the first half of 2015, but at the end of 2014 IMCI, PLS and APLS training was on target. No facilities had yet met the coverage targets for numbers trained in the WHO Pocket Book (see Table 7).

¹⁷ Undated, The New Vaccine Evaluation Project, Fiji Health Sector Support Program and the Ministry of Health and Medical Services collaborative achievements

Table 7: Progress in training coverage

Course	Indicator and target	baseline (date)	2014 results
IMCI	26 targeted facilities: 60% of the nurses in each facility must be trained	46% (2013)	50% of audited facilities have achieved the target
PLS	16 targeted SDH facilities: 30% of doctors and nurses trained	15% (2013)	100% of 16 target SDHs
	12 targeted level A health centres: at least 50% of medical officers and nurses trained		100% of 12 health centres
APLS	3 targeted divisional hospitals: all emergency medical doctors who take care of children should be trained	32% (2013)	75% of audited facilities have at least one medical officer trained
	17 targeted SDHs: at least one medical officer trained per facility		
	8 targeted level A health centres: at least one medical officer trained per facility		
WHO Pocket Book Hospital Care for Children	17 targeted subdivisional hospitals: a facility is counted as covered if all medical officers and at least 50% of are nurses trained	15% (quarter 2, 2014)	None

Source: 2015, Fiji Health Sector Support Program, Progress report: July – December 2014

The evaluation Team met several staff who had been trained with the support of the Program. They felt better able to meet the needs of sick children, in particular the nurses who were able to deal with more cases, rather than referring them straight on to a doctor. The Team saw designated IMCI areas, and were also informed that staff were using the infant health records developed with FHSSP support.

Effectiveness summary

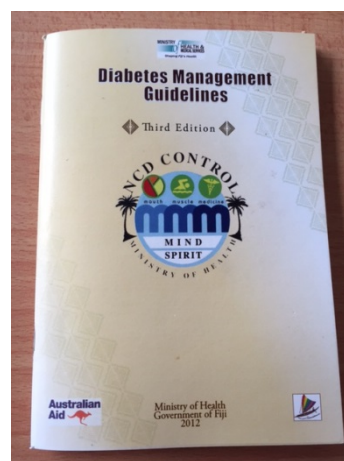
Support to vaccine procurement and EPI has been very effective, although sustaining improvements in surveillance will be challenging beyond the end of the program (see Section 5.6, sustainability) and the team notes the high proportion of Program funds spent on the New Vaccine Evaluation Project (See section 5.4 value for money). The program has performed well in terms of numbers of people trained but the impact of that training has not been measured in terms of quality of care and patient outcomes. It is therefore difficult to conclude that training has been effective.

5.1.1.3 Objective 3: Noncommunicable Diseases

This Objective aims to improve prevention and management of targeted NCDs, including diabetes, and cervical cancer.

The FHSSP PDD had originally envisaged a broad role for the Program in improving the prevention, detection and management of diabetes and its complications at decentralised health service levels. (The addition of cervical cancer came in Phase

2.) The four original diabetes-focused outcomes were: population screening for diabetes undertaken biannually for all persons over 30 years of age; the *Adult Personal Diabetes Record Book* providing an effective mechanism for ensuring the continuum of care of people with diabetes; quality diabetes centres established at all 16 SDHs and selected large urban Health Centres servicing at least 50 per cent of the target population; and the National Diabetes Centre functioning as a national focal point for diabetes training and policy¹⁸. These outcomes evolved in the course of implementation of Phase 1 but the emphasis on screening and establishing diabetes centres remained.



In the course of Phase 1 the Program successfully contributed to improvements in **screening** coverage (from zero per cent coverage in 2011 to 54 per cent by the end of 2013¹⁹) and case detection (which increased fivefold from 2011 to 2013²⁰). This was achieved by the Program equipping and training staff to deliver the national screening Program for hypertension and diabetes.



Upgrades to Specialist Outpatient Departments (SOPDs) to establish quality **diabetes centres** were much more problematic. An initial audit identified that no facility met the minimum standard in terms of staffing, equipment, training and tools/ IEC materials. Upgrades were a joint effort between FHSSP and MOH, and both

parties struggled with the challenge. The major limiting factor for achieving full functionality was the lack of adequate numbers of staff for the diabetes centres²¹. This was responsibility of MOH but it was unable to assign the necessary staff within the wider context of nursing shortages. The Program struggled with infrastructure upgrades for its own internal reasons (personnel issues in the Program) and also because of protracted tender and land title approvals processes. Procurement of equipment by the Program was very limited, again because of its own staffing issues but the Team made some inroads into training, revision of the diabetes management guidelines and development of a supporting audit tool. However by the end of 2013, an audit against the minimum standards showed that the average level of functionality or adherence to the minimum standards was only two per cent across the 10 audited facilities²². The high-level review in preparation for Phase 2 recommended that MoHMS assume screening responsibility (with some ongoing limited support from the Program) and FHSSP focus on tackling diabetic foot

¹⁸ 23 Nov 2010, Fiji Health Sector Support Program 2011-2015: Design Document – Final, D. Wilkinson, L. Evans, R. Sutton, p28

¹⁹ March 2014, Fiji Health Sector Support Program 2013 Annual Progress Report, p 25

²⁰ March 2014, Fiji Health Sector Support Program 2013 Annual Progress Report, p25

²¹ March 2014, Fiji Health Sector Support Program 2013 Annual Progress Report, FHSSP Team

²² Nov 2014 Fiji Health Sector Support Program – monitoring and evaluation plan. Draft release 5.0 p27

disease²³. The rationale for this was that the Phase 1 screening program had highlighted the need to strengthen diabetes management after diagnosis to prevent amputations. In Phase 2, the Program also supported MoHMS in its development of a cervical cancer prevention and screening Program, the rationale being high estimated rates of cervical cancer and mortality, very low rates of screening, and the availability of a vaccine.

MoHMS has now taken on responsibility for achieving its diabetes **screening** targets and has performed well. By the end of 2014, 21 per cent of the 30+ population had been screened against the end of Program target of 25 per cent annually, and MoHMS is confident that it will achieve this target²⁴. Of those screened, more than the target percentage received on-the-spot behaviour change counselling. However the audits of Diabetes Centres against the minimum standards (human resources, appropriate infrastructure, adequate equipment etc.) developed in Phase 1, which have been continued by MoHMS, reveal that their functionality remains very low (6 per cent at the end of 2014 against a modest target of 15 per cent²⁵).

The Phase 2 focus on **foot care** has involved development of a Preventive Foot Care Assessment and Referral training package and training of nurses in targeted facilities in its use. The training in 2015 is progressing ahead of plans so that target is being revised upwards²⁶. The evaluation Team met doctors and nurses involved in diabetic foot care some of whom reported their impressions that referrals for amputations had reduced as a result of this training. The trained nurses met by the Team reported more confidence, competence and effectiveness in dealing with problem cases. It is an omission by FHSSP that data is not being gathered to support this.

Phase 2 support to addressing **cervical cancer**, which was instigated by MoHMS, has focused on provision of the HPV vaccine and improving cervical cancer screening coverage through introducing the "VIA method" (visual inspection through acetic acid) which also enables immediate treatment through cryotherapy in some cases. The technique can be undertaken by nurses instead of doctors making it more accessible, cost effective and in cases where health centre doctors are male, gender appropriate.

MoHMS has met its commitments under the vaccine cost sharing agreement such that it is now solely responsible for funding vaccine procurement (see Table 6) and it has met its targets to date for vaccination coverage among Class 8 girls in school. FHSSP has supported development of the Cervical Cancer Screening Policy 2015, updated cervical cancer screening training materials and carried out training, provided some equipment to enable alternatives to pap smears to be used and treatment to be given in some cases, and funded MCRI to work with MoHMS to strengthen the cervical cancer reporting system and assess vaccine efficacy.

Effectiveness summary

The Program has undertaken a more limited role in improving the management of diabetes than had originally been envisaged largely because of the difficulties in establishing diabetes centres. However the program has successfully supported

²³ 9 May 2014 High Level Strategic Review: Fiji Health Sector Support Program - Final Report p12

²⁴ 23 Sept 2015 Fiji Health Sector Support Program – Program progress report: January – June 2015 p33

²⁵ 2015 Fiji Health Sector Support Program – progress report: July – December 2014 p32

²⁶ 23 Sept 2015 Fiji Health Sector Support Program – Program progress report: January – June 2015 p34

MoHMS to develop and sustain a national screening program. The impact of training in assessment and referral for diabetic foot care has not been measured so it is not possible to conclusively say whether it has been effective. HPV vaccine coverage is on target and effectively supports the implementation of the cervical cancer screening policy.

5.1.1.4 Objective 4: Community Health Worker Network

Objective 4 aims to revitalise an effective and sustainable network of CHWs as the first point of contact with the health system for people at community level.

The original PDD had anticipated a broad role for FHSSP in revitalising the CHW network, which had been languishing as a result of a lack of investment. It was envisaged that FHSSP would achieve the following outcomes: create an effective network of at least 1000 trained VHWS/CHWs who were able to provide basic first aid, promote healthy practices and health seeking behaviours and effectively refer patients to health services; and increased community ownership of, and engagement in, primary health care.²⁷ During Phase 1, however, the Program made limited inroads into the issue. This was due to ongoing unresolved debate within MoHMS about the role and scope of CHWs, how they should be institutionalised in their communities, and how they should be paid. There was also no suitable MoHMS counterpart with whom the Program could engage and, during most of 2013, FHSSP lacked its own technical lead.

The MTR therefore recommended a significant scaling back of this objective in Phase 2, suggesting that future support to this component be provided through a 12-month pilot demonstration in the Northern Division. However, discussion with MoHMS, which preferred a wider coverage by the Program, led to an agreement to focus on training of all active CHWs.

The extent of the scaling back can be seen in the funds allocation to Objective 4. In the original PDD, \$A2.2 million or nine per cent of the original FHSSP budget was allocated, whereas cumulative expenditure by November 2015 of \$1.09 million was less than half this amount²⁸.

Implementation of the more limited objective has been successful. Four training modules have been developed and are in the process of being delivered (an initial Core Competencies module plus three further modules on Safe Motherhood, Child Health and Wellness). The Program has already exceeded its End of Program (EOP) target of training 65 per cent of active CHWs in the Core Competencies module, and is expected to cover 100 per cent by Program end. Training targets for the safe motherhood and child health modules are lower (37 per cent and 34 per cent respectively) and have been met. It should be noted that the original targets were based on a MoHMS estimate of 1,019 CHWs, which proved to be an understatement. The Program then worked with MoHMS to confirm the number of

²⁷ 23 Nov 2010, Fiji Health Sector Support Program 2011-2015: Design Document – Final, D. Wilkinson, L. Evans, R. Sutton, p31

²⁸ Sources of this analysis are the PDD and expenditure data provided by FHSSP.

active CHWs, finally agreed at 1,581, i.e. the total number of CHWs to be targeted for training increased by approximately 50 per cent²⁹.

The EPE Team met two CHWs, who were relatively new to the role and had completed the core competency training. Both women were highly enthusiastic and committed to their roles even though they had busy lives with other responsibilities. Neither of them were salaried and they had to pay most travel expenses including visits to their Zone Nurse to submit monthly reports, and accompanying some patients to seek medical care, out of their own pockets. They described the training as very beneficial and in the course of the interviews were able to demonstrate some of what they had learned. For example, they were able to describe how they had encouraged community members to visit the Zone Nurse, or a health facility, writing referral letters and sometimes accompanying them if the patient requested it. This included encouraging women in the first trimester to attend early ANC appointments. CHWs were also aware of disabled and mentally ill people in their communities, and their needs. They were both very active in their villages, encouraging higher standards of environmental and domestic hygiene by organising community clean-ups and systematic rubbish disposal. The women had also undertaken various initiatives of their own such as 'green vegetable week' to encourage healthy eating. They used the FHSSP-provided flip charts to run health promotion activities in their communities. Both were filing monthly activity data returns to their local coordinator. The impression was that they were performing an active and useful role in their communities in line with the health promotion and advocacy philosophy of the CHW.

The evaluation Team heard positive feedback about the importance of the role of CHWs from other health practitioners from senior paediatricians at CWMH down to staff at health facilities. There seems to be widespread understanding of the importance of CHWs in creating a link between communities and health services, and mobilising the population to take more responsibility for their own health. MoHMS has also recently published a CHW Policy, officially launched on 27 November 2015, demonstrating renewed commitment to revitalising the network nationally.

Effectiveness summary

Although this has been a successful intervention by the Program, it has been more limited than originally planned, and a number of factors, including lack of remuneration, weak links with the health system in some areas, and the future recurrent costs of training, supervising and monitoring CHWs make it a fragile investment. This issue is further discussed in sections 5.6 and 6. Moreover although the training was reported by the program to have been warmly received by participants there is no evidence of the impact upon CHWs' practice.

5.1.1.5 Objective 5: Health Systems Strengthening

Objective 5 aims to strengthen key components of the health system to support decentralised service delivery.

At design stage it was anticipated that the Program would address health information, monitoring and evaluation (M&E), supervision, strategic and corporate

²⁹ Recent revised estimates supplied by FHSSP now put the number of active CHWs at 1833.

planning, and transport. Of those, health information and M&E have become the most significant strategic areas under this objective, along with a substantial input on workforce planning³⁰. However other smaller areas within and additional to the original objectives have received support including development of the MoHMS National Strategic Plan (2016 – 2020), and support for Clinical Services Plan activities, including the CSNs developed under FHSIP, some of which have evolved into valuable vehicles for service improvements. The range of activities included under this objective early on in the Program reflects the more ad hoc approach to system strengthening that existed under FHSIP. In contrast FHSSP, particularly since 2012, has had a more strategic approach.

As a consequence, there has been much higher expenditure on Objective 5 than initially anticipated. In the PDD, Objective 5 had been allocated \$A1.8 million or 7.5 per cent of the original Program funds, but in actuality, to November 2015, expenditure has amounted to \$A4.2 million or 16.1 per cent of the larger Program.³¹

FHSSP's support to the Health Information Unit has enabled significant improvements to be made to the two information systems, PHIS (the public health information system) and PATIS/PATISPlus (the hospital information system). PATIS had been in a particularly poor state at the start of the Program and required wholesale reworking. In addition to supplying technical assistance throughout the Program, FHSSP has successfully supported essential software development and training, production of manuals and supported manual data entry to compensate for lack of connectivity and/or computers. A reasonably high proportion of facilities are now sending in monthly reports on time (see Table 8) and MoHMS had, up until the end of 2014, been carrying out an increasing number of data quality assurance activities, although no further progress was reported in Q1/2 2015³² (see Table 9)

Table 8: Hospital monthly returns, reporting rate

		Percentage of on-time submissions		
Return	Division	2015 Q1	2015 Q2	2015 Q3
Hospital monthly return	Eastern	73%	73%	93%
	Central	75%	79%	83%
MCH forms	Eastern	67%	87%	93%
	Central	62%	57%	71%
Hospital inpatient tear offs	Eastern	60%	60%	67%
	Central	74%	67%	96%

Source: Health Information Unit Presentation, Central/Eastern Divisional Meeting, 4th Quarter 2015

³⁰ 23 Nov 2010, Fiji Health Sector Support Program 2011-2015: Design Document – Final, D. Wilkinson, L. Evans, R. Sutton, p32

³¹ Sources of this analysis are the PDD and expenditure data provided by FHSSP.

³² Based on latest report made available to the EPE team: 23 Sept 2015, Fiji Health Sector Support Program – Program progress report: January – June 2015 (draft), FHSSP

Table 9: MoHMS data quality assurance

Program indicator	2012 (baseline)	2013	2014
Percentage of the annual corporate plan indicators that have meta data documented	0%	9%	69%

Source: 23 Sept 2015, Fiji Health Sector Support Program – Program progress report: January – June 2015 (draft), FHSSP

The establishment of a Resource Network across all four divisions means that there is a network of trained staff supporting planning process and delivery of data in the 45 units that do business planning. This intervention has enabled MoHMS to make major improvements in the quality of its health information at both primary and secondary levels, and has underpinned work by MoHMS and FHSSP on M&E. It has also underpinned improvements in strategic planning. However much remains to be done, in particular improving the rates of online submission (50% of 20 subdivisions submitted online in mid-2015³³), addressing the general under-utilisation of PATISPlus at hospitals, and scaling up and sustaining the Resource Network.

Support to **M&E** within MoHMS has been another success story. In 2012 MoHMS established an M&E technical Team co-chaired by the Director of Planning and Policy with the intention to build capacity for M&E, in order to improve the relationship between activities and outcomes and build a results based approach to planning. FHSSP supplied a long-term technical adviser (LTA) from the end of 2012 funded by the increased budget from scale up, who helped to build a broader understanding of M&E at several levels of MoHMS, and refocus and refine MoHMS national indicators towards outcomes instead of process measures. FHSSP encouraged capacity development in evidence-based decision-making by supporting the Ministry of Health (MoH) annual corporate planning process and providing ongoing support to the quarterly divisional plus workshops, where each division meets with their sub divisional Teams and monitors progress against work plans.

The Evaluation Team met MoHMS staff at a number of different levels who enthused about the benefits of both the HIS and M&E interventions. The phrase “changing culture” was often used, with staff at Divisional level able to describe how, as a result of training and newly available data, and a forum to meet with colleagues, they regularly reviewed and analysed activity information and used it for business planning and to establish and respond to trends. The Team was told that the Divisional meetings are now much more focused on performance and analysis of evidence, with robust discussion of trends and what needs to change. There seemed to be a genuine demand for information, which can be attributed to activities supported by the Program. Although much remains to be done in the future, in terms of quality and completeness of data, necessary software and hardware development,

³³ 23 Sept 2015, Fiji Health Sector Support Program – Program progress report: January – June 2015 (draft), driven FHSSP

and the capacity of the system to respond to evidence, this has clearly been a very successful contribution by FHSSP to health system strengthening.

In late 2012, the Program provided an LTA to support **workforce planning and development** in order to strengthen workforce policies and strategies, and address chronic staff shortages and retention issues. This also has been a successful area of work by FHSSP. MoHMS has been committed to workforce development, endorsing a Strategic Workforce Plan, and a Retention Policy and Strategies. A Human Resources for Health Policy has been developed and a Human Resource Information Management System has been introduced. There is now a Master In-service Training Plan for all cadres and the unit is implementing Master Position Descriptions. Over the course of the Program, doctor, nurse and midwife ratios have improved and average recruitment time has gone down, although the percentage of vacancies still exceeds the target (See Annex 9). A significant achievement by the Workforce Development Unit, supported by FHSSP, was the staff workload ratio and projection assessment process which led to the approval by Cabinet of 93 new allied and technical posts, changing the establishment of MoHMS.

Effectiveness summary

This has been an effective intervention. Support to health information has had an impact on the functionality of PHIS and PATIS and increased the availability of better quality data. Support to M&E has helped to improve the coherence and quality of indicators being used in the corporate planning process. Investments in workforce planning and development have had some demonstrable impact on staffing levels.

5.1.2 Analysis and Learning

The Program has promoted analysis and learning through its work in supporting better M&E in MoHMS (See 5.1.1.5). The Monitoring and Evaluation Technical Team (METT), which is tasked with building capacity for M&E in MoHMS, is also keen to implement its 10-year costed survey plan and is trying to develop research capability. In support of this, the Program developed a one day training module to help Resource Network members facilitate research in their work units³⁴.

The Program is also investing in building surveillance and epidemiology capacity through the NVEP implemented by MCRI. The project reports there is increased understanding of the importance of surveillance within the Fiji Centre for Communicable Disease Control, and at senior levels of MoHMS who value being able to understand Fiji's burden of disease. As a result, surveillance has been included in the new National Strategic Plan (2016 – 2020). MoHMS has also, with the assistance of MCRI, put in place a molecular meningitis surveillance system³⁵.

Data available on Program progress against activity plans has been used in work planning, and some individual activities are assessed e.g. participant and facilitator feedback is gathered at the end of training courses, although changes in clinical practice as a result of training are not measured. However it is not clear that higher level learning, beyond that generated by technical reviews, has significantly informed

³⁴ Monitoring & Evaluation: Research Fundamentals, applied learning. M&E Resource Network Facilitator's Guide, Version 1.1, May 2015, FHSSP

³⁵ Reported in interview

Program planning and delivery. As discussed in sections 5.5 and 5.2.5 (Impact and M&E) the Program does not have much outcome data on its specific interventions so this is not available to inform the design of future interventions.

5.1.3 Gender and disability

5.1.3.1 Gender

FHSSP engaged a gender specialist to produce a *Gender Equality and Social Inclusion Strategy* in 2012. However, it appears that there was no readiness in MoHMS for the *Strategy* at that time. In contrast, since that earlier input, prioritisation by the Prime Minister's Office for Ministries to demonstrate gender awareness and inclusion created a demand for training, and so FHSSP training in gender awareness delivered early in 2015 was well received. Several stakeholders reported a recent turnaround in attitude towards gender equality within MoHMS, (although recent reviews by the PM's office has shown a consistent low rating by the MoHMS in gender) The training reportedly created an increased readiness within MoHMS to engage with the implementation of the National Gender Policy, underway in the Ministry of Women, Children and Poverty Alleviation (MWCPA) with support from the National Gender Adviser funded by DFAT. Policy decisions were to be made regarding whether MoHMS needed its own gender policy or just guidelines on implementation of the MWCPA policy.

Gender analysis and policy setting are relevant to both the MoHMS workforce and patient care. Looking at the gender dimensions of the workforce, several EPE stakeholders noted that female staff out-number men in health facilities. Staff gender data collected at facilities visited by the Team indicated that stereotypical roles are breaking down with a small but increasing number of male nurses and substantial numbers of female doctors (see Table 10 below).

Table 10: Gender Mix at Selected Sites

Health Facility	F Dr	M Dr	% F/Total	% M/Total	F Nurse	M Nurse	% F/Total	% M/Total
Ba Hospital	8	2	80	20	42	3	93	7
Savusavu Hospital	3	3	50	50	28	4	88	13
Sigatoka Hospital	4	2	67	33	39	5	89	11
Seaqaqa Health Centre	3	1	75	25	6	1	86	14
Nabalebale Nursing Station	0	0	0	0	1	0	100	0
Notes:								
1. Nurses include midwives								
2. Figures are unofficial - as collected in the field.								

The Team was told that there are increasing numbers of male students in training as nurses at FNU. Having an explicit gender lens in future planning will aid adaptation in the workplace as the gender ratios continue to change in health facilities.

While technically not MoHMS staff, even though they perform duties essential to the health system and effective primary health care, the situation of CHWs is also

relevant here. Concern was expressed that gender is the primary reason why CHWs, who traditionally are women, have been expected to work on a voluntary basis. In contrast, male village officials receive a stipend. Interestingly, the gender stereotype is starting to break down among CHWs too. For example, in Lautoka/Yasawa 4 of the 73 CHWs are male, and in Macuata, 2 of 35.

Increased gender awareness among health workers and administrators would improve service delivery. An example described to the EPE Team is outlined in Box 2 below.



CHW Glenda Cawara & CHW Champion, Sr Loata Pio, Macuata

Box 2 Gender Responsive Health Care

Cervical cancer screening patient numbers had dipped in one locality in the Division, where the Health Centre had only one doctor who happened to be male. As he was local to the area he knew all the families, which on face value would build good rapport and trust. However, a negative consequence was that women were unwilling to have pap smears. Once this was recognised the situation was rectified by sending in a female doctor. This is an example of good monitoring pinpointing a gender issue and follow-up to solve the issue (Source: interviews at Seaqaqa Medical Centre, Northern Division).

It was noted by respondents that there is under-representation of men in the FHSSP Team, particularly the leadership, and that this could potentially affect relationships with MoHMS leaders. As non-Fijians the Team felt unqualified to make a judgement about this observation, which is couched in cultural values which value older men in leadership roles. However, in terms of the gender mix among staff, the low number of men (four including the driver), presumably affects both social cohesion and the ability to apply diverse perspectives to tasks at hand.



Women waiting at the antenatal clinic at Labasa Hospital

Female patients are intended beneficiaries of Objectives 1-4 and emergent activities. Activities targeted at women and girls include the various MCH interventions, cervical screening and HPV vaccinations. Achievements in these Programs have been described in Section 5.1.1 above). Patient data is disaggregated at point of collection by both gender and ethnic group.

There appeared to be no greater barrier to accessibility of health services for women than men from a health services provision viewpoint. From a patient perspective, lack of awareness and knowledge have been limiting factors, particularly for pregnant women. FHSSP has addressed early presentation for ANC, partly through activities under objective one and also through the CHW model which encourages women to seek medical care at optimal times in their pregnancy.

Overall, the Team believes that FHSSP has made some advances in awareness of gender equality issues within MoHMS from a fairly low base and made a difference in the field to service access by women. These changes are timely, given the greater readiness now in MoHMS to understand and work towards gender equality, resulting from and the need to engage with the new National Gender Policy and recent training by the Program

5.1.3.2 Disability

Targeting the health needs of people with disability has not been prioritised to date in FHSSP, nor within MoHMS. DFAT's *Development for All 2009-14* policy (revised in May 2015) requires inclusive development to be mainstreamed in all Australian aid activities.

Importantly, FHSSP can be seen to have contributed to reducing and even preventing disability. Two key areas described to the EPE Team (although without supporting data) were:

- improved diabetes screening and foot care have reduced leg / foot amputations;
- training (EmONC, PLS, APLS, post-graduate training) and equipment provision (e.g. incubators, Doppler scanners) have reduced risk in deliveries



The diabetes foot care clinic at Labasa Hospital is wheelchair accessible

and neo-natal care.



Western Division MoHMS Office in Lautoka – less accessible

There are clear opportunities for the future Program to work to increase awareness of the rights of all citizens to access health care services. This involves both greater targeting of marginalised groups and improved physical access by Public Works Department to buildings where health clinics operate. The two photos in this section contrast a wheelchair accessible diabetes clinic with a building with stairs which limit access to the clinic conducted inside.

5.1.3.3 Equity

The fact that health services are available free of charge to Fijians is important when considering access to health services. It means that the direct costs associated with service delivery do not prevent poor and vulnerable populations from accessing care. From interviews, it appears that what is limiting access is knowledge and for the poorest and the cost of transport. Knowledge and awareness of which service to seek and when has driven several of the initiatives in FHSSP, particularly the work by Zone Nurses and CHWs with poorer communities, leading to positive results in both Objectives 1 and 3 as described above;

5.1.4 Capacity Development

5.1.4.1 Capacity Development Strategy

Prior to travel to Fiji, it was clear to the EPE Team that the Program Design Document (PDD) lacked a capacity development (CD) focus. CD had been included in each of the five objectives in the PDD but had not been unified into a central foundational strategy of the Program.

The 2012 TAG review also recognised that an overall CD strategy was missing and recommended that additional TA be engaged. As noted in the MTR (p17) the response was to recruit an LTA Workforce Development who took on a dual role of working with the MoH and FHSSP Technical Facilitators to develop a long-term plan for workforce capacity building within Objective 5, and supported the Senior Program Administrator (SPA) in developing standards and guidelines for all FHSSP training. Both the SPA and the LTA Workforce Development brought with them workplace training experience from previous assignments which was of significant value to FHSSP.

Box 3 below lists CD characteristics after recognition of the need to improve CD in FHSSP.

Box 3 Training characteristics from year 3 onwards

- Adult appropriate learning principles in place
- Training standards set
- Competency Based Training
- WHO standards and guidelines used where appropriate
- Training customised to needs of learners
- Additional training in facilitation for trainers who trained their peers (ToT)
- High quality manuals and other reference materials
- Quality assurance of curricula and teaching and learning materials
- Training in English with follow-up discussion in Fijian or Hindi if appropriate

The FHSSP model used the expertise of the CSNs, LTAs and STAs to develop training courses and materials in close consultation with MoHMS partners. They used pre-existing international standards where possible. For example, the *Pocket Book of Hospital Care for Children*, *Mother Safe Hospital Initiative*,

and *Workload Indicators of Staffing Needs* were all adapted from WHO standards. The training model used MoHMS champions to train others. These champions received both technical training and additional training to be effective facilitators. The model appears to have been cost effective and avoided the risks of multi-layered cascade training where the message can become diluted if there are too many layers. Although there has been no formal assessment of long term changes in practice after training, from interviews carried out by the Team it appears that staff responded well to learning from their peers and the training achieved the desired outcomes.

With the benefit of hindsight, a key lesson is that the absence of a Capacity Development Adviser on the FHSSP Team undermined the quality and cohesion of CD, particularly in the early years. A CD specialist could have established training standards and guidelines during mobilisation in 2011, and encouraged assessment

of impact. This person could have made strategic inputs to support CD across all five objectives. Furthermore, the strategy could have included not only training but other means of CD including on-the-job coaching and mentoring. In reality, these functions were spread across the SPA (who already had a full-time Program management role) and a number of LTAs and STAs who put in extra effort beyond their job descriptions to lift the quality of MoHMS training. This came at some cost to those individuals whose work responsibilities grew to beyond a full-time role, with perhaps some hidden cost to themselves and the Program.

5.1.4.2 Capacity Development Results

The Kirkpatrick evaluation hierarchy of four ascending levels of training effectiveness – reaction, learning, behaviour and results – is useful when considering the effectiveness of FHSSP training and capacity development³⁶. Feedback from both training participants and ToT trainers on the quality and relevance of the training and skills acquired was extremely positive. These satisfy Kirkpatrick's Levels 1 and 2. Learning and skills development alone does not always lead to results on the ground. Importantly, the Team also learned of reports of changed behaviour as a result of the training (Kirkpatrick Level 3) and of lives and limbs saved (Kirkpatrick Level 4).

The Team heard directly from health workers and Ministry officials about their ability to apply new learning and their increased confidence – and pride - in doing a better job. Training success stories have been described elsewhere in Sections 5.5 and 5.6. To have indications of achievement of all four Kirkpatrick levels is an endorsement that MOHMS's ToT TA model, supported by FHSSP, is delivering results, although the Program lacks data to substantiate this. Further M&E could also pinpoint opportunities for improvement, and could help to justify further investment, but the ToT model appears to be working well.

Box 4 Unexpected Outcome

The CHW Champion in Lautoka/Yasawa in Western Division noted how her work had become easier following her training as a CHW trainer by FHSSP. Before, she had developed her own training materials, but now she was using the modules and training materials provided by FHSSP in the training. She said that her last group of 23 CHWs had formed a group after the training. They each paid a voluntary contribution of \$F1-2 to the group to use for costs. They now meet monthly to exchange ideas and get/give peer support.

CD is larger than training. An opportunity for the future would be to broaden capacity building strategies. The example in Box 4 includes an unexpected outcome of CHW training which promotes sustainable ongoing learning and fits this broader definition of CD:

In this case it is peer support. Other models include on-the-job learning, coaching and mentoring, staff exchanges, twinning between institutions, and so forth. This is already happening between LTAs/STAs and their counterparts, but not recognised or monitored as capacity development.

A further important CD result was the institutional change in MoHMS brought about through Evaluation Capacity Building. It started as a brief presentation by the LTA on the fundamentals of M&E, but became a 3-day training package with Facilitator's

³⁶ Donald Kirkpatrick, (1996) 'Great Ideas Revisited', *Training & Development*, Vol. 50, No. 1.

Guide for roll-out to different MoH work units, cadres and facilities. Outreach was comprehensive with 358 (274 female / 84 male) staff trained across all Divisions.

Through the training several EPE respondents noted the cultural change in MoHMS as staff felt confident in M&E. The quality of analysis and therefore reporting and presentations improved. Furthermore, this demystification of M&E saw it being integrated with broader planning so that MoHMS staff started to have ownership of business plans, seeing them as central to their work, rather than documents to be shelved. This is further evidence of achievement of Kirkpatrick's Level 4 (impact).

5.2 Accountability

5.2.1 Program Governance

Program governance was deemed to be highly effective. There was consensus in interviews with DFAT, MOHMS and AbtJTA personnel that the Program Coordinating Committee (PCC) works well. The PCC, chaired by the Permanent Secretary, MoHMS, draws its voting members from MoHMS, DFAT and the Ministry of Finance. The FHSSP Team is the Secretariat. Through its biannual meetings held in May and November each year, the PCC provides leadership and direction. Six-monthly progress reports and Annual Plans are tabled, considered and approved at these Meetings. The EPE Team learned that the Program had developed a *modus operandi* which involves pre-meetings and conversations to try to minimise "surprises" at the actual meetings although MoHMS reported this did not always happen (see 5.2.3). These processes are indicative of strong relationships and high levels of trust. If it is necessary to attend to urgent matters between the meetings, the PCC has a 'flying minute' system. Having an effective PCC has given FHSSP the responsiveness and agility required to deal with the unusually high number of changes resulting from the political and economic circumstances since 2011.

The second critical governance body is the Finance and Audit Committee, which meets quarterly (initially, until end 2012, monthly). It had been chaired by the SPA, Karen Kenny, but upon her departure in November 2014 this role shifted to the MoHMS Principal Finance Officer. FHSSP provides secretariat functions. As its name implies, this committee has responsibility for all financial matters and operates at a working level. For example, the FAC monitors expenditure and reasons for variance against the FHSSP budget; prepares recommendations to the PCC for drawdown of the Unallocated Fund; manages financial risk including any suspected fraud; ensures financial recommendations of the PCC (including those made initially by FHSSP auditors), are implemented; and supports MoHMS Teams to prepare their annual budgets³⁷.

An additional body, the Program



Dr Eric Rafai, Dr Luisa Cikamatana & Ms Muniamma Goundar, MoHMS with the Results Framework, 2015 Corporate Plan

³⁷ Information is based on interviews with FAC members and FAC records.

Management Group, was found to be superfluous given that management was embedded in MoH, and the PCC sensibly disbanded it in late 2012³⁸.

Interview respondents noted and approved of the FHSSP governance model, particularly the change from the predecessor FHSIP. Previously, the FHSIP PD had chaired the PCC. The current model with MoHMS chairing both the PCC and the FAC offers MoHMS more autonomy and responsibility, paving the way for sustainability. The acting Permanent Secretary described the PCC as the 'ideal forum' to discuss the Program, having good representation from stakeholders. The EPE Team had expected a third model - co-chairing by DFAT and MoHMS – which is often used in DFAT Programs. However, the FHSSP model seems appropriate and indicative of the evolution of the long-term partnership between Australia and Fiji in the health sector.

5.2.2 Program Management

5.2.2.1 Contracting Arrangements

All three bilateral Programs (FHSRP, FHSIP and FHSSP) have been tendered out by DFAT (formerly AusAID). The Managing Contractor (MC) appointed as a result of the tenders is AbtJTA, formerly known as JTA International. This has provided continuity in relationships with DFAT (AusAID) and MoHMS (formerly MoH) as entities, and through some personnel. It has also meant there has been consistency in corporate oversight and office systems, and even some Program staff.. DFAT is able to devolve responsibility for day-to-day management to the MC while retaining strategic leadership and relationships through the PCC, as well as quality assurance through oversight of the MC contract.

There have been small aberrations to the model. For example, the sub-contracting of Empower Pacific, a provider of counselling services, by the MC under FHSSP for two years only was not driven by FHSSP. It was expedient for DFAT at the time and potentially, if fully integrated with relevant elements of FHSSP– for example, promotion of early ANC booking, diabetes screening, cervical cancer screening and continuum of care more generally - could have led to some positive outcomes. But this sub-activity was removed from FHSSP in 2015 which has been a disincentive to developing ongoing synergies.

5.2.2.2 Effectiveness of Program Management

Program management has been effective in that it has delivered program outputs (see 5.1, above, and Annex 9) and is well regarded by stakeholders. However there has been little investment in staff professional development and a higher than optimal turnover of staff.

Table below summarises findings from the 22 people who were asked to respond to questions relating to Program management³⁹. Questions 7 – 11 in the Interview

³⁸ Advised by Managing Contractor staff.

³⁹ The Team tailored the questions asked each interview. Program management questions were not deemed as relevant or appropriate for all interviews and site visits. Roughly one-third of the 63 people met by the Team responded to Program management questions and shared their insights.

Schedule (Annex 6) ask interviewees to rate five statements. Interviewees had opportunity to substantiate their scores and to raise additional points relating to Program management when responding to Questions 12 and 13. While the sample is small, the insights given are valuable. For example, financial management was the area where the Program was rated most highly, with 77 per cent of respondents strongly agreeing that financial management in FHSSP is efficient.

Table 11: Summary of Responses to Management Questions

	Topic	Strongly Disagree %	Disagree %	Agree %	Strongly Agree %	N/A %	Total %
Q7	Leadership & direction in this Program are effective.			64	36		100
Q8	Management and administration in this Program are effective.			41	59		100
Q9	Financial management is efficient.			18	77	5	100
Q10	Data collected about program activities is accurate.			41	45	14	100
Q11	Program progress reports are useful.		7	39	32	23	100

The FHSSP Team includes the Program leadership and management group who share an office within MoHMS in Suva, coordination personnel in the Divisions, the Corporate Representative and corporate manager in Brisbane, and technical advisers embedded in MoHMS when they are in-country. Each person is contracted by AbtJTA with a set of deliverables in their position description. Team members seem highly committed and very busy. The ratings in Table 11 against the various statements were positive.

Several staff said that they had had limited opportunity for professional development beyond introductory computer courses, and that requests for training had been knocked back. The EPE team did not have time to follow this up with the senior management team to understand these concerns more fully. It may be that a more collaborative supportive culture, which values learning among the team, would build the confidence of staff to continuously improve.

FHSSP has had a higher turnover of staff over its five-year period than the Team would have expected. There has been fluidity in the position titles and in the individuals who have filled the various positions. For example, the SPA position was filled for only three months in 2011 before the incumbent was terminated, then it was filled successfully for three years. When the second SPA left (November 2014), the position was changed to separate out the quality assurance functions that the SPA had taken on which became the TTL position, leaving the financial and management functions for the incoming SPA. The TTL role was filled for seven months only from November 2014 to June 2015, before the incumbent resigned. This left a gap of about four months until the current TTL commenced. Her appointment will last only about eight months in total through to the end of the Program. These changes place added pressures on the team to maintain relationships and manage workflow through transitions. There appears to have been no consistent corporate message to staff

and partners about separations, leaving people puzzled as to why their former colleagues and managers had left.

The (short-lived) initial period of scale-up in 2012 led to appointment of LTAs who were able to make a significant contribution in their fields of expertise. AbtJTA recruited excellent technical specialists, who also had the right personal characteristics to work well in a culturally sensitive manner with their counterparts. The Team learned that the Advisers supported each other, particularly where there was complementarity in their roles. However, while peer support was strong, the diverse leadership functions (relationships, quality assurance, technical inputs, meeting contractual requirements) did not result in one person providing strong leadership and coordination across the five objectives and the Unallocated Fund activities. This role seemed to be split between the Program Director and the SPA (later TTL).

While financial management was rated highly by respondents, the Team did become aware of the use of personal bank accounts rather than the FHSSP bank account for transfers of Program funds to the Divisions to pay for participant per diems and other training costs. While staff did not seem overly concerned, mixing of Program and personal funds is not recommended as it places staff in a vulnerable position. The EPE Team was surprised that the external auditors had not commented adversely on the practice.

Turning to reporting, 23 per cent of the people who answered the Program management questions did not feel qualified to respond to Question 11 on the usefulness of Program progress reports. This is surprising to the EPE Team. Probing further, it appears that only a small group of people actually see the reports. In some cases the respondents prepared inputs to the reports but did not see the final product, or, more usefully, a summary.

5.2.2.3 Alignment with MoHMS Systems

The Managing Contractor had set up systems in previous phases which have been adjusted over time in accordance with external changes such as the change from AusAID's financial processes to DFAT's system. There is a high level of integration of the Program with the Ministry so that systems and processes used align closely where possible.

Financial flows are governed by the head contract between DFAT and AbtJTA. AbtJTA has put in place financial systems which align with Australian requirements (Commonwealth Procurement Rules) and where possible with GoF systems. For example, the financial year used for Program budgets and annual planning is the Fijian year (calendar year) not the Australian financial year. Allowances paid to trainees accord with the Fiji public service rates.

In terms of reporting, as mentioned above in Section 5.1.1.55, FHSSP has strengthened M&E, producing data useful to planners. This, in turn, has supported development of the Ministry's corporate and business plans and helped to create a culture which values use of evidence in planning processes. Program M&E uses MoHMS data, including data from health information systems such as the PHIS and

PATIS which have been strengthened by FHSSP, supplemented by FHSSP records on activities such as training.

5.2.3 Risk Management

The Program manages risks well. A comprehensive risk register is kept up-to-date covering the themes of political commitment, environmental, and financial risks and also addresses Program and objective specific risks; those risks are closely aligned to the MEF and the workplan so that anticipation and mitigation of risk is an integral part of Program management and delivery of technical support.

The risk register is regularly reviewed at PCC meetings, which enables FHSSP to engage openly in dialogue about risks with DFAT and MoHMS, although senior staff in MoHMS said they would appreciate being warned in advance if critical risks were going to be raised.

The ring fencing of specific money (21 per cent of Program total in the initial PDD budget, later reduced to nine per cent of the five-year budget) into an Unallocated Fund to support emergencies and emergent issues – has helped protect FHSSP from derailment and promoted an ongoing focus on ‘core business’, while still enabling the Program to be responsive to MoHMS needs. Throughout the course of the Program, MoHMS has had to deal with a variety of emergencies and problems including dengue outbreaks, natural disasters and preparing for Ebola. Some of these emergencies temporarily delayed activities, for example because staff tackling dengue were too busy to attend training. FHSSP has provided funding to help address specific issues by supporting the dengue outbreak response and a typhoid survey for example, and it has also funded a new disaster plan and supported donor coordination around dengue.

The Program has had to deal with a period of significant uncertainty around funding. In November 2011, DFAT asked FHSSP to consider how it could use more funding to scale up its expenditure from July 2012. The scale up went ahead but seven months into that new financial year when some more long-term advisers had been appointed, it looked likely there would be a significant cut to the Program due to changes in the Australian aid budget. Therefore, implementation was significantly scaled back for the first 6 months of 2013. MoH and AbtJTA absorbed some Program costs themselves: for example MoH pre-funded some co-financing of vaccines, and some international advisers and Program staff took leave without pay. Both scale up and the possible scale down necessitated an extensive process of consultation, planning and re-prioritisation with MoHMS, a lot of work for both parties. The MTR however commended the Program for its response noting that *‘the positive consequence of the scale back is that it is providing opportunities for the Program to adopt creative approaches to identify cost savings, for example in reducing training costs’*⁴⁰. Eventually, the Program did scale up although not to the level originally anticipated.

⁴⁰ 27 May 2013 Fiji Health Sector Support Program Technical Advisory Group: Mid-term Review, piii

5.2.4 Stakeholder Engagement

The Program has generally had effective relationships with MoHMS at both central and divisional levels in terms of agreeing priorities, reporting progress and communicating on specific problems or issues. The PCC and FAC are important vehicles for engagement in Suva (as discussed under Section 5.2.1). Under the previous Program, FHSIP, the Program Director had chaired PCC meetings. Under FHSSP, the Permanent Secretary chairs the meetings and MoHMS has taken a stronger role in leadership of the Program. This has been helped by 'normalisation' of the relationship between the Australian and Fiji governments since the 2014 election.

Effective Program communications have been enhanced by the ability to convey decisions and share information with key MoHMS stakeholders through the Divisional and Divisional Plus Meetings attended by Medical Officers and Sisters in Charge from health facilities in each respective sub-division. These meetings have encouraged horizontal information sharing between sub-divisions, reporting upwards of trends and progress, as well as downward from Suva headquarters of new policies and practices. Furthermore, these meetings appear to have promoted access and enthusiasm for FHSSP activities among Divisional and Sub-Divisional Medical Officers and Health Sisters and health professionals⁴¹.

Program technical staff, Program managers and project officers, by and large have maintained effective relationships with their counterparts in MoHMS, particularly at director level. Many of the Program staff had previously worked within MoHMS which made gave them a head start when building relationships, although not surprisingly Program progress and engagement was challenged when no counterpart was available. There were also instances of Program staff needing to be encouraged to engage better with their counterparts. There was a very strong sense of ownership of Program activities by counterparts and their Teams. Program planning processes and the work in M&E to nest FHSSP activities within the wider MoHMS Program have been very important in encouraging ownership and pride in progress made⁴².

5.2.5 Program Monitoring and Evaluation

Although it has taken some years to get to this point, the Program now has a Monitoring and Evaluation Plan⁴³ (MEP) which is strong as a monitoring plan: it rigorously monitors program progress at input and output level. Work undertaken by a short-term DFAT consultant and the Program in mid-2014 on FHSSP objectives, and then by the long-term M&E adviser on the whole MEP, has produced a Plan which is clearly defined, and based on the government's own indicators where possible. Most of the indicators have baselines and targets. The right data is being collected for assessing Program progress at output level. Because of the work done by the same long-term adviser on the MoHMS results framework, it is clear where FHSSP outputs fit alongside those of government.

The process of workshopping the objectives, using those to define Phase 2 activities, and then developing the MEP, has meant that there is now a much closer link between individual activities and Program outputs (or outcomes as they are termed in

⁴¹ source: interviews and observation of divisional plus meeting

⁴² reported in interview

⁴³ Nov 2014, Fiji Health Sector Support Program – monitoring and evaluation plan. Draft release 5.0, FHSSP

the MEP) , and indicators are relevant. It would have been beneficial to the Program to have gone through this process much sooner so that Phase 1 could have benefited from a similarly rigorous approach.

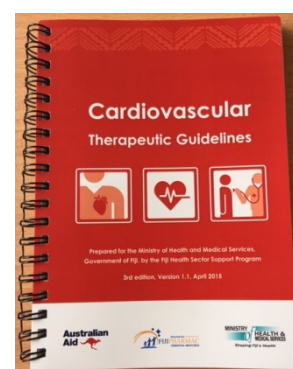
This higher level thinking also meant the Program, with MoHMS, took a more strategic view of the activities to be supported, helping to move away from what was the less coherent approach of FHSIP. The strategy of having the M&E adviser fulfil dual roles of revising FHSSP monitoring as well as working with the government on its own wider results framework (see section 5.1.1.5), underpinned by support to HIU which has significantly increased the volume and quality of data available, has led to excellent alignment by the Program with MoHMS monitoring.

Generally within FHSSP there is a culture of using activity data from a variety of sources, including indicators specified in the MEP, to guide Program management and implementation. Internal assessment of progress against activity targets is very evidence-based.

An area of weakness of the MEP lies in its lack of outcome indicators. The end-of-Program outcomes stated in the MEP are really outputs, and the assumption has to be made that they are then resulting in better health outcomes. For example there is an assumption implicit in the Program that inputs of training and equipment etc., leading to better performance against audit standards, are in turn leading to better quality of care, which is leading to lower morbidity and mortality rates. However all those things are necessary but not sufficient to improve quality and outcomes.

The MEP emphasises inputs and processes but does not really allow space for evaluation of the impact of the Program, i.e. an assessment of outcomes in between outputs delivered by the Program and the high level outcomes of improvements in maternal, child, infant and perinatal mortality rates. There are a couple of exceptions: rates of amputation (diabetic sepsis) and diabetes complications admissions are being recorded (although the introduction of the foot care intervention is too recent to affect annual figures and there is no clear link between the intervention and e.g. amputation rates in facilities where staff have been trained). Also the NVEP is assessing the impact of the respective vaccines on pneumonia, IPD, diarrhoea and HPV infection/cervical dysplasia. It is quite possible that staff trained in IMCI, the WHO Pocket Book, etc., are delivering better outcomes in terms of morbidity, as well as mortality, but neither the Program nor MoHMS are capturing this.

This is in part a product of the restrictions of the two health management information systems and a wish to align with government monitoring but it may have been possible to do small scale evaluations, for example contrasting the perinatal mortality and morbidity outcomes of facilities before and after improvements in audit. Indeed greater emphasis on impact evaluation was recommended by the 2014 High-Level Strategic Review⁴⁴. This should be part of future Australian support to the health sector.



⁴⁴ 9 May 2014, High Level Strategic Review: Fiji Health Sector Support Program -Final Report, Gillian Biscoe & Carol Jacobsen P18,

5.3 Relevance

5.3.1 Millennium Development Goals

The initial drivers of the PDD were assisting GoF to meet Millennium Development Goals (MDG) 4 and 5, to *Reduce Child Mortality* and *Improve Maternal Health* respectively. MDG 3, *Promote Gender Equality and Empower Women* is also relevant although at that time not seen as a driver. The initial proportion of expenditure targeted at Objectives 1 and 2 in the PDD of about 16 per cent has increased substantially to 27 per cent,

5.3.2 Government of Fiji priorities

The Program aligns with the Government's national strategic policy, Roadmap for Democracy and Sustainable Socio-Economic Development. (2009 – 2014), which has two overall strategic objectives for health:

- Communities are serviced by adequate primary and preventive health services thereby protecting, promoting and supporting their wellbeing.
- Communities have access to effective, efficient and quality clinical health care and rehabilitation services.

The Program is well aligned to the Ministry of Health Strategic Plan (2011 – 2015), specifically Health Outcome 1 (Reduced burden of Non-Communicable Diseases), Health Outcome 3 (Improved family health and reduced maternal morbidity and mortality), Health Outcome 4 (Improved child health and reduced child morbidity and mortality), and Strategic Goal 3 (health system strengthening).

FHSSP has been able to contribute directly to health service delivery (bottom-up, through Objectives 1 – 4) as well as support national strategy and health systems in Suva headquarters (top-down, through Objective 5).

5.3.3 Government of Australia priorities

The Government of Australia has a long history of supporting the health sector in Fiji through the Fiji Health Management Reform Project, (1998-2003), followed by the Fiji Health Sector Improvement Program (2005 – 2010). Australia has also provided support to the former Fiji Schools of Medicine and Nursing, to vaccination, and, as part of a broader community development program, is supporting a community grants program which includes community health worker support, separate to FHSSP. The current health program continues and complements the work already supported by Australia in the health sector.

FHSSP is well aligned to DFAT's Fiji Country Strategy 2012–14 and to the subsequent Fiji Aid Investment Plan (2015/16 to 2018/19) particularly the focus on increasing the capacity and efficiency of the current health system and supporting Fiji to respond to its emerging epidemic of non-communicable diseases with a focus on cost-effective primary care and prevention. The Program directly contributes to the

benchmark for improved health outcomes: reduction in common childhood illnesses resulting from introduction of rotavirus and, pneumococcal vaccines⁴⁵.

5.3.4 Consistency with aid effectiveness principles

Aid effectiveness principles include: developing countries set their own strategies; donor Programs align with partner objectives and systems; donor harmonisation; delivering results; mutual accountability; inclusive partnerships; and capacity development⁴⁶. FHSSP meets most of these criteria as described below.

The rolling annual plan model has allowed FHSSP to prioritise activities within the five objectives in line with MoHMS' priorities over time, achieving ownership. The governance model supports MoHMS having a proactive role. Respondents have noted the improvement from the previous FHSIP where the Program did things 'for MoHMS' rather than 'with MoHMS'. Not only is alignment much closer, but FHSSP has been able to support MoHMS' strategic planning. Examples include: strengthening the M&E which informs the strategic planning process; influencing development of the Ministry's 2016 budget submission to the Ministry of Finance; and, supporting development of the *National Health Strategy 2016-2020*.

Donor coordination in the health sector is driven by the MoHMS. Initially, FHSSP had organised donor meetings, continuing a practice established in FHSIP. However, appropriately, the Permanent Secretary took over this role early in the FHSSP implementation years and now MoHMS holds donor coordination meetings and gives presentations on recent Program progress along with associated expenditure.

The program engages with other donors (UNICEF, UNFPA, WHO, Japan International Cooperation Agency (JICA), NZ Ministry of Foreign Affairs), on specific issues and coordinates with other DFAT funded projects as required (FCDP, the Access to Quality Education Program and AVID). For example, FHSSP supported donor coordination to tackle dengue.

Clearly, JICA are actively engaging with FHSSP. The Team met representatives of the JICA *Fiji & Kiribati Project for Prevention and Control of NCDs, 2015-2020* both at the Central and Eastern Divisional Meeting and the Aide Memoire presentation along with a representative of the JICA Suva office.

The EPE team believes that in the wake of the Fiji election there is scope to improve strategic planning and coordination in the health sector with other donors active in Fiji. However, this is more relevant for design and implementation of a future program than for FHSSP given that there are only a few more months to run.

One of the hallmark achievements of FHSSP is the close relationship established between the Program Team and their MoHMS counterparts. A true partnership has developed, ironically without 'partnership' having been an explicit aim of the design. Examples of this close relationship included:



⁴⁵ 2015, Fiji Aid Investment Plan (2015/16 to 2018/19)

⁴⁶ OECD DAC The Paris Declaration on Aid Effectiveness

- the Divisional Plus Meetings serving the purposes of both MoHMS and FHSSP;
- the FHSSP office is co-located with MoHMS and individual technical advisers are embedded with their counterpart Teams within the Ministry;
- the dual role taken on by Douglas Glandon, LTA in M&E (now STA), to develop both the MEP for the Program and support the M&E strategy for the Ministry as a whole, and its integration with the corporate and business planning cycle;
- use in FHSSP reporting of information from MoHMS databases;
- FHSSP representation on key MoHMS committees, such as the Budget Steering Committee.

5.4 Efficiency

Value for money (VfM) includes considerations of economy, efficiency, effectiveness and equity⁴⁷. It has not been possible to do a detailed VfM analysis within the EPE scope of work. However, this Section includes some relevant observations and insights gained from the data within each of these categories.

5.4.1 Economy (least cost inputs relative to their quality)

Two observations below are relevant when considering FHSSP's achievement of economy:

- i) The Team queries whether FHSSP had achieved VfM from the composition of its leadership Team. Reshaping of positions and re-hiring is indicative that the initial mix of technical and management expertise across positions was not optimal. It is good that this was recognised and fixed, but the additional costs of unanticipated staff changes included recruitment and mobilisation costs, and time for new replacement staff to establish relationships and become fully operational. These costs have to be weighed against the benefit of increased contribution from the affected position and overall program effectiveness. For the two short-lived appointments (of two months for the initial SPA, and eight months for the first Technical Team Leader) the cost outweighed the benefit.
- ii) the cost-sharing model for vaccine purchase described in Section 5.1.1.2, which has a sliding scale reducing Australian contribution and increasing Fiji's contribution over time, is considered efficient, effective and sustainable. It is recommended as a model for the future, not just for vaccines.
- iii) The program appears to have achieved better value for money than expected on its overheads. Other program expenditure/internal business has to date represented 33.1% of program expenditure rather than the 37.1% allowed for a program design.

⁴⁷ http://betterevaluation.org/evaluation-options/value_for_money

5.4.2 Efficiency (value of results relative to cost of inputs)

Table below provides analysis on the breakdown of FHSSP expenditure from July 2011 until November 2015 by Objective and the Unallocated Fund⁴⁸. It compares actual expenditure with the allocation projected in the PDD, revealing some interesting observations. When combined with other disaster relief expenditure, the Unallocated Fund amounts to 11.2 per cent of total expenditure. Although this is significantly lower than the 20 per cent budgeted in the PDD, it is not a surprising finding as the original volume had proven unmanageable and deliberate action had been taken by the PCC to reduce the Fund.

Table 12: Expenditure to November 2015 by Objective

Category	Actual to Nov 2015 AUD	Actual as % of Total	PDD % of Total
Obj 1: Safe Motherhood	\$ 2,024,419	7.8	8.3
Obj 2: Healthy Child	\$ 5,035,532	19.4	7.5
Obj 3: Specific NCDs	\$ 2,090,150	8.1	9.6
Obj 4: CHW Program	\$ 1,092,221	4.2	9.2
Obj 5: Targeted HSS	\$ 4,188,790	16.1	7.5
SUB-TOTAL	\$ 14,431,113	55.6	42.1
Unallocated Fund	\$ 1,996,465	7.7	20.8
Flood Recovery/Dengue Response	\$ 917,618	3.5	
Other Program Expenditure/ Internal Business	\$ 8,597,291	33.1	37.1
SUB-TOTAL	\$ 11,511,373		
TOTAL	\$ 25,942,486	100	100

Source: Financial report summary, July 2011 – Nov 2015, FHSSP, Dec 2015

What is notable is the distribution across the five Objectives, where Objective 2 has swallowed up almost 20 per cent of funding (when only 7.5 per cent was planned) and at 4.2 per cent, Objective 4 has realised less than half its budget (a reflection on the difficulties of addressing CHWs). The reason for the blow-out relative to the design in Objective 2 appears to be the retro-fitting of the purchase of the vaccines (albeit in the cost-sharing model with MoHMS) and the NVEP sub-contracted to MCRI. For example, expenditure on these two categories alone in the six-month period January to June 2015 was \$A651,583. While the principle of evaluating the effectiveness of the vaccination Program is sound, the cost is high. The Team wondered about the extent to which the PCC had considered VfM when approving the NVEP, particularly the opportunity cost of those funds.. For example, the Program has under-invested in other impact evaluation. Training has absorbed

⁴⁸ It should be noted that this analysis is approximate as the Phase 1 accounting practice adopted of grouping 'carry-over' underspent funds from previous years as 'Other Program Expenditure' without distributing it by category makes it impossible to be more precise.

significant funds, but there has not been any evaluative research on overall training effectiveness.

5.4.3 Effectiveness (achieving program outcomes in relation to the cost of inputs)

A big change, which came about during the scale-up, was approval for the LTAs. This contributed to an increase in expenditure on Objective 5 from the planned 7.5 per cent to the actual 16.1 per cent (see Table 12). It is the view of the EPE Team that the contribution of the LTAs has been significant, and that without the MEP and workforce planning support in particular, the overall impact of FHSSP would have been less⁴⁹. The question then should be posed that if scale-up was needed to provide the budget for LTAs, which in turn allowed FHSSP to achieve its objectives, was the PDD budget under-funded? Was it realistic to expect the planned level of change without sufficient input by international advisers? Feedback from MoHMS respondents was that Fiji values international expertise and that this investment was most worthwhile as it contributed substantially to skilling up MoHMS staff to produce planned outputs.

The context at the time is also important. Under the Rudd Government, a review was undertaken into remuneration of advisers employed by the aid Program⁵⁰. It is assumed that the design Team was under direction to minimise adviser inputs. Sufficient investment in TA, and determining exactly what is 'sufficient', is an interesting VfM question which has implications for the future design.

At the other end of the scale, the Team learned of success stories which came out of relatively small targeted investments such as printing training materials, health cards and manuals, and providing logistics support for audits (see section 5.1), which plugged gaps in the MoHMS budget and enabled activities to take place. These represent efficient and effective uses of Australian and MoHMS funding.



Health information forms an important part of the child health record

5.4.4 Equity (benefits are distributed fairly)

FHSSP resources have been invested in all four divisions, as well as MoHMS in Suva. In terms of MoHMS staff beneficiaries there has been broad participation from MoHMS headquarters in Suva and from the decentralised health offices and facilities in the four Divisions, aided by Divisional Plus meetings.

Distribution of investment within each of Objectives 1 to 4 has aimed at affected populations fairly broadly⁵¹. However, one exception may be the decision to focus

⁴⁹ Based on meetings with MoHMS and the implementing team and review of key documents produced by the LTAs and their counterparts.

⁵⁰ The *Joint Adviser Review Report* was issued by Government of Australia in February 2011. This resulted in the *Adviser Remuneration Framework* also issued in February 2011.

⁵¹ Bearing in mind observations made in Section 5.1.3 above on gender and disability

MCH support to health facilities where a very high proportion of deliveries occur. While this was made on the grounds of efficiency, assessing the consequences in terms of equity would take further investigation.

5.5 Impact

Activities carried out by the program have the *potential* to have a long-term impact:

- The introduction of three new vaccines, coupled with continuing high EPI rates, is very likely to have a positive impact on the incidence of rotavirus, pneumonia and cervical cancer.
- Improved childbirth practices could reduce disability and infant mortality.
- The audit approach supported by the Program has highlighted shortfalls in service provision and helped to develop a common focus on how to address them. It is also demonstrated that the audit approach is an effective lever for improvement. Long-term impact could be achieved if these audits are sustained, and the results used after the end of the Program, and service shortfalls are addressed.
- Investments in developing the two health information systems (PATIS and PHIS) have had immediate impact and will provide the necessary foundation for improvements in the future. In particular, the Program took the essential step of revamping PATIS into PATISPlus, turning it from a non-functional system into one that is better able to complement PHIS⁵².
- The additional staffing levels approved as a result of the efforts of the workforce development unit and the LTA could increase access to care.
- The continued support to the Clinical Service Networks has underpinned many of the Program initiatives and has created new collegiality, and promoted higher standards⁵³. The paediatric CSN at least looks likely to continue this work beyond the end of the Program.
- Assuming that MoHMS is able to sustain it, diabetic screening and counselling could lead to better outcomes for those with the condition. Similarly, cervical cancer screening and early treatment have the potential to reduce deaths from this condition.
- The trained CHWs could have a long-term positive impact on the health seeking behaviour of the population of Fiji. However much depends on policy environment, how they are managed and whether they are paid.



A patient from Taveuni transferred by boat was joined by a patient from Savusavu Sub-Divisional Hospital. Both destined for treatment at Labasa Divisional Hospital.

However as discussed in section 5.2.5, the Program has little outcome data on its specific interventions, with the exception of the preliminary RV vaccine impact study which is showing a drop in the incidence of rotavirus among children admitted to

CWMH⁵⁴. This means that there is no evidence of impact.

The FHSSP biannual progress reports present data on maternal, child, infant and perinatal mortality rates, and rates of amputation (diabetic sepsis) and diabetes complications admissions. In the absence of impact data from program activities, it may be possible to say that FHSSP has *contributed* to wider government efforts to improve these outcomes, even though it cannot claim specific *attribution*.

Anecdotal data gathered during the EPE suggests that the Program may be making a difference across all five objectives although as mentioned above, this is not supported by robust Program data which is not available:

- Staff who had been trained in foot care by the Program reported that they believed they were referring fewer patients for amputation⁵⁵.
- A consultant at a divisional hospital reported a significantly reduced workload in obstetrics and gynaecology because Sub-Divisional hospitals were better able to cope with cases instead of referring them upwards. In addition, he observed that where a sub-division did need to refer cases e.g. incomplete miscarriage, they were better stabilised and had referral letters.
- A divisional medical officer estimated that she had received fewer unusual occurrence forms for childbirth which she believed was indicative that training had resulted in fewer emergencies.
- There were informal reports of reduced sepsis rates among new mothers.
- Some nursing staff involved in delivering IMCI reported that they were admitting fewer cases of children with diarrhoea, were able to treat sick children more effectively, with greater confidence, rather than simply refer them to a doctor. This freed up the doctor to do other work. They also reported shorter waiting times for treatment and fewer complaints from parents.
- MoHMS staff from Ministry down to sub divisional level reported that they are using information more effectively, because data is now more available and accurate, they now understand its importance and how to use it. This was borne out by interviews in which several staff referred to data that they were collecting that had influenced their service delivery, or where they described trends in service usage with reference to data. The Divisional Plus meetings provide a forum for monitoring progress against workplans and consulting with colleagues.

The EPE strongly recommends that if possible FHSSP carry out some small scale impact studies before the end of the Program, particularly in those areas where sustainability is likely to be a problem after the June 2016. For example hard data demonstrating an impact of training on health outcomes (morbidity and disability reduced, lives saved, amputations reduced etc.) would add weight to the argument that training should be funded by MoHMS. There is considerable volume of data recorded in the registers at facility level, which combined with a review of patient notes may give an insight into whether some simple outcomes have been achieved.

⁵⁴ NVEP. Preliminary RV vaccine Impact Results, 28th September 2015

⁵⁵ Outcome data noted by the Program in its biannual reports includes reduced amputation rates, but this data is probably not yet responding to specific Program inputs beyond screening, as the FHSSP foot care training package only started to be rolled out in 2015.

5.6 Sustainability

The project has taken an early and strategic approach to sustainability and, since November 2014, has been implementing an Exit Strategy which is designed to engage all partners in the issues that need to be addressed to achieve sustainability beyond the end of the Program. The Exit Strategy is closely aligned to the M&E plan and is clearly a comprehensive and useful tool, which the evaluation Team encourages the Program to continue to use. The EPE Team was less convinced by the usefulness of the end of Program sustainability self-assessment survey as it is not clear what added value or new information it will produce that could be acted on in the time available once the results have been analysed.

MoHMS has already successfully taken on responsibility for some Program activities, e.g. funding 100 per cent of vaccines (see section 5.1.1.2), and delivering diabetes screening. This reflects a strategic approach by the Program, particularly in Phase 2, to build sustainability into its activities from the outset wherever possible.

However the MoHMS budget remains very constrained so the need for external funding for the day-to-day recurrent costs of many activities remains. It is significant that FHSSP was able to support MoHMS in putting together its 2016 Budget submission to the Ministry of Finance, but disappointing that there was a shortfall of \$F60 million in the budget appropriation. Moreover, MoHMS' absorptive capacity is still problematic, with staff shortages, competing demands, early retirement and staff rotation all presenting problems to sustainability. This is particularly acute at the divisional level.

Much will depend on MoHMS being able to fund specific posts beyond the end of the Program in the areas of health information (four posts to sustain PHIS), surveillance (appointment of three people trained by the Program) and cervical cancer Program coordination (one post). The Permanent Secretary has recently given approval for these posts to be funded by MoHMS⁵⁶. The Program had already had some success in transferring an FHSSP position to MoHMS: the Project Officer Workforce Development and Training transitioned to an established MoHMS position in July 2015.

Improvements to date in PHIS and PATIS software will remain, but MoHMS lacks funding and staffing for important further development and maintenance contracts, and is only able to make minimal investment in hardware, so improvements will stall without further support. Access to PHIS online and PATISPlus will not become available at any more facilities without further investment. The dispute with the supplier of the pathology system linked to PATIS, which means no maintenance or development is now taking place, will, if it is not resolved, become a bigger problem as more clinical data is required in future. The Program has identified that sustaining the momentum of the METT and Resource Network will also be a key challenge. MoHMS has no specific budget for M&E despite this being an area of increasing importance.

⁵⁶ Funding was made available within the existing MoHMS budget as a result of an exercise, supported by the Program, to reallocate funding from persistently "vacant" positions to an HR contingency fund which will support an extra 57 positions that were missed out in the budget.

MoHMS has taken on responsibility for some training e.g. family planning counselling, and some of the CSNs, e.g. paediatrics, and obstetrics and gynaecology, are likely to remain active beyond the end of the Program which will be important to ensure service standards and the continuation of training. There have also been efforts to find low-cost training alternatives e.g. online, to reduce travel costs et cetera. The Program is likely to meet most of its training coverage targets and FHSSP's investment in training will continue to be of benefit to those individuals trained, but there is a high rate of staff turnover at facilities. This may lead to a trickle-down effect as staff are posted into other facilities but it also means that experienced facilitators move on, necessitating an ongoing investment by MoHMS in training. Although training is included in the Master In-Service Training Plan, the FHSSP January to June 2015 progress report noted that no specific allocations were made to each course, and divisions have been expected to allocate funding. However in 2015 these divisional budgetary allocations were put on hold, thereby increasing the dependency of in-service training on donor funding ⁵⁷. Again in the 2016 budget no specific funding has been allocated to mother safe audits and training or child health training beyond an inadequate amount ear-marked in the In-Service Training Plan for the Paediatric CSN's training plan. However this alone will not be sufficient for them to implement it.

Maintaining the quality of training in the future may be an issue. The experience with the post-miscarriage care training which was taken up by MoHMS, shows that there is a risk that the content of training may shift without ongoing technical monitoring. There is also evidence from other countries that a training of trainers approach may not always be able to sustain quality. The continued involvement of senior clinical staff through the CSNs, will be important to ensure quality is maintained.

Even with the recently approved surveillance posts the expectation that MoHMS will conduct routine surveillance of pneumococcal and rotavirus vaccines in the long term may be ambitious given the investment needed to improve laboratory infrastructure. There may be some ongoing technical support by WHO, but MoHMS does not contribute any funding to surveillance, nor has it committed to do so beyond the approved posts.

The benefits from supporting the Workforce Development Unit will be dependent upon those in leadership roles continuing to own and progress its achievements, e.g. implementing the Strategic Workforce Plan.

The introduction of a national cervical cancer screening Program, is important given the high incidence of and mortality arising from cervical cancer. Although in the long-term incidence of cervical cancer should reduce as the HPV vaccine is given to more girls, there is likely to be a short-term increase in the need for cancer treatment among newly detected advanced cases. The EPE did not have the opportunity to look at this in depth but it was not apparent that there has been specific planning to address this knock-on effect on cancer treatment services.

The investment in training community health workers is probably the most vulnerable of all the projects' activities. Although the policy has now been launched, there will be recurrent costs of training, supervision and monitoring which are currently not

⁵⁷ PR 15 P 30

covered by an MoHMS budget line. And very importantly the issue of how they should be paid remains, with MoHMS looking to other ministries to contribute. A one-off payment promised for this December will go some way towards covering their out-of-pocket expenses, but this is not a long-term solution.

5.7 Summary of Lessons Learned

5.7.1 Success Factors

Success factors in the Program are as follows:

- Long-term support by the Australian aid Program to the Fiji health sector through one contractor has built good relationships and trust, which has enabled the three parties to maintain Program momentum and weather changes in political circumstances and variations in donor funding.
- FHSSP, and particularly Phase 2, has taken a more strategic approach to Programming, moving on from FHSIP's more eclectic approach. The Program has been able to strike a balance between maintaining focus and meeting individual requests from MoHMS, which have not always fitted into the Program's core business, and supporting emergency responses. This has contributed to FHSSP's and by extension DFAT's good relationship with MoHMS.
- Although the variations in funding were problematic for the Program at the time, they did mean that FHSSP and MoHMS had to think very carefully about what interventions the Program should be funding and where the greatest impact could be made with the funds available.
- Program scale up bought added value. This enabled the deployment of long-term advisers in key areas of interest to MoHMS – M&E and workforce development – and the continuation of long-term support to HIU.
- Technical assistance, particularly through the LTAs has been acknowledged by MoHMS as generally being of good quality. MoHMS has appreciated having LTAs embedded in its Teams, because they were more effective than STAs at building capacity, they understood the environment much better and therefore were better able to recommend appropriate and sustainable solutions. Although MoHMS would rather have kept the advisers as long-term, it acknowledges that transitioning them to short-term has been successful. It has also contributed to exit planning.
- The Program has spent some of its funds on some fairly low-cost interventions (e.g. printing child health records, funding travel costs to enable staff to do supervision visits, supporting Divisional and Divisional Plus meetings) which have enabled vital gaps in the MoHMS budget to be plugged and which have had an impact beyond the scale of the investment.
- Having one adviser work on both FHSSP's and MoHMS's M&E promoted alignment of Program monitoring and content.
- Within MoHMS, the Program successfully identified a level of staff – directors and national advisers – where it could have a direct influence on their capacity and, by extension, the work they do.

- FHSSP has supported useful things that have made an immediate difference to service delivery e.g. training, developing standards, in addition to supporting higher level policy level interventions e.g. on workforce development. This has built goodwill towards the Program at all levels of MoHMS.
- Maintaining the involvement of the CSNs has been important to bring about change in service delivery, driving up standards, building relationships between different cadres of clinical staff, linking public health and clinical services and promoting better alignment between policies, clinical interventions and training.
- In some activities, FHSSP has had an upfront exit strategy built into the design of the intervention e.g. vaccine cost sharing.

5.7.2 Challenges

The Program has faced a number of different challenges:

- Although Phase 2 of the Program ultimately ended up being better funded than Phase 1, periods of budgetary uncertainty in both 2013 and 2015, generated extra work for both the Program and MoHMS, reduced implementation to a minimum for 6 months and caused upheaval.
- The absorptive capacity of MoHMS has been an ongoing challenge in a number of different areas for example staff availability for training. This has been particularly acute when MoHMS has been dealing with an emergency such as dengue. More broadly, the fundamental problem of lack of available budget for non-staff recurrent costs threatens the sustainability of the Program and has made implementation challenging.
- Although ultimately the civil service reform environment may be beneficial to the health sector, in the short-term it has meant a freeze on new posts. In addition, MoHMS continues to be challenged by losing its older and more experienced staff to retirement at age 55.
- High staff turnover in MoHMS, and also to a certain extent in FHSSP, has meant posts have been vacant and new staff have had to be 'brought up to speed'.
- Not surprisingly, the Program has struggled to find traction where the policy environment has been weak. Although progress has been made on the CHW Program, sustainability in this area is questionable and Objective 3 on NCDs has had limited impact partly because the Ministry has been evolving its thinking on 'wellness' but also because the wider policy environment vis a vis NCDs, beyond that controlled by MoHMS, means that making an impact on NCDs is challenging.
- Throughout the Program, interventions dependent on infrastructure have been problematic. Objectives 1 and 3 have suffered from this, and the Program did well to contend effectively with the request to fund a new birthing centre.

An ongoing issue is the failure of MoHMS systems to fund the equipment needed for people to do their jobs. Often FHSSP was asked to fund procurement of basic equipment because it was easier than waiting months for the system to provide. This is neither sustainable nor a strategic use of project funds.

6. Recommendations for the next phase of DFAT funding

These recommendations have been selected to inform the design of the next phase of DFAT funding for health in Fiji. In depth analysis of the recommendations, their prioritisation and feasibility should be undertaken during the design phase.

6.1 Strategic framework

The United Nations' Sustainable Development Goals should help to frame the priorities for the Program including Goal 3, Good Health and Well-Being, (reducing maternal mortality, ending preventable deaths of newborns and children under five, reducing premature mortality from NCDs, increasing health financing, building capacity to deal with national and global health risks and addressing HR shortages), Goal 5, Gender Equality (access to sexual and reproductive health and reproductive rights, end discrimination, opportunities for leadership) and Goal 16 Strong Institutions (Effective accountable and transparent institutions).

The forthcoming Health National Strategic Plan 2016 – 2020 should also frame engagement by the Australian aid Program.

6.2 Continuity from FHSSP

Continued support to health information will be important to underpin any efforts in health systems strengthening. FHSIP and FHSSP have made a very important contribution to helping MoHMS improve its M&E, and the future Program should continue to support a growing results focused culture.

Continued support to workforce planning and development could also help to address MoHMS staff shortages and misalignment of human resources with workload.

A focus on hard to reach women, linked to efforts to reduce maternal mortality. Efforts to mobilise more women to attend early ANC should be continued, linked with investments in CHWs.

A more strategic multi-sectoral view of noncommunicable diseases is needed. These are a growing problem in Fiji. Despite its efforts, MoHMS has had little effect on incidence rates of diabetes and hypertension, and their risk factors. The emphasis in FHSSP on better clinical responses to diagnosed conditions should continue, and there should be wider support to implementation of the NCD strategic plan (2015 – 2019). However the Australian government should also consider how it can work with MoHMS and other government departments to support multi-sectoral action. An approach based on health promotion and disease prevention is important but without wider action on, for example, lifestyle, social policies, food regulation and education, the work of MoHMS alone will have limited impact.

The model of cost sharing should be replicated. This has been successful in the introduction of vaccines and to a certain extent in other areas where MoHMS has picked up funding to ensure the continuation of interventions. The Program has demonstrated that dialogue about an exit strategy is effective. Program staff recommend starting the dialogue early in the Program.

Selected continued investment in CHWs. A significant proportion of active CHWs will have been trained by the end of FHSSP. The focus of any future support therefore needs to be on institutionalising their role in line with the new CHW Policy, and establishing some sort of incentive scheme to ensure their continued work.

An explicit focus on capacity development. As discussed above, an important element of FHSSP has been capacity building. The next phase of support should have a more explicit focus on this with clearer measures of outcomes.

A more coordinated and evidence-based approach to planning and evaluating aid Program activities to ensure better alignment and integration with MoHMS priorities and activities. Aid funded activities make demands on other parts of the health system, and better program planning in the context of the sector as a whole would ensure readiness of the system to accommodate changes brought about by investment of Australian aid. This would for example help to ensure MoHMS can supply adequate staffing and equipment to sustain Program supported improvements. The next phase of Australian support should seek to ensure from the outset that policies, systems and budgets are in place to support interventions.

6.3 New areas

Support to more coherent evidence based results focused planning and budgeting. Although there is now more information about the health sector than ever before, there is a weak link between inputs and outcomes. Also there is little understanding of what it costs to deliver services at each level or what it would cost to introduce new ones, for example the cost of necessary follow-on treatment identified by national cervical cancer screening. Not only does this make service planning difficult, but it has undermined MoHMS' ability to draw higher levels of financing towards the sector. The Ministry of Finance can be swayed by evidence and analytical rationalisation – for example the Workforce Development Unit exercise to analyse staff workload ratio and projections justified the creation of newly funded posts - but Fiji's General Government Health Expenditure as % of General government expenditure is still less than most other countries in the Pacific. Capacity needs to be built in MoHMS to plan, cost and thereby justify services based on an assessment of likely impact. A forthcoming World Bank public expenditure review will provide a useful start to this process.

Promoting gender equality: A new Program will provide an opportunity to build on the increasing gender awareness in MoHMS following training delivered by FHSSP in 2015, and the Ministry's engagement with the Ministry of Women, Children and Poverty Alleviation regarding operationalising the new National Gender Policy. The follow-on Program could seek opportunity to engage with DFAT's Pacific Women facility, to see if there are opportunities to create synergies, potentially through a joint pilot activity of relevance to both. This would give a jump-start to gender-aware activities in health.

Targeting vulnerable groups: Disability reduction has been a by-product of FHSSP but there has been no focus on the needs of people with disability through the Program to date. There would be scope to work both at the strategic level on policy-setting as well as service delivery.

6.4 Potential areas for future exploration

The team also recommends that MoHMS and DFAT, supported by the design team, consider the following new areas. These were flagged to the team in the course of fieldwork as developing technical challenges.

Reduce the high and growing birth rate among teenagers. The Team learned that a particular at-risk group for childbirth complications and low birthweight babies are teenagers who become pregnant through failure to use contraception. Early childbearing also limits educational attainment and other personal development opportunities.

Rational and cost-effective provision of services needs to be addressed. Patients are choosing to go to divisional hospitals rather than Sub-Divisional hospitals or health centres leaving some facilities overcrowded and others under-utilised. This inefficiency has a possible knock-on effect on availability of essential items in outpatient departments, and longer waiting times, and may also divert resources away from primary care.

Forthcoming civil service reforms should be supported. The details of the devolution of budgets to the Divisions were unclear at the time of the review. However concern was expressed to the evaluation Team that Divisional Medical Officers would become responsible for budgets in January 2016, when they had had no training and little capacity to be so. There may be an opportunity for the next phase of funding to support MoHMS in reforms.

Resources for Program delivery: The Team learned of several instances where Australian volunteers had contributed to FHSSP activities (e.g. through Empower Pacific, and in development of training materials for foot care). Engaging AVID volunteers in appropriate roles would potentially make available additional skilled resources to MoHMS and encourage people-to-people links. Exploration of a partnership arrangement of mutual benefit which plans and supports regular placements of volunteers could be beneficial.

Annex 1: Terms of Reference

Australia Fiji Health Sector Support Program (FHSSP)

End of Program Evaluation: Terms of Reference

These terms of reference serve to commission an independent End of Program Evaluation of DFAT's support for Fiji's health sector through the Ministry of Health and Medical Services.

This review will evaluate the extent to which the Fiji Health Sector Support Program has achieved its objectives, assess its implementation approach, compile lessons learnt, and provide recommendations that will inform and shape DFAT's future engagement with the Government of Fiji through the Ministry of Health and Medical Services.

1.0 Context and Background

1.1 Australia and Fiji have an enduring bilateral relationship, underpinned by strong people to people links and longstanding trade and investment ties. Australia's national interest is in a stable and prosperous Fiji that is an active member of the Pacific community. A robust bilateral relationship and our shared historical connections enable Australia and Fiji to work together in areas of mutual interest including through business, trade, security and between government organisations.

1.2 Fiji has made progress against many of its development objectives despite a period of economic stagnation over the past decade. Economic growth now sits at between three and four per cent, with two to three per cent growth projected for 2016 and 2017. Fiji is on track to achieve Millennium Development Goals numbers 2 and 7 (education and environmental sustainability). Most school aged children are enrolled with equal numbers of girls and boys in primary and secondary education. Fiji has also increased access to safe water and sanitation, and decreased rates of maternal mortality.

1.3 Despite progress in some areas, Fiji's health system still needs to evolve to address the growing burden of noncommunicable diseases (NCDs). As of 2011, NCDs already accounted for 40% of all healthcare costs for diseases, and this figure is expected to continue to rise in the near future, as the NCD epidemic will get worse before it gets better. The impact of NCDs on the Fiji economy is high in terms of the financial bottom line of the government and households, labor supply, saving rates and capital accumulation.

1.4 Fiji's Ministry of Health and Medical Services National Strategic Plan (2016-2020) has two strategic pillars: (i) Preventative, curative, and rehabilitative services, and (ii) Health systems strengthening. Through the NSP the Ministry has made a commitment to slowing down the rate of NCD's; strengthening reproductive health services in an effort to address the rising number of teenage pregnancies and new STI's cases; and prioritising crucial aspects of systems strengthening from workforce planning and development to information technology systems.

1.5 The Fiji Health Sector Support Program (FHSSP) has been delivering Australia's current bilateral support to the Fiji health sector since July 2011 and will

be completed on 30 June 2016. The Program aims to support access and delivery of health services to the people of Fiji and strengthen health systems. The AUD33m Program has five key focus areas: maternal health; child health; NCD's (diabetes and hypertension); primary health care revitalisation; and health systems strengthening. The Program is aligned to the Ministry of Health and Medical Services National Strategic Plan (2011-2015) and lends support to the Ministry to meet its strategic and corporate objectives.

1.6 DFAT has commissioned several independent assessments over the life of the Program including the TAG Mid-term review in March 2013 and a High Level Strategic Review in 2014. This End of Program Evaluation of FHSSP is being commissioned as part of DFAT's quality reporting requirements. Findings from the review will assist in the planning and design of the replacement Australia-Fiji bilateral health Program (2016-2020).

1.7 The FHSSP End of Program Outcomes (EoPO) were finalised in 2013-2104 as part of the revamped Monitoring and Evaluation Framework. These EoPO's were formulated with guidance from independent evaluation consultants and are as follows:

Objective 1: Safe Motherhood

- i. EoPO 1.1: MoHMS sustains behaviour change campaign to promote early booking.
- ii. EoPO 1.2: MoHMS sustains mother safe audits in hospitals to guide improvement in care.
- iii. EoPO 1.3: MoHMS sustains effective post-miscarriage services.

Objective 2: Healthy Child

- i. EoPO 2.1: MoHMS fully funds pneumococcal and rotavirus vaccines.
- ii. EoPO 2.2: MoHMS conducts routine surveillance of pneumococcal and rotavirus vaccines
- iii. EoPO 2.3: MoHMS sustains child health training care audits to guide improvement

Objective 3: Prevention and management of NCDs including cervical cancer

- i. EoPO 3.1: MoHMS sustains national diabetes screening and behaviour change campaign
- ii. EoPO 3.2: MoHMS routinely monitors diabetes screening coverage to target outreach
- iii. EoPO 3.3: MoHMS sustains audits of diabetes centre minimum standards to guide continuous improvement
- iv. EoPO 3.4: MoHMS sustains HPV vaccination for Class 8 girls and cervical cancer screening for women

Objective 4: Revitalisation of the CHW network

- i. EoPO 4.1: At least 65% of active CHWs nationwide have been trained in the CHW core competencies.

Objective 5: Targeted Health Systems Strengthening

- i. EoPO 5.1: PHIS and PATIS are functional, accessible and responsive to user needs
- ii. EoPO 5.2: MoHMS regularly extracts compiles and disseminates key PHIS and PATIS data to MoHMS staff at all levels.
- iii. EoPO 5.3: MoHMS routinely conducts data quality assurance activities for key data sources and databases.
- iv. EoPO 5.4: MoHMS annually trains and supports M&E Resource Network facilitators at all levels of the organisation.

Progress against all EoPOs are monitored and reported against on a 6 month basis.

2.0 Objectives

To prepare an End of Program Evaluation Review Report to independently assess relevance, efficiency, effectiveness, accountability, impact, and sustainability of the FHSSP activities, with specific focus on:

- i. Capacity building approaches
- ii. Management effectiveness
- iii. Stakeholder cohesion and cooperation
- iv. Monitoring and evaluation
- v. Analysis and learning
- vi. Cross-sectoral issues like gender & disability; and
- vii. Relevant applicability of the Project Design Document.

3.0 Scope

The Scope of the EPE will consider the following:

- i. Over the life of the Program, were the objectives relevant to broad priorities of the health sector in Fiji? Were the objectives relevant to the context/needs of the beneficiaries and key stakeholders?
- ii. Were the objectives achieved, if not what were the key barriers/challenges?
- iii. To what extent has DFAT's Programming approach and implementation been consistent with Aid Effectiveness Principles?
- iv. Was a risk management approach applied to the management of the Program? What were the risks and how were they managed?
- v. Does quality data and evidence exist to show that objectives are achieved? Have the benefits of the Program been evenly distributed to men and women? Is data sex-disaggregated to measure the outcomes of the activity on men and women?
- vi. Were the governance and contracting arrangements sufficient enough to support Program activities? Did the implementation of the Program make effective use of time and resources to achieve the outcomes? Did it support MoHMS systems and provide good value for money?
- vii. To what extent has evidence and learning fed back into the Program cycle? How well has the Program communicated successes and risks with counterpart governments and development partners?
- viii. Could the Program have delivered more outputs for the same inputs? Or, could the Program have delivered the same outputs for less input?

- ix. How did the Program perform against the End of Program Outcomes for each of the strategic objectives? Is there adequate data to support this assessment?
- x. Are there any areas of the Program that are clearly not sustainable? Are there any foreseeable consequences of exiting Australian support from key activities currently supported by the Program? What measures are recommended to mitigate these consequences?

4.0 Outputs

4.1 The Outputs will be:

- i. an Evaluation Plan (2-3 pages) prior to commencing the Review. The Evaluation Plan should clearly demonstrate the methodology the Review Team intends to follow to answer evaluation questions, the roles and responsibilities of Team members. It should also ensure the timeframe set in this ToR is appropriate given the scope of the review, and if necessary, suggest alternative methods and activities for the evaluation that will achieve better results. The Evaluation Plan should also outline how the EPE process will actively engage with Program beneficiaries and implementing partners;
- ii. an independent End of Program Evaluation Report (EPER). The EPER should be 40 pages or less plus attachments. The Executive Summary should be a short document that can be read in isolation if necessary. The EPER focus areas will include assessment of the issues identified in the Scope of this Review, as well as on the judgement and skills of the EPER Team.

4.2 The EPER will include Quality at Completion ratings to be considered based on:

- i. Relevance: *Was this the right thing to do?*
- ii. Effectiveness: *Are we making the progress we expected at this point in time?*
- iii. Efficiency: *Is this investment making appropriate use of Australia's and other partners' time and resources to achieve objectives?*
- iv. Impact: *What positive and negative changes were produced by the initiative, directly or indirectly, intended or unintended?*
- v. Sustainability: *To what extent will benefits endure after Australia's contribution has ceased?*
- vi. Monitor and evaluation. *Is an M&E system being used to effectively measure implementation progress, and progress towards meeting expected outcomes?*
- vii. Gender: *How do we respond to gender equality concerns and are we doing it well?*

5.0 Evaluation Method

The Review should be participatory and results-oriented. It should focus on checking key assumptions and methodological risks, including reviewing the barriers to access and what scope do key stakeholders have to address these barriers. This should be apparent in the evidence and analytical base of the EPE Report; and in gathering and analysing new, additional data (qualitative and quantitative) when there is real value in this be done by the Team.

Desk Review

The Team will engage in a review of Program reports and documents describing the design, design changes, key reporting, special reporting and research on key Program focus areas.

The focus for analysis includes an assessment of the appropriateness and effectiveness of the strategies utilised by the Program and evidence of any outcomes in the following key areas:

- i. Capacity building (including the role of the MoHMS and FHSSP staff)
- ii. Management and coordination of the Program including staffing levels, efficiency, and contracting arrangements
- iii. Contribution made by FHSSP to the Fiji health sector
- iv. The extent to which issues for gender and disability were appropriately addressed and
- v. The M&E systems used during project implementation.

Stakeholder Interviews

Interviews shall be scheduled with key stakeholders in Fiji including any key partner agencies. These may include technical and development partners such as UN agencies, recipients of FHSSP assistance, government and non-government agencies, DFAT and the Abt JTA/FHSSP management Team.

6.0 Evaluation Team

Team composition

Key skills for the two-member Team collectively include:

- Impact assessment and monitoring and evaluation skills from relevant technical, social, economic and financial perspectives;
- Strong knowledge of health systems strengthening for service delivery in a development context
- Capacity development
- Strong Pacific/regional experience
- Sound knowledge and understanding of aid effectiveness
- Consultative skills and participatory research methods
- Critical thinking, broad evaluation, analytical and research skills
- Report writing.

The Team will consist of two members, who will collectively provide the above skill-set:

- The independent health specialist shall act as Team Leader for the EPE and shall bear the reporting responsibilities for the EPE
- The independent evaluation specialist will provide strong analytical assessments of the Program

The Team Leader/Health Specialist will:

- a. plan, guide and develop the overall approach and methodology for the evaluation
- b. manage and direct the evaluation's activities, represent the evaluation Team and lead interviews with evaluation participants

- c. collate and analyse data collected through the evaluation by all Team members
- d. manage, compile and edit inputs from other Team members to ensure the quality of reporting outputs
- e. produce an aide memoire, synthesise evaluation material into a clear draft evaluation report and a final evaluation report
- f. provide timely delivery of high-quality written reports
- g. represent the Team in peer reviews if required

The Evaluation Specialist will:

- a. coordinate the evaluation process
- b. contribute to the required dialogue, analysis and writing of the report, as directed by the Team leader.

DFAT will be responsible for the contractual aspects of the review and the review Team, logistical of the initial Team briefing and debriefing sessions. DFAT will develop the in-country evaluation schedule and be the point of liaison for stakeholders including the Ministry of Health. The contract will be output based.

The independent FHSSP EPE Review Team will report to DFAT, Suva.

7.0 Timing and Duration

The EPE will commence on 23 October 2015 and will be completed by 30 January 2016.

The timing and duration for the scope of services is as follows:

INDICATIVE DATES 2015	ACTIVITY	LOCATION	Input days Team leader	Input days Evaluation Specialist
23 October	Briefing with DFAT Suva Post	Teleconference	.5	.5
24 October – 4 November	Document review/desk review	Home base	3	3
5 Nov – 9 Nov	Develop Evaluation Plan	Home base	3	2
10 November 2015	Draft Evaluation Plan to DFAT	Via email		
12 November 2015	DFAT feedback on the draft Evaluation Plan	Via email/teleconference	.5	.5
13 November	Revise Evaluation Plan	Via email	1	1

INDICATIVE DATES 2015	ACTIVITY	LOCATION	Input days Team leader	Input days Evaluation Specialist
2015	and submit to DFAT			
16 November – 28 November.	In-country visit to Fiji	Fiji	12	12
27 November	Presentation of Evaluation Aide Memoire			
18 December 2015	Submission of draft Evaluation Report to DFAT	At base	12	8
15 January 2016	DFAT Review & send comments to Team	Via telecom/email		
30 January 2016	Incorporate DFAT feedback and submit Final FHSSP EPE Report	Via email	3	2
TBC	DFAT Peer Review of FHSSP EPE Report	Via telecom (Team Leader)	.5	
	Travel days		4	2
Total input days			39.5	31

7.0 Outputs

The following outputs are required:

- Evaluation Plan/Draft Methodology* – provided to DFAT for agreement prior to the commencement of field visits and consultations.
- Evaluation Mission Aide Memoire* - to be presented to DFAT and other stakeholders at the completion of the in-country mission. The format for the Aide Memoire will follow DFAT's template.
- Draft End of Program Review Report* – to be provided to DFAT Suva Post, within the timeframes specified above. Feedback from DFAT and other stakeholders will be provided within 3 working days of receiving the draft report.
- Final End of Program Review Report* - final document within 4 working days of receiving the feedback, incorporating advice from evaluation peer review.

The report will be no more than 40 pages (plus annexes). The report will include an executive summary of up to 2 pages, key findings and lessons-learned, conclusions, and recommendations. Annexes should include these terms of reference, the final evaluation plan, consultations undertaken, documents reviewed and any other information the consultants deem relevant and useful.

All reports will be in Microsoft Word format.

Annex A: Key Documents

- FHSSP Design Document (2011-2016)
- FHSSP Quality at Implementation Reports
- FHSSP Activity Quality Check Report
- FHSSP Annual Reports
- FHSSP M&E Framework
- FHSSP Program Coordinating Committee Minutes

Annex 2: References

No.	Date	Document Name	Author
1.	1996	'Great Ideas Revisited', Training & Development , Vol. 50, No. 1	Donald Kirkpatrick
2.	2008	The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action	OECD DAC
3.	19 Jul 2010	Fiji Health Sector Improvement Program (FHSIP): Independent Completion Report	Paul Freeman & Ross Sutton
4.	Sep 2010	Fiji Health Sector Support Program 2011-2015: Design Document	David Wilkinson, Lynleigh Evans, Ross Sutton
5.	23 Nov 2010	Fiji Health Sector Support Program 2011-2015: Design Document - Final	David Wilkinson, Lynleigh Evans, Ross Sutton
6.	28 Mar 2011	Subsidiary Arrangements for the Australian Government's Bilateral Health Assistance to Fiji: 2011-2015	DFAT
7.	2011	Shaping Fiji's Health: Strategic Plan 2011-2015	MoH
8.	Nov 2011	Fiji Budget Estimates 2012	GoF
9.	2012	DFAT's Fiji Country Strategy 2012–14	DFAT
10.	2012	Fiji Health Sector Support Program 2011 Annual Report	FHSSP Team
11.	09 Mar 2012	Fiji Health Sector Support Program Technical Advisory Group: Review of Mobilisation Phase and Appraisal of QAI Report	David Wilkinson, Sara Webb & Cate Keane
12.	March 2012	Quality at Implementation Report for Fiji Health Sector Support Program	DFAT
13.	October 2012	Proposal to FHSSP for consideration for funding – evaluation of pneumococcal conjugate fight vaccine, rotavirus vaccine and the human papilloma virus vaccine immunisation Program in Fiji	MCRI
14.	2013	Fiji Health Sector Support Program 2012 Annual Report	FHSSP Team
15.	March 2013	Quality at Implementation Report for Fiji Health Sector Support Program	DFAT
16.	March 14, 2013 Draft No 4	Fiji Health Sector Support Program Monitoring and Evaluation Framework	FHSSP Team
17.	27 May 2013	Fiji Health Sector Support Program Technical Advisory Group: Mid-term Review	David Wilkinson, Sally Duckworth

			&Cate Keane
18.	Nov 2013	Fiji Budget Estimates 2014	GoF
19.	Dec 2013	Fiji - Maternal Health Services Review and Strategic Action Plan	Dr Janet Hohnen & Mary Bythell
20.	Dec 2013	Pacific Regional Health Program Delivery Strategy 2013-2017	DFAT
21.	2014	Quarterly Performance Reports for the Provision of Hospital Based Psychosocial Support Services, Quarters 1-4, 2014,	Empower Pacific
22.	March 2014	Fiji Health Sector Support Program 2013 Annual Progress Report	FHSSP Team
23.	March 2014	Quality at Implementation Report for Fiji Health Sector Support Program	DFAT
24.	9 May 2014	High Level Strategic Review: Fiji Health Sector Support Program -Final Report	Gillian Biscoe & Carol Jacobsen
25.	June 2014	DFAT Monitoring and Evaluation Standards	DFAT
26.	20 Oct 2014	FHSSP – six-month workplan: July – December 2014 (final)	FHSSP
27.	29 Oct 2014	Aid Program Performance Report 2013-14: Fiji	DFAT
28.	Nov 2014	Fiji Health Sector Support Program – monitoring and evaluation plan. Draft release 5.0	FHSSP
29.	11 Nov 2014	Fiji health sector support Program – annual workplan: January – December 2015	FHSSP
30.	25 Nov 2014	Program exit strategy	FHSSP
31.	4 Dec 2014	Research Project Agreement: New Vaccine Evaluation Project	MoHMS & Murdoch Children's Research Institute
32.	Dec 2014	FHSSP Newsletter	FHSSP
33.	2015	Fiji Aid Investment Plan (2015/16 to 2018/19)	DFAT
34.	2015	Fiji Health Sector Support Program – progress report: July – December 2014	FHSSP
35.	2015	Fiji Community Development Program (FCDP): Achievements of the First Three Years	FCDP
36.	5 March 2015	Fiji Health Sector Situational Analysis 2014	Ashleigh O'Mahony
37.	May 2015	Monitoring & Evaluation: Research Fundamentals, applied learning. M&E Resource Network Facilitator's Guide,	FHSSP

Version 1.1,			
38.	15 June 2015	Health for Development Strategy 2015–2020	DFAT
39.	May 2015	Aid Quality Check for FHSSP	DFAT
40.	2015	Aid Investment Plan Fiji 2015-16 to 2018-19	DFAT
41.	23 Sept 2015	Fiji Health Sector Support Program – Program progress report: January – June 2015 (draft)	
42.	Oct 2015	Australian Aid to Fiji	DFAT
43.	16 Oct 2015	Address to Australia Fiji Business Forum, delivered in Sydney	The Hon Steven Ciobo MP, Minister for International Development and the Pacific
44.	Nov 2015	Fiji Country Brief	DFAT
45.	Nov 2015	Overview of Australia's aid Program to Fiji	DFAT
46.	Nov 2015	Improved human development in Fiji	DFAT
47.	Nov 2015	Community Health Worker Policy	MoHMS
48.	Nov 2015	FHSSP Exit Strategy	FHSSP
49.	Nov 2015	Fiji Budget Estimates 2016	GoF
50.	Nov 2015	Program Handover Plan	FHSSP
51.	Dec 2015	Financial report summary, July 2011 – Nov 2015, FHSSP,	FHSSP
52.	Undated	The New Vaccine Evaluation Project, Fiji Health Sector Support Program and the Ministry of Health and Medical Services collaborative achievements	MCRI

Annex 3: Evaluation Plan

A3.1 Introduction

The Department of Foreign Affairs and Trade (DFAT) has commissioned Mott MacDonald to carry out an End of Program Evaluation (EPE) of the Australia Fiji Health Sector Support Program (FHSSP). This Evaluation Plan outlines the methodology for the evaluation, for discussion with DFAT prior to commencement of the in-country fieldwork. Terms of Reference (TOR) are at Annex 1.

A3.2 Background to the evaluation

FHSSP has been delivering Australia's bilateral support to the Fiji health sector since July 2011, continuing from the predecessor Fiji Health Sector Improvement Program (2003-2010) and the Fiji Health Sector Reform Program (2000 – 2003). FHSSP is due to be completed on 30 June 2016, with a final total value of AUD 33m. The program aims to support access and delivery of health services to the people of Fiji and strengthen health systems. The program has five key focus areas: maternal health, child health, NCDs (diabetes and hypertension), primary health care revitalisation, and health systems strengthening.

This EPE is being commissioned as part of DFAT's quality reporting requirements.

A3.3 Purpose of the evaluation

The evaluation will assess the extent to which FHSSP has achieved its objectives. It will also assess its implementation approach, compile lessons learned and provide recommendations that will inform and shape DFAT's future engagement with the health sector in Fiji.

Specifically the objective of the evaluation is

‘to independently assess relevance, efficiency, effectiveness, accountability, impact and sustainability of the FHSSP activities, with specific focus on:

- viii. capacity building approaches
- ix. management effectiveness
- x. stakeholder cohesion and cooperation
- xi. monitoring and evaluation
- xii. analysis and learning
- xiii. cross-sectoral issues like gender and disability
- xiv. relevant applicability of the project design document’.⁵⁸

A3.4 Audience

The primary audience for this evaluation is DFAT. The Ministry of Health and Medical Services (MOHMS) and the program itself are the secondary audience. We also

⁵⁸ TOR p3

anticipate this evaluation being of interest to other stakeholders such as development partners.

A3.5 Focus and limitations

The evaluation will cover the life of the program to date (i.e. from July 2011), but will particularly focus on the period since the TAG Mid-Term Review (MTR) in March 2013. That MTR gave a good analysis of progress to date which does not need to be repeated so we will draw on its findings for our assessment of the program as a whole.

In the TOR, DFAT identifies a significant number of questions for evaluation. In the interests of making the EPE both manageable within the time available as well as useful, we have identified 13 focus questions which bring those initial questions together under the six DAC criteria and rationalise some areas of duplication.⁵⁹ Within this group of 13 focus questions, based on our telephone briefing and review of the literature, we anticipate that effectiveness and accountability are of more interest and importance to DFAT than others. We will therefore prioritise the following focus questions:

Table A3.1: Priority focus questions

DAC criteria	Focus questions
Effectiveness	1. Did the program achieve its objectives?
	2. What was the contribution of analysis and learning?
	3. How well have gender and disability been addressed?
	4. How effective have the program's capacity building strategies been?
Accountability	5. Were the program governance arrangements appropriate?
	6. How well was the program run?
	7. Were risks managed appropriately?
	8. How effective was stakeholder cooperation and engagement?
	9. What was quality of monitoring and evaluation?

We will also cover the following secondary focus questions but to a lesser extent:

⁵⁹ The Development Assistance Committee (DAC) of the Organisation for Economic Cooperation and Development evaluation criteria are defined in the *Glossary of Evaluation and Results Based Management (RBM) Terms*, OECD (2000).

Table A3.2: Secondary focus questions

DAC criteria	Focus question
Relevance	10. How consistent was the program with beneficiary requirements, country needs, global priorities and partner and donor policies?
Efficiency	11. Did the program provide good value for money?
Impact	12. What long term outcomes are likely to result from the program?
Sustainability	13. Are program benefits likely to last beyond the life of the program?

We suggest that when we meet with the DFAT team in Suva on 16 November at the start of the in-country work, we discuss whether these are indeed the correct priorities.

In terms of value for money, an economic analysis would be needed to provide a rigorous answer to this question, which is beyond the scope of this review. We will, however, try to draw some broad conclusions about whether more could have been achieved with the same resources, or whether fewer resources could have achieved the same results.

In terms of measuring program impact it will not be possible within the scope of the fieldwork to do a systematic analysis of the contribution of FHSSP to the Fiji health sector. We should however be able to draw some broad conclusions about the impact of the program.

This AUD33m program has been underway since 2011, addressing five challenging objectives, operating in and responding to a complex and difficult environment. The length of this review is limited to two weeks of in-country work including consultations with central MOHMS. We will therefore not be able to verify independently all the results claimed by the program, but will need to rely on the accuracy of data provided by the program, (whilst also taking into account the strength of the monitoring and evaluation (M&E) system) and focus on inputs and processes to achieve them. We also note that M&E Framework underwent a significant revision in 2013 – 14. This may mean that it might be difficult for us to assess overall progress since the start of the program.

A3.6 Evaluation questions

Table A3.3 below presents the 13 focus questions aligned to the DAC criteria, with associated sub questions.

Table A3.3: Evaluation questions and sub questions

Priority	DAC criteria	Focus questions	Sub questions
1	Effectiveness	1. Did the program achieve its objectives?	1.1 How is the program performing against the planned End of Program Outcomes? 1.2 What were the key success factors and barriers/challenges?
		2. What was the contribution of analysis and learning?	2.1 To what extent has evidence and learning fed back into the program cycle?
		3. How well have gender and disability been addressed?	3.1 Have the benefits of the program been distributed equitably to men and women?
		4. How effective have the program's capacity building strategies been?	4.1 Was there an overall capacity development strategy? 4.2 What were the respective roles of MOHMS staff and FHSSP team members and short-term advisers in developing the capacity of MOHMS?
1	Accountability	5. Were the program governance arrangements appropriate?	5.1 Were the governance arrangements sufficient to provide program leadership and direction?
		6. How well was the program run?	6.1 How appropriate and effective have program management and coordination been? Including: - staffing levels - management processes - contracting arrangements 6.2 How well did the program support MoHMS systems?
		7. Were risks managed appropriately?	7.1 How effectively has the risk management approach led to anticipation and mitigation of risk? 7.2 What significant risks emerged and how were they managed?
		8. How effective was stakeholder cooperation and engagement?	8.1 How effective were relationships between the program and MoHMS in both Suva and the Divisions? 8.2 How well has the program communicated successes and

Priority	DAC criteria	Focus questions	Sub questions
			risks with government counterparts and development partners?
		9. What was the quality of monitoring and evaluation?	9.1 Is there adequate data to support assessment of program progress? 9.2 Is the right data being collected? 9.3 Is M&E data being used to guide the programme? 9.4 Is data sex-disaggregated to measure the outcomes of the activity for men and women?
2	Relevance	10. How consistent was the program with beneficiary requirements, country needs, global priorities and partner and donor policies?	10.1 Over the life of the program, were the objectives relevant to the health sector in Fiji? Including: - context and broad priorities of the sector? - beneficiaries? - stakeholders ? 10.2 To what extent has DFAT's programming approach and implementation been consistent with Aid Effectiveness Principles?
2	Efficiency	11. Did the program provide good value for money?	11.1 Did the implementation of the program make efficient use of time and resources to achieve the outcomes? Specifically: - Australia's resources? - Other partners' resources? 11.2 How efficient were management processes and contracting arrangements?
2	Impact	12. What long term outcomes are likely to result from the program?	12.1 What is the contribution made by FHSSP to the Fiji health sector? 12.2 What positive and negative changes were produced by the initiative, directly or indirectly, intended or unintended?
2	Sustainability	13. Are program benefits likely to last beyond the life of the program?	13.1 To what extent will benefits endure after Australia's contribution has ceased? 13.2 What measures are recommended to promote sustainability?

Priority	DAC criteria	Focus questions	Sub questions
			13.3 Are there any foreseeable consequences of exiting Australian support from key activities currently supported by the program?

A3.7 Phases and timeline

The evaluation mission will be carried out in four phases:

1. **Desk review:** telephone briefing by DFAT Suva Post; gathering and analysing existing data and information through review of the literature; preparing the evaluation approach and methodology (23 October – 11 November)
2. **Fieldwork:** including face-to-face briefing by DFAT Suva Post; interviews with MOHMS and other stakeholders including selected development partners; interviews with the program team; an informal workshop where numbers make this approach advantageous; site field visits. The in-country program developed by DFAT is at Annex 2
3. **Analysis and debriefing:** including two to three days for the consultants to process data and form their initial conclusions and debrief DFAT (26 – 28 November)
4. **Reporting:** a draft report will be submitted on 18 December 2015. On receipt of feedback by DFAT the consultants will finalise the report by 30 January 2016.

A3.8 Methods

This EPE is designed to build on, and add value to existing monitoring, evaluation and review reports. The team will draw on qualitative and quantitative data and will triangulate analysis from different stakeholder perspectives. The review process will be consultative and inclusive, particularly drawing upon the experiences of stakeholders and health sector staff whose work has been influenced by the program.

Document analysis

A review of the literature has informed the development of this evaluation framework. The consultants will continue this literature review prior to travel to Fiji. Documents have been provided by DFAT and are being supplemented by material from the web, to provide an initial picture of context, challenges and progress. Further material may be requested on arrival in country (for example the 2014 annual report) and clarification may be sought of some of the documents already provided.

Data collection

An initial briefing by **DFAT** personnel will confirm priorities for the evaluation and key challenges of program implementation. Subsequent interaction with DFAT staff during the fieldwork will enable the team to gain further understanding of progress and challenges over the life of the program.

The most common form of data collection will be interviews. The team has prepared a semi-structured interview form. This will be the starting point for tailoring interview questions to respondents' areas of experience and expertise. Having a standard interview schedule will allow data to be aggregated and triangulated. Having open-ended questions will allow the team to probe further as they become engaged in discussion. There will always be opportunity to ask additional questions specific to the stakeholder's role.

Before each interview, the team will confer on the specific requirements of the interview in relation to both the stakeholder's experience and the evaluation questions. This will ensure the discussion is tailored to the context.

Interviews with **MOHMS** will give insight into the alignment of program objectives and achievements with national priorities, governance issues, stakeholder engagement, risk management, effectiveness, sustainability and M&E. Meeting with the Health Sector Design Working Group will inform our understanding of expectations around subsequent investments in the health sector.

Interviews with other **health sector stakeholders** such as development partners will provide insight into the contribution of Australia to the health sector, the relevance of the program, and the effectiveness of stakeholder engagement.

Interviews with **program management and implementation staff and program technical advisers** will probably focus on effectiveness, analysis and learning, capacity building, program management, challenges and opportunities, value for money and sustainability.

Meetings with **health sector** staff in the field will enable us to understand the effectiveness and impact of the program at service delivery level, and the challenges faced by the program.

For group meetings, depending on numbers, rather than conduct the session as an interview, the team may use a workshop format. Informal workshop sessions will allow the team to make the most of this opportunity to engage with a larger number of people and learn about their perceptions of the program. Where sensitive issues are being discussed, if we think that minority views are not being heard, we will follow up on an individual basis. A workshop outline was attached as Annex 4 to the submitted evaluation plan.

Where possible we will meet with **beneficiaries** to gain impressions of changes that have been brought to bear on access and utilisation of services by the program. Observation during site visits to hospitals, health centres and nursing stations will also gain insight into quality of service delivery. When visiting health delivery sites, the EPE team will be able to see the conditions in which the program is being implemented, meet relevant staff, look at project records and observe the physical surroundings. The team will document these observations, where practicable, to support analysis. Annex 7 is an Observation Checklist to guide the team and encourage consistent note-taking regarding observations across multiple sites. If permission is granted, they will take photos as a supplementary form of evidence.

Data analysis

During the field trip, the EPE Team will aim to meet at the end of each day to review and document the day's achievements. Information collected through interviews, workshops and site visits will be collated using a large grid matrix so that data from multiple meetings / events is organised under themes which relate to the evaluation questions in Table A3.3 above. Table A3.4 below illustrates the grid format. Meetings and site visits form the rows and the themes by which information is sorted form the columns. The Team will populate the grid with key information extracted from notes, interview forms, or workshop flip-charts.

Table A3.4: Data summary grid

Meeting (Interview /workshop)	Theme 1 e.g. Governanc e	Theme 2 Capacity building	Theme 3 Value for money	Theme 4 Gender	etc
1 e.g. DFAT Suva	<i>Findings</i>	<i>Findings</i>	<i>Findings</i>	<i>Etc</i>	
2 FHSSP team					
3					
4					
Etc					

The information in the grid will form the basis for analysis. The team will use visual pattern recognition to identify patterns and trends in the grid data including unexpected issues which may emerge. If there is not agreement on a particular finding, it will be important to tease out points of disagreement. Findings and recommendations based on this analysis will therefore be evidence-based and contested by team members, rather than based solely on impressions held by the team. The actual grid is a tool for the team and, like the raw data, will not be part of the final report.

Debriefing and report writing

Key findings from this analysis will be shared with DFAT and other stakeholders in an Aide Memoire PowerPoint presentation on 27 November 2015. Ideally, there will be time for full and open discussion of the Aide Memoire. This will provide an opportunity for the team to both seek clarification on any points of uncertainty and receive initial feedback on the ideas presented.

Through these methods the team should be well equipped to write the EPE Report from their home offices in England and Australia, respectively, using Skype and email to communicate. An indicative Report structure was attached at Annex 6 of the submitted evaluation plan.

A3.9 Review team and division of labour

The review team will consist of an Independent Health Specialist and Team Leader (Adrienne Chattoe-Brown) and Independent Evaluation Specialist (Susan Majid).

The Team Leader has responsibility for oversight of the overall approach and methodology for the evaluation, manage the evaluation's activities and take overall responsibility for the delivery of this Evaluation Plan and the final report.

The Evaluation Specialist will coordinate the evaluation process, ensure the approach and methods used or of an appropriate professional standard and independence, and contribute to report writing as required. Both team members will take collective responsibility for the analysis of findings and discussing overall conclusions and recommendations.

It is assumed that the team will be accompanied to field meetings by a DFAT representative. For some meetings it will be appropriate also to be accompanied by a team member from FHSSP – but this will not be appropriate for all meetings. Details can be discussed in Suva.

A3.10 Standards and ethical considerations

DFAT's 2014 Australian aid *Monitoring and Evaluation Standards* will be a useful guide for this EPE. Standards 5 on *Independent Evaluation Plans* and Standard 6 on *Independent Evaluation Reports* are of particular relevance.⁶⁰

Both team members are bound to follow the contractor, Mott MacDonald's, *MMA Code of Conduct*, adhere to the company's *Ethics* statement, and the *MMA Child Protection Code of Conduct*. In addition, they have signed DFAT's *Deed of Confidentiality* in relation to non-disclosure of any confidential information accessed through this evaluation.

In addition, the Independent Evaluation Specialist, as a member of the Australasian Evaluation Society (AES), is bound by the *AES Guidelines for the Ethical Conduct of Evaluations* and the *AES Code of Ethics*.⁶¹

⁶⁰ Available at: <http://dfat.gov.au/about-us/publications/Documents/monitoring-evaluation-standards.pdf>

⁶¹ Available at http://www.aes.asn.au/images/stories/files/membership/AES_Guidelines_web_v2.pdf and http://www.aes.asn.au/images/stories/files/About/Documents%20-%20ongoing/code_of_ethics.pdf respectively.

Annex 4: Final Program

FIJI HEALTH SECTOR SUPPORT PROGRAM – END OF PROGRAM EVALUATION IN-COUNTRY MISSION

PROGRAM – 16-28 NOVEMBER 2015

Time	Organisation	People Met*
16 November (Suva)		
8.30-10am	DFAT, Australian High Commission	Margaret Vuiyasawa & Rodney Yee
10.30am-2pm	Fiji Health Sector Support Program (FHSSP)	Dr Rosalina Sa'aga-Banuve, & Leah Ekbladh
2.30pm	MoHMS	Dr Meciusela Tuicakau
6pm	Travel to Nadi	
17 November (Western Division)		
9.00am	Lautoka Hospital	Dr Jimmy Taria & Sr Emma Tiloi
11.00am	MoHMS Western Division	Dr Susana Nakalevu & Sr Leslie Boyd
12.30pm	FHSSP	Talatoka Tamani & Ponipate Baleinamau
2.00pm	Lautoka/ Yasawa Sub-Division	Sr Lavinia Cuva
3.30pm	Empower Pacific	Patrick Morgam, Vijayanti Karan, Vasemaca Natoga, Paulini Valcacegu, Meranda Emrose, Salesh Kumar, Mark Vitlin & Margaret Vitlin
18 November (Western Division)		
9.30am	Ba Hospital	Dr Anna Tabua, SDMO & Sr iLitiana Tuwai
2.30pm	Sigatoka Hospital	Sr Lavenia Dokonivalu
6.00pm	Travel to Suva	
19 November (Central & Eastern Division)		
8.30 -11.30am	FHSSP	Meeting preparation
12.00-4pm	Attend Central Eastern Divisional meeting	MS, SDMO, MO, SIC, Zone Nurses, Masako Kunichi, JICA
20 November (Suva)		
9.00am	FHSSP	Kelly Robertson
9.30am	Attend Central Eastern Divisional Plus meeting – briefing by FHSSP	Presentation by Leah Ekbladh
10.30am	Former National Adviser Family Health, MoHMS	Dr Rachel Dewi
12.00	FHSSP	Josua Ligairi
2.30pm	Murdoch Children's Research Institute	Rita Reyburn
21 November		
12.30pm	FHSSP	Marybeth Sarran
22 November		
11.00am	FHSSP	Douglas Glandon
2.30pm	FHSSP	Karen Kenny

23 November (Northern Division)		
7.00am	Travel to Labasa	
9.00am	Labasa Hospital	Dr Inosi Voce & Sr Tavaita Suraki
11.30am	Community Health Worker (CHW) Program, Macuata	Sr Matelita Kadin & Glenda Cawara,
2.30pm	Seaqqa Medical Centre	Dr Ashneel Prasad & Sr Katherine May Degi
4.30pm	Nabalebale Nursing Station	Sr Salote Tikoibua
24 November		
8.45am	Savusavu Hospital	Dr Kusitino Saumalua, Sr Tarisi Racule & Sr Ateca Lepper
10.00am	CHW Program, Cakaudrove	Sr Loata Pio & Tirisa Viti
12.30pm	FHSSP, Northern Division	Vivita Vasaqa
4.00pm	Travel to Suva	
25 November (Suva)		
8.15	DFAT Suva	Joanne Choe & Margaret Vuiyasawa
10.00am	MOHMS - Health Sector Design Working Group	Dr Luisa Cikamatana, Dr Eric Rafai, Muniamma Goundar
12.30pm	FHSSP	Atelini Wainiveikoso, Amini Mucunabitu & Naomi May
1.00pm	MOHMS	Nanise Raika,
2.30pm	Senior clinicians - Colonial War Memorial Hospital	Dr Lisi Tikoduadua, Dr Ilisapeci Tuibeca, Sr Silina Waqa & Mr Apolosi Vosanibola
4.30pm	MOHMS Information Systems / FHSSP	Shivnay Naidu & Don Lewis
4.30pm	FHSSP	Mary Bythell
26 November		
9.00am-4.30pm	Follow up meetings/writing	
27 November		
8.00am	FHSSP debrief	Dr Rosalina Sa'aga-Banuve, Leah Ekbladh, Karen Kenny & Kelly Robertson
10.00am	DFAT debrief	Joanne Choe, Rodney Yee & Margaret Vuiyasawa
2.30pm	Presentation of Aide Memoire	Rodney Yee (Chair), Dr Eric Rafai, Dr Isimeli Tukana, Dr LV Tikoduadua, Dr Ilisapeci Tuibeca, Sr Vositi Vatuwaqa, Margaret Vuiyasawa, Shinya Matsuura, Kozue Shimizu & Nila Prasad

*Positions of people met are given in Annex 5

Annex 5: People Met

No	Name	Position	Organisation	Sex
Monday 16 November				
1	Margaret Vuiyasawa	Program Manager, Bilateral Health / Social Protection	DFAT, Suva	F
2	Rodney Yee	Senior Program Manager, Health – Bilateral;	DFAT, Suva	M
3	Dr Rosalina Sa'aga-Banuve	Program Director	FHSSP	F
4	Leah Ekblad	Technical Team Leader	FHSSP	F
5	Dr Meciusela Tuicakau	A/g Permanent Secretary	MoHMS	M
Tuesday 17 November				
6	Dr Jimmy Taria	A/g Medical Superintendent	Lautoka Hospital	M
7	Sr Emma Tiloi	Sister in Charge	Lautoka Hospital	F
8	Dr Susana Nakalevu	DMO Western Division	MoHMS Western Division	F
9	Sr Leslie Boyd	Divisional Health Sister,	MoHMS Western Division	F
10	Talatoka Tamani	Divisional Coordinator, West	FHSSP	F
11	Ponipate Baleinamau	Operations Officer, West	FHSSP	M
12	Sr Lavinia Cuva,	Sub-Divisional Health Sister	Lautoka/ Yasawa	F
13	Patrick Morgam	CEO	Empower Pacific	M
14	Vijayanti Karan	Branch manager /Counsellor	Empower Pacific	F
15	Vasemaca Natoga	Health Screening Counsellor	Empower Pacific	F
16	Paulini Valcacegu	M&E Officer	Empower Pacific	F
17	Meranda Emrose	Social Worker	Empower Pacific	F
18	Mark Vitlin	Australian volunteer	Empower Pacific	M
19	Margaret Vitlin	Australian volunteer	Empower Pacific	F
20	Salesh Kumar	Manager HR/Legal	Empower Pacific	M
Wednesday 18 November				
21	Dr Anna Tabua	SDMO	Ba Hospital	F
22	Sr Litiana Tuwai	Sister in Charge	Ba Hospital	F
Thursday 19 November				
	Central and Eastern Divisional Meeting	Presentations	MoHMS, Central & Eastern	
23	Masako Kikuchi	Project Officer, <i>Fiji & Kiribati Project for Prevention and Control of NCDs, 2015-2020</i>	JICA	F

No	Name	Position	Organisation	Sex
Friday 20 November				
	Central and Eastern Divisional Plus Meeting	Presentation by Leah Ekbladh	MoHMS, Central & Eastern Divisions	
24	Kelly Robertson	Program Administrator	FHSSP	F
25	Dr Rachel Dewi,	Former National Adviser Family Health	Formerly, MoHMS	F
26	Josua Ligairi	Senior Project Officer, Targeted NCDs	FHSSP	M
27	Rita Reyburn	Epidemiologist	Murdoch Children's Research Institute	F
Saturday 21 November				
28	Marybeth Sarran	Workforce Development Adviser	FHSSP	F
Sunday 22 November				
29	Douglas Glandon	M&E Adviser	FHSSP	M
30	Karen Kenny	Corporate Representative (and former Senior Program Administrator)	AbtJTA	F
Monday 23 November				
31	Dr Inosi Voce	Consultant Gynaecologist	Labasa Hospital	M
32	Sr Tavaita Suraki	Matron & Manager Nursing	Labasa Hospital	F
33	Sr Matelita Kadin	CHW Champion	Macuata, Northern Division	F
34	Glenda Cawaru	CHW	Macuata, Northern Division	F
35	Dr Ashneel Prasad	Medical Officer	Seaqaqa Medical Centre	M
36	Sr Katherine May Degi	Sister in Charge	Seaqaqa Medical Centre	F
37	Sr Salote Tikoibua	Zone Nurse	Nabalebale Nursing Station	F
Tuesday 24 November				
38	Dr Saumalua Kusitino	SDMO	Savusavu Sub-Divisional Hospital	M
39	Sr Tarisi Racule	Sister in Charge	Savusavu Sub-Divisional Hospital	F
40	Sr Ateca Lepper	Sangam School of Nursing & formerly SDHS, Savusavu	Savusavu Sub-Divisional Hospital	F
41	Sr Loata Pio	CHW Champion	Cakaudrove, Northern Division	F
42	Tirisa Viti	CHW	Nabaka Settlement	F
43	Vivita Vasaqa	Northern Operations Officer	FHSSP	F

No	Name	Position	Organisation	Sex
Wednesday 25 November				
44	Joanne Choe	Counsellor, Fiji and Tuvalu aid Programs	DFAT	F
45	Dr Luisa Cikamatana	A/g Deputy Secretary Hospital Services	MoHMS	F
46	Dr Eric Rafai	Deputy Secretary Public Health	MoHMS	M
47	Muniamma Goundar	A/g Director, Policy and Planning	MoHMS	F
48	Atelini Wainiveikoso	Program Manager, MCH	FHSSP	F
49	Amini Mucunabitu	Program Manager, Health Systems	FHSSP	M
50	Naomi May	Program Manager, CHW	FHSSP	F
51	Nanise Raika	Director, Workforce Development	MoHMS	F
52	Dr Lisi Tikondudua	Consultant paediatrician and former and Head of Paediatric Department	CWM Hospital, Suva	F
53	Dr Ilisapeci Tuibeca	Consultant paediatrician and Head of Paediatric Department	CWM Hospital, Suva	F
54	Sr Silina Waqa	National Director of Nursing Services	CWM Hospital,	F
55	Apolosi Vosanibola	Chief Pharmacist	CWM Hospital,	M
56	Don Lewis	Short-Term Adviser, Health Information Systems	FHSSP	M
57	Shivnay Naidu	Director, Health Information, Research and Analysis (DIRA)	MoHMS	M
58	Mary Bythell	Health Data Specialist	MoHMS	F
Friday 27 November				
59	Dr Isimeli Tukana	National Adviser, NCDs & Wellness	MoHMS	M
60	Sr Vositi Vatuwaqa	Midwife	Sigatoka Hospital	F
61	Shinya Matsuura	Project Formulation Adviser	Wellness Centre, JICA	M
62	Kozue Shimizu	Project Officer	Wellness Centre, JICA	F
63	Nila Prasad	Program Officer	JICA Fiji Office	F

Annex 6: Interview Schedule

AUSTRALIA FIJI HEALTH SECTOR SUPPORT PROGRAM (FHSSP) END OF PROGRAM EVALUATION, NOVEMBER 2015

INTERVIEW SCHEDULE

Date / Time	
Names & Positions of People being Interviewed	
Organisation	
Number of People being Interviewed	

Thank you for your time today in agreeing to meet with the Evaluation Team.

QUESTIONS

1. What is your role/are your roles in FHSSP? **[intro - context]**

2. What are examples of FHSSP activities have you participated in to date? **[intro - context]**

3. What has changed since FHSSP supported activities in your unit / hospital / geographic area? **[Focus Q 1]**
 - What do you think helped make these changes occur? **[1.1]**

 - What may have blocked intended changes from occurring, or slowed down progress of FHSSP activities? **[1.1]**

4. *If not raised already in answer to No 3.) We would be interested to know more about how local people have benefitted from changes or improvements in* (select appropriate component(s) – maternal & child health, childhood vaccinations, diabetes control, primary health care via village Health Workers, health systems) **[1, 10 & 12]**
5. a) We would be glad of any comments you would like to make on the usefulness of any training or mentoring that you have been involved in through FHSSP. **[4]**
- b) if not mentioned already....Have MOHMS staff been involved in designing and delivering training? Or mentoring? **[4.2]**
6. a) How are women integrated into the management of FHSSP and its activities? **[3 & 6]**
- b) How do women benefit from the FHSSP component you work on? **[3.1]**
- c) How are people with disability integrated into FHSSP? **[3]**
- d) How do people with disability benefit from the FHSSP component you work on? **[3.1]**

For the next five questions we are seeking a response on a 4-level scale where 1 is Strongly Disagree, 2 is Disagree, 3 is Agree and 4 is Fully Agree. We ask you to be frank and open in responding.

Q No.	Question	1 SD	2 D	3 A	4 SA
7	Leadership & direction in this Program are effective. [5]				
8	Management and administration in this Program are effective. [6]				
9	Financial management is efficient. [6]				
10	Data collected about Program activities is accurate [9]				
11	Program progress reports are useful [2 & 9]				

12. In your opinion, what has worked well in the organisational arrangements for this Program? *(NB organisational arrangements may include: direction/ leadership through Program Coordinating Committee(PCC); management including financial management,; and administration)* **[5, 6, 8]**

13. In your opinion, what could be improved in the organisational arrangements for this Program? **[5, 6, 8]**

14. Has anything unexpected come up in FHSSP which has required a change in plans? What happened? **[7]**

15. In your office/ health facility who collects, reports and uses data? What happens to the data that is collected? Is this MOHMS or FHSSP data or both (combined or separate)? **[9 & 2]**

16. Has the FHSSP achieved its targets? Why or why not? Are the targets realistic? **[12]**

17. Is the current Programmatic focus and strategy appropriate? If not, what adjustments need to be made in the follow-on activity? [10]

18. What is happening now (or planned to happen) which will help sustain the momentum and benefits of the Program? [13]

19. Are there any other points you wish to discuss?

Thank you for your participation in the Evaluation.

Annex 7: Observation Checklist

AUSTRALIA FIJI HEALTH SECTOR SUPPORT PROGRAM (FHSSP) END OF PROGRAM EVALUATION

NOVEMBER 2015

OBSERVATION CHECKLIST

Date / Time	
Names & Positions of Hosts	
Site / Location	
Team Member	

Objective

The overall objective of the health facility observation checklist is to document observations relating to the availability and quality of the health service delivery in selected Divisional and Sub-Divisional hospitals, Health Centres and Nursing Stations visited by the Evaluation Team.

The specific objectives are to:

- Observe the physical infrastructure
- Determine the level of human resource capacity (the number of staff and level of training/mentoring)
- Review the existence and use of guidelines, job aids, SOPs and IEC material for the priority FHSSP areas such as maternal and child health, child immunisation, management of diabetes, effective primary health care, and efficient health systems
- Understand data collection at the local level
- Discuss with health workers implementing the Program their perceptions of progress over the past four years, success factors and areas for improvement

Facility Overview

General Facility Overview	Comments/Observations
Facility infrastructure (water, power, building, ventilation, etc.)	
Size and location of population served by the centre / hospital	
Major health priorities for the geographic area and this facility	
Staffing / Human resources / Leadership and management	
Communication with other layers of the health system (re policy, information, learning, patient referrals)	
Evidence of Progress towards EOPOs	Comments/Observations
Obj 1: Safe motherhood	
Obj 2: Healthy children	
Obj 3: Diabetes prevention & management	
Obj 4: Village / Community Health Workers	
Obj 5: Health systems	
Overall progress through FHSSP – success factors/barriers	

Annex 8: Evolution of FHSSP Objectives

Obj	Contract 59506 (pages 5, 6)	Contract 59506 (page 1)	M&E 2013	2013 APR FHSSP Work Plan	2014 6/12 FHSSP WP	FHSSP M&E plan v5 (Nov 2014, current)
1	To institutionalise a safe motherhood Program at decentralised levels	Institutionalise Safe Motherhood Program	Institutionalised safe motherhood Program in decentralised levels	Safe Motherhood	Safe Motherhood	To institutionalise a safe motherhood Program throughout Fiji
2	To institutionalise a 'healthy child' Program throughout Fiji	Institutionalise Healthy Child Program	Institutionalised 'healthy child' Program at decentralised levels	Healthy Child	Infant and Child	To strengthen infant immunisation and care and the management of childhood illnesses and thus institutionalise a "healthy child" Program throughout Fiji
3	To improve prevention and management of diabetes and hypertension at decentralised levels	Address Diabetes & Hypertension	Improve diabetes and hypertension management and prevention at decentralised levels	Diabetes Prevention	NCDs – Diabetes Control	To improve prevention and management of targeted noncommunicable diseases, including diabetes and cervical cancer
4	To revitalise an effective and sustainable network of village/community health workers as the first point of contact with the health system for people at community level	Revitalise Primary Care (VHW/CHW Program)	Revitalise CHW network as the first point of contact with the health system for people at community level	Revitalising the Community Health Workers Program	Primary Health Care	To revitalise an effective and sustainable network of community health workers as the first point of contact with the health system for people at community level

5	To strengthen key components of the health system to support decentralised delivery	Targeted Systems Strengthening	Stronger health system for supporting decentralised health delivery	Targeted Health Systems Strengthening	Health Systems Strengthening	To strengthen key components of the health system to support decentralised service delivery
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Source: Columns 1 to 6 from High Level Strategic Review, Fiji Health Sector Support Program Final report. G. Biscoe & C. Jacobsen, May 2014

Annex 9: FHSSP: Results Table

Latest available data (incomplete) from Sept 2015, Fiji Health Sector Support Program – Program progress report: January – June 2015 (draft)

Strategic Approaches	End-of-Program (EOP) Outcome	Progress indicator or evaluation	Baseline (date)	Target (date)	Latest results
Objective 1 – Safe Motherhood					
Early and adequate antenatal care	1.1 MoHMS sustains behaviour change campaign to promote early booking	Percent (%) of pregnant women with first ANC visits in the first trimester	0% 2012	15.7% 2015	22% Q1, 2015
		Percent (%) of mothers with at least 4 ANC visits	39% Q2, 2014	50.6% 2015	59% Q1, 2015
Safe pregnancy, motherhood and childbirth	1.2 MoHMS sustains Mother Safe audits in hospitals to guide improvement in care	Percent (%) adherence to MSHI standards in FHSSP targeted hospitals	36% average Q4, 2013 39% average Q2, 2014 Nadi, Sigatoka, Nausori, CWMH, Lautoka, Labasa	80% CWMH, Lautoka and Labasa 60% Nadi, Sigatoka, Nausori (2015)	61% average for CWMH, Lautoka, Labasa 69% average for Nadi, Sigatoka, Nausori (Q2, 2015)
		80% of all cadres of maternity staff are trained by facility: EmONC BPP/CRP	EmONC 0% (Q2, 2014) BPP/CRP 0% (Q2, 2014)	100%, 6 out of 6 targeted hospitals meet the MSHI standard for EmONC and BPP/CRP (Nadi, Sigatoka, Nausori, CWMH, Labasa, Lautoka) (2015)	EmONC and BPP/CRP – 83% 5/6 target facilities have met the MSHI standard: Nadi, Nausori, Sigatoka, CWMH, Labasa hospitals (Q2, 2015)

Strategic Approaches	End-of-Program (EOP) Outcome	Progress indicator or evaluation	Baseline (date)	Target (date)	Latest results
		Percent (%) adherence to MSHI standards in all hospitals comprising 3 divisional hospitals and 15 subdivisional hospitals and to specialise maternity facilities (20 facilities in total)	44% average for all SDH (Q4, 2013)	≥ 60% adherence in 10/19 SDH (2015)	TBC, this information will be available in quarter 4, 2015 in line with MoHMS audit schedule for non-target facilities
		Percent (%) adherence to MSHI standards in all (divisional) hospitals	25% for divisional hospitals (Q2, 2014)	≥ 80% adherence in 3/3 divisional hospitals (2015)	61% average for divisional hospitals – CWMH, Lautoka, Labasa (Q2, 2015)
Safe and effective post-miscarriage services	1.3 MoHMS sustains effective post-miscarriage services	Staff training adequacy in MVA, by facility	(Q2, 2014) Labasa – 2 CWMH – 4 Lautoka – 3 Nadi – 1 Sigatoka – 1 Navua – 1 Nabouwalu – 1 Dreketi H/C – 1	Not applicable	Labasa – 8 CWMH – 5 Lautoka – 5 (Q2, 2015)
Objective 2 – Child Health					
Childhood immunisation for rotavirus and pneumococcal disease	2.1 MoHMS fully funds pneumococcal & rotavirus vaccines	Total amount (FJD) of annual MoHMS funding towards vaccines	FJD 434,043 July 12 – July 13 FJD 1,312,628 July 13 – June 14	FJD 1,728,017	
		% MoHMS contribution for	17%	50%	68%

Strategic Approaches	End-of-Program (EOP) Outcome	Progress indicator or evaluation	Baseline (date)	Target (date)	Latest results
		vaccines relative to external funding	July 12 – July 13 51% July 13 – June 14	July 14 – July 15 80% July 15 – June 16	July 14 – June 15
		Percent (%) coverage for RV immunisation	0% 2012	95% 2015	76.3% Q1, 2015
		Percent (%) coverage for PCV 1 one immunisation	0% 2012	95% 2015	76.2% Q1, 2015
	2.2 MoHMS conducts routine surveillance of pneumococcal & rotavirus vaccines	-			Outcome flagged by Program for transition to next phase of support
	2.3 Vaccine evaluation results guide MoHMS procurement planning	-			Outcome flagged by Program for transition to next phase of support
Consistent, high quality child health care	2.4 MoHMS sustains child health training and quality of care audits to guide improvement	Staff training adequacy by facility:			
		IMCI 26 targeted facilities, 60% of the nurses in each facility must be trained	46% (2013) 31% (Q2, 2014) 50% (Q4, 2014)	100% of target facilities (26/26) have 60% of the nursing staff trained on IMCI (2015)	Data not yet available
		PLS subdivisional level: 16 targeted SDH facilities, 30% of the doctors and nurses need	PLS 15% (2013) 31% (Q2, 2014) 15% (Q4, 2014)	30% of staff at SDHs (6/16 facilities) 50% of staff at	Data not yet available

Strategic Approaches	End-of-Program (EOP) Outcome	Progress indicator or evaluation	Baseline (date)	Target (date)	Latest results
		to SDH must be trained. Level a health centres: 12 target facilities Central 8 Eastern 1 Western 3 At least 50% of medical officers and nurses trained per facility		H/C level trained (2015)	
		APLS 3 divisional hospitals: all emergency medical doctors who take care of children should be trained per facility 17 subdivisional hospitals: at least one medical officer (DMO) trained per facility 8 level a health centres: at least one medical officer trained per facility	32% (9/28 facilities) (2013) 69% (Q2, 2014) 71% (Q4, 2014)	100% of facilities (28/28) have at least one MO trained (2015)	Data not yet available
		WHO pocket book hospital care for children 17 subdivisional hospitals. (The facility is counted as covered if all medical officers and at least 50% of nurses are trained per facility)	15% (Q2, 2014) none of the facilities met the requirement in Q4, 2014	100% (17/17) of subdivisional hospitals (2015)	Data not yet available
		Percentage of subdivisional hospitals adhering to WHO	0% (2013) 53% (9/17) (Q4,	100% (17/17) subdivisional	Data not yet available

Strategic Approaches	End-of-Program (EOP) Outcome	Progress indicator or evaluation	Baseline (date)	Target (date)	Latest results
		pocket book standards (17 subdivisional hospitals)	2014)	hospitals (2015)	
Objective 3 – Diabetes and Noncommunicable Disease					
Diabetes prevention and early intervention	3.1 MoHMS sustains national diabetes screening and behaviour change campaign	Percent (%) of 30 year + population screened for diabetes	2% (2012) 20% (2013) 21% (2014)	25% (2015)	4.3% (Q1, 2015)
		Percent (%) of the population screened for diabetes that received on the spot behaviour change (a.k.a. SNAP) counselling	N/A (2012) 66.8% (2013) 76% (2014)	75% (2015)	83.5% (Q1, 2015)
		Number (#) new diabetes cases detected (medical area level and below)	30+: 3481 new cases <30: 1269 new cases (2013) 30+: 1726 new cases, <30: 469 new cases (2014)	30+: 4000 new cases <30: 1500 new cases (2015)	30+: 756 new cases <30: 6 new cases (Q1, 2015)
		Number (#) of new hypertension cases detected (medical area level and below)	30+: 6084 new cases <30: 1472 new cases (2013) 30+: 3030 new cases <30: 463 new cases (2014)	30+: 6500 new cases <30: 1500 new cases (2015)	30+: 703 new cases <30: 30 new cases (Q1, 2015)

Strategic Approaches	End-of-Program (EOP) Outcome	Progress indicator or evaluation	Baseline (date)	Target (date)	Latest results
	3.2 MoHMS routinely monitors diabetes screening coverage to target outreach	-	-	-	No information given
	3.3 MoHMS sustains audits of diabetes centre minimum standards to guide improvement	Percent (%) adherence to diabetes centre minimum standards for all MoHMS SOPDs (20 facilities)	2% average (2013) 14% average (2014)	15% 3 of the 20 targeted facilities (2015)	MoHMS has fully taken over audits in phase 2. The tool for SOPDs audits is in the process of being reviewed and finalised.
Cervical cancer prevention and screening	3.4 MoHMS sustains HPV vaccination for Class 8 girls and cervical cancer screening for women	Total amount (FJD) of annual MoHMS funding toward HPV vaccines	\$225,487 July 12 – June 13 \$387,780 July 13 – June 14	\$517,041 July 14 – June 15 \$631,939 July 15 – July 16	\$517,041 July 14 – June 15
		Percent (%) of MoHMS contribution for HPV vaccines relative to external funding	33% July 12 – June 13 52% July 13 – June 14	69% July 14 – July 15 85% July 15 – June 16	69% July 14 – July 15
		HPV vaccination coverage among class 8 girls in school	0% (2012)	HPV1: > 95% (2015)	HPV1: > 100 % (Q1 2015)
		Cervical cancer screening coverage	8% (2004 – 2007) 15.8% (2013)	25.8% (2015)	data not yet available
	3.5 MoHMS monitors vaccine and screening coverage and assesses vaccine efficacy	-	-	-	No information given
Objective 4 – Community Health Worker Network					
Standardised core	4.1 ≥65% of active CHWs	Training coverage for core	Curative figure –	65%	69% national

Strategic Approaches	End-of-Program (EOP) Outcome	Progress indicator or evaluation	Baseline (date)	Target (date)	Latest results
competencies for active CHWs nationwide	nationwide have been trained in the CHW core competencies	competencies in active CHWs	404 CHWs trained (Q2, 2014)	(1028/1581) CHWs (2015)	coverage 1097/1581 CHWs trained in core competences module
	4.2 MoHMS staff opportunistically collaborate with CHWs at subdivisional level	-	-	-	Anecdotal evidence that CHW training by zone nurses is strengthening the link between communities and the formal health sector
Objective 5 – Health Systems Strengthening					
Key information systems providing accurate, meaningful data	5.1 PHIS and PATIS are functional, accessible and responsive to user information needs	Training adequacy among targeted staff in use of the Public Health Information System (PHIS) and hospital extension	254 staff (2013)	214 staff to be trained in Data Collection for Hospital Maternal and Child Health Services (DCM) Enhancement (2015)	PHIS training was completed in phase 1. DCM enhancement is now underway in phase 2. 225 have been trained in Q1/2 2015 – target exceeded
				63 for CMRIS (2015)	67 (Q2, 2015) 2015 target exceeded
		Training adequacy among targeted staff in use of the PATISPlus	174 (2014)	Not available. Ongoing discussion with MoHMS to establish target	26 staff trained on ATD/SOPDs/PMI modules at CWMH (Q1/2, 2015)

Strategic Approaches	End-of-Program (EOP) Outcome	Progress indicator or evaluation	Baseline (date)	Target (date)	Latest results
	5.2 MoHMS regularly extracts, compiles, and disseminates key PHIS and PATIS data	-	-	-	Progressing through PHIS and PATIS improvements
	5.3 MoHMS routinely conducts data quality assurance activities for key data sources	Percent (%) of the Annual Corporate Plan indicators that have meta data documented (e.g. in the national health data dictionary)	0% (2012) 9% (2013) 69% (2014)	100% (2015)	69% (2014) data based on MoHMS documentation. No progress reported Q1/2, 2015
	5.4 MoHMS annually trains and supports M&E Resource Network facilitators all levels	# Of national Programs, divisions, subdivisions, major hospitals and CSNs with trained resource network facilitators	0 (2013)	42	31 (Q2, 2015)
Results-oriented M&E to guide continuous improvement	5.5 MoHMS applies M&E concepts, skills, and tools to guide planning and implementation	-	-	-	Divisional plus meetings held. Divisional METTS established.
Systematic, evidence-based HRH recruitment, retention, and training	5.6 MoHMS sustains and monitors systematic HRH recruitment, retention and training	Doctor to population ratio	4.3:10,000	8.3:10,000 (equivalent to 753 doctors)	753 doctors (8.3:10,000 – Q1, 2015)
		Nurse to population ratio	20:10,000	29:10,000 (equivalent 2666 nurses)	2679 nurses (29.7:10,000, Q1, 2015)
		Midwife to population ratio	3:10,000	4:10,000 (equivalent to 400 midwives)	midwives – 355 (3.9:10,000, Q1, 2015)

Strategic Approaches	End-of-Program (EOP) Outcome	Progress indicator or evaluation	Baseline (date)	Target (date)	Latest results
		Average recruitment time	>16 weeks	6 – 8 weeks (2015)	12 weeks (Q1, 2015)
			NU – 154/519 MO – 172/519 Dental – 48/48/519 Dieticians – 17/519 Engineering – 9/519 HI – 14/519 Laboratory – 12/519 Physio – 5/519 Radiology – 8/519 Pharmacy – 18/519 Accounts – 4/519 Admin – 45/519 IT – 3/519 Stores – 5/519 Technical General – 4/519 Upper Scale – 1/519	MoHMS indicator values: NU < 2.5% of total at any time in the year MO < 5% of total at any time of the year Dental <10% of cadres at any time in the year	MoHMS indicator values: NU: 163/2679 – 6.1% (Q1, 2015) MO: 239/753 – 31.7% (Q1, 2015) Dental: no report
		# and % of vacancies by cadre and facility			

Strategic Approaches	End-of-Program (EOP) Outcome	Progress indicator or evaluation	Baseline (date)	Target (date)	Latest results
		Ratio of vacancies to the establishment	NU – 6.2% (154/2466) MO – 28.5% (172/603) Dental – 24% (48/201) Dieticians – 28% (17/61) Engineering – 41% (9/22) HI – 11.3% (14/124) Lab – 7.3% (12/164) Physio – 14.3% (5/35) Radiology – 9% (8/87) Pharmacy – 21% (18/87) Admin – 19.6% (45/230) Accounts – 23.5% (4/17) IT – 33% (3/9) Stores – 16% (5/31)	To maintain also cadres within 5 – 10% of establishment in any time over the year	654:4679 – 14% (Q1, 2015)
		Attrition rate for medical, nursing and administrative	NU – 55/2279	NU: <2% of nursing	NU – 38:1.4%

Strategic Approaches	End-of-Program (EOP) Outcome	Progress indicator or evaluation	Baseline (date)	Target (date)	Latest results
		cadres	MD – 23/433 TC – 55 SS – 10 GW E – 34/1700	workforce MD:<5% of medical workforce	MD – 9:1.2%
		Ratio of staff of the job description relative to total staff	> 40% (2013)	80%	924/5819:16%
		% of nurses meeting their pro rata target for professional credentialing	98% (2014)	98%	25%
		% of doctors meeting their pro rata target for professional credentialing	100% (2014)	100%	25%

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