Fiji Health Sector Support Program
Program Coordinating Committee
Minutes of Meeting
1400 Friday 26 August, 2011
MoH Conference Room

Chair: Dr Salanieta Saketa, Permanent Secretary for Health

Participants: Dr Josefa Koroivueta (Deputy Secretary Public Health), Dr Isimeli Tukana (Deputy Secretary Policy Planning and Analysis), Mr Emosi Koroi (Deputy Secretary Administration and Finance), Ms Sarah Goulding (Counsellor Fiji and Tuvalu, AusAID), Ms Paulini Sesevu (Senior Program Manager Health Law and Justice AusAID), Ms Margaret Logavatu (Program Manager Health and Social Protection AusAID), Ms Sarah Gwonyoma (Assistant Program Manager Bilateral Health AusAID), Mrs Marica Turaganivalu (A/ing Chief, ODA Unit, MoF), Dr Rosalina Sa'aga-Banuve (Program Director, FHSSP), Dr Asinate Boladuadua (Deputy Program Director – Technical, FHSSP), Mr Peter Vanderwal (Program Administrator, FHSSP)

Observers: Dr Berlin Kafoa (Projects Team Leader, FSMed), Ms Katrina Mills (Senior Program Manager, JTA International)

Apologies: Dr Eloni Tora (Deputy Secretary Hospital Services), Alipate Mataivilia (Economic Planning Officer, ODU Unit, MOF)

Item	Action
Meeting opened at 1400. Dr Saketa welcomed participants and Mr Koroi led the meeting in Devotion. The agenda was adopted as tabled.	
1. MoH update a. Policy, Planning and Analysis Division Dr Saketa provided a brief in the institution of a new Divisional within the Ministry. She noted that over time the capacity for the Minsitry to to provide appropriate high level policy analysis and development and subsequent evidence-based planning had not kept pace with the emerging challenges. The institution of the new Division was one of Ministries 2012 deliverables. The Division will also coordinate donor and health partner inputs to the sector. She noted that a proopsal made to FHSSP would be discussed later in the meeting, but that there was a noticeable lack of depth in this area, which resulted in the request for long term mentoring TA from outside Fiji.	

Although the post of Deputy Secretary Policy Planning and Analysis was created following the recent restructuring, the majority of the new Division will be taken from existing establishment. Dr Sa'aga-Banuve noted that the detailed proposal received from the Ministry had been incorporated in the Annual Plan to be discussed at agenda item 5, however was available for viewing if interested from the FHSSP office.

b. 2012 Budget

Dr Saketa informed the PCC that the 2012 MOH budget had already largely been set, with the only changes likely to centre around the allocations between operating and capital budget. The enveloped for MOH for 2102 is roughly FJD132mil, of which FJD8 mil will go towards capital costs, and the rest for operating and activity expenditures. The details are currently being finalised.

Dr Saketa also noted that over the last 2 years a number of major proposals had been developed – Ba and Nausori Hospitals, Makoi Birthing unit, a regional mental health institution, the intorduction of 3 new vaccines.

As the overall enveloped was not increasing, MOH is looking for donor assistance, while at the same time asking GoF to capture some of the costs to give greater chance of sustainability. The example given was the seed money for new vaccines, amounting to FJD500,000 out of FJD4.7 mil proposal in 2012, with GoF contribution increasing to the total over the 5 year period, and donor contributions dropping off to nothing over the same period.

c. Annual Corporate Planning process

Dr Saketa informed the PCC that the first meeting to plan for the Annual Corporate Planning (ACP) workshop to be held on 15 and 16 September took place yesterday (August 25). Dr Saketa noted that a request has been made to FHSSP to support this ACP process, and that plans were progressing on this basis. In terms of approach, for the 2012 plan the Ministry is trying to incoirporate a bottom up approach as well to elicit input from operational staff. Ministry is using the Strategic Framework for Change Coordinating Office (SFCCO) quarterly monitoring of the 2011 Corporate Plan to gauge what activities will be completed by December and what it's realistic to carry over

to the 2012 plan. In terms of KPIs, in 2011 there were approximately 80, and there is an emerging concensus that the Ministry needs to assess whether it's realistic to assess that many, or whether in terms of accountavility it makes more sense to be assessed on progress towards the 7 outcome areas and the strategic goals of the 2011-2015 plan. A draft of the 2012 coporate plan is expected to be out prior to the budget announcement, which ODA Unit had noted at the Finance and Audit Committee (FAC) meeting on 24 August has been scheduled to take place on November 30. Specific areas that the Ministry are trying to improve on for 2012 include trying to balance out implementation across the 12 month period rather than having everything rished in the final 2 quarters, and incorporating an annual procurement plan and an annual maintenance plan in the document. No questions were tabled.	
2. Governance Dr Sa'aga-Banuve described the proposed structure, and noted how important it was to get these governance issues right to steer the Program for the next 3 years. Dr Saketa asked whether the JTA CEO should be included in the membership of the Program Coordinating Committee (PCC), and further proposed that FNU School of Medicine, Nursing and Health Science be confirmed a member of the Committee. Ms Goulding noted that the inclusion of the JTA CEO was an interesting suggestion, and that she would need to get advice from Canberra as this could change the acountabilities articulated in the head contract between AusAID and JTA. Dr Rosa further noted that a JTA Representative was included as an Observer in the proposed TORs. Ms Goulding noted that the PCC was scheduled to only meet 6 monthly and asked if Dr Saketa was happy with that, given that the great majority of the operational questions would then fall to the Program Management Group (PMG). Dr Saketa noted that it would be appropriate	Ms Goulding to seek advice from AusAID Desk re inclusion of Dr Thomason on the PCC

	to have the PCC more concerned with policy and strategic issues, but that thought would need to be given to the quantum of dollars that the PMG would be able to make independent decisions on, and that all requests for utilisation of the Unalllocated Fund would still need to be considered by the PCC.	
	It was proposed that in order to ensure that there was continuity and through flow of information between the PMG and the PCC, the PMG be chaired by a PCC member. Given Dr Tukana's dual role as Acting Deputy Secretary Policy, Planning and Analysis and National Adviser Non-Communicable Diseases, it was agreed that he should Chair the PMG.	Dr Tukana to Chair the PMG
	In terms of the decision regarding the use of the Unallocated Funds, it was agreed that Extraordinary PCCs can be held, and noted that one would need to be held in November/December to deliberate on the 2012 plan, which could also be used to finalise the plan for the use of the Unallocated Fund.	Extraordinary PCCs to be called as needed to discuss emerging needs
	As a result, Dr Sa'aga-Banuve proposed that the limit for PMG to decide on be increased to FJD 100,000. This proposal was approved, with the exception that any variations with policy implications or outside of the agreed FHSSP objectives would still need to be handled by PCC.	PMG variation authority limit increased to FJD100,000
	Ms Goulding went on to note that, in relation to the PMG, lessons learned from other programs indicate the damage that the setting up of alternate meeting structures could inflict, and suggested that the PMG be aligned with the NHEC meeting instead, which meets Quarterly and whose membership consists of the proposed members of the PMG in any case. This proposal was approved.	PMG to be run back to back with the NHEC
	Minor amendments were agreed on in the membership of the three governance boards. It was further discussed that the Divisional Plus Meetings held no real governance role in the structure of FHSSP, but were designed to monitor FHSSP and other donor activities in the Divisions, as well as to coordinate between public and clinical health services.	Mr Vanderwal to circulate the revised TORs for the three levels of governance
	Dr Saketa thanked PCC members and noted that FHSSP was a new program, with new reporting structures, and that we should try as proposed, note any teething programs, and maintain a flexible approach, with	FHSSP leadership team to provide mentoring and guidance on the role, function and

	governance structures changing if necessary. The proposed structure is aimed at empowering the implementers. With that in mind, Dr Saketa noted that she felt there was a need to support the divisions, particularly in relation to their new role in the PMG. She requested, and Dr Sa'aga-Banuve acceded to the request, to provide mentoring and guidance prior to the first PMG meeting.	functioning of the PMG to Divisional colleagues prior to the first PMG meeting.
3.	FHSSP start up report a. Mobilisation Dr Sa'aga-Banuve presented the brief as included in the documentation. In a discussion on the manuals, Dr Saketa asked whether they would be shared, and Mr Vanderwal referred the question to Ms Mills, who noted that they did not contain any commercial in confidence information and as such could be distributed to the PCC. Dr Saketa requested that they be circulated more widely, to Divisional colleagues, to ensure they have an understanding of how the FHSSP operations will be structured, and what is expected of them. The manuals will also have the New Proposal templates to addended, and these templates will be drafted by the end of September. Following Dr Sa'aga Banuve's presentation of the Mobilisation Report, Ms Goulding gave a vote of thanks to the FHSSP team for mobilising the Program and working so hard. She commended the team and noted that the start-up had been very smooth, which she felt speaks highly of the team and the support given by MoH. She stated that AusAID is very pleased with how the mobilisation process has gone. b. Team Structure Dr Sa'aga Banuve introduced the proposed structure, noting that the team consisted of two main areas, namely Operations and Technical. She noted that the structure included a Deputy Program Director – Technical who, in addition to leading the technical area, was also the Health Systems Strengthening Technical Facilitator, and that the Program Administrator headed up the operations area. Dr Sa'aga Banuve confirmed that all positions were now filled. In addition to the young professional role of Assistant Technical Facilitator to assist The Deputy Program Director – Technical, another key area of differentiation in the structure was the	FHSSP Manuals to be distributed to PCC and Divisions by Mr Vanderwal once approved

inclusion of two mentors; Don Lewis to support the Health Information Systems and M&E areas, and Clare Whelan to mentor the safe motherhood areas. Dr Sa'aga Banuve described the solution as a response to two areas the Program perceived as having most challenges inherent in them. Dr Saketa noted that the original intention of the Design Document was to have the Technical Facilitators co-located with their MOH Counterparts, however that due to constraints regarding space and resources, it was decided to allow the TFs to operate from Namosi House, on the proviso that the team is able to provide evidence of a high level of interaction, and that this should be reviewed in 6 months.	
Dr Saketa went on to note that she had considered the organisational structure, and felt that it was more appropriate given both the bi-sphered structure and the level of responsibility and scope inherent in the role that the Program Administrator role be renamed as Deputy Program Director – Operations. Dr Sa'aga Banuve agreed, noting that this aligned with the internal thinking about the structure, which had developed a three person management team of the Program Director, Deputy Program Director – Technical and the Program Administrator, and that the only difference was one of nomenclature. Ms Goulding agreed and noted that she felt that the proposed title appropriately reflected the role.	Program Administrator role to be renamed Deputy Program Director – Operations and necessary contractual and administrative changes made by AusAID, JTA and the FHSSP team to reflect this.
c. Start-up Expenditure Dr Sa'aga Banuve tabled the financial expenditure relating to the first 2 months of start-up. No comments were made. Mr Vanderwal expressed the sincere gratitude of the team to the MoH for the continued use of the office space at top floor Namosi House, and noted that it had made the job of seamless transition and quick start-up much easier. Ms Goulding echoed these points and expressed what substantial value was added by being co-located with the Ministry, embedded amongst other teams.	
d. Branding Dr Sa'aga Banuve presented the proposed logo that will represent the Program. The logo was endorsed for use.	Branding roll-out to go ahead
e. Major Progress Milestones Dr Sa'aga Banuve presented the progress of the approved	

	Mobilisation Plan, and noted the hard work of both the operational and technical teams. Ms Mills gave a quick précis of the progress, with particular reference to the 4 amber and 1 red traffic lights from the 96 process indicators. These are: • Staff Professional Development program (amber) – no funds are set aside for staff professional development at this stage, and JTA is in communication with AusAID to develop a strategy to ensure the team is kept abreast of best practice and able to provide quality advisory and support services • Recruitment Manual (amber) – draft form, needs to be quickly progressed as recruitments about to commence • Payroll system (amber) – currently on the JTA payroll but using manual transfers • ANZ pay transfers (red) – new payroll software not communicating with ANZ in Fiji. Solutions being sought • Independent audit (amber) – this now progressed to green, first audit to be at 6 months and then annually to synch with calendar year The PCC accepted and endorsed the Mobilisation Plan Process Indicator Report, and Dr Saketa noted that she looked forward to the resolution of the remaining pending items.	
4.	2011 Plan Dr Sa'aga Banuve presented the 2011 Annual Plan and described the structure and outline of the narrative. Each objective was summarised and discussed in turn, with a focus on major initiatives, procurements, and additional technical inputs. In relation to the technical inputs, following a query from Ms Goulding Dr Sa'aga Banuve clarified that all technical inputs were integrated into the plan, with a specific section on the use of technical inputs at section 4.6, TORs for Technical Assistance (TA) at annex 5, TORs for Technical Support Officers (TSOs) at annex 6, and the costs for all TAs and TSOs appearing as separate line items at the top of each objective's budget lines. Following this clarification all technical inputs were discussed as part of the discussion around each consecutive component. As part of these discussions, Ms Goulding emphasised that the Independent Review of the Aid Program had resulted in	All TORs to be reviewed to ensure

	increased scrutiny on technical inputs as compared to other forms of aid, and that the Program will be scrutinised and evaluated on the use and evaluation of technical inputs. With this in mind, it was agreed that the technical inputs for the most part should be short term, extremely focussed, will add value not already present in the team or in the Ministry, and that their output, or product, will be specified in detail and evaluated rigorously. The outcome of the discussion on each objective is as follows: Objective 1 – Activity plan and Technical Support Officers approved Objective 2 – Activity plan and Technical Support Officers approved following discussion on how the support for Mataika House fits into the broader FHSSP objectives, and how the Unallocated Fund will be used (see below) Objective 3 – Activity plan and Technical Support Officers approved, including the Mental Health Strategy development support Objective 4 – Activity plan and Technical Support Officers approved Objective 5 – Activity plan and Technical Support Officers approved (with comment on duration of Annual Corporate Plan TSO taken into consideration). Under Objective 5, further discussion was held on the TA positions. In relation to the STA PHIS Scoping, Ms Goulding expressed concern over potential overload of Health Information System (HIS) capacity in the Ministry considering the ongoing PATIS and LIS implementations. Dr Saketa noted that there was a real need for further support in the area to ensure the gains weren't lost. Dr Boladuadua detailed the spread out and light footprint nature of the proposed inputs. Dr Sa'aga Banuve highlighted the critical nature of the work to the forward plans. Ms Sesevu queried the potential to respond to this need using existing in-country resources, and Dr Sa'aga Banuve noted the ongoing work with FSMed to develop these ties. Dr Kafoa, in response to a direct query from Ms Sesevu, noted that at present, despite growing capacity, the technical expertise within FSMed to undertake this work was currently not sufficient. Following the discussion it was agreed to revert to the HIS Committee, where the need and TORs had originally been developed, to confirm the timing, sequencing and TORs. On this basis it was agreed that the technical input was warranted, and that following the confirmation from the HIC Committee the Program could move forward with recruitment to this role.	adherence to these guidelines FHSSP team to move forward with approved activity plans and recruitment FHSSP to move forward with TA PHIS Scoping contingent on HIS Committee response

Further discussion was also held around the long-term Planning and Monitoring TA. It was agreed that there was an evident need for this position given the lack of depth within Fiji in the area, and as such the role was approved, contingent on the relationship between this role and the FHSSP HIS Mentor being detailed.

Relationship between this role and the HIS Mentor to be detailed under the background section of the TORs

Substantial discussion was also held over the use of the Unallocated Fund. This originated from a query from Ms Goulding during the description of the Objective 2 activities, specifically relating to Mataika House support, and whether this support is part of the agreed Objective 2 activities, or whether this nominally came from the Unallocated Fund. Dr Sa'aga Banuve responded that this request was a response to an emergency need, as envisaged in the Design Document.

Discussion on how these requests would be dealt with in future ensued. It was agreed that it was appropriate to have these discussions and approvals normally during the annual planning process, and extraordinary meetings and the use of Flying Minutes for new requests and emergency responses. Mr Vanderwal then went on the describe the proposal on the use of the Unallocated Fund, particularly:

- Programming a substantial amount to the existing objectives
- Programming another portion to emerging priorities and areas of need in the ACP process
- Reinstituting the Divisional Funds
- Making funds available for community health projects
- Retaining a smaller amount of funds for immediate disaster response, and planning for longer term relief initiatives for the following year's planning cycle
- Consider contracting an NGO for the disaster relief

Structure for the use of the Unallocated Fund to be developed by Mr Vanderwal and tabled during the 2012 Annual Plan discussions

Other principles discussed and agreed on:

- Restrict as much as possible to the Annual Planning Process
- All decisions regarding use of it to be made in the PCC
- Review of the name of the Fund
- Highlight in the workplan that the activity is funded from the Unallocated Fund, and note same in narrative as well.
- Consider the support of NGOs active in MCH
- Only use from 2012 onwards following the development and approval of clear plans, guidelines and processes

	Ms Goulding noted that it was the experience of AusAID that the use of a Divisional funding mechanism posed a high administrative burden, and that AusAID Canberra already had a standing agreement with the Red Cross in relation to disaster response. Both comments were received and considered.	
5.	Budget a. Dr Sa'aga Banuve summarised the budget, noting • Objective 1 – FJD377,100 • Objective 2 – FJD519,600 • Objective 3 – FJD183,000 • Objective 4 – FJD217,400 • Objective 5 – FJD409,900 Dr Sa'aga Banuve also noted that for the purposes of these meetings, and for the operation of FHSSP, FJD will be used in reporting and in funding requests and other areas. The budget as presented was approved.	FHSSP team to move forward with implementation on the basis of the tabled budget
6.	Communications and engagement Mr Vanderwal presented the communications and engagement strategy, which consists of using all media and opportunities at the Program's disposal to engage with all levels of Fijian society to engender an understanding and appreciation of the Program's work, the Australian Government's suppport, and the partnership and collaboration with the Ministry. Key messages that span the time from Program inception to Program close were presented. The communication and engagement strategy includes initiatives that are already well underway, such as the face-to-face meetings between FHSSP staff and donors, development partners, Central Agencies, and Divisionl and Sub-Divisional Staff, the development of a Program website and a quarterly newsletter, and the branding of the Program in a highly visible and recognisable manner. It also includes a proposal to use branding on the tools and materials used by people throughout the health system, from Community Health Workers to staff at different levels of the health system. AusAID noted that they welcome this approach, congruent as it is with the recommendation of the Independent Aid Review to clearly communicate the partnerships the Aid Program are successfully developing.	Mr Vanderwal to facilitate the development of a detailed plan to support the endorsed strategy.

The approach was endorsed by the PCC, and a detailed plan will be costed and presented to PCC during the 2012 Annual Plan deliberations. Some mention was made of the potential, when the time is right, of encouraging groups such as the Parliamentary Friends of the MDGs, to visit Fiji to see the work that is being done with the Australian Government's support.

7. Risk Issues

Mr Vanderwal noted the risk management matrix and attached narrative, and that although the team had only been functioning under the current program for less than two months, that the experience of the team members of many years in the health sector in Fiji had enabled some of the key risk areas to be considered. He presented three that were potentially critical:

i. Political – the uncertainty of the current environment has the capacity, if tensions increase, to potentially impact negatively on program implementation. The risk mitigation strategy is the ongoing emphasis on clear, open and regular communicatiion between the Program, AusAID and the Ministry
ii. Management – some of the financial management systems necessitated by the new contractual arrangements may slow down implementation. The mitigation strategy revolves around tighter forward planning and clear communication of the potential for delays in funds release.
iii. Human Resources – the turnover of key staff and the stretched establishment of the Ministry were often highlighted during initial consultations as areas that could have significant negative impact on Program implementation. Mitigation strategies include maintaining a high level of training and capacity building support but with more of a focus on in-service training, and developing South-South learning opportunities in the region and in ACP countries, including clinical placements.

Dr Saketa acknowledged these key risks, and proposed the PCC accept the risks and mitigation strategies, which was carried.

8. FHSIP Interim Activities report – FSMed

Dr Kafoa thanked AusAID, the Ministry and the current FHSSP team for enabling FSMed to keep supporting Ministry in a flexible manner.

Noted that for some activities eg southern Lau outreach there were too many focal points, which was proving difficult for his

	team to manage. Dr Kafoa expressed particular gratitude to Mr Vanderwal and the FHSSP finance team for supporting FSMed to complete and submit the VAT reimbursement claims, and for the ongoing support to finalise payments and activities. Dr Saketa thanked FSMed for their ongoing support, and looked forward to continuing to work closely with FSMed. Ms Goulding similarly expressed gratitude to FSMed for continuing to progress the agreed activities on time and budget.	
9.	Other matters Dr Saketa tabled a new proposal, mentioned briefly earlier in the meeting, requesting Australian Government financial support for the intorduction of the three new vaccines to come into the health system in 2012. Dr Sa'aga Banuve described the proposal, which requests FJD4.2million out of a mooted FJD4.7million need in the first year, which tails off over a period of 5 years. The proposal was strongly endorsed by Dr Koroivueta. Ms Goulding recognised the excellent initiative that was being taken to address a number of increasing health issues, and took the question on notice due to the size of the requested commitment.	Ms Goulding to revert with a response to the proposal
	There being no further business, Dr Saketa drew the meeting to a close as 1700 hours approached. In final comments, Ms Goulding thanked Dr Saketa for her leadership and excellent chairing of the first PCC, and thanked the FHSSP team for starting off the implemention of this important program so stronglly. Dr Tukana gave thanks to AusAID and the Program for the agreed support in the area of M&E. Dr Sa'aga Banuve gave thanks on behalf of the team to Ministry and AusAID for all their support, and for enabling a fantastic launch. Ms Mills expressed gratitude at being included in the meeting.	

10. Next Meeting The next meeting of the PCC will be an unscheduled Extraordinary PCC Meeting in November or early December to consider the 2012 FHSSP Annual Plan.	