

**Fiji Health Sector Support Program
Monitoring and Evaluation Framework
Release 1.1**

Contents

1. INTRODUCTION	1
1.1 Document purpose	1
1.2 Audience	1
1.3 Basic definitions	1
1.4 Overall approach	2
1.5 Evaluation	2
1.6 Risks	2
1.7 Program logic and accountability	3
2. PROGRAM DESCRIPTION AND OBJECTIVES	3
2.1 Overview of FHSSP	3
2.2 Strategic Context of FHSSP	4
2.2.1 Policy Context	4
2.2.2 Socio-Economic Context	5
3. NATIONAL PLANNING CONTEXT AND GOALS	5
4. FRAMEWORK OVERVIEW AND APPROACH	6
4.1 Introduction	6
4.2 Logic overview	6
4.3 Framework and alignment	7
5. ARTICULATION WITH MoH M&E	7
5.1 Guiding principles and considerations	7
5.2 Organisational interfaces	8
5.3 MoH capacity building	9
5.4 Health Information Unit interaction	9
6. IMPLEMENTATION	10
6.1 Introduction	10
6.2 Roles and responsibilities	10
6.3 Resourcing	10
6.4 Data collection	10
6.5 Reporting	12
6.6 Baseline development	12
6.7 Evaluation	13
7. CROSS CUTTING ISSUES	14
ANNEX 1 – Program Logic	15

Acronyms

ALSO	Advanced Life Support – Obstetrics training
APDRB	Adult Personal Diabetes Record Book
APLS	Advanced Paediatric Life Support training
CDC	Communicable Disease Control
CG	Clinical Governance
CH	Community Health
CHS	Central Health Service
CHW	Community Health Workers
CPG	Clinical Practice Guidelines
CSN	Clinical Service Networks
CSP	Clinical Service Plan
DHS	Divisional Health Sisters
DPS	Director Program Support
DMOs	Divisional Medical Officers
DSHS	Deputy Secretary Hospital Services
DSAF	Deputy Secretary Administration and Finance
DSPH	Deputy Secretary Public Health
EHS	Eastern Health Service
EPI	Expanded Program on Immunization
FAC	Finance and Audit Committee
FBoS	Fiji Bureau of Statistics
FHSIP	Fiji Health Sector Improvement Program
FHSSP	Fiji Health Sector Support Program
FMA	Fiji Medical Association
FSMed	Fiji School of Medicine
FSN	Fiji School of Nursing
GFATM	Global Fund to fight AIDs Tuberculosis and Malaria
GoA	Government of Australia
GoF	Government of Fiji
HCW	Health Care Worker
HIS	Health Information Systems
HP	Health Promotion
HRD	Human Resource Development

HSD	Health Services Development
IEC	Information Education Communication
IMCI	Integrated Management of Childhood Illness
ICV	Infection Control Vaccination
JICA	Japan International Cooperation Agency
JTA	JTA International
KPI	Key Performance Indicators
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MEF	Monitoring and Evaluation Framework
MoH	Fiji Ministry of Health
MS	Medical Superintendent
NAC	National AIDs Council
NAFM	National Adviser Family Health
NANCD	National Adviser Non Communicable Disease
NCD	Non Communicable Disease
NCHP	National Centre for Health Promotion
NDC	National Diabetes Centre
NHEC	National Health Executive Committee
NHS	Northern Health Service
NGO	Non-Government Organisation
NHS	National Health Service
PATIS	Patient Information Systems
PCC	Program Coordinating Committee
PDD	Program Design Document
PHC	Public Health Coordination
PHC	Primary Health Care
PHIS	Public Health Information System
PIPS	Pacific Immunisation Program Strengthening
PSH	Permanent Secretary Health
QI	Quality Improvement
QMS	Quality Management System
RFT	Request For Tender
RM	Risk Management

RMP	Risk Management Plan
SFCCO	Strategic Framework for Change Coordinating Office
SD	Subdivisional
SDH	Sub Divisional Hospital
SDMO	Sub-Divisional Medical Officers
SPA	Senior Program Administrator
SPC	Secretariat of the Pacific Community
STC	Short Term Contract
TA	Technical Assistance (International recruitment)
TOR	Terms of Reference
TF	Technical Facilitator
TM	Technical Mentor
TNA	Training Needs Analysis
TSO	Technical Support Officer (Local recruitment)
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
WHS	Western Health Service

1. INTRODUCTION

1.1 Document purpose

This is Release 1 of the Fiji Health Sector Support (FHSSP) Monitoring and Evaluation (M&E) framework. It describes the overall program logic, the related performance indicators and the mechanisms for collecting data. Where there are gaps in indicator definition, quality or availability these are highlighted. The inter-relationship of the Program framework with the broader Fiji Ministry of Health (MoH) structures and processes are described.

This is an operational working document. Release 2 of this Framework, scheduled for February 2012, will refine the indicator set based on collaborative work with the MoH to address the identified gaps in indicator definition. Release 2 will also provide baseline measures for indicators where feasible as well as refine the proposed data collection methods, ensuring that the methods are practicable.

The Framework shows clearly the health outputs and outcomes to which the Program contributes. Where practical, the indicators align with existing or proposed MoH indicators to assist in ease of data measurement and sustainability.

Measuring progress towards achievement of these program-specific outcomes is at the heart of the Program's M & E activities; with stronger health information and M&E systems leading to the ability to measure the impact of the program's outcomes on the health of the people of Fiji and the quality of service provided by the MoH.

1.2 Audience

The external audience consists of the Fiji MoH and AusAID, specifically the Program Coordinating Committee. Internally, a key audience is the FHSSP team for who the document will provide a guide for the development of the Program's M&E processes.

1.3 Basic definitions

The overall purpose of monitoring and evaluation is to ensure that programs inputs flow through to achieving the objectives and outcomes of the program at the higher level and individual outputs at the Annual Plan level.

Monitoring refers to the continuous assessment of activity implementation in relation to agreed program plans. It is a means of determining the immediate results of outputs which support the longer term objectives. Thus monitoring involves the ongoing process of gathering, analysing, recording and reporting on the progress of the Program. The value of monitoring is to provide data for management decision making, and thus to refine implementation.

Evaluation is the periodic assessment of performance on outcomes. Thus the function of evaluation is broader than that of monitoring. Where monitoring allows managers to track progress and quality of activities, evaluation seeks to assess efficiency, effectiveness, likely sustainability and importantly the impact of the intervention.

1.4 Overall approach

It is intended that the M&E systems used in FHSSP, including key outcome indicators and data collection processes will, as far as possible, be those of MoH. While the MoH recognises the need for robust M&E and has established basic M&E systems, MoH does not have a strong culture or skills in M&E. The Program will therefore support strengthening M&E skills within the central MoH and at Divisional level.

While the overall outcome indicators will be those of the MoH and the data used will as far as possible be that collected by MoH it is recognized that there will be a need for some program specific indicators and data collection.

The intention is that the reporting of both activity and outcome indicators become a routine part of the joint MoH / FHSSP annual planning processes at both the national and divisional levels and the results are used in determining the following year's activities. By using MoH indicators, FHSSP will leverage off existing and proposed data and tools, whilst working with the MoH to strengthen M&E in areas where M&E is currently lacking.

The program will take a targeted approach to measurement; not everything that is important can be measured and not everything that can be measured is important. The approach is to use a small number of useful indicators to inform management and dialogue rather than a comprehensive set of indicators that attempts to provide complete information.

1.5 Evaluation

Whilst the bulk of this Framework deals with the ongoing routine monitoring of the Program there are key areas where intermediate and final formal evaluations will be done as highlighted in the FHSSP Design Document.

These include:

- acceptance by staff and community of the upgrading of the roles and functions of the SDH;
- a review of the VHW/CHW program to assess community support;
- diabetes risk factors to evaluate if Program is having an impact;
- diabetes screening to determine if it is effective in identifying diabetics patients at an early stage; and
- population survey immunisation coverage to determine if maintained at greater than 90% and to validate the measurement of immunisation coverage.

The conduct of these evaluations will be built into the yearly work programs of the FHSSP and the details of this are described in section 6.6.

1.6 Risks

Both the FHSIP Activity Completion Report (2009) and Lessons' Learnt Workshop held in December 2010 found that the lack of an M&E framework was a weakness in the program and led to difficulties in evaluating the success or otherwise of the program. The documents recommended that M&E activities need to be reinforced and integrated into the program and sub-projects. It is important to take note of this lesson and ensure M&E becomes fully integrated into FHSSP and MoH activities.

There are a number of characteristics of the Program which add particular risks to the development and ongoing functioning of an effective M&E system.

MoH senior management recognise the importance of M&E for contributing to evidence based decision making and accountability, whilst acknowledging the current M&E culture needs strengthening throughout the MoH, both at the national and divisional levels.

The Program's M&E philosophy is to use the MoH's indicators and processes wherever possible. Within the current MoH reporting systems there are significant issues with timeliness of reporting and completeness of data. For some indicators the necessary data is either not collected or there is no effective mechanism for centrally collating locally collected information. This impacts on the Program's ability to report in the areas using these indicators and data, with alternative data and indicators required in the short-term.

A key aspect of the FHSSP is the direction of support and funds to decentralised service delivery and to addressing the needs of vulnerable groups, such as the peri-urban settlements. Monitoring of the first of these, decentralised service delivery, introduces difficulties in the definition of appropriate measures and in robust data collection. While the monitoring of services to such vulnerable groups will have particular issues in regards to data collection and the establishment of baselines, approaches to mitigate these risks are discussed below, particularly in Chapter 5.

1.7 Program logic and accountability

Annex I shows the program logic hierarchy for each out the five program objectives. For the most part, the Program is directly accountable for delivering the Outputs. The outcomes though have numerous dependencies outside of the control of the Program and the Program must be considered in that light, of being a contributor towards these outcomes rather than being solely accountable for them. This distinction between accountable and contribution is highlighted in the Program Design Document.

2. PROGRAM DESCRIPTION AND OBJECTIVES

2.1 Overview of FHSSP

FHSSP is a 5 year, AUD25 million dollar program funded by Australian Aid, through AusAID, working closely with the Fiji Ministry of Health (MoH). The Program is being implemented by Brisbane-based company, JTA International (JTA), following an international competitive procurement process to identify a Managing Contractor.

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

The FHSSP Objectives are:

1. To institutionalise a safe motherhood program at decentralised levels throughout Fiji;
2. To strengthen infant immunisation and care and the management of childhood illnesses and thus institutionalise a "healthy child" program throughout Fiji;

3. To improve prevention and management of diabetes and hypertension at decentralised levels;
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; and
5. To strengthen key components of the health system to support decentralised service delivery (including Health Information, Monitoring and Evaluation, Strategic and Operational Planning, Supervision and Operational Research).

2.2 Strategic Context of FHSSP

The activities of FHSSP are aligned with the Cairns Compact and the Paris Declaration. Overarching responsibility for planning, implementation and monitoring lies in the hands of the MoH. FHSSP's primary responsibility is to provide technical coordination and management support to the MoH to help the Ministry achieve its health outcomes.

2.2.1 Policy Context

FHSSP has a clearly defined set of outcomes for which it will be accountable and which lead to higher level outcomes for which the Ministry is accountable. The Program therefore embraces the principle of managing for results while at the same time supporting mutual accountability within the Ministry.

FHSSP will work with and seek to strengthen the Ministry's own systems. In particular it will:

- be aligned with the MoH planning processes, which will determine the priority activities that will be supported with FHSSP Program funds, consistent with the Program objectives;
- be guided by the policies, guidelines and standards of the MoH and will support the Ministry to effectively implement its clinical services framework;
- implement all activities through current MoH operational and management systems, including Divisional and Sub-divisional public health frameworks and existing MoH committees; and
- work alongside the MoH in the evaluation of FHSSP outputs and outcomes.

By adopting this approach, the FHSSP will provide both financial and technical support to strengthen existing MoH systems, to support the management and coordination of program activities.

By focusing on the achievement of Millennium Development Goals (MDGs) 4 and 5, and improving prevention and management of diabetes and hypertension at Divisional and Sub-Divisional levels, the Program will support the achievement of three of the seven Health Outcomes identified in the MoH's Strategic Plan 2011-2015, namely:

- reduced burden of non-communicable diseases;
- improved family health and reduced maternal morbidity and mortality; and
- improved child health and reduced child morbidity and mortality.

Furthermore, the Program supports other MoH's key priorities for the coming five years, and in particular "Revitalizing primary health care approaches to address the burden of NCDs, maternal and child health and preventing communicable diseases". The Program also reflects the priorities of AusAID who have made a commitment globally to support countries to achieve their individual MDGs, and at the regional level made NCDs a priority area for support to the Pacific Island Countries and Territories (PICTS).

2.2.2 Socio-Economic Context

Although Fiji has recently transitioned to upper-middle income status and enjoys an important role as a regional hub, its development has been constrained over the last two decades by political instability. This has affected Fiji's position on the UN Human Development Index (falling from 81st in 2003 to 92nd in 2008), its achievements against its MDG targets¹, and its rising poverty levels, which reflect the country's deteriorating economic situation². The Reserve Bank of Fiji (RBF) had forecast a decline of 0.3 per cent in 2009, following very low growth of 0.2 per cent in 2008. However, other forecasts (e.g. the ADB forecast of 1.2 per cent decline in 2009) suggest a more pronounced contraction of Fiji's economy.

In an attempt to slow the pace of falling foreign reserves the RBF devalued the Fiji dollar by 20 per cent in April 2009. Unemployment data from the 2007 Census indicate high unemployment levels (over 8 per cent); more than double the rates for earlier estimates in 1996 and 2004. Inflation accelerated to a 20-year high of 9.8 per cent in September 2008, driven by rising food and fuel prices coupled with second round effects of higher oil prices, such as on transport. While inflation decelerated to 6.6 per cent by the end of 2008 as global oil and commodity prices declined, it still averaged a high 7.7 per cent for the year³.

Political and economic uncertainty has resulted in widespread migration overseas, especially among the educated and professional groups, including doctors and nurses.

The attrition of human resources has been exacerbated by recent government policies requiring that public sector staffing be cut by 10%, and the civil service's compulsory retirement age has been lowered from 60 to 55 years. Although some exemptions have been made for practicing clinical staff in the health sector, approximately 1000 health staff has been lost, many of them consultants and nurses with special skills in areas such as paediatrics, obstetrics, intensive care and oncology.

3. NATIONAL PLANNING CONTEXT AND GOALS

The FHSSP operates within the context of Fiji's Health Strategic Plan 2011-15 and is designed to support the achievement of the goals of that plan.

This strategic plan has identified 7 priority Health Outcomes;

- Health outcome 1: Reduced burden of Non-Communicable Diseases
- Health outcome 2: Begun to reverse spread of HIV/AIDS and preventing, controlling or eliminating other communicable diseases
- Health outcome 3: Improved family health and reduced maternal morbidity and mortality
- Health outcome 4: Improved child health and reduced child morbidity and mortality

¹ AusAID (2009), Tracking Development and Governance in the Pacific

² For example, 34.4 per cent of the population has an income below the basic needs poverty line, an increase from 25.5 per cent in 1990/1991 (source: 2002-03 Household Income and Expenditure Survey)

³ ADB (2009), Asian Development Outlook 2009,

- Health outcome 5: Improved adolescent health and reduced adolescent morbidity and mortality
- Health outcome 6: Improved mental health care.
- Health outcome 7: Improved environmental health through safe water and sanitation

The activities of the FHSSP will contribute to Outcomes 1, 3 and 4 as well as contributing to the achievement of MDG 4 – Reduced Child Mortality and MDG 5 – Improved Maternal Health.

4. FRAMEWORK OVERVIEW AND APPROACH

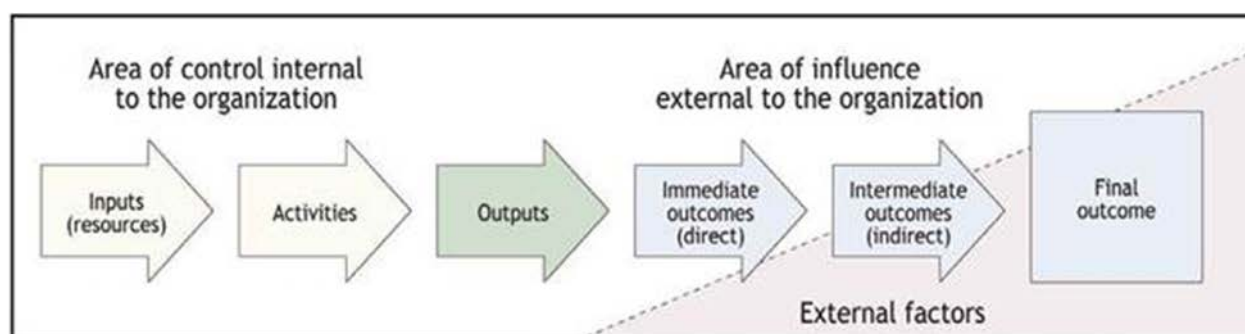
4.1 Introduction

This chapter provides a model which describes the overall framework for the Program logic and indicators. The overall purpose of M&E for FHSSP is to ensure that program inputs and activities are designed and effectively implemented so that the planned goal and outcomes are achieved.

4.2 Logic overview

Health outcomes are driven by a logical chain from the Program inputs through the activities and processes to the outputs, then through the immediate outcomes to the final outcomes. The diagram below illustrates this logical flow.

Figure 1 Logic model for FHSSP intervention



At the left side of the chain are those aspects which are to a large degree under the control of the program; that is the inputs (resources) and activities. As we move to the right the immediate, intermediate and final outcomes are increasingly influenced by determinants outside of the control or possibly even the influence of the health Program. These external determinants may be such things as the actions of the broader Fiji health system, socioeconomic factors or be individual health related behaviours such as smoking or exercise.

The logic of this model is that if we provide appropriate resources (training materials for example) and carry out the correct activities (such as staff training), then we will achieve the immediate outcomes of high risks pregnancies being detected early and the intermediate outcome of increased numbers of high risk pregnancies being delivered in Divisional Hospitals with the final outcome of reduced maternal mortality. Of course there are other factors and dependencies contributing to that final outcome, some such as ensuring facilities are adequately equipped are outputs to which the

Program will also contribute, but other dependencies such as having adequate transport for referrals are outside the scope of the Program

It may take many years to discern a significant change in final outcome measures and such changes that are attributable to the impact of the Program may be masked by the effects of other influencing factors. An overall monitoring framework needs to provide mechanisms for measuring key aspects of all components in the chain of the program logic, not just the final outcome measures.

Monitoring progress towards the Program's outputs and immediate outcomes provides a mechanism for the Program to manage its own performance and take corrective action if outcomes are not being achieved and provides assurance to external stakeholders, principally the Program Coordinating Committee, that the Program is on target.

4.3 Framework and alignment

Annex 1 provides the M&E framework for the program showing the hierarchy of outputs and outcomes which lead to each of the five program objectives

Each output and outcome has one or more associated indicators. The bulk of the final outcome indicators are MoH's own indicators drawn from its strategic plan. Many of the measures for the intermediate outputs and outcomes are program specific, though in many cases the underlying data will be recorded by MoH, but not collated systematically or reported. This alignment is explored in detail in the following chapter.

5. ARTICULATION WITH MoH M&E

5.1 Guiding principles and considerations

FHSSP is based on the premise that sustainable health development is best achieved by supporting the health service to implement its own plans and as such the Program has been designed with the emphasis on supporting Fiji's MoH to implement its own plan across the sector. The Program is underpinned by values such as increased trust, collaboration, partnerships, and increased ownership by the Government.

The Program annual work plans will be developed in collaboration with the MoH annual planning process and will describe the inputs and activities for the following year; aligned with the outputs and outcomes to which they will contribute. Reporting of these will be incorporated in the regular reports from the Program to the Program Coordination Committee (PCC), AusAID and the MoH.

This structure of FHSSP has implications for performance measurement and evaluation. The measures for the final outcomes will in all cases be those defined by the Fiji Ministry of Health in its strategic plan. The aim of FHSSP M&E is for the outcome indicators of the FHSSP to be a subset of the broader M&E framework of the MoH. The Program M&E systems, including key indicators and data collection processes, should be those of the MoH.

The goal of using solely existing MoH indicators will not be fully achievable immediately for two reasons. Firstly the Program will require some program specific output indicators to satisfy its reporting and accountability requirements to the PCC and AusAID. These will fall into three types;

- where data is collected and centrally collated by MoH but not reported by MoH. This will refer for example to data collected through PATIS or PHIS where the Program will set up a relationship with the Health Statistics Unit to access the data;
- where the data is collected by the MoH but not collated above the sub-divisional level. For these cases the MoH will establish relationships and processes with appropriate units and roles at the sub-divisional level; and
- where data is not currently collected within MoH. In these cases the Program will establish specific data collection processes.

The Program will establish processes for reporting these indicators, as far as possible drawing on data already collected by MoH. It is likely that some of these indicators will later be incorporated within the expanding MoH M&E system.

Secondly, while the MoH recognises the need for robust M&E and has established basic M&E systems, the MoH does not currently have a strong culture or skills in M&E. This is particularly evident for some measures, where data quality through routine systems is currently poor or where processes to collect indicators defined within the MoH Strategic Plan have not been established or where indicator definitions, such as for contraceptive prevalence need refinement. Also for many measures, the current MoH systems and processes report indicators up to 9 months after the end of the reporting period where the Program will require reporting much sooner than that to meet its obligations.

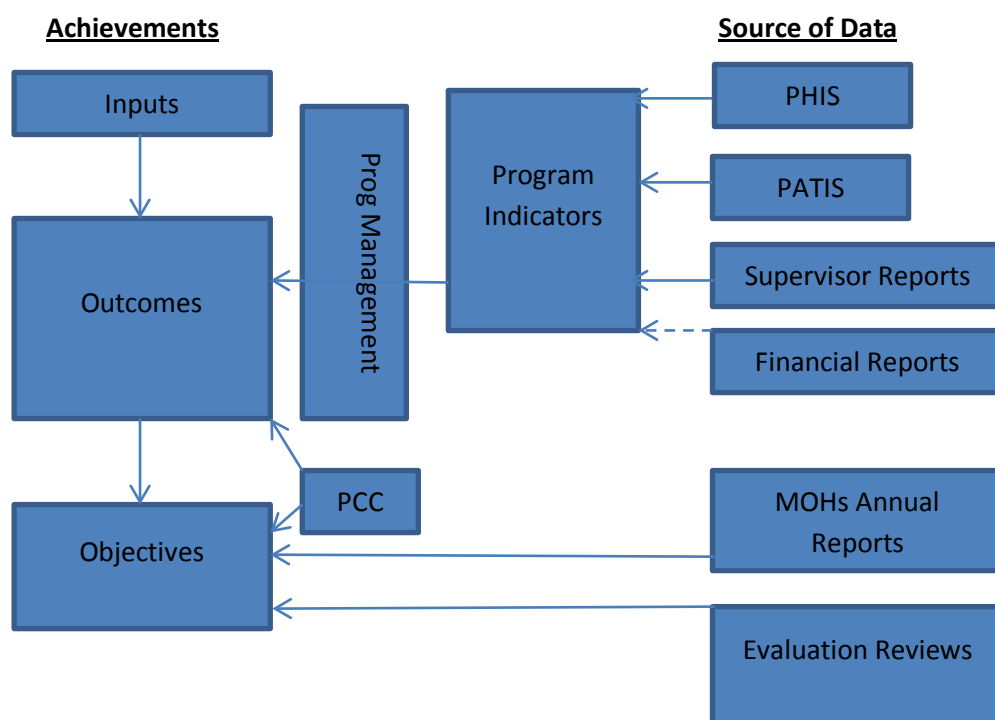
These gaps pose a risk to the Program's capacity to meet its reporting obligations. The risk will be addressed in two ways;

- through program activities, particularly under objective 5, to strengthen the culture, systems, processes and capacity of the MoH for data management and reporting. This will involve both specific targeted initiatives and also a general approach by all FHSSP Technical Facilitators and Technical Support Officers to support M&E in their various domains of operation; and
- where necessary as a short term, time limited solution, establishment of data management processes in parallel to the MoH. This will be done rarely and only for a limited time while the corresponding MoH processes are being developed and strengthened.

5.2 Organisational interfaces

The following diagram illustrates the interfaces that will be established by the Program with the MoH systems to enable Program reporting.

Figure 2 Program interaction with MoH systems and processes⁴



5.3 MoH capacity building

The capacity of the MoH to effectively institutionalise M&E is inextricably tied to the capacity of its health information systems (HIS) to provide the supporting data. In fact, the capacities and functions of its HIS should in a large measure be driven by the requirements of its M&E systems. To build the capacity of the MoH in M&E the Program will;

- provide long term TA in M&E to the Policy, Planning and Information Division;
- support the redevelopment of the current Public Health Information System (PHIS) with a particular focus on improving the access to and timeliness of the outputs and reports;
- support particular data quality and access improvement initiatives as defined within the MoH Health Information System Policy and Strategy; and
- support the use of TSOs to strengthen capacity for monitoring at decentralised levels.

5.4 Health Information Unit interaction

The monitoring and evaluation of the Program will be critically dependent on information supplied by the MoH Health Information Unit. As noted in Annex I, for a significant number of indicators the MoH systems are currently unable to provide the necessary data and for many others the MoH systems are unable to provide the data in a timely manner to meet the Program reporting requirements. In the development of Release 2 of the M&E Framework the following steps will be implemented with the HIU;

⁴ Australia - Fiji Health Sector Support Program 2011-2015 Final Design Document, AusAID, 2010.

- an agreement to provide data needed to report relevant Program indicators or where this not currently possible, an agreed pathway to the future provision of the data
- direct technical support to extract and report data necessary to establish baselines for Release 2 of the Framework.

6. IMPLEMENTATION

6.1 Introduction

This chapter describes the actions that will be undertaken to implement this M&E Framework. In this release of the Framework there is an emphasis on the activities that will be undertaken between October 2011 and January 2012 to finalise Release 2 of the Framework.

6.2 Roles and responsibilities

Within the FHSSP, the overall responsibility for ensuring the Program meets its reporting obligations under this Framework resides with the Deputy Program Director – Technical Facilitator Health Systems Strengthening. Each individual program area (Objective area) is responsible for ensuring that it has systems and resources in place to collect and report the data required by the Framework.

Under the direction of Deputy Program Director, the Program Administrator and the Assistant Technical Facilitator M&E will be responsible for compiling the Program's reports as per the schedule shown in section 6.5 below.

The Program Mentor for M&E and Health Information Systems will be responsible for establishing the details of the data supply agreement with the MoH Health Information Unit and providing any technical assistance initially needed in extracting and reporting data, particularly for establishing baselines.

Once processes are agreed and established, the MoH Health Information Unit will be responsible for supplying data as agreed to support the FHSSP M&E reporting.

Once the FHSSP funded Planning and Monitoring Advisor commences in early 2012, there will also be strong linkages between FHSSP M&E activities and the MoH Planning Division.

6.3 Resourcing

Other than the input of the Technical Facilitators, the Technical Mentor and other FHSSP staff, all other resources to support the reporting against the M&E Framework will be identified and provided through the FHSSP annual work plan. This will include both the activities to strengthen MoH processes and systems and the in program activities to collect and report program specific data.

6.4 Data collection

The following routine data collections will be established by each of the program objective areas to provide data for reporting against the Framework.

Objective 1 – Safe Motherhood

Register of all SDH will be maintained showing desired minimum number of staff with each type of following types of training and/or skills:

- Partogram training

- EmONC/ALSO Drills
- Reproductive Health and Family Planning
- FP Counselling
- BPP and CRP [Birth Preparedness Plan & Complications Readiness Plan]
- Clinical attachment and up skilling in obstetric and maternity services.
- Clinical attachment in Family Planning [IUCD insertion, Pap smear, Jadelle]

Actual number of staff in place will be recorded at six monthly intervals from report from hospitals and used as basis for the Program performance reporting and planning further training delivery.

Objective 2 – Healthy child program

Register of all SDH will be maintained showing desired minimum number of staff for the size of the hospital with each of the following types of training:

- Integrated Management of Childhood Illness
- Paediatric Life Support
- Advanced Paediatric Life Support
- WHO Pocket Book Training
- EPI Training

Actual number of staff in place will be recorded at six monthly intervals from report from hospitals and used as basis for the Program performance reporting and planning further training delivery.

Objective 3 – Diabetes

Registers of adults over the age of 30 years who are screened each year will be established and maintained by zone and district nurses. Clients with confirmed diabetes will be reported to the national diabetes register maintained by the HIU. Summary information will be reported at six monthly intervals to the FHSSP program office. This will include:

- Estimated size of population catchment
- Number of known diabetics
- Number of adults screened in preceding 6 months
- Number of new diabetic cases detected
- Number of non-diabetics with various risk factors (including lack of exercise)

The FHSSP program office will maintain a summary register which will be used to provide six monthly performance reports against the Framework indicators.

Objective 4 - VHW strengthening

There are particular challenges associated with data collection and monitoring in regards to Objective 4, the revitalisation of primary health care. There is a significant lack of baseline data in relation to VHW/CHW. While, in theory, it is a common practice for all villages to have a village health worker appointed by the village, this practice has not been well maintained in recent years and the number of villages with an active VHW/CHW is not known. The Program seeks to increase the number of trained and functioning VHW / CHW, ensure they have the required resources, are

supported in establishing community based projects and are engaged with their community through a functioning community health committee

The Program will establish;

- A program scope register which lists all villages and communities in Fiji which could have a VHW/CHW. This list will be stratified by urban – rural status and other key socio-economic characteristics. (This will provide the sampling frame for all subsequent monitoring activities);
- baseline measures of proportion of villages and communities with functioning VHW/CHW and with functioning health committees; and
- mechanisms for routinely updating register to record villages with:
 - trained VHW / CHW
 - resourced VHW/CHW
 - functioning health committees
 - locally initiated community health promotions or interventions including water supply monitoring

Routine data will be sourced from zone nurses supplemented by site visits by FHSSP staff where necessary.

It is anticipated that two independent evaluation surveys will be conducted over the life of the program; one at mid-project and one near the completion of the Program. The details of this survey sampling and the resources to conduct are described further in section 6.6.

6.5 Reporting

The program specific indicators will be reported six monthly to the Program Coordinating Committee. The reporting of the outcome and impact indicators will align with the MoH reporting cycle and will hence be reported yearly. The intent of the Program is to strengthen MoH processes to make the reporting of these indicators more timely. This strengthening will be built into the annual work programs under Objective 5 as agreed with the MoH.

6.6 Baseline development

For the most of the long term outcome indicators, the baselines will be drawn from the most recent MoH annual reports. There are a number of indicators, such as the diabetes prevalence, which are defined in the MoH strategic plan but which cannot currently be reported. Based on discussions with the MoH, mechanisms for reporting these indicators over the longer term will be agreed and proxy indicators that will serve in the mean time will be developed. The development of the mechanisms and processes for reporting those 'missing' indicators will then be factored into the annual FHSSP work plans.

The bulk of the program specific output and outcome indicators are based on proportions not numbers. The calculation of these indicators will require the definition of the appropriate denominator for each indicator. These denominators will be such things as the number of candidate staff that could receive a particular type of training or the number of villages that could have a VHW/CHW. For many of these indicators, the most effective way of determining the potential target number will involve the establishment of a register maintained by FHSSP.

6.7 Evaluation

The following evaluations and non-routine data collections will be conducted throughout the five year life of the Program.

Enhanced role of sub-divisional hospitals

At mid project and end of project, focus group discussions will be conducted with staff and the general population to assess the acceptance of the enhanced role of sub-divisional hospitals in maternal, and child health and Diabetes management services. The results of the mid-term review will be used to revise the community and staff engagement strategies.

Immunisation coverage.

The Program will fund additional data collection in the national Demographic Health Survey to be conducted in 2012 to ensure that the immunisation coverage results are comparable with the data collected in previous WHO immunisation coverage surveys.

In 2016 the Program will fund a standard immunisation coverage survey to provide end of Program data on immunisation coverage.

The information from both surveys will be compared against data reported through the MoH routine information systems with the long term goal of strengthening the routine reporting to provide accurate and timely coverage estimates.

Diabetes prevalence and risk factors.

Baseline information on diabetes prevalence and risk factors will be sourced from the STEPs survey being conducted in 2011 and scheduled to be reported in 2012.

Ongoing measures of risk factors and prevalence should be sourced from the screening registers and national diabetes register. If these are determined by the mid-term review to not be providing reliable estimates then a targeted small scale STEPs survey will be repeated in the last year of the Program

Village / Community Health worker program

At mid-term and end of Program, formal evaluations will be conducted on the village / community health worker Program. These evaluations will be managed and funded by FHSSP but conducted by an independent body.

Planning and monitoring evaluation strengthening

A mid-term evaluation, funded by FHSSP, will be conducted following the completion of the two year Planning and Monitoring LTA input and then at the end of program to determine if sustainable changes have been made in the MoH Planning and Monitoring processes.

7. CROSS CUTTING ISSUES

The implementation of FHSSP will be informed by a number of overarching principles that the Government of Australia has put in place to ensure the quality and effectiveness of the aid program. Cutting across all aspects of program are the underlying principles and consideration of gender equity, HIV and poverty and these will be taken into consideration when developing activities and subsequent indicators.

Consideration and incorporation of gender aspects into implementation of this program is implicit in its design, and especially through its strategic focus on improving maternal and child health. The strengthening of resources and empowerment village/community health workers, the majority of whom are women, will be a key component of this strategy.

Under the Health Systems Strengthening component of the Program (Objective 5), operational research will be conducted to identify health status and health system issues impacted by social mobility and the expansion of urban/peri-urban settlements. Resulting from this work will be a detailed design for approaches on how to obtain accurate ongoing information on these hard to reach population groups.

HIV mainstreaming is an important focus for AusAID and the Government of Fiji to address factors of HIV susceptibility and vulnerability. The work around Safe Motherhood and Infant and Child Health will contribute to ensuring that health workers are skilled in addressing issues surrounding HIV in both mother and child. This will contribute in addressing the increasing feminisation of HIV in the Pacific as noted in the WHO-SPC second generation surveillance studies in 2006.⁵

The revitalisation of the village/community health worker component will look at the support that is available at the formal but also the informal settings to health care. Communities / villages will be classified by key socio-economic characteristics and Program outputs and outcomes will be reported by this classification to demonstrate that the most vulnerable groups are being reached.

⁵ Second Generation Surveillance Surveys of HIV, STIs and risk behaviours in 6 Pacific Island Countries (2004-2005) by WHO. SPC and UNSW

ANNEX 1 – Program Logic

The following table shows the outcome hierarchy for the Fiji Health Systems Support Program.

Level	Outcomes	Measures / indicators	Source	Notes
Program goal	Contribute to the Fiji Ministry of Health's efforts to achieve its higher level strategic objectives in relation to reducing infant mortality (MDG4), improving maternal health (MDG 5) and the prevention and management of diabetes			
Objective 1	To institutionalise a safe motherhood program at decentralised levels throughout Fiji	1.a Maternal mortality ratio 1.b Incidence of anaemia at booking	1.a Mortality data maintained by HIU 1.b Estimated from PHIS data collection	
Outcome 1.1.1	Women receive best practice ante-natal care	1.c Proportion of pregnant women who have first antenatal visit in first trimester	1.c Can be derived from PHIS data collection and the pregnancy module within PATIS	Currently not reported by MoH. Two related issues are that (i) not all ANC is reported through PHIS, ANC delivered at SDH and Div hospitals is not recorded in PHIS and (ii) HIU not clear on what appropriate denominator is.
Outcome 1.1.2	Identified high risk cases deliver in Divisional hospitals	1.d Proportion of deliveries with complications delivered in SDH decreases 1.e Proportion of deliveries with complications delivered in divisional hospitals increases	1.d,1.e PATIS and hospital discharge data accessed from through Health Statistics Unit.	Indicator will need definitional work to specify ICD codes for complications. HIU currently doesn't have the technical capability to extract and report this indicator
Outcome 1.1.3	All non-emergency deliveries occur at SDH or Divisional hospitals	1.f Percentage of births that occur in SDH or Divisional hospital	1.f From the Health Statistics Unit, derived from PATIS and the monthly returns for the non PATIS hospitals.	
Outcome 1.1.4	Women deliver at facility classified as baby – mother safe	1.g Proportion of SDH that achieve basic level	1.g Audit reports bi-yearly conducted by CSN and reported to FHSSP.	
Outcome 1.1.5	Increased contraceptive prevalence rate and reduced unmet need for family planning	1.h Contraceptive prevalence rate.	1.h PHIS once revised	Current data collected within PHIS does not support the reporting of population

Level	Outcomes	Measures / indicators	Source	Notes
				prevalence. Better indicator would be couple years protection.
Output 1.2.1	Increased number of facilities and sessions delivering family planning awareness.	1.i Proportion of facilities (by type) delivering family planning awareness promotion and providing family planning resources	1.i Annual questionnaire managed by FHSSP	
Output 1.2.2	All SDH have adequate number of staff trained in all disciplines of obstetric, reproductive health and family planning.	1.j Proportion of SDH with adequate number of trained staff in : <ul style="list-style-type: none"> • Partogram training • EmONC/ALSO Drills[including neonatal resuscitation] • Reproductive Health and Family Planning • FP Counselling • BPP and CRP [Birth Preparedness Plan & Complications Readiness Plan] 	1.j Six-monthly questionnaire completed by head of O&G at each hospital, managed by FHSSP	
Output 1.2.3	Health care facilities equipped to minimum standards by role delineation	1.k Proportion of facilities equipped to minimum standards	1.k Report from Obstetric CSN	
Output 1.2.4	Maternal health services are regularly, audited	1.l Proportion of facilities audited each year	1.l Report from Obstetric CSN	
Output 1.2.5	Clinical Service Guidelines and protocols related to MCH are used systematically throughout all service delivery areas	1.m Proportion of hospitals audited each year that are effectively using the guidelines and protocols	1. m Yearly audit of a sample of SDH and divisional hospitals by CSN.	
Objective 2	To strengthen infant immunisation and care and the management of childhood illnesses and thus institutionalise a “healthy child” program throughout Fiji			
Outcome 2.1.1	Systems in place to maintain Expanded Program of Immunization	2.a EPI immunisation rates > 90%	2.a Baseline from national survey in 2012 the repeat survey in 2016	Routine immunisation data is collected through PHIS but there are significant concerns about the quality and completeness of this data. This will addressed through the PHIS strengthening project.
Outcome 2.1.2	Child health to be more focused on reducing peri-natal mortality	2.b Endorsed standalone child health policy and strategy 2.c Under 5 mortality rate	2.c Mortality register maintained in PATIS by HIU.	

Level	Outcomes	Measures / indicators	Source	Notes
Outcome 2.1.3	The “Baby Friendly Hospital Initiative” to promote breast feeding Nationally continues and is effective	2.d Proportion of women exclusively breast feeding at 6 months	2.d PHIS reported through Health Statistics Unit	Needs improved data definitions and data collection guidelines as denominator not clear. Will be tackled as part of PHIS strengthening project
Output 2.2.1	All sub-divisional hospitals have appropriate equipment and facilities to deliver paediatric care	2.e Proportion of facilities equipped to minimum standards2.e	2.e Annual reports from CSN	
Output 2.2.2	All sub-divisional hospitals operate to appropriate standards and protocols to deliver quality secondary level paediatric care	2.f Proportion of facilities using standards , protocols and guidelines	2.f Annual Report from CSN	
Output 2.2.3	Staff at all SDH have all skills for the treatment of a sick child	2.g Proportion of SDH with adequate number of trained staff in all disciplines	2.g Six-monthly questionnaire completed by head of O&G at each hospital, managed by FHSSP	
Output 2.2.4	Child Health services are regularly audited	2.h Proportion of facilities audited annually	2.h Annual report from CSN	
Objective 3	To improve prevention and management of diabetes and hypertension at decentralised levels	3.a Prevalence rate of diabetes 3.b Amputation rate for diabetic sepsis 3.c Admission rates for diabetes and its complications, hypertension and cardiovascular disease	3.a Baseline through STEPS survey. Then monitored through ongoing screening. Diabetes register has potential to provide data if strengthened. 3.b , 3.c Can be extracted from PATIS for all divisional hospitals and those SDH with PATIS. Can be reported from manually entered data from non-PATIS hospitals. Data held by HIU.	3.a This is an MoH key indicator but is not currently reported. Current diabetes register maintained by HIU has limited coverage and functionality. A comprehensive, properly functioning, diabetes register would provide the best measure of population prevalence without need for repeated surveys 3.b Currently this is reported by phoning each of the hospitals and manually collating the data. The data exist electronically but is not used.
Outcome 3.1.1	Adequate physical activity conducted daily by teenagers and adults	3.e Proportion of population over 35 years engaged in sufficient leisure time activity	3.e STEPS survey to establish baseline. Then monitored through ongoing screening. Possibly repeat survey if indicated from screening	
Outcome	Screening of all adult population	3.f Proportion of population screened	3.f From registers maintained at	

Level	Outcomes	Measures / indicators	Source	Notes
3.1.2		each year, cumulative over a five year period.	nursing stations and health centres.	
Outcome 3.1.3	The Adult Personal Diabetes Record book, is providing an effective mechanisms for ensuring the continuum of care of all people with diabetes;	3.g Ratio of books distributed (by facility) compared with number of patients on diabetes register 3.h Percentage of patients presenting with books at time of consultation	3.g Annual routine reports from each facility 3.h Mid-project and end of project random sample survey looking at % of patients presenting with books.	
Outcome 3.1.4	Quality diabetes centres established at all Sub-Divisional Hospitals and selected large urban health centres.	3.i Proportion of facilities with established diabetes centres	3.i Annual reports from each facility	
Output 3.2.1	Diabetic health services are regularly monitored, audited	3.j Proportion of facilities monitored and audited each year by medical CSN	3.j Annual report from medical CSN	
Output 3.2.2	Clinical Service Guidelines and protocols related to diabetes are standardised, disseminated and used systematically throughout all service delivery areas;	3.k Proportion of facilities using guidelines and protocols	3.k Annual report from diabetes CSN	
Objective 4	To revitalize an effective network of village / community health workers as the first point of contact with the health system for people at community level		The high level measures of success of this objective will be the success of objectives 1 to 3. Objective 4 is a key enabler for these objectives	
Outcome 4.1.1	An effective system of trained and resourced VHW/CHW who are able to provide basic first aid, promote healthy practices and health seeking behaviours and effectively refer patients to health services;	4.a Percentage of villages/communities having functioning VHW/CH in the Community	4.a This will be measured routinely by six monthly returns from zone nurses. Secondly measured as part of mid and end of project evaluations by survey of sample of villages and communities.	
Outcome 4.1.2	Increased community ownership of, and engagement in, primary health care with effective local management structures	4.b Percentage of village/communities with an active community health committee that has been established and is functioning	4.b As above	
Output 4.2.1	VHW/VHW adequately resourced in sustainable manner	4.c Percentage of VHW/CHW with kits supplied and evident.	4.c This will be measured routinely by number of kits supplied and % of active VHW / CHW who have a kit reported by zone nurse. Secondly measured as part of mid and end of project	

Level	Outcomes	Measures / indicators	Source	Notes
			evaluations by survey of sample of villages and communities.	
Output 4.2.2	Ongoing supervision and quality assurance of performance of VHW/CHW	4.d Proportion of VHW/CHW who receive at least one supervisory or support visit from a zone nurse each six months.	4.d Routine six monthly reports from zone nurses.	
Output 4.2.3	Active support from nursing stations and health centres	4.e Proportion of villages and communities where zone nurses are providing active support	4.e Mid and end of project evaluations by survey of sample of villages and communities.	
Output 4.2.4	Baseline analysis with identification of priority needs identified conducted and endorsed locally	4.f Cumulative proportion of villages / communities with completed baseline needs analysis	4.f Register maintained by FHSSP	
Output 4.2.5	Local initiatives to address identified needs being adequately resourced and supported and conducted effectively.	4.g Proportion of villages / communities with at least one supported initiative per year 4.h Proportion of villages / communities who have carried out a water quality analysis	4.g, 4.h Register maintained by FHSSP	
Objective 5	To strengthen key components of the health system to support decentralized service delivery			
Outcome 5.1.1	An expanded PHIS provides timely, complete and accurate information for all Fijians that is being used at national, divisional and local levels to measure public health outcomes and plan future activities	5.a Timeliness and adequacy of reports verified against documented system requirements.	5.a Verified by PHIS steering committee	
Outcome 5.1.2	Ongoing culture and capacity for evidence based review and planning (i.e. M&E) at national and divisional levels	5.b Yearly M&E plans with quantitative indicators reported against for each Division within defined time. 5.c National indicators dictionary established	5.b, 5.c Observation by FHSSP Technical Facilitator, validated by mid-term and end of program reviews, SFCCO reports for MoH annual corporate plans	
Outcome 5.1.3	Improved strategic and operational planning is functioning in a sustainable manner at national and divisional levels		5.d Mid term review of MoH Strategic Plan	
Outcome 5.1.4	Operational research provides information to support evidence-based planning of health services in urban and peri-urban areas	5.f Plans based on defined research developed and implemented.	5.f Research reports with action recommendations endorsed by NHEC.	

Level	Outcomes	Measures / indicators	Source	Notes
Output 5.2.1	All national and divisional annual (operational plans) contain means of monitoring progress and evaluation of success.	5.g Plans contain indicators primarily chosen from the national indicator dictionary with documented means of collection and reporting	5.g SFCCO reports, annual reports and observation by FHSSP Technical Facilitator	
Output 5.2.2	Policy , Planning and Information Division functioning effectively in sustainable manner	5.h Division provides technical input on monitoring, evaluation and indicator selection to all national and divisional planning processes which continues after cessation of two year TA input	5.h Validated by mid-term and end of program reviews	
Output 5.2.3	Quality information available in timely manner to report all indicators in MoH annual and strategic plans	5.i Indicators from previous year are reported as part of annual planning process	5.i SFCCO reports, annual reports and observation by FHSSP Technical Facilitator	

Footnote: 1. Baseline are not be populated in release 1 but will be populated in Release 2