# Fiji Health Sector Support Program

# Annual Plan 2012

Australian Aid: managed by JTA International on behalf of AusAID

# Contents



## ANNEXES

## 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 Worker |
| CMNHS | College of Medicine, Nursing and Health Sciences |
| CPG | Clinical Practice Guideline |
| CSN | Clinical Service Network |
| CSP | Clinical Service Plan |
| DHS | Divisional Health Sister |
| DPS | Director Program Support |
| DMO | Divisional Medical Officer |
| 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 |
| FHSIP | Fiji Health Sector Improvement Program |
| FHSSP | Fiji Health Sector Support Program |
| FMA | Fiji Medical Association |
| FNU | Fiji National University |
| 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 |
| SD | Subdivisional |
| SDHS | Sub Divisional Health Sisters |
| 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

This report presents the 2012 Annual Plan for the Fiji Health Sector Support Program (FHSSP). The report outlines the key priorities and work plan for each of the five objective areas and the linkages to the Ministry of Health (MoH).

FHSSP's goal is the continual engagement in the Fiji health sector through contributing to the MOH's efforts to achieve its 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). As such, FHSSP planning is closely linked to the MoH planning process and priorities. An integral part of the FHSSP 2012 work planning was the assistance and facilitation provided to the MoH during the MoH annual corporate planning process for 2012. Following the drafting of the MoH 2012 corporate plan, FHSSP held a consultative workshop with key MoH counterparts to develop the 2012 FHSSP work plan. The MoH 2012 strategic objectives and FHSSP five key objectives were used as the basis for planning activities. The Annual Plan presented in this report and individual objective work plans presented in Annex 1 are the result of this process.

## 1.1 Structure of the Annual Plan

The 2012 FHSSP Annual Plan is broken into six sections.

Section One provides a brief overview of the report. Section Two provides a description of the Program, including the strategic context of FHSSP, program governance and the operational management and program delivery mechanisms.

Section Three is a brief description of the progress of FHSSP for 2011; the highlights and challenges. Section Four outlines the FHSSP work plan for the next twelve months, broken down by the five key objective areas. The overall program budget for 2012 is FJD8,880,679, consisting of FJD4,817,000 in program costs (objective 1-5), FJD1,724,138 in unallocated funds and FJD2,339,601 in operational costs. A consolidated work plan is presented in Annex 1 and the resource and cost schedule is outlined in Annex 2.

The Strategy for Implementation section presented in Section Five details the way that FHSSP will address vulnerable groups and provides an overview of the Monitoring and Evaluation Framework (MEF), the pilot activities and use of technical assistance for FHSSP. The MEF Release One is provided at Annex 3.

Section Six provides a high level overview of the program risks and their management. This is supported by the Risk Management Matrix presented in Annex 4.

In order to deliver the expected outcomes, it is anticipated that FHSSP will recruit two Technical Advisors and ten Technical Support officers in 2012. An overview of the Terms of References for these advisors and officers is presented in Annex 5 and 6. A range of capacity building approaches will be supported to ensure that key skills are maintained and updated, these include:

- training across all five objective areas including CHWs and NCDs;
- health worker exchanges between divisional and lower level health facilities; and
- doctor exchanges between the divisional hospitals.

FHSSP will purchase equipment to assist with effective and efficient delivery of care at service levels. The training and procurement plans for FHSSP are included in Annexes 7 and 8 respectively.

Proposals that have been submitted for funding for FHSSP that falls outside the key objective areas is presented in Annex 9 and a schedule of meeting and key dates for 2012 is outlined in Annex 10.



# 2. PROGRAM DESCRIPTION

## 2.1 Overview of FHSSP

FHSSP is a 5-year, AUD25 million dollar program funded through AusAID, on behalf of the Australian Government and working closely with the Fiji Ministry of Health (MoH). The Program is implemented by Brisbane-based company, JTA International (JTA).

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).

There are five key objectives for FHSSP:

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 MoH 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 the higher level outcomes for which the MoH is accountable. The Program embraces the principle of managing for results while at the same time supporting mutual accountability within the MoH.

FHSSP will work with and seek to strengthen the MoH'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 MoH 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.

The goals of FHSSP enable the Program to 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 maternal health and reduced maternal morbidity and mortality; and
- improved child health and reduced child morbidity and mortality.

Furthermore, the Program is closely aligned with the MoH's key priorities outlined in the MoH Strategic Plan 2011-2015 for the coming five years; 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 targets[1], and its rising poverty levels, which reflect the country's deteriorating economic situation[2]. 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

[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)

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 year[3].

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.

## 2.3 Program Governance

Effective governance arrangements for the Program ensure there are appropriate forums for both the MoH and AusAID to jointly monitor and evaluate progress of the program, ensure accountability for program process and outcomes, and for disbursement of funds.

The Program Coordinating Committee (PCC) is the primary high-level strategic decision-making and monitoring mechanism, and as such is the highest level governance committee for the program. The PCC is chaired by the Permanent Secretary of the MoH, with meetings held on a six monthly basis. Any major decisions concerning future directions for the program are presented and discussed at these meetings, with the Annual Plan for the Program submitted to the PCC for review and approval each November. The PCC will need to consider all requests for variations above FJD100,000 and all requests that have not been budgeted and approved in each Annual Plan.

The Program Management Group (PMG) is responsible for the operational management of FHSSP; undertaking monitoring of the program progress and ensuring coordination with existing MoH activities. The PMG meets quarterly, the timing of which aligns to the timing of the National Health Executive Committee (NHEC) meetings, and is chaired by the Deputy Secretary Policy, Planning and Analysis. The PMG is able to make decisions on variation requests up to FJD100,000.

Program expenditure is monitored by the Finance and Audit Committee (FAC), which provides advice and recommendations to the PMG and PCC on FHSSP expenditure. The FAC is chaired by the Program Director and meets monthly.

In order to support and facilitate decentralised management and monitoring, FHSSP will attend the quarterly divisional plus meetings where public health management and divisional hospital staff get together to report and discuss ongoing issues.

[3] ADB (2009), Asian Development Outlook 2009, http://www.adb.org/documents/books/ado/2009/FIJ.pdf

## 2.4 Delivery of the Program and Operations Management

The Program Director has overall responsibility for the implementation of FHSSP, supported by the Deputy Director—Technical and the Senior Program Administrator (SPA). These three positions make up the in-country FHSSP management team and the structure aims to ensure that the program meets its objectives and is implemented with strong financial and governance principles. The program is supported by five Technical Facilitators; with one attached to each Objective area. Each Technical Facilitator provides technical advice and liaises with key stakeholders to ensure effective and efficient coordination of activities.

Each year the Annual Plan and budget is developed in line with the MoH strategic planning process. This is reviewed on an on-going basis throughout the year, with quarterly update reports, to ensure the program is on track to meet its deliverables.

FHSSP operations are managed by the in-country SPA, who works closely with the FHSSP Management Team. The FHSSP in-country team is supported by the fulltime JTA Senior Project Coordinator—FHSSP in Brisbane, who works closely with the SPA and FHSSP support team to provide financial, human resources, secretariat, administrative and corporate support. Oversight is provided by the JTA Senior Program Manager responsible for FHSSP. The management of FHSSP by the in-country team with support from the JTA head office ensures smooth running of the program from an operational perspective, as well as ensuring the overall program goals and objectives of the MoH are met.

Manuals covering the financial, administrative and HR processes have been developed to support the operations of FHSSP and are reviewed annually. These manuals are supported by the JTA ISO 9001-accredited Quality Management System and existing HR and financial practices and systems. Appropriate technologies are in place to support an environment of clear and responsive communication ensuring that all team members can access the FHSSP Management Team, both to respond to emerging programmatic issues and to ensure safety and security during emergencies.

# 3. REVIEW OF FHSSP PROGRESS TO DATE

FHSSP commenced in July 2011, with the first 6-months of the program dedicated to mobilisation, start-up of key program activities and development of long-term plans, such as the FHSSP MEF. The FHSSP Management Team and Technical Facilitators spent much of July and August working on the development of the 2011 work plan and budget, with the majority of 2011 activities commencing in mid-August.

## 3.1 Key achievements in 2011

The focus of 2011 was for the Technical Facilitators to undertake situation analyses in the five key objective areas, in order to ensure there was a baseline for activities from 2012 onwards. In the first quarter of FHSSP, audits for safe motherhood, infant and child health and diabetes services commenced along with a situation analysis of the community health workers. Training and/or awareness raising activities occurred in all five key objective areas and included:

- safe motherhood outreach training for community health workers and nurses;
- Integrated Management of Childhood Illness (IMCI) training in the Western Division;
- NCD activities to coincided with World Diabetes Day;
- development of a primary health care training manual for community health workers; and
- mentoring on monitoring and evaluation activities.

In addition, the Program management team and the Technical Facilitators provided support in priority areas as identified in the 2011 work plans, supported the MoH develop the 2012 Annual Corporate Plan and provided secretariat services to the donor coordination meetings.

In August and September 2011 the first round of FHSSP governance meetings were held. Feedback from these meetings indicated strong on-going support and commitment to FHSSP activities by MoH counterparts.

### 3.2 Key challenges in 2011

In 2011 the key challenges were:

- ensuring the program and staff were mobilised in a timely manner and developing the financial and administrative policies, to enable program activities to commence quickly;
- developing the 2011 workplan and budget within the first 2-months of the program, again to ensure program activities commenced quickly;
- evaluating existing monitoring and evaluation capabilities and commencing the development of a suitable MEF which meets the needs of FHSSP and the MoH; and
- building relationships and understanding with counterparts in the MoH to ensure FHSSP is understood, funds are utilised appropriately and requests for funds are submitted in a timely manner.

### 3.3 Budget 2011

By the end of the fourth month of program activities, AUD681,564 had been spent; AUD131,759 on program activities and AUD549,804 on operational costs.

In addition $5,705 of the unallocated funds was used under objective two. These funds provided support to address a rubella outbreak, which was classified as an urgent emerging health priority. The procurement of additional testing kits, new equipment and transport will be made possible through the use of these funds.

As part of the 2011 budget, ten Technical Support Officers (TSO) and one Technical Assistance (TA) were recruited in 2011 across the objective areas. The TSOs were short-term engagements bought in to support the Technical Facilitators in the achievement of their 2011 work plans. The TA provided support to the Public Health information system under Objective 5.

## 4. ANNUAL WORK PLAN 2012 BY OBJECTIVE AREAS

This section of the report presents the work plans for each of the five key objectives, outlining the key areas of support for 2012. The focus in 2012 is on using the information from the audits and situation analyses conducted in 2011 to upgrade and equip facilities, and continue training and capacity building initiatives.



## 4.1 Safe Motherhood

*Objective 1: to institute a Safe Motherhood program at Divisional and Sub-Divisional Levels*

### 4.1.1 Context

Safe motherhood means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth. Safe Motherhood and mother/baby safe initiatives are based on a number of underlying principles that are fundamental components of the primary health care system. The intrinsic components that require strengthening include:

- the need to base interventions on scientific evidence;
- the redistribution of resources to communities where people live (decentralization);
- the delegation of responsibility whilst maintaining support and supervision; and
- the provision of cost effective, sustainable, quality of care through community participation and teamwork.[4]

### 4.1.2 Issues for Consideration

Several constraints to achieving optimal outcomes in the area of maternal health were identified during the design of FHSSP. These include:

- a high incidence of late presentation for ante natal checks;
- the ability of staff to undertake outreach visits to sub divisional health institutions;
- a shortage of standardized protocols and guidelines for both nursing and medical staff at nursing stations, health centres and the sub-divisional hospitals (SDH); and
- a weak system and culture of monitoring and evaluating services.

In addition, there was an inconsistency in the size and population catchment for similar level of health facilities. Some facilities with small workloads were better equipped and staffed than others with much larger workloads. Many of the SDHs require upgrading in relation to staffing skills, equipment and facilities before they could be classified as mother/ baby safe.

### 4.1.3 Key activities for 2012

To assist in addressing the issues, FHSSP will work with MoH and other local and regional partners to:

- raise awareness of the need for early presentation through a mass media campaign and use of other Information Education Communication (IEC) materials;

[4] WHO (1994), "Mother Baby package, implementing safe motherhood in countries".

- build on previous training and existing skills to strengthen skills for nursing and medical staff at the subdivisions on antenatal, labour and post natal care;
- strengthen family planning and counselling skills through training;
- update and expand the existing available Clinical Practice Guidelines (CPG) for the management of high risk pregnancies and update CPG's for the management of planned and low risk deliveries at sub divisional levels;
- implement the proposed role delineation for deliveries so that only planned and normal deliveries are done at the nursing stations and health centres, while all low risk deliveries are referred to SD Hospitals and the high risk deliveries to divisional hospitals;
- upgrade selected SDH to 'mother safe' status to improve quality care for women and reduce the load on divisional hospitals; and
- formalise regular outreach services at all levels of the decentralized health system.

The specific activities for 2012 for Objective One that will be undertaken in partnership with the MoH are outlined below:

- conduct of comprehensive media campaigns for safe motherhood will be conducted on a quarterly basis. These aim to deliver messages that incorporate early booking and will be broadcast through radio and television and accompanied by banners, posters and pamphlets;
- develop and trial of a 'modified' early booking kit that will include equipment for a blood 'spot' test for syphilis and anaemia will be facilitated. The kits are earmarked for health centres and nursing stations to provide quick and easy results for those women in rural areas coming for early bookings. Early detection and treatment of these two conditions can decrease the impact on mother and baby;
- support the upgrade of facilities for maternity services at selected SDH's including purchasing basic obstetric equipment, improving the quality of care and upgrading the services to the 'mother safe' standard will be provided. To enable effective use of the new equipment by staff, FHSSP will work with the CSN Obstetric Committee to develop accreditation criteria for 'mother safe' training based on the WHO 12-point checklist. Support for Emergency Obstetric and Neonatal Care (EmONC) training at the national and divisional levels with the view to maintaining doctors' and nurses' skills to meet obstetric emergencies will also be provided;
- establish post miscarriage services in the five identified SDH, to enable them to achieve EmONC 'basic facility' status will be facilitated. Activities will include developing a training package for doctors and purchase of essential equipment necessary for delivery of the service;
- support capacity development with midwives visits from divisional hospitals to sub divisional hospitals to conduct in- service training on midwifery practices, and to accommodate short-term attachments of nurses from the sub-division to divisional hospital for midwifery up skilling together with doctor rotations amongst the divisional hospitals will be facilitated;
- coordinate with other stakeholders, including civil society organisations (CSO), to support the reproductive health program through the promotion of family planning (FP) awareness, contraceptives use and a media campaign to educate teenagers about safe sex, contraception and prevention of Sexually Transmitted Infections and HIV. A training package on family planning for nurses at the sub divisional level incorporating Jadelle implants will be developed and presented to the Fiji Nurses and Midwives Board/ Fiji Nursing Council for endorsement;

- maintain Baby Friendly Hospital Initiative (BFHI) status in all hospitals throughout the divisions through training of assessors will be supported. This will enable each facility to be responsible for monitoring and maintenance of their BFHI status;
- support for nurses to undertake midwifery training using a cost sharing mode' at both FNU and Sangam Schools of Nursing; and
- work with the CSN Obstetric Committee to draft a memorandum of understanding for Fiji National University (FNU)/MOH partnership for nursing and midwifery training will occur.

## 4.2 Infant and Child Health

*Objective 2: To strengthen infant immunisation and care and the management of childhood illnesses and thus institutionalise a "healthy child" program throughout Fiji*

### 4.2.1 Context

In order to institutionalise a healthy child program in Fiji and ensure the provision of high quality service delivery at the decentralized level, two key areas of child health have been identified as needing support in 2012:

- the need to strengthen the capacity of both medical and nursing staff to manage childhood illness at decentralised levels; and
- the need to reduce the high rate of immunisation defaulters.

### 4.2.2 Issues for Consideration

A number of constraints to achieving these goals have been identified and will be addressed in the activities proposed for 2012. These relate to staff skills; transport issues; the need to upgrade facilities; and adequate monitoring of child health indicators.

### 4.2.3 Key activities for 2012

This objective has been broken down into four outputs to be achieved in 2012.

The first output focuses on strengthening the EPI Program through planning for the introduction of, and funding for the pneumococcal, rotavirus and human papilloma virus vaccines. FHSSP will provide support to activities including:

- develop a communication strategy and training package to promote and build the capacity for the new vaccine introduction. This training will be delivered concurrently with training for the new MCH card;
- support to Child Health week in 2012, which will serve as the official launch for the new vaccine introduction and IEC package;
- support for an immunisation coverage survey as part of the Demographic Health Survey that MoH has planned for 2012; and
- support for basic EPI training ensuring it reaches all nurses new to EPI in each sub division. Revision of the EPI training package developed by FHSIP will be undertaken to ensure inclusion of the new vaccines and other important child health activities and the subsequent training will

be delivered by MoH staff. Micro planning workshops aimed at middle level managers will focus on EPI data review and planning for new vaccine introduction.

Aligned to this output, linkages with WHO, UNICEF, JICA and NZAID will continue through PIPS (Pacific Immunisation Program Strengthening) Partners.

FHSSP will support MoH and FHSSP staff to attend the Public Health Association of Australia (PHAA) 13th Immunisation Conference which is the premier immunisation conference in the southern hemisphere. The conference will provide valuable updates and current advances in vaccines, vaccine stock management and cold chain; benefits will also include updates on pneumococcal, rotavirus and HPV vaccines. It will also provide a valuable networking opportunity to re-establish linkages with the PHAA with the aim of revitalising the Public Health Association of Fiji.

The second output relates to the training and capacity building around the Integrated Management of Childhood Illnesses (IMCI). The key activities of IMCI support will involve:

- training of Sub Divisional IMCI supervisors who can assess competencies; ensuring those who are IMCI trained have the necessary equipment and supervision;
- supporting IMCI master training and IMCI basic training; and
- reviewing the IMCI register to assist in identification of priority areas to target IMCI training in 2012, ensuring there are quality paediatric services at decentralised levels. This will complement the modified community health worker IMCI training that aims to improve access to care though identification of a sick child and early referral.

The third output focuses on capacity building and training of health care professionals to ensure whole of spectrum of continuum of care. Specifically:

- support for specialised paediatric training such as paediatric life support and further roll out pocket book training, promoting the standard treatment guideline for treatment of sick children in Fiji. Training priorities will include those nurses who have completed all 4 specialist paediatric training courses thus aiming to certifying these nurses as Paediatric Nursing Specialists, after a clinical attachment. The aim is to certify 10 nurses in 2012 and to have these recognised as part of a specialist cadre of nurses. This specialist training will be embedded in FNU in the coming years and the nurses trained will be included for vocational registration under the Nurses Decree;
- implement the recommendations from the 2011 national malnutrition study will be addressed in 2012;
- support a training of trainers for Infant and Young Child Feeding (IYCF) ensuring there are IYCF trainers at decentralised levels across Fiji. Support will also include reprinting of existing nutrition IEC; and
- support will be provided to the Oral Health Unit for capacity building of oral health workers and in the reprint of IEC materials. This will complement the inclusion of the oral health information in the revised MCH card.

The fourth output will focus on reducing peri-natal mortality. The results of the equipment audit for treatment of paediatric cases undertaken in 2011 will inform the equipment procurement in 2012. This will be endorsed by the paediatric CSN, with MoH being responsible for ongoing maintenance of

the equipment. Procurement will focus on sub-divisional hospitals having appropriate equipment and facilities to deliver quality neonatal and paediatric care.

Ongoing support to Mataika House will be provided to ensure a quality vaccine preventable surveillance system is established. This complements the support provided by FHSSP in 2011 during the rubella outbreak and will support the planned new vaccine introduction in 2012. MoH will take over this support in 2013.

And finally, support will continue for the Paediatric CSN ensuring one national Paediatric and Public Health CSN meeting and three smaller clinical CSN's meetings in 2012. Support will also be provided to clinical attachments to the neonatal unit as well as to general paediatric wards for IMCI nurses.

## 4.3 Non-Communicable Diseases (NCDs) – Diabetes Control

*Objective 3: To improve prevention and management of diabetes and hypertension at decentralised levels*

### 4.3.1 Context

As Fiji transitions to a lower-middle income country, non-communicable diseases (NCD) are becoming an increasing cause of mortality and morbidity. By 2007, around 82% of deaths in Fiji were due to NCDs, 10% to communicable diseases and another 8% to other causes. High prevalence rates of diabetes, cardiovascular disease, cancer and hypertension are attributed to lifestyle changes, poor diet, smoking and changing patterns in physical activity, and continuing nutritional problems particularly in school children and women. Diabetes now affects over 16% of the adult population and together with hypertension is a significant risk factor for coronary vascular disease. Importantly, diabetes itself also carries a very significant morbidity[5]. Diabetic foot sepsis and diabetic retinopathy are major and preventable complications, which both lead to considerable disability if not managed effectively. Ministry of Health data indicate that amputation rates for diabetic foot sepsis continue to increase.

### 4.3.2 Issues for Consideration

The FHSSP design team noted that awareness of the risk factors for diabetes, and the importance of early detection and management of diabetes at the community level were low. This, together with low rates of screening, is resulting in the late presentation of patients with diabetes. Moreover, a poor understanding about the complications of diabetes and a lack of diabetes outreach services in some subdivisions is contributing to late presentation and sub-optimal care of patients with diabetic complications such as foot sepsis.

### 4.3.3 Key activities for 2012

Working in partnership with the MOH the key activities for 2012 are outlined under five output areas for this objective.

[5] 2002 data is based on the NCD STEPS Survey (for age groups between 15-64yrs) and there is not sufficient data by year to measure the trend. A new STEPS survey is currently in progress, and the report is expected to be available in mid-2012.

The first of these is to improve prevention and management of diabetes and hypertension at Divisional and Sub-Divisional levels. This will be achieved through:

- supporting population screening during the World Health Day in April and NCD month including World Diabetes Day in November. Sub-divisions will submit the targets for the number of people to be screened, a record of all clients screened and the interventions provided will be documented;.
- collaborating with major stakeholders such as the Ministry of Education and the WHO Health Promoting Schools Project initiative to ensure accuracy and consistency of key health promotion messages. This is an important entry point for healthy living including the prevention of obesity in school children and to build in good lifelong eating habits. This also complements and informs all the support that AusAID is giving to the Ministry of Education and to WHO; and
- reviewing the Green Prescription.

The second output focuses on the roll-out of a Fiji Adult Personal Diabetes Record Book (APDRB). A distribution register will be kept to ensure all registered people with diabetes are receiving an APDRB for continuum of care. The pilot sites will be the first ones to distribute the record book, with the aim of rolling this initiative out to all sites managing people with diabetes. A monitoring tool will be developed to ensure that the APDRB is used for continuum of care. Input received from the clinicians and patients in the use of the APDRB will contribute to improvement of the book.

The third output aims to ensure the setup of quality diabetes centres at sub-divisional hospitals and selected major health centers. At a minimum, thirty-two centres need to be audited including:

- Divisional and sub divisional hospitals; and
- Level A health centres.

Audits carried out in 2011 will be used to upgrade the facilities and further sites will then be identified for auditing. As a result of the audit findings a number of activities will occur:

- upgrading at the first eight pilot sites focusing on space, equipment, training, consumables and other aspects to improve diabetes management. Documented standards for management of NCDs at the SDH and Health Centre level will be developed once the upgraded services begin to roll out; with on-going Diabetes CSN then able to be undertaken;
- identifying and developing of further tools for training for example, a Foot Care manual. The NCD Tool Kit audit will also continue at the other identified sites. The gaps, numbers and lists of equipment will be identified to ensure that the requirements for fully full functional NCD Tool Kit can be rectified; and
- training in the use of NCD Tool Kits will continue in all identified health facilities using the trained mentors at the sub divisional hospitals. There will also be a program to supply and train the SOPD staff in the use of the Screening equipment for the complications of diabetes which are skin conditions (sores, ulcers), nerve damage (numbness of toes), artery damage (heart, eyes and feet) kidney involvement and eye damage (cataracts, blindness) commonly referred to as SNAKE.

The fourth output aims to strengthen the role of the National Diabetes Centre (NDC) and the NCD HUBs at the divisional level. Revised roles and responsibilities will be implemented and this will include training, equipment, development of processes and procedures as well as other identified

needs especially of the NCD Hubs. Outreach services, review of the NCD services at the divisional Hospital SOPDs as well as the mid-term review of the NCD Strategic Plan will also be supported.



The final output in the diabetes control objective is the building of capacity and training of health care professionals. A number of activities will occur as follows:

- conduct of a training needs analysis for Health Care Workers (HCW) at the additional health facilities will be conducted and the training plan for the previous 8 pilot health facilities will be implemented;
- support to Community Health Workers (CHW) training in prevention of NCDs; and
- support the building of partnerships with major stakeholders for accredited training packages in NCD prevention and management.

## 4.4 Primary Health Care

*Objective 4: To revitalise an effective network of Village/Community health workers (VHW/CHW) as the first point of contact with the health system for people at community level.*

### 4.4.1 Context

The FHSSP design document highlighted the increasing burden of diseases and strain on health facilities in Fiji is a result of poor health practices and health seeking behaviours by people at the community level. Community participation in activities that improve healthy lifestyles and health seeking behaviours including accessing primary health care is essential for community members if they are to assume responsibility for their health.

The design document also highlighted the need for the MoH to revitalise primary health care through the CHW program, including training in the importance of Safe Motherhood, Childhood immunisation and illnesses, prevention and control of diabetes, strengthening patient follow-up and improving compliance with medications. The aim of the revitalisation of the CHW is to maintain wellness as well as to prevent and control illness. In order to achieve this goal CHWs need to have the training and tools to assist them in monitoring wellness levels and controlling illnesses of those already afflicted. They will also need to understand the importance of early referral of a sick client.

### 4.4.2 Issues for Consideration

Given the nature of the Community Health Worker roles and place in the community, activities under objective four require collaboration across all FHSSP five objectives as well as with other ministries outside of health. The focus for CHW training must be on 'wellness' rather than an extension of clinical services. Collaboration with clinicians and other key stakeholders will be essential to ensure the revitalisation of the CHWs is a success.

### 4.4.3 Key activities for 2012

The first output for this objective will address the revitalisation of CHW training to ensure there is an effective cadre of trained and resourced CHW who are able to promote public health practices and health seeking behaviours, provide basic first aid and effectively refer patients to the next level of health services. This will be achieved through:

- finalising the CHW manual in early 2012;
- procuring CHW tool kits to monitor changes in health status of community, which will complement the revitalisation of CHW training and will be distributed in 2012. These tools will also be used to monitor the control of NCDs such as diabetes and hypertension in the community as well as taking assessment vitals during an emergency;
- implementing in the Northern Division Health Services which has commenced this process;
- focussing the majority of training at communities to ensure relevant context training and foster empowerment and ownership; and
- setting up of community support groups will be explored and initiated to strengthen this objective.

The second output under this activity involves increasing community ownership and engagement in primary health care. The key focus of this output will be:

- establish health status baselines across Fiji with the data utilised as a base line to measure changes in community health status and the impact on CHW training and resourcing;
- mobilise support for this objective using the traditional community or village set up through the I-Taukei, Rural Development, Town Councils and Social Welfare offices will be emphasised through stakeholder meetings at the divisional levels; and
- implement health promotion activities at village level including smoke free environments, HIV, safe water and will also complement other FHSSP objectives of child health, safe motherhood and diabetes control in health promotion activities.

The third output under this activity will focus on the rolling out of a CHW training of trainers leading to pool of trainers who can conduct CHW training. These master trainers will then be responsible for rolling out CHW training nationally reaching the number of CHW indicated in the individual division's business plans.

Output four will involve the training of supervisors for CHW as well as the establishment of a meaningful M&E reporting system. Supervision for CHW will be supplied by nurses who will need to have knowledge and skills on planning, how to increase objective oriented contact with CHW as well as problem solving at community level. This activity will be conducted in conjunction with the in-service supervisor project that is supported by JICA.

## 4.5 Health Systems Strengthening

*Objective 5: To strengthen key components of the health system to support decentralised service delivery*

### 4.5.1 Context

Strengthening of MoH systems to enable effective delivery of services at divisional and sub divisional levels is an important part of FHSSP, as the success of system strengthening impacts on the MoH ability to capture health data, monitor and measure both patient information, health statistics and the ability of the MoH to provide quality services to the people of Fiji.

### 4.5.2 Issues for Consideration

Currently there are a number of constraints facing the MoH with regards to health systems. These include:

- Ineffective and inefficient use of data for policy planning and service delivery;
- Weak analysis and feedback of public health data;
- Critical knowledge gaps; and
- Weak monitoring and evaluation, supervision, clinical services quality improvement and risk management.

### 4.5.3 Key activities for 2012

The identified key areas for support under this objective are broken down into five outputs.

The first output relates to the strengthening of Public Health Information System (PHIS). The focus in 2012 will be on the revision of all forms and manuals to ensure these collect the information needed to report performance indicators and to develop basic intermediate data collation tools at divisional and sub divisional levels. Training on data collection, analysis and use will be conducted, as will support for the development of presentation skills. Finally, the design of a roadmap for a long term electronic solution and support for higher level statistical analysis at the Health Information Unit including use of population estimates will occur.

The second output focuses on operational research to provide information to support evidenced based policy and planning of health services. The MoH research capacity will be strengthened through specific training programs and partnering with FNU College of Medicine, Nursing and Health Sciences (CMNHS) Research Unit. In order to inform and manage human resources the analysis of the function and workload of district and zone nurses will be conducted.

The third output aims to continue to support capacity building in health systems. This includes the implementation of clinical services plan; specifically to support health worker exchange for attachment between hospitals to up-skill them. The Clinical Services Networks activities will include the compilation of clinical practice guidelines. Capacity building with the development and institutionalizing for infection control, risk management and quality improvement will be further supported in 2012 through:

- Attachments for one officer at the John Hunter Hospital in Australia;
- Review of the Unusual Occurrence Reports[UOR] database;
- Workshop on RCA Infection Control; and
- Meetings for national quality improvement and strengthening.

A Health Symposium is planned to be held in the middle of the year in collaboration with the CMNHS. This forum is a platform to allow MoH to receive updates on key areas of work, present any operational research and collaborate with FNU and the health professional bodies for continuing professional development.

The fourth output will focus on the support for the MoH Planning process. Activities planned include:

- support to the development of Oral Health Strategic Plan, which will be based on the results of the current oral health survey in progress;
- support to capacity building for senior staff in policy development and cabinet paper preparation and is envisaged that this will be conducted by the newly formed Division of Planning, with the assistance of the Long term Technical Advisor due to commence in early 2012. The LTA is also expected to assist in capacity building of staff in the area of planning, monitoring and evaluation; and
- support the development of the MoH Annual Corporate Plan for 2013 as part of the package of support to the PPDA division.

The fifth and final output is Sectorial Coordination which encompasses:

- coordination of development partners' biannual meeting with the Ministry of Health and other Government main line ministries such as Finance, National Planning, Education and Foreign Affairs; and
- support for Divisional Plus meetings at quarterly basis involving divisional hospitals, public health heads of units as well as officers in charge of sub divisions. Sub divisional management meetings are supported to encourage planning, monitoring and evaluation of programs and services at their level and lower levels as well.

## 4.6 Unallocated Fund

The provision of an Unallocated Fund (UF) is in response to a need identified by both MoH and AusAID for flexibility in program funding within defined financial limits. Annually, the Unallocated Fund is AUD1 million (approximately FJD1.8 million) and will be allocated for:

- emergency response situations;
- emerging health priorities; and
- strategic areas not specifically covered in the FHSSP objectives.

Guidelines to govern the use of the Unallocated Fund will be presented to the PCC at the November 2011 meeting.

To date, in 2012, the Unallocated Fund will support:

- upgrades to Mataika house, to strengthen and consolidate the ability of Mataika house to response to disease outbreaks and especially vaccine preventable diseases; and
- conduct of a Demographic Health Survey in Fiji, the results of which FHSSP will use to inform some of the work that is being supported. EPI coverage and family planning coverage will be some of the areas identified to be included in this survey.

Four other proposals have been submitted to FHSSP for consideration for funding under the UF and these include:

- upgrade of the inventory system at the Fiji Pharmaceutical and Biomedical and Services (FPBS);
- upgrade of Levuka hospital;
- provision of medical boats for Vatulele and Nacula health centres; and

- upgrade of Lautoka hospital.

## 4.7 Training

To ensure the provision of high quality service delivery at the decentralized levels requires capacity building of both medical and nursing staff. In 2012 FHSSP will support training of staff at divisional level and below, across the five objective areas. To ensure the maximum benefit to staff from training activities, without taking away from their core duties, a coordinated approach will be taken to training, with a training plan covering the five objective areas at Annex 7. Exact dates for the training courses will be scheduled based on the availability of the individual areas and other training commitments.

Training activities in 2012 will include:

- Objective 1: EMOC workshops across each Division, obstetric emergency training, family planning training, midwifery training and training for Assessors for Baby Friendly Hospital Initiative;
- Objective 2: EPI training, integrated management of childhood illness supervisor and management training, paediatric and advanced life support training, WHO Pocket Blue Book;
- Objective 3: NCD toolkit usage training, diabetes centre training by CSN specialist clinicians, training for HCW and training in diabetes educational material;
- Objective 4: training in community health action plans, training of Village Health Care Worker trainers and Village Health Care Workers, M&E training of supervisors; and
- Objective 5: PHIs training in data collection, analysis and use, management skills training and capacity building of senior staff in policy development and government writing skills.

## 4.8 2012 Budget

The budget as per Table 1 is provided in both AUD and FJD. The exchange rate used below is FJD1: AUD 0.58. This budget is based on the Year 2 budget as shown in the FHSSP Scope of Services, which works on the Fiji financial year (January – December). A month-by-month and detailed breakdown by objective is included at Annex 2. Although the budget presented is detailed to single activity level, this is presented for transparency reasons, it is expected that the program will be accountable to higher level parameters.

Table 1: FHSSP 2012 Work Plan Budget

| | FJD | AUD | Year 2 Budget as per Head Contract (AUD) |
|---|---|---|---|
| **Objective 1** | $895,700 | $519,506.00 | $550,000 |
| **Objective 2** | $1,042,500 | $604,650.00 | $320,000 |
| **Objective 3** | $1,023,840 | $593,827.20 | $450,000 |
| **Objective 4** | $1,040,200 | $603,316.00 | $360,000 |
| **Objective 5** | $814,700 | $472,526.00 | $340,000 |
| **Unallocated Fund** | $1,724,138 | $1,000,000.04 | $1,000,000 |
| ***TOTAL PROGRAM BUDGET*** | ***$6,541,078*** | ***$3,793,825.24*** | ***$3,020,300*** |

*Note: Where activities have been funded from the unallocated fund the item is listed in its objective, but the funds held against the unallocated fund line in the budget (Annex 2).*

The proposed budget is currently well over the limits for year two as defined the Scope of Services; by AUD773,825. This is due to objective two, three and four having significant expenditure, primarily on equipment in year two that the Scope of Services document initially marked as occurring in Year 1 of the program. Due to the audits required to identify equipment and training

needs prior to the purchase of equipment or development of training, these activities have been pushed out to Year 2. Furthermore, in objective five there is a significant spend for 2012 due to the inclusion of the planning element of FHSSP as well as the HMIS. The PHIS system and funding of a 2-year LTA for the MoH Planning Division have resulted in an over budgeting by AUD132,526.

There are three ways this can be addressed:

1. Reduce the budget by the over budget amount for each objective to fit within the year two budget allocation. This is not recommended, as the budget and work plan has been developed in conjunction with the MoH and it is anticipated this level of work and expenditure is achievable in year two.
2. Make use of the unallocated fund, as per the draft Unallocated Fund Guidelines. Currently only objective two has budgeted unallocated fund usage in 2012 (at FJD175,000), as there are clear links between the unallocated fund criteria and the proposed activities. If AUD773,825 of proposed budgeted activities are reallocated to the unallocated fund, this will take the unallocated fund proposed usage in 2012 approximately 94%. However this does not leave much room for emergency and emerging issues and goes above the 80% limit the Unallocated Fund Guidelines recommend for pre-allocation outside of emergencies. However, the November FAC meeting is proposing that PCC consider rolling over FJD 370,000 (AUD214,600) of budgeted funds for activities in 2011 that were not completed. If this was to occur, only AUD559,255 would be required from the unallocated fund, or 56%. It is also important to note that if the unallocated fund is reallocated to 80% capacity, with remaining 20% for emergencies, consideration may need to be given to re-allocating those funds if in an emergency situation there is a need for more than the allocated 20%.
3. Roll over all remaining funds from 2011, both budgeted and unspent (FJD370,000) and unbudgeted but allocated in the Scope of Services to year one (FJD1,603,345) totalling FJD1,973,345 (approximately AUD1,145,000). Should unspent funds from year one be rolled over into year two, this will negate the over budget issues as well as enable a higher level of usage of the unallocated fund in an emergency situation as well for emerging priorities and the inclusion of additional proposal during the year.

The final issue on the budget is to ensure that the unallocated fund spending is monitored throughout the year, with additional activities planned, should the fund not be needed for emergencies. The unallocated Fund Guidelines will assist the PCC in making these decisions.

# 5. STRATEGY FOR IMPLEMENTATION

## 5.1 Targeting vulnerable groups

FHSSP seeks to address vulnerable groups and individuals through several strategies as embedded in the design.

*People living in settlements*: In recent years there has been an increase in the drift of rural people to urban and peri-urban areas – especially in the Suva-Nausori and the Nadi-Lautoka corridors. Anecdotal reports suggest that people living in these settlements may have increased socio-economic vulnerability – in part because they are often jobless. Furthermore, the traditional links between residents and their local health facility are less likely to exist in settlements, with many settlement dwellers going directly to CWM or Lautoka Divisional Hospital for basic health care. The design acknowledges that it may be important to increase demand and access to local public health

services for these communities and establish links with the CHW network. The consultations that the TF Primary Health Care has started with I-Taukei ministries have set up a good foundation in how FHSSP can access these non-formal settings. These consultations will be expanded to other ministries like Rural and Urban Development, Social Welfare and Town Councils to get their support for the health initiatives that FHSSP and MoH are doing. The community profiling that is being conducted by the MoH will give us some data on health practices and health-seeking behaviour in peri-urban settlements.

Operational research proposed under Objective 5 of this Program could include assessing settlement community habits in relation to exercise, diet, health practices and health-seeking behaviour. This research, when combined with findings from Fiji's forthcoming second STEP Survey on NCDs, will provide an enhanced evidence base on which to develop strategies and initiatives to reduce the vulnerability of settlement dwellers, especially in regard to safe motherhood, child health and the prevention and management of diabetes.

*High rates of amputation from diabetes*: Currently there are some 200-300 amputations per year resulting from the complications of diabetes. It is understood that after surgery, these amputees often lose their jobs and the ability to support their families. A central plank of this program is the prevention of diabetes and the early detection and management of complications, thus over time reducing the incidence of amputations within the community.

*The mentally ill*: There is concern that mental illness is an "iceberg" disease in Fiji, with much of the problem being hidden. One of the successful activities of FHSIP was to train nurses to identify mental illness at an early stage, refer clients for assessment by a specialist psychiatrist and, where appropriate, enable patients to be treated in an outpatient environment – rather than late detection and long term hospitalisation at the specialist psychiatric hospital. While mental illness is not a core strategic focus of the program, provision will be made under the unallocated fund for the continuation of priority areas initiated under FHSIP, such as mental health. Support for the development of the Mental Health Strategic Plan will be provided by FHSSP in the next six months.

## 5.2 Monitoring and Evaluation

The development of a MEF for FHSSP will be achieved through a two stage release phase.

Release one, finalised in October 2010, described the overall program logic, the related performance indicators, the mechanisms for collecting dates and the inter-relationship of the Program framework with the broader Fiji Ministry of Health structures and processes.

Release two, scheduled for February 2012, will refine the indicator set based on collaborative work with the MoH to address the identified gaps in indicator definition as well as provide baseline measures for indicators and refine the proposed data collection methods.

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 the MoH. However, it is recognized that there will be a need for some program specific indicators and data collection.

Furthermore, it is the intention 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 with the results 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 that are currently weak.

## 5.3 Use of Technical Support Officers and Technical Assistance

In order to achieve the 2012 work plan for FHSSP, it will be necessary to bring in specific expertise to undertake activities and ensure that the right mix of skills is deployed to achieve the program outcomes, without draining scarce MoH resources. The core FHSSP Team consists of the five Technical Facilitators (TFs), one Assistant TF and two Technical Mentors (TMs). Additional technical support officers would work closely with the TFs to deliver program outcomes.

There are a number of guiding principles that will be used when the decision is being taken to mobilise either international Technical Assistance (TA) or Fijian Technical Support Officers (TSO).

The positions will be:

- Short term
- Tied to specific deliverables
- Needs driven
- Appropriate
- Value for money
- Regularly and closely monitored

In 2012 it is anticipated 2 TA and 10 TSOs will be required. The details and Terms of Reference for these positions can be found at Annex 5 and 6.

# 6. RISKS AND THEIR MANAGEMENT

FHSSP is proactive in managing and monitoring risks with the Risk Management Plan (Annex 4) reviewed and updated at least six monthly. FHSSP's approach to implementing the FHSSP Risk Management Plan is founded on the following principles:

- thorough risk identification, assessment and prioritisation;
- development and implementation of effective risk mitigation strategies;
- ongoing monitoring of risk mitigation and management strategies;
- timely reporting of ongoing and emerging risks, implemented mitigation strategies and risk management outcomes with AusAID and other key stakeholders, both on a regular and on ad hoc basis;
- regular review and evaluation of Program risks and mitigation strategies; and
- development and maintenance of effective formal and informal communication networks to support the identification and ongoing management of risks.

The FHSSP team recognises that the management of the FHSSP Risk Management Plan will be most effective when undertaken in close collaboration with key stakeholders (particularly the MoH and

AusAID). Open communication, clear role definition, accountabilities and transparency are required in the identification, sharing and management of risks with the MoH and AusAID—and critical to the success of the Program. The team also recognises that effective management of the FHSSP Risk Management Plan is reliant on the maintenance of strong corporate policies to ensure that supportive frameworks exist to minimise risks.

The key program risks are identified below and expanded upon in the Risk Matrix. Activities to address these risks are also contained in the Risk Matrix.

- ensuring appropriate management of the program given the current Government to Government relationships in the current political environment;
- ensuring that due to the high level of funding available through the Program there is not a skewing of MoH priorities towards the Program areas, or Program funds displacing available MoH resources;
- ensuring that FHSSP issues are picked up at the Divisional level, through the use of the Divisional meetings;
- continuing monitoring of the governance mechanisms, to ensure that sufficient operational oversight is being provided in a meaningful manner.
- ongoing assessment and refining of monitoring and evaluation activities, which continue to be a concern due to data being both incomplete and insufficiently analysed to assess the progress of this program; and
- managing of the financial risks which include issues due to currency fluctuation, potential underspend of program funds, poor management of the unallocated funds and potential for slow transition of funds in emergency situation.

Whilst FHSSP will support MOH in strengthening systems and processes the high turnover of staff, lack of experienced staff and competing priorities are a major risk to achieving Program outcomes.