Australia - Fiji Health Sector Support Program 2011-2015

Final Design Document

23 November 2010

Contents

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care/Clinics
AusAID	Australian Agency for International Development
AUD	Australian Dollar
CHW	Community Health Worker
CSO	Civil Society Organisation
CWM	Colonial War Memorial (Hospital), Suva
DMO	Divisional Medical Officer
EmOC	Emergency Obstetric Care
EPI	Expanded Program on Immunisation
FHSIP	Fiji Health Sector Improvement Program (2003-2010)
FHSRP	Fiji Health Sector Reform Program (2000 – 2003)
FHSSP	Fiji Health Sector Support Program (2011-2015)
FJD	Fijian Dollar
FSMed	Fiji School of Medicine
FSN	Fiji School of Nursing
GOA	Government of Australia
GDP	Gross Domestic Product
GF	Global Fund
HC	Health Centre
H1N1	The “swine flu” virus
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HPS	Health Promotion Settings
HR	Human Resources
HSS	Health Systems Strengthening
ICR	Independent Completion Review (Report)
IGOF	Interim Government of Fiji
IMCI	Integrated Management of Childhood Illnesses
IT	Information Technology
JICA	Japan International Cooperation Agency
LTA	Long Term Adviser
M and E	Monitoring and Evaluation
MBBS	Bachelor of Medicine, Bachelor of Surgery
MCH	Maternal and Child Health
MDG	Millennium Development Goal

MoF	Ministry of Finance
MoH	Ministry of Health
MoU	Memorandum of Understanding
NB-IST	Need-based In-service Training
NCD	Non Communicable Diseases
NCHP	National Centre for Health Promotion
NHEC	National Health Executive Committee, Ministry of Health
NS	Nursing Station
PATIS	Patient Information System
PCC	Program Coordinating Committee
PM	Director Program Support/ Program Manager
PDD	Program Design Document
PHIS	Public Health Information System
PICT	Pacific Island Countries and Territories
PO	Project Officer
PR	Principal Recipient (of the Global Fund)
PRSIPll	Pacific Regional HIV & STI Strategy Implementation Plan 2009-2013
PS	Permanent Secretary
PSC	Public Service Commission
PST	Program Support Team
QAE	Quality at Entry (Report)
QAC	Quality at Completion (Report)
RBF	Reserve Bank of Fiji
SDH	Sub-Divisional Hospital
SGS	Second Generation Surveillance
SPC	Secretariat of the Pacific Community
STA	Short-term Advisor
STI	Sexually Transmitted Infection
TAG	Technical Advisory Group
TORs	Terms of Reference
UNAIDS	United Nations Joint Programme on HIV & AIDS
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
VHW	Village Health Worker
WHO	World Health Organisation

Executive Summary

Introduction

This design document articulates a framework and delivery mechanism within which Australia's assistance to the Fiji health sector can be delivered from 2011 to 2015, with a proposed budget envelope of AUD$5 million per year, (depending on parliamentary appropriations for the Australian Aid Program). The overall aim of the Fiji Health Sector Support Program (FHSSP) is to support the Ministry of Health (MoH) and other development partners in improving health outcomes in Fiji. FHSSP focuses on improving the quality of health service delivery at decentralised levels, and increasing the demand for, and access to, these services. FHSSP specifically supports activities that will contribute to improving health outcomes in maternal and child health, strengthening diabetes prevention and management, and revitalising primary health care.

The design outlined in this document was prepared following a design mission to Fiji from 16th May to 13th June 2010 by a team of three design specialists, David Wilkinson (Team Leader), Dr Lynleigh Evans and Dr Ross Sutton.

The design team held a wide range of consultations and participatory meeting with MoH Core Teams, Departments and Programs; AusAID Suva and Canberra; FHSIP core staff; bilateral and multilateral donors and health development partners. The team conducted field visits to Central, Northern and Western Divisions, including site visits to a range of Divisional Hospitals, Sub-Divisional Hospitals, Health Centres and Nursing Stations, and conducted interviews and group discussions with MoH managers, service delivery staff and patients in all three Divisions. Towards the end of the design mission the team held feedback sessions with Divisional staff in North and West Divisions; senior MoH personnel in Suva, health donors and development partners; and key AusAID personnel in Suva and Canberra (via teleconference). These consultations were supported by an extensive review of key reports on the Fiji health situation, and together these have ensured that the Design is grounded in recent analysis of the constraints faced by the Fiji health sector.

The Fiji Health Sector Support Program was designed in the context of a complex implementation environment resulting from the current political situation. This complex environment affects not only what can be supported but how the support can be provided and implemented. In this context, a major design challenge was to achieve the appropriate balance between a focus on resourcing service delivery to achieve health outcomes in the medium-term and providing broader long-term health systems support.

The design took into account a number of factors and key risks. These include the concern about fungibility of funding provided to the MoH and the associated need for AusAID to have adequate assurances with regard to the security of its funds, and the need for a rapid and responsive funding mechanism. The design builds on the documented[1] lessons learned during the current Fiji Health Sector Improvement Program (FHSIP), including the relative success of the current FHSIP governance and management arrangements. These considerations guided the proposed management and governance arrangements of the new Program.

[1] Fiji Health Sector Improvement Program (FHSIP) Independent Completion Report, Draft 3rd May 2010

The design took particular account of the current and future strategic priorities of the Fiji MoH, and the Program objectives are closely aligned with those of the MoH Strategic Plans 2007-2011 and 2011-2015.

The design was also guided by the priorities outlined during the AusAID briefing, namely to improve the delivery of essential health services at decentralised levels; to revitalise primary health care; to support the MoH in working towards the achievement of the MDGs; and to increase health development partner harmonization, with the long term aim of working towards sectoral coordination.

While AusAID does not currently have a formal Fiji Country Strategy, it does have an engagement philosophy and guidelines to focus its inputs. The design incorporates key elements of the engagement philosophy in that: Program activities are aligned with the Cairns Compact and the Paris Declaration; activities are consistent with the Fiji MoH strategic plans and will be owned by the MoH; funds will be directed primarily to decentralized levels; the needs of vulnerable groups will be addressed; the Program integrates with the work of other donors and builds on the work of other AusAID-supported activities.

It is noted that donor coordination in Fiji is currently weak, and therefore the design provides two opportunities for strengthening health partner coordination in Fiji. The first lies in the Program's strategic focus on Maternal & Child Health and diabetes prevention & management. There are indications that both the MoH and health development partners view these areas as platforms around which donors can coalesce and align with MoH priorities. The second opportunity lies in the proposed program oversight & governance mechanism, and there are indications from both MoH and health development partners that the mechanism has the potential to be expanded to include other donors.

Program Description

Program Goal

The Goal of the Fiji Health Sector Support Program is to remain engaged in the Fiji health sector by contributing to the Fiji Ministry of Health's efforts to achieve its higher level strategic objectives in relation to infant mortality (MDG4), maternal mortality (MDG 5) and the prevention and management of diabetes as outlined in the MoH Strategic Plan.

Program Objectives

The 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 revitalize an effective 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 decentralized service delivery (including Health information, Monitoring & Evaluation, Strategic and Operational Planning, Supervision, Operational Research)

The identification of the Program Goal and Objectives was conducted in close consultation with the Ministry of Health, through a series of participatory meetings at both central and divisional levels. The MoH has confirmed that achievement of these program objectives will directly support the achievement of three of the seven Health Outcomes[2] identified in the MoH's Strategic Plan 2007-2011, namely

- Reduced Burden of Non-Communicable Diseases;
- Improved Maternal Health and Reduced Maternal Morbidity and Mortality;
- Improved Child Health and Reduced Child Morbidity and Mortality.

Furthermore, the MoH clearly indicated that the program of support proposed under this design is closely aligned with their evolving strategic priorities for the coming five years.

During the finalization of this design, the MoH drafted their new five-year strategic plan 2011-2015. The MoH new draft strategic plan has two Strategic Goals[3]:

> *Strategic Goal 1*: *Communities are served by adequate primary and preventive health services thereby protecting, promoting and supporting their well-being; and*
>
> *Strategic Goal 2:* *Communities have access to effective, efficient and quality clinical health care and rehabilitation services.*

The key focal areas identified in the MoH's new draft strategic plan are:

- Making the Fiji population healthier;
- Revitalizing primary health care approaches to address the burden of NCDs, maternal and child health and preventing communicable diseases;
- Strengthening key areas of clinical service delivery with continued emphasis on patient safety and risk management;
- Strengthening mental health, rehabilitation services and oral health.

The draft MoH Strategic Plan 2011-2015 indicates that the MoH's approaches with regard to primary health care and MCH services[4] are to:

Revitalize Primary Health Care, and specifically:

- Prevention and early intervention
- Strengthen health protection and promotion
- Enhance continuity of care
- Provide services closer to where people live

Reform Maternal and Child Health Services, and specifically

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[2] The seven outcomes are: 1. Reduced burden of NCDs; 2. Reduced spread of HIV/AIDS and other CDs prevented, controlled or eliminated; 3. Improved maternal health and reduced maternal morbidity and mortality; 4. Improved child health and reduced child morbidity and mortality; 5. Improved adolescent health and reduced adolescent morbidity and mortality; 6. Improved mental health care; 7. Improved environmental health

[3] Presentation by Permanent Secretary for Health at the MoH Strategic Planning Workshop, Suva, 11-12 August 2010

[4] Presentation by Permanent Secretary for Health at the MoH Strategic Planning Workshop, Suva, 11-12 August 2010

- Reduce maternal mortality by 2/3
- Encourage early booking
- Promote safe motherhood concept
- Reduce infant and under 5 mortality by 2/3
- Provide friendly MCH services

The Ministry of Health's continued focus on maternal and child health and addressing the burden of non-communicable diseases, coupled with the new focal area of revitalizing primary health care, means that this proposed Program of support is closely aligned with the MoH's strategic priorities for the period 2011-2015.

Program Outcomes

Anticipated outcomes (under each Objective) of the Program include:

Objective 1: To institutionalise a safe motherhood program at decentralised levels

- An increasing number of women routinely presenting for first ante-natal check-up (ANC) in the first trimester
- At least half of Sub-Divisional Hospitals classified as "baby safe"
- High proportion of deliveries being carried out in Sub-Divisional Hospitals or higher level institutions
- Increased contraceptive prevalence rate and reduced unmet need for family planning.
- Capacity building and training of health care professionals to ensure the whole spectrum of continuum of care

Objective 2: To institutionalise a "healthy child" program throughout Fiji

- Systems in place to maintain Expanded Program of Immunization (EPI) rates > 90%
- Comprehensive training in Integrated Management of Childhood Illnesses (IMCI) leading to more secondary level paediatric care being safely carried out at Sub-Divisional Hospital level or below.
- Capacity building and training of health care professionals to ensure the whole spectrum of continuum of care
- Child health to be more focused on reducing perinatal mortality given the recent findings of the child health review

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

- Population screening for diabetes undertaken bi-annually for all persons over 30 years of age (timed to coincide with World Diabetes Day)
- Adult Personal Diabetes Record book is providing an effective mechanism for ensuring the continuum of care of people with diabetes
- Quality diabetes centres established at all Sub-Divisional Hospitals and selected large urban health centres
- National Diabetes Centre strengthened to serve as the national focal point for diabetes training and policy.
- Capacity building and training of health care professionals to ensure the whole spectrum of continuum of care

Objective 4: To revitalize an effective network of village and community health workers (VHW/CHW) as the first point of contact with the health system for people at community level

- An effective system of trained and resourced VHW/CHW who are able to provide basic first aid, promote healthy practices and health seeking behaviours and effectively refer patients to health services
- Increased community ownership of, and engagement in, primary health care.
- An effective trained VHW/CHW who are able to meet the health service needs of the urban settlements and communities

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

- Public Health Information System (PHIS) provides timely, complete and accurate information that is being used to measure public health outcomes and plan future activities
- Maternal & Child Health and diabetic health services are regularly monitored, audited and evaluated, and gaps/weaknesses addressed
- Clinical Service Guidelines and protocols related to MCH and diabetes standardised, disseminated and used systematically throughout all service delivery areas
- Operational research provides information to support evidence-based planning of health services in urban/peri-urban areas; and
- Implementation of Clinical Services Plan activities including Clinical Service Networks, Clinical Practice Guidelines, Role delineation and short term clinical attachments.

In addition to supporting the achievement of the Objectives outlined above, the Program will include an unallocated fund under Objective 5, to address health emergencies, and emerging health needs and priorities not specifically covered under the other four Program objectives. The provision of an unallocated fund is in response to a need identified by both the MoH and AusAID for flexibility in program funding within defined financial limits and agreed program areas.

It is anticipated that the unallocated fund will be used:

a) to help the MoH to respond to health situations resulting from national emergencies such as flooding, cyclones etc.;

b) to respond to emerging health priorities such as a typhoid epidemic; and/or;

c) for key activities identified during the annual planning process or by operational research or through the Health Systems in Transition (HiT) process that require funding but which lie outside the main program focal areas.

It will be important however, to ensure that the unallocated fund isn't used merely to support ad hoc activities, but is used strategically so that activities funded under this component become sustainable. Activities supported through the unallocated fund will be jointly agreed by the MoH and AusAID through the Program governance mechanism.

It should be noted that the Program addresses both supply and demand side constraints. Supply side constraints are addressed through improving service quality and availability through capacity building, strengthening clinical protocols and

guidelines, strengthening primary health care, and upgrading selected health facilities. Demand side constraints are addressed through expanding access to, and increasing demand for, quality services at decentralised levels, by bringing quality services closer to the people, targeted health promotion, fostering community level decision-making and using incentives to address client and provider transport constraints.

Implementation, Management and Governance Arrangements

Management and Implementation

The approach to the overall delivery of the FHSSP program, including the technical assistance (TA) component, is a flexible programmatic approach that closely aligns with MoH strategic priorities and allows for the annual planning of priorities and activities linked to MoH processes. The Program will adopt a rolling Annual Plan based on the Ministry of Health's annual planning cycle.

A managing contractor will be sourced through open tender to implement the proposed Program. The role of the managing contractor will be to:

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

It is intended that FHSSP will develop capacity and mechanisms that could be built upon for future pooling of TA, which could be used as a stepping stone to improved sector coordination.

Furthermore, the managing contractor will establish a Program Management team to support the management and implementation of the Program by the MoH. The managing contractor will engage the Program Management team as follows:

- a Director, Program Support *(to lead the team; with responsibility for the overall management and day to day running of the Program*);
- a Program Administrator *(responsible for the financial management, logistics and program operations)*; and
- a clerical/administrative assistant.

The Program Management Team will contribute to the achievement of the five Program objectives through the provision of technical and management support to the MoH, capacity building of MoH staff, equipment and supplies and minimal rehabilitation of selected public health facilities.

The Managing Contractor will also recruit a Program Support Team (PST) consisting of up to six specialist Technical Facilitators in the following areas - safe motherhood; infant and child health; diabetes prevention and management; primary health and community mobilization, and public health information/monitoring & evaluation. The Program Support Team will work closely with the MoH, by supporting Ministry staff and by aligning with MoH systems and processes as appropriate.

The Director, Program Support will be responsible for managing sub-contracts with any NGOs/CBOs, multilateral agencies, universities or institutions engaged in the implementation of program activities. In addition, the Director, Program Support will be responsible for managing an appropriate financial mechanism that will enable the effective dispersal of funds for agreed activities under the Program, and will facilitate the rapid access and responsiveness to health emergencies as appropriate.

AusAID technical oversight of the program will be provided either a) through a full time Health Technical Specialist contracted directly through AusAID or b) through a Technical Advisory Group (TAG) and/or one or more part-time technical advisors who could be tasked by AusAID to provide specific technical, support and advice when needed.

Governance Arrangements

The Governance arrangements for FHSSP are designed to ensure that there is an appropriate mechanism for the MoH and AusAID to jointly monitor and evaluate progress of the Program and ensure accountability for Program process, outcomes and disbursement of funds.

Governance and strategic oversight of FHSSP will be through a Program Coordinating Committee (PCC) comprising of senior executive staff from the MoH and senior representatives from AusAID, Ministry of Finance & National Planning, WHO, UNICEF, UNFPA, and the Fiji School of Medicine (College of Medicine, Nursing and Health Sciences. The PCC will be chaired by the Permanent Secretary of the Ministry of Health. The governance arrangements for FHSSP are a continuation of those currently in place to oversee the existing FHSIP, with new membership proposed for FHSSP. While the current FHSIP Coordinating Committee arrangements have not yet been formally evaluated, there are indications from both AusAID and MoH that they are working smoothly and therefore the design team saw no reason to change them.

As outlined above, the Program will adopt a rolling Annual Plan, based on the Ministry of Health's annual planning cycle, during which the FHSSP Program's annual plan will be developed. The draft FHSSP annual plan will be submitted to the PCC for review. The PCC will have decision making authority in approving the annual plan prior to obtaining final endorsement from MoH's National Executive Committee (NEC).

The PCC will meet every six months, and any major decisions concerning future directions for the program will be presented by the Director, Program Support and discussed at these meetings. No significant changes to the FHSSP Program's direction will be made without the full endorsement of the PCC.

In order to support and facilitate MoH's decentralised management, each of the four Divisions will hold a joint monthly meeting between their respective clinical and public health teams. Outcomes of these monthly meetings will feed into the divisional quarterly meetings, which will be attended by members of the Program Coordinating Committee on a quarterly rotational basis as appropriate. Outcomes of these respective divisional quarterly meetings will then feed into the Program Coordinating Committee's six monthly meetings. The FHSSP will ensure that key outcomes from these meetings are effectively disseminated to all key parties.

FHSSP Program Monitoring and Review

Ongoing FHSSP program monitoring and reporting will be through existing MoH structures and mechanisms. At Divisional level, program monitoring will be conducted by MoH staff, in collaboration with the Program's six technical facilitators, and MoH's National Advisors and Divisional Medical Officers as appropriate. The

technical facilitators will support the National Advisers and Divisional Medical Officers to present monthly progress reports at the quarterly Divisional Management Meetings. Furthermore, to ensure informed coordination at the central level, the FHSSP Program Director will present monthly progress reports to the MoH Management Group of National Advisors; and will also maintain regular liaison with AusAID as appropriate.

The FHSSP Program progress will be regularly reviewed every six months through the PCC meetings. In addition, a mid term review of the Program will be held at the end of the second year of implementation; and an independent completion review in the Program's final year of implementation.

It should be emphasized that the Program monitoring and evaluation framework is essentially a subset of the MoH's own M&E framework. The FHSSP Program's own monitoring and evaluation systems, including key indicators and data collection processes, will be those of the MoH. While the MoH recognises the need for robust M&E and has established basic M&E systems, it, unfortunately, does not have an inculcated culture of monitoring and evaluation. The design therefore will support strengthening M&E skills within the central MoH and at Divisional level.

A detailed M&E Framework is provided in Annex 7.

1. Analysis and Strategic Context

1.1. Introduction

Australia provides significant bilateral support to Fiji through the current Fiji Health Sector Improvement Program (FHSIP), and through its regional health programs. FHSIP commenced in October 2003 and, after one extension, was expected to end in December 2009. Support under the current program was extended for a further 12 months to December 2010 to facilitate, as far as possible, a seamless transition from the current FHSIP to the new Program of support outlined in this Design Document.

Fiji is clearly not a donor-dependent nation, with development assistance constituting less than 6% of the total health budget in most years. However, the current economic climate due to the global economic recession appears to have resulted in escalating rates of poverty among the people of Fiji.

1.2. Country and Sector Issues

1.2.1 Economic and Political Situation

Although Fiji has recently transitioned to upper-middle income status and enjoys an important role as a regional centre, 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[5], and its rising poverty levels, which reflect the country's deteriorating economic situation[6]. The Reserve Bank of Fiji (RBF) had forecast a decline of 0.3 per cent in 2009, following very low growth of 0.2 per cent in 2008. However, other forecasts (e.g. the ADB forecast of 1.2 per cent decline in 2009) suggest a more pronounced contraction of Fiji's economy.

In an attempt to slow the pace of falling foreign reserves the RBF devalued the Fiji dollar by 20 per cent in April 2009. Unemployment data from the 2007 Census indicate high unemployment levels (over 8 per cent); more than double the rates for earlier estimates in 1996 and 2004. Inflation accelerated to a 20-year high of 9.8 per cent in September 2008, driven by rising food and fuel prices coupled with second-round effects of higher oil prices, such as on transport. While inflation decelerated to 6.6 per cent by the end of 2008 as global oil and commodity prices declined, it still averaged a high 7.7 percent for the year.[7]

The abrogation of Fiji's Constitution in April 2009 has led to an uncertain legislative environment. Political 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 have been lost, many of them consultants and

[5] AusAID (2009), Tracking Development and Governance in the Pacific

[6] 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).

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

nurses with special skills in areas such as paediatrics, obstetrics, intensive care and oncology.

Australia remains dedicated to continuing its substantial support to the people of Fiji particularly in health and education. Australian support is being carefully managed in light of Fiji's current political/economic situation and complex operating environment. This difficult environment limits the extent to which the Australian Aid Program can fully engage with its partner government's systems and processes.

Australia's aid program in Fiji continues to focus on providing support to the health and education sectors and to support the people of Fiji by maintaining programs that improve their livelihoods, but suspends assistance where the actions of the interim government render programs ineffective or compromised. Consistent with Australian whole of government engagement in Fiji, the Aid Program has been recalibrated to focus on mitigating the social and economic impacts on vulnerable groups affected by political instability and the global recession.

In 2009-10, Australia's total development assistance to Fiji is approximately A$18 million, covering social protection and financial inclusion measures to support vulnerable communities affected by the global recession and the floods of January 2009, as well as small and medium rural enterprise development focusing on measures that promote better access to financial services for the poor. Australia also provides bilateral assistance to support health and education systems through continued provision of funding for essential health and education services; and partnering with civil society and regional organisations to promote an enabling environment for improved governance and accountability.

1.2.2 The Health Sector

The health care delivery framework

The MoH is the largest player in the health sector, providing health care services directly to citizens of Fiji, and to a limited extent to visitors and persons referred from within the region, through a hierarchy of facilities:

- village/community health workers,
- nursing stations,
- health centres,
- sub-divisional hospitals and
- divisional and specialized hospitals.

This framework was established some 40 years ago to provide health access to all, and has continued to serve the people of Fiji very well.

The main clinical services are provided through a network of 16 Sub-divisional Hospitals and 3 Divisional Hospitals located in Suva, Lautoka and Labasa that provide a comprehensive range of services. They also serve as teaching hospitals for nursing and medical students. There are 5 subdivisions in Central, 4 in Eastern, 6 in Western and 4 in Northern Divisions.

The Colonial War Memorial Hospital (CWM) in Suva serves as the Divisional Hospital for Central and Eastern Divisions, and also serves as the National Referral Hospital. It is supported by specialist hospitals that include the national St. Giles Psychiatric Hospital, the P.J. Twomey Hospital for tuberculosis and leprosy and the Tamavua Rehabilitation Hospital for specialist rehabilitation services.

Public health services are provided through the 16 Sub-divisional hospitals (SDH) and the 77 Health Centres (HC) and 101 Nursing Stations (NS). A health centre is

essentially an extended nursing station, which provides the initial clinical referral point for a number of nursing stations within a designated SDH supervised medical area. A HC is managed by a Medical Officer or Nurse Practitioner plus 1 or 2 nurses. A NS is generally staffed by one nurse who conducts outreach visits to communities in a designated nursing area. In addition, Community Nursing Stations are facilities that fully operate and function as a nursing station except that they are built and funded by the community themselves on approved based on adherence to the minimum standards of a government station[8].

The MoH has provided basic training to community members to create a cadre of Village Health Workers (VHW) in rural villages and Community Health Workers (CHW) in urban areas. Patients may first see a VHW/CHW or enter the public health service system directly by being visited at home by a nurse or by going to a NS, HC or SDH. They may then be referred to higher level health facilities as appropriate. All consultations, laboratory and radiological investigations and admissions are free to the public attending public health facilities, except for some treatments in dental services and where they choose to be admitted to the paying wards.

A small private sector includes one private hospital in Suva that provides a range of specialized services, several day clinics and 110 private general practitioners located in the urban centres of the two main islands Viti Levu and Vanua Levu.

There is also a wide and increasing range of health services, including antenatal and postnatal care provided privately through some 120 private practitioners, a private hospital and a range of NGOs.

The major NGOs working in health in Fiji include the Fiji Reproductive Health Association, the Fiji Red Cross, Marie Stopes, and the Fiji Network of People Living with HIV – all of which receive direct or indirect support from Australia.

In relation to this service delivery structure, a Situational Analysis[9] of the Fiji Health Sector carried out in November 2008 identified a number of issues that impinge on the effectiveness of this framework. In particular, the Situational Analysis highlighted three key issues, which were confirmed during the design process:

1. Changes in demographics, accelerated in recent years by the urban drift and the development of settlements, especially in the peri-urban areas.
2. Increased social mobility, enhanced by greater access to public and private transport, is resulting in patients increasingly by-passing lower level health facilities (which are often perceived by the community as sub-standard) and going directly to Divisional Hospitals for basic health care. This increases the pressure on these facilities, resulting in longer waiting times and consequently poor public perception of the services provided therein.
3. An identified need for a more evidence-based approach to policy and planning, which requires a more systematic approach to monitoring, evaluation and assessment of the impact of new health initiatives, supported by a dedicated program of operational research.

[8] Health Systems in Transition (HiT) DRAFT Vol.1 No. 1, 2010 The Fiji Islands Health Systems Review

[9] Fiji Health Sector Situational Analysis, December 2008

Management of the health system

The organisation and management structure of the MoH follows traditional lines. The Ministry is headed by an (Interim) Minister of Health and the MoH is managed on a day to day basis by the Permanent Secretary.

At the headquarters level, the Permanent Secretary is supported by three Deputy Secretaries (public health, hospital services and corporate services) who in turn oversee a number of Departments, each headed by a Director. This group is responsible for the overall planning, management, budgeting and priority setting that guide day to day activities.

Implementation – and the management of that implementation – is primarily at the divisional level. The 4 Divisional Health Services (DHS), Central & Eastern Divisional Offices based in Suva, Western Divisional Office in Lautoka and Northern Divisional Office in Labasa are each led by a Divisional Medical Officer (DMO) responsible for providing public health services. The DMO has overall responsibility for service delivery at all Sub-Divisional hospitals, health centres and nursing stations within his/her geographic region. Each Divisional Hospital and Sub-divisional Hospital has a Medical Superintendent responsible for the running of the hospital, and reports to the Deputy Secretary Hospital Services, who heads the clinical administration section within the MoH headquarters in Suva.

The MoH has a range of clinical and technical committees and clinical service networks, established to provide guidance in terms of quality, setting standards and establishing guidelines. The Clinical Services Plan developed in 2005 details the delivery of clinical health services at the various service levels within each specialty area benchmarked against the Ministry's Strategic Plan. Although the system is in theory a good one, there are gaps in the number and, in some cases, the skills mix, of personnel required to effectively manage, supervise, monitor and evaluate the quality of work and the impact of the services being provided. In the event of an emergency, such as the recent typhoid epidemic, human resource constraints often lead to senior managers being taken away from their key management responsibilities to deal with these emergencies at first hand.

Human resources and human resource development

Fiji is fortunate to have strong training institutions in the health sector. The Fiji School of Medicine trains medical practitioners (MBBS), medical specialists (Master and Diplomas of Medicine), pharmacists, radiographers and a range of allied health workers. The Fiji School of Nursing provides basic nurse training and offers a range of post-basic courses. Both of these institutions have recently been integrated into the Fiji National University, forming the College of Medicine, Nursing and Health Sciences; and are now under the auspices of the Ministry of Education.

The 2010 draft Health Systems in Transition (HiT) report for Fiji[10] notes that *"there is sufficient evidence to suggest that the number and quality of health workers are positively associated with immunization coverage, primary health care outreach, infant and maternal child survival and cardio vascular diseases outcomes"*.

The draft HiT report also notes that *"human resources in government services are partly supplemented by donor agencies as components of health projects/programs, or to complement government staff in the provision of selected health services, such as WHO support to immunisation and AusAID's support to the Fiji Health Sector Improvement Program (FHSIP)*".

[10] Health Systems in Transition (HiT) DRAFT Vol.1 No. 1, 2010 The Fiji Islands Health Systems Review

Health financing

Financial constraints remain an ongoing problem facing the Ministry of Health. Total health expenditure in Fiji remains low, despite increasing demand for services, placing significant pressures on the health system. The MoH budget as a percentage of GDP was 2.57 in 2008, representing a continuing and steady decline from over 4 percent in 1993, and remains the lowest, in comparison to other Pacific Island countries[11]. While there is some level of cost recovery, charges are very low and the amount of revenue collected is negligible. There is some level of private health insurance but this is limited to those in the workforce and provides access to Suva Private Hospital and, in most cases, covers offshore medical referrals.

The MoH budgetary figures indicate that although there has been an increase in the size of the health budget in recent years, the per capita health expenditure has declined from FJ$176 in 2005 to FJ$163 in 2008. However, the current fiscal situation is not allowing for any increases in the health budget. The 2010 Budget allocated FJ$148,157,000 to the Ministry of Health, with forward estimates for 2011 and 2012 remaining static (2010 Revised Budget Estimates[12]), representing in real terms, a decline in funding to health.

The situation is further compounded by the Public Service Commission's directive to all government agencies to reduce operational budgets by 50%[13]. As the bulk of Fiji's health resources are directed at curative care, which is less cost-effective than preventive services, it poses significant challenges for Fiji to sustain its health system against increasing health care costs[14].

Current Australian bilateral support to the Fiji health sector accounts for less than 3% of the total MoH budget (approximately A$140m in 2008), but is approximately 7% of the Ministry's non-staff costs. Further analysis of public and private health financing and expenditure trends, in conjunction with WHO's current work on Fiji's National Health Accounts[15], would assist MoH to improve its evidence-based assessments to guide use of public money and explore effective health financing options and partnerships with the private sector.

There is limited presence of other bilateral donors in the health sector. While WHO, UNICEF, UNFPA, UNIFEM, UNAIDS, UNDP and SPC all have a presence in Fiji, the support they provide is largely technical rather than financial. The Ministry of Health has recently secured US$11 million from Global Fund (Rounds 8 and 9) for Tuberculosis and health systems strengthening to address TB. However, Fiji's recent transition to an upper-middle income country; coupled with its low HIV and Malaria disease burdens, means that it is ineligible to apply for the forthcoming GF Round 10 and will be eligible for GF support in subsequent Rounds.

1.3. Problem Analysis

The problem analysis was informed through extensive field visits and consultations in Fiji by the design team, together with a number of high quality recent reports and

[11] Fiji Health Sector Situational Analysis Report, 2008

[12] 2010 Revised Budget Estimates, Ministry of Finance,

[13] Directive issued in March 2009

[14] The 2005 National Health Accounts indicated that Curative Services accounted for 58% of health expenditure (35% inpatient care, 23% on outpatient care), while only 5% of health expenditure was devoted to preventative/primary health care

[15] National Health Accounts track the comprehensive flow of funds through the health system and inform (i) how much the entire nation is spending on health care, (ii) what goods and services and being delivered, and (iii) who is paying for these services.

reviews specific to Fiji. Key amongst these were: the *Fiji Health Sector Situational Analysis, December 2008; the FHSIP Activity Completion Report, FHSIP Independent Completion Report, Draft May 2010; the Health Systems in Transition (HiT) Draft Vol.1 No. 1, 2010; the Child Healthcare Review, 22 August 2010; MoH Annual Report 2009; MoH National Strategic Plan 2007-2011; MoH Draft Strategic Plan 2011-2015; Report of the MoH Strategic Planning Meeting, August 2010.*

The literature review, field visits and in-country consultations highlighted a number of key issues in the Fiji health sector, which are outlined below.

Failure to make any real progress in achieving the MDG goals

The *Tracking Development and Governance in the Pacific 2009* report[16], notes Fiji's lack of progress towards achieving its MDG goals, particularly the marked increase in incidence of basic needs poverty in Fiji over the past decade[17] and regressed maternal mortality rates. The report also notes that Fiji's public health system is currently facing a severe shortage of senior medical officers and specialists. At divisional hospitals, waiting times for surgery are increasingly longer and the shortage of obstetricians and paediatricians is reportedly impacting on the care of mothers and babies. Some sub-divisional hospitals are no longer able to provide specialist medical services that they previously were able to (for instance caesarean sections). The continued shortage of senior doctors and specialists will over time lead to deterioration of health services and may lead to worsening health-related MDG outcomes. Reduced public health budgets and migration of doctors are two factors contributing to the issue[18].

Fiji made considerable progress in improving its key MDG health indicators in the 1990s. During that period, life expectancy, maternal and infant mortality improved significantly, with maternal mortality ratios (MMR) improving from 156.5 (per 100,000 live births) in 1970 to 53.0 in 1980, to 41 in 1990 and to 22 in 2003. However from around 2003 progress stalled and began to deteriorate, with MMR peaking at 50 in 2005 and with a current MMR of 31.7 in 2008, well above the 2015 MDG target of 10.3 (see Table 1 and Chart 1 below).

Table 1 MMR: Maternal deaths per 100,000 live births (MDG)

(Source: MoH Annual Reports 1990, 2000-2008)

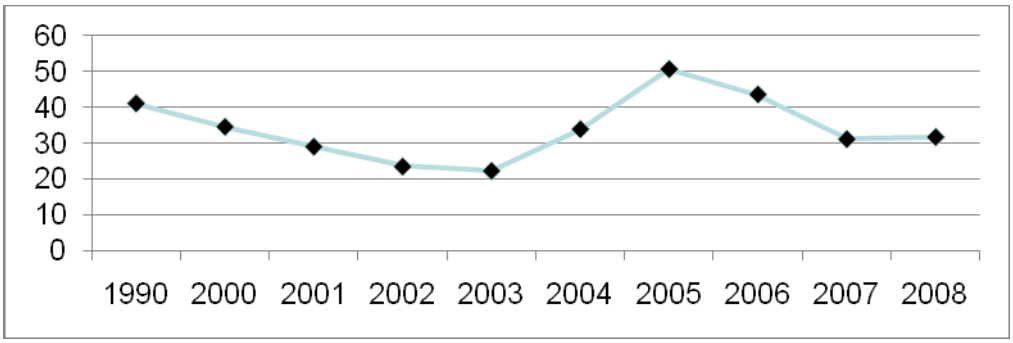
1990	2000	2008	2011-2015	2015 MDG target
41	34.6	31.7		10.3

Chart 1: Maternal Mortality Ratio 1990 - 2008

[16] AusAID (2009), Tracking Development and Governance in the Pacific launched at the Cairns Forum Leaders Meeting in August 2009

[17] From 26 percent in 1996 to 24 percent in 2007

[18] AusAID, Fiji Health Sector Situational Analysis, Executive Summary. 2008



The major causes of maternal mortality include ectopic pregnancy, pre-eclamptic toxaemia, post partum haemorrhage, cardiac disease and septicaemia.

Provision of high quality antenatal, obstetric and post-natal care is essential if indicators for maternal health (MDG 5) are to be achieved. During the design mission, several constraints to achieving optimal outcomes in this area were identified. These include a high incidence of late presentation for antenatal checks; transport issues both for patients visiting health facilities and for staff undertaking outreach; a shortage of standardized protocols and guidelines for both nursing and medical staff at nursing stations (NS), Health Centres (HC) and Sub-Divisional Hospitals (SDH), and a weak system and culture for monitoring and evaluating services. In addition, there is inconsistency in size and population catchment for similar levels of health facility, with some facilities with small workloads being better equipped and staffed than others with much larger workloads. While the percentage of births attended by skilled personnel has remained consistently above 98% since 2001 and is currently estimated to be 98.8% (2008 data), many of the SDHs visited by the design team would require upgrading with respect to both staffing skills, and equipment and facilities before they could be classified as “Baby Safe”.

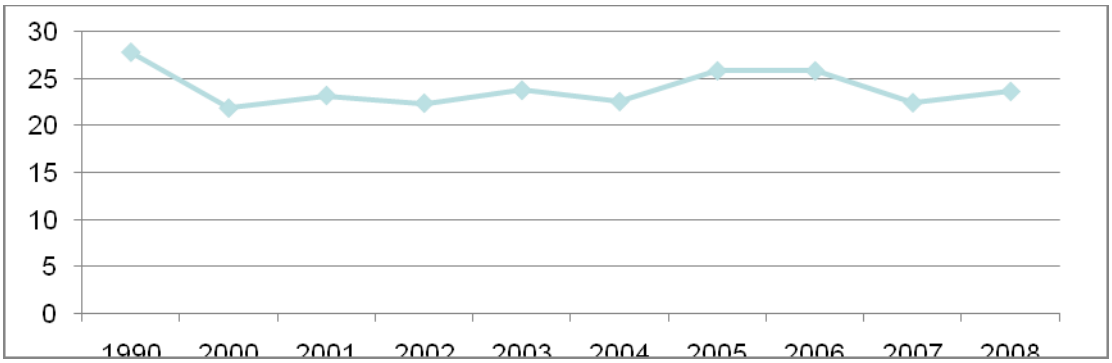
Despite the establishment of family planning clinics in all health centres throughout the country, the contraceptive prevalence rate (CPR) has remained stagnant at around 40 for the last decade and is currently estimated at 44.7, well short of the 2015 target of 56. This indicates the need for improved counselling to increase awareness of family planning methods, address concerns about side effects and reduce discontinuity rates.

While Fiji has a low HIV prevalence[19], recent Second Generation Surveillance data indicates very high STI rates. Among pregnant women attending ANC the rates of Chlamydia are as high as 30%. This high incidence of previously undetected STIs in pregnant women demonstrates an unmet need for raising awareness about STIs and improving access to sexual and reproductive health services, including STI prevention.

With regard to infant and child health, Fiji made considerable progress in the 1990s, reducing Under-five mortality from 27.8 to 21.8 in that decade. However, since 2000 Under-five mortality has crept up and is currently estimated at 23.6, significantly higher than the 2015 MDG4 target of 9.2 (see Chart 2 below).

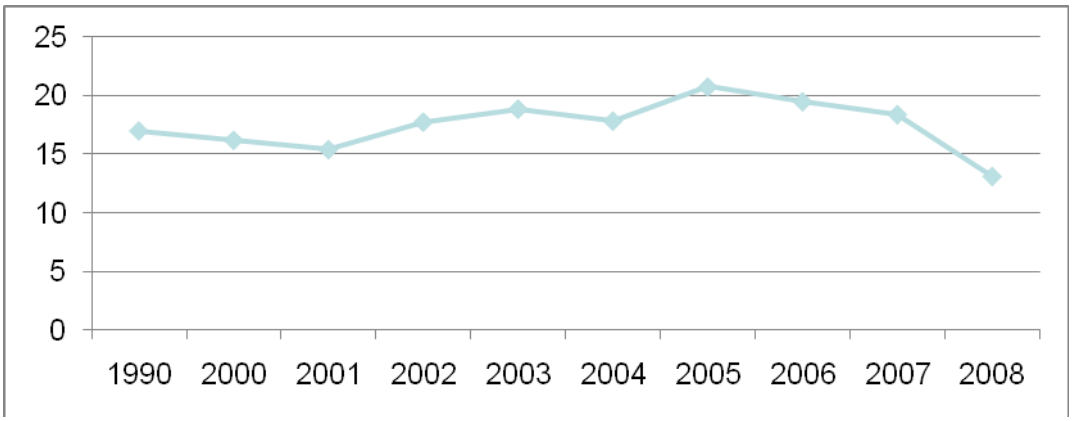
[19] HIV prevalence currently estimated as 0.05%

Chart 2: Under-five mortality rate (U5MR) 1990-2008 (Source MoH Annual Reports 1990, 200-2008)



Infant mortality has also shown a slight upwards trend over the past decade, with the infant mortality rate (IMR) rising from 16.2 per 1000 live births in 2000 to 18.4 in 2007, although there seems to have recently been some progress and the current (2008) estimate is 13.1, although this is significantly higher than the 2015 MDG4 target of 5.5 (see Chart 3 below).

Chart 3: Infant mortality rate (IMR) 1990-2008 (Source MoH Annual Reports 1990, 2000-2008)



A recent Child Healthcare Review[20], commissioned under the Fiji Health Sector Improvement Program, indicated that Fiji's 2015 MDG 4 targets for Fiji are unrealistic, as the set targets are similar to Australia's current IMR. The Review notes that a more realistic IMR target for Fiji for 2015 is 12 per 1,000 live births and for the U5MR is 18 per 1,000 live births. Nevertheless, as outlined earlier, both U5MR and IMR in Fiji have remained relatively static over the last decade, with perinatal and neonatal mortality both contributing substantially to the IMR/U5MR.

The Child Healthcare Review highlights a number of factors that are most frequently associated with childhood deaths. These include: delayed health seeking behaviour due to lack of recognition of the severity of illness, coupled with transportation issues and delayed referral from subdivisional hospitals. The Review notes that IMCI[21] is not operational in many of the divisions, and shortages of IMCI drugs are common. Clinical Practice Guidelines are being developed but there is a need for continued training in core paediatric skills to improve capacity at the subdivisional hospital level.

[20] Russell, F., Child Healthcare Review, 22 August 2010, Report prepared for FHSIP

[21] Integrated Management of Childhood Illnesses

Many factors contributing to childhood morbidity and mortality need to be continually strengthened. This includes breastfeeding, where rates were low at six months of age despite relatively high levels of early initiation of breastfeeding. This is partly a result of low levels of community support for breastfeeding.

The Review notes that EPI coverage rates have improved; although in 2009 measles vaccine coverage rates appeared to be below target. This is attributed to a loss of experienced health staff, following the mandatory retirement of senior health workers.

With regard to health promotion, the Review notes that there are few teaching aids or health promotional materials available in health centres and little evidence of key health messages reaching the community level although in some areas, village health workers (VHW), were actively engaged by the health system.

The Review also notes that while large volumes of information are collected by the MoH and used in annual reports and for centralised planning, there is a need for end users to analyse their data and use it for planning activities based on need (such as community nutrition, breastfeeding etc).

The issues highlighted in the Review are consistent with those identified during the design mission, which noted that the provision of high quality service delivery at the decentralized level is critical in improving infant and child health outcomes. Constraints relating to staff skills; transport; standardized protocols and guidelines, and upgrading of facilities were similar to those found for safe motherhood. In addition, the design team identified a generalised need for strengthening the capacity of both medical and nursing staff to manage childhood illnesses and a specific need to reduce the high rate of defaulters with respect to the Expanded Program of Immunization (EPI).

Increasing problem of diabetes and its complications

As Fiji transitions to an upper-middle income country, non-communicable diseases (NCD) are becoming an increasingly important 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[22]. 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 18% of the population[23] and together with hypertension is a significant risk factor for coronary and vascular disease. Importantly, diabetes itself also carries a very significant morbidity. Although diabetes prevalence in 2008 has been noted as 18% (up from 16% in 2003), this figure does not include the deaths of patients with diabetes each year. It should also be noted that the 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.

Diabetic foot sepsis and diabetic retinopathy are major and preventable complications, which both lead to considerable disability if not managed effectively. MoH data indicate that amputation rates for diabetic foot sepsis continue to increase (see Table 2 below).

[22] http://www.wpro.who.int/countries/2008/fij/health_situation.htm
[23] MOH Annual Report 2009

Table 2: Amputation rate for diabetic sepsis and its complications *(Source MoH Annual Reports 2001-2008)*				
2004	2005	2006	2007	2011 target
22.3%	23.6%	33.9%	33.9%	9%

The 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; was 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.

Reduced effectiveness of Village/Community Health Workers as the first points of contact with the health system.

Fiji signed up to the 1978 Declaration of Alma Ata of "health for all" by the year 2000 and adopted a village based approach to primary health care. Until the last decade or so, Fiji had a strong and well-respected mechanism of volunteer village health workers (known as community health workers in urban areas)[24] who provided basic health care and served as the first points of contact with the health system for people at village and community level.

However, a lack of general investment over time in primary health and the VHW/CHW system in particular has resulted in inadequate resources, weak supervision, monitoring and evaluation, and the attrition of VHW/CHW. It has also resulted in reduced motivation and skills to effectively perform VHW/CHW key roles as the first point of contact with the health system. Some VHW/CHWs have retired or moved on, and new squatter settlements have evolved in urban/peri-urban areas with little or no planning, with the result that some villages and a number of urban/peri-urban squatter communities are without a VHW/CHW. In addition, there is inadequate awareness of the VHW/CHW mechanism, especially in urban and peri-urban squatter communities.

The importance of revitalising the VHW/CHW network was repeatedly emphasized by virtually all the key stakeholders consulted during the design process, including clinicians and senior officials at the MoH. They noted that poor health practices and health-seeking behaviour by people at community level are resulting in high burdens of disease and putting additional strain on health facilities at divisional level.

In part, this problem reflects the fact that the VHW/CHWs are not part of the public sector; they are volunteers and are not remunerated. There is some indication that the MoH is exploring how to provide some financial incentives to the VHW/CHWs, but such payments are outside the scope of this Program.

[24] With the urban drift over recent years, more and more communities no longer follow the traditional village basis. For this reason the VHW are sometimes referred to as Community Health Workers (CHW). The term VHW/CHW here is used to cover both settings.

A decline in the capacity of some components of the health system to support decentralised service delivery

In addition to the problems outlined above, the design team identified a number of systemic issues that impact negatively on the effective delivery of services at divisional and sub-divisional levels. These include:

- **Ineffective and inefficient use of data for policy, planning and service delivery:** Data are routinely processed at the MoH Health Information Unit, but information is rarely disseminated back to health service delivery points, where it is most needed for situational assessments and planning. The weakness in analysis and feedback of public health data was repeatedly raised as an issue by MoH headquarters and during site visits by the design team.
- **Weak monitoring and evaluation:** The design team noted that the MoH does not have a strong culture of monitoring and evaluation (M&E). Nor does its current Annual Plan include a detailed performance measurement framework. There is an identified need to strengthen monitoring and evaluation skills both within the central MoH headquarters in Suva and also at divisional and sub-divisional levels, and to foster a culture where M&E becomes a routine component of service delivery.
- **Critical knowledge gaps:** The design team noted that there were some critical knowledge gaps where information is not available from routine information sources. The issue of urban and peri-urban migration and the effect this is having on health parameters was identified as an area that needs further research; other potential research areas include investigation of new disease trends and a review of the effectiveness of health interventions.
- **Weak supervision:** Senior officers at each level in the health system are expected to provide an important role in supporting; supervising, monitoring, and providing in-service training for their junior colleagues at lower levels in the system. There was concern, however, that this system was not institutionalized and that it was highly dependent on the initiative and motivation of the doctor or nurse practitioner. There was also a concern about whether supervising staff have the appropriate skills for this supervisory role. JICA has identified this as a key area of constraint and has developed and piloted a nursing supervision program in the Central Division prior to rolling it out to other areas. It is believed that strengthening this vital link could significantly improve health outcomes.
- **Clinical Quality Improvement and Risk Management:** A component of the current FHSIP program is the introduction of risk management and Clinical Quality Improvement (CQI) at the divisional level. The value of this was highlighted several times by MoH staff during the design mission, but it was also noted that it needed to be consolidated and expanded to the sub-divisional level.
- **Transport constraints:** Transport was identified as a major constraint with respect to timely access to health services for patients and for Ministry staff conducting outreach. The Design Team noted the need for vehicles, boats and even horses to improve access to services. However, there was some indication that existing transport facilities could be better managed and coordinated.
- **Attrition of human resources in the health sector**

As outlined earlier, the combination of political uncertainty and recent government policies on public sector staffing cuts and lowering of the civil service compulsory retirement age to 55 years has resulted in the loss to the MoH of up to 1000 health staff, many of them consultants and nurses with specialist skills in areas such as

paediatrics, obstetrics, intensive care and oncology. Table 3 below provides an indication of the loss of MoH staff over the period 2003-2007.

Table 3: Staff leaving MoH between 2003-2007 (Source Situational Analysis 2008)

Cadre	2003	2004	2005	2006	2007	Total
Medical Officers	29	40	37	31	23	160
Nurses	25	64	162	216	78	545
Paramedical	15	15	19	19	13	81
Dental	4	4	13	10	5	36
Pharmacy	4	3	18	8	8	41
TOTAL	77	126	284	284	127	863

The human resource gaps left by MoH staff exodus are most acute at the senior levels and particularly Consultant Specialists and Chief, Principal and Senior Medical Officers, as indicated in Table 4 below.

Table 4: MoH Medical Cadres and staffing levels as of 31 August 2008

Cadre	Grade	Approved establishment	Filled	Vacant
Consultant Specialist	MD01	35	22	13
Chief Medical Officer	MD02	25	18	7
Principal Medical Officer	MD03	44	32	12
Senior Medical Officer	MD04	79	46	33
Medical Officer	MD05	168	170	+2
Medical Intern	MD06	35	49	+14
Medical Assistant	MD07	10	10	0
Total		396	347	49

The 2008 Situational Analysis noted that the continued and escalating shortage of senior and specialist Medical Officers will, over time, lead to a serious deterioration of the delivery and standards of health services, service quality and professional training.

The Situational Analysis also noted that the approved establishment levels were not based on existing epidemiological needs nor did they take into account the significant and escalating urban drift over time. It is anticipated that the ongoing Review of the Health Services will provide a clearer picture of the human resource needs for health.

1.4. Lessons Learned

Lessons relevant to the design of this Program have been learned from previous and ongoing programs supported by AusAID, and particularly from the current Fiji Health Sector Improvement Program (FHSIP). These are outlined below:

- While FHSIP achieved a number of important outputs, the program lacked strategic focus and therefore supported too wide a range of activities, so resources were spread too thinly. As a consequence, it was hard to demonstrate sectoral outcomes. To achieve an impact on key MoH health indicators, the new program of support should be limited in its scope, and focused in its objectives.
- Because of the slow and cumbersome nature of the partner government's (MoH's) finance and procurement mechanisms, an independent financing mechanism should be established in the new Program that is flexible, responsive and provides protection for Australian funds. Funding through FHSIP was managed via an imprest account, which proved popular with the MoH due its flexibility and responsiveness. However, changes in AusAID regulations related to the use of imprest accounts have precluded the use of this mechanism in the new program of support.
- The Project Officer model implemented under FHSIP filled key human resource gaps and catalysed activities. However, there were concerns about the sustainability of the model, especially as the majority of seconded Project Officers were returned to their original positions in the MoH without their enhanced skills being fully exploited. Whilst there is a case to be made for retaining this proven and effective model in the new Program, this needs to be balanced against the need to draw on best practice in the provision of TA and the need to ensure sustainability. Any engagement of Project Officers in the new Program of support should therefore be restricted to contracted staff, (in keeping with PSC guidelines) and their deployment should be limited.
- FHSIP engaged a team of specialist advisors, located at central level. In keeping with the identified need to support service delivery at decentralised levels, the new program of support should establish technical facilitators at national level, supporting the National Advisers and Divisional Medical Officers. The Program should seek to engage, wherever meritoriously feasible, program expertise locally.
- The Program should also ensure that TA adds value and contributes to long term capability by supporting the overall capacity development of the MoH, rather than filling short term human resource gaps in the government system. In addition, the TA should have a strong M&E focus to monitor its effectiveness and learn lessons
- The TA should work towards supporting harmonisation across development partners, UN agencies and other technical assistance providers;
- Over time, the Program should support the integration of TA planning and budgeting into government planning cycles.
- The economic and political climates in Fiji remain volatile, and the design should therefore contain significant flexibility to be able to adapt to changing circumstances. The draft HiT 2010 report notes that: *"all components of the health sector are in a fluid state and require flexible responses, so it can be anticipated that the issue of decentralisation will re-emerge from the revitalisation of primary health care".*

These lessons have all been incorporated into the design of this new Program of support.

1.5. Program Principles

While AusAID does not currently have a formal Fiji Country Strategy, it does have an engagement philosophy and guidelines to focus its inputs. The design of this program incorporates the following elements of the engagement philosophy:

Activities are aligned with the Cairns Compact and the Paris Declaration

As outlined below, the design team has ensured harmonization of FHSSP with ongoing and planned activities supported by other health development partners in Fiji and regionally in the Pacific. The Program Goal (see Section 2 below) is to remain engaged in the Fiji health sector by contributing to the efforts of the MoH to achieve its strategic objectives in relation to reducing infant mortality (MDG4), improving maternal health (MDG 5) and the prevention and management of diabetes, as outlined in the 2007-2011 Strategic Plan of the MoH and the subsequent MoH Draft Strategic Plan for 2011-2015. The Program is therefore fully aligned with current and future MoH strategies and priorities.

Overarching responsibility for planning, implementation and monitoring lies in the hands of the MoH. FHSSP's primary responsibility is to provide technical coordination and management support to the MoH to help the Ministry achieve its health outcomes. The principle of country ownership is therefore respected. FHSSP has a clearly defined set of outcomes for which the program will be accountable that lead to higher level outcomes for which the Ministry is accountable. The Program therefore embraces the principle of managing for results and supports mutual accountability.

Activities are consistent with the recipient's own Strategic Plans and be owned by the partner government or institution.

Adherence to this principle underpins the objectives and approaches described in this design document. In particular, wherever possible the Fiji Health Sector Support Program will be aligned with MoH systems. While the Program will not use the MoH financial and procurement systems and processes, it will in all other respects work with and seek to strengthen the Ministry's own systems. In particular it will:

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

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

Funds will be primarily directed to decentralized levels.

While the Program will provide some support at the central level, primarily for broad health systems strengthening, approximately 80 percent of the proposed Program budget is expected to be directed to divisional and sub-divisional levels (not including the unallocated fund for emergencies and emerging health priorities).

The Program addresses the needs of vulnerable groups

The Program seeks to address vulnerable groups and individuals through several strategies 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 VHW/CHW network.

However, there is no reliable 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.

The Program integrates with the work of other donors and builds on the work of other AusAID-supported activities[25].

The design team identified a number of opportunities for FHSSP to integrate with the work of other donors and development partners in Fiji (including the UN) and to build on the work of other AusAID-supported activities. These are summarised below:

Pacific Regional NCD Program (jointly implemented by SPC/WHO)

There are several areas of potential linkage with this regional program:

- In seeking to improve the prevention and management of diabetes and hypertension at decentralised levels (Objective 3), FHSSP will draw upon the

[25] The specific modalities for integration of FHSSP activities with those of other donors and with AusAID-supported regional programs are provided in detail in Annex 9,

findings of Fiji's forthcoming NCD STEPS survey to be undertaken in late 2010 to provide baseline data on diabetes and other NCDs.

- FHSSP will also draw upon the Regional NCD Strategic Framework currently being implemented by the Secretariat of the Pacific Community (SPC) and WHO with AusAID support; and
- Health promotion activities within the regional program that seek to encourage healthier lifestyles (exercise, diet, etc) will support FHSSP Objective 3 (prevention and management of diabetes).

Pacific Regional HIV/STI Response Fund (SPC)

Given the high levels of STIs in women attending antenatal clinics, FHSSP could draw upon the activities implemented under the Pacific Regional HIV & STI Strategy Implementation Plan 2009-2013 to leverage support to address STIs, especially among pregnant women.

Pacific Human Resources for Health Alliance

This project is being implemented by WHO, which acts as the PHRHA Secretariat. FHSSP should maintain links with the project through work that is being supported on workforce issues, including the implementation of recommendations relating to the Fiji nursing workforce review.

The Health Systems in Transition (HiT) profile

HiT is a country-based report that provides a detailed description of the health care system and of reform and policy initiatives in progress or under development. HiT is currently being undertaken in Fiji under WHO auspices and coordinated at FSMed. It is anticipated that the Fiji HiT will identify areas for policy research and program development that could be supported under FHSSP.

Other health development partner initiatives in Fiji

- A major focus of FHSSP is supporting the MoH to achieve its MDGs 4 and 5 (Objectives 1 and 2 of the Program). This will include working with UNICEF in strengthening MCH/EPI through immunizations/vaccines/cold chain support and the promotion of breast-feeding through the Baby Friendly Hospital Initiative, in conjunction with WHO. In seeking to reduce maternal mortality by strengthening Emergency Obstetric Care (EmOC) the Program will draw upon the Health Facilities Survey supported by UNFPA in relation to emergency obstetric care (EmOC)[26]. Much of the work being undertaken by WHO, UNFPA, FSMed and UNICEF is being supported in part by AusAID.
- Where appropriate, FHSSP will also collaborate with the activities of the AusAID funded 'maternal health knowledge hub' in Fiji. These include: prioritizing and taking forward the key recommendations presented in the recent Child Healthcare Review[27]; drawing on the findings from the baseline outcomes assessment of neonatal morbidity; supporting the development of clinical practice guidelines for follow-up care of newborns discharged from intensive care services; supporting locally appropriate systems and guidelines for monitoring child development to facilitate early identification of developmental disabilities.

[26] EmOC Survey Document is now in draft form and is expected to be published in the coming months

[27] Russell, F., Child Healthcare Review, 22 August 2010, Report prepared for FHSIP

- Under Objective 3, FHSSP seeks to improve the prevention and management of diabetes and hypertension at decentralised levels. With technical support from WHO, the Fiji STEPS Report was published in 2005. The Report provided data on the key NCDs and their risk factors, including diabetes and hypertension. The FHSSP will draw upon the findings of Fiji's forthcoming second NCD STEPS survey to be undertaken in late 2010. This will provide useful baseline data in relation to diabetes and other NCDs prevalent in Fiji. In addition, the Program will draw upon the Pacific Regional NCD Strategic Framework, which is being jointly implemented by SPC and WHO, with funding support from AusAID and NZAID.
- In order to revitalize the Village/Community Health Worker (VHW/CHW) system (Objective 4), FHSSP will liaise closely with WHO as they have a ongoing VHW/CHW pilot in the central division. The WHO pilot program includes reviewing and revising the MoH VHW curriculum and the definition of service packages, and conduct training of VHW/CHW. Zone nurse supervisors will also receive training in VHW/CHW supervision including the use of indicators to monitor the work of the VHW/CHW. The zone nurse supervision training will be linked to the JICA In-service Training (IST) project. The WHO pilot project is expected to be evaluated six months after completion of training (June 2011), and FHSSP will draw on the lessons learned by this pilot to inform further developments of this initiative, including scaling up and rolling it out across all four Divisions if deemed appropriate;
- FHSSP activities to strengthen the MoH Public Health Information System (Objective 5) will complement and harmonize with activities to be implemented under the recently signed Round 9 Global Fund (GF) support to the MoH for Health Systems Strengthening to address TB. GF support includes the development of a National Policy for Health Information and a National Health Information Strategic Plan (2010-2014). In addition, the GF grant will support the provision of computers to all Sub-Divisional Hospitals and 76 Health Centres, together with running costs. GF will also support the engagement of health information staff at central and divisional levels and the training of 200 nurses at health centre and nursing station levels on HIS management. However, GF support does not extend to the existing public health information system (PHIS), or to the systematic use of public health data for policy, planning and improved service delivery - areas that FHSSP will focus upon under this sub-component. FHSSP will draw upon the human resource and IT support provided under GF, when its activity plans are developed FHSSP will liaise closely with the implementing unit for the GF support (the Principal Recipient at the MoH) to avoid duplication and ensure that activities are fully aligned.
- FHSSP support to strengthen facilitative supervision at divisional and sub-divisional levels (Objective 5) will work in close collaboration with JICA’s ongoing project on supporting Need-based In-service Training (NB-IST) for Community Health Nurses. The JICA project was piloted from 2005-2008 at a model site in the Central Division and JICA is currently working with MoH's Department of Human Resources to formulate a policy package for the integration of NB-IST into the Ministry's overall IST system. The Program will build on the work of JICA and incorporate the lessons learned in a broader system of support to facilitate supervision at divisional levels.
- FHSSP will draw upon, (and support where appropriate), ongoing and planned evaluations and operational research initiatives to strengthen evidence-based policy, planning and service delivery in Fiji, including WHO’s work on Fiji’s National Health Accounts; a further expansion of the analysis on the Fiji

component of the WHO and UNSW work on the regional health mapping exercise; the Fiji Health Workforce Plan Phase 2 and the EmOC Health Facilities Survey supported by UNFPA. The Program may commission new operational research and/or undertake additional analysis of existing data sets to address identified information gaps, based on needs identified during the MoH planning processes. Operational research and critical analysis will provide a sound platform on which to base long-term AusAID assistance to Fiji's health sector.

- FHSSP will build upon and integrate the work that has been implemented through FHSIP in both public health and clinical areas. Examples where integration could take place include:
    - The Fiji School of Nursing (FSN) was strengthened under FHSIP and is now in a position to provide a range of specialised training. In the new Program, FSN (under the auspices of FNU) could be sub-contracted to work with others to provide special in-service training in areas such as IMCI;
    - Under FHSIP, nursing standards were developed and nurse competencies are in the process of being developed. Under FHSSP, nursing standards will be supervised by the MoH nursing unit, and subject to agreement within MoH, the Program will support the roll out of these standards and continue training in their application;
    - FHSIP initiated a strong program of support for planning to address NCDs, including a national NCD Strategic Plan and a National Eye-care Plan. FHSSP will utilize the NCD Strategic Plan and the Eye Care Plan as important guiding documents in program implementation in relation to diabetes;
    - FHSIP supported initial work to improve foot care for patients with diabetes, and a program of home based foot care was introduced at the National Diabetes Centre and CWM which is still at an embryonic stage. Under FHSSP these initiatives will be continued and scaled up as appropriate;
    - FHSIP provided support to strengthen the functioning of the National Health Promotion Centre. Under FHSSP the National Health Promotion Centre will conduct integrated media campaign aligned with the VHW/CHW initiative;
    - FHSIP supported the development of a clinical services plan, clinical services framework and the establishment of a Clinical Services Advisory Committee and clinical services networks. This support will be continued under FHSSP as appropriate; and
    - FHSIP supported the introduction of the public health information system (PHIS) for the collection of data from individual health facilities and this was reviewed in July 2010. FHSSP will utilize the findings of the review to continue to improve and expand PHIS.

Annex 10 contains specific details of all areas of integration of FHSIP and FHSSP.

1.6. Rationale for AusAID Involvement

The Australian government remains committed to providing support to the people of Fiji. As outlined earlier, the health sector has for many years been a key pillar of AusAID's support to Fiji, most recently through FHSIP. This new Program of Support builds on the FHSIP approach that program activities should support the MoH to achieve the objectives of its strategic plan using its own planning processes.

However, drawing on the key lessons learned from FHSIP, this new Program of Support will have a clear strategic focus, with support channelled towards achieving agreed outcomes.

By focusing on the achievement of MDGs 4 and 5, and improving prevention and management of diabetes and hypertension at decentralised levels, the Program will support the achievement of three of the seven Health Outcomes identified in the MoH's Strategic Plan 2007-2011[28], namely: Reduced burden of non-communicable diseases; Improved maternal health and reduced maternal morbidity and mortality; Improved child health and reduced child morbidity and mortality. Furthermore, the Program is closely aligned with the MoH's key priorities for the coming five years, and in particular "Revitalizing primary health care approaches to address the burden of NCDs, maternal and child health and preventing communicable diseases" as outlined in the MoH Draft Strategic Plan 2011-2015[29].

The Program also reflects the priorities of AusAID. The Agency has made a commitment globally to support countries to achieve their individual MDGs, and at the regional level AusAID has made NCDs a priority area for support to the Pacific Island Countries and Territories (PICTS). This priority was recently reaffirmed through the Madang Commitment made by the PICTs at the Health Ministers Conference in PNG in 2009.

Furthermore, a report of a UN meeting held in April 2010 highlighted the need to:

> "consider integrating indicators to monitor the magnitude, the trend and the socio economic impact of NCDs into the Millennium Development Goals monitoring systems, and … to raise the priority accorded to NCDs in development cooperation by enhancing cooperation in this regard."

The design of this new Program of Support was guided by the priorities outlined during the AusAID briefing, namely to improve the delivery of essential health services at decentralised levels; to revitalise primary health care; to support the MoH in working towards the achievement of the MDGs; to explore increased convergence between AusAID's regional and bilateral programs; and to increase health development partner harmonization, with the long term aim of working towards sectoral coordination.

The design outlined in this document is consistent with AusAID's global and regional strategies and provides a rational platform for continued Australian support to Fiji. Towards the end of the design process the design team held a series of review and feedback meetings with key stakeholder groups including the MoH, development partners based in Fiji, AusAID Suva and via teleconference with AusAID Canberra. The proposed design received strong support from all stakeholders consulted, and there was a clear indication from bilateral and multilateral donors that the Program has the potential to serve as a platform for increased donor coordination and convergence.

It is noted that donor coordination in Fiji is currently weak, and the design therefore provides two opportunities for strengthening health partner coordination in Fiji. The

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[28] The seven outcomes in the MoH plan 2007-2011 are: 1. Reduced burden of NCDs; 2. Reduced spread of HIV/AIDS and other CDs prevented, controlled or eliminated; 3. Improved maternal health and reduced maternal morbidity and mortality; 4. Improved child health and reduced child morbidity and mortality; 5. Improved adolescent health and reduced adolescent morbidity and mortality; 6. Improved mental health care; 7. Improved environmental health

[29] Presentation by Permanent Secretary for Health at the MoH Strategic Planning Workshop, Suva, 11-12 August 2010

first lies in the Program's strategic focus on MCH and diabetes prevention & management. There are indications that both the MoH and health development partners view these areas as platforms around which donors can coalesce and align with MoH priorities. The second opportunity lies in the proposed program oversight & governance mechanism, and there are indications from both MoH and health development partners that the proposed mechanism has the potential to be expanded to include other donors.

2. Program Description

2.1. Overview

At the heart of this Design is a Program of Support to address four key problems that the Fiji health sector faces. The first two are programmatic while the second two are systemic:

1. Fiji's failure to make any real progress in achieving its Millennium Development Goals (MDG) in relation to improving maternal health (MDG5) and reducing child mortality (MDG4).
2. The increasing problem of diabetes and its complications. Not only does diabetes place a personal burden on individual patients, but the chronic nature of the disease and its wide range of serious complications place ongoing pressures on the financial resources of the health sector.
3. Reduced effectiveness of Village/Community Health Workers as the first points of contact with the health service for people at village/community level.
4. A decline in the capacity of some components of the health system to fully support decentralized service delivery.

As outlined earlier, the Design is grounded in recent analysis of the constraints faced by the Fiji health sector, and builds upon the documented lessons learned from the current FHSIP.

2.2. Program Goal and Objectives

The **Goal** of the program is:

To remain engaged in the Fiji health sector by contributing to the Fiji Ministry of Health's efforts to achieve its higher level strategic objectives in relation to reducing infant mortality (MDG4), improving maternal health (MDG 5) and the prevention and management of diabetes, as outlined in the Strategic Plan of the MoH.

The 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 **revitalize an effective 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 decentralized service delivery** (including Health information, Monitoring & Evaluation, Strategic and Operational Planning, Supervision and Operational Research)

The identification of the Program Goal and Objectives was conducted in close consultation and collaboration with the Ministry of Health through a series of participatory meetings at both central and divisional levels. Achievement of these program objectives will support the achievement of three of the seven Health Outcomes[30] identified in the MoH's Strategic Plan 2007-2011, namely:

- Reduced Burden of Non-Communicable Diseases;
- Improved Maternal Health and Reduced Maternal Morbidity and Mortality;
- Improved Child Health and Reduced Maternal Morbidity and Mortality.

Furthermore, the MoH clearly indicated that the program of support proposed under this design is closely aligned with their evolving strategic priorities for the coming five years.

During the finalization of this design, the MoH drafted their new five-year strategic plan 2011-2015. The new draft strategic plan has two Strategic Goals[31]:

> *Strategic Goal 1: Communities are served by adequate primary and preventive health services thereby protecting, promoting and supporting their well-being;*
>
> *Strategic Goal 2: Communities have access to effective, efficient and quality clinical health care and rehabilitation services.*

The key focal areas identified in the new draft MoH strategic plan are:

- Revitalizing primary health care approaches to address the burden of NCDs, maternal and child health and preventing communicable diseases;
- Strengthening key areas of clinical service delivery with continued emphasis on patient safety and risk management;
- Strengthening mental health, rehabilitation services and oral health;
- Making the Fiji population healthier;

The draft MoH Strategic Plan 2011-2015 indicates that the MoH's approaches with regard to primary health care and MCH services[32], are to:

Revitalize Primary Health Care, and specifically:

- Prevention and early intervention
- Strengthen health protection and promotion

[30] The seven outcomes are: 1. Reduced burden of NCDs; 2. Reduced spread of HIV/AIDS and other CDs prevented, controlled or eliminated; 3. Improved maternal health and reduced maternal morbidity and mortality; 4. Improved child health and reduced child morbidity and mortality; 5. Improved adolescent health and reduced adolescent morbidity and mortality; 6. Improved mental health care; 7. Improved environmental health

[31] Presentation by Permanent Secretary for Health at the MoH Strategic Planning Workshop, Suva, 11-12 August 2010

[32] Presentation by Permanent Secretary for Health at the MoH Strategic Planning Workshop, Suva, 11-12 August 2010

- Enhance continuity of care
- Provide services closer to where people live

Reform Maternal and Child Health Services, and specifically

- Reduce maternal mortality by 2/3
- Encourage early booking
- Promote safe motherhood concept
- Reduce infant and under 5 mortality by 2/3
- Provide friendly MCH services

The continuing MoH focus on maternal and child health and addressing the burden of non-communicable diseases coupled with the new focal area of revitalizing primary health care, means that the proposed program of support therefore remains closely aligned with the MoH's focal priorities for the period 2011-2015.

Key Program Rationale

The comprehensive Year 1 activities include up to six technical facilitators in the areas of safe motherhood, child health, diabetes prevention & management, primary health/community mobilization, and health information/M&E. In addition, since the bulk of the program will be implemented at divisional level and below, these technical facilitators will also facilitate and support program implementation at divisional level; including addressing capacity gaps in monitoring & evaluation and the use of data for planning and programming at decentralised levels.

Objective 1: To institutionalise a safe motherhood program at decentralised levels

Constraints

Provision of high quality antenatal, obstetric and post-natal care is essential if indicators for maternal health (MDG 5) are to be achieved. The Design process identified several constraints to achieving optimal outcomes in this area. These include a high incidence of late presentation for antenatal checks; transport issues both for patients visiting health facilities and for staff undertaking outreach; a shortage of standardized protocols and guidelines for both nursing and medical staff at nursing stations (NS), Health Centres (HC) and Sub-Divisional Hospitals (SDH), and a weak system and culture for monitoring and evaluating services. In addition, there was an inconsistency in 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 visited by the design team would require upgrading with respect to both staffing skills, and equipment and facilities before they could be classified as "Baby Safe".

Reproductive health is also an area that needs consideration. The high incidence of the previously undetected STIs found in pregnant women shows an enormous unmet need for raising awareness about STIs and improving access to reproductive health services.

The Obstetrics and Gynaecology (O&G) section of the Clinical Services Planning Framework-2005 (CSPF) provides an excellent summary of the key issues relating to antenatal and obstetric care and presents key strategies to overcome these. The design team recommends that significant support under this program should be given to implementing this plan.

The recent Child Healthcare Review[33] provides the following recommendations with regard to safe motherhood:

- Urgent need for midwives and doctors for divisional hospitals based on services provided & population served;
- Need for a dedicated Safe Motherhood Technical Facilitator/Project Officer;
- Need for a community level Safe Motherhood programme for early detection, health information, discussion of birth planning, and early intervention;
- Need for a review of antenatal care services and the quality of services provided

Indicative Program Inputs

In order to achieve the objective of institutionalizing safe motherhood, the Program would support the following inputs:

Personnel: Maternal Health technical coordinator, supported by the Program Director and Administrator

Essential equipment and supplies related to safe motherhood - including portable ultrasounds

Transport costs to support capacity building, patient transport, workshops, supervision, outreach, and on-the-job training to improve essential skills related to safe motherhood

Materials and supplies to support training, capacity building and strengthening the preparation and implementation of clinical service guidelines

Infrastructure – upgrading and refurbishment of selected facilities to 'baby-safe' status

Indicative activities

Key activities under this objective may include, but not be restricted to:

- Introducing a targeted skills improvement program, focused on antenatal, delivery and post natal care, for nursing and medical staff at the NS, HC and SDH levels;
- Raising awareness of the need for early antenatal care and introducing systems to ensure that pregnant women present for their first antenatal check-up in the first trimester;
- Strengthening counselling skills in family planning at all levels;
- Expanding demand for, access to, and availability of short-term, permanent and long-term methods of contraception, including Jadelle;
- Reviewing the delineation of health facilities to ensure their categorization with respect to maternity services is appropriate for their catchment and service load;
- Implementing the proposed role delineation for deliveries so that only emergency deliveries are carried out at Nursing Stations and Health Centres, while all low risk deliveries are referred to Sub-Divisional Hospitals and high risk deliveries to Divisional Hospitals:

[33] Russell, F., Child Healthcare Review, 22 August 2010, Report prepared for FHSIP

- Preparing and introducing clear protocols and guidelines, including ones for emergency deliveries at Nursing Stations and Health Centres and for timely referral of higher risk pregnancies to Divisional Hospitals;
- Upgrading selected SDHs to "Safe Motherhood" status both to improve access and quality of care for women and to reduce the load on Divisional Hospitals;
- Formalising regular outreach services at all levels of the decentralized health system;
- Introduce innovative and incentive-based approaches to address transport issues

The following outcomes are expected under this component:

- An increasing number of women routinely presenting for first ante-natal check-up (ANC) in the first trimester (increased by 10% per annum)
- At least 8 of the 16 Sub-Divisional Hospitals classified as "baby safe"
- High proportion of deliveries being carried out in Sub-Divisional Hospitals or higher level institutions (increased by 10% per annum)
- Increased contraceptive prevalence rate and reduced unmet need for family planning. (increased by 10% per annum)

Objective 2: To institutionalise a "healthy child" program throughout Fiji

Constraints

Improving infant and child health outcomes (MDG 5) is another key objective of the program of support, and the provision of high quality service delivery at the decentralized level is important in achieving this. Constraints relating to staff skills; transport; standardized protocols and guidelines, and upgrading of facilities were similar to those found for safe motherhood. In addition, for infant and child health the design team identified a generalised need for strengthening the capacity of both medical and nursing staff to manage childhood illness and a specific need to reduce the high rate of defaulters with respect to the Expanded Program of Immunization (EPI).

The recent Child Healthcare Review[34] provides the following recommendations with regard to improving child health and reducing child mortality and morbidity:

- Need for a standalone child health policy, strategy, and implementation budget.
- Need for child health technical facilitator/project officer to co-ordinate the implementation of the strategy and liaise with divisions on the inclusion of child health activities in annual plans.
- Staffing should be based on population and services provided.
- All nurses undertaking pre-service, midwifery, and public health nursing should be trained in basic child health (including IMCI, MCH, PLS, neonatal resuscitation etc) with regular refresher courses.
- Specialist paediatric nurses including PICU and NICU should be developed. Nurse practitioners in paediatrics should be supported and be based at subdivisions to support and supervise health facilities.

[34] Russell, F., Child Healthcare Review, 22 August 2010, Report prepared for FHSIP

- General practitioners to have access to ICATT (IMCI) training.
- Divisional hospitals need to be resourced to be able to provide mentoring.

The Paediatrics section of the Clinical Services Planning Framework provides an overview of the key issues facing the country and provides some strategies to address key areas. Strategies relating to the decentralized health services will receive specific support under this Program. In addition, a strong focus on ensuring that a sustainable system to maintain high levels of immunization through the EPI program is necessary.

The Child Healthcare Report indicates that implementation of IMCI at first level health facilities will result in 10 to 20% of the children diagnosed as severely ill being referred to sub-divisional and/or divisional hospitals. Good quality hospital care for children is required to increase the impact of appropriate primary care interventions on child survival and contribute to achieving MDG 4.

However, there is some evidence that hospital care is often deficient. FHSIP has been supporting the development of the Clinical Service Guidelines via the Clinical Services Networks. The aim is to improve the quality of care for patients, reduce unnecessary or harmful treatment, and reduce wastage of limited resources. The Program will continue and build upon the initiatives of FHSIP to strengthen and implement the Clinical Service Guidelines and will support the Fiji-based activities of the AusAID-funded Women & Children's Knowledge Hub. This includes provision of training for the WHO Pocketbook for inpatient care; which will help to improve the skills base of all doctors to provide paediatric hospital care at all levels.

Indicative Program Inputs

In order to achieve the objective of institutionalising a health child program, the following indicative inputs would be supported:

Personnel: a Child Health technical coordinator, supported by the Program Director and Administrator.

Essential equipment and supplies related to the integrated management of child health - including neonatal equipment

Transport costs to support capacity building, patient transport, workshops, supervision, outreach, and on-the-job training to improve essential skills related to child health

Materials and supplies to support training, capacity building and strengthening the preparation and implementation of clinical service guidelines and to support the Women and Children's Knowledge Hub in Fiji to provide training for the WHO Pocketbook for inpatient care

Infrastructure – upgrading and refurbishment of selected facilities to 'baby-safe' status

Indicative activities

Key activities under this objective could include, but not be limited to:

- Introducing strategies to ensure a high level of EPI is maintained at 95% coverage rate;
- Introducing and/or reinforcing the "Integrated Management of Childhood Illness (IMCI) training program for all nursing and medical staff working in decentralised health services;

- Reviewing and revising role delineation for child health services to be carried out at NS, HC, SDH and above;
- Maintaining and strengthening secondary level paediatric capability in SDHs;
- Continuing to support the “Baby Friendly Hospital Initiative” to promote breast feeding nationally;
- Formalising regular outreach services at all levels of the decentralized health system;
- Ensuring that Divisional paediatric services have the basic equipment required for neonatal emergency care.

The following outcomes are expected:

- Systems in place to maintain Expanded Program of Immunization (EPI) rates > 90% (vaccination of x no. of children per annum)
- Comprehensive training in Integrated Management of Childhood Illnesses (IMCI) leading to at least 10% increase in secondary level paediatric care being safely carried out at Sub-Divisional Hospital level or below.

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

Constraints

Non Communicable Diseases (NCD) is becoming an increasingly important cause of mortality and morbidity in Fiji. Amongst these, the lifestyle diseases related to obesity and reduced levels of activity are of paramount importance. Diabetes now affects over 18% of the population[35]. Together with hypertension, diabetes is a significant risk factor for coronary and vascular disease. Diabetes itself also carries a very significant morbidity, and diabetic foot sepsis and diabetic retinopathy are major and preventable complications, which both lead to considerable disability if not managed effectively.

With respect to these conditions, the design team found that awareness of the risk factors for diabetes and the importance of early detection and management at the community level was 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.

To address these issues, the Program will improve the prevention, detection and management of diabetes and its complications at decentralized health service levels. The initiatives outlined below are in line with relevant sections of the MOH NCD Strategic Plan (2004) and the Internal Medicine section of the CSPF. It should be noted that the strategy proposed under this design of revitalizing primary health care will include a significant component relating to increasing awareness of both the lifestyle factors that increase the risk of diabetes and hypertension and the importance of early detection and management of diabetes and diabetic foot sepsis.

Indicative inputs

In order to achieve the objective of improving prevention and management of diabetes and hyperetension at decentralised levels, the following indicative inputs would be supported

Personnel: A Diabetes/NCD technical coordinator, supported by the Program Director and Administrator.

Essential equipment and supplies related to diabetes prevention & management - including foot care surgical kits

Transport costs to support capacity building, workshops, supervision, outreach, and on-the-job training to improve essential skills related to diabetes prevention & management

Materials and supplies to support training, capacity building and strengthening the preparation and implementation of clinical service guidelines and in support of institutionalising the diabetes personal care record book

Infrastructure – upgrading and refurbishment of the national diabetes centre and diabetes centres in all SDHs

Indicative activities

Key activities under this objective could include, but not be limited to:

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- Improving the detection of undiagnosed diabetes and hypertension in the community through annual population screening;
- Building capacity of Sub-Divisional hospitals, health centres and nursing stations in screening, treating and monitoring diabetes and hypertension;
- Introducing a diabetes personal care record booklet to ensure a continuum of care for patients who have a variety of service providers;
- Strengthening SDHs to be able to undertake high quality diabetes clinics that include ongoing management and monitoring of diabetic patients and prevention and treatment of diabetic foot sepsis;
- Upgrading selected SDH to improve facilities for more advanced diabetic care (including outreach diabetic retinopathy and debridement);
- Strengthening specialist medical outreach clinics (esp. for diabetes) from divisional hospitals. These should be delineated as a core function of the outreach program and should also provide in-service training and ongoing monitoring of services to strengthen SDH services;
- Strengthening the role of the National Diabetes Centre to function as a focal point for diabetes policy and training.

The following outcomes are expected:

- Population screening for diabetes undertaken bi-annually for all persons over 30 years of age (increased coverage of at least 10% of target population)
- Adult Personal Diabetes Record book is providing an effective mechanisms for ensuring the continuum of care of people with diabetes
- Quality diabetes centres established at all 16 Sub-Divisional Hospitals and selected large urban health centres, servicing at least 50% of the target population
- National Diabetes Centre functioning as the national focal point for diabetes training and policy.

Objective 4: To revitalize 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

Constraints

Poor health practices and health-seeking behavior by people at community level are resulting in high burden of diseases and strain on health facilities at divisional level. Until the last five years, Fiji had a strong and well-respected mechanism of volunteer village health workers (known as community health workers in urban areas)[36] who provided basic health care and served as the first points of contact with the health system for people at village and community level. However, as outlined in section 1.3, a lack of investment over time in primary health in general and the VHW/CHW system in particular has resulted in inadequate resources, weak supervision, monitoring and evaluation, and the attrition of VHW/CHW motivation and skills to effectively perform their key role as the first point of contact with the health system. Some villages and a number of urban/peri-urban squatter communities are without a

[36] With the urban drift over recent years, more and more communities no longer follow the traditional village basis. For this reason the VHW are sometimes referred to as Community Health Workers (CHW). The term VHW/CHW here is used to cover both settings.

VHW/CHW and there is inadequate awareness of the VHW/CHW mechanism, especially in these urban and peri-urban squatter communities.

The importance of activities at the village/community level targeted at improving healthy lifestyles and fostering appropriate health-seeking behaviour, including preventive health care, cannot be overemphasized. This includes increasing awareness of common illnesses and the provision of basic first aid. Early and effective interventions at this level could dramatically improve outcomes for maternal and child health and diabetes, as well laying the foundation for broader health improvements.

Community participation and decision making are crucial to primary health care success and the MoH is currently assessing ways of revitalising the VHW/CHW programme through the Health Promotion Unit.

The recent Child Healthcare Review provides the following recommendations with regard to primary health care:

- Revitalise the VHW with specialist input into the revised VHW curriculum
- Expand IMCI at all levels
- Revision of MCH card/booklet.
- Teaching aids for MCH nurses and VHW.
- Supervisor training to provide ongoing supervision and support to health facilities.
- Strengthen partnerships with community organisations and offer VHW training to their community health workers.

The Program will revitalize and strengthen the VHW/CHW system, as a key component of the MoH's broader strategy to revitilize primary health care (outlined in the MoH new draft strategic plan 2011-2015). The Program will improve VHW/CHW resources and support a capacity building program for VHW/CHWs that includes: training in the importance of antenatal care and childhood immunisation; strategies aimed at preventing and detecting diabetic foot sepsis; strengthening patient follow-up and improving compliance with medications.

The recent Child Healthcare Review[37] noted the importance of a strong VHW/CHW system to improve MCH outcomes and indicated that revitalizing the VHW/CHW program would require:

- An active village/community health committee,
- Active support and engagement from nursing stations and health centres,
- The development of a revised curriculum with inputs from specialist areas including paediatricians and obstetricians, etc.
- The development of teaching aids.

The enhanced resources and improved skills of the VHW/CHW will both improve health outcomes and reduce the burden on the zone nurses in particular, and health services in general. Any activities related to VHW/CHWs will be closely coordinated with those currently being developed and piloted through WHO.

[37] Russell, F., Child Healthcare Review, 22 August 2010, Report prepared for FHSIP

Supporting the VHW/CHW mechanism will be part of a broader strategy to strengthen community health engagement in primary health care, and improve health practices and health-seeking behaviour. To support this initiative and to improve access and demand particularly in urban areas, a targeted health promotion program could significantly improve the outcomes from the individual interventions being implemented through VHW/CHWs.

Indicative inputs

In order to achieve the objective of revitalizing 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, the following indicative inputs would be supported:

Personnel: specialist technical assistance in primary health/community mobilization; to support program implementation at divisional level and below; sub-contracted organisation(s) to rollout the VHW/CHW training and mobilization

Essential equipment and supplies to support the work of VHW/CHW - including VHW/CHW kits and supplies

Transport costs to support capacity building, workshops, supervision, outreach, and on-the-job training, community level meetings and committees

Materials and supplies to support training, capacity building and community level meetings, etc

Materials and supplies to support generalized health promotion initiatives, including a multi-media program coordinated by National Centre for Health Promotion (NCHP) that specifically reinforces and complements the work of the village or community health

Technical assistance to conduct VHW/CHW program review after 2 years

Indicative activities

Key activities under this objective could include, but not be limited to:

- Developing and introducing a targeted program to increase the skills and awareness of the village and community health workers (VHW/CHWs), building on and taking to scale the work that WHO is piloting with the MoH;
- Ensuring that VHW/CHWs are adequately resourced with VHW/CHW kits that include first aid supplies, condoms, informational materials, (such as flipcharts and leaflets written in Fijian and Hindi on diabetes, breastfeeding, family planning etc);
- Strengthening the system of monitoring of VHW/CHWs by the zone nurses;
- Raising awareness of the village headmen to create buy-in for the program and support for the VHW/CHWs;
- Providing support to community-level meetings and committees to strengthen community health engagement in primary health care, and improve health practices and health-seeking behaviour;
- More generalized health promotion initiatives such as a multi-media program coordinated by National Centre for Health Promotion (NCHP) that specifically reinforces and complements the work of the village or community health worker program.

The expected outcomes are:

- An effective network of at least 1000 trained and resourced VHW/CHW who are able to provide basic first aid, promote healthy practices and health seeking behaviours and effectively refer patients to health services
- Increased community ownership of, and engagement in, primary health care

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

Constraints

While the bulk of activities supported by the Program will be targeted at the divisional and sub-divisional levels, there is a need to strengthen key components of the health system at the MOH headquarters level to support decentralized service delivery.

The key health systems components that will be strengthened under the Program are:

*Health Information***:** The design noted gaps in the management, analysis and utilization of health information, especially at decentralized levels. The weakness in analysis and feedback of public health data was repeatedly raised as an issue by MoH headquarters and during site visits by the design team.

The Program will provide technical assistance and capacity building to improve collection, collation, analysis, and use of health data for planning, service delivery, monitoring and evaluation at both central and decentralized levels This support will help to ensure that information being collected and collated within the Public Health Information System are appropriate and that the system and skills of staff are strengthened to ensure that data are analysed at the sub-divisional level and used to plan and implement activities to address deficiencies or emerging issues identified. At the Ministry level, the Health Information Unit must routinely collate and report on information and feed this back both to the executive committees and to the managers at the decentralized level.

As a first step, the recommendations from the recent review of the Public Health Information System (PHIS) should be reviewed. Where appropriate, these recommendations should be implemented to strengthen the system as well as its utilization for evidence-based planning and improved service delivery.

It will be important to ensure that activities are integrated with those supported under the Global Fund Round 9 grant for Health Systems Strengthening to address TB.

*Monitoring and Evaluation***:** The design team noted that both the culture and the skills for monitoring and evaluation need strengthening at all levels of the MoH. The Program will therefore provide targeted TA and capacity building to instil a culture of M&E and strengthen M&E skills at central and decentralized levels throughout the MoH. A key role of the proposed TA roles will be to help address capacity gaps in monitoring & evaluation and the use of data for planning and programming at decentralised levels.

Supervision: Public health officers at each level of the health system are expected to supervise, monitor and provide in-service training for their junior colleagues. The design noted that supervisory skills are uneven and that public health staff expressed concerns about the lack of appropriate management skills to be effective supervisors. JICA is currently piloting a community nursing supervision project within the MoH.

Operational Research to Address Knowledge Gaps and Support Evidence Based Policy, planning and programming: It was noted that there were some critical knowledge gaps where information would not be able to be obtained from routine

information sources. Funding will be allocated for activities to address these knowledge gaps where they are required to inform decision making. The Program will sub-contract local or international institution(s) to undertake operational research in areas identified by MOH/AusAID and/or as needed (e.g urban and peri-urban migration and the effect this is having on health parameters; investigation of new disease trends; a review of effectiveness of health interventions, etc). Other potential areas for operational research may be identified by the ongoing Fiji Health Systems in Transition (HiT) profile. The operational research component will be used to support evidence-based policy, planning and programming.

*Strategic and Corporate Planning***:** While there has been significant input into strategic planning over recent years, it was identified that this could be strengthened further. It was also determined that the inputs from the support areas listed above could help inform the process of developing these plans.

*Transport***:** Lack of transport was identified as a major constraint to timely access to health services for patients and for public health staff conducting outreach. Constraints related both to the absolute need for vehicles, boats, and horses; as well as the effective and efficient management and coordination of existing transportation systems. The Program will work with MoH to find innovative ways of addressing these transportation issues.

Indicative inputs

In order to achieve the objective of strengthening key components of the health system to support decentralised service delivery, the Program would provide the following indicative inputs:

Personnel: technical specialist in health information/monitoring & evaluation; to support program implementation at divisional level and below; sub-contracted institution(s) to conduct operational research as required;

Transport costs to support capacity building, workshops, supervision, monitoring & evaluation, operations research, mid-term and end of program evaluations

Materials and supplies to support training, capacity building workshops, supervision, monitoring & evaluation, operations research, mid-term and end of program evaluations

Expected outcomes include:

- Public Health Information System (PHIS) provides timely, complete and accurate information that is being used to measure public health outcomes and plan future activities at central and decentralised levels;
- Maternal & Child Health and diabetic health services are regularly monitored, audited and evaluated, and gaps/weaknesses addressed;
- Improved M&E at central level and across service delivery areas;
- Clinical Service Guidelines and protocols related to MCH and diabetes standardised, disseminated and used systematically throughout all service delivery areas;
- Improved supervisory system institutionalised across MoH;
- Operational research provides information to support evidence-based policy and planning of health services in urban/peri-urban areas. Other potential areas for operational research may be identified by the ongoing Fiji Health Systems in Transition (HiT) profile;

- Improved corporate and strategic planning leading towards a sectoral approach to planning; and
- Improved transport systems to: a) facilitate patient referrals and access to health services from remote villages/islands, and b) facilitate outreach and supervisory visits by health staff to remote locations.

Unallocated Fund

In addition to supporting the achievement of the Objectives outlined above, the Program will provide an unallocated fund to address health emergencies, and emerging health needs and priorities not specifically covered under the four Program objectives. The provision of an unallocated fund is in response to a need identified by both MoH and AusAID for flexibility in program funding within defined financial limits.

It is anticipated that the unallocated fund will be used: a) to help the MoH to respond to health situations resulting from national emergencies such as flooding, cyclones etc; b) to respond to emerging health priorities such as a typhoid epidemic; and/or c) for key activities identified during the annual planning process or by operational research or through the HiT process that require funding but which lie outside the main program focal areas.

It will be important however, to ensure that the unallocated fund isn't used merely to support ad hoc activities, but is used strategically so that activities funded under this component become sustainable. Activities supported through the unallocated fund will be jointly agreed by the MoH and AusAID through the Program governance mechanism (see Section 3.1.4 below).

Key Assumptions underpinning the proposed Program

The Program objectives and outcomes are clearly outlined in the above section and all contribute towards the Program goal:

> To remain engaged in the Fiji health sector by contributing to the Fiji Ministry of Health's efforts to achieve its higher level strategic objectives in relation to reducing infant mortality (MDG 4), improving maternal health (MDG 5) and the prevention and management of diabetes, as outlined in the Ministry's Strategic Plan 2011-2015

It is important to reiterate that the Program *can only make a contribution* to the achievements of the higher level MDG Goals 4 and 5 and to the reduced incidence of diabetes and diabetic complications. The major contributor to these higher level goals remains the Ministry of Health, supported by its health development partners. The achievement of these higher level goals therefore is contingent on a number of key assumptions, which are outlined below:

<u>Political</u>

- increased funding and staffing resources made available to the Ministry of Health; and
- the legal, social and political environments remains stable to enable program implementation.

<u>Operating Environment</u>

- the existing close relationship between AusAID and the MoH is maintained;
- cooperation is maintained between government and non-governmental partners;

- MoH remains committed to achieving the MDGs as evidenced by their new Strategic Plan 2011-2015;
- the level of government funding to the health sector is sustained, or not significantly decreased;
- the level of external donor support to the health sector is sustained;
- bilateral and multilateral health development partners in Fiji remain supportive of the Program's goal and objectives;
- health workforce establishment levels are maintained or not significantly decreased; and
- the Government of Fiji's focus on increasing financial sustainability through cost recovery within the health sector does not fundamentally undermine access by poor and vulnerable groups to health services.

Program Implementation

- there will not be a significant time gap between the end of the current FHSIP and the commencement of the new Program of support (FHSSP);
- MoH maintains the capacity to lead and manage the Program;
- MoH health planning is robust and evidence-based;
- MoH develops the culture and capacity to lead and co-ordinate relevant monitoring, evaluation and research;
- MoH operational staff embrace the key objectives and approaches of the Program – specifically the 'safe-motherhood' and 'healthy child' approaches;
- MOH provides financial support to the VHW/CHW network;
- both Program staff and MoH counterparts remain aware that a key aim of the Program is to improve the allocative and technical efficiency of spending of all available funding (including that provided through the MOH) in the Program focal areas;
- Program governance arrangements remain effective and efficient;
- Program funding is flexible and responsive;
- Preparedness plans are in place to deal effectively with national emergencies (e.g. floods, cyclones, etc) so that Program activities are not adversely affected; and
- AusAID Suva staff are able to devote appropriate time and technical oversight to the Program

Note – Program risks and risk mitigation strategies are discussed in depth in Section 3.6 and a risk matrix is provided in Annex 8.

2.3. Form of Aid Proposed

Three forms of aid delivery were considered for this program:

(i) Budget support provided to the MoH, with an accompanying MOU. Under such an arrangement all activities, including financial management, would be managed directly by the MoH.

(ii) A traditional project, implemented by an external managing contractor or an NGO, with tightly defined activities and outputs. In keeping with this stand-alone project approach, there would be a detailed logframe, implementation schedule, detailed milestone payments, etc.

(iii) A flexible programmatic approach that aligns closely with MoH strategic priorities and allows for the annual planning of priorities. A Managing Contractor will be engaged to establish a resource centre to support the management and implementation of the program by the MoH.

Because of the complex implementation environment that currently exists in Fiji, the third alternative received strong support of both AusAID Suva and the Fiji Ministry of Health.

The proposed Program addresses both supply and demand side constraints. Supply side constraints are addressed through improving quality and availability of services through capacity building, strengthening clinical protocols and guidelines, strengthening primary health care, and upgrading selected health facilities. Demand side constraints are addressed through expanding access to, and increasing demand for, services at decentralised levels. This brings quality services closer to the people, targeting health promotion and fostering community decision-making.

Activities supported under the proposed Program will be agreed annually as part of the regular MoH planning cycle, and in line with the agreed Program Objectives (see Section 2.2 above). Strategic oversight will be provided by the MoH and AusAID through a Program Coordinating Committee. Day to day implementation and management will be the responsibility of the MoH at national and divisional levels. A key role of the Managing Contractor will be to provide technical and management support to the MoH.

Although this model is proposed as the preferred management option, it is recognised that circumstances in Fiji may change, and some of the risks to the Program may recede (or escalate). A review of the management arrangements will be included as part of the mid term program review. The review will assess the prevailing political environment and associated risks, and make recommendations on the continuation or revision of management arrangements as appropriate.

It is possible that the annual MoH planning and budgeting arrangements may provide a platform for AusAID (through the Program) to gain an understanding of the strengths and weaknesses of MoH processes that would be useful if and when a transition to other direct forms of aid evolves. The arrangements could also potentially provide a base from which a costed Health Sector plan could be developed.

2.4. Estimated Program Budget

The estimated budget summary is provided in Table 5 below. **NOTE – The budget is indicative and is intended as a guide only**. The budget is divided into five categories as follows:

1. **Reimbursable Establishment Costs** are the costs of establishing offices in Suva and one off costs related to these including the purchase of motor vehicles, office furniture and equipment and computers and phones. They will be paid as reimbursable items on presentation of purchase receipts.

2. **Program Operating Costs** relate to the ongoing costs of maintaining offices in Fiji and undertaking the operational and administrative activities required of the contractor. The funds will be paid to the Contractor as a set monthly fee.

3. **In-Country professional Team Costs** cover the costs of employing the Director, Program Support; the Program Administrator, clerical/administrative assistant and between four and six technical facilitators. The amount will be paid to the contractor as a set monthly fee; and will be reconciled at the end of each calendar year.

4. **Program Activity Costs**. These are the costs of undertaking the Program activities in Fiji.

5. **Contractor Fee:** This is a set fee, which will be paid to the Contractor for taking on the Managing Contractor responsibilities. It will be paid in two parts. 80% of the fee will be paid as regular quarterly payments while the other 20% will be paid following successful Contractor Performance Assessment each six months.

An allocation for external reviews and the Technical Advisory Group, which will be paid directly by AusAID, has also been included in the indicative budget allocation below.

Table 5: Costing Summary (NOTE: all figures are in thousands)

Costing Summary											
		Year One				Yr 1 Tot.	Yr 2	Yr 3	Yr 4	Yr 5	Total
Reimbursable Establishment Costs		**400**				**400**					**400**
Program Operating Costs		**70**	**70**	**60**	**60**	**260**	**260**	**260**	**260**	**260**	**1,300**
In-Country Professional Team costs		**80**	**140**	**150**	**150**	**520**	**670**	**670**	**670**	**670**	**3,200**
Program Activity Costs (by SA)											
	SA 1 (Safe Motherhood)	10	20	320	50	400	550	510	270	270	2,000
	SA 2 (Healthy Child)	10	60	80	370	520	320	320	320	320	1,800
	SA 3 (Diabetes)	10	50	150	150	360	450	450	520	520	2,300
	SA 4 (Primary Health care)	10	70	100	80	250	360	430	580	580	2,200
	SA 5 (Targeted Systems Strengthening	10	180	100	100	390	340	360	380	330	1,800
	SA 6 (Unallocated Fund)	250	250	250	250	1,000	1,000	1,000	1,000	1,000	5,000
Total Program Activity Costs		**300**	**630**	**1,000**	**1,000**	**2,920**	**3,020**	**3,070**	**3,070**	**3,020**	**15,100**
Total Program Contractor Costs		**850**	**840**	**1,210**	**1,210**	**4,100**	**3,950**	**4,000**	**4,000**	**3,950**	**20,000**
Contractor Profit and Overhead		200	200	200	200	800	800	800	800	800	4,000
Mid-term/ Final Reviews							75			75	150
Term/Final ref				50	50	100	175	200	200	175	850
Grand Total		1,050	1,040	1,460	1,460	5,000	5,000	5,000	5,000	5,000	25,000

3. Implementation Arrangements

3.1. Management and Governance Arrangements

3.1.1 Introduction

Australia has directly supported the Ministry of Health (MoH) in Fiji for over ten years. During this time, AusAID has developed a close working relationship with the MoH and has directly supported the Ministry in addressing its strategic priorities. Both the MoH and AusAID are keen to continue this strategic partnership, and the governance and management structures described below have been designed to strengthen this relationship.

In developing the governance and management structures for the Program, the design team has balanced a governance structure that formalises the joint wishes of both the MoH and AusAID to achieve a cohesive and cooperative partnership based on progression towards the Cairns Compact, Accra Agenda and Paris Declaration, with a management and implementation framework which takes into account the complex implementation environment currently existing in Fiji.

3.1.2 Management Arrangements

When designing the management and implementation arrangements for the Program, a number of factors and risks were considered. These include:

- The complex implementation environment that results from the current political situation;
- The need for AusAID to have assurances with regard to the security of its funds;
- The concern about fungibility of funding provided to MoH;
- The need for a rapid and responsive fund flow mechanism;
- The relative success of the previous FHSIP management and governance arrangements.

The FHSSP will be managed by the Ministry of Health with technical and management support provided by a “Managing Contractor”, sourced through open tender. The Managing Contractor will be engaged using a commercial contract to provide a package of management support and technical assistance (TA) to the MoH to support the implementation of its strategic and operational plans, in line with the Program Objectives outlined above.

The proposed approach to the provision of TA incorporates lessons learnt through FHSIP and elsewhere. Other approaches to TA include traditional and pooled approaches. TA has often been criticised for being supply-driven, expensive, poorly planned and integrated, and failing to promote country ownership.

Traditional approaches mean a TA delivery approach led by external agencies and focused on the linear development of individual and project-level capacities. These approaches have been shown to have limited effectiveness due to issues relating to needs assessment and ownership. A pooled arrangement for technical assistance is not yet a possibility given the prevailing complex implementation environment and the currently under-developed harmonisation among agencies providing TA to the health sector.

The approach to the overall delivery of the FHSSP program, including the TA component, is a flexible programmatic approach that closely aligns with MoH strategic priorities and allows for the annual planning of priorities and activities linked

to MoH processes. Detailed activities, inputs and outputs are only designed for Year One activities. Indicative long-term TA has been proposed for the five years of the Program.

A managing contractor will be sourced through open tender to implement the proposed Program. The role of the managing contractor will be to:

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

It is intended that FHSSP will develop capacity and mechanisms that could be built upon for future pooling of TA, which could be used as a stepping stone to improved sector coordination.

Furthermore, the managing contractor will establish a Program Management team to support the management and implementation of the Program by the MoH. The managing contractor will engage the Program Management team as follows:

- a Director, Program Support (to lead the team; and responsibility for the management and day to day running of the Program);
- a Program Administrator (will be responsible for the financial management, logistics and program operations; and
- assisted by a clerical/administrative assistant.

The Program Management Team will contribute to the achievement of the five Program objectives through the provision of technical and management support to the MoH, capacity building of MoH staff, equipment and supplies and minimal rehabilitation of selected public health facilities. It is anticipated that the Program team will be co-located with the Ministry of Health.

The Managing Contractor will also recruit a Program Support Team (PST) comprising contracted staff that include up to six specialist Technical Facilitators in the areas of safe motherhood; infant and child health; diabetes management; primary health and community mobilization, and public health information/monitoring & evaluation. The Program Support Team will work closely with the MoH by supporting Ministry staff and by aligning with MoH processes.

The Director, Program Support will be responsible for managing sub-contracts with any NGOs/CBOs, multilateral agencies, universities or institutions engaged in the implementation of program activities. In addition, the Director, Program Support will be responsible for managing an appropriate financial mechanism that will enable the effective dispersal of funds for agreed activities under the Program, and will facilitate the rapid access and responsiveness to health emergencies as appropriate.

AusAID technical oversight of the program will be provided either a) through a full-time Health Technical Specialist contracted directly through AusAID or b) through a Technical Advisory Group (TAG) and/or one or more part-time technical advisors who could be tasked by AusAID to provide specific technical support and advice when needed.

Over time AusAID may be able to work with government and development partners to progress to some kind of TA pooling arrangement to improve coordination and encourage country leadership and ownership. It is intended that the FHSSP will develop capacity and mechanisms that could be built upon for TA pooling in the future. Future pooling of TA could be used as a stepping stone to improved sector coordination.

The proposed approach will:

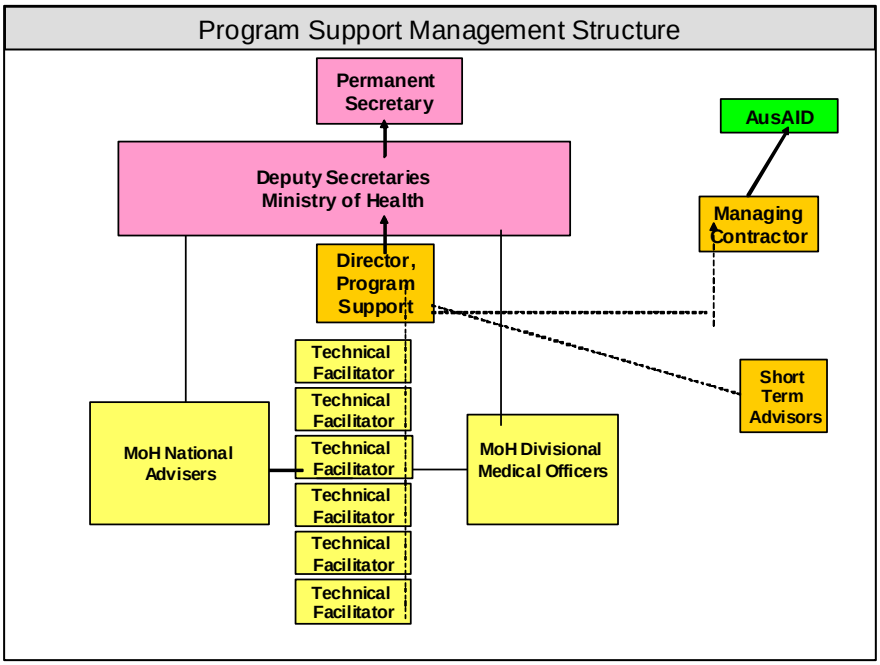
- Be implemented in a way that is consistent with good practice in aid effectiveness and capacity development;
- Ensure that program funds are used to support MoH identified priorities with the Ministry's full ownership and involvement;
- Ensure TA works in a way that supports the overall capacity development of MoH, rather than gap-filling short term staffing gaps in the health system, except in an emergency or extraordinary situation;
- Ensure that TA adds value and contributes to long term staffing capacity, including through agreed workplans and outputs at an early stage; so that roles and the results expected from each partner are clear from the outset;
- Focuses on the procurement of local expertise, and be knowledge based;
- Have a strong M&E focus to monitor its effectiveness and learn lessons;
- Work towards supporting harmonisation across development partners, UN agencies and other TA providers;
- Over time, support the integration of TA planning and budgeting into MOH planning cycles.

Issues to be considered during implementation are:

- TA needs will be identified and prioritised through the FHSSP governance mechanism as described in Section 3.1.4. This process will be linked to the development of the FHSSP rolling Annual Plan, which will be developed in conjunction with the MoH annual planning process. A TA plan will be a component of each respective annual plan. This will include specific TA requirements and TORs as appropriate;
- The comprehensive Year 1 activities include recruitment of up to six technical facilitators, and it is projected that these roles will be required for the duration of the program. The needs and performance of these TA positions will be reviewed annually with MoH;
- MoH may request additional TA to assist them in annual planning and the identification of TA needs. Alternatively existing TA provided by the FHSSP or through a different mechanism may be able to fulfil this role.

The program management team will:

- Establish and operate mechanisms for the timely supply of quality TA and management which are aligned to MoH processes and the governance mechanisms of the FHSSP program and ensure value for money;
- Determine a process for advertising and selecting long-term and short-term TA following good procurement practice so ensuring that all personnel have the necessary skills and profiles to fulfil the identified roles;
- Establish a consultant database;



- Determine what approval processes will be instituted to approve TA requests, how the TA can be quality assured and how the M&E of the TA will be undertaken
- Ensure that all TA is performance managed;
- Design and manage a mechanism for contracting and transferring funds to subcontracted agencies, including multilaterals or NGOs as appropriate and agreed;
- Consider a strategy for learning and disseminating knowledge and lessons from the TA approaches, including capacity development approaches for MoH staff.

The Managing Contractor will engage a Director, Program Support to provide overall direction to the program and to manage the Program Support Team. The managing contractor will also appoint a Senior Program Administrator who will be responsible for financial management, administration, logistics for program operations and for accurate and transparent accounting and reporting, including fiduciary accountability to AusAID.

The Director, Program Support will be responsible to AusAID and MoH for the financial management of the program, for recruitment and contracting Program Team members; for managing sub-contracts with any local NGOs/CBOs or multilateral agencies engaged in the implementation of program activities; for procurement; for managing the logistics of activities such as training workshops and for administration of the program. In addition, the Director, Program Support will be responsible for establishing an appropriate financial mechanism that will enable the effective and efficient dispersal of funds for agreed activities under the Program and will facilitate the rapid access and responsiveness to health emergencies as appropriate.

The Program Team Structure is illustrated below.

Program Support Team

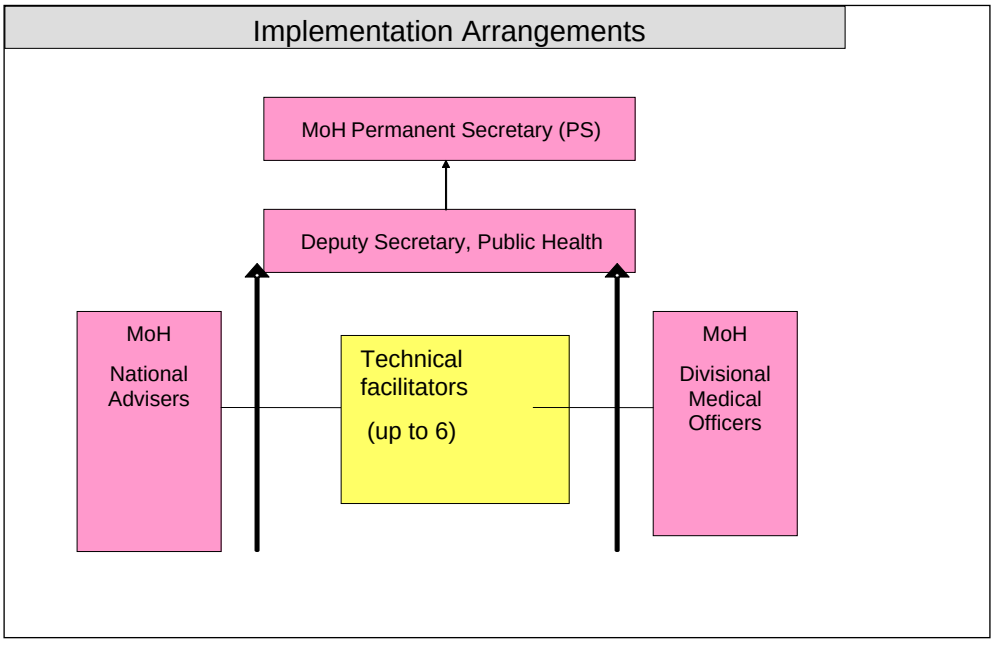
To support the MoH at both central and divisional levels, the FHSSP Program team will support the day to day operational management and implementation of the program. Overall governance and direction will be provided by the Program Coordination Committee (see section 3.1.4 below), while management and implementation will be the responsibility of the MoH – at both national and divisional levels. While not a member of these management and governance committees, the Director, Program Support will be expected to provide secretariat support

Terms of Reference for the key program management and technical positions are included in Annex 4.

The Program Support Team will include six technical facilitators located centrally at MOH headquarters working alongside MoH's National Advisers and Divisional Medical Officers. The technical facilitators will also assist the Divisional Medical Officers in ensuring that all activities being implemented by all four divisions are effectively coordinated at the divisional and national levels. In addition, they will ensure that there is good communication and liaison between Divisions, between the National and Divisional levels, and between the Divisional level and the sub-divisional MoH facilities.

The six Technical Facilitators will be responsible for supporting the MoH and facilitating the development and effective implementation of the core technical streams of the proposed program of support, namely (a) Safe Motherhood; (b) Infant and Child Health; (c) Diabetes Prevention and Management and (d) Primary Health/community mobilization, with a further one/two possible positions relating to Public Health Information and Monitoring & Evaluation. Technical Facilitators in each of these core areas will be an integral part of the Program Support Team and will be co-located with, and work closely alongside and support MoH staff at the national Advisor level. There will also be a facility for contracting a limited amount of short term technical assistance (STA) as required. In addition, the Managing Contractor will engage an administrative support team who will report to the Senior Program Administrator.

The Program Support Team will work closely with the MoH by supporting Ministry staff and by aligning with MoH processes and using existing MoH reporting mechanisms, as depicted below.



Financial Management

Program finances will be managed by the Managing Contractor, which will be responsible for ensuring that all processes comply with Australian Government Guidelines. Finances will be subject to audit.

AusAID will disburse funds to the Managing Contractor at regular intervals on a reimbursable basis under conditions agreed in the contract. The Managing Contractor will establish a dedicated bank account in Fiji and all funds for operations in Fiji will be drawn from this account. While fund disbursement will be directly from the dedicated bank account, processes followed in Fiji will align with those of the Ministry of Health (shadow systems alignment). The Managing Contractor may pay international consultants directly

In the case of natural disasters or health emergencies, AusAID may wish to provide additional funding to the Ministry of Health. If this occurs, the Managing Contractor will be expected to help with the logistics of disbursing the additional aid.

There will be clear accountability for all funds disbursed and full disclosure of cash flows and predictions will be presented at the monthly finance and audit meeting to which AusAID, the MoH and the Director, Program Support and the Senior Program Administrator will be present.

The Managing Contractor will be paid an annual fee for these services. It is envisaged that payment of a Senior Program Administrator, who manages the finances and procurement for the Program in-country, will be covered by this fee.

3.1.3 Program Implementation

The Program will adopt a rolling Annual Plan, based on the Ministry of Health's annual planning cycle.

Around June each year, the Ministry of Health conducts a mid-year review of its Annual Corporate plan. With the exception of the first year, the Director, Program Support will participate in and, where necessary, help to facilitate this exercise. As part of the review process, the Director, Program Support will also update the MoH on the progress in implementation of the activities supported under the Program.

In August of each year, divisional planning meetings are held to plan activities for the following year. These should include proposals for activities to be funded both from MoH funds and from external donors. The Director, Program Support will be expected to help facilitate this process, where necessary.

The MoH national planning meeting, which includes Divisional representation, takes place in September each year. Following this, a draft MoH Corporate plan, including a proposed budget for submission to Cabinet, is developed. This draft Corporate Plan covers all activities for which the MoH seeks funding from the government, and includes activities for which it will seek funding from external donors. It is at this stage that the Program Support Team will work with the MoH and especially with the DMOs develop its draft budgeted program of support for the MoH and allocate the use of program funds within the overall budget.

TA needs will be identified and prioritised during this planning process and endorsed through the FHSSP governance mechanism as described in Section 3.1.4 below. A technical assistance plan will be a component of the FHSSP annual plan.

The Program Support Team will engage closely with the MoH to respond appropriately to changes that may impinge on program effectiveness, such as changes in key personnel, resource/budget cuts or reallocations, etc. The response may involve a measure of re-planning and re-programming, although any

reprogramming of funds will be subject to the approval of the Program governance mechanism.

In November the budget is announced and the MoH is informed of which activities will be funded by government. This enables the MoH to identify funding gaps, and the opportunity to negotiate what could additionally be funded by donor agencies.

The budgeting process for the program of support will be closely linked with the Annual Planning cycle of the MoH. As outlined above, the MoH will request funding for activities within the plan which align with the program key focal areas. Because of the risk that the Program will miss the MoH annual planning process for the first year, a more detailed plan and budget has been prepared for the first year

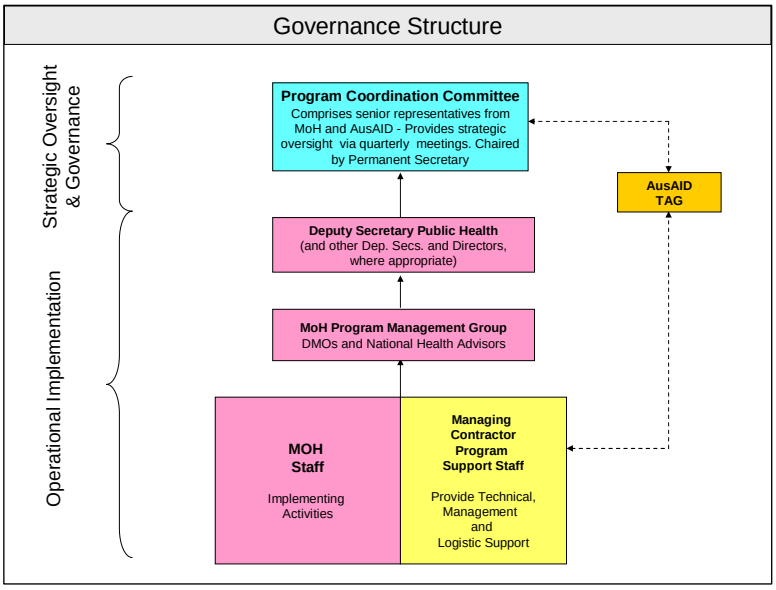
Procurement will be arranged by the Managing Contractor, and must be in line with the Commonwealth Procurement Guidelines and, where appropriate, the guidelines of the Fiji Ministry of Health. Procurement will be subject to audit, if required.

3.1.4 Governance Arrangements

Governance arrangements for the Program of Support will be aimed at ensuring that there are appropriate forums for both the MoH and AusAID to jointly monitor and evaluate progress of the program and to ensure accountability for program process and outcomes, and for disbursement of funds. The governance arrangements for FHSSP are a continuation of those currently in place to oversee the existing FHSIP. While these arrangements have not yet been formally evaluated, there are indications from both AusAID and MoH that they are working smoothly and therefore the design saw no reason to change them. These governance arrangements are described below.

A Program Coordinating Committee (PCC) will be the main high-level strategic decision making and monitoring mechanism for the proposed program of support, and as such will be the highest level governance committee for the program. The PCC Chair will be the Permanent Secretary of the MoH and the other members will comprise members of the MoH Executive Team, Ministry of Finance & National Planning; WHO, UNICEF, UNFPA and the Fiji School of Medicine (College of Medicine, Nursing and Health Sciences, and AusAID. Meetings will be held on a six monthly basis. Any major decisions concerning future directions for the program will be presented and discussed at these meetings, and no significant changes in direction will be made without endorsement from this committee.

The governance structure is illustrated in the diagram below:



In order to support and facilitate decentralised management, it is expected that each Division will hold a monthly joint clinical and public health management meeting and that members of the PCC will attend each Divisional meeting on a quarterly rotational basis.

The Annual Plan for the Program of support developed through the MoH annual planning process discussed above will be submitted to the PCC for review and approval. The PCC will have decision making authority in approving the annual plan prior to obtaining final endorsement from the National Health Executive Committee (NHEC).

3.1.5 AusAID Technical Oversight to the Program

AusAID is expected to provide close supervision of this Program, and the complex implementation environment in which the Program operates. It is recommended that AusAID technical oversight would be provided either a) through a full time Health Technical Specialist contracted directly by AusAID and based in Suva, or b) through a Technical Advisory Group (TAG) supported by or one or more part-time technical advisors tasked by AusAID to provide specific support to the Program and technical advice as required. The roles of the Health Specialist/TAG would be able to:

- provide sound technical advice to the Program, taking into account the expectations and priorities of the Ministry of Health and of AusAID and in line with the MoH's Strategic Plan;
- ensure that operational decisions made by the MoH Management Group and the Director, Program Support are fully in line with the strategic direction of the Program and its objectives, and work towards achieving the agreed outcomes of the Program; and
- identify and help to facilitate the resolution of conflicts that might potentially arise; and ensure that the Permanent Secretary and AusAID are made aware of significant areas of conflict;

3.2. Reporting

Quarterly progress reports will be forwarded from the Program Support Team to the MoH Management Group at divisional levels. These reports should be concise and include: a general review of the previous three months; progress against targets; key issues and constraints; and requests for alterations to the planned activity schedule. The report should be the key background document for each six monthly PCC meeting and should also be used as part of the basis for payments by AusAID. A summary of expenditure against the budget should be forwarded independently to AusAID and MoH.

In addition, a more comprehensive Annual Report should be prepared each year and should include an annual review against the monitoring and evaluation framework and implementation against the Program Design Document, and a reconciliation of the yearly expenditure.

3.3. Year One Implementation Plan

The Program is expected to commence by May 2011. The Program will adopt a rolling Annual Plan approach. The annual plan activities will be determined in collaboration with the MoH annual planning processes described above, in line with the agreed Program objectives and working towards agreed Program outcomes.

The design team have suggested some indicative activities for Year 1, as the first year of Program implementation would be out of synchronisation with the MoH

planning processes. However, these activities will be finalised after discussions with the MoH. It will be necessary to build in some flexibility to the first year implementation of the MoH feels that it needs more time to make the required decisions.

Suggested first year activities largely comprise of reviewing plans, and progress against these plans, for ongoing activities supported under FHSIP, and refining these plans where appropriate. Year One activities should also focus on building on existing activities implemented under FHSIP, where these are in line with the new Program objectives and other AusAID assistance to the Fiji health sector. A list of FHSIP activities to be integrated into FHSSP is provided in Annex 10. Facilitating procurement for facility upgrades and equipment should also be initiated in Year One.

A summary of the suggested activities is documented below, and more detail can be found in the First Year Implementation Schedule in Annex 6. It is strongly recommended that to avoid overwhelming local staff, pilots of different activities and rolling out of generalized training should rotate between the four divisions.

Objective 1: Institutionalize Safe Motherhood Program

Key year 1 activities for Safe Motherhood include: planning upgrades for subdivision hospitals; purchasing portable ultrasound machines; reviewing and rationalizing guidelines and protocols and undertaking reviews and/or commencing planning in the areas of early presentation for antenatal check-ups; role delineation for maternity services (deciding what activities should be performed at each service level and what staffing, facilities and equipment are required to perform those activities effectively); capacity building and family planning. The concept of “safe motherhood” should be promoted among MoH staff at all service delivery levels.

Objective 2: Institutionalize Healthy Child Program

Key year 1 activities for the Healthy Child component include: determining the steps to consolidate and ensure sustainability of the EPI program; reviewing and rationalizing guidelines and protocols; expanding and/or reinforcing the IMCI training program; purchasing basic neonatal equipment for Divisional hospitals; and determining the requirements for upgrading SDHs so that they can undertake and improve the quality of secondary level paediatric services.

Objective 3: Address Diabetes

Key year 1 activities for the Diabetes component include: planning and commencing upgrades for SDHs and high volume Health Centres (linked with a more detailed role delineation for diabetes); reviewing and rationalizing guidelines and protocols; and developing a targeted capacity building program with respect to prevention of diabetes (and hypertension) and detection and management of diabetes and its complications. In addition, it is suggested that planning for two important initiatives i.e. annual diabetes screening and the Diabetes Personal Record (DPR) book should commence in year one.

Objective 4: Revitalise Primary Care (VHW/CHW Program)

Key year 1 activities for the Revitalising Primary Care SA comprise a detailed review and planning process for this major support area and development and implementation of initial health promotion activities.

Objective 5: Targeted Systems Strengthening

Key year 1 activities for targeted Systems Strengthening include: support for the MoH corporate planning processes, development of a Monitoring and Evaluation Plans at national and divisional levels; prioritizing the recommendations from the recent review of the Public Health Information System (PHIS); the planning of strategies to strengthen supervision by, and of, both nursing and medical staff; engagement of an external group to undertake operations research on the effect of urban and peri-urban migration on health outcomes and health service delivery; and continuing activities in clinical quality improvement and risk management

Unallocated Fund

The unallocated fund will be used a) to help the MoH to respond to health situations resulting from national emergencies such as flooding, cyclones etc. b) to respond to emerging health priorities such as a typhoid epidemic, and/or c) for key activities identified during the annual planning process or by operational research or through the HiT process that require funding but which lie outside the main program focal areas.

While the Unallocated Fund is to be utilised for MoH priorities that do not fall under the five core objective areas, it has been suggested that, in order to allow the MoH time to prepare Year One requests and ensure the timely use of these funds, mental health and the Clinical Service Networks are given priority for early support; in collaboration with other planned AusAID assistance to the Fiji health sector.

Risk Management

An early task of the Contractor will be to develop an updated Risk Management Plan in the first year, to be reviewed six monthly by the PCC and updated as required.

Year 1 M&E

In relation to M & E for the first year, the opportunity should be taken as early as possible to crystallize baseline data for key indicators. As examples - the results from the 2nd STEP Survey on NCDs is likely to be available at the time of commencement of the Program and this should provide robust baseline data in relation to diabetes and other NCDs. Similarly the 2009 MoH Annual Report will have been finalized and would contain useful baseline data.

It will also be valuable to obtain baseline data in relation to the role of VHWs in those villages that will be targeted for the roll-out of objective 4.

The following section contains a broader discussion of Program M&E.

3.4. Monitoring & Evaluation (M&E)

3.4.1 M&E Arrangements

The overall purpose of monitoring and evaluation is to ensure that program inputs and activities are designed and effectively implemented so that the planned goal and outcomes are achieved. Indicators and targets have been built into the program design and details of these, including baselines, targets and methods of verification can be found in Annex 7. The Program Coordination Committee will form a key mechanism for reviewing progress against the monitoring and evaluation framework.

Quality at Entry (QAE) and Quality and Implementation (QAI) reports will be developed separately by AusAID, with respect to its external monitoring and evaluation role of the Program's implementation progress.

Primary responsibility for day to day monitoring of Program activities will rest with the Director, Program Support, and the MoH at the Divisional level. It should be emphasized that Program monitoring and evaluation framework is a subset of the MoH's own M&E framework. The Program M&E systems, including key indicators and data collection processes, will be those of the MoH. While the MoH recognises the need for robust M&E and has established basic M&E systems, unfortunately the MoH does not have a strong culture or skills in monitoring and evaluation. The design therefore will support strengthening M&E skills within the central MoH and at Divisional level. The design also allows for initial technical support from a specialist M&E adviser recruited by the Program.

While it will be necessary to develop an M&E Plan during the first 6 months of the program, subsequent M&E activities will be implemented as part of the MoH's annual planning and reporting cycles and will intersect with existing MoH M&E processes and indicators. Nevertheless, it is important that some early process-type indicators are established to assure the PCC that activities are underway and to provide a basis for longer term implementation. Some examples of process indicators that can be used to monitor progress in the early months of the Program are:

- Key program staff positions filled. In particular this should include the Director, Program Support and the technical facilitators.
- Financial management arrangements are in place that enables funds to be disbursed in a timely manner.
- Governance and management structures are finalised and first meetings are held within three months of program start-up.
- A Six-Monthly Plan for July - December 2011 developed within two months of establishment of the new Program.
- The Program's Annual Plan for 2012 is developed by November 2011.
- Specific plans for achieving each of the program objectives are developed. These are important as the current MoH annual plans are developed along departmental lines (public health, curative services, and corporate services).
- An M&E plan developed for each Division, in consultation with local staff and workshops held in each division to discuss the processes for the collection and analysis of data
- Reporting timeframes and formats are developed and agreed with the PCC.

A report on these "early stage process indicators" should be reviewed by the PCC within six months of program commencement.

Baseline data

Data on health statistics such as population, crude birth rate, infant mortality, neonatal mortality, <5 mortality, maternal mortality, contraceptive prevalence rate, unmet need for family planning, immunisation coverage, diabetes prevalence and incidence and number of amputations is given in the MoH Annual reports which are usually released midway through the following year. Other sources of data are held by national advisers in specific departments such as NCD, Family Health, and at the divisional and sub-divisional hospitals. This information will serve as baseline data for measuring program progress.

However, there is a paucity of baseline data in relation to VHW/CHW. While, in theory, it is a common practice for all villages to have a village health worker appointed by the village, this practice has not been well maintained in recent years

and the number of villages with an active VHW/CHW is not known. The program will need to work closely with the Department of Fijian Affairs to collect this data.

It is acknowledged that there are particular challenges associated with the revitalisation of primary health care (Objective 4). For this reason, a comprehensive review is planned during the second year of the Program, to evaluate progress and outcomes, and assess the potential sustainability of the VHW/CHW mechanism beyond the life of FHSSP.

Measuring progress towards the FHSSP Program goal and objectives

The five objectives and outcomes of the Program are clearly stated in section 2 of this document. All contribute to achievement of the program goal:

> *"To remain engaged in the Fiji health sector by contributing to the Fiji Ministry of Health's efforts to achieve its higher level strategic objectives in relation to reducing infant mortality (MDG4), improving maternal health (MDG 5) and the prevention and management of diabetes, as outlined in the Strategic Plan of the MoH".*

It is important to reiterate that the Program can only make a contribution to the achievement of higher level MDGs 4 and 5 and the reduced incidence of diabetes and diabetic complications.

However, the Program can be held accountable for the achievement of the program specific outcomes as outlined in Table 6 below.

Table 6: Indicative Program-Specific Outcomes and Indicators

Outcome	Indicator	Source of data
Relevant MoH Outcomes to which the Program will contribute		
Reduced maternal morbidity	Maternal mortality ratio	Hospital records/MoH annual reports
	Prevalence of anaemia at booking	PHIS Baseline needs to be developed
	Contraceptive prevalence rate in the child bearing age group	PHIS Annual report
Improved child health and reduced child morbidity and mortality,	Prevalence of under 5 malnutrition	Hospital data Better data sources need to be developed
	Percent of one year olds fully immunised	PHIS
	Under 5 mortality rate	Hospital records/MoH annual reports
Reduced burden of communicable diseases (diabetes in this Program)	Proportion of population over 35 years engaged in sufficient leisure time activity (moderate or vigorous activity up to 30 mins per day)	MoH agrees it currently has no means of routinely measuring this other than periodic (each 5-10 years) STEP

Outcome	Indicator	Source of data
		surveys
	Admission rates for diabetes and its complications, hypertension and cardiovascular disease.	PATIS/hospital records
	Amputation rate for diabetic sepsis	PATIS/hospital records
Outcomes for which program will be accountable		
Higher proportion of deliveries being carried out in SDH or higher level institutions	Percentage of hospital births vs total births during relevant period	Individual Hospital and HC records - from PHIS and hospitals
Higher proportion of women routinely presenting for first ANC check-up in first trimester	Percentage of all births in which mother presented for antenatal visit during first trimester	PHIS** and hospital records
At least half of SDHs classified as “baby safe”	50% baby-safe at completion Determine percentage by year of program	Inspection and “certification” report
Increased contraceptive prevalence rate and reduced unmet need for family planning.	Proportion of women using contraceptives on a regular basis (and type)	PHIS
Systems in place to maintain EPI rates > 90%	EPI coverage - percentage for each zone	PHIS
Comprehensive Training in IMCI leading to more secondary level paediatric care being safely carried out at SDH level or below	Number of IMCI courses given and number of staff trained	Training course records Follow up supervisor reports
Regular screening for diabetes undertaken for all persons over 30 years of age. This should include annual mass screening to coincide with World Diabetes Day	At least 60% in first year and 75% in second year of eligible patients being screened Number of special ”population” screening days held No. of undiagnosed diabetic patients detected	Hospital records and PHIS
Quality diabetes centres established at all SDHs and selected large urban health centres	Number of diabetes centres by year. Annual plans to determine	Inspection and certification

Outcome	Indicator	Source of data
Adult Personal Diabetes Record book is providing an effective mechanism for ensuring the continuum of care for people with diabetes	% of patients presenting with books at time of consultation MoH to determine targets for each year as part of the Annual Plan	PHIS and hospital records and SDH diabetic centres
National Diabetes Centre strengthened to serve as national focal point for diabetes training and policy	TORs for role of the diabetic centre agreed by MoH Centre providing functions outlined in its TORs	Inspection
An effective system of trained and resourced VHW/CHW who are able to provide basic first aid, promote healthy practices and health seeking behaviours and effectively refer patients to health services.	% of villages having functioning VHW/CHW Community participation increased as recorded by zone nurse	Reports from relevant zone nurse
PHIS provides timely, complete and accurate information that is being used to measure public health outcomes and plan future activities	Review of PHIS undertaken Reports show that it is providing relevant data in a form suitable for assessing progress towards outcomes	Revised PHIS and its respective tools
MCH and diabetic health services are regularly monitored, audited and evaluated, and gaps/weaknesses addressed	At least 20% of all facilities monitored and audited in any year As determined in the annual plan	Regular audits of centres
Clinical service Guidelines and protocols related to MCH and diabetes are standardized, disseminated and used systematically throughout all service delivery areas	Standardised guidelines in use	DMO and Divisional Facilitator

3.4.2 External Reviews

Two external independent reviews will be held during the life of the Program. The first will be a Mid-term Review, to be undertaken at the end of the second year of program implementation. During this review, an assessment will be made of the technical progress and implementation arrangements. In addition, in depth discussions and/or workshops to inform future activities will be undertaken, and recommendations for any changes in design will be made. If agreed by both the GoF

and GOA, these will be presented to the next PCC meeting for discussion and endorsement.

An independent completion review will be undertaken early in Year Five. The aim of this review will be to assess the outcomes from the Program and assist AusAID in determining if a future phase of activities should be considered. If the outcomes of this are positive, a new design process will be undertaken.

In addition to the independent reviews described above, it is recommended that periodic external assessments are conducted, as follows:

- Annual Quality at Implementation Reports prepared by AusAID according to standard guidelines;
- Periodic Progress Reviews by AusAID's TAG;
- A comprehensive review of the success of the VHW/CHW program. It is recommended that an independent review is undertaken, as sustainability of this program will have significant cost implications for the Ministry of Health.

3.5. Overarching Policy and Cross Cutting Issues

(Including Gender, Anticorruption, Environment and Child Protection)

The implementation of the program of support will be informed by a number of overarching principles that the Government of Australia has put in place to ensure the quality and effectiveness of the aid program. These overarching principles are outlined below.

Accra Agenda and Paris Declaration on Aid Effectiveness

Consistent with Australia's commitments under the Paris Declaration on Aid Effectiveness, the program incorporates the key themes of: increased policy engagement and alignment with government strategies; working through government systems; working towards increased donor harmonisation and alignment with MoH priorities; mutual accountability and innovative forms of aid and funding.

Gender

Gender equality is an overarching principle of Australia's aid program. Consideration and incorporation of gender aspects into implementation of this program is implicit in its design, and especially through its strategic focus on improving maternal and child health.

Another key component of the program is to strengthen resources and empower village/community health workers, the majority of whom are women. Resourcing and building the capacity of this cadre of health staff will help to strengthen the role of women in community health needs assessment and decision-making, thus helping to improve health practices and health-seeking behaviour. Furthermore, by increasing women's participation in community decision making, both male and female stakeholders become more aware of women's ability and right to lead, thereby increasing their critical awareness regarding women's leadership.

The Terms of Reference for positions to be funded under this Program and recruitment methods should encourage gender equality and follow equal employment opportunity policy. Recruited staff will be familiar with gender issues, and methodologies to amplify women's voices in decision-making.

All appropriate indicators in the M&E framework will be sex-disaggregated. The proposed operational research to identify patterns and issues around social mobility and the expansion of urban/peri-urban settlements will identify characteristics of the population, and through M&E and impact assessments will provide data

disaggregated by age, gender, economic status, education, and thereby highlight population sub-groups for more focused health interventions.

The Program will ensure that as many women will be screened for diabetes as men and the sex ratio of persons receiving diabetes care and treatment will reflect the ratio of those detected on screening.

Disability-inclusive Development

The program was developed in line with the principles espoused in the Development for All: Towards a Disability-inclusive Australian Aid Program 2009-2014, and will be guided by the principles in this document, particularly around promoting active participation of people with disability, acknowledging the interaction of gender and disability, and strengthening people-to-people links and partnerships involving people with disability.

Anti-Corruption

The risk of corruption in this Program has been reduced by the direction of funds through an external Contractor directly engaged by AusAID through an open tender process. The Contractor's responsibilities include the procurement component for which AusAID has strict tendering processes. Oversight of the program is provided by a Program Coordination Committee comprising senior staff from AusAID and MoH, Ministry of Finance & National Planning and other development partners , which will ensure regular and close monitoring of activities and program spending.

Environment

As a Commonwealth agency, all AusAID activities must comply with the Environment Protection and Biodiversity Conservation Act 1999. There is no need for a comprehensive environmental impact assessment to be undertaken in relation to this Program as it will not involve any environmentally sensitive locations, sectors or interventions.

Child Protection

AusAID has zero tolerance for child abuse, as stated in the Child Protection Policy. In the event that any activities are developed in future that involve working with children, AusAID and all relevant contractors or partners will undertake to ensure the personnel positions involved put in place risk management measures in accordance with the Child Protection Policy. The Managing Contractor will develop a specific policy for the Program in accordance with AusAID Guidelines on Child Protection.

3.6. Critical Risks and Risk Management Strategies

Political Risks

Fiji's recent history suggests a potential risk of political instability, which could pose a threat to implementation of Program activities. It will be important for the Program Support team to maintain close liaison with AusAID and MoH to monitor the situation on a regular basis. Security plans, including evacuation of expatriate staff, should be kept updated.

Linked to this, there is a risk that any deterioration in diplomatic relations between the Australian government and the authorities in Fiji could impact adversely on the Program.

Within the Fiji public service, HR policy decisions such as the recent cuts in public sector staffing levels also pose a risk to program implementation, should they continue. While the overarching program strategy is to work with and support the MoH to carry out program activities through its own staff, the management structure

includes a number of key technical facilitator positions. These will provide increased capacity within the MoH, and will help mitigate potential impacts on program activities should further redundancies occur.

Operating Environment/Sectoral Risks

- **Financial Constraints**

Public sector budget forecasts indicate that there will be no growth in the operating budget for the health sector for 2011 and 2012, with the current 2010 budget being marginally below the actual expenditure of 2009. Hence a "no growth" scenario is expected, despite the likely growth in demand for services.

In such tight financial constraints there is some risk that the MoF may choose to cut the health operating budget in those areas of activity being supported by this program, e.g. infant and maternal health, diabetes, support for sub-divisional hospitals. AusAID program funds could be at risk of replacing the government health budget rather than providing additional assistance.

To help mitigate this possibility, it is recommended that AusAID includes in the MOU, specific clauses that includes continued budgetary support for priority areas within the health sector.

- **Staffing constraints**

In addition to the enforced redundancies described earlier, the new retirement age of 55 adds to the risk of reduced human resource capacity for the Program. Many key staff who had received management and/or specialist skills training have retired. Although the PSC has provided some exemptions which lessened the HR impact for the health sector, the risk of HR attrition persists.

This Program will continue many of the capacity building and training activities that have been undertaken within FHSIP to help address this situation. These include training in frontline management, supervision, data analysis and interpretation, planning, monitoring and evaluation, as well as training in technical areas such as EPI, diabetic foot care, clinical quality improvement, etc.

Program Implementation Risks

- **The Program governance and management frameworks are not effective**

Although these are modelled closely on governance mechanisms currently used in the transitional phase of the FHSIP, it has not been reviewed and its effectiveness needs to be continually assessed, especially during the first year.

The Program management structure has been changed slightly for this program and includes a management group at the central level as well as the divisional levels. This management process is currently in place; however this also needs to be reviewed progressively by AusAID and MOH.

- **MoH Staff at the operational level are not supportive of some of the key objectives and approaches used in this program**

This program will seek to institutionalise important "concepts" that, although in theory are key components of MoH strategies, are often not specifically acknowledged. These include the introduction of the "Safe Motherhood " program, which needs to be seen not only as a set of activities but to be embraced as a "culture", (in a similar way that the concept of 'baby- friendly hospitals' was embraced by staff). Other examples include the introduction of an Adult Diabetes Health Card, the strengthening of the cadre of village health workers and the need for their acceptance by zone nurses.

It is important that DMOs understand the Program rationale and design as they will be instrumental in ensuring that divisional staff also understand the critical issues.

- **Gaps in data collection and analysis**

Whilst all the outcomes listed within this program are measureable, and pathways already exist to collect this data, there is concern that this data is both incomplete and insufficiently analysed to assess the progress of this program.

The program includes activities to strengthen data collection and analysis. Furthermore, the three technical coordinators engaged by the Program will help to continually monitor this risk.

- **Key staff positions are not adequately filled**

While it is important that all positions funded through this program are filled, it is critical that the key positions of Director, Program Support, and the three technical coordinators are quickly established. The quality and effectiveness of these key staff will be critical to the success of the program.

- **Supervision of program activities is compromised by continued difficulty with transport**

Transport was constantly raised as a significant issue and risk to the success of the ongoing work of the MoH. It will also be an issue for this program. The Program will work closely with MoH to identify innovative ways to address this issue.

- **There is a significant time gap between the termination of FHSIP and the commencement of new Program**

The current transition period for the FHSIP ends on 31 December 2010. The new FHSSP Program is expected to commence in May 2011.

- **Lack of Village/Community Health workers impacts on success**

There is concern that success of the VHW/CHW component will be at risk due to their high turnover. This is directly correlated to VHW/CHWs not receiving motivational payments from the Ministry of Health.

This is a serious concern and the program plans a full evaluation of this component during the second year of implementation.

- **Gender is not mainstreamed by the MOH**

Although the MoH has a good “in house” gender policy, and the target of many of the program initiatives are women and children, the Program staff will need to continually liaise with MoH at all levels to ensure that gender issues are acknowledged and addressed. It is important that program data is disaggregated by gender from the outset.

- **Program focus is diverted by unanticipated emergencies**

In recent years Fiji has suffered from floods, cyclones, the H1N1 epidemic and recently by a serious typhoid epidemic. Attention to these matters is drawing key MoH staff away from their normal duties. Dealing with such emergency situations, especially during the first year of the program, would be a serious risk.

Adequate emergency preparedness plans will need to be in place to ensure that such situations are prioritised appropriately.

- **The Program suffers from AusAID’s many competing priorities**

This is a large program of support with a strong technical emphasis. The design recommends that AusAID either engages a Specialist Health Adviser or a Technical

Advisory Group, to provide sound technical advice to AusAID and the Program. This includes ensuring that operational decisions are aligned with the Program's strategic directions; and identifying and facilitating the resolution of potential conflicts.

A complete Risk Matrix is provided in Annex 8.

An initial task of the Managing Contractor will be to develop an updated Risk Management Plan in the first year, to be reviewed annually by the PCC and updated as required.

Annex 1: Key Areas of Support: Constraints, Indicative Activities and Expected Program Outcomes

Objective 1: To institutionalise a safe motherhood program at decentralised levels

Constraints	Indicative activities	Expected outcomes
• High incidence of late presentation for antenatal checks • a shortage of standardized protocols and guidelines for both nursing and medical staff at nursing stations (NS), Health Centres (HC) and Sub-Divisional Hospitals (SDH) • a weak system and culture for monitoring and evaluating services • an inconsistency in size and population catchment for similar level of health facility, with some facilities with small workloads being better equipped and staffed than others with much larger workloads • Many SDHs require upgrading with respect to both staffing skills, and equipment and facilities before they could be classified as “Baby Safe” • The high incidence of previously undetected STIs found in pregnant women shows an enormous unmet need for raising awareness about STIs and improving access to reproductive health	• Raise awareness of the need for early antenatal care and introducing systems to ensure that pregnant women present for their first antenatal check-up in the first trimester; • Prepare and introduce clear protocols and guidelines, including ones for emergency deliveries at Nursing Stations and Health Centres and for timely referral of higher risk pregnancies to Divisional Hospitals; • Introduce a targeted skills improvement program, focused on antenatal, delivery and post natal care, for nursing and medical staff at the NS, HC and SDH levels; • Strengthen counselling skills in family planning at all levels; • Review the delineation of health facilities to ensure their categorization with respect to maternity services is appropriate for their catchment and service load; • Implement the proposed role delineation for deliveries so that only emergency deliveries are carried out at Nursing Stations and Health Centres, while all low risk deliveries are referred to Sub-Divisional Hospitals and high	• An increasing number of women routinely presenting for first ante-natal check-up (ANC) in the first trimester • At least half of Sub-Divisional Hospitals classified as “baby safe” • High proportion of deliveries being carried out in Sub-Divisional Hospitals or higher level institutions • Increased contraceptive prevalence rate • Reduced unmet need for family planning.

Constraints	Indicative activities	Expected outcomes
services; • transport issues both for patients visiting health facilities and for staff undertaking outreach	risk deliveries to Divisional Hospitals: • Upgrade selected SDHs to “Safe Motherhood” status both to improve access and quality of care for women and to reduce the load on Divisional Hospitals; • Formalise regular outreach services at all levels of the decentralized health system; • Expand demand for, access to, and availability of short-term, permanent and long-term methods of contraception, including Jadelle • Work closely with MoH to identify innovative ways to address transportation issues	

Objective 2: To institutionalise a "healthy child" program throughout Fiji

Constraints	Indicative activities	Expected outcomes
• Limited staff skills especially in Integrated Management of Childhood Illnesses (IMCI) • High rate of defaulters with respect to the Expanded Program of Immunization (EPI). • Lack of standardized protocols and guidelines for both nursing and medical staff at nursing stations (NS), Health Centres (HC) and Sub-Divisional Hospitals (SDH) • Inconsistency in size and population catchment for similar level of health facility, with some facilities with small workloads being better equipped and staffed than others with much larger workloads • Many SDHs require upgrading with respect to both staffing skills, and equipment and facilities before they could be classified as "Baby Safe"	• Introduce and/or reinforce the "Integrated Management of Childhood Illnesses (IMCI) training program for all nursing and medical staff working in decentralised health services; • Introduce strategies to ensure a high level of EPI coverage is maintained; • Prepare and introduce clear protocols and guidelines related to child health • Review and revise role delineation for child health services to be carried out at NS, HC, SDH and above; • Maintain and strengthen secondary level paediatric capability in SDHs; • Continue to support the "Baby Friendly Hospital Initiative" to promote breast feeding nationally; • Formalise regular outreach services at all levels of the decentralized health system; • Upgrade selected SDHs to "Baby-safe" status; • Ensure that Divisional paediatric services have the basic equipment required for neonatal emergency care.	• Systems in place to maintain Expanded Program of Immunization (EPI) coverage rates > 90% • Comprehensive training in Integrated Management of Childhood Illnesses (IMCI) leading to more secondary level paediatric care being safely carried out at Sub-Divisional Hospital level or below.

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

Constraints	Indicative activities	Expected outcomes
• Limited awareness of the risk factors for diabetes and the importance of early detection and management at the community level • Low rates of screening for diabetes • Late presentation of patients with diabetes • Poor understanding about the complications of diabetes • Lack of diabetes outreach services in some Subdivisions • Late presentation and suboptimal care of patients with diabetic complications such as foot sepsis	• Improve the detection of undiagnosed diabetes and hypertension in the community through annual population screening; • Build capacity of Sub-Divisional hospitals, health centres and nursing stations in screening, treating and monitoring diabetes and hypertension; • Introduce a diabetes personal care record booklet to ensure a continuum of care for patients who have a variety of service providers; • Strengthen SDHs to be able to undertake high quality diabetes clinics that include ongoing management and monitoring of diabetic patients and prevention and treatment of diabetic foot sepsis; • Upgrade selected SDH to improve facilities for more advanced diabetic care (including outreach diabetic retinopathy and debridement); • Strengthen specialist medical outreach clinics (esp. for diabetes) from divisional hospitals. These should be delineated as a core function of the outreach program and should also provide in-service training and ongoing monitoring of services to strengthen SDH services; • Strengthen the role of the National Diabetes Centre to function as a focal point for diabetes policy and training.	• Population screening for diabetes undertaken annually for all persons over 30 years of age • Adult Personal Diabetes Record book is providing an effective mechanism for ensuring the continuum of care for people with diabetes • Quality diabetes centres established at all Sub-Divisional Hospitals and selected large urban health centres • National Diabetes Centre strengthened to serve as the national focal point for diabetes training and policy.

Objective 4: To revitalize an effective network of village/community health workers (VHW/CHW) as the first point of contact for community members with the health system

Constraints	Indicative activities	Expected outcomes
• Poor health practices and health-seeking behaviour by people at community level are resulting in high burden of disease and strain on health facilities at divisional level • Lack of investment in primary health and VHW/CHW system has resulted in inadequate resources, weak supervision, monitoring and evaluation, and the attrition of VHW/CHW skills to effectively perform their key role as the first point of contact with the health system for people at community level • Some villages and many peri-urban squatter communities are without VHW/CHW • Inadequate awareness of VHW/CHW mechanism, especially in urban and peri-urban squatter communities	• Develop and introduce a targeted program to increase the skills and motivation of the village and community health workers (VHW/CHWs), building on work piloted by WHO in Fiji • Support the registration and accreditation of VHW/CHW • Ensure that VHW/CHWs are adequately resourced with VHW/CHW kits that include first aid supplies, condoms, informational materials, (such as flipcharts and leaflets written in Fijian and Hindi on diabetes, breastfeeding, family planning etc); • Strengthen the system of monitoring of VHW/CHWs by zone nurses; • Raise awareness of the village headmen to create buy-in for the program and support for the VHW/CHWs; • Provide support to community-level meetings and committees to strengthen community health engagement in primary health care, and improve health practices and health-seeking behaviour • More generalized health promotion initiatives such as a multi-media program coordinated by National Centre for health Promotion (NCHP) that specifically reinforces and	• An effective system of trained and resourced VHW/CHW who are able to: o provide basic first aid, o promote healthy practices and health seeking behaviours and o effectively refer patients to health services • Increased community ownership of, and engagement in, primary health care

Constraints	Indicative activities	Expected outcomes
	complements the work of the village or community health worker program.	

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

Constraints	Indicative activities	Expected outcomes
• **Health Information:** Gaps in management, analysis and utilization of health information, especially at decentralized levels. Data are routinely processed at the MoH Health Information Unit, but information is rarely disseminated back to health service delivery points, where it is most needed for situational assessments and planning. • **Monitoring and Evaluation:** weak skills for monitoring and evaluation at all levels • **Supervision:** Supervisory system not institutionalized and presently dependent on the initiative and motivation of individual health staff. Uneven supervision skills among MoH staff. • **Clinical Quality Improvement and Risk Management.** Clinical Quality Improvement (CQI) is currently underway at Divisional level but needs	• Provide TA to improve collection, collation, analysis and use of health data for planning, service delivery, monitoring and evaluation at both central and decentralised levels • Review of the Public Health Information System (PHIS) to strengthen the system and its utilization for evidence-based planning and improved service delivery. • Provide targeted TA to instil a culture of M&E and strengthen M&E skills at central and decentralised levels • Build on, and take to scale the JICA pilot initiative with the MoH to strengthen supervision. • Sub-contract local or international institution(s) to undertake operational research in areas indentified by MoH and AusAID and/or as needed (eg urban and peri-urban migration and the effect this is having on health parameters; investigation of new disease trends; a review of effectiveness of health interventions, etc). Other potential areas for operational	• Public Health Information System (PHIS) provides timely, complete and accurate information that is being used to measure public health outcomes and plan future activities at central and decentralized levels • Maternal & Child Health and diabetic health services are regularly monitored, audited and evaluated, and gaps/weaknesses addressed • Improved M&E at central level and across service delivery areas • Clinical Service Guidelines and protocols related to MCH and diabetes standardised, disseminated and used systematically throughout all service delivery areas • Improved supervisory system institutionalized across MoH • Operational research provides information to support evidence-based policy and planning of health services

Constraints	Indicative activities	Expected outcomes
to be consolidated and expanded to SD level. • **Operational Research to Address Knowledge Gaps and Support Evidence Based Policy:** There are some critical knowledge gaps that need to be addressed to support evidence-based policy, planning and programming, where information cannot be obtained from routine information sources • **Strategic and Corporate Planning:** Strategic and corporate planning is broadly on track, but may need additional strengthening to help MoH work towards a sector wide approach. • **Transportation:** Transport was identified as a major constraint, both in respect to access to health services for patients and for Ministry staff conducting outreach and supervision. Constraints relate both to the absolute need for additional vehicles, boats, horses etc., and to the effective management and coordination of existing transportation systems	research may be identified by the ongoing Fiji Health Systems in Transition (HiT) profile. • Provide targeted TA to help facilitate and improve MoH strategic and corporate planning	in urban/peri-urban areas • Improved strategic and corporate planning leading towards a sectoral approach to planning • Improved transport systems to a) facilitate patient access to health services from remote villages/islands and b) facilitate outreach and supervisory visits by health staff to remote areas.

Annex 2: Scope of Services for Managing Contractor

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Annex 3: Contractor Performance Assessment Framework

KPI	KPI Definition	Means of Verification	Perf. Rating %	Comments	Evidence to support Assessment
1.	**Engage and Manage Program Personnel in a timely and effective manner**				
1.1	50% of Program Personnel recruited within 3 months of Program commencement and 100% within 6 months.	Personnel section of Quarterly Progress Report			
1.2	100% of vacancies recruited within 3 months (after initial recruitment)	Personnel section of Quarterly Progress Report			
1.3	100% of Program Support Personnel complete a comprehensive orientation.	Documented orientation check lists recorded and available on file			
1.4	100% of Short Term Advisors recruited in accordance with Annual Plan (or Implementation schedule in Yr 1)	Personnel Report within Quarterly Progress Report			
2.	**Take all reasonable steps to ensure the safety and security of program personnel and property, including due regard for occupational health and safety issues**				
2.1	Security section of Operations Manual completed, regularly updated and communicated to relevant staff	In-country orientation checklist and Security Acceptance form signed during orientation			
2.2	All security incidents dealt with in accordance with security section of Operations Manual	Security report within Quarterly Progress Report			
3.	**Administer and Manage Procurement services as required under the contract in an efficient and effective manner, including quality control of tendering and contracting for procurement of goods and services**				

3.1	All procurement carried out in compliance with Procedures Manual	Successful six monthly independent audit			
5.	**Manages Finances in a timely and accurate manner in accordance with the procedures outlined in the financial Management Section of the Operations Manual.**				
5.1	Finances managed according to budget for the Annual Plan (or Implementation Schedule in Yr 1)	Monthly Reports to Finance and Audit Committee			
	Financial management carried out in accordance with Financial Management Section of Operations Manual	Successful six monthly independent audit			
2.	**Source and deliver Activities in appropriate quality, quantity and timeframe**				
2.1	All activities delivered in accordance with Annual Plan (or Implementation Schedule in Yr 1)	Activity Report within the Quarterly Progress report			
6.	**Demonstrate Competence in Identifying and Managing Risks**				
6.1	Proactive exemption reporting on emerging risk issues to AusAID	AusAID, Suva, informed of emerging issues in a timely manner. Evidence of risk mitigation and follow-up in the risk management section of the Quarterly Progress Report.			
6.2	Up-to-Date Risk Management strategy for presentation to AusAID on a quarterly basis	Documented narrative of risk management in Quarterly Progress Report			
7.	**Maintain high standards of reporting and service to the AusAID Program Office**				

7.1	100% of programmed and ad hoc reports meet AusAID requirements	% of reports accepted by AusAID, Suva, with no major revisions.			
8.	**Provide secretariat support to the PCC and the Program Ministry Management Group**				
8.1	MoH and AusAID satisfied with the level of secretariat input provided by the Program Operations Team	Secretariat support provided for all meetings of the PCC and PMG.			

Rating		Definition of Rating Scale	
Business as Usual	6	Very High quality; needs ongoing management and monitoring only	100%
	5	Good quality initiative; needs minor work to improve in some areas	90%
	4	Adequate quality initiative; needs some work to improve	80%
Unsatisfactory Performance	3	Less than adequate quality; needs work to improve in core areas	70%
	2	Poor quality; needs major work to improve	60%
	1	Very poor quality; needs major overhaul	50%

Annex 4: Terms of Reference for Key Positions

Deliberately left blank. See RFT Part 3 Scope of Services Annex 1

Annex 5: Basis of Payment

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Annex 6: Proposed First Year Implementation Schedule

(Note: all activities are undertaken by, or in conjunction with, MoH staff at both central and divisional levels)

Activities	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Comments
SA 1: Safe Motherhood					
Early presentation for antenatal care			Commence developing plan for increasing incidence of early antenatal check-ups.	Technical Coordinators and DMOs to liaise with FSN re their role in emphasizing need for early natal care in nursing curriculum.	
Role delineation			Review role delineation of NS, HCs and SDHs for maternity care to ensure appropriateness based on health workforce review	Develop plan for improving compliance with assigned role delineation (esp with respect to birthing).	
Upgrading SDHs for “Safe Motherhood”	Assess requirements and criteria for upgrading SDHs to “baby-safe” status	Determine 3 SDHs to be upgraded first	Develop plans to upgrade 3 SDHs (facilities and equipment)	Prepare tenders for SDH upgrades	
Protocols and Guidelines		Undertake review of current protocols and CSGs being used within MoH for maternity care (medical and nursing)		Commence process of rationalizing guidelines and protocols	Must involve CSNs and Nursing Division
Capacity Building				Commence planning capacity building	

				program for NS, HCs and SDHs
Family Planning				Review reasons for low incidence of contraception (unmet need) and ways this may be increased
Other	Begin to explain and promote the concept of “safe motherhood” to staff at all levels so that they understand and implement this concept	Undertake assessment of portable ultrasounds available Continue to promote safe motherhood concept/philosophy	Facilitate procurement of 4 portable ultrasound machines (1 per Division) Continue to promote safe motherhood concept/philosophy	Purchase machines Continue to promote safe motherhood concept/philosophy
SA 2: Healthy Child				
Expanded Program of Immunisation (EPI)		Review strengths and weaknesses of activities implemented during FHSIP	Develop plan to continue strengths and address weaknesses to ensure sustainably high EPI coverage rates.	Obtain endorsement for plan
IMCI Training and ongoing reinforcement		Determine best program of strengthening IMCI training for all nurses and doctors at NS, HC and SDH Consider best ways to provide IMCI training (eg contract external agency, NGO, FSMed or WHO)		Prepare plan for widespread dissemination of training program. Commence training if able.

Guidelines and protocols		Undertake review of current protocols and CSGs being used within MoH for paediatric care (medical and nursing)		Commence process of rationalizing guidelines and protocols	• Must involve CSNs and Nursing Division • Emphasis should be on NSs, HCs and SDHs
Strengthening SDHs for secondary level paediatric services				Determine requirements (in addition to IMCI) for SDHs to operate secondary level paediatric services.	May involve training and equipment
Neonatal Equipment at Divisional Hospitals	Determine basic neonatal equipment to be purchased for 3 Divisional Hospitals	Undertake assessment of equipment suppliers and costs.	Facilitate procurement of neonatal equipment	Purchase equipment	
SA 3: Diabetes					
Role Delineation		Undertake more detailed role delineation planning for diabetes services at NS, HC and SDH			
Upgrading diabetes clinics in SDHs and	Assess requirements for upgrading diabetes clinics in SDH/larger HCs	Determine SDH/HC diabetes clinics to be upgraded first and plan upgrades for selected	Ensure diabetes clinic upgrades align with diabetes role delineation and	Assess and award tenders	

larger HCs		SDH/HC diabetes clinics (facilities and equipment)	prepare tenders for SDH/HC upgrades		
Protocols and Guidelines		Undertake review of current protocols and CSGs being used within MoH for diabetes and hypertension (medical and nursing)		Commence process of rationalizing guidelines and protocols	• Include CSNs and Nursing Division. • Emphasis on NSs, HCs and SDHs
Capacity building				Determine most effective areas for focus of capacity building, target audiences and means of delivery	
Diabetes Personal Record booklet		Widespread consultation and literature review for style of, and information in, Diabetes Personal Record (DPR) book	Agreement on style of, and information in, DPR book	Commence developing Plan for piloting DPR book	
Diabetes detection			Commence planning for mass diabetes screening	Continue planning for mass diabetes screening	
SA 4: Primary Health Care (VHW/CHW Program)					
CHW/VHW program	Liaise with MOH and Ministry of Fijian Affairs to determine number of	Review activities already being undertaken by WHO	Commence planning (including budgeting)	Finalise planning for pilot/initial roll out of	N.B. Starting point may depend on outcomes of WHO

	villages in each Division and subdivision and determine the best "sample" of villages/settlements to constitute the first 100 participating villages.	and GoF/MoH and other donors in Fiji and review literature from other countries	for program: • Capacity building • Supervision • VHW/CHW kits • Raising awareness of role and importance	program	funded VHW program pilot
Health Promotion		Determine targets for funding for first year funds.	Prepare materials	Launch first year health promotion program	
SA 5: Targetted Systems Strengthening					
Strategic and Corporate Planning	Assistance for MoH with strategic plan, if required	Assistance for MOH with Divisional annual plans and MoH corporate plan	Development of Program plan for 2012	Finalisation of Program plan for 2012	Exact timing of these activities will depend on date of mobilization of program
Monitoring and Evaluation	Develop M&E Plans for each operational plan	Endorsement of M&E plans by MoH and AusAID	Commence implementation of M&E plans (including ensuring alignment with recommendations from PHIS)		A key data collection mechanism for M&E framework will be PHIS
Health Information (PHIS)		Prioritize recommendations from PHIS review	Agreement on way forward with respect to recommendations from review	Plan for implementation of agreed recommendations	
Supervision			In collaboration with MOH and JICA, review	• Determine best approach to	Supervision will be important both for

			the nursing supervision program and discuss gaps and areas for future funding	improve medical supervision	ensuring the data entered into PHIS is accurate and timely and that the M&E framework is effective.
Operations Research (urban and peri-urban migration)		Develop TORs for comprehensive study on the effect of urban and peri-urban migration on health outcomes and health service delivery	Engage group to undertake research	Commence research	
Transport Innovation Scheme	Work closely with MoH to identify innovative ways of addressing transportation problems	Divisions to commence transport improvement plan	Divisions continue plan	Divisions commence preparing report on success of innovations	
CQI and Risk Management	Continue risk management and CQI activities from FHSIP with gradual increase in emphasis to SDHs and to ensuring sustainability when Program funding ceases				

Program Management

• Program mobilisation	Mobilise Contractor finance and admin staff
	Fit out offices
	Purchase vehicles
	Purchase mobiles, computers etc
• Personal	Recruit key personnel

	recruitment			
• Financial Management	Establish dedicated bank account Organise payment of salaries Organise insurance policies Organise systems for office purchasing Organise systems for tendering and procurement			
• PCC and Divisional Meetings		Organise and fund initial PCC and Divisional meetings	Organise and fund ongoing PCC and Divisional meetings	Organise and fund ongoing PCC and Divisional meetings

Annex 7: Monitoring and Evaluation Framework

The M and E framework provided here expands on the summary given within the Implementation section of the main text of the Design Document. It represents the situation “at entry”. Because this is a program that will support the MoH to implement its own plans, and not a tightly defined project, the M&E plan for this program will align with the detailed M&E plan of the MoH at National and Divisional level. Nevertheless indicative indicators are given here for each of the program outcomes and there is some discussion as to how these will be measured to assess progress towards achieving the outcomes of the program.

Monitoring and Evaluation (M and E) are essential planks in any AusAID funded program. The overall purpose of monitoring and evaluation is to ensure that programs inputs do flow through to achieving the objectives and outcomes of the program at the higher level and individual outputs at the Annual Plan level. The process should not only identify areas of success but should also identify areas where progress is not satisfactory and the reasons for this poor progress. Results from M and E activities will thus feed into future years plans and help identify emerging risks to the program. Importantly M and E will also provide a level of accountability to AusAID.

For these reasons it is important that M and E activities begin at an early stage and are built into the first year's implementation plans.

Some definitions are useful. Within this document monitoring refers to the continuous assessment of activity implementation in relation to agreed program plans. It is a means of determining the immediate results of outputs which support the longer term objectives. Thus monitoring involves the ongoing process of gathering, analysing, recording and reporting on the progress of the Program. The value of monitoring is to provide data for management decision making, and thus to refine implementation activities. In terms of this program, monitoring will involve:

- Collecting and analysing information at all levels to determine whether outputs are being achieved in keeping with the annual plan
- Confirming the quality and timeliness of inputs especially in the early years when important institutional strengthening activities such as upgrading sub-divisional hospitals are taking place.
- Ensuring actions are taken to avert risks – e.g. assessing whether ongoing budget and staffing constraints are impacting adversely on the program and whether the management structures established for this program are providing sufficient guidance and oversight to what is a relatively intense implementation plan across all geographic divisions of the MoH. The risk management plan should be part of the Annual Planning process.

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

- The program will wish to evaluate whether upgrading the Sub-Divisional hospitals to provide a greater range of essential services is being well accepted by clinicians and importantly by the community; and whether it is cost effective.
- Assess the impact of the enhanced village and community health worker program that will be put in place through the program. Is it improving health-seeking behaviour of villagers and is it leading to meaningful referrals to the

formal health sector ie Nursing Stations, Health Centres, Sub Divisional Hospitals and Divisional Hospitals.

- Similarly the MOH may wish to assess whether more extensive screening for diabetes in identifying diabetic patients at an earlier stage and thus seek support from the Program to develop strategies to ensure better compliance of newly diagnosed patients with their medical and “green” prescriptions.

Monitoring and Evaluation responsibilities

Monitoring and Evaluation should be shared between the MoH, AusAID and the Director, Program Support. In keeping with the structures outlined within the management section of this document, responsibility for day to day monitoring of AusAID funded activities will rest with the Director, Program Support and the DMO, with data collection and analysis being done through the MoH’s own service delivery framework.

While it will be necessary to develop an M and E Plan during the first 6 months of the Program, it is important to ensure that the M&E Plan is aligned with the Ministry's own M&E plans at the national and divisional levels. Subsequent M&E activities should be done on an ongoing basis at the activity level, with the results being used to feed into the annual reporting and annual planning cycles i.e. M and E is seen as an integral part of both annual reporting and annual planning.

Unfortunately the MoH does not have a strong culture of monitoring and evaluation. Nor does its current Annual Plan include a detailed performance measurement framework. It will therefore be necessary to provide training in this area – both by strengthening skills within the central MoH in Suva, but also at Divisional offices. Divisional level managers will, in turn, have responsibility for installing a culture of performance management within their division. Strengthening the systems used to collect and importantly to analyse data is part of this process.

It is suggested that in the first instance this should be done by engaging closely with the relevant MoH staff during the preparation of the initial Monitoring and Evaluation Plan - a form of "learning by doing". The Director, Program Support should build this need for teaching and monitoring into the terms of reference for any short term adviser engaged to help develop the M&E Plan. The initial engagement of a consultant should be done during the first 3 months of the Program and it is likely that multiple consultant visits will be needed before there is capacity in this area. These subsequent visits might best correspond with annual planning cycles.

Measuring Progress towards the program goal and objectives.

The 5 objectives and outcomes of the Program are clearly stated in section 2 of the design document. All contribute to achievement of the program goal.

To remain engaged in the Fiji health sector by contributing to the MoH’s efforts to achieve its higher level strategic objectives in relation to infant mortality (MDG4), maternal mortality(MDG 5) and the prevention and management of diabetes as outlined in its own National Strategic Plan.

Although it has been stated earlier, it is important to restate that the program **can only make a contribution** to the achievement of these higher level Millennium Development Goals 4 and 5 and the reduced incidence of diabetes and diabetic complications. The MoH must hold prime responsibility in this regard.

However the program can be held accountable for the achievement of the program-specific outcomes. Therefore measuring progress towards achievement of these program-specific outcomes is at the heart of the “programs” M and E activities. This includes agreement on the data required to measure progress, the collection method

for that data, the reporting and analysis of that data and the feedback from this analysis (what is working, what is not) into future program plans.

Monitoring and Evaluation Framework

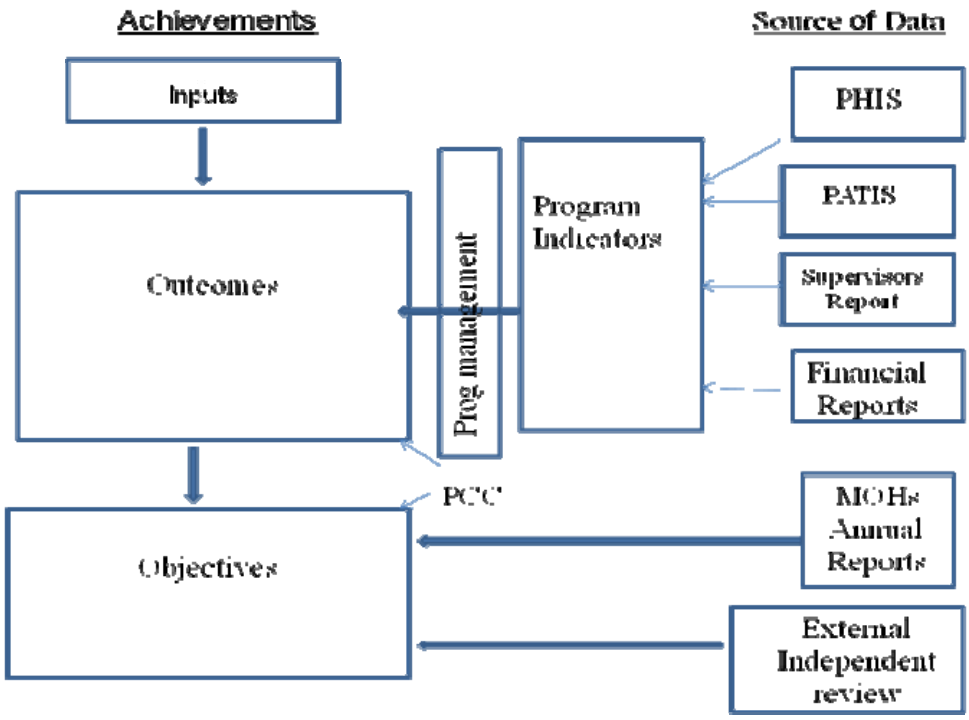

Table 1 on the next page lists the key elements of the Monitoring and Evaluation Framework, how they are used in the Framework and the responsibility for update and review of each element.

Table 1: Key Elements of the Monitoring and Evaluation Framework

Key Element	Feature	How used in the M and E process	Responsible for update/review
Overall Program Operational Plans	To be developed in early stage of program and reviewed annually for approval by PCC	Provide guidance for implementation teams at all levels and a measure of annual performance against outcomes and timeframes	DMO/Director, Program Support to review progress in their Division and send to PCC. Lessons learnt to feed into future plans
Operational Plan for Specific Objectives	To be developed in early stage of program and reviewed annually for approval by PCC Sets out implementation pathway, data requirements etc. Developed through a participatory approach	Provides measure of success in a specific outcome area at any point of time	Relevant Facilitator (Maternal, Infant, Diabetes etc). Divisional Med Officer/ Div Facilitator
Use of Short term Process indicators	Targeted at early stage activities	Gives some assurance to the PCC that key elements of program have been put in place and that program is on course	Director, Program Support
Use of Long term Outcome Indicators	Given in this design document but to be reviewed regularly and affirmed by the PCC	Used by Divisional Management team and PCC to measure long term progress Use by external monitoring groups as focal points for their reviews	Director, Program Support to review Approval by PCC
Progress towards MDGs	To be consistent with MOHs strategic	Gives a measure of success	PCC

Key Element	Feature	How used in the M and E process	Responsible for update/review
MOH own indicators	Plan	against the overall goal of program	Div and National Mgmt Committee
Monthly reports from Divisional Facilitators	Ensure data is collected and analysed in a timely manner	Reports to Director, Program Support and to Divisional meetings	Divisional Med Officer/ Divisional Facilitator
Risk Matrix	Lists key risks and provides suggested risk management approach	Must be continually consulted by individuals and management groups. New risks must be identified and emerging risks must be managed and overcome.	Director, Program Support to review and if necessary to revise at least twice per year
Use of External Monitoring processes	Make use of independent perspective and provides fresh ideas for managers	To be reviewed by PCC and taken into account when setting direction of the Program	AusAID and MoH
Six monthly progress reports to PCC	Consolidate progress data from each division and for each specific targeted outcome Underscores the core purpose of the PCC to monitor progress	Review of reports at this level provides a platform for recommendations for change if that is needed	Director, Program Support

Sources of Data

It has already been stated that data will be captured through the MoH's own processes - modified if necessary for the special purposes of the Program. Currently, important data relevant to this program is captured at all levels of the system ie nursing station to Divisional hospitals. The number of antenatal visits, diabetic screening, immunisation records, number of deliveries, incidence of certain childhood illness, maternal and childhood deaths etc is collected routinely through the PHIS (which will be reviewed with support from the program), from PATIS (hospital based patients information system) and special reports for different partners e.g. WHO. Most are collated and given in the MoH annual reports.

Data in relation to the Objective 4 will need to be collected in collaboration with the Department of Fijian Affairs who will be a valuable partner in this initiative

Baseline data

Much baseline data is already available. Data on vital health statistics, such as population, crude birth rate, infant mortality, neonatal mortality, <5 mortality, maternal mortality, family planning protection rates, immunisation coverage, diabetes prevalence and incidence and number of amputations is routinely given in the MoH Annual reports which are usually released midway through the following year. Other sources of data are held by national advisers in specific departments such as NCD, family health, and at the divisional and Sub-Divisional hospitals. This information will serve as baseline data for measuring progress in many areas of the Program. While this data is considered to be relatively accurate it will need to be tested.

However there are areas where baseline data is not available. One such area is in relation to the VHW/CHW. While, in theory, it is a common practice for all villages to have a village health worker appointed by the village (some have more than one) this practice has been eroded in recent years and the number of villages with an active VHW/CHW, and the extent of their activities, is not known. As stated earlier the program will need to work closely with the Ministry of Health and Ministry of Fijian Affairs to collect this data and in all other activities relating to Objective 4.

It is recognised that there are particular challenges associated with Objective 4. For this reason it is planned that a comprehensive review be undertaken during the second year of the program, to measure its impact and importantly to assess its likely sustainability beyond the life of the program. Ongoing costs to the Ministry of Health will be a sustainability issue that needs review. It is also important that this be done before engaging additional villages in the program beyond those already included in year 1.

The results of the 2nd Fiji NCD STEPS survey, to be carried out in late 2011, will provide valuable baselines data in relation to diabetes and other NCDs.

Table 2 below lists the program outcomes and indicative key performance indicators that could be used to measure progress and the person(s) responsible for collecting and reporting on this data.

Examples of "early stage" process indicators that could be used for this Program.

Even with a good M and E framework, the achievement of program outcomes will take time and visible evidence may not be apparent in the early years. It is important therefore that some early process type indicators are put in place to assure the PCC that activities have commenced within the allocated timeframes and thus give some indication of likely longer term success. Listed below are some examples of process indicators that can be used to monitor activities in the early months of the Program.

Key program staff positions filled - in particular this should include the Director, Program Support and the 3 technical coordinators

Financial management arrangements (including financial reporting, mechanisms for transferring funds for day to day use for program activities and acquittal arrangements) in place that enable funds to be distributed in a timely manner

The governance and management structures agreed and first meetings held

Program's Annual plan for 2011 and 2012 developed

Specific plans for achieving each of the program objectives are developed. These are important as the current MoH annual plans are developed along department lines eg: public health, curative services, and corporate services. It has long been recognised that addressing maternal mortality, infant mortality and diabetes and its complications cut across departmental lines. Success will therefore come from addressing specific plans prepared for each. It will be important that the expertise and resources of partners such as WHO, UNICEF, UNFPA and relevant NGOs should be consulted.

An M and E plan has been developed for each division in consultation with local staff and workshops held at each divisional level to discuss the processes for the collection and analysis of data

Reporting timeframes and formats agreed with the PCC

A report on each of these so called "early stage process indicators" should go to the PCC within 6 months of program commencement.

Reporting

Timely and accurate reporting is an important element of any Monitoring and Evaluation Framework. However there will be a need to reach a balance between the number of reports prepared and the time taken to prepare these reports.

Reports should be prepared for use by AusAID and the MoH and for the key inbuilt monitoring groups within the Program e.g. the PCC and program management groups at national and divisional levels. They must be seen by those preparing them as a part of the monitoring and evaluation process and not simply a statement of what has taken place during the reporting period. Therefore reports must be targeted at program outputs and outcomes. They should discuss progress to date, whether there are problems and provide suggestions for addressing those problems. Information collected should be disaggregated by gender where this is applicable and possible.

Frequency of reporting is also important - and in the final analysis this will be determined by those making use of the reports. Reaching agreement on the format and frequency of reports should be a priority during the early phase of the Program.

Without pre-empting the role of the MoH and key stakeholders to determine their reporting needs the following are seen at this stage as being important reports:

- Early Implementation reports that address the many issues included in the list of short term "process indicators" should be a priority during the early stage of the program.
- Reports prepared jointly by the three technical coordinators and the DMO for presentation at scheduled management meetings and more frequently if required.
- Regular Financial reports
- Consolidated reports for PCC and Management meetings

- At least half yearly reports from those responsible for coordinating achievement of each of the agreed program outcomes.
- Annual Plan
- Annual Monitoring and Evaluation Plan

The format of these reports is not being predetermined here and will best be determined in conjunction with the PCC and the Director, Program Support.

Table 2: Program outcomes and Indicative Indicators and their measurement

Outcome	Indicator	Source of data	Person Responsible
1. Relevant MOH Outcomes to which to which the Program will only <u>contribute</u>			
Reduced maternal morbidity	Maternal mortality ratio	Hospital records/MOH annual reports	Hospital Med Super
	Prevalence of anaemia at booking	PHIS Baseline needs to be developed	Divisional Med Officer
	Contraceptive prevalence rate in the child bearing age group	PHIS Annual report	Divisional Med Officer
Improved child health and reduced child morbidity and mortality,	Prevalence of under 5 malnutrition	Hospital data plus Better data sources need to be developed	Divisional Med Officer
	Percent of one year olds fully immunised	PHIS	Divisional Med Officer
	Under 5 mortality rate	Hospital records/MOH annual reports	Hospital Med Super
Reduced burden of communicable diseases (diabetes in this Program)	Proportion of population over 35 years engaged in sufficient leisure time activity (moderate or vigorous activity up to 30 mins per day)	MOH agrees it currently has no means of routinely measuring this other than periodic (each 5-10 years) STEP surveys	Perm Secretary
	Proportion of population with a sufficient intake of fruit and veg (400 gms per day)	As above	Perm Secretary
	Admission rates for diabetes and	PATIS/hospital records	Hosp Med Super

	its complications, hypertension and cardiovascular disease.		
	Amputation rate for diabetic sepsis	PATIS/hospital records	Hospital Med Super
2. Outcomes for which program will be accountable			
Higher proportion of deliveries being carried out in SDH or higher level institutions	Percentage of hospital births vs total births during relevant period	Individual Hospital and HC records - from PHIS and hospitals	Divisional Med Officer/ Div Facilitator
Higher proportion of women routinely presenting for first ANC check-up in first trimester	Percentage of all births in which mother presented for antenatal visit during first trimester	PHIS** and hospital records	Divisional Med Officer/ Div Facilitator
At least half of SDHs classified as “baby safe”	50% baby safe at completion Determine percentage by year of program	Inspection and “certification” report	Dir, Prog Support/ Chair Obstet CNS Divisional Med Officer/ Div Facilitator
Increased contraceptive prevalence rate and reduced unmet need for family planning.	Proportion of women using contraceptives on a regular basis (and type)	PHIS	Divisional Med Officer/ Div Facilitator
Systems in place to maintain EPI rates > 90%	EPI coverage - percentage for each zone	PHIS	Divisional Med Officer/ Div Facilitator
Comprehensive Training in IMCI leading to more secondary level paediatric care being safely carried out at SDH level or below	Number of IMCI courses given and number of staff trained	Training course records	Divisional Med Officer/ Div Facilitator

		Follow up supervisor reports	
Regular screening for diabetes undertaken for all persons over 30 years of age. This should include annual mass screening to coincide with World Diabetes Day	At least 60% in first year and 75% in second year of eligible patients being screened Number of special "population" screening days held Number of undiagnosed diabetic patients detected	Hospital records and PHIS	MOH NCD Adviser Divisional Med Officer/ Div Facilitator
Quality diabetes centres established at all SDHs and selected large urban health centres	Number of diabetes centres by year. Annual plans to determine	Inspection and certification	Director, Prog Support/ MoH NCD Adviser Divisional Med Officer/ Div Facilitator
Adult Personal Diabetes Record book is providing an effective mechanisms for ensuring the continuum of care of people with diabetes	% of patients presenting with books at time of consultation MOH to determine targets for each year as part of the Annual Plan	PHIS and hospital records and SDH diabetic centres	Divisional Med Officer/ Div Facilitator
National Diabetes Centre strengthened to serve as national focal point for diabetes training and policy	TORs for role of the diabetic centre agreed by MOH Centre providing functions outlined in its TORs	Inspection	NCD Adviser PS Director, Prog Support
An effective and sustainable system of trained and	% of villages having functioning	Reports from relevant zone	Divisional Med

resourced VHW/CHW who are able to provide basic first aid, promote healthy practices and health seeking behaviors and effectively refer patients to health services.	VHW/CHW Community participation increased as recorded by zone nurse	nurse	Officer/ Div Facilitator
PHIS provides timely, complete and accurate information that is being used to measure public health outcomes and plan future activities	Review of PHIS undertaken Reports show that it is providing relevant data in a form suitable for assessing progress towards outcomes	Revised PHIS and its respective tools	Divisional Med Officer/ Div Facilitator
MCH and diabetic health services are regularly monitored, audited and evaluated, and gaps/weaknesses addressed	At least 20% of all facilities monitored and audited in any year (as determined in the annual plan)	Regular audits of centres	NCD Adviser
Clinical service Guidelines and protocols related to MCH and diabetes are standardized, disseminated and used systematically throughout all service delivery areas	Standardised guidelines in use	DMO and Div Facilitator	Director, Prog Support Chair National Clinical service Networks

External Monitoring

While internal monitoring against progress towards achieving the programs outcomes and objectives will be important, independent external monitoring is also an essential feature of a good monitoring and evaluation program. This external monitoring might include:

- *Annual Quality at Implementation Reports* prepared by AusAID according to standard guidelines
- *A mid-term Review* – that is undertaken by a team of independent experts during the 2nd year of the program and follows AusAID guidelines
- *Periodic Progress Reviews by AusAID's Fiji based Health Adviser/TAG* (see Section 2.5 on management structure).
- *An Independent Program Completion Report* – prepared at or near the end of the program and following AusAID guidelines

Reports from each of these external monitoring approaches should feed into the PCC who will make decisions in relation to the recommendations included in those reports.

Annex 8: Risk Matrix

L = Likelihood (5 = almost certain, 4 = likely, 3 = possible, 2 = unlikely, 1 = rare)

C = Consequences (5 = severe, 4 = major, 3 = moderate, 2 = minor, 1 = negligible)

R = Risk Level (5 = extreme,4 = very high 3 = high, 2 = medium, 1 = low).

Risk event	L	C	R	Risk Management Plan	Responsible
Political instability leading to civil unrest	3	4	3	Monitor situation and maintain flexibility in programming Ensure good evacuation and security plans are in place	AusAID/. Director Prog Support
Deterioration in diplomatic relations	3	5	4	Flexibility in programming	AusAID/MOH Director, Prog Support
Unexpected government policies affecting staffing levels and other areas influencing operational efficiency	3	4	3	The design makes use of contracted Fiji nationals in key “program” positions to help offset staffing gaps.	PCC/MOH Director, Prog Support
Financial constraints affecting ongoing budgets for MOH	4	4	4	Flexibility in design, to ensure that activities are directed towards areas less affected by budget cuts. A sizeable amount of “flexible funding” is included in the design	PCC/MOH Director, Prog Support
Risk of substitution, with the MoF reducing the MOH budget in those areas where program funds are directed	3	4	3	AusAID to insert clause in MOU to address this. Continually monitor	AusAID/MOH Director, Prog Support
Staffing constraints and loss of skills base resulting	3	3	2	Use of externally contracted staff in key positions	Director, Prog

Risk event	L	C	R	Risk Management Plan	Responsible
from the loss of staff due to early retirement				(Divisional Facilitators/POs) plus an extensive program of training to upgrade skills	Support
Governance mechanism not fulfilling needs	2	2	2	Mechanism to be reviewed by Partners (MoH and AusAID) of not found to meet their needs	AusAID MOH
Changes in Leadership within MOH.	2	4	3	Outside ambit of Program to control. AusAID and Director, Prog Support will need to engage constructively with any new leadership to ensure their support for the Program	Director, Prog Support AusAID
MOH staff at decentralised level do not embrace objective and outcomes such as the Safe Motherhood and healthy child initiatives	1	1	1	MoH leadership, especially at Divisional level, assisted by program staff, to "sell" the ideas and institutionalise them	DMOs
Difficulty collecting timely data. The New PHIS still not fulfilling its role	3	4	3	Director, Prog Support and DMOs to give priority at an early stage to improving the quality and timeliness of data capture and analysis	DMOs Director, Prog Support
Difficulty contracting good program staff	4	4	4	Appropriate selection process to appoint successful managing contractor	AusAID
VHW/CHW initiative become ineffective due to lack of morale and high turnover among this cadre	4	3	3	The design includes a detailed evaluation during year 2.	
Mainstream international agencies do not engage	1	1	1	Wrap-up workshops have already been held and as of June 2010 they all strongly embrace the program. However the Program and the MoH will need to continually work closely with them to keep them engaged	MOH
Transport difficulty to ensure adequate supervision	3	3	3	Vehicle provided to each Division. An "incentive" scheme	DMOs

Risk event	L	C	R	Risk Management Plan	Responsible
of the decentralised service				introduced to encourage better management of the MOHs own transport, plus use of private services eg bus, delivery vehicles.	Director, Prog Support
Delay in the start of the program	3	3	3	AusAID to ensure no delays in Finalisation (including prompt peer review) of report and tight tender and mobilisation process	AusAID
Lack of gender mainstreaming	1	3	2	MoH have good gender policy and focus of program is women and children. However all parties will need to continually monitor and keep good gender disaggregated records	MOH/DMO
Natural disasters and other emergencies take MOH staff away from their routine duties	3	2	2	Contracted program staff may provide extra capacity in such situations, plus the design includes a flexible fund resource that can be used in such situations	AusAID Director, Prog Support MOH
Work overload on AusAID Suva, coupled with limited health technical capacity could impact negatively on program management and governance	3	3	3	Design recommends that a health specialist or TAG is engaged by AusAID.	AusAID

Annex 9: Links with other Health Development Partner Initiatives

A key principle guiding the design of FHSSP is that it should build on other AusAID-supported initiatives and integrate the work of other health development partners. This annex outlines other major ongoing and planned health development partner programmes that are pertinent to the design of FHSSP and indicates how FHSSP activities will integrate with the work of other health development partners in Fiji and the region and with AusAID-supported Regional Programs.

1. Ongoing and planned programs of support by AusAID and other health development partners

a) AusAID Regional Support Programmes

Fiji School of Medicine (FSMed)

Australia, through AusAID's Pacific Health Systems Strengthening Initiative, committed A$8.95m for the implementation of the FSMed's Strategic Plan 2008-2012 to improve its academic and management capacity and increase the number of trained medical practitioners in the region. Under this initiative, assistance was also provided for the establishment of a secretariat for the Pacific Human Resources for Health Alliance, currently based at the WHO Suva Country Office. Additional support was also provided through the Fiji School of Medicine for strengthening the provision of specialised clinical services to Pacific Island Countries. These activities are complementary and aim to address the shortage of health professionals in the Pacific. Since 2000, about 1380 Fiji students have graduated from FSMed.

FSMed is currently expanding its research capacity by establishing professional links with AusAID's knowledge hubs (Health Policy & Financing - Nossal Institute, Human Resources for Health issues - UNSW and health information systems – QUT).

Regional NCD Programme

Australia provides regional support through the Secretariat of the Pacific Community (SPC) to the Regional Non-Communicable Disease Program to support implementation of the regional NCD Strategic Plan. The Pacific Regional Non-Communicable Diseases Program jointly delivered by SPC and WHO has a country grant provision, in which PICTs are eligible to apply for assistance to implement their NCD strategies. Of particular importance to Fiji is the 2nd STEP survey planned for late 2011. Information from this survey will provide vital baseline data for activities being addressed within Objective 3 of the FHSSP.

Regional HIV/AIDS Programme

Australia also provides regional support through the Response Fund managed by SPC for Pacific Regional HIV & STI Strategy Implementation Plan 2009-2013 (PRSIPll). The Response Fund provides financial and technical assistance to PICT's national governments, civil society agencies and regional and multilateral organisations for the implementation of the PRSIPll. The Response Fund has various funding streams to cater for specific groups. Funding stream one is specifically to support the work of PICT governments in implementing their National Strategic HIV/AIDS/STI Plans or equivalents. Based on population and scope of its National HIV/AIDS Strategic Plan (2007-2011), the Fiji government is eligible to apply for funding on an annual basis to support HIV and STI activities.

Pacific Family Health Associations

With increased links being drawn between HIV and sexual reproductive health, Australia supports the Pacific Family Health Associations (FHAs) to improve their overall organizational capacity, including governance, management, advocacy and service delivery. Fiji benefits from this Program through the provision of budgetary support and capacity building of the Fiji Reproductive Health Association.

The Pacific Islands Program

This program supports specialist consultants to provide surgery in Pacific countries, in consultation with Ministries of Health. Fiji has benefited significantly from this Program, with surgeries being conducted in country by teams focused on cardiac surgery and pediatrics. In collaboration with NZAID, AusAID is supporting various Ministries of Health to establish a small team of technical advisers to assist PICTs with planning, needs assessment, coordination and monitoring of specialised clinical services.

The Health Systems in Transition (HiT) profile

HiT is a country-based report that provides a detailed description of the health care system and of reform and policy initiatives in progress or under development. The report contains a section on human resources for health, including an overview of the situation and specific health workforce statistics. HiT is currently being undertaken in Fiji under WHO auspices and coordinated at FSMed.

AusAID Bilateral Support to the Fiji Health Sector

Australia currently provides significant bilateral support through the current Fiji Health Sector Improvement Program (FHSIP). FHSIP commenced in October 2003 and was initially expected to end in December 2009. The Program was extended for a further 12 months to December 2010 to facilitate, as far as possible, a seamless transition from the current FHSIP to the new program of assistance that will begin in 2011.

The AusAID Women and Children's Knowledge Hub for Health in Fiji

Under the auspices of the Women and Children’s Knowledge Hub, and with support from AusAID through FHSIP, a recent Child Healthcare review (Aug 2010) was undertaken in Fiji to make recommendations on improving child health services, including clinical services for child health care, the Integrated Management of Childhood Illness (IMCI), the Expanded Programme of Immunization (EPI), the Baby Friendly Hospital Initiative (BFHI), child nutrition, health information, research and surveillance, and monitoring and evaluation.

The recent Child Healthcare Review highlighted the importance of newborn health initiatives in national efforts to improve child survival and accelerate progress towards MDG4. One aspect of improving quality of newborn care in Fiji is improving follow-up care for seriously-ill newborns after hospital discharge To address this issue, the paediatric team at CWMH in collaboration with the WCH (through Centre of International Child Health (CICH), University of Melbourne), UNICEF Pacific and the Carabez Alliance have established the Newborn Integrated Care Initiative. In 2010-2011, through undertaking a baseline outcomes assessment, this initiative will seek to establish local long-term newborn morbidity data. This data will then be used to assist development of clinical practice guidelines for follow-up care of newborns discharged from intensive care services in Fiji.

FHSIP has been supporting the development of the Clinical Practice Guidelines via the Clinical Services. The aim is to improve the quality of care for patients, reduce unnecessary or harmful treatment, and reduce wastage of limited resources. The CPGs for paediatrics have been determined as IMCI for outpatient care, the WHO

Pocketbook for inpatient care at all levels and the more specialist guidelines, for NICU, PICU etc that are not contained within the WHO Pocketbook. In 2010 the WCH will be providing the training for the WHO Pocketbook for inpatient care. This is will provide important upskilling of all doctors in providing paediatric hospital care at all levels.

b) Other development partner activities with potential synergies with the proposed AusAID program of support

WHO

Village Health Worker (VHW) pilot initiative

With seed funding from the Government of South Korea, WHO is piloting an initiative to strengthen community-based services by village health workers (VHW) in the Rewa Sub-division of Central Division. The pilot will review and revise the MoH VHW curriculum and the definition of service packages. Fifteen selected VHWs from the Rewa Sub-division will be trained in public health monitoring, health promotion and disease prevention, minor first aid and referral to other health services. Their immediate zone nurse supervisors will also receive training in supervision including the use of indicators to monitor the work of the VHW. The zone nurse supervision training will be linked to the JICA In-service Training (IST) project: Community Health Nurses Management programme. The pilot project will be evaluated six months after completion of training (June 2011).

Strategic Planning

WHO expects to provide technical support for the development of the new National Health Strategic Plan, beginning in late 2010.

Health Financing

One round of National Health Accounts (NHA) was completed in 2005. In a collaboration between WHO and the Fiji School of Medicine, a second round of the NHA is expected to be completed mid 2010. WHO is also providing technical input to establish a Health Care Financing Unit in the Ministry of Health, including a NHA team, and will provide ongoing technical support to consolidate the HCF unit. In addition, WHO seeks to support research about the use of information produced through NHA for policy making.

Human Resources for Health

WHO provided technical assistance in the review of the Fiji Health Workforce Plan Phase 1 in 2009 and Phase 2 in 2010. Technical assistance was also provided by WHO for the review of the role, functions and structures of the Fiji Nurses, Midwives and Nurse Practitioners (NMNP) Board in preparation for the movement of nursing and midwifery education from the Fiji MoH to the FNU College of Medicine, Nursing and Health Sciences.

The Pacific Human Resources for Health Alliance (PHRHA) collaborates with the Ministry of Health and are working together to prepare and pilot a basic HRH course and toolkit adapted specifically for use in the Pacific.

WHO has established a collaborative partnership with the Fiji School of Nursing and James Cook University (JCU), Townsville to: upgrade the School of Nursing curriculum, facilities and teaching staff; develop a clinical governance model for nursing with appropriate nursing competencies and standards for Fiji; develop and implement a curriculum for Mental Health in 2006; review the curriculum for Midwifery.

Pacific Open Learning Health Net (POLHN)

WHO has provided technical support to establish 3 Open Learning Centres (OLCs) and

delivered over 25 courses last year with over 100 students from Fiji and is providing ongoing training of academic staff at Fiji School of Medicine (FSMed) in the development and delivery of online courses including courses in the Masters in Public Health programme resulting in the availability of an online Diploma in Public Health from FSMed. WHO is also increasing access to POLHN course through establishment of mini POLHN sites at 11 sites including all of the sub divisional hospitals in Fiji.

Maternal and child health and nutrition

In collaboration between WHO and UNICEF, all 21 public hospitals with maternity facilities in Fiji have been declared Baby Friendly. WHO has collaborated with JICA to provide support for the development of the National Nutrition Policy which has been endorsed by cabinet. WHO has supported the development of the National Food Based Dietary Guidelines developed, which have been endorsed for implementation. WHO plans to scale up the implementation of the nutrition policy with community based programmes, and provide support to the implementation of Food based Dietary Guidelines in the context of a communication campaign.

Non-communicable diseases (including diabetes) and mental health

With technical support from WHO, the Fiji STEPS Report was published in 2005, which provided the scientific and national data on the key NCDs and their risk factors. Based on the key results, the Fiji National NCD Strategic Plan 2004 - 2008 was developed and implemented. WHO is also implementing an outpatient clinic pilot to improve the management of type 2 diabetes among patients with high fasting blood sugar through an intensive education programme.

WHO proposed and supported a mental health outreach program, which includes overseas experts for visits and for mentoring of MoH staff.

Global Fund

The recently signed Round 9 GF support to the MoH for Health Systems Strengthening will include the development of a National Policy for Health Information and a National Health Information Strategic Plan (2010-2014). The GF grant will also support the upgrading of the MoH's IT system through the provision of computers to all 19 Sub-Divisional Hospitals and 76 Health Centres together with running costs and four Divisional IT systems support staff. In addition GF will support the establishment of a National Health Information Manager, two Statisticians and a Project Officer within the MoH's Health Policy, Planning and Information Unit, as well as three Divisional Health Information Officers in Central, Northern and Western Divisions. GF will also support the training of 200 nurses at HC and NS levels on HIS management including analysis and evidence-based decision making.

JICA

JICA is implementing a project (NB-IST) to strengthen Need-based In-service Training for Community Health Nurses in Fiji, Tonga and Vanuatu. In Fiji, the project was piloted from 2005-2008 at a model site in Central Division and JICA is currently working with the Department of Human Resources in the MoH to formulate a Policy Package for the integration of NB-IST into the overall IST system, prior to rolling it out across all four Divisions. The initiative focuses on strengthening nurse supervision by identifying at the Divisional and Sub-Divisional levels the in-service training needs of nurses and providing supervision and coaching from the Sub-Divisional Health Office to Community Nurses at Nursing Stations.

JICA has also indicated that it may continue to provide support to strengthening EPI though vaccine management and cold chain support, although at the time of writing this remains unconfirmed.

UNICEF

UNICEF is supporting a range of activities including strengthening MCH/EPI through immunizations/vaccines/cold chain support and the promotion of breast-feeding through the Baby Friendly Hospital Initiative, in conjunction with WHO.

The UNICEF Pacific Program provides child immunisation in PICTs, with additional funds being available for specific immunisation interventions in other high-risk Pacific countries, subject to agreement with UNICEF. Through the assistance of this program Fiji recorded a 94% immunization coverage rate. However, recent assessments in Fiji have indicated a significant decline in immunization coverage, indicating the need for sustained support in this area.

UNFPA

UNFPA is supporting the Regional Reproductive Health Training program and the Men as Partners in Reproductive Health initiative (with ILO). UNFPA also supports RH commodity security within the region, although Fiji purchases all it own RH commodities. UNFPA has recently supported the Health Facilities Survey in relation to emergency obstetric care (EmOC) and the survey document is expected to be released in the coming months.

2. Specific opportunities for FHSSP to integrate with the work of other health development partners and build on other AusAID-supported initiatives.

A major focus of FHSSP is supporting the MoH to achieve its MDGs 4 and 5 (Objectives 1 and 2 of the Program). The Program will integrate the work of UNICEF in strengthening MCH/EPI through immunizations/vaccines/cold chain support and the promotion of breast-feeding through the Baby Friendly Hospital Initiative, in conjunction with WHO. In seeking to reduce maternal mortality by strengthening Emergency Obstetric Care (EmOC) the Program will draw upon the Health Facilities Survey supported by UNFPA in relation to emergency obstetric care (EmOC)[38]. Much of the work being undertaken by WHO, UNFPA, FSMed and UNICEF is being supported in part by AusAID – generally through its regional programs.

FHSSP will also collaborate with, and where appropriate, support selected activities of the AusAID Women and Children's Knowledge Hub for Health in Fiji. These include: prioritizing and taking forward the key recommendations presented in the recent Child Healthcare Review[39]; drawing on the findings from the baseline outcomes assessment of neonatal morbidity; supporting the development of clinical practice guidelines for follow-up care of newborns discharged from intensive care services; supporting locally appropriate systems and guidelines for monitoring child development to facilitate early identification of developmental disabilities.

Under Objective 3, FHSSP seeks to improve the prevention and management of diabetes and hypertension at decentralised levels. With technical support from WHO, the Fiji STEPS Report was published in 2005, which provided scientific and national data on the key NCDs and their risk factors, including diabetes and hypertension. The AusAID Program will draw upon the findings of the 2nd Fiji NCD STEPS survey to

[38] EmOC Survey Document is now in draft form and is expected to be published in the coming months

[39] Russell, F., Child Healthcare Review, 22 August 2010, Report prepared for FHSIP

be undertaken in late 2011 to provide baseline data in relation to diabetes and other NCDs. In addition, the Program will draw upon the Regional NCD Strategic Plan currently being implemented by the Secretariat of the Pacific Community (SPC) with AusAID support.

Under Objective 4 FHSSP seeks to revitalize the Village/Community Health Worker (VHW/CHW) system. FHSSP will liaise closely with WHO and build upon their ongoing VHW/CHW pilot initiative in the Rewa Sub-division of Central Division, initiated with seed funding from the Government of South Korea. The pilot will review and revise the MoH VHW curriculum and the definition of service packages, and conduct training of VHW/CHW. Zone nurse supervisors will also receive training in VHW/CHW supervision including the use of indicators to monitor the work of the VHW/CHW. The zone nurse supervision training will be linked to the JICA In-service Training (IST) project. The pilot project will be evaluated six months after completion of training (June 2011), and FHSSP will draw on the lessons learned by this pilot to scale up and roll out the initiative across all four Divisions.

As a sub-component of its Objective 5 (health systems strengthening), FHSSP will support strengthening of the MoH Health Information System (HIS). Activities supported under this objective will complement and harmonize with those to be implemented under the recently signed Round 9 Global Fund (GF) support to the MoH for Health Systems Strengthening. GF support includes the development of a National Policy for Health Information and a National Health Information Strategic Plan (2010-2014). In addition, the GF grant will support the provision of computers to all Sub-Divisional Hospitals and 76 Health Centres, together with running costs. GF will also support the engagement of health information staff at central and divisional levels and the training of 200 nurses at health centre and nursing station levels on HIS management. However, GF support does not extend to the existing public health information system (PHIS), nor to the systematic use of public health data for policy, planning and improved service delivery - areas that FHSSP will focus upon under this sub-component. FHSSP will draw upon the human resource and IT support provided under GF, and when developing its activity plans FHSIP will liaise closely with the implementing unit for the GF support (the Principal Recipient at the MoH) to ensure that activities are fully aligned.

A further sub-component of Objective 5 is support to strengthen facilitative supervision at decentralised levels. The Program will work in close collaboration with JICA's ongoing project supporting Need-Based In-service Training (NB-IST) for Community Health Nurses. The JICA project was piloted from 2005-2008 at a model site in Central Division and JICA is currently working with the Department of Human Resources in the MoH to formulate a Policy Package for the integration of NB-IST into the overall IST system. The Program will build on the work of JICA and incorporate the lessons learned in a broader system of support to facilitative supervision.

FHSSP will draw upon, (and support where appropriate), ongoing and planned evaluations and operational research initiatives to strengthen evidence-based policy, planning and service delivery in Fiji. This includes WHO's work on Fiji's Health Accounts to track and analyse Fiji's public and private health expenditure trends; a further expansion of the analysis on the Fiji component of the WHO and UNSW work on the regional health mapping exercise to determine the impact of social and demographic changes to the current health infrastructure, the Fiji Health Workforce Plan Phase 2 and the EmOC Health Facilities Survey supported by UNFPA. The Program may commission new operational research and/or undertake additional analysis of existing data sets to address identified information gaps. Operational research and critical analysis will provide a sound platform on which to base long-term AusAID assistance to Fiji's health sector. It is anticipated that the Fiji HiT will

identify areas for policy research and development that could be supported under FHSSP.

Finally, FHSSP will build upon and integrate the work that has been implemented through the earlier Fiji Health Sector Improvement Program (FHSIP) in both public health and clinical areas. A listing of the relevant outputs of the FHSIP and the areas where they will be integrated into the program are shown in Annex 10. Although they lie outside of the focal areas of the new Program of Support, a small number of activities initiated under FHSIP require additional funding (e.g. support to the mental health program), and the new Program includes an unallocated fund, to enable support to be continued to selected FHSIP initiatives.

Indicative linkages of FHSSP with AusAID's Regional Programs

Regional Program	Linkage with the proposed Program
Regional NCD program (SPC/WHO)	There are several area of potential linkage with this regional program: • In late 2010, the regional program will support the 2nd STEP program which will provide valuable baseline data for diabetes and other NCDs that will be taken up by the proposed program. • Health promotion activities within the regional program that seek to encourage healthier lifestyles (exercise, diet etc) will support FHSSP Objective 3 (prevention and management of diabetes) • FHSSP can draw upon planning activities undertaken by SPC in relation to NCD
Regional HIV/AIDS program	Given the high reported levels of STIs in women attending for ANC, FHSSP could draw upon the activities implemented under PRSIPll to leverage support to addressing STIs, especially among pregnant women.
Support for FSMed	FSMed is a key training and research institution in Fiji. As such, they should be encouraged to submit competitive tenders to undertake operational research activities within the Program. FSMed also have capacity to provide short term training in both technical and management area will be an asset to the Program.
Pacific Human Resources for Health Alliance	This project is being coordinated by WHO, which acts as the PHRHA Secretariat. FHSSP should maintain links with the project through work that is being supported on workforce issues including the implementation of recommendations relating to the nursing workforce review
Support for Multilateral agencies	AusAID support for WHO and UNICEF is particularly relevant to objectives 1 and 2 (infant and maternal mortality) and objective 4 (village health workers)

Regional Program	Linkage with the proposed Program
Support for a number of NGOs • Support for Marie Stopes • Other NGOs	Given the reported high levels of STIs in Fiji and high unmet need for family planning, Marie Stopes can be a key FHSSP partner in expanding their condom social marketing program and promoting the use of condoms and other barrier methods for dual protection against pregnancy and STIs. Some consideration is being given by AusAID to support an NGO based in Lautoka called FRIEND, through their “Prism” project. This project addresses NCDs, and especially diabetes, primarily in peri-urban areas the settlements. FRIEND has submitted a “Prism” proposal to AusAID for consideration, although it was felt that the budget and sustainability components needed review and revision.

Annex 10: FHSIP Activities Integrated into FHSSP

The Independent Completion Review of the FHSIP identified many important achievements both within the public health and the curative health sectors. The design of this program builds on a large number of these achievements and continues to use them to strengthen the overall capacity of the health sector. These include:

FHSIP Achievement	How used to achieve objectives in this Program design
General - across both clinical and public health	
A flexible and responsive financial mechanism was put in place that facilitated the implementation of many activities	Modality modified to reflect changes to AusAID's financial policy guidelines
The Fiji School of Nursing was strengthened and is now in a position to provide a wider range of special training and has a limited research capacity	The program will give consideration to using FSN (FNU) in training eg offer post basic training in management and administration and may be called upon to work with others to provide special *in-service training* in areas such as IMCI,
Development of midwifery training at Lautoka Hospital	Midwives will play an important role in the MCH activities throughout this program. The increased output from Lautoka will be welcome provided positions are established for them within the MOH
Nursing standards have been developed and nurse competencies are in process of being developed	These will be fed into the MOH nursing unit, and subject to agreement within MOH, the program will support the roll out of these and continue training in their understanding and application.
Nurse work force plan and commenced support for implementation of recommendations	No specific plans to continue this support.
Health Workforce Review has been done and in process of developing a Health Workforce Plan (due Nov '10). As far as practical will take account of the Clinical Services Framework	No plans to provide specific support for this although implementation of the HWP will be taken into context of annual planning
The capacity and systems within the Fiji Pharmaceutical Services Store have been strengthened. However, drug stocks needs to be continually monitored to avoid stock outs,	No specific support is planned for FPSS .

Widespread in-service training across the sector in both technical public health and clinical areas • Eg EPI/ cold chain • Frontline management • planning • Clinical areas • Attachments overseas • Twinning relationships with Australian institutions	A strong program of in-service training will continue but areas for this training will be defined by the PCC
Public Health	
A strong program of support for planning to address NCDs including • A national NCD strategic Plan • A National Eye care Plan • Strengthened dental services – now has a CSN	Will make use of MOH NCD Strategic Plan and the Eye Care Plan as important guiding documents in program implementation in relation to diabetes
Supply of NCD "tool kits" to enable heath facilities to better screen and manage diabetic patients.	These will be important elements in the Diabetic Program within this overall Program. Although the great majority of facilities were supplied with NCD tool kits, the Program will continue to supply some kits and "strips" to assist screening
Initial work to improve foot care for patients with diabetes and a program of home based foot care introduced at National Diabetes Centre and CWM (still in its embryo stage)	This will be continued and extended
There has been a program to train nurses at the public health level (eg sub divisional hospital level to identify mental health patients and refer them for further assessment (eg by an outreach clinic) Also in relation to mental health a community education program has been developed – but needs to be rolled out more widely	While not falling within the core objective, the design team would consider this as an important option for continuation within the unallocated funding pool,
Support for National Health Promotion Centre and health	Support will be provided to NCHP to conduct integrated media campaign aligned with the

promoting settings	VHW/CHW initiative
Provision of radio telephones to health facilities at all levels – solar power to selected centres	The design team recognises the importance of radio telephones and notes that during the FHSIP transition period training is to be given in the maintenance of these units
Use of the Project Office model to strengthen capacity and "focus" across a large number of areas.	Subject to need and ongoing discussions with the PSC project officers could be included on a limited basis in specific areas.
Improvements to the EPI vaccine coverage rates through changes at the FPSS level and at the public health level through the use of project officers	This work needs to be continually enhanced as part of the Child Health Element of the program
Introduction of the PHIS for the collection of data from individual health facilities. A workshop planned to review PHIS (July '10). Global Fund is helping strengthen Health Information in MOH and may look at training staff in "how to use" the data from PHIS	This will need to be extended and reviewed to improve the analysis of data and to make it more "real time" so that it can be used to detect problems and assist with planning As the global fund is also doing work in the area of Health Information, it will be important for FHSSP to liaise closely with the GF PR to ensure harmonisation of activities and to share plans and results
Curative Health	
Introduction of the concept of Performance enhancing projects to encourage innovation and operational research by individuals or groups of staff. While this has been mainstreamed by the MOH, the constraints posed by bureaucratic public sector systems have been a disincentive. Note that these PEPs also have relevance at the public health sector	
Introduction of a program of risk management /clinical quality improvement, initially at Divisional hospital level and in latter stages at selected subdivision level	Continued work to expand this work to the Sub-Divisional level and even to the HC level will likely lead to improvements in the quality of care but will need to extend beyond the life of this Program as this represents a significant long term change.
Development of a clinical services plan and establishment of a Clinical Services Advisory Committee	These will continue to be supported
Establishment of Clinical Services Networks	Networks in obstetrics, paediatrics and medicine will be important elements of the program of support.

Clinical services framework	Will continue to be an important guiding document; and will be reviewed during the life of the Program
Emergency Paediatric Life Support – Additional visit from Aust planned for 2010. to result in Accreditation so that CWM can become an accredited training unit to run courses for other hospitals in the country	It is understood that this will continue to be supported during the Transition to ensure sustainability. Although it is an important aspect of this program's objectives, decisions as to whether to commit more funds will be made by the PCC
Emergency Maternal and Obstetric Care (EmOC). Additional visit from Aust planned for 2010. to result in Accreditation so that CWM can become an accredited training unit to run courses for other hospitals in the country	As for the EPLS (see above)
Continued strengthening of PATIS including Coder training and training of doctors in how to use PATIS in patient care (this is still ongoing)	No specific plans to continue this support.

Annex 11: List of Key Stakeholders Consulted

Australian Embassy, Suva	
Ms Sarah Roberts	Acting High Commissioner, AusAID
Ms Judith Robinson	Minister Counsellor, AusAID
Ms Sarah Goulding	Counsellor, AusAID
Ms Paulini Sesevu	Senior Program Manager, AusAID
Ms Margaret Logavatu	Program Manager, AusAID
Ms Kirsty McNeil	Acting Counsellor, DFAT
AusAID, Canberra	
Jim Tulloch	Consultant Health Advisor
Joanne Greenfield	Health Adviser, HHTG
Sophia Close	Fiji Focal Point
Tim Gill	Pacific Health Branch
Ministry of Health Headquarters	
Dr Salanieta Saketa	Permanent Secretary for Health
Dr Eloni Tora	Acting Permanent Secretary and Dep Sec Hospital Services
Public Health	
Dr Joe Koroivueta	Dep. Sec. Public Health
Dr Josaia Samuela	National Advisor, Family Health
Clinical Services	
Mr Josefa Bolaqace	National Coordinator Blood Services
Mr Phillip Chew	National Manager Ambulance Services
Ms Kelera Bahbasaga	A/Principal Admin Officer – Hosp Services
Mr Jonisio Mara	Director Fiji Pharmaceutical Services
Dr Ifereimi Waqainaete	Medical Superintendent Curative Services/ Consultant Surgeon
Sr Selina Ledua	A/Director Nursing Services
Milika Narogo	Health System Standard/National Risk Manager
Infrastructure, Planning & Health Information	
Ms Laite Cavu	Director
Finance and Corporate Services	
Ms Alefina Vuki	Dep. Sec. Finance and Corporate Services
Ms Jennifer Turaga	Act. Principal Admin Post Processing

Ms Filomena Browne	Act. Principal Admin Personnel
Ms Maria Furroubit	Act. Principal Accts Officer
Mr Albert Rosa	Director Human Resources
Mr Alefin Vuka	A/DSAT
Central/Eastern Division Meeting	
Dr Frances Bingwor	Divisional Medical Officer – Eastern Division
Dr Dave Whippy	Acting DMO – Central
Dr Ifereimi Waqainabete	Medical Superintendent, CWM Hospital & Consultant Surgeon
Dr James Fong	HOD O&G
Dr Jai Narayan	HOD Ophthalmology
Dr Paula Narkobea	HOD Radiology
Dr Shrio Acharya	HOD Internal Medicine
Dr Amelita Mejia	Acting HOD paediatrics
Dr Gyaeshwar Rao	Consultant, Internal Medicine
Dr Jiesa Baro	Principal Dental Officer, HOD Oral Health
Dr Josese Vuki	HOD A&E
Dr Enosi Takoga	HOD Surgery
Dr Eka Buadromo	HOD pathology; Chair Pathology CSN
Sr Penina Druavesi	Manager Health – Community Health Central
Dr Shrish Narayan	Medical Superintendent & Psychiatrist St Giles Hospital
National Centre for Health Promotion	
Dr Pita Vuniqumu	Acting Director/Advisor NCHP
Tailevu Subdivision Hospital	
Dr James Kalougivaki	Medical Officer In-Charge
Naquali Health Centre	
Dr Praneed Krishna	Medical Officer
Sub-Division Vunidawa; Natisari Subdivisional Hospital	
Dr Kaleli Vuinimasi	Medical Officer In-Charge
Western Division	
Dr Tharid Ali	Divisional Medical Officer – Western Division
Dip Chand	Divisional Health Inspector
Dr Jone Waqaleru	Divisional Dental Officer

Kanchan Kumar	Divisional Dietician
Pasmaca Vatu	Manager Corporate Services
Dr Praveena Ali	SD Medical Officer
Lautoka Hospital	
Leslie Boyd	Matron Administrator
Saras	Risk Management Unit
Oripi N	A/Manager Nursing
Dr J. Tudrava	A/MS Lautoka Hospital
Aseli Raikubakous	Principal Pharmacist
John Brown	Supt Radiographer (previously PO Asset Management)
Setaita Bulai	Infection Prevention and Control Officer
Ba Sub-Division Hospital	
Tageeta Singh	Dietician in-charge
Kelera Ubitau	Act-Sr in Charge
Ivona Tavuki	A/SDHS
Keleri Oli	Health Inspector
Dr Tonka Tamam	SDMO
Dr Penaia Semtabula	A/SDO
Nialaga Health Centre	
Dr Joyce	
S/N Lulsa Lubi	
S/N Ana Vulalevu	
S/N Sujata Kumari	
Ba Health Centre	
Dr Manasa Baleinanau	
Dr Mairini Baleinamau	
Western Divisional Meeting	
Dr Tharid Ali	DMO
Dip Chand	DHI
Dr Jone Waqalevu	DDO
Sr Karalaini Macanawai	DHS
Pasemace Vatu	MCS
Dr Praveena Ali	SDMO L/Y
Dr Torika Tamani	SDMO Ba
Dr Sravaniya Dasi	SDMO Tavua

Dr Charlie Rasue	SDMO Rakiraki
Dr Samu Kailawacoko	SDMO Nadi
Dr Deo Narayan	Consultant Physician
Dr Luisa Cikamatana	Consultant Ophthalmologist
Dr Jemesa Tudrava	MS Lautoka Hosp
Losana Ugavule	Hosp Admin
Sr Oripa Nuimataiwalu	MNS
Dr Arun Murari Lai	Consultant Surgeon
John Brown	Supt Radiographer
Sr Saras Kumar	Manager RMU
Venkat Swami	Senior Biomedical Technician
Arthur McGoon	Supervisor hospital services
Siri Ram	EO
Temo Ravulu	HQ Planning Unit
Dr Margaret Cornelius	FHSIP
Peter Vanderwaal	FHSIP
Nasau Health Centre	
S/N Arti	
S/N Roshni	
Ra Maternity Hospital	
S/N Udite Kanagagai	
S/N Saimiana Tunakau	
S/N Vallawa Tuigaloa	
Ra Sub-Divisional Hospital	
Charlie Rasue	A/SDMO
S/N Amali Kovonawa	
Naiuukuloa HC	
Dr Vivek	MO
Labasa Hospital	
Dr Jaoq Vulibeci	Medical Superintendent
Rajendra Sheromani	Lab-in-Charge
Dr Mereoni Voce	A/HOD A&E
Ilisabeta Pesamino	A/Principal Pharmacist
Dr Anne Veu	Medical registrar – Int. medicine Unit
Dr Zia Tuiyasawa	A/Senior Dental Officer
Froni Cevamaca	A/CHA

Luisa Sivo	A/MNS
Dr Abhay Choudhari	A/Consultant Surgeon
Dr Frangel Chipongian	O&G Dept.
Dr Dennis Buenafe	Acting Med Super
Josinne	Physiotherapist
Sainimere	Dietician
Labasa Public Health Division	
Dr Samuela Korovou	Divisional Medical Officer, Northern
Losena Yabaladna	A/SDHS, Macuata
Titilia Dakuliga	A/ DW Health sister (N)
Siliveni Hazelman	SDHS Cakaudrove
Silipa Calalevu	Risk Unit Manager – Labasa Hosp
Sugu Daunipolau	A/semior Administration Officer
Setareki Siowani	SDMO Cakaudrove
Vakatoloma Yavala	Nurse practitioner, Naduri
Labasa Hub Centre	
Asivorosi Tora	HIV Project Assistant
Latileta Bau	S/N
National Diabetes Centre	
Dr Isimeli Tukana	National Advisor NCD Prevention and Control
Dr Luciana Marda-Tuiloma	MO in charge, National Diabetes Centre
Fiji School of Medicine (FNU)	
Dr Ian Rouse	Director
Wayne Irava	
Dr Graham Roberts	Director Research
Berlin Kator	
Kamal Kishore	
Annie Rodgers	
Albert McLaren	
Ministry of National Planning	
Mr Krishna Prasad	Acting Deputy Secretary
Mr Shiu Raj Singh	Sectoral Division, Planning
Ministry of Finance	
Ms Sereima Bulounicoasa,	Aid Unit, MoF
Public Service Commission	

Mr Parmesh Chand	Permanent Secretary
Iva Tavai	Deputy Secretary
Kelera	Director HRM
Ms Jitoko	Director, Training
Strategic Framework for Change Coordination Office	
Mr Philimani Kau	Deputy Secretary
WHO	
Juliet Fleischl	Technical Officer, Human Resources & Health Systems
Lkhagva Vanchinsuren	Pharmaceuticals
Renee Dodds	Comms and resource mobilisation
Zamberi Sekawi	Laboratory
Jacob Kool	Communicable Diseases
Li Dan	NCD Medical Officer
Rosalina Saaga-Banuve	Pacific Human Resources for Health Alliance
Monica Fong	HSD and Nursing
Temo Waqanivalu	Nutrition & Physician affairs
Martina Pellny	HSD & Health Care Financing
Raul Bonifacio	EPI
Linh Nguyen	TB & leprosy
Steven Iddings	EH & Emergency Response
SPC	
Dennie Iniakavala	Section Head, HIV & STI Section, Fiji
Lara Studzinski	Health Management Team Coordinator, Fiji
Jason Mitchell	Exe3c officer, Fiji
Robert Verebasaga	Program Development Officer, Response Fund, Fiji
Bill Parr	PHD Director & SRD Director, Noumea
Viliami Puloka	Healthy Pacific Lifestyle Section Head (NCD program), Noumea
Tom kierdzynski	PHS & CDC Section Head, Noumea
JICA	
Nariaki Mikuni	Deputy Resident Representative, JICA Fiji Office
Miyuki Harui	Project formulation Advisor (Health)
Nila Prasad	Program Officer
UNFPA	
Mr Dirk Jena	Director and Representative

Dr Annette Sachs Robertson	Deputy Director and Deputy Representative
Mr Isikeli Vulavou	Programme Associate
PC&SS	
Joanne Cohen	Director
Sandep Prasad	Finance Manager
Aleta	Counselling Services
Fiji Nurses Association	
Kuini Lutua	General Secretary
Tarai Nakolinivalu	Representative of the Nurses Council
FRIEND	
Sashi Kiran	Director
Dr Anumesh	Medical Officer
FHSIP	
Dr Vilikesa Rabukawaqa	Prog Director
Peter Vanderwal	Programme Administrator
Dr Margaret Cornelius	Coordinator Clinical Services
Sr Ateca Lepper	Senior Project Officer Nursing
Clare Whelan	Risk Management Advisor
Keleni Bolatagici	Project Officer Health Systems Development
Vasiti Nailele	Office Manager
Annu Pillay	Finance and Administration Officer
Keleni Bolatagici	Project Officer
Krishniel Singh	Project Officer
Florence Masianini	Project Officer
Dr Boladuadua	FHSIP Project Officer, Clinical Service Guidelines

Annex 12: List of Documents Reviewed

MOH National Strategic Plan 2007-2011

MOH Annual Report 2008

MOH Draft Annual Report 2009

MOH organisation Structure

MOH Fiji Non-Communicable disease STEPS survey 2002

Fiji National Nutrition Survey – National Food and Nutrition Centre, Suva

Fiji Household Income and Expenditure Survey 2002-03

MOH budget papers 2010 and draft forward estimates 2011-2012

FHSIP Activity Completion Report

FHSIP Building Sustainable Partnerships for Health; Transition Phase 2010

FHSIP Transition Period Annual Plan and Budget 2010

Fiji Health Sector Improvement Program (FHSIP) Independent Completion Report, Draft 3rd May 2010

Miscellaneous reports and reviews conducted by FHSIP

Fiji Health Sector Situational Analysis, December 2008

Strengthening Capacity of the Fiji School of Medicine – Program Design Document

Fiji Islands - Economic Review prepared by Emma Ferguson, ADB

Fiji's Far reaching Population Revolution – Prof Wadan Narsey - USP

ODI - Senior Level Forum on Development Effectiveness in Fragile States Harmonisation and Alignment in Fragile States

Achieving the health Millennium Development Goals in Fragile states Abujan -2004 High Level Forum on the Health MDGs

AusAID Program Design Guidelines and reporting templates

ODE Evaluation of Health Service Delivery in Melanesia

Cairns Compact

AusAID Fiji Program Annual Program Performance Review

Performance Management and Evaluation – AusAID policy document

AusAID guidelines Activity level Monitoring and Evaluation

Good Practice Hints Series – A checklist for Consideration: Monitoring and Evaluation Framework - AusAID

Design Team Kit – Design Rules and Tools AusAID 2009

Fiji Country Analysis – Asia and Pacific Representatives Meeting UNICEF 2008

Prevention and control of non-communicable diseases - UN General Assembly April 2010

Madang Commitment: Report of the Pacific Island Countries - the Health Ministers Conference, Madang PNG in 2009.

Takitaki. The newsletter of FRIEND – a Nadi based NGO

MoH – JICA Project of Strengthening the Need-Based In-Service Training for Community Health Nurses: Project design Matrix

UNFPA Pacific Sub-Regional Office: Strategy and Policy Document 2008-2011

Reproductive Health Policy – Draft May 2010, Ministry of Health, Fiji

Health Systems in Transition (HiT) DRAFT Vol.1 No. 1, 2010, The Fiji Islands Health Systems Review

Russell, F., Child Healthcare Review, 22 August 2010, Report prepared for FHSIP