Solomon Islands
Ministry of Health and Medical Services
Health Sector Support Program
HSSP
2007 - 2012

PROGRAM IMPLEMENTATION PLAN
PIP

Discussion Version 8.0 5July, 2007

CONTENTS

LIST OF ANNEXES

AHC	Area Health Centre
AUSAID	Australian Agency for International Development
CPR	Contraceptive Prevalence Rate
CBR	Community Based Rehabilitation
DOTS	Direct Observation of Treatment Short Course
DCU	Disease Control Unit
EPI	Expanded Program Immunisations
EPHF	Essential Public Health Functions
FP	Family Planning
GCC	Grand Coalition for Change
HES	Health Expenditure Survey
HIES	Health Income and Expenditure Survey
HIS	Health Information Systems
HISP	Health Institutional Strengthening Project
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HSPMA	Health Sector Planning and Management Adviser
ICD -10	International Classification of Diseases - ten
IMCI	Integrated Management of Childhood Illnesses
JICA	Embassy of Japan
MDG	Millennium Development Goals
MDR	Multi Drug Resistance
MOH	Ministry of Health (formerly MHMS)
MOV	Means of verification
MH	Mental Health
NAP	Nurse Aid Post
NNMR	Neonatal mortality rate
NMS	National Medical Stores
NRH	National Referral Hospital
OVI	Objective verifiable indicators
PHC	Primary Health Clinic
PHP	Public Health Promotion
PHS	Primary Health Services
PS	Permanent Secretary
PSC	Project Steering Committee
RAMSI	Regional Assistance Mission to Solomon Islands
ROC	Republic of China
RWSS	Rural water supply and sanitation
RHC	Rural Health Clinic
ROC	Republic of China
RWSS	Rural Water Supply & Sanitation
SIDS	Small Island Developing States
SIG	Solomon Islands Government
SIMTRI	Solomon Islands Medical Research & Training Institute
SMART	Measurable, Appropriate, Relevant, Time bound
SWAp	Sector Wide Approach
SWD	Social Welfare Department
STI	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendants

TFR	Total Fertility rate
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USHC	Under Secretary for Health Care
USHI	Under Secretary for Health Improvement
VBDCD	Vector Borne Diseases Control Division
WISN	Workforce Indicators of Staffing Needs
WHO	World Health Organisation

This document draws heavily on preparation work undertaken during 2005 – 2007 by joint donor missions, (jointly led by AusAID and The World Bank). Aide Memoires prepared by those missions for the Ministry of Health (MOH) have become the foundation of MOH thinking and MOH has used such documents extensively in the preparation of this PIP. Additionally the work of consultants employed under the SWAp Support Team and HISP and their advice to MOH is reflected in this document.

At the broadest level the aim of this document is to; provide a brief historical sketch of health issues in the Solomon Islands, (see **Part A chapter 1**), identify emerging trends, (see **Part A chapters 2**), and describe the MOH's proposed responses to those issues (see **Part A chapter 7**) - focusing specifically on the transition period from the end of the current AusAID funded project HISP in early August 2007 to end-December 2008. Post August 2007 program funding under the SWAp will be known as the Health Sector Support Program, HSSP.

The PIP details funding principally sourced from AusAID during this transition period. This document attempts to detail the specific activities envisaged for the first 18 months of the SWAp (see **Part A chapter 7** and accompanying activity matrices), describe institutional and implementation arrangements put in place to facilitate delivery of the planned program (see **Part B chapter 1**) and the monitoring and evaluation regimes set up to monitor implementation progress and evaluate impact, (see **Part B chapter 4**). There is a brief description of the factors leading to the choice of a SWAp as the preferred vehicle for future donor support to the Ministry of Health, (see **Part A chapter 3**), a summary of the agreements underpinning the SWAp, (see **Part A chapter 4**) and a description of the interrelationship and agreed roles for the donor community, (see **Part A chapter 5**).

A perspective is provided of the mid-term budget envelop (see **Part A chapter 6**), and the description of the program is set against an overview of the prevailing legal and regulatory framework; (see **Part B chapter 2**) for a description of financial arrangements and financial management and (see **Part B chapter 3**) for a description of procurement arrangements.

In parallel to the activities described in Chapter 7 the overall health budget also includes activities described in the Solomon Islands budget for 2007. The operational planning process for 2007 was supported by the previous AusAID project (HISP) and was reflective of an earlier set of priorities adopted by the MOH up to 2006. The PIP is referred to as covering a "transitional period" as it spans the move towards the eight strategic areas of The Solomon Islands National Health Strategic Plan 2006-2010 (NHSP). While these eight strategic areas underpin this PIP and the budget allocation from donor sources supporting a SWAP through the Health Sector Support Program, they are not directly reflected in the Solomon Islands budget appropriation for health – the "SIG" monies. Commencing in June 2007 the budget preparation cycle for Fiscal years 2008 and beyond will employ the planning templates and processes detailed in **Part A chapter 6** and future versions of the PIP will amalgamate "SIG" and donor monies under a single format based on the eight strategic areas of the NHSP.

The PIP is a constantly evolving document and should be seen in its current version not as a final description but as a document to be revised based on lessons of experience. Ultimately the PIP aims to encompass in a single document health funding from all sources,

donor, Development partners, and Solomon Islands, unified under the objectives of the eight strategic areas of the NHSP and measured against common performance and impact indicators.

1 HISTORICAL & EMERGING HEALTH SECTOR TRENDS IN THE SOLOMON ISLANDS

The improvements in health outcomes made by the Solomon Islands throughout the 1980's and early 1990's have flattened or reversed in recent years. High infant and maternal death rates and high fertility rates remain key challenges for the health system. While the health care system has had considerable success in ensuring staff, equipment, and drugs across a relatively wide network, the problems posed by endemic communicable diseases and maternal health issues need to remain a critical focus of the delivery system. Emerging challenges from HIV and diabetes mellitus add to the significant public health challenges facing the Solomon Islands.

The health system has made dramatic progress in re-establishing itself over the past three years following the end of civil conflict and has now reached system performance levels comparable to the pre-conflict situation. The challenge for the health system, both for central programmes and service delivery ion the periphery, is how to translate this recovery into a health system better able to improve health outcomes. System performance varies for different types of health service and for different provinces, suggesting that measures to improve performance should be flexible enough to respond to local contexts. Geographical access is clearly difficult in some areas and raises geographical equity issues. However, measures to improve health system performance also need to look at demand-side factors driving patient behaviour, options for providing (and financing) selected services through the non-public sector, and the technical quality of services. Staff accountability and incentives to ensure quality will also be central in improving system performance at this important juncture for health in the Solomon Islands.

Infant Mortality Rate In the Solomon Islands, the infant mortality rate (IMR)[1]—probably the best single indicator of overall health system performance in a low income country—remains high at 66 per 1,000 live births, but has improved significantly since 1986 when the IMR was estimated at 96 per 1,000 live births. A more recent small cohort study, subject to greater error than a census, estimated an IMR of 68 per 1,000 live births in 2004, indicating that the IMR in the immediate post-crisis setting is comparable to the late 1990's.[2] Nevertheless, the IMR in the Solomon Islands remains higher than in other Pacific Island countries and hides important regional variations—ranging from 60 per 1,000 live births in Honiara to around 70 in Guadalcanal and Isabel provinces (1999 Census). Information on urban-rural differences in provinces is not available, but higher IMRs in rural areas would be expected. Reliable data for child mortality are not available but the child mortality rate is known to be significant.

Malaria and acute respiratory infections (ARI) are the drivers of infant mortality and also account for over half of the total burden of disease seen in primary health care facilities. Together, they represent 77% of disease in children (malaria 36.5%, ARI 41.1%) and 53% of the total adult and child disease burden (31.8%, 20.9 % respectively) in primary care services. Given the importance of malaria as a driver of health outcomes, recent reported increases in incidence are of concern. Malaria incidence increased by 30% nationally from 1999 to 2003, after considerable reduction in the early 1990's. Following the relative stability brought by the arrival of the Regional Assistance Mission to the Solomon Islands (RAMSI) and the increased funding from the

[1] IMR from 1999 Census, which is the most recent reliable estimate.

[2] Solomon Islands Reproductive Health Surveillance System, reported in *Annual Report on Reproductive Health: Solomon Islands, 2004* (MOH, 2004).

GFATM, the malaria program in the Solomon Islands has been in a period of rebuilding. In the last two years there has been a significant improvement in the national annual incidence of malaria. The 2006 annual malaria incidence rate for Solomon Islands is reported as 156 per 1,000 population; a 4.2% reduction from the 2005 rate[3]. This national trend hides geographical differences. The annual malaria incidence rates for slide confirmed malaria are highest in Central and Guadalcanal Provinces, and Honiara city; with rates greater than 200 per 1000 population. Malaita and Makira provinces also recorded rates of more than 100 per1000 population. 72% of slide confirmed cases were reported as Plasmodium falciparum. ARI rates also vary considerably by province but have remained high, although largely static, in recent years.[4]

Fertility rate The Solomon Islands continue to have a high population growth rate and a very high fertility rate. Progress in reducing the total fertility rate (TFR) has been slow, decreasing from 4.7 in 1995 to 4.05 in 2001. More generally, reproductive health outcomes in the Solomon Islands remain problematic. There is evidence of serious risks during pregnancy, compounded by elevated fertility levels. Thus, the maternal mortality ratio (MMR) is high and may be increasing. The national MMR was estimated at 141.5 per 100,000 live births in 2004, up from 78.4 in 1997, but this again masks important differences between provinces. For example, 61% of reported maternal deaths in 2004 occurred in Malaita province. Malaria in pregnancy, high but stable at 7-8% since the late 1990's, is an important contributor to this pregnancy risk, as is the number of teenage pregnancies (14.4% in a recent study).[5]

HIV is not yet demonstrating an impact on health outcomes at the population level, as seroprevalence appears to be low, but high risk factors for an HIV epidemic and the experience of neighbouring Papua New Guinea make HIV a major concern. The recent HIV surveillance study reported no cases of HIV in surveyed women attending antenatal clinics but found high prevalence of sexually transmitted infections. Similarly, the behavioural surveillance component reported reasonable knowledge about HIV transmission and prevention but also showed low rates of condom use, early sexual debut, and high rates of transactional sex.[6] Although the population HIV prevalence is currently low, the HIV prevalence amongst commercial sex workers, mobile workers, and other risk groups is unknown but of critical importance to targeting behaviour change strategies which prevent transmission in high risk groups and, ultimately, to the general population.

Diabetes mellitus is the other emerging disease on the policy agenda in the Solomon Islands, but the evidence that diabetes is having an important impact on health outcomes remains limited. Noting that reporting systems for diabetes are very inadequate, the cumulative incidence up to 2004, based on cases presenting to dedicated clinics in Honiara and some provinces, is low (4 per 1,000). However, 14% of admissions to the National Referral Hospital's general surgical service in 2004 were diabetes related and several provincial hospitals have set up diabetes clinics in response

[3] Annual Health Report 2006, Solomon Islands. Solomon Islands Ministry of Health, Division of Policy and Planning, National Health Statistics Office, March 2007

[4] Higher rates in Temotu, Isabel, Renbel.

[5] Solomon Islands Reproductive Health Surveillance System, reported in *Annual Report on Reproductive Health: Solomon Islands, 2004* (MOH, 2004).

[6] *STI/HIV Surveillance* (MOH, 2005). Syphilis prevalence 10%, Chlamydia prevalence 11%; 74% respondents never use condoms; 40% respondents younger than 14 years old at first sexual intercourse; 31% of female respondents reported ever engaging in transactional sex.

to an increase in patients. This raises the question of the cost implications to the health system of managing diabetes, even if prevalence is low. The upcoming STEPs survey and the health public expenditure review will help to understand these issues better.

Tuberculosis remains an important communicable disease and will become an even bigger health problem if HIV is allowed to spread into the general population. Tuberculosis control efficacy is not yet performing at the standards recommended by WHO. While the cure rate has increased in recent years, it has not yet attained pre-conflict levels and, at 72%, is below the international norm of 85%.

Health System Performance The health system has largely recovered after the civil unrest, with national programmes re-establishing themselves and health care services experiencing significant increases in utilization. This is in large part because of the commitment of peripheral health staff and MOH leadership to restore services and because of significant financing and technical support from development partners, particularly AusAID through the Health Institutional Strengthening Project (HISP). In primary health care, outpatient contacts increased by 14% from 2003 to 2004, part of a trend seen in most provinces since 2002, and have returned to 1997 levels. Outpatient utilization is now 2.6 contacts per capita in 2004— only 1.7 visits per capita for diseases other than malaria, which accounts for about 36% of outpatient visits. Increasing outpatient visits to the roughly four visits per capita expected in a population with the disease burden of the Solomon Islands may require more time. To do this, it is critical to ensure that the health system is responsive to population needs. However, indications of weak performance in some areas of the health system highlight the need to ensure the system can respond to this increasing demand for health care services.

National Referral & Provincial Hospitals The hospitals consume a significant portion of MOH and donor financing to the health sector, although a shortage of data makes it impossible to analyse this in detail. The Solomon Islands is served by seven provincial hospitals, three government funded, church operated rural hospitals and the National Referral Hospital (NRH) in Honiara. These account for a significant but not currently estimable proportion of health sector expenditure because, at the provincial level, hospitals are fully integrated into provincial budgeting and management processes. However, the 2005 Health Expenditure Review estimated that hospitals overall consumed 32% of total sector expenditure. The NRH alone consumed SBD 42.7 million, which was 22.7% of resources from all sources allocated to health services. This was equivalent to 79% of total recurrent expenditure on hospitals/clinics.

2 KEY ISSUES AND EMERGING PRIORITIES

The Solomon Islands National Health Strategic Plan 2006-2010 (NHSP) sets a sound basis for defining the Health Sector Support Program's (HSSP's) priority programs and outcomes. HSSP's programs and outcomes will be a subset of the government's priorities, selected from the NHSP strategic areas (see Table below).

Focus areas of the *National Health Strategic Plan 2006-2010*

Strategic Area 1 **People Focus**	**Strategic Area 5** **Non-communicable Diseases (NCDs)**
Strategic Area 2 **Public Health Programs**	**Strategic Area 6** **HIV / AIDS & STIs**
Strategic Area 3 **Malaria Program**	**Strategic Area 7** **Family Planning & Reproductive Health**
Strategic Area 4 **Childhood Diseases**	**Strategic Area 8** **Health System Strengthening**

*** The areas identified as the principle priorities for HSSP funding through AusAID are indicated by shading.**

The NHSP also sets out a range of indicators for these health program areas. They include outcome indicators of disease rates, such as the incidence/prevalence of malaria; indicators of mortality, such as under 5 mortality rate; and indicators of utilisation or uptake, such as contraceptive prevalence rate, EPI coverage, and the proportion of births attended by skilled health personnel. Priority outcome indicators are identified for the HSSP and, in parallel, a set of output and process indicators to guide program monitoring are defined.

The disease burden in the Solomon Islands is a mix of communicable public health issues and rapidly growing lifestyle diseases such as diabetes and, potentially, HIV. MOH services have been effective in responding to some of these areas but much less so in others, with notably low performance in programs such as family planning, facility-based deliveries, and diabetes prevention. Capital and recurrent financing and management capacity have been inadequate to run good quality services and outreach activities. Further, demand-side factors influencing lifestyle risk factors and health-care seeking behaviours have received little attention to date.

This sector context provides the HSSP with the principles for its support to the MOH, with a focus on improving targeted health outcomes. A synopsis of the eight strategic areas of the NHSP is at **Annex 1**.

2.1 Improving Planning and Budgeting

Refinements to the current MOH operational planning process have been supported during the preparation phase of the HSSP and are required to meet an improved and coordinated planning and budgeting cycle. Factors key to these reforms will be:

- Linkage to the budget can be achieved if the operational plans are produced by mid-year and are available to feed into MOH budget discussions with each unit;
- Operational plans need to be prepared within a budget envelope for each unit, so that activities are prioritized and costed within that budget constraint and those beyond the envelope are identified as standby activities;
- Activity implementation needs to be monitored and reported accurately to feed into the annual implementation review, which in turn will help MOH make sound decisions on the following year's budget allocations.
- Currently, hospital and clinic budget and expenditures are not differentiated by service facility. Few provinces maintain a separate budget or expenditure record of public health program activity and there is no capital vs. recurrent breakdown. MOH is moving toward a new accounting system for the provinces, so that they can better categorize and record expenditures. Under the HSSP, the system should be improved to include the following basic budget categories: (i) Facility (clinic expenses, hospital expenses); (ii) Expenditure category (capital expenses, salary recurrent expenses, non-salary recurrent); and (iii) Functional category (public health vs. curative care expenses).

See Part B Chapter 1.6 for discussion of a proposed operational planning strategy and process to address the above concerns.

2.2 Improving Resource Allocation

HSSP will support the MOH in shifting resources, though the annual sector expenditure plan process, to areas with higher burdens of disease, frontline services, and priority public health programs consistent with improving the defined priority health outcomes. It will also support policies and implementation reforms which bring about efficiency gains through controlling costs that are already high as a proportion of total expenditure. With regard to MOH resource allocation, **several finding of the Health Expenditure Review (HER)[7] were encouraging**:

- Non-salary recurrent costs are 65% of total public expenditure, providing sufficient resources to operate health services, such as pharmaceuticals;

- Capital expenditure is 11% of total public expenditure for health, certainly not crowding out recurrent cost financing, and allowing for what will need to be an expansion of capital spending under the HSSP;

- Budget allocation is 14% of total government resources, in line with other Pacific countries of a similar level of development;

[7] Health Expenditure review, 2006 based on Solomon Islands MOH 2005 data.

- Overall public health expenditure per capita also follows regional trends, taking into account SI's level of development; and

- The donor financing of health expenditure is concentrated among two donors that will support HSSP (AusAID, World Bank), at about 82% of total donor financing. This provides a strong foundation, in conjunction with SIG financing, for a flexible, effective, and broad sectoral program. This will only improve if other donors are able to more formally support the program.

Other findings of the HER present some **promising opportunities to shift resources with potentially significant impacts on health outcomes over the medium term**. In particular, the HER highlighted potential improvements from improving expenditure allocations between the provinces and the centre and between programs, linking expenditure to indicators of population health need, and seeking out savings in pharmaceuticals and hospital care to reallocate to public and primary health functions.

*Health expenditure in the provinces is low***.** The HER showed a pro-Honiara bias in expenditure allocations with provincial expenditure, representing only 32% of total public expenditure on health, well under the expenditure on national programs and the NRH which are centered in Honiara. A gradual increase in resources to the provinces—in particular to clinics—will be an important factor in improving primary care outcomes.

Expenditure across the sector is high on hospital services but low on primary and public health. The allocation of public expenditure (SIG and donor financed) is concentrated in hospital services, at 32% of total, and in administration, which is unusually high at 17%. In contrast, the primary and public health function receives 17% of total public expenditure, which is low given the importance of public health issues and health outcome patterns in the Solomon Islands. Reproductive health is a particular concern, given high fertility, maternal mortality, and HIV risks. In addition, diabetes prevention and control are under-funded in light of the apparently rapid growth of the disease. Interventions to improve the information base about diabetes epidemiology, backed up by improved prevention and case management, will require increased resource allocation.

Health expenditure does not correlate well with population health needs, as inter-provincial allocations favor provinces with apparently better health outcomes. This leaves Malaita with the second lowest per capita public expenditure but the third highest IMR and Guadalcanal with the lowest per capita public expenditure (excluding costs from the NRH, which is Guadalcanal's "provincial hospital") but the second highest IMR[8]. These patterns of expenditure are driven by donors and the MOH budget together, thus challenging both to better align allocations with need.

The NRH accounts for a very high proportion of expenditures. The NRH consumes 79% of total recurrent expenditure on hospitals/clinics and 25% of total public expenditure. It is also expected to encounter growing demand for care of non-communicable diseases, particularly diabetes. Costs will need to be carefully managed, as these pressures mount, or the hospital sector generally will consume higher proportions of donor and government funds. Managing these expenditures against other health priorities is a central concern.

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[8] IMR from 1999 Census, which is the most recent reliable estimate.

The infrastructure agenda remains large, as hospital construction expenditure has been relatively modest, focusing in recent years on rebuilding existing facilities such as NRH and the Auki hospital in Malaita. A judicious balance is also needed between hospital and primary care facilities, where deferred maintenance and rehabilitation have also created a substantial infrastructure deficit. New facilities and high-maintenance health services can drive up recurrent costs unsustainably. The HSSP will support recurrent cost management through the MTEF, which will establish medium-term limits, and by incorporating recurrent cost financing planning into capital investment decisions.

Absorptive capacity of certain programs is a potentially important issue. In particular, the malaria program was well supported in 2005 and continues to receive strong support from donor agencies. As Japan and Australia both have plans to further support malaria control efforts in 2006 and beyond, the MOH and donors will need to monitor and plan their overall resource commitments so that the program can absorb the support effectively and make further gains in reducing incidence.

Donor funding could be better correlated with disease priorities and health needs. Some priorities seem well funded in 2005, such as *HIV/AIDS* which has attracted rapid growth in donor support. Other priorities, such as diabetes, are certainly under funded in light of its apparently increasing prevalence and high complication rate. Diabetes prevention and case management will need a fresh strategic focus and an increase in resources to implement an expanded program. The differences in allocations between provinces (above) are also partly driven by donors, thus challenging donors to work with the MOH to improve this general picture.

With some careful adjustments and increments, these imbalances in expenditure allocation could be corrected so as to deliver more needed resources at the frontline clinics and to the key public health programs. Better alignment of expenditures with disease priorities, as identified in the NHSP and the analytical work underpinning it, and with different provinces' health needs has the potential to improve priority health outcomes. Similarly, potential cost savings from the NRH and pharmaceuticals could contribute to increased funding for priority programs.

A longer-term challenge is transparent management of health service revenues. Currently the Constitution and regulations direct health facilities to turn over all income to the SIG treasury. This inhibits accurate recording and reporting of revenue from fees and other charges to the MOH and prevents management of the potential inequities of unregulated fees. Over the longer term, the MOH and SIG will need to consider whether the relevant laws can be adjusted to allow the health system to collect and retain fees transparently, so as to help finance the health system on budget and better regulate the equitable application of currently unreported practices. Analysis and policy advice on this and other health financing options will be a valuable contribution to the MOH.

2.3 Improving the Technical Quality of Priority Services

HSSP will support a process of technical improvement in health programs which align with the priority health outcomes, including ensuring that the interventions delivered are effective and efficient. Examples include updating clinical protocols and treatment guidelines (as recently done for malaria), introducing preventive programs (such as secondary prevention for diabetes patients) and surveillance systems (as for

HIV), and ensuring supplies of equipment and drugs. It will also support an infrastructure program which is prioritised and phased in implementation.

The MMR, despite relatively high antenatal attendance and supervision of delivery, suggests that access alone is not the main performance problem and that improved quality of care may improve maternal outcomes if more high-risk pregnancies can be identified and managed before crises arise. In this, efficient referral services for emergency obstetric care are critical. Currently low maternal tetanus vaccination rates reduce the impact of health service utilization and may also affect patients' perception of, and demand for, health care. A perceived low quality of obstetric services, where nurse aides may not have significantly better skills than traditional birth attendants, is a possible explanation for the drop out rate between antenatal care and assisted deliveries.

HSSP will also focus on improving the system's capacity to deliver these services through management and organisational improvements. Core areas identified by the MOH are human resources development to address performance management and incentives issues; adapted health information systems to guide policy, management, and monitoring; and new methods of delivering health services. In this, the MOH is looking at using NGOs/CBOs to deliver health education services, initially for HIV but with a view to expanding to other priority diseases.

Accountability mechanisms as a means to improve performance are currently under-used. The current system aims to ensure technical quality through vertical accountability between health workers. However, the importance of demand-side factors, including patients' satisfaction with services, argues for mechanisms which strengthen accountability to patients and the community. An additional argument for this is the isolation of many communities in the Solomon Islands, which makes supervision from the centre difficult. The malaria programme has already had some success with community-selected and managed microscopists, for whom performance accountability is to the community and technical accountability to the malaria programme.

2.4 Addressing Demand-side Factors: Stimulating community awareness and demand is an essential precursor to improve health services utilisation and health outcomes

Demand-side factors are likely to be a factor in health system performance. Despite good attendance at antenatal clinic and for first vaccinations, drop out rates at delivery or before completing vaccination courses are notable in many provinces. This suggests that patients exercise considerable choice in deciding which services to use in primary health care and when to use them—including ambulatory care. A possible explanation of why outpatient utilization has not yet translated into better outcomes is that patients present to facilities late in an illness, when treatment is less effective. This suggests that a systematic and holistic approach to community organising/health promotion is necessary to increase the awareness of communities about the health status of their village and to develop plans to improve the health of their community. There are a number of local NGOs already employing participatory planning approaches with communities and MOH could engage in dialogue with these groups with a view to developing a MOH/NGO compact to facilitate a systematic community organising / health promotion approach linked to the Provincial Primary Health Care services.

HSSP will support a program of demand-side interventions, which are a core component of the "people focus" centrepiece of the NHSP. The health sector has paid little attention to demand-side factors to date, despite clear opportunities to improve health outcomes by influencing population behaviour and strengthening accountabilities to communities. These opportunities include direct involvement with communities, via NGOs/CSOs/CBOs and faith-based organisations to improve community awareness of health issues and empower communities to address these issues; renewing and reinforcing linkages between communities and health services; reducing unhealthy lifestyles and behaviours; and increasing uptake of priority services, such as family planning and deliveries in-facility, to complement supply-side investments. There are also important opportunities to link demand for traditional health care and for "western" health services, as there appears to be significant overlap between these in diagnosis and treatment of certain diseases and in managing pregnancy.[9] The program of demand-side interventions will be further developed during HSSP implementation.

2.5 Program Delivery & Outcome Issues

The current picture of a high burden of disease from communicable diseases and maternal and child health conditions supports a policy of strengthening primary health care to improve preventative and curative services—in particular communicable disease control, prevention (including vaccinations), reproductive health, and treatment of common conditions (malaria, ARI). The isolation of many communities in the Solomon Islands may be an argument for judicious expansion of access by improving the clinic network, increasing outreach activities, and encouraging community care. Enabling private clinical care is another option. Similarly, reducing malaria incidence, preventing an HIV epidemic, and addressing risk factors for NCDs are all commonly addressed by expanding health promotion activities to change health related behaviours in communities.

Tapping the NGO, church, and private sectors to enhance capacity may help ensure the delivery of services. Consistent with public finance criteria, the public sector should (i) finance health programs that confer benefits to society as a whole and need to be provided collectively (e.g. vector control and health promotion), and (ii) ensure the poor have access to services. In many instances, the non-public sector may be able to provide some primary health care services more effectively and efficiently than MOH. Potential providers include church organisations (which run some hospitals and clinics already), NGOs and CBOs (which are already in the health sector and expanding their operations), or private providers groups. These groups could be contracted to provide services such as health promotion, bed net distribution, and other community-based activities, in partnership with the MOH. Private providers may also have a role in providing some curative care services and ensuring an enabling environment for private providers to register and operate as appropriate. Understanding how different income groups in Solomon Islands access and pay for health services, including the need and opportunities to focus on the poor, will be enhanced by the HIES results.

2.5.1 Reproductive health

Performance challenges are evident in reproductive health. Reproductive health services appear not to be providing consistently adequate coverage of good quality, which may in fact be at least partly related to demand factors.

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[9] Alex Edmonds, Making Health Care Decisions in the Solomon Islands: A Qualitative Study, 2006. Commissioned by the World Bank & AusAID as part of HSSP preparation.

- Contraceptive use is very low, with a national contraceptive prevalence rate (CPR) between 7 and 16% depending on source.[10] Provincial CPRs vary widely, with the highest of 25% in Temotu, but fall short of national targets established by MOH.

- About three quarters of mothers receive antenatal care (75%) or have a delivery supervised by a trained health care worker (78%).[11] This is a significant achievement in a low income country and has been relatively stable since the mid-1990's. A recent (2004) population-based survey produced similar findings on supervised deliveries, supporting HIS based data.[12] However, HIS indicates that postnatal care attendance is low, at 44% nationally, and has not changed significantly in recent years.

- A significant proportion of mothers who attend antenatal care do not deliver in a health facility—around 23% in Guadalcanal and 18% in Malaita. This raises questions about these women's understanding of the need to deliver in a health facility or perception of the quality of antenatal services.

- Coverage of mothers with maternal tetanus vaccine (range 50-76% by province), is clearly less than optimal. It is important that the reasons for this are better understood and efforts made to improve the technical quality of services provided.

2.5.2 Immunisation

National vaccination coverage in the Solomon Islands is better than many low income countries and compares well to the rest of the Pacific. Nevertheless, coverage varies across provinces and needs to be brought up to the recommended thresholds to be able to block epidemics of key diseases.[13]

- Measles coverage (range 61-92% in the six provinces sampled) and polio coverage (72-89%) are generally below thresholds to block epidemics of these diseases.

- Coverage with standard EPI vaccines varies significantly between provinces, being lowest in Malaita (73% DTP3).

- Drop out rates between first vaccination and completion of the schedule are high in some provinces, most notably Malaita in which 20% of children who receive the first DTP dose do not complete the full course.

2.5.3 Malaria

Despite signs of strong recovery after the civil conflict and significant donor support, malaria control efforts are still in the process of trying to achieve wide population coverage with some key inputs.

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10 Figures do not include tubal ligations.

11 Facility data from national reproductive health programme. To be confirmed. Differ from figures cited later, which are taken from the immunisations survey.

12 *2004 Immunisations Coverage Survey—Solomon Islands*, MOH/UNICEF 2004.

13 Findings here are from the *2004 Immunisations Coverage Survey* (MOH/UNICEF 2004), which found higher vaccination coverage than routine MOH reporting. This highlights the need to improve MOH reporting systems.

- Bed net coverage of the population is reportedly constrained to only 33%, largely owing to funding constraints. Priority in bed net distribution is given to pregnant mothers. Distribution of bednets increased by 22% from 2005 to 2006. Surveys show that utilization of those nets which are available is quite high, at 80% in most provinces. Better understanding why some people with nets do not use them may assist in achieving higher utilization rates and, ultimately, higher coverage.

- Availability of trained microscopists in facilities is incomplete, with a coverage of 58% in 2006.

5.2.4 Quality of care

The capacity of clinics to provide good quality care remains problematic. More specifically:

- 50-75% of facilities are in need of refurbishment or rehabilitation, including adequate water, power supplies, and sanitation.

- Supplies of equipment, drugs, and vaccines have dramatically improved after the civil unrest (largely as a consequence of AusAID support), but reports of shortages, stock outs, expired drugs, and logistics problems indicate supply and management systems need strengthening. Evidence of this is that mothers reported lack of vaccines as the leading cause for not vaccinating their children in a recent study.[14]

- Provincial and central supervision of the quality of services provided by clinics is infrequent and there is limited feedback on performance of health facilities from the centre to the provincial authorities and clinics who report through the HIS.

2.6 Nutrition Issues

Considerable concern exists regarding the nutritional status of the Solomon Islands people. Despite the shortage of recent data, there is almost certainly a dual burden of under nutrition, particularly in children (low birth weight rate 122/1000 births), and over nutrition, primarily in adults (33% overweight and 11 % obese from 1989 data). These are potentially very important contributors to childhood morbidity and mortality and to increasing burden of NCDs in adults, respectively.

There is evidence in the Solomon Islands of under-nutrition and specific nutrient deficiencies:

- A small cohort of women of childbearing age in 2004 established a high prevalence of anaemia (166/1000), thought to contribute significantly to the Solomon Islands relatively high Maternal Mortality Rate (MMR), estimated at 165/100 000 women in 2005.
- Only 65% of babies are exclusively breast fed at 4 months (1998 data) and there are anecdotal reports regarding poor quality supplementary foods.

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14 *2004 Immunisations Coverage Survey—Solomon Islands*, MOH/UNICEF 2004.

- Given concerns about low intakes of micronutrients, Vitamin A deficiency is a likely contributor to a high IMR in the small 2004 cohort of 68.7/ 1000 births. In addition, low folate probably contributed to the Birth Defect Rate of 51.7 /1000 births reported in the same group. In general, under-nutrition is suspected to underpin 60% of childhood deaths in the SE Asia/Pacific region.
- Children are also suspected to suffer from iron deficiency anaemia in an environment where no regular de-worming is undertaken, despite an intestinal pinworm load in children exceeding 33% in a recent WHO study.
- These nutritional deficiencies would be largely related to the transition to modern diets, particularly in urban areas and areas where logging has led to greater access to cash and abandonment of traditional farming techniques has led to high carbohydrate, low protein diets poor in micronutrients including iron.

Further information will be available after final analysis of the Demographic and Health Survey (DHS) and the Non Communicable Disease STEPS about nutritional risk factors for diabetes mellitus and other chronic diseases, which appear to be increasing.

This information should also increase the profile of nutrition in the MOH. Widespread micronutrient deficiencies exist in the Pacific and data obtained in the surveys may help persuade the MOH of the need for supplementation of micronutrients, such as Vitamin A and iron, via legislation and distribution programs. The survey results may also support an increased allocation for the national nutritional program, which has received little budget support in recent years. This would continue recent efforts to boost the Nutrition Unit of the Division of Reproductive and Child Health, following the appointment of three nutritionists after three years without staff. Tthe Unit's 2007 Operational Plan seeks to address the above issues (with a modest budget) through a focus on promoting breastfeeding and increasing community knowledge of infant and child nutrition and also targets increased NCD risk factor awareness, monitoring and interventions. Nutrition issues appear to be an important issue for the health sector in the Solomon Islands and a strengthened response, in alignment with the NHS priority areas of improving child health and combating NCDs, should be developed.

2.7 The Hospital Sector

A review of the hospital sector, with a focus on the NRH, was undertaken in 2006[15]. Noting the relative lack of data on hospitals in the Solomon Islands, the review aimed to gather qualitative and, if possible, quantitative information about the sector's performance, case-load, management, and resource use. It concluded that there are significant opportunities to improve the technical quality of hospital services and to improve linkages with the primary health care system. It may be possible to improve technical quality without increasing the overall resource envelope to hospitals, given the significant opportunity for efficiency gains through better financial, staff, and asset management.

The MOH is principally focused on the development of primary care and disease prevention and has only limited resources dedicated to hospital accountability and support. Hospitals are not required to routinely collect or report on their activity or outputs. Donors fund a major proportion of operating and capital expenditure in

[15] Chris Scarf, Hospital Services in Solomon Islands. Commentary on Management and Development Issues, July 2006.

hospitals. In the NRH in 2005, 56.8% of funding came from donor sources but much of the investment was without the levels of technical support and monitoring usually associated with health projects. One exception has been a proportion of the technical assistance provided by the AusAID HISP has been allocated to improving aspects hospital management and facilities assessment in NRH and provincial hospitals; positive improvement and progress has been made at NRH during the final Phase of HISP establishing a sound basis for HSSP activities.

Accountability and management systems in hospitals are weak, undermining the capacity to prepare realistic budgets and to monitor expenditures and performance. At the provincial level, the hospital is the administrative base under the direct control of the provincial health director who is also responsible for other health services. The NRH management and provincial health directors have had control of limited AusAID funded Health Services Trust Account (HSTA) discretionary budgets to acquire supplies other than medical and drugs, to undertake minor repairs and replacements and to pay non-establishment salaries up until July 2007. For the NRH in 2005 this amounted to SBD 8.42 million or just under one fifth of the hospital's total expenditure. Most managers are unaware of and unaccountable for their remaining costs which are met directly by the Ministry of Finance (salaries) or MOH. In addition, despite focused technical assistance and investment by AusAID funded projects, the routine gathering and coding of activity data are incomplete and unreliable. Formal systems to review clinical outcomes or quality have not been established in any hospital.

Shortages of key inputs, such as staff and equipment, are also undermining hospitals' ability to provide quality care. Hospitals face shortages of key skilled clinical staff and the MOH is finding that its efforts at international recruitment are now much less successful that previously. Shortages of staff, particularly doctors, are reported to be creating high workloads despite low bed occupancies in some locations. Some departments also lack key items of functioning equipment and buildings are often poorly maintained.

The NRH could better fulfil its role as a technical leader in the health sector under the current system. To date, despite its resources and role as the repository of clinical expertise in the nation, NRH plays only a limited role in the coordination between preventative, primary and higher level health services. This is a lost opportunity to harness the significant resources devoted to the NRH to strengthen quality of care at lower level facilities in the health system.

Within this background, there are substantial opportunities for introducing modern management methods that would help staff to better analyse their outputs and to achieve significant efficiencies in the use of resources. For example:

- Bed occupancies in provincial hospitals are generally low. Recent estimates of bed occupancy rates in some provincial hospitals were under 70%, with some reported as low as 50%, despite an average length of stay on the upper end of normal limits.[16] This suggests that management and staff could analyse trends and investigate reasons to decide how demand could be increased and services expanded within available resources, or what efficiencies and improved health

16 *Utilisation Analyses of Gizo, Taro and Tulagi Hospitals.* MOH/HISP 2005.

outcomes for the community could be achieved by reallocation of staffing and other resources to primary care functions.

- Lengths of stay in some NRH wards are longer than needed because of systematic problems. An example is that some orthopaedic patients cannot go home when clinically ready because there are problems in the supply of crutches and long term problems with the provision of orthotics. Similarly, discharge planning is not routinely undertaken, delaying arrangements for discharge or transfer, causing inconvenience for patients and families and placing unnecessary demand on hospital beds.

- Some wards and services are clearly overburdened, reducing the effectiveness of services and the level of attention patients should receive. This compromises the quality of care. Regular monitoring of workloads and outcomes and preparing staff through necessary training and support could enable safe staff transfers to specialised areas during periods of peak demand and produce better outcomes for patients and staff.

- Two-way referral arrangements are not well coordinated. There are few jointly developed clinical management protocols and provincial and NRH services operate with less than optimal cooperation and communication. An example is the coordination of diabetes detection and treatment. Increasing numbers of patients are presenting with serious complications of adult onset diabetes without them having been previously diagnosed or adequately educated or treated. NRH services for diabetes are developing quickly but these are not yet integrated with provincial services. The development of programs of care, shared between NRH and provincial providers using common protocols and allocating appropriate responsibility for sound patient management has the potential to dramatically reduce both the disastrous consequences that patients now experience and the demand for expensive tertiary care.

Possible approaches to these issues, for consideration during implementation of HSSP include;

- The MOH should clearly identify the proposed roles and functions of hospitals in implementation of the NHSP.

- The MOH and MOF should develop processes and systems to further advance the allocation and monitoring the use of financial and other resources consumption within the hospital sector.

- The MOH should develop, implement and follow up on routine activity reporting requirements for hospitals including definitions, modes of collection and reporting, and points of accountability. Hospitals should receive technical assistance to implement and effectively respond to the results of the reporting system.

- The MOH should develop services plans for key hospitals (initially NRH and Kilu'ufi Hospital) to complement their role delineation, identifying expected workloads and the (human, financial, equipment, facilities) resources that should be allocated to meet projected levels of demand.

- The MOH should review or develop strategic plans for key services (initially diabetes management and maternal health) to ensure that modern strategies are

incorporated in guidelines so as to better integrate services delivery and improve outcomes.

2.8 Human Resource Issues

Unlike other health inputs, such as facility infrastructure and drugs, doctors and nurses have legitimate needs and preferences. This means that the size and composition of the health workforce cannot simply be determined by government, but depends, at least in part, on the active choices of current or prospective health professionals. Similarly, the skills and motivations of health workers cannot be taken for granted, but reflect how prospective health workers are selected to the profession, and the incentive and support environment they face in the workplace. These features of human resources in the health sector result in difficult policy and management challenges

A failure to effectively address these challenges risks resulting in health system problems which, by now, are all too familiar around the world: internal and external brain drain, unequal geographical distribution of health workers, inadequate skills and inappropriate skill mix, low morale, etc.[17] Attrition, deployment, and performance are clearly also important policy issues in their own right -- trends in the workforce will depend in important ways on policy decisions relating to these issues.

The ideal starting point for any human resource assessment is an overview of stocks and flows of the health workforce as a whole—considering both employed and unemployed health workers, and health workers in both the public and private sectors. At present there is not available a complete picture of the health workforce in the Solomon Islands covering either the whole of the public sector nor of the private sector.

In 2006, the MOH has, according to the human resource data base, 1663 staff position with 314 (19.3 percent) at the headquarters level, 488 (28.6 percent) at the National Referral Hospital and 779 (45.6 percent) located in the provinces, including provincial hospitals. Some 82 staff (6 percent) are accounted for by supernumerary and nurse training positions. It is interesting to observe that 884 or 53 percent of staff are located in Honiara, see Table below.

In addition to the above MOH staff provincial governments employ significant numbers of Direct Wage Employees (DWEs) who are financed from the grant from MOH to provinces. These may account for 1,000 or more staff. They comprise kitchen staff and other workers at hospitals and are health centers as well as a significant number of public health staff delivering provincially located health services and as such constitute an important component of the MOH staffing complement. The MOH does not have a data base of DWEs – either of the total number or what functions (hospital/public health services) or qualifications (nurse aid, nurse, cook driver etc.) they have.

[17] PAHO, *Development and Strengthening of Human Resources Management in the Health Services*. Pan American Health Organisation and World Health Organisation. 2001. Processed; Dussault, G. and C.-A. Dubois, *Human resources for health policies: a critical component in health policies*. Human Resources for Health, 2003. 1(1); WHO, *Human resources and national health systems: shaping the agenda for action*. 2002, WHO/EIP.OSD/03.2; USAID, *The Health Sector Human Resource Crisis in Africa: An Issues Paper*. 2003, USAID: Washington, DC; Van Lerberghe, W., O. Adams, and P. Ferrinho, *Human resources impact assessment*. Bull World Health Organ, 2002. 80(7): p. 525; ILO, *Terms of employment and working conditions in health sector reforms*. 1998, International Labour Office: Geneva; Joint Learning Initiative, *Human Resources for Health: Overcoming the Crisis*. 2004.

Ministry of Health Establishment 2005 and 2006 (excludes provincial DWEs)

MOH System	2005	2006	Percent of Total Workforce 2005	Percent of Total Workforce 2006
HEADQUARTERS				
Public Servants	314	305	18.9%	18.3%
Direct Wage Employees	8	9	0.4%	0.6%
Total HQ	**322**	**314**	**19.3%**	**18.9%**
National Referral Hospital				
Public Servants	402	417	24.1%	25.1%
Direct Wage Employees	74	71	4.5%	4.2%
Total Ref Hospital	**476**	**488**	**28.6%**	**29.3%**
PROVINCES				
Public Servants	709	727	42.6%	43.7%
Direct Wage Employees	51	52	3.0%	3.1%
Total Provinces	760	779	45.6%	46.8%
SUPERNUMERIES	13	11	0.8%	0.7%
NURSE STUDENTS	84	71	5.1%	4.3%
TOTAL	**1665**	**1663**	**100%**	**100%**

3 BACKGROUND AND RATIONALE LEADING TO THE CHOICE OF A SWAP

SIG, with the support of development partners – primarily AusAID – has stabilized the health system following the major civil disturbances of 2002/03 when health services almost collapsed. The MOH through its NHSP has mapped the outcomes, policies and priorities of the health sector for the next 5 years. Moreover, there is strong motivation to enhance coordination, reduce fragmentation and transaction costs related to multiplicity of projects. This, together with the desire to increase accountability and build capacity of government processes, provide the rationale for a programmatic or a SWAp approach.

In terms of key purposes, the HSSP aims to (i) improve health outcomes for the Solomon Islands population - this will likely require special emphasis on major causes of disease especially malaria and TB and reproductive health; (ii) improve sectoral policy and link to results to support the desired outcomes; (iii) identify system issues and reforms needed to align incentives and strengthen capacities in support of sectoral strategies and outcomes; (iv) strengthen all of government process including the application of public finance principles to public expenditure priorities; and (v) enhancing the financial sustainability of the health program .

3.1 Stakeholder Consultations and Endorsements

Undertaking a sector wide program in health involves important realignments in accountabilities and relationships. During the HSSP development, and consistent with the program rationale, discussions emphasized the shift of accountability from a shared paradigm between donors and the MOH to a clear assignment of leadership to the MOH and its Executive. The second vital shift was on the strategic front, from the securing of service inputs to the improvement of health outcomes.

3.2 SIG endorsements

MOH management is strongly committed to a sector wide approach. SIG agencies outside the MOH, such as the Ministry of Finance and Treasury (MOF) and the Ministry of National Planning and Aid Coordination (MOP) which both play a direct role in equipping the MOH to do its work, have endorsed the broad strategy of the SWAp.

The MOP have indicated its support for the principles underlying a sector wide approach, including the realignment of accountabilities from external advisors to MOH staff and management and the better coordination of donors under sector wide arrangements. Similarly, MOF is supportive of sector wide initiatives for the health sector. The MOF identified the following important points in relation to a health SWAp:

- MOF welcomes the move toward a sector wide approach in several sectors, such as in transport, and the Ministry of Education (MOE) program is already established. However, MOF noted that the MOE has been unable to contain expenditure commitments for tertiary scholarships—an important lesson for the health SWAp;
- proposed sector wide strategies should take into account the longer-term sustainable level of government support to health within a multi-sectoral financing framework and the potential role of private sector providers to ease the demand for public services;

- there is a need to look at the quality of all public expenditures—however financed—to ensure alignment with outcomes (the MDGs were seen as a sound starting point);
- incremental recurrent costs arising from donor- (and government-) financed development programs under the HSSP should be carefully assessed in terms of the capacity of SIG recurrent budget to be able to finance programs sustainably in the medium term;
- the government's revenue base over the next few years will remain fragile—the anticipated reductions in forestry revenue are particularly significant in this respect;
- the Solomon Islands HSSP should be supported if it enhances the capacity of SIG/MOH to better manage government systems and to be increasingly accountable for improved outcomes; and
- agreements on donor financing of the sector wide health program should be with SIG as a whole and not just with the MOH.

3.3 Donor consultations

In 2006 the MOH convened its first donor stakeholder forum attended by bilateral, UN, and NGO partners. Previously, the MOH convened donor coordination around specific events rather than as a regular event. The MOH presented the proposed sector wide approach and invited participants' views on the concept and its development for the Solomon Islands. Overall, the participants in the forum were positive about the development of sector wide assistance and looked forward to engaging in the process in its later stages. NGOs indicated their interest as operational partners, delegated to provide explicit services to MOH.

In March 2007, WHO, UNICEF and UNFPA confirmed their support of sector programming for their activities in the health sector. The GFATM, through SPC, has also stated its support to the sector wide approach. The World Bank will consider its support to the MOH. The two major health sector donors: Japan (JICA and Japanese Embassy) and Republic of China (ROC) express support to the health sector programming but are not able to participate at this time: Japan is limited to providing project type support at this time; and, ROC proposes to continue its involvement in the NRH renovation, ongoing since 1985, as its centre piece. For ROC, other activities through micro-projects and the Prime Minister's office might result in further support to provincial health infrastructure, depending on demand. There is no explicit annual budget for health, which fits within an annual resource envelope with other sectors and is allocated according to SIG demand. Given those arrangements, ROC is pleased to work in a complementary way to the sector wide strategy and donor assistance.

4 THE HEALTH SWAP GUIDING PRINCIPLES

4.1 The Core Agreements for a Health Sector SWAp. The central themes of programmatic or sector wide support to a sector by development partners typically emphasize the need for a natio*nal health strategic plan or strategy* which focuses on health outcomes to be improved and the prioritization of expenditures and scarce administrative capacities in support of achieving these outcomes. This approach emphasizes a focus on:

- *programmatic reforms* (e.g. what the MOH does to effect improved change in health outcomes) and *organisational and management reforms including capacity enhancement* to enable the outcomes to be improved (e.g. how MOH, MOP, or the Public Service Division (PSD) changes the way they do business to enable MOH (and the provinces) to implement programs successfully;
- *improving health status (outcomes)* rather than just on input management, i.e. all inputs (pharmaceuticals, technical assistance, facilities, hospitals, staffing, contracting to the private sector, church and NGOs, etc.) should be judged in terms of their contribution to efforts to improved health status;
- *Empowering communities* to strengthen their capacity to address health risk behaviours and environmental factors, as well as raising their awareness and capacity to demand improved health services and outcomes;
- *increased use of core government systems* (a "whole of government" approach) to manage resources and the supported programs (including through strategic partnerships with the private, church, and NGO sectors);
- developmental and recurrent support of *programs to be supported within a medium-term fiscal or budget framework with a focus on sustainability*;
- *stakeholder inclusiveness in design and implementation of strategies*;
- *transparency and probity in all processes* including through sound financial and procurement management;
- *government ownership* and accountability of the strategy and program being supported.

Under such new arrangements, the development of the HSSP through a SWAp has built on three ways (compacts) that relate to the NHSP as well as the interactions between development partners and SIG. These are:

- the Solomon Islands NHSP (Compact 1)
- the Solomon Islands–Development Partner Compact designed to enable programmatic support for the Solomon Islands NHSP (Compact 2); and
- the relationship or organisational agreements and understandings between development partners financing the SWAp for the health sector in order to implement Compact 2 without sending conflicting signals to government on policies, strategies and financing of health (Compact 3).

This set of arrangements is in and of itself a form of capacity development for MOH and SIG more generally.

4.2 The Solomon Islands NHSP: Compact 1.

The NHSP meets the key objective of articulating a strategic vision for the health sector. It is the compact (plan) within government to deliver health services focused on

achieving a set of agreed target outcomes. Central to the development of such a compact was the notion of a need for a "whole of government" approach in:

- developing a national vision for the health sector and for the desired outcomes, consistent with the MDGs;
- establishing enforceable policy oversight arrangements at the national and sub-national government levels to ensure MOH can implement the plan;
- setting priorities for sectoral reforms that are based on a consensus between the national and provincial authorities and other stakeholders;
- identifying both implementation and financing constraints at each level of government and ensuring that their implications are embodied in the priorities for sectoral reforms; and
- developing implementation plans and arrangements for monitoring and evaluating progress over time, including by national and provincial authorities.

Furthermore, methods of interaction between development partners, government and local NGOs/CSOs will also underpin the implementation of the NHSP: that is, *SIG-NGO agreements designed to address community organising / health promotion as an essential precursor for improved demand for health services and outcomes*. The NHSP recognises that in order to stimulate genuine community awareness of health issues and demand for improved health care services and outcomes, greater efforts must be made to empower communities. The NHSP specifically refers to the need to "strengthen village health committees for planning and community mapping" and to "improve the accountability of health programs and resources to the people"[18]. The intensive social preparation work envisaged by the NHSP may best be performed by NGOs/CSOs already experienced in village level participatory planning.

The sector program has been developed with regard to the following guidelines identified and agreed with the MOH and development partners:

Focus on the key desired outcomes; (e.g., reducing IMR and MMR, reducing the burden of malaria, TB and HIV/AIDS) using the most cost-effective options with emphasis on targeting the poor. This will require (i) identifying the technical options for achieving the agreed outcomes and the ways in which the options might be packaged for delivery; (ii) prioritizing these packages in terms of public expenditure, using public finance criteria; and (iii) establishing indicators for monitoring progress towards agreed targets and ensuring consistent evaluation of sector outcomes.

Identification of ways to (i) confine the role of the public sector to delivering those public services that it can deliver effectively; (ii) encourage the private sector to deliver private goods and services (in other words, those goods with limited, if any, benefits to society as a whole as a consequence of their private consumption); and (iii) strengthen the collaboration between the public and private sectors in service delivery, including churches and NGOs to ensure all capacities available are tapped to achieve the results desired.

Preparing an expenditure and implementation plan for the whole of the publicly funded part of each sector (covering all programs financed by either the government or its development partners) based on the high-priority activities identified in the preceding

[18] NHSP 2006-2010 Appendix One: Linkages between MOH NHSP and GCC health policy pp 38-39

steps as the best for achieving the desired outcomes and are consistent with the indicative available resources (see below).

Creating fiscal space in the health budget to make room for high-priority sectoral expenditures. This can be achieved in three ways: (i) by generating savings in the sector; (ii) by making more efficient use of existing resources; and (iii) by allocating additional resources to the sector.

Preparing a financing plan. To finance the strategy, it will be necessary to identify and secure the required resources. A medium-term financing plan will need to be prepared, in which MOH, provincial governments, and the major donors all indicate what resources they can make available to the sector over the next specified number of years.

Enhancing and guaranteeing the integrity of government processes. It is important to eventually bring off-budget donor funds into the budget so that planning and implementation can take into account the full level of resources available to the health sector. Restoring and maintaining the integrity of government processes—planning, budgeting, accounting, managing, and auditing of funds use is the first step in this process.

4.3 The Solomon Islands–Development Partner Agreements: Compact 2.

The arrangement between SIG and development partners in support of the preparation of the NHSP and its financing forms Compact 2. It is designed to enable programmatic support for the Solomon Islands NHSP in a manner which ensures Solomon Islands ownership and accountability for (i) the strategic outcome focus of the NHSP and (ii) implementation of the program, including development partners' support and program financing.

Compact 2 is how SIG and development partners interact to support a more coherent, outcome-focused approach to health. The achievement of Compact 2 has been reached through:

- an agreement on the strategy and long-term vision for the health sector (Compact 1) – that is the NHSP - and, within this overall sector strategy, an agreement on the subset of priority outcomes, policy reforms, and indicators on which donors will focus under the SWAp;
- an agreement on the set of *programmatic policy reforms*, such as essential health care packages (e.g. primary reproductive health care, malaria control and eradication, child health, HIV prevention) as the basis for achieving the desired health outcomes, and on a set of *organisational and management reforms* aimed at implementing the programmatic reforms according to agreed benchmarks and monitoring indicators; and
- a rolling public expenditure and implementation plan covering the first 18 months of the HSSP, consistent with the medium-term resource envelope determined by the government in consultation with development partners' financing programs. This will be updated annually to form the basis for more detailed annual expenditure and operational plans.

This process also reinforced the importance of focusing on the entire resource management process, rather than just the recurrent budgeting process or the development budget processes. MOH and provinces will need to make and implement annual operational plans to introduce agreed policies, to ensure the timely funding of activities, to manage expenditures, and to ensure that accounting and auditing mechanisms and procurement processes are in place. To the extent possible, donor resources will be disbursed through the government's own budget.

4.4 Donor agreements to work together in support of the Solomon Islands-Development Partner Agreement: Compact 3.

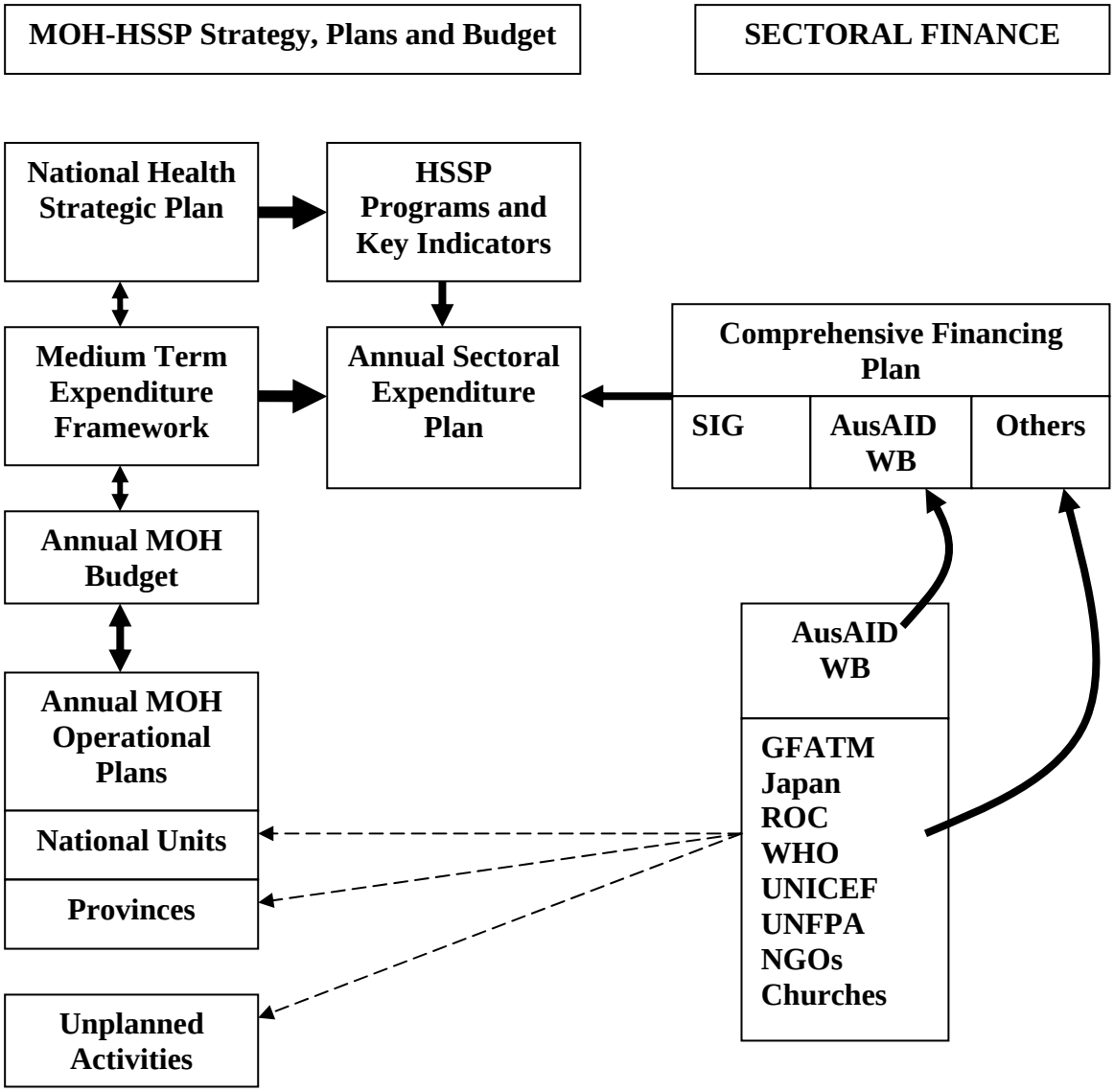
Among the objectives of a SWAp is a concerted effort by development partners to (i) support SIG ownership and accountability for implementing the health strategy; (ii) ensure a focus on outcomes and on reforms that will enable outcomes to be achieved; (iii) ensure sustainability of the financing of health programs; (iv) support monitoring and evaluation (and use international evidence) as the basis for policy dialogue with SIG to avoid conflicting signals to SIG/MOH on policies, strategies, and financing of health; (v) ensure sustainable and certain financing for health programs; (vi) reduce fragmentation of health programs from multiple projects with differing fiduciary arrangements and encourage use of government systems and accountability mechanisms; and (vii) reduce the transaction cost to government.

Compact 3 is the arrangement between development partners to the SWAp. The essential agreement is how they work together (i) to implement the overall HSSP agreement as outlined above (Compact 2); and (ii) to work together on the review and monitoring of the program according to joint terms of reference. There are several options open to other donors who wish to participate in the sector wide program, from partial to full engagement. These include participation and engagement in the joint review and monitoring missions, and joint financing or parallel financing of MOH activities under the sector support program.

5 PROGRAMS & FUNDING FROM DONOR SOURCES OUTSIDE THE HEALTH SWAP

5.1 Features of the overall HSSP framework and some of its key relationships

The major building blocks of the sector wide approach under the HSSP are conceptualised below:



The figure above implies some important features:

- there is alignment between the NHSP, the MTEF, and the annual expenditure plan;
- the priorities for the HSSP are a subset of the NHSP;
- the Annual Sectoral Expenditure Plan sets in motion the financing of sectoral expenditure;
- all donors are invited to participate in development of the Annual Sectoral Expenditure Plan and its financing;

- World Bank and AusAID financing of sectoral expenditures are on the consolidated fund (recurrent budget);
- over time, other donors may decide to join HSSP on budget.

5.2 Other Support to the Health Sector

Donors and organisations currently identified in providing support to the health sector but not currently within the HSSP are detailed in the following Table:

DEVELOPMENT ORGANISATION/ACTIVITY	AREAS OF FOCUS	APPROACH	PROVINCE
Adventist Development Relief Agency (ADRA)	HIV/AIDS	Training; Health promotion	Honiara National (Media)
Australian Volunteers international (AVI)	HIV/AIDS	Volunteers	Through ADRA
International Women's Development Association (IWDA)	Reproductive health;	Training; Health Promotion; Advocacy	Guadalcanal
Catholic Church	Health Care Services	Clinics	Malaita
Church of Melanesia	HIV/AIDS; Primary Health; Sex Abuse; Trauma; Psychological Issues	Service Delivery; Training; Advocacy; Resource provision; Health promotion	Temotu; Makira; Isabel; Choisel; Guadalcanal; Central Province; Honiara
Commonwealth Youth Program	HIV/AIDS; Sex/Reproductive Health	Training; Advocacy; Participatory processes	Honiara

Inclusive Communities Program	HIV/AIDS	Training; Health Promotion	Operated through Church of Melanesia
Don Bosco	Diseases	School-based training	Honiara
Family Planning Australia Project	HIV/AIDS; Primary Health ; Family Planning; Sex/Reproduction; Sex Abuse; Psychological Issues; Diseases	Training; Advocacy	
Girl Guides Association	HIV/AIDS; Sex/Reproduction		Honiara
Grassroots Network	Disability; Diseases; Sex Abuse; Trauma		
Honiara O Clinic	HIV/AIDS; Primary Health; Sex/Reproduction; Family Planning; Diseases	Counseling; Training; Advocacy	Honiara
Inclusive Communities Program	HIV/AIDS		
IWDA	Reproductive health;	Training; Health Promotion; Advocacy	Guadalcanal
JICA (Japan International Cooperation Agency)	Primary Health; Family Planning; Disability	Building clinics; Malaria	
Oxfam International	HIV/AIDS; Sex Abuse	Training; Advocacy; Participatory development processes (BCC, VCCT)	Honiara
Regional Rights Resources Team	HIV/AIDS; Disability		
Rotary Against Malaria	Malaria	Equipment; Resources	Choisel; Guadalcanal; Malaita; Western Province
Save the Children	HIV/AIDS	Health Promotion; Training; Advocacy; Research; Planning	Western; Isabel; Malaita; Guadalcanal; Makira; Honiara
National Council of Women	HIV/AIDS	Health Promotion	Makira; Western; Temotu; Honiara National (media)
Seventh Day Adventist Church	Health care services; Primary health care	Service Delivery; Training; Health Promotion	Malaita; Guadalcanal; Western Province; Isabel; Makira
SICA (Solomon Islands Christian Association)	HIV/AIDS; Primary Health; Family Planning	Health Promotion; Advocacy; Training; Participatory development processes	Honiara
SIPPA (Solomon Islands Planned Parenthood Association)	Disability; Sex/Reproduction; Sex Abuse	Health promotion; training; Resource provision; Research; Advocacy; Community development; Participatory Development; processes	Honiara; Makira
Soroptomistics	HIV/AIDS; Primary Health; Family Planning; Sex/Reproduction		
SWIM (Short Workshop In Mission)	Disability		
UNIFEM	HIV/AIDS; Sex Abuse		
UNICEF	Primary Health; Psychological Issues	Provision of resources (including medications[EPI]); training	
UNFPA	Reproductive Health	Training; resource provision	National and provincial levels

UNDP	HIV/AIDS		
Wesley United Church	Primary health care	Service provision	Choisel; Western Province
West Areare Rototanikeni Association	HIV/AIDS		Areare; Malaita
World Vision	HIV/AIDS; Primary Health	Health promotion; Training; Resource provision; Participatory development processes (BCC)	Makira; Honiara; Guadalcanal
Rotary Against Malaria	Primary Health ; Diseases		
WHO	Primary Health, Diseases		
GFATM	Primary Health, Diseases		

Additional support to the health sector is also provided through: (i) the Community Sector Program; (ii) Isabel Women's Association Regional Cooperation; (iii) Live & Learn Environmental Education; (iv) Scouts Association; and (v) YMCA.

5.3 AusAID support to the Health Sector

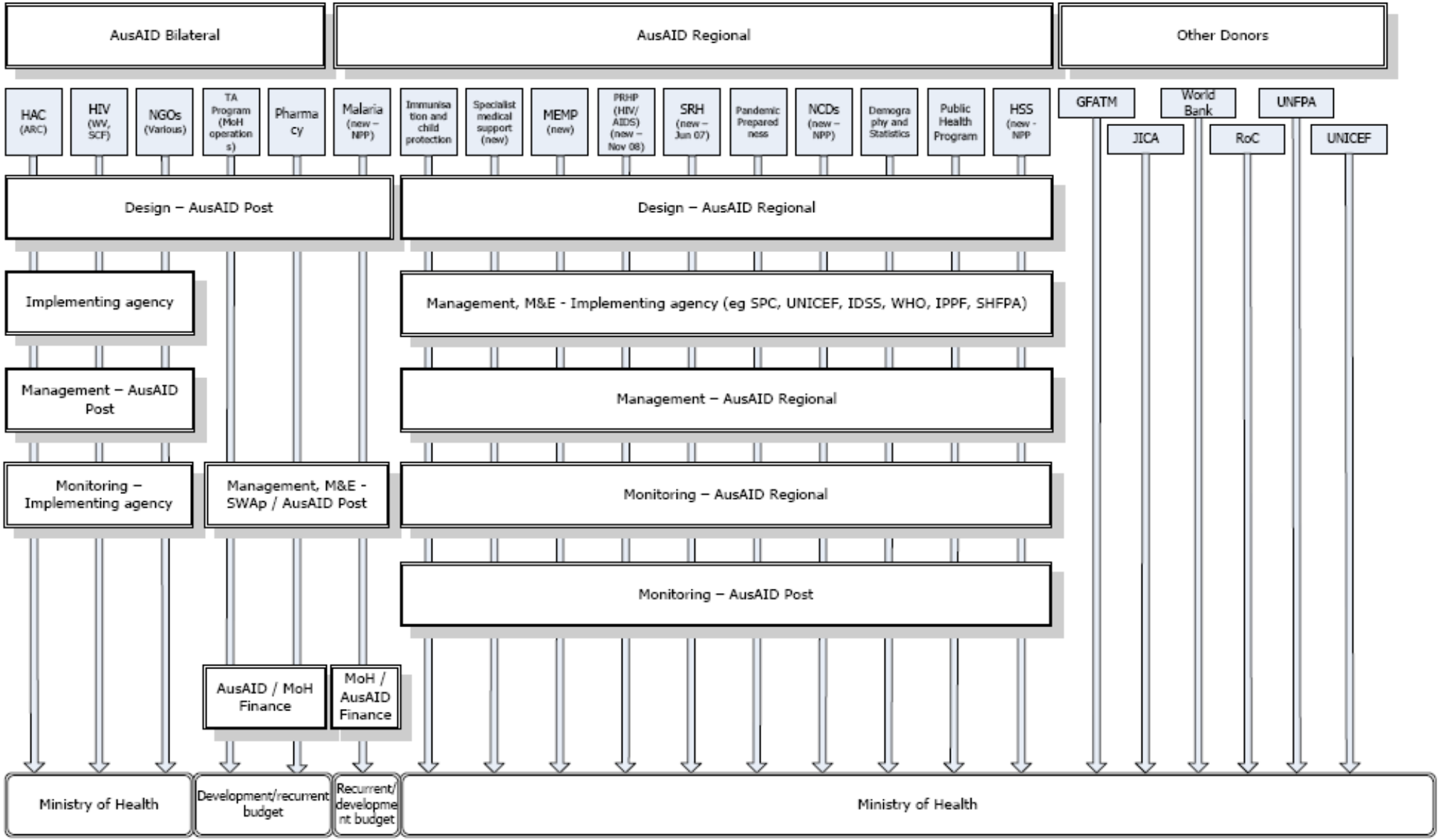
AusAID's support to the health sector is through both its bilateral and regional programs. These are briefly described in the following Table and presented in the schematic diagram below:

Activity	Acronym	Implement-ing agency	Counterpart	Summary	Commence-ment date	Completion date	Est. 2007	Total monetary value (AUD	Status
Bilateral									
SWAp support		Health adviser	MHMS						Design
Health Institutional Strengthening Project	HISP	JTAI	MHMS	Institutional strengthening project with components - 1. MOH exec, 2. MOH province support, 3. Hospital support	6/08/2001	6/08/2007		19.6m	Current
Health Sector Trust Account	HSTA	MOH / JTAI	MHMS	Trust account to support MOH with its operational costs	28/06/2002	6/08/2007		50.0m	Current
Health Awareness Project	HAP	Red Cross	Communities	Focus on health awareness raising in key conflict-affected areas in North Malaita and Weathercoast Guadalcanal	1/05/2005	31/04/2008	195,145	600,000.00	Current
Solomon Islands HIV and AIDS Prevention Program	SIHPP	SCF and WV	MHMS / SINAC	Targeted HIV prevention program to be delivered by 2 NGOs commencing early 2007	26-Jul-06	1-Jan-10	365,000.00	1,050,000.00	Design
SI NGO Cooperation Agreements		various NGOs		Various NGOs have health components in their cooperation agreements. Eg WV Stap Helti, ADRA HIV?? Etc					Current
PACTAF	PACTAF		MHMS	Ray Skinner, Director Pharmaceutical Services	18/04/2006	17/04/2007		97,065.48	Current
Australian Volunteers International	AVI	Various volunteers	MHMS	Libby Wrench - Chief Pharmacist Tash Hobbit - Principal Pharmacist Stuart ? - Mental Health ?? - physio	various	various			Current
Regional									

Pacific Island Project	PIP	RACS	MHMS	Teams of volunteer surgeons providing tertiary health care services	1-Jul-02	30-Jun-07		4,870,188.14	Current
Medical Equipment Maintenance Project	MEMP		MHMS		1-Apr-00	1-May-05		3,500,950.27	Completed
Pacific Regional HIV / AIDS Project	PRHP	IDSS	SINAC / MHMS / Oxfam	Capacity building of SINAC / MHMS, small grants for local organisations to implement activities. Budget is for regional activities.	20-Aug-99	30-Dec-08	$3,248,904.21	$17,652,627.00	Current
NCDs									Pending
South Pacific Reproductive Health and Family Planning Training Program	SPRHFPTP	SHFPA	SIPPA	Reproductive health training,	1-Jul-00	30-Jun-07		5,122,850.00	Current

5.4 Interrelationship between SWAp and other donor sources

The matrix over page provides schemata of the interrelationship between SWAp and other donor sources funding the Ministry of Health program. A significant issue for the MOH is the transaction costs involved in relating to all the separate development partners and implementating agencies. A sector program such as the HSSP will provide the opportunity to realign projects to directly support the MOH's NHSP in addition to streamlining fiduciary arrangements (funds flow and procurement), management and monitoring procedures.


AusAID Bilateral
AusAID Regional
Other Donors
HAC (ARC)
HIV (WV, SCF)
NGOs (Various)
TA Program (MoH operations)
Pharmacy
Malaria (new – NPP)
Immunisation and child protection
Specialist medical support (new)
MEMP (new)
PRHP (HIV/AIDS) (new – Nov 08)
SRH (new – Jun 07)
Pandemic Preparedness
NCDs (new – NPP)
Demography and Statistics
Public Health Program
HSS (new - NPP
GFATM
World Bank
UNFPA
JICA
RoC
UNICEF
Design – AusAID Post
Design – AusAID Regional
Implementing agency
Management, M&E - Implementing agency (eg SPC, UNICEF, IDSS, WHO, IPPF, SHFPA)
Management – AusAID Post
Management – AusAID Regional
Monitoring – Implementing agency
Management, M&E - SWAp / AusAID Post
Monitoring – AusAID Regional
Monitoring – AusAID Post
AusAID / MoH Finance
MoH / AusAID Finance
Ministry of Health
Development/recurrent budget
Recurrent/ development budget
Ministry of Health

6.1 Rationale for preparing an MTEF

A Medium Term Expenditure Framework (MTEF) is a multi year public expenditure planning exercise[19] which, in the context of projected funding, is used to:

- set out the future resource requirements for existing services; and
- assess the resource implications of future policy changes and any new programs implied by this.

MTEF's can be prepared on a whole of government basis, or for major sectors. Preparation of an MTEF involves a combination of "top-down" thinking in relation to resource availability and resource allocation to meet priorities, and "bottom-up" costing of existing services and new policies and programs.

While requiring time and effort to produce, potential benefits from an MTEF include:

- improving the efficiency of public expenditure through moving resources from low value to high value uses;
- ensuring that key services are adequately funded, and allowing the future financial implications of new policies to be fully assessed;
- improving predictability of resource flows;
- raising resource consciousness and promoting greater output or outcome focus;
- promoting inter-sectoral approaches; and
- improving accountability through considering the medium term financial implications of policy choices.

6.2 Methodology used in preparing the MTEF

The Solomon Islands Health SWAp MTEF provides an overview of funding available for the health sector from both government and development partners over the period 2008-11[20] (with comparative data for 2005-7 where available), together with a statement of expenditure priorities in the sector.

The MTEF draws on the recently completed Health Expenditure Review (HER) for Solomon Islands[21]. The HER collected and analyzed data for 2005, and this is used as the baseline for the MTEF. The HER classified data by source of funding, provider of health goods and services, health function, cost category, and region, now the MTEF uses the same classification system as used in the HER, but also attempts to provide a breakdown by organisational unit (reflected in the sub-heads of expenditure in the Solomon Islands Government recurrent budget) and by the strategic areas identified in the National Health Strategic Plan[22] (NHSP), though there is no baseline for these last two classifications provided by the HER.

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19 A good introduction to MTEF's in Health is provided in *Medium Term Expenditure Frameworks*, a paper published by the Health Systems Resource Centre of the UK Department for International Development in 2002.

20 The MTEF would be updated annually on a rolling basis.

21 *Solomon Islands Health Expenditure Review*, Solomon Islands Ministry of Health and AusAID, August 2006.

22 *Solomon Islands National Health Strategic Plan 2006-2010*, August 2006

Sources of funding are projected forward based on information available from the Solomon Islands Government and development partners.

A sectoral MTEF of this kind normally takes its lead from an MTEF at the national level. In the absence of a national level MTEF for Solomon Islands, projections of funding available for health (both from the government and from donors) provide the resource constraint for the Health MTEF. The policy driver of the Health MTEF is the NHSP. A further complication in initiating the Health MTEF was the lack of definition of activities to implement the NHSP, together with the limited information available on the costs associated with existing services. Normally an MTEF of this type would attempt to overlay the cost of new activities (such as those associated with the implementation of the NHSP) onto the cost of maintaining existing services, to plan the best use of available resources.

In this context, a number of different approaches to the Health MTEF were explored[23]. Initially, the approach taken to projecting expenditure focused on "top-down" thinking in relation to overall expenditure allocations. Under this approach, MOH was encouraged to define its expenditure priorities in aggregate terms through the MTEF, which would then act as a guide to budget allocations.

A second approach involved projections of the cost of maintaining existing services, on to which could be built the cost of new initiatives[24]. The baseline for these projections was the 2005 data on current expenditure by donors and SIG from the Health Expenditure Review (with SIG recurrent expenditure pro rated upwards to the level of the 2006 SIG recurrent estimates). The projections made some allowance for inflation, but no allowance for growth in demand for services due to population growth, etc. It was noted that the *current* expenditure captured in the baseline for these projections may not all be *recurrent* expenditure, suggesting that there was scope for funding to be freed up for new programming. Further, new programming could also be addressed via reallocation from existing programs where appropriate in terms of pursuing expenditure priorities. No capital expenditure was provided for in the initial projections. The cost of maintaining existing services was then compared with projected funding, to identify funding available for new programming. Known new initiatives (and their costs) were progressively deducted from the amount available for programming.

Neither of these approaches showed signs of embedding themselves into MOH management processes. Further, new information became available in the form of a much more complete definition and costing of HSSP activities designed to implement the NHSP, at least until the end of 2008. With this in mind, the focus of MTEF preparation shifted in this final draft to the more modest goal of planning for 2008[25].

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23 As Health MTEF preparation has proceeded, briefings have been provided to the MOH Executive and to the National Health Conference held in November 2006.

24 This approach was more in line with the public expenditure management principle of separating the cost of ongoing programs and activities from that of new initiatives (though it is difficult to apply this principle in the context of the Solomon Islands budget process because budget allocations are not linked clearly to the costs of delivering particular programs or services).

25 It is noted that the important transitional issues to be faced by MOH in 2007 as HSSP funding replaces existing mechanisms (HSTA and HISP in the main) are not addressed in the MTEF, which is predominantly a planning tool. These transitional issues are the subject of other detailed work.

HSSP costing for 2008 are built into the MTEF. SIG funded activity for 2008 is also projected in the MTEF, based on the recently finalised budget allocations for 2007. The expenditure projections for 2008 treat SIG baseline recurrent funding, the HSSP costing, and funding identified from other donors as programmed expenditure, though not all of this expenditure can be allocated in accordance with the various expenditure classifications (expenditure which can't be allocated is deemed unallocated expenditure in the MTEF). Total programmed expenditure is then compared with the funding envelope to determine whether there is additional funding available for programming (or, alternatively, whether there is over-programming).

It is recognized that the 2007 budget allocations do not fully reflect NHSP expenditure priorities, given that the MOH operational planning process for 2007 was not yet linked to the NHSP. MOH operational planning for 2008 will be linked to the NHSP, and projections of SIG funded expenditure in 2008 can be reviewed as operational planning for 2008 proceeds[26].

The draft MTEF is included in the following sections. It can be seen that the draft continues to include projections through to 2011 on the funding side, while on the expenditure side the focus is now on planning for 2008. While it is desirable for the MTEF to project expenditure beyond 2008 in order to allow for staged introduction of change in expenditure priorities, it is clear that MOH is not at a stage where this can be done meaningfully. Thinking in relation to expenditure priorities will advance in the context of preparing operational plans for 2008. Once the new operational planning process is functioning, it should then be possible to focus greater attention on expenditure allocation in the medium term. There will then be the opportunity for the MTEF to play its desired role in driving expenditure allocation and re-allocation within MOH, rather than simply reflecting allocations determined elsewhere.

Once formally adopted, The MTEF will then guide the planning and budgeting process for the SWAp each year, subject to review and possible modification annually to take up new information and to address emerging or changing priorities. The MTEF will also be used in relation to the monitoring and evaluation of the SWAp, with actual results compared with MTEF projections.

6.3 The funding envelope

The estimated funding envelope for 2008-11 is SI$985 million, with growth from SI$240 million in 2008 to SI$252 million in 2010, before a decline to SI$249 million in 2011. This compares with annual spending of SI$173 million in 2005, as estimated in the HER.

The Solomon Islands Government (SIG) accounts for 55 percent of funding over the period 2008-11, compared with 45 percent in 2005. SIG spending on health was estimated (in the HER) to be SI$77.5 million in 2005. This compares with a budget of SI$87.1 million (indicating that there was significant under-spending in that year).

[26] Expenditure ceilings for organisational units will need to be set and issued at the end of Stage 1 of operational planning for 2008 (by the end of April 2008). This may entail some changes to the projections for 2008 included in the MTEF as it currently stands (as these projections are based on the 2007 budget allocations). These changes would flow from the review of Stage 1 operational planning submissions from organisational units.

SIG spending on health is budgeted at SI$120.9 million in 2007 (including SIG funded development projects amounting to SI$6.6 million). There are no forward estimates of health expenditure prepared by SIG, though forward estimates of aggregate expenditure are now being produced. The 2007 budget figure is projected in the MTEF to grow at 5 percent per annum over the period 2008-11. Guidelines issued by MoF allow departments to escalate their baseline budgets by 3 percent each year (after removing any one-off expenditure items, which would include the capital items in the development budget). The budget process also allows departments to propose new initiatives for funding, and it is assumed that MOH will have some success in securing additional funding through this channel (the growth in the MOH recurrent budget from SI$87.1 million in 2005 to SI$114.3 million in 2007, representing growth of 31 percent over two year period, supports this assumption). There is no certainty that the current guidelines for preparing the budget will continue over the period 2008-11. It is also likely that the strong revenue growth experienced in recent years as a result of improved revenue administration and some recovery in the economy will level out, with consequences for the expenditure side of the budget. In this context, it is considered reasonable to project the MOH budget forward at 5 percent per annum (in nominal terms) over the period 2008-11. Discussions with the Budget Section of MOF uncovered no objections to this as a planning assumption.

The projections included in the MTEF in relation to donor funding draw on projections included in aide-memoires from past joint missions, projections included in the 2007 SIG Development Estimates, and other information obtained from individual donors. Data availability was discussed with the Department of National Planning and Aid Coordination. Funding identified from "other donors" in the aide-memoire from the June 2006 joint mission is distributed in the MTEF among the respective donors in accordance with the proportions revealed in the HER for 2005, except that higher levels of funding are projected for WHO, Japan and ROC based on more detailed information obtained in relation to the forward programs of these donors.

6.4 Expenditure priorities

The strategic areas identified in the NHSP 2006-10 (and their associated goals, outcome indicators, and objectives) define the priorities for MOH in the medium term. Seven of the strategic areas in NHSP focus on specific health issues or health service delivery issues, while the eighth focuses on organisational reform and strengthening of systems within the ministry.

Activities to address these strategic areas and to achieve the objectives associated with each strategic area are still being defined, and development of systems to facilitate this forms part of the SWAp preparation process. Many of these activities will already appear in the operational plans of divisions, but are yet to be presented in the context of the newly adopted strategic plan. Operational planning for 2008 will provide much clearer linkages to the NHSP.

It is unlikely to be possible to allocate all proposed health expenditure to the eight strategic areas in the NHSP. However, those health services with the greatest focus on the strategic areas should expect to see growth in the proportion of the overall funding envelope for health which is allocated to them. Other health services which cannot establish their priority in this way should expect to see their share of funding

contract, though this does not necessarily mean that they would experience funding cuts in dollar terms. Some of the allocations of health expenditure by organisational unit (recurrent budget sub-head) are notional, recognizing that these units may not have full responsibility for managing all of these resources.

Conclusions reached by the HER in relation to resource allocation and targeting provide useful insights into expenditure priorities. These include:

- as much is being spent on health administration as on primary and preventive health, and this balance may need adjusting away from overheads towards frontline services;
- the National Referral Hospital accounts for a high proportion of recurrent costs, suggesting the need for cost controls;
- the regional distribution of expenditure appears unbalanced, suggesting the need for some redistribution of expenditure away from Honiara and towards the provinces;
- distribution of expenditure does not correlate well with population health needs (inter-provincial allocations favour provinces with apparently better health outcomes);
- the cost of pharmaceuticals requires close management to ensure its share of total expenditure is controlled; and
- capital expenditure is low, and the share of expenditure allocated to capital projects may need to increase in the medium term.

6.5 Building HSSP costing into the MTEF

The costing referred to above are reflective of a simple database of HSSP activities[27] prepared for use in building up the MTEF for 2008. The database applies the classifications developed earlier in the Health Expenditure Review, adding new fields for organisational unit and NHSP Strategic Area. The database is included as Attachment 3 to this report.[28]

In addressing HSSP costing, the MTEF focuses on 2008 (the first full year of HSSP). This is because the MTEF is predominantly a planning tool, and not the appropriate tool for addressing the important transitional issues involved in the move from HISP and HSTA to HSSP during 2007. HSSP has yet to be defined and costed beyond 2008.

HSSP recurrent costs; Projected civil works to be funded under HSSP over the period August 2007 to December 2008 are estimated to cost SI$17.2 million (including $5.3 million in 2008). Purchases of capital equipment over the same period are estimated to cost $4.8 million.

A rough estimate of the annual recurrent costs associated with these capital items is $0.73 million, calculated as follows:

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[27] Given that HSSP costing is still being worked on, it is important that changes made to the spreadsheet "SWAp Activity and Cost Matrix Version 1.10" can be tracked so that the database used to update the MTEF can be amended accordingly.

[28] Given that HSSP costing is still being worked on, it is important that changes made to the spreadsheet "SWAp Activity and Cost Matrix Version 1.10" can be tracked so that the database used to update the MTEF can be amended accordingly.

- an allowance of 3 percent of the capital cost for maintenance costs associated with health facilities, and 1 percent for staff housing[29]; and
- an allowance of 5 percent of the capital cost for maintenance costs associated with equipment.

Provision for maintenance within the SIG budget is not as transparent as it should be. The line items "repair of official buildings" and "repair of government housing" are drawn on for maintenance, but are also used for minor new works. Further, while some funding is provided within the Ministry of Health budget under these line items, the bulk of funding is centralized in the sub-head for the Urban Works and Services Division of the Department of Infrastructure Development.

These estimates of maintenance costs are no doubt higher than what will actually be spent. Other recurrent costs associated with the projected civil works include any additional staffing requirements, and the cost of utilities and other services associated with the facilities. Some of the projected works replace existing facilities, and in these cases costs associated with staffing and services are already being incurred (though these costs are likely to be at a higher level for the replacement facilities).

Given that the projected capital expenditure over the period to December 2008 is relatively modest, the recurrent costs associated with this capital expenditure are likely to be manageable. However, it is noted that the civil works program planned under HSSP for the period August 2007 to December 2008 is part of a larger infrastructure agenda being developed by MOH. This suggests that the recurrent cost requirements of planned infrastructure will need to be monitored closely[30].

Also of concern in relation to the sustainability of the health system is the fact that many of the major items to be funded under HSSP are themselves recurrent costs. The largest item of this nature is pharmaceuticals and medical supplies and consumables (costed at $50 million for the period August 2007 to December 2008), while the other major item is operational support to NRH.

6.6 Review of the Provincial Resource Allocation Formula

The Resource Allocation Formula (RAF) was developed under HISP to provide a more objective means of allocating funding in health. The original formula involved an initial allocation between national and provincial expenditure, and within the provincial allocation an allocation among the Provincial Health Services (relating principally to the distribution of provincial health services grants among the provinces).

The RAF is no longer used by MOH, and there is little remaining institutional memory in relation to how it was used. No documentation could be sighted relating to the national / provincial split in the formula, while the formula for allocations among the provinces is documented in the HSTA manual. This formula calculates the *proportion* of funding available for provincial health services grants that should go to each province. It does not address the *level* of funding for provincial health services. A hard copy of the

[29] These are the rates used by the Central Property Unit of the Department of Lands and Survey, which is being set up to manage government housing, and eventually government buildings.

[30] There are other donor funded infrastructure projects in the pipeline that will bring with them additional recurrent costs e.g. Stage 4 of the NRH redevelopment.

application of the formula to the 2001 budget is contained in the HSTA manual. Factors addressed in the formula included:

- population (with an attempt to account for people displaced by the ethnic tension);
- age /sex distribution;
- disease pattern (malaria incidence, maternal deaths, life expectancy);
- provincial logistics (distance, size of province, frequency of transport services, travel costs);
- church health services;
- current infrastructure level; and
- other factors (referral costs, provincial size factor, new year migration).

To assist in projecting expenditure requirements by province)[31], the Provincial RAF has been reviewed in the course of preparing the MTEF. In addition to addressing the relevant issues in allocating funding to Provincial Health Services, ease of use and sustainability were important considerations in the review. As with the MTEF, it is envisaged that the Provincial RAF will be maintained by the Policy and Planning Division of MOH, and the Director of Policy and Planning has been engaged in the review. If supported by MOH, the introduction of the RAF will be preceded by piloting, and an assessment with finalisation and agreement prior to implementation. Should the Provincial RAF receive Should the Provincial RAF receive endorsement from MOH, then it could readily be applied to the 2008 projections.

Factors addressed in the revised formula include:

- population[32];
- an indicator of workload (PHC outpatient contacts)[33];
- impact of hospitals etc. not funded by the Provincial Health Service[34];
- an indicator of disease burden (infant mortality rate);
- a poverty indicator (average annual per capita expenditure);
- a cost factor to account for differences in the cost of delivering health services in the provinces relative to Honiara due to remoteness, provincial logistics, and scale of operations (for example, in the case of Rennell / Bellona); and

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31 It is noted that the Provincial RAF was originally devised to assist in allocating health services grants to provinces, and the revision has also been prepared on his basis. From a resource allocation perspective, there would also be merit in applying the RAF to aggregate allocations to provinces including health services grants, salaries and wages paid by the national government, and grants to church-based service providers (in which case the adjustment for church-based facilities which is included in the RAF could be dropped). It would then be necessary to provide for the management of each of these components of the aggregate, within the context of the RAF.

32 Population projections used in the draft Provincial RAF come from the 1999 Census demographic projections, which remain the Government's official source and are used by MOH. It is noted that the recently completed Household Income and Expenditure Survey includes population projections which differ considerably from the census projections (both in terms of the total population and its distribution among the provinces), together with commentary suggesting that the 1999 census was "grossly undercounted" due to the ethnic tension.

33 As a general principle, parameters used for allocation should be independent variables rather than internally generated measures of workload (to avoid any incentive for a focus on manipulating this data). However, in the short term it is considered that the inclusion of this indicator is justified, albeit with a low weighting.

34 This adjustment estimates the proportion of the demand for routine lower secondary care, primary care, and preventive services in each province which is met by providers not funded by the Provincial Health Service i.e. NRH and church-based service providers. In a broader exercise to model the financing of the health system this estimate would be transferred to allocations to those other service providers, while in this more limited exercise it is accounted for via a redistribution among provincial allocations.

- capacity for a performance bonus for provinces performing well, should management wish to use this.

Adjustments built into the formula in relation to the above factors involve a degree of judgment, and should be reviewed by the MOH before the formula is adopted. In particular, the adjustments relating to the impact of hospitals etc. not funded by the Provincial Health Service and the "cost" factor are significant, and warrant discussion in MOH. It is desirable for adjustments such as these to be based on objective data, but relevant data is difficult to identify. Provided that assumptions made in the RAF are transparent, they can then be debated and reviewed over time.

Additional factors could be built in to the formula in an attempt to better capture the different situations facing the various provincial health services in meeting health needs, though it is also important to avoid making the formula unduly complex. One factor which could be included if and when data is available would be the level of access to health services, on the assumption that provinces where access is poorest could be given extra funding to pursue outreach activities. As the formula stands, this can be captured indirectly via the "cost" factor. The draft revised RAF is presented below.

Provincial Resource Allocation Formula (RAF)
(a formula for use in allocating health services grants to provinces)

Provincial Health Service		Honiara City Council	Guadalcanal	Malaita	Makira / Ulawa	Central	Isabel	Western	Temotu	Choiseul	Rennell / Bellona	TOTAL
	weight											
Population 2007 ^		59,060	73,032	149,180	37,674	26,052	24,542	75,759	22,771	24,132	2,822	495,024
Proportion of population	*4*	11.9%	14.8%	30.1%	7.6%	5.3%	5.0%	15.3%	4.6%	4.9%	0.6%	100.0%
PHC outpatient contacts (2005) #		111,000	125,000	207,000	69,000	48,000	43,000	134,000	39,000	40,000	4,100	820,100
Proportion	*1*	13.5%	15.2%	25.2%	8.4%	5.9%	5.2%	16.3%	4.8%	4.9%	0.5%	100.0%
Progressive allocation		12.3%	14.9%	29.2%	7.8%	5.4%	5.0%	15.5%	4.6%	4.9%	0.6%	100.0%
Impact of Hospitals etc not funded by PHS		Yes	Yes	Yes	No	No	No	Yes	No	Yes	No	
Adjustment		0.50	0.30	0.15	0.00	0.00	0.00	0.20	0.00	0.10	0.00	
Progressive allocation		7.5%	12.8%	30.4%	9.5%	6.6%	6.2%	15.2%	5.7%	5.4%	0.7%	100.0%
(female IMR per thousand) +		59.4	68.4	66.4	63.4	62.4	69.4	64.4	60.4	64.4	62.4	
Disease burden indicator		Lowest	Highest	Highest	Medium	Medium	Highest	Medium	Lowest	Medium	Medium	
Adjustment		1.00	1.04	1.04	1.02	1.02	1.04	1.02	1.00	1.02	1.02	
Progressive allocation		7.3%	12.9%	30.8%	9.5%	6.6%	6.2%	15.1%	5.5%	5.3%	0.7%	100.0%
(average annual per capita expenditure: $) ^		10,830	5,240	3,305	2,852	5,537	3,718	4,671	2,850	3,557	5,393	
Poverty indicator		Lowest	Medium	Highest	Highest	Medium	Highest	Medium	Highest	Highest	Medium	
Adjustment		1.00	1.02	1.04	1.04	1.02	1.04	1.02	1.04	1.02	1.02	
Progressive allocation		7.1%	12.8%	31.1%	9.6%	6.5%	6.3%	15.0%	5.6%	5.3%	0.7%	100.0%
Cost factor *		Lowest	Medium	Medium	Medium	Medium	Medium	Medium	Highest	Highest	Highest	
Adjustment		1.00	1.05	1.05	1.06	1.03	1.06	1.10	1.20	1.15	1.50	
Progressive allocation		6.6%	12.6%	30.5%	9.5%	6.3%	6.2%	15.4%	6.3%	5.7%	0.9%	100.0%
	rate											
Performance bonus (Yes / No)	*2%*											
Final allocation		**6.6%**	**12.6%**	**30.5%**	**9.5%**	**6.3%**	**6.2%**	**15.4%**	**6.3%**	**5.7%**	**0.9%**	**100.0%**

^ from 1999 Census Demographic Projections
# primary health care data from MoH National Health Report 2005
+ from 1999 Census
* estimate of cost of delivering health services in provinces relative to Honiara due to remoteness, provincial logistics, and scale (in the case of Rennell / Bellona)

Comparison of population estimates		Honiara City Council	Guadalcanal	Malaita	Makira / Ulawa	Central	Isabel	Western	Temotu	Choiseul	Rennell / Bellona	TOTAL
Population 2007 (Census projections)		59,060	73,032	149,180	37,674	26,052	24,542	75,759	22,771	24,132	2,822	495,024
Proportion of population		11.9%	14.8%	30.1%	7.6%	5.3%	5.0%	15.3%	4.6%	4.9%	0.6%	100.0%
Population 2005/6 (HIES)		69,189	84,438	140,569	50,026	24,491	23,638	81,852	23,800	31,259	4,409	533,671
Proportion of population		13.0%	15.8%	26.3%	9.4%	4.6%	4.4%	15.3%	4.5%	5.9%	0.8%	100.0%

Comparison of RAF with 2007 allocations		Honiara City Council	Guadalcanal	Malaita	Makira / Ulawa	Central	Isabel	Western	Temotu	Choiseul	Rennell / Bellona	TOTAL
2007 Health Services Grant ($)		1,613,780	3,112,292	5,532,962	2,190,130	1,613,780	1,613,780	4,495,532	1,729,050	1,452,402	461,081	23,814,789
Proportion		6.8%	13.1%	23.2%	9.2%	6.8%	6.8%	18.9%	7.3%	6.1%	1.9%	100.0%
2007 Staffing Budget ($)		2,227,512	2,095,218	5,734,039	2,469,329	1,372,974	2,100,537	3,857,134	2,046,013	1,660,612	383,370	23,946,738
Proportion		9.3%	8.7%	23.9%	10.3%	5.7%	8.8%	16.1%	8.5%	6.9%	1.6%	100.0%
2007 Total SIG Allocation to Provinces ($) **		3,841,292	5,207,510	11,267,001	4,659,459	2,986,754	3,714,317	8,352,666	3,775,063	3,113,014	844,451	47,761,527
Proportion		8.0%	10.9%	23.6%	9.8%	6.3%	7.8%	17.5%	7.9%	6.5%	1.8%	100.0%
Resource allocation formula		6.6%	12.6%	30.5%	9.5%	6.3%	6.2%	15.4%	6.3%	5.7%	0.9%	100.0%

** not including grants to church hospitals, or any SIG funded development expenditure

6.7 Linking the MTEF with existing MOH planning and budgeting systems

The MTEF will play an important role in guiding the annual planning and budgeting process engaged in by MOH.

The MOH planning and budgeting system has been developed in the context of the government-wide planning system[35] and the centralized SIG financial system. MOH is alone among departments in also running a separate financial package (MYOB), set up to manage the Health Sector Trust Account (HSTA). The MOH planning system has also been adapted to meet the requirements of a government-wide departmental corporate planning process which involves the preparation by departments of medium term corporate plans, annual work plans and annual reports[36].

6.8 Corporate Planning and "sign-off"

MOH's annual planning and budgeting process currently involves the preparation of operational plans by organisational units within MOH (driven by the strategic plan of MOH, now the NHSP 2006-10) that are used to prepare the MOH budget submission for negotiation with MOF (covering both the recurrent budget and activities for which donor funding is sought and, if successful, reported in the development budget).

Under the SWAp, operational planning will be guided both by the NHSP (in terms of priorities) and the MTEF (which will set out the broad implications for expenditure of NHSP priorities, based on projected funding). Operational plans will be aggregated into an MOH Annual Sectoral Expenditure Plan (covering expenditure funded from both SIG and donor sources), within the funding envelope set out in the MTEF. The MOH budget submission will be prepared as a sub-set of the Annual Sectoral Expenditure Plan, and negotiated with MoF.

Using the MTEF to guide the process of preparing annual operational plans has the potential to significantly improve the efficiency of this process. The process currently appears somewhat open-ended, with some divisions bidding for very substantial increases in resources. This is not to say that these bids do not reflect needs, but that they are unrealistic in terms of available funding. Providing strong guidance on priorities at the outset of the operational plan preparation process will curtail ambit bidding and focus attention on planning the use of available resources. This guidance should be provided in the form of ceilings agreed by MOH management, with the ceilings being consistent with the MTEF.

Budget preparation guidelines issued by MOF encourage departments to redistribute their budgets across sub-heads and line items to better reflect expenditure patterns and emerging priorities, provided that they remain within the expenditure ceilings set at the departmental level (ministry level in the case of MOH). Few

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35 The Grand Coalition for Change (GCC) Government has issued a *Policy Framework Document* and associated translation document; GCCG health policy statements are reflected in the NHSP.

36 For a description of this system refer to *SIG Corporate Planning Process – Handbook for Departments*, April 2005, issued by the Cabinet Office, Department of the Prime Minister and Cabinet and also published in the Permanent Secretary's Handbook issued by same office. The departmental corporate planning process links with the national planning system and the SIG annual budget process. The status of this system under the GCC Government is not clear.

departments take advantage of this opportunity, and it would appear that MOH should be addressing this at an early stage in the planning and budgeting cycle.

6.9 Maintaining the MTEF

The MTEF is designed as an operational planning tool, to be updated as and when new information becomes available, and to be used as a tool to refine thinking on priorities through scenario building.

With this in mind, the MTEF needs a home within the MOH, with responsibility for processing updates as and when required. A regular update of the MTEF is proposed in the Draft Program Cycle (coinciding with the proposed second joint donor mission in September/October each year), and new information to facilitate this review should be collected through the year. The Policy and Planning Division of MOH has been identified as the appropriate place to house the MTEF. This has been agreed with the Permanent Secretary (Special Duties) and support has been provided to the Director of Policy and Planning since November 2006 to develop the institutional capacity to manage the MTEF. In addition to assuming responsibility for updating the MTEF, this division will take the opportunity to use the MTEF as a planning tool through scenario building to trace the implications of possible changes in expenditure priorities or funding.

It is also important that the Ministry of Finance and Treasury and the Ministry of National Planning and Aid Coordination maintain a stake in the MTEF (both Ministries have been consulted during the preparation of the MTEF). It is not suggested that a separate formal structure would be needed to facilitate this continued involvement, but that the MTEF be addressed as part of the participation of these departments in monitoring and coordinating the SWAp and through the ongoing dialogue between the MOH and these departments in relation to planning and budgeting.

6.10 The Funding envelope and draft MTEF

HEALTH SWAp MEDIUM TERM EXPENDITURE FRAMEWORK

Health Expenditure Sources

HER Code	Source	2005 (SI$m)	(%)	2006 (SI$m)	(%)	2007 (SI$m)	(%)	2008 (SI$m)	(%)	2009 (SI$m)	(%)	2010 (SI$m)	(%)	2011 (SI$m)	(%)	2008-11 (SI$m)	(%)
HS1	Public	77.51	45%	99.73	47%	120.94	52%	125.00	52%	131.25	54%	137.82	55%	144.71	58%	538.79	55%
HS1.1	*Central Government*	*77.51*	*45%*	*99.73*	*47%*	*120.94*	*52%*	*125.00*	*52%*	*131.25*	*54%*	*137.82*	*55%*	*144.71*	*58%*	*538.79*	*55%*
HS1.2	*Provincial Governments*																
HS2	Donors	95.47	55%	111.12	53%	113.36	48%	114.98	48%	113.72	46%	113.75	45%	104.13	42%	446.58	45%
HS2.1	*Australia*	*74.99*	*43%*	*78.14*	*37%*	*75.63*	*32%*	*85.25*	*36%*	*85.25*	*35%*	*85.25*	*34%*	*75.63*	*30%*	*331.38*	*34%*
HS2.2	*World Bank*	*5.25*	*3%*	*10.01*	*5%*	*1.00*	*0%*	*3.00*	*1%*	*3.00*	*1%*	*3.00*	*1%*	*3.00*	*1%*	*12.00*	*1%*
HS2.3	*Global Fund*	*5.47*	*3%*	*5.00*	*2%*	*5.00*	*2%*	*5.00*	*2%*	*5.00*	*2%*	*5.00*	*2%*	*5.00*	*2%*	*20.00*	*2%*
HS2.4	*WHO*	*2.82*	*2%*	*7.00*	*3%*	*7.00*	*3%*	*7.00*	*3%*	*7.00*	*3%*	*7.00*	*3%*	*7.00*	*3%*	*28.00*	*3%*
HS2.5	*UNICEF*	*0.04*	*0%*	*0.10*	*0%*	*0.10*	*0%*	*0.10*	*0%*	*0.10*	*0%*	*0.10*	*0%*	*0.10*	*0%*	*0.40*	*0%*
HS2.6	*UNFPA*	*0.85*	*0%*	*0.80*	*0%*	*0.80*	*0%*	*0.80*	*0%*	*0.80*	*0%*	*0.80*	*0%*	*0.80*	*0%*	*3.20*	*0%*
HS2.7	*Japan*	*0.41*	*0%*	*3.96*	*2%*	*7.73*	*3%*	*7.73*	*3%*	*6.47*	*3%*	*6.50*	*3%*	*6.50*	*3%*	*27.20*	*3%*
HS2.8	*ROC*	*2.54*	*1%*	*3.00*	*1%*	*13.00*	*6%*	*3.00*	*1%*	*3.00*	*1%*	*3.00*	*1%*	*3.00*	*1%*	*12.00*	*1%*
HS2.9	*NGOs*	*0.54*	*0%*	*0.60*	*0%*	*0.60*	*0%*	*0.60*	*0%*	*0.60*	*0%*	*0.60*	*0%*	*0.60*	*0%*	*2.40*	*0%*
HS2.10	*Churches*																
HS2.11	*NZ*	*1.07*	*1%*	*1.00*	*0%*	*1.00*	*0%*	*1.00*	*0%*	*1.00*	*0%*	*1.00*	*0%*	*1.00*	*0%*	*4.00*	*0%*
HS2.12	*EU*	*1.49*	*1%*	*1.50*	*1%*	*1.50*	*1%*	*1.50*	*1%*	*1.50*	*1%*	*1.50*	*1%*	*1.50*	*1%*	*6.00*	*1%*
Total		172.98	100%	210.85	100%	234.30	100%	239.98	100%	244.98	100%	251.57	100%	248.83	100%	985.36	100%

Notes

1. Classification follows *Health Expenditure Review*
2. Figures for 2005 from *Health Expenditure Review* (Central Government figure includes grants to church hospitals and clinics)
3. Central Government figure for 2006 and 2007 from budget (recurrent plus SIG funded development projects)
4. Central Government funding for 2008-2011 escalated at 5% nominal (3% allowed by MoF for escalation of baseline, plus allowance for some new initiatives)
5. Funding from Australia for 2008-11 based on advice that program would be $A12 million per annum plus additional funding related to malaria programs (exchange rate used is A$1 = SI$5.5)
6. Funding from World Bank for 2008-11 based on advice that input would be $US2 million over five years, commencing 2008.
7. Funding from other donors for 2007-11 prepared by working back from SI$20 million estimate in aide memoire, with reference to 2005 baseline from HER (WHO and Japan funding reviewed separately)
8. Additional malaria funding from Australia: 2007, 2011 SI$m 9.625
   2008,9,10 SI$m 19.25
9. Allocation to stage 4 of NRH from ROC 2007 SI$m 10

HEALTH SWAp MEDIUM TERM EXPENDITURE FRAMEWORK

Providers of Health Goods and Services

HER Code	Provider	2005 (Sl$m)	2005 (%)	2006 (Sl$m)	2006 (%)	2007 (Sl$m)	2007 (%)	2008 (Sl$m)	2008 (%)	2009 (Sl$m)	2009 (%)	2010 (Sl$m)	2010 (%)	2011 (Sl$m)	2011 (%)	2008-11 (Sl$m)	2008-11 (%)
PS1	Public (MOH)	170.11	98%					85.08	37%							85.08	37%
	SIG							0.00									
	HSSP							85.08									
	Other donors							0.00									
PS1.1	*National Referral Hospital (NRH)*	*41.59*	*24%*					*6.66*	*3%*							*6.66*	*3%*
	SIG																
	HSSP							6.66									
	Other donors																
PS1.2	*Provincial Hospitals and Clinics*	*48.72*	*28%*					*4.01*	*2%*							*4.01*	*2%*
	SIG																
	HSSP							4.01									
	Other donors																
PS1.3	*Overseas Hospitals, incl. travel*	*1.13*	*1%*					*0.00*	*0%*							*0.00*	*0%*
	SIG																
	HSSP																
	Other donors																
PS1.4	*Medical Store*	*9.78*	*6%*					*30.50*	*13%*							*30.50*	*13%*
	SIG																
	HSSP							30.50									
	Other donors																
PS1.5	*Malaria Program*	*7.39*	*4%*					*9.34*	*4%*							*9.34*	*4%*
	SIG																
	HSSP							9.34									
	Other donors																
PS1.6	*Reproductive Health Program*	*2.47*	*1%*					*0.66*	*0%*							*0.66*	*0%*
	SIG																
	HSSP							0.66									
	Other donors																
PS1.7	*Disease Control Program*	*2.03*	*1%*					*7.25*	*3%*							*7.25*	*3%*
	SIG																
	HSSP							7.25									
	Other donors																
PS1.8	*Disease Control Program - HIV*	*1.20*	*1%*					*2.28*	*1%*							*2.28*	*1%*
	SIG																
	HSSP							2.28									
	Other donors																
PS1.9	*Education and Training*	*9.89*	*6%*					*2.31*	*1%*							*2.31*	*1%*
	SIG																
	HSSP							2.31									
	Other donors																
PS1.10	*Health Administration*	*43.45*	*25%*					*18.39*	*8%*							*18.39*	*8%*
	SIG																
	HSSP							18.39									
	Other donors																
PS1.11	*Health Promotion*	*0.81*	*0%*					*3.67*	*2%*							*3.67*	*2%*
	SIG																
	HSSP							3.67									
	Other donors																

HER Code	Provider	2005 (SI$m)	(%)	2006 (SI$m)	(%)	2007 (SI$m)	(%)	2008 (SI$m)	(%)	2009 (SI$m)	(%)	2010 (SI$m)	(%)	2011 (SI$m)	(%)	2008-11 (SI$m)	(%)
	Other	*1.65*	*1%*					*0.00*	*0%*							*0.00*	*0%*
	SIG																
	HSSP																
	Other donors																
PS2	Private & Non Profit	2.87	2%	0.00	0%	0.00	0%	*0.10*	0%	0.00		0.00		0.00		0.10	0%
	SIG							*0.00*									
	HSSP							*0.10*									
	Other donors							*0.00*									
PS2.1	*Hospitals (2 church) & related Clinics*	*2.66*	*2%*					*0.00*	*0%*							*0.00*	*0%*
	SIG																
	HSSP																
	Other donors																
	Other	*0.21*	*0%*					*0.00*	*0%*							*0.00*	*0%*
	SIG																
	HSSP																
	Other donors																
	Unallocated by provider			210.85	100%	234.30	100%	144.45	63%	0.00		0.00		0.00		144.45	63%
	SIG			99.73		120.94		117.72								117.72	
	HSSP							0.00								0.00	
	Other donors			111.12		113.36		26.73								26.73	
Total Programmed Expenditure		172.98	100%	210.85	100%	234.30	100%	229.62	100%	0.00		0.00		0.00		229.62	100%
	Escalator for inflation	1.03															
	Funding envelope							239.98		244.98		251.57		248.83		985.36	
	Total programmed expenditure							229.62		0.00		0.00		0.00		229.62	
	Available for programming							10.36		244.98		251.57		248.83		755.74	
				breakdown:		HSSP donors		3.08									
						SIG development		5.00									
						SIG recurrent		2.28									

Notes

1. Classification follows *Health Expenditure Review*
2. Figures for 2005 from *Health Expenditure Review*
3. Breakdown by provider not available for subsequent years.

HEALTH SWAp MEDIUM TERM EXPENDITURE FRAMEWORK

Health Expenditure Functions

HER Code		Function	2005 (SI$m)	2005 (%)	2006 (SI$m)	2006 (%)	2007 (SI$m)	2007 (%)	2008 (SI$m)	2008 (%)	2009 (SI$m)	2009 (%)	2010 (SI$m)	2010 (%)	2011 (SI$m)	2011 (%)	2008-11 (SI$m)	2008-11 (%)
HF1		Hospital Care	57.32	33%					8.41	4%							8.41	0%
		SIG							0.00									
		HSSP							8.41									
		Other donors							0.00									
	HF1.1	*Inpatient*							*0.13*									
		SIG																
		HSSP							0.13									
		Other donors																
	HF1.2	*Outpatient*							*0.00*									
		SIG																
		HSSP																
		Other donors																
HF2		Primary Care	5.88	3%					2.27	1%							2.27	0%
		SIG																
		HSSP							2.27									
		Other donors																
HF3		Prev and Public Health	22.45	13%	2006.00	90%	2007.00	90%	28.67	12%	2009.00		2010.00		2011.00		6058.67	97%
		SIG																
		HSSP																
		Other donors																
	HF3.1	*Malaria control*	*6.03*	*3%*					*12.40*	*5%*							*12.40*	*0%*
		SIG																
		HSSP							12.40									
		Other donors																
	HF3.2	*Reproductive Health*	*2.26*	*1%*					*0.66*	*0%*							*0.66*	*0%*
		SIG																
		HSSP							0.66									
		Other donors																
	HF3.3	*Disease Control*	*2.10*	*1%*					*7.25*	*3%*							*7.25*	*0%*
		SIG																
		HSSP							7.25									
		Other donors																
	HF3.4	*Disease Control HIV*	*2.76*	*2%*					*2.28*	*1%*							*2.28*	*0%*
		SIG																
		HSSP							*2.28*									
		Other donors																
	HF3.5	*Health Promotion*	*0.95*	*1%*					*6.09*	*3%*							*6.09*	*0%*
		SIG																
		HSSP							6.09									
		Other donors																
	HF3.6	*Other Public Health*							*0.00*	*0%*							*0.00*	
		SIG																
		HSSP																
		Other donors																

HER Code	Function	2005 (SI$m)	(%)	2006 (SI$m)	(%)	2007 (SI$m)	(%)	2008 (SI$m)	(%)	2009 (SI$m)	(%)	2010 (SI$m)	(%)	2011 (SI$m)	(%)	2008-11 (SI$m)	(%)
	Other	*8.35*	*5%*					*0.00*	*0%*							*0.00*	*0%*
	SIG																
	HSSP																
	Other donors																
HF4	Medical goods (pharmacy)	29.14	17%					31.17	14%							31.17	0%
	SIG																
	HSSP							31.17									
	Other donors																
HF5	Health Administration	29.11	17%					9.34	4%							9.34	0%
	SIG																
	HSSP							9.34									
	Other donors																
HF6	Education and Training	10.72	6%					2.31	1%							2.31	0%
	SIG																
	HSSP							2.31									
	Other donors																
HF7	Various Functions	18.37	11%					3.00	1%							3.00	0%
	SIG																
	HSSP							3.00									
	Other donors																
	Unallocated by function			210.85	10%	234.30	10%	144.45	63%							144.45	2%
	SIG			99.73		120.94		117.72								117.72	
	HSSP							0.00								0.00	
	Other donors			111.12		113.36		26.73								26.73	
Total Programed Expenditure		172.98	100%	2216.85	100%	2241.30	100%	229.62	100%	2009.00		2010.00		2011.00		6259.62	100%
	Escalator for inflation	1.03															
	Funding envelope							239.98		244.98		251.57		248.83		985.36	
	Total programmed expenditure							229.62		2009.00		2010.00		2011.00		6259.62	
	Available for programming							10.36		-1764.02		-1758.43		-1762.17		-5274.26	
				breakdown:		HSSP donors		3.08									
						SIG development		5.00									
						SIG recurrent		2.28									

Notes

1. Classification follows *Health Expenditure Review*
2. Figures for 2005 from *Health Expenditure Review*
3. Breakdown by function not available for subsequent years

HEALTH SWAp MEDIUM TERM EXPENDITURE FRAMEWORK

Health Cost Categories

HER Code	Cost category	2005 (Sl$m)	(%)	2006 (Sl$m)	(%)	2007 (Sl$m)	(%)	2008 (Sl$m)	(%)	2009 (Sl$m)	(%)	2010 (Sl$m)	(%)	2011 (Sl$m)	(%)	2008-11 (Sl$m)	(%)
HC1	Current	154.43	89%	96.33	46%	113.67	49%	192.11	84%							192.11	84%
	SIG			96.33		113.67		117.07									
	HSSP							75.04									
	Other donors							0.00									
HC1.1	*Salaries, wages, benefits*	*54.08*	*31%*	*46.93*	*22%*	*61.84*	*26%*	*63.69*	*28%*							*63.69*	*28%*
	SIG			46.93		61.84		63.69									
	HSSP																
	Other donors																
HC1.2	*Supplies*	*38.05*	*22%*	*26.07*	*12%*	*27.38*	*12%*	*59.73*	*26%*							*59.73*	*26%*
	SIG			26.07		27.38		28.20									
	HSSP							31.53									
	Other donors																
HC1.3	*Services*	*30.78*	*18%*	*21.09*	*10%*	*22.14*	*9%*	*36.13*	*16%*							*36.13*	*16%*
	SIG			21.09		22.14		22.81									
	HSSP							13.32									
	Other donors																
HC1.4	*Subsidies/transfers*	*0.08*	*0%*	*2.24*	*1%*	*2.31*	*1%*	*16.43*	*7%*							*16.43*	*7%*
	SIG			2.24		2.31		2.38									
	HSSP							14.06									
	Other donors																
HC1.5	*Technical assistance*	*16.39*	*9%*					*16.13*	*7%*							*16.13*	*7%*
	SIG																
	HSSP							16.13									
	Other donors																
	Other	*15.06*	*9%*					*0.00*	*0%*							*0.00*	*0%*
	SIG																
	HSSP																
	Other donors																
HC2	Capital	18.55	11%	3.39	2%	17.27	8%	10.77	5%							10.77	5%
	SIG			3.39		7.27		0.64									
	HSSP							10.14									
	Other donors					10.00		0.00									
HC2.1	*Infrastructure*	*7.95*	*5%*	*2.50*	*1%*	*16.35*	*7%*	*5.34*	*2%*							*5.34*	*2%*
	SIG			2.50		6.35		0.00									
	HSSP							5.34									
	Other donors					10.00											
HC2.2	*Equipment*	*5.22*	*3%*	*0.89*	*0%*	*0.92*	*0%*	*5.44*	*2%*							*5.44*	*2%*
	SIG			0.89		0.92		0.64									
	HSSP							4.80									
	Other donors																
	Other	*5.38*	*3%*					*0.00*	*0%*							*0.00*	*0%*
	SIG																
	HSSP																
	Other donors																
	Unallocated by cost category			111.12	53%	103.36	44%	26.74	12%							26.74	12%
	SIG			0.00		0.00		0.01								0.01	
	HSSP							0.00								0.00	
	Other donors			111.12		103.36		26.73								26.73	
Total Programmed Expenditure		172.98	100%	210.85	100%	234.30	100%	229.62	100%	0.00		0.00		0.00		229.62	100%
	Escalator for inflation	1.03															
	Funding envelope							239.98		244.98		251.57		248.83		985.36	
	Total programmed expenditure							229.62		0.00		0.00		0.00		229.62	
	Available for programming							10.36		244.98		251.57		248.83		755.74	
				breakdown:		HSSP donors		3.08									
						SIG development		5.00									
						SIG recurrent		2.28									

Notes

1. Classification follows *Health Expenditure Review*
2. Figures for 2005 from *Health Expenditure Review*
3. Limited data available by cost category for 2006 and 2007. Focus is on planning for 2008.

HEALTH SWAp MEDIUM TERM EXPENDITURE FRAMEWORK

Regional

HER Code	Region	2005 (SI$m)	(%)	2006 (SI$m)	(%)	2007 (SI$m)	(%)	2008 (SI$m)	(%)	2009 (SI$m)	(%)	2010 (SI$m)	(%)	2011 (SI$m)	(%)	2008-11 (SI$m)	(%)
HR1	NRH Honiara	38.79	2%					9.54	4%							9.54	0%
	SIG																
	HSSP							9.54									
	Other donors																
HR2	Provinces	2099.92	96%	2006.00	90%	2007.00	90%	54.66	24%	2009.00		2010.00		2011.00		6084.66	97%
	SIG							0.00									
	HSSP							54.66									
	Other donors							0.00									
HR2.1	*Honiara city*	*37.29*	*2%*					*0.00*	*0%*							*0.00*	*0%*
	SIG																
	HSSP																
	Other donors																
HR2.2	*Guadalcanal*	*5.00*	*0%*					*1.03*	*0%*							*1.03*	*0%*
	SIG																
	HSSP							1.03									
	Other donors																
HR2.3	*Malaita*	*18.48*	*1%*					*0.52*	*0%*							*0.52*	*0%*
	SIG																
	HSSP							0.52									
	Other donors																
HR2.4	*Makira / Ulawa*	*5.62*	*0%*					*0.40*	*0%*							*0.40*	*0%*
	SIG																
	HSSP							0.40									
	Other donors																
HR2.5	*Central*	*4.22*	*0%*					*0.00*	*0%*							*0.00*	*0%*
	SIG																
	HSSP																
	Other donors																
HR2.6	*Isabel*	*4.33*	*0%*					*0.60*	*0%*							*0.60*	*0%*
	SIG																
	HSSP							0.60									
	Other donors																
HR2.7	*Western*	*8.78*	*0%*					*0.39*	*0%*							*0.39*	*0%*
	SIG																
	HSSP							0.39									
	Other donors																
HR2.8	*Temotu*	*4.12*	*0%*					*0.00*	*0%*							*0.00*	*0%*
	SIG																
	HSSP																
	Other donors																
HR2.9	*Choiseul*	*5.37*	*0%*					*0.00*	*0%*							*0.00*	*0%*
	SIG																
	HSSP																
	Other donors																

HER Code	Region	2005 (SI$m)	(%)	2006 (SI$m)	(%)	2007 (SI$m)	(%)	2008 (SI$m)	(%)	2009 (SI$m)	(%)	2010 (SI$m)	(%)	2011 (SI$m)	(%)	2008-11 (SI$m)	(%)
HR2.10	*Rennell / Bellona*	*1.72*	*0%*					*0.00*	*0%*							*0.00*	*0%*
	SIG																
	HSSP																
	Other donors																
HR3	National	34.51	2%					20.46	9%							20.46	0%
	SIG																
	HSSP							20.46									
	Other donors																
HR4	Overseas	4.76	0%					0.52	0%							0.52	0%
	SIG																
	HSSP							0.52									
	Other donors																
	Unallocated by region			210.85	10%	234.30	10%	144.45	63%							144.45	2%
	SIG			99.73		120.94		117.72								117.72	
	HSSP							0.00								0.00	
	Other donors			111.12		113.36		26.73								26.73	
Total Programmed Expenditure		2177.98	100%	2216.85	100%	2241.30	100%	229.62	100%	2009.00		2010.00		2011.00		6259.62	100%
	Escalator for inflation	1.03															
	Funding envelope							239.98		244.98		251.57		248.83		985.36	
	Total programmed expenditure							229.62		2009.00		2010.00		2011.00		6259.62	
	Available for programming							10.36		-1764.02		-1758.43		-1762.17		-5274.26	
				breakdown:		HSSP donors		3.08									
						SIG development		5.00									
						SIG recurrent		2.28									

Notes

1. Classification follows *Health Expenditure Review*
2. Figures for 2005 from *Health Expenditure Review*
3. Breakdown by region not available for subsequent years

HEALTH SWAp MEDIUM TERM EXPENDITURE FRAMEWORK

Organisational units

Account Code	Organisational unit	2005 (Sl$m)	(%)	2006 (Sl$m)	(%)	2007 (Sl$m)	(%)	2008 (Sl$m)	(%)	2009 (Sl$m)	(%)	2010 (Sl$m)	(%)	2011 (Sl$m)	(%)	2008-11 (Sl$m)	(%)
276-0001	Headquarters and Administration			15.74	7%	19.14	8%	34.02	15%							34.02	15%
	SIG			15.74		19.14		19.72									
	Staff			2.97		2.90		2.98									
	Operations			12.77		16.25		16.74									
	Capital																
	HSSP							14.30									
	Other donors																
276-0002	National Policy and Planning Division			0.55	0%	3.73	2%	4.00	2%							4.00	2%
	SIG			0.55		3.73		0.55									
	Staff			0.29		0.27		0.27									
	Operations			0.26		0.27		0.27									
	Capital					3.20											
	HSSP							3.45									
	Other donors																
276-0380	National Non-Communicable Diseases			0.37	0%	0.37	0%	2.00	1%							2.00	1%
	SIG			0.37		0.37		0.38									
	Staff			0.13		0.13		0.13									
	Operations			0.24		0.24		0.25									
	Capital																
	HSSP							1.62									
	Other donors																
276-0381	National Reproductive and Child Health Services			1.66	1%	1.20	1%	3.12	1%							3.12	1%
	SIG			1.66		1.20		1.23									
	Staff			0.61		0.61		0.63									
	Operations			1.05		0.59		0.61									
	Capital																
	HSSP							1.88									
	Other donors																
276-0382	Nursing Council Board			0.29	0%	0.20	0%	0.21	0%							0.21	0%
	SIG			0.29		0.20		0.21									
	Staff			0.14		0.14		0.15									
	Operations			0.16		0.06		0.06									
	Capital																
	HSSP																
	Other donors																
276-0383	National HIV/STI Division			0.93	0%	0.56	0%	2.85	1%							2.85	1%
	SIG			0.93		0.56		0.58									
	Staff			0.26		0.00		0.00									
	Operations			0.67		0.56		0.58									
	Capital																
	HSSP							2.28									
	Other donors																
276-0384	National TB/Leprosy Division			0.12	0%	0.20	0%	5.83	3%							5.83	3%
	SIG			0.12		0.20		0.21									
	Staff			0.07		0.10		0.11									
	Operations			0.06		0.10		0.10									
	Capital																
	HSSP							5.62									
	Other donors																

Account Code	Organisational unit	2005 (SI$m)	(%)	2006 (SI$m)	(%)	2007 (SI$m)	(%)	2008 (SI$m)	(%)	2009 (SI$m)	(%)	2010 (SI$m)	(%)	2011 (SI$m)	(%)	2008-11 (SI$m)	(%)
276-0385	National VB Disease Control Division			1.03	0%	2.12	1%	15.17	7%							15.17	7%
	SIG			1.03		2.12		2.18									
	Staff			0.75		1.81		1.87									
	Operations			0.29		0.30		0.31									
	Capital																
	HSSP							12.99									
	Other donors																
276-0390	National Referral Hospital			17.55	8%	27.05	12%	37.40	16%							37.40	16%
	SIG			17.55		27.05		27.86									
	Staff			15.78		25.68		26.45									
	Operations			1.77		1.37		1.41									
	Capital																
	HSSP							9.54									
	Other donors																
276-0391	National Dental Program			0.40	0%	0.36	0%	0.37	0%							0.37	0%
	SIG			0.40		0.36		0.37									
	Staff			0.00		0.13		0.14									
	Operations			0.40		0.23		0.23									
	Capital																
	HSSP																
	Other donors																
276-0392	National Medical Imaging Services			0.32	0%	0.66	0%	0.68	0%							0.68	0%
	SIG			0.32		0.66		0.68									
	Staff			0.02		0.39		0.40									
	Operations			0.30		0.27		0.28									
	Capital																
	HSSP																
	Other donors																
276-0393	National Laboratory Program			0.79	0%	0.39	0%	0.40	0%							0.40	0%
	SIG			0.79		0.39		0.40									
	Staff			0.05		0.02		0.02									
	Operations			0.75		0.37		0.38									
	Capital																
	HSSP																
	Other donors																
276-0394	National Pharmacy Division			1.09	1%	0.81	0%	0.83	0%							0.83	0%
	SIG			1.09		0.81		0.83									
	Staff			0.75		0.63		0.65									
	Operations			0.33		0.17		0.18									
	Capital																
	HSSP																
	Other donors																
276-0503	National Medical Stores Division			0.63	0%	0.91	0%	32.11	14%							32.11	14%
	SIG			0.63		0.91		0.94									
	Staff			0.00		0.60		0.61									
	Operations			0.63		0.32		0.32									
	Capital																
	HSSP							31.17									
	Other donors																
276-0395	National Health Promotion			1.15	1%	0.86	0%	1.35	1%							1.35	1%
	SIG			1.15		0.86		0.89									
	Staff			0.26		0.30		0.31									
	Operations			0.89		0.57		0.58									
	Capital																
	HSSP							0.46									
	Other donors																

Account Code	Organisational unit	2005 (SI$m)	(%)	2006 (SI$m)	(%)	2007 (SI$m)	(%)	2008 (SI$m)	(%)	2009 (SI$m)	(%)	2010 (SI$m)	(%)	2011 (SI$m)	(%)	2008-11 (SI$m)	(%)
276-0396	National Environmental Health			1.33	1%	2.81	1%	1.82	1%							1.82	1%
	SIG			1.33		2.81		1.82									
	Staff			0.53		1.14		1.17									
	Operations			0.81		0.63		0.65									
	Capital					1.04											
	HSSP																
	Other donors																
276-0397	National Health Training and Research			0.94	0%	1.26	1%	2.38	1%							2.38	1%
	SIG			0.94		1.26		1.30									
	Staff			0.28		0.71		0.73									
	Operations			0.66		0.55		0.56									
	Capital																
	HSSP							1.08									
	Other donors																
276-0398	Social Welfare Development			0.45	0%	1.27	1%	1.00	0%							1.00	0%
	SIG			0.45		1.27		1.00									
	Staff			0.29		0.54		0.55									
	Operations			0.16		0.44		0.45									
	Capital					0.30											
	HSSP																
	Other donors																
276-0399	Eye Division			0.53	0%	0.31	0%	0.32	0%							0.32	0%
	SIG			0.53		0.31		0.32									
	Staff			0.00		0.06		0.06									
	Operations			0.53		0.25		0.26									
	Capital																
	HSSP																
	Other donors																
	Provincial Health Service			48.88	23%	52.27	22%	52.44	23%							52.44	23%
	SIG			48.88		52.27		51.65									
	Staff			21.01		24.03		24.75									
	Health services grant			23.12		23.82		24.53									
	Other			4.74		4.42		2.38									
	HSSP					0.00		0.78									
	Other donors					0.00		0.00									
276-0307	*Honiara Town Council*			*3.37*	*2%*	*3.84*	*2%*	*3.96*	*2%*							*3.96*	*2%*
	SIG			3.37		3.84		3.96									
	Staff			1.81		2.23		2.29									
	Health services grant			1.57		1.61		1.66									
	Other							0.00									
	HSSP																
	Other donors																
276-0482	*Malaita*			*11.60*	*6%*	*12.38*	*5%*	*13.14*	*6%*							*13.14*	*6%*
	SIG			11.60		12.38		12.75									
	Staff			5.15		5.73		5.91									
	Health services grant			5.37		5.53		5.70									
	Other			1.08		1.11		1.15									
	HSSP							0.39									
	Other donors																
276-0483	*Makira/Ulawa*			*4.09*	*2%*	*4.66*	*2%*	*4.80*	*2%*							*4.80*	*2%*
	SIG			4.09		4.66		4.80									
	Staff			1.97		2.47		2.54									
	Health services grant			2.13		2.19		2.26									
	Other							0.00									
	HSSP																
	Other donors																

Account Code	Organisational unit	2005 (SI$m)	(%)	2006 (SI$m)	(%)	2007 (SI$m)	(%)	2008 (SI$m)	(%)	2009 (SI$m)	(%)	2010 (SI$m)	(%)	2011 (SI$m)	(%)	2008-11 (SI$m)	(%)
276-0484	*Western*			*8.83*	*4%*	*9.34*	*4%*	*10.01*	*4%*							*10.01*	*4%*
	SIG			8.83		9.34		9.62									
	Staff			3.51		3.86		3.97									
	Health services grant			4.37		4.50		4.63									
	Other			0.96		0.99		1.02									
	HSSP							0.39									
	Other donors																
276-0485	*Isabel*			*3.26*	*2%*	*3.72*	*2%*	*3.83*	*2%*							*3.83*	*2%*
	SIG			3.26		3.72		3.83									
	Staff			1.69		2.10		2.16									
	Health services grant			1.57		1.61		1.66									
	Other							0.00									
	HSSP																
	Other donors																
276-0486	*Central*			*3.24*	*2%*	*3.49*	*1%*	*3.08*	*1%*							*3.08*	*1%*
	SIG			3.24		3.49		3.08									
	Staff			1.17		1.37		1.42									
	Health services grant			1.57		1.61		1.66									
	Other			0.50		0.50		0.00									
	HSSP																
	Other donors																
276-0487	*Guadalcanal*			*5.01*	*2%*	*5.29*	*2%*	*5.45*	*2%*							*5.45*	*2%*
	SIG			5.01		5.29		5.45									
	Staff			1.99		2.18		2.24									
	Health services grant			3.02		3.11		3.21									
	Other							0.00									
	HSSP																
	Other donors																
276-0488	*Temotu*			*3.32*	*2%*	*3.78*	*2%*	*3.89*	*2%*							*3.89*	*2%*
	SIG			3.32		3.78		3.89									
	Staff			1.64		2.05		2.11									
	Health services grant			1.68		1.73		1.78									
	Other							0.00									
	HSSP																
	Other donors																
276-0489	*Choiseul*			*5.26*	*2%*	*4.94*	*2%*	*3.42*	*1%*							*3.42*	*1%*
	SIG			5.26		4.94		3.42									
	Staff			1.65		1.66		1.71									
	Health services grant			1.41		1.45		1.50									
	Other			2.20		1.83		0.21									
	HSSP																
	Other donors																
276-0490	*Rennell/Bellona*			*0.89*	*0%*	*0.84*	*0%*	*0.87*	*0%*							*0.87*	*0%*
	SIG			0.89		0.84		0.87									
	Staff			0.44		0.38		0.39									
	Health services grant			0.45		0.46		0.47									
	Other							0.00									
	HSSP																
	Other donors																
276-0500	Physiotherapy and Rehabilitation			1.01	0%	0.75	0%	0.77	0%							0.77	0%
	SIG			1.01		0.75		0.77									
	Staff			0.31		0.13		0.13									
	Operations			0.70		0.62		0.64									
	Capital																
	HSSP																
	Other donors																

Account Code	Organisational unit	2005 (SI$m)	(%)	2006 (SI$m)	(%)	2007 (SI$m)	(%)	2008 (SI$m)	(%)	2009 (SI$m)	(%)	2010 (SI$m)	(%)	2011 (SI$m)	(%)	2008-11 (SI$m)	(%)
276-0501	National Nursing Administration			1.14	1%	2.34	1%	2.41	1%							2.41	1%
	SIG			1.14		2.34		2.41									
	Staff			0.16		0.61		0.63									
	Operations			0.98		1.73		1.78									
	Capital																
	HSSP																
	Other donors																
276-0502	National Mental Health Division			1.55	1%	1.39	1%	1.43	1%							1.43	1%
	SIG			1.55		1.39		1.43									
	Staff			1.02		0.92		0.95									
	Operations			0.53		0.47		0.48									
	Capital																
	HSSP																
	Other donors																
276-0503	Probationary Nurses			1.28	1%	0.00	0%	0.00	0%							0.00	0%
	SIG			1.28		0.00		0.00									
	Staff			1.28													
	Operations																
	Capital																
	HSSP																
	Other donors																
	Unallocated by organisational unit	172.98	100%	111.12	53%	113.36	48%	26.73	12%							26.73	12%
	SIG	77.51		0.00		0.00		0.00								0.00	
	HSSP							0.00								0.00	
	Other donors	95.47		111.12		113.36		26.73								26.73	
Total Programmed Expenditure		172.98	100%	210.85	100%	234.30	100%	229.62	100%	0.00		0.00		0.00		229.62	100%
	Escalator to account for inflation	1.03															
	Funding envelope							239.98		244.98		251.57		248.83		985.36	
	Total programmed expenditure							229.62		0.00		0.00		0.00		229.62	
	Available for programming							10.36		244.98		251.57		248.83		755.74	
					breakdown:		HSSP donors	3.08									
							SIG development	5.00									
							SIG recurrent	2.28									

Notes

1. Classification follows SIG Recurrent Budget sub-heads.

HEALTH SWAp MEDIUM TERM EXPENDITURE FRAMEWORK

National Health Strategic Plan 2006-10 Strategic Areas

Number	Strategic Area	2005 (SI$m)	(%)	2006 (SI$m)	(%)	2007 (SI$m)	(%)	2008 (SI$m)	(%)	2009 (SI$m)	(%)	2010 (SI$m)	(%)	2011 (SI$m)	(%)	2008-11 (SI$m)	(%)
Strategic area 1	People focus							8.71	4%							8.71	4%
	SIG							0.89									
	HSSP							7.82									
	Other donors																
Strategic area 2	Public health programs							7.66	3%							7.66	3%
	SIG							2.03									
	HSSP							5.62									
	Other donors																
Strategic area 3	Malaria							27.79	12%							27.79	12%
	SIG							2.18									
	HSSP							15.58									
	Other donors							10.02									
Strategic area 4	Common childhood diseases							3.67	2%							3.67	2%
	SIG																
	HSSP							0.96									
	Other donors							2.71									
Strategic area 5	Non-communicable diseases							0.90	0%							0.90	0%
	SIG							0.38									
	HSSP							0.52									
	Other donors																
Strategic area 6	HIV/AIDS and sexually transmitted diseases							2.85	1%							2.85	1%
	SIG							0.58									
	HSSP							2.28									
	Other donors																
Strategic area 7	Family planning and reproductive health							3.06	1%							3.06	1%
	SIG							1.23									
	HSSP							0.92									
	Other donors							0.90									
Strategic area 8	Health System Strengthening							51.47	22%							51.47	22%
	SIG							0.00									
	HSSP							51.47									
	Other donors							0.00									
8.1	*Accountability*							*0.00*	*0%*							*0.00*	*0%*
	SIG																
	HSSP																
	Other donors																
8.2	*Infrastructure*							*2.15*	*1%*							*2.15*	*1%*
	SIG							0.00									
	HSSP							2.15									
	Other donors																
8.3	*Information management*							*0.00*	*0%*							*0.00*	*0%*
	SIG																
	HSSP																
	Other donors																
8.4	*Organisational change*							*49.32*	*21%*							*49.32*	*21%*
	SIG																
	HSSP							49.32									
	Other donors																
	Unallocated by strategic area	172.98	100%	210.85	100%	234.30	100%	123.53	54%							123.53	54%
	SIG	77.51		99.73		120.94		110.43								110.43	
	HSSP							0.00								0.00	
	Other donors	95.47		111.12		113.36		13.10								13.10	
Total Programmed Expenditure		172.98	100%	210.85	100%	234.30	100%	229.62	100%	0.00		0.00		0.00		229.62	100%
	Funding envelope							239.98		244.98		251.57		248.83		985.36	
	Total programmed expenditure							229.62		0.00		0.00		0.00		229.62	
	Available for programming							10.36		244.98		251.57		248.83		755.74	
				breakdown:		HSSP donors		3.08									
						SIG development		5.00									
						SIG recurrent		2.28									

Notes

1. Classification follows *Solomon Islands National Health Strategic Plan 2006-10.*

7.1 Program Development Objective (PDO)

The HSSP development objective is consistent with the goals of the NHSP: "To support the Solomon Islands Government in achieving agreed priority health outcomes through effective, efficient, and equitable services responsive to the population's health needs". This PDO aims to focus on priority health outcomes drawn from the NHSP; to bring together supply- and demand-side interventions to improve these outcomes; and to identify quality, efficiency, and equity as the key principles underlying the program.

Through a sector-wide approach, the HSSP will be aligned with the eight (8) strategic areas of the Solomon Islands National Strategic Plan 2006 – 2010 and broadly reflective of seventeen (17) goals for the MOH described in the Corporate Plan for the Ministry of Health 2006 – 2010. The HSSP will form a 'sub-set' of the MOH's overall operational plans. To that end the proposed program activities described below encompass 'gaps' identified by the MOH that through support will assist the MOH to address each of the strategic areas. The se will be further prioritised and refined as the donor partners develop their future programs in consultation with the MOH, for example WHO, UNICEF and UNFPA. The specific activities to be supported through each donor partner and will be identified within the Implementation schedule. This approach allows both close alignment with MOH operational plans and the ability to include donor activities as their programs are developed in the future. The HSSP will provide a key focus on supporting health service delivery to the poorest and most vulnerable.

7.2 STRATEGIC AREA 1: PEOPLE FOCUS

Program activities will support the MOH's delivery of Strategic Area One of the NHSP "to promote a people centred approach to health"[37]. The overall objective will be to support the MOH to adopt "as a core value a people focus, centered on the needs and aspirations of the Solomon Island people through a people centered approach"[38] The program activities will introduce a two-fold approach: (i) supporting a community organizing / health promotion approach throughout each Province to empower communities to take more responsibility for, and participate in, decision making for their health and (ii) reorienting and strengthening MOH staff at the central and provincial levels to support a 'people focused' approach to health through support for organized communities.

A health settings approach is acknowledged by the MOH as the most appropriate, model for delivering health care in an environment that is fraught with geographical and logistical constraints as well as wide provincial variations in disease burden. It is also an expressed objective that health service delivery will recognize, prioritise and target those communities and people who are most vulnerable[39].

[37] Goal, Strategic Area One, Ministry of Health and Medical Services. Solomon Islands National Health Strategic Plan 2006-2010
[38] Outcome Indicator, Strategic Area One, Ministry of Health and Medical Services. Solomon Islands National Health Strategic Plan 2006-2010
[39] Strategic Area One, Ministry of Health and Medical Services. Solomon Islands National Health Strategic Plan 2006-2010

The HSSP will support community organizing / health promotion approach which will be implemented through the Provincial Primary Health Care (PHC) services in partnership with local NGOs/CSOs and faith-based organisations. This approach will aim to improve health outcomes by raising community awareness of health issues, encouraging communities to reduce unhealthy lifestyle and behaviours, linking demand for traditional ("kastom") health care and for "western" health services and increasing uptake of priority services, such as family planning and deliveries in-facility[40], to complement supply-side investments.

The National Health Education and Promotion Division (HEP) will be supported to develop a health promotion practice that incorporates disease prevention but also addresses broader social, environmental and cultural issues impacting on health key activity areas. Key priorities identified in epidemiological data, the determinants of health and health seeking behaviours will inform complementary approaches to health promotion activities and service delivery. A key feature of the approach, however, is that both the phasing and focus of health promotion activities will recognize and respond to community demand. Support will be provided in the following key areas:

(i) Strengthening the National Health Education and Promotion Division and the provincial health services to develop policy and program guidelines.

Support will be provided to undertake a review of the existing program, develop guidelines and program implementation strategies in order to ensure that health promotion activities are: a) consistent with the focus of the NHSP on the most vulnerable; b) respect the importance of social preparation and community organizing as a precursor for effective health promotion activities; and that health promotion activities are integrated across all service delivery areas at national and provincial levels.

(ii) Capacity building to provide skilled health workers in health promotion.

Training programs will be developed and supported for national and provincial health workers to enable them to implement quality health promotion practices within a Primary Health Care approach. Staff will be encouraged be encouraged to focus not only on individual behaviour change approaches, but to recognize the importance of the approach outlined in (iii) below which empowers communities to improve control over the determinants of their health.

(iii) Community organizing / health promotion to develop 'healthy settings' and improve health services utilization and health outcomes.

Communities will be prioritized and targeted to identify the most vulnerable. In consultation with the NGO Sector, a review of local NGOs/CSOs and faith-based organisations will be conducted to identify potential partner organisations (POs) to work with MOH in community organizing/health promotion. Once potential POs have been identifies MOH will engage in dialogue with these organisations with a view to establishing an MOH/PO Compact which will provide for the recruitment / deployment of community facilitators (CFs) to carry out the community organisation work. This Compact may also provide for appropriate capacity building support for local NGOs/CSOs; this will also provide an avenue to link other donors, such as Japan Grass Roots, to activities at the community level.

[40] Alex Edmonds, Making Health Care decisions in the Solomon Islands. A Qualitative Study, 2006. Commissioned by the World Bank & AusAID as part of HSSP preparation.

Relevant National HEP and Provincial PHC staff, together with CFs will then undergo training in effective community organizing / health promotion approaches in accordance with the overview contained in Box 1. As will be seen from the process outlined in Box 1, the CFs are not required to maintain a permanent presence in a community but, rather, after having assisted a community to organize themselves and plan for their future, the CFs can move on to work with other communities.

This community organizing / health promotion approach will further support some of the already established "new horizons" within the MOH such the integrated Community Based Rehabilitation (CBR), the integrated Social Welfare Division (SWD) and the integrated Mental Health Visions, along with the ongoing disease control programs such as the HIV/ STI prevention, malaria control, adolescence, maternal and child health programs.

As the community organizing /health promotion program develops, potential exists to introduce innovative concepts such as insurance for overseas treatment; incentives for pregnant women to attend antenatal care and for facility births; community/household-based treatment (e.g. ORS); contracting out behaviour change interventions to NGOs and CBOs; and, incentives to communities to reach target outcome levels for example for immunisation coverage.

AN OVERVIEW OF THE COMMUNITY ORGANISING / HEALTH PROMOTION APPROACH

- **The National Health Strategic Plan is an integrated approach of the Solomon Islands Government which aims to improve the health of the people through effective, efficient and equitable health services which respond to the needs of the people. Each part of the plan is important but PEOPLE are the focus.**

- The community organizing / health promotion approach has three phases:

SOCIAL PREPARATION (3 months)	→	**PARTICIPATORY PLANNING** (3 months)	→	**IMPLEMENTATION AND REVIEW** (3 months)

- The aim of the **SOCIAL PREPARATION** phase is to generate community participation and management – the community develops strong groups and organisations and then plans how to improve the health of their community.

The Social Preparation phase consists of the following steps:

Step 1: Getting to know the Community
Step 2: Small group formation (e.g. women, youth)
Step 3: Core group formation (representative of whole community)
Step 4: Core group / Small group activities (health awareness, community action)
Step 5: Participatory Survey / Situation Analysis of health status of community
Step 6: Village Self Assessment

- The aim of the **PARTICIPATORY PLANNING** phase is for communities to take charge of planning to improve the health and well being of their community, and to develop a clear idea of what they can do for themselves and where they need outside help to achieve their goals.

Step 7: Development of Village Health Plan to improve the health status of the community.
Step 8: Building a strong Village Health Committee and formally registering the VHC with the MOH for the purposes of gaining access to grants)
Step 9: Health promotion during Village Participatory Planning process
Step 10: Preparation of VHC proposal for submission to MOH.

- The aim of the **IMPLEMENTATION AND REVIEW** phase is to for communities to take responsibility for the on-going improvement of their environment and for seeking assistance from health service providers when needed.

- The VHC will continue health promotion activities in the community after the Community Facilitator leaves and maintain links with the Provincial PHC Services.

(iv) Supporting socio-behavioural research on behaviour change.

Socio-behavioural research will be undertaken to support program development in key areas such as non-communicable diseases (NCDs) and their risk factors, and community participation and empowerment for health. The promotion of awareness of gender issues and their mainstreaming will also be addressed.

(v) Foster intersectoral collaboration

The aim will be for activities under this component to support, both in focus and phasing, the process of community organizing / health promotion which is taking place at the community level. The activities under this component will build on the ongoing efforts and are designed to achieve the following key objectives:

- Health care services and health workers at all levels are aware of, and support, the Village Health Committees and Community Health Plans and use these committees / plans as the focal point for health promotion activities.

- The MOH develops an effective and coordinated organisational framework and infrastructure for health promotion to individuals, communities and through multi-sector commitment and collaboration.

- Capacity created within the MOH, through its skilled health workers, to support well targeted 'people focused' health promotion approaches and programs with community participation and partnerships.

Strategic Area 1 PEOPLE FOCUS Identified "unfunded" Activities (July 2007 - December 2008)		Location	MOHMS UNIT Responsible to Implement	Nature of Procurement	Estimated Budget SBD Thousands (AUD 1 = SBD 5.65) (USD 1 = SDB 7.1)	Funding Source	2007						2008											
							Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1 People Focus																								
1.1	**Strengthening the National Health Promotion unit and the provincial health services to develop policy and program guidelines, and through supporting program implementation. Capacity building to provide skilled health workers in health promotion through training to support the implementation of quality health promotion practice within a Primary Health Care approach**				SBD 820,000			Total Aug - Dec 07				**SBD 600,000**											Total Jan - Dec 08	**SBD 220,000**
1.1.1	TA to review existing program and work with unit and policy branch to establish a strategic plan and explore implementation options	all Provinces	Health Promotion Unit	**TA**	SBD 640,000	**AusAID**			160000	160000	160000						160000							
1.1.2	Training for all health promotion staff by TA from 1.1.1	center & various Provinces	Health Promotion Unit	**TR**	SBD 180,000	**AusAID**				60000	60000						60000							
1.3	**The development, and implementation through community-oriented activities, of well-targeted effective and responsive programs that reflect a continuum of health promotion approaches.**				SBD 120,000			Total Aug - Dec 07				**SBD 40,000**											Total Jan - Dec 08	**SBD 80,000**
1.3.1	Community seminars and workshops	all Provinces	Health Promotion Unit	**OC**	SBD 120,000				40000						40000						40000			
1.3	**Ensure a 'healthy settings' / 'healthy lifestyle' approach is adopted at the community level**				SBD 420,000			Total Aug - Dec 07				**SBD 0**											Total Jan - Dec 08	**SBD 420,000**
1.3.2	TA Service training at community level, health promotion resource centres including materials and transport	Malaita, Western Province and Temotu.	Health Promotion Unit	**TA**	SBD 420,000								140000	140000	140000									
1.3	**Raise community awarness of disease risk factors - Community involvement in health & Gender Issues**				SBD 500,000			Total Aug - Dec 07				**SBD 400,000**											Total Jan - Dec 08	**SBD 1,100,000**
1.3.3	Study - Socio-behavioural research project: priority diseases and their risk factors. Community participation and empowerment for health. Gender Issues and follow up training	Malaita, Western Province and Temotu.	Natioal NCD Division	**TA**	SBD 500,000					200000	200000				200000			300000	300000	300000				
1.3	**Develop capacity of CBOs, NGOs and Church groups to undertake health promotion activities**				SBD 510,588			Total Aug - Dec 07				**SBD 147,059**											Total Jan - Dec 08	**SBD 363,529**
1.3.4	Proposal-based grants for GONGO (Government owned NGO), CBOs, local NGOs and Church Groups	all Provinces	Health Promotion Unit	**OC**	SBD 510,588			29412	29412	29412	29412	29412	30294	30294	30294	30294	30294	30294	30294	30294	30294	30294	30294	30294
1.5	**Foster inter-sectoral collaboration and develop programs that "re-orientate" the health system to focus on the determinants of health through broad multi-focused approaches.**				SBD 500,000			Total Aug - Dec 07				**SBD 40,000**											Total Jan - Dec 08	**SBD 100,000**
1.5.1	Community seminars and workshops	all Provinces	Health Promotion Unit	**OC**	SBD 500,000						40000					40000						60000		
				Toal Strategic Area 1 People Focus	**SBD 2,870,588**		**Sub-Total 2007**					**SBD 1,227,059**											**Sub-Total 2008**	**SBD 2,283,529**

WK	Civil Works	
GD	Goods	
PH	Pharmaceuticals	
TA	Consulting Services	SBD 1,560,000
TR	Training	SBD 180,000
OC	Operating Costs	SBD 1,130,588

Note:

AuSAID funding available for 1.1.1 and 1.1.2 only

7.3 STRATEGIC AREA TWO: PUBLIC HEALTH PROGRAMS

The program will support activities to assist the MOH in "reducing the incidence and prevalence of TB"[41] in Solomon Islands. The program will Tuberculosis control program

(i) Strengthen the External Quality Assurance (EQA) and Quality Control (QC) capacity for smear/sputum microscopy and culture at the national laboratory and in all provinces.

Activities will assist the MOH to implement procedural guidelines and a supportive structure, including a process to address review/assessment of samples from treatment failures and relapses. Support will be provided to undertake a review of the staff establishment to support service provision; and to provide training for laboratory technicians from all provinces in QA and QC.

(ii) Support well-equipped TB laboratory and diagnostic facilities in all provinces.

Through the program, Establish and equip TB microscope centres will be established and equipped in all provinces as based on disease burden and priorities.

(iii) Strengthen DOTS service delivery through training, monitoring and supervision to ensure correct implementation and follow-up of program.

Staffing roles to deliver DOTS will be reviewed and guidelines provided as appropriate (TB Coordinator; nursing roles). Refresher training to service providers, including private practitioners, in DOTS to ensure adoption of MOH treatment guidelines will be undertaken. The provinces of Malaita and Western will be the initial target priority provinces.

(iv) Strengthen surveillance and recording system for TB and TB-HIV co-infection.

Support will be provided to undertake a review of the existing recording and reporting system. Rationalisation within HIS of TB reporting processes and database, including confidential reporting for HIV testing will be a key feature of data collection and recording.

(v) Develop and implement a community awareness and education program for TB that complements and expands current activities throughout the provinces.

Health promotion and awareness activities will be strengthened through the coordination and program development with National Health Promotion Department.

(vi) Support the finalisation and implementation of the TB/HIV collaboration / co-infection policy.

Activities will assist in guideline preparation and introduction; and, training for service delivery ensuring coordination with activities in HIV – VCCT.

At the end of the program period, the expected objectives and outputs from the activities under this sub-component are:

- Capacity of MOH increased, through human resource development and service provision and delivery, to implement TB disease prevention activities, early case detection, appropriate treatment and management.

[41] Strategic Area Two, Ministry of Health and Medical Services. Solomon Islands National Health Strategic Plan 2006-2010

- Capacity of MOH enhanced to sustain and optimize the quality and provision of DOTS services throughout the provinces.

- Capacity of MOH strengthened to develop and implement public health policy as it relates to TB, including the adaptation of DOTS to respond to TB/HIV and MDR-TB.

- A strengthened community response to addressing TB prevention and treatment.

Strategic Area 2 Public Health Programs Identified "unfunded" Activities (August 2007 to December 2008)		Location	MOHMS UNIT Responsible to Implement	Nature of Procurement	Estimated Budget SBD Thousands (AUD 1 = SBD 5.65) (USD 1 = SDB 7.1)	Funding Source	2007						2008											
							Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2	**Tuberculosis Control Program**																							
2.1	**Strengthen the External Quality Assurance (EQA) and Quality Control (QC) capacity for smear/sputum microscopy and culture at the national laboratory and in all provinces.**				**SBD 960,000**			Total Aug - Dec 07			**SBD 480,000**									Total Jan - Dec 08			**SBD 480,000**	
2.1.1	TA to design procedural guidelines and a supportive structure, including process to address review/assessment of samples from treatment failures and relapses.	Center		**TA**	SBD 320,000					160000										160000				
2.1.2	Study to review staff establishment to support service provision and provide training for laboratory technicians from all provinces in QA and QC.	all Provinces		**TA & TR**	SBD 640,000						160000	160000										160000	160000	
2.2	**Ensure a well-equipped TB laboratory and diagnostic facilities in all provinces. Establish and equip TB microscope centres in provinces; based on disease burden and priorities.**				**SBD 4,800,000**			Total Aug - Dec 07			**SBD 0**									Total Jan - Dec 08			**SBD 4,800,000**	
2.2.1	Procurement and maintenance of lab equipment especially microscopes	all Provinces		**GD**	SBD 4,800,000									800000	400000									
2.3	**Strengthen DOTS service delivery**				**SBD 224,000**			Total Aug - Dec 07			**SBD 112,000**									Total Jan - Dec 08			**SBD 112,000**	
2.3.1	Short term TA to conduct training, monitoring and supervision	Malaita and Western Provinces		**TA**	SBD 224,000					5600	5600										5600	5600		
2.4	**Strengthen surveillance and recording system for TB and TB-HIV co-infection. .**				**SBD 310,000**			Total Aug - Dec 07			**SBD 190,000**									Total Jan - Dec 08			**SBD 120,000**	
2.4.1	TA to review existing recording and reporting system	all Provinces		**TA**	SBD 310,000				160000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000
2.5	**Develop and implement a community awareness and education program for TB**				**SBD 190,000**			Total Aug - Dec 07			**SBD 0**									Total Jan - Dec 08			**SBD 190,000**	
2.5.1	Short term TA to design and assist in implementation of the program and materials for the program	Center		**TA**	SBD 190,000									160000	10000	10000	10000							
2.6	**Finalisation and implementation of the TB/HIV collaboration / co-infection policy**				**SBD 160,000**			Total Aug - Dec 07			**SBD 0**									Total Jan - Dec 08			**SBD 160,000**	
2.6.1	TA for guideline preparation and introduction, training for service delivery ensuring coordination with activities in HIV – VCCT	Center		**TA**	SBD 160,000									160000										
Sub - total Tuberculosis Control Program					**SBD 6,644,000**	**Sub-Total 2007**					**SBD 782,000**		**Sub-Total 2008**											**SBD 5,862,000**

WK	Civil Works	
GD	Goods	SBD 4,800,000
PH	Pharmaceuticals	
TA	Consulting Services	SBD 1,204,000
TR	Training	SBD 640,000
OC	Operating Costs	

Note:

No AusAID funding allocated

7.4 STRATEGIC AREA THREE: MALARIA

Program activities will support sound approaches to reduce malaria transmission with the key objective to reduce malaria incidence and mortality[42]. Activities will focus on intensified malaria control through a combination of multidisciplinary approaches and available measures directed against parasite and vector; increased community participation and understanding of malaria control and prevention activities; and multi-sectoral partnerships. This package of support will focus on the following areas:

(i) Malaria prevention to reduce the burden of malaria.

This will include the following activities:

- Intermittent preventive treatment (IPT) roll-out across provinces through policy implementation and M&E support following on from the IPTp pilot study (RCT) currently being conducted in HCC from April 2007 – June 2008, supported through the GFATM. Approximately four to five Provinces per year, determined through highest to lowest priority, will receive support.
- Scaling up of Permanets through replacement of ineffective Permanets and distribution of current LLINS and replacement purchase and distribution across all Provinces .
- Indoor residual spraying through procurement of ICON pesticides and provision of temporary labour. The additional procurement of ICON will support the current focused (selective) spraying required to deal with epidemic-prone areas. IRS will be used to control endemic malaria; prevention of annual seasonal increase and peaks of malaria transmission; control and/or prevention of malaria epidemics; elimination of malaria; and elimination of new foci of infection in malaria-free areas.
- Support environmental control using physical methods combined with chemical larviciding throughout the Provinces. Investment will be in effective insect growth regulators with residual lifespan of 6 months.
- Undertake a feasibility study of scaling-up of pipeline installation and implementation in highly endemic island provinces as a further means of environmental management. The GFATM and WHO are currently supporting the evaluation of pipelines installed in river mouths and effects on malaria transmission in a coastal environment in Guadalcanal.

(ii) Prevention and control of malaria epidemics.

Key activities will support the development of guidelines for epidemic preparedness and control, and will be done within the MOH's overall epidemic surveillance response. This focus will also explore the integration with other disease outbreaks; training of health workers which will include incorporation in other health worker training, for example IMCI and reproductive health courses; and the procurement of RDTs.

(iii) Early diagnosis and case management.

Key activities will include the following:

- Focus will be on increasing access to parasitological diagnostic services (microscopic services; MRDTs)[43] through the purchase and distribution of

[42] Strategic Area Three, Ministry of Health and Medical Services. Solomon Islands National Health Strategic Plan 2006-2010

[43] The critical point between cost (which is the less expensive) for RDTs (STD) and CM is RDTs are less expensive when 2 or less tests per day. Quality CM or RDTS will decrease treatment costs (both

RDTs[44] to NAPs where no microscopy services and other health facilities where it is not cost effective to maintain community microscopy, and QA and accreditation of microscopists throughout the provinces where it is established (AHCs, RHCs, NAPs). Support VBDCP policy development for quality parasitic diagnostic services: guidelines for the efficient and effective use of community microscopy and RDTs. This will be based on results from WHO proposed cost-consequence analysis in mid 2007.

- Support to case management will also include increasing access to Artemisin Combination treatment through drug supply supporting GFATM funding, training of health workers to implement ACTs and treatment guidelines, M&E for adverse drug reactions and pharmacovigilance of ACTs.
- Support enhanced interaction and collaboration between MOH and the private medical practitioners to inform and support adherence to use of the MOH's Malaria Standard Diagnosis, Treatment & Management Guidelines; and case reporting.
- "High-dependency" units for patient care will be established in NRH and Kilu-Ufi hospitals through provision of equipment (ventilators, infusion pumps, cardiac monitors, blood gas and biochemistry analyses, microscopy or RDT).

(iv) *Health system development across all Provinces to support the malaria program.*

Activities will target:

- Human resource capacity building and malaria program policy and management support to the VBDCP to set policy guidelines, coordinate donor resources and expenditures, and enhance service delivery at national and provincial levels. This will be addressed through:
  - Review and assessment of role and capacity of SIMTRI as training unit for Solomon Islands and as a sub-regional (PNG, Vanuatu) training facility;
  - Refurbishment and renovation of teaching facility and distance learning centre in SIMTRI;
  - Refurbishment of a clinical trial unit facility;
  - Strengthening a core training group in SIMTRI in malaria diagnosis and treatment, parasitology, entomology and vector control;
  - Post graduate training of doctors in public health, tropical medicine and epidemiology;
  - Short courses for vector control managers, for example in malaria program management, overseas through ACT MalariaFoundation;
  - Short training course on management of severe malaria for private GPs and medical officers in NRH and provincial nurses; and
  - Provision of technical advisory support to VBDCP in program management and administration to support a scaled up response to malaria control.

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for malaria and non-malaria fever diagnoses) compared to presumptive treatment. If CM is poor quality (as has been found in some cases) then RDTs will have a more positive impact on treatment costs than CM.

[44] Graves P et al (unpublished study) Cost Analysis of Malaria Diagnostics in Solomon Islands 2002, reported that RDTs (Optimal) 98% correct compared to microscopy 83% in one clinic; and 98% correct RDT compared to 93% microscopy at another clinic.

A recent study of Honiara fulltime microscopists found 56.2% error rate: false positive 32.4%, and false negatives 20%, WHO, Solomon Islands.

- Strengthening primary health care and integration with programs outside of VBDCP (for example, Reproductive Health (antenatal clinics), EPI, IMCI). This will be addressed through:
    - Improved integration of IPTp and IPTi with the Reproductive Health division through joint M&E, joint planning and supervision;
    - Joint management and distribution of a Healthy Solomon Woman Package (comprising long life insecticide treated nets (LLINS), de-worming medications, iron-folate supplementation, condom promotion through antenatal care and routine EPI activities);
    - Joint training with IMCI practitioners and TOTs; and
    - Shared distribution of RDTs, bednets and IRS through the cold chain with the National Medical Stores. Also use CBO/NGO grant mechanism for support to distribution in the provinces.

- Community action and partnerships through broad involvement that includes church based programs, local groups and NGOs. Support for community action may be through a CBO/NGO grant mechanism. Information and social education campaigns within a "Healthy Village" approach may be introduced and supported through: training of community NGOs and faith-based organisations in health promotion, environmental management, distribution and treatment of mosquito nets, and referrals of severe complicated malaria to second level health facilities; and reporting and sharing of information. Grant selection and procurement processes will be managed in accordance with the MOH Procurement Manual and in conjunction with MOH Procurement Unit.
    - Printing and dissemination of teachers' and students' learning guides on malaria within a "Healthy Schools" approach.

- Enhancement of surveillance, information systems, monitoring and evaluation, and epidemic response through
    - Refresher training in SIMIS and monitoring epidemic response for national and provincial staff;
    - Support for national and provincial monitoring officers to improve quality of malaria information and strengthen the role of monitoring and evaluation;
    - Linking and rationalizing SIMIS and HIS data collection and analyses; and
    - GIS data input training.

(v) Intersectoral development through support to sector initiatives.

Support will be provided for:

- Pilot provision of support, guidance and incorporation of malaria prevention activities within wider SIG program on rural development. In addition key areas would be
    - the private-public sector with mining and rural sector (for example, palm oil plantations); and
    - improved livelihoods with rural agriculture/primary industry sector, for example: subsistence or established farming enterprises; seed funding for malaria prevention using mosquito repellents; social

marketing of LLINs; awareness raising among villages in proper recognition of waterways drainage and environmental management.

- Pilot provision of support and incorporation of malaria prevention activities within multi-sectoral programs, for example roads and housing. Activities would include
    - Liaison with road construction, logging, quarrying, agriculture and other infrastructure works which create conditions favourable to the breeding of mosquitoes through enforcement of related Public Health legislation.

(vi) Malaria operational research (that strengthens and facilitates links between SIMTRI and research institutions in Australia and the region.

Activities may include:

- Pilot study for the establishment of an efficient and effective supply chain encompassing the national need for procurement, storage and distribution of malarial drugs and supplies.
- Evidence-based research to inform policy and treatment guidelines (including IPT), through drug resistance efficacy studies and surveillance for antimalarial drugs, and including pharmacoeconomic review of proposed new drugs. Specific areas for support will include: a) Research in the efficacy of alternative drugs for IPTp if sulphadoxine-pyrimethamine resistance develops; b) Cost benefit analysis of ACT drugs and RDTS; and c) Therapeutic efficacy studies of first and second line antimalarial drugs in sentinel sites including patient management for severe and complicated malaria.
- Malaria parasite research to improve control strategies. Specific program activities will include: a) A regional program of research focusing on development of new treatment modalities of vivax malaria (including a review of vivax biology, diagnosis and treatment), monitoring systems for antimalarial drug resistance and malaria in pregnancy; b) Research in determining the prevalence of severe G6PD deficiency and develop rapid diagnostic tests for G6PD deficiency variants; and c) Research in long lasting residual insecticides suitable for house spraying or long lasting mosquito repellants.
- Research and support to behavioural and social aspects of malaria and its control. Qualitative research will address health seeking behaviour. Other areas of research will consider the impact of RDTs, blister packs and ACTs on patients adherence.

(vii) Malaria infrastructure support projects.

These will include investment in (i) staff housing for provincial and regional malaria staff; (ii) VBDCP and NMS integrated storage sheds; (iii) integrated malaria microscopy and PHC clinic laboratories at AHC and RHC; (iv) integration of solar power and water at microscopy clinics; (v) cool storage boxes for RDTs and pharmaceuticals; (vi) integration and supply of transport (eg OBM, boats); (vii) provision of incinerators; and, (viii) radio rapid response network.

(viii) Explore the possibility of malaria elimination through the well-planned pilot of activities in areas where epidemiology indicates it is feasible.

Planning for malaria elimination can be targeted on Isabel and/or Temotu provinces where incidence rates are 18/1000 and 63/1000 respectively. This will be done through the implementation and consolidation of the above defined activities.

At the end of the program period, the expected objectives from the activities under this sub-component are:

- Capacity strengthened within MOH to provide timely, appropriate and effective early diagnosis and treatment of malaria.

- A strengthened community response to addressing malaria prevention and treatment as well as community involvement in and support of malaria programs to create synergy in control efforts.

- Malaria prevention activities, including environmental vector control measures, supported through established partnerships between the MOH and other government sectors.

Strategic Area 3 Malaria Program (August 2007 to December 2008) cont … page 1 of 2		Location	MOHMS UNIT Responsible to Implement	Nature of Procurement	Estimated Budget SBD Thousands (AUD 1 = SBD 5.65) (USD 1 = SDB 7.1)	Funding Source	2007																		
							Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
3.1	**Malaria prevention to reduce the burden of malaria**				**SBD 5,581,000**			Total AusAID Aug - Dec 07		**SBD 715,000**										Total AusAID Jan - Dec 08		**SBD 4,866,000**		
3.1.1	Expansion of IPT, health worker training, community education, M&E following on from the IPTp pilot study (RCT) commencing July 2008	5 Provinces	MOH VBDCP Unit	**TR**	SBD 900,000	AusAID													180000	180000	180000	180000	180000	
3.1.2	Replacement of ineffective Permanets and provision of pyrethroid insecticides for re-treatment of these nets, (25,000 units in 2007 and 120,000 units in 2008 plus distribution costs estimate at SBD 7.1 per unit)	all Provinces	MOH VBDCP Unit	**GD**	SBD 3,500,000	AusAID		40000	40000	40000	40000	40000	275000	275000	275000	275000	275000	275000	275000	275000	275000	275000	275000	275000
			MOH VBDCP Unit		SBD 3,991,088	GFATM	185931	185931	185931	185931	185931	185931	239625	239625	239625	239625	239625	239625	239625	239625	239625	239625	239625	239625
3.1.3	Indoor residual spraying, procurement of ICON pesticides and provision of temporary labour, (100,000 households twice per year)	epidemic-prone areas	MOH VBDCP Unit	**OC**	SBD 691,000	AusAID		95000	95000	95000	95000	95000	18000	18000	18000	18000	18000	18000	18000	18000	18000	18000	18000	18000
			MOH VBDCP Unit		SBD 2,166,743	GFATM	193090	193090	193090	193090	193090	193090	84017	84017	84017	84017	84017	84017	84017	84017	84017	84017	84017	84017
3.1.4	Environmental control using physical methods combined with chemical larviciding effective insect growth regulators with residual lifespan of 6 months	all Provinces	MOH VBDCP Unit	**OC**	SBD 160,000	AusAID			20000		20000		20000		20000		20000		20000		20000		20000	
3.1.5	Feasibility study of scaling-up of pipeline installation, short-term TA (6 weeks in 2008)	highly endemic island provinces	MOH VBDCP Unit	**TA**	SBD 330,000	AusAID								220000	110000									
3.2	**Prevention and control of epidemics.**				**SBD 440,000**			Total AusAID Aug - Dec 07		**SBD 220,000**										Total AusAID Jan - Dec 08		**SBD 220,000**		
3.2.1	TA for development of guidelines for epidemic preparedness and control	centre	MOH VBDCP Unit	**TA**	SBD 440,000	AusAID			220000							220000								
3.2.3	Training of health workers guidelines developed under 3.2.1	all Provinces	MOH VBDCP Unit	**TR**	SBD 546,700	GFATM			68338	68338	68338	68338				68338	68338	68338	68338					
3.3	**Early diagnosis and case management**				**SBD 8,346,000**			Total AusAID Aug - Dec 07		**SBD 1,813,000**										Total AusAID Jan - Dec 08		**SBD 6,533,000**		
3.3.1	TA to establish QC and QA of microscopists, (6 weeks 2007, 12 mid and 18 end of 2008)	centre	MOH VBDCP Unit	**TA**	SBD 1,430,000	GFATM					220000	110000					220000	220000				220000	220000	220000
3.3.2	Procurement of 15,000 RDT units for 138 Nurse Aid posts	all Provinces	MOH VBDCP Unit	**GD**	SBD 1,583,000	AusAID				83000							150000							
3.3.3	Distribution of RDTs, & QA & accreditation of microscopists to increasing access to parasitological diagnostic services (microscopic services; MRDTs) locally engaged staff in Malaita, Guadalcanal, Western, Central, Choiseul, Makiira and Temotu est. USD3000/month/Province)	Malaita, Guadalcanal, Western, Central, Choiseul, Makiira and Temotu	MOH VBDCP Unit	**GD&TA**	SBD 1,152,000	AusAID	150000	150000	150000	150000	150000	150000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000
3.3.4	Increase ACT provision for approx. 140,000 patients with uncomplicared malaria and 7,100 patients with treatment failures for one year by 2008	all Provinces	MOH VBDCP Unit	**PH**	SBD 3,000,000	SWAp							300000											
3.3.5	Short term TA to enhance interaction and collaboration between MOH and private medical practioners to support adherance to Malaria standard Diagnosis Treatment and Reporting Guidelines	centre	MOH VBDCP Unit	**TA**	SBD 440,000	AusAID				220000									220000					
3.3.6	Short term TA to review progress and impate of RDT distribution	all Provinces	MOH VBDCP Unit	**TA**	SBD 990,000	AusAID					220000	110000					220000	110000				220000	110000	
3.3.7	Establish & equip "high-dependency" unit in NRH (ventilators, cardiac monitors, blood gas and biochemistry analyses)	NRH	MOH VBDCP Unit	**GD**	SBD 500,000	AusAID					60000	220000	220000											
3.3.8	Training of health workers to familarize them with new equipment for high dependency unit NRH	centre	MOH VBDCP Unit	**TR**	SBD 110,000	AusAID									110000									
3.3.9	Establish & equip "high-dependency" unit in Kilu-Ufi hospitals (ventilators, cardiac monitors, blood gas and biochemistry analyses)	Malaita	MOH VBDCP Unit	**GD**	SBD 500,000	AusAID								60000	220000	220000								
3.3.10	Training of health workers to familarize them with new equipment for high dependency unit Kilu-Ufi	centre	MOH VBDCP Unit	**TR**	SBD 71,000	AusAID											71000							

Strategic Area 3 Malaria Program

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		Location	MOHMS UNIT Responsible to Implement	Nature of Procurement	Estimated Budget SBD Thousands (AUD 1 = SBD 5.65) (USD 1 = SDB 7.1)	Funding Source	2007						2008											
							Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
3.4	**Health system development**				**SBD 5,621,000**			Total AusAID Aug - Dec 07		**SBD 1,580,000**										Total AusAID Jan - Dec 08			**SBD 4,041,000**	
3.4.1	TA to develop and deliver training programs and review role and capacity of SIMTRI as a training unit for SI and sub-regional (PNG, Vanuatu)	centre	MOH VBDCP Unit	**TA & TR**	SBD 880,000	AusAID								220000	220000				220000				220000	
3.4.2	Refurbishment of teaching facility and distance learning center in SIMTRI	centre	MOH VBDCP Unit	**WK**	SBD 249,000	AusAID									83000	83000	83000							
3.4.3	Refurbishment of clinical trail unit, office, computer equipment and IT connectivity	centre	MOH VBDCP Unit	**WK**	SBD 144,000	AusAID									48000	48000	48000							
3.4.4	Core training group in SIMTRI in malaria diagnosis and treatment, parasitology, entomology and vector control	centre	MOH VBDCP Unit	**TR**	SBD 520,000	AusAID				130000					130000				130000				130000	
3.4.5	Post graduate training of doctors in public health, tropical medicine and epidemiology	Australia	MOH VBDCP Unit	**TR**	SBD 450,000	AusAID									50000	50000	50000	50000	50000	50000	50000	50000	50000	
3.4.6	Short courses severe malaria management private practioners, NRH and Provincial staff, (Prof Tim Davis (Perth) and Dr Tran Hien (Vietnam))	Australia	MOH VBDCP Unit	**TR**	SBD 120,000	AusAID					60000												60000	
3.4.7	TA support to VBDCP management, admin & logistical systems - scaled up response to malaria control suport joint M&E, joint planning and supervision and improve integration of IPTp and IPTi with the Reproductive Health division	centre	MOH VBDCP Unit	**TA**	SBD 504,000	AusAID			110000	220000	220000	220000									220000	220000	110000	
3.4.8	Distribution of a Healthy Solomon Woman Package (comprising insecticide treated nets, deworming medications, iron folate supplementation, condom promotion through antenatal care and routine EPI activities)	all Provinces	MOH VBDCP Unit	**GD**	SBD 48,000	AusAID								8000	15000	25000								
3.4.9	Joint training with IMCI practitioners and TOTs	all Provinces	MOH VBDCP Unit	**TR**	SBD 100,000	AusAID					50000												50000	
3.4.10	Training of community NGOs and faith-based organizations in health promotion, environmental management, distribution & treatment of mosquito nets, and referrals of severe complicated malaria to second level health facilities	all Provinces	MOH VBDCP Unit	**TR**	SBD 100,000	AusAID					50000												50000	
3.4.11	Grants to Community NGOs and faith-based organizations in health promotion for environmental management, distribution & treatment of mosquito nets, and referrals of severe complicated malaria to second level health facilities	all Provinces	MOH VBDCP Unit	**OC**	SBD 200,000	AusAID			50000					150000										
3.4.12	Printing and dissemination of teachers' and students' learning guides on malaria within a Healthy Schools approach	all Provinces	MOH VBDCP Unit	**GD**	SBD 530,000	AusAID								150000	300000	20000	20000	20000	20000					
3.4.13	Local expenses for Private sector engagement travel costs	all Provinces	MOH VBDCP Unit	**OC**	SBD 150,000	AusAID				10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000
3.4.14	Refresher training in SIMIS and epidemic response for provincial and regional staff including procurement of computers	centre	MOH VBDCP Unit	**TR**	SBD 590,000	AusAID								50000	300000	120000	120000							
3.4.15	Linking and rationalizing SIMIS and HIS data collection and analysis and enhanc information systems including surveilance)	all Provinces	MOH VBDCP Unit	**TA**	SBD 440,000	AusAID					220000	220000												
3.4.16	Short term TA to provide GIS data input training (6 weeks in 2008)	all Provinces	MOH VBDCP Unit	**TA**	SBD 330,000	AusAID										220000	110000							
3.5	**Intersectoral Development - support to sector initiatives**				**SBD 520,000**			Total AusAID Aug - Dec 07		**SBD 220,000**										Total AusAID Jan - Dec 08			**SBD 300,000**	
3.5.1	Small grants to CBOs to support Rural development Program initiatives	all Provinces	MOH VBDCP Unit	**OC**	SBD 520,000	AusAID			220000						300000									
3.5.2	Local hire coordinator of Small grants to CBOs to support Rural development Program initiatives	all Provinces	MOH VBDCP Unit	**TA**	SBD 340,000	AusAID		20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000
3.6	**Malaria Operation Research Program**				**SBD 3,600,000**			Total AusAID Aug - Dec 07		**SBD 2,000,000**										Total AusAID Jan - Dec 08			**SBD 1,600,000**	
3.6.1	Treatment Modalities and drug efficacy studies	centre	MOH VBDCP Unit	**TA**	SBD 1,200,000	AusAID				400000	400000	400000												
3.6.2	Prevention approaches and methods	centre	MOH VBDCP Unit	**TA**	SBD 1,200,000	AusAID					400000	400000	400000											
3.6.3	Research and support to behavioural and social aspects of malaria and its control.	centre	MOH VBDCP Unit	**TA**	SBD 1,200,000	AusAID									400000	400000	400000							
3.7	Malaria Infrastructure Support Program				**SBD 3,648,600**			Total AusAID Aug - Dec 07		**SBD 2,027,000**										Total AusAID Jan - Dec 08			**SBD 1,621,600**	
3.7.1	Provincial housing for Malaria Division Staff (9 houses over 18 months construct SBD200,000, fitout SBD100,000 transport SBD45,000, contigency 15% - unit cost SBD396750), in 2007 the 4 houses will constructed in Western & Choisel in response to the tsunami destruction	selected Provinces	MOH Infrastructure Unit	**WK**	SBD 3,600,000	AusAID		400000	400000	400000	400000	400000	400000	400000	400000	400000								
3.7.2	Construction Manager / site manager for houses in 3.7.1 at SBD5400 per house	selected Provinces	MOH Infrastructure Unit	**TA**	SBD 48,600	AusAID		5400	5400	5400	5400	5400	5400	5400	5400	5400								
	Total Strategic Area 3 Malaria Program				**SBD 27,756,600**		**Sub-Total 3 2007**				**SBD 8,575,000**		**Sub-Total 3 2008**											**SBD 19,181,600**

WK	Civil Works	SBD 3,993,000
GD	Goods	SBD 7,813,000
PH	Pharmaceuticals	SBD 3,000,000
TA	Consulting Services	SBD 8,002,600
TR	Training	SBD 2,961,000
OC	Operating Costs	SBD 1,721,000

Footnotes:

1 The programed budget for the Malaria Program August 2007 - December 2007 is calculated as 5/6th of the budget envelope provided by AusAID for half a year being (AUD 1,750,000*6)/5 converted to SBD at the rate of AUD 1 = SBD 5.65.

2 The programed budget for the Malaria Program January 2008 - December 2008 complies with the budget envelope provided by AusAID for a full year, being AUD 3,500,000 converted to SBD at the rate of AUD 1 = SBD 5.65.

3 A malaria specific batch of pharmaceuticals is included here instead of Strategic Area 8.4 (see 3.3.3)

7.5 STRATEGIC AREA FOUR: COMMON CHILDHOOD DISEASES

Program activities will provide support for policy development and implementation of effective and economical approaches, with the key objective to "reduce morbidity and mortality of children less than 5 years of age due to common childhood illnesses"[45]. These approaches will include: (a) focusing on prevention, leading to reduction in treatment costs; (b) using integrated delivery strategies within comprehensive child survival programs rather than parallel delivery of disease-specific interventions including provision of intensive support for the implementation and evaluation of an essential integrated package of interventions; and (c) expanding coverage through improved delivery at community level as a complement to health facility-based services. Major strategies will be:

(i) *Implementation of a carefully evaluated essential package of proven effective child survival interventions in selected provinces initially, but with the intention of eventually rolling out this approach country-wide.*

Within this, support will be provided for the three components that comprise the Integrated Management of Childhood Illness (IMCI) strategy: improving health worker skills, health systems, and community practices and care seeking. This program will integrate and promote expanded immunisation coverage, the skilled management of childhood illness, and improved care for women of childbearing age (before, during and after pregnancy) and for newborns via an essential package that includes: provision and promotion of EPI and TT in pregnancy; promotion of insecticide-treated bednets; promotion of iron supplementation, deworming, iodine and iron food fortification - the latter via national advocacy; vitamin A supplementation; promotion of VCCT, promotion of Emergency Obstetric Care services; promotion of community IMCI; promotion of childhood nutrition – inclusive of good feeding practices; promotion of child injury prevention and response; promotion of use of improved drinking water and improved sanitation facilities; strengthening of outreach health worker essential competencies and service systems.

Promotion of community IMCI will mean that mechanisms to better engage and support families and communities in preventing disease and caring for their sick children will be explored. Through this, interventions will be introduced that may be delivered at the household level, with limited need for external material inputs such as promotion of breastfeeding, oral rehydration therapy, education on complementary feeding, and use of insecticide-treated bednets. Community demand for quality services will be fostered and new evidence-based social mobilisation and behaviour change communication tools and methods will be developed.

Communities will be provided with support from the health system, in the form of accessible clinics and responsive services, and health workers able to give effective advice, drugs, and more complex treatments when necessary. As a result, partnerships between health facilities (and services) and the communities they serve will improve. Use of the Family health Card will be expanded across all provinces. Within each province, district-level responsibility for implementation and district-level capacity building will be emphasized.

[45] Strategic Area Four, Ministry of Health and Medical Services. Solomon Islands National Health Strategic Plan 2006-2010

(ii) Support to the Expanded Program of Immunisation (EPI)

The immunisation system will be strengthened and GAVI support will assist in this process. It will be ensured that effective EPI planning processes are in place including policy formulation, micro-planning, monitoring of implementation status of the annual work-plan, and regular reviews with a special focus on low performing districts. Cold chain systems will be addressed to ensure that these are effective, vaccine needs are accurately forecasted and ordered in a timely manner, and a quality program of pre-service curriculum EPI training and annual updates for all health workers delivering immunisations will be in place.

(iii) *Support to the National Nutrition program*

Policy and program development will be supplemented through review and program implementation of National nutrition policies, and support to mainstream nutrition into health services. Activities will target the introduction of essential nutrition packages of care in health facilities: pre-natal care; delivery and postpartum care; postnatal checks; immunisations; well-baby visits; sick child visits. These will include improving child and maternal nutritional practices, such as exclusive breastfeeding (EBF) and complementary feeding through community-based IMCI, sustained vitamin A supplementation, de-worming and reduction of iron-deficiency among children, adolescents and women of child-bearing age. In addition, improvement of private sector performance in food fortification will be addressed.

The MOH will be assisted to mobilise communities through well-planned communication programs and close involvement with communities and NGOs in design, monitoring and managing nutrition activities. These will include growth monitoring using the Family Health Card, annual village visits by nurses, expansion of the high risk register nationally; and expansion of school canteen programs.

(iv) *Support to improved hygiene practices and environmental sanitation*

To contribute to the alleviation of water and sanitation problems within Solomon Islands, the program will focus on mobilizing families, communities and schools initially in the selected areas, to significantly improve essential hygiene practices and environmental sanitation. Communities will be supported to rehabilitate and build low-cost water systems and latrines where necessary. In addition, the management capacity of key national and provincial staff of the Ministry of Works Department will be strengthened. School-based water and sanitation activities will be coordinated with the Department of Education.

(v) *Support to the Hospital care for children program.*

Activities will build on the MOH's introduction of the WHO Pocketbook Hospital care for children and the Management of the child with a serious infection or severe malnutrition as the standard technical resources for in-patient paediatric care for nurses and non-specialist doctors in provincial areas. Extension of this approach to all hospitals throughout the country will be supported through the provision of provincial nurse training in the use of these standard technical resources in everyday clinical practice. To further strengthen service delivery, support will be provided for the establishment of a program of provincial hospital supervision across the provinces. Through the Hospital care for children program and provincial supervision other obstacles to good quality paediatric care, including drug and equipment supplies will also be addressed.

At the end of the program period, the expected objectives from the activities under this Strategic area are:

- Improved capacity within the MOH in effective early diagnosis, provision of appropriate treatment and management of childhood infections, via the expanded introduction of the IMCI program across all Provinces.

- Improved family knowledge of common childhood infections and the importance of prevention of disease and injuries and seeking early care through increased number of communities supporting IMCI.

- Good infant and young child feeding practices in place with exclusive breastfeeding (for at least the first six months of life) and appropriate complementary feeding, in selected areas initially that is integrated with health care services, responsive to the identified needs and supported through community interventions.

- Social networks and multi-sectoral collaboration established and operational to address the reduction in common childhood diseases.

- Improved capacity within the MOH to provide quality of paediatric care in provincial hospitals and area health centres through coverage of all provincial hospitals with training, implementation of guidelines and system of data collection for paediatric care.

	Strategic Area 4 Common Childhood Diseases Identified "unfunded" Activities (August 2007 to December 2008)	Location	MOHMS UNIT Responsible to Implement	Nature of Procurement	Estimated Budget SBD Thousands (AUD 1 = SBD 5.65) (USD 1 = SDB 7.1)	Funding Source	2007						2008											
							Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
4.1	**Implementation of a carefully evaluated essential package of proven effective child survival interventions in selected provinces initially but with the intention of a later country-wide approach.**				**SBD 720,000**			Total Aug - Dec 07			**SBD 200,000**									Total Jan - Dec 08			**SBD 520,000**	
4.1.1	training to improving health worker skills	all Provinces	**UNICEF**[1]	**TR**	SBD 180,000																			
4.1.2	promote breastfeeding, malaria prevention, immunisation, nutrition	all Provinces	**UNICEF**[1]	**OC**	SBD 180,000																			
4.1.3	Family health Card will be expanded across all provinces	all Provinces	**UNICEF**[1]	**OC**	SBD 180,000																			
4.1.4	training in the use of WHO Pocketbook *Hospital care for children* and the *Management of the child with a serious infection or severe malnutrition*	all Provinces	**UNICEF**[1]	**TR**	SBD 180,000																			
4.2	**Support the Expanded Program of Immunization (EPI)**							Total Aug - Dec 07												Total Jan - Dec 08				
4.2.1	Short term TA to review Provincial performance with a focus on poor performing Provinces (see 8.4)	all Provinces	**UNICEF**[1]	**TA**																				
4.2.2	Short term TA to improve forecasting of needs and enhanced cold chain supply (see 8.4)	all Provinces	**UNICEF**[1]	**TA**																				
4.3	**Support the National Nutrition program**				**SBD 720,000**			Total Aug - Dec 07			**SBD 200,000**									Total Jan - Dec 08			**SBD 520,000**	
4.3.1	communication programs and close involvement with communities and NGOs in design, monitoring and managing nutrition activities	all Provinces	**UNICEF**[1]	**OC**	SBD 180,000																			
4.3.2	Family Health Card annual village visits by nurses	all Provinces	**UNICEF**[1]	**OC**	SBD 180,000																			
4.3.3	expansion of the high risk register nationally	all Provinces	**UNICEF**[1]	**OC**	SBD 180,000																			
4.3.4	expansion of school canteen programs;	all Provinces	**UNICEF**[1]	**OC**	SBD 180,000																			
4.4	**Support improved hygiene practices and environmental sanitation**				**SBD 1,650,000**			Total Aug - Dec 07			**SBD 200,000**									Total Jan - Dec 08			**SBD 1,450,000**	
4.4.1	Community grants to rehabilitate or build low-cost water systems & sanitation	all Provinces	**UNICEF**[1]	**OC**	SBD 1,000,000																			
4.4.2	Capacity building of key national and Provincial staff of Dept of Works	Center	**UNICEF**[1]	**TA & TR**	SBD 350,000																			
4.4.3	School based water and sanitation program	all Provinces	**UNICEF**[1]	**TA & TR**	SBD 300,000																			
4.5	**Support the Hospital Care for Children Program**				**SBD 830,000**			Total Aug - Dec 07			**SBD 0**									Total Jan - Dec 08			**SBD 830,000**	
4.5.1	Short term TA and Training to extend familiarity with WHO Pocket Hospital care for children and management of children with serious infection and / or malnutrition	all Provinces	**UNICEF**[1]	**TA**	SBD 330,000																			
4.5.2	Drug and equipment procurement as needed to support initiatives under 4.5.1 above	all Provinces	**UNICEF**[1]	**GD**	SBD 500,000																			
	Total Strategic Area 4				**SBD 3,920,000**		**Sub-Total 4 2007**				**SBD 400,000**									**Sub-Total 4 2007**			**SBD 988,800**	

WK	Civil Works	
GD	Goods	SBD 500,000
PH	Pharmaceuticals	
TA	Consulting Services	SBD 980,000
TR	Training	SBD 360,000
OC	Operating Costs	SBD 2,080,000

Note:

1 UNICEF have reviewed and indicated their intention to fund the above program activities but formal negotiation have not been completed and no MOU exists.

2 No AusAID funding allocated

7.6 STRATEGIC AREA FIVE: NON-COMMUNICABLE DISEASES

The program will support the MOH to "prevent, moderate and control non-communicable diseases"[46]. Strengthening early detection and chronic disease will improve health outcomes of individuals but also better manage future health costs associated with these diseases. Prevention of disease, through promotion of healthy lifestyles and reduction of risk factors, is the most important long term measure for reducing prevalence of chronic non-communicable diseases. The program will assist the MOH through activities that focus on:

(i) Strengthening the NCD Unit and its program planning and implementation capacity.

Support will be provided to undertake a review of structure, functions and organisational roles; to develop guidelines and policies; to enhance expanded service delivery particularly to provincial and rural areas through protocol / guideline / manual development; training and supervisory support; and surveillance; support, as appropriate, the introduction of provincial satellite diabetic clinics.

(ii) Developing and implementing general and targeted primary and secondary prevention programs to address major NCD risk factors (tobacco use, physical inactivity and nutrition).

Capacity will be developed / enhanced to ensure integration of activities with the National Health Promotion unit to support relevant programs both within the health facilities and the community. This will be a key focus area and will support CBO and NGOs to introduce community programs.

(iii) Improving and expanding clinical services for diabetic and hypertension patients through the development and introduction of guideline and treatment protocols; training and supervisory support; and surveillance.

This will include strengthening the Diabetic clinic at NRH in the provision of quality treatment and secondary prevention, and as the central training unit for provincial health workers. Support will be provided through organisation and function review, development of protocols, and provision of equipment and drug availability. Consideration will be given to the establishment of a "twinning" relationship with the Australian Centre for Diabetes, building on the relationship with the Royal Newcastle Hospital, Newcastle.

(iv) Expanding the introduction of 'healthy settings' throughout each Province to empower communities to take more responsibility and participate in decision making for their health.

This activity links with Strategic Area One.

(v) Establishing inter-sectoral collaboration to develop and support a healthy lifestyle approach.

This may include the Ministry of Education, Ministry of Agriculture; Department of Customs. Activities will also develop the capacity to advocate for legislative changes to address the key determinants of diabetes. This activity links with Strategic Area One.

The activities under this sub-component are designed to achieve the following key objectives and outputs:

[46] Strategic Area Five, Ministry of Health and Medical Services. Solomon Islands National Health Strategic Plan 2006-2010

- Capacity of MOH increased, to implement a diabetes prevention and disease management program and service delivery that is effectively delivered by the health system.

- An effective and established organisational framework and infrastructure that supports diabetes and other NCDs prevention, care and treatment at national and provincial levels.

- Communities implementing 'health lifestyles' programs that address diabetes and other NCDs prevention supported by a network comprising health system, CBOs, NGOs and Church groups.

Strategic Area 5 Prevent, Moderate & Control NCDs Identified "unfunded" Activities (August 2007 to December 2008)		Location	MOHMS UNIT Responsible to Implement	Nature of Procurement	Estimated Budget SBD Thousands (AUD 1 = SBD 5.65) (USD 1 = SDB 7.1)	Funding Source	2007						2008											
							Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
5.1	**Strengthening the NCD Unit and its program planning and implementation capacity**				**SBD 600,000**			Total Aug - Dec 07			**SBD 300,000**										Total Jan - Dec 08			**SBD 300,000**
5.1.1	Study to review of structure, functions and organisational roles; develop guidelines and policies; develop protocols / guidelines / manual; training al with a focus on improving provincial / rural delivery & satellite diabetic clinics	all Provinces		**TA**	SBD 600,000																			
5.2	**Primary and secondary prevention programs to address major NCD risk factors ((tobacco use, physical inactivity and nutrition)**				**SBD 800,000**			Total Aug - Dec 07			**SBD 200,000**										Total Jan - Dec 08			**SBD 600,000**
5.2.1	TA to ensure integration with Health promotion unit and a key focus on support to CBO and NGOs	all Provinces		**TA**	SBD 800,000																			
5.3	**Improving and expanding clinical services for diabetic and hypertension patients**				**SBD 600,000**			Total Aug - Dec 07			**SBD 400,000**										Total Jan - Dec 08			**SBD 200,000**
5.3.1	Study to develop guideline and treatment protocols; training and supervisory support; and surveillance and strengthening the Diabetic clinic at NRH	NRH	NRH	**TA**	SBD 600,000																			
5.4	**Expanding "healthy settings" to all Provinces**				**SBD 600,000**			Total Aug - Dec 07			**SBD 200,000**										Total Jan - Dec 08			**SBD 400,000**
5.4.1	Short term TA and training	NRH	NRH	**TA & TR**	SBD 600,000																			
5.5	**Establish and foster inter-sector collaboration to develop and support the healthy lifestyles approach.**				**SBD 600,000**			Total Aug - Dec 07			**SBD 200,000**										Total Jan - Dec 08			**SBD 400,000**
5.5.1	Short term TA	NRH	NRH	**TA**	SBD 600,000																			
Total Strategic Area 5 Prevent, Moderate and Control Selected NCDs					**SBD 3,200,000**		**Sub-Total 5 2007**				**SBD 0**		**Sub-Total Strategic Area 5 2008**											**SBD 3,200,000**

WK	Civil Works	
GD	Goods	
PH	Pharmaceuticals	
TA	Consulting Services	SBD 3,200,000
TR	Training	
OC	Operating Costs	

Note:

No AusAID funding allocated

7.7 STRATEGIC AREA SIX: HIV/AIDS & SEXUALLY TRANSMITTED INFECTIONS

The program will implement activities that assist the MOH in its objective of ensuring that the "health and wellbeing of the people of Solomon Islands will not be undermined due to the burden of HIV/AIDS"[47]. This package of support will focus on

(i) *Developing and implementing well-targeted awareness, prevention and advocacy campaigns at all levels within the community to reduce risk taking behaviour and vulnerability to HIV and STIs.*

This will be undertaken in collaboration with NGOs, CBOs and faith based organisations. Key areas to address include: further defining at risk groups; universal precautions; destigmatisation; safe motherhood; mother-to-child transmission (PMTCT); and workplace initiatives. A comprehensive approach to prevention of PMTCT of HIV will also be promoted and will include technical support for policy development, upgrading of VCCT sites to PMCT entry points; training of health facility staff; strengthening and increasing access to MCH services as well as vertical transmission interventions in specific facilities. In addition, the activities will strengthen health promotion and awareness activities through coordination and program development with the National Health Promotion unit.

(ii) *Strengthening the National HIV unit and integrated service delivery at provincial level.*

Support will be provided to undertake a review and revision of the structure, functions and organisational roles of the National HIV unit and SINAC. Key activities will also include supporting capacity building to enhance implementation of HIV program activities, including the relationship and operational role of SINAC at the provincial level; supporting the establishment of provincial SINAC from 2008 following a review and resource planning, with the initial focal provincial priorities to include Western, Shortlands, and Guadalcanal; and, defining and strengthening the coordination, monitoring and evaluation role of SINAC for HIV activities implemented through all stakeholders.

(iii) *Improving the information base for STIs and HIV/AIDS*.

SINAC, through the MOH, will be supported to undertake a behavioural and sero-surveillance survey for high risk groups, including youth, sex workers and their clients, mobile populations and seafarers; operational research; and program monitoring and evaluation.

(iv) *Strengthening and defining the intersectoral working group (ISWG).*

Support will be provided to undertake a review and revision of the structure and roles of the ISWG. The leading role of the MOH in policy, program development, treatment, care and blood safety will be clearly identified within the parameters of the ISWG . Activities will assist the MOH to build coalition and networks with all its partners, including within government sectors (eg immigration, works), the DSE (including churches, NGOs and CBOs) and the private sector. Support will be given to training initiatives within network members.

(v) *Enhancing service delivery through well-defined local initiatives*. Local initiatives to be supported may include. :

- the strengthening and expansion of voluntary counselling and testing (VCCT) for HIV throughout the provinces to provide an entry point for confidential prevention and treatment services for STIs and AIDS (including blood safety).
- cross-border initiatives with PNG.

[47] Strategic Area Six, Ministry of Health and Medical Services. Solomon Islands National Health Strategic Plan 2006-2010

- the introduction of activities for support on safe motherhood and PMCT from Honiara and throughout the provinces.
- linking activities with partners, such as NGOs.
- expanding and strengthening HIV and STI surveillance system for prevention and care.
- prevention of HIV and STI through strengthening STI treatment services, universal precautions and blood safety.

At the end of the program period, the expected objectives and outputs from the activities under this sub-component are:

- Communities implementing prevention and advocacy programs with a reduction of risk taking behaviours and vulnerability to HIV and sexually transmitted infections supported by a network comprising health system, CBOs, NGOs and church groups.

- Enhanced capacity building for the national HIV response at both the community and institutional level.

- Skilled health workers, as well as NGOs, churches and CBOs effectively and efficiently implementing integrated HIV programs and activities.

- Capacity of MOH strengthened to provide voluntary confidential counseling and testing (VCCT) for HIV as an entry point for PMTCT and treatment services for STI and HIV and AIDS amongst high risk target groups.

- Inter-institutional, organisational and sectoral collaboration supporting an enabling environment for behavioural change, de-stigmatisation and against discrimination impacting on prevention and care.

Strategic Area 6 Sexually Transmitted Infections and HIV AIDS Program Identified "unfunded" Activities (August 2007 to December 2008)		Location	MOHMS UNIT Responsible to Implement	Nature of Procurement	Estimated Budget SBD Thousands (AUD 1 = SBD 5.65) (USD 1 = SDB 7.1)	Funding Source	2007						2008											
							Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
6.1	**Developing and implementing well-targeted awareness, prevention and advocacy campaigns at all levels within the community to reduce risk taking behaviour and vulnerability to HIV and STIs.**				**SBD 200,000**			Total Aug - Dec 07			**SBD 0**									Total Jan - Dec 08			**SBD 200,000**	
6.1.1	Short term TA to develop the campaign materials and strategy and implementation costs	Center		**TA**	SBD 200,000																			
6.2	**Strengthening the national HIV unit and integrated service delivery at provincial level**				**SBD 860,000**			Total Aug - Dec 07			**SBD 0**									Total Jan - Dec 08			**SBD 860,000**	
6.2.1	TA to review and revision of the structure, functions and organisational roles;	Center		**TA**	SBD 400,000																			
6.2.2	TA to upport the establishment of provincial SINAC from 2008. Review and plan resources	Western, Shortlands, and Guadalcanal.		**TA**	SBD 400,000																			
6.2.3	Define and strengthen the coordination, monitoring and evaluation role of SINAC for HIV activities implemented through all stakeholders and improve / expand information data base	all Provinces		**TA**	SBD 60,000																			
6.3	**Improving the information data base for STIs and HIV / AIDS**				**SBD 600,000**			Total Aug - Dec 07			**SBD 0**									Total Jan - Dec 08			**SBD 600,000**	
6.3.1	TA supporting capacity building to enhance implementation of HIV program activities, including relationship and operational role of SINAC at national and Provincial level, to enable it to undertake behavioural and sero-surveilance of nigh risk	all Provinces		**TA**	SBD 600,000																			
6.4	**Strengthening and defining the intersectoral working group (ISWG)**				**SBD 100,000**			Total Aug - Dec 07			**SBD 0**									Total Jan - Dec 08			**SBD 100,000**	
6.3.1	Training initiatives for network members (intersectoral working group (ISWG))	Center		**TR**	SBD 100,000																			
6.5	**Enhance service delivery**				**SBD 1,550,000**			Total Aug - Dec 07			**SBD 50,000**									Total Jan - Dec 08			**SBD 1,500,000**	
6.5.1	Strengthen and expand voluntary counselling and testing (VCCT) for HIV throughout the provinces	all Provinces		**OC**	SBD 250,000																			
6.5.2	Cross-border initiatives with PNG.	Choisel		**OC**	SBD 300,000																			
6.5.3	Support to PMCT from Honiara and throughout the provinces.	Center		**OC**	SBD 200,000																			
6.5.5	TA to develop protocols / guidelines and provide training to expand and strengthen HIV and STI surveillance system	Center		**TA**	SBD 400,000																			
6.5.6	TA and training to strengthen STI treatment services, universal precautions and blood safety.	all Provinces		**TA**	SBD 400,000																			
Total 6 Sexually Transmitted Infections and HIV/AIDS program					**SBD 3,310,000**		**Sub-Total 6 2007**				**SBD 50,000**									**Sub-Total 6 2008**			**SBD 3,260,000**	

WK	Civil Works	
GD	Goods	
PH	Pharmaceuticals	
TA	Consulting Services	SBD 2,560,000
TR	Training	SBD 100,000
OC	Operating Costs	SBD 750,000

Note:

No AusAID funding allocated

7.8 STRATEGIC AREA SEVEN: FAMILY PLANNING & REPRODUCTIVE HEALTH

The activities in this strategic area will provide targeted support to assist the MOH "to improve reproductive health services and increase uptake of family planning methods"[48]. Key activities will be

(i) *Supporting the delivery of quality reproductive health and family planning services at all levels and enhancing the availability of appropriate technical skills covering all reproductive health needs, sympathetic behaviour and attitude of health professionals and provision of services.*

The capacity of health workers will be strengthened to provide essential packages of care, based on evidence-based interventions, such as: 'Making Pregnancy Safer', 'Life Saving Skills', Family Planning, PMTCT, and Neonatal health. This will include skilled birth attendance through provision of support to pre-service, post and in-service training through the School of Nursing and Health Studies, Nurse Aid training program, Nurse Distance education program and the Midwifery School. Support to service delivery will also focus on strengthening a functioning referral system that includes organisation of emergency transport, safe blood and communication systems backed up by support supervision.

(ii) The MOH will be supported in its provision of youth oriented and friendly (reproductive) health services that are sensitive to their increased vulnerabilities and designed to meet the needs of youth.

These will include age-appropriate sexuality education and services; school and community-based education programs, mass media education programs, youth-friendly information and service delivery, including possible expansion of service provision by NGOs and CBOs, and the introduction of school-health models. The interventions for youth will also explicitly target early pregnancy, unmet need for contraceptives, unsafe abortion, nutrition, HIV/AIDS and other STIs, and lack of access to reproductive health services and information.

(iii) To contribute to reduction in malnutrition in women of child bearing age.

New strategies will be developed for: (a) sustained vitamin A supplementation, de-worming and reduction of iron-deficiency anaemia among children, adolescents and women of child-bearing age; and (b) improving private sector performance in food fortification initiatives. Furthermore, child and maternal nutritional practices will be improved through community-based IMCI.

(iv) Supporting Community involvement and linkages.

Program activities will support the introduction of demand side incentives to increase community involvement and linkages for more appropriate reproductive health care seeking behaviour and referral. Activities will address the partnerships between TBAs and midwives, and the establishment of 'waiting houses'. Subsequent review and evaluation of the cost effectiveness of community interventions will be undertaken.

[48] Strategic Area Seven, Ministry of Health and Medical Services. Solomon Islands National Health Strategic Plan 2006-2010

At the end of the program period, the expected objectives and outputs from the activities under this sub-component are:

- Improved capacity within the MOH to provide strengthened delivery of quality reproductive health and family planning services.

- Improved health and family planning health care services in the program areas that are available and responsive to reproductive health emergencies and prevent maternal and newborn deaths.

- Optimisation of access and increased utilization of essential health, PMTCT and family planning services that prevent maternal and infant mortality by the community.

- Created capacity within the MOH to provide appropriate 'youth friendly' health services, supported as required through established inter-sectoral and non-government partnerships.

- A well detailed program of nutrition activities initially in selected areas that is integrated with health care services, responsive to identified needs and supported through community interventions.

Strategic Area 7 Family and Reproductive Health Program (August 2007 to December 2008)		Location	MOHMS UNIT Responsible to Implement	Nature of Procurement	Estimated Budget SBD Thousands (AUD 1 = SBD 5.65) (USD 1 = SDB 7.1)	Funding Source	2007						2008											
							Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
7.1	**Support School of Nursing and Health Studies,Nurse Distance education program and the Midwifery School, and Strengthen the referral system: organisation of emergency transport, safe blood and communication systems backed up by support supervision.**				**SBD 600,000**			Total Aug - Dec 07			**SBD 300,000**									Total Jan - Dec 08			**SBD 300,000**	
7.1.1	Short-term TA support to pre-service, post and in-service training to strengthen a functioning referral system that includes organisation of emergency transport, safe blood and communication systems backed up by support supervision.	Schools of Nursing & Midwifery		**TA & TR**	SBD 600,000																			
7.2	**School and community-based education programs, mass media education programs, youth-friendly information and service delivery & introduction of school-health models.**				**SBD 440,000**			Total Aug - Dec 07			**SBD 0**									Total Jan - Dec 08			**SBD 440,000**	
7.2.1	Short term TA to develop programs & materials with a specific target of early pregnancy, unmet contraceptive needs, unsafe abortion, nuitrion, HIV/AIDS and other STIsand the lack of access to reproductive health services and information.			**TA**	SBD 440,000																			
7.3	**Development of Strategies for the reduction in malnutrition of women of childbearing age.**				**SBD 440,000**			Total Aug - Dec 07			**SBD 0**									Total Jan - Dec 08			**SBD 440,000**	
7.3.1	Short term TA to develop programs for (i) sustained Vitamin A supplementation, de-worming and reduction of iron deficiency anaemia and (ii) improving private sector performance in food fortification initiatives , and (iii) maternal nuitrition improvement through community-based IMCI			**TA**	SBD 440,000																			
7.4	**Community involvement and linkages: demand side incentives to increase community involvement**				**SBD 1,100,000**			Total Aug - Dec 07			**SBD 550,000**									Total Jan - Dec 08			**SBD 550,000**	
7.4.1	The establishment of 'waiting houses', (Community based construction 18 @ SBD60,000 each)			**WK**	SBD 1,100,000																			
Total Family and Reproductive Health Program					**SBD 2,580,000**	**Sub-Total 7 2007**					**SBD 850,000**		**Sub-Total 7 2008**											**SBD 1,730,000**

WK	Civil Works	SBD 1,100,000
GD	Goods	
PH	Pharmaceuticals	
TA	Consulting Services	SBD 1,480,000
TR	Training	
OC	Operating Costs	

Note:

No AusAID funding allocated

7.9 STRATEGIC AREA EIGHT: HEALTH SYSTEM STRENGTHENING - Overview

Support to Health System Strengthening is over-arching in that it encompasses the broad elements of the health system that are critical in translating the key inputs into service delivery for clients at all levels. National and provincial health systems will be strengthened to assist the MOH to "improve management and leadership throughout the Ministry of Health to achieve health outcomes"[49].

Central and provincial level functions will be specifically targeted; extending focus on building capacity of the Essential Public Health Functions[50] coupled with consolidation of primary health care and extending secondary care to areas (based on evidence) at the provincial level.

Support will be provided to specific strategies for future health planning that are comprehensive in their approach: encompassing institutional strengthening and capacity building at all levels of the health service, and are aimed at positively influencing health service utilization. Support will be provided to improve sector coordination horizontally and vertically through, for example, strengthening information and knowledge management; scaling-up of successful strategies based on operational research; and fostering cooperation with the private sector by involving local institutions, NGOs and private stakeholders in the quality improvement of services.

AusAID through its Health Sector Trust Account (operated within the HISP) has provided operational support that includes the provision of funds for: (i) medical drugs and supplies; (ii) NRH, (iii) non-government church hospitals and training facilities, (v) medical equipment replacement, (vi) DIG, overseas referrals and pathology costs. This support has been key to maintaining the operation of these vital health services. There is an ongoing requirement for funding these essential services through continued financing of operational expenditures which have not been adequately covered by the SIG budget. This funding will be continued while at the same time support will be provided to the MOH to enable expenditure for these operational costs to be met over time by the SIG budget through both assistance to the budget and operational planning process as well as support for representations to the MOF.

[49] Strategic Area Eight, Ministry of Health and Medical Services. Solomon Islands National Health Strategic Plan 2006-2010

[50] Essential Public Health Functions for Solomon Islands, national Health Strategic Plan 2006-2010 are:

Function 1 – Monitor and analyse health status
Function 2 – manage disease surveillance, prevention and control
Function 3 – develop/evaluate legislation, regulations & policies for public health
Function 4 – Manage health systems to improve public health
Function 5 – Protect public health through enforcement
Function 6 – Develop human resources in public health
Function 7 – Promote health through community participation
Function 8 – Ensure the quality of Public Health services
Function 9 – Research for public health
Function 10 – Disaster and emergency preparedness and response

(i) National health systems

Activities at the national level, will be prioritized based on the availability of resources, and will focus on overall policy and financial management, monitoring and evaluation, human resource development, infrastructure planning, procurement and supply chain management, and, strengthening pre-service training and curricula. Key operational areas of service delivery including tertiary level care as provided through the National Referral Hospital will also be addressed. Activities that address the mainstreaming of gender within MOH policy, program and operations will be supported.

National Activity Summary

3 Malaria Program																									
3.2.1	TA for development of guidelines for epidemic preparedness and control	centre	MOH VBDCP Unit	**TA**	SBD 440,000	**AusAID**			220000							220000									
3.3.1	TA to establish QC and QA of microscopists, (6 weeks 2007, 12 mid and 18 end of 2008)	centre	MOH VBDCP Unit	**TA**	SBD 1,430,000	**GFATM**					220000	110000					220000	220000				220000	220000	220000	
3.3.5	Short term TA to enhance interaction and collaboration between MOH and private medical practioners to support adherance to Malaria standard Diagnosis Treatment and Reporting Guidelines	centre	MOH VBDCP Unit	**TA**	SBD 440,000	**AusAID**				220000									220000						
3.3.7	Establish & equip "high-dependency" unit in NRH (ventilators, cardiac monitors, blood gas and biochemistry analyses)	NRH	MOH VBDCP Unit	**GD**	SBD 500,000	**AusAID**					60000	220000	220000												
3.3.8	Training of health workers to familarize them with new equipment for high dependency unit NRH	centre	MOH VBDCP Unit	**TR**	SBD 110,000	**AusAID**									110000										
3.3.10	Training of health workers to familarize them with new equipment for high dependency unit Kilu-Ufi	centre	MOH VBDCP Unit	**TR**	SBD 71,000	**AusAID**											71000								
3.4.1	TA to develop and deliver training programs and review role and capacity of SIMTRI as a training unit for SI and sub-regional (PNG, Vanuatu)	centre	MOH VBDCP Unit	**TA & TR**	SBD 880,000	**AusAID**								220000	220000				220000				220000		
3.4.2	Refurbishment of teaching facility and distance learning center in SIMTRI	centre	MOH VBDCP Unit	**WK**	SBD 249,000	**AusAID**									83000	83000	83000								
3.4.3	Refurbishment of clinical trail unit, office, computer equipment and IT connectivity	centre	MOH VBDCP Unit	**WK**	SBD 144,000	**AusAID**									48000	48000	48000								
3.4.4	Core training group in SIMTRI in malaria diagnosis and treatment, parasitology, entomology and vector control	centre	MOH VBDCP Unit	**TR**	SBD 520,000	**AusAID**				130000					130000				130000				130000		
3.4.7	TA support to VBDCP management, admin & logistical systems - scaled up response to malaria control suport joint M&E, joint planning and supervision and improve integration of IPTp and IPTi with the Reproductive Health division	centre	MOH VBDCP Unit	**TA**	SBD 504,000	**AusAID**			110000	220000	220000	220000										220000	220000	110000	
3.6.1	Treatment Modalities and drug efficacy studies	centre	MOH VBDCP Unit	**TA**	SBD 1,200,000	**AusAID**				400000	400000	400000													
3.6.2	Prevention approaches and methods	centre	MOH VBDCP Unit	**TA**	SBD 1,200,000	**AusAID**					400000	400000	400000												
3.6.3	Research and support to behavioural and social aspects of malaria and its control.	centre	MOH VBDCP Unit	**TA**	SBD 1,200,000	**AusAID**									400000	400000	400000								
8.1 Accountability																									
8.1.1a	Long-term Advisor Financial Management initially 2 year appointment renewable	Ministry Finance Unit	Ministry Finance Unit	**TA**	SBD 3,740,000	**AusAID**		220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000
8.1.1b	Long-term Advisor Procurement Management & Implementation initially 2 year appointment renewable	Ministry Procuremnt Unit	Ministry Procuremnt Unit	**TA**	SBD 3,740,000	**AusAID**		220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000
8.1.1c	Domestic External Audit Firm	center	Ministry Finance Unit	**TA**	SBD 150,000	**AusAID**						60000	60000												30000
8.2 Infrastructure																									
8.2.1a	Short- term Assignment to Develop a Hospitals Master Plan - infrastructue & equipment needs	Ministry and travel throughout all Provinces	Infrastructure Unit	**TA**	SBD 1,456,000	**AusAID**							280000	112000	112000	112000	560000	280000							
8.2.1b	Short- term Assignment to Support the Infrastucture Committee	Ministry Infrastucture Committee	Infrastructure Unit	**TA**	SBD 1,980,000	**AusAID**		220000	220000	220000	220000	220000	220000			220000			220000				220000		
8.2.1a	TA service contract to implement recommendations of electrical system and potential fire hazard	NRH	NRH	**TA**	SBD 3,000,000	**AusAID**													500000	500000	500000	500000	500000	500000	

8.3 Information Management																										
8.3.2a	Short-term TA Health Information Surveilance (20 weeks in total) see overlap and connection with 3.4	Center	HR Division	TA	SBD 1,100,000	AusAID				220000					220000	220000				220000	220000			
8.4 Organization																										
8.4.1a	Long-term Advisor - Principal Health Program Advisor (Overall Program Coordination initially 2 year appointment renewable)	MOH Executive	MOH Executive	TA	SBD 2,720,000	AusAID		160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000
8.4.1b	Long-term Advisor Hospital Management (NRH & Provincial) initially 2 year appointment renewable	NRH & Provincial Hospitals	NRH & Provincial Hospitals	TA	SBD 2,720,000	AusAID		160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000
8.4.1c	Short- term Assignment Medical Supply Planning and Tender Specialist	National Medical Store	National Medical Store	TA	SBD 1,320,000	AusAID			220000	220000	220000								220000	220000	220000					
8.4.1d	Short-term assignment Work force planning and policy development	HR Division	HR Division	TA	SBD 660,000	AusAID								220000	220000	220000										
8.4.1e	Short-term assignment at vaious points to assist the MOH establish and maintain a monitoring regime for grant programs	HR Division	HR Division	TA	SBD 660,000	AusAID								220000	220000	220000										
8.4.1f	Short-term TA Health Information Surveilance (20 weeks in total) see overlap and connection with 3.4	Center	HR Division	TA	SBD 1,100,000	AusAID				220000					220000	220000				220000	220000					
8.4.1g	Short term TA for pharmaceutical procurement, supply chain & warehouse management specialist (especially for Malaria see overlap and connection with 3.4)	Center	VBDCP Unit	TA	SBD 1,320,000	AusAID					220000			220000	220000				220000			220000				220000
8.4.2a	Grant to NRH - Operational Support	NRH	NRH	OC	SBD 8,500,000	AusAID		500000	500000	500000	500000	500000	500000	500000	500000	500000	500000	500000	500000	500000	500000	500000	500000	500000	500000	500000
8.4.2b	Grant to Headquarters - Operational Support	MOH Executive	MOH Executive	OC	SBD 2,125,000	AusAID		125000	125000	125000	125000	125000	125000	125000	125000	125000	125000	125000	125000	125000	125000	125000	125000	125000	125000	125000
8.4.3a	Doctor / Locum Fees / Recruitment	Center	MOH Executive	OC	SBD 56,100	AusAID		3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300
8.4.3b	Overseas Referal Costs	Center	MOH Executive	OC	SBD 1,122,000	AusAID		66000	66000	66000	66000	66000	66000	66000	66000	66000	66000	66000	66000	66000	66000	66000	66000	66000	66000	66000
8.4.3c	Overseas Pathology Services	Center	MOH Executive	OC	SBD 357,000	AusAID		21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000
8.4.4a	HR skills Training and Research Initiatives	HRD Unit	HRD Unit	TR	SBD 150,000	AusAID			25000	25000											25000	25000	25000	25000		
8.4.4b	HQ Renovation (maintenance and upgrades)	Center	Infrastructure Unit	WK	SBD 225,000	AusAID		25000	25000	25000	25000					25000	25000	25000	25000	25000						
8.4.6	**UNALLOCATED**	Center	MOH Executive	UN	**SBD 3,000,000**	AusAID		Total AusAID Aug - Dec 07		**SBD 3,000,000**										Total AusAID Jan - Dec 08						
8.4.7	**Operational Grants - Provincial Development Grants**	Center	MOH Executive	OC	**SBD 5,800,000**	AusAID		Total AusAID Aug - Dec 07		**SBD 2,500,000**										Total AusAID Jan - Dec 08		**SBD 3,300,000**				
8.4.8	**Pharmaceuticals & Medical Supplies and Consumables**	Center	Pharmacy Division & Procurement Unit	PH	**SBD 47,875,000**	AusAID		Total AusAID Aug - Dec 07		**SBD 11,300,000**										Total AusAID Jan - Dec 08		**SBD 36,575,000**				

(ii) Provincial health systems

Activities will support the operational management of national health policies at the provincial levels, through improving operational planning, budgeting and monitoring expenditures by provincial hospitals and clinics, capacity building, implementation of priority activities, supervision, monitoring and evaluation, infrastructure planning and maintenance, and complementary outreach to communities and non-governmental entities.

A key initiative to the success of this sub-component is the provincial sub-grant mechanism for channeling funds to enable provincial health teams to deliver the priority services with the inputs provided by the central level. As part of the grant mechanism, the program will explore the introduction of performance incentives across the provinces. The program will support the development of provincial capacity to improve health services operations and outreach activities through human resource development, including training, service delivery improvement and provision of equipment and needed infrastructure. Secondary level care as provided by the provincial hospitals will also be included. Support will be provided to community public-private partnerships and community innovations

Provincial Activity Summary

1 People Focus																								
1.1.1	TA to review existing program and work with unit and policy branch to establish a strategic plan and explore implementation options	all Provinces	Health Promotion Unit	TA	SBD 640,000	AusAID				160000	160000	160000					160000								
1.1.2	Training for all health promotion staff by TA from 1.1.1	center & various Provinces	Health Promotion Unit	TR	SBD 180,000	AusAID					60000	60000					60000								
1.3.1	Community seminars and workshops	all Provinces	Health Promotion Unit	OC	SBD 120,000	?			40000						40000						40000				
1.4.1	TA Service training at community level, health promotion resource centres including materials and transport	Malaita, Western Province and Temotu.	Health Promotion Unit	TA	SBD 420,000	?								140000	140000	140000									
1.5.1	Study - Socio-behavioural research project: priority diseases and their risk factors. Community participation and empowerment for health. Gender Issues and follow up training	Malaita, Western Province and Temotu.	Natioal NCD Division	TA	SBD 500,000	?				200000	200000				200000			300000	300000	300000					
1.6.2	Proposal-based grants for GONGO (Government owned NGO), CBOs, local NGOs and Church Groups	all Provinces	Health Promotion Unit	OC	SBD 510,588	?		29411.8	29411.8	29411.8	29411.8	29411.8	30294.1	30294.1	30294.1	30294.1	30294.1	30294.1	30294.1	30294.1	30294.1	30294.1	30294.1	30294.1	30294.1
1.7.1	Community seminars and workshops	all Provinces	Health Promotion Unit	OC	SBD 500,000	?					40000					40000				60000					
3 Malaria Program																								
3.1.1	Expansion of IPT, health worker training, community education, M&E following on from the IPTp pilot study (RCT) commencing July 2008	5 Provinces	MOH VBDCP Unit	TR	SBD 900,000	AusAID													180000	180000	180000	180000	180000		
3.1.2	Replacement of ineffective Permanets and provision of pyrethroid insecticides for re-treatment of these nets, (25,000 units in 2007 and 120,000 units in 2008 plus distribution costs estimate at SBD 7.1 per unit)	all Provinces	MOH VBDCP Unit	GD	SBD 3,500,000	AusAID		40000	40000	40000	40000	40000	275000	275000	275000	275000	275000	275000	275000	275000	275000	275000	275000	275000
			MOH VBDCP Unit		SBD 3,991,088	GFATM	185931	185931	185931	185931	185931	185931	239625	239625	239625	239625	239625	239625	239625	239625	239625	239625	239625	239625
3.1.3	Indoor residual spraying, procurement of ICON pesticides and provision of temporary labour, (100,000 households twice per year)	epidemic-prone areas	MOH VBDCP Unit	OC	SBD 691,000	AusAID		95000	95000	95000	95000	95000	18000	18000	18000	18000	18000	18000	18000	18000	18000	18000	18000	18000
			MOH VBDCP Unit		SBD 2,166,743	GFATM	193090	193090	193090	193090	193090	193090	84017	84017	84017	84017	84017	84017	84017	84017	84017	84017	84017	84017
3.1.4	Environmental control using physical methods combined with chemical larviciding effective insect growth regulators with residual lifespan of 6 months	all Provinces	MOH VBDCP Unit	OC	SBD 160,000	AusAID			20000		20000		20000		20000		20000		20000		20000		20000		
3.1.5	Feasibility study of scaling-up of pipeline installation, short-term TA (6 weeks in 2008)	highly endemic island provinces	MOH VBDCP Unit	TA	SBD 330,000	AusAID								220000	110000										
3.2.3	Training of health workers guidelines developed under 3.2.1	all Provinces	MOH VBDCP Unit	TR	SBD 546,700	GFATM			68338	68338	68338	68338				68338	68338	68338	68338						
3.3.2	Procurement of 15,000 RDT units for 138 Nurse Aid posts	all Provinces	MOH VBDCP Unit	GD	SBD 1,583,000	AusAID				83000							1500000								
3.3.3	Distribution of RDTs, & QA & accreditation of microscopists to increasing access to parasitological diagnostic services (microscopic services; MRDTs) locally engaged staff in Malaita, Guadalcanal, Western, Central, Choiseul, Makira and Temotu est. USD3000/month/Province)	Malaita, Guadalcanal, Western, Central, Choiseul, Makiira and Temotu	MOH VBDCP Unit	GD& TA	SBD 1,152,000	AusAID	150000	150000	150000	150000	150000	150000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000
3.3.4	Increase ACT provision for approx. 140,000 patients with uncomplicared malaria and 7,100 patients with treatment failures for one year by 2008	all Provinces	MOH VBDCP Unit	PH	SBD 3,000,000	AusAID							3000000												
3.3.6	Short term TA to review progress and impate of RDT distribution	all Provinces	MOH VBDCP Unit	TA	SBD 990,000	AusAID					220000	110000					220000	110000			220000	110000			
3.3.9	Establish & equip "high-dependency" unit in Kilu-Ufi hospitals (ventilators, cardiac monitors, blood gas and biochemistry analyses)	Malaita	MOH VBDCP Unit	GD	SBD 500,000	AusAID								60000	220000	220000									
3.4.8	Distribution of a Healthy Solomon Woman Package (comprising insecticide treated nets, deworming medications, iron folate supplementation, condom promotion through antenatal care and routine EPI activities)	all Provinces	MOH VBDCP Unit	GD	SBD 48,000	AusAID								8000	15000	25000									
3.4.9	Joint training with IMCI practitioners and TOTs	all Provinces	MOH VBDCP Unit	TR	SBD 100,000	AusAID					50000											50000			
3.4.10	Training of community NGOs and faith-based organizations in health promotion, environmental management, distribution & treatment of mosquito nets, and referrals of severe complicated malaria to second level health facilities	all Provinces	MOH VBDCP Unit	TR	SBD 100,000	AusAID					50000											50000			
3.4.11	Grants to Community NGOs and faith-based organizations in health promotion for environmental management, distribution & treatment of mosquito nets, and referrals of severe complicated malaria to second level health facilities	all Provinces	MOH VBDCP Unit	OC	SBD 200,000	AusAID			50000					150000											
3.4.12	Printing and dissemination of teachers' and students' learning guides on malaria within a Healthy Schools approach	all Provinces	MOH VBDCP Unit	GD	SBD 530,000	AusAID								150000	300000	20000	20000	20000	20000						
3.4.13	Local expenses for Private sector engagement travel costs	all Provinces	MOH VBDCP Unit	OC	SBD 150,000	AusAID				10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000	10000
3.4.15	Linking and rationalizing SIMIS and HIS data collection and analysis and enhanc information systems including surveilance)	all Provinces	MOH VBDCP Unit	TA	SBD 440,000	AusAID					220000	220000													
3.4.16	Short term TA to provide GIS data input training (6 weeks in 2008)	all Provinces	MOH VBDCP Unit	TA	SBD 330,000	AusAID										220000	110000								

3.5.1	Small grants to CBOs to support Rural development Program initiatives	all Provinces	MOH VBDCP Unit	**OC**	SBD 520,000	**AusAID**			220000						300000										
3.5.2	Local hire coordinator of Small grants to CBOs to support Rural development Program initiatives	all Provinces	MOH VBDCP Unit	**TA**	SBD 340,000	**AusAID**		20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000	20000
3.7.1	Provincial housing for Malaria Division Staff (9 houses over 18 months construct SBD200,000, fitout SBD100,000 transport SBD45,000, contigency 15% - unit cost SBD396750), in 2007 the 4 houses will constructed in Western & Choisel in response to the tsunami destruction	selected Provinces	MOH Infrastructure Unit	**WK**	SBD 3,600,000	**AusAID**		400000	400000	400000	400000	400000	400000	400000	400000	400000									
3.7.2	Construction Manager / site manager for houses in 3.7.1 at SBD5400 per house	selected Provinces	MOH Infrastructure Unit	**TA**	SBD 48,600	**AusAID**		5400	5400	5400	5400	5400	5400	5400	5400	5400									
8.2 Infrastructure																									
8.2.3a	Kirra Kirra Hospital	Makira Ulawa	Infrastructure Unit	**WK**	SBD 500,000	**AusAID**		100000	100000	100000	100000	100000													
8.2.3b	Gizo Hospital [1]	Western	Infrastructure Unit	**WK**	SBD 500,000	**AusAID**		100000	100000	100000	100000	100000													
8.2.4a	Marau PHC	Guadalocanal	Infrastructure Unit	**WK**	SBD 1,650,000	**AusAID**										450000	300000	300000	300000	300000					
8.2.4b	Marau Staff Housing (2)	Guadalcanal	Infrastructure Unit	**WK**	SBD 300,000	**AusAID**									50000	50000	75000	50000	75000						
8.2.4c	Afo PHC	Malaita	Infrastructure Unit	**WK**	SBD 1,450,000	**AusAID**							350000	300000	300000	300000	200000								
8.2.4d	Aifo Staff Housing (2)	Malaita	Infrastructure Unit	**WK**	SBD 300,000	**AusAID**									50000	50000	75000	50000	75000						
8.2.4e	Namuga PHC	Makira Ulawa	Infrastructure Unit	**WK**	SBD 950,000	**AusAID**								150000	200000	200000	200000	200000							
8.2.4f	Namuga Staff Housing (2)	Makira Ulawa	Infrastructure Unit	**WK**	SBD 300,000	**AusAID**										50000	50000	75000	50000	75000					
8.2.4g	Tatamba PHC	Isabel	Infrastructure Unit	**WK**	SBD 1,650,000	**AusAID**									450000	300000	300000	300000	300000						
8.2.4h	Tatamba Staff Housing (2)	Isabel	Infrastructure Unit	**WK**	SBD 300,000	**AusAID**							50000	50000	75000	50000	75000								
8.3 Information Management																									
8.3.1c	Radio Network Completion	various Provinces	Infrastructure Unit	**GD**	SBD 3,600,000	**AusAID**		1600000		2000000															
8.4.4c	Radio Project (installations)	various	Infrastructure Unit	**WK**	SBD 40,000	**AusAID**									40000										
8.4 Organization																									
8.4.2c	Atoifi Hospital	Atoifi Hospital	Atoifi Hospital	**OC**	SBD 714,000	**AusAID**		42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000
8.4.2d	Atoifi School of Nursing	Atoifi School of Nursing	Atoifi School of Nursing	**OC**	SBD 112,200	**AusAID**		6600	6600	6600	6600	6600	6600	6600	6600	6600	6600	6600	6600	6600	6600	6600	6600	6600	6600
8.4.2e	Helena Goldie Hospital	Helena Goldie Hospital	Helena Goldie Hospital	**OC**	SBD 714,000	**AusAID**		42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000
8.4.2f	Helena Goldie Scool of Nursing	Helena Goldie Scool of Nursing	Helena Goldie Scool of Nursing	**OC**	SBD 56,100	**AusAID**		3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300
8.4.2g	Malu'u School of Nursing	Malu'u School of Nursing	Malu'u School of Nursing	**OC**	SBD 56,100	**AusAID**		3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300

7.10 Accountability (finance, staff and accountability)

Financial Management, Budget and Operational planning

Support will be provided to strengthen financial management, operational planning and budgeting within the health sector.

A Technical Specialist will be provided through the HSSP to build the capacity within the MOH to implement sound fiduciary mechanisms. Activities will build on the work to date and facilitating the linkages between the MOH operational plans, the annual sectoral expenditure plan, and the MOH budget. Improved categorisation and record expenditures for the provinces will expand the basic budget categories to address, for example: facility (clinic expenses, hospital expenses); expenditure category (capital expenses, salary recurrent expenses, non-salary recurrent); and functional category (public health vs. curative care expenses).

Strategies to improve resource allocation will be addressed. These may include 'shifting' of resources through the annual sector expenditure plan process to areas with higher burdens of disease, frontline services, and priority public health programs consistent with improving the defined priority health outcomes. Activities will also support policies and implementation reforms which bring about efficiency gains through controlling costs that are already high as a proportion of total expenditure. A major focus will be on those areas identified through the Health Expenditure Review: provincial expenditure and inter-provincial allocations; primary and public health programs; diabetes; NRH expenditure; and, recurrent cost escalation. Included will be a focus on establishing systems to ensure monitoring of activity implementation, with accurate reporting fed into the annual implementation review, which in turn, will help the MOH make sound decisions on the following year's budget allocations.

Procurement

The MOH's capacity to undertake its own procurement will be developed and strengthened.

The MOH Procurement Unit will be supported to assist the departments and divisions at the national and provincial level achieve value-for-money outcomes in the procurement of pharmaceuticals and medical supplies, civil works, goods, services and, the recruitment of technical assistance. The procurement functionings of the Ministerial Tender Board, and as appropriate, the Central Tender Board, will be further supported in accordance with the guidelines detailed in the MOH's Procurement Manual.

Strategic Area 8.1 HEALTH SYSTEM STRENGTHENING Accounting - Finance & Staff (August 2007 - December 2008)		Location	MOHMS UNIT Responsible to Implement	Nature of Procurement	Estimated Budget SBD Thousands (AUD 1 = SBD 5.65) (USD 1 = SDB 7.1)	Funding Source	2007						2008											
							Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
8.1.1	Technical Assiatnce to develop & maintain management systems, provide imlementation and mangaement advice, and support and train counterparts				SBD 7,630,000			Total Aug - Dec 07			SBD 2,260,000									Total Jan - Dec 08			SBD 5,370,000	
8.1.1a	Long-term Advisor Financial Management initially 2 year appointment renewable	Ministry Finance Unit	Ministry Finance Unit	TA	SBD 3,740,000	AusAID		220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000
8.1.1b	Long-term Advisor Procurement Management & Implementation initially 2 year appointment renewable	Ministry Procuremnt Unit	Ministry Procuremnt Unit	TA	SBD 3,740,000	AusAID		220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000	220000
8.1.1c	Domestic External Audit Firm	center	Ministry Finance Unit	TA	SBD 150,000	AusAID						60000	60000											30000
Total 8.1 Health System Strengthening - Accounting Finance & Staff					SBD 7,630,000	Sub-Total 8.1 2007					SBD 2,260,000		Sub-Total 8.1 2008										SBD 5,370,000	

WK	Civil Works	
GD	Goods	
PH	Pharmaceuticals	
TA	Consulting Services	SBD 7,630,000
TR	Training	
OC	Operating Costs	

7.11 Infrastructure

More than half of all MOH health facilities do not meet an adequate standard in such areas as: water and sanitation, housing, transport, and communications. The MOH's Infrastructure plan will commence in August 2007 until December 2008. The design of the plan is done in conjunction with the NHSP and linked to targets and outputs delineated in the plan. Due to the extensive scale of the problem and limited resources available, priorities have been attached to each infrastructure activity.

The MOH over the last five years has been developing policies, strategies & projects to deal with these problems. With support from the AusAID funded HISP, the MOH set up an Infrastructure Office & Infrastructure Committee in June 2005. Support was given for: funding for small projects, provincial development initiative grants, refurbishment of the MOH Headquarters, capacity building of the Infrastructure Office, Committee, NRH & Provincial Health Authorities. A large Health Radio installation project to all PHC Clinics is near completion. Each province now has a Provincial Health Infrastructure Plan and several have formed committees to implement these plane. These committees are formed as a partnership between the MOH, Provincial Governments, donors & communities. The review of primary health care infrastructure and housing, using the guideline for the Minimum Standard for Clinic Infrastructure (MSCI), was conducted in 2005/06. This review formed the basis for the MOH's National Infrastructure Plan and the strategy to be developed as part of its sector-wide health program.

(i) Support to MOH's 2007 / 2008 Infrastructure Plan

Support will be provided to the priorities identified in the MOH's 2007 / 2008 Health Infrastructure Plan (Annex 5). Over the past 20 years there has been a degradation of the Solomon Islands hospitals, clinics, staff housing, without adequate investment in new infrastructure to meet the evolving needs of a rapidly growing and essentially regional population. Basic building services such as power water, sanitation and amenities for waste disposal and infection control are not adequate at more then half of MOH facilities. The April 2007 earthquake and tsunami caused extensive damage to health facilities, staff housing and transport assets throughout the affected areas of Western and Choiseul provinces.

Technical specialist support in the areas of infrastructure project management, maintenance and asset management, and procurement will be provided to the MOH Infrastructure Unit, working closely with the Procurement Unit, which will be responsible for liaison with regulatory agencies including the Central Tender Board, procurement of equipment, as well as support for the tender and contract administration of capital works. Infrastructure needs and priorities fall within 3 Asset management categories:

- Facility Management and Maintenance;
- Policy Development and Planning (including NRH and Provincial Hospital Master Plans); and

- Capital Works and Improvements (Buildings, Services, Water and Sanitation, Equipment).

Capacity building for the Infrastructure Office and the Infrastructure Committee will be a core activity of this technical support in the areas of implementation of capital works projects, and the development of a Maintenance Plan, a Housing Policy, and a Transport Infrastructure Audit and Policy. Project management will also be provided for existing capital works projects and for implementation of the PHC Clinic Rehabilitation Project and the Malaria Infrastructure Support Project. Support will also be provided in the areas of maintenance and asset management, including support to the finalisation and implementation of a preventative maintenance program as well as maintenance schedules for all new work & refurbishments with adequate recurrent funding at both the national and Provincial levels.

(iv) Solar lighting for provincial health facilities

As of July, 2006, 122 solar light kits have been installed in AHCs, RHCs and NAPs. Solar lights have proven of benefit for both emergency medical cases and deliveries at night. Frequency of the use of solar lights varies between daily, to on average 2-3 times weekly depending on cases. There is a clear benefit in its quality, utility and the absence of need for kerosene supplies. Solar light kits have been installed concurrently with the radio installation and maintenance checks in order to reduce costs. The program will support the installation for the remaining solar lights in the provincial health facilities.

Component 8.2 HEALTH SYSTEM STRENGTHENING Infrastructure (August 2007 - December 2008)		Location	MOHMS UNIT Responsible to Implement	Nature of Procurement	Estimated Budget SBD Thousands (AUD 1 = SBD 5.65) (USD 1 = SDB 7.1)	Funding Source	2007						2008											
							Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
8.2.1	**Technical Assiatnce to develop & maintain management syatems, provide imlementation and mangement advice, and support and train counterparts**				**SBD 3,436,000**		8.2.1 AusAID sub-total 2007				SBD 1,100,000								8.2.1 AusAID sub-total 2008			SBD 2,336,000		
8.2.1a	Short- term Assignment to Develop a Hospitals Master Plan - infrastructue & equipment needs	Ministry and travel throughout all Provinces	Infrastructure Unit	**TA**	SBD 1,456,000	**AusAID**							280000	112000	112000	112000	560000	280000						
8.2.1b	Short- term Assignment to Support the Infrastucture Committee	Ministry Infrastucture Committee	Infrastructure Unit	**TA**	SBD 1,980,000	**AusAID**		220000	220000	220000	220000	220000	220000			220000			220000				220000	
8.2.2	**National Referal Hospital Support**				**SBD 3,000,000**		8.2.2 AusAID sub-total 2007				SBD 0								8.2.2 AusAID sub-total 2008			SBD 3,000,000		
8.2.1a	TA service contract to implement recommendations of electrical system and potential fire hazard	NRH	NRH	**TA**	SBD 3,000,000														500000	500000	500000	500000	500000	500000
8.2.3	**Provincial Hospital Building Service and Repair**				**SBD 1,000,000**		8.2.6 AusAID sub-total 2007				SBD 1,000,000								8.2.6 AusAID sub-total 2008			SBD 0		
8.2.3a	Kirra Kirra Hospital	Makira Ulawa	Infrastructure Unit	**WK**	SBD 500,000	**AusAID**		100000	100000	100000	100000	100000												
8.2.3b	Gizo Hospital [1]	Western	Infrastructure Unit	**WK**	SBD 500,000	**AusAID**		100000	100000	100000	100000	100000												
8.2.4	**Provincial Clinics Rehabilitation**				**SBD 6,900,000**		8.2.7 AusAID sub-total 2007				SBD 0								8.2.7 AusAID sub-total 2008			SBD 6,900,000		
8.2.4a	Marau PHC	Guadalocanal	Infrastructure Unit	**WK**	SBD 1,650,000	**AusAID**										450000	300000	300000	300000	300000				
8.2.4b	Marau Staff Housing (2)	Guadalcanal	Infrastructure Unit	**WK**	SBD 300,000	**AusAID**									50000	50000	75000	50000	75000					
8.2.4c	Afio PHC	Malaita	Infrastructure Unit	**WK**	SBD 1,450,000	**AusAID**							350000	300000	300000	300000	200000							
8.2.4d	Aifo Staff Housing (2)	Malaita	Infrastructure Unit	**WK**	SBD 300,000	**AusAID**									50000	50000	75000	50000	75000					
8.2.4e	Namuga PHC	Makira Ulawa	Infrastructure Unit	**WK**	SBD 950,000	**AusAID**								150000	200000	200000	200000	200000						
8.2.4f	Namuga Staff Housing (2)	Makira Ulawa	Infrastructure Unit	**WK**	SBD 300,000	**AusAID**										50000	50000	75000	50000	75000				
8.2.4g	Tatamba PHC	Isabel	Infrastructure Unit	**WK**	SBD 1,650,000	**AusAID**									450000	300000	300000	300000	300000					
8.2.4h	Tatamba Staff Housing (2)	Isabel	Infrastructure Unit	**WK**	SBD 300,000	**AusAID**							50000	50000	75000	50000	75000							
	Tsunami rehabilitation	Western and Choiseul	Infrastructure Unit	**WK**	SBD 12,486,500	**AusAID**																		
	Sub - total 8.2 Health System Strengthening - Infrastructure				SBD 24,979,498						**AusAID Sub-Total 8.2 2007**	SBD 2,100,000							**AusAID Sub-Total 8.2 2008**					SBD 12,236,000

WK	Civil Works	SBD 24,979,498
GD	Goods	
PH	Pharmaceuticals	
TA	Consulting Services	
TR	Training	
OC	Operating Costs	

Notes:

1 Following the 2007 earthquake and tsunami Helena Goldie Hospital has been designated as the regional referal hospital until Gizo hospital regains full function, the funds allocated to 8.2.3b may be reallocated to Helena Goldie to assist increasing its capacity as the temporary regional referal hospital as funding is being prepared under programs outside the SWAp for specific earthquake / tsunami disaster relief for which Gizo would qualify.

7.12 Information Management

(i) Implementation and roll-out of newly revised HIS

Support will be provided to strengthen the introduction and usage of the revised HIS. Activities will target provincial HIS coordinators, nurse educators and primary care nurses as many HIS problems have flowed from failure to adequately support the system and its primary users over several years. This has allowed differing interpretations and poor practices. The implementation plan will include introductory workshops on HIS (the new tools, basic statistics, quality data management and responsibilities) in each province. Particular focus will roll-out. Provincial workshops in 2007 September to October

Surveillance

(ii) Early warning and response protocols

Technical assistance will be provided to develop early warning and response protocols for identified and newly emerging diseases. This activity will also overlap and strengthen Strategic Area Three.

(iii) Complementarity and performance of information systems and surveillance

Support will be provided to undertake a review of the current information systems – HIS, RHIS and SIMIS – to consider complementarity and streamlining of the data management, collection and dissemination process. Systems should be reviewed for completeness, accuracy, scope of usage, data management and acceptability to nurses and other health care workers; and will include laboratory capacity for surveillance and reporting – the role of the NPHL will also be considered. Based on the agreed recommendations from this review, program activities will strengthen and enhance the health information systems and surveillance. This activity will also overlap and strengthen Strategic Area Three.

(iv) National Health Radio Network (NHRN)

Through its support to the Provincial primary health care services, the program will purchase, install and undertake training in its use, the remaining radios required under the National Health Radio Network (NHRN) to achieve complete national coverage. This will mean a radio in every provincial health clinic: AHC, RHC and NAP. The HISP/MOH radio project has now installed 250 HF radios in clinics throughout Solomon Islands. Within the MOH, the Radio Program Cooordinator will oversee future installations, maintenance and operations of the national health radio network, including providing support for provincial radio officers (currently established in most provinces) who have been trained to monitor and maintain provincial radio networks. The radio is important for clinical use, administrative use, supporting nurses in the field and to a lesser extent, educational purposes. Pattern of use indicates that radios are used for more than just referral of patient cases; they are a support tool for clinical as well as administrative functions, reducing higher cost interventions and in supporting primary health care preventive and early intervention activities. In conjunction with the malaria program activities, a radio rapid response network will be established.

Strategic Area 8.3 HEALTH SYSTEM STRENGTHENING Information Management (August 2007 - December 2008)		Location	MOHMS UNIT Responsible to Implement	Nature of Procurement	Estimated Budget SBD Thousands (AUD 1 = SBD 5.65) (USD 1 = SDB 7.1)	Funding Source	2007						2008											
							Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
8.3.1	**Provincial Radio Network**				**SBD 4,070,000**		8.3.1 AusAID sub-total 2007 SBD 4,070,000						8.3.1 AusAID sub-total 2008 SBD 0											
8.3.1a	Maintenace of existing Network	Headquarters	Infrastructure Unit	**WK**	SBD 30,000	**AusAID**		6000	6000	6000	6000	6000												
8.3.1b	Short-term assignment Radio Installation Supervision and Technical Support	Headquarters	Infrastructure Unit	**TA**	SBD 440,000	**AusAID**			220000			220000												
8.3.1c	Radio Network Completion	various Provinces	Infrastructure Unit	**GD**	SBD 3,600,000	**AusAID**		1600000		2000000														
8.3.2	Teachnical Assistance for capacity building				SBD 1,100,000		8.3.2 AusAID sub-total 2007 SBD 220,000						8.3.2 AusAID sub-total 2008 SBD 880,000											
8.3.2a	Short-term TA Health Information Surveilance (20 weeks in total) see overlap and connection with 3.4	Center	HR Division	**TA**	SBD 1,100,000	**AusAID**				220000					220000	220000				220000	220000			

WK	Civil Works	SBD 30,000
GD	Goods	SBD 3,600,000
PH	Pharmaceuticals	
TA	Consulting Services	SBD 1,540,000
TR	Training	
OC	Operating Costs	

Note:

Radio procurement is the completion of an order placed under HSTA

7.13 Organisational change

7.13.1 National Medical Stores

Support for National Medical Stores - Pharmaceuticals and Medical Supplies Procurement Strengthening

A Pharmaceutical Needs Assessment (August 2006)[51] concluded that the general population in Solomon Islands has poorer access to basic essential medicines than other low income countries. In terms of pharmaceuticals only, it was estimated that annual expenditure is about US$1.86 per capita, which is consistent with average public spending in other low income countries. Private sector spending on pharmaceuticals in the Solomon Islands, however, appears to be significantly lower than in other low income countries. The World Health Organisation (WHO) reports the average private spending in low income countries to be US$3.20 whereas in the Solomon Islands it appears to be below US$1 per capita. This raises policy questions for the government in relation to either what steps can be taken to encourage the private sector to play a broader role and/or increase spending in the public sector to compensate for the private sector gap. Access to pharmaceuticals through the private sector in the Solomon Islands is poor outside of those places with private pharmacies, namely Honiara, Gizo, Kilufi, and Helena Goldie. Therefore in the immediate to medium term, the public sector is expected to remain the major provider of pharmaceuticals to the population.

A key challenge is to make the most of the financing that is available for expenditures on essential medicines and supplies and further cuts to this spending would further exacerbate this inequity and further limit access to essential medicines for Solomon Island people.

The performance of NMS in procurement is generally characterized by low levels of competition and high prices. The evidence gathered indicates prices being on average 20% above international indicator prices while most business is given to a relatively small number of companies. Poor control of inventory leads NMS to place a relatively high number of 'urgent' orders for which a premium price is paid. Evidence points to NMS paying more than three times an international indicator price for urgently ordered items. On an annual budget, the analysis suggests the potential for making an extra 20% of funds available to the public health service for essential supplies if a sound procurement process is introduced.

Support for International Competitive Bidding (ICB) process for NMS procurement

Reforms are underway to improve cost efficiencies to the procurement of pharmaceutical supplies through an international competitive bidding process. Three year contracts will be let for the supply of goods following a rigorous prequalification and tender process. This will result in cost savings and greater efficiencies in supply. It is expected that these benefits will commence flowing from 2008.

In 2007, the MOH initiated an International Competitive Bidding (ICB) process for NMS procurement. It was decided to offer three year contracts with an option of an extension for a further year. The benefits included increasing contract value and demand

[51] Pharmaceutical Suply System Assessment, Solomon Islands, August 2006. Malcolm Clark. Report commissioned as part of SWAp preparation

in an otherwise small market and avoiding the necessity of repeating a demanding process soon after completing the present tender. It is anticipated that contracts will be in place by the end of September/early October. Following award of contract, ongoing support over 12 months will be provided to the NMS to assist with contract management and price review at the end of year one of the contract.

Support for National Medical Stores Operations

Technical support will continue to address fundamental problems in the management and operation of the National Medical Stores (NMS), including inventory and warehouse management, and quality of data management, at NMS to achieve sound management and operating practices at the NMS. Whilst it has operated the procurement and supply of drugs, medicines and supplies, it is not as efficient or as effective as required by Good Manufacturing Practice or, more importantly, by the health facilities. A review in December 2006, identified problems requiring immediate action, and those requiring action in the short-term, medium- term and long-term. During the SWAp preparation phase in 2007, support has been provided through the implementation of solutions to address these identified problems.

Consolidation and operational follow-up to the implementation of the Warehouse Management System (WMS), Purchase Order Management, Sales Order Management and the Pharmaceutical Management Information System (PMIS) enhancements

Support will be provided to follow-up on workings of WMS implemented during the SWAp preparation phase. This will include a review of Standard Operating Procedures in line with WMS operation. And review of the capabilities and correct usage of the new procurement structure.

Pilot study for the establishment of an efficient and effective supply chain encompassing the need for procurement, storage and distribution of drugs and supplies

The pilot study is aimed at providing a long-term platform for the central procurement, storage and distribution of Malaria drug and medical supplies through the strengthening of the current medical supplies supply chain. The aim of the pilot project is to create a seamless supply chain from clinic back to the National Medical Stores via a regional second tier dispensary and storage point and to integrate the move to central procurement; storage and distribution of malarial drugs and supplies. Utilising data acquisition and analysis, target stocks would be created that when they reach a minimum level would be topped-up by each subsequent level of inventory. This will be a tri-partisan project encompassing the NMS; the Vector Borne Disease Control Program and the direct purchases by donor/partner agencies e.g. WHO and GFATM. By strengthening the existing supply chain and making it more responsive to national needs and demand, the VBDCP can "piggy-back" its aims and objectives onto the back of the strengthening program, thereby ensuring the effective procurement; storage and distribution of Malarial drugs and supplies. The pilot study will be undertaken in Western Province with Helena Goldie hospital pharmacy as the pilot centre and 25% of the Munda supported clinics (8).

Review and evaluation of Pilot project

Following evaluation, support will be provided to 'roll-out' the PMIS to all clinics in Western province by end 31 December 2008. At this time, a schedule will be developed for full Provincial roll-out – approximately 4 provinces per year. This will include the establishment of provincial clinic storage sites, a training program with implementation of the new supply chain.

7.13.2 MOH Policy and Programming

Support strategy formulation and policy implementation

A key activity will be to assist the MOH to increase coordination and efficiency through strategy formulation and policy implementation. This approach hinges on the focus of achieving positive health outcomes and improved health status of the Solomon Islands people by the MOH. This can be achieved through an increased focus on working in partnerships with donors and other stakeholders, a realignment of budget resources to health priorities, and by ensuring clear accountability. Support will be provided to the introduction of strategic interventions recommended by the Essential Public Health Review[52][53], for example, modifying the existing organisational structure both limiting the number of segregated vertical programs and combining areas where there is synergy of function and task. There is a demonstrated need for health service delivery to become more user friendly and respond to the demand side of community need. The program will support the strengthening of organisational linkages at all levels of the health system with coordination mechanisms that result in integrated, user friendly, patient focused services.

Strengthen effective and efficient Workforce Planning

The MOH will be assisted to define and develop a medium term Workforce Plan. Although the delegations through the PSD and MOH are clear, the roles and responsibilities at each level require strengthening. Considerable clear roles and responsibilities between national divisions and provincial programs, and national divisions and provincial health services overall. The Workforce Plan will address skill mix of staff, training needs for each occupation and what skills are incorporated in the curriculum, and overall staff numbers and allocations in the health sector. remuneration rates for key occupations As a key feature, it will also consider performance management in the sector; how incentives could be better used to improve quality of work; how incentives could be better used to improve quality of work and encourage appropriate staff deployment in rural areas and the nature of any additional incentives in the system; the human resource implications of the revised program priorities; and, the role of the private sector as a provider. Particularly important will be the composition and deployment of staff within public health functions at the provincial level, and the capacity to deliver a range of key priority public health functions (e.g., reproductive health, malaria, IMCI). This will have implications for: (a) the skill mix of staff; and (ii) the number and deployment of staff to implement the program. Estimates of attrition in the health work force for the key occupational groups (nurse aides, nurses, doctors, accountants/bookkeepers etc) will be detailed.

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[52] Essential Public Health Functions report. Dr David Phillips 2006.

[53] Essential Public Health Functions for Solomon Islands are:

Function 1 – Monitor and analyse health status
Function 2 – manage disease surveillance, prevention and control
Function 3 – develop/evaluate legislation, regulations & policies for public health
Function 4 – Manage health systems to improve public health
Function 5 – Protect public health through enforcement
Function 6 – Develop human resources in public health
Function 7 – Promote health through community participation
Function 8 – Ensure the quality of Public Health services
Function 9 – Research for public health
Function 10 – Disaster and emergency preparedness and response

Overall, the Workforce Plan will outline the links to the key planning of health services — that is, infrastructure, delivery models, intervention priorities, the role and function of different health professions — which in turn are to be rooted in a fiscal framework and an assessment of health needs.

Strengthening Pre-service and In-service Training and Training Institutions

Support will be provided to undertake a review of basic medical, nursing and nurse aide training curricula to ensure that appropriate skills are included in pre-service training to meet the current and expected demands of service delivery. The review will provide the opportunity to consider the role and provision of Nurse Practitioners within the MOH. Recommendations will also address the need for In-service training programs to be revised, strengthened or established to ensure that the existing staff are able to develop and sustain their professional skills; and have the pre-requisite skills needed to deliver the strategic program areas of the NHSP.

HR skills training and research initiatives

The program will support the continuation of the MOH's priority new initiative. Funding will be provided for research initiatives accessed through a competitive grants application process. Such an activity will enable applied research activities in health for Solomon Islanders, including students undertaking post graduate studies.

7.13.3 Operational expenditures

National Headquarters Operational expenditure and Renovation (maintenance and upgrades)

This budget provides day to day operational funds for MOH headquarters to cover items such as fuel (vehicles and generator), stationary, freight etc not covered by the SIG budget. The MOH headquarters underwent a major renovation during 2006. A small budget has been allocated in 2007 to support the completion of a number of initiatives including upgrading the water and sanitation facilities, tree lopping, and surfacing the car park.

Support Operational expenditure grants for Hospitals and Schools of Nursing

NRH

With 240-300 beds, the National Referral Hospital (NRH) is the largest and only hospital in SI providing primary and tertiary services. It is the referral hospital for the eight Provincial hospitals. HSTA contribution to the operational budget at the NRH for the period 1 Jan-6August 2007, (SBD6m), constitutes about 83% of the total NRH operational budget (SIG allocated SBD1.3m to NRH in the 2007 budget). This level of contribution will assist to maintain hospital services at a minimal safe working level only and leaves very little margin for unforeseen costs such as an epidemic outbreak. Based on the findings of the 2005 Audit Report a number of comprehensive reform mechanisms are underway within NRH. These will result in improved efficiencies and operational cost savings in many departments within NRH. However, in the short-term support will be provided to the following operational expenditures as the impact on further reduction of funds at this stage may adversely impact and result in the further downgrading and possible closure of essential functions within the NRH.

Provincial Hospitals and Nurse Training Schools

Provincial hospitals are servicing the health needs of nearly 80% of Solomon Islands population. Hospital services include primary health care and secondary health care commonly operating from the same facility. In response to this, a definition of

secondary health services has been adopted as "specific health interventions including the management and delivery of general medical consultation, therapeutics, surgical procedures, technical services, diagnostic services and in-patient care delivery by a hospital organisation"[54]. In addition, Provincial hospitals are responsible for the service provision and support of Area Health Centres, Rural Health Centres and Nurse Aid Posts. In general, however, provincial hospitals have demonstrated very limited linkages to local community organisations. It is evident that there are opportunities to engage the communities exist at a local level and such engagement can be utilized to identify community need, and hence aid in the betterment of services and care.

AusAID, through its HSTA has provided grants through the MOH for operational expenditure to some provincial activities. In the short-term, the program will maintain support for the following activities:

Provincial non-government Church Hospitals Operational expenditure grants

The United Church operates three provincial hospitals in Solomon Islands, two of which incorporate nurse and nurse aid training. These institutions improve access to secondary level health services for large populations in Malaita, Western Province and to a lesser extent in Choiseul. The workload they absorb relieves the burden on the government hospitals in these provinces. These services are integrated with the MOH through MOUs between the MOH and each hospital.

For the period 1 Jan-6 August 2007, HSTA supports approximately one third of the operational costs of these facilities. Any reduction to this level of support for the remaining 2007 period would reduce the ability of these facilities to offer anything more than very basic services, given the current SIG funding allocations. The three facilities are: Atoifi Hospital, Helena Goldie Hospital, and Sassamunga Hospital.

Operational grants to Non-government Church Nurse Training Schools

Operational grants will be provided to Atoifi School of Nursing, Helena Goldie School of Nurse Aide Training, and Malu'u School of Nursing.

Doctor/Locum Fees/Recruitment operational expenses

These funds are required to recruit and employ essential medical specialist services for periods when consultants to permanently fill MOH positions are unavailable. During 2006, the NRH was unable to fill its permanent anaesthetist positions for much of the year.

Overseas Referral Costs operational expenses

This fund provides access to lifesaving treatments (eg chemotherapy, acute pediatric care) not available in Solomon Islands for ordinary Solomon Island people through an arrangement supported by St Vincents hospital in Sydney. The current referral policy has been reviewed and amended following negotiation with St Vincent's hospital in an attempt to reduce costs. A review of the clinical referral policy is underway with a view of seeking further reduction in costs by minimising referrals. A revision to the current policy may be seen as essential in an effort to contain the costs of this service in light of the increasing incidence of chronic disease and cancer in the Solomon Islands, and therefore the increasing numbers of people eligible to access this service.

[54] Ministry of Health and Medical Services, Corporate Plan for the Ministry of Health. Solomon Islands Government 2006-2010, August 2006.

Overseas Pathology Services operational expenses

This fund is used to access pathology services (including basic services such as pap smears) not available in Solomon Islands. The return of a newly qualified Solomon Island pathologist in the second-half of 2007 should allow increased pathology testing to be performed locally, but this local capacity will also increase the cost of chemical reagents and other testing equipment and supplies. Pathology samples will continue to be sent to Australia until then and there remain constraints imposed by a lack of specialized testing equipment.

Pacific Island Project (PIP) operational expenses

The PIP provides specialist medical services to Solomon Islands through teams that visit to provide surgical and other services both at NRH and Provincial hospitals. A number of team visits are programmed for 2007 and funds are required to provide logistic support to maximize the benefits of these visits. Funds are used to provide travel expenses for patients traveling to hospitals for surgery and for surgical pre assessments.

Support to the purchase of Pharmaceuticals and medical supplies and consumables

The program will provide funds to purchase pharmaceuticals and medical supplies and consumables through the NMS. This will be supported by improvements to the tender process and warehouse management systems as detailed above.

7.13.4 Development Initiative Grants

Support to the Provincial Development Initiative grants (DIGs)

AusAID, through its HSTA, has provided DIGs to provincial health services (PHS) to support improvements in health infrastructure and service delivery to the rural population. These grants have proven to be vital in rehabilitating health services accessed by 80% of the Solomon Island population. PHS SIG grants are insufficient to support the activities undertaken using these funds. DIGS have to date been provided to provinces: Central Islands, Choiseul, Guadalcanal, Honiara City Council, Isabel, Makira, Malaita, Renell & Bellona, Temotu, Western; DIGs have also been provided to non-government hospitals: Atoifi, Helena Goldie and Sasamunga.

A more structured approach to using these funds will be introduced during 2007. It is anticipated these funds will be used to focus on priority areas within the provinces in accordance with the MOH strategic priorities. Each province will use its provincial data to develop priority approaches for small-scale project activities that support essential health services to communities in the Solomon Islands. Grants will be accessed via a prescribed application process, requiring MOH Executive approval following careful evaluation against MOH priorities.

The activities under this component will build on the ongoing efforts and are designed to achieve the following key outcomes and objectives:

- Capacity of MOH strengthened through human resource development, financial and management practices, to implement a sector wide approach for health service delivery.

- An enhanced capacity in MOH to provide health services that support an integrated approach to health care at all levels to address community needs.

- Stakeholder partnerships and inter-sectoral collaboration established through effective networks to address positive health outcomes.

Strategic Area 8.4 HEALTH SYSTEM STRENGTHENING Organisational (August 2007 - December 2008) page 1 of 2		Location	MOH UNIT Responsible to Implement	Nature of Procurement	Estimated Budget SBD Thousands Aug 2007 - Dec 2008	Funding Source	2007						2008											
							Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
8.4.1	**Technical Assistance to develop & maintain management systems, provide imlementation and mangaement advice, and support and train counterparts**				**SBD 10,280,000**			Total AusAID Aug - Dec 07				**SBD 2,700,000**								Total AusAID Jan - Dec 08				**SBD 7,580,000**
8.4.1a	Long-term Advisor Overall Program Coordination initially 2 year appointment renewable	MOH Executive	MOH Executive	**TA**	SBD 2,720,000	**AusAID**		160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000
8.4.1b	Long-term Advisor Hospital Management (NRH & Provincial) initially 2 year appointment renewable	NRH & Provincial Hospitals	NRH & Provincial Hospitals	**TA**	SBD 2,720,000	**AusAID**		160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000	160000
8.4.1c	Short- term Assignment Medical Supply Planning and Tender Specialist	National Medical Store	National Medical Store	**TA**	SBD 1,320,000	**AusAID**			220000	220000	220000								220000	220000	220000			
8.4.1d	Short-term assignment Work force planning and policy development	HR Division	HR Division	**TA**	SBD 660,000	**AusAID**								220000	220000	220000								
8.4.1e	Short-term assignment at vaious points to assist the MOH establish and maintain a monitoring regime for grant programs	HR Division	HR Division	**TA**	SBD 660,000	**AusAID**								220000	220000	220000								
8.4.1f	Short-term TA Health Information Surveilance (20 weeks in total) see overlap and connection with 3.4	Center	HR Division	**TA**	SBD 1,100,000	**AusAID**				220000					220000	220000				220000	220000			
8.4.1g	Short term TA for pharmaceutical procurement, supply chain & warehouse management specialist (especially for Malaria see overlap and connection with 3.4)	Center	VBDCP Unit	**TA**	SBD 1,320,000	**AusAID**					220000			220000	220000			220000			220000			220000
8.4.2	**Operational Grants Hospitals and Schools of Nursing**				**SBD 12,277,400**			Total AusAID Aug - Dec 07				**SBD 3,611,000**								Total AusAID Jan - Dec 08				**SBD 8,666,400**
8.4.2a	Grant to NRH - Operational Support	NRH	NRH	**OC**	SBD 8,500,000	**AusAID**		500000	500000	500000	500000	500000	500000	500000	500000	500000	500000	500000	500000	500000	500000	500000	500000	500000
8.4.2b	Grant to Headquarters - Operational Support	MOH Executive	MOH Executive	**OC**	SBD 2,125,000	**AusAID**		125000	125000	125000	125000	125000	125000	125000	125000	125000	125000	125000	125000	125000	125000	125000	125000	125000
8.4.2c	Atoifi Hospital	Atoifi Hospital	Atoifi Hospital	**OC**	SBD 714,000	**AusAID**		42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000
8.4.2d	Atoifi School of Nursing	Atoifi School of Nursing	Atoifi School of Nursing	**OC**	SBD 112,200	**AusAID**		6600	6600	6600	6600	6600	6600	6600	6600	6600	6600	6600	6600	6600	6600	6600	6600	6600
8.4.2e	Helena Goldie Hospital	Helena Goldie Hospital	Helena Goldie Hospital	**OC**	SBD 714,000	**AusAID**		42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000	42000
8.4.2f	Helena Goldie Scool of Nursing	Helena Goldie Scool of Nursing	Helena Goldie Scool of Nursing	**OC**	SBD 56,100	**AusAID**		3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300
8.4.2g	Malu'u School of Nursing	Malu'u School of Nursing	Malu'u School of Nursing	**OC**	SBD 56,100	**AusAID**		3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300
8.4.3	**Other Operational Expenditure**				**SBD 1,535,100**			Total AusAID Aug - Dec 07				**SBD 451,500**								Total AusAID Jan - Dec 08				**SBD 1,083,600**
8.4.3a	Doctor / Locum Fees / Recruitment	Center	MOH Executive	**OC**	SBD 56,100	**AusAID**		3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300	3300
8.4.3b	Overseas Referal Costs	Center	MOH Executive	**OC**	SBD 1,122,000	**AusAID**		66000	66000	66000	66000	66000	66000	66000	66000	66000	66000	66000	66000	66000	66000	66000	66000	66000
8.4.3c	Overseas Pathology Services	Center	MOH Executive	**OC**	SBD 357,000	**AusAID**		21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000	21000
8.4.4	**Micellaneous Projects**				SBD 420,000			Total AusAID Aug - Dec 07				**SBD 125,000**								Total AusAID Jan - Dec 08				**SBD 295,000**
8.4.4a	HR skills Training and Research Initiatives	HRD Unit	HRD Unit	**TR**	SBD 150,000	**AusAID**			25000	25000										25000	25000	25000	25000	
8.4.4b	HQ Renovation (maintenance and upgrades)	Center	Infrastructure Unit	**WK**	SBD 225,000	**AusAID**		25000	25000	25000	25000					25000	25000	25000	25000	25000				
8.4.4c	Radio Project (installations)	various	Infrastructure Unit	**WK**	SBD 40,000	**AusAID**									40000									
8.4.4d	Radio Project (maintenance & operations)	various	Infrastructure Unit	**OC**	SBD 30,000	**AusAID**									10000			10000		10000				
8.4.4e	Overseas study for national division heads and provincial directors	Australia	HRD Unit	**TR**	SBD 600,000	**AusAID**							50000	50000	50000	50000	50000	50000	50000	50000	50000	50000	50000	50000
8.4.6	**UNALLOCATED**	Center	MOH Executive	**UN**	**SBD 3,000,000**	**AusAID**		Total AusAID Aug - Dec 07				**SBD 3,000,000**								Total AusAID Jan - Dec 08				
8.4.7	**Operational Grants - Provincial Development Grants**	Center	MOH Executive	**OC**	**SBD 5,800,000**	**AusAID**		Total AusAID Aug - Dec 07				**SBD 2,500,000**								Total AusAID Jan - Dec 08				**SBD 3,300,000**
8.4.8	**Pharmaceuticals & Medical Supplies and Consumables**	Center	Pharmacy Division & Procurement Unit	**PH**	**SBD 47,875,000**	**AusAID**		Total AusAID Aug - Dec 07				**SBD 11,300,000**								Total AusAID Jan - Dec 08				**SBD 36,575,000**
	Total 8.1 Health System Strengthening - Organisational				**SBD 81,187,500**		**Sub-Total 8.4 2007**					SBD 23,687,500	**Sub-Total 8.4 2008**											SBD 57,500,000

WK	Civil Works	SBD 265,000
GD	Goods	
PH	Pharmaceuticals	SBD 47,875,000
TA	Consulting Services	SBD 10,280,000
TR	Training	SBD 750,000
OC	Operating Costs	SBD 19,642,500
UN	Unallocated	SBD 3,000,000

7.14 Summary tables

Procurement of GOODS (August 2007 - December 2008)		Location	MOH UNIT Responsible to Implement	Estimated Budget SBD Thousands	Preparation Phase			2007						2008										
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
3.1.2	Replacement of ineffective Permanets and provision of pyrethroid insecticides for re-treatment of these nets, (25,000 units in 2007 and 120,000 units in 2008 plus distribution costs estimate at SBD 7.1 per unit)	all Provinces	MOH VBDCP Unit	SBD 3,500,000																				
3.3.2	Procurement of 15,000 RDT units for 138 Nurse Aid posts	all Provinces	MOH VBDCP Unit	SBD 1,583,000																				
3.3.3	Distribution of RDTs, & QA & accreditation of microscopists to increasing access to parasitological diagnostic services (microscopic services; MRDTs) locally engaged staff in Malaita, Guadalcanal, Western, Central, Choiseul, Makira and Temotu est. USD3000/month/Province)	Malaita, Guadalcanal, Western, Central, Choiseul, Makira Ulawa and Temotu	MOH VBDCP Unit	SBD 1,152,000																				
3.3.7	Establish & equip "high-dependency" unit in NRH (ventilators, cardiac monitors, blood gas and biochemistry analyses)	NRH	MOH VBDCP Unit	SBD 500,000																				
3.3.9	Establish & equip "high-dependency" unit in Kilu-Ufi hospitals (ventilators, cardiac monitors, blood gas and biochemistry analyses)	Malaita	MOH VBDCP Unit	SBD 500,000																				
3.4.8	Distribution of a Healthy Solomon Woman Package (comprising insecticide treated nets, deworming medications, iron folate supplementation, condom promotion through antenatal care and routine EPI activities)	all Provinces	MOH VBDCP Unit	SBD 48,000																				
8.3.1c	Radio Network Completion	various Provinces	Infrastructure Unit	SBD 3,600,000																				
		Total AusAID financed Goods Aug 2007 - Dec 2008		**SBD 10,883,000**																				

Procurement of Works (August 2007 - December 2008)		Location	MOH UNIT Responsible to Implement	Estimated Budget SBD Thousands	Preparation Phase			2007						2008											
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
3.4.2	Refurbishment of teaching facility and distance learning center in SIMTRI	centre	MOH Infrastructure Unit	SBD 249,000																					
3.4.3	Refurbishment of clinical trail unit, office, computer equipment and IT connectivity	centre	MOH Infrastructure Unit	SBD 144,000																					
3.7.1	Provincial housng for Malaria Division Staff (10 houses over 18 months construct SBD200,000, fitout SBD100,000 transport SBD45,000, contigency 15% - unit cost SBD396750.	selected Provinces	MOH Infrastructure Unit	SBD 3,600,000																					
8.2.6a	Kirra Kirra Hospital		MOH Infrastructure Unit	SBD 500,000																					
8.2.6b	Gizo Hospital		MOH Infrastructure Unit	SBD 500,000																					
8.3.1a	Ongoing Maintenance of existing Radio network		MOH Infrastructure Unit	SBD 600,000																					
8.2.7a	Marau PHC		Infrastructure Unit	SBD 1,650,000													450000	300000	300000	300000	300000				
8.2.7b	Marau Staff Housing (2)		Infrastructure Unit	SBD 300,000												50000	50000	75000	50000	75000					
8.2.7c	Afio PHC		Infrastructure Unit	SBD 1,450,000										350000	300000	300000	300000	200000							
8.2.7d	Aifo Staff Housing (2)		Infrastructure Unit	SBD 300,000												50000	50000	75000	50000	75000					
8.2.7e	Namuga PHC		Infrastructure Unit	SBD 950,000											150000	200000	200000	200000	200000						
8.2.7f	Namuga Staff Housing (2)		Infrastructure Unit	SBD 300,000													50000	50000	75000	50000	75000				
8.2.7g	Tatamba PHC		Infrastructure Unit	SBD 1,650,000												450000	300000	300000	300000	300000					
8.2.7h	Tatamba Staff Housing (2)		Infrastructure Unit	SBD 300,000										50000	50000	75000	50000	75000							
	Tsunami Rehabilitation		Infrastructure Unit	SBD 12,486,5000																					
		Total AusAID funded Civil Works Aug 2007 - Dec 2008		**SBD 24,979,498**																					

Recruitment of Consultants (August 2007 - December 2008)		Location	Implementation Responsiblity	Estimated Budget SBD Thousands	Preparation Phase			2007						2008											
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1.1.1	TA to review existing program and work with unit and policy branch to establish a strategic plan and explore implementation options	all Provinces	Health Promotion Unit	SBD 640,000																					
3.1.5	Feasibility study of scaling-up of pipeline installation, short-term TA (6 weeks in 2008)	highly endemic island provinces	MOH VBDCP Unit	SBD 330,000																					
3.2.1	TA for development of guidelines for epidemic preparedness and control	centre	MOH VBDCP Unit	SBD 440,000																					
3.3.5	Short term TA to enhance interaction and collaboration between MOH and private medical practioners to support adherance to Malaria standard Diagnosis Treatment and Reporting Guidelines	centre	MOH VBDCP Unit	SBD 440,000																					
3.3.6	Short term TA to review progress and impate of RDT distribution	all Provinces	MOH VBDCP Unit	SBD 990,000																					
3.4.1	TA to develop and deliver training programs and review role and capacity of SIMTRI as a training unit for SI and sub-regional (PNG, Vanuatu)	centre	MOH VBDCP Unit	SBD 880,000																					
3.4.7	TA support to VBDCP management, admin & logistical systems - scaled up response to malaria control suport joint M&E, joint planning and supervision and improve integration of IPTp and IPTi with the Reproductive Health division	centre	MOH VBDCP Unit	SBD 504,000																					
3.4.15	Linking and rationalizing SIMIS and HIS data collection and analysis and enhanc information systems including survielance)	all Provinces	MOH VBDCP Unit	SBD 440,000																					
3.4.16	Short term TA to provide GIS data input training (6 weeks in 2008)	all Provinces	MOH VBDCP Unit	SBD 330,000																					
3.5.2	Local hire coordinator of Small grants to CBOs to support Rural development Program initiatives	all Provinces	MOH VBDCP Unit	SBD 340,000																					
3.6.1	Treatment Modalities and drug efficacy studies	centre	MOH VBDCP Unit	SBD 1,200,000																					
3.6.2	Prevention approaches and methods	centre	MOH VBDCP Unit	SBD 1,200,000																					
3.6.3	Research and support to behavioural and social aspects of malaria and its control.	centre	MOH VBDCP Unit	SBD 1,200,000																					
3.7.2	Construction Manager / site manager for houses in 3.7.1 at SBD5400 per house	selected Provinces	MOH Infrastructure Unit	SBD 48,600																					
8.1.1a	Long-term Advisor Financial Management initially 2 year appointment renewable	Ministry Finance Unit	Ministry Finance Unit	SBD 2,720,000																					
8.1.1b	Long-term Advisor Procurement Management & Implementation initially 2 year appointment renewable	Ministry Procuremnt Unit	Ministry Procuremnt Unit	SBD 2,720,000																					
8.1.1c	Domestic External Audit Firm	center	Ministry Finance Unit	SBD 150,000																					
8.2.1a	Short- term Assignment (FIRM) to Develop a Hospitals Master Plan - infrastructue & equipment needs	Ministry and travel throughout all Provinces	Infrastructure Unit	SBD 1,456,000																					
8.2.1b	Short- term Assignment (INDV) to Support the Infrastucture Committee	Ministry Infrastucture Committee	Infrastructure Unit	SBD 1,980,000																					
8.2.1a	TA service contract to implement recommendations of electrical system and potential fire hazard	NRH	NRH	SBD 3,000,000																					
8.3.1b	Short-term assignment (INDV) Radio Installation Supervision and Technical Support	Headquarters	Infrastructure Unit	SBD 440,000																					
8.3.2a	Short-term TA Health Information and Surveilance (20 weeks in total) see overlap and connection with 3.4	Center	HR Division	SBD 1,100,000																					
8.4.1a	Long-term Advisor - Principal Health Program Advisor (Overall Program Coordination initially 2 year appointment renewable)	MOH Executive	MOH Executive	SBD 2,720,000																					
8.4.1b	Long-term Advisor Hospital Management (NRH & Provincial) initially 2 year appointment renewable	NRH & Provincial Hospitals	NRH & Provincial Hospitals	SBD 2,720,000																					
8.4.1c	Short- term Assignment Medical Supply Planning and Tender Specialist	National Medical Store	National Medical Store	SBD 1,320,000																					
8.4.1d	Short-term assignment (INDV) Work force planning and policy development	HR Division	HR Division	SBD 660,000																					
8.4.1e	Short-term assignment (INDV) at vaious points to assist the MOH establish and maintain a monitoring regime for grant programs	HR Division	HR Division	SBD 660,000																					
8.4.1f	Short term TA for pharmaceutical procurement, supply chain & warehouse management specialist (especially for Malaria see overlap and connection with 3.4)	Center	VBDCP Unit	SBD 1,320,000																					
		Total AusAID funded TA Aug 2007 - Dec 2008		**SBD 31,948,600**																					

	TRAINING (August 2007 - December 2008)	Location	Implementation Responsiblity	Estimated Budget SBD Thousands	Preparation Phase			2007						2008										
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1.1.2	Training for all health promotion staff by TA from 1.1.1	center & various Provinces	Health Promotion Unit	SBD 180,000																				
3.4.4	Core training group in SIMTRI in malaria diagnosis and treatment, parasitology, entomology and vector control	centre	MOH VBDCP Unit	SBD 520,000																				
3.4.5	Post graduate training of doctors in public health, tropical medicine and epidemiology	Australia	MOH VBDCP Unit	SBD 450,000																				
3.4.6	Short courses severe malaria management private practioners, NRH and Provincial staff, (Prof Tim Davis (Perth) and Dr Tran Hien (Vietnam))	Australia	MOH VBDCP Unit	SBD 120,000																				
3.4.9	Joint training with IMCI practitioners and TOTs	all Provinces	MOH VBDCP Unit	SBD 100,000																				
3.4.10	Training of community NGOs and faith-based organizations in health promotion, environmental management, distribution & treatment of mosquito nets, and referrals of severe complicated malaria to second level health facilities	all Provinces	MOH VBDCP Unit	SBD 100,000																				
3.4.14	Refresher training in SIMIS and epidemic response for provincial and regional staff including procurement of computers	centre	MOH VBDCP Unit	SBD 590,000																				
8.4.4a	HR skills Training and Research Initiatives	HRD Unit	HRD Unit	SBD 150,000																				
8.4.4e	Overseas study for national division heads and provincial directors	Australia	HRD Unit	SBD 600,000																				
		Total AusAID funded Training Aug 2007 - Dec 2008		**SBD 2,810,000**																				

Operational Costs & Operational Support via Grants (August 2007 - December 2008)		Location	Implementation Responsiblity	Estimated Budget SBD Thousands	Preparation Phase			2007						2008										
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
3.1.3	Indoor residual spraying, procurement of ICON pesticides and provision of temporary labour, (100,000 households twice per year)	epidemic-prone areas	MOH VBDCP Unit	SBD 691,000																				
3.1.4	Environmental control using physical methods combined with chemical larviciding effective insect growth regulators with residual lifespan of 6 months	all Provinces	MOH VBDCP Unit	SBD 160,000																				
3.4.11	Grants to Community NGOs and faith-based organizations in health promotion for environmental management, distribution & treatment of mosquito nets, and referrals of severe complicated malaria to second level health facilities	all Provinces	MOH VBDCP Unit	SBD 200,000																				
3.4.13	Local expenses for Private sector engagement travel costs	all Provinces	MOH VBDCP Unit	SBD 150,000																				
3.5.1	Small grants to CBOs to support Rural development Program initiatives	all Provinces	MOH VBDCP Unit	SBD 520,000																				
8.4.2a	Grant to NRH - Operational Support	NRH	NRH	SBD 8,500,000																				
8.4.2b	Grant to Headquarters - Operational Support	MOH Executive	MOH Executive	SBD 2,125,000																				
8.4.2c	Atoifi Hospital	Atoifi Hospital	Atoifi Hospital	SBD 714,000																				
8.4.2d	Atoifi School of Nursing	Atoifi School of Nursing	Atoifi School of Nursing	SBD 112,200																				
8.4.2e	Helena Goldie Hospital	Helena Goldie Hospital	Helena Goldie Hospital	SBD 714,000																				
8.4.2f	Helena Goldie Scool of Nursing	Helena Goldie Scool of Nursing	Helena Goldie Scool of Nursing	SBD 56,100																				
8.4.2g	Malu'u School of Nursing	Malu'u School of Nursing	Malu'u School of Nursing	SBD 56,100																				
8.4.3a	Doctor / Locum Fees / Recruitment	Center	MOH Executive	SBD 56,100																				
8.4.3b	Overseas Referal Costs	Center	MOH Executive	SBD 561,000																				
8.4.3c	Overseas Pathology Services	Center	MOH Executive	SBD 357,000																				
8.4.4d	Radio Project (maintenance & operations)	various	Infrastructure Unit	SBD 30,000																				
8.4.7	Operational Grants - Provincial Development Grants	Center	MOH Executive	SBD 5,800,000																				
		Total AusAID funded Operational Support inluding Grants Aug 2007 - Dec 2008		**SBD 20,802,500**																				

AusAID Financed Procurement Expenditure Profile August 2007 - December 2008	Percent of Total	AUD
Total Projected Technical Assistance	**26.4%**	AUD 7,143,00
Total Projected Civil Works	**16.3%**	AUD 4,421,000
Total Projected Goods (excl. Pharmaceuticals)	**7.1%**	AUD 1,926,000
Total Projected Pharmaceuticals	**33.3%**	AUD 9,004,000
Total Projected Training	**1.8%**	AUD 497,000
Total Projected Operational Support	**13.6%**	AUD 3,682,000
Unallocated	**1.5%**	AUD 406,000
Total Projected	**100.0%**	AUD 27,079,000

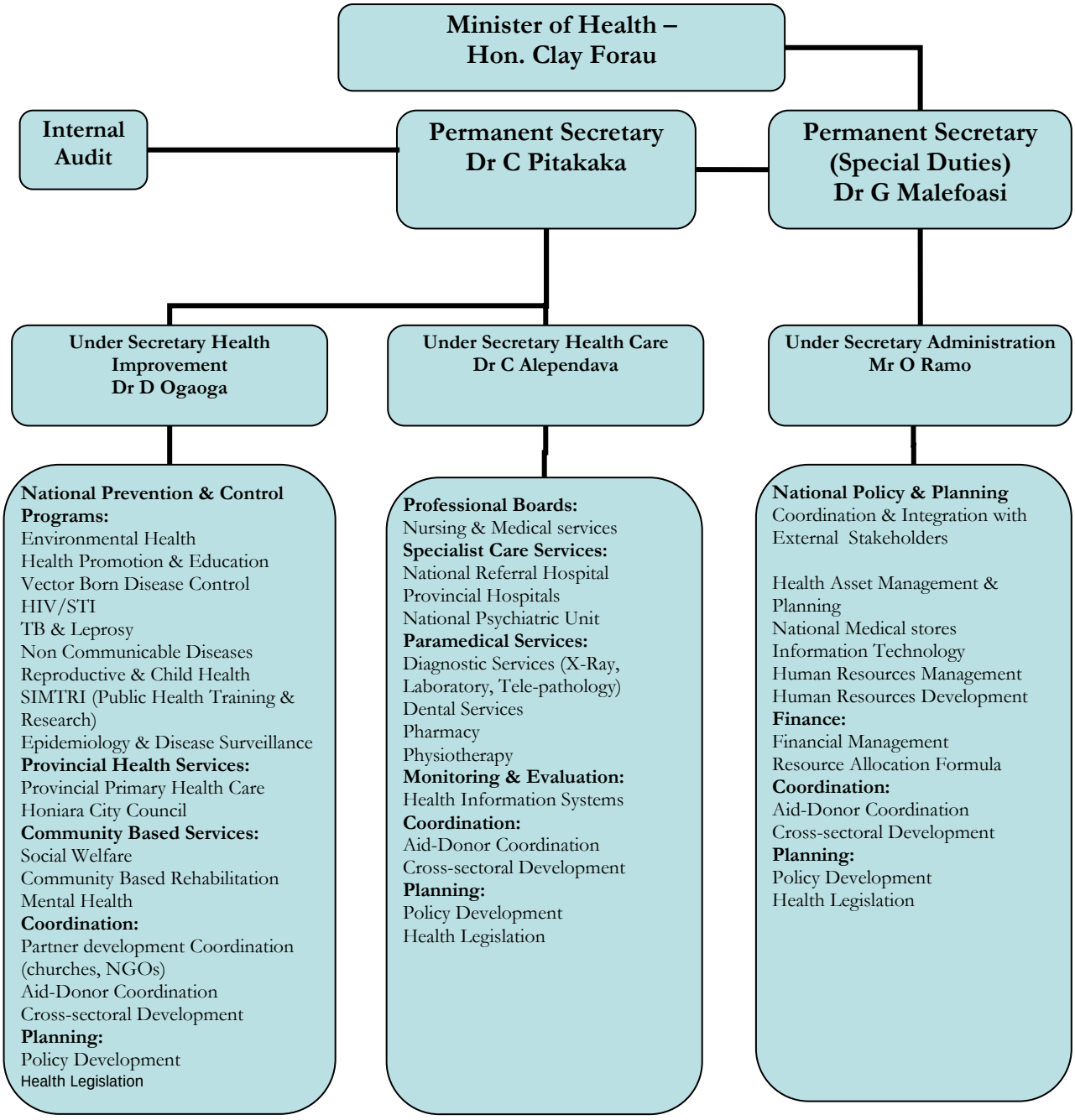
AusAID Funded by Strategic Area	Percent of Total	2007	2008
People Focus Area 1	**0.5%**	AUD 106,000	AUD 40,000
Malaria Area 3	**18.2%**	AUD 1,520,000	AUD 3,395,000
System Strengthening ACCOUNTABILITY 8.1	**5.0%**	AUD 400,000	AUD 951,000
System Strengthening INFRASTRUCTURE 8.2	**17.5%**	AUD 1,293,000	AUD 3,455,000
System Strengthening INFO. MANAGE 8.3	**3.2%**	AUD 720,000	AUD 156,000
System Strengthening ORGANIZATION 8.4	**54.1%**	AUD 4,362,000	AUD 10,275,000
UNALLOCATED	**1.5%**	AUD 332,000	AUD 74,000
	100.0%	AUD 8,733,000	AUD 18,346,000

AUD = SBD 5.65

PART B INSTITUTIONAL & IMPLEMENTATION ARRANGEMENTS

1 MINISTRY OF HEALTH STAFFING AND INSTITUTIONAL ARRANGEMENTS

1.1 Organisational Chart (Central & Provincial)



1.2 MOH National and Provincial levels of responsibility

Institutional arrangements for the Health Sector Support Program have been defined by the MOH. The MOH Executive will be the key management body of the Program; the MOH executive is responsible for management oversight of the health expenditure program and service delivery. Program direction will be guided through the weekly MOH Executive meetings. Strategic guidance and oversight to the Health Sector Support Program will be provided by the bi-monthly MOH Executive Special Sessions. Participants will include other key Departments and Ministries, for example Department of Finance & Treasury; Department of National Planning and Aid Coordination, and Ministry of Education. Other key stakeholders within the health sector, such as development donors, NGOs, CBOs and Churches will also be represented at the MOH Executive Special Sessions.

Responsibilities for health service programming and delivery are shared between the national and provincial levels.

1.3 National MOH key responsibilities include:

- overall health strategy development, policy planning and development, and policy guidance to provinces;
- strengthening technical programs (e.g. essential public health functions) provided at the national level;
- ensuring availability of skilled human resources;
- Strengthening pre-service training and curricula;
- infrastructure planning and, currently, management and maintenance planning;
- monitoring and evaluation (M&E) of the sector's performance through M&E of national programs and support to provincial M&E; and
- coordinating, packaging, and undertaking procurement of inputs for programs.

1.4 Provincial MOH key responsibilities are:

- operational management of national health policies at provincial levels;
- Implementation of key health strategies and 'rolling out' technical initiatives;
- planning, budgeting, managing, accounting for, and monitoring health service delivery (including both primary health programs and provincial hospital services);
- integrating national health policies into health service delivery at the provincial level; and
- staffing management.

1.5 Organisational Implementation arrangements for HSSP

Technical specialist support for the HSSP has been identified for the initial 18 months of AusAID-funded program support. In each case, the Technical specialist will be directly recruited by and contracted to the MOH. Performance assessments for each Technical specialist will be the responsibility of the individual MOH Unit that is directly supported by the Technical specialist. The following Table details Technical specialists that have been identified for the HSSP:

Technical Specialist	MOH Unit	Duration
Principal Health Sector Program Specialist	Permanent Secretary Permanent Secretary (Special Duties) MOH Executive	Full-time –2 years initially
Hospital Management Specialist	Medical Superintendent NRH MOH Executive	Full-time –2 years initially
Financial Management Specialist	Under Secretary Administration MOH Executive	Full-time –2 years initially
Procurement Management Specialist	Policy and Planning Division National Medical Stores Procurement Unit MOH Executive	Full-time –2 years initially
Community Organisation and Health Promotion Specialist	National Health Education and Promotion Division VBDCP MOH Executive	Full-time –2 years initially
Medical Supply Planning and Tender Specialist	National Medical Stores MOH Executive	Part-time – 28 weeks
Pharmaceutical Procurement, Supply Chain and Warehouse Management Specialist	National Medical Stores MOH Executive	Part-time – 24 weeks
Infrastructure Management Specialist	Infrastructure Committee MOH Executive	Part-time – 36 weeks
Health Information and Surveillance Specialist	MOH Statistics Unit MOH Executive	Part-time – 20 weeks
Malaria Program Management and Administration Specialist	VBDCP MOH Executive	Part-time – 24 weeks
Malaria Parasitological Diagnostics Specialist	VBDCP MOH Executive	Part-time – 6 weeks
Malaria Training Specialist	SIMTRI VBDCP MOH Executive	Part-time – 22 weeks
Malaria GIS Specialist	VBDCP MOH Statistics Unit MOH Executive	Part-time – 6 weeks
Hospital Care Specialist (malaria)	Medical Superintendent NRH MOH Executive	Part-time – 5 weeks
Radio Communication Specialist	Infrastructure Committee MOH Executive	Part-time – 8 weeks
Epidemic preparedness and Control Specialist	Under Secretary Health Improvement VBDCP MOH Executive	Part-time – 8 weeks

1.6 Operational planning, budgeting and program implementation

Implementation of the HSSP will be through the NHSP. Operational planning has been successfully introduced in the MOH in recent years, with support from HISP. National Divisions and Provincial Health Services are now familiar with the process, and there is universal acknowledgement that the system is a major step forward from earlier approaches to planning.

Some changes are being made to the operational planning system, to support the implementation of the NHSP. These changes build on achievements to date, and should be viewed as fine-tuning of a system that has been a major success story for the MOH. Changes that are being made to the system are designed to achieve the following:

- building up operational plans in stages to allow for progressive approval by management;
- streamlining the amount of information that is sent up to MOH management;
- enabling budget preparation to flow more smoothly from operational plans; and
- strengthening capacity to monitor and report on implementation of operational plans.

New desirable features of an annual planning and budgeting system include:

- Preparation of annual plans and budgets should be inclusive and participatory
- The annual planning and budgeting system should involve strong linkages between MOH headquarters and provincial health offices
- The system should cover all resources deployed by MOH
- The planning system should facilitate budget preparation
- Programs and expenditure allocations should be driven by government policy on health
- The system should focus on identifying, specifying and costing programs and activities to implement government policy on health
- The planning system should facilitate monitoring and reporting on budget implementation
- The system should be efficient in its use of staff time and other resources

1.7 The current annual planning and budgeting system

The key instrument of the annual planning and budgeting system currently used by MOH is the annual operational plan. Each organisational unit within the Ministry, including provincial health offices, produces an annual operational plan in the first half of the year covering the activities it would like to implement in the following year[55]. These operational plans are then reviewed by senior management and adjusted to align with perceptions as to the level of resources which can be secured from SIG and donor sources (including the existing HSTA), and expenditure priorities. This forms the basis of the MOH budget submission (though operational plans are not produced in a form which readily translates into the accounts codes required for the budget) and requests to donors. Resources secured are likely to be significantly below this (already trimmed) proposal[56].

MOH managers are supportive of the operational planning system, and recognise it as a major advance on planning systems used previously. The current system can be examined in relation to the criteria set out above, as follows:

Preparation of annual plans and budgets should be inclusive and participatory

The current system involves a wide range of staff and organisational units (including provincial offices) at an early stage in the cycle i.e. in the preparation of operational plans. The level of participation declines as operational plans are processed through the system, and feedback from the centre to organisational units along the way appears to be limited.

The annual planning and budgeting system should involve strong linkages between MOH headquarters and provincial health offices

These links appear to be strong at the commencement of the process when operational plans are prepared, but it is not clear that strong links are maintained during budget preparation and implementation. In some cases the roles of national programs and the respective programs at provincial level are not clearly defined and understood.

The system should cover all resources deployed by MOH

The current system attempts to cover both SIG and donor funding, though in some cases there is a focus on bidding for new resources rather than planning core business activities. In relation to expenditure of SIG resources, the system focuses on "other charges". Personnel costs are not addressed systematically[57], the argument appearing to be that these are paid by SIG centrally without MOH involvement. While this argument may have some relevance in the short term, in the medium term MOH can

[55] The process has a stated goal of distinguishing between core business and new initiatives. In practice, a more important consideration in the context of limited funding is how much "core business" can be undertaken.

[56] It is understood that organisational units are directed to work within ceilings set by Finance, but still tend to bid for additional resources. It should also be noted that Finance is only concerned with the aggregate ceiling for MOH, with the ministry having the flexibility to allocate this ceiling among sub-heads and line items to achieve the best results. Bids by organisational units for new initiatives need to be separated in operational plans from plans for core activities, unless they can be funded within ceilings set by headquarters.

[57] A separate exercise in relation to the MOH establishment is built in to the SIG budget timetable, but not well integrated with the MOH annual planning and budgeting system. The importance of this issue is illustrated by the large increase in the ratio of personnel costs to operating costs evident in the 2007 recurrent budget for MOH.

and should be managing personnel costs carefully[58], given that they form a significant proportion of expenditure.

The planning system should facilitate budget preparation

Annual operational plans are used to prepare budget submissions, though the format of operational plans is less than ideal as a source document for budget preparation.

Programs and expenditure allocations should be driven by government policy on health

Annual operational plans are structured to address MOH strategic plans (issues in relation to MOH policy direction are discussed in a later section of this report).

The system should focus on identifying, specifying and costing programs and activities to implement government policy on health

The current system does this, but is unwieldy in that resource constraints are not applied effectively and too much detail is submitted to management (management should be dealing with more concise summary information).

The planning system should facilitate monitoring and reporting on budget implementation

Annual operational plans do not appear to be revised when resource levels are finalised for the year ahead. They do not appear to be much used to monitor and report on budget implementation. A separate system is in place for monitoring and reporting, though coverage is low.

The system should be efficient in its use of staff time and other resources

The preparation of annual operational plans is unwieldy – it functions mainly as a bidding exercise, rather than as a process of planning implementation of core programs and activities. Budget submissions do not "drop out" of operational plans easily, and they are of little use for monitoring and reporting on implementation unless revised to reflect actual resources secured (a step which does not appear to take place).

1.8 The national context in which MOH prepares annual plans and budgets

Policy direction for the MOH annual planning and budgeting system comes from the medium term strategic plan for health, currently the *NHSP*[59]. The key health strategies in the NHSP are developed in response and in-line with the Grand Coalition for Change Government (GCCG)'s policy statements for health and social welfare. These policy statements are detailed within the GCCG's *Policy Framework Document* and subsequent *Translation and Implementation Matrix*. The SI government is planning in the next five years to strengthen and expand through upgrading of the existing primary health clinics, strengthen the efficiency of the hospitals, and roll-out preventive and promotive public health programs.

The Department of the Prime Minister and Cabinet is leading a rolling three year *Plan of Action* relating to the implementation of GCCG policies through the 2006-2008 Corporate Plan. The Corporate Plan for the MOH aims to maintain gains made in 2004-2005 and further improve the health status of the population. It further aims to

[58] Planning in relation to personnel costs would be facilitated if the SIG budget allocated all such costs to the appropriate sub-heads (perhaps MOH should push for this with Finance).

[59] Operational plans for 2006 and 2007 took their policy direction from the 29 National Health Goals and Strategies issued in the context of planning for 2006.

consolidate the progress of the Government's commitment to meet the MDG, ICPD Goals and other relevant and broader goals. The Ministry's 2006-2008 Corporate Plan provides the strategic direction and goals through the eight strategic areas of the NHSP. Thus, the national goals and strategies detailed in the NHSP will provide the guide for operational planning.

MOH must also respond to the timetable for the preparation of the SIG annual budget, which contains a number of deadlines in relation to various stages and aspects of budget preparation (covering both the recurrent and development budgets[60]). The SIG budget system has constraints as an aid to planning by ministries – it focuses on inputs with the only functional classification available being at the sub-head level, and the economic classification of expenditure is blurred.

There are proposals for further reforms to the SIG budget process including combination of the recurrent and development budgets, reducing the number of line items (and perhaps even sub-heads) through consolidation, and providing a more complete breakdown of expenditure by province. These proposals are still being explored by the Ministry of Finance and Treasury, and will need to be addressed as they develop. Current indications are that the system of issuing baseline budget ceilings (the previous year's budget, less any one-off items, plus three percent) early in the budget cycle, and providing some scope for bidding for new initiatives at a later stage in the cycle, will be retained.

1.9 Changes to the annual planning and budgeting system to improve its effectiveness

The annual planning and budgeting system used by MOH has a number of strengths, most notably the high level of participation in the preparation of operational plans and the focus on activity costing. These strengths should be built upon. Changes to the system which are planned in the context of the introduction of the HSSP have commenced in the form of a three stage process. This process begins with strategic thinking in relation to broad allocations of expenditure, moves on to preparation of an Annual Sectoral Expenditure Plan and MOH budget submission, and then addresses detailed operational planning aimed at facilitating implementation of programs and activities.

Stage 1 – MTEF and expenditure ceilings

It is planned that the annual planning and budgeting process be initiated on a more strategic basis, focusing at this initial stage on management team deliberations on resource availability and expenditure priorities. Preparation of a Medium Term Expenditure Framework (MTEF) for Health will facilitate this step. Organisational units would identify activities they wish to pursue in the following year, and show links to the NHSP. Part of this stage would be reaching agreement via the management team on annual expenditure ceilings (both for SIG funding and overall funding including donor funds) for each organisational unit within MOH for the coming year, reflecting

[60] The national budget cycle calendar includes deadlines related to the development budget, including a deadline related to the submission (to the Department of National Planning and Aid Coordination) of new projects for which development funding is sought. It would appear that activities funded via HSSP will not go through this central appraisal process individually, though requests for funding from other donors may. It should also be recognised that the central project processing system operates rather loosely at present, though this may change.

expenditure priorities. Setting of ceilings in relation to SIG funding would involve allocating the aggregate ceiling for MOH set by Finance. During this stage the management team could also nominate a limited number of priority areas for seeking additional funding (if this is likely to be available).

Stage 2 – Annual Sectoral Expenditure Plan and MOH budget submission

Each organisational unit would then allocate the ceilings issued at the end of Stage 1, among their activities, preparing costings in a form suitable for budgeting purposes. These would be ongoing activities in the main. Ceilings for organisational units handling priority functions may allow for new initiatives[61], while some organisational units may need to cut back activity[62]. Programs and activities relating to priority areas for additional funding would also be identified and costed. The management team would review the list of programs and activities proposed by organisational units, and summary information on costs[63]. Preparation of the Annual Sectoral Expenditure Plan and MOH budget submission would follow.

Stage 3 – detailed operational planning

Detailed operational planning would be finalised later in the year when resource availability is largely known. The format for operational planning would be revised to facilitate monitoring of and reporting on program implementation. Specific actions required to implement programs and activities would be identified, together with the planned timing and location of these actions, and the organisational unit or officer responsible. Implementation of operational plans would be reviewed periodically (probably quarterly) by the MOH management team on the basis of reports from heads of organisational units.

A revised operational planning template was developed, and presented to the 2006 National Health Conference. It is emphasised that the revised template builds upon the progress made to date with operational planning, and that some changes must be made in response to changes in the environment in which planning is undertaken (in particular the adoption of the NHSP, and the shift to a SWAp from existing funding arrangements including HISP and HSTA). The revised operational planning template is presented below at 1.12.

Features of the revised template are:

- Building up the operational plan in three stages, with the aim of progressively refining the plan and avoiding the need for detailed work on proposals which do not eventually secure management approval. The three stages are:

    1. *Setting strategic direction in the context of resource availability and planned activities.* Organisational units[64] would complete columns A and B of the template for consideration by management (the deadline for this could be 31 March).

[61] Care is needed to ensure that organisational units handling functions deemed priorities do not become complacent in their expectations in relation to funding. The programs and activities they nominate would be subject to management review, as would their performance in implementation.

[62] These units would retain the ability to launch new initiatives, provided sufficient savings can be identified in ongoing activities.

[63] Emphasis should be placed on providing the management team with a manageable amount of information, suitable for strategic decision-making.

[64] Organisational units should correspond to sub-heads in the SIG Recurrent Estimates.

Activities would at this stage be approved for further work or declined, and management would set funding ceilings for each organisational unit.

2. *Costing of agreed activities within a funding envelope.* Organisational units would complete columns A to F for activities approved by management in stage 1 above (the deadline for this could be 30 June)[65]. This information would be used by management to prepare the MOH budget submission (within the funding guidelines set by Finance), with feedback to managers of organisational units on what has been included in the budget submission.

3. *Planning implementation of funded activities.* Organisational units would complete columns G to J when advised by management as to what has been

4. approved by Finance (and eventually Parliament) for inclusion in the annual budget (the deadline for this could be 31 December).

- Streamlining the amount of information that is sent up to management. Measures to achieve this include:

  - Refining the definition of "activity" within operational plans. Activities should be significant areas of work (mainly ongoing, and perhaps some new), rather than one-off actions (activity structure should remain relatively constant from year to year)[66]. Detailed costing of any one-off actions could be kept by individual units and aggregated to provide information to management at the activity level.

  - Coding activities by Strategic Area from NHSP rather than repeating a lot of text from the NHSP.

  - Capturing the entire operational plan for each organisational unit in one table, using sub-headings where appropriate for sections of the organisational unit.

- Enabling preparation of the MOH budget submission to Finance to flow more readily from the operational plans.

  - Preparing operational plans in Excel rather than Word, to make data extraction and aggregation simpler.

  - Coding activities by accounts code. Detailed costings would be maintained by individual organisational units, with aggregates for each activity under the relevant accounts codes submitted to management.

[65] Column F requires expenditure on activities to be coded by accounts code. At present both SIG accounts codes and MYOB job and accounts codes are used by MOH, depending on the context. National divisions receiving most of their funding via the SIG budget are familiar with SIG accounts codes, while organisational units receiving funding under HSTA are familiar with the MYOB codes. A system has been established for provincial health services under MYOB, covering both SIG and HSTA funding. This suggests that managers are likely to experience some difficulty in identifying accounts codes for future expenditures, unless they know the source of funding and how accounting will be handled.

[66] Examples of how activity structures might be set up for two divisions were presented at the 2006 National Health Conference as part of a presentation on operational planning and MTEF.

- Incorporating the capacity to monitor and report on implementation of the operational plan within the template:

    - Column L (and M if expenditure can be tracked at activity level) would be used to report progress to management quarterly on the implementation of the operational plan.

It is envisaged that the Policy and Planning Division will assume responsibility for managing the introduction of the new template. This has been discussed with the Director of Policy and Planning. An intensive effort is underway to prepare divisions and provincial health services for the use of the new template in operational planning for 2008 (which is due to commence in March 2007). A draft set of guidelines for operational planning and budgeting in MOH have been prepared.

1.10 Operational planning for 2008

Two workshops for national divisions and departments were organised by the Policy and Planning Division of MOH during February 2007, to raise awareness in relation to the revised template for operational planning and to take staff through the guidelines for operational planning, step by step. Workshops were subsequently conducted for staff of Provincial Health Services on the revised template and guidelines[67].

Issues emerging in the workshops included lack of access to the NHSP and budget documentation among those responsible for preparing operational plans, fragmentation of budgets for some organisational units among various sub-heads, and a perception among participants that processes used within MOH for organising operational planning through the year (including feedback from management) could be improved.

1.11 Institutional capacity for operational planning and budgeting

The Policy and Planning Division is developing the capacity to manage the operational planning process. The Director was briefed on the process during November 2006, while the Chief Planning Officer has taken the lead in organising workshops for staff on the revised template and guidelines for operational planning. Strong management oversight of the process will be required during 2007 to ensure that the process is understood and that deadlines are met. The onus is also on management to turn around submissions from organisational units quickly, in order to meet the deadlines set for management feedback at the relevant stages of the process.

The Policy and Planning Division, and MOH management, may require further technical support during 2007, to implement the revised operational planning process. As an example, the process of determining expenditure ceilings for individual organisational units (based on the MTEF projections for 2008, refined through recourse to Stage 1 operational planning submissions from organisational units) may require some support.

The MYOB accounting system that has been set up under HISP provides Provincial Health Services with some capacity to manage their resources. This system gives a classification of expenditure by provider (hospitals, clinics, programs) through job codes, and an economic classification of expenditures (expense types) and a classification of income through account codes. Schedules of these job and accounts codes have been prepared for each province. If this system was fully operational it would be generating a satisfactory level of management information.

For most provinces, entry of source documents into the system occurs in the accounts section of MOH headquarters. Entry tends to lag, due to delays in submitting batches of source documents from the provinces. Headquarters accounts staff have difficulty classifying source documents by job code due to poor descriptions on the source documents, with the result that for some provinces most expenditure ends up in a "catch-all" job code (overall costs). This undermines the usefulness of resulting monthly

[67] This timing suggests that there will need to be some flexibility this year in relation to the deadlines set for operational planning for 2008, particularly for Stage 1.

reports as a management tool. Attempts are being made to equip those provinces based in Honiara with MYOB systems.

Provincial Health Services are encouraged to maintain their own expenditure tracking records in the form of Excel spreadsheets, using the MYOB job and accounts codes. This does not appear to be happening in most provinces, though tracking by accounts code is reported to be working well in at least one province (Western Province). Operational plans for Provincial Health Services are meant to provide the budgets against which provincial expenditure is tracked, though current operational plans have limitations in this regard. If the revised template for operational planning is followed through, then the 2008 operational plans for Provincial Health Services should be able to function more effectively as budgets against which expenditure can be tracked.

National divisions receive most of their funding via the SIG budget, and this is accounted for by the accounts section in headquarters in accordance with the requirements of the SIG finance system. Some divisions (NRH in particular) also receive funding from HSTA, which is accounted for using the MYOB system.

It is desirable for a review to be undertaken as to what additional information could be captured via the six digit MYOB job codes, to facilitate management of resources allocated to provinces. At present the first two digits represent the province, the second two the year, and the final two the classification by provider (hospital/clinic/program). There may be scope for a closer match with NHSP strategic areas to be generated from the final two digits of the code e.g. by relying on one digit for the provider, thus freeing up one for a strategic area classification.

The process of translating operational plans into the MOH budget submission to SIG is very centralised at present within MOH headquarters, and there would appear to be merit in giving the Policy and Planning Division a greater role in this process. This would complement the role of this division in managing the operational planning process, and assist in improving links between policy and budget allocations.

1.12 Operational Planning Template

MoH Operational Plan

Year: Progress Report

Organisational unit (National Division, Provincial Health Service, NRH etc): Quarter:

A	B	C	D	E	F	G	H	I	J	L	M
Activity	**Reference to NHSP**	**Input Staff**	**Other Inputs**			**Location**	**Timing**	**Person Responsible**	**Output Indicators**	**Progress**	
			Type	**Cost ($)**	**A/C code**					**Physical**	**Financial ($)**

Notes

Activities	List in order of NHSP reference, and under sub-headings for sections within the organisational unit if appropriate. Activities should be significant areas of work (mainly ongoing, and perhaps some new), rather than one-off actions (activity structure should remain relatively constant from year to year).	
Reference to NHSP	First two digits would be used for strategic area number. Third digit would be used for objective number within strategic area.	10, 20, 30, 40, 50, 60, 70, 81, 82, 83, 84 (90 could be used for "other")
A/C code	Show the relevant accounts code (under the SIG or MYOB chart of accounts), if known	

Columns A & B would be completed in Stage 1 of the process (see *MoH Guidelines for Operational Planning and Budgeting* for a description of the three stages of the process).
Columns C to F would be completed in Stage 2 of the process (adjusting columns A & B as necessary following Stage 1).
Columns G to J would be completed in Stage 3 of the process (adjusting columns A to F as necessary following Stage 2).
Columns L & M would be used for quarterly progress reports during implementation (if expenditure cannot be tracked by activity, then financial reporting should be for the organisational unit).

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1.13 Examples of Activity Structures

Health Promotion - Core Business Activities		Budget SBD Thousands
1	**Capacity building for HP staff, Health Workers and stake holders.**	
276-0395-2001	Repair of Office buildings	
276-0395-2010	Office Expenses	
276-0395-2013	Telephone and Faxes	
276-0395-2017	Printing	
276-0395-2018	Publicity and Promotion	
276-0395-2050	Fuel	
276-0395-2070	Staff Travel and Transport (Local)	
276-0395-2071	Tours and Travel	
276-0395-2150	Maintenance of Vehicles	
276-0395-2191	Capital Expenditure - Office Equipment	
276-0395-3010	Motor Vehicles	
276-0395-4001	Training - General	
276-0395-4030	Conferences and Seminars - Cost	
2	**Integrate Healthy Settings Activities into the Public Health Functions**	
3	**Production of IEC materials to support Public Health Functions**	
4	**Coordinate media support for Public Health Functions**	
5	**Mobilize community support for Public Health Functions**	
6	**Promote Health Promoting School Programs**	
7	**Research to support Health Promotion Intervention**	

TB - Core Business Activities		Budget SBD Thousands
1	**Strengthen Laboratory capacity for sputum microscopy and culture**	
276-0384-2010	Office Expenses	
276-0384-2013	Telephone and Faxes	
276-0384-2017	Printing	
276-0384-2018	Publicity and Promotion	
276-0384-2050	Fuel	
276-0384-2070	Staff Travel and Transport (Local)	
276-0384-2150	Maintenance of Vehicles	
276-0384-2191	Capital Expenditure - Office Equipment	
2	**Empower people with TB and Communities**	
3	**Maintain Recording & Reporting System**	
4	**Training of service delivery staff**	
5	**TB/HIV Co infection Framework for collaboration developed and implemented**	
6	**Monitoring and Supervision - supervisory visits to Provinces**	

1.14 Waste Management

1.14.1 Situation Analysis

Good progress has been made to date, in the movement towards an environmentally sustainable health care system. MOH has developed National Priorities for the health care systems that include health care waste management. The MOH has drafted a Health Care Waste Management Plan 2007. Significant support was provided to the MOH through the Technical Assistance for the Improvement of the Management of Healthcare Wastes in the Solomon Islands, November, 2006, (WHO), and the Solomons Islands Safeguards Report Project Preparation Mission, December 2006 (WB and AusAID). The Infection Control Manual (draft 2002) has not yet been formally adopted by MOH, and has not yet been fully implemented. While the Infection Control Manual is a good general document, facility-specific plans and the national plan will provide additional guidance and direction.

In addition, as part of the five year strategic Infrastructure Plan MOH will undertake the development of a services plan, survey and physical master plan. The goals of the MOH are adequate water supply and sanitation (wastewater treatment) in the MOH facilities, as well as a health care waste management system that affords infection control.

Location, Type, and Status of New Incinerators in the Solomon Islands:

Location	Institution	Combustion Type	Donor	Status
Makira	Kirakira Hosp	Single stage	JICA	Not Installed
Choiseul	Taro Hosp	Single stage	JICA	Installed
Honiara	HCC	Single stage	JICA	Installed
Guadalcanal	Grove AHC	Single stage	JICA	Operating
Isabel	Buala Hosp	Single stage	JICA	Not Installed
Malaita	Afio AHC	Single stage	JICA	Not Installed
Malaita	Kilu'ufi Hosp	2 -stage	AusAID	Not Installed
Western	Gizo Hosp	2 -stage	AusAID	Operational
Honiara	NRH	2 -stage	AusAID	Operational

Status as of November 11, 2006

Source: Mission Report: Healthcare Wastes in the Solomon Islands, November, 2006 (WHO)

1.14.2 Current Health Care Waste Management Practices

Current Practices	**Related risk**
There is no proper segregation of HCWs	Incorrect and incomplete destruction of HCWs
Raw sewage is discharged directly onto beaches and near shore.	Disposal of health care waste in burn pits on the beaches, and in unmarked pits in upland areas.
Disposal of health care waste in burn pits on the beaches, and in unmarked pits in upland areas.	Risk of infection and injury by persons coming into accidental contact with sharps and infectious materials. Contamination of surface waters via rainfall runoff.
Infectious waste is not collected in designated containers.	There is risk of infection by personnel who handle the containers, who may not realize the containers are potentially infected. The containers may not be disinfected on a regular basis, prolonging the infection hazard. WHO guidelines call for segregation of health care waste (hazardous and non-hazardous, chemical, sharps) into color-coded and designated containers in order to protect hospital staff and the public from inadvertent exposure.
There is no designated storage area for health care waste, other than the general rubbish bin. There is no temperature control for the rubbish bin.	There is risk of infection by personnel who handle the containers, who may not realize the containers are potentially infected. WHO guidelines call for separate, secured (locked) temperature-controlled storage areas for hazardous health care waste, to avoid proliferation of infectious agents.
There are no training programs in place concerning health care waste risk for staff or handlers of health care waste.	Hospital staff may become exposed, or expose the public, to hazardous health care waste (and needle-stick injuries/infections) due to a lack of awareness of the hazards.
There is no designated vehicle for transport of health care waste. The general rubbish disposal vehicle is used.	The transport vehicle can carry infectious agents into the community it serves, and expose waste transport workers as well as the public to hazardous health care waste. WHO guidelines call for a dedicated transport vehicle that is equipped to contain spillage, and can be thoroughly cleaned (sterilized) on a regular basis. The transport vehicle should have an impermeable bulkhead between the waste and the operator(s).
Pharmaceutical waste is disposed along with the general domestic waste. Lab chemicals are collected in plastic and disposed with the general waste or dumped into the wastewater treatment system via the sink. Thermometers are disposed along with the general domestic waste.	Toxic chemicals and heavy metals (mercury in thermometers for example) in these unsegregated waste streams are not properly treated or disposed, allowing them to be released into the environment: 1) during transport in a vehicle that is not contained to prevent spillage; 2) through the wastewater treatment system; and 3) once released at the open dump which does not have controlled access for humans and disease vectors, air contaminant, groundwater contaminant or storm water runoff controls. WHO guidelines call for the segregation and proper treatment and disposal of each type of health care waste stream.

Based on the situational analysis, the following approaches are being suggested to improve the management of Health Care Wastes. These approaches represent an optimization of low cost-high impact technical alternatives to be combined with institutional strengthening through international technical assistance in order to increase capacity and promote sustainability within the operations of MOH.

1.14.3 Program Activities:

1. Establish a Healthcare Waste Management Committee.
2. Revise and endorse the Infection control guideline.
3. Ensure installation of any outstanding already purchased incinerators.
4. Development of a Health Care Waste Management Policy.

   The policy should emphasize the importance of proper segregation at the point of generation.

5. Develop Site Specific Health Care Waste Management Plans.
6. The Ministry of Health to develop a dedicated budget for health care waste management to include staff training, equipment capital and operations and maintenance costs, and other recurrent costs, to be undertaken under the technical assistance during project implementation.
7. Develop an Inspections and Corrective Actions system in consultation with the national and provincial Environmental Health Departments (in conjunction with technical assistance).
8. Develop and implement a public education program (environmental sanitation) to be spearheaded by the national and provincial Environmental Health Departments, with international technical assistance.
9. Liaise with SICHE school of Nursing to incorporate Health Care Waste Management as part of undergraduate training.

1.14.4 Program Equipment and Consumables:

1. Obtain personal protective equipment (PPE) for waste handlers (boots, aprons, face shields, gloves and surgical masks). Assess needs (in conjunction with technical assistance).
2. Obtain color coded plastic bags and bins of suitable sizes with biohazard labels (yellow bins) and local language markings "infectious waste only" and "rubbish only – no infectious materials" (green bins). Assess needs (in conjunction with technical assistance).
3. Establish a maintenance plan for incinerators. Obtain and maintain spare parts stocks for incinerators and wastewater treatment facilities.
4. Investigate use of draft fan and drum type waste incinerators for rural facilities with power supplies (an example is in use at the RAMSI facility).

1.14.5 Site-Specific Activities:

1. Closure of unused disposal pits where incinerators have been installed – cover with earth and cover general waste disposal pits with earth after every waste dump.
2. Fence all incinerators, ash pits, and HSW disposal pits.
3. Cease disposal of cytotoxic waste into sewers – collect on routine basis for incineration or return to vendors.

Install Best Engineering Practice chimneys on incinerators located near occupied structures

1.15 Gender Issues

Gender mainstreaming improves the efficient and effectiveness of health service delivery. With a gender-related development index of 0.596[68] and a gender empowerment measure of 0.593[69] the United Nations Human Development Report illustrates that Solomon Islands has significant differences between men and women in access to resources, decision-making and status. A gender sensitive approach to the health sector draws attention to the fact that women's health is not limited to their biological reproductive role, but rather that men and women's health is a factor of social, cultural and economic particularities that construct the social context (Mackintosh and Tibandebage, 2004). Further, a gender sensitive approach is able to draw out where the health sector contributes to reinforcing gender inequalities and what opportunities are available to reduce these inequalities.

MOH's commitment to gender mainstreaming is articulated in the *NHSP*. Within the eight key strategic areas are a set of organisational and social values, some of which refer to gender equality. Goal 1 of this plan, '[t]o promote a people centered approach to health', states '[i]ncrease implementation of a people focus and gender mainstreaming within health care services at all levels' as an objective. Achieving this objective will require the implementation of a gender equality approach across each of the other seven strategic areas identified within the plan.

In Solomon Islands the gendered nature of ill health and health service delivery poses a number of challenges for implementation of the MOH's commitment to a people-focused approach and gender mainstreaming. The key challenge for gender mainstreaming is developing an institutional culture that recognizes difference and disadvantage, builds on the strengths of individuals, communities and institutions, and strives to empower women through health service delivery.

Although gender mainstreaming is established within the MOH institutional discourse, its translation into planning, management and the delivery of services has yet to take form. Indeed, within the various divisions of MOH little evidence is found that the specificities of gender relations and the nature of women's social, economic and cultural status, are incorporated. Nonetheless, different strategies to target men and women in decision-making[70], and efforts to engage men in family planning and reproductive health[71] are some examples of the shift to a Gender and Development (GAD) approach in the MOH.

MOH's commitment to an approach that is people focused forges avenues for implementing gender mainstreaming. The strategic areas of the *NHSP* cover a wide array of issues – from management through to service delivery. Gender considerations are important to each of these strategic areas.

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68 The gender related development index considers the level of equity between men and women in measuring social development (UNDP, 2002).

69 The gender empowerment measures the levels of women's participation in political activities, management and decision-making including access to economic resources (UNDP, 2002).

70 Reference from the Health Promotion Division.

71 Counselling on pre and post vasectomy and national training on family planning with men's involvement was developed by the National Reproductive and Child Health Services Division in 2004/5. This Division is currently working on engaging men with family planning.

- The efficiency and effectiveness of planning and health service delivery need to consider the social and economic norms and positions that shape gender relations. For example, the National Reproductive and Child Health Services Division is piloting the establishment of a 'waiting room', complete with house and garden area for growing food in an attempt to encourage mothers to arrive to health facilities well-before child birth.
- To ensure robust health interventions the nature of the gender division of labor, the roles and social representations of both men and women within the community need to be recognized.
- In spite of the key role played by women as caregivers[72], men should be explicitly included in health interventions. An exclusive focus on women as caregivers reinforces perceptions of what the appropriate role for women within the community is and fails to consider the role that men play in decision-making on access to health services within the household. For example, the National Reproductive and Child Health Services Division is preparing for the implementation of childbirth plans to enable both parents to prepare in advance ensuring that all conditions for a safe child birth are meet.
- An effective move from women-centered interventions, evident in today's MOH structure, to gender mainstream interventions can produce more efficient and effective outcomes. MOH's current commitment to women's health is evident for example, in the extensive portfolio of activities on family planning and reproductive health targeting women.
- Planning needs to recognize that men and women are not homogenous groups. Age and ethnicity are key variables to understand women and men's roles and social status in the health sector.
- The success of a gender mainstreaming approach relies on the commitment of the MOH staff and the engagement of citizens and civil society to 'voice' and monitor change.
- Engaging of all divisions of the MOH to reflect on past women-centred intervention's, in preparation for the development of a gender mainstream approach, may encourage institutional learning and enable the emergence of mainstreaming opportunities across divisions.

The MOH's commitment to a gender-sensitive approach to health delivery is in line with the Solomon Islands National Women Policy (WDD, 1998). This policy identifies health, connected with welfare and nutrition, as an issue of major concern to women. Table 1 below highlights the consistency of the NHSP and the National Women Policy.

[72] Key stakeholders referred to the fact that women are more cooperative in implementing health initiatives within communities, yet their voices do not emerge within community initiatives.

Table - Mapping the direct linkages between National Women Policy and MOH National Health Strategic Plan

National Women Policy (1998)	Solomon Islands National Health Strategic Plan Strategic Areas							
	1	2	3	4	5	6	7	8
Recognizing the importance of women's health towards the improved health status of the family unit, the community and the country and the overall contribution a healthy nation could make to the overall development of the country and realizing the importance of relevant program planning to address the specific health problems of women.	X	X	X	X	X			X
Recognizing that the country has a high population growth rate of 3.5%[73] and its consequential impact on every aspect of the development of the country.							X	
Recognizing that the country has a very high fertility rate of 6.7 and its impact on reproductive health status of women.							X	
Realizing that there is rapid increase of single mothers and teenage pregnancies.							X	
Recognizing the increasing negative effects and socio-economic problems of unemployment, urbanization, national development projects and so on, on both the urban and rural women.	X	X						
Acknowledging the roles that women play within the family unit in relation to the upbringing of children and adolescents and the issues of concern facing the youth of today.				X		X		
Faced with increased incidence of Nutritional related problems affecting women's health.	X	X			X			
Being aware that women are the primary health care providers, and the main users of health care services and in recognition of the fact that the level of knowledge of the mother is vital in understanding and practicing health habits.	X	X	X	X	X			X
Being aware of the negative effects and the implications of women's health by large national development programs and acknowledging the primary role which women play in food security and sufficiency at the family level	X	X	X	X	X			

1.15.1 Gender and organisational change

The recording of data on the workforce engaged with the MOH demonstrates many weaknesses: inconsistency in classification and poor recording and updating of each of the variables. Improved data would allow for a more detailed analysis of sex-disaggregated data by the nature of the work performed. Analysis of available data shows that in 2005, women represented around 49% of the total workforce engaged by the MOH[74]. However, with regard to MOH management levels, women's representation

[73] These statistics refer to 1998.

[74] Planning Division, Ministry of Health, 2006.

fades away as the level of seniority increases. Although women represent more than 50% of staff engaged at junior levels (less responsibility and lower remuneration), they represent a mere 10% at the executive level (executive responsibility and higher remuneration packages)[75]. It is recognized that a gender-sensitive policy for HR management has not been developed in the MOH.

Access to training within the MOH should recognize the social and economic disadvantage that women face in the Solomon Islands. Furthermore, opportunities for training of administrative staff are extremely limited and there appears to be no strategy for effective management and development of this important segment of the MOH workforce. An analysis of the further education applications endorsed for 2006 highlights that women represent less than 40% of the endorsed candidates. The Health Institutional Strengthening Project (HISP) has contributed decisively to reinforce knowledge and skills in basic management tools and has been effective in engaging women in short term training activities[76].

There is recognition within the MOH that the inclusion of a more gender-sensitive approach to delivery should be addressed with the main institutions that provide nursing and medical qualification in the Solomon Islands. Such training will contribute to improvement of the quality of service provided to the communities and to men and women alike. The MOH should also consider the development of an internal training plan comprising key gender-sensitive tools and methods; gender focused training for health professionals has not been recorded within the MOH's activities.

Gender is not a targeted focus of the majority of donor-funded programs within the Solomon Islands health sector and coordination with different donors will significantly improve the effective delivery of assistance. Gender issues are generally accommodated within existing programs. The assistance provided by donors for women's empowerment and leadership is an important contribution to gender mainstreaming in the health sector. The challenge of mainstreaming gender across the public health sector may benefit from the synergies and learning accumulated by other sectors in the effort to encourage and support women's leadership and participation. Examples of such initiatives are the Community Sector Program's support to women provincial centers as well as the support to the Women in Leadership desk located in NCW, both funded by AusAID.

1.15.2 Data collection on health

To date, the absence of sex-disaggregated data within the Health Information System (HIS) does not allow any further investigation into who uses the health services and the gendered characteristics of ill health within the population. The focus of health research has been on biomedical determinants of health and illness at the level of individuals rather than the relationship between ill-health and population groups, i.e. gender or ethnicity (Ostlin *et al.*, 2004).

Across all information systems within the MOH, sex-disaggregated data needs to be collected to ensure quality health information is available to inform sound health policy design and implementation. Sex-disaggregated data would permit the identification

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75 2004 statistical analysis on the public service establishment highlighted that of the 937 total workforce women represented 6% of the senior public service positions (in Emmott, 2004).

76 Planning Division, MOH and HISP, 2006.

of the differential impacts of ill-health on men and women, and would improve understandings of the social, economic and cultural factors shaping ill-health for improved health service delivery. The revised HIS currently being developed and programmed for implementation in 2008 includes a limited number of sex-disaggregated data fields.

1.15.3 Gender mainstreaming in MOH

The HSSP will support the MOH in its implementation of gender mainstreaming in the health sector through key initiatives within the program activities. These initiatives will incorporate the following recommendations:

- **Taking an integrated approach to gender in all facets of health service delivery:** A concerted effort to mainstream gender in the health sector requires the explicit incorporation of gender at all stages of health sector program development, from conceptualizing and planning health sector assistance through to the provision of health services and monitoring and evaluation of their delivery.

- **Establishing inter-departmental partnerships between the MOH and other relevant government departments:** The commitment of the MOH to gender mainstreaming will be enhanced through engaging other relevant departments in SIG. Of particular relevance will be the WDD within the Department of Home Affairs, the Royal Solomon Islands Police force (RSIP) and the Ministry of Education.

- **Establishing partnerships between MOH and civil society organisations:** Civil society institutions in Solomon Islands play an important role in both the delivery of health services and in advocating for improved health services. Establishing partnerships with these institutions can serve the dual purpose of increasing the coverage of health services (particularly to isolated rural areas) and providing an external accountability check on the effectiveness of implementation of gender mainstreaming in the health sector. Efforts by the MOH to move towards a more people-centered approach should be supported by a culture that encourages the voices of health users, particularly women. Such an approach is likely to highlight new and gender sensitive methods for the more effective and efficient delivery of health services.

- **Establishing a gender focal point within the MOH:** Effective gender mainstreaming will require a concerted and focused effort within the MOH. To achieve this an establishment period will be necessary. A gender focal point, in the form of a specific position or team of people dedicated to progressing gender mainstreaming within the Ministry, is one measure to improve the efficacy of initiatives aimed at achieving gender equality. Further, such a focal point will facilitate the translation of current strategies and policies into *Plans for Action.*

- **Collecting improved sex-disaggregated data:** In order to better understanding the complex set of issues related to gender and health, and to support the development of sound public health policy, sex-disaggregated data needs to be collected throughout all data recording systems within the MOH.

This includes updating the existing HIS and improving the current information regarding the sex and distribution of staffing across the MOH.

- **Taking steps to improve HR Management within the MOH:** HR procedures, including recruitment and training management, should be reviewed to ensure that women have equal access to professional development opportunities within the Ministry, a particular focus should be given to women's inclusion in key management positions. Partnerships should be established with local institutions involved in providing health related qualifications to include gender mainstreaming in their teaching i.e. Solomon Islands College of Higher Education (SICHE).

- **Developing gender-sensitive monitoring and evaluation:** To ensure MOH commitments related to gender mainstreaming are being realized, methodologies and instruments to monitor and evaluate progress need to be developed.

2 FINANCIAL MANAGEMENT & THE FLOW OF FUNDS

2.1 Background

As a result of systemic weaknesses in SIG financial and procurement systems at the time of the crises (2000), Health Sector Trust Account (HSTA) was designed as a parallel financial and reporting system. Expenditure is not reported through the SIG financial accounting or recurrent budgeting system and is not presented in any SIG consolidated accounts. This decision was made to ensure AusAID complied with its responsibilities under the Financial Management and Accountability Act 1997 and Commonwealth Procurement Guidelines. Recently, substantial progress has been made in strengthening SIG systems and oversight agencies, including the Auditor Generals Office. There are now improving levels of compliance with the provisions of the SIG Public Finance and Audit Act and related Financial Instructions. The Office of the Auditor General has started to become effective. The HSTA mechanism is no longer required and will cease operation in August 2007.

2.2 Capacity Assessment

A precondition for the SWAp was the appointment of the following positions in MOH:

- Under- Secretary for Administration & Finance
- Chief Accountant
- Procurement Officer

Notwithstanding the appointment of these positions, significant capacity constraints exist within MOH, which, if not addressed, will preclude donors from using the SWAp as the preferred financing mechanism.

Three recently completed external audits have identified serious and systemic weaknesses within MOH's system of internal controls; MOH, with the assistance of the HSTA financial management advisor has responded to the audit recommendations and developed an "Audit Action Plan" (August 2006 updated April 2007). Although the plan is comprehensive and time bound, the nature and extent of the audit findings will require significant improvement in levels of compliance by MOH with SIG Financial Instructions in order to ensure future audits are satisfactory.

Provision is made under the HSSP for the engagement of a financial adviser post August 2007 (completion of MC's contract) for a period of twenty four months to assist with the implementation of the SWAP and provide transitional support to the Chief Accountant. With the closure of HSTA in August 2007, all assets including computers, printers and servers will be transferred to MOH. It is not anticipated that the SWAp will need to finance replacement equipment until 2009. The MOH is in the process of recruiting an Internal Audit officer. This position could also assist with the implementation of the audit action plan referred to above.

2.3 Pharmaceutical and Medical Services

Under HSTA, payment for Pharmaceutical and Medical Services was facilitated through direct funding by AusAID into a Singapore bank account managed by the Australian Managing Contractor, JTA International. This bank account, together with all other HSTA bank accounts will be closed shortly after the commencement of the Program. For 2007, AusAID contributions for Pharmaceutical and Medical Services (including Technical Services and Malaria Program Support) will be reflected in the Development Budget. It is hoped that all donor funding for the Program will, in the future, form part of the SIG Recurrent Budget and funded through the

SWAp Special Fund. In this section, Program is used to describe the Health Sector Wide Approach within the Health Sector Support Program.

2.4 Legal and Regulatory Framework

2.4.1 Public Finance and Audit Act

The Public Finance and Audit Act of the Solomon Islands, 1978 is an Act to provide for the control and management of public finances of Solomon Islands. Financial Instructions are a code of practice on accounting matters and are issued by the Permanent Secretary, Ministry of Finance under the direction of the Minister pursuant to section 6(2) of the Act. It is this Act that will regulate the SWAp's financial operations. An AusAID funded project is currently updating the Financial Instructions. A preliminary assessment by this mission considers that compliance with this Act and the Financial Instructions will meet donor's financial fiduciary requirements. The audit reports referred to earlier identified non compliance with the Financial Instructions as the major audit finding.

2.4.2 Consolidated Fund

All revenues or moneys raised or received by or for the purposes of the Government (except for moneys received into a Special Fund – refer below) shall be paid into and form part of one Consolidated Fund (S100 (1) of the Constitution). S101 (1) provides that no money shall be issued from the Consolidated Fund except upon the authority of a warrant under the hand of the Minister for Finance and Treasury. No warrant may be issued unless the expenditure has been authorized for the financial year during which the issue is to take place by an Appropriation Act (S101 (2) (a)). Estimates of heads of expenditure (the budget) shall be included in a bill to be known as an Appropriation Bill, which shall be introduced into Parliament to provide for the issue from the Consolidated Fund of the sums necessary to supply those heads and the appropriation of those sums for the purposes specified therein (S102(2)).

2.4.3 Special Funds

Special Funds may be established by Parliament and shall not form part of the Consolidated Fund (S100 (2)). The balance remaining in each Special Fund at the close of each financial year (31 December) shall be retained for the purposes of that fund. The Minister for Finance and Treasury, with the approval of Cabinet, is authorised to make financial provisions for the establishment of a Special Fund (S 5(1) of the Public Finance and Audit Act). A separate (bank) account shall be maintained for each Special Fund and may receive funds either by an Appropriation or, at the direction of the said Minister, from other sources (S 21(1), for example donor funds. The Minister for Finance and Treasury may give directions for the control and management of any Special Fund (S 21 (4)).

2.4.4 Solomon Islands Auditor General

The Auditor General derives his power and authority from S 108 of the Constitution. In summary he is required to audit all "public money" as that term is defined under Part I to the Public Finance and Audit Act. Monies to the account of the Consolidated Fund (S 38 (1)) and any Special Fund are required to be audited by the Auditor General (S 38 (2)).

2.5 Financing Mechanism for the SWAp

There are two financing mechanisms available for the SWAp, namely the use of the Consolidated Fund or a specially created Special Fund. There is some concern that if the SWAp is financed through a Special Fund, the SWAp will be "off balance sheet" i.e. not included in SIG Recurrent Budget estimates or form part of the annual Appropriation Act. This is not the case, MOF are proposing revisions to the Budget process that will simplify SIG programme elements and include all funding sources, SIG and donors, regardless of whether financing is through the Consolidated Fund or a Special Fund. The Special Fund may receive funds either by way of an Appropriation or directly from the SWAp donors.

The proposed financial reporting system for the SWAp will use an existing MOH MYOB accounting system. This will ensure SWAp expenditures are captured in the SIG central accounting system on a monthly basis.

The SWAp will potentially fund in excess of SIG $ 1 billion (AUD $ 100 million) over the life of the program. The selected financing mechanism must ensure donor funds are adequately safeguarded and used only for agreed purposes.

The relative 'pros' and 'cons' of each mechanism follows:

- The use of the Consolidated Fund results in donor monies being treated in exactly the same manner as SIG revenue and expenditure and therefore subject to those benefits and risks that underpin their use, namely the annual SIG budget cycle, the Appropriation Bill and the issue of Ministerial warrants.
- MOH have received legal advice from the SIG State Solicitor that the Special Fund affords greater benefits in terms of security of "supply" of SWAP monies over the Consolidated Fund. Consolidated Fund monies can only be spent following passing of the annual Appropriation Bill and the issue by the Minister for Finance and Treasury of the required warrants. It is intended that the SWAP be included in the SIG Recurrent budget estimates from 2008 onwards, regardless of the financing mechanism. If the SWAP is financed through the Consolidated Fund and the SWAP program estimates are delayed and not included in the 2007 SIG budget, a SIG supplementary budget will be required before any SWAP expenditures can be incurred. If the SWAP program budget fails to meet the annual SIG budget deadline, warrants for the use of SWAP monies financed through the Consolidated Fund cannot be issued without a supplementary budget approved by Parliament. The financing of the SWAP by way of a Special Fund ensures continuity of supply regardless of its inclusion or exclusion in the SIG Recurrent budget or passing of an Appropriation Act. A SWAP Special Fund may receive funds directly from the donors if there are delays in passing the SIG budget.
- If there is a delay in approving the Appropriation Act in subsequent years, the Minister for Finance and Treasury may, for a period of up to four months, issue warrants for the payment out of the Consolidated Fund such sums as he considers necessary for the continuance of "public services." In this instance SWAp monies financed through the Consolidated Fund could be expended for "public services" other than health. Special Funds do not require a warrant to spend monies and may only be spent against a defined purpose and in a manner specified in the Special Fund Act.
- Every Appropriation in respect of any SIG financial year shall lapse and cease to have any effect at the close of that financial year. If the SWAp is financed through the Consolidated Fund, new warrants will need to be issued to authorise the use of unspent SWAp balances. The balance of SWAp monies on hand in the Special Fund are not affected by lapsed warrants.
- The SWAp Special Fund will be audited by the SIG Auditor General (S 38(2) of the Public Finance and Audit Act). Monies in the Consolidated Fund are audited englobo.

The SWAp Special Fund presents lower fiduciary risk to donors and is the recommended option for the SWAp and to finance agreed MOH activities.

2.6 Funding Arrangements

The proposed arrangements for the opening of the required bank accounts in anticipation of the SWAp becoming effective 6 August 2007 are:

- A designated SWAp Special Fund to be established in accordance with S100 (2) of the Constitution. This account will be used for the receipt of SWAp monies from donors and subsequent transfer to MOH. This account is to be called the "Health SWAp Special Fund Account". This bank account will be opened with the Solomon Islands Central Bank.
- An MOH Bank Account for the receipt of funds from the Health SWAp Special Fund Account. This bank account will be called the "MOH Development Partners Bank Account". This bank account will be opened with a commercial banking institution operating in the Solomon Islands and internationally.

All of the bank accounts will be regulated by the Public Finance and Audit Act and related Financial Instructions.

2.7 Operation of the Bank Accounts

2.7.1 Operation of the Health SWAp Special Fund Account.

Donor contributions will be deposited bi-monthly, in advance, into the Health SWAp Special Fund Account. Bi-monthly advances are then made by MOF to a MOH controlled bank account for the payment of goods and services. Expenditure is acquitted and journalised monthly into the SIG central accounting system against SIG budget elements.

The benefit of this mechanism for MOH is that it permits MOH to incur and pay for goods and services without having to go through the centralised (and sometimes delayed) MOF payment system. Further MOF do not at this time have the capacity to manage the full roll back of HSTA into the centralised system. MOF will continue to process MOH payroll, Provincial grants and other payments such as utilities, staff travel and minor works. A diagrammatic presentation of the SWAP mechanism is set out below.

The Health SWAp Special Fund Account will need to be established in accordance with the provisions of S100 (2) of the Constitution and S 5 of the Public Finance and Audit Act. This will require the following:

- MOH to prepare a briefing paper to the Permanent Secretary Finance and Treasury detailing the purpose of the SWAp, the rationale for the use of the Special Fund as the financing mechanism and proposed administrative arrangements for its operation.
- MOH, through the Permanent Secretary Finance and Treasury, prepares a Cabinet Submission for the establishment of the Health SWAp Special Fund Account.
- Minister for Finance and Treasury and Treasury to issue a Ministerial Order to the Permanent Secretary Finance and Treasury to open the Health SWAp Special Fund Account with the Central bank of the Solomon Islands.
- MOH will need to establish a new bank account for the receipt of funds from the Special Fund. This will require an application to the Permanent Secretary Finance and Treasury in accordance with FI 382.
- MOH to advise the Auditor General once the bank accounts are opened.

2.7.2 MOH Development Partners Bank Account

The existing Health Sector Trust Account Manual will form the cornerstone as to how the MOH Development Partners Bank Account will operate. The Chief Accountant MOH, , with assistance from the HISP Financial Management Adviser, has prepared the required Financial Management (Accounting and Operations) Manual (see **Annex 2**).

2.7.3 HSTA Bank Accounts

HSTA currently operate five National and sixteen Provincial bank accounts. Once the SWAp bank accounts becomes fully operational, all remaining HSTA accounts should be closed and the balance of funds transferred to the Health SWAP Special Fund Account.

2.8 Reporting Regime

HSTA are using the MYOB as its accounting platform. MYOB is a commercial off the shelf accounting package supported in the Solomon's. Discussion with the SIG Accountant General confirms that NZAID are using MYOB for a funding mechanism not dissimilar to the SWAp. MOH Payroll is processed by MOF and no change to this arrangement is envisaged under the SWAP. Use of MYOB for the Program is recommended.

The Financial Management (Accounting and Operations) Manual includes revision to the MYOB chart of Accounts.

2.9 Auditing Requirements

The use of the Health SWAp Special Fund Account mechanism as a replacement for HSTA poses increased risk to donors in terms of their own legislative requirements to ensure ODA is spent efficiently, effectively and ethically (refer section 44 of the Australian Financial Management and Accountability Act 1997).

The filling of the positions of Under-Secretary Finance and Administration, Chief Accountant, Procurement Officer and the establishment of an effective internal audit function within MOH, mitigates some of this risk. Regular independent audit of SWAp expenditure and procurement practices (refer section on MOH procurement practices) will be required to place the Program within an acceptable ODA risk profile.

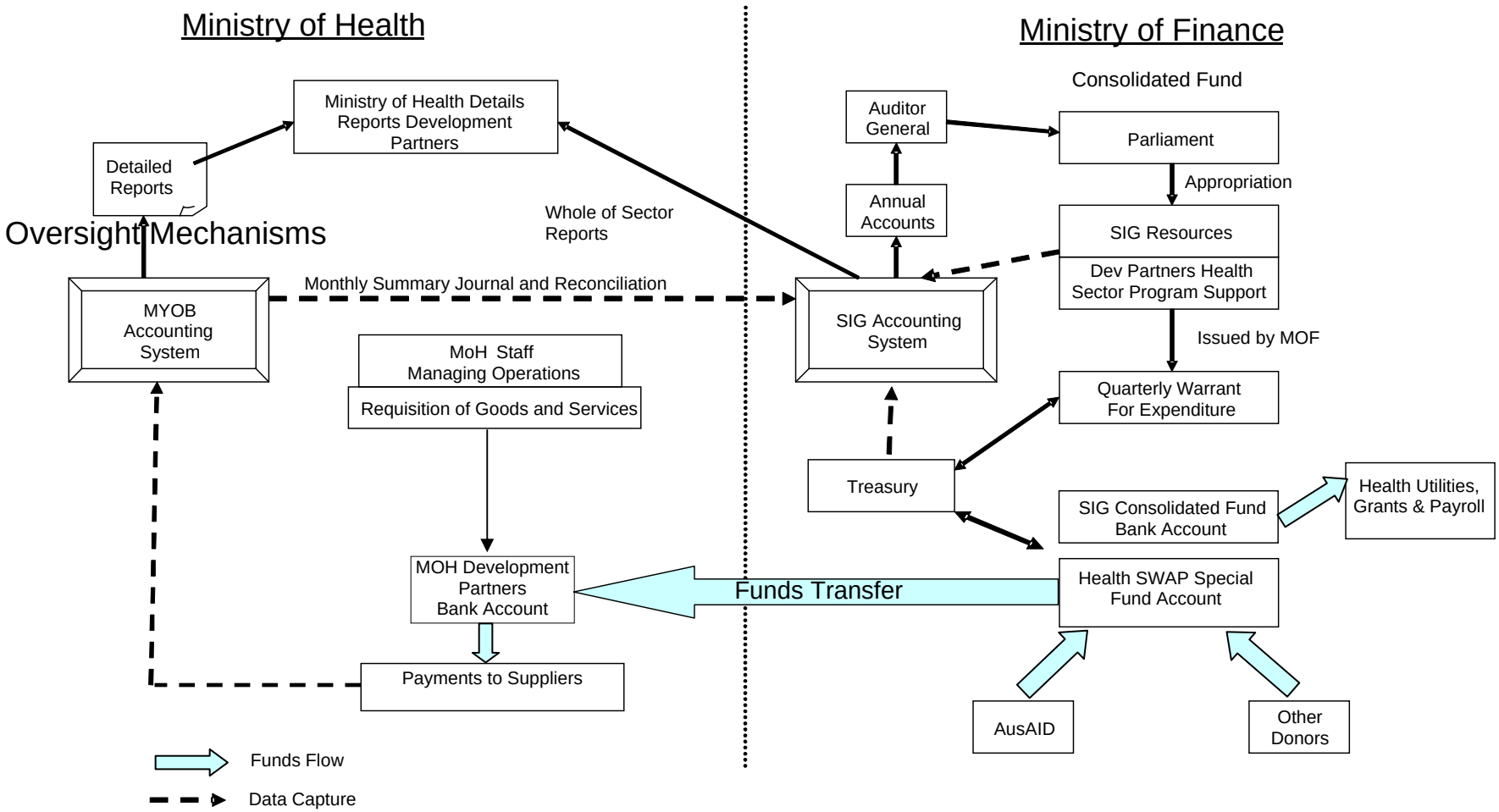
It is proposed that Program tranches be released bi-monthly in advance. Tranches (other than the first tranche) will be released on acquittal of the previous tranche. The Accountant General does not have the resources to undertake any detailed examination of acquittals. The MOH internal audit will validate the accuracy of the bi-monthly acquittals. Annual independent audit of the Program expenditure by the SIG Auditor General is also proposed and, in the first year, bi-annual audit. Although the Auditor General is strengthening their capacity to discharge their mandate, there is a significant backlog of audits to complete. Nevertheless a discussion with the Deputy Auditor General highlights that office's desire to undertake the audit of the Program.

These two attest functions combined with other fiduciary arrangements referred to earlier, will provide the required financial safeguards to SIG and donors for the HSSP through the SWAp.

2.10 Memorandum of Understanding

Two draft Memoranda of Understanding to give effect to the SWAP are attached at **Annex 3**. These Memoranda provide for the arrangements including fiduciary arrangements covering both Health SWAP Special Fund Account and MOH Development Partners Bank Account

Funds Flow and Reporting



3 Procurement Management

3.1 Overview

The goal of procurement management and the purpose of the MOH Procurement Manual **(Annex 4)** is to assist the departments and divisions at the central and provincial level of the MOH achieve value-for-money outcomes in the procurement of civil works, goods, services, and the recruitment of technical assistance. The MOH Procurement Manual outlines policies, directives and simple step-by-step processes to assist the realisation of the five key principles of good Government procurement practice:

- value-for-money,
- transparency,
- effective competition,
- fair and ethical dealing, and
- efficiency and effectiveness

Value-for-money 'Value-for-money' procurement means obtaining goods and services for the MOH that best meet the Government's need at the lowest total cost. For complex civil and building works care must be taken to ensure whole of life costs are also considered. Also, for the procurement of goods, where the item is not standard and value-for-money cannot be established easily, then whole of life costs may also be considered. But consideration of whole of life cost is complex and should only be formulated by a specialist consultant. The main objective of MOH procurement is to obtain value-for-money in the acquisition of works, goods and technical assistance using ethical, transparent processes and promoting open and effective competition. All decision makers in the procurement process must satisfy themselves that a proposed contract will make effective use of Government or donor agency funds.

Transparency Transparency involves the clear and public documentation of procurement processes, tender requirements, selection criteria, and decisions. All processes used and decisions made should be able to withstand independent review and scrutiny. Transparency is best obtained by using the public tendering process when establishing major contracts. It is the responsibility of all MOH staff involved in major procurements to act in a transparent manner.

Effective Competition Effective competition is a key principle that must be applied if value-for-money is to be achieved. Competition that is effective will see a number of independent companies tendering to provide works, goods and services to the MOH through the public tendering process. Creating effective competition involves publicly requesting tenders from contractors, providing timely and adequate information to contractors, and ensuring that new entrants and small contractors are able to participate.

Fair and Ethical Dealing The central principles underpinning fair and ethical dealing are: treating potential and existing contractors with equality and fairness, not seeking personal or family gain, and treating tenderers and tender information with respect and confidentiality. This can be achieved by:

- ensuring that all aspects of the tendering process are be conducted with honesty and fairness at all levels,
- all parties conforming to all legal obligations,

- tenderers only submitting tenders with a firm intention to proceed,
- parties not engaging in any practice which gives one party an improper advantage over another,
- tenderers not engaging in any form of collusive practice,
- ensuring conditions of tendering are the same for each tenderer on any particular project,
- Divisions clearly specifying their requirements and the criteria for evaluation in the tender documents,
- ensuring that the evaluation of tenders is based on the conditions of tendering and selection criteria defined in the tender documents,
- ensuring that the confidentiality of all information provided in the course of tendering is preserved, and
- any party with a conflict of interest declaring that interest as soon as the conflict is known to that party.

It is important that all staff involved in procurement follow these principles and that they be seen at all times to follow these principles. Failure to do so undermines the credibility of the whole procurement process.

Efficiency and Effectiveness The principle of efficient and effective procurement requires procurement staff to use procurement processes that match the amount of money being spent. For example, it would not be efficient or effective to conduct a public tender for expenditure of SBD 5,000. The cost of running a public tender is substantial, and such a small purchase would not be able to justify the expense of the procurement process. The appropriate processes for different levels of expenditure are detailed in the MOH Procurement Manual.

3.2 Institutional Arrangements – Roles & Responsibilities

3.2.1 Minister of Finance & Treasury

The Minister of Finance & Treasury has overall responsibility for the Government's procurement function. The powers and responsibilities of the Minister are detailed in legislation and in Section 2.1.3 (a) – (e) of Financial Instructions (2006 Draft).

3.2.2 Central Tender Board

The Central Tender Board (CTB) is responsible for procurement with an estimated value of greater than SBD 500,000.

The CTB will consist of the Permanent Secretary, Ministry of Finance & Treasury, who acts as Chair; and three (3) senior public officers appointed by the Chair (FI 6.3.23(1)). The CTB is responsible for deciding if there will be a **competitive tender** for the purchase or if a competitive tender process should be set aside and a restricted tender called in cases where the estimated cost of a procurement action is greater than SBD 500,000. (FI 6.3.23(3)).

Where the decision is to call a competitive tender the Central Tender Board will instruct the Procurement Unit of the MOH to:

- advertise the tender or issue the invitations to bid,
- issue the tender documents,
- receive the tenders,

- open the tenders,
- keep full records of all original tender documents submitted to it,
- form a Tender Evaluation Committee (TEC) and consider the recommendations of the TEC

On completion of the tender evaluation the Procurement Unit of the MOH will submit a summary Bid Evaluation Report, incorporating the TEC evaluation report, to the CTB with a recommendation to award the tender to the successful supplier / contractor. The decision to award will rest with the CTB. At the same time the Procurement Unit of the MOH will submit a draft contract for CTB review. The CTB will instruct the Procurement Unit of MOH to enter into a contract with the approved supplier / contractor. Signatory to the contract on behalf of the Government will be the Chair of the CTB, who will appoint/delegate a superintendent of works. Contract Administration will be the responsibility of the Procurement Unit MOH

Where the decision is to proceed with a **restricted tender** the Central Tender Board will record all reasons for a restricted tender in the Board Minutes and instruct the Procurement Unit of the MOH to:

- ensure that a minimum of three (3) suppliers / contractors are invited to bid
- identify all suppliers / contractors who will be invited to give written bids
- issue the invitations to bid
- open all bids
- form a Tender Evaluation Committee (TEC) consider the recommendations of the TEC

On completion of the tender evaluation the Procurement Unit of the MOH will submit a summary Bid Evaluation Report, incorporating the TEC evaluation report, to the CTB with a recommendation to award the tender to the successful supplier / contractor. The decision to award will rest with the CTB. At the same time the Procurement Unit of the MOH will submit a draft contract for CTB review. The CTB will instruct the Procurement Unit of MOH to enter into a contract with the approved supplier / contractor. Signatory to the contract on behalf of the Government will be the Permanent Secretary MOH. Contract Administration will be the responsibility of the Procurement Unit MOH

In the case of **both** competitive tender & restricted tender the MOH Procurement Unit will: keep all tenders and bids in a locked box in the MOH; tenders and bids will be opened in front of the a meeting of all members of the Ministerial Tender Board (MTB), immediately on close of bidding / tender; the bid opening will be open to the public including representatives of the suppliers / contractors who have submitted bids / tenders; and. minutes for the bid opening will be maintained by the MTB secretary and signed by members of the public and/or representatives of the suppliers / contractors present. The MTB secretary will date and number each bid / tender as it is opened and announce to the meeting

- the number of the tender / bid
- the name of the supplier / contractor
- the amount of the tender / bid
- any special conditions attached to the tender / bid

3.2.3 Ministerial Tender Board

The MTB is responsible for procurement with an estimated value of greater than SBD 50,000 but less than SBD 500,000.

The MTB will consist of the MOH Procurement & Inventory Manager, who acts as Chair; the MOH Procurement Officer, the MOH Finance Officer and one other public officer appointed by the MOH Permanent Secretary. The MTB is responsible for deciding if there will be a competitive tender for the purchase or if a competitive tender process should be set aside and a restricted tender called in cases where the estimated cost of a procurement action is greater than SBD 50,000 but less than SBD 500,000. (FI 6.3.22(3)).

Where the decision is to call a **competitive tender** the MTB will instruct the Procurement Unit of the MOH to:

- advertise the tender or issues the invitations to bid,
- issue the tender documents,
- receive the tenders,
- open the tenders,
- keep full records of all original tender documents submitted to it,
- consider the recommendations of the Tender Evaluation Committee (TEC) and
- award the tender to the successful supplier / contractor.

Where the decision is to proceed with a **restricted tender** the MTB will instruct the Procurement Unit of the MOH to:

- record all reasons for a restricted tender in the Board Minutes
- ensure that a minimum of three (3) suppliers / contractors are invited to bid
- identify all suppliers / contractors who will be invited to give written bids
- issue the invitations to bid
- open all bids
- consider the recommendations of the TEC and
- award the tender to the successful supplier / contractor.

In the case of **both** competitive tender & restricted tender:

- keep all tenders and bids in a locked box in the MOH Procurement Office,
- tenders and bids will be opened in front of the a meeting of all members of the MTB, immediately on close of bidding / tender;
- the bid opening will be open to the public including representatives of the suppliers / contractors who have submitted bids / tenders and minutes for the bid opening will be maintained by the MTB secretary and signed by members of the public and/or representatives of the suppliers / contractors present

The MTB secretary will date and number each bid / tender as it is opened and announce to the meeting: the number of the tender / bid; the name of the supplier / contractor; the amount of the tender / bid; and, any special conditions attached to the tender / bid.

3.2.4 Tender Evaluation Committee

The TEC is a small team of specialists from the Ministry of Health which evaluates tenders. The membership of the TEC is recommended by the MOH Procurement Unit and approved by the MOH Permanent Secretary.

The membership of the TEC may be different for each contract depending on the nature of the procurement. The Financial Instructions allow for the TEC to consist of one technical officer only. However, it is advisable that the TEC consist of at least two members. (6.3.28 (1)). At least one technical officer should be one of those involved in the preparation of the bidding documents. If designs, specifications or other technical documents have been prepared by a consultancy, such as design engineer, then a member of the consultancy should be a member of the TEC.

The role of the TEC is to carry out the tender evaluation in accordance with Financial Instructions using the processes outlined in this Manual. In a practical sense, this requires the TEC to evaluate tenders according to the requirements of the bidding documents and previously defined selection criteria. The formats of the Bid Evaluation Reports (BERs) for different types of procurement are attached as annexes.

The TEC must submit a written report to the MTB providing a score for each of the selection criteria outlined in the bidding documents and at a minimum this BER must address the following:

- an assessment of a reasonable cost for the goods / works or assignment
- an assessment of the technical competence of each bidder / tenderer to carry out the work / provide the goods / undertake the assignment
- an assessment each bidder / tenderers' ability to complete the work / assignment/ deliver the goods, on time and within the quoted price,
- an assessment of each bidder / tenderers' previous performance,
- an assessment of each bidder / tenderers' compliance with the bidding documents

3.2.5 MOH Procurement Unit

The Unit will be comprised of a Procurement & Inventory Manager (Under Secretary Adminstration), Procurement Officer, and Assets Management/National Health Facilities Manager. The Procurement Unit will be closely aligned with the National Medical Stores Manager, the Internal Audit Officer and the Finance Section.

The key role of the Unit is to provide a focal point for MOH procurement, specifically:

- develop a consolidated annual procurement plan for the MOH based on the annual operation plans developed by Provinces and MOH Divisions and, in consultation with the MOH Infrastructure Committee, plan for the procurement of works
- assist the MOH Infrastructure Committee and MOH Divisions develop and refine (a) specifications and bills of quantity for the procurement of works, (2) detailed specifications for the purchase of goods and equipment and (3) terms of reference for technical assistance assignments
- identify where additional technical expertise will be required to develop the bills of quantity, specifications and / or terms of reference, arrange recruitment of that expertise and manage the contracts of these short-term inputs
- assist the MOH Infrastructure Committee and MOH Divisions develop and refine bid documents for specific procurement actions identify where additional technical expertise may be required complete bid documents, arrange

recruitment of that expertise and manage the contracts of these short-term inputs
- recommend appropriate staff to form the TEC and establish TECs after approval of the staffing recommendation by the MOH Permanent Secretary
- act as the communication link between the CTB, MTB and TECs
- under direction of the CTB and MTB conduct procurement actions
- maintain procurement files for all procurement actions,
- coordinate the establishment, development and maintenance of an asset register for MOH, and
- prepare a consolidated annual report for the MOH and all donor organisations associated with the MOH covering acquisitions during the previous twelve months by source of budget, by MOH Division, by hospital and by Province.

To facilitate the efficient use of procurement methods for small value items the Procurement Unit should also:

Establish a Register (List) of Potential Suppliers, Contractors and Consultants, if such a register does not already exist. Information about their experience, staff, references, financial situation should be collected either through personal contacts with them or through mail. This information should be evaluated using a simple common benchmark (for example, years of experience, number and quality of its staff (engineers, accountants, surveyors, etc.), and references (i.e., the contact information of the firm's recent clients), and the annual turnover, etc. The firms that meet the minimum requirements should be listed.

Create a Unit Price Reference Register. Information on unit prices for goods, works and services required in the grant funded project area should be collected. This information can be collected through direct contacts with local shopkeepers, contractors and consultants (mostly individual experts) as well as their clients. This information should be placed on a register which may be a simple exercise book used when conducting purchases with small grant funds. This is a task for the selected beneficiary which may also seek assistance from the project implementation agency. This Reference Register should be updated every six months.

3.2.6 MOH Infrastructure Committee

Core Members
(Min 2 of below)

Under Secretary of Administration (Chair)
National Health Facilities Manager (NHFM)
Director of Policy & Planning
Chief Accountant

Other Member
(+ Min 2 of below)

Permanent Secretary
Permanent Secretary Special Duties
Under Secretary of Health Improvement
Under Secretary of Health Care

Part-Time Member, (Where appropriate)
Representative of National Referral Hospital Executive
Representative of Provincial Health Services
Representative of National Division
Infrastructure Adviser

The core function of the Infrastructure Committee (IC) is as a decision making body that has input into health infrastructure management. The goal is also to stimulate discussion between different areas within the MOH for both individual projects & wider

infrastructure issues. It is also a forum for discussion of infrastructure policy, planning, project appraisals as well as the monitoring & evaluation of asset management & civil works in progress. An important function of the committee is to co-ordinate infrastructure work between the provinces, divisions, headquarters, donors, communities and other government agencies. Project Appraisals are prepared by the National Health Facilities Manager and Director of Policy & Planning. It is now MOH policy that all infrastructure work be submitted to the NHFM before approval. The MOH Infrastructure Plan 2007-2008 is at **Annex 5**.

The responsibility of the IC is to approve actions and make recommendations and summaries to the MOH Executive for:

Project Appraisals
Project Approvals
Establishment of New Clinics
- Civil Works to existing facilities
- Project Progress Updates

Policy & Planning Endorsement & Appraisal
Approval for use of funds
Certification for payment of invoices

The role of the NHFM is to pre-appraise each project before each committee meeting & present in respect to the following criteria; Budgets/Costs, Design & Quality, Planning, Standards, Policies & Guidelines, Time Frame, Accountability & Transparency, Co-ordination with other activity

The following is a brief list of the standards & guidelines endorsed and put into effect by the IC:

- MOH Policy, Standards & Guidelines
    - Policy Governing Establishment of a new health facility (clinics & hospitals) in Solomon Islands
    - Guideline for Repair & Renovation of a existing health facility (in progress)
    - Minimum Standard for Clinic Infrastructure
    - Guideline for donating medical equipment
    - Guideline for disposal of surplus equipment
- Goals of MOH Strategic Health Plan
- Goals of MOH Strategic Infrastructure Plan
- Goals of Individual Divisions & Provinces Operational Plans
- SIG Financial Instructions

3.3 Summary Table of Roles and Responsibilities for Procurement

Role / Task	Central Tender Board	Ministerial Tender Board	Technical Evaluation Committee	MOH Procurement Unit	MOH Infrastructure Committee	MOH Division or Province
Establish need for Works or Goods or TA						√(in annual planning process & subject to budget approval)
Develop procurement strategy					√	
Approval to tender and advertising means > SBD 500,000	√					
Approval to tender and advertising means SBD 50,000<X< SBD 500,000		√				
Develop specification and bidding documents			√ (provide advice on request)	√(ensuring end user agree with specifications)		√ (providing comments as end users)
Approve form of contract	√					
Develop selection criteria			√ (provide advice on request)	√(ensuring end user agree technical criteria)		√ (providing comments as end users)
Advertise				√		
Issue bidding documents				√(ensuring end user agree with specs & special conditions)		√(providing comments as end users)
Receive tenders				√		
Open tenders				√		
Evaluate tenders			√(ensuring the end users are involved)			√(providing comments as end users)
Raise local purchase order				√(in consultation with the Finance Officer & Infrastructure Committee)		
Recommend preferred tenderer to Board				√		
Consider recommendation and award tender > SBD 500,000	√					
Consider recommendation and award tender SBD 50,000<X< SBD 500,000		√				
Execute contract				√		
Enter in Contracts Register				√		
Implement contract				√		
Approve any variations up to 10%				√(in consultation with the Finance Officer & Infrastructure Committee)	√	
Approve any variations over 10% > SBD 500,000	√				√ (provide advice on request)	
Approve any variations over 10% SBD 50,000<X< SBD 500,000		√			√ (provide advice on request)	
Post implementation review > SBD 500,000	√				√ (provide advice on request)	
Post implementation review SBD 50,000<X< SBD 500,000		√			√ (provide advice on request)	

3.4 Procurement of Pharmaceuticals in 2007

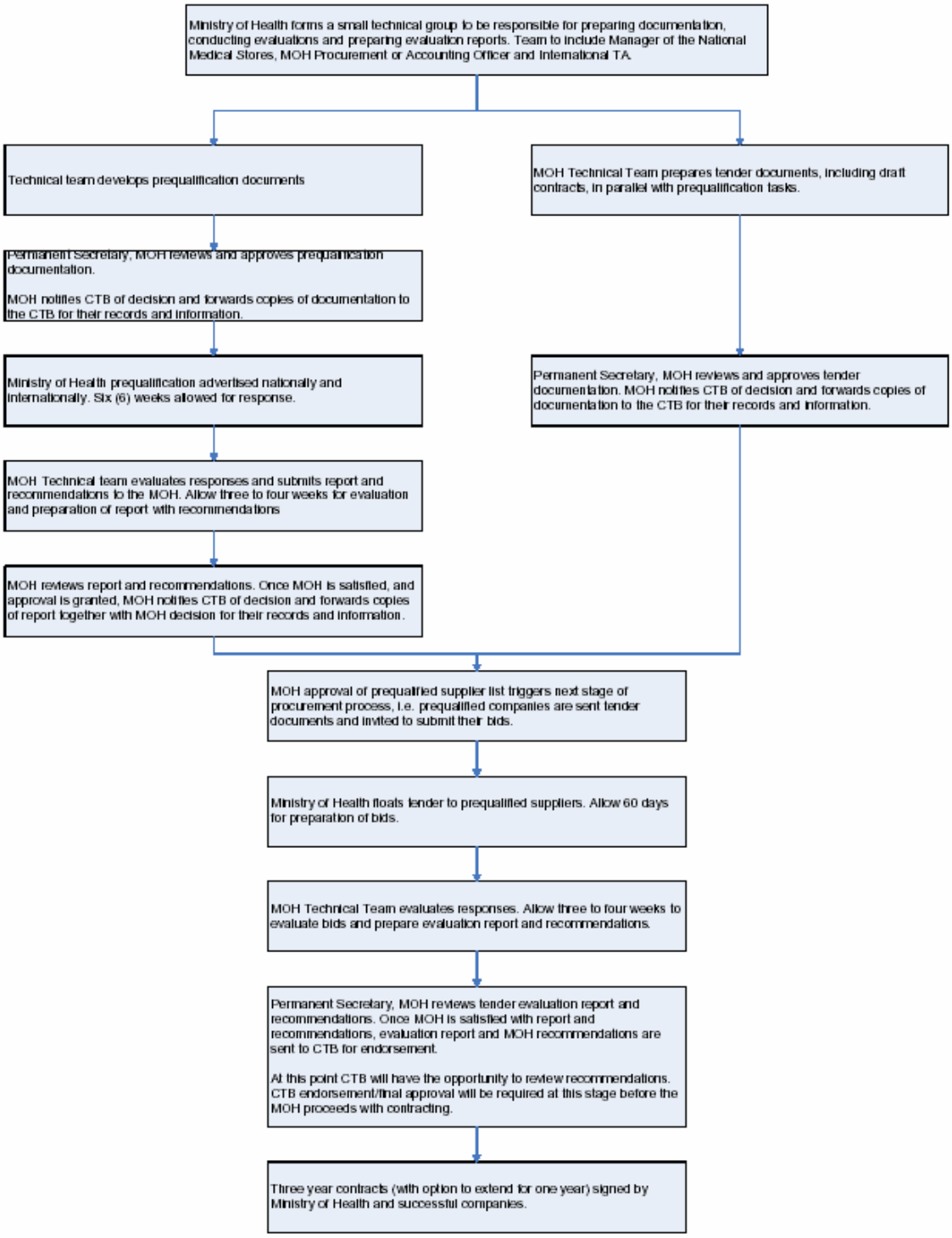
Procurement of pharmaceuticals and medical supplies within the MOH is the responsibility of the National Medical Stores (NMS). In order to achieve the best possible results in terms of quality, price and service for the public health system it will be necessary that procurements for pharmaceuticals and medical supplies follow an International Competitive Bidding (ICB) process.

At the same time, however, the demands of a tight timetable for the first SWAp procurement also have to be borne in mind. The current financing mechanism for purchasing health supplies, the AusAID-financed HSTA, ends in early August 2007. It is therefore vital that contracts arising from the first SWAp procurement, and associated payment mechanisms, are in place prior to HSTA ending so as to ensure continuity of supply.

The demands of completing an ICB within a tight timeframe, however, make it unrealistic to both manage the procurement and conduct significant institutional strengthening simultaneously. In recognition of these constraints, the first SWAp procurement is being conducted with a view to awarding multi-year contracts with suppliers. This will not only avert the necessity of having to repeat the process almost immediately the first one was completed, but would also create the opportunity for reviewing and strengthening SIG procurement systems so that subsequent procurements can be managed within those systems.

The well elaborated World Bank documentation has formed the basis for the MOH tender with suitable adaptations as required. This documentation meets the requirements of SIG and provides a solid platform on which to proceed. The approval of the MOH Accounting Officer is sought at each key point in the process and will be the trigger to take the process to each successive stage. The Central Tender Board will be notified by the MOH on the status at appropriate intervals with final approval of MOH recommendations for tender contract awards being requested of the Central Tender Board by the MOH. A schematic presentation of the procurement process for pharmaceuticals and medical supplies is outlined below.

Procurement process for pharmaceuticals and medical supplies, 2007



3.5 The Prevention of Fraud and Corruption

There are three areas of concern within government procurement which are either illegal or should be avoided: corruption, fraud, and conflict of interest.

3.4.1 Corruption

Corruption is defined as the abuse of power by politicians or civil servants for personal gain or for the benefit of a group. It is motivated by greed for money or power.

Examples of corruption within government procurement which can occur are:

- a politician placing pressure on public servants to award a contract to a wantok;
- a public officer receiving or demanding money (extortion) or gifts from a contractor in return for preferential treatment or an award of a contract;
- procurement staff writing tender documents which are biased so as to award a contract to a particular contractor; and
- avoiding a proper evaluation process so as to award a contract to a particular contractor.

Politicians, public officers and contractors dealing in corruption can receive harsh penalties. For example, any public officer who corruptly asks for, solicits, receives or obtains any property or benefit of any kind for himself or any other person can be imprisoned for up to seven years. Similarly, contractors dealing in corrupt activities can be imprisoned for up to seven years. Details of offences and penalties are contained in the Penal Code, *Part X Corruption and the Abuse of Office* and *Part XXXVIII Secret Commissions and Corrupt Practices*. Politicians are subject to both the Penal Code and the Leadership Code.

The effects of corruption are clear - corruption deprives communities of needy services and infrastructure.

3.4.2 Fraudulent Activities

Fraudulent practices are those which misrepresent facts in order to influence the procurement process or the execution of a contract to the detriment of the MID. Examples include:

- tenderers making arrangements amongst themselves about tender prices,
- contractors and public officers working together to give one contractor an advantage over others, and
- tenderers submitting tenders without the intention to proceed on the contract.

These practices are inconsistent with the establishment and maintenance of the ethical business practices which must underlie good working relationships between the MOH and any contractors, subcontractors, consultants and suppliers seeking to do business with the MOH.

These practices have both direct and indirect adverse impacts on the cost of government projects. They include: direct costs through the inclusion of allowances for unsuccessful tenders in tender prices and special fees; and, indirect costs through reduced effectiveness of the competitive tendering process.

MOH staff need to ensure, to the maximum extent possible, that collusive practices do not occur. They can do this by:

- clearly specifying their requirements in the tender documents;
- determining an accurate cost estimate for all contracts;
- building a history of contractors by maintaining good records of all tenders for all contracts, the performance of contractors in the tendering process and the performance of contractors in the execution of contracts; and,
- making contractors and suppliers aware that if they engage collusive tendering practices they can excluded from future contracts.

3.4.3 Conflict of Interest

A conflict of interest arises where the private interest of a public officer involved in procurement:

- conflicts, or
- might reasonably be thought to conflict, or
- have the potential to conflict,
- with the duties of the person as a member of an evaluation committee, or as a head of a Division, or other relevant position, signing off on a recommendation report in relation to a procurement.

A conflict of interest may occur if a public officer involved with the tendering process or contract implementation has some direct or indirect relationship with a tenderer or contractor awarded a contract.

Conflicts of interest may result in allegations of corruption which attract harsh penalties if the allegations are found to be correct. Public officers should be aware that a conflict of interest could lead to prosecution under Section 94 of the Penal Code which carries a maximum penalty of one year imprisonment.

Therefore, a MOH officer who finds themselves in a conflict of interest situation in relation to a MOH purchase:

- **must** disclose the nature of their interest to the Permanent Secretary, and
- **must not** take part in any evaluation or deliberations in respect of the contract, and
- **must not** take part in any recommendation in respect of the contract, and
- **must not** be involved in the administration of the contract, and
- **must not** attempt to influence others involved in such tasks.

In order to ensure efficient use of procurement methods for small value items , the MOH Procurement Unit should take the following steps: Establish a Register (List) of Potential Suppliers, Contractors and Consultants, if such a register does not already exist. Information about their experience, staff, references, financial situation should be collected either through personal contacts with them or through mail. This information should be evaluated using a simple common benchmark (for example, years of experience, number and quality of its staff (engineers, accountants, surveyors, etc.), and references (i.e., the contact information of the firm's recent clients), and the annual turnover, etc. The firms that meet the minimum requirements should be listed. Create a Unit Price Reference Register. Information on unit prices for goods, works and services required in the grant funded project area should be collected. This information can be collected through direct contacts with local shopkeepers, contractors and consultants (mostly individual experts) as well as their clients. This information should be placed on

a register which may be a simple exercise book used when conducting purchases with small grant funds. This is a task for the selected beneficiary which may also seek assistance from the project implementation agency. This Reference Register should be updated every six months.

4 MONITORING AND EVALUATION

The Health Information System (HIS) redevelopment is at the pilot stage. Twenty sites are involved in the pilot across three provinces – Choiseul, Malaita and Guadalcanal – encompassing AHC, RHC, NAP, and two hospital sites. The HIS has been redesigned, as much as possible, to report against the NHSP and international indicators. It articulates with, but does not replace the Solomon Islands malaria information system (SIMIS) dataset and aims to make it easier to report relevant data side by side for trend analysis. There is limited overlap with the Reproductive health surveillance system (RHSS). Within the HIS, not all fields are disaggregated by sex: non-communicable diseases, malaria and mental health are analysed by gender. Data is not disaggregated by socio-economic group; information to this level is not currently nor routinely available in Solomon Islands. The HSSP will support improved data collection; in addition addressing the systematic identification and focusing upon the poorest and most vulnerable.

4.1 Performance Framework

4.1.1 Use of Outcome Indicators

The indicators are a select subset that will show some of the results of improvement in the delivery of and access to improved health services. Indicators will be reviewed at the Annual Reviews; based on the findings, the strategies to achieve stated targets would be continued or modified. Lack of progress will result in recommended modifications to the sector program strategy and/or analysis to understand relationship between the sector program strategy and the outcomes. Annual Reviews will be 'learning events' and contribute to the on-going refinement of the sector program and its operational planning process.

4.1.2 Use of Performance Monitoring

Progress will be assessed by government and development partners at the Annual Reviews (based on most recently available data). Lack of anticipated progress will result in analysis of obstacles to implementation and reconsideration of assumed linkages between inputs/processes and outcomes. Low levels of participation and coverage may indicate lack of appropriate inputs, poor management or both. Slower progress may indicate lack of community and/or institutional support, the need for additional technical support, and weak capacity at local levels. Lack of progress may mean weak MOH commitment to the institutional strengthening; to be addressed through constant dialogue.

Detailed indicators for each intervention will be monitored at the national level through the National Program Managers and at the provincial level through the Provincial Health Directors. Performance monitoring will also input the program monitoring and redirection through the program review process, providing evidence-base for the development of sector priorities and the national and provincial operational plans. These plans are developed by each national program, national division and provincial health department.

Furthermore, the HSSP will support the MOH introduce 'learning events' for health program monitoring and evaluation. Representatives from the national programs and provincial health officers will participate in quarterly workshops to review and discuss the results emerging from the monitoring system. These workshops provide the

opportunity from an operational viewpoint that MOH staff can (a) learn about other program areas other than their own and the 'cross-implications' of results from other areas; (b) learn how to 'read' data; (c) jointly make decisions about changes in emphasis or approach based on results; and, (d) modify indicators or targets if they prove to be unsatisfactory in any way.

4.2 Key Performance Indicators and the Results Framework

PDO and High level goals	Program Impact / Outcome Indicators	Frequency and Reports	Data Collection Instruments	Responsibility for Data Collection
PDO: To support the SIG in achieving improvements in priority health outcomes for the population through effective, efficient, and equitable services responsive to the population's needs. High level goals: Contribute to reducing child mortality Contribute to reducing maternal mortality Contribute to reversing the incidence of HIV/AIDS, malaria and other major diseases Mitigate the effects of HIV/AIDS	Infant mortality rate	Annual Census 2009	HIS RHSS	MOH Statistics Unit Reproductive and Child Health Division
	Under five mortality rate	Annual Census 2009	HIS RHSS	MOH Statistics Unit Reproductive and Child Health Division
	Maternal mortality ratio	Annual Census 2009	Survey	MOH Statistics Unit Reproductive and Child Health Division
	Prevalence and mortality rates associated with malaria	Annual	SIMIS HIS	VBDCP MOH Statistics Unit
	Prevalence of HIV among risk populations	Annual	Survey HIS	MOH Statistics Unit
	HIV/AIDS mortality	Annual	HIS	MOH Statistics Unit
	Prevalence and mortality rates associated with other major diseases	Annual	HIS	MOH Statistics Unit

Immediate goals by Strategic Area	Program Impact / Outcome Indicators	Frequency and Reports	Data Collection Instruments	Responsibility for Data Collection
Strategic Area 1: People focus – Province specific and National levels				
▪ Increased community participation in health services ▪ Increased health staff focus on community behavioural change interventions and outreach activities ▪ Revised strategy and guidelines for community health promotion and trained	Number of village health committees established and operational	Annual reports	HIS	Provincial Health Divisions National Programs
	Number of healthy setting activities conducted in collaboration with NGOs, CBOs, and churches	Annual reports	NGO, CBO, church reports Partnership meetings	Provincial Health Divisions National Programs
	Number of skilled health workers/health facilities active in community health promotion activities.	Annual reports	HIS	Provincial Health Divisions National Programs
	Number of appropriate service packages are implemented at community level by health facilities	Annual reports	HIS	Provincial Health Divisions National Programs

provincial health staff ▪ Strengthened support from the Health Promotion Unit to integrated health promotion activities in the divisions and provinces				
Immediate goals by Strategic Areas 2-7				
▪ Build the capacity to respond to high burden diseases ▪ Strengthen technical quality and service delivery of priority health programs ▪ Build health systems capacity to reduce vulnerability to HIV/AIDS ▪ Improve access to basic health services, especially those addressing priority diseases and the needs of women and children				
Strategic Area 2: Public Health programs – Province specific and National levels				
	Tuberculosis control			
	Treatment success rate (cure rate)	Annual	HIS	TB control program
	Case detection rates	Annual	HIS	TB control program
	Capacity building indicators for TB program?			
	Community involvement indicators?			
Strategic Area 3: Malaria – Province specific and National levels				
	Access to reliable diagnostic testing and correct antimalarial treatment according to national guidelines	Annual report	Survey SIMIS HIS	VBDCP
	Percentage of pregnant women attending antenatal care	Annual	SIMIS HIS	VBDCP MOH Statistics Unit

	in a health facility who receive a LLIN			
	Percentage of households with at least one LLIN	Annual report	Survey SIMIS HIS Census (2009)	VBDCP MOH Statistics Unit
	Proportion of children under 5 years old who slept under a LLIN the night before	Annual report	Survey SIMIS HIS	VBDCP MOH Statistics Unit
	Percentage of pregnant women and infants receiving IPT	Annual report	HIS SIMIS	MOH Statistics Unit VBDCP
	Capacity building indicators for malaria program? If not captured by the % of pop with access…(above)			VBDCP
	Community involvement indicators?			
Strategic Area 4: Common Childhood diseases– Province specific and National levels				
	Incidence of common childhood illnesses in infants and children (ARI, diarrhoeal disease, malaria, skin and vaccine preventable illnesses - neonatal tetanus, tetanus, whooping cough, polio, measles)	Annual	HIS RHSS	Provincial Health Divisions Reproductive and Child Health Division
	Coverage of selected preventive and treatment interventions on diarrhoea, pneumonia and malnutrition		HIS RHSS	Provincial Health Divisions Reproductive and Child Health Division
	Improved family knowledge of common childhood infections and the importance of prevention and seeking early care	Annual	HIS Survey	Provincial Health Divisions Reproductive and Child Health Division
	Percentage of children with cough or fever who are taken to a health facility	Annual	HIS Survey	Provincial Health Divisions Reproductive and Child Health Division
	Percentage of villages implementing community based IMCI	Annual	Survey HIS	Provincial Health Divisions Reproductive and Child Health Division
	Percentage of underweight and/or malnourished children under five years of age	Annual	HIS	Nutrition Reproductive and Child Health Division
	Percentage of children immunized	Annual	RHSS EPI survey	Reproductive and Child Health Division

			HIS	
	Proportion of children aged 12 months immunized against measles	Annual	HIS EPI survey	Provincial Health Divisions Reproductive and Child Health Division
	Percentage of children 12-23 months who have received DPT3 immunisations		HIS EPI survey	Provincial Health Divisions Reproductive and Child Health Division
	Indicators for social networks and multi-sectoral collaboration?			Provincial Health Divisions Reproductive and Child Health Division
	Capacity indicators on paediatric care?			Provincial Health Divisions Reproductive and Child Health Division
Strategic Area 5: Non-communicable diseases– Province specific and National levels				
	Knowledge and practice indicators for risk factors for diabetes and hypertension (obesity, physical exercise, tobacco use) in sentinel surveys – percentage of population understanding main risk factors	Bi-annual	Survey	Non-communicable diseases Division
	Availability of diabetes diagnostic services in clinics in high prevalence areas	Annual	HIS Diabetes registration system	Non-communicable diseases Division
	Number of health facilities providing improved services for diabetic and hypertension clients	Annual	HIS	Non-communicable diseases Division
	Communities with 'healthy settings' approach incorporating risk factors for diabetes and hypertension	Annual	Survey	Non-communicable diseases Division
	Indicators for inter-sectoral collaboration and networks?			Non-communicable diseases Division
Strategic Area 6: HIV/AIDS and Sexually transmitted infections– Province specific and National levels				
	Condom use at last high risk sexual contact	Bi-annual	BSS	HIV and STI Division Reproductive and Child Health Division
	Percentage of women and men aged 15-24 years reporting the use of a condom the last time they had sex	Bi-annual	BSS	HIV and STI Division
	Number of surveillance rounds undertaken and disseminated in country	Bi-annual	HIS – VCCT and laboratory-based	Reproductive and Child Health Division
	Knowledge of HIV-related prevention practices (proportion of survey respondents who correctly identify all three major ways of preventing sexual transmission of	Bi-annual	HIS – VCCT monitor program and laboratory	HIV and STI Division

	HIV, and who also reject three major misconceptions about HIV transmission or prevention)			
	Availability of VCCT to high risk groups	Annual	HIS – VCCT monitor program and laboratory	Reproductive and Child Health Division
	Number of new STI cases	Annual	HIS Laboratory –based notification	HIV and STI Division
	Number of identified at risk groups with active STI/HIV prevention campaigns	Annual	Provincial reports	Reproductive and Child Health Division
	Number of health facilities implementing syndromic treatment	Annual	RHSS/HIS	HIV and STI Division
	Seroprevalence in antenatal clinic tracking surveys	Annual	RHSS	Reproductive and Child Health Division
	Capacity indicators on skilled health workers			HIV and STI Division
	Capacity indicators for inter-institutional			Reproductive and Child Health Division
Strategic Area 7: Family Planning and Reproductive health– Province specific and National levels				
	Percentage of births attended by skilled health workers (excluding traditional birth attendants)	Annual	RHSS	Reproductive and Child Health Division
	Contraceptive prevalence rate (women of child bearing age using family planning)	Annual	RHSS HIS	Reproductive and Child Health Division
	Teenage pregnancy rate (number of deliveries to adolescents 10-19 years)	Annual	HIS RHSS	MOH Statistics Unit Reproductive and Child Health Division
	Number of and adolescents' use of appropriate 'youth friendly' health services	Annual	Survey	Reproductive and Child Health Division
	Capacity building indicators for strengthened delivery of quality reproductive health and family planning services?			
	Nutrition indicators (e.g., prevalence of micronutrient deficiencies)			
Strategic Area 8: Health systems strengthening – Province specific and National levels				
▪ Strengthened capacity of the national and provincial authorities in planning and budgeting, accounting, management, and monitoring of operational plan implementation and expenditures.	Budget execution and implementation rate of annual operational plans by province.	Annual	Operational plans Audit report MTEF	Policy and Planning Division
	Human resources policy and plan reviewed	Annual	WinHR database	HR division

▪ Improved health care staff management, planning and allocation, skills, and performance in alignment with priorities. ▪ Strengthened capacity of the national and provincial authorities in procurement, supply chain and warehouse management ▪ Strengthened health infrastructure planning, refurbishment and development, and equipment provision and maintenance which corresponds to local needs.	and recommendations implemented.		WISN Workforce Indicators of Staffing Needs	National Training Unit
	National Medical Stores and provincial facilities meeting standard operational procedures	Annual	NMS report	NMS
	Facilities meeting minimum standards for infrastructure and equipment.	Annual	Infrastructure report Infrastructure equipment and assets report	Infrastructure Committee Procurement Unit
	Analysis and planning capacity that supports progress towards sustainable financing and adequate human resources	Annual	Workforce planning and financial reports	Finance Division National Policy and Planning Division
	Percentage of population with continuous, sustainable access to affordable essential drugs	Annual	HIS NMS reports	NMS
	Functioning and efficient health information system	Quarterly	HIS	MOH Statistics Unit National Policy and Planning Division
	Percentage of public expenditures on primary health care and public health programs in the provinces / ?increased public expenditures on provincial health services	Annual	Operational Plans Budget MTEF	National Policy and Planning Division Finance Division
	Percentage of facilities reporting stock-outs of essential drugs / reporting no disruption of stock for more than one week during the previous three months	Quarterly	Facility reports	NMS
	Utilization rate of primary health care facilities (by sex, age:) Number of clients accessing and utilizing services	Annual	HIS	Provincial Health Divisions

5 RISK MANAGEMENT

5.1 Key constraints and policy options

5.1.1 External constraints

There are many constraints to achieving rapid progress in the NHSP strategic areas. Some important constraints have origins outside of the health sector and are largely beyond the control of the health sector (or are only marginally susceptible to influence by health policy). In some cases these "external" constraints can be addressed by other sectors, but in other cases they have to be recognized as challenges that are likely to confront the health sector for some time to come. Important "external" constraints are shown in the following Box:

External constraints to the health sector:

1. Political instability
2. Poor education, including high rates of illiteracy
3. The unequal social position of women
4. Widespread perception of practicing favouritism, including the wantok system
5. Rapid population growth
6. Weak administrative capacity
7. Slow economic growth and limited fiscal resources
8. A tropical climate that is conducive to the endemnicity of parasitic diseases
9. Small population size and low population density in some areas
10. Remote rural areas, some of which are difficult to reach

Although the origin of all of these constraints is external to the health sector, health policy should certainly contribute to lessening these constraints whenever possible. For example, as recognized in the NHSP, the public health system should conduct itself in a way that lessens ethnic tensions and helps to control corruption, including the wantok system. In order to contribute to improved educational outcomes over time, which is a critical element in improving health outcomes as well as promoting overall economic and social development, health policy should give special consideration to interventions that can improve school attendance and educational outcomes.

Health policy can certainly make a significant contribution over time in reducing Solomon Islands high rate of population growth (for example, improving the accessibility and quality of family planning services as well as strengthening related information, education and communications services). Doing so will directly benefit health outcomes (for example, reducing maternal mortality), reduce the cost of providing maternal and child health care, and contribute to overall economic development. Improved access to reproductive health services can also help to enhance the status of women. In addition, the health sector can leverage its substantial donor funding to introduce improved administrative practices (such as output-based budgeting and contracting out services) that can serve as positive examples for the entire government. Community organisation through the health sector can address non-formal education through raising awareness of health issues and of both an individual and the health care worker's responsibilities to supporting healthy outcomes.

Although there are numerous external constraints to achieving rapid progress in the priority areas, there are also a few "external" factors that may make it easier make some rapid progress in these priority areas, including:

- The health sector is currently receiving very substantial donor assistance that is expected to continue during the next several years
- The Solomon Islands are geographically compact compared to many other Pacific Island countries (i.e., the distances between major islands are not great in most cases)
- The population is relatively large, compared to many other Pacific Island countries

5.1.2 Internal constraints

Despite the obvious importance of external constraints, many additional constraints to achieving rapid progress in priority areas have their origins within the health sector (i.e., are "internal constraints"), and are detailed in the following Box:

Internal constraints to the health sector:

1. Lack of "fiscal space" in the health budget and resource allocation that is insufficiently focused on the priority areas
2. The population's health-seeking behavior (e.g., risky behaviour in some areas)
3. The population's beliefs about disease and their health care-seeking behaviour
4. Poor technical quality of health services
5. Insufficient attention to demand-side factors
6. Underdeveloped and poorly utilised information systems
7. Poor condition of the existing health infrastructure
8. Poor management within the public health system
9. Ineffective planning and budgeting practices
10. Problems in attracting and retaining key medical staff and ineffective human resources management

5.2 Internal Constraints and Policy Options

The following Table identifies a range of policy options that may be considered as possible interventions to address these "internal constraints". The MOH is currently in the process of addressing some of these issues; others will be supported through the HSSP.

Internal Constraints	Policy Option	Comments	Action commenced to address options
1.To increase "fiscal space"	(i) reduce the cost of existing activities and shifting the resources saved to the priority areas	Secure cost savings: by adjusting the MOH payroll based on a physical audit of all staff and facilities. Significant savings could also be obtained from improved procurement procedures and inventory control, particularly for pharmaceuticals and medical supplies, medical equipment, catering in hospitals, housing rental and provision, office supplies, travel, and civil works, as well as prevention of theft.	Yes NMS reforms and Tender process NRH reforms
	(ii) by reducing public funding in some areas and shifting the resources to the priority areas,	Potential improvements from improving expenditure allocations between the provinces and the centre and between programs, linking expenditure to indicators of population health need and the defined priority health outcomes, and seeking out savings in pharmaceuticals and hospital care to reallocate to public and primary health functions	Yes Annual sector expenditure plan process
	(iii) by mobilizing additional domestic resources.	Options to mobilize additional domestic resources sustainably[77] include: (1) expanded reliance on user fees, (2) health insurance, and (3) earmarked (health-related) taxes, for example, on tobacco products or alcoholic beverages.	No
2. To improve the population's health-seeking behavior	(i) health promotion, (ii) taxes and subsidies, and (iii) increasing the private cost of health care.	Examples of significant SI health risks include an estimated smoking prevalence of about 50%, widespread use of betel nuts, low reported condom use and high rates of obesity. There are many potential weaknesses of health promotion as an option in SI: (a), there are limited channels for disseminating information to the SI population. Illiteracy rates are still high, newspaper and television coverage is limited, and ownership of radios is far from universal. One important potential channel for health information is the school system. (b) education levels are still very low in SI. (c) effective health promotion can be a very challenging activity: efforts to retrain health workers in these areas are not always effective.	Yes - partial
		Taxes (for example, tobacco taxes) have been convincingly shown to be effective measures to reduce consumption of the taxed commodity. Subsidizing healthy behavior (for example, subsidized recreation facilities or subsidized school lunches) is also likely to have a positive impact on health-seeking behavior. Subsidies (unlike taxes) require a sustainable source of financing, which is not always available.	No

[77] At least theoretically, additional resources could be obtained by increasing the flow of donor resources to the health sector. However, the high current dependency on donor financing in the health sector is a constraint to this approach. Another theoretical possibility would be to increase the share of the SIG budget allocated to health. However, this is already fairly high (at 14% of the total budget), and it would be difficult to make a strong case for additional funding without being able to demonstrate that the existing resources are being used as effectively and efficiently as possible (which is not the case currently).

3. to improve the population's beliefs about disease and their health-care seeking behavior	(i) health education, (ii) integrating western and traditional health care, (iii) training providers.	Beliefs in traditional medicine can potentially be an obstacle to improving health outcomes in the Solomon Islands. However, there may be significant benefits from closer cooperation between practitioners of western and traditional medicine. There may also be opportunities to link demand for traditional health and western, as there appears to be significant overlap between these two health-care systems in the diagnosis and treatment of certain diseases and in managing pregnancy and delivery (Edmonds 2006).	
4. to improve the technical quality of services	(i) provider training; (ii) performance-based incentives linked to effective quality monitoring, (iii) education of patients about quality, and (iv) vouchers.	Provider training is mostly frequently used to improve the technical quality of health services. Clearly, appropriate training of the right individuals is a necessary part of any strategy to improve quality. However, it is rarely sufficient to achieve better quality in developing countries where providers are poorly paid and under-motivated and where patients do not recognize and appreciate good-quality health services. At the clinical level, there has probably been more work done on monitoring the quality of family planning and other reproductive health services than other types of services. Since improving the quality of reproductive health services is high-up on SI's policy agenda, this might be a good entry point for performance-based incentives linked to systematic quality monitoring. Vouchers (coupons) are most often considered as one of several demand-side policy tools that can be used to improve access to a service, particularly from private providers.[78]	Yes - partial
5. to strengthen the demand side	(i) Providing additional information (ii) reimbursement of travel costs (iii) conditional cash grants.	Relatively little attention has been given to the demand side in SI health policy. It is apparently assumed that if services are accessible and of reasonably good quality that the population will use them. However, there are many examples of services that are under-utilized (for example, family planning) or of services that experience high drop-out rates in some areas (for example, antenatal care and immunisations). In some cases, utilization may be low because of supply-side problems (for example, reports by some mothers that vaccines were not available), but in other cases utilization is clearly demand-constrained. Although most services are free (or provided at very low cost) in SI, travel costs and the opportunity cost of time can be high. The MOH already reimburses travel costs on referral, although the policy is not well understood by the public and there are reports of the policy being implemented in a way that favours wantoks. Reimbursement of travel costs is administratively burdensome and difficult to implement when a non-standard distance is involved (for example, from home	No

[78] Vouchers can also be used to foster increased competition among providers, although they have seldom been used for this purpose in the health sector.

[79] However, when evaluating their expected benefits against their cost, it should be considered that the economic cost of conditional cash grants is limited to the cost of administering the grants (as well as to any distortional costs related to their financing). The cash grants themselves are a transfer and not an economic cost from the perspective of cost-benefit analysis.

		to a primary care facility as opposed to from a primary care facility to the nearest referral facility). Conditional cash grants are payments made to households (usually, but not always poor households) by governments to encourage the utilization of education and/or health services that are considered socially desirable. The main drawback to conditional cash grants is that they are expensive (i.e., the fiscal burden can be substantial).[79]	
6. to improve information systems	(i) Standalone versus piggy-backed surveys; (ii) Frequency of household surveys; (iii) Scope and content of household health surveys; (iv) Community-level data	Any initiative to improve SI information systems is likely to include additional investment to expand and improve the HIS. However, the HIS cannot provide the most reliable information on all health indicators. Data on some indicators (for example, indicators that involve activities conducted outside the public health system) can be most effectively and reliably collected through household surveys. In other cases, surveillance data may be needed to verify HIS data; linking HIS data to administrative data. There may also be a need to complement HIS data with qualitative studies It is useful to collect data on health-care utilization and expenditure in connection with an economic survey in order to obtain information on the relationship of health expenditure to total household expenditure (for example, to investigate the economic burden of out-of-pocket health expenditure or to calculate standard measures of health equity).	Yes - partial
7. To improve the condition of infrastructure	(i) formulating and implementing plans for the maintenance and replacement of infrastructure, (ii) a freeze on new infrastructure investments, and (iii) joint planning of infrastructure investments by government and donors.	Joint planning of infrastructure investments by government and donors. In the current circumstances, under which donors have agreed to provide recurrent expenditure support, joint planning of new infrastructure investments by government and donors appears reasonable. Under these arrangements, donors proposing to fund new infrastructure might be asked to make longer-term commitments to finance the associated recurrent costs through the SWAP.	Yes - partial
8. To improve system management	(i) improved facility planning within the current system, (ii) providing management training to system managers, (iii) decentralizing the management of health facilities, and (iv) contracting out facility management to churches or NGOs.	SI's public health system is still highly centralized. Most inputs are provided directly by the center (for example, personnel are paid by a central personnel unit, while most other inputs, such as drugs and supplies, are provided directly by the MOH). This means that system managers, such as hospital directors, have little if any control over (or even systematic information about) their inputs and are therefore not really "managers" in the usual sense. Instead, system managers are mostly focused on getting the centralized bureaucratic system to do what is needed (management focus is external, rather than internal). Based on the situation analysis presented above, the centralized system frequently fails to provide what is needed. Critical supplies are often missing, and needed repairs are not made, while many hospitals and clinics are chronically under-staffed. Improving the management of public health facilities would also probably lead to cost savings that would provide additional "fiscal space" to focus more resources on priority health areas.	Yes - partial
9. to improve planning and	(i) use a systematic approach to	Although achieving improved primary health outcomes is likely to require additional	Yes - partial

budgeting include	allocating resources, (ii) strengthen linkages between MOH operational plans and the annual budget, (iii) disaggregate provincial health budgets, and (iv) return all donor funding to the national budget.	resources, it is equally important that those resources be carefully allocated. A systematic approach will set priorities for public expenditure across the priorities identified in the NHSP using public finance criteria. Setting priorities for public expenditure should look at equity (protecting and ensuring access to health services for the poor), alleviating market failures (such as under-provision of public health activities that benefit communities as a group, e.g. vector control, and those health activities that benefit others if consumed by enough individuals, e.g. immunisations), and feasibility of implementation within a budget constraint. This budget constraint should be laid out in a medium term expenditure framework (MTEF) in consultation with the MOF.	
10. To attracting and retain medical staff	(i) provide incentives to qualified staff who agree to work in previously unfilled posts, (ii) introduce performance-based incentives, (iii) improve personnel management and supervision practices, (iv) introduce cost-of-living allowances, (v) improve workplace quality and safety, and (vi) developing a human resources review and plan for hospitals.		Yes - partial

5.3 Risk Management Matrix

The following Table outlines possible Risk events, impact of the program and the proposed mitigation initiatives.

Key
L = Likelihood (5 = Almost certain, 4 = Likely, 3 = Possible, 2 = Unlikely, 1 = Rare)
C = Consequence (5 = Severe, 4 = Major, 3 = Moderate, 2 = Minor, 1 = Negligible)
R = Risk level (4 = Extreme, 3 = High, 2= Medium, 1= Low)

Risk Event	Source of Risk	Impact on the Program	L	C	R	Risk Treatment	Responsibility	Timing
Collapse of the Solomon Islands economy.	Solomon Islands Government (SIG), global economic pressure, internal civil disturbance.	Major reduction in health funding, leading to a potential collapse of health sector. Delay/reduction in achievement of Program outputs and possible suspension of the Programt.	2	5	1	Review role and level of Health Sector Support Program.	Minister of Health (MH), Permanent Secretary (PS) Ministry of Health (MoH), AusAID, other Development partners	Y1, and ongoing
Declining economy, breakdown in basic services, utilities and other infrastructure, creates significant logistical difficulties in implementing Program Implementation Plan (PIP).	SIG, global economic pressure, internal civil disturbance.	Delay in achieving Program outputs in all components.	3	4	2	Flexibility and reorientation of outputs and/or timing of outputs to accommodate the reality of the emerging situation.	PS, MoH, AusAID, other Development partners	Y1, and ongoing
A reoccurrence of civil disturbance in Guadalcanal and Malaita Provinces.	Militants, SIG.	Major delay/reduction in achievement of Program outputs, possible suspension of Program and/or major reduction in funds for health.	4	5	3	Continued monitoring of the political, security and economic environment. Consider temporary suspension of Program or for some areas of support in extreme circumstances.	MH, PS, MoH, AusAID, other Development partners	Y1, and ongoing
Declining SIG political and public support for RAMSI.	Militants, SIG, Members of Parliament, public.	Threat to the public perception of the Program, and loss of public support for Health Sector Support Program activities.	5	4	4	Ensure a responsive awareness in Program activities, particularly in those actions which are subject to public scrutiny. AusAID and other Development partners maintain good relationships with counterparts and MoH staff; and monitor political situation.	AusAID, other Development partners	Y1, and ongoing
Change in political support for health.	SIG, Members of Parliament.	Threat to achieving objectives of Program.	2	4	1	Explain and gain support for basis of all allocation of resources.	MoH, AusAID, other Development partners	Y1, and ongoing
Political interference in resource management decisions.	SIG	Reorganisation of Program priorities.	3	3	2	Ensure all decisions are undertaken in consultation with the MoH. Explain and gain support for the basis of allocation of all resources.	MH, PS, AusAID, other Development partners	Y1, and ongoing

Risk Event	Source of Risk	Impact on the Program	L	C	R	Risk Treatment	Responsibility	Timing
Human Resource Management (HRM) and Finance delegations to health sector delayed and not occurring.	Public Service Division (PSD), Ministry of Finance and Treasury (MOF).	Delay to MoH and Program initiatives.	4	3	3	Support will be provided to the MoH Executive to liaise with key individuals in central SIG department to overcome blockages. Continued coordination with the AusAID funded Machinery of Government Project (MOGP).	PS, MoH, AusAID, other Development partners	Yr 1, and ongoing.
Loss of skilled Solomon Islands health professionals.	SIG, MoH, PSD and training organisations, institutions, and particularly future SIG elections	Loss of Program effort, increased inability to transfer skills and threat to achieving objectives of Program.	5	4	3	Improvement in skills transfer provides motivation to remain in health system. Ensure skills transfer process permeates all management levels in health system.	SIG, PS, MoH	Y1, and ongoing
Donor/ Development partner co-ordination is not effectively achieved.	Donors/Development partners and MoH	Cost implications, duplication causes confusion and waste.	3	3	2	Active donor co-ordination and Communication. Support and liaison with HSSP.	PS, Ministry of National Planning and Aid Coordination, AusAID, other Development partners	Y1, and ongoing
The absorptive capacity of MoH staff limited due to heightened donor activity in the Solomon Islands following the RAMSI intervention.	Donors/Development partners	Threat to achieving Program objectives (no skills transfer and improvement in health service delivery and outcomes).	3	3	2	Ensure HSSP works with donors/Development partners to coordinate activities.	MoH	Y1, and ongoing
Reduced availability of MoH due to commitments to other donor programs and particularly during future SIG elections	MoH	Threat to achieving Program objectives (no skills transfer and improvement in health service delivery and outcomes).	4	3	3	Strengthen Program planning and integration. Strengthen MoH staff resource planning and allocation.	PS, MoH, AusAID, other Development partners	Y1, and ongoing
The Development partners may fail to agree on health priorities within HSSP	Donors/Development partners and MoH	Threat to achieving Program objectives (no skills transfer and improvement in health service delivery and outcomes).	2	2	2	The design of the SWAp and Program Implementation Plan allows flexibility in the allocation of funding source. Additionally, the flexibility of the PIP design allows for donor support to be directed to specific procurement category.	PS, MoH, AusAID, other Development partners	Y1, and ongoing
Operational Planning capacity within the MoH may be insufficient at both the National and Provincial levels	MoH	Threat to achieving Program implementation and objectives.	2	2	2	New planning process introduced during development of SWAp and PIP streamlines existing planning process to be better aligned with the NHSP strategic areas. 2007 and 2008 have been targeted as "transition years" in which to gradually introduce the new processes.	PS, MoH, AusAID, other Development partners	Y1, and ongoing

Risk Event	Source of Risk	Impact on the Program	L	C	R	Risk Treatment	Responsibility	Timing
Financial management capacity within MoH may be insufficient	MoH, PSD	Threat to achieving Program implementation and objectives.	3	4	3	MYOB budget and expenditure categories to be better aligned with NHSP strategic areas to enable a better match between budgets, expenditure and cost centres. Support the appointment of suitably qualified and experienced international Financial Management Specialist and national staff.	PS, MoH, MoF	Y1, and ongoing
Procurement management capacity within MoH may be insufficient	MoH, PSD	Threat to achieving Program implementation and objectives	3	4	3	The design of SWAp and PIP is based on the adoption of agreed procurement practices and procurement manual. Support the appointment of suitably qualified and experienced international Procurement Management Specialist and national staff.	PS, MoH, MoF	Y1, and ongoing
Political (or fraudulent) rather than price and technical considerations may influence procurement decisions	MoH, PSD, MoF	Threat to achieving Program implementation and objectives	3	4	3	Procurement process divorces as far as possible administrative and decision-making roles through the Ministerial or Central tender Board reviews. Implementation and administration is undertaken by the Procurement Unit. Support the appointment of suitably qualified and experienced international Procurement Management Specialist and national staff.	PS, MoH, MoF	Y1, and ongoing
Voluntary testing has revealed that prevalence of HIV/AIDS is considerably higher than the cases estimated by MoH using WHO calculations.	HIV/AIDS epidemic	Divert resources to emerging pandemic.	3	5	4	HSSP will monitor the response to voluntary testing. Coordinate with MoH, AusAID and Development partners to ensure this issue remains a priority.	PS, MoH, AusAID, other Development partners	Y1, and ongoing
Natural Disasters.	Environment	Delay and possible suspension of Program	2	4	2	MH, PS, MoH assess the situation to develop a suitable response in conjunction with AusAID, other Development partners.	PS, AusAID, other Development partners	Y1, and ongoing
Major disease outbreak (eg measles due to low immunisation rates).	Environment	Redirection of SIG health resources, human, financial and material, to address critical public health issue	3	4	2	MH, PS, MoH assess the situation to develop a suitable response in conjunction with AusAID, other Development partners. MoH has drafted an avian influenza and other disease pandemic contingency plan	PS, AusAID, other Development partners	Y1, and ongoing