Fiji Health Sector Support Program

2011 Annual Report

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Annexes

2. List of Acronyms and Abbreviations

ALSO	Advanced Life Support – Obstetrics training
CHW	Community Health Workers
CPG	Clinical Practice Guidelines
CSN	Clinical Service Networks
DMOs	Divisional Medical Officers
EPI	Expanded Program on Immunization
FHSIP	Fiji Health Sector Improvement Program
FHSSP	Fiji Health Sector Support Program
FSMed	Fiji School of Medicine
FSN	Fiji School of Nursing
GFATM	Global Fund to fight AIDs Tuberculosis and Malaria
GoF	Government of Fiji
IMCI	Integrated Management of Childhood Illness
JICA	Japan International Cooperation Agency
JTA	JTA International
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MoH	Fiji Ministry of Health
NCD	Non Communicable Disease
NDC	National Diabetes Centre
NHEC	National Health Executive Committee
NGO	Non-Government Organisation
PATIS	Patient Information Systems
PCC	Program Coordination Committee
PHIS	Public Health Information System
PIPS	Pacific Immunisation Program Strengths
SPC	Secretariat of the Pacific Community
TF	Technical Facilitator
TSO	Technical Support Officer (Local recruitment)
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

1. Introduction

Though entitled the Annual Report, this Report details the achievements and challenges of the first six months of the Fiji Health Sector Support Program (FHSSP) which commenced on 1 July 2011. This Report addresses the Program's key achievements and implementation challenges as well as outlining future strategies for Program implementation in 2012.

The first six weeks of the Program were focused on mobilisation and program inception including:

- Development of key documents for administration and finance
- Office set up including information and communication technologies
- Drafting of communication and engagement protocols
- Procurement of assets including vehicles
- Team building and values development for the core team, and
- Briefings with all divisions on the Program objectives.

By mid-July, the team began to develop the work plan and budget to guide the Program in 2011. These documents were prepared in consultation with MoH counterparts and subsequently endorsed by the Program Coordination Committee (PCC) in August. From mid-August, implementation of the work plan began in earnest. Initially expenditure was slow however, by close of the year the Program had expended 61 per cent of the 2011 Fiji dollar (FJD) budget (65 per cent in the Australian dollar (AUD) financial report[1]). This Program under spend is attributed to a range of factors including:

- The mid-year commencement of the Program, initial focus on program start up activities and time needed to consult and prepare the work plan for the remainder of the year
- Currency fluctuations impacting the FJD budget
- Understanding of the FHSSP proposal process at MoH, the divisions and sub-divisions levels, and
- Absorptive capacity of the MoH; FHSSP works through MoH systems and processes where possible and overloaded staff with many competing priorities resulted in delays for some activities until 2012.

To overcome under expenditure, the PCC agreed that delayed 2011 commitments, would roll over into 2012 budget. In addition, at the time of reporting, FHSSP had received a request from the MoH to support training for key MoH staff in the objectives areas. This request will provide funding for post-graduate training in obstetrics, paediatrics, dietetics, midwifery, mental and oral health. This request together with the rollover of the delayed 2011 commitments will result in 100 per cent of the 2011 program funds being expended prior to 30 June 2012. A flying minute has been made for PCC approval of this request.

Strategies to minimise the impact of issues effecting the under spend, and ensure that the Program expends the budget allocation in 2012, are detailed in this Report. In addition, implementation challenges for each FHSSP Objective have been identified and are detailed in the relevant sections below. However there are three common themes occurring across the Program which include:

- absorptive capacity of the MoH, with high staff turnover and vacancies rates at each level of the health system impacts on the scheduling and completion of activities;
- poor compliance with FHSSP proposal development, particularly the sign-off process, leads to delays as proposals need to be re-submitted; and
- weak monitoring and evaluation (MoH) systems in the MoH that does not support evidenced-based decision-making on service delivery.

[1] AUD expenditure percentage is higher in the financial report due to the currency exchange rate fluctuation

1.1 Outline of the Report

Section Two is a brief overview of the Program, noting the goal and objectives. Section Three is a description of the Program's key achievements, implementation challenges and future strategies by objective for the reporting period. Annex 1 is a detailed report from each Technical Facilitator (TF) against the outputs for the first six months of the program. The main focus for the first six months for FHSSP was to take stock of the situation in the each program objective, provide support in priority areas and plan for 2012.

Section Four details program recruitment activities. A list of program reports submitted to the MoH by technical advisers in 2011 is included in Annex 2.

Section Five outlines the program management update on the operations and FHSSP team, including the program mobilisation.

Section Six details the risk management plan and key issues affecting the progress of the program with an updated risk matrix included in Annex 3. Cross sectoral issues including development partner coordination activities is presented in Section Seven. Section Eight details the financial report and program financial performance in Annex 4. While program procurement is detailed in Annex 5 and Section Nine outlines the contractor performance assessment method.

2. Overview of FHSSP

FHSSP is a five year, AUD$15 million dollar program funded by Australian Aid, through AusAID, working closely with the Fiji Ministry of Health (MoH). The Program is managed by JTA International (JTA).

The strategic context within which FHSSP operates has been well documented in the *Australia-Fiji Health Sector Support 2011-2015 Design Document* and *FHSSP Annual Plan 2012.* Importantly 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 assist the MoH to achieve its health outcomes. The principle of country ownership is therefore respected and the Program supports mutual accountability—embracing the principle of managing for results.

Therefore, 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 five program 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.
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).

3. Major Activities and Achievements by Objective

This section breaks down by each of the five FHSSP objectives the key achievements for the first six months of the program and implementation challenges faced. These challenges have informed the future strategies for implementation of the Program in 2012.

The impact of the achievements will be measured in the future using monitoring and evaluation (M&E) framework and data largely provided through the MoH Health Information Unit. However at this stage the M&E Framework is being finalised in coordination with the MoH. Due to the reliance on MoH data to complete this section of the Report, it is proposed that the FHSSP Annual Report be provided at the end of the first quarter (March) to ensure timely collection and analysis of relevant data. See Section 4 below for further details.

3.1 Safe Motherhood

Objective 1: to institute a Safe Motherhood program at divisional and subdivisional Levels

Key achievements

- **Behaviour Change**—as part of the effort to reduce maternal mortality, extensive mass media campaign coverage through television, radio, LED video screens, and print was conducted to promote awareness and encourage early ante-natal bookings during the first trimester of pregnancy.
- **Clinical Practice Guidelines**—the final draft of the first edition for the MoH Obstetrics and Gynaecology Clinical Practice Guidelines covering six major scenarios in the management of obstetric emergencies at the sub divisional level was finalised. This will act as reference material for staff to provide quick and adequate quality service for pregnant and labouring mothers.
- **Mother safe**—eight CTG machines were procured by FHSSP. These will assist clinicians in rural subdivisional hospitals (Vunisea on Kadavu and Waiyevo Hospital on Taveuni) to better monitor a pregnant woman through simultaneous measurement of both the foetal heart rate and the uterine contractions of the mother.
- **Champions**—a group of mature senior and experienced retired nurses were employed as mentors in divisional hospital maternity units and community health divisional offices to be 'champions' for safe motherhood. These champions have acted as:
    - Preceptors for subdivisional nurses on obstetric and midwifery clinical attachments at the divisional maternity units
    - Coordinators to family planning training and counseling at subdivisional levels, and
    - Mentors to subdivisional hospital nurses on the 'early- morning handover report' conducted via telephone which is now gaining momentum in its importance for improved management of antenatal, labouring and post natal mothers.
- **Training—**54 doctors and nurses were trained in the Advance Life Support Obstetrics (ALSO) course. This course will help ensure that all births in Fiji are attended to by a skilled birth attendant and increase the number of health workers up skilled in emergency obstetrics.

Major implementation challenges

- **Communication**—communication channels between hospital and community health is weak and needs to be strengthened. The inability to follow due process in the submission of proposals to FHSSP has led to delays and misunderstanding among subdivisional and divisional staff and FHSSP. The current inefficiencies affect the ability for quick handling and processing of proposals sent to FHSSP.
- **Donor coordination**—there is a need for better coordination of activities of donor agencies by MoH to avoid duplication and repetition of work.

- **Absorptive capacity**—FHSSP works through the MoH systems and process, an approach designed to strengthen the MoH, however this can result in delays to FHSSP activities when MoH, divisional and subdivisional staff have competing priorities, many positions are vacant and staff turnover is high.

Future strategies

- **Proposal training**—FHSSP will increase training to MoH and divisions on proposal preparation and reinforce that submission of proposals must be signed off and viewed by the relevant senior MoH officials.
- **Coordination**—to improve communication, the Technical Facilitator will attend as many of the relevant meetings at all levels of the health services.

3.2 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

Key achievements

- **Integrated management for childhood illnesses (IMCI)**—FHSSP supported IMCI facilitator training resulting in an additional 14 IMCI facilitators for the Western Division. These facilitators immediately ran an IMCI training course certifying a further 29 IMCI nurses for the Western Division.
- **New vaccines**—FHSSP worked closely with the MoH to develop the tender for the introduction of three new vaccines to the childhood immunisation schedule in Fiji (to address mortality and morbidity from rotavirus, pneumococcal disease and human papilloma virus). The tender is due to be finalised in early 2012 and the vaccines will be introduced later in the year.
- **Paediatric Clinical Services Network (CSN)**— the CSN meeting, held in September 2011, provided a forum for child health professionals across Fiji to meet and discuss key issues. FHSSP funded the two-day meeting that deliberated a range of issues including the recent Child Health Review, Child Health Policy and received updates from key paediatric sub-specialties.
- **WHO Pocket Book training**—FHSSP supported five 3-day WHO Pocket Book training courses in the Central and Northern divisions. The courses were facilitated by the paediatric departments with FHSSP providing the funding; there are now 92 nurses and doctors across the two divisions trained. The WHO Pocket Book is the Paediatric CSN endorsed standard treatment guideline for the treatment of paediatric patients nationally.
- **Malnutrition**—FHSSP responded to the emerging and growing concerns related to the increase in numbers of cases of severe acute malnutrition by funding an urgent meeting to discuss and address the issues.
- **Increasing technical capacity**—in August, FHSSP supported the Deputy Secretary Public Health, National Expanded Program on Immunisation (EPI) Coordinator and the FHSSP Technical Facilitator–Infant and Child Health, to attend the 7th Pacific Immunisation Program Strengthening Workshop and Workshop on Lessons Learnt from pandemic Influenza A (H1N1) Vaccine Deployment and Vaccination, from 22-27 August. The workshop is coordinated by the Pacific Immunisation Program Strengthening (PIPS) partners with secretarial support from WHO, UNICEF, JICA, with representation by FHSSP, AusAID and NZAID.

Major implementation challenges

- **Planning**—much of the child health training was delivered by the Paediatrics department in the last few months of 2011, overloading MoH staff. As noted in the introduction of this Report, the absorptive capacity of MoH staff is a broader issue that impacts on each of the FHSSP Objectives.
- **Absorptive capacity**—Lack of staff in the MoH resulting in the same people dealing with competing priorities. A further impact of this challenge is that at the divisional level, the coordination, development and responsibility for FHSSP proposal development falls to already overloaded MoH staff.

Future strategies

- **Training Plan**—a detailed training plan will be developed early in 2012 that staggers training over the course of the year reducing pressure on trainers and staff.
- **Coordination**—Continuation of Technical Support Officers in 2012 to support FHSSP funded activities including providing coordination on FHSSP proposal development.

3.3 Diabetes

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

Key achievements

- **Personal Diabetes Record Book** – the first edition of the diabetes record book was printed after thorough consultation. This will be distributed through the pilot facilities in 2012 to all registered diabetics. It will serve as an appointment book, record for a multidisciplinary service as well as provide previous results for the attending clinician at every visit. Patients will benefit with the continuum-of-care process and appreciate the need for controlling their conditions.
- **Specialised outpatients departments (SOPD)—**ten pilot health facility SOPDs were audited for diabetes and non-communicable diseases (NCD) services and NCD training needs of the health staff. This will provide information for upgrading the services at the decentralised SOPD for diabetes and NCDs and provide appropriate capacity building for health staff. In the long run, it will help people with diabetes control their conditions and delay or avoid the complications of diabetes.
- **NCD Tool Kit procurement** — nine subdivisions have been audited, this will enable procurement of equipment and consumables to help strengthen NCD screening for people at risk. The NCD Tool Kit program will, through early screening, identify people with risk factors as well as asymptomatic people with diabetes, hypertension and other NCDs. Early diagnosis and early intervention will help reduce ill health and early deaths in young people.
- **NCD month—**November 2011 was dedicated by the MoH as NCD month. FHSSP supported the MoH media campaign with coverage through television, radio and print to promote awareness on the risk factors for NCD.

Major implementation challenges

- **MoH human resources**—the number of vacancies of MoH positions, high staff turnover and overloaded staff impacted on ability of FHSSP in completing the audits in a timely manner. There is also an absence of defined standards for management of NCDs in the decentralized health.
- **Health information**—Lack of up-to-date records on current patients hindered audit results, many registers are very old with some patients now deceased or no longer in the area.
- **Weak monitoring and evaluation (M&E)—**the M&E system within the MOH is weak impacting on decisions made around service delivery.

Future strategies

- **Health information**—FHSSP will continue to encourage the MoH to invest in new patient registers and undertake a review of the previous registers.
- **Clinical Practice Guidelines**—support will be given to develop CPGs for diabetes management at the divisional and subdivisional levels.
- **M&E—**continue to work with the MoH to develop a strong culture of M&E in the MoH, including encouraging the MoH to effectively monitor the standards for facilities that support diabetes management and upgrade facilities as needed.
- **Training—**FHSSP will continue to support capacity building of staff to provide improved care in the prevention and management of diabetes.

3.4 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

Key achievements

- **Community Health Worker (CHW) Situation Analysis**—the FHSSP TSO completed a situation analysis of the CHW and village health worker (VHW) training manual. This work provides a sound platform to guide future priorities. The findings have been presented to the MoH, significant findings include:
    - Inconsistencies in length, location and quality of training provided
    - The existence of CHW/VHW in communities who are not active
    - Lack of IEC materials and toolkits to support CHW/VHW in their roles
    - Lack of community support.
- **CHW Training Manual**—several key documents have been drafted for endorsement by stakeholders in February 2012 which include the:
    - CHW Guide
    - CHW Reference Manual
    - CHW Referral Guide.
- **Stakeholder engagement**—FHSSP supported a range of activities with various stakeholders in particular a meeting of the Roko Tui (Provincial Heads) where an entire day was dedicated to addressing community health issues.
- **Primary Health Care concepts launch**—presided over by the then Permanent Secretary for Health (Dr Salanieta Saketa) at the Lami Health Centre where FHSSP funded community resources for staff training.

Major implementation challenges

- **Cross sectoral collaboration**—initially the MoH was reluctant to engage with other relevant ministries limiting the possible impact of the project. However through consistent technical coordination from the FHSSP Technical Facilitator, a joint Steering committee has been formed and this is working well to date.
- **Policy on Community Health Worker Program**—the lack of a clear policy and strategic direction for community health workers with a focus on wellness and ownership by the communities rather than MoH has limited full engagement and understanding within MoH.

Future Strategies

- **Steering Committee**—FHSSP will continue to support the Steering Committee to ensure that MoH and FHSSP staff are consistent in their communications with the major stakeholders involved in this objective
- **Policy Development**—FHSSP will support the recently appointed MoH Health Promotion Coordinator in developing a policy on the community health worker program

3.5 Targeted Health Systems Strengthening

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

Key achievements

- **Public Health Information System (PHIS)**—prioritisation and implementation of activities identified during the recent review of the Public Health Information System (PHIS) through the National Health Information Committee (NHIC) has begun. In 2011 this included the following activities:
    - Redevelopment of PHIS has commenced with a two-week short term adviser (STA) input to consolidate relevant recommendations from previous reports, as well as reviewing the M&E

requirements of the *MoH Strategic Plan* through a stakeholders' workshop. A plan with budget was also developed for the implementation of the agreed changes in 2012.

- Up skilling Health Information officers on the use of public health data for analysis from the Health Information Unit of the MoH, and Divisional Health Information Officers has resulted in enhancing the production of feedback reports on hospital data, NCDs and tuberculosis data to stakeholders.

- **National CSN Workshop**— a two-day workshop was held on 10-11 November which focused on *The Role of CSN in the NCD Crisis*. This forum enabled the respective CSNs to discuss and map the way forward in resolving this crisis. The Diabetes Clinical Services Network, formed and chaired by the Medical CSN representative, commenced drafting the Clinical Practice Guideline for Diabetes Mellitus.
- **National Quality Improvement Committee**—supported by FHSSP, the agenda focused on drugs and consumable procurement, storage, distribution and usage strengthening.
- **Risk training**—clinical risk issues continued to be addressed and supported through the risk managers in the divisions. Training on the management of clinical incidents and root cause analysis were done in the Eastern and Northern divisions while 32 staff completed quality improvement training in the Western, Central and Eastern divisions.
- **MoH Annual Corporate Plan**—FHSSP supported the MoH Planning, Policy Development and Analysis Division to facilitate the development of this Plan which was endorsed in December.
- **Annual Business Plans**–FHSSP supported divisional hospitals and Public Health Offices to develop business plans in November and December.

Major implementation challenges

- **FHSSP proposal development—**late submissions and tardy acquittals from the MoH and all levels of health services required increased FHSSP follow up delayed activities.
- **MoH Human resources**—high MoH staff turnover resulted in slow implementation of activities.
- **Training coordination**—coordination of training and meetings logistics delayed implementation of some activities.

Future strategies

- **FHSSP proposal development**—improved communication with relevant officers at decentralised levels to complete proposals accurately and in a timely manner.
- **Strengthened monitoring and evaluation**—FHSSP will continue to support and encourage a culture of M&E at the MoH at various levels to improve evidence-based decision making.

3.6 Unallocated Fund

The PCC endorsed guidelines for use of the Unallocated Fund in November. These guidelines note that the unallocated fund should not be used to support ad hoc activities, but used strategically so that activities under this component become sustainable. Additionally the Unallocated Fund must remain flexible and be used to address unexpected emerging needs and emergencies, whilst ensuring the funds are structured for maximum use. Funds will therefore be allocated as follows on an annual basis:

- 40 per cent will be programmed across existing Objectives during the FHSSP annual planning process each October. This may be kept as 'unallocated' with priorities identified during the year, or 'allocated' to specific activities
- 40 per cent will be programmed to support identified emerging issue during the FHSSP annual planning process each October, and
- 20 per cent will be held for emergency response. If by October of the budget year there are substantial funds left in the emergency response allocation, this can be reprogrammed for use that calendar year, on

the assumption that should there be a natural disaster; adequate funding from the following year's Unallocated Fund will be programmed to address the emergency.

FHSSP continues to support Mataika House, providing technical coordination and equipment in response to a rubella outbreak in August 2010. This outbreak was identified as an urgent emerging health priority. The national laboratory Mataika House required urgent support to procure rubella (and measles) testing kits. In addition the equipment used to run tests for rubella (an Elisa Machine) is old and often broke down delaying results and reports to the rubella outbreak taskforce.

Procurement of additional testing kits, an Elisa Machine and a vehicle were finalised in 2011, with handover in January 2012. These items will assist in surveillance and response to future outbreaks. This support will also contribute to FHSSP's objective of 'strengthened infant immunisation and care' through quality vaccine preventable disease surveillance and ongoing EPI program evaluation.

Through the FHSSP objective of revitalising primary health care, significant support has been provided to a typhoid outbreak in Nanoko village in the Western Division. The severity of the outbreak resulted in restrictions being placed on the movements of community members and social gatherings; a large multi-sectoral response was activated. The support provided by FHSSP included:

- Potable water for health staff drinking and hand washing
- Use of the FHSSP vehicles by MoH Environmental Health Officers.
- Procurement of four sprayers and chemicals for village decontamination
- Materials for improvements to the water supply, and
- Materials for the construction of 60 flush toilets.

In addition FHSSP funded the official opening of the health centre at Ono-i-lau constructed with funds from the Australian aid program following the devastation of Cyclone Tomas in 2010.

4. Program Recruitment

To support the Technical Facilitators roll out the work plan activities, ten Technical Support Officers (TSO) commenced employment in late September, the recruitment period for which took seven weeks from approval to commencement. Furthermore, the PCC has endorsed a total of ten TSO positions in the 2012 Annual Plan, a recruitment process commenced in late December for four of these positions as they were new to the program. The remaining five positions have been recontracted as their terms of reference are unchanged and performance of the individuals met expectations.

Following an open recruitment process the replacement Senior Program Administrator, Ms Karen Kenny commenced her contract in late November and was therefore able to attend the second PCC.

Recruitment commenced in November for a long term adviser (LTA) Monitoring and Planning to be embedded in the MoH Planning , Policy Development and Analysis Division to work with MoH counterparts to strengthen planning and monitoring capacity across all levels of the health system. A candidate was found and a selection report lodged with AusAID after following the standard recruitment process. However this candidate was found to be unsuitable and AusAID have requested that the position be readvertised. The Acting Permanent Secretary (Dr Eloni Tora) has reviewed the terms of reference which have now been revised to an LTA Planning and Policy. The shift in focus to policy is to support evidenced-based decision making in the MoH. This position was readvertised in mid-January. Due to the extended delays in recruiting this position, discussions with AusAID representatives has resulted in FHSSP including AusAID in the shortlisting process for future technical adviser recruitment to minimise future delays.

The PCC also approved a short term adviser (STA) position to support the Public Health Information System (PHIS). In order to provide immediate support to this work a sole provider justification was made and the STA PHIS, Mr Don Lewis was able to undertake a scoping visit for work required in 2012. However given the ongoing nature of the STA PHIS role, an open recruitment process commenced in early January for future support in 2012. A list of the roles and incumbents can be found at Annex 7.

5. Program Management Update

The Program mobilised on the first of July, and the office was operational with the FHSSP team fully mobilised by mid-July. The in-country FHSSP core team consists of the Program Director, Deputy Program Director-Technical, (as the Technical Facilitator for Public Health Information), Senior Program Administrator, four Technical Facilitators, an Assistant Technical Facilitator and a support team of eight staff, (inclusive of the office cleaner). Two team workshops were held during the first six weeks of the program to articulate roles and responsibilities as well as to clarify team values. The 2011 Work Plan was developed and approved by the first PCC in August. The official program launch was held on the 25 August 2011.

The governance structure for the Program has been finalised with terms of reference developed for the Finance and Audit Committee, the Program Management Group and the PCC. The Finance and Audit Committee has met monthly since Sept, the Program Management Group has met once and there have been two PCC meetings. Divisional briefings have been held in Northern, Western and Central and Eastern divisions along with Divisional Plus meetings in December.

The monthly Financial Report format has been endorsed by the Finance and Audit Committee with reporting in AUD and FJD. Key documents to guide Program policies and procedures have been endorsed by the PCC these include:

- Financial Procedures Manual
- Human Resources and Administration Manual
- Security Plan
- Communications Strategy, and
- Risk Management Matrix.

These manuals have drawn on lessons learnt and best practice from the previous program of support to the MoH (Fiji Health Sector Improvement Program), JTA processes and procedures and through consultation with the in-country team, to ensure they meet the operational needs of the program.

The M&E Framework has been drafted through an intensive consultation process and the final version (release 2) is due at the end of January. The framework will describe the overall program logic, the related performance indicators and the mechanisms for collecting data as well as the linkages to MoH M&E. The M&E Framework relies heavily on MoH systems and processes to collect and analyse data to report FHSSP contribution to the MoH broader strategic goals. The FHSSP contract requires that this Annual Report provide a detailed update of progress against the M&E Framework however as this is yet to be finalised with the baselines required for this update, FHSSP proposes that a detailed update be undertaken in March. Furthermore, obtaining data from MoH M&E systems is slow; FHSSP proposes that the Annual Report be completed at the end of the first quarter each year to enable data collection and analysis to occur. The Finance and Audit Committee would continue to review end of year expenditure and a December quarterly report would replace the Annual Report.

For reasons communicated to both the MoH and AusAID, the Senior Program Administrator's contract (Mr Peter Vanderwal) was terminated in early September. The new Senior Program Administrator (Ms Karen

Kenny) commenced on the 21 November, she was therefore able attend the PCC. During the recruitment period for this position Ms Enkhee Lunden, Senior Project Coordinator backfilled this role, with support from Ms Katrina Mills, Senior Program Manager.

6. Risk Management

FHSSP is proactive in managing and monitoring risks and PCC endorsed Risk Management Plan is reviewed regularly (the last update being November 2011 for the Annual Work Plan). FHSSP's approach to implementing the FHSSP Risk Management Plan is founded on the following principles:

- Thorough risk identification, assessment and prioritization.
- 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.
- The 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 is 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 key program risks, many of which are those identified as the program challenges, these are:

- 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.
- Continued 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.
- Management 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.

A positive example of FHSSP risk management is the prompt handling of the termination of the Senior Program Administrator in September 2011. Key Brisbane-based staff provided continuity of operational support to the program during the recruitment phase for a replacement Senior Program Administrator. The FHSSP Management Team worked quickly to address any issues and concerns AusAID and the MoH had relating to the termination and continuity of functions, producing a Scope of Works document, which is updated weekly to ensure all project milestones continue to be met.

7. Cross Sectoral Issues

On commencement of FHSSP, the Program Director was introduced with courtesy visits to UN Agencies, SPC, JICA and to the Bilateral Aid Coordination Committee by the AusAID Counsellor for Fiji and Tuvalu in order to establish relationships and investigate areas for future collaboration. The Program Director also attended two Team Leader's meetings organised by AusAID to strengthen cross sectoral relationships, promote FHSSP and gain a deeper understanding of the other AusAID programs being run in Fiji. Linkages have been made with the health promoting school program with Ministry of Education and WHO.

FHSSP funded the second Health Sector Donor Coordinating Committee for MOH in September 2011. FHSSP representatives undertook secretariat services, assisting the MoH team to collect relevant information from development partners who then contributed to the completion of the Annual Corporate Plan of MOH.

Since July, the Technical Facilitators have also been working with WHO and other donors engaged in FHSSP core technical areas to ensure all health sector partners are across one another's work and areas of responsibility. These activities will assist the MOH manage donor expectations and funding.

Consultation meetings have been held with JICA for discussions on collaboration regarding in-service training including supervision. FHSSP will work with them to strengthen supervision to improve the support to the zone nurses with the intention that they will in turn provide good support to the community health workers.

The community health worker program needs the support of other key ministries and FHSSP has supported and held consultations with the iTaukei Ministry to engender their support and ownership of the community health workers and to make health everyone's business. Meetings have also taken place with the Peace Corp Volunteers to familiarise them with the community health worker concept.

FHSSP has worked with the MoH to ensure that there is no duplication to the support we are providing to the safe motherhood initiative together with agencies such as UNFPA.

To assist with effective communications, the FHSSP team developed a Communication Strategy covering internal and external stakeholders and the various communications channels used to reach these stakeholders. This includes attendance by the Program Director at senior MoH meetings, the divisional plus meetings which the FHSSP team contribute and participate in, and the Technical Facilitators along with the Deputy Program Director-Technical and Program Director regularly meeting with counterparts and other key stakeholders. This strategy also includes details on how the program will promote its activities and engage with the community at a broader level.

Furthermore, FHSSP seeks to address vulnerable groups and individuals through several strategies as embedded in the program's design document including:

- Ensuring a gender balance as well as strengthening the MoH to put in place a gender responsive health system with the inclusion of gender awareness strategies when delivering activities.
- Consulting broadly to ensure FHSSP can access people living in settlements. Through community profiling activities being undertaken by the MoH, data on health practices and health-seeking behaviours in peri-urban settlements, FHSSP will be better able to address the issues facing these communities.
- Addressing issues faced through physical and mental illnesses. This includes the early detection and management of diabetes and the associated complications and support for the development of a mental health strategy.

8. Financial Report & Program Financial Performance

The program budget for July-December 2011 was approved by the PCC in August, with a total budget of FJD$2,980,040. The exchange rate for this budget was 0.58 FJD to 1 AUD. This translated to AUD$1,769,023.

While monthly reporting and forecasting are provided in both Australian dollars and Fijian dollars, the FAC has requested that reporting be in Fijian dollars. The fluctuations of the Fijian dollar budget have created difficulties for forecasting in that currency. For that reason, minor adjustments have been made to the original budget, primarily relating to the exchange rate and internal business line, as discussed in the November FAC meeting.

The exchange rate for the December financial report is 0.5 FJD to 1 AUD. Total Program budget at this exchange rate is FJD$2,985,463. Table 1 below details the percentage of budget spent and amount spent by Objective, in addition there are comments on the variance.

Table 1: Expenditure by FHSSP Objective.

Objective	% of budget Spent	Amount spent (FJD)	Comment on Variance
Objective 1: Safe Motherhood	62%	$210,221	The under spend was due to some activities being delayed, such as the Birth Preparedness training package delivery and printing. Many other activities were completed under budget.
Objective 2: Healthy Child Program	47%	$220,082	There have been delays in some activities that will occur in 2012 including the revision of the Child Health Card, the MoH also decided not to proceed with an EPI Strategic Plan. The under spend can also be attributed to the strong Australian dollar for those items procured internationally, procurement is significant part of the budget for this objective. Many activities where completed under budget.
Objective 3: Diabetes prevention and management	68%	$111, 732	The delay in procurement of food models and diabetes management tools contributed to this under spend, along with the postponement by the MoH in the development of a new Mental Health Strategic Plan. Many activities were completed under budget.
Objective 4: Revitalising Primary Health Care	74%	$143,438	The activities that did not occur were the printing of the CHW Manual as it awaits endorsement by the MoH and the purchase of the toolkits for the CHW as it awaits finalisation by the Steering Committee.
Objective 5: Health Systems Strengthening	67%	$244,441	The delay in appointing the LTA Monitoring and Planning resulted in a significant underspend ($93,145 budgeted with $725 spent). Additionally the STA PHIS was budgeted at $53,640 with only $20,170 spent.

As at 31st December 2011, the overall program expenditure in 2011 was 81%, using the FJD report; with 61% of approved budgeted program activity funds spent.

For the 2011 period, the total Program under spend is FJD$594,355. As noted in the introduction, approximately FJD$100,000 of this figure is committed for activities that were delayed and will now be undertaken in the first quarter of 2012. Additionally, the MoH has submitted a proposal to FHSSP to support training for key MoH staff in the objectives areas. This request will provide funding for post-graduate training in obstetrics, paediatrics, dietetics, midwifery, mental and oral health. This request together with the 2011 commitments will result in 100 per cent of the 2011 program funds being expended by the end of March 2012.

The overall program performance with respect to the budget must take into consideration the following factors which have impacted on expenditure:

- The Program mobilised in mid-July and the Work Plan was not approved until the end of August, therefore expenditure did not commence against the objectives until late August.
- Several activities required MoH endorsement to commence. In some instances, this endorsement took longer than expected and thus implementation was delayed (e.g. media campaigns and brochure development).
- Some procurement activities were delayed in order to ensure the most appropriate and cost effective item was procured.
- The operational budget was almost fully expended and this made up a significant proportion of the 2011 budget due to the program mobilization costs.
- The budget approved by the PCC in August applied a 0.58 exchange rate. However, the December financial report applies a 0.5 exchange rate. This results in an increase of 8 per cent or $FJD238,404 more being available to the Program.

The issues affecting expenditure were discussed on a monthly basis with the FAC. Work with the FHSSP Finance Officer and Technical Facilitators, along with the JTA Financial Controller has been on-going to address expenditure and exchange rate issues.

9. Contractor Performance Assessment

The Contractor Performance Assessment will be completed by a Technical Advisory Group during a visited planned for 7 February 2012. The Contractor Performance Assessment is an annual requirement as part of AusAID's Advisor Remuneration Framework performance arrangements. The proposal to shift the Annual Report date to the end of the first quarter (31 March each year) will also support the completion of this assessment in readiness for the Annual Report. Any contractor performance issues will then be addressed in the relevant areas of the subsequent annual reports.