Health Resource Facility
for Australia's Aid Program

High Level Strategic Review

Fiji Health Sector Support Program

Final report

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Acronyms

AbtJTA	The FHSSP managing contractor
ACP	MoH Annual Corporate Plan
ANC	Antenatal Care
APA	Assistant Program Administrator
ATF	Assistant Technical Facilitator
AUD	Australian Dollar
CHN	Community Health Nurse
CHW	Community Health Worker
CSN	Clinical Service Network
CWM	Colonial War Memorial (Hospital)
DPD	Deputy Program Director
EmONC	Emergency Obstetric and New Born Care
PI	Expanded Program on Immunisation
FAC	PCC Finance and Audit Committee
FHSSP	Fiji Health Sector Support Program
FJD	Fijian Dollar
FMHSR	Fiji Maternal Health Services Review and Strategic Action Plan (Dec 2013)
GoA	Government of Australia
GoF	(Interim) Government of Fiji
HC	Health Centre
HIS	Health Information System
HiT	Health in Transition Report (Asia Pacific Health Observatory commissioned for GoF/MoH)
HPV	Human Papilloma Virus
HR	Human Resources
IMCI	Integrated Management of Childhood Illness
LTA	Long Term Adviser
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MEF	Monitoring & Evaluation Framework
MCH	Maternal and Child Health
MoFA	Ministry of Foreign Affairs, Fiji
MoH	Ministry of Health
MSHIS	Mother Safe Hospital Initiatives Standards

MTR	Mid-term review
NCD	Non Communicable Disease
OB/GYN	Obstetrics/Gynaecology
PATISPlus	Patient Information System
PEN	WHO Package of Essential NCD Interventions
PCC	Program Coordinating Committee
PD	Program Director
PHIS	Public Health Information System
PMG	Program Management Group
RSSED	GoF *Roadmap for Democracy and Sustainable Socio-Economic Development*
SDH	Sub-Divisional Hospital
SPA	Senior Program Administrator
STA	Short-term Advisor
STSPT	Service Targets Staff Projection Tool
TF	Technical Facilitator
TOT	Training of Trainers
CHW	Community Health Worker
VIA	Visual Inspection of Acetic Acid
WISN	Workload Indicators of Staffing Need
WHO	World Health Organization

Executive Summary

This is the report of a high-level strategic review of the Fiji Health Sector Support Program (FHSSP) on its Phase 2 (1 July 2014 to 30 June 2016) focus and scope, program management arrangements, and platforms for possible Australian government (GoA) support after FHSSP.

A 2013 TAG MTR recommended that FHSSP proceed to a two-year Phase 2 from mid-2014. This Review concludes that in Phase 2 FHSSP should focus its activities for maximum impact and avoid doing the large number of activities, with at times overly broad focus, of Phase 1.

The review findings include that FHSSP:

- is providing important support to MOH and is aligned with both its strategic direction and current issues;
- has good synergies, linkages and relationships, internal and external;
- responded well to the 2012-2013 GoA-initiated scale up and scale down, with some positive consequences, and has supported national emergency efforts.

The review recommends that in Phase 2, FHSSP should:

- clarify its objectives (see annex 5) given definitional ambiguity around 'decentralised' levels and to allow an appropriate sharpening of focus, where this is not at the decentralised level;
- sharply focus strategies and activities for maximum impact, value-for-money and sustainability, for example by
    - focusing the safe motherhood component on the six facilities where 85 per cent of births take place;
    - focusing the diabetes component on the critical gap in the continuum of care of provision of clinical services for those who have undergone screening to prevent foot sepsis and amputations;
- be more succinct and results-oriented in its reporting;
- adjust some staffing to better suit Phase 2.

Any future GoA support after FHSSP will be informed by a variety of interdependent factors including lessons learned and better data and analysis available from Phase 2, including increased understanding of the causes of maternal and infant mortality; health policy priorities after the 2014 Fiji elections and Australian government priorities; and progress in all FHSSP objectives informing sustainability and impact of FHSSP support.

Future programming should also address health system weaknesses, harmonising with the work of other donors, for example WHO's Asia Pacific health system observatory work on the Health in Transition (HiT) profile, which describes the health system in some detail. The inevitable growth in NCDs will put pressure on the national health budget, and, as for most of the Pacific, sustainable health financing will be a critical issue to be addressed.

In general, a possible approach to future Australian government support should focus on health priorities and health system strengthening to support their sustainable targeting. Experience in other countries would suggest that there should be a move towards a higher proportion of aid being provided as flexible funding through government systems, where minimal conditions exist for using such an approach.

The Review Team sincerely thanks all those who gave so generously of their time and insights to assist its thinking and deliberations.

The key recommendations are:

- FHSSP Phase 2 develop a two-year Work Plan anchored within the current results-based Monitoring and Evaluation Framework (MEF) IV, which includes exit strategies and intended operational research to gather evidence of impact.
- FHSSP contract a planning expert as a short term adviser to support the MoH strategic planning for 2016-2020, working in close liaison with the M&E, HIS and other FHSSP advisers/TFs, and including supporting the integration and alignment of all other MoH strategic plans.
- MoH endorse the proposal for the national HR Network taking responsibility for cascading gender equity learning and development as well as its mainstreaming throughout the health system in Phase 2, with FHSSP support.
- Endorse FHSSP recommendations to base Phase 2 safe motherhood initiatives on the anticipated April 2014 Rapid Formative Research on Barriers to Antenatal Care and more comprehensive antenatal visits data capture; on a proposed new study analysing the causes of maternal mortality in Fiji; and on the MSHIS audit data of the six hospitals where 85 per cent of babies are born.
- FHSSP Phase 2 continue current approach of immunisation support based on the MOU between GoA and GoF; shift the IMCI focus to health centres; develop a team of learning and development facilitators for IMCI and paediatric standards for sustainability; and support MoH to analyse causes of infant mortality and develop targeted strategies.
- FHSSP have an NCD focus in Phase 2 on (i) reducing diabetic-related foot sepsis and consequent amputation, aligned with WHO's Package of Essential NCD Interventions with new short term adviser (STA) support and (ii) supporting MoH nationalise cervical screening using Visual Inspection of Acetic Acid (VIA).
- FHSSP continue approach established in Phase I to develop a cadre of learning and development facilitators for CHW core and other technical competencies and support their rolling-out of a CHW program of learning.
- FHSSP continue HIS, M&E, and workforce advisor support during Phase 2, including for (i) PATISPlus and a revised HIS strategic plan, (ii) a results-based MoH 2016-2020 strategic plan, (iii) workforce mapping and strategy development, including attraction and retention of midwives currently not working as midwives, capacity building for tubal ligation services and advocating with MoH/Fiji Nursing Association for contraceptive implant insertion/removal to be included in nurses' scope of practice.
- The PCC agree that Phase 1 FHSSP governance and management arrangements continue for Phase 2, and consider augmenting the PCC by appointing an independent health system development expert to the PCC to provide independent expert technical input to debate and decisions.
- FHSSP streamline its management structure and advertises for locally engaged PD and DPD, and a local or internationally engaged SPA, rolls over the contracts for continuing technical facilitators/advisors and advertises for new short term advisors in planning and diabetic foot care, based on the Review's recommendations and the agreed Phase 2 work plan.

1. Background

The purpose of this assignment was a high-level strategic review of the current FHSSP, given an evolving operating and political environment, and to provide recommendations for the direction of FHSSP Phase 2 assistance (2014-2016). The TORs are provided at Annex 1.

The objectives of the review were:

- To review the scope of Australia's bilateral health assistance to Fiji and provide advice on FHSSP Phase 2 assistance (2014-2016) based on lessons learnt during Phase 1 (2011-2014)
- To review the current management and personnel model and make recommendations for increased efficiency
- To recommend a more focused program of assistance during Phase 2
- Recommend program strategic direction for 2014-2016 which will help set the scene for Australian bilateral health assistance beyond 2016.

FHSSP follows on from two previous GoA health sector support programs - the five-year Fiji Health Sector Improvement Program (FHSIP) and the Fiji Health Management Reform Project (FHMRP) which supported Fiji's health system decentralisation.

A 2013 Technical Advisory group (TAG) review of the FHSSP recommended that the program continue to Phase 2. The FHSSP design aligns with GoA-required policies, guidelines and frameworks for aid effectiveness.

The goal of FHSSP is:

> *To remain engaged in Fiji's health sector by contributing to the Fiji MoH efforts to achieve its higher level strategic objectives in relation to reducing infant mortality (MDG4), improving maternal health (MDG5), and the prevention and management of diabetes, as outlined in the MoH's strategic plan 2011-2015.*

The report includes suggested underlying principles for Phase 2 against which activities should be tested before proceeding, and high-level Phase 2 approaches for each objective. Activity details are to be developed at the late March/April 2014 FHSSP planning, for approval by the May PCC.

2. Review Methodology

The two-person review team used a rapid assessment approach, analysed relevant documents (Annex 2) and consulted with key stakeholders (Annex 3) by phone in Australia and face-to-face in Fiji over a one week period. Recommendations for Phase 2 are grounded within the scope of the original contracted FHSSP framework, and are based on MoH progress, lessons learned and issues in Phase 1 and the need for better data.[1] The recommendations aim to ensure clear foci of strategic approaches for greatest value-for-money, impact and sustainability.

[1] Data quoted in this Review is mainly from the 2012 MoH annual report; 2013 MoH data is not yet available, and will not be until possibly Q3 2014.

3. Situation Analysis[2]

3.1. Overview

With a population in 2014 of 896,758[3], Fiji has 300 islands, 110 of them populated. Since 2006 Fiji has been under military rule, the third time since its independence from Britain in 1970. Democratic elections are planned for later in 2014. Per capita income has decreased since 2006, reducing taxation revenue, through which Fiji's health system is largely funded, and the health budget has decreased to 3.8% of GDP in 2013[4], down from 4.3% in 2009. Urban drift and squatter settlements on urban fringes are contributed to by land leases expiring and the need to find work.

The Fiji government's primary policy platform is the 2009-2014 Roadmap for Democracy and Sustainable Socio-Economic Development (RSSED). MoH's strategic plan and annual corporate plans (ACPs) align with its health-related policy objectives:

- Communities are served with adequate primary and preventive health services thereby protecting, promoting and supporting their well-being.
- Communities have access to effective and quality clinical health care and rehabilitation services.
- Health system strengthening is undertaken at all levels of the Ministry.

Fiji's health system is partially decentralised through a divisional structure,[5] within the frameworks of the MoH five-year strategic plan, ACPs, and overall leadership of the MoH. Human resource, finance and procurement functions remain centralised. Fiji's comprehensive and multi-tiered health system includes a national referral hospital (the Colonial War Memorial Hospital in Suva), and two divisional hospitals[6], sixteen sub-divisional hospitals, 77 health centres (HCs), and 101 nursing stations. In addition, the MoH trains community members as (unpaid) community health workers (CHWs). There is small private health sector, primarily smaller hospitals and 130 private general practitioners mainly in urban areas.

The MoH has recently developed a draft 'wellness' policy as an overarching and cross-cutting strategic direction, while hospitals continue to absorb an increasing proportion of the reduced health budget. At 3.8 per cent, Fiji's health budget as a proportion of GDP is less than most other countries in the Pacific (e.g. Papua New Guinea, 4.3 per cent; Samoa 7 per cent; Solomon Islands 8.8 per cent; Tonga 5.3 per cent) and a long way behind more developed countries (e.g. Australia 9.0 per cent; New Zealand 10.1 per cent).[7] It is anticipated that the new wellness approach will be fully integrated with the next MoH five-year strategic plan, 2016-2020 and be fully reflected in the MoH indicators.

3.2. Australian Support

GOA and other donors have long supported Fiji's health sector. The five-year Fiji Health Management Reform Project (FHMRP), from 1998-2003, focused on components of health system strengthening including data capture and information use[8], leadership and management, human resources for health, planning, and financial management. The Kadavu and Taveuni community health projects supported primary health care. The five-year Fiji Health Sector Improvement Program (FHSIP) followed FHMRP in 2005. FHSIP had

[2] This section has been informed by Living HiTs Fiji. Asia Pacific Observatory. 2014.
[3] www.countrymeters.info/en/Fiji.
[4] WB figures, as quoted in the FHSSP Fiji Maternal Health services Review. December 2013.
[5] Central and Eastern, with 'head office' in Suva; Western in Lautoka; and Northern in Labasa.
[6] In Suva, Lautoka, and Labasa.
[7] World Bank data derived from World Development Indicators. www.data.worldbank.org.
[8] PATIS, Fiji's Patient Information System, was developed during FHMRP.

a broad remit, from patient safety to the supply of boats for patient transport. The assessment at the end of FHSIP[9] found that the program design could have benefited from closer targeting of Fiji's key performance indicators, including MDG goals. Australia has also provided support to the former Fiji Schools of Medicine and Nursing, to vaccination, and, as part of a broader community development program, is currently supporting a community grants program which includes community health worker support, separate to FHSSP.

3.3. Fiji Health Sector Support Project Overview

FHSSP commenced mid-2011, with an original budget of AUD25 million over 5 years. FHSSP represents about 1 per cent of the Fiji MoH's budget. A 2013 mid term review (MTR) by the FHSSP Technical Advisory Group (TAG) found that FHSSP targeted Fiji's key health issues, and that its three year Phase 1 should continue to a two-year Phase 2, with the same managing contractor. It found that, despite natural disasters and some fluctuation of funding levels (a significant scale-up closely followed by a scale-down) due to changes in Australia's funding environment, FHSSP was robust and responsive, enjoyed good relationships with the MoH, and was achieving. FHSSP refocused in the areas of M&E, workforce policy and strategies and health information – approaches that were endorsed by the TAG. Some key technical reviews were commissioned by FHSSP in 2012/2013 on maternal health services, NCDs, PATISPlus, PHIS, and gender equity and they have been useful to this Review's thinking for Phase 2.

FHSSP has five objectives relating to: (1) safe motherhood, (2) healthy child, (3) community health worker revitalisation (4) prevention and management of diabetes and hypertension, and (5) targeted health system strengthening. Objective 5 addresses key factors negatively impacting on objectives 1-4: health workforce issues, data capture and information use, and monitoring and evaluation. Each of the five areas reflected in the FHSSP objectives is now discussed in sequence, providing both a backdrop and linkages to the following section, Findings and Recommendations.

3.4. Safe Motherhood

The December 2013 *Fiji Maternal Health Services Review and Strategic Action Plan* (FMHSR) found that the MMR five-year rolling average steeply declined since the 1970s, with a slower decline since the 1980s, and a slight increase in the rolling average from 2011-12, from 39.2 to 59.2/100,000. [10] The MDG MMR is 10.6 and is unlikely to be reached.

Data is such that the cause of death cannot always be verified, but analysis indicates over a quarter of direct maternal deaths are early pregnancy emergencies (septic abortion and ectopic pregnancies). Low uptake of antenatal care in the first trimester of pregnancy and not seeking care early enough in an emergency, are contributing factors. Access is difficult from some rural and remote areas. Fiji's infant mortality rate was 15.2/1,000 live births in 2006[11]; this, and the number of stillbirths and perinatal deaths, remain of concern[12] .

The MHS Review made a clear statement on the strategic response required in Fiji:

> *"The…analysis carried out during this review confirms the challenge of moving beyond the enumeration of maternal and perinatal deaths to understanding the factors associated with adverse outcomes. This move is vital…if Fiji is to achieve and maintain lower rates of maternal and perinatal mortality."*

[9] Sutton et al. DFAT. 2010.

[10] 2012 MOH Annual Report table 12 page 49Fiji's small numbers means that one or two more, or less, deaths, has a significant effect on MMR.

[11] Fiji Bureau of Statistics. 2006 Census.

[12] *Fiji Maternal Health Services Review and Strategic Action Plan.* FHSSP.

More than 85 per cent of all births take place in three divisional hospitals and three subdivisional hospitals, none of which are "Mother Safe" compliant.[13] The MoH 2014 ACR target is five (5) subdivisional hospitals 'Mother Safe' compliant by end 2014.

While there is a longstanding pattern of hospital deliveries in Fiji, which has contributed to the low maternal mortality in Fiji, the divisional hospitals are overcrowded and many services could be more efficiently provided at lower levels of the health system. The FMHSR review reported that a high proportion of women go to hospital for their first antenatal visit. The review recommended upgrading the sub-divisional hospitals (SDHs) with current high delivery loads, to full international EmONC capability, to reduce travel time and relieve crowding at the divisional hospitals. Also recommended was a trial of midwife-led PNC at urban health centres (HCs) for those women whose pregnancy and delivery were normal. There is an official ban on trained and licensed nurses inserting contraceptive implants which hinders integrating this aspect of family planning in PNC. This, and the unavailability of tubal ligations due to medical specialist shortages, in particular an extreme shortage of anaesthetists, contributes to the large number of unplanned pregnancies in Fiji.

Antenatal counselling services including on HIV/STI, mental health, domestic violence and other social issues, are also provided by Empower Pacific, which is co-funded by MoH and FHSSP in 2014.

3.5. Healthy Child

Fiji's immunisation rates are excellent, after much and continuing effort, including with GoA support. There are three new vaccines available: HPV for cervical cancer, Rotavirus and Pneumococcal. There are also new child health records and communication strategies supporting the vaccine initiative. GoF and GoA have agreed a four-year cost-sharing approach for vaccine procurement to the end of Phase 2, and that the Murdoch Children's Institute in Australia will evaluate the vaccination program.

IMCI has also been a focus in Phase 1 at sub-divisional hospital level, through learning and development programs and some procurement. However, a large number of women attend health centres to access post natal care for their babies, and Community Health Workers (CHWs) are also a key part of ensuring healthy children. There has also been strong support for paediatric clinical guidelines, with the paediatric CSN endorsing WHO's 'pocket book' on guidelines for medical management of sick children.[14]

3.6. Prevention and Management of Diabetes and Hypertension

Despite a focus on health promotion and disease prevention over the last three decades at least, there has been little impact in Fiji on NCDs and their incidence continues to rise. From 2002 to 2011, for example, there was an increase from 23.6 to 32.1 per cent of people who are overweight, and an increase from 19.6 to 29.6 per cent in the number of people with a raised fasting blood glucose,[15] indicating risk of Type II diabetes. NCDs result from a complex set of interdependent factors including social policies, lifestyle, diet and genetics.

To reduce the incidence, prevent an increase in incidence, or prevent complications arising from NCDs, a strong primary health care system is needed, as well as healthy habits along the lifecycle, and well-coordinated and focused multi-sectoral action. Fiji has pieces of these but there are gaps: for example in focused multi-sectoral action[16] [17], and in prevention of

[13] Three SDH: Nadi, Sigatoka and Nausori. And three divisional hospitals: Labasa, CWMH, Lautoka.

[14] Paediatric Life Support (PLS); Advanced Paediatric Life Support (APLS); and Clinical protocols detailed in the WHO (2013) *Hospital care for sick children: Guidelines for the Management of Common Childhood Illnesses 2nd edition* (Pocket book). The Pocket Book has been endorsed by the Paediatric CSN as the Standard Treatment Guideline for sick children at SDHs.

[15] *Non-communicable Diseases Strategic Plan. 2015-2019.* FHSSP.

[16] *Living HiTs, Fiji*, Asia Pacific Observatory. 2014.

complications, for example, foot amputation from diabetic foot sepsis.[18] Without well-coordinated multi-sectoral action, with a whole of government approach to create healthy environments, or avoid obesogenic environments, health promotion efforts alone have reduced impact. Without adequate clinical responses, better diagnosis does not equal improved outcomes from NCD-related complications, and can act as a disincentive for people to access screening services.

Cervical cancer is the second highest cause of death in Fijian women aged 15-49 years. In Phase 1 there was a successful trial of Visual Inspection of Acetic Acid (VIA).[19] VIA is provided at the community level and is cheaper than PAP smears and diagnosis and treatment immediate. The more expensive PAP smears have a lag time of several weeks for results and follow up does not reach all women tested.

NCDs, particularly cardiovascular disease, have a major impact on maternal and child mortality and morbidity; the (maternal) review cited above, recommends pre-pregnancy screening of high school girls for NCDs, which would prevent some NCD-related complications in pregnancy (cardiac issues from rheumatic fever).

3.7. Revitalising CHW

In the 1970s, Fiji developed a PHC system based on community health workers[20] and health centres. The strength of this PHC system has diminished over the last 15 years in parallel with the increasing urban drift, and also perhaps because people prefer to seek health care where there is a wider range of services than can be provided by CHWs or health centres (HCs). The 130 mainly urban-based general practitioners (GPs) are a key part of urban PHC. Urban squatter communities provide a further challenge for strengthening PHC, with community support systems and relationships differing from those traditionally found in villages, and access to GPs not affordable for all. The MoH has a strong focus on strengthening primary health care through CHWs, with active debates on their role. In Phase 1 core competencies were agreed by the MoH and learning and development packages developed.

The FMHSR found that in most settings visited, the community played a passive role in relation to the health service, and that opportunities for health service providers to understand local priorities and to tap local goodwill and resources are often missed. The CHWs' role, as defined through the core and additional technical competencies, will be critical to community engagement, and the achievement of reduced maternal and infant mortality, and to aspects of NCD management proposed later in this report, as well as to other public health areas.

3.8. Targeted Health System Strengthening

There are health workforce shortages and imbalances, exacerbated by high emigration rates, a mandatory early retirement age since 2006 of 55, and high staff internal rotation and turnover. FHSSP and WHO are closely collaborating to support the strengthening of workforce policies and strategies. For example, there are said to be some hundreds of midwives not working as midwives, but few strategies to encourage them to return to the workforce (e.g. flexible working hours or free refresher courses). There are shortages of various types of medical specialists impacting on services and people's health. The FMHSR found that, overall, 40 per cent of senior specialty posts for three critical disciplines -

[17] *Non-communicable Strategic Plan. 2015-2019*. FHSSP.

[18] MoH Strategic Plan 2011-2015, Health Outcome 1, Objective 1.1.

[19] VIA entails washing of the cervix with acetic acid (vinegar), which picks up lesions that can be seen, and then treated with cryotherapy.

[20] Village Health Workers were from indigenous Fijian villages and Community Health Workers from villages with Indian ethnicity background; the generic term 'community health worker' was introduced in 2013/2014.

obstetricians, anaesthetists and paediatricians - are vacant. There are calls from senior MoH officials for recognition of nursing specialities in career structures. There is a 2014 update of the GoF Strategic Workforce Plan 2013-2017, which reflects progress in some needed reforms.

The MoH has moved in the last 18 months to a results-based planning framework, still in progress but reflected in a new M&E framework, supported well by the new PHIS, but not supported well by PATISPlus. Although PATISPlus is being rapidly strengthened, it is not yet able to provide data which gives confidence. PATISPlus strengthening includes other 'products' that are needed for a robust health information system, including a National Health Data Dictionary, which is underway. Parallel paper systems are being used, and there are data gaps. The aim is a user friendly, efficient and effective PATISPlus by the end of FHSSP, a bold challenge which is, however, on track. PHIS is new and also needs Phase 2 support for sustainability.

The third pillar of the RSSED is 'to ensure enlightened and accountable leadership'. Gender equality and women's development is a target. Fiji is also a signatory to the Biwako Millenium Framework for Action, 2003-2012 where the aim is an inclusive, barrier free and rights based society for people with disabilities in the Pacific.[21] The MoH ACP includes gender equity indicators including mainstreaming gender activities, increasing the focus on men's health, and increasing women's participation in key MoH roles. The Prime Minister's Office assessed MoH's gender performance as poor, and FHSSP is building gender awareness capacity during Q1 and Q2 of 2014. The gender division at DFAT Canberra, supported by the Pacific regional health advisor, have recently commissioned a gender, equity and social inclusion (GESI) appraisal of DFAT's health programming in the Pacific to support further roll out of this approach.

Infrastructure was also a feature of Phase 1. FHSSP provided various levels of support to the proposed Nausori Subdivisional Hospital, Makoi Low Risk Birthing Unit, extensions and renovations in Sigatoka, and roof repairs, and renovations in Levuka. SDH renovations were prioritised in the scale up, with only two then completed by end Phase 1, due to the scale down.

4. Findings and Recommendations

4.1. Phase 2 Overview

FHSSP is aligned with MoH strategic directions and current issues and has good synergies, linkages and relationships. Phase 1 has been busy with the many activities for each objective to be designed, managed, monitored and evaluated, as well as managing the scaling up and scaling down, and supporting MoH respond to natural disasters and a dengue fever outbreak. Despite these challenges, the 2013 TAG MTR found that Phase 1 was managed well. The Review confirmed this and that FHSSP is providing important support to MoH's achievements.

FHSSP uses evidence where it is available, and the MoH has moved quickly in Phase 1 to reorient its planning and M&E to a results-based framework. These have highlighted data gaps, and the need for strengthened use of data and information where available for planning, management, monitoring and evaluation.

A risk for Phase 2 is FHSSP continuing its heavy load of activities where the focus is sometimes overly broad. Strategies and interventions in Phase 2 need to be sharply focused, for impact, consolidation, sustainability and smooth exiting. For example, Phase 1

[21] *Gender Equality and Social Inclusion Strategy.* 2012. FHSSP.

safe motherhood efforts are focused at sub-divisional level, when 85 per cent of births occur at six hospitals, three divisional and three sub-divisional. Having safe motherhood in the hospitals where most mothers give birth in Fiji seems to the Reviewers to be an ethical priority, notwithstanding current crowding. Cascading these standards to other SDHs where fewer babies are born is perhaps something for support after FHSSP.

The NCD screening focus in Phase 1 has highlighted the need for strengthening clinical responses to the complications of NCDs, e.g. to prevent death or foot amputation from diabetic foot sepsis. In Phase 1, FHSSP conducted a large number of learning and development programs. A consistent Training of Trainers (TOT) approach, fully harmonised with MoH workforce efforts to achieve MOH's strategic and operational priorities, will be required in Phase 2 to support sustainability and exiting.

Strategic approaches for each objective in Phase 2 are proposed from sections 4.2 through 4.8 below, **and are in bold**. Activities and budgets will be developed in a FHSSP Phase 2 planning process to take place in Fiji in March/April 2014. To maximise focus on impact, exiting and sustainability, a two-year work plan is proposed, updated at twelve months, which should also provide for a completion report. This two-year Phase 2 plan should remain anchored within the current results-based Monitoring and Evaluation Framework (MEF) version 4, to mirror and align with the new results-based approach of MoH currently in progress. The MEF, as a living document, will be revised based on the results of the planning for Phase 2, as well as to draw more heavily on the MoH results-based framework.

It is further proposed that all Phase 2 strategies and activities should be tested by the Program Coordinating Committee (PCC) against the following principles before being agreed:

i. be within clear parameters
ii. be transparently and sharply focused on achieving each objective
iii. be designed to build up evidence of impact and results
iv. ensure value-for-money and be within FHSSP budget
v. maximise sustainability potential at exit.

For building up evidence of impact and results, the current work on data integrity and use (through PATISPlus remediation and PHIS) will be important. Well targeted operational research studies, focused on impact, may also be required.

To support the FHSSP Phase 2 planning, and to further support MoH's development of its next five-year strategic plan (2016-2020), one FHSSP short term adviser (STA) for planning is proposed, working in close liaison with the MoH and with the FHSSP M&E, HIS and other advisers/TFs. The MoH may also like to consider that, as part of this planning process support, all other MoH strategic plans on specific topics (e.g. NCDs, workforce) are revised and aligned within the framework of the MoH Strategic Plan 2016-2020.

Recommendations

FHSSP Phase 2 develop a two-year Work Plan anchored within the current results-based MEF vs 4, , which includes exit strategies and intended operational research to gather evidence of impact. This Work Plan, along with a revised MEF, incorporating results of Phase 2 planning and specifying the requirement for a completion report, should be signed off by the PCC in May 2014.

FHSSP contract a planning expert as a short term adviser to support the MoH strategic planning for 2016-2020, working in close liaison with the M&E, HIS and other FHSSP advisers/TFs, and including integration and alignment of all other MoH strategic plans.

4.2. Gender Equity Integration

FHSSP support for MoH gender equity capacity building is in progress. The gender equity learning and development package was developed by the Queensland University of Technology who also provided the first round of training to the senior executive. The curricula will be shared with the Ministry of Women, Social Welfare, and Poverty Alleviation, the Fiji government's lead agency for gender training. FHSSP's plan for Phase 2 support for gender equity is to **cascade gender equity capacity building through the HR Network** with the Network then assuming responsibility for further gender equity work in Phase 2 and beyond. This type of system-wide integration would be in line with current international thinking, which is to move beyond a gender focal point[22] and is endorsed by the Review team. MoH advises that gender equity and gender inclusion will be an integral part of the MoH's 2016-2020 strategic plan, and reflected in each ACP.

FHSSP documents its own gender mainstreaming through a gender mainstreaming matrix[23] and uses the MoH gender equity indicators within objective 5. Gender disaggregated data collection should continue in Phase 2, and gender equity mainstreaming approaches reflected in all strategies and activities. In designing any future support to Fiji's health sector after FHSSP, the input of a gender equity design expert would be useful.

Recommendations

DFAT consider including a gender equity design expert if there is GoA support after FHSSP.

MoH endorse the proposal for the HR Network taking responsibility for cascading gender equity learning and development and its mainstreaming throughout the health system in Phase 2.

4.3. FHSSP Objectives

The objectives of FHSSP are stated differently in various documents, including within the GoA/managing contractor contract. There is also definitional ambiguity for 'decentralised levels', a phrase used in some FHSSP objectives. Decentralisation originally meant the decentralisation of some decision-making powers from MoH to divisional level.[24] In FHSSP, decentralisation appears to mean sub-divisional hospital level or less. In Phase 2, if this definition is retained, some proposed strategies to sharpen the focus in Phase 2 will not be possible without renegotiating the objectives (for example, objective 1 for safe mothers currently specifies 'decentralised levels', but this Review proposes to also include divisional hospitals). Annex 5 contains a table showing the variations in the wording of the objectives and the wording recommended for Phase 2 to ensure clarity and therefore assist a clear and sharp focus in Phase 2. The 2013 TAG MTR recommendations to change the objectives to reflect that the program "contributed to" rather than was entirely responsible for result, have been superseded, in the Reviewers' view, by the strengthened M&E framework and results based approach.

FHSSP suggested merging objectives 1 and 2 (safe mothers and safe babies) in Phase 2. While there are obvious linkages, we recommend that safe mother and safe baby should remain separate objectives, for ease of planning and clarity of reporting, but should be managed together to maximise synergies and efficiency.

Recommendations

DFAT, MoH and the MC renegotiate FHSSP objectives for Phase 2, adjusting them for clarity.

[22] Mehra and Gupta, 2006, as quoted in the FHSSP Gender and Social Inclusion Strategy, 2012. P. 20.
[23] See FHSSP Workplan for the six months to end Phase 1, June 2014.
[24] See FHMRP documentation (1998-2003).

FHSSP manage objectives 1 and 2 together by the appropriate TF/adviser in Phase 2.

4.4. FHSSP Objective 1

Proposed: To institutionalise a safe motherhood program

Formerly: To institutionalise a safe motherhood program at decentralised levels

MMR data from 2013 is not yet available, but indicators are that MMR has not decreased. In line with the recommendations of the maternal health review cited earlier, analysis of the causes of maternal death is an imperative, if strategies and activities are to be appropriately targeted in Phase 2 and beyond. We propose FHSSP Phase 2 support to MoH and the relevant Clinical Services Network (CSN) to **analyse the causes of MMR** when 2013 data is available (expected in 3rd quarter 2014). MoH/CSN can then develop, with FHSSP support, appropriate strategies to target the root causes. Early antenatal visits are critical to ensuring the safety of mothers and their babies. Because of the PATISPlus deficiencies, comprehensive and accurate data on early antenatal visits is not currently available, although indications are that early antenatal visits have increased in some areas, in response to FHSSP-supported initiatives. Comprehensive data is anticipated from mid-2014, with FHSSP continuing support, which will give a more accurate understanding of the scale of late visits.[25] **This data,** together with the proposed FHSSP April 2014 **rapid formative research on antenatal visit barriers**, will **inform the Phase 2 antenatal focus**.

For **contraception**, the Review proposes **FHSSP advocate to the OB/GYN CSN** for their leadership for a visiting surgical team, including anaesthetists, to clear the back-log of women waiting for tubal ligation (>150). This would be a short term arrangement and would need to be complemented by a longer term workforce development policy to fill the existing gaps, including the FHSSP planned activity to provide supplementary support to MoH in filling anaesthetist posts with external qualified clinicians. To **increase access to contraceptive implants, and support task shifting to appropriate levels of care, FHSSP should advocate for its inclusion in nurses' scope of practice, and provide training support if needed.**

Refocusing of safe motherhood initiatives, including EmONC and clinical practice guidelines, to the six hospitals where 85 per cent of babies[26] are born will have greatest impact and sustainability, while there will also be potential for a 'trickle down' effect to lower levels, through staff rotation. The specific Phase 2 activities should be based on the findings of the FHSSP March 2014 **gap analysis against MSHIS audit findings** in these six hospitals.

Midwife shortages are a risk to safe motherhood initiatives**,** and attraction, retention and clinical workplace availability strategies should be **vigorously addressed through workforce activities under objective 5**. We propose FHSSP **continue co-funding Empower Fiji** with the MoH, noting the budget envelope may need to be reduced[27], with **MoH assuming full funding when FHSSP ends**. There was Phase 1 support for post-miscarriage support. Given the high cause of death data from septic post abortion/ miscarriage the Review suggests support is continued in Phase 2.

[25] PHIS captures the data at SDH level and below; data from divisional hospitals where most women present is not captured because of the PATISPlus problems. Manual data is being collected at divisional hospitals but there are gaps. This is being addressed with FHSSP support, including the PATISPlus remediation. More comprehensive data should begin to be available from mid-2014.

[26] Three SDH: Nadi, Sigatoka and Nausori. And three divisional hospitals: Labasa, CWMH, Lautoka.

[27] Currently MoH funds F$250,000 pa and FHSSP F$700,000 pa. In 2013, 12,000 women (60% of new mothers) accessed Empower Fiji. Services include HIV and STI information and testing, screening for gender-based violence, mental health issues, and NCDs at some sites. Partners are also supported.

Recommendations

Endorse the FHSSP proposal that Phase 2 safe motherhood initiatives are based on i) evidence from the April 2014 Rapid Formative Research on Barriers to Antenatal Care and the anticipated more comprehensive antenatal visits data capture; ii) a proposed new study analysing the causes of maternal mortality in Fiji; and iii) the MSHIS audit data of the six hospitals where 85% of babies are born.

FHSSP advocate to OB/GYN CSN for a visiting tubal ligation surgical team to clear the >150 women on the waiting list in the short term, and to address this capacity shortage through workforce development policy.

FHSSP advocate to MoH / Fiji Nursing Association to support inclusion of contraceptive implants insertion/removal in nurses' scope of practice.

FHSSP focus support for MSHIS, EmONC and clinical practice guidelines on the six hospitals where 85 per cent of babies are born.

FHSSP fund Empower Fiji on a sliding scale, leading to full MoH funding at end FHSSP, within Phase 2 budget parameters.

4.5. FHSSP Objective 2

Proposed: To institutionalise a healthy child program

Formerly: To institutionalise a healthy child program throughout Fiji

The need to **continue vaccination support in Phase 2** is reflected in the GoF/GoA agreements on **vaccination procurement** co-funding and the ongoing **Murdoch Children's Institute Evaluation**.

In Phase I, IMCI has been focused at sub-divisional level, when mothers bring their babies also to health centres for post-natal care. For **IMCI** in Phase 2, the sub-divisional focus should be replaced, or complemented by, a **focus on health centres**, given the level of post-natal care they provide. Early in Phase 2 there should be support for **analysing the causes of infant and child mortality** to increase understanding and strengthen the health system's capacity to develop targeted responses to decrease IMR and CMR. The FMHSR focused only on early neonatal deaths (first 7 days) and found that 56.7 per cent of these deaths were unexplained.

Finally, the focus on sustainability could be enhanced by developing strong local teams of learning and development facilitators for IMCI and paediatric standards.

Recommendations

FHSSP Phase 2 continue current approach of immunisation support based on the MOU between GoA and GoF; shift the IMCI focus to health centres; develop a team of learning and development facilitators for IMCI and paediatric standards for sustainability; and support MoH to analyse causes of infant mortality and develop targeted strategies.

4.6. FHSSP Objective 3

Proposed: To improve prevention and management of specific NCDs

Formerly: To improve prevention and management of diabetes and hypertension at decentralised levels

The Phase 1 diabetes and hypertension screening program highlighted the need to strengthen diabetes management after diagnosis; the current lack of strongly coordinated multisectoral action suggests to the Reviewers that Phase 2 broad health promotion efforts through FHSSP support would have little impact. We suggest instead that MoH assume screening responsibility in Phase 2, and FHSSP focus on what the International Diabetic

Federation calls the global burden of **diabetic foot disease,** which they further highlight is a high cost to the health system, a high socio-economic cost to the patient and family, and is inexpensively and relatively easily prevented.[28] [29] This focus on **preventing diabetic foot ulcers and amputations** would provide a technical point of entry that makes diabetes 'real' to the community thereby having a wider 'health promotion' impact, and which could be delivered through CHWs and health centres, as well as diabetic clinics, GPs, hospitals, and, importantly, family and community members (through appropriate foot wear, regular foot inspections by family members, 3-6 monthly foot inspections by trained providers, and promotion of early presentation), aligning with WHO's Package of Essential NCD Interventions.[30] The purpose would be to reduce hospital admission rates and amputation rates for diabetic foot sepsis[31] and to decrease the hospital length of stay for diabetic foot sepsis to less than 15 days (these align with MoH objectives). Changes in the skill set for FHSSP NCD adviser/TF support will be required.

Cervical cancer is being tackled through the HPV vaccination for girls, as well as Visual Inspection of Acetic Acid (VIA) for women. VIA is low cost, and reportedly effective. We propose Phase 2 **support to MoH for a national VIA program** to enable MoH to continue post-FHSSP.

Recommendations

FHSSP adopt an NCD focus in Phase 2 on (i) reducing diabetic-related foot sepsis and consequent amputation, aligned with WHO's Package of Essential NCD Interventions with new STA support and (ii) supporting MoH nationalise VIA.

4.7. FHSSP Objective 4

Proposed: To strengthen primary health care through community health worker services

Formerly: To revitalise an effective and sustainable network of village/community health workers as the first point of contact with the health system for people at community level

FHSSP expressed dissatisfaction with progress on this component in Phase 1, but, on the positive side, CHW core competencies have been approved, and training manuals developed for these including pregnancy and preparing for birth, promoting healthy children, and wellness promotion (incorporating NCD causes and risk mitigation approaches). There are 1,227 CHWs active in Fiji, but the Reviewers were informed that in some areas CHWs are not active, including some squatter areas.

The MoH is actively discussing CHW-related policies and roles, which will be informed by the FHSSP-commissioned Options Paper of Specific CHW Fiji Models, currently in preparation. Phase 2 activities may therefore be further guided by any changes in MoH CHW policies. In Phase 2, FHSSP proposes training community leaders as learning and development facilitators for CHWs, on the grounds that MoH staff workloads will preclude their training CHWs. This has implications for sustainability. The Review instead proposes a TOT approach for MoH and community leaders, with MoH retaining overall responsibility for a functioning PHC system based on CHWs, given the inextricable linkages to safe mothers and safe babies and children, in objectives 1 and 2, and to foot care in objective 3.

[28] Boulton, J. M. *The Global Burden of Diabetic Foot Disease*. 2006.

[29] For example, the work of Professor Robyn McDermott et al (James Cook University) in the Torres Strait Islands.

[30] See page 27 of the WHO Package.

[31] Amputations are ~ 42% per 100 admissions for diabetes and complications; hospital admissions for diabetes-related illnesses were ~98 per 1000 hospital admissions in 2012.

Recommendations

FHSSP continue approach established in Phase I to develop a cadre of learning and development facilitators for CHW core and other technical competencies and support their rolling-out of a CHW program of learning using a TOT approach.

4.8. FHSSP Objective 5

Proposed: To strengthen key components of the health system

Formerly: To strengthen key components of the health system to support decentralised delivery

PHIS has been well received by end users who appear to be using it well. PATISPlus is being 'remediated', meaning its current glitches and user-unfriendly screens are being 'fixed' following widespread user dissatisfaction and the redevelopment of parallel paper systems. Until PATISPlus is efficient and effective for the end-user, data will not be sufficiently captured through this system. To achieve a fully functioning PATISPlus by end FHSSP, the Review proposes the current HIS STA inputs are around 8 months per annum in each year of Phase 2. Skills and knowledge transfer to MoH HIS staff should be strengthened in Phase 2, and a revised HIS Strategic Plan developed to reflect the data, information and technology changes in Fiji, and to align with and inform the MoH 2016-2020 strategic plan. The essential National Health Data Dictionary should continue to be supported in Phase 2.

In tandem with the HIS strengthening, is re-orientation of MoH planning and reporting to a results-based approach, with the support of the FHSSP STA for M&E. This re-orientation requires ongoing M&E STA support in Phase 2, and the additional support of a STA Planning to assist the alignment and/or revision of all current strategic plans with, and the development of, the MoH Strategic Plan 2016-2020. [32]

For workforce, FHSSP support should continue in Phase 2, continuing its strong support to MOH efforts including the MoH Workforce Strategic Plan (to 2017) and continuing the collaboration with WHO, including the aid of its well-tested health workforce planning software, aiming for skills transfer to the national HR network by end-FHSSP.[33] The aim by the end of Phase 2 is Fiji's the health workforce mapped, data interpreted, gaps identified, position descriptions reviewed, L&D plans developed, and attraction, deployment and retention addressed, including for attraction of midwives back to the workforce.[34]

This Review understands that there will be no further infrastructure support for SDH renovation in Phase 2. It is expensive (FJD200,000-350,000 per SDH renovation); can take a long time (e.g. land title issues in Nausori); and, importantly, MoH's 2014 capital budget has been increased from FJD 14.8 million to FJD36.8 million in 2014.[35]

Recommendations

FHSSP continue HIS, M&E, and workforce advisor support during Phase 2, including for (i) PATISPlus and a revised HIS strategic plan, (ii) a results-based MoH 2016-2020 strategic plan, (iii) workforce mapping and strategy development, including attraction and retention of midwives currently not working as midwives, capacity building for tubal ligation services and advocating with MoH/Fiji Nursing Association for contraceptive implant insertion/removal to be included in nurses' scope of practice.

[32] The Review Team proposes that the planning adviser also work with the parties at the FHSSP March 2014 Phase 2 planning, to give insight and continuity.

[33] Health HR practitioners across Fiji and senior manager champions at central, divisional and SDH levels, with skills transfer including for using WISN (workforce mapping) and STSPT (workforce targets).

[34] For example, flexible hours, refresher courses.

[35] MoH budget figures provided by FHSSP.

5. Program Matters

5.1. Program Modality

The approach to the overall delivery of the FHSSP program, including the technical assistance (TA) component, is a flexible programmatic approach that is aligned with MoH strategic priorities and allows for the annual planning and activities linked to MoH processes. The Program is a rolling design and implementation approach, based on the Ministry of Health's annual planning cycle. The managing contractor, Abt JTA, was sourced through open tender to establish and operate a resource centre to support the management and implementation of the program by the MoH. The purpose of the resource centre is to contribute to the achievement of the five Program objectives through the provision of technical and management support to the MoH, capacity building of MoH staff, equipment and supplies and minimal rehabilitation of selected public health facilities.

The role of the managing contractor is to:

- ensure that all support and activities funded through FHSSP are planned and implemented to contribute to the goal of the program and the MoH's overall strategic vision for improving the health of Fijians
- procure, manage and quality assure long term and short term TA on behalf of the MoH at national and divisional levels and in support of existing staff and structures
- manage any subcontracts that are agreed between the MoH and DFAT (for example, UN agencies, local or international NGOs, technical assistance agencies, universities, research organisations, etc. to provide TA, training or operations research, where they have a comparative advantage).

During Phase 1, evidence suggests that the placement of FHSSP within MoH structures fosters institutional strengthening, MoH ownership and sustainability. Meetings during this review with MoH directors (Deputy Secretary Public Health, NCD, Nursing and Health Systems Strengthening) and the Permanent Secretary unanimously confirmed the importance of the program and its strong, integrated and supportive role. Of particular mention was the value placed on the advisers and support staff, facilitators and extension personnel who liaise with the geographic divisions and coordinate across the Ministry. With the strong relationships it has created, the program has avoided the risk of parallel programming which could undermine MoH ownership. The program modality is thus realistic and appropriate, given the historical context, existing environment, capacity and resources at hand. For this reason it is recommended that the modality should continue in Phase 2.

5.2. Governance and Management Oversight[36]

Phase 1 FHSSP governance and management functions are carried out through the Program Coordinating Committee (PCC), the Finance and Audit Committee (FAC), the monthly MoH Directors' meeting and the quarterly Divisional Plus meetings. The PCC is the primary high-level oversight, strategic decision-making and monitoring mechanism, and as such is the highest-level governance mechanism for the Program. The Permanent Secretary of the MoH chairs the six-monthly PCC meetings, which consider high level issues, including approval of the FHSSP Annual Workplan. Membership includes MoH (4 people), DFAT (4 people), MoFA (1 person) and FHSSP (2 people), and FHSSP provides the Secretariat. To augment technical discussions, an independent health systems development expert on the PCC is proposed, contracted using FHSSP mechanisms.[37] This draws on the FHSIP Charter Board experience, including that PCC membership of an independent health systems

[36] See Annex 7, FHSSP Governance and Management Arrangements.

[37] This would differ from the Charter Board model in FHSIP where a consultant sat on the PCC but was not a member of the PCC.

strengthening expert, i.e. as a member of the PCC rather than as a consultant, may have strengthened some FHSIP PCC deliberations and decision making processes. It would be useful for this expert to be in place for the final PCC in Phase I.

FHSSP management processes were changed following recommendations made by the TAG MTR in 2013 in support of the PCC's December 2012 recommendation to disband the Program Management Group (PMG).[38]. The FHSSP management arrangements through the monthly MoH Directors' meetings and the quarterly Divisional Plus meetings, both reporting to the PCC, appear effective, and should continue. As the MoH meetings effectively replaced the Program Management Group meetings in the Governance structure, however, it is important to document clearly how they fulfil this role and make clear their reporting lines to the PCC. In Phase 2, the Review suggests that the PCC minutes record actions and decisions relevant to FHSSP from these two meetings.

Recommendations

The PCC agree that Phase 1 FHSSP governance and management arrangements continue for Phase 2, and consider augmenting the PCC by appointing an independent health system development expert to the PCC to provide independent expert technical input to debate and decisions.

The PCC minutes include decisions and actions pertaining to FHSSP from the MoH Directors and Divisional Plus Meetings.

5.3. Staffing[39]

The FHSSP has been well managed in Phase 1: in addition to its original core FHSSP business, it has responded to the scaling-up and scaling-down requests, supported the MoH response to two natural disasters and the 2014 dengue fever outbreak. See Annex 7 for a summary of FHHSP Phase 1 Staffing.

The challenge for the Review in providing concrete suggestions on staffing for Phase 2 now is that, according to organizational wisdom, 'form follows functions': ideally management and other staffing needs would be determined after Phase 2 activities are decided. However assuming the Phase 2 budget envelope returns to around pre-scale up levels (not known until after the 2014-2015 GoA budget is delivered on 13 May), and assuming that the FHSSP Phase 2 activities are focused as above (or similar), then some revisions to the management and technical teams will be needed.

Four months ago, FHSSP did a thorough review of job roles, which clarified and distinguished the current roles including within the management team. Notwithstanding this review of job roles and position descriptions, it is self-evident that a Phase 2 at pre-scale-up level (or similar) would need a different (smaller) management approach than the current structure, which was designed with scale-up levels of funding in mind. The current FHSSP management structure includes a program director, a senior program administrator, a deputy program director (whose foundation role is the TF for HSS, and who receives no additional money for the deputy role), and an assistant program administrator (APA). This structure is reasonably expensive not only because of the number of people but also because of international salaries and allowances for some. There is also potential for role overlap, 'position creep', and, one person strongly believed, conflict. The Review noted that the SPA's role had changed three times during Phase 1, expanding to encompass technical as well as administrative and managerial responsibilities.

[38] Largely because the same people on existing management committees made up the PMG. These arrangements were approved by December 2012 PCC.
[39] See Annex 8, FHHSP Phase 1 Staffing.

Some other assumptions can be made: staff uncertainty can impact heavily on morale, motivation, relationships and achieving. FHSSP has achieved well in Phase 1 - a real team effort. The transition to Phase 2 needs to be handled with care, sensitivity, and good change management approaches. This would be assisted by (i) Phase 2 planning being concluded in April, and the proposed staffing and management structures submitted to the PCC as soon as possible; (ii) DFAT / Abt-JTA contract negotiations commencing and concluding expediently thereafter.

The Review presents some options below as a basis for discussions for management approaches in Phase 2.

Option 1: Do nothing. Business as usual.

This would ensure continuity and stability, and would maintain relationships across the MoH and the greater health system. It would be at scale-up levels, and would continue the higher costs associated with international salaries. Additionally, the current management structure may not be a fit for Phase 2, including if infrastructure work ceases.

Option 2: Do ‘almost nothing’.

As above but cease the APA role if infrastructure work ceases. This would save one international salary. Review the SPA role to see where APA responsibilities can be either absorbed or delegated elsewhere.

Option 3: Do ‘almost nothing plus one’.

As for option 2, but with the DPD role also ceased, and this role split between the PD, who will have high level strategic oversight of all technical matters, as well as leadership matters, just as a CEO would; the operational technical matters would be managed by the SPA who moves more transparently to a deputy role, including having oversight and management of the ATFs.

Option 4: Return to original Phase 1 FHSSP model.

The PD has overall management and technical strategic responsibilities, including assuming the role of the DPD which disappears as a separate position, supported by a PA. The TFs oversee the technical work of the ATFs and the SPA has management responsibility for the ATFs. The Abt-JTA Brisbane office assumes greater administrative support if needed.

Options 5: Restructure the PD role to high-level strategic oversight and relationships. Amalgamate the SPA and DPD roles. As above; consider amalgamation of the APA’s role with some other administrative support roles. This would reduce costs and streamline roles.

Option 6: Variation on the above (allowing for other scenarios with Phase funding envelope and Phase 2 activities agreed).

The key point is that the Phase 2 management structure needs to assure management excellence in Phase 2, represent value-for-money and also needs to have ownership by Government.

Decisions on restructuring or downsizing could be usefully informed by the lessons learned in FHSIP, where staff were seconded from MoH as project officers, with short term technical assistance inputs to provide guidance and oversight. This was also intended as a sustainability strategy to ensure that MoH retained corporate knowledge and experienced staff were able to continue activities within the Ministry upon the Program’s completion. Of the 15 MoH staff seconded to the Program, at least 5 had been re-absorbed back into the civil service establishment. MoH was able to maximise the efficient use of its limited staffing resources by redeploying seconded staff to areas where their newly gained skills and experience acquired under FHSIP could be utilised. The centralised nature of staffing level decisions in the Fiji public service may impact this but it is a matter worthy of discussion.

Prior to and after the scale up, there were five technical facilitators (TF)/advisers in Safe Motherhood, Infant and Child Health, Diabetes Prevention and Management, Community Mobilization and Targeted Health Systems Strengthening (who is also the Deputy Program Director) plus Assistant Technical Facilitators (ATF) in Public Health Information and Monitoring and Evaluation. These TFs/advisers are either fully embedded in, or allocate a significant proportion of their time within, the corresponding MoH departments. This is a successful approach to establishing relationships, engendering trust, assisting with knowledge and skills transfer, and supporting individual and system change. This 'embedding' should continue in Phase 2.

Some specific changes to technical staff skills and competencies will be needed if the Review's earlier recommendations on the Program's strategic direction, or similar approaches, are accepted in Phase 2 planning. First, it makes strategic, technical and operational sense to manage objectives 1 and 2 together (M&CH) through one TF - the current TF for Objective 1. Secondly, if the proposal to focus on preventable diabetic-related foot care is accepted, then a change in TF skill set will be required, and this position should be advertised as soon as possible. In addition, the Review recommends the M&E and HIS advisors continue, and a new planning advisor is appointed, with several short-term inputs during Phase 2.

Additional staff at scale up included two divisionally-based Assistant Technical Facilitators (ATFs), an M&E Officer, a Communications Coordinator, Infrastructure Coordinator and administrative staff (9 in total). Senior officials consulted in this Review spoke of the considerable added value of the ATF role, seeing the role as an important link between the program and the MoH. The Review proposes the ATFs continue. They are currently managed by the DPD with the support of the SPA.

The additional administrative support staff appear to be adding value to operational matters, at acceptable costs, and responding to capacity building afforded by working within FHSSP. The level of administrative support needed after Phase 2 strategies and activities have been agreed may have restructuring and/or downsizing implications.

Recommendations

DFAT, AbtJTA and the MoH consider options to ensure the FHSSP management structure meets Phase 2 needs, and represents value-for-money; and that technical staff also meet Phase 2 needs, based on the agreed Phase 2 workplan.

5.4. Monitoring and Evaluation

The monitoring and evaluation framework aligns with MoH M&E. The FHSSP Responsibility Matrix for M&E shows FHSSP staff M&E responsibilities. The M&E framework will need further revision for Phase 2, reflecting the proposed two year work plan. The new FHSSP M&E approach is satisfactory for Phase 2.

The Review notes that the FHSSP M&E Advisor supports both the MoH and FHSSP in an approximate 70:30 ratio. The Review team proposes this ratio should be monitored with a sliding scale to 90 per cent of MoH support in Phase 2.

During their consultations, the review team were told that it would be helpful to external parties to have regular M&E reports from FHSSP produced through independent assessment. The interval for these could be quarterly, or perhaps six-monthly prior to each PCC meeting, as a key input to the PCC's deliberation, or mid-way between PCC meetings to enable corrective action to be taken if needed. This would not be another TAG, with changing terms of reference for each visit. Instead the Review team sees this as a single independent reviewer having two higher-level foci: (1) M&E using the FHSSP results-based framework, including verifying the veracity of the data where possible; (ii) consultations with key stakeholders on both technical progress and issues to supplement the M&E Framework

findings and to assess the constructiveness of internal and external dynamics for Phase 2 success. These independent assessments could perhaps lay further groundwork for informing thinking and discussions about any future possible Australian government support.

Recommendations

PCC consider requesting FHSSP to provide independent quarterly (or six-monthly) monitoring.

DFAT consider incorporating M&E at 12 months into any design preparation and an external program completion report.

5.5. Documentation and Reporting

FHSSP produced a large number of reports and other documents in Phase I. While FHSSP is intelligent and diligent in its reporting, shorter, sharper, more focused reports would provide external parties with the information they need, and provide it more clearly. Reports can tend to focus on activities, and this sometimes obscures the strategic direction and achievements during Phase 1. Some people consulted during the review commented that it was sometimes challenging to find, efficiently, key points for understanding FHSSP's progress and impact. .

The Review Team proposes documentation in Phase 2 (including reports to DFAT, the PCC and the management oversight groups) should be succinct, clear and highlight what is happening as a result of FHSSP activities. Operational research in Phase 2 could be usefully focused on FHSSP impact to support M&E and gather evidence for future possible GoA support.

Recommendations

FHSSP ensure reports are succinct and clear, and focus on the results or impact of FHSSP activities.

FHSSP consider focusing Phase 2 Operational Research on areas which should have been impacted by FHSSP support, to gather evidence and lessons learned, adjust activities as appropriate, and contribute to the evidence platform for possible future GoA support.

6. Possible future Australian support post-FHSSP

The Review team was asked to recommend the program strategic direction for 2014-2016 to help 'set the scene for Australian bilateral health assistance beyond 2016'. This type of high-level rapid review does not lend itself to more than a general overview that may assist future thinking, including for Australia's Fiji Country Strategy beyond 2014.

The strategic direction proposed for Phase 2 leads from and is linked to activities in Phase 1, within the FHSSP design framework. This may or may not be appropriate for the next phase of possible support. However, lessons learned and impact during Phase 2 will inform possible Australian support after FHSSP, as will some specific proposed strategies in Phase 2 including:

- proposed analyses on the cause of maternal and infant mortality
- strengthened data giving a more accurate picture of risk factors such as early antenatal visits
- strengthened data per se providing the opportunity for its more effective use across the MoH
- the proposed new clear link to WHOs Package of Essential NCD Interventions in Phase 2, which could lead to possible support for this integrated approach to NCD prevention and care

- workforce mapping, gaps and consequent strategy development which may need support when FHSSP ends
- MoH progress with planning for 2016-2020, overall management, monitoring and evaluation.

The inevitable growth in NCDs will put pressure on the national health budget, and, as for most of the Pacific, sustainable health financing will be a critical issue to be addressed. This would suggest an even greater need for efficiency and rationalisation of health service utilisation by providing services at the lowest appropriate level of the health system. Under-utilisation of sub-divisional hospitals for routine care is an issue that may return to the fore.

The next round of analysis of Fiji's National Health Accounts, scheduled for 2014, will provide useful insight into the current use of the health budget. A future costing study of selected MNH/FP and NCD services in Fiji could be useful as a basis for advocacy and to inform future budget and planning decisions. Support to ensure funds flow well through the system and to reduce bottlenecks could be considered.

Obviously, also key will be the health policy priorities of the Fiji government following the planned 2014 elections, Fiji's economy, and Australian Government policies and priorities. Future bilateral programs will be complemented with DFAT's regional programming in the Pacific – which aims to align with country programs and will be delivered through fewer, larger and longer-term activities that promote sustainability and predictability. According to the Pacific Regional Health Program Delivery Strategy 2013-2017, the regional program will engage in whole-of-government processes to develop and prosecute particular regional policy agendas, such as: regional actions to address the NCD epidemic (e.g. trade reform); opportunities to improve the efficiency of country-level health systems (e.g. through possible pooled provision of training and services); and actions that benefit women, the poor and people with disability.

With funding constraints, it will be important to seek new innovative ways to deliver services, and to leverage contributions from interested partners and associations, and perhaps explore more partnership with the small but important private sector. To deal with barriers to accessing care for under-served remote communities, more trial of innovation, for example use of Information, Communication and Technology, could be explored, which is also consistent with the new Australian Government's desire for a "new way of doing business" within its aid programs.

In general, a possible approach to future Australian government support should focus on health priorities and health system strengthening to support their sustainable targeting. Appraisal of the original program design highlighted that "ideally, one would have liked to see a different type of program proposed i.e. one that assists the government to tackle one or more of the fundamental problems of a health system that needs reform and one that moved away from dependence on a managing contractor".[40] Experience in other countries would suggest that there should be a move towards a higher proportion of aid being provided as flexible funding through government systems, where minimal conditions exist for using such an approach. However the design was heavily influenced by the current complex situation in Fiji and helping to ensure services to "ordinary Fijians" did not deteriorate further in the short term. Working through a managing contractor was an understandable approach given the relationship with the GoF and uncertainty around it, and has worked well to date.

In future, if the political economy worsened, there might be a strong rationale for continuing this type of arrangement. Conversely, should inter-government relations improve, working with MOH systems and providing some strengthening of the budgeting, planning and financial systems would provide a useful "platform" from which to transition to using other forms of aid (e.g. more use of partner systems), should circumstances allow.

[40] QAE completed by Jim Tulloch, 2 August 2010.

Also highlighted in the design appraisal was the importance of considering the role of UN agencies and other partners in providing technical assistance. The WHO Asia Pacific health system observatory has supported the Health in Transition (HiT) profile that describes the health system in some detail and analyse its strengths and weaknesses and opportunities for reform. Future programming should build on this work in a harmonized way.

Governance and management arrangements should follow best practice and efficiency considerations, suitable to the support being provided. As always, alignment with Australia's obligations and GoF needs would underpin decisions.

Annex 1 Terms of Reference

Bilateral Health Program Strategic Review
Fiji Health Sector Support Program 2014 – 2016
Terms of Reference

1.0 Background

The Australian Aid Program has provided significant support to the Fiji health sector over the last decade. DFAT launched its five year Fiji Health Sector Support Program (FHSSP) in July 2011, worth AUD$25 million over five years. This is a significant investment in Fiji's health sector, to ensure that the ordinary people of Fiji can access quality healthcare and improved service delivery.

The goal of the FHSSP (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:

(a) To institutionalise a safe motherhood program at decentralised levels throughout Fiji

(b) To strengthen infant immunization and care and the management of childhood illnesses and thus institutionalise a 'healthy child' program throughout Fiji

(c) To improve prevention and management of diabetes and hypertension at decentralised levels

(d) 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

(e) 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 Non Communicable Diseases (NCDs) in Fiji; through health promotion and strengthening primary health care; including revitalising the village/community health workers to improve service delivery. Importantly, the program will also strengthen key areas of the health system (namely health workforce planning, vaccine procurement and coverage, health information systems, and health infrastructure) that supports delivery of essential health services at the sub-divisional and divisional levels.

The MoH provides health care services directly to citizens of Fiji, and to a limited extent to visitors and persons referred from within the Pacific region. Key issues impacting on the MoH's capacity to deliver health services include: limited improvements in making any real progress towards achieving the MDG goals, increasing NCD prevalence, particularly diabetes and hypertension, weak and ineffective community health workers at grassroots level, declining health systems and significant drain of skilled and qualified staff from the Ministry of Health.

In February 2012, DFAT engaged a three-person Technical Advisory Group (TAG) to review the FHSSP and to provide independent advice to AusAID Fiji. As part of that engagement, the TAG was asked to appraise the FHSSP Scale Up Concept Note, submitted in February 2012 by Abt JTA Pty Ltd to DFAT Suva. Following the TAG appraisal, Abt JTA/FHSSP submitted a revised proposal to DFAT in April 2012 and the TAG was requested by DFAT to appraise this revised proposal, to assess whether JTA/FHSSP have taken into consideration the recommendations made by the TAG in their initial response, and to see whether they have 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 the recommendations had been incorporated into the revised proposal.

In December 2012, a change in the AusAID funding environment as communicated by an executive directive from Canberra meant that Abt-JTA/FHSSP were asked by AusAID Post 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. Close communication between AusAID Post and the program has helped the program to manage the scale-back.

In March 2013, DFAT again engaged a three-person TAG (including two of the original three team members) to conduct a mid-term review (MTR) of FHSSP progress and specifically to provide recommendations on whether or not the program should be continued to end June 2016. The TAG noted that, with the exception of the community health care component, the program had performed exceptionally well, given the constraints under which it had been operating. These included: a series of national emergencies, a change in the Australian aid program funding environment, the significant expansion of the infrastructure component, and ongoing changes with MoH counterparts. There was evidence that the program was demonstrating results in the program focal areas, and that program support was resulting in the establishment of key health systems and processes within the MoH and that there was strong justifications to continue the program to end of June 2016 and retaining the same managing contractor.

In October 2013, the newly elected Australian government as part of its election commitment reduced the 2013/2014 aid budget to address the budget deficit and improve efficiency and impact of the aid program. This resulted in a 7% reduction in the Fiji bilateral country program budget in 2013/14 with a *possibility* for further reductions in future financial years.

2.0 Purpose

2.1 The purpose of this assignment is to provide a high-level strategic review of the current FHSSP, given an evolving operating and political environment, and to provide recommendations for the direction of FHSSP Phase 2 assistance (2014-2016).

The objectives of the FHSSP Phase 2 Planning assignment are:

- To review the scope of Australia's bilateral health assistance to Fiji and provide advice on FHSSP Phase 2 assistance (2014-2016) based on lessons learnt during Phase 1 (2011-2014) and evidence of what is or is not working well and is likely to lead to sound results;
- To review the current management and personnel model and make recommendations for increased efficiency and effectiveness;
- To recommend a more focused program of assistance during Phase 2 including whether to include all components and how to focus assistance within each component;
- To recommend how investments (personnel and funds) could best be directed so that coherence between the components recommended for Phase 2 can be maximised in order to show some concrete results in two years;
- Recommend program strategic direction for 2014-2016 which will provide evidence and inform a theory of change for Australian bilateral health assistance beyond 2016.

3.0 Scope of Services

3.1 The team will be expected to focus on the 'what and how' to provide Australian support to the Fiji health sector over the period 2014-2016 including the following:

- Determine whether the current scope of the bilateral health program is realistic, effective, and represents the most effective use of resources. Can we streamline the program/reduce the number of interventions to focus our limited resources on a common, synergistic outcome across components while setting a platform for a longer term program of bilateral health assistance?
- Determine whether the current FHSSP management modality is appropriate and effective or whether other modalities should be considered. Are the staffing levels adequate? Is the current staffing arrangement effective and relevant? Are the roles of technical advisers, facilitators and management effective? What has and has not worked in the current operating environment?;
- Identify service delivery and health priority areas which could be supported through Australian funding in 2014-2016 which offer the best *value for money* (while remaining within the ambit of the original FHSSP program design as much as possible).

- Review the extent to which the program has analysed and addressed issues of access for those who are not currently utilising health services;
- Highlight areas from FHSSP Phase 1 requiring additional consideration and propose performance enhancing strategies/actions to address these;
- Where appropriate, identify risk management issues to consider during Phase 2;
- Where appropriate, identify M&E opportunities for a streamlined health program that will assist in demonstrating clear results after Phase 2;
- Recommend possible strategic approaches for planning future Australian assistance to the Fiji health sector via, inter alia, regional mechanisms, partner government systems, and civil society.

For this assignment the team should be guided by FHSSP reports and recommendations for Phase 2, FHSSP TAG review and other health reviews commissioned by FHSSP during Phase 1 (Maternal Health Review, NCD Strategic Review, & Primary Health Review).

4.0 Specifications of the Team

Key skills for the review team collectively include:

a) Strong programming, review, and design preparation experience, preferably in the Pacific and/or developing country context;
b) Strong knowledge of health systems strengthening for service delivery within a constrained operating environment, including use of different aid modalities;
c) Good appreciation of social inclusion in primary health care services;
d) Working knowledge and understanding of the Australian Aid Program agenda desired; and
e) Leadership and team management skills.

The Team Leader will be responsible for:

a) Managing team inputs and responsibilities and delivering assignment outcomes;
b) Managing the review to effectively utilise the expertise available within the team in meeting the Terms of Reference;
c) Taking primary responsibility for the overall program review ensuring alignment with DFAT policies and guidance; and
d) Liaising with DFAT Suva during all stages of the assignment.

The Program Management Specialist will:

a) Provide inputs into the review relevant to program management;
b) Review the program modality and rationalise challenges/bottlenecks in the context of the operating environment of Phase 1;
c) Take primary responsibility for the review of staffing model effectiveness while making recommendations for future programming consideration;
d) Work collaboratively with the Team Leader and DFAT; and
e) Contribute to achieving the objectives of the mission and required outputs; including any additional input to the final report as agreed with the Team Leader.

5.0 Duration and Phasing

5.1 The review is expected to commence on 10 February 2014 and will be completed by 3 March 2014. Components of the assignment include a comprehensive desk review and in-country mission.

In undertaking the assignment the team will:

a) Conduct a thorough desk review of relevant documentation, including documents in the reading list attached and advise all relevant parties of any additional materials that may be required prior to an in-country visit;
b) Liaise and consult with DFAT staff in Suva, FHSSP staff in Suva, and Abt JTA Pty Ltd staff in Brisbane;

c) Participate in key meetings as required; including in-country meetings with DFAT staff, key development partners and beneficiaries;
d) Submit a draft report to DFAT Suva Post by (timing to be confirmed);
e) Revise the report following one round of comments by DFAT and one round of comments by other stakeholders.

Indicative timeframes for the review team is as follows:

		Number of Days	
Date	**Task**	**Team Leader**	**Program Management Specialist**
10 Feb	Document review	4	2
	Review plan	1	0
	Canberra/Brisbane telephone consultations	2	1
17-21 Feb	In-country visit Fiji	5	5
	Travel days	2	2
24 Feb – 3 March	Report writing (including responding to comments)	7	4
	Total	21	14

6.0 Reporting and Deliverables

6.1 At the conclusion of the assignment the team will submit the following to DFAT Suva:

(i) Report – developed for DFAT and will be no more than 20 pages long, meeting the above specified assignment objective and scope; and
(ii) Confidential Note (if required) – this note will be developed as an annex to the report and will highlight for DFAT any issues deemed sensitive.

Annex 2 Documents Reviewed

Title	Date	Author
Government of Australia		
An Effective Aid Program for Australia	2012	GoA
Fiji Country Strategy 2012-20		GoA
Comprehensive Policy Framework 2015-2016		GoA
Australia's Comprehensive Aid Policy Framework		GoA
Fiji Community Development Program. Grants by Health Sector	2014	GoA
Fiji Ministry of Health		
Strategic Plan 2011-2015		MoH
ACRs and M&E Frameworks	2012, 2013	MoH
Revised Public Health Information System. User Guide.	2012	MoH
Public Health Information System (PHSIS) Online. In-service Training. Facilitators Guide. 1st and 2nd editions.	2012	MoH
Gender equity and social inclusion strategy	2012	MoH
NCD Toolkit Manual for Nurses in Fiji. 1st Ed.	2012	MoH
Scope of Practice – Registered Nurse	2012	MoH
Workforce Development Plans and Outcomes	2012	MoH
Strategic Workforce Plan	Dec. 2012; updated for 2014	MoH
Community Health Worker manual: Core Competencies. In-service training.	2013	MoH
Fiji National Immunisation Coverage Survey	2013	MoH
Health in Transition Report (HiT)	2013	MoH
Healthy Eating Guidelines in Diabetics		MoH
Personal Diabetes Record Book	2013	MoH
Situational Analysis of Health, Information Systems, CRVS and Surveillance (Pacific)	2013	MoH
FHSSP TAG Report Review - MoH response part 1 & 2	2013	MoH
My Health is My Wealth. Personal Health Record Book.	2014	MoH
Annual Corporate Plan	2014	MoH
Terms of Reference for a Community Health Worker - Draft	2014	MoH
Wellness Promotion Manual	2014	MoH

AusAID Health Resource Facility		
Fiji Health Sector Support Program 2011-2015 - Design Document	Sept. 2010	David Wilkinson, Lynleigh Evans and Ross Sutton for the AusAID Health Resource Facility
Fiji Health Sector Support Program Technical Advisory Group - Review of Mobilisation Phase and Appraisal of QAI Report	Mar. 2012	David Wilkinson, Sara Webb and Cate Keane for the AusAID Health Resource Facility
Fiji Health Sector Support Program Technical Advisory Group - Mid-term review	May 2013	David Wilkinson, Sally Duckworth and Cate Keane for the AusAID Health Resource Facility
FHSSP		
Annual Progress Reports	2011, 2012, 2013	
Annual Workplans	2012, 2013 and 6/12 2014	
Quarterly Progress Reports	2011-2013	
FHSSP - Program Coordinating Committee - Proposed Terms of Reference	2011	
FHSSP - Program Management Group - Proposed Terms of Reference	2011	JTA International
FHSSP - Finance and Audit Committee - Proposed Terms of Reference	2011	JTA International
FHSSP - Mobilisation Progress Report	2011	JTA International
Proposed FHSSP Organisational Structure	2011	JTA International
FHSSP - Team Structure	2011	JTA International
FHSSP - Set Up Expenditure	2011	JTA International
FHSSP - Branding	2011	JTA International
FHSSP – Mobilisation/ Start Up Plan	2011	JTA International
FHSSP – July-December 2011 Workplan with annexes	2011	JTA International
FHSSP – Budget	2011	JTA International
FHSSP Draft Communication Framework July 2011	2011	JTA International
FHSSP - Program Coordinating Committee - 26 August 2011 - Agenda	Aug. 2011	JTA International
FHSSP - Program Coordinating Committee - 26 August 2011 – Governance Structure Annex	Aug. 2011	JTA International
FHSSP - Program Coordinating Committee - 26 August 2011 – Governance Annex	Aug. 2011	JTA International
Communications Strategy	2012	

Finance and Audit Committee papers	2012, 2013	
Program Coordination Committee papers	2012, 2013	
Program Management Committee papers	2012	
PHIS Redevelopment and Software Review	2012	
Monitoring and Evaluation Frameworks - v 1-3, 2012 and v 4 2013	2012, 2013	
FHSSP - March 2012 Quarterly Report	2012	JTA International
FHSSP - June 2012 Quarterly Report	2012	JTA International
FHSSP - September 2012 (Q3) Quarterly Report	2012	JTA International
FHSSP - Program Coordinating Committee - 6 December 2012 - Minutes of Meeting	Dec. 2012	JTA International
FHSSP - 2012 Annual Report	Feb. 2013	JTA International
FHSSP Progress Report - Quarter 1, 2013	May 2013	JTA International
FHSSP - 6 Month Work Plan January - June 2014 - For PCC Endorsement	2013	Abt JTA
ANC Strategic Health Communications Plan	2013	
Change Frame 2013 Budget	2013	
Clinical Services Plan Review	2013	
Concept Paper for Scale Up	2013	
Draft Scope of Practice for Fiji Registered Nurses and Midwives	2013	
NCD Review and Strategic Action Plan	2013	
Non-communicable Diseases Strategic Action Plan 2015-2019		
Maternal Health Review and Strategic Action Plan	2013	
MoH Master Training Plan	2013	
PATIS Review	2013	
PATISPlus Review	2013	
Survey Report. Joint planning MoH & FHSSP	2013	
TAG Report Mid Term Review	2013	
FHSSP - Program Coordinating Committee - 25 July 2013 - Change Frame - FHSSP 2013 budget revisions post Micro Planning workshop June 2013	Jun. 2013	Abt JTA
Typhoid Fever in Fiji: Progressing the recommendations of the Expert Panel	Jun. 2013	Abt JTA
FHSSP - Program Coordination Committee Meeting - 25 July 2013 - Agenda	Jul. 2013	Abt JTA
FHSSP - Program Coordinating Committee - 25 July 2013 - Action Points from PCC 04 December 2012	Jul. 2013	Abt JTA
FHSSP - Program Coordinating Committee - 25 July 2013 - FAC and Q1 2013 Update	Jul. 2013	Abt JTA
FHSSP - Program Coordinating Committee - 25 July 2013 - Innovation Fund – Guidelines	Jul. 2013	Abt JTA

FHSSP - Program Coordinating Committee - 25 July 2013 - 2012 Annual Report Summary	Jul. 2013	Abt JTA
FHSSP - Program Coordinating Committee - 25 July 2013 - Typhoid Briefing Note	Jul. 2013	Abt JTA
FHSSP - Program Coordinating Committee - 25 July 2013 - Monitoring and Evaluation Framework - Version 4	Jul. 2013	Abt JTA
FHSSP Logic Model – Objectives 1, 2 and 3	Jul. 2013	Abt JTA
FHSSP - Program Coordinating Committee - 25 July 2013 - FHSSP intervention areas	Jul. 2013	Abt JTA
FHSSP - Program Coordinating Committee - 25 July 2013 - Risks and Issues Update	Jul. 2013	Abt JTA
FHSSP - Program Coordinating Committee - Minutes of Meeting - 25 July 2013	2013	Abt JTA
FHSSP - Outline of Revised Program Planning Approach	Aug. 2013	Abt JTA
FHSSP Progress Report - Quarter 2, 2013	Aug. 2013	Abt JTA
FHSSP - Program Coordinating Committee - Minutes of Meeting - 1 August 2013	2013	Abt JTA
FHSSP - Program Coordination Committee Meeting – 11 December 2013 - Agenda	Dec. 2013	Abt JTA
FHSSP - Program Coordination Committee - 11 December 2013 - Business arising from the Previous Minutes	Dec. 2013	Abt JTA
FHSSP - Program Coordination Committee - 11 December 2013 - FAC Update and Q3 Implementation	Dec. 2013	Abt JTA
FHSSP - Program Coordination Committee – 11 December 2013 – Process for Submission to Australian Government for Phase 2 FHSSP 2014-2016	Dec. 2013	Abt JTA
FHSSP - Innovation Fund – Guidelines - June 2013 (Revised December 2013)	Dec. 2013	Abt JTA
FHSSP - Program Coordinating Committee - 11 December 2013 - Minutes of Meeting	Dec. 2013	Abt JTA
Financial Procedures Manual v. 1.6	2014	
Monitoring and Evaluation Highlights	2014	
Proposal for 2014-2016 Phase 2 Abbreviated	2014	

Annex 3 People Consulted

MoH

Dr Eloni Tora, Permanent Secretary, Health

Dr. Eric Rafai, Deputy Secretary – PH

Dr. Meciusela Cakau, Deputy Secretary – H

Mr. Marika Luveniyali, Deputy Secretary – AF

Ms. Selina Waqa, Director Nursing

Mr. Ratish Singh, Director Policy & Planning Unit

Dr. Isimeli Tukana, National Advisor – NCD

Dr. Racel Devi, National Advisor – Family Health

Mr. Mukesh Nath, Director Human Resource

Dr Dasi, Sub-division Medical Officer Sigatoka

Shivnay Naidu, Director, Health Information, Research and Analysis

Dr Susana Nakalevu, Division Medical Officer (West)

Dr. Pablo Romakin, Sub-divisional Medical Officer (Suva)

Dr. Lisi Tikoduadua, Chair, Paediatrics CSN

Arieta Latianara, Project Officer, Community Mobilisation

Dr. Rao, Chair, Medical CSN

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Karen Kenny, Senior Program Administrator

Don Lewis, HIS STA

Kelly Robertson, Assistant Program Administrator

Dr Rosalina Sa'aga Banuve, Program Director

Marybeth Sarran, Workforce Development

DFAT

Joanne Choe, Counsellor, Fiji and Tuvalu

Dr. Frances Bingwor, Program Manager, Regional Health

Eleazar O'Connor, Assistant Program Manager, Bilateral Health

Iris Low-McKenzie, Community Development Grants Program

Paulini Sesevu, Senior Program Manager, Regional Health

Margaret Vuiyasawa, Program Manager - Bilateral Health

Rodney Yee, Senior Program Manager – Bilateral Health

Annex 4 Empower Fiji

Separately attached because of formatting (pdf).

Annex 5 FHSSP Objectives

(The 2013 TAG MTR also had suggestions on changing the objectives, which were not adopted)

Obj	*Contract 59506 (pages 5, 6)*	*Contract 59506 (page 1)*	*M&E 2013*	*2013 APR FHSSP Work Plan*	*2014 6/12 FHSSP WP*	*Review Team Suggestions, for Phase 2 (March 2014)*
1	To institutionalise a safe motherhood program at decentralised levels	Institutionalise Safe Motherhood Program	Institutionalised safe motherhood program in decentralised levels	Safe Motherhood	Safe Motherhood	***To institutionalise a safe motherhood program***
2	To institutionalise a 'healthy child' program throughout Fiji	Institutionalise Healthy Child Program	Institutionalised 'healthy child' program at decentralised levels	Healthy Child	Infant and Child	***To institutionalise a healthy child program***
3	To improve prevention and management of diabetes and hypertension at decentralised levels	Address Diabetes & Hypertension	Improve diabetes and hypertension management and prevention at decentralised levels	Diabetes Prevention	NCDs – Diabetes Control	***To improve prevention and management of specific NCDs***
4	To revitalise an effective and sustainable network of village/community health workers as the first point of contact with the health system for people at community level	Revitalise Primary Care (VHW/CHW Program)	Revitalise CHW network as the first point of contact with the health system for people at community level	Revitalising the Community Health Workers Program	Primary Health Care	***To strengthen primary health care through community health worker services***
5	To strengthen key components of the health system to support decentralised delivery	Targeted Systems Strengthening	Stronger health system for supporting decentralised health delivery	Targeted Health Systems Strengthening	Health Systems Strengthening	***To strengthen key components of the health system***

Annex 6 FHSSP Governance and Management Arrangements

Forum	Purpose	Membership	Comment
Program Coordination Committee (PCC)	Strategic decision making and monitoring of program	Chair: Permanent Secretary MOH MOH Executives X 4 DFAT X 4 FHSSP X2 PD and PDD MOF Secretariat: FHSSP Administrator	Semestrial and ad hoc Recommend a review of voting membership and placement of an independent adviser to assist the PCC
Program Management Group	Undertake monitoring of the program progress and ensure coordination with existing MoH activities	Senior MOH Division Officers National Advisers FHSSP team FHSSP TF as appropriate Secretariat: MOH Divisions	Disbanded in place of the MOH Directors meeting which needs stronger emphasis as agenda item in the PCC
Divisional Plus	Discussion on implementation of FHSSP and other donor activities in the Divisions	Chairs- DMO and MS alternate Clinical and public health divisional teams MOH Executive DFAT Representative FHSSP Leadership FHSSP TF as appropriate Secretariat: MOH Divisions	Quarterly This feeds the MOH Directors meeting? Where are the issues and actions passed? Does the performance-monitoring framework include these actions?
Finance and Audit Committee (FAC)	Monitor cash flows and expenditure against budget, and review forward quarterly expenditure forecasts. Reports to PMG quarterly and PCC semestrially	Chair: FHSSP PD MOH Senior Finance Manager or delegate DFAT Representatives AbtJTA Senior Program Manager AbtJTA Sr Project Coordinator FHSSP Finance Officer Secretariat: Sr Project Coordinator FHSSP- AbtJTA	Does FAC send reports to the MOH Directors meeting?

Annex 7 FHSSP Phase Staffing

Attached separately because of formatting (Excel)

HLSP Disclaimer

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