Fiji Health Sector Support Program Technical Advisory Group

Mid-term review

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27 May 2013 – Final report

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Acronyms

Abt-JTA	Abt Associates-JTA
ANC	Antenatal Care
ATF	Assistant Technical Facilitator
AUD	Australian Dollar
BCC	Behaviour Change Communication
CHW	Community Health Worker
CSN	Clinical Service Network
CSO	Civil Society Organisation
CWM	Colonial War Memorial (Hospital)
DMO	Divisional Medical Officer
EPI	Expanded Program on Immunisation
FAC	Finance and Accounts Committee
FHSSP	Fiji Health Sector Support Program
FJD	Fijian Dollar
FNU	Fiji National University
FSMed	Fiji School of Medicine
HC	Health Centre
HIS	Health Information System
HPV	Human Papilloma Virus
HR	Human Resources
HRIS	Human Resource Information System
HSS	Health Systems Strengthening
IEC	Information, Education & Communication
IMCI	Integrated Management of Childhood Illness
JICA	Japan International Cooperation Agency
LTA	Long Term Adviser
M & E	Monitoring and Evaluation
MDG	Millennium Development Goal
MEF	Monitoring & Evaluation Framework
MCH	Maternal and Child Health
MoH	Ministry of Health
MTR	Mid-term review
NCD	Non Communicable Diseases
NCHP	National Centre for Health Promotion

NHEC	National Health Executive Committee
PATIS	Patient Information System
PCC	Program Coordinating Committee
PD	Program Director
PHIS	Public Health Information System
PMG	Program Management Group
PS	Permanent Secretary
QAI	Quality at Implementation (Report)
SDH	Sub-Divisional Hospital
SPA	Senior Program Administrator
STA	Short-term Advisor
TA	Technical Assistance
TAG	Technical Advisory Group
TNA	Training Needs Assessment
TOT	Training of Trainers
TSO	Technical Support Officer
UNSW	University of New South Wales
VCCT	Voluntary & Confidential Counselling and Testing (HIV)
VHW	Village Health Worker
WHO	World Health Organization
WMIS	Warehouse Management Information System

Executive summary

In March 2013, a technical advisory group (TAG) consisting of three independent consultants was engaged by AusAID Fiji to conduct a mid-term review (MTR) of the Fiji Health Sector Support Program (FHSSP, 2011-2015) progress to date, and specifically to provide recommendations on whether or not the program should be continued for the full five-year term to end June 2016. A recent change in the AusAID funding environment has necessitated a shift from the earlier scale-up approach to a scaling-back of implementation. The TAG was tasked with reviewing the implications of this, and the response by both the program team and the MOH to the implementation challenges represented. The TAG was further tasked with specifically reviewing the implications of the significant expansion of the infrastructure component, and the slow pace of implementation of the primary health care component (objective 4).

The TAG notes that, with the exception of the primary health care component, the program has performed exceptionally well, given the constraints under which it has been operating. These include: a series of national emergencies, including major floods in January and April 2012 , and Cyclone Evan which struck the islands in December 2012; a change in the AusAID funding environment in December 2012, which has necessitated a significant scaling-back of program implementation for the first six months of 2013; the significant increase in the infrastructure component of the program, which continues to divert human and financial resources away from key program infrastructure upgrades; and ongoing changes in key MoH counterparts.

There is evidence that the program is beginning to demonstrate results in the program focal areas, and program support is resulting in the establishment of key health systems and processes within the MoH and is beginning to foster a culture of evidence-based decision-making within the MoH. The program has significant credibility and excellent working relationships with the MoH and other key stakeholders in the sector, and has recently received a good QAI report from AusAID.

Program expenditure is also largely on track. The financial report for 2012 shows that 77% of the budget was expended, with 94% of program activities budget being spent, 56% of the unallocated/ carry-over funds spent, and 89% of the management contractor internal management fees being charged.

Based on the TAG's review findings, there is strong case to be made for extending the program for a further two years up to 30 June 2016. There are also strong justifications for retaining the same managing contractor. Abt-JTA has a proven understanding of the sector and is well embedded within the MoH. The program team is well respected by AusAID, MoH and other development partners. The team absorbs change well, is robust and resilient, embodies a learning culture and has proven to be responsive to TAG and AusAID recommendations. The program team also proactively seeks solutions to problems and has demonstrated persistence and commitment to see things through. The program demonstrates good governance and financial and administrative procedures, with robust internal control mechanisms, clean internal audits and good and improving external audits.

The TAG notes that the program has made significant efforts to strategically manage the scale-back in funding. Implementation for the first six months of 2013 has been reduced to a bare minimum, and the program is using this time to take stock, and to consolidate planning, preparation, monitoring and reporting systems and processes. The program is also focusing on capacity development of MoH counterparts by locating the newly appointed long-term and short-term advisors within MoH units, and engaging key MoH staff in planning and scoping exercises. A 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.

The program has made significant efforts to liaise closely with MoH management about the implications of the scale-back. As a result, the MoH has offered to absorb some of the impact of the scale-back themselves, for example by paying for some equipment and supplies, and in pre-funding next year's co-financing of vaccines. The TAG notes however, that all negotiations between the program and MoH are based on good faith, given the lack of clear written advice from AusAID to the program and the MoH about the extent of the scale-back.

The significant expansion and re-focusing of the infrastructure component on the relocation of the Nausori Hospital and the construction of a birthing unit at Makoi is having a negative impact on other program outcomes. Diversion of human and financial resources means that the planned scoping of Sub-Divisional Hospitals (SDH) has been severely constrained, with only 3 out of 17 scoping exercises completed. Given these constraints, coupled with the further delays resulting from the scale-back in funding, it is now unlikely that the remaining scoping exercises can be completed much before the end of the program.

At the Program Coordination Committee (PCC) meeting in December 2012, both the Permanent Secretary and the Deputy Secretary Public Health raised concerns over the slow pace of implementation of objective 4 – 'the revitalisation of an effective network of CHWs'. The TAG notes that in its current form this objective is unlikely to be achieved in the funding term, and recommends that future support to this component is provided through a 12-month pilot demonstration in the Northern Division. The TAG further recommends that the Northern Division demonstration is independently reviewed in 12 months' time to determine the effectiveness, efficiency and sustainability of the initiative. The review findings will inform decisions on whether the component should continue and be expanded to other divisions, and will identify lessons from the demonstration that could be used for future roll out to other divisions. The review should also highlight any specific requirements and concerns for rolling out to peri-urban settings.

The TAG notes that the recent downturn in funding, following hard on the heels of the scale-up in funding, is likely to have negative consequences for the achievement of the program outputs for 2013, and that it is unrealistic for the program to attempt to achieve all the targets outlined in its 2013 work plan, which was based on the scale-up and developed prior to the scale-back. The program should take the opportunity during the micro-planning exercises scheduled for May to review and to set realistic targets for 2013.

The TAG also notes that the scale-back, coupled with the significant expansion in the program infrastructure component, is likely to impact negatively on the achievement of the overall program objectives in the long-term. Following preliminary discussions with AusAID and the FHSSP team, the TAG therefore recommends revising all five of the program objectives to better reflect what the program is likely to achieve in the two years that remain. These revisions, which draw upon the program's revised theory of change, also re-emphasize MoH ownership of the program, in line with the program design. The TAG also recommends including an additional objective to reflect the work and associated budget that the program devotes to emergency responses. This will address concerns that this work is not explicitly reflected in the program achievements, and that the diversion of human resources during emergencies can pose a risk to the achievement of other program objectives.

The suggested revisions are outlined in the table below:

Original program objectives	Suggested revised program objectives
1. To institutionalise a safe motherhood program at decentralised levels throughout Fiji.	1. To improve demand, access and quality of maternal health services, and thus support the MoH to operate a safe motherhood program at decentralised levels throughout Fiji.
2. To strengthen infant immunization and care and the management of childhood illnesses and thus institutionalise a 'healthy child' program throughout Fiji.	2. To strengthen infant immunization and care and ensure that more secondary level paediatric care is safely carried out at sub-divisional level, and thus support the MoH to operate a 'healthy child' program throughout Fiji.
3. To improve prevention and management of diabetes and hypertension at decentralised levels.	3. To support the establishment of quality diabetes centres at all sub-divisional hospitals and selected large urban health centres, and improved early detection of undiagnosed diabetes and hypertension, and thus support the MoH to improve prevention and management of diabetes and hypertension at decentralised levels.
4. To revitalise an effective network of village/community health workers as the first point of contact with the health system for people at community level.	4. To pilot a demonstration model of CHW revitalization in Northern Division as a basis for the MoH to roll out an effective network of CHWs 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 service delivery.	5. To support the MoH to ensure that health system planning and monitoring for quality service delivery is more effective to support decentralised service delivery.
	6. (Additional objective) To support the MoH to respond strategically and effectively to emerging health priorities and emergency health needs.

The TAG suggests that these revisions should be discussed and agreed between AusAID, MoH and the program, and raised at the next PCC meeting. The TAG proposes the following **recommendations**:

Program extension

- AusAID should continue to fund the program to its full term, to end June 2016, retaining the same managing contractor.
- AusAID and FHSSP should seek agreement on revising the program objectives, as outlined above, to better reflect what the program is likely to achieve in the two years remaining. The revised objectives should be discussed at the next PCC meeting.
- FHSSP should continue to engage with the MoH to explore and implement cost-savings and other efficiencies that were identified as a result of the scale-back in funding.

Infrastructure development

- Finalize the draft 'Health Service Planning Strategy for the Suva-Nausori Corridor' to ensure that the data can, where possible, be verified and the report updated if necessary.

- Support further scoping, surveys and costing work to determine the resources required for the preferred infrastructure option, including the proposed Nausori Hospital relocation program.
- Prioritize program funds to allow the STA Infrastructure position to be extended to support this additional work.
- The program should continue to engage with the MoH to further utilize evidence-based approaches to infrastructure development.

Revitalization of primary health care

- Future support to the revitalization of primary health care (objective 4) should be provided through a 12-month pilot demonstration in the Northern Division, which should be independently reviewed in 12 months' time to inform decisions on whether the component should continue and/or be expanded to other divisions.
- As a matter of urgency, the program should initiate the recruitment process for a replacement Technical Facilitator or a Long-term Advisor to manage objective 4.

Data for decision-making

- FHSSP should undertake a review in 2014 of the effectiveness of the Public Health Information System (PHIS), and ensure that the findings from the review are used to inform how data for decision making can be further strengthened to enhance decision making and improve health outcomes.

Human resource development

- FHSSP should continue to support the MoH to re-invigorate the HRIS to provide a sound evidence base for training programs.

Governance

- Revise the Unallocated Fund Guidelines to reflect the increased number of activities classified under 'Emerging Issues', and to provide AusAID with greater predictability on how the unallocated fund is utilized.
- Key recommendations from the TAG review reports should be shared at PCC meetings to facilitate follow-up and foster mutual accountability.

Monitoring, evaluation and reporting

- FHSSP should continue to move from activity-based reporting to results-based reporting. In the absence of benchmark data, the program should set annual milestones against which progress can be reported.
- FHSSP should add a new section to MEFv4 titled 'Program Evaluation' that includes key evaluation activities that will be conducted in the funding term. The TAG recommends that the document gives consideration to evaluating each of the five program objectives, and their overall contribution to the program goal.

Risk management

- Refine the risk management/mitigation strategies to address the additional risks to the achievement of the program objectives, stemming from a) the significant increase in the infrastructure component, b) delays in implementation resulting from the scale-back in funding for the first six months of 2013, c) relationship risks with the MoH related to the scale-back in funding, d) the slow pace of implementation of the CHW component, e) increasing ad hoc use of the unallocated fund, f) uncertainties in the political environment.

Financial management

- Funds paid to FHSSP from AusAID, and funds recorded as received by the program, should be reconciled quarterly and reviewed during the periodic joint meetings between AusAID and FHSSP.

1. Introduction

1.1. Background

The Australian Aid Program has provided significant support to the Fiji health sector over the last decade. AusAID launched its new five-year Fiji Health Sector Support Program in July 2011, worth AUD$25 million over five years. This is a major investment in Fiji's health sector, to ensure that the ordinary people of Fiji can access quality healthcare and improved service delivery. The 2012 FHSSP budget of AUD 8,409,220 represents 6% of the total Ministry of Health annual Government budget.

The major public health concerns in Fiji are non-communicable diseases, emerging and re-emerging communicable diseases, maternal and child health, mental health and pandemics or other disasters affecting the health and well-being of the community. A major focus of the MoH Strategic Plan is to operationalize programs at decentralized levels in the areas covering MDG 4-5-6 and NCDs including diabetes, hypertension, cardiovascular diseases and cancer. There is a need to focus on human resource development and staff retention to meet the acute shortage of health professionals, and the need to strengthen the health system through improving investment in technical infrastructures.[1]

The goal of the Fiji Health Sector Support Program (2011-2015) is to remain engaged in the Fiji health sector by contributing to the Fiji Ministry of Health's (MoH) efforts to achieve its higher level strategic objectives in relation to infant mortality (MDG 4), maternal mortality (MDG 5) and the prevention and management of diabetes, as outlined in the MoH Strategic Plan 2011-2015.

The FHSSP objectives are:

1. To institutionalise a safe motherhood program at decentralised levels throughout Fiji;
2. To strengthen infant immunization 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;
4. To revitalise an effective network of village/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 service delivery.

FHSSP's support is targeted towards improving child health, maternal health and reducing NCDs in Fiji; through health promotion and strengthening primary health care; including revitalising the village/community health workers to improve service delivery. The program will also strengthen key areas of the health system that support delivery of essential health services at the sub-divisional and divisional levels.

The Program was designed as a five-year 25 million Australian dollar (AUD) Program of support to the Fiji MoH to improve health outcomes in Fiji over the period 2011–2015. In November 2011, the Australian Government announced an increase in bilateral Australian aid to Fiji, which in turn resulted in FHSSP being scaled-up via an AUD 8 million budget increase in September 2012.

[1] MoH Strategic Plan 2011-2015.

Recognising the potential positive impact on under-5 mortality and decreased cervical cancer rates in women[2], FHSSP committed in 2012 to the introduction of three new vaccines - pneumococcal, rotavirus and HPV, on a cost-sharing basis with the MoH.

In February 2012, AusAID engaged a three-person Technical Advisory Group (TAG) (David Wilkinson, Cate Keane and Sara Webb) to review FHSSP progress to date, and to provide independent advice to AusAID Fiji to inform its policy, planning and programming support to the Ministry of Health in Fiji. As part of that engagement, the TAG was asked to appraise the FHSSP scale-up concept note, submitted in February 2012 by JTA International to AusAID Suva for consideration. Following the TAG appraisal, Abt-JTA/FHSSP submitted a revised proposal to AusAID in April 2012, and the TAG was requested by AusAID to appraise this revised proposal, and in particular, to assess whether Abt-JTA/FHSSP had taken into consideration the recommendations made by the TAG in their initial response, and to see whether they had been able to incorporate these recommendations into the revised proposal. The TAG noted that the activities presented in the revised proposal were more coherent and strategic and that TAG recommendations had been incorporated into the revised proposal.

In December 2012 a change in the AusAID funding environment meant that Abt-JTA/FHSSP were asked by AusAID to scale back program implementation. At the time of the TAG visit, Abt-JTA/FHSSP had not received any clear written communication about the extent of the scale-back, but had been asked to reduce spending to a minimum for the first six months of 2013.

1.2. FHSSP mid-term review

The FHSSP Design envisaged a three-year program with the possibility of extension for a further two years depending on performance. In March 2013, a TAG consisting of three independent consultants (David Wilkinson, Cate Keane and Sally Duckworth) was engaged by AusAID Fiji to conduct a mid-term review (MTR) of FHSSP progress to date, and specifically to recommend program extension or otherwise. The TAG was tasked with reviewing the implications of the scale-back, and the response by both the program team and the MoH to the implementation challenges represented. The TAG's scope of work is described in Annex 1, while the review approach and methods and key review questions are outlined in Annexes 2 and 3.

2. General oversight

The following sections outline the key findings from the review, in response to the specific questions in the TOR. The review findings take into account the context in which the program operated over the past twelve months since the last TAG review. Five major constraints, almost entirely outside the control of the program, have negatively affected program implementation:

(i) A series of national emergencies, which included major floods in January and April 2012 and February/March 2013, and Cyclone Evan which struck the islands in December 2012;

[2] Fiji has the second highest rate in the world of cervical cancer.

(ii) A protracted process in signing the scale-up contract amendment, which resulted in the commencement of scale-up activities being delayed until September 2012;

(iii) A change in the AusAID funding environment in December 2012, which has necessitated a shift from the earlier scale-up approach to a significant scaling-back of implementation for the first six months of 2013;

(iv) Diversion of program resources to address the significant increase in the infrastructure component of the program that resulted from commitments made by AusAID to the MoH;

(v) Ongoing changes in key MoH counterparts.

The TAG was tasked to:

a) Review the extent to which the TAG recommendations in the inception report and scale-up report have been implemented;

b) Review the program's 2013 Work Plan; assess the extent to which it aligns with the principles of the FHSSP design while responding to the changes in the funding environment announced at the end of 2012; comment on how effectively the program management team has addressed the downturn in funding;

c) Review overall program performance and progress and provide advice on effective Program implementation and – if required – recommend improvements to the mix or design of activities supporting implementation, in view of the recent necessary budget changes for this financial year and the challenges faced by the Program as noted in program reports and risk analysis;

d) Assess any recent changes in the operational and strategic environment in the Fiji health sector and identify emerging issues, and provide recommendations for AusAID's consideration.

2.1. The extent to which the 2012 TAG recommendations in the inception report and the scale-up report have been implemented.

The TAG developed two data collection forms that summarized the key TAG recommendations in the inception review report, and the scale-up review report, and provided the opportunity for the FHSSP program team to comment in writing on the extent to which the TAG recommendations from the previous review have been/are being implemented. These forms, and the program's responses, were used as a checklist by the TAG during the in-country visit. The full summary table of the scale-up review report, including the program's responses, are provided as Annex 7 to this report.

The TAG notes that the program has made significant efforts to respond positively to all the TAG recommendations from the previous (2012) review. The program's responses to the key recommendations in the inception review report are summarized below:

M&E

The 2012 TAG review noted that program M&E capacity could be strengthened, and recommended that the program engage additional technical support. The appointment of an M&E long-term adviser (LTA) and locally engaged M&E officer as

part of program scale-up has strengthened M&E capacity within FHSSP and is beginning to strengthen capacity within the MoH.

The TAG highlighted the need for the program to clearly demonstrate how the work plan builds on previous activities, and how it fits into the broader program strategy, noting that the M&E framework should be used both for planning and monitoring. The program has revised the M&E Framework (MEF) to include a specific section on how monitoring implementation of FHSSP against the annual work plan will be achieved, together with a Progress Tracking Matrix for output-level reporting of program activities.

Workforce capacity development

The TAG recommended that the program should take a broader strategic approach to supporting in-service training, and support the MoH to develop a long-term plan for workforce capacity building. In response, the program recruited a LTA Workforce Development, who is working with the MoH and FHSSP Technical Facilitators to develop a long-term plan for workforce capacity building. The LTA is also helping to coordinate FHSSP funded training activities and MoH workforce training, and supporting improved monitoring and evaluation of training activities to ensure that training is effective and sustained.

Public health communication/media campaigns

The 2012 TAG recommended that the program adopt a more strategic approach to behaviour change communication (BCC), supported by additional technical personnel with public health communication skills and expertise. The TAG noted that: (i) the existing media campaign supported by the program could benefit from a clear and documented BCC plan that includes formative research, baselines, targets and clear communication objectives; (ii) behaviour change objectives should be more closely linked to messages; and (iii) both messages and media should undergo pre-testing with target audiences. As a direct result of the recommendations from the TAG, an STA Public Health Communications (PHC) and a locally engaged communications officer were appointed. However, due to budget constraints, the continuation of the work of the STA PHC will now be delayed until after June 30, 2013. The TAG wishes to emphasize that, pending the re-engagement of the STA PHC, it is imperative that the program addresses the remaining TAG recommendations, especially those related to the development of a BCC plan and pre-testing messages and media with target audience(s).

The 2012 TAG recommended that, if print materials are developed then there needs to be a logistics plan for how the materials will be distributed to decentralized levels, stored, distributed to providers and clients, and providers trained in their use. There are presently no clear indications that the program is effectively addressing this issue.

Health facility audits

In response to the 2012 TAG recommendation for whole facility audits, the audits in November/December 2012 were completed using a combined program audit tool coordinated by the divisionally based ATFs. Improvements to audit processes are also being reviewed by the M&E team.

Program financial management

The 2012 TAG recommendations to improve financial management resulted in changes to the financial procedures manual and the format of the financial report. The updated financial procedures manual incorporated all of the recommendations from the 2012 TAG review. Furthermore additional finance staff as well as an assistant program administrator have been recruited since the last TAG, ensuring

that there is sufficient finance staff to maintain and control the financial management of the FHSSP.

Program governance

The 2012 TAG noted some overlap in the TORs of the Program Management Group (PMG) with those of the Program Coordination Committee (PCC) and Finance and Admin. Committee (FAC), and highlighted the possibility of repetition and overlap of functions. Given that the PMG was not part of the original design, the TAG suggested that the PMG may be superfluous. This review notes that the PMG has not proved to be an effective mechanism, and has been disbanded (with approval at the December 2012 PCC). Instead, the fortnightly MoH Director's meetings, quarterly Divisional Plus meetings and Clinical Service Networks (CSN) will be formally used to support the coordination, monitoring and communication of the Program's activities in addition to the Quarterly FAC and bi-annual PCC meetings.

The TAG also notes that the program has made significant efforts to respond positively to all the TAG recommendations in the scale-up report. The program's responses to the key TAG comments and recommendations are summarized below:

Improved service delivery at SDH

As part of the scale-up, FHSSP proposed expanding the number of sub-divisional hospitals (SDH) providing baby-friendly, mother-safe and diabetes-focused services from 8 in the existing work plan to all 17 SDH across Fiji, and proposed undertaking a comprehensive scoping exercise for all SDH. The 2012 TAG fully endorsed the comprehensive scoping exercise for all SDH as this would provide a key opportunity to confirm the rationale for investment.

The 2012 TAG noted that the construction of a birthing centre at Makoi had been identified by MoH and AusAID as a priority for future funding support. The TAG noted with concern that if the decision was made to pursue the construction of the birthing centre, this could have negative implications on the budget and timeframe for SDH upgrades. The TAG strongly recommended that AusAID did not pre-empt the findings of the scoping exercise by committing upfront to the construction of the Makoi birthing centre – especially if this implied that SDH upgrades would suffer as a result.

This 2013 TAG review notes with approval that scoping of a prioritised list of SDH upgrades has commenced, and a rolling program recommended by the program. In addition, servicing planning has commenced for the Suva-Nausori corridor to review the planning data and service options for Makoi and Nausori, which will result in a functional plan and clearer costs estimates for the proposed facilities – including workforce requirements.

Improved distribution of essential medicines and biomedical equipment

The 2012 TAG fully endorsed a proposed scoping exercise with a view to upgrading the current warehouse management system to address inefficiencies in the current system. The understanding was that the scoping exercise would result in a comprehensive plan to improve the access to essential medicines and biomedical equipment that will inform the 2013 annual planning process. The program offered the services of an STA to the MoH to support a plan and specifications for a warehouse management information system (WMIS), but it appears that the MoH has formed its own working group to do this. In February 2013, the MoH called an open tender for bidders to develop a WMIS; however, FHSSP has indicated that this cannot be funded by the program as it was not planned in the current budget. Discussions by the TAG with the PS on this issue highlight the need for further constructive dialogue between the program and the MoH on this issue.

Introduction of three new vaccines

In late 2011, the Fiji Cabinet endorsed the introduction of three new vaccines in 2012—pneumococcal, rotavirus and HPV. AusAID committed to the introduction of the three new vaccines, and that commitment was reflected in the inclusion in the scale-up proposal of the procurement costs for the new vaccines on a cost-sharing basis. An evaluation of the impact of the vaccines was also proposed, through a sub-contracting arrangement with the International Centre for Child Health. The 2012 TAG fully endorsed the proposed inputs and activities, noting that the approach was consistent with the program design objectives and represented a relatively large expenditure at low risk.

In the third quarter of 2012, FHSSP procured the first two of three vaccines, Rotarix and Synflorix, and the HPV vaccines started to arrive in January 2013. Due to budget constraints in the Australian Aid program, the 20% contribution of the MoH for year 2 of vaccine procurement was brought forward into year 1 (February 2013). Phase 1 of the vaccine evaluation completed in December 2012 and Phase 2 has been delayed due to budget constraints within the Australian Aid Program. Phase 2 set up will commence in early 2013 with the bulk of the work (recruitment of epidemiologist and capacity building of surveillance systems) to commence in July 2013 and conclude in June 2014 – pushing the schedule back by 6 months.

Additional technical personnel

To support the scale-up activities, FHSSP proposed adding two long-term technical advisers (LTA) - workforce development and M&E, and three short-term technical advisers (STA) – public health communications, gender, infrastructure & planning; and a technical support officer (TSO) – training. FHSSP also proposed four additional locally engaged personnel: Assistant Technical Facilitator Infrastructure; Assistant Technical Facilitators Western and Northern divisions, and an M&E officer. The TAG strongly endorsed the proposed engagement of these additional advisors and technical facilitators. All scale-up positions recommended by FHSSP and endorsed by the TAG commenced in September and October, with the exception of LTA M&E and ATF infrastructure who both commenced in December due to a need to re-advertise these positions.

The Workforce Development LTA is contributing to more sustainable in-service training planning and management, and is supporting health systems strengthening. The M&E LTA was recruited in response to a prior TAG recommendation, and is building M&E capacity both in FHSSP and MoH and helping to ensure that M&E activities are embedded in program planning and implementation.

The Infrastructure & Planning STA is effectively managing the scoping and upgrading of all SDH, and providing ongoing due diligence on the tendering of capital works, as well as mentoring the locally engaged ATF Infrastructure. The Gender STA was recruited in response to a prior TAG recommendation, and will help to ensure effective integration of gender-sensitive practices into implementation and M&E. The appointment of the Communications STA was in response to a prior TAG recommendation and will help to: a) ensure that the program-related BCC initiatives are strategic, coherent, evidence-based and monitored; b) build the capacity of FHSSP to ensure that the program's support to BCC is technically sound; c) build the capacity of the National Centre for Health Promotion to plan, implement, monitor and evaluate its own BCC initiatives. While the STAs for Communications and Gender have been recruited, they are currently taking unpaid leave due to the scale-back in funding.

Additional management and administration personnel

The 2012 TAG fully endorsed the FHSSP proposal that five new management and administration positions were created: LTA Assistant Program Administrator, Senior Finance Officer, Communications Officer, Project Coordinator- Western Division Project Coordinator- Northern Division. All proposed administrative and management appointments by FHSSP and endorsed by the TAG commenced post scale-up.

The additional technical, management and administration personnel – the majority of whom were recruited to manage the scale-up in funding - bring the FHSSP staffing contingent to a total of 44 staff, broken down as follows: 4 senior management and administration (3 international recruitment); 12 finance and administration (all local recruitment); 4 technical facilitators (all but one is local recruitment); 4 assistant technical facilitators (all local recruitment); 3 LTAs (all international recruitment); 4 STAs (all international recruitment);13 locally engaged technical support officers – including one currently unfilled position (all local recruitment). Overall, the use of external TA has decreased for the program, with 75% of staff locally engaged.

2.2. Review of the Program's 2013 Work Plan

The TAG notes that, while the 2013 work plan aligns with the principles of the FHSSP design, the recent downturn in funding, following hard on the heels of the scale-up in funding, is already impacting negatively on program implementation, and is likely to have negative consequences for the achievement of the program outputs for 2013 and the overall program objectives in the long-term.

These concerns are exacerbated by the significant increase in the infrastructure component of the program, which was expanded in part as a result of the scale-up and in part by AusAID commitments to the MoH in 2012. This is reviewed in greater detail in the sub-section on infrastructure, in the technical section below.

A general comment on the 2013 work plan is that it could go further in demonstrating: (i) how the work plan builds on 2012 activities and achievements; (ii) how the various elements of the program are linked; and (iii) the contribution that the annual work plan will make towards achieving the longer term program objectives. In mid-2012 the program undertook an externally facilitated program logic/theory of change workshop, which articulated and documented the links between key elements of the program and how these contribute towards achieving the program objectives. The TAG feels that it would be useful for the program to incorporate the workshop outcomes into the annual plan.

The main body of the work plan - Section 5 'Workplan by Objectives' consists of sub-sections: 'Issues for Consideration' and 'Expected Achievements' for each of the program objectives. The 'Issues for Consideration' sub-sections provide some helpful context, although they would benefit from greater consistency. For example, the text under objective 3 (NCDs) relates to building the capacity of the MoH Asset Management Unit and strengthening public health communication, and therefore has more direct relevance to objective 5 (health systems strengthening).

While the 'Expected Achievements' sections are helpful in headlining selected achievements, they also vary in consistency, don't always provide a complete picture, and in some cases are difficult to reconcile with the outputs that are listed in detail in the work plan's Annex 1 Excel spreadsheet - Activities and Budget by Quarter. The TAG feels that the 'Workplan by Objectives' section of the 2013 workplan could be strengthened by outlining key activities against the program outcomes and outputs for each objective. This would help to retain the program logic without burdening the reader with the level of detail that is included in the annexed

Activities and Budget spreadsheet. An example of how this could be structured for Objective 1 is provided as Annex 8 of this report.

The 2013 work plan was developed by the program and approved by the PCC prior to the announcement by AusAID in December 2012 of the scale-back in funding. AusAID Post has indicated that the scale-back is expected to be temporary, and anticipate that full funds will be released for programming in July 2013, although confirmation of this from Canberra remains elusive. Discussions by the TAG with the program team revealed that, while they have scaled back implementation to a minimum for the period January-June in line with the (temporary) scale-back, the expected achievements for the year remain unchanged. Discussions by the TAG with the program and with AusAID highlighted the need for both parties to manage expectations about what can be achieved in 2013 (and in the longer term), given the major constraints outlined above. This is explored in further detail in section 2.3 below.

The TAG notes that the program has made significant efforts to strategically manage the scale-back in funding. Implementation for the first six months of 2013 has been reduced to a bare minimum, and the program is using this time to take stock, and to consolidate planning, preparation, monitoring and reporting systems and processes. The program is also focusing on capacity development of MoH counterparts by locating the newly appointed long-term and short-term advisors within MoH units, and engaging key MoH staff in planning and scoping exercises.

A 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, the MoH had requested the program to support training for 22 MoH staff leading to the Integrated Postgraduate Paediatric Certificate (IPPC), conducted by UNSW/Westmead. The program identified an equivalent course that can be conducted online via Skype, and certified by FNU/FSMed at no cost, and can be extended to additional students. The program is also linking MoH staff into the Pacific Online Learning Health Network (POLHN), which will enable MoH staff to obtain MPH, MHSM and Graduate Diplomas, and is helping MoH staff to enrol in MEDSCAPE to further their continuing medical education – all at low or no cost. The program estimates that these initiatives will result in savings of around AUD 200,000, and are raising awareness among MoH staff about low-cost approaches to human resource development, with significant implications for the sustainability of the program.

FHSSP has developed an Options Paper on the scale-back, which reveals that the program has cut spending to a minimum. The TAG notes that Abt-JTA is already bearing some of the impact institutionally and personally. Some LTAs have agreed to take leave without pay, and Abt-JTA has indicated that it is willing to defer management fees. The TAG notes that further staff reductions will result in minimal savings, yet may have costly contractual implications and may impact negatively on the existing good relationships with the MoH.

The program has made significant efforts to liaise closely with MoH management about the implications of the scale-back. As a result, the MoH has offered to absorb some of the impact of the scale-back themselves. For example, the MoH has agreed to pre-fund the 20% cost of the new vaccines from its co-financing allocation for the coming year; the MoH is also funding glucometers and some consumables for the NCD toolkit from the MoH NCD budget. The willingness of the MoH to absorb a portion of the impact of the scale-back is an indication of increased MoH ownership of the program and thus its longer-term sustainability. It also demonstrates the high degree of collaboration and trust that has developed between the MoH and the program.

Notwithstanding this level of trust, the TAG notes that all negotiations between the program and MoH are based on good faith, given the lack of clear written advice from AusAID to the program and the MoH about the extent of the scale-back. Both the program and the MoH have expressed some concerns that the scale-back may be permanent, thus posing a major risk to relationships between the program, MoH and AusAID.

2.3. Review of overall program performance and effective program implementation; recommendations on improvements to the mix and design of activities supporting implementation.

As noted in Section 4 below, the program's M&E system is still in the process of development, and program reporting remains largely activity-based. Furthermore, the program is designed to support MoH implementation, including building the capacity of the MoH's inherently weak M&E system. Program baselines and targets are still being determined and refined, and MoH data collection and analysis remain limited. The program therefore has little robust data on which to assess progress towards the achievement of the objectives, and the TAG assessment of program performance is therefore largely based on transactional progress.

The TAG notes that the program continues to closely follow the design, remains strongly aligned with AusAID's strategic priorities and the MoH's planning process, and continues to support MoH implementation. The TAG notes that, with the exception of the primary health care component (objective 4), there are indications that the program is generally performing exceptionally well, given the constraints outlined earlier in this section.

The following sub-sections set out the intended outcomes under each objective, based on the evolving M&E framework, and summarize progress against the key program outputs for each one:

Objective 1: Safe motherhood - Outcomes

1.1 More women receiving antenatal check-up during the first trimester of pregnancy.

1.2 All SD hospitals maintaining "Baby Friendly" standard and at least half SD hospitals classified as achieving "mother-safe" standards.

1.3 Maintain high proportion of deliveries carried out in SDH or higher level institutions.

1.4 Increased awareness of family planning.

1.5 Improved capacity of health care professionals to ensure the whole spectrum of continuum care.

1.6 Maternal health services are regularly monitored, audited and evaluated.

Progress against the key program outputs for this objective includes:

- All SDH have maintained 'baby-friendly' status.
- Building HR capacity; training midwives, nurses and doctors.
- At least one staff member from each of the 9 targeted SDH is trained in EmONC.

- Developing key guidelines and protocols, e.g. birth preparedness & complications readiness plans.
- Launched *health-care on air* to provide continuing education to nurses in geographically isolated locations; topics included record keeping, immunisation and introduction of clinical practice guidelines. The program is supporting annual audits of maternal health services conducted by the Clinical Service Network.

While the outputs all contribute towards achieving the outcomes, progress towards upgrading the targeted SDH to achieve 'mother-safe' standards has been constrained, due to the scale-back in funding coupled with the diversion of human and financial resources for other infrastructure development.

MoH data on women receiving ANC check-ups and deliveries in SDH remain pending.

Objective 2: Child health - Outcomes

2.1 Systems in place to maintain EPI rates greater than 90%.

2.2 Comprehensive training in IMCI is leading to more secondary level paediatric care being safely carried out at SDH level.

2.3 Improved capacity of health professionals to ensure whole spectrum of continuum of care.

2.4 Child health is more focused on reducing perinatal mortality.

2.5 Child health services are regularly monitored, audited and evaluated.

Progress against the key outputs includes:

- Introduced 3 new vaccines – rotavirus, pneumococcal and HPV.
- Revitalized MoH vaccination programme through introduction of new vaccines and via media campaign.
- Reached approximately 8000 babies with pneumococcal & rotavirus vaccination (>90% coverage).
- HPV roll out has started.
- Supported evaluation by Murdoch Institute of vaccine introduction.
- Initiated roll-out of MCH card with associated training.
- Provided IMCI training to all 511 staff identified at decentralized level.
- Staff inventory conducted by FHSSP six monthly.
- Annual audits of child health services are conducted by CSN supported by FHSSP.

The outputs all contribute towards the achievement of the outcomes. Quantitative data on paediatric admissions are theoretically available from the MoH PATIS, but currently quality and completeness remain inadequate. The introduction of the three new vaccines on a cost-sharing basis with the MoH has attracted international recognition and acclaim, since Fiji was the first country to do this.

Objective 3: Reducing NCDs - Outcomes

3.1 Improved early detection of undiagnosed diabetes & hypertension cases through population screening.

3.2 The Adult Personal Diabetes Record book is providing an effective mechanism for ensuring the continuum of care of people with diabetes.

3.3 Thirty two quality diabetes centres are established at all SDH and selected large urban health centres.

3.4 Diabetes health services are regularly monitored, audited and evaluated.

3.5 Improved capacity of health care professionals to ensure the whole spectrum of continuum of care.

Progress against key outputs includes:

- Procured and distributed all NCD screening toolkits, with associated training of zone nurses in central and eastern districts in toolkit use.
- Printed and distributed diabetes record books.
- Developed health record books for general population.
- Developed standards and clinical practice guidelines for diabetes management.
- Supported policy and planning for NCD evidence-based decision-making.

The outputs all contribute towards the achievement of the program outcomes. However, as outlined above, constraints on the scoping and upgrades to SDH are impacting negatively on progress towards the establishment of quality diabetes centres in all SDH.

Objective 4: Revitalizing CHW program - Outcomes:

4.1 CHW network is able to provide first aid, health promotion and referrals.

4.2 Ongoing supervision provides quality assurance of performance of CHW.

4.3 Increased community ownership of, and engagement in, PHC.

Progress against key outputs includes:

- Supported national community (3000 communities) profiling and water quality audit - implemented by nurses, in collaboration with the Environmental Health Unit; this will establish a baseline to inform CHW program; data has been collected and is awaiting input and analysis.
- Trained and resourced 500 CHW in basic first aid.
- Conducted TOT in Northern Division to establish cadre of core trainers for CHW and other training content.
- Program beginning to gain traction with MoH; Minister and PS are now fully engaged; PS met with ITaukei, Ministry of Local Government and will meet with Ministry of Provincial Development; MoH has identified focal unit within MoH (Wellness Unit).

Progress against objective 4 is reviewed in detail in Section 3.1 below.

Objective 5: HSS - Outcomes

5.1 The PHIS provides timely, complete and accurate information for all Fijians that is being used to measure public health outcomes and plan future activities.

5.2 Clinical Practice Guidelines and protocols related to maternal health, child health and NCDs are standardized, disseminated and used systematically throughout all service delivery areas.

5.3 Operational Research gives information to support evidence-based planning of health services in urban and peri-urban areas.

5.4 Clinical Services Plan activities including Clinical Service Networks; Clinical Practice Guidelines; Role delineation and short term clinical attachments are effectively implemented.

5.5 Ongoing culture and capacity for evidence based planning and review (i.e. M&E) established at national and divisional levels.

5.6 Annual planning processes at national and divisional level are evidence-based.

5.7 Organisation and processes for timely reporting of performance indicators are well established across the whole continuum.

Progress against key outputs includes:

- LTAs – Policy and Planning, Workforce Planning, M&E; and STAs - gender, communications, infrastructure are valued by MoH and were specifically acknowledged by the Permanent Secretary during the TAG visit; FHSSP annual planning meeting involved other donors and opened channels of communication with WHO, JICA, UNICEF.
- Support to clinical service planning and CSNs is helping to improve scale and quality of health service delivery.
- Program support to expansion and roll-out of PHIS is strengthening access to quality data.
- Facility audits (96 facilities) are providing the evidence base for infrastructure and equipment upgrades.

Work on the expansion and roll-out of the PHIS is proceeding as planned, and the program is on track to achieving a functional PHIS by 2014.

The facility audits and infrastructure scoping exercises, coupled with the health service planning initiative are supporting evidence-based planning of health services in urban and peri-urban areas and are beginning to engender a culture of evidence-based planning within the MoH. This is being strengthened through ongoing capacity development of MoH staff by the program LTAs and STAs.

As outlined earlier however, the constraints highlighted above are already inhibiting program implementation, and pose a significant risk that the program will not achieve its long-term objectives.

The scale-back in funding cuts across all the objectives, and the TAG feels that it is unrealistic for the program to attempt to achieve all the targets outlined in its 2013 work plan, which was based on scale-up funding and developed prior to the scale-back. The program should take the opportunity during the micro-planning exercises scheduled for May to review and to set realistic targets for 2013.

Challenges associated with the expansion of the infrastructure component are dealt with in section 3.4 below. The consequences of the infrastructure expansion for the

program are that human and financial resources are being diverted away from the planned upgrades to the sub-divisional hospitals, and it now appears unlikely that these will be fully completed much before the end of the program in 2015. Since these upgrades are key outputs leading to the achievement of objective 1 (safe motherhood), objective 2 (child health) and objective 3 (NCDs), the delay in SDH upgrades poses a major risk to the achievement of these objectives.

Concerns have already been raised over the slow progress on objective 4 (revitalizing the CHW program), and this is discussed in detail in section 3.1 below. The implications are that this objective as stated is unlikely to be achieved, and the TAG strongly recommends revising this objective, as discussed below.

Furthermore, in the debriefing session with AusAID Suva, the TAG was specifically requested to review all the program objectives, and if necessary to suggest revised objectives that better reflect what the program is likely to achieve in the two years remaining.

Given the scale-back in financing, coupled with the ongoing constraints outlined earlier the TAG recommends revising all five of the program objectives, as outlined in Table 1 below. The revised objectives, which draw upon the program logic/theory of change workshop conducted mid-2012, are more evaluable and should facilitate more effective monitoring. They also re-emphasize MoH ownership of the program, which is in line with the original program design.

The theory of change workshop also identified the possible need for an additional (6th) objective, which captures the program's response to emerging health priorities and emergency health needs. The proposed additional objective reflects the sometimes highly significant work and associated budget that the program devotes to emergency responses, following ad hoc requests from AusAID and the MoH. For example, in the aftermath of Cyclone Evan in December 2012, FHSSP was able to mobilize post cyclone assessment support for the MoH within 24 hours. There is some concern that, while this work is broadly acknowledged by AusAID and the MoH, it is not explicitly reflected in the program achievements. There are also concerns that the diversion of human resources during emergencies can pose a risk to the achievement of other program objectives.

The revised objectives (including the proposed additional objective) are designed to better reflect the existing financial realities and would not require any additional financial revision.

Although the revised objectives have not yet been discussed with the MoH, the TAG has no reason to believe that the proposed revisions would adversely affect the program's relationship with the MoH. The TAG suggests that the proposed revised objectives are discussed and agreed between AusAID, MoH and the program, and raised at the next PCC meeting.

Table 1: Original vs Revised Objectives

Original objective	Suggested revised objective
1. To institutionalise a safe motherhood program at decentralised levels throughout Fiji.	1. To improve demand, access and quality of maternal health services, and thus support the MoH to operate a safe motherhood program at decentralised levels throughout Fiji.
2. To strengthen infant immunization and care and the management of childhood illnesses and thus institutionalise a 'healthy child' program throughout Fiji.	2. To strengthen infant immunization and care and ensure that more secondary level paediatric care is safely carried out at SD level, and thus support the MoH to operate a 'healthy child' program throughout Fiji.
3. To improve prevention and management of diabetes and hypertension at decentralised levels.	3. To support the establishment of quality diabetes centres at all SDH and selected large urban health centres, and improved early detection of undiagnosed diabetes and hypertension and thus support the MoH to improve prevention and management of diabetes and hypertension at decentralised levels.
4. To revitalise an effective network of village/community health workers as the first point of contact with the health system for people at community level.	4. To pilot a demonstration model of CHW revitalization in Northern Division as a basis for the MoH to roll out an effective network of CHWs 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 service delivery.	5. To support the MoH to ensure that health system planning and monitoring for quality service delivery is more effective to support decentralised service delivery.
	6. (Proposed new objective) To support the MoH respond strategically and effectively to emerging health priorities and emergency health needs.

2.4. Recent changes in the operational and strategic environment in the Fiji health sector

Recent and projected changes in the operational and strategic environment - many of which have been discussed earlier - are summarized below:

- Throughout the lifetime of the program, Fiji has suffered a series of national emergencies. Most recently, these included major floods in January and April 2012, and Cyclone Evan which struck the islands in December 2012. The program has effectively utilized the unallocated fund, together with additional AusAID funding, to rapidly mobilize resources to respond to the ensuing health emergencies. Given the effectiveness of the program response, coupled with the fact that these emergencies negatively impact on regular program implementation, the TAG feels that there is a strong case for adding an additional objective (and associated indicators) to capture this (as outlined in the table above).

- A change in the AusAID funding environment in December 2012 has necessitated a significant scaling-back of program implementation for the first six months of 2013. This is discussed elsewhere in the report, and poses a significant risk to the achievement of program objectives as originally stated. The TAG recommends the revision of the program objectives, as discussed in the previous section.
- Ongoing changes in key MoH counterparts, including the Deputy Secretary Public Health, Deputy Secretary Administration and Finance, National Advisor Family Health, Divisional Medical Officers, Head of Asset Management Unit, Director of Human Resources and the Principal Finance Officer. These changes continue to pose a risk to sustained engagement by program management with MoH counterparts. The TAG notes however, that the program approaches and achievements are highly acknowledged by the MoH, and the program team is adept at quickly establishing and fostering good relationships with new MoH counterparts.
- The Australian federal budget in May 2013 and the forthcoming federal elections in September 2013 both pose a measure of uncertainty for future program support from Australia. Furthermore, the Government of Fiji has indicated that national elections will be held by September 2014, and there may be disruptions to program implementation during the run up to the elections. The TAG recommends that AusAID and the program closely monitor developments related to these changes, and make adjustments to implementation plans and related outputs accordingly.

3. Technical issues

3.1. Revitalising Community Health Workers (Objective 4)

The Australia-FHSSP 2011-2015 Final Design Document included support to the revitalisation of an effective network of CHWs (objective 4). Support was needed due to the lack of investment over time in primary health care and the CHW system, which has resulted in inadequate resources at community level, weak supervision and monitoring and attrition of CHWs' motivation and skills. Large scale CHW systems require substantial support for training, management, supervision and logistics.

As discussed earlier, there has been slow progress on objective 4, and in its current form it is unlikely to be achieved in the funding term. At the PCC meeting in December 2012, both the Chair and the Deputy Secretary Public Health raised concerns over the pace of implementation, noting that trained CHWs should already be in place and commenting that 'the CHW program has become intellectualised and should remain simple with its core focus to promote health at community level.' Only recently has there become a consensus that the CHW role is to link in with primary health and to provide health promotion in relation to non-communicable diseases and triaging, rather than to administer medication and to manage wounds.

These challenges in implementation and strategic focus are partly due to a shortage of dedicated personnel within FHSSP, and available MOH counterparts to drive the revitalisation of the CHW initiative. The TAG also considers that this program component lies outside the comfort zones of FHSSP and the MOH.

Despite these constraints, there is a commitment from FHSSP and the MOH to revitalise the CHW network and this program of work is firmly on their agendas.

FHSSP and MOH resourcing

Performance on objective 4 has been significantly constrained by a lack of capacity within FHSSP to drive this objective. The Technical Facilitator for objective 4 resigned in January 2013 and left FHSSP in February 2013. The program has delayed replacement of the TF pending the TAG review and any potential revision to the TOR. This approach was agreed to by AusAID. This objective is currently being overseen by the Technical Facilitator for objective 5, who has a number of other important priorities and a heavy workload. The TAG recommends that the program urgently start the recruitment and appointment process for a replacement Technical Facilitator or a LTA to manage objective 4, so that the revitalisation of the program can get back on track. It is recommended that this role description should have a strong focus on community development and mobilisation within a wellness setting.

A further key constraint has been the lack of a suitable MOH counterpart (or team) who can commit to revitalising the CHW program. Following discussions with the MOH, the National Advisor for Non-communicable Disease (now the Director of the newly established Wellness Unit) was nominated as the counterpart for the program. However, given the burden of non-communicable diseases, coupled with the increased workload involved in managing the Wellness Unit, the support that the National Advisor can provide to the program is likely to be limited. The absence of a MOH dedicated focal point has made implementing this objective challenging.

For sustainability reasons, the MoH must be the lead agency for CHW policy development, and for the revitalisation to be successful it must draw on other government ministries. It is a positive development that the Minister and the Permanent Secretary appear to be now fully engaged with the initiative. The Permanent Secretary recently held discussions with his counterparts in the I-Taukei, and the Ministry of Local Government, and has planned to meet with the Ministry of Provincial Development to discuss how best to revitalize the CHW program.

Operational progress in 2012

Despite the resourcing challenges, there has been operational progress in relation to community profiling, identifying divisional champions, training of CHW trainers, training CHWs in basic first aid, and completing an early draft of the CHW training manual. Implementation has mainly focused on the Northern Division, where there appears to be significant commitment of the Divisional Medical Officer (DMO) to revitalize the CHW program.

- Data collection for national community profiling and water auditing has been undertaken, and once analysed will provide the MOH and the program with sound data for planning and implementation.
- 20 TOT ‘champions’ have been identified in the Northern Division to support supervision and performance of CHWs.
- 13 nurses have been trained to become certified trainers for training CHWs through Fiji National University.
- Approximately 500 CHWs in Northern, Central and Eastern Divisions have been trained by the Fiji Red Cross in first aid and referral to emergency services, injury prevention, and the calculation of Body Mass Index (BMI) to assist with the management of non-communicable disease. CHWs also received toolkits.
- A training manual for CHWs has been drafted. However, it was found upon peer review to be too clinically focussed and not suitable for unskilled, unpaid workers. The manual is currently in the process of being revised.

- Stakeholder workshops have been conducted to strengthen ownership of the CHW model at both national and Northern Divisional levels.

Activities planned for 2013

Internationally, CHW programs are vulnerable unless they are driven and owned and firmly embedded in communities. CHW programs thrive in mobilised communities but struggle where individual CHWs are given the responsibility of galvanising and mobilising communities. The role and influence of community health committees and turaga-ni-koros (village chiefs) will therefore be critical to the success of the CHW program.

In 2013, the FHSSP program intends to focus on wellness within the community by confirming the role and purpose of the community health committees, their links with the MOH and other stakeholders, and to identify mechanisms to invigorate these committees. The program also intends to undertake a literature review of how the CHW model works in Papua New Guinea, Brazil and other countries. The TAG fully supports these activities, which are important to get the program back on track.

Future support to the CHW program

The TAG recommends that the program continues to support objective 4, given the rise of non-communicable disease, the role that CHWs have in promoting healthy practices and health seeking behaviours, and the renewed commitment from the MoH to revitalise the CHW network. However, the TAG recommends that this program objective is revised to be less ambitious, given the limited progress to date, the scale back in funding, and the timeline for program completion.

The TAG therefore recommends that future support to this component is provided through a 12-month pilot demonstration in the Northern Division, in light of the ongoing initiatives and the commitment of the DMO to CHW revitalisation in the Northern Division.

The TAG further recommends that the program identifies a dedicated Technical Facilitator/LTA with strategic skills and community development experience to support the MoH focal point within the Wellness Unit, and provide significant support to the demonstration initiative in the Northern Division, to mobilize and engender support, monitor implementation and document lessons learned.

The TAG also recommends that the Northern Division demonstration is independently reviewed in 12 months' time to determine the effectiveness, efficiency and sustainability of the demonstration. The review findings will inform decisions on whether the component should continue and be expanded to other divisions, and identify lessons from the demonstration that could be used for future roll out to other divisions. The review should also highlight any specific requirements and concerns for rolling out to peri-urban settings.

3.2. Training

Human resource capacity development cuts across all the program objectives and underpins the program approach to support MoH implementation. The 2012 TAG review noted that training appeared to be somewhat ad hoc, and recommended that the program should take a broader strategic approach to supporting in-service training. The TAG specifically recommended that the program should engage additional technical support to develop a rationalized and harmonized approach to human resource capacity development within the MoH. In response, the program recruited a LTA Workforce Development, who is working with the MoH and FHSSP Technical Facilitators to develop a long term plan for workforce capacity building. The

LTA is also helping to coordinate FHSSP-supported training activities and MoH workforce training, and supporting improved monitoring and evaluation of training activities to ensure that training is effective and sustained. Key achievements in the last six months include:

- Support to MoH to conduct its first workforce survey (of 4931 staff), to assess the current situation and assist in workforce planning. The survey highlighted the need to enhance standard operating procedures across HR and training and develop a coordinated master training plan for all MOH services. The Workforce Development Planning survey will become an annual review and data collection process to continue to support planning and more effectively respond to staff capacity development needs;
- Support to MoH to conduct a rapid training needs assessment (TNA) to identify training priorities and succession planning;
- The workforce survey also highlighted the need to re-invigorate the human resource information system (HRIS) to be fully operational and a 'live' reporting of MoH workforce. The objective is to provide relevant, accurate and current information reports for review and decision making, and to promote evidence-based decision making based on reliable HRIS data. FHSSP is supporting a MoH task force to take this forward. Discussions with the MoH training unit revealed that they can draw upon Education sector's HRIS software that is free access.

The MoH has acknowledged the major contribution provided by LTA for human resource development, noting that "*this will go down in the history of MoH as a turning point*".

However, despite the significant progress made in this area, the TAG notes that neither the MoH nor the program are able to identify training baselines or targets, so it remains hard to see what needs to be achieved in terms of training. The TAG recommends that FHSSP continues to support the MoH to re-invigorate the HRIS to provide a sound evidence base for training programs.

3.3. Health Information System

The WHO identifies health information as one of the six building blocks of a strong health system. Health systems require quality data from health information systems to plan for and ensure that the workforce is fully funded and equipped with the necessary commodities, infrastructure, resources and policies to deliver services.

Previous reviews and discussions with stakeholders have identified various challenges with the MOH's Public Health Information System (PHIS). These challenges include inadequate alignment between data collected and key MOH indicators, poor data quality and completeness, lack of timely and meaningful reports and feedback to users, inadequate data definitions and collection guidelines, and poor data verification.

Based on the MOH's priorities, the FHSSP program has as one of its key objectives 'the achievement of a functional PHIS providing timely, complete and accurate information that is being used to measure public health outcomes and plan future activities'.

Based on the evidence, the program is on track to achieving a functional PHIS. In the last 12 months the program has made steady progress towards redesigning and strengthening the PHIS. The program engaged a short term advisor to work closely

with the MOH's Health Information Unit to support the change management process for the new system. Activities included aligning data collection with the MOH indicators, tendering and procuring a web-based interface for PHIS (version 2 is currently being tested), developing a User Guide for the revised PHIS and other training materials, and training MOH sub divisions on the redesigned system. As of December 2012, 65% of sub divisions had completed training in the redesigned PHIS. The redesigned system is due to be completed in 2013.

Strengthening data for decision making

Given the importance of a robust health information system to decision making, and the program's investment in redesigning PHIS, the TAG recommends that there is a commitment to undertake a review of the effectiveness of PHIS 12 months after completion to:

- Determine the extent to which the PHIS has identified and engaged data users and data producers, identified information needs, built data capacity, improved data quality and availability to measure health outcomes, strengthened the MOH's data demand and use infrastructure and communicated results of data to data users and producers;
- Determine the extent to which the PHIS is contributing to program review and planning, advocacy, policy development and decision making;
- Determine to the extent possible given the timeframe, whether there is evidence of the PHIS contributing to the improvement of WHO building blocks – health workforce, health services, health financing, governance and leadership, medical products, vaccines and technologies.

The TAG recommends that the findings from the above review are used to inform how data for decision making can be further strengthened to enhance decision making and improve health outcomes.

3.4. Infrastructure management

Current situation

The FHSSP program design, together with the 2012 scale-up, provided for a limited infrastructure program, largely focused on upgrading all sub-divisional hospitals (SDH) to ensure that they are baby-friendly and mother-safe, and contain quality diabetes centres. A key initial component of this work included a series of scoping exercises, coupled with facility audits, to provide a sound evidence-base for the infrastructure upgrades.

When scale-up funding was provided by AusAID in 2012, the MoH requested support for the construction of a birthing centre at Makoi and the relocation of the Nausori Hospital. The TAG notes that significant infrastructure development was never part of the program design and that there are limitations in the extent to which the program can manage this with the existing staff and budget. In response, the program agreed, as part of the scale-up, to support scoping and planning activities for the Makoi birthing centre, and to explore service planning options for the Suva-Nausori corridor. Although the scale-up proposal did not include the use of program funding to construct the Makoi birthing centre or the Nausori Hospital relocation, AusAID Canberra committed to supporting the construction of the Makoi birthing centre.

Table 2 below shows the 2013 budgeted infrastructure programs:

Table 2: Original Budget for Infrastructure

Objective	Activity Description	2013 Budget AUD$
1.3	Plan, design, document and tender for Makoi birthing unit	385,000
3.2	Prioritised refurbishment and capital works to support quality diabetes centres	250,000
5.5	Evidence based planning for infrastructure investments – Suva-Nausori Plan	16,500
Unallocated	Preliminary Phase Nausori subdivisional hospital (geotechnical site survey)	165,000
Unallocated	Subdivisional hospital scoping for 17 SOPD mother and child safe upgrades	110,000

FHSSP recruited a short term Infrastructure advisor (STA) to carry out the scoping works, together with a Health Planner to facilitate the Suva-Nausori Plan. The original terms of reference for the STA Infrastructure included developing the capacity of the Ministry of Health Asset and Infrastructure staff; undertaking the scoping of the 17 sub-divisional hospitals and diabetes facilities; and facilitating the plan and design of the Makoi birthing unit. However, due to reprioritisation of infrastructure programs, as noted below, the STA Infrastructure has only been able to complete scoping of three sub-divisional hospitals. The 2013 Annual Workplan identifies 85 days for the STA Infrastructure. The Program is awaiting confirmation of the extent of the AusAID scale-back before proceeding with scheduling of his inputs.

Reprioritisation of Infrastructure Program – Nausori and Makoi

In the context of political commitments to infrastructure development by both AusAID and the Fiji Ministry of Health, FHSSP has been tasked to work on the development of the Makoi birthing unit, together with the relocation of the Nausori hospital.

The Ministry of Health had prepared concept plans for both these facilities, which were the starting point for FHSSP to engage with the MoH. A review of the concept plans highlighted the need for a more evidence-based approach to infrastructure design and development, including the need for health service planning. Subsequent engagement of a consultant by FHSSP resulted in a health service planning report based on population projections and future service demands within the Suva – Nausori corridor.

The report identified three options for the way forward. Based on the evidence provided in the report option B appears to provide the most effective and efficient approach to address the health service needs in the Suva-Nausori corridor. This option recommends not constructing a birthing unit at Makoi, but instead proposes the development of a new Maternal and Child Health (MCH) unit and a new dental clinic at the Makoi site, coupled with an upgrade of the health centre at Valelevu to provide additional services; utilizing spare capacity at Tamavua for low acuity patients, and rationalization of existing facilities at CWM hospital, together with the new Nausori hospital of 60-80 beds. The significant advantages of this option are:

- Balance of the Minister's and clinicians' preferences;
- More efficient use of midwifery staffing and clinical support services;
- Aligns with AusAID objectives and MoH strategic plan;

- Improves MCH services, antenatal care and dental services at Makoi, making use of the available site;
- Improves access to ANC and low risk birthing;
- Closer to CWM in case of emergencies; and
- Encourages changes to clinical practice and increased efficiency.

Way forward and challenges

Overall, the approach to the proposed significant expansion of infrastructure component adopted by FHSSP is strategic in providing a sound evidence-base, through scoping based on international standards of quality. There are indications that the MoH has embraced this approach and that it highly values the processes involved in building the capacity of MoH planning personnel. The approach is also aligned with the AusAID commitment for infrastructure development, pursuing evidence-based options to address service provision and integration.

However the following challenges remain with regards to infrastructure:

1. As noted above, the Health Planning consultant has prepared a draft 'Health Service Planning Strategy for the Suva-Nausori Corridor', which includes the preferred option of not constructing a stand-alone Makoi Birthing Unit. In order to move this forward, it is recommended that the following issues are addressed:
    a. The Health Planning consultant was engaged for a three-week period to complete the health service planning strategy, although normally such an exercise would take three to four months to complete. The time constraints, together with the difficulties in collecting detailed health information data, have highlighted limitations regarding the robustness of the data. For example, the draft report does not have complete outpatient numbers, and assumptions have been made with regard to population projections, which should be verified with the Fiji Government statistics department. It is recommended that funds are identified for further work on the strategy to ensure that the data can, where possible, be verified and the report updated, if necessary.
    b. Further scoping and costing work is required to determine the resources required for the preferred option.
    c. At the time of the TAG mission, the report had not been formally endorsed by the Ministry of Health, although there were verbal indications that the MoH was pleased with the planning process and outcomes. In order to move the option paper forward, it needs to be presented to the Ministry of Health for discussion and subsequent approval.
2. Further work is required on the proposed Nausori Hospital relocation program as follows:
    - Further service planning work is required to determine the service needs (i.e. is it 60 or 80 beds, and what are the workforce and training needs and the equipment needs?).
    - A geotechnical site survey is required to determine the amount of groundwork required on the new site.
    - Further discussions and work on the design and construction materials to be used are required; for example should they use wood

as per most current Fiji facilities or move to concrete or steel frame construction.

- Costing estimates are yet to be completed for the recommended option for Makoi and also for Nausori.

FHSSP estimates a three to six month timeframe to complete all the preliminary work, and therefore provide a basis for realistic cost estimates.

3. The focus of the infrastructure program on Nausori and Makoi has significantly delayed the original work of the STA infrastructure. The planned scoping of SDHs has been severely constrained, with only 3 out of 17 scoping exercises completed. Given this delay, coupled with the further delays resulting from the scale-back in funding, it is now unlikely that the remaining scoping exercises can be completed much before the end of the program. These delays are likely to significantly affect the achievement of program outcomes for the first three of the program objectives (maternal health, child health and NCDs). Furthermore, the current STA contract is due to expire shortly, further inhibiting infrastructure development. The TAG therefore recommends that program funds are prioritized to allow the STA Infrastructure position to be extended.
4. As noted above, the original intention was for the STA infrastructure to work alongside and build capacity within the MoH Infrastructure/Assets Unit. At the time of the TAG review, the STA Infrastructure was working with the staff from the MoH planning unit, as there were no clearly identified counterparts within MoH Infrastructure/Assets Unit. It is recommended that this issue is raised for discussion with the MoH and at the next PCC meeting.

4. Program management systems

4.1. Monitoring and evaluation

In 2012, the TAG raised a number of concerns about the program's monitoring and evaluation (M&E) system. The TAG noted weak linkages between the Monitoring and Evaluation Framework (MEF) Version 2 and the way the annual plan and report were presented. Other concerns noted included inconsistent use and labelling of outcomes and outputs, and that the Results Framework was not being used to inform program management, planning or reporting. These concerns were partly explained by the low level of resourcing of M&E within the program.

The program has made significant progress is laying the foundations for an effective M&E system. Given the starting point of low M&E capacity within the Fiji health system, it is acknowledged that progress in building an effective M&E system will be gradual and evolving.

The program has addressed or is in the process of addressing many of the concerns raised by the TAG on MEF Version 2. In July 2012, MEF Version 3 was released that more closely aligned with the MOH's Strategic Plan and strengthened the linkages between outputs and outcomes. In early 2013, work commenced on MEF version 4 (currently in draft), which includes a progress tracking matrix for output-level reporting of program activities. Version 4 also includes updated indicators that more closely align with FHSSP activities. Overall, there has been a steady improvement in the iterations of the MEF, with the development of each version of the document following extensive consultation with the FHSSP team, MOH counterparts and AusAID.

The program has supported M&E capacity training during the last 12 months. In July 2012, the FHSSP team and key MOH counterparts participated in a theory of change workshop to further develop the logic for the program, and to incorporate the scale up activities. The workshop was facilitated by the AusAID M&E Advisor Ms Sara Webb, who has provided advice, guidance and support to the program over the last 12 months. In January 2013, M&E refresher training was provided to the FHSSP team as part of FHSSP's annual work planning to further build M&E capacity.

M&E resources within the program have been significantly strengthened from late 2012 through the appointment of an M&E Long Term Advisor (LTA), and a locally engaged M&E Officer, bringing the size of the M&E team to two full-time personnel. The LTA is strategically located in the MOH and is the focal point for all M&E issues for both the program and the MOH. The role involves leading the development of MEF Version 4, and ensuring there is clear linkage between the program and reporting. The LTA has the respect of his colleagues, and is committed to strengthening M&E and instilling a culture of monitoring for results within the Fiji health system.

The TAG notes that the LTA M&E is in high demand by both the program and the MoH. However, this demand needs to be carefully monitored to ensure that the LTA is not overburdened by requests and that the focus continues to be on advising and capacity building, rather than 'doing' evaluation to ensure the role is effective at developing and sustaining M&E capacity within the Fiji health system.

Key challenges for building an effective M&E system continue to be an absence of M&E champions within the MOH national and subdivisional levels, and a weak data collection system at hospital level (PATIS).

Review of MEF Version 4

The 2013 TAG was asked to review and make recommendations for improving MEF version 4. The following outlines key improvements that are evident in MEF version 4, and suggests ways to strengthen the document.

MEF version 4 includes an expanded introduction section and a new section on the purpose of the MEF to frame the intent and content of the document. This includes a flow diagram that shows the application of M&E to program planning, implementation and assessment.

It is positive that the program logic section in MEF version 4 has been expanded to describe the draft Results Framework and articulate what outputs and outcomes are attributable to/ partially attributable to the program and what outcomes the program contributes towards. The Results Framework has been revised and changed from a table to a diagram and is included in Annex 1. The latest version of the Results Framework more clearly aligns with AusAID's intermediate outcomes for strengthening primary health services outlined in the Fiji Country Strategy 2012-2014. However, the TAG notes that the intermediate outcome listed in the draft Results Framework 'Strengthened Primary Health Services' is listed as an end-of-program outcome in the Fiji County Strategy, which the other intermediate outcomes contribute to.

The TAG notes that the latest Results Framework focuses heavily on activities, rather than articulating short-term or immediate outcomes, and does not illustrate the link between Objective 5 outcomes and the outcomes for the other objectives. Furthermore, while MEF in the body of the document explains what the program is accountable for, the Results Framework does not articulate the boundaries of the program, e.g. by not stating end-of-program outcomes that are clear, objective and measurable. The TAG therefore suggests referring to the appendices included in the

theory of change workshop report and page 26 of the Fiji Country Strategy for guidance when making these improvements.

The TAG notes with approval that the MEF version 4 includes a new section on progress and performance monitoring, including an example of the progress tracking matrix to facilitate micro-level planning to serve as a link between program activities and outcomes and to streamline tracking process for quarterly and annual reporting.

The TAG also notes that while MEF Version 4 provides a *tactical explanation* or objective-level understanding of the relationship between the program's resources, planned activities and anticipated results, through the Results Framework, there is a lack of a *strategic picture* (or Theory of Change) of the multiple interventions required to produce the short-term and intermediate outcomes that are preconditions of reaching the ultimate goal. Essentially, MEF Version 4 (and the later program documentation as a whole) lacks clarity of *how* and *why* the desired outcomes are expected to occur across the program's five objectives. The absence of a clear Theory of Change has made it challenging to evaluate the program, which will continue to be problematic unless this gap is addressed in MEF Version 4. Again the TAG recommends revisiting the appendices of the Theory of Change workshop report, which more clearly articulates the *how* and *why* of the program and include this material in MEF Version 4.

MEF version 4 includes a new section on evaluating program contributions, which outlines the process for FHSSP/MOH reflection on program performance, identifying key strengths, weaknesses and lessons learnt from previous years to inform the coming years' activities. However, the TAG notes that on the whole there is insufficient emphasis on evaluation in the document (discussed further below).

The TAG recommends that MEF version 4 could be strengthened by referencing the Development Assistance Committee (DAC) principles for evaluating development assistance – relevance, efficiency, effectiveness, impact and sustainability. The TAG recommends that the referencing to the DAC principles is included in Section 4: Guiding Principles and Aid Effectiveness. It is also recommended that training for program staff on the DAC principles is included in micro-planning in June.

While not yet stated in the current draft, this version intends to reference the program's linkages with the Fiji Program Performance Assessment Framework. The TAG also recommends that Section 4: Guiding Principles and AID Effectiveness should also reference the following AusAID publications:

- An Effective Aid Policy for Australia – Making a Real Difference, Delivering Real Results
- Australia's Comprehensive AID Policy Framework to 2015-16
- Fiji Country Strategy 2012-2014.

This latest version also includes useful additional annexes for example Indicator Summary Tables, which will be used for routine reporting of program results, Performance Indicator Reference Sheets, which describe each of the indicators in detail and the process used for developing the MEF.

Extent to which MEF version 4 includes both monitoring and evaluation

MEF version 4 has a strong emphasis on monitoring, which is evidenced in Section 5: Program Logic and Section 6: Progress and Monitoring Performance. However, the document places insufficient emphasis on evaluations and systematic reviews of the program's design, implementation and results.

The TAG therefore recommends adding a new section to MEF version 4 titled 'Program Evaluation' that includes key evaluation activities that will be conducted in

the funding term. The TAG recommends that the document gives consideration to evaluating each of the five program objectives, and their overall contribution to the program goal. For each of the planned evaluations, the document should include the overall purpose, the overarching objectives which would be aligned to DAC principles, data sources, timing and resources required (including whether reviews and evaluations will be conducted by the program or independently). This section should also make reference to any AusAID-funded reviews and evaluations e.g. the final review of the program.

The TAG also recommends that references to evaluations in Section 8: Data Sources should be moved into the Program Evaluation section, as Section 8 should more correctly reference the data to be gathered for monitoring and evaluation activities.

The content under Section 7: Evaluating Program Contributions which discusses program reflections could be embedded into this new evaluation section.

Using the MEF for planning and managing the program and reporting achievements

There is evidence that Technical Facilitators and other program personnel are using the MEF to plan and manage the program. However, it is not being used effectively to report program achievements in quarterly and annual reports. As a result, the program often 'undersells itself' in relation to progress against the program's intended outcomes.

4.2. Reporting

Moving towards results-based reporting

Effectiveness is the cornerstone of Australia's aid policy. For Australia to deliver aid effectively to support the Fiji health system it requires results-based reporting to determine and make clear what is working and not working and to abolish any program or activities that are not delivering on their objectives or undertake immediate changes to make sure they are.

The current format of the program's quarterly and annual reports do not support AusAID's requirement for accountability. The current reporting format focuses heavily on activities and outputs (what the program is doing and what the program has done), rather than reporting results.

The FHSSP team note a number of challenges with reporting, mostly in relation to their reliance on MoH data, which is generally untimely and often unreliable, and the absence of benchmark information.

While in Fiji, the TAG workshopped with the FHSSP team how to move from activity to results-based reporting and provided examples of reporting by results. The TAG also recommended, in the absence of benchmark data, setting milestones or annual targets against which to report progress.

The FHSSP team is committed to make the necessary improvements to move towards results-based reporting, and are developing a quarterly report template for AusAID's review and approval.

4.3. Risk matrix

The TAG has identified additional risks to the achievement of the program objectives, stemming from a) the significant increase in the infrastructure component, b) delays in implementation resulting from the scale-back in funding for the first six months of

2013, c) relationship risks with the MoH related to the scale-back in funding, d) the slow pace of implementation of the CHW component, e) increasing ad hoc use of the unallocated fund, f) uncertainties in the political environment. These have been outlined earlier in the report, and are summarized below.

The consequences of the infrastructure expansion for the program are that human and financial resources are being diverted away from the planned upgrades to the sub-divisional hospitals. The situation is exacerbated by the budget restrictions in 2013, which reduce the likelihood that any of the SDH work will be completed by the end of 2013 or June 2014. It now appears unlikely that the SDH upgrades will be fully completed much before the end of the program in 2015. Since these upgrades are key outputs leading to the achievement of objective 1 (safe motherhood), objective 2 (child health) and objective 3 (NCDs), the delay in SDH upgrades poses a major risk to the achievement of these objectives.

The TAG notes that all negotiations between the program and MoH related to the scale-back in funding are based on good faith, given the lack of clear written advice from AusAID to the program and the MoH about the extent of the scale-back. Both the program and the MoH have expressed concerns that the scale-back may be permanent, thus posing a major risk to relationships between the program, MoH and AusAID.

Concerns have already been raised over the slow progress on objective 4 (revitalizing the CHW program). The implications are that this objective as stated is unlikely to be achieved.

The TAG has also identified risks related to the unallocated fund. The TAG notes that there are an increasing number of ad hoc requests and agreements for use of the unallocated fund, some of which appear to be poorly justified. An underlying principle is that the unallocated fund should not be used to support ad hoc activities, but should be used strategically so that activities supported by the fund remain sustainable.

The Australian federal budget in May 2013 and the forthcoming federal elections in September 2013 both pose a measure of uncertainty for future program support from Australia. Furthermore, the Government of Fiji has indicated that national elections will be held by September 2014, and there may be disruptions to program implementation during the run up to the elections.

These additional risks have been incorporated into the revised risk register, attached as Annex 10 (Risks 1.6, 1.7, 3.13, 5.7, 7.6 and 8.3).

5. Program governance

5.1. PCC/PMG/FAC

Program governance and management is through three structures: the Program Coordination Committee (PCC), the Program Management Group (PMG) and the Finance and Audit Committee (FAC).

The Program Coordinating Committee is the primary high-level oversight, strategic decision-making and monitoring mechanism, and as such is the highest level governance committee for the program. The PCC is chaired by the Permanent Secretary of the MoH, with meetings held on a six-monthly basis. Any major decisions concerning future directions for the program are presented and discussed at these meetings, with the Annual Plan for the program submitted to the PCC for review and approval each November. The PCC considers all requests for variations

in budget above FJD100,000 and all requests that have not been budgeted and approved in each Annual Plan.

The PCC has met four times over the life of the program to review and approve 2011 and 2012 Annual Plans, 2011 Annual Report, scale-up concept note, activity proposals outside of endorsed annual plans, unallocated funds, and program risks and strategies for managing them. Requests or issues requiring PCC input or approval in between formal meetings have been successfully managed with the use of 'flying minutes' via email. Participation by members in the PCC has generally been active, with a commitment to providing oversight and monitoring of the program's progress and strategic direction.

The role of the FAC is to review reporting procedures and manuals, review and approve program budgets and financial reports, and to identify related risk issues. The meetings are chaired by the Program Director and are well attended by representatives from FHSSP, MoH, MoF and AusAID. Whilst the format of the meetings ensures thorough review of variations to monthly budgets, there has been limited value in bringing all members together monthly, as attendance and participation in meetings has declined over the course of the year. Then TAG supports the proposal that, from 2013, FAC meetings are held quarterly, where significant budget variations can be discussed along with other financial issues. FHSSP will continue to produce monthly financial reports, and the FAC can be supplemented with formal monthly meetings with AusAID to review the reports along with technical monitoring. Budgetary information will be provided to MoH at the fortnightly Director's meetings thus reaching a wider audience.

The 2012 TAG review noted that the PMG was not specifically part of the design, and that there was some overlap in the TORs of the PMG with those of the PCC and FAC, and hence the possibility of repetition and overlap of functions. Given the effectiveness so far of the PCC and the FAC, and the overlap of some of the roles and functions of the PMG with those of the PCC and FAC, the TAG 2012 review suggested that the PMG may be superfluous, and that its roles could be shared amongst the PCC and FAC.

This review notes that the PMG has not proved to be an effective mechanism, due to the membership's competing priorities, workloads and commitments. To date, the forum has not been used to make decisions regarding the operations of the program—even within the limits outlined in its terms of reference—but has instead referred all proposals and issues to the PCC for further review and approval. In an effort to reduce the number of meetings created by the program, and to leverage off existing MoH governance mechanisms, the TAG fully supports the proposal that the PMG is disbanded and instead the fortnightly MoH Directors' meetings, quarterly Divisional Plus meetings and Clinical Service Networks (CSN) are formally used to support the coordination, monitoring and communication of the program's activities. The fortnightly MoH Directors' meeting is a recently established mechanism that brings together key MoH managers and is chaired by the Permanent Secretary. The memberships of these existing committees contain all of the members of the PMG, with the additional benefit of reaching the sub-divisional levels. The TAG also endorses the program's suggestion to support the committees to strengthen their secretariat capacities to ensure decisions and action items are recorded, distributed and followed up.

5.2. Use of unallocated fund

The provision of an Unallocated Fund under FHSSP is in response to a need identified by both MoH and AusAID for flexibility in program funding within defined financial limits. As recommended by the Program Design Document, there has been an amount of AUD$1 million (approximately FJD$1.8 million) set aside for this Unallocated Fund per annum.

The purpose of the Unallocated Fund is to:

- Assist the MoH respond to health situations resulting from national emergencies (i.e. floods or cyclones);
- Address emerging health needs and priorities (i.e. typhoid outbreaks, mental health issues, etc.); and
- Support innovative activities identified during the annual planning process, or during the year. These activities must be related to the five objectives and have the potential to be implemented more broadly if proven to be an effective implementation mechanism.

An underlying principle is that the unallocated fund should not be used to support ad hoc activities, but should be used strategically so that activities supported through the fund remain sustainable. Activities under the unallocated fund must be jointly agreed by the MoH and AusAID through the PCC.

The TAG notes that there are an increasing number of ad hoc requests and agreements for use of the unallocated fund, some of which appear to be poorly justified. For example, the PCC has recently approved approximately FJ$740,000 from the unallocated fund to support 'Empower Pacific' – a local NGO - to provide ante-natal VCCT and hospital-based counselling services in CWM, Lautoka, Nadi and Labasa. The TAG found little justification for the use of program funds to support Empower Pacific, as the counselling program is poorly aligned with FHSSP objectives, does not appear to contribute significantly to the achievement of program outcomes, and it remains unclear how the value of the investment would be assessed.

The TAG notes that, given the recent outbreaks of typhoid identified in Fiji, a more strategic use of the unallocated fund that is in line with its principles and rationale, would be to support research on typhoid, prevention, transmission and treatment.

Unallocated Fund Guidelines were originally developed at the commencement of the program. The use of the Unallocated Fund in the first 18 months focused on addressing emergencies, emerging issues and specific requests related to the program objectives. Due to the higher number of activities that have been classified as 'emerging activities' in 2013 and the high rate of ad hoc requests, the Unallocated Fund Guidelines have been revised and are attached as Annex 9.

The TAG supports the proposal in the revised Guidelines (see Annex 9) that the unallocated fund is subject to the following restrictions:

- 20% programmed across existing Objectives—intended to support innovation;
- 60% programmed to support emerging issues;
- 20% held for emergency response; however if by 1st May there are substantial funds remaining, they may be re-programmed.

5.3. TAG reporting

The purpose of the Technical Advisory Group (TAG) is to review the Fiji Health Sector Support Program (FHSSP) and provide independent advice to AusAID Suva, to inform its policy, planning and programming support to the Ministry of Health in Fiji. TAG reviews are commissioned annually by AusAID, and the TAG reports directly to AusAID Suva, although the reports, or at least the key recommendations, are shared with the program management team. In line with the principle of transparency, the TAG suggests that the key recommendations from the TAG review reports are also shared at PCC meetings. This will help to facilitate follow-up and foster mutual accountability.

6. Financial management

The total 2012 FHSSP budget amounted to AUD$8,409,220, which represents 6% of the total Ministry of Health annual Government budget. The Ministry of Health annual allocation from the Government of Fiji has been increasing since 2011. In nominal terms, i.e. ignoring the inflation rate, the Health budget has increased by 11% in 2012 and 9% in 2013, suggesting a commitment by the Fiji Government to the health sector. The majority of the additional funds within the Health budget have been allocated to drugs (63% increase from 2011 to 2012 and a 13% increase from 2012 to 2013) and sub-divisional hospitals (8% increase from 2011 to 2012 and a 11% increase from 2012 to 2013). The allocation to Public Health, while increasing, has remained at 3% of the total MoH annual budget.

Overall there has been excellent improvement in the financial management reporting and systems since the last TAG mission. The scale up resulted in an additional budget of AUD$532,735, approximately 18% of the total 2012 program activity budget. Despite the scale up funds only coming on line in September 2012 the program was able to achieve an overall expenditure execution rate of 77%, with 94% being achieved on the 5 program objectives.

The TAG was tasked to review three specific areas within Financial Management: 1.financial management systems; 2. recent audit reports; and 3. financial reporting. These areas are addressed in more detail below, with only minor recommendations noted.

Overall Expenditure Summary 2012

The financial report for the year ended 31 December 2012 shows that 77% of the budget was expended with 94% of program activities budget being spent, 56% of the unallocated and carry over funds spent and 89% of the management contractor internal management fees being charged. Refer to Table 3 below.

Section 5 of the 2012 annual report provides an overview of the finances for the year which includes a good analysis of the total expenditure and explanations for any over or under spends against the budget.

Table 3: Expenditure against Budget 2012 AUD$

Program Component	Annual Budget 2012	Actual Expenditure 2012	Balance Remaining	% Expended
1. Safe Motherhood	497,700	449,389	48,311	90%
2. Healthy Child Program	594,228	603,834	(9,606)	102%
3. Diabetes Prevention & Management	553,750	548,093	5,657	99%
4. Community Health Worker Network	430,000	361,660	68,340	84%
5. Targeted Systems Strengthening	837,056	778,844	58,212	93%
Subtotal Program Components	**2,912,735**	**2,741,820**	**170,914**	**94%**
Total 2012 Unallocated Funds	1,200,000	780,922	419,078	65%
Total 2011 Underspend	2,364,019	1,204,122	1,159,897	51%
Total Unallocated & Underspend	**3,564,019**	**1,985,044**	**1,578,975**	**56%**
Total Internal Business	1,932,467	1,719,616	212,851	89%
Total For Year Ended 31/12/2012	**8,409,220**	**6,446,480**	**1,962,740**	**77%**

Financial management systems and processes

Overall, the financial management systems within the FHSSP program are robust and working well. The program has employed an assistant program administrator, who oversees the finances within the Suva office, as well as an additional finance officer since the last TAG review. There is a full complement of finance staff with sufficient capacity to manage the financial transactions within the program.

The financial management manual has been updated and provides clear guidance on the procedures to be followed; furthermore the finance staff are competent and well versed with the financial management manual. There is a good working relationship between the Suva and Brisbane Office, whereby the Brisbane office provides the monthly financial reports (based on the information received from Suva together with the Brisbane expenditure) back to Suva for distribution to relevant stakeholders.

The Finance and Audit Committee is functioning well, and the monthly meetings have now moved to a quarterly basis which is more practical for all stakeholders. FHSSP management staff have requested monthly meetings with Suva AusAID staff to discuss financial matters - we would encourage this initiative.

The FHSSP annual work plan (budget) is prepared after the Ministry of Health annual budget. It was noted by the Deputy Secretary of Administration and Finance that it would be useful for FHSSP to advise the Ministry during their budget preparation of the estimated annual budget envelope for FHSSP. The FHSSP policy and planning advisor is working closely with the Ministry of Health to ensure that there is a

combined planning and budget exercise within the Ministry and it is expected that the planning and budgeting processes will over time become more aligned with the Ministry system.

Review of recent audit reports and status of recommendations

The FHSSP program has undergone two external audits (2011 and 2012 financial years) and one internal audit since the last TAG review. The external audits were carried out by Ernst & Young, whilst the internal audit was conducted by SAI Global.

The internal audit found no areas of concern within the systems and procedures of the FHSSP.

Both external audit reports resulted in a clean audit opinion on the financial reports. The audit closing report for 2011 highlighted four areas for management to address, three of these issues were rated risk category 2 (medium risk) and one was risk category 3 (low risk). The 2012 audit closing report highlighted two areas for management to address, one risk category 2 and the other risk category 3. These two areas were both carried forward from the 2011 audit and relate to:

- Receipt of goods and services – it was not clear to the auditors that all goods and services had been signed off as received prior to payment being made; and
- Preferred suppliers - it was recommended that management develop a list of preferred suppliers.

The audit findings were discussed with the finance team and it is considered that while neither of these issues was considered high risk the program is adequately addressing them.

The TAG notes with approval an improvement in the external audit report from 2011 to 2012. This, together with a good internal audit report, further suggests good internal controls are in place and are working well.

Review recent financial management reports

The financial reports have continued to evolve over the life of FHSSP. The financial report is now being prepared on a quarterly basis to coincide with the Finance and Audit Committee meeting. There is also a monthly finance report being prepared for AusAID. The quarterly and monthly financial report provides comprehensive information on budget execution by program objective. The quarterly report provides a clear one-page summary of overall financial progress. Whereas the monthly financial report provides only a detailed summary, it is recommended that a one-page summary of overall financial progress is included with the monthly finance report.

During the TAG mission AusAID highlighted the fact that the funds recorded as paid out in AIDWORKS did not reconcile to the funds recorded as received in the FHSSP quarterly financial report. FHSSP prepared a comprehensive reconciliation report which assisted AusAID in reconciling the two reports. However as this reconciliation involved twelve months of transactions it proved to be time consuming. In order to minimise the amount of time required to reconcile the two reporting systems it is recommended that this reconciliation is prepared at least quarterly and discussed during the monthly AusAID and FHSSP meetings.

7. Recommendations for continuity of the program

The FHSSP Design envisaged a three-year program from July 2011 to June 2014 with the possibility of extension for a further two years up to 30 June 2016,

depending on performance. A key output of the TAG mid-term review is a justified recommendation on whether the program should be continued for a further two years, and if so, justifications as to whether the agreement with the current managing contractor should be extended.

The TAG's review findings indicate that there is strong case to be made for continuing the program for its full term up to 30 June 2016. This can be justified on a number of counts: there is evidence that program support is resulting in the establishment of key health systems and processes within the MoH, and is beginning to establish a culture of evidence-based decision-making within the MoH. The program is also beginning to demonstrate results in the program focal areas, as outlined in the earlier sections of this report. The program has significant credibility and excellent working relationships with the MoH and other key stakeholders in the sector. The program has also recently received a good QAI report from AusAID.

Program expenditure is also largely on track. The financial report for 2012 shows that 77% of the budget was expended, with 94% of program activities budget being spent, 56% of the unallocated/carry-over funds spent, and 89% of the management contractor internal management fees being charged. The TAG notes that the financial management systems within the program are robust, and appear to be functioning effectively and efficiently.

There are also strong justifications for retaining the same managing contractor. Abt-JTA has a proven understanding of the sector and is well embedded within MoH. It has now initiated a significant number of activities and has traction. It has engaged a number of new staff with good technical and managerial capacity, which was acknowledged by MoH and AusAID during the TAG visit.

The program team, and especially the Program Director, are well respected by AusAID, MoH and other development partners. The team absorbs change well, and is robust and resilient. The team embodies a learning culture and has proven to be responsive to TAG and AusAID recommendations. The program team also proactively seeks solutions to problems and has demonstrated persistence and commitment to see things through.

The recent partnership of JTA with Abt Associates to form Abt-JTA has the potential to enhance technical capacity and resources. Abt-JTA has also demonstrated willingness to absorb some of the impact of the scale-back, both institutionally and personally.

The program demonstrates good governance and financial and administrative procedures, with robust internal control mechanisms, clean internal audits and good and improving external audits.

Annex 1 TAG Scope of Work

1. Scope of the review

1.1. General Oversight

The TAG is tasked to:

a) Review the extent to which the TAG Recommendations in the Inception and Scale-up Report have been implemented;
b) Review the Program's 2013 Work Plan; assess the extent to which it aligns with the principles of the FHSSP design while responding to the changes in the funding environment announced at the end of 2012; comment on how effectively the program management team has addressed the downturn in funding
c) Review overall Program performance and progress and provide advice on effective Program implementation including strategic program directions, institutional arrangements, relevance, quality and feasibility of work programs and activities and – if required – recommend improvements to the mix or design of activities supporting implementation ; in view of the recent necessary budget changes for this financial year and the challenges faced by the Program as noted in program reports and risk analysis;
d) Assess any recent changes in the operational and strategic environment in the Fiji health sector and identify emerging issues, and provide recommendations for AusAID's consideration.

1.2 Technical Issues

Advise on emerging issues within the program including, but not limited to, the following:

1 Revitalising PHC: support for Community Health Workers
a) Strategic issues including institutional support from MOH for CHWs
b) Need for CHW capacity building
c) Operational progress of the objective
d) Accountability to the community and to MOH
e) The future of support for Community Health Workers in any possible extension to the program
f) The evidence-base for continued support, if continued
g) Should support be scaled up or implemented on a pilot region basis
h) Other relevant issues to be explored as appropriate

2 Training

Progress in rationalising and harmonising training programs

3 Health Information Systems

How can use of data for decision making be strengthened?

4 Infrastructure

Challenges for the program presented by the significant enhancement of the infrastructure component, noting the impact of delays due to the reallocation of funding in 2013.

1.3 Program Management Systems

1.3.1 Monitoring and Evaluation

a) Review and make recommendations on the next draft of the M&E Framework
b) Consider the extent to which both formative monitoring and summative evaluation is captured in the draft M&E framework
c) Make recommendations on how the M&E framework can be used for planning and managing the program and reporting achievements (see below)

1. Quarterly Report

- Review how effective and efficient (time taken to complete each quarter) the present report format is in conveying progress on FHSSP implementation
- Make recommendations for streamlining the report and structuring it to align with the new M&E Framework

2. Risk matrix

- Review the risk matrix and make recommendations, with particular reference to the substantial inclusion of new infrastructure (as opposed to upgrading existing infrastructure) which will bring additional risks for MOH, JTAI and AusAID

1.4 Program Governance

1.4.1 Review the functioning of the Program Management Group in the context of the governance arrangements for FHSSP (i.e., PCC, FAC and PMG) and make recommendations for its continuation or otherwise, noting the discussions held by the PCC in December 2012 regarding the governance structure and the PCC endorsed approach moving forward

1.4.2 Review and advise on the process for identifying, reviewing and deciding on proposals for the use of Unallocated Funds and make recommendations in line with aid effectiveness principles

1.4.3 Consider the appropriate mechanism for reviewing TAG reports and the implementation of TAG Recommendations in line with the principle of mutual accountability

1.5 Financial Management

1.5.1 Review financial management systems processes and capacity of the program in the context of the Scale-up and inclusion of new items including the planned infrastructure works

1.5.2 Review recent audit reports and status on recommendations and findings;

1.5.3 Review recent financial management report and make any recommendations for improvement where necessary.

1.6 Recommendations

The FHSSP Design envisaged a three year program with the possibility of extension for a further two years depending on performance. The TAG of 2013 is tasked with the responsibility of recommending program extension or otherwise. A recommendation for FHSSP extension should clearly indicate the grounds for the recommendation and make proposals on the shape of the continuing program (whether all objectives should continue, some objectives be dropped or revised) and management arrangements (continuation of the existing management arrangements or otherwise).

(i) Roles and responsibilities of team

David Wilkinson is the team leader and will plan, guide and develop the overall review approach and methodology for the TAG, be responsible for developing a review plan with team member inputs, be responsible for managing and directing the TAG's activities, represent the TAG and lead consultations with government officials and other donor agencies, be responsible for managing, compiling and editing inputs from other team members to ensure the quality of reporting outputs, be responsible for delivery of the TAG outputs, and represent the TAG in peer reviews, if required.

Cate Keane is a financial management specialist and will have responsibility for reviewing FHSSP workplans, budgets, costing, financial management systems, recent audit reports and status on recommendations and findings, recent financial management reports, and making any recommendations for improvement where necessary.

Sally Duckworth is an M&E specialist and will focus on reviewing and making recommendations on the next draft of the M&E Framework, reviewing the extent to which both formative monitoring and summative evaluation is captured in the draft M&E framework, making recommendations on how the M&E framework can be used for planning and managing the program and reporting achievements, reviewing the effectiveness and efficiency of the present reporting format and making recommendations for streamlining the report and structuring it to align with the new M&E framework.

(ii) Deliverables

The Team Leader will be responsible for submitting a report (30 pages excluding executive summary and annexes) and AusAID will provide feedback according to the following schedule:

- First draft (quality assured by HRF) submitted to AusAID by 10 April 2013
- Consolidated comments from AusAID provided to HRF by 19 April 2013
- Revised draft report submitted to AusAID by 26 April 2013

Annex 2 Review approach and methods

In undertaking the appraisal of the scale-up concept note, the team members:

- Conducted a thorough desk review of relevant documentation;
- Developed a succinct review plan, which included methodology, how the specific questions listed above would be addressed (in the context of the AusAID quality criteria) and identification of key respondents and further documentation as required. Annex 3 provides a summary of the key questions linked to the AusAID quality criteria relevant for this appraisal;
- Liaised and consulted with AusAID staff from Canberra and in Suva;
- Participated in key meetings, including in-country meetings with AusAID staff, Ministry of Health staff, key development partners and beneficiaries;
- Held debriefing sessions with AusAID Suva and the FHSSP team in-country.

Three methods of data collection were employed to conduct the review:

- Document review;
- Semi-structured interviews and group discussions with selected key informants from MoH, FHSSP, AusAID and other stakeholders, where feasible and appropriate;
- A field visit to a selected service delivery site.

These approaches are outlined further below.

Document review

Prior to arrival in Fiji, the team reviewed selected key documentation, including FHSSP quarterly and annual reports, annual workplans, briefing notes, minutes of PCC, PMG and FAC meetings, audit reports, etc. During the TAG visit, the program team provided the TAG with supplementary documentation, the full list of which is outlined in Annex 5.

The document review was undertaken to: a) provide background information and context to the review; b) elicit answers to the key review questions; and c) help to formulate specific questions to stakeholders and key informants.

Semi-structured interviews and group discussions

Semi-structured interviews and group discussions were held with selected key informants from MoH, FHSSP, AusAID and with selected key stakeholders in Northern Division as part of the field visit. In February the TAG received a briefing via skype from AusAID Suva. At the weekend prior to the review, the team leader received an informal briefing by the AusAID Health Advisor. The TAG team met in the evening prior to the review for briefing with the team leader and to discuss the week ahead.

On day 1 of the review the team was briefed by AusAID Suva and met with the FHSSP team in Suva. On day 2 the team met with key personnel at the Ministry of Health, including the Permanent Secretary for Health, Deputy Permanent Secretary for Health, Deputy Secretary Health Services, Director, Wellness Centre, Chief Pharmacist. On day 4 the TAG held meetings with the MoH Health Information, Research and Analysis Team, and the MoH Training Unit, and followed up specific issues with the FHSSP program team. On day 5, the TAG conducted a debriefing

session with the FHSSP program team, followed by a full debriefing with AusAID Suva, including the new AusAID Counsellor.

Interviews and group discussions with stakeholders and key informants explored the key review questions, and built on the information provided by the document review.

Field visit

On day 3, two members of the TAG undertook a field visit to Labasa, to meet with the Northern Divisional Medical Officer and his team, to visit Labasa hospital, and to meet with community health workers who have recently received training supported by the program. The visit provided an opportunity for the review team to gain perspectives from the field and to interact with service delivery staff and people at community level.

The list of persons met during the TAG mission is provided in Annex 6.

Annex 3 Key review questions

Key review questions are outlined in the table below, and formed the basis for consultations with stakeholders and key informants. The specific questions asked during interview or group discussion were appropriate for the particular stakeholder(s) being interviewed or group discussion, and not all questions were asked of all stakeholders. Where appropriate, responses were document-verified, and wherever possible the TAG triangulated data using multiple data sources. The TAG placed emphasis on seeking solutions and suggestions from key informants where challenges or barriers are identified.

Table of key review questions for exploration with stakeholders and key informants

AusAID quality criteria	Management	Governance	Programme Content & Performance
Relevance	• Is the FHSSP management structure appropriate to deliver the program outputs and outcomes?	• Is the governance structure appropriate and relevant to provide strategic guidance and oversight to the programme?	• To what extent does the 2013 workplan align with the principles of the FHSSP design, while responding to the changes in the funding environment? • To what extent are the activities and programs of work relevant and feasible? • Are there any changes needed to the mix or design of activities supporting implementation?
Effectiveness	• To what extent have the TAG recommendations in the inception and scale-up reports been implemented? • How effective has the program management team been in addressing the reallocation of funding? • What are the risks to the successful implementation of the program and achievement of the program objectives, especially with	• What changes (if any) should be made to governance arrangements (especially to the PMG) to improve effectiveness? • How effective is the process for identifying, reviewing and deciding on proposals for the use of unallocated funds?	• What is the anticipated overall impact on the program objectives of the reallocation of funding? • To what extent is the program meeting its objectives? • How effective is the rationalization and harmonization of training programs? • How can the use of data for decision-making

	regard to the substantial inclusion of the scoping, planning and tendering of new infrastructure? • Are these risks being effectively managed, and what additional measures should be taken to manage and mitigate risks? • How effective has the program management been in responding to findings and recommendations from recent audit reports? • How effective are financial management reports?		be strengthened? • What are the challenges for the program presented by the significant of the infrastructure component? • How effective are the financial management systems, processes and capacity of the program in the context of the scale-up and inclusion of new items, including the planned infrastructure works?
Efficiency	• Is the management structure optimally efficient and providing value for money? • Has programme management responded to changing needs? • What changes (if any) should be made to management and reporting arrangements to improve efficiency?	• Is the governance structure optimally efficient? • What changes (if any) should be made to improve efficiency?	• Are the FHSSP 2013 budget and resources adequate and appropriate? • Has the programme made good use of time and resources to achieve objectives? • How effective and efficient is the present quarterly report format in conveying progress on FHSSP implementation? • What changes should be made to streamline the report and restructure it to align with the new MEF
Monitoring & Evaluation		1. Is there evidence that the oversight body is adopting a management for results	• Is the M&E framework robust, with appropriate baseline data, targets, indicators and means of verification?

		approach to FHSSP?	• Is the M&E system collecting the right information to allow judgments to be made about achieving objectives at the next evaluation point? • To what extent is both formative monitoring and summative evaluation captured in the revised MEF? • How can the MEF be used for planning and managing the program and reporting achievements?
Sustainability	• Should the program be extended for a further two years, and what are the justifications for this? • If the program is extended for a further two years, what changes (if any) should be made to the management arrangements?		• Are there any recent changes in the operational and strategic environment in the Fiji health sector, and are there emerging issues that would affect the sustainability of the program? • What are the key issues affecting the future of support for the CHW component? • Should support for the CHW initiative be scaled up or implemented on a pilot region basis? • If the program is extended for a further two years, what changes (if any) should be made to the shape of the continuing program?
Gender Equality			• To what extent do program activities integrate gender-sensitive practice in implementation, monitoring and evaluation?

Annex 4 TAG schedule

Dates	Activity	Location	# of days
1 Feb - 15 March	Preparation, reading, preparation of the review plan	Home station	2
7 Feb 2013	TAG Briefing by AusAID Suva	Home station	0.5
16/17 March	Travel to Suva. TL meets AusAID Health Advisor for preliminary briefing	Suva, Fiji	1
17 March	TAG team briefing meeting	Holiday Inn, Suva	
18 March 8:30 – 11:00am 11:30am – 1pm 2pm – 4.30pm	 Briefing with AusAID Suva Post Meeting with FHSSP Management team - Introduction and TAG Team leader to set scene of the week Meeting with FHSSP to discuss the following in more detail: • Infrastructure works • CHW program • Health Information Systems data • Harmonising training programs • Programme monitoring and reporting • The recent Scale-Back imperative and implications for the program • Budget downturn and financial management issues	Australian High Commission FHSSP Office	1
19 March 9:00 am 10:15am 11.15am 2:00 pm 3:00 pm	 Meeting with Dr. Eloni Tora, Permanent Secretary Health, together with MoH senior management team Meeting with Dr. Isimeli Tukana – NCD Advisor and Una Bera – A/g Deputy Secretary for Health Meeting with Dr Joe Koroivueta – A/g Secretary, Ministry of Social Welfare, Women and Poverty Meeting with MoH Finance Team – Nina Felipe and Aseri Matewale Follow-up meetings with FHSSP management team and technical facilitators	MoH MoH Ministry of SWWP MoH FHPPS offices	1
20 March	Site Visit to Labasa to meet CHWs and see	Labasa	1

	CHW project in action, to meet DMO and team and to meet with ANC staff at Labasa Hospital		
21 March 9:00 am 10:30am 2:00 pm	 Meeting with Health Information, Research and Analysis Team Meeting with MoH Training Unit Follow-up meetings with FHSSP team	 MoH FHSSP Office	1
22 March 9 am 10.30am 4pm	 Debrief with FHSSP program team Debrief with AusAID Suva post. TAG team meeting to agree next steps on report preparation	 FHSSP Office Australian High Commission	1
23rd March	Travel from Suva to home station	Suva	1
March-April	Report preparation	Home station	8.5/4.5

Annex 5 List of documents reviewed

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AusAID. July 2011. *Quality at Implementation Report for Fiji Health Sector Support Program*. AusAID: Canberra.

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AusAID. ND. *Annex 1 - Q2 Progress Assessment Summaries. Objective 1: To Institutionalize a Safe Motherhood program at Decentralized Levels*. AusAID: Canberra.

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Annex 6 List of people met

AusAID

Joanne Cho, Counsellor
Tim Gill, First Secretary
Margaret Vuiyasawa, Program Manager, Health/Social Protection
Sarah Gwonyoma, Assistant Program Manager, Bilateral Health
Anne Austen, Health Advisor

Fiji Health Sector Support Program (FHSSP)

Brendon Douglas, Executive Director, Development Programs (Brisbane)
Dr Rosalina Sa'aga Banuve, Program Director
Dr Asinate Boladuadua, Deputy Program Director/Technical Facilitator
Karen Kenny, Senior Program Administrator
Kelly Robertson, Assistant Program Administrator
Mereani Tukana, Technical Facilitator
Kylie Jenkins, Technical Facilitator
Margaret Cornelius, Technical Facilitator
Ateca Lepper, Technical Facilitator (resigned early 2013)
Eleni Kata, Assistant Technical Facilitator, Northern Division
Melania Tibika, TSO Training
Aminiasi Mucunabitu, Assistant Technical Facilitator, Monitoring and Evaluation
Sunia Soakai, Long Term Advisor, Policy and Planning
Douglas Glandon, Long Term Advisor, Monitoring and Evaluation
Marybeth Sarran, Long Term Advisor, Workforce Development
Aaron Sommerfeld, Short Term Advisor, Infrastructure and Planning
Phillipa Milne, health service planning consultant
Vinita Prasad, Senior Finance Officer
Vishwa Kanta Kumar, Finance Officer

Ministry of Health

Dr Eloni Tora, Permanent Secretary
Ms Una Bera, Acting Deputy Secretary, Public Health
Dr Meciusela Tuicakau, Deputy Secretary Hospital Services
Dr Isimeli Tukana, National Advisor, National Centre for Wellness
Dr Apolosi Vosanibola, Head of Pharmacy Department
Shivnay Naidu, Director, Health Information Research and Analysis
Ratish Singh, Director Health Planning, Policy and Budget Analysis
Arvind Kumar, Principal Administrative Officer, Policy Planning Development Unit
Nauise Ranka, Principal Administration Officer
Nilesh Ram, SAS Training
Vamarasi Fasala, Training Officer
Jioneli Vakamoce, Training Clerk
Mr Marika Luveniyali, Deputy Secretary Administration and Finance
Ms Aseri Matewale, Finance Manager

Ministry of Social Welfare, Women and Poverty

Dr Joe Koroivueta, Acting Permanent Secretary

Northern Division Field visit

Ministry of Health (Northern Division)

Dr Pablo Romakin, Divisional Medical Officer
Dr Bainato Naivaluvou, Divisional Dental Officer
Sunia Ubitau, Divisional Health Inspector
Sister Titi, Divisional Nursing Services
Mukesh Nath, Hospital Administrator, Labasa Hospital
Sister Luse Sivo, Labasa Hospital
Sister Kinisena Bolalevu, Sister i/c ANC clinic, Labasa Hospital

Ministry of Provincial Development (Northern Division)

Mr Josefa Rokonai, Northern Provincial Administrator

Community Forum

Two Turaga-ni-koros (Village Chiefs)
Five TOT 'Champions'
Seven Community Health Workers

Empower Pacific

One social worker and two trainee social workers

Annex 7 FHSSP implementation of TAG scale-up report

Theme	***Revised scale-up concept note***	***May 2012 TAG Comment / Recommendation***	***FHSSP action response (as of March 2013)***
Improving the impact of BCC through media campaigns	STA Public Health Communications will be recruited to provide appropriate technical expertise to develop a clear and documented public health communication plan and a BCC evaluation plan of reach, coverage and comprehension by target audiences providing a clear link between the campaigns and behaviour change outcomes. The STA will develop guidelines for use by NCHP to ensure that key messages are consistent with BCC objectives and that materials are pre-tested for appropriateness.	The TAG fully endorses these proposed inputs and activities, as they will help to: • ensure that the program-related BCC initiatives are strategic, coherent, evidence-based and monitored; • build the capacity of FHSSP to ensure that the program's support to BCC is technically sound; • build the capacity of the NCHP to plan, implement, monitor and evaluate its own BCC initiatives.	STA Public Health Communications was appointed in September. An approach to support MoH and FHSSP was developed by the STA late 2012. Recommendations were incorporated into the 2013 work plan including additional evaluations of past campaigns and mentoring MoH through a PHC campaign however planned STA inputs in Q1 and Q2 of 2013 have been delayed due to budget restrictions.
Improved service delivery at SDH	FHSSP proposes expanding the number of sub-divisional hospitals (SDH) providing baby friendly, mother safe and diabetes-focused services from 8 in the existing work plan to all 17 SDH across Fiji. FHSSP will undertake a comprehensive scoping exercise for all SDH. A comprehensive capital	The TAG fully endorses the comprehensive scoping exercise for all SDH as this will provide a key opportunity to confirm the rationale for investment; funding may need to be reallocated if the rationale is not confirmed. The proposal notes that the construction of a birthing centre at Makoi has been identified by MoH and AusAID as a	Technical support was provided in the scale up (an STA infrastructure and ATF – infrastructure); scoping of a prioritised list of SDH upgrades has commenced and a rolling program recommended. In addition servicing planning has commenced for the Suva-Nausori corridor to review the planning data and service options for Makoi and Nausori – this will result in a functional plan and

Theme	*Revised scale-up concept note*	*May 2012 TAG Comment / Recommendation*	*FHSSP action response (as of March 2013)*
	improvements plan will be developed in Phase 1, which will detail support to facility upgrades to achieve mother, baby and child safe standards as well as diabetes focused services at SDHs and major health centres (including Makoi Birthing Unit and redevelopment of Nausori Hospital). The plan will include a rolling program of capital improvements for the life of the Program with indicative budgets, technical drawings and other relevant documentation prepared. To support this activity FHSSP will recruit an STA Infrastructure Planning and a Technical Facilitator-Infrastructure. FHSSP will also sub-contract FNU to undertake operations research to identify recommendations on improving access of patients to sub-divisional services with a focus on transport to and outreach from sub-divisional facilities.	priority for future funding support. However, the scale-up concept note makes no mention of using scale-up funding to construct the birthing centre, and the TAG notes that support by stakeholders for the construction of the birthing centre appears to be mixed. The TAG notes with concern that if the decision is made to pursue the construction of the birthing centre, the budget for SDH upgrades will apparently be greatly reduced. The TAG strongly recommends that AusAID does not pre-empt the findings of the scoping exercise by committing upfront to the construction of the Makoi birthing centre – especially if this implies that SDH upgrades will suffer as a result.	clearer costs estimates for the proposed facilities –including workforce requirements. Budget was included in the 2013 work plan for preliminary work at Nausori and sufficient funds to construct Makoi. The Makoi plans are based on the existing MoH concept which has many unanswered planning questions so these costs may change and also roll across to 2014. Funds were included in the 2013 work plan for upgrades to three SDH include Levuka, Sigatoka and Savusavu. There is also budget in 2013 for continued scoping and documentation of SDH upgrades at other facilities. Budget restrictions in 2013 reduce the likelihood that any of the SDH work will be completed by end of 2013 or June 2014. Focus of Q1 and Q2 in the absence of funds is to improve services and infrastructure planning guidelines and procurement processes.
Improved coordination and effectiveness of MoH	FHSSP will recruit a long term adviser (LTA) Workforce Development and a Technical Support Officer (TSO) to work with the MoH In-service Training Unit. These additional personnel will	The TAG rated this activity as high priority, noting that there is a strong case to be made for FHSSP providing a broad package of support to help the MoH develop a long-term plan for workforce	LTA Workforce Development was appointed in September along with a locally engaged Training Division officer. This increased technical capacity of FHSSP supports development of a long-

Theme	***Revised scale-up concept note***	***May 2012 TAG Comment / Recommendation***	***FHSSP action response (as of March 2013)***
capacity building through training	assist the MoH to develop a long-term workforce capacity development plan to enable core staff to provide safe services to mothers, children and diabetic patients. The Plan will consider multiple options for achieving improved performance through training provision and will link to other relevant local and international training institutions as well as technical and donor partners.	capacity building through training. The TAG fully endorses the proposed inputs and activities, as these will contribute to more sustainable in-service training planning and management, and will therefore support health systems strengthening.	term workforce capacity development plan for the MoH. A tender has been called to support the development of a Training Materials and Delivery Framework for the Fiji Ministry of Health (MoH) to ensure high quality training materials are produced that support performance improvement of the health workforce across a range of disciplines.
Improved distribution of essential medicines and biomedical equipment	A scoping exercise is proposed with a view to upgrading the current warehouse management system to address issues of stock outs, stock losses, expirations and other inefficiencies in the current system. The scoping exercise would result in a comprehensive plan to improve the access to essential medicines and biomedical equipment that will inform the 2013 annual planning process. The plan will consider links to other implementation partners for capacity building including regional and local training mechanisms, procurement of a cost effective warehouse management system and change	Given the proposed significant expansion of the immunization programme outlined below, this initiative will help to address the issue of procuring a large number of vaccines and tracking and monitoring these through the logistics system. The TAG therefore fully endorses the proposed inputs and activities.	MoH requested support late last year for an Auditor to review divisional and subdivisional level supplies and SOPs. This was approved and an auditor appointed however this individual became acutely unwell and was unable to continue his duties. We are awaiting further discussion with MoH on rehiring. Additionally offers of STA to support a plan and specifications for a WMIS were rejected by the MoH as they formed their own working group to do this – the report of the WG has not been shared with FHSSP despite requests. There was no supported requested by the Director of FPBS or MoH during the 2012 planning process. In February the MoH called an

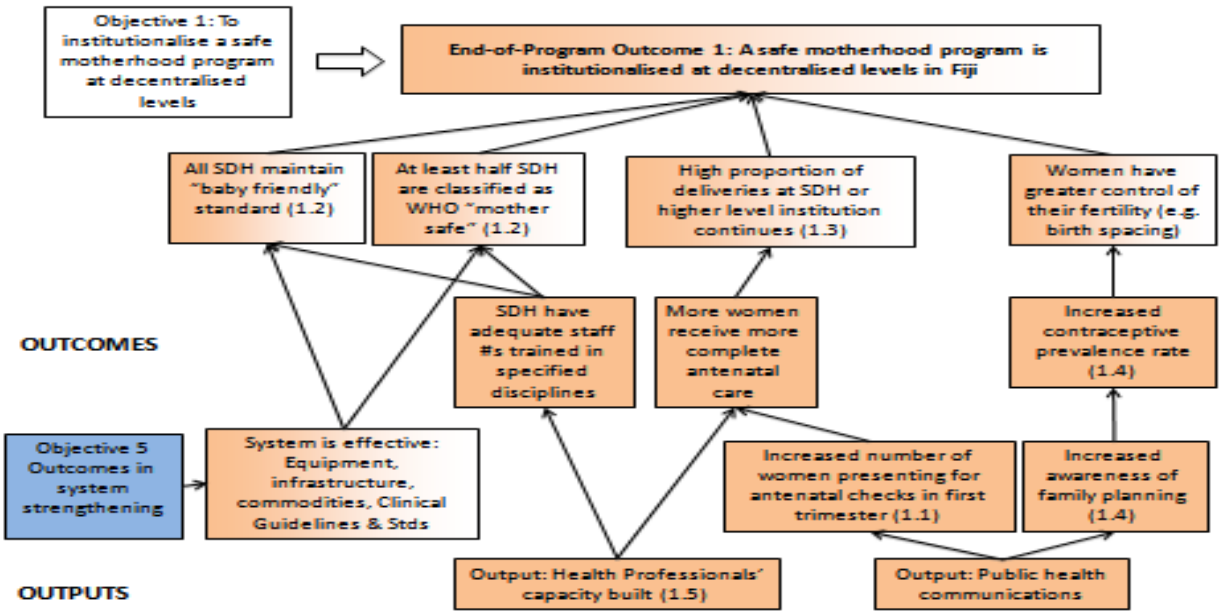
Theme	*Revised scale-up concept note*	*May 2012 TAG Comment / Recommendation*	*FHSSP action response (as of March 2013)*
	management approach to ensure sustained improvement from any investment		open tender for bidders to develop a WMIS and FHSSP has indicated that this cannot be funded by the Program as it was not planned in the current budget. FHSSP provides technical support and administrative support for the vaccine procurement and UNICEF/JICA provide significant input into the cold chain logistics management for vaccines. Biomedical equipment is procured in collaboration with FPBS and CSNs – with particular emphasis on specifications appropriate for the context, ease of use and repair, relevant maintenance agreements and training of clinicians.
Introduction of three new vaccines	In late 2011, the Fiji Cabinet endorsed the introduction of three new vaccines in 2012—pneumococcal, rotavirus and HPV. Recognising the potential positive impact on under-5 mortality and decreased cervical cancer rates in women, AusAID committed to the introduction of the three new vaccines, confirming this commitment in writing to the MoH in February 2012. That commitment is reflected in the inclusion in this proposal of the	The TAG fully endorses the proposed inputs and activities outlined above, noting that the approach is consistent with the program design objectives and represents a relatively large expenditure at low risk. The TAG considers the evaluation a key element of the proposed activities, as it will provide the MoH with important evidence to support future planning, and build capacity for vaccine procurement, distribution and disease surveillance.	In the third quarter of 2012, FHSSP procured the first two of three vaccines, Rotarix and Synflorix. The HPV vaccines started to arrive in January 2013. Due to budget constraints in the Australian Aid program, the 20% contribution of the MoH for year 2 of vaccine procurement was brought forward into year 1 (February 2013). Phase 1 of the vaccine evaluation completed in December 2012 and Phase 2 has been delayed in commencing due

Theme	*Revised scale-up concept note*	*May 2012 TAG Comment / Recommendation*	*FHSSP action response (as of March 2013)*
	procurement costs for the new vaccines on a cost-sharing basis. An evaluation of the impact of the vaccines has also been proposed, through a sub-contracting arrangement with the International Centre for Child Health		to budget constraints within the Australian Aid Program. Phase 2 will commence in early 2013 with the bulk of the work (recruitment of epidemiologist and capacity building of surveillance systems) to commence in July 2013 and conclude in June 2014 – pushing the schedule back by 6 months.
Additional technical personnel	To support the scale-up activities, FHSSP proposes adding two long term technical advisers (LTA) - workforce development and M&E, and three short term technical advisers (STA) – public health communications, gender, infrastructure & planning; and a technical support officer (TSO) – training. FHSSP also proposes four additional locally engaged personnel: technical facilitator infrastructure; assistant technical facilitators western and northern divisions, and an M&E officer	The TAG strongly endorses the proposed engagement of these additional advisors and technical facilitators.	All scale-up positions recommended by FHSSP and endorsed by the TAG commenced in September and October with the exception of LTA M&E and ATF infrastructure who both commenced in December due to a need to go out to advertise a second time for these roles.
Additional management and administration	At a minimum, it is proposed that five new management and administration positions are created, as outlined below. However, requirements may	The TAG fully endorses all these proposed appointments.	All proposed administrative and management appointments by FHSSP and endorsed by the TAG commenced post scale-up.

Theme	***Revised scale-up concept note***	***May 2012 TAG Comment / Recommendation***	***FHSSP action response (as of March 2013)***
personnel	change once the scoping exercises of Phase 1 are completed. LTA Assistant Program Administrator, Senior Finance Officer, Communications Officer, Project Coordinator- Western Division Project Coordinator- Northern Division		

Annex 8 Example of how Section 5 of 2013 Annual Workplan could be structured

OBJECTIVE 1: TO INSTITUTIONALISE A SAFE MOTHERHOOD PROGRAM AT DECENTRALISED LEVELS.



Outcome 1.1: Increase in number of women presenting for ante-natal check-up in the 1st trimester of pregnancy	
Output 1.1.1 BPP training plan and associated SHC strategy developed and implemented	
Activity	**Indicator**
Evaluate previous media campaigns funded by FHSSP to determine effectiveness	Data on effectiveness of previous campaigns available
Develop new strategic health communications campaign based on results of the evaluation and implement (focus on poor peri-urban women)	Campaign messages, channels targeting poor peri-urban women and M&E developed
BPP/CRP training and rollout i.e. 'early booking kit'	At least 50% of all Community Health Nurses in Nadi, Rewa, Levuka and Cakaudrove SDs trained in BPP/CRP
Outcome 1.2: All sub-divisional hospitals maintaining 'baby friendly' standard and at least half SD hospitals classified as achieving 'mother safe' standards, in accordance with	
Output 1.2.1: A Training and procurement schedule for supporting baby friendly hospitals is developed and implemented	
Activity	**Indicator**
Training to maintain mother safe standards including manual vacuum aspirators	At least 50% of doctors in divisional (plus SDs of Nadi, Rewa, Levuka and Cakaudrove) hospital maternity units trained in MVA
National EmONC instructors training + Staff training in each division	At least 10 instructors trained. At least 20 staff trained per division.
Equipment procurement to support 5 SDHs reach 'basic status' accreditation	Relevant equipment procured and distributed to targeted subdivisional hospitals
Support training unit of MOH to develop a clinical attachment program for doctors and implement	Competency for attachments developed. Three doctors per division complete safe motherhood clinical attachments
Support safe motherhood clinical attachments to divisional maternity units	At least 25 nurses attached to divisional maternity units for at least 1 week.

Annex 9 Unallocated Fund Guidelines 2013

Purpose of the Unallocated Fund

The provision of an Unallocated Fund under FHSSP is in response to a need identified by both MoH and AusAID for flexibility in program funding within defined financial limits. As recommended by the Program Design Document, there has been an amount of AUD$1 million (approximately FJD$1.8 million) set aside for this Unallocated Fund per annum.

The purpose of the Unallocated Fund is to:

- Assist the MoH respond to health situations resulting from national emergencies (i.e. floods or cyclones);
- Address emerging health needs and priorities (i.e. typhoid outbreaks and mental health issues); and
- Support innovative activities identified during the annual planning process, or during the year, these activities must be related to the five objectives and have the potential to be implemented more broadly if proven to be an effective implementation mechanism.

The unallocated fund should not be used to support ad hoc activities, but used strategically so that activities under this component become sustainable. Activities under the Unallocated Fund must be jointly agreed by the MoH and AusAID through the PCC.

Programing Unallocated Fund Expenditure

In order to balance out emerging priorities with the capacity to respond to emergencies, the Unallocated Fund will be managed on an annual basis. The use of the unallocated funds needs to remain as flexible as possible, to address unexpected emerging needs and emergencies, whilst ensuring the funds are structured for maximum use. Funds will therefore be allocated as follows on an annual basis:

- Twenty per cent will be used to pilot an innovative activity related to the individual Objective, with the potential to be implemented more broadly should the initiative prove to be effective;
- Sixty per cent will be programmed to support identified emerging issues, that arise either during the FHSSP annual planning process each October or throughout the year;
- Twenty per cent will be held for emergency response. If by March 31 of the budget year there are substantial funds left in the emergency response allocation, this can be reprogrammed for use that calendar year, on the assumption that should there be a natural disaster; adequate funding from the following year's Unallocated Fund will be programmed to address the emergency.

Requests for use of Unallocated Funds

The Technical Facilitators will be required to work with MoH counterparts to identify and prioritise the needs as outlined in the bullet points above. For requests to be

considered in the annual planning process, these must be submitted to FHSSP on a new expenditure request form two weeks prior to the FHSSP annual planning process.

For emergency or non-planned requests, a new expenditure request form must be submitted to FHSSP as soon as the need arises.

Expenditure of funds that have not been allocated during the annual planning process will need to be approved by the PCC or through the use of Flying Minutes for new requests and emergency responses.

Reporting on Expenditure

To ensure the unallocated funds can be reported on accurately, the use of these will be highlighted in the work plan that the activity is funded from the Unallocated Fund, and coded as such in the monthly budget report.

Annex 10 Revised risk register

Objective/s	Risk No.	Risk (what will prevent you achieving the objective/s?)	Impact (what will happen if the risk occurs?)	Existing Controls (what's currently in place?)	Risk rating with existing controls in place			Is risk rating acceptable? Y/N (if no, please propose treatments)	Proposed Treatments (If no further treatment required or available, please explain why)	Person Responsible for Implementing Treatment/s	Implementation Date for Proposed Treatment/s
					Consequence (refer to matrix)	Likelihood (refer to matrix)	Risk Rating (refer to matrix)				
1.0 Commitment Risks											
Political commitment from the Governments of Australia and Fiji to the successful implementation of the Fiji Health Sector Support Program	1.1	Political instability and/or civil unrest.	• Disruption to Program activities • Cessation of some Program activities • Possible cessation of all Program activities	• Continuously monitor current risk environment • Establishment and management of robust risk communication, emergency and security management systems • Review and revise Program activities and engagement in line with Australian Government policy and advice	Severe	Likely	Very High	Yes	• Continuously monitor current risk environment. • Establishment and management of robust risk communication, emergency and security management systems. • Review and revise Program activities and engagement in line with Australian Government policy and advice.	Program Director (PD)	Ongoing
	1.2	Diplomatic instability between the Governments of Australia and Fiji	• Disruption to Program activities • Cessation of some Program activities • Possible cessation of all Program activities.	• Maintain regular consultation and liaison with AusAID Post. • Continuously monitor current risk environment. • Establishment and management of robust risk communication, emergency and security management	Severe	Likely	Very High	Yes	• Maintain regular consultation and liaison with AusAID Post • Continuously monitor current risk environment • Establishment and management of robust risk communication, emergency and security management	PD	Ongoing

				systems. • Review and revise Program activities and engagement in line with Australian Government policy and advice.					systems • Review and revise Program activities and engagement in line with Australian Government policy and advice		
	1.3	Central agencies do not understand FHSSP	• Some initiatives not achieved due to central agency constraints • Dissatisfaction with funding model from central agencies • Pressure to move to budgetary support	• Regular engagement of central agencies and annual briefing to Cabinet.	Moderate	Possible	Moderate	Yes	• Regular engagement of central agencies. • Conduct a briefing once each year with central agencies via the MoH Permanent Secretary's forum • Regular engagement of relevant central agency staff in pursuit of various initiatives	PD, AusAID	Ongoing
	1.4	Constraints resulting from GoF reforms (i.e. MoF, MoH and PSC)	• Lack of MoH responsiveness • Pressure on FHSSP to fund recurrent budget expenditure or duties • Delays/restrictions in recruitment of staff leading to lack of counterparts • Potential for the compulsory retirement age to be lowered again, once again stripping Ministry of senior managers and leaders and appropriately qualified and experienced personnel in the Ministry to work with • Uncertainty around	• FHSSP will respond as appropriate in the instance that these risks become a reality.	Moderate	Possible	Moderate	Yes	• FHSSP assistance to the MoH in adapting to the changes • Ongoing liaison between MoH and central agencies • Focus on capacity building of middle managers	PD, MoH	Ongoing

			stability of existing structures leads to reticence to invest sufficient resources to ensure success								
	1.5	Government policies affect operations	• Implications on MoH staffing and resources available to support the Program	• FHSSP will respond as appropriate in the instance that these risks become a reality. • On-going monitoring of environment to assess policy changes which will affect Program Operations.	Moderate	Possible	Moderate	Yes	• Regular engagement of central agencies through the PCC • FHSSP to continuously monitor the environment and establish strong relationships with central agencies	MoH, PD	Ongoing
	1.6	Australian federal budget in May 2013 and forthcoming federal elections pose uncertainties for future levels of program support	Funding cuts could negatively affect the ability of the program to achieve its objectives	On-going monitoring of environment to assess changes which will affect Program operations.	Moderate	Possible	Moderate	Yes		PD	Ongoing
	1.7	Scale-back in funding is extended beyond July 2013	Damaged relationships between FHSSP/AusAID and MoH	Verbal assurances from AusAID that scale-back is likely to be temporary	Major	Possible	Moderate	No	Written confirmation from AusAID on extent and timeframe of scale-back	AusAID	Following Australia budget announcement in May 2013

Minimal disruption to FHSSP's capacity to support to the MoH during times of natural disasters.	2.1	Natural disasters e.g. cyclones, floods	• Threaten staff safety and security • Interrupt continuity in service delivery • Reputational risk if response and/or outcomes perceived negatively	• Monitor socio/political, regional emergency warnings; domestic and international security • Robust risk communication, emergency and security management systems ain place which are reviewed annually. • Review and revise Program activities and engagement in line with Australian Government policy and advice as required.	Major	Almost Certain	Very High	Yes	• Monitor socio/political, regional emergency warnings; domestic and international security • Establish robust risk communication, emergency and security management systems and appropriate staff training • Assess appropriate response immediately • Review and revise Program activities and engagement in line with Australian Government policy and advice	PD, Senior Program Administrator (SPA)	Ongoing with increased intensity around cyclone season.
3.0 Program Risks											
	3.1	MoH monitoring systems are inadequate	• Planning, financial management and M&E systems do not provide monitoring data for key indicators • FHSSP impact is unable to be effectively/reliably measured and evaluated	• MEF developed in line with MoH and Program requirements. This is reviewed at least annually through engagement with the MoH and AusAID.	Major	Likely	High	Yes	• Clear articulation of M&E requirements to the PCC members • Active reviewing by the PCC of the M&E data • High impact TA inputs to improve MoH data collection and analysis capabilities	PCC, PD	Ongoing

	3.2	PCC does not maintain integrity to design in activity planning/delivery	• Confusion on what FHSSP is designed to deliver • Lack of strategic focus • Loss of Program impact • Disillusionment from all stakeholders	• All PCC members and stakeholders are fully briefed on the Program Design Document (PDD) and intent of the Program and discussions are held as changes within the Program occur. • Ensuring all planning activities are undertaken through the scope of the PDD • Ensuring unallocated expenditure is allocated with fidelity to the Program Design	Major	Possible	High	Yes	• Ensuring all planning activities are undertaken through the scope of the PDD • Ensuring unallocated expenditure is allocated with fidelity to the Program Design	PCC	Six-monthly in line with PCC meeting schedule and ongoing through processing and review of ad-hoc requests.
	3.3	Insufficient capacity within the MoH to meet obligations as a PCC Member	• Reduced leadership/ownership of the Program • Underachievement of Program deliverables • Reduced capacity building and overall effectiveness of Program	• Undertake clear dialogue at outset outlining expectations for MoH and all PCC members • Clearly articulated support to MoH by the FHSSP team • Increased involvement in the Program by AusAID Post • Emphasis on Divisional Meetings for planning and coordination	Major	Likely	High	Yes	• Clearly articulated support to MoH by the FHSSP team • Increased involvement in the Program by AusAID Post • Emphasis on Divisional Meetings for planning and coordination	AusAID, MoH, other PCC representatives	Ongoing

	3.4	Managing competing priorities / MoH workforce capacity constraints; Enforced early retirements, high turnover and vacant positions impact day-to-day business of the MoH, with many key counterparts for FHSSP changing in 2013 including; the National Adviser Family Health; the Director Health Information Research and Analysis attending a 5-week fellowship Health Information Systems Hubs; the Director Asset Management Unit taking up the position of Hospital Administrator Labasa; and the Deputy Secretary Public Health due for retirement in mid-2013 .	• MoH management and staff required to manage competing priorities such as emergencies or other unplanned yet urgent priorities may limit the ability of FHSSP and the MOH to focus on the delivery of programmed activities and as such impact program expenditure.	• Work with MoH to re-prioritise as needed and provide additional support through Program funds where possible. These risks are assessed on an as needs basis.	Major	Likely	High	Yes	• Work with MoH to re-prioritise as needed and provide additional support through Program funds where possible. • LTA Workforce Development to assist with developing more strategic approach to training and workforce development.	PCC, PD, LTA Workforce Dev	Ongoing

	3.5	FHSSP may operate successfully but service delivery may not improve	• Uncertainty as to FHSSPs impact • Uncertainty as to the value of FHSSP activities • Potential loss of Program impact	• Continuous monitoring and reporting against Annual Plan • Identify areas of achievement against MoH objectives and transfer lessons learned • Identify bottlenecks (constraints) to service delivery and develop strategies to acquire the capabilities to improve performance	Severe	Possible	Very High	Yes	• Identify bottlenecks (constraints) to service delivery and develop strategies to acquire the capabilities to improve performance • Encourage the PCC to push for reform / intervention where resistance to change has been identified	PCC, PD	Ongoing
	3.6	Potential for relationship breakdown between FHSSP, AusAID and/or MOH	• Disrupts the implementation of the Program • Limit effectiveness of the PCC • Reduce Program impact	• Maintain strong, accurate and regular lines of communication • Negotiate clear relationships in the Program management and reporting structure • Continuously monitor relationships to ensure they are managed effectively	Major	Possible	High	Yes	• Address issues as they arise using existing controls.	AusAID, MoH, FHSSP	
	3.7	Donor coordination is not achieved	• Duplication of FHSSP initiatives • Drain on MoH resources • Lack of support for the FHSSP	• FHSSP Annual Planning synchronized with MoH Planning • PCC to be used as a communication forum for FHSSP activities with other donors/stakeholders • FHSSP to actively engage with other Fijian donors	Moderate	Possible	High	Yes	• Address issues as they arise using existing controls. • Participate in Development Partners meetings.	PCC, PD	

	3.8	Lack of engagement with AusAID regional strategies	• FHSSP fails to leverage off current AusAID activities in the region • Reduced efficiencies	• AusAID to support FHSSP engagement with regional activities • PCC to ensure regional activities considered in activity planning • FHSSP to ensure relationships are developed and maintained with regional AusAID interventions	Moderate	Possible	High	Yes	• Address issues as they arise using existing controls.	FHSSP, PCC, AusAID	Ongoing
	3.9	AusAID Health Adviser not engaged in a timely manner, or not sufficiently experienced to provide appropriate technical guidance	• The new model suffers from delayed or ill-informed technical advice • The dynamics of introducing a new key stakeholder cause stress and confusion as to roles	None.	Major	Almost Certain	Moderate	Yes	• Terms of Reference and role of Health Adviser in the FHSSP are collaboratively developed. • MoH to participate in selection process • Ensure regular, clear and open communications are provided. • All stakeholders remain flexible and positive on the advantages of this model	AusAID, PD	
	3.10	Limited capacity of the MoH particularly at divisional level	• FHSSP activities do not progress within planned timeframes• Under-achievement of capacity building initiatives leading to unsustainable outcomes	• Active monitoring of MoH capacity by FHSSP• Clearly articulated and transparent support to MoH by the FHSSP team • Monitor support provided by Technical Facilitators and target as necessary	Moderate	Possible	Moderate	Yes	• Address issues as they arise using existing controls. • Participate in Divisional Plus meetings to assist with coordination and communication of Program workplans.	PCC, PD, TFs	

	3.11	Lack of HIV mainstreaming	• FHSSP not seen as a role model on HIV mainstreaming and advocacy	• FHSSP ensures all staff/advisers are briefed on HIV and appropriate prevention and mainstreaming strategies	Minor	Possible	Moderate	Yes	• FHSSP plays a lead role in mainstreaming and advocacy of HIV and AIDS throughout the Program • FHSSP ensures all staff/advisers are briefed on HIV/AIDs and appropriate prevention and mainstreaming strategies	PD, TFs	Ongoing
	3.12	Lack of gender mainstreaming (and uptake of the Gender and Social Inclusion Strategy's Recommendations)	• FHSSP not seen as a role model on Gender mainstreaming and advocacy	• Currently developing a Gender and Social Inclusion Strategy for the MoH and FHSSP via the STA Gender and MoH Counterpart.	Minor	Possible	Moderate	Yes	• FHSSP plays a lead role in mainstreaming and advocacy of gender throughout the Program. • FHSSP ensures all staff/advisers are briefed on issues related to gender in development and gender mainstreaming • STA Gender inputs sought to strengthen Program's gender focus.	PD, TFs	Ongoing
	3.13	Significant scale-back in funding for first six months of 2013	Significant delays in program implementation until July 2013, negatively affecting the likelihood that program will achieve its objectives	Program utilizing delay to consolidate planning and systems development	Major	Possible	High	No	Revise program objectives to better reflect realities of what can be achieved in the two years remaining. Agree revisions with PCC	PD	Next PCC meeting

	3.14	Lack of disability mainstreaming	• FHSSP not seen as a role model on Disability mainstreaming and advocacy	• Currently developing a Gender and Social Inclusion Strategy for the MoH and FHSSP.	Minor	Possible	Moderate	Yes	• FHSSP actively engages and plays a lead role in mainstreaming and advocacy of disability throughout the Program. • FHSSP ensures all staff/advisers are briefed on issues related to disability in development and disability mainstreaming	PD, TFs	Ongoing
4.0 Financial Risks											
	4.1	Currency exchange fluctuation	• Inaccurate Program budgeting • Program budget (FJD) variation • Constant monitoring and adjustment on planned Program activities • Accurate financial reporting	• Procedures implemented to managed currency fluctuations and reporting (in both AUD and FJD). This is reviewed by the JTA Financial Controller and advice provided to FAC on a 6-monthly basis.	Major	Almost Certain	Very High	Yes	• Continuously monitor current risk environment	SPA, Financial Controller	Ongoing and monthly
	4.2	Program fund underspend	• Lack of achievement on Program outcomes • Large amount of budget remaining to be spend in short period • Time pressure may affect the quality of Program deliverables	• Monthly financial reporting to FAC and monitoring of expenditure. • Strategies developed with FAC, PMG and PCC to address underspend if required.	Moderate	Possible	Moderate	Yes	• Address issues as they arise using existing controls.	PD, SPA, TFs	Ongoing and monthly

	4.3	Poor management of Unallocated Funds	• Pool of unallocated fund may remain unspent by end of financial year • Unallocated fund may have used up for the Program planned activities • Too many ad hoc requests not aligned to program objectives	• Monthly financial reporting to FAC and monitoring of expenditure. • Strategies developed with FAC, PMG and PCC to address underspend if required.	Moderate	Possible	Moderate	Yes	• Address issues as they arise using existing controls. • Strengthen guidelines for the use of Unallocated Funds to assist PCC/AusAID with approval of requests.	AusAID, FHSSP	Ongoing
	4.4	Slow transition of funds in emergency	• Lack of responsiveness in emergency situation	• Financial Procedures address transition of funds. • Work with MoH to ensure funds are received in a timely manner, although this is dependent on MoH and AusAID responsiveness.	Minor	Unlikely	Moderate	Yes	• Continuously monitor current risk environment • Establishment and management of robust risk communication, emergency and security management systems.	SPA, finance team	Ongoing
	4.5	Fraudulent activities	• FHSSP funds are misappropriated• FHSSP and AusAID receives a bad reputation for fraudulent activities	• Financial Procedures address fraud and are in line with AusAID Guidelines. • Training on financial procedures is provided to MoH and FHSSP staff.	Moderate	Possible	Moderate	Yes	• Continuously monitor current risk environment • Review and revise in line with Australian Government policy and advice.	PD, SPA, TFs	Ongoing
Objective Specific Risks											
To institutionalise a safe motherhood program at decentralised levels	5.1	Media campaigns to promote early ante-natal bookings during 1st trimester of pregnancy do not result in behaviour change.	• Inefficient use of resources with no positive health outcomes.	• Campaign messages developed in consultation with MOH.	Moderate	Possible	Moderate	No	• Conduct an evaluation of media campaigns conducted to-date to assess effectiveness and impact, especially with vulnerable women residing in peri-urban communities. Incorporate lessons into future strategic	TF, Evaluation Consultant and Assistant Program Administrator (APA)	Q1 2013

									health communication campaigns to improve likelihood of behaviour change.		
	5.2	Mother safe' standards developed for sub-divisional hospitals do not comply with yet to be released WHO standards.	• Results from audit based on locally developed 'mother safe' standards invalid if the non-compliant with WHO standards.	• Consultation with WHO consultant to ensure locally developed standards are in line with those being developed by WHO.	Moderate	Unlikely	Low	Yes	• Clinical service network consultations on mother safe standards to ensure applicability and suitability for Fiji	TF	Q1 2013
	5.3	Equipment procured for sub-divisional hospitals to gain 'basic status' accreditation to support increased number of deliveries at that level are not maintained and/or consumables become unavailable.	• Equipment not utilised by sub-divisional hospitals and therefore unable to provide for safe deliveries, resulting in deliveries occurring at divisional hospitals. Subdivisional hospitals well equipped but women still going to deliver at divisional hospitals	• Specifications of equipment discussed with clinical service networks and FPBS prior to procurement. • Ensure biomedical technicians trained in maintenance of equipment. • Procure sufficient consumables for equipment to operate for at least 12 months to provide opportunity to incorporate on-going costs into MOH budget. • Ensure staff are upskilled to handle deliveries and community mobilisation to ensure them the safety of delivery at subdivisional hospitals	Moderate	Possible	Moderate	No	• Continue with existing controls in place. • TFs/TSOs to monitor the use and state of procured equipment and report back to FHSSP/MOH	TF, Technical Support Officers (TSOs), SPA	Ongoing

	5.4	Makoi Birthing Centre construction budget insufficient after detailed scoping exercise completed.	• Building not constructed.	• STA Infrastructure providing guidance on scoping, detailed design etc. to establish more accurate budget and liaising with SPA on financial implications.	Major	Possible	High	No	• Support proper planning and budgeting for capital works. • Spread budget over two Australian financial years	STA Infrastructure, SPA	
	5.5	MOH unable to staff and fund ongoing operational costs associated with Makoi Birthing Centre	• Building completed but not fully utilised	• Working with Divisional Medical Officer Central Division for projections of staffing and operational costs.	Major	Possible	High	No	• Support the MoH with good service and workforce planning to enable as accurate as possible forecast of future commitments to the facility.	MoH, PD, SPA, LTA Policy & Planning Adviser, external Health Planner TA support.	Q4 2012 - Q1 2013
	5.6	Human resource capacity constraints within MOH result in minimal community training and outreach activities around education on safe sex, family planning, prevention of HIV & STIs etc.	• Contractive prevalence rate not increased and no improvement of awareness of family planning within communities supported by FHSSP.	• Ensuring MoH planning down to subdivisional level includes community and outreach activities.	Minor	Possible	Low	Yes	• Support the MOH to utilise its partnerships with CSOs and NGOs to conduct this outreach work.	TF	2013
	5.7	Significant infrastructure expansion diverting human and financial resources away from SDH upgrades	Delays to establishment of mother-safe status for all SDH	Engagement of STA and ATF Infrastructure to help progress SDH scoping and upgrades	Major	Likely	High	No	Continued engagement of Program and AusAID with MoH to adopt most effective and efficient infrastructure option. Continuation of contract of STA Infrastructure to help manage the scoping and upgrading process.	PD	Ongoing

To institutionalise a healthy child program throughout Fiji	6.1	No National Adviser for Family Health, counterpart to the FHSSP Technical Facilitator	• Capacity to coordinate with MOH on healthy child activities limited.Limited advocacy within MOH for healthy child program.	• Working with Clinical Service Network and Deputy Director Public Health to ensure implementation of program support	Minor	Likely	Low	Yes	• MOH/PSC commence the recruitment of a replacement Adviser	MOH	2013
	6.2	Healthy Child Policy not released by MOH	• No policy for strategic guide/framework to the program	• Support provided by Technical Facilitator to finalise the Policy	Moderate	Unlikely	Low	Yes	• TF to continue support to MOH with finalising the Policy as requested.	MOH	2013
	6.3	New vaccine program not taken up by the public (esp. the HPV vaccine)	• Inefficient use of resources with no positive health outcomes.	• Extensive media campaign being run to support the new immunisation schedule for infants.	Moderate	Unlikely	Low	Yes	• Continue with existing controls and vaccine evaluation to establish whether objectives are met.	PD, TF	2013
	6.4	Weak surveillance system unable to monitor impact of the new vaccine program.	• Unable to provide data to justify ongoing cost of the vaccine program. • Unable to detect replacement diseases resulting from removal of common PCV types.	• Sub-contract with MCRI to support the strengthening surveillance and epidemiology capacity within MOH around these diseases in place.	Moderate	Possible	Moderate	Yes	• Strengthen hospital laboratory surveillance and at Mataika House with support from MCRI	PD, TF, MCRI	2013 onwards
	6.5	MOH is unable to meet its financial commitment to the new vaccine program in the coming years.	• Program having to cover the costs for vaccines	• Contract with MoH signed and input into budgets annually to ensure commitment	Major	Possible	High	Yes	• Support the MoH's annual planning process and ensure budget for vaccines is incorporated to meet commitments.	PD, TF	Each year
	6.6	IMCI trainees do not implement acquired skills to standard.	• Secondary level paediatric care not delivered safely at sub-divisional level and/or referrals to divisional hospitals continue.	• Development of standardised IMCI policies and procedures for nurses • Train IMCI supervisors, identify IMCI champions, IMCI attachments	Moderate	Unlikely	Low	Yes	• Continue with existing controls and evaluate the training to establish whether objectives are being met.	TF	2013

To improve prevention and management of diabetes at decentralized levels	7.1	Non-Communicable Disease Policy not finalised and released by MOH.	• Lack of clear strategic direction and policy for NCDs.	NCD Policy has been drafted, but needs to be reviewed by MOH/key stakeholders before dissemination to wider audience for further comment.	Moderate	Unlikely	Low	Yes	• Policy and Planning Unit strengthened to oversee policy direction for the Ministry	PD, LTA Policy & Planning	2013
	7.2	Lack of food nutrient standards in Fiji contributing to intake of high risk foods that contribute to diabetes and hypertension.	• Diabetes not prevented through inability of population to make informed lifestyle choices	• Food Security Task Force in place who is addressing this issue. FHSSP Technical Facilitator is a member of the task force.	Moderate	Possible	Moderate	No	• This is out of the scope of FHSSP however the TF is available to provide technical support where requested. • An enabling environment is very important to the achievement of this Program Objective.	TF	2013
	7.3	Weak procurement processes within MOH/FPBS may impact on sustainability of NCD program (procurement of NCD kits and consumables) when transferred over to them.	• NCD kits and consumables not procured post-FHSSP, resulting in no new kits and exisiting ones being unusable due to lack of consumables. • Impact on capacity of health workers to undertake screening activities.	• Currently FHSSP is procuring the NCD toolkits and consumables outside of MOH processes.	Moderate	Possible	Moderate	No	• Support to FPBS to strengthen procurement services as requested by MOH.	TF	2013
	7.4	Lack of counterpart or focal point within MoH for the work associated with the NCD Hubs/National Diabetes Centre	• Work will stall and this will impact on the ability to support the NCD hubs and the National Diabetes Centre.	Work with the MoH to identify a counterpart or strengthen the focal point within the MoH for this work. If this cannot be done, FHSSP need to identify how best to support and progress this work, within the limitations faced.	Major	Likely	High	No	Work with the MoH to identify a counterpart or strengthen the focal point within the MoH for this work. If this cannot be done, FHSSP need to identify how best to support and progress this work, within the limitations faced.	TF, Director, STA Infrastructure	2013

	7.5	Media campaigns to promote healthy lifestyle choices do not result in behaviour change.	• Minimal behaviour change amongst the Fijian population in regards to adopting healthy lifestyle habits and therefore prevention of diabetes and hypertension.	• Messages developed in consultation with MoH	Major	Likely	High	No	• Evaluate effectiveness of previous campaigns. • Identify a more specific target group for future strategic health communication campaign (rather than general population) to enable targeted campaign. • Ensure M&E built into future campaigns. • Fund activities that facilitate the development of an enabling environment over general awareness campaigns (which have not been proven to generate behaviour change).	TF, LTA M&E, Market Research Contractor	2013
	7.6	Significant infrastructure expansion diverting human and financial resources away from SDH upgrades	Delays to establishment of quality diabetes centres in all SDH	Engagement of STA and ATF Infrastructure to help progress SDH scoping and upgrades	Major	Likely	High	No	Continued engagement of Program and AusAID with MoH to adopt most effective and efficient infrastructure option. Continuation of contract of STA Infrastructure to help manage the scoping and upgrading process.	PD	Ongoing

To revitalise an effective and sustainable network of community health workers (CHWs) as the first point of contact with the health system for people at community level.	8.1	The CHW program relies upon unpaid volunteers (mainly women) to fill the positions so this creates issues around managing work performance, standards and its sustainability.	• High turnover of CHW and the need to continuously train them	• Minimal controls in place	Major	Likely	High	No	• Working with communities and settlements to embed community health workers as part of their community structures with supportive mechanisms in place.	MoH, TF	Ongoing
	8.2	Unrealistic community expectation developed by the CHW program for CHWs to provide all health related advice and information.	• Community expectations not met. • Lack of support for the CHW program	• Minimal controls in place	Major	Likely	High	No	• Desk based review of other CHW/Community Health Volunteer programs for lessons learned and models that could be adopted into the Fiji program. • Educate community leaders in the scope of work that can be undertaken by the CHWs.	TF	Ongoing
	8.3	Lack of MoH focal point and policy direction for the CHW program	• Heavy reliance on FHSSP to make this program work	• Joint Steering Committee to maintain cross-ministrial and agency coordination and commitment	Major	Likely	High	No	• Working with Provincial and Rural Development and i-Taukei ministries to embed CHW as part of their programs for support • Supporting gender and social analysis work on the CHW to better inform the MoH in the development of a policy for CHW	TF	Ongoing

	8.4	Slow pace of implementation of CHW component	Program objective unlikely to be achieved as stated	AusAID, PCC and FHSSP are aware of the risk and are initiating mitigation measures	Major	Likely	High	No	Program objective revised to reflect realities of what can be achieved in the 2 years remaining. Future support will focus on a demonstration pilot in the Northern Division that will be reviewed after 12 months to assess progress and potential to be used as a model for future roll-out to other divisions	PD	Ongoing
To strengthen key components of the health system to support decentralised service delivery	9.1	Improvements to the PHIS do not result in improved reporting and use of public health information data.	• Poor planning and decision making	• Extensive training being undertaken to introduce and educate MoH staff on the use of the PHIS system. • New PHIS software being developed to support the system.	Moderate	Possible	Moderate	Yes	• Continue with existing controls and monitor progress.	TF	Ongoing
	9.2	Ineffective and inefficient use of data for policy planning and service delivery that is exacerbated by critical knowledge gaps.	• Poor planning and decision making	• LTA Policy & Planning supporting the MOH's Policy & Planning Unit.	Major	Likely	High	No	• Plan to support development of health services plan to support capital works program in Nasouri-Suva area. • Other Technical Advisers and TSOs be better utilised to support the development of systems capacity within various Units to plan, implement and monitor in accordance with	LTA Policy & Planning, TA, TSOs	Ongoing

									established (or new) standards.		

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