



Independent Completion Evaluation of
Australia's Contribution to the Solomon
Islands Health Sector Support Program

Final

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Disclaimer

This document contains the independent opinion of the two consultants and as such does not necessarily represent the views of either DFAT, the MHMS, Mott MacDonald or any other party. Similarly, the recommendations made are those of the consultants alone.

An overview of the findings and the recommendations were presented, both as a written aide memoire and at a presentation before leaving the Solomon Islands and this report expands on the aide memoire.

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Acronyms

AOP(s)	Annual Operational Plan(s)
AUD	Australian Dollars
AusAID	Australian Agency for International Development
ARI	Acute Respiratory Infection
CEWG	Core Economic Working Group
DFAT	Department of Foreign Affairs and Trade
DFID	Department for International Development
DHIS	District Health Information System
DHS	Demographic and Health Survey (2006-2007)
DP	Development Partner
DPCG	Development Partners Coordination Group
DSID	Design Summary and Implementation Documents
EU	European Union
GDP	Gross Domestic Product
GESI	Gender Equity and Social Inclusion
GoA	Government of Australia
GNI	Gross National Income
H4D	DFAT Health for Development Strategy 2015-2020
HDI	Human Development Index
HISP	Health Improvement Strengthening Project
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HISP	Health Institutional Strengthening Project
HRF	Health Resource Facility for Australia's Aid Program
HSSP	Health Sector Support Program
HSSP2	Health Sector Support Program – Second Phase
HSSP3	Health Sector Support Program – Recommended Third Phase
HSTA	Health Sector Trust Account
IMF	International Monetary Fund
IPA	Independent Performance Assessment
IPR	Independent Performance Review
JICA	Japan International Cooperation Agency
JPA	Joint Performance Assessment
MDG	Millennium Development Goal
MHMS	Ministry of Health and Medical Services
M&E	Monitoring and Evaluation
MFT	Ministry of Finance and Treasury
MRG	Malaria Reference Group (of the Australian funded malaria support to Vanuatu and Solomon Islands)
MTEF	Medium Term Expenditure Framework
MTEP	Medium Term Expenditure Plan
NCD	Non-Communicable Diseases
NDS	National Development Strategy
NHSP	National Health Strategic Plan
NRH	National Referral Hospital

NVBDPCP	National Vector Borne Disease Control Programme
ODE	Office of Development Effectiveness
PacMI	Pacific Malaria Initiative (AusAID)
PacMISC	PacMI Support Centre
PACTAM	Pacific Technical Assistance Mechanism
PFM	Public Financial Management
PHA	Provincial Health Authorities
PPP	Purchasing Power Parity
RAMSI	Regional Assistance Mission to Solomon Islands
RDP	Role Delineation Policy
RWASH	Rural water supply, sanitation and hygiene
SIG	Solomon Islands Government
SLMS	Second Level Medical Store
SPC	Secretariat of the Pacific Community
SWAp	Sector-wide approach
TA	Technical Assistance
TB	Tuberculosis
The Tensions	The 1998-2003 national civil unrest
ToR	Terms of Reference
UHC	Universal Health Care
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US\$	United States Dollar
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Glossary

Budget	An estimate, often itemised, of expected income and expense for a given period in the future. A plan of operations based on such an estimate. An itemised allotment of funds, time, etcetera for a given period.
On-budget	Included in the regular government budget; activities funded through government disbursement rules
Off-budget	not included in the regular government budget; funded through separate agencies using those agencies disbursement rules
On-plan	Included in the regular government operational plan, no matter how managed or funded.
Off-plan	Not included in the regular government operational plan.

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Aid Activity Summary

Investment Name		Solomon Islands Health Sector Support - Phase 2	
Investment Number	INK561		
Commencement date	1 July 2012	Completion date	30 June 2016
Total Australian \$	80 million		
Total other \$	N/A		
Delivery organisation(s)	The primary delivery organisation is the Solomon Islands Government acting through the Ministry of Health and Medical Services through a sector wide approach. The Government is supported by Australia with other Development Partner staff.		
Country/Region	Solomon Islands		
Primary Sector	Health		

Executive Summary

Introduction

The aim of this evaluation is to assess the effectiveness and efficiency of Australia's support through the Health Sector Support Program – Phase 2 (HSSP2) with a view to identifying opportunities for improvement for a third phase of support from 2016 to 2020. HSSP2 began in July 2012, is due to end in June 2016 and is an investment of an indicative amount of AUD80 million. Whilst HSSP and HSSP2 are often seen as synonymous with the Solomon Islands health sector-wide approach (SWAp), this evaluation only considers the single Australian Aid investment as detailed in the Aid Activity Summary above.

Context

Performance of the Solomon Islands health sector has been strong when compared to neighbouring and wealthier countries. HSSP2 has been successful in ensuring that a cost effective publicly funded health service has continued to provide equitable services throughout Solomon Islands. Whilst the private sector is a minimal player in health care in Solomon Islands, opportunities have been taken to bring private sector agencies on-board in micronutrient fortification of foodstuffs. Government has sustained a significant percentage of its Gross Domestic Product (GDP) to the sector. The sector is not yet able to go it alone and without the Australian support would be severely compromised. A third phase of support is recommended with various adjustments to address the changing burden of disease.

Changes in service delivery – the AOPs and the Provinces

Under HSSP2, a series of costed Annual Operational Plans (AOPs) have been put in place for the major cost-centres, including the Provinces. Australian support has facilitated funding directed to the Provinces. The Ministry of Health and Medical Services (MHMS) has also met targets in budgeting and in the use of AOPs and budgets at the provincial level. This is a significant step in decentralisation and local management. This opens up opportunities for greater efficiencies, including integrated outreach programs. In 2013 HSSP2 introduced provincial performance related payments, with additional payments to Provinces, which are assessed at the annual Joint Performance Assessment meetings.¹

Gender Equity and Social Inclusion

Gender Equity and Social(ly) Inclusive (GESI) development are integral to the national development strategy, and generally, there is a good enabling policy environment for GESI in Solomon Islands contained in the Solomon Islands National Development Strategy.² Gender has been included in the AOPs and monitored since 2013, with annual reports capturing disaggregated data and highlighting gender equity issues. However, stronger integration of GESI into the SWAp design and monitoring processes will require negotiation and agreement between government and development partners, and agreement on specific GESI indicators.

¹ Previously known as Independent Performance Reviews (IPRs)

² Solomon Islands: National Development Strategy 2011-2020. Ministry of Development Planning and Aid Coordination. July 2011.

Performance and role of Australia's investments

Relevance

Policy alignment. HSSP2 is fully consistent with both Solomon Islands Government (SIG) and Australian policies and fully supports the Paris Declaration on Aid Effectiveness, the Pacific Island Principles on Aid Effectiveness and the 2008 Accra Agenda for Action on Aid Effectiveness, declarations to which both Governments are signatories. HSSP2 is consistent with the Australian Aid Policy tests (see Annex 4).

Continuity and dependability of funding. The consistency and dependability of the funding has been a significant positive aspect in enabling the MHMS to plan efficiently and effectively and has increased the value of the Australian investment.

Changing burden of disease. HSSP2 closely supports the MHMS National Health Strategic Plan (NHSP). With hindsight, it is possible to conclude that there was lack of emphasis on some health areas in the NHSP and consequently HSSP2 – that is in nutrition (particularly the problems relating to stunting)³, family planning, and the emergence of non-communicable diseases. The 2015 AOPs have been revised to address the issues, and the new draft NHSP addresses these.

Attribution

Attribution in SWAp is problematic, and internationally considered less important than in project support. The Solomon Islands health SWAp is easier to conceptualise than are some SWAp, in that it has (effectively) only one funding Development Partner (DP), and Australia has contributed a significant amount of total budget – 25 – 40% of the SWAp life cycle under review.. Therefore, without the HSSP funding, a significant proportion of all health activities would not have been possible. Attribution is further complicated as over HSSP2 earmarking for specific 'programs' (which are easier to measure, for example malaria) has decreased, while earmarking for systems changes to improve overall efficiency has increased – for example the dedication of a percentage of funding to the provinces. Whilst making attribution more difficult this is overall a positive move.

Effectiveness

HSSP2 has significantly contributed to the effectiveness of the health sector in Solomon Islands. Without the Australian investment, it would not have been possible for SIG to deliver the level of health outcomes achieved. HSSP established a set of annual performance indicators tied to the release of funds. The introduction of performance-linked payments has focused the program on results as contrasted with other possible approaches based on inputs or processes. This has focused SIG performance on the achievement of results and led to dialogue on best approaches, systems and procedures to improve performance. Furthermore, the HSSP2 performance-based funding focused attention on shifting budget to the Provinces. However, the provincial performance grants should be reviewed to ensure that they remain a positive incentive mechanism. While the introduction of the AOPs has been a major achievement in implementing the SWAp and HSSP2, they are relatively

³ Although the Food Fortification initiative, a DFAT separately funded activity xxxxx is helping to address nutrition and stunting.

complex and some SIG officers remark that they have a history of frequent change. The Medium Term Expenditure Framework (MTEF), although designed as a forward planning tool does not seem to be used on a regular basis and this reduces the effectiveness of the HSSP2 policy debate and introduces risks to future investment.

Efficiency

Solomon Islands achieves efficient and equitable health results at a small fraction of the costs in other Asian and Pacific countries. This would not be possible without the support of HSSP2. When designed, and at inception, HSSP2 had a significant earmarking component in the funding, not least for the malaria program. Decreasing the degree of earmarking and the removal of regional and other fragmented funding streams over the past three years has increased the efficiency of the Australian investment and ensured greater Government ownership.

Sustainability

The support to health has played a significant part in the stabilisation efforts and has earned the Department of Foreign Affairs and Trade (DFAT) considerable respect. While it is unlikely that the SIG health system can become self-supporting in the near or medium-term future, Australian plans should consider the entirety of Australian support to Solomon Islands and not just health sector support in isolation. Elements of the health system that have been supported by HSSP2 are potentially sustainable – for example the District Health Information System (DHIS), the improved financial management systems, the pharmaceutical procurement and distribution systems and many more.

Modality of investment – on-budget – on-plan

A major thrust of HSSP2 has been to move DP funding on-plan and where possible on-budget⁴. Effort was invested in preparing a MTEF⁵ to guide future investment. However, this does not seem to have become a working tool and does not seem to be a living, rolling document as would be expected. An updated and current Medium Term Expenditure Plan (MTEP) would be a useful tool to inform the partners' policy debates over future investment decisions, particularly those (for example facility construction and staff training) which may have significant future recurrent cost implications.

SWAp governance and management arrangements

In Solomon Islands, the quality of policy dialogue has been compromised and MHMS leadership is sub-optimal, with donors visibly dominant and driving the process^{6,7}. This would appear to be due to a combination of factors:

- Lack of ownership of the SWAp management process by the MHMS.
- Limited capacity within the executive of the MHMS to devote significant time and focus to a process which they do not control (with this portrayed by some as overall “lack of capacity” of the executive).

⁴ On-budget also infers managed through government systems. See glossary preface.

⁵ Now Plan (MTEP)

⁶ M Kelly & K Tuckwell, *Solomon Islands Health Sector Support Program (HSSP): Independent Performance Assessment for 2013*, Health Resource Facility, Canberra, May 2014.

⁷ Personal communication from attendee at the 2015 JPA.

- Lack of coordination between the DPs with difficulty in some partners in moving support on-plan as per their commitments.

With regard to monitoring, MHMS good governance and effective SWAp management, the 2013 Independent Progress Review recommended the establishment of a SWAp management device that is useful to and owned by MHMS, and is not merely ritualised in its adoption.⁸ While in progress, this has not yet happened with the process managed by WHO on behalf of the SWAp partners.

Health systems capacity and technical assistance

One of the most consistent comments made by all parties during this evaluation was the perception that there was a 'lack of capacity' within the MHMS. HSSP has used Technical Assistance (TA) effectively to solve immediate problems of program implementation. TA has served a number of roles, including performing staff functions in the MHMS, providing assurance and response to program crises, and building the capacity of departments and managers. However, this seems to have grown in a reactive manner. A departmental capacity study, formal TA needs assessment and coordinated TA plan would be of benefit in the design process of HSSP3.

The cost of technical assistance is not currently reflected in the AOPs and thus the MHMS is not aware of the full cost of running the health service. Reflecting the costs of TA in the AOPs would allow MHMS to see the full costs of support and facilitate management and ownership of TA. Redesign of the TA program through a needs assessment process could also address the mix of capacity building services, clarify the model and reduce the cost of DFAT inputs.

Risk Management

Fiduciary risk remains a concern. Both SIG and the Australian Government have taken a mature approach to the recently discovered major fraud. Both SIG and MHMS staff accept the additional fiscal and financial management support to implement fully the SIG systems and to ensure compliance with the Public Financial Management Directive⁹ and with SIG financial regulations. The introduction of locally contracted auditing TA to support the Provinces is considered a particularly appropriate area of support. However complaints were made to the team during this review that the system of disbursement for HSSP money at the central level has slowed to the point that activities are compromised. The internal audit system is functioning and is the only internal audit department within SIG with a fully functioning audit committee. Support should be continued to the MHMS internal audit department until it is fully functional and sustainable. A critical element will be for SIG to resolve the outstanding suspensions and to fully staff the finance and audit departments.

Main Findings

- HSSP2 is impressive in its achievements with its partners, is highly appreciated by government and is an investment of which Australia should be proud. The health system requires substantial continuing support to maintain its current gains and to move forward.

⁸ Kelly and Tuckwell. May 2014.

⁹ DG Direction on Controls on AusAID Funds Through Partner Systems in Melanesia. Unclassified Internal AusAID Minute October 2013. The Public Finance Directive. Also referred to by some as the 'Melanesia Directive'. See ToRs Annex 1.

Australia has a strong comparative advantage as the major supporter of SIG and the health sector.

- Three issues stand out as needing increased focus in the next phase:
 - Increased focus on developing the policy dialogue and ensuring that Australia has an effective seat at the policy table, and developing and strengthening effective tools to manage the relationship.
 - A more formal, wider strategic and systematic focus on health systems strengthening (building on the financial strengthening already done) with a formal systems wide review, including both central and provincial systems.
 - Once the health systems gaps are identified, there can then be a similar formal, strategic and systematic review of the TA needs of the next phase to support the systems strengthening needs identified.
- The SWAp approach using variable degrees of earmarked budget support in support of SIG policies has been appropriate. The investment is aligned – on-plan and on-budget. The approach has allowed the MHMS increasingly to take ownership of the management of the sector (even though there is still work to do here) while allowing efficient and effective use of the Australian investment.
- The consistency and dependability of the funding has been a significant positive aspect in enabling the MHMS to plan efficiently and effectively and has increased the value of the Australian investment.
- Support has increasingly focused on MHMS activities at the provincial level, with strengthening of financial systems at the provincial level. This offers the potential for efficiency gains to be made with the management of resources placed nearer to the delivery point and the opportunity for MHMS Divisions to combine resources (for example in outreach activities) resulting in cost savings and efficient and effective use of resources.
- Emerging and additional disease priorities are recognised, prioritised and addressed in the New NHSP now in draft.
- Government leadership of the SWAp partnership, while improving, to now is poorly developed and a weakness appears to be limited to constructive engagement at the policy level. There is a perception of a degree of DP control.
- Financial risk management has been a significant aspect of HSSP2, but appears to have been managed well. However, this has had significant financial consequences (for example the recruitment of additional TA and while the team were not able to verify the claim is perceived by some respondents to have slowed implementation of activities. There has also been significant management load on DFAT staff.
- While MHMS technical skills are strong, there is reportedly a lack of management capacity. This has resulted in support from a number of TA. There does not appear to be an overall strategic plan for TA and this should be addressed.

Summary of Recommendations

- Australia should invest in continued support to health when HSSP2 ends in June 2016.
- Support should continue to be as budget support to the health sector, with limited earmarking as appropriate. Australia should continue to act as “honest broker” to assist the MHMS to bring other DPs fully into the SWAp partnership. The focus of the next phase of support is likely to be on systems development and strengthening, while maintaining strong financial management support.
- Australia must intensify efforts to improve the mechanisms available for, and the quality of, the policy debate between MHMS and DPs, while ensuring the MHMS ownership of the process is strengthened.
- The move towards placing increasing investment at the provincial level is a positive move and should continue and accelerate in any follow-on funding.
- The performance related provincial grants are at an early stage of implementation. While successful to date, this approach should be considered to ensure that the process remains simple and a positive incentive and not seen as a penalty system for under-performance.
- The program should consider encouraging the SIG to allocate a greater share of own revenue to health. An increase to 15 per cent has been proposed.
- Significant support for financial risk management will need to be included in the design of HSSP3 and TA resources continued for the foreseeable future. This should include support at the provincial level and to the internal audit team.
- There should be a formal wide-ranging health systems review to identify capacity gaps in the MHMS management and propose a strategic plan to address any gaps. The review should propose a plan for TA across the MHMS, including recommendations for recruitment and management. This plan would also identify the role of TA and clarify the approach of each TA – that is the balance between capacity building and line-function – and consider the TA procurement and management approach.
- Once a TA plan is agreed, the costs of TA should then be reflected in the AOPs. This will increase ownership and allow line managers to better understand the true costs of managing their AOP.
- DFAT staff workload is unlikely to reduce in the next phase of support. Management should plan to ensure effective high-level technical SWAp support for the incoming First Secretary as the highly experienced incumbent moves on.

1. Introduction

The Health Sector Support Program Phase 2 (HSSP2) began in July 2012 and is due to end in June 2016. HSSP2 is Australia's program of support to the Solomon Islands health sector delivered through earmarked budgetary support using a Sector-wide approach (SWAp) mechanism. It is a follow-on program to HSSP. The program value is an indicative amount of AUD80 million. This report contains an independent evaluation of HSSP2 and makes recommendations for follow-on support. Whilst HSSP and HSSP2 are often seen as synonymous with the Solomon Islands Health SWAp this evaluation does not evaluate the SWAp in its entirety, but only considers the single Australian Aid project as detailed in the Aid Activity Summary at the start of this document.

2. Background and changing health context

Solomon Islands consists of a large number of islands in Oceania lying to the east of Papua New Guinea, northwest of Vanuatu and covering a land area of 28,400 square kilometres (11,000 square miles). The country's capital, Honiara, is located on the island of Guadalcanal. The United Kingdom established a protectorate over Solomon Islands in the 1890s, self-government was achieved in 1976 and independence two years later.

Solomon Islands has the lowest per capita income in the region and is one of the lowest ranked countries in the region by Human Development Index (HDI) indicators. HDI is a broad measure of social development of a country. Solomon Islands' 2013 HDI of 0.491 is below (that is 'worse than') the average of 0.493 for countries in the low human development group and below the average of 0.703 for countries in East Asia and the Pacific. The HDI ranking index is out of 187 countries where one is the best. See Table 1 below.



Table 1: Solomon Islands' HDI indicators for 2013 relative to selected countries and groups¹⁰

	HDI value	HDI rank	Life expectancy at birth	Expected years of schooling	Mean years of schooling	GNI ¹¹ per capita (PPP ¹² US\$)
Solomon Islands	0.491	157	67.7	9.2	4.5	1,385
Vanuatu	0.616	131	71.6	10.6	9	2,652
Kiribati	0.607	133	68.9	12.3	7.8	2,645
East Asia and the Pacific	0.703	N/A	74	12.5	7.4	10,499

Solomon Islands has faced some of the most difficult development challenges within the Pacific Islands sub-region. These have included a series of human and natural disasters, which have impeded sustainable development progress on community and national levels. Most notable among these incidents was the 1998-2003 national civil unrest, referred to as the 'tensions'. Beginning in late 1998, ethnic violence, government malfeasance, endemic crime and the narrow economic base began to undermine stability and civil society. Major governmental institutions became inoperable and violence led to the largest internal displacement (estimated 20,000 people) in the entire Pacific region. In June 2003, the Prime Minister sought the assistance of an Australian-led multinational force to restore peace and disarm ethnic militias. The Regional Assistance Mission to the Solomon Islands (RAMSI) has generally been effective in restoring law and order and rebuilding government institutions¹³, and the health support should be seen in the context of the wider nation-building support. However, Solomon Islands' social service institutions continue to face significant challenges compounded by the impacts of the global economic crises and successive natural disasters.

Decadal Trends

Decadal¹⁴ macroeconomic trends demonstrate Solomon Islands' fragility. Gross Domestic Product (GDP) growth was five to seven per cent per annum from 2005-8, led by gold, fisheries and logging, but plunged to negative 5 per cent in 2009 and then rebounded to 12 per cent in 2011. Growth has now come down with the closure of the country's gold mine and floods and was only 1.5 per cent in 2014. However, the International Monetary Fund (IMF) estimates 2015 real growth at 3.3 per cent and inflation at a low 3.8 per cent. Economic activity is likely to increase moderately in the near term led by agriculture, tuna processing, construction and mining prospects, but long term sustainable growth remains uncertain and is not forecast to increase significantly in the medium term. The IMF warns

¹⁰ http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/SLB.pdf. Accessed 11 August 2015

¹¹ Gross National Income.

¹² Purchasing Power Parity

¹³ <https://www.cia.gov/library/publications/the-world-factbook/geos/bp.html>. Accessed 13 July 2016

¹⁴ Decadal indicators were chosen based on availability of data from c. 2006/7 to compare with 2012/14 data (or as close as possible to give a 10 year perspective) and to fulfil the requirements of the Terms of Reference (ToR).

that the pace and scale of spending needs to be consistent over the medium term with the country's absorptive capacity and reflect realistic plans for revenue mobilisation.¹⁵

Changing health context

While the political tensions set back the country's growth, health services recovered relatively quickly from the tensions and have continued to develop. The way forward was first set out in the National Health Strategic Plan (NHSP) 2006-10, followed by the NHSP 2011-2015.¹⁶ For details of health status changes see Annex 3. During the past 10 years, good progress was made on several health indicators, notably maternal deaths and communicable disease rates and malaria, tuberculosis (TB), diarrheal disease, and acute respiratory infections (ARI) have all declined. Some indicators have stagnated or late resulting in only small progress (for example, infant mortality rates) while stunting rates have remained high, contraceptive prevalence rates are low at 27 per cent. More generally Solomon Islands is in the early stage of an epidemiological transition that is negatively affecting health status changes with increases in the rates of non-communicable diseases (NCD).

Solomon Islands is on track to achieve Millennium Development Goal 5 (MDG 5) (improve maternal health) and MDG 6 (combat HIV/AIDS, malaria, and other diseases), but not MDG 4 (reduce child mortality rates). Maternal mortality fell from 320/100000 in 1990 to 184 in 2006 to 110 in 2014, placing the country on course to meet MDG 5.¹⁷ Immunisations have risen by 20 per cent and measles immunisation is now at 95 per cent of the population (though this is the highest rate for the various immunisations). Diarrhoea incidence has reduced by about 30 per cent and tuberculosis management has been successful.¹⁸ TB mortality and morbidity has fallen by 79 per cent and 76 per cent since 1990. Infant mortality declined from 32 per thousand live births in 1990 to 26 in 2006 and to 24 in 2014 showing good initial progress but a later slowing of the rate of decline.¹⁹ Under 5 mortality declined from 39/1000 in 1990 to 37 in 2006 (Demographic and Health Survey – DHS²⁰) and then to 30 in 2014 (District Health Information System - DHIS), a small change. Neonatal mortality was stationary at 16 per 1000 in 1990 and 17 in 2006 (DHS) and then declined to 11 in 2014 (good progress). Both infant and child mortality rates, while low in comparison to other low-middle income countries, have not declined further recently, making it unlikely that the Solomon Islands will reach MDG 4. The 2012 Child Health Strategy indicates that the leading causes of childhood death were neonatal conditions (44 per cent) pneumonia (18 per cent) malaria (nine per cent) and diarrheal disease (four per cent).²¹

The contraceptive prevalence rate has remained at 27 per cent, indicating that effective family planning services are not being provided. Long-term child (<5 years) malnutrition (stunting) has remained at 33 per cent with cognitive developmental implications, with underweight young children (<2 years) at 12 per cent indicating possible issues with

¹⁵ Fourth Review Under the Extended Credit Facility, International Monetary Fund, March 20, 2015

¹⁶ National Health Strategic Plan, the Ministry of Health & Medical Services, SIG, 2011-2015. March 2011.

¹⁷ Trends in Maternal Mortality, 1990-2013, WHO, 2014

¹⁸ Solomon Islands Health Systems Review, Health Systems in Transition Vol. 5 No 1 2015; Asia Pacific Observatory on Health Systems and Policies

¹⁹ Committing to Child Survival, UNICEF, 2014

²⁰ Solomon Islands Statistics Office. Secretariat of the Pacific Community. Macro International Institute for Resource Development. May 2009. Demographic and Health Survey. Solomon Islands Demographic and Health Survey 2006-2007.

²¹ Solomon Islands Child Health Strategy 2011-2015. Ministry of Health and Medical Services. Not dated.

weaning.²² Sanitation services, especially in the rural areas have not improved during the past 10 years.

The Global Burden of Disease analysis (2010) identified changing patterns of disease in Solomon Islands. Based on available data (in Solomon Islands this was primarily the 2006 DHS and MHMS DHIS updates)²³ the results show an evolving pattern of increasing NCDs contributing to an increasing number of Years of Life Lost. Numbers of overweight men have increased by about 30 per cent in the past 10 years, while numbers of overweight women have increased by almost 50 per cent, 16.1 per cent of adults nation-wide have diabetes and 33 per cent have hypertension. The analysis shows that diabetes and stroke are now the major contributors to the burden of disease followed by lower respiratory infections, heart disease, TB and preterm birth complications. Diarrheal disease and malnutrition are also significant factors.

Health services

During the past 10 years health service achievements in Solomon Islands have been led by a network of well-trained provincial/rural nurses managing a network of community-based nurse-aides, integrated with the communities where they live and serve. Health gains during the past 10-15 years have been a result of this public health approach²⁴. This includes the reductions in maternal mortality, increases in immunisation coverage, pre-natal visits, post-natal visits, deliveries assisted by skilled medical personnel, reductions in neonatal mortality, improvements in TB treatment, and children taken to health facilities with diarrhoea and ARI, all mediated by the network of health workers led by registered nurses and community-based nurse-aides.²⁵

Although rural health clinics and area health centres have deteriorated during the past years from lack of maintenance, and are in urgent need of repair and upgrading, they still form the foundation for the delivery of services.²⁶ They are not properly maintained due to funding and management constraints and there are shortages of clinical equipment and medical supplies, with hospitals often relying on old and poorly maintained medical, diagnostic and surgical equipment.²⁷ However, the clinics and health centres have sufficient equipment to deliver most basic services and the registered nurses are capable of delivering a range of services with the supplies and equipment they have at hand. This is being reviewed through the role delineation policy (RDP), which defines the services to be delivered by each type of facility in the health care system, and the facilities, equipment, and staffing they need.²⁸ A reform process will see planning and budgeting decentralised to the provincial level by defining the levels of service and functions or 'packages of care' to be provided at the different health facilities that make up the Solomon Islands health system.²⁹

²² Global Nutrition Report, UNICEF, 2014

²³ GBD Profile: Solomon Islands, Institute for Health Metrics and Evaluation, Seattle WA 2010

²⁴ WHO, Health Service Delivery Profile, Solomon Islands, 2012.

²⁵ WHO. http://www.wpro.who.int/asia_pacific_observatory/hits/series/hits_sol_5_services.pdf

²⁶ MHMS. MTEF November 2011. States: *estimates from the Infrastructure Unit of MoHMS that 70-80% of all health facilities need to be either fully replaced or major repairs*

²⁷ Personal communications infrastructure team confirmed during field visits.

²⁸ RDP Work plan. Jan-May 2015. Ministry of Health and Medical Services internal working document.

²⁹ http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_slb_en.pdf Accessed 27 July 2015.

Changes in service delivery approach – the AOPs and the Provinces

The Solomon Islands Government (SIG) led health SWAp introduced costed annual operational plans (AOPs). These are now in place for the major cost-centres including, this year, for each of the Provinces. These are the foundation for establishing administrative and financial confidence at both national and provincial levels. Support for the implementation of the AOPs has been led by World Bank funded TA. In addition to support to the input and planning end of the financial cycle, there has also been strengthening of financial management and audit functions.

However, discovery of a significant fraud set back the program during 2013. The MHMS, working with the Department of Foreign Affairs and Trade (DFAT) responded well to the crisis and the systems established in response have strengthened the program for the future. Australia has supported additional TA focused on financial management and reporting, both centrally and in the Provinces, following which financial reporting and accounts reconciliation have been acceptable at both national and provincial levels.

The majority of service delivery activity (excepting the National Referral Hospital (NRH)) takes place at the provincial level. It is now MHMS policy to delegate the funding for such activities to the Provincial AOPs and budgets. MHMS has met targets in budgeting and in the use of AOPs and budgets at the provincial level. This is a significant step in decentralisation and local management. This opens up opportunities for greater efficiencies, including integrated outreach programs. To further support the MHMS in its intent to delegate resources to the Provinces, in 2013 HSSP2 introduced provincial performance related payments, with additional payments to Provinces assessed annually at the annual Joint Performance Assessment (JPA) meetings.

The health system and GESI

Gender Equity and Social Inclusion (GESI) development are integral to the national development strategy (NDS), and there is a good enabling policy environment for GESI in the Solomon Islands NDS.³⁰ Gender mainstreaming is being promoted across the whole of government and there is an embryonic structure in place in the MHMS with the Permanent Secretary as the lead responsible for gender, supported by a Gender Focal Person.³¹

Infant mortality rates, the only health outcome variable for which data on socioeconomic differentials are available, are characterised by few inequalities between rich and poor groups. With regard to health care use, not only are coverage rates high, there are also few inequities in the distribution of service use. Both the DHS and the DHIS show that health care utilisation rates are relatively equal across rich and poor households, and in some cases, are quite pro-poor.³²

Gender has been included in the AOPs and monitored since 2013, with annual reports capturing disaggregated data and highlighting gender equity issues, that is access rates to child and maternal health services, family planning etc. Specific programs include a GESI

³⁰ Solomon Islands: National Development Strategy 2011-2020. Ministry of Development Planning and Aid Coordination. July 2011.

³¹ Gender, Equity and Social Inclusion Assessment of the Health Sector in Solomon Islands. No lusim eniwan (don't leave anyone out). Deborah Thomas and Emele Duituraga. Health Resource Facility April 2014.

³² World Bank. 2010. Solomon Islands - Health financing options. Washington, DC: World Bank. <http://documents.worldbank.org/curated/en/2010/06/16358926/solomon-islands-health-financing-options>

Review (2014), human papillomavirus (HPV) vaccine introduction; Rural Water Supply, Sanitation and Hygiene (RWASH) and community engagement with strong gender focus, and *Safeples* (a gender based violence clinic for women) and other programs.

Twenty per cent of the population live in urban areas, and the urban growth rate was estimated at 4.7 per cent in 2009, the highest in the Pacific region. Honiara is the main urban centre and as noted above has the highest poverty levels in the country. Poor access to basic amenities and health services places poor peri-urban communities at high risk.

Women and girls, the poor, remote dwellers, peri-urban dwellers, and people living with disability are recognised to be vulnerable populations in Solomon Islands. In addition, there are small minority populations of I-Kiribati and Chinese that are at risk of social exclusion though evidence is not available to assess if this is the case in practice. Other vulnerable groups include orphans, children born from rape or incest, and child prostitutes. Lesbian, gay, transgender persons are also at risk of social discrimination.

Stronger integration of GESI into the SWAp design and monitoring processes and into HSSP3 will require negotiation and agreement between government and development partners, and agreement on specific GESI indicators³³.

The review team did not contain specific expertise in GESI. However, Thomas and Duituturaga's (2014) report does provide a detailed analysis and recommendations and should be read along with this review to provide an expert and detailed view.

3. Australian support to health

Australia intervened in the health sector during the ethnic tensions (1998-2003) providing direct finance to Provincial Health Authorities (PHA) as SIG domestic revenues had almost entirely collapsed. Australia supported the reestablishment of essential health services, which supported the network of nurse-aide posts and registered nurses at rural health clinics. This is the basis for the health care system currently in place, which delivers low cost services. Despite the scattered low-density population, health facilities are accessible and used by most people and use of services appears equitable.³⁴

The support helped clinics to remain open. During 2003-2007 Australia funded the Health Sector Trust Account (HSTA) and Health Institutional Strengthening Project (HISP) through an Australian Managing Contractor (with some 31 advisers) as emergency measures to re-establish essential health services.

The health SWAp - HSSP

With increased national stability, Australia and the World Bank sought a more harmonised and integrated approach to working with the SIG to finance the health sector. Australia began providing sector budget support to the MHMS through a SWAp, from 2008³⁵. This was the HSSP, which ended in June 2012. The incremental move from project and regional based funding to sectoral support on a country-by-country basis was driven by Australia's

³³ Thomas and Duituturaga. Ibid. pg 34 and Key Messages.

³⁴ Tyson, S. October 2011. Solomon Islands Health Sector Wide Approach Progress Review 2008-2011. Final Report. Health Resource Facility.

³⁵ Commonwealth of Australia. May 2008. Subsidiary Arrangement Between The GoA and The Government Of Solomon Islands for The Solomon Islands Health Sector Support Program (HSSP) 2008-2012. And Amendment 1 (2011). AusAID Agreement 45033.

overall policy development. HSSP supported implementation of the NHSP (2006-10). The plan, developed in 2005, outlined the SIG intention to adopt a SWAp. This was in line with the direction in which the policy of Australia and the World Bank was moving. All local donors supported the approach, committed to align and harmonise their assistance around the national plan and to support stronger local ownership of policy reforms and technical inputs. Only Australia, the largest donor provided predictable, un-earmarked budget support, a central feature of this development approach. The World Bank supported Technical Assistance (TA) for capacity development in planning, budgeting and financial management. Australia provided TA in health workforce planning, health information, policy and planning and provided earmarked financial support, in particular to malaria.

The SWAp approach has been increasingly the policy of the Australian government, and is a component of the Australian Government's high-level international agreements. The rationale behind the SWAp approach is analysed in numerous international documents – and is supported by the 2030 Agenda for Sustainable Development,³⁶ which endorses the Addis Ababa Action Agenda.³⁷ Apart from the broader international commitments, whilst it is outside the remit of this review to comment on Government of Australia (GoA) or SIG foreign policy, it would seem in the economic and security interests of both GoA and SIG for health care to be sustained at a minimum level, as it is now. This can only be achieved by support across the whole sector as now. Australia clearly has the comparative advantage in this area.

HSSP2

HSSP2 followed on from HSSP and was designed to start 1 July 2012. The design documents (Design Summary and Implementation Documents (DSID))³⁸ are somewhat formulaic in approach and have been analysed critically by Mick Foster.³⁹ He finds that the:

Objectives are formulated slightly differently in different sources and are scattered across several documents and annexes. Within the DSID and its Annexes, there are three distinctly different descriptions of what the programme is intended to achieve.

and he details these in his report and proposes revisions. The structure of the design documents does not make it easy to get a clear overall view of HSSP2, either at inception or as changes have occurred as implementation has gone forward. While there clearly have been incremental changes to the design of HSSP2 as implementation has progressed – as one would expect and as the design seems to envisage.

Perhaps the clearest sight of the thinking behind the original design is in the Concept Paper for HSSP2.⁴⁰ The note sets out the rationale for continued engagement in the Solomon

³⁶ UN 2015. Transforming our world: the 2030 Agenda for Sustainable Development. Quote: *We recognize that the full implementation of the Addis Ababa Action Agenda is critical for the realization of the Sustainable Development Goals and targets.*

³⁷ Addis Ababa Action Agenda of the Third International Conference on Financing for Development (Addis Ababa Action Agenda) The final text of the outcome document adopted at the Third International Conference on Financing for Development (Addis Ababa, Ethiopia, 13–16 July 2015) and endorsed by the General Assembly in its resolution 69/313 of 27 July 2015. In particular see Section C. International development cooperation.

³⁸ Commonwealth of Australia. Design Summary and Implementation Document (DSID) for the Health Sector Support Program - Phase 2. July 2012.

³⁹ Program Management Review for GoA support to the Solomon Islands Health Sector. Options Paper. Mick Foster. November 2013.

Islands health sector and justifies the funding modality proposed, that is, continuing whole sector support implemented through national systems with additional measures to manage a number of identified risks. It identifies how progress will be measured and suggests staff resourcing requirements to manage the program. It highlights the substantial risk of losing gains made during HSSP in not continuing support. It would seem to this review team that this analysis has been proven correct, with many of the conditions at that time still pertaining.

While the design approach poses some difficulties in conducting a formal evaluation, the design documents and various other documents emphasise that the approach is to support the SIG and the MHMS to manage and oversee health in Solomon Islands. This has happened.

HSSP2 was further itemised in the HSSP Partnership Arrangement Document signed between the government and the participating Development Partners (DPs), which specified the guiding principles, shared objective and implementation responsibilities of the partners.⁴¹ HSSP2 was formalised in a written intergovernmental agreement between the SIG and the GoA (DFAT agreement Number 64501)⁴² further revised by an exchange of letters in December 2014, which addressed various issues including some of those reflected in Mick Foster's analysis. Therefore as anticipated and planned, the approach of HSSP2 has evolved over the lifetime of the support in discussion with government and partners and this process approach is evaluated as such.

The focus of NHSP has incrementally shifted over the time of HSSP2, led by the MHMS but reflecting an on-going dialogue with Australia and other partners. The incremental changes in the operationalisation of the NHSP by the MHMS are reflected in the AOPs of each year. Most notable has been the progressive shift from centrally planned, funded and managed implementation of activities in the provinces to funding delegated to the provincial budgets. This has been facilitated by support to the production of provincial AOPs by HSSP2. This has been accompanied by the introduction of earmarked provincial funding with HSSP2 targets for provincial budgets being set at 15 per cent in 2013, with the subsequent introduction of Provincial Performance Payments that are assessed at each JPA. This has been a success and the 2014⁴³ JPA states:

The main strengths shown by analysis of the 2104 performance indicators are the continued flow of increased financial resources to the provinces and improved performance of the operational planning/budgeting, financial management and Health Information systems at the provincial level. This groundwork provides the opportunity to move to a much more active outcome focus, with all parts of the MHMS playing their role in using resources efficiently to improve sector outcomes.

Possibly the main changes at the central level have been in financial management. Firstly, in the way that HSSP2 funds are dispersed to SIG – with a move to a reimbursable model and secondly, the financial management regulations introduced and strengthened following the

⁴⁰ Solomon Islands AusAID Health Program 2012-2016. Concept Paper. Dr Stewart Tyson. 8 February 2012. Health Resource Facility. Presented as Annex D of DSID (*ibid*) for the Health Sector Support Program - Phase 2. July 2012.

⁴¹ Partnership Arrangement Between SIG and Health Development Partners, 2012

⁴² DFAT agreement Number 64501. Final Countersigned Amended Direct Funding Agreement, December, 2014

⁴³ Slatyer. 2015. *ibid*.

fraud and the subsequent issuing of the Public Financial Management (PFM) Directive⁴⁴. Other issues have seen further changes. HSSP2 supports a public-private-partnership in food fortification, (starting in July 2015 which will see flour fortified with iron, zinc, folate, thiamine, niacin, and riboflavin, and with rice added in 2016) and “Communications 4 Development” and Sanitation support, after recognising that more sophisticated demand side and health promotion activities were required to improve public health outcomes. The flexibility of HSSP2 has been a major positive aspect, but results in an increased management load for DFAT staff.

The flexibility of HSSP2 to support the MHMS in addressing emerging health issue (for example food fortification) within the broad outlines of the national plan has been much appreciated by the MHMS.

Other partners

The SIG/DP Partnership Arrangement recognised SIG's commitment, ownership and leadership of the SWAp, along with the support of DPs, communities, non-government organisations and the private sector across Solomon Islands and the important role of Development Partners in supporting SIG to improve and maintain health service delivery. All parties to the Partnership Arrangement supported the centrality, transparency and accountability of SIG budget and planning processes, including the Medium Term Expenditure Framework (MTEF),⁴⁵ agreed to work in accordance with MHMS governance and management structures and principles, participate in the Solomon Islands Independent Performance Assessments (IPAs) and in the meetings of the Development Partners Coordination Group (DPCG).

One unusual factor in the partnership in Solomon Islands is that a significant amount of the funding supporting the work of the multilateral partners (and the partners except for Australia are all multilateral agencies) comes by varying routes from Australia. The reason for this is that Australia is actively diversifying the partners it is working with by bringing in the comparative advantages of other organisations such as the World Bank and WHO. This factor perhaps somewhat increased the dependency factor of the SIG on the one donor.

The contributions of the various DPs other than Australia in support of the MHMS in the implementation of the SWAp are not assessed in this review which is limited to the Australia funded HSSP2 project. However, it is accepted that this support is significant, and that supporting the MHMS in the delivery of health is a team effort.

⁴⁴ DG Direction on Controls on AusAID Funds Through Partner Systems in Melanesia. Unclassified Internal AusAID Minute October 2013. Ibid.

⁴⁵ Ministry of Health and Medical Services. November 2011. Medium Term Expenditure Framework. SIG.

4. The purpose of the evaluation⁴⁶

The aim of this evaluation is thus to evaluate the performance of Australia’s support to the Solomon Islands health sector to collect evidence to help improve Australia’s next phase of support. Specifically, this evaluation seeks to:

- Conduct an analysis of the overall health sector to inform the assessment of the relevance of Australia’s contribution to the sector.
- Evaluate Australia’s bilateral program of support to the Solomon Islands health sector over the period 2012-2015, including an assessment of its relevance, effectiveness, efficiency and sustainability.
- Based on the evaluation findings, make recommendations to improve the relevance, effectiveness, efficiency, and sustainability for Australia’s future support to the sector.

The recommendations of this evaluation are intended to feed into the design of the next phase of Australia’s support. As such the primary users of this evaluation will be the GoA, represented by Honiara Post, DFAT and the SIG – primarily the MHMS, but including other relevant ministries – for example the Ministry of Finance and Treasury (MFT) and the Ministry of Development, Planning and Aid Coordination and their various appointed agents. Secondary users of this report may be other development partners in planning their future support in parallel to or alongside any Australian funded support.

Summary of the evaluation methodology

The evaluation was conducted in two phases using a mixed methods approach including document review and analysis, field visits and stakeholder interviews, and review of project and other data, including government and financial data. The literature review began on 25 May 2015 with the in-country visit conducted 18 June to 2 July 2015 (see Annex 2).

Table 2: Summary of evaluation methodology

Phase 1: Document and literature review
Review and analysis of existing primary data / literature
Review and analysis of existing secondary sources / literature
Review of documents and data not readily available but identified during field work
Analyses of data / information
Phase 2: In-country Visit
Interviews with selected key informants
Visits to two selected Provinces and interviews with key informants
Triangulation and verification of quantitative and qualitative data
Observation of central level and provincial health facilities

⁴⁶See Annex 1, the ToR, Purpose, page 3.

Where project and government data were not sufficient for the purposes of the review, the review team sought further information from government and partner staff – including from in-line and other TA staff. The team identified several additional documents and resources and the DFAT team were extremely helpful in providing access to the documents.

Field visits included:

- Guadalcanal: meeting with the Provincial Health Authority, visits to the NRH and Good Samaritan Hospital.
- Central Province: visits to Tulagi, meetings and group discussions with the Provincial Health Authority, viewing the second level medical stores and a visit by boat to Tarbawara Area Health Clinic.
- Makira-Ulawa Province: meetings with the Provincial Health Authority, visits to the provincial hospital, the second level medical stores and visits to two peripheral health units by boat, Kerepe health clinic on Ugi island and Maonosugu health clinic.

Data from the literature review and the in-country visit were triangulated and verified where possible. Discrepancies in information (both in qualitative and quantitative data) were noted. Quantitative data were compared with qualitative data available from government, program and consultants reports and discussions/interviews in the field from implementers and partners to confirm reliability. There was a very well attended and useful focus group session with National Program Directors. Qualitative data collected in group discussions and interviews were examined for themes, and compared and confirmed with data collected across the program. A meetings program for the in-country visit is shown at Annex 2.

Limitations of the evaluation

- The ToR call for the team to conduct an analysis of the overall health sector to inform the assessment of the relevance of Australia's contribution (Annex 1). Whilst this was possible to some extent, in the time available, the evaluation of the sector was limited to the data readily available and did not entail a full and detailed new analysis of the whole health sector. While there is extensive documentation of HSSP and HSSP2, there is less formal documentation of the health sector as a whole, particularly the capacity constraints. This is addressed in the recommendations.
- The ToR call for recommendations to improve the relevance, effectiveness, efficiency and sustainability for Australia's future support to the sector. However, given the fiduciary concerns identified in the ToR, and confirmed during the in-country work, recommendations are likely to carry different levels of fiduciary risk, a level of risk that this evaluation is not equipped to assess fully. Detailed fiduciary risk and procurement assessments had been completed just before the fieldwork for this review was completed. The preliminary results were available to the evaluation team and the recommendations of this evaluation should be interpreted in conjunction with the recommendations of the fiduciary risk and procurement assessments.

5. Findings and Analysis – performance and role of Australia's investment

This section is grouped around the four key areas detailed in the ToR: relevance, effectiveness, efficiency and sustainability. The final section provides comments on the modality of Australia's investment and management of the health portfolio.

Relevance

The team considered the relevance of HSSP2 against three main aspects: its policy alignment; the consistency of funding and relevance in relation to the burden of disease and details some conclusions from the team's findings. HSSP2 was found to be relevant in relation to all these parameters, but the relevance of the program could have been improved by a greater MHMS (and therefore HSSP2) focus on nutrition (stunting), family planning (contraceptive prevalence rate 27 per cent) and in the management and prevention of NCDs, which did not receive sufficient focus in the NHSP 2006-10. However, these comments are made with full hindsight and have been addressed in more recent AOPs with HSSP 2 support (see comments earlier about the positive response by MHMS to the flexibility of HSSP2 support) and are being addressed in the draft NHSP 2011-2015.⁴⁷

Policy alignment

HSSP2 is designed to support the SIG's own NHSP (2011-2015), and as such is fully consistent with the SIG NDS.⁴⁸ At design, HSSP2 was fully consistent with the GoA policies and strategies of the time. The program is supportive of both Australia and SIG commitments to the various Paris, Accra and Port Moresby Declarations and is supportive of the Solomon Islands–Australia Partnership for Development. These policies strongly support the SWAp approach taken by HSSP2. Furthermore, HSSP2 is fully consistent with the DFAT Health for Development Strategy 2015-2020 (H4D).⁴⁹ For further analysis, see Annex 4. More recently, HSSP2 implementation has been revised to comply with the PFM Directive. To follow the current Australian and SIG policy directives it would be expected that HSSP3 would also adopt a Sectoral funding approach. Furthermore, this would maximise investment to date.

Continuity and dependability of funding

HSSP2 was developed from HSSP with essentially no break in support⁵⁰. The funding has been continuous, except that there was a temporary hiatus in funding in 2013 while a major fraud was investigated and a unilateral reduction in allocated budget by Australia in 2015. The planning of 'HSSP3' is beginning in good time and allocation of appropriate funds seems to be likely. The delay in releasing grants in the first quarter of 2015 was due to delays in SIG budgetary processes following the change of SIG government.

⁴⁷ NHSP 2006-10, NHSP 2011-2015. Ibid.

⁴⁸ Ibid. Ministry of Health and Medical Services. March 2011 and internal draft.

⁴⁹ Health for Development Strategy 2015–2020. June 2015. <http://dfat.gov.au/about-us/publications/Documents/health-for-development-strategy-2015-2020.PDF>

⁵⁰ Although there was a hiatus in program design which was covered by using unspent funds from HSSP. It is hoped to avoid this problem with the next phase of support and this the early evaluation study.

The continuous nature (that is, not stop-start as project funding tends to be) and dependability (that is the ability for SIG to forward plan over multi-years with confidence) of the Australian funding has been a significant positive aspect in enabling the MHMS to plan efficiently and effectively and has increased the value of the Australian investment.

There were some recent uncertainties over the degree of future Australian support caused by a major review of the Australian aid budget, giving cause for some trepidation within the MHMS, but this issue is now resolved and the commitment to the Solomon Islands has not been reduced in the most recent budget announcements.

The consistency and dependability of the Australian funding should continue, flagging any possibility of future change to the SIG at the earliest opportunity. This is particularly important given the unusually large proportion of the health budget that Australian support provides.

Is the investment relevant to the burden of disease?

HSSP2 closely supports the MHMS NHSP. As such, given that the NHSP is designed to address the main disease issues and was formulated in discussion with DPs, including Australia, the Australian investment has been relevant to the burden of disease.

By placing HSSP2 funding in support of the NHSP, *de facto* Australia's support is placed to support the MHMS to deliver the most appropriate health care. Where the SIG and Australian priorities differ, this is resolved by the ongoing policy debates.

For example, in the early stages of HSSP2, the more rigid earmarking of funds by Australia for malaria control – and malaria elimination – led to some distortion of the SIG MHMS budget with greater budget allocation to malaria issues than might otherwise have been allocated.⁵¹ This earmarking has been adjusted throughout the life of HSSP2 to better balance overall budgetary allocations and to surrender greater control to the MHMS.

Disease burden focus needs adjustment

However, with hindsight, it is possible to conclude that there was lack of emphasis on some health areas in both the NHSP and consequently HSSP2. These are most notably family planning (contraceptive prevalence rate remaining low at 27 per cent) and stunting rates being unacceptably high. Once this was recognised, interim AOPs have been revised to address the issues and HSSP2 supports nutrition activities in Solomon Islands through the funding provided to the maternal and child health division (deworming, vitamin A supplementation etc.) (AUD0.5 million in 2015-16). HSSP2 also catalysed the food fortification in Solomon Islands, with fortification of wheat flour with six essential vitamins and minerals (see above).

Major new investments are planned – for example, the European Union (EU) funded RWASH support. At the same time, the MHMS Universal Health Care Policy / Role Delineation / De-concentration Policy is focusing activities and investment decisions.

⁵¹ Leading to the National Vector-Borne Disease Control Programme previously being ironically referred to as the 'Ministry of Malaria' due to its significant external funding from Australia and the Global Fund.

Emerging and additional priorities have been recognised by the MHMS and partners and are prioritised and addressed in the New NHSP 2016-2020, now in early draft⁵². The pattern of disease is changing with NCDs contributing an increasing number of Years of Life Lost (see section 2.2 above) with diabetes and stroke major contributors to the burden of disease.⁵³ Preterm birth complications are becoming more important in securing further reductions in the infant mortality rate, although malaria, diarrheal disease and malnutrition remain significant factors.⁵⁴

Effectiveness

The team considered effectiveness of HSSP2 against the effectiveness of service delivery, the effectiveness of the focus on results, the effectiveness of increased provincial service delivery support and the effectiveness of financial management and control systems. Overall HSSP2 has significantly contributed to the effectiveness of the health sector in the Solomon Islands, but the effectiveness of the SIG program could have been improved by greater focus on user friendly AOPs, and the effective use of the MTEF or latterly Medium Term Expenditure Plan (MTEP) as forward planning tools.

Effectiveness of Service Delivery

With HSSP2, support to essential primary health interventions is delivered throughout the country. Skilled birth attendance has been maintained at 89 per cent; over 424,000 long life insecticide treated bed-nets have been distributed since 2010 (2015 target, 500,000), essential medicine availability at primary health facilities increased each year and is now 73 per cent. In 2014, 42 per cent of the MHMS budget was allocated to the Provinces against a target of 37 per cent. This has been supported by the Australian investment.

HSSP2 has supported MHMS in significant improvements in delivery of drugs and supplies to second level health medical stores and improvements in the availability of essential medicines at the provincial hospitals and in area health clinics and other community level facilities. In addition, with direct support from HSSP2, the MHMS DHIS has been improved and now is effective in reporting on services delivered at the provincial and rural facility level. The integrated health information system is in place in all Provinces, and facility-based information is available to enable the MHMS to plan more effectively.

Focus on results

Beginning in 2008, HSSP aligned support to the MHMS and thus the objectives of the NHSP and helped to establish a set of annual indicators tied to the release of funds. The introduction of the performance-linked payments has focused the program on results as contrasted with other possible approaches based on inputs or processes. This has focused SIG performance on the achievement of results and led to dialogue on best approaches and systems, and procedures to improve performance and reach the indicated levels of results. Indicators were developed in a number of areas. Overarching indicators were established requiring the SIG to allocate at least 10 per cent of domestic sources of revenue to the recurrent health budget and more latterly to implement the PFM Directive regarding financial

⁵² National Health Strategic Plan 2016-2020. Early incomplete internal draft provided by MHMS Planning Division in hard copy.

⁵³ GBD Profile. Ibid.

⁵⁴ Solomon Islands Child Health Strategy 2011-2015. Ibid.

management. Indicators also were established at the national level and at the provincial level focusing on organisational and management issues and specific program result indicators were established measuring the progress in improving health status.

The evaluation team concluded that this focus on results was critical to the successes of HSSP2, as it has allowed the progressive loosening of earmarking as focus moved from input monitoring to results monitoring. This resulted in '*reinforcing the need for an outcomes focussed approach to planning and management that prioritises basic service delivery, including outreach*',⁵⁵ and has resulted in significant improvements in program organisation and management and to date has provided the primary focus for the SIG-DFAT policy dialogue.

Good progress has been made in organisational and management issues, which are the focus of both national and provincial indicators, and in establishing administrative and financial confidence at the health sector level at both national and provincial levels. The MHMS has met its targets in budgeting and planning (national indicator) and the use of AOPs and budgets at the provincial level (provincial indicator) is a significant step in decentralisation and local management. Financial reporting and accounts reconciliation also has been satisfactory. These are the foundation for a SWAp and the best indications of its effectiveness⁵⁶. The national and provincial indicators are focused on elements that form the basis for a SWAp and these aspects seem to be established and working.

Provincial service delivery support

Working with the MHMS HSSP2 introduced a performance-based element to the Australian funding to the Provinces. This has effectively focused SIG attention and the attention of MHMS Directors on shifting budget to the Provinces.

The SIG has exceeded its targets for the allocation of recurrent health budget to the Provinces. The target for 2014 was set at 37 per cent and in 2014, 42 per cent of the budget was allocated to the Provinces. In addition, all Provinces prepared costed AOPs, which served as the basis for the national MHMS allocation of resources. These guide the implementation of the program at the provincial level. The AOPs were linked to the budget and submitted through the MHMS Budget and Planning Subcommittee within funding ceilings and on time for national review.

Health program funding and expenditure shifted significantly from the national MHMS to the Provinces, bringing resource allocations closer to service delivery in order to improve their effectiveness. Local management of staff and facilities should produce efficiencies in program implementation through the consolidation of outreach activities and better scheduling and responsiveness to local requirements for drugs and pharmaceuticals and services provision and back up. However, this will require additional provincial health management capacity and capacity building in order to take full advantage of this potential.

PHAs will need additional control over staff operating at the provincial level including the staff of vertical national programs. They also need authority over human resource issues including absenteeism and discipline issues. The need to improve outreach to improve

⁵⁵ Slatyer, B. April 2015. Solomon Islands Health Sector, Joint Performance Assessment 2014. Health Resource Facility.

⁵⁶ Slatyer B. *ibid*.

results in family planning and nutrition focuses attention on the need for increased control and improved management at the provincial level and specifically in the PHA. Some issues may be addressed through the RDP, which will realign services to be provided at different levels and result in changes in facilities, equipment and staffing.

Other provincial improvements that have been supported by HSSP2 include expansion of the DHIS, which now covers all Provinces. This has significantly improved the effectiveness of the Monitoring and Evaluation (M&E) aspects of government, and therefore of HSSP2. The system collects data at health facilities and consolidates at the provincial level. The information system permits analysis of facility utilisation and disease patterns, drug utilisation and comparison of provincial results and requirements. DHIS reporting has been improving each year and all Provinces are reporting on time although the all required data is not included in some reports. DHIS reports are one of the HSSP2 selected core indicators. This improvement was led by HSSP resources.

A further major element of systems effectiveness improvement has been in drug procurement and distribution. This was supported by HSSP and support has continued in HSSP2. This has been managed from the national level, however the system is increasingly responsive to provincial and local health facility requirements. The drug distribution effort has been effective and availability at the provincial second level medical stores (SLMS) and facility level has been improving each year. The availability of drugs at the SLMS (provincial) level is one of the HSSP2 selected core indicators and is a major effectiveness achievement of HSSP2.

Effectiveness of financial management and control systems

Strengthening government systems has been a focus of Australian support since it began with HISP. With HSSP, the World Bank focused its support on planning and financial management support, and this support was instrumental in the introduction of the AOPs and the MTEF or latterly the MTEP.

The critical need for the correct implementation of effective financial management and control systems was brought to a head by the discovery of fraud involving Australian funds in 2013. The investigation by SIG in collaboration with DFAT resulted in significant improvements in financial control systems and the introduction of the PFM Directive by Australia.⁵⁷ This has necessitated the introduction of additional control measures. However, the overall effect of the newly introduced control measures are to effectively implement SIG rules and regulations that were already in place – just poorly implemented to that date.

This included strengthening the Planning and Finance committee that prioritised decentralisation and ensured the allocation of funds to the provincial health programs. This also resulted in all Provinces completing an AOP during 2014. MHMS established an Audit Committee and an internal audit group, introduced fiduciary controls in all Provinces, and worked with Finance and Treasury to strengthen financial controls at all levels of the system.⁵⁸ HSSP2 provided technical support to this improved financial control system and worked collaboratively with the MHMS, which has made significant administrative changes to institutionalise the financial control system.

⁵⁷ *Ibid*

⁵⁸ The MHMS Audit Committee is regarded by the MFT as the best functioning of any Ministry and an example to be followed.

Barriers to effectiveness

Annual operational plans

While the introduction of the AOPs has been a major achievement in implementing the SWAp and HSSP2, they are relatively complex and some MHMS officers remark that they have a history of frequent change. The result would appear to have been significant investment in TA support to assist in the production of the AOPs in a timely manner. Conversely, the plans have indeed been completed in a timely manner and there appears to be a significant degree of ownership of the plans by directors and provincial staff. There may need to be continued support to ensure the timely production of the AOPs in the next phase of support.

Medium Term Expenditure Framework and Plan

The MTEF was put forward in 2011. The document notes that:

The production of this MTEF has been externally driven and there is still much more to be done to ensure that it becomes owned by the finance department in the Ministry,

and states that further development of the MTEF should be seen as an on-going progress, with medium term comprehensive financial planning being updated year by year. It presents plans for ongoing capacity building. Unfortunately, this does not seem to have happened and no updated version of the MTEF or Plan was seen, though this is referred to in the draft of the new NHSP. This is somewhat concerning as the 2011 MTEF report identifies several proposed or ongoing items that would have the potential for significant financial consequences for the health budget⁵⁹. These include:

- Organisational Review.
- Hospital Costing (including the potential for greenfield construction of a new referral hospital).
- Role Delineation.
- TA Requirements⁶⁰.
- Workforce plan - Improving the costs of training needs and TA.
- Infrastructure Plan - improving the costs of Infrastructure.

Whereas these items have been identified since 2011, the potential for unknown future costs with regard to these items continues to be of concern to partners, and with regard to TA costs of concern to SIG. In the absence of an updated MTEF, or alternate longer-term financial planning tool, there is no obvious mechanism whereby these issues can be easily discussed between partners. It would be timely to have an updated version of the MTEF in discussing and agreeing the new HSSP 2016-2020.

⁵⁹ Medium Term Expenditure Framework. Ministry of Health and Medical Services. November 2011

⁶⁰ The MTEF notes the significant real and opportunity costs to SIG of the DP provided technical assistance across the health program.

Efficiency

The team considered the efficiency of HSSP2 against the efficiency of the budget support model, the shift of resources to provincial budgets and provincial service delivery management and the focus on primary and preventive care. Overall HSSP2 has contributed to the efficiency of the health sector in the Solomon Islands, the primary effect being brought about by the HSSP2 focus on primary and preventive care. In addition to direct HSSP2 support, the main effect was through its policy focus on primary and preventive care in the policy debates with SIG. The main barriers to efficient program implementation were the missing tools used for forward financial planning which limited the forward policy debate.

The budgetary support model used is one of the most pure used in the various SWAp seen by the review team. Efficiency improvement is the key result of such a SWAp model. HSSP2 has supported and encouraged this approach, based on alignment with the NHSP. As such, the Australian support has been a significant driver to encourage efficiency in the health development sector and the SWAp approach reduces transaction costs for government. The Solomon Islands achieves good and equitable health results at a small fraction of the costs in other Asian and Pacific countries with minimal out-of-pocket expenditures.

Budget support

Sector budget support has helped MHMS organise around AOPs and budgets that drive service delivery and improve efficiency. Sector budget support and donor coordination as practiced by SIG and GoA reduces transaction costs, resulting in more efficient delivery of services, especially provincial services for the poor.

Good progress has been made in bringing together plans and budgets and producing information for decision-making.⁶¹ DFAT support is generally 'on-plan', 'on-budget and "on system"⁶² and SIG and DFAT encourage other development partners to also align with the MHMS plan and budget. Other donors are mainly on-plan, but most are off-budget and "off system" although they are making efforts to coordinate budgets with the MHMS budget cycle to the extent possible.

Shift to provincial focus

HSSP2 has supported the MHMS and the NHSP in its efforts to shift resources to provincial service delivery and invest more in prevention and public health functions, which improves efficiency. The system functions reasonably well as a nurse-led primary health care system, providing equitable access to basic health services at the provincial level⁶³. HSSP2, by supporting a program monitoring indicator in coordination with the MHMS for the percentage of budget allocated to the Provinces has aided the MHMS to direct increased resources to provincial health, which has improved service delivery efficiency. Support was also directed towards improving the delivery of medicines and supplies at the provincial secondary stores and area health clinics. This further supports provincial service delivery and improves provincial service efficiency by making drugs and medicines available at the point of service.

⁶¹ Slatyer B. 2015. *ibid*.

⁶² On-budget also infers managed through government systems. On system infers funding channelled through HSSP account. See glossary preface.

⁶³ Asia Pacific Observatory on Health Systems and Policies, Solomon Islands Health System Review; Health Systems in Transition, Vol. 5 No 1 2015

Focus on primary and preventive care

Health is most efficiently delivered by concentrating effort (funds and personnel) on primary and preventive care.⁶⁴ The Solomon Islands health system as a nurse-led primary care system is relatively efficient in delivering good health outcomes. It achieves high coverage of services,⁶⁵ which have been identified as critical to system efficiency. This model of health care delivery is also the approach best suited to having an effect on NCDs that are an evolving focus for the Solomon Islands health system as NCDs form a greater proportion of the burden of disease. Reducing these predominately life style diseases will require a communications strategy, which may be most effectively implemented through a personal and community-based approach.

Barriers to efficiency

Lack of regular planned investment in infrastructure stock

While the health system, following the NHSP, has efficiently increased coverage and delivered primary and public health services, it has not routinely invested resources in improving the physical condition of health facilities or in equipping or re-equipping these facilities to maintain or enhance capabilities. This is both at the provincial hospitals and area health clinics and at the secondary and tertiary levels, including the NRH. Provincial and lower level health facilities need repair, renovation and maintenance and have not received the necessary support to improve their physical condition. There also is a need to improve the quality of the equipment provided to these facilities. These improvements, while needed, will adversely affect the efficiency of the health system. Diversion of resources from preventive and primary care towards capital improvements, while needed, will make the health system less efficient unless carefully planned.

Missing tools used for forward financial planning

As mentioned in the previous section, one of the lacks of HSSP2 is the apparent absence of appropriate tools (for example a current MTEF or other fully costed rolling forward plan) by which to assess and plan for significant additional or new expenditures, which have recurrent cost effects. While the major capital investment mooted at the start of HSSP2 using rollover HSSP funds was cancelled,⁶⁶ other examples remain. Examples include a new green-field NRH and the investments needed for the upgrading of peripheral units if the RDP is fully implemented⁶⁷. While the document seen (see footnote) states that the goal of Universal Health Care (UHC) is to ensure that everyone in the Solomon Islands has access to an affordable package of quality health services, there appears to be an assumption made that, given the funding model of the health sector in the Solomon Islands, that the upgrades necessary to implement the policy will be funded by government and its donor partners. This

⁶⁴ http://www.who.int/topics/primary_health_care/en/. Accessed 27 August 2015.

⁶⁵ Foster November 2013. Ibid. pg 8 ff.

⁶⁶ Solomon Islands Malaria Training and Research Institute.

⁶⁷ The RDP reflects the principle of UHC and was developed through a series of consultations and meetings beginning in 2011. The policy is a tool for better defining the range and level of services – or packages of care – to be delivered to given populations across the Solomon Islands. The policy forms the basis of the UHC/RD program that aims to further develop, upgrade and extend rural health services under primary health care. The goal of UHC is to ensure that everyone in the Solomon Islands has access to a package of quality health services without falling into financial hardship by paying for them. From: *Service Delivery Packages for Solomon Islands Primary Health Care Services*. MHMS. January 2014

could involve considerable capital expenditure over several years with accompanying possible additional recurrent costs. Also, see the previous paragraph about maintenance planning. The lack of formal forward planning tools is a risk to the efficiency of the remaining HSSP2 and to future HSSP3 investments.

Earmarking

When designed, and at inception, the HSSP2 had a significant earmarking component in the funding, not least for the malaria program. This was partly due to a legacy of regionally managed Australian support being funded from discrete allocations. DFAT staff have gradually realigned the Australian funding to ensure both greater relevance and increased efficiency of the support with reduction of regionally managed support and of management fees. This has increased the efficiency of the investment. Increased programmatic earmarking would decrease efficiency.

The PFM Directive

While financial management procedures strengthened following the PFM Directive which principally required the implementation of existing financial instructions of SIG, comments were made to the team during the evaluation that the system of disbursement for HSSP money had slowed to the point that activities were being compromised. The delays were reported to be within the MHMS rather than MFT. This review was not competent or able to validate these claims but notes that this has been addressed by the MHMS and DPs have been informed that, for those putting funds into the SIG/HSSP accounts, once funds are in, access cannot be immediate and processes need to be followed. An advance warrant takes about two weeks before requisition can be presented and before they advise division⁶⁸. An analysis of the potential for implementation challenges under various financial scenarios is given in Foster's Program Management Review⁶⁹.

Some MHMS cost centres reported devising mechanisms to circumvent perceived delays – for example by devolving additional funds to the provincial level, or by substituting the use of SIG funds for HSSP funds. While both of these approaches may in fact be desirable moves, the introduction of procedures that result in different financial management procedures for the disbursement of HSSP2 and SIG funds is likely to decrease the efficiency effects of the budgetary support approach. The PFM review is better placed to explore and resolve this issue and should advise on this issue.

Sustainability

It is unlikely that the SIG health system as it stands can become entirely self-supporting in the near future or the medium term. While SIG funding covers salaries, the Australian support contributes significantly to ongoing operational costs. If the Australian funding was to be ended or significantly reduced, it is likely that the health services would be compromised with significant consequences for the population, in particular for the poorest as those least able to access any alternative means of health care.

However, individual elements resulting from the HSSP2 support are potentially sustainable (given the caveat in the paragraph above). These are the systems improvements that are

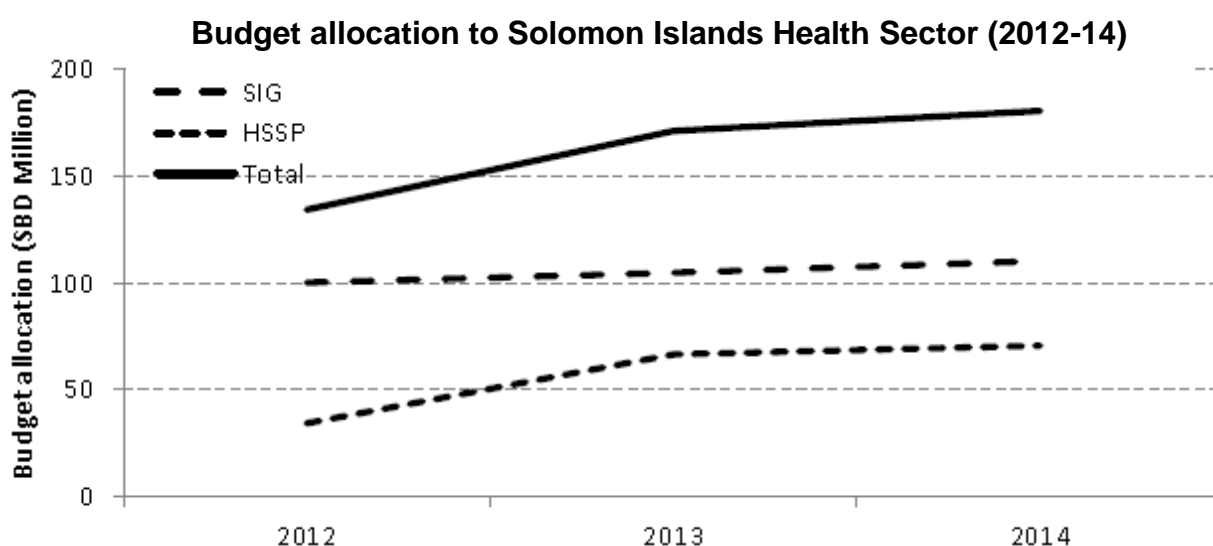
⁶⁸ Health Development Partners Meeting. Minutes & Action Register. Held Thursday 21st August 2014

⁶⁹ Foster November 2013. *Ibid.* pg 8 ff.

leading to efficiencies in the health system. Examples include the DHIS, the AOPs and the development of delegated provincial budgets and the drug procurement systems. Areas where further support is needed are the infrastructure and equipment procurement, and following the PFM Directive the financial management systems.

Sustainability of the Solomon Islands health program is dependent on the continuation of SIG support for health, continuation of the HSSP program support and both increasing cost effectiveness and lower costs in the Solomon Islands health program. The SIG has demonstrated good support for the health program. It has increased the percentage of government revenue expenditure allocated to health during the past several years and now provides the health program with 12 per cent of Government expenditure. See diagram below.⁷⁰

Figure 1: Budget allocation to Solomon Islands Health Sector (2012-2014)



However, this amount while good in relation to other Pacific countries, does not reach the level of support provided by many other countries. Many countries allocate more than 15 per cent of government expenditure for health. Antigua allocates 17.2 per cent, Rwanda, 22 per cent, Bahamas, 15.1 per cent, Tuvalu, 22 per cent, Nicaragua, 21 per cent, El Salvador, 19 per cent, and if the Solomon Islands is to improve its sustainability, it will need to allocate at least that level of resources to health. With reference to Africa, the World Health Organization (WHO) has proposed 15 per cent as an international norm.⁷¹ The DHIS has enabled MHMS to track program effectiveness and improvements in financial reporting have improved MHMS ability to identify cost savings. The allocation of funds to the Provinces has made it possible to integrate functions to improve efficiency. The integration of the malaria program at the national level has produced cost savings and this may be replicated in other programs as the Provinces assume responsibility for provincial service delivery. At the national level, the integration of broader systems such as Health Information Systems, procurement, equipment and health promotion, particularly in the provinces will help improve prospects for long-term sustainability. At the provincial level, as service delivery

⁷⁰ Kelly & K Tuckwell. 2013. *Ibid.*

⁷¹ Abuja Health Declaration (by African heads of State), WHO, September 2000,

responsibilities are transferred to the provincial health office, savings can be found by integrating outreach functions including immunisation, maternal and child health and family planning, antenatal and post-natal visits, community-based nutrition and providing preventive and promotive services at the community level.

However, the above analysis (particularly see the health financing paper prepared under the World Bank with Australian support)⁷² relies on ensuring cost-containment as well as improved efficiencies and highlights the need for robust Australian involvement in policy debate and forward financial planning.

The above being said, this does not mean that the individual components of the health system that have been targeted and supported by HSSP2 are not sustainable. On the contrary, particularly where the focus has been on systems development – for example in the DHIS, in the financial systems strengthening and in the pharmaceutical procurement systems – these improved systems show evidence of sustainability. This review recommends further focus on system strengthening (see recommendations) in the next phase of support.

Change in the MHMS – possible?

The 'political economy' of an organisation such as the senior management of the MHMS is complex and functions on several levels – both overt and hidden. This is particularly intense in a very small society such as the Solomon Islands. This situation is normal.

Yes, it is possible for Australian influence to effect change in the MHMS. This is proven by the implementation of the financial management changes in response to the fraud. However, this is also an example of a reactive approach, an approach that seems to have been the norm to identified capacity problems during HSSP2.

The 'lack of capacity' of the MHMS (at various times at all levels both centrally and in the Provinces) is identified anecdotally and across written documents⁷³ as a problem. The response to this has been to provide TA support, and TA support is consuming significant resources in TA costs. While surely an oversimplification, the working model appears to have been reactive (and the MHMS have been grateful of the flexibility of HSSP2 funding that has allowed this). However, there is less evidence of a strategic approach to capacity issues, or of a strategic approach to other remedies, the default option being TA, and not just TA, but long-term TA.

The focus to date (though certainly not exclusively) has tended to be on PFM issues, and significant advances have been made in this field. The main recommendations of this report are that the strengthening of the systems approach should be strategically expanded to all systems (for example management, HR, GESI, communicable diseases, NCD, health promotion etc.) and a formal in-depth capacity review of the health systems be conducted, from and following which a strategic plan for TA support can be crafted. This would seem particularly relevant given the rapid moves to delegation of expenditures to the Provinces combined with concerns over Provincial systems capacity. For more details see later.

⁷² World Bank. 2010. Solomon Islands - Health financing options. Washington, DC: World Bank.

⁷³ For examples see Kelly and Tuckwell 2013 IPA report, *ibid.* Health Development Partners Meeting Minutes & Action Register July 2014, Foster 2013. *Ibid.*

Attribution

Attribution has always been problematic in SWAp and some would argue for not attempting, but instead looking at the overall sector outcomes. This is summarised in a World Bank presentation, which states:

*donors give up 'attribution' for a voice over overall strategy/resource allocation*⁷⁴.

While as long ago as 1998 DFID was being advised that:

For development agencies, a major implication of a move away from project funding to is the loss of attribution. If an agency contributes funds to the general health budget of the nation, it is not possible to show what was achieved with its "own funds". This makes it more difficult to demonstrate results against objectives.

This has been further complicated as over HSSP2 Australian earmarking for specific 'programs' (for example malaria) has decreased, while earmarking for systems changes to improve overall efficiency has increased – for example the dedication of a percentage of funding to the provinces.

However, the Solomon Islands health SWAp is perhaps easier than others are, in that it Australia has built on the strengths of complementary development partners, all funded by Australia through a number of different funding sources (e.g. core funding, regional funds). Therefore, it could be said that without Australian funding a significant proportion of all health activities under HSSP2 would not have been possible.

What can be clearly said is that HSSP2 has worked with SIG to improve administrative and management performance and to develop and sustain a culture of performance across the sector. Given almost all health sector funding is publicly funded, without the Australian investment, and technical assistance from other partners such as WHO and the World Bank, it would not have been possible for SIG to deliver the level of health outcomes that have been achieved and that the investment has been strongly positive.

Innovation

Solomon Islands is the only country in Asia and the Pacific where earmarked sector budget support is used by Australian Aid to support a government-driven program. All significant funding supports a single sector policy and expenditure program, under government leadership, adopting common approaches across the sector. Only the Australian aid program provides un-earmarked funds at the sectoral level (as well as earmarked funds, along with other donors).

In discussing Australian support in Solomon Islands, Martinez notes in a recent Office of Development Effectiveness (ODE) report⁷⁵ that:

Earmarked sector budget support is an unusual approach, little discussed in the literature, which may warrant further study.

⁷⁴ Kanda, C. OPCIL. Sector-wide Approaches Concept, Applications & Implications http://siteresources.worldbank.org/EXTWAT/Resources/4602122-1213366294492/5106220-1213389414833/1.0Sector_wide_Approaches.pdf. Accessed 26 August 2016

⁷⁵ Sector-wide approaches in the health sector: A desk based review of donors' experience in Asia and the Pacific. Office of Development Effectiveness. J Martinez. March 2015.

The most unusual nature of the support is that it fulfils the conditions of a SWAp as described in the literature more closely than do many initiatives of this nature in other countries.

This is a strongly positive achievement of HSSP2 and DFAT should consider replicating the model more widely – perhaps after further study.

6. Modality of investment and management of the health portfolio

How effective, efficient and appropriate has the sector budget support approach been

The effectiveness and the efficiency of the program are described in some detail under the separate headings above. The evaluation team's assessment is that compared with other possible alternatives the approach was both rational, and offered the best opportunities for Australia to achieve its policy and strategy objectives and to deliver on its various international commitments relating to working with government in the Pacific and in Solomon Islands. See policy alignment, paragraph above.

At design, the following were considered in selecting the delivery modalities, partnerships and forms of aid in the delivery strategy and in the program design.⁷⁶

1. National and international commitments.
2. Opportunities for strategic engagement in the sector and capacity to maximise achievement of results aligned to SIG development outcomes and Australia's aid framework.
3. The impact of the projected SIG health budget over next five years on capacity to deliver services.
4. Implications of withdrawal from sector budget support on SIG financial planning.
5. The most appropriate form of aid to build national capacity for long-term sector stewardship.
6. Strength of national systems and identified weaknesses.
7. Findings of the "Solomon Islands Health SWAp Progress Review."⁷⁷
8. Findings and recommendations from the Assessment of National Systems (2011).⁷⁸
9. Findings and recommendations from the Procurement Audit and Review (2011).⁶⁵
10. Appropriate controls to protect AusAID investment, if working in Government systems.
11. Alternative approaches, such as targeted programs using earmarked funds and/or managing contractors.

These confirmed the benefits of continued predictable financing through sector budget support, along with targeted technical assistance, additional controls to protect against misuse of funds, ongoing policy dialogue, donor collaboration on service delivery and a framework for research and analysis.

⁷⁶ Commonwealth of Australia. AusAID Health Delivery Strategy for Solomon Islands 2012 – 2016

⁷⁷ Tyson, S. October 2011. Solomon Islands Health Sector Wide Approach Progress Review 2008-2011. Final Report. Health Resource Facility.

⁷⁸ Commonwealth of Australia. Included in DSID as annexes. *ibid*

The alternatives of a full traditional project approach using managing contractors was considered a retrograde step, contrary to the direction of policy change of both governments, likely to be considerably more expensive, and unable to achieve the desired transfer of ownership of the program to government. A managing contractor model running its own funds and advisers would not harmonise assistance with other donors or SIG and would be a regressive and inefficient step, which might reduce health outcomes and damage relationships with SIG.

The option of doing nothing (that is withdrawing from health after HSSP2) was considered unacceptable.

The view of this evaluation is that overall the conditions listed in the box above have continued throughout HSSP2 (the fraud issue being an anticipated risk) and that the budgetary support approach has not only been effective, efficient and appropriate but has also been innovative.

Approach and changes

How can Australian investment influence change – and should it?

Australian investment has profoundly changed the Solomon Islands health sector, mostly for the good. Without the Australian investment, the health services would not have recovered as they have after the tensions, and services now available would be significantly reduced.

The evaluation team considers that this has been a highly legitimate investment, and as far as the team could establish given the limited time available, the health investment has been one of the most valued components of the recent Australian investment, and has had a positive effect on the nation building aspects of the Australian led RAMSI support.

This does not come without cost and the feeling of 'interference' by the recipient nation. However, the use of the SWAp approach is the approach most likely to soften any negative feelings. The DFAT team is to be commended for its careful management of these issues.

Approach

A major thrust of HSSP2 has been to move DP funding on-plan and where possible on-budget and to reduce the degree of Australian fixed earmarking.

HSSP2 originally had a significant component of earmarked funding, principally for malaria but also for water and sanitation support. While this earmarked funding could be (and was) described as being fully on-plan and on budget – in that the Australian financial support was reflected in the government plans and budgets – the reality was that as the Australian support formed such an unusually large proportion of the government budget, the earmarked Australian support, in some instances drove the government plans. This resulted in the budget allocations and plans of some divisions – again most notably the National Vector Borne Disease Control Programme (NVBDCCP), which is responsible for Malaria – being effectively out of the control of the MHMS executive. This was reflected in that the NVBDCCP became known as the “ministry of malaria”. This was not completely due to the earmarked

Australian support through HSSP, but was also a factor of the then Global Fund⁷⁹ malaria funding.

This earmarking was understandable as it reflected an ongoing policy shift by Australia from regional Pacific-wide support models to a bilateral country-to-country mode of support⁸⁰. The program was managed from Canberra and while operational funds from the Pacific Malaria Initiative (PacMI) were on-budget (though controlled by NVBDCP) the TA support PacMI Support Centre (PacMISC)⁸¹, while on-plan, was not fully on-budget. The support through the Malaria Reference Group (MRG), a supra-national group to effect regional support and direction, was neither on-budget nor on-plan. Government did not fully control the off-budget elements and this had a negative effect on country ownership.

The move from formal earmarking of the previous PacMI funding to fully rolling this into the budgetary support element is a significant achievement of HSSP2 and this has strengthened government ownership of the malaria budget. Similarly, the move from regionally managed TA, to TA managed directly by the NVBDCP and the end of the MRG have further increased government ownership. However, the TA that is provided to support malaria remains off-budget with regard to the NVBDCP operational plan.

The situation with regard to malaria support is described in some detail as it provides a model within HSSP and HSSP2, and for HSSP3 whereby a shift is seen from project support with fully earmarked funding (controlled by Australia even if nominally on-budget), to greater MHMS control. Focus of Australian funding on Australian priorities is then effected by effective policy dialogue rather than by the partial 'projectisation' of funding through earmarking.

However, the TA provided by Australia and other DPs remains effectively off-budget. This report recommends that this should be corrected in HSSP3 where possible.

Sector budget approach

Fully on-budget, fully on-plan – multiyear planning

The Australian support to malaria in HSSP and HSSP2 also highlights the lack of an effective forward planning mechanism that links policy decisions with cost and budget implications. While the current years costs may be on-budget, for future year commitments, as stated in the draft NHSP, '*the actual decision on allocation to any item is taken at the time of the budget*'⁸². This is discussed in more detail in the sections on the lack of an effective MTEF/P.

The policy for the Solomon Islands as articulated by the NVBDCP, in its Malaria Plans, is of working towards malaria elimination. The forward costs of this policy (which may be significant in maintaining effective elimination given the open boarder with Papua New Guinea) were queried as early as July 2010⁸³. However, malaria elimination appears to

⁷⁹ The Global Fund to Fight AIDS, Tuberculosis and Malaria

⁸⁰ Australia - Solomon Islands Partnership for Development. Signed at Port Moresby by the respective Prime Ministers 27 January 2009.

⁸¹ Managed by University of Queensland.

⁸² Draft NHSP 2016-2020. Appendix 5. Ibid.

⁸³ Mike Toole, Caroline Lynch and Roberto Garcia. *Pacific Malaria Initiative Independent Progress Review*. Health Resource Facility, Canberra. July 2010

remain the policy objective of the NVBDCP⁸⁴, even if not overtly of the MHMS⁸⁵. Furthermore, while the Draft NHSP 2016-2020 does include a table of out of year cost expenditures (Appendix 5) the costs of malaria elimination (rather than control) are not included. It might be seen that malaria elimination (as opposed to control) was a policy advocated for by Australia and other DPs (through the MRG). This policy issue should be clarified through policy dialogue during the preparation of HSSP3, as if Australia wishes to continue to support elimination as policy for HSSP3 this will have future possibly significant budgetary consequences.

Fully on-plan, on-budget, on system – other development partners

At present, none of the other development partners supporting health (except for the Global Fund) are fully on-plan, on-budget and on system. The only donor that will possibly be so in the near future is the EU⁸⁶ when its planned funding focused in the water and sanitation sub-sector comes on-stream. Even so, this will be budgetary support channelled through the MFT, not using the same approach as Australian support.

For the other DPs and partners to the SWAp, all are making efforts for their support to be on-plan, but only United Nations Children's Fund (UNICEF) and WHO have attempted to put funding on-budget. The other main UN partner – the World Bank – has elected not to fund operational costs and only to fund TA.

The Solomon Islands SWAp is unusual in that the majority of the partners other than Australia are UN agencies, and there is not to date any another major bilateral agency engaged (accepting that the EU funding is on-budget through a different modality and that Japan have funded through Japan International Cooperation Agency (JICA) programs). International experience would seem to show that despite the best will in the world it is very difficult, for various reasons, for the UN agencies to channel their funding completely through the host government budget. Australia should accept this as a fact and while continuing to advocate for all DP funding to go through government systems, and not become overly concerned or devote substantial management time and effort if this is not the case.

The most effective role of the UN agencies in a SWAp may well be as the providers of specialist TA in support of the bigger bilateral donors. This seems to be the role that the UN agencies are adopting in the Solomon Islands, following the example of the World Bank. This is a very valuable role and should be encouraged. In particular, the World Bank's forward plans seem to have a reduced focus on health in Solomon Islands and Australia should seek to ensure that this partner does not completely disengage from the health sector (not that this is suggested to date).

Emerging donors

Solomon Islands is a Pacific nation, and as such is placed to attract development funding from agencies and emerging donors, which are not yet members – or at least not full members – of the SWAp. Japan has to date funded program support through JICA, but if major additional funding were to be on offer, they would possibly be discussed at the

⁸⁴ Ministry of Health and Medical Services. Directorate of Public Health. National Vector-Borne Disease Control Programme. *Malaria programme performance review 2013*. June 2013. This review comments that Political commitment towards progressive elimination of malaria was stated by the SIG..

⁸⁵ There is no clear statement of elimination as a policy in the current or draft National Health Strategic Plans.

⁸⁶ Though it is not clear how any TA will be funded.

government-to-government level. The DFAT in-country staff are fully aware of the possibilities of a new and or significant funder emerging and have monitored this through the DPCG and through diplomatic channels in-country. Any new donor should be encouraged to join the SWAp. At present DPs who are not yet members of the DPCG are encouraged to attend and discuss plans, even if they are not in the position to, or do not wish to, sign the formal partnership agreement.

A risk is that SIG may accept significant one-off funding for health, which will then impose future recurrent cost implications, which will affect the sustainability of future Australian investments in HSSP3. The DFAT health staff should continue to monitor this situation as before, and the senior diplomatic staff, both in country and in Australia, should be aware of the risks and assist the health staff in monitoring any developments.

The seat at the policy table

While progress has been strong and with positive results in HSSP2, one area that needs attention and strengthening in HSSP3 is 'the seat at the policy table'. A central tenet of the SWAp approach is that as DPs give up their right to direct their investments through projects and through directly managed managing agents, they do this in exchange for investing in the greater health plan, and so earning a seat and a voice at determining the overall policy and direction of the health sector. The situation is particularly delicate in Solomon Islands where not only do the DPs contribute an unusually large proportion of the health budget, but that the main donor (Australia) also is the leading supporter of RAMSI, which still has a significant presence in the islands.

The DFAT health staff are to be commended for the relationship that exists between the MHMS and the GoA in health. Anecdotal evidence suggests that strong and consistent Australian support to health, with early restoration of effective services following 'the tensions' and continued support since was a strong positive influence in ameliorating any possible negative feelings towards Australia's role in RAMSI as well as providing much needed services. However, Australia is not the only member of the SWAp and, whilst the largest financial contributor, is not necessarily always the most vocal. In Solomon Islands, the quality of policy dialogue has been compromised and MHMS leadership has appeared reduced, with donors visibly dominant and driving the process^{87,88}.

One area supported by HSSP2 which needs continuing attention in HSSP3 is in the engagement at the policy level. This has been a noted success of HSSP2, but there are some signs that further improvement is required, and improving the quality of policy dialogue with a continuing focus on empowering ownership of the process by MHMS should be a focus of HSSP3. There would appear to be a combination of factors needing attention.

- Lack of ownership of the SWAp management process by the MHMS with domination of the process by donor representatives.
- Limited capacity within the executive of the MHMS to devote significant time and focus to a process which they do not control (with this portrayed by some as overall 'lack of capacity' of the executive by some).

⁸⁷ M Kelly & K Tuckwell, *Solomon Islands Health Sector Support Program (HSSP): Independent Performance Assessment (IPA) for 2013*, Health Resource Facility, Canberra, May 2014.

⁸⁸ Personal communication from attendee at the 2015 JPA.

- Lack of coordination between the DPs themselves with difficulty in some partners (or resistance) in moving support on-plan as per their high-level commitments.
- Significant off-budget expenditure by all partners – including Australia. This is in TA procurement for all partners and in operational costs for many.
- Management of the SWAp process by the DPs with a DP managed secretariat rather than management by the MHMS. The 2013 IPR recommended the establishment of a SWAp management device that is useful to, owned by MHMS, and is not merely ritualised in its adoption⁸⁹. While in progress, this has not yet happened with the SWAp management process managed by WHO on behalf of the SWAp partners.
- Some recent uncertainty amongst both Australian and MHMS officials as to the degree and certainty of funding to be expected from Australia, following the change in Government, the consolidation of AusAID into DFAT and the subsequent Australian aid budget review. As Australia is the biggest and most significant donor, this was of critical importance to SIG in planning, but an issue over which they felt helpless to influence or control⁹⁰.

This issue is of particular importance to Australia as part of ongoing risk-management. Australia is currently (and possibly for the immediate and medium-term future) a significant contributor to the SI Health budget. As such, even though it does not nominally fund salaries, Australia supports the recurrent side of operations. Thus, policy decisions which have significant future recurrent operational cost implications (and there are several noted above) must be of concern to DFAT (and the MHMS) and are best discussed at a fully functional policy forum.

We would note on this issue that engagement in the DPCG requires significant skill and time on behalf of the DFAT staff. As the proceedings of this group can invoke substantial investment changes on the behalf of the MHMS, it is imperative that Australia is an active participant in order to protect any investment. This role has been very well fulfilled during HSSP2 but with a year still to run and a change of in-country staff imminent sufficient support must be given to allow the new staff time to bed-into this role and ensure continuity.

A further issue that may become more apparent as time goes by is the lack of formal representation of the provincial managers in the DPCG. This has been recognised, and provincial managers are invited to the annual health forum. However, a more formal participation may be required.

Does the current suite of health investments align with the priorities of the new aid paradigm?

Yes, HSSP2 does align with the priorities of the new aid paradigm. The four priorities are:

1. Pursues Australia's national interest and extends its influence
2. Impacts on promoting growth and reducing poverty
3. Reflects Australia's value-added and leverage
4. Makes performance count.

⁸⁹ Kelly and Tuckwell. Ibid.

⁹⁰ Eventually the Australian aid budget to Solomon Islands was not reduced, though other countries were reduced significantly. However, the period of uncertainty was unsettling for the program.

HSSP2 aligns with all four. For HSSP2 These are described in more detail in Annex 4 using an adapted version of the table in Annex 1 – *Application of the Australian Aid Policy tests to health* from the DFAT H4D document.⁹¹ There is however limited evidence of engagement with the private sector, despite attempts to address this issue. This is a result of very limited private sector in activity relevant to health in the Solomon Islands, combined with limited capacity (or desire) to increase out-of-pocket expenditure.

Health systems capacity and technical assistance

One of the most consistent comments made by all parties during this review was the perception that there was a 'lack of capacity' within the MHMS. Along with greater involvement in the policy debate (see above), this primary issue needs to be addressed in HSSP3. It is not possible to have a meaningful policy debate if there is no capacity to have that debate or implement the decisions.

Sector capacity

Although 'lack of capacity' in the MHMS was frequently cited (and not just by non-governmental representatives – sometimes by government officers themselves) there was less clarity around what this 'lack of capacity' entailed. It seems to refer variously – and not necessarily exclusively to:

- In a nebulous way, to lack of management capacity in the MHMS executive, particularly when referring to policy engagement and strategic planning (see above)
- In a very specific way, to lack of financial management and audit capacity following the fraud. These lacks have been addressed and ongoing support was in place both centrally and at the provincial level

While the financial management and audit capacity had been 'patched', relying heavily on TA in response to the PFM Directive there remained concerns about more long-term financial management capacity and 'will to change'. Perhaps the most positive view was expressed by the respondent who was positive for change this regard, but who felt that this was a generational issue, a generation being needed to change the mind-set of thinking of government resources as in common ownership and therefore rightly to be 'pillaged'

While the recent and increasing trend towards increased delegation of responsibilities for delivery of services at the provincial level to provincial health teams raised questions about their capacity to deliver the increased responsibilities, it was noted that this move to increased provincial delegation is not government wide, but restricted to the health sector. This is proceeding on a seemingly ad hoc basis, with some Divisions being early adopters and actively seeking to extend delegation to the Provinces (for example NVBDCP) while other Divisions were more reluctant to delegate budget and delivery. This also applied to some DPs.

While to date the concentration on systems strengthening has been mainly, but not exclusively, in PFM, the next phase needs to encompass all necessary systems – including the thorny one of HR. There will need to be attention paid to the sector capacity required to manage in an increasingly 'decentralised' system where activities are increasingly the

⁹¹ Commonwealth of Australia, Department of Foreign Affairs and Trade. H4D. *ibid.* Annex 1.

responsibility of non-central cost centres. The management needs are significantly different. There is evidence that this is already starting to happen with increasing TA support to the provincial level to build appropriate capacity – most notably in planning and budgeting the formulation of AOPs and in financial management with locally recruited TA embedded in provincial finance offices.

Technical Assistance – identification and deployment

The HSSP2 and its predecessors have used TA effectively to solve immediate problems of program implementation and to support capacity building. The primary model has been of long-term expatriate TA embedded in MHMS Divisions. More recently, there has been local long-term TA embedded at provincial level to support financial reporting (see paragraph above). Over the years, this has involved up to 18 expatriate TA. In addition, given the Australian support to central functions (for example the MFT) and through RAMSI there can be the impression that TA is reporting to TA – especially following the changes induced by the PFM Directive.

TA has served a number of roles, including performing staff functions in the MHMS, providing assurance and response to program crises, and designed to support building the capacity of departments and managers. TA is procured by several of the partners, with some (for example the World Bank) channelling all their support through TA. WHO also provides significant investment through TA as does Australia, which is the major funder of TA. In fact, as Australia is the major funder of the multilateral agency programs in Solomon Islands, even if TA is recruited and managed by the multilateral agencies (for example WHO), it may be funded indirectly by Australia. Australia thus recruits and fields TA for HSSP2 by two primary methods, both of which have opportunity and financial costs.

- Firstly, directly through a recruitment agency. During HSSP2 this has been the Pacific Technical Assistance Mechanism (PACTAM) managed by Australian Volunteers International and then Scope Global. While offering 'ongoing assignment monitoring, support and debriefing'⁹², PACTAM is essentially a recruitment and deployment mechanism, and is not and does not represent itself as capable of providing on-going technical support to the assignments. The TA reports to MHMS counterparts and to a varying degree, depending on the individuals, to DFAT in-country staff. Contracts are short, and there are high levels of 'churn' of staff. However, staff can be deployed relatively rapidly.
- Secondly, through partner agencies – for example WHO. While funded by Australian monies, these TA are recruited and managed by the host agency and are TA staff of that agency. They report in-country to that agency and are perceived by all to 'belong' to that agency not to DFAT (nor to the MHMS). As well as first costs, there is a management fee payable to the host UN agency. This methodology is used for specialist technical support where the multilateral agency is perceived to have particular expertise – for example historically malaria and WHO.

There is a third method of recruitment used by DFAT – though much less significant in HSSP2 – and that is of recruitment by DFAT of short-term TA either directly (rare) or through the Health Resource Facility for Australia's Aid Program (HRF), now known as Specialised

⁹² <http://www.australianvolunteers.com/programs/technical-assistance/pactam/> Accessed last 12 August 2015

Health Services. This TA is primarily used to assist DFAT to manage the DFAT program (for assignments similar to this evaluation for example) or where short-term intermittent support is needed for the SWAp (for example fielding an independent consultant to assist the JPA). This mechanism provides technical support to its consultants and as such is more expensive than direct hire – but much less managerially demanding for DFAT staff.

The vast majority of TA is procured by DPs on behalf of Government using the procurement system of the DP⁹³. However, there does not seem to be a formalised forward plan for technical assistance agreed between the MHMS and DPs. The mechanisms that do exist for identification of TA could be interpreted to be reactive, and as these decisions are made in the DP dominated and led DPCG in some cases there have been questions about ownership of the TA and whether the drive for TA came from DPs or the MHMS.

Technical assistance – management

TA reporting relationships also cause confusion in some cases. TA is procured directly by the DPs and deployment coordinated through the DP dominated SWAp partners meetings. This does not allow effective management and control or ownership by the MHMS.

It was described to the review team that there was a continuum among the individuals occupying the TA positions, with some seeing themselves as very firmly responsible to their government counterpart, and others seeing their primary responsibility to DFAT or to their managing agency while supporting their government counterparts. These, sometimes subtle differences in allegiances were observed by the team during the field visits.

That this fundamental issue of ownership and responsibility is not clear in day-to-day work (even if it is nominally clear in ToR) must be a cause of lack of clarity for MHMS staff, and may be one cause of a perception of lack of capacity within MHMS by the individual TA members where this exists⁹⁴.

Technical assistance – not fully on-budget

While the estimated costs of TA are reflected in the MHMS non-appropriated development budget, the costs are not reflected in the departmental AOPs. The reasons for not divulging the TA costs in the AOPs (or to receiving governments generally) are well known. Firstly, it is a common problem in SWAps that while international partners see the pressing need for international TA to support their investments, that government is loath to pay the required costs once publically known. Furthermore, there is concern (and from the experience of one of the authors of this report who has been through this process personally legitimate concern) that these costs will be misinterpreted by government officers as salaries to the individuals, rather than costs, with consequent potential damage to relationships with government officers on government salaries – or stories in the press.

That being said, while there may be some justification for withholding TA costs in project funded support, there seems less justification in the SWAp approach and this report recommends that the costs be moved from the non-appropriated development budget and

⁹³ Although in the case of the World Bank this may be the same as the SIG own system.

⁹⁴ For example, if an individual line manager does not trust a TA to be loyal to him/her, it will prejudice what the line manager asks or allows the TA to do – possibly creating the feeling of lack of capacity within the manager in the TA as 'she/she is not using me to best advantage'.

are reflected in the departmental AOPs. This does not imply any change in the recruitment or management methodologies for the TA.

Technical assistance – what is it there for?

There has been a long tradition within Australian development assistance – and also internationally – that unless deliberately justified and stated otherwise, the primary purpose of TA should be to build capacity with the receiving organisation in order that the TA is eventually no longer needed. The primary arguments for this approach seem to be around sustainability and the inherent sovereignty of the host nation.

It does not seem clear whether there has been a consistent approach to capacity building in HSSP2 and it may be that this has (perhaps correctly) differed over time in response to circumstances or that the degree of balance between capacity building and filling a line function has varied for different positions and at different times. This needs to be clarified.

Technical assistance – way forward

The unique circumstances of the Solomon Islands and its relationship with Australia (the tensions, the presence of RAMSI, the repeated natural disasters and the recent urgent need to strengthen financial systems after the fraud) have created particular circumstances.

However, it remains the case that there seems a need for a more strategic approach to TA provision in Solomon Islands. Given that a further phase (HSSP3) of support is being planned this seems timely. The capacity development approach should be examined and detailed.

This review recommends a fundamental review of TA needs and delivery mechanisms. This should be subsequent to a systems capacity review to first identify TA needs. Then the costs of any TA plan for HSSP3 should be fully shared with MHMS to allow them to participate fully in the design process in an informed way.

7. Risk Management

Risk management is a primary concern of the DFAT in-country team and consumes much time and management effort. It is the inherent nature of a SWAp that a degree of day-to-day control is surrendered (and in the case of HSSP2 a significant degree) in exchange for increased efficiency and effectiveness in the investment. The in-country team are to be commended in this aspect of HSSP2 support; in particular, as it has the aspects of a thankless task poised as they are managing a major investment, tasked to make this move smoothly with zero risk while themselves at risk of criticism from both SIG and GoA senior management.

Operational risks

The biggest overall risk to the implementation of the program is seen to be the perceived lack of capacity and commitment within senior MHMS management with burn out of champions. The DFAT team have worked to provide support in this area; both personally and through the identification of TA support (for example support to the planning division) although this has not always been fully successful.

The second most important and linked risk is the lack of development of the policy debate. This exposes Australia to the risks of potentially unsustainable future costs in a health system where it is a committed major contributor. The draft NHSP 2016-2020 identifies and attempts to cost:

- New medical graduates (returning trainees from Cuba) – recurrent costs only, no additional capital costs shown (for example additional housing).
- The NRH and Honiara Secondary Care Facilities – development costs included only, not recurrent.
- Kilu'ufi development – development costs.
- UHC / RDP infrastructure – the capital costs are outlined, but not the recurrent costs.

To this list we would add the potential capital and recurrent costs of maintaining a malaria elimination rather than a control policy.

These risks are recognised by the incumbent DFAT in-country team and management of these risks needs to be urgently addressed in the policy dialogue around the design of HSSP3. In addition to direct discussions with the MHMS, DFAT should leverage the experience of the governance team to in accessing and addressing the Core Economic Working Group (CEWG).

The program has been aware of the design and imminent EU funding for WASH, and this will need to be considered in the design of HSSP3. The benefits of available synergies between the EU funded support and HSSP3 should be fully utilised. This should be part of the TA review to ensure no duplication of technical support.

The real operational risks of natural disasters have been demonstrated in HSSP2 and the rapid response provided by HSSP2 funding much appreciated by SIG. The risk of natural disasters will need to be part of planning for HSSP3.

Fiduciary risk

The management of fiduciary risk remains a concern and has been a major management issue for DFAT throughout the program, particularly in the last two years following the discovery of a major fraud. This appears to have been perpetrated by lax and corrupt implementation of existing regulations, rather than to have been possible by deficient regulations.

Both SIG and the GoA have taken a mature approach to the recently discovered fraud and it might be considered that the discovery of the fraud is consequent on the strengthening of control systems within the SIG following HSSP2 support. Substantial progress was made in 2014 to improve protection of Australian investments from fiduciary risk.

- A new funding agreement was negotiated and signed which moved the program to reimbursable funding model. This ensures Australia only reimburses 'eligible expenditure' providing a quick and effective ex-post control in the event of a suspected fraudulent transaction (these will not be reimbursed by Australia) or erroneous procurement or activity outside of agreed annual operational plans. The reimbursement model also mitigates the risk that cash balances build up and more strongly aligns incentives to improve quality of expenditure.
- From July 2012, ex-ante controls have been introduced in all the major Provinces (covering 75 per cent of provincial expenditure). A local accounting firm was procured with contracted financial support staff now embedded within each of the smaller Provinces.
- Centralised procurement functions continue to be strengthened and additional TA was put in place reporting partly to DFAT. The No Objection Letter process is being implemented. DFAT has observer status in Central Tender Board meetings. All procurements over \$100,000 have been listed on an Annual Procurement Plan and Provinces are being supported through their local accounts teams. Preferred supplier arrangements are being put in place for small value goods, which both better protects funds and reduce unit costs (improving value for money).
- A financial procedures manual has been produced and training provided to support provincial officers comply with the new Public Financial Management Act. MHMS has a PFM reform plan that is regularly monitored.

Both SIG and MHMS staff accept the above additional fiscal and financial management support to implement fully the SIG systems and to ensure compliance with the PFM Directive. However, there are repeated complaints that the system of disbursement for HSSP money has slowed to the point that activities are compromised. The delays are reported to be within the MHMS rather than MFT.

The introduction of locally contracted accountancy TA to support the Provinces is a particularly appropriate area of support. It is an acknowledged fact that it is often difficult for government to attract and retain good quality accounting staff as they are frequently poached by the private sector. While this may be less of a problem in the Solomon Islands, given the small size of the private sector, this evaluation recommends that this support be continued until assessed as no longer required..

Audit

Development partner staff may overlook the importance of the audit function in civil service financial management based on a British system. This has not been the case in HSSP2. With support from Australia, the MHMS internal audit system is functioning well and MHMS has the only internal audit department within SIG with a fully functioning audit committee. The MFT and DFAT are members of the committee. This support is highly regarded and considered particularly appropriate by this evaluation. Support to the internal audit department should continue as long as is necessary. This is an area where in-line TA support may be appropriate.

8. Conclusions

1. HSSP2 should be regarded as a flagship program for Australia and for DFAT. Developed from HSSP in a situation of resolving post-conflict economic disorder, the HSSP support has been a critical and successful component of Australia's support to Solomon Islands and to the Pacific region. It seems likely that HSSP and HSSP2 have been a significant element of the success of the RAMSI mission.⁹⁵ Despite being designed in a fragile political environment, the program has focused on working with and through government and has been instrumental in allowing Australia to move towards its stated policy objectives. Given the unusually predominant position as a donor that Australia occupies in the Solomon Island health sector, it would have been very easy for Australia to slip back into project mode despite its higher-level policy objectives and international commitments, but this temptation has been resisted and this alone should be seen as a positive achievement of HSSP2. The DFAT management team should be congratulated for this success.
2. The design of HSSP2 allowed for process style flexibility and 'tweaking' in discussion with partners. This has allowed HSSP2 to move towards less earmarked and an arguably more pure form of sectoral budget support. This has supported the winding-down of Australia's regional programs. It also allowed rapid response to natural disasters.
3. The health status of the Solomon Islanders is good when one considers the expenditure per capita and when compared with comparable Pacific Island nations. In health, during HSSP2, the expenditure made appears to result in good cost efficiency.
4. There is minimal private health care available in the Solomon Islands, except to those people rich enough to travel offshore for treatment. Furthermore, available evidence is that out of pocket expenditures are comparatively very small.⁹⁶ Faith Based Organisations manage three out of the twelve hospitals and some other health facilities such as nurse aide posts, but these receive significant financial and other support from government. This leaves the public, government managed sector as by far the most significant provider of health care in the Solomon Islands. As the Australian Government

⁹⁵ c.f Nepal where the post conflict reconstruction plans led by the UN after the more extensive civil war/peoples war of 1996-2006 also included a significant component of support to the health sector to assist in re-establishing the credibility and out-reach of central government.

⁹⁶ World Bank. 2010. *ibid*.

over the life of HSSP2 has provided up to 40 per cent⁹⁷ of the government budget, it can be confidently assumed that the good health results achieved in the Solomon Islands during HSSP2 are in large part attributable to the Australian investment.

5. Put another way – without the Australian investment of HSSP2 the government health services of the Solomon Islands would have been severely compromised – and the health status of all Solomon Islanders, and in particular the health status of the poorest, would have been significantly worse.
6. Australia (and the SIG) must recognise that the present situation is not sustainable if assessed in a conventional manner. Conversely, as stated above, without the Australian support, health services in the Solomon Islands would be severely compromised.
7. It is the view of the evaluation team that the situation in Solomon Islands is unique, and that the GoA might consider its support to the health sector in the light of the greater bilateral support from Australia to Solomon Islands (of which the Australian support to RAMSI is a significant part). GoA should perhaps recognise that in the longer term the good-will and nation building generated by its investment in health is of intrinsic value to both Governments and peoples, even if not sustainable in a conventional manner.
8. The approach whereby funds are placed as sector budget support possibly offers the purest version of support of the aid effectiveness agenda in Australia's investment portfolio. The large majority of funds are both on-plan on-budget and on-system. However, several minor elements of Australian support to the Solomon Islands health sector remain not fully on plan or fully transparently on budget. Where funds are managed through a second party (for example the UN agencies) the totality of the funding as allocated for SIG support is not immediately apparent. The other element is the funding allocated for TA, which is directly procured by Australia on behalf of HSSP. While this is reflected in the non-appropriated development budget, the TA costs are not allocated to the individual AOPs.
9. HSSP2 financial mechanisms have been refined both from the disbursement mechanisms (with the introduction of payments in arrears) and in the financial management procedures – particularly following the introduction of the PFM Directive.
10. Overall, the consistency and dependability of the funding over the past some eight years of HSSP, building on the previous support, has been of significant value to the SIG in planning the management of the health sector. This dependability has been a significant positive aspect in enabling the MHMS to plan efficiently and effectively and has increased the value of the Australian investment. The only failing in this regard has been in the previous year where there was a reduction in Australian funding along with a fundamental review of the Australian aid budget which introduced significant uncertainty (and some apprehension) to SIG officers.

⁹⁷ Although this is falling somewhat in the latter stages of HSSP2.

11. Emerging and additional priorities have been recognised by the MHMS and partners throughout the progress of HSSP2 and are prioritised and addressed in the new NHSP now in draft. Furthermore, in the interim AOPs have been revised to address the issues, and major new investments are planned – for example the EU funded RWASH support. At the same time, the MHMS UHC Policy / Role Delineation / De-concentration Policy is focusing activities. However, the increasing burden of disease attributable to NCDs is increasing, and while the new investments focused on water and sanitation and food fortification will assist to address the stunting problems, family planning rates remain unacceptably low. Additional support may need to be focused on family planning and NCDs in the next plan period (the last year of HSSP2) until the new NHSP is fully developed. SWAp management must be also be aware of the manner in which that EU support is channelled (that is through the general budget rather than the sector budget), and the time required for EU support to come on line.
12. Decreasing the degree of earmarking and the removal of regional and other fragmented funding streams, including those managed from Canberra, has increased the efficiency of the Australian investment and ensured significantly greater Government ownership and increased efficiency in Australia's investment and management.
13. It should not be assumed that management of a SWAp is less management intense than traditional project management for DFAT. In fact, as the latter may often be contracted to a management company this often makes projects less management intense for DFAT.⁹⁸ The present DFAT team are to be complemented for keeping the program on track, and particularly for managing the fiduciary risk elements around the major fraud without significant effect on service provision to the population. Canberra must be prepared to provide appropriate senior high level sectoral focused support as required.

9. Focus for the next phase

Two issues stand out as needing increased focus in the next phase:

- Increased focus on continuing to develop the policy dialogue and ensuring that Australia continues to have an effective seat at the policy table and developing and strengthening effective tools to manage the relationship.
- Focusing in a more formal way on strategic system-wide health systems strengthening (building on the financial strengthening already done), shifting slowly to more investments in preventive health (nutrition, stunting, sanitation, NCDs) and reviewing the TA needs of the next phase to support the additional systems strengthening identified.

Government ownership with DPs having seat at the policy table needs continuing development

The established constructive engagement at the policy level needs further strengthening. This would appear to be due to a combination of factors:

- Lack of full ownership of the SWAp management process by the MHMS.

⁹⁸ But often less efficient and significantly more expensive.

- Limited capacity within the executive of the MHMS to devote significant time and focus to a process which they do not control (with this portrayed by some as overall 'lack of capacity' of the executive).
- Lack of coordination between the DPs with difficulty in some partners in moving support on-plan and on-budget as per their commitments.
- Some recent uncertainty in MHMS as to the degree and certainty of support to be expected from Australia, the biggest and most significant donor, and thus a critical issue in planning.
- Non-use of effective management tools for forward planning – for example, an agreed and easily usable MTEF or other costed forward rolling plan.

This issue is of particular relevance to any forward Australian investment. If it is accepted that the Australian support is critical to the sector in the medium to longer term (see the sustainability sections) then it is critical given the level of Australian investment that the GoA has an effective voice in policy decisions that may have significant longer-term recurrent cost implications for the health sector.

Health systems and technical assistance strategic review

Health systems review

While one of the most commonly expressed comments made during this evaluation was the 'lack of capacity' comment, it was more difficult to get a clear view on to what this referred. The capacity needs of the health system, (system wide, not just centrally and not just in PFM) needs to be formally assessed and gaps identified. With the drafting of the next strategic plan and as part of the design of HSSP3, this seems an appropriate opportunity for this.

TA review

What did seem apparent was that there did not seem to be a clear strategic plan of what TA was needed to address capacity gaps, and at least some of that TA which was in place had been identified in a reactive way as crises or problems arose. This perhaps was to be expected in the absence of a pre-existing strategic systems review.

Furthermore, there was uncertainty over the management of TA, and questions being debated within DFAT on the recruitment and management methodology. One suggestion floated was that there should be increased external management of the DFAT recruited TA (maybe by the same company that did recruitment, or another external company). A further suggestion was to create an internal management structure within the TA itself – maybe by the appointment of a TA team leader. While the review team accepted that change was required, in the view of the review team, both of these approaches would be a somewhat retrograde step with regard to the key SWAp principle of Government ownership. The team felt that the approach of the TA reporting to line directors should be retained as much as possible.

A further criticism levelled was lack of clarity around the role of individual TA, with some querying the appropriate capacity building approach.

Given the above, and given that the role and numbers of TA is dependent on the capacity needs, it was felt that this was a significant piece of work that should be planned in full consultation with Government. Thus, this evaluation does not make specific recommendations with regard to the system needs, or to the appropriate levels or methods of management of TA, but recommends that DFAT proposes to the MHMS and its partners that a formal health systems and TA review be commissioned. This review should include TA recruited through all partners. As part of this review, the transparent costs of the TA should be shared with the MHMS to allow the government officers to participate fully in the debate and planning.

Risk Management

Financial risk management has been a significant aspect of HSSP2 but appears to have been managed well. However, it has consumed a disproportionate amount of DFAT management time and effort. While significant support for financial risk management will need to be included in the design of HSSP3 and appropriate TA resources included for the foreseeable future, DFAT might review the analysis of the risks in various fiduciary approaches as in the Foster report and consider options during the design of HSSP3.

Support should be continued to the MHMS internal audit department until it is fully functional and sustainable. A critical element will be for SIG to resolve the outstanding suspensions and to fully staff the finance and audit departments.

10. Summary of recommendations

General recommendations

- Australia should invest in continued support to health when HSSP2 ends in June 2016. This is for mixed reasons, health related, technical and political.
- That support should continue to be as budget support to the health sector, with earmarking as appropriate as per GoA policy. Australia should continue to act as an 'honest broker' to assist the MHMS to bring other DPs fully into the SWAp partnership.
- The support should continue to be aligned and focused on supporting the MHMS to deliver the existing and any successor NHSPs through the SWAp partnership mechanisms.
- Australia must intensify efforts to improve the mechanisms available for, and the quality of the policy debate between MHMS and DPs while ensuring that the MNHS ownership of the process is strengthened. This will involve being a lead partner in the finalisation of the new NHSP, working with the MHMS in focusing the strategy on maintaining gains in primary health care; shifting slowly to more investments in preventive health care; and supporting a strategic approach to health systems strengthening focused to support the NHSP.
- The move towards placing increasing investment at the provincial level is a positive move and should continue and accelerate in any follow-on funding.
- The performance related provincial grants are at an early stage of implementation. While apparently successful to date this approach should be carefully considered at design of

- any follow-on support to ensure that the process remains simple and a positive incentive and not seen as a penalty system for under-performance.
- The program should consider encouraging the SIG to allocate a greater share of own revenue to health.
 - There should be a formal wide-ranging health systems-wide review to identify capacity gaps in the MHMS, including in management and propose a strategic plan to address any gaps. The review should be system-wide, not restricted only to PFM issues and should include both the central and province levels and systems. This review will assist to identify any particular areas of focus (for example human resource strategies and management, health information systems, procurement) that may need additional focus in the new NHSP and support under any new Australian funding.
 - Following on from, or as part of, the systems review and building on the findings of that review, there should be a formal assessment, led by the MHMS with external support, to review the TA needs to support any gaps as identified in the systems review. The TA review should propose a plan for TA across the MHMS both centrally and provincially, including recommendations for recruitment and management. This plan would also identify the role of TA and clarify the approach of each individual TA – that is the balance between capacity building and line-function – and consider the TA procurement and management approach. This MHMS led review should propose and agree a management model for the TA.
 - Once a TA plan is agreed, the costs of TA should then be reflected in the individual AOPs. This will increase ownership and allow line managers to better understand the true costs of managing their AOP.
 - Significant continuing support for financial risk management will need to be included in the design of HSSP3 and additional TA resources included for the foreseeable future. This should include support at the provincial level and to the internal audit team.
 - DFAT staff workload is unlikely to reduce in the next phase of support.

Specific recommendations

Strengthen the process of policy debate with government and government ownership of the process

- Review the SWAp management mechanisms and ensure that they are 'government friendly'.
- Support the development of the proposed Partnership Coordination Unit of the MHMS .
- An updated and current MTEP would be a useful tool to inform the partners' policy debates over future investment decisions, particularly those (for example facility construction and staff training) which may have significant future recurrent cost implications. HSSP3 should be designed to encourage and support the MNHS and partners in the production of such a critical planning tool.
- The risks inherent in policy decisions being taken, which have far-reaching recurrent cost implications for the future are appreciated by the incumbent DFAT in-country team. Management of these risks needs to be urgently addressed in the policy dialogue around

the design of HSSP3. In addition to direct discussions with the MHMS, DFAT should leverage the experience of the governance team in accessing and addressing the CEWG if appropriate, and the wide experience of the World Bank in this area.

Sector Capacity and TA

- A detailed departmental capacity study, formal TA needs assessment and coordinated TA plan would be of benefit in the design process of HSSP3.
- The costs of TA are not currently reflected in the AOPs and thus the MHMS is unaware of the full cost of running the health service. Reflecting the activities and costs of TA in the AOPs would allow MHMS to see the full costs of support and facilitate management and ownership of TA.
- Redesign of the TA program through a needs assessment process could also address the mix of capacity building services, clarify the management model for the TA and reduce the cost of DFAT management inputs. The capacity development approach should be examined and detailed.

Continue support to the internal audit unit until assessed as no longer required.

Performance based funding

- Performance based payments should be reviewed for HSSP3 to ensure that they remain effective as incentives. Focus should be on rewards that can be implemented for better performance within the government system.
- The program should encourage the SIG increasingly to allocate a greater share of revenue to health. WHO have proposed 15 per cent as an international norm. Any such increase should be justified by economic analysis in the Solomon Islands setting.

Annex 1 – Terms of Reference

TERMS OF REFERENCE

Commissioning of an Independent Completion Evaluation of Australia's Contribution to the Solomon Islands Health Sector Support Program

Preamble

Australia has been providing support to the Solomon Islands health sector for over a decade through a range of approaches. Performance of the sector has been relatively strong when compared to neighbouring and wealthier countries. The underlying aim of this evaluation is to assess the effectiveness and efficiency of Australia's support through the Health Sector Support Program with a view to identifying opportunities for improvement for a third phase of support from 2016 to 2020.

Background

Australia began supporting the Solomon Islands health sector in 2003 in the aftermath of the ethnic tensions, and after Government revenues started to collapse. Initial Australian support was provided through an Australian Managing Contractor and the Health Improvement Strengthening Project (HISP). Upon independent evaluation findings in 2007 (Foster), a sector wide approach was developed. Australia began providing direct financial support to the Ministry of Health and Medical Services (MHMS) from 2008.

Under the current phase of the program Australia committed up to AUD\$90 million over 4 years (2012-2016), which represents around 30 per cent of recurrent public annual health funding. Up until recently Australia was the only donor providing substantial budget support to the health sector, but the EU has recently committed EU76m in direct budget support over the next 5 years for rural water, sanitation and hygiene (a portfolio also managed by MHMS). Other SWAp partners include World Bank, WO, SPC, JICA, UNICEF and UNFPA. The SWAp is governed through quarterly Development Coordination Group (DPCG) meetings and monthly operational meetings.

Although SIG's medium term fiscal outlook remains weak, the new Government has demonstrated a willingness to increase investment in other parts of the economy (e.g. rural infrastructure, constituency development funds and tertiary scholarships). SIG has traditionally allocated 11-13 per cent of its revenue to health however the new Government's priorities raise challenging questions for Australia's future role in the health sector and the broader Governance and fiscal reform agenda. A key question for the next phase of support will be what Australia should ask in return for its funding and specifically, whether in the circumstances, SIG should be asked to invest more in health given the enormity of the challenges ahead.

To track sector performance, SIG have identified measurable, time bound targets for a set of core sector indicators. The indicators draw on existing targets outlined in the NHSP. Australia has aligned its overriding GoA-SIG Partnership Assessment Framework (PAF) to selected objectives of the NHSP and MHMS' core indicators. According to the Ministry's

health information system and results framework⁹⁹ some reasonably good results have been achieved over the life of the program:

- Infant, under-5 mortality and maternal deaths are declining with the sector appearing to be making progress towards MDG 4 and 5a.¹⁰⁰
- There have been some exceptional results in malaria (national incidence dropped from 199/1000 in 2003 to less than 40/1000 in 2014 – an 80 per cent reduction).
- The availability of critical medicine and supplies in the provincial medical stores has nearly doubled from less than 40 per cent in 2008 to nearly 90 per cent in 2013.
- 90 per cent of births attended by a skilled health attendant (2013) (from ~84 per cent in 2010)
- Since 2010, over 130 water and sanitation facilities have been constructed, providing access to an estimated additional 36,000 people with safe water or basic sanitation (approx. 6 per cent of the population).

While the disease burden is shifting, pneumonia, diarrheal disease and newborn infections remain the biggest killers of children. Progress has been slipping on other fronts e.g. nutrition (more than 30 per cent of children are stunted due to chronic under nutrition and 50 per cent of pregnant women are severely anaemic), access to water and basic sanitation (less than 30 per cent have access to safe drinking water and less than 20 per cent basic sanitation) and new challenges are emerging, for example, a growing non-communicable disease (NCD) burden (diabetes and hypertension) and unmet family planning needs (Contraceptive Prevalence Rate: stagnating at 27 per cent). Gender based violence remains endemic and services for people living with a disability and mental health concerns are inadequate.

Per capita health funding is in decline and there are increasing expenditure demands.

SIG revenue prospects are weak over the medium term and the population is growing rapidly. Major expenditure decisions threaten the sustainability of the sector and weaken primary health care system if not properly managed. For example, a possible decision to relocate the NRH, make it autonomous, operate two referral hospitals in Honiara, and train over 135 graduate doctors from Cuba (representing the sum total of doctors trained since independence) threatens to push up tertiary health costs reducing scarce health funding for primary health care. At the same time, the MHMS Universal Health Care Policy / Role Delineation / De-concentration Policy aims to upgrade health care services for the rural poor, which is also likely to increase pressure on recurrent health budgets. It is important to ensure these changes to the sector are sustainable so the system is strengthened over time and Australia can viably exit the sector.

⁹⁹ Which has recently been improved with the introduction of a district health information system and a results framework (core indicator set) which tracks results to 2015.

¹⁰⁰ Despite a fall in the actual number of child, infant and maternal deaths, caution is required in relation to using mortality figures in SI and the MDG4 and 5a indicators in particular. Large variations in mortality rates are the norm as a result of the relatively small population of the SI and large variations in live births recorded by the county's developing health information system. The recent improvements to both health information reporting and monitoring will help improve the credibility of mortality rates over time but for now the better indicator of performance is the actual number of reported child, infant and maternal deaths or a multi-year average of mortality rates.

Health system strengthening – gains made but still much work to do

There have been some public financial management improvements over the life of the program however gains remain fragile. For example: funding for the recurrent health budget has remained relatively constant (in line with Australia's expectations) and primary health care has increased to 37 per cent. Annual planning and budget processes and the quality of expenditure have improved although with significant technical support. An active internal audit unit, a stronger national medical store and central procurement unit have begun using more efficient procurement techniques with some success such as improving the availability of drugs at the provincial level. To further strengthen incentives for improved health system strengthening activities a performance program has been established which ties 20 per cent of HSSP2 funds to the achievement of jointly agreed performance milestones.

Fiduciary risk remains a concern

In September 2013 a large fraud was discovered, which involved collusion of several officers in MHMS and MFT and the suspected loss of approximately SBD\$10m of SIG and Australian funds. Following the discovery, the Australian Government issued a directive requiring an Australian officer or contractor to sign off on all Australian funded transactions when using partner Government systems across Melanesia (the Melanesia Directive). Australia recruited a Financial Controller in MFT and a Deputy Financial Controller in MHMS, provincial support officers and accounting support has recently been introduced in the provinces. Australia has adopted several of the recommendations flowing from Dec 2013 Program Management Review which introduced a reimbursable funding instrument and removed earmarking to reduce the build-up of cash balances.

Purpose

The underlying aim of the evaluation review is to evaluate the performance of Australia's support to the Solomon Islands health sector to collect evidence to help improve Australia's next phase of support. Specifically, this evaluation seeks to:

- (i) Conduct an analysis of the overall health sector to inform the assessment of the relevance of Australia's contribution to the sector.
- (ii) Evaluate Australia's bilateral program of support to the Solomon Islands health sector over the period 2012-2015, including an assessment of its relevance, effectiveness, efficiency, and sustainability.
- (iii) Based on the evaluation findings, make recommendations to improve the relevance, effectiveness, efficiency, and sustainability for Australia's future support to the sector.

Scope and key evaluation questions

1. Changing health context / situation analysis

What is the health sector and health system context that Australia is operating in?

- Have health outcomes improved over the last 10 years and why or why not?
- In this context, have Australia's investments been and remained relevant? How could their relevance been improved?

It is expected the consultants will conduct a rapid situation analysis of health sector needs and constraints in Solomon Islands. The consultants will use existing literature, monitoring reports and other documentation and their analysis will be supplemented by key informant interviews in-country.

The rapid analysis should include decadal trends in disease burden; changes to institutional and financing arrangements for health service delivery (trends in recurrent budget allocation to health as per cent national budget and per cent GDP; human resources in MHMS, MHMS management and governance); and a brief examination, based on existing literature of factors (positive and negative) that drive the observed trends.

The analysis will also consider the role and capacities of other partners (UN, NGO, EU, Regional Organisation) as part of the assessment of Australia's comparative advantage. This part of the evaluation will synthesize existing information and confirm information in country rather than collect new data.

2. Performance and role of Australia's investments, including gaps and opportunities

Within the context of the Solomon Islands health sector, how have Australia's health investments performed in regard to relevance, effectiveness, efficiency, and sustainability?

- Can positive impact be attributed, either in terms of health outcomes or better performing health systems functions?
- What practical improvements could be made by Australia to improve the performance and sustainability of the health system in Solomon Islands?

It is expected that this analysis will include consideration of how change happens in the Ministry of Health and whether Australia support has supported reform in the most effective way. Looking forward, how could DFAT apply its influence or work more politically to support more positive change (especially in terms of strengthen the MHMS leadership and stewardship of the health sector) and improve organisational performance and health service delivery impacts.

3. Modality of investment

- How effective, efficient and appropriate has the sector budget support approach been, including performance linked aid program component, vis a vis other possible alternatives?
- Has the program struck the right balance with respect to levels of technical support, and has the program been creative enough?
- Are there some changes to the program, TA, funding instrument, policy dialogue, monitoring system etc. that could be made that would lead to better performance?
- Does the current suite of health investments align with the priorities of the new Aid Paradigm, i.e., do they meet the 'four tests' in the Australian Government's new aid policy framework.
- What changes could the program make in its next phase to maximise performance.

In making recommendations the team should be aware that DFAT's staff establishment and technical assistance dedicated to supporting the health program is unlikely to increase over the next phase of support. Specialist advisory services have also significantly declined. Therefore, how can the program do more with less?

Recommendations and use

Based on the outcomes of the evaluation, the team will provide recommendations on how Australia's portfolio of health investments can be improved in relation to:

- a. Relevance
 - b. Effectiveness
 - c. Efficiency
 - d. sustainability
- Recommendations for improvements, if any, to the management of the health portfolio (e.g. strengthening monitoring and evaluation, better access to TA);

The recommendations of this evaluation are intended to feed into the design of the next phase of Australia's support.

Evaluation process

The evaluation will include:

1. An evaluation plan will be produced, specifying timeframes, analytical lens to be applied and evaluation questions to be used;
2. A desk review of available literature will be conducted with a specific focus on the first evaluation question and to assist in-country investigations;
3. A two week in-country visit. An aid memoire following the mission will be produced and all major stakeholders will be debriefed on mission findings.
4. A draft evaluation report will then be produced and circulated to all stakeholders. Feedback will be integrated and a final completion evaluation will undergo a peer review process involving external stakeholders.

DFAT staff will be available to discuss or provide input at each stage of the evaluation. DFAT staff will assist in the provision of relevant DFAT data for the team, provide organisational context, provide contacts for key informants, and will be available to discuss emerging issues and challenges.

Reference group

Honiara Post will establish a reference group to help steer the evaluation team comprising experts in health and governance. The reference group will meet as required.

Team composition

- Team Leader (Health Systems Evaluation Specialist) – ideally with experience of working in fragile/ environments – responsible for coordinating team inputs and finalising written reports;
- Governance (Fragile States) Specialist – ideally with an understanding of Solomon Islands expertise and / or service delivery expertise in fragile environments.

Personnel specifications

The **Team Leader** will have the following skills and experience:

- At least 10 years' experience completing health sector reviews and evaluations, including developing country experience.
- Demonstrated experience in leading review or evaluation teams.
- Awareness and understanding of health system issues including capacity building, health workforce, decentralisation, public financial management, procurement, health information expertise.
- Skilled in quantitative and qualitative data analysis, synthesis and reporting for evaluation.
- A thorough understanding of Australia's aid program and its policy settings.
- High level analysis and written skills.
- Excellent interpersonal and communication skills, including a proven ability to liaise and communicate effectively with multi-cultural colleagues.
- Experience in Melanesia would be desirable.

The **Governance (Fragile State) Specialist** will have the following skills and experience.

- Demonstrated experience with different aid modalities, including program based approaches financed by sector budget support
- Demonstrated experience in service delivery in fragile states , including policy frameworks, management, regulation and accountability mechanisms (with some experience of health service delivery essential)
- Understanding of public finance management as it relates to government systems mobilising and allocating resources
- Strong political economy skills
- Experience in quantitative and qualitative analysis, synthesis and reporting for evaluation.
- Health sector experience highly desirable
- Previous experience in the Pacific and Solomon Islands preferable

Team responsibilities

To be determined by the Team Leader, who is responsible for delivering each output within agreed timeframes and budget.

Timing and Duration

The program review will commence in May 2015 and be completed by July 2015. An indicative table of input ceilings is set out below. Timing and duration for the scope of services will be negotiated with the team.

Key Task	Working Days Team Leader (up to)	Working Days – Health Governance Specialist (up to)	Dates
1st SO with HRF			
Evaluation Plan	4	1	Evaluation Plan incorporating Literature Review May 25 th
Literature Review	5	3	
In-country consultations (including field work and production of Aide Memoire)	13	13	In country from 18 th June to 2 nd July (6 day week) Present Aide Memoire 2 nd July
International travel	4	4	
2nd SO with <u>Mott MacDonald Australia (MMA)</u>			
Draft report	8	5	14 August 2015 to MMA for submission to DFAT by 21 August 2015. Comment from DFAT by 28 August
Final report	3	2	Submitted to MMA by 2 September 2015 Submitted to DFAT 4 September 2015 Comment from DFAT by 11 September 2015
Final report following peer review	3	2	Submitted to MMA by September 15 2015 Submitted to DFAT by 18 September 2015
Sub-total	40	30	

Outputs and monitoring requirements

The following outputs are to be provided in line with the DFAT Monitoring and Evaluation Standards 2014 Version. Department of Foreign Affairs and Trade, Canberra, Australia (See: <http://aid.dfat.gov.au/publications/Pages/dfat-monitoring-evaluation-standards.aspx>):

- 1. An evaluation plan (DFAT Standard 5)** – summary of evaluation questions, methodology and report outline, no more than 10 pages in length, to be submitted for agreement with the Australian Aid Program and GoV prior to in-country mission.

2. **Aide memoire** – summary of key findings and recommendations, to be presented at debrief with key stakeholders in Honiara. No more than 5 pages in length.
3. **First draft report and annexes (DFAT Standard 6)** – overall evaluation report detailing key findings and recommendations, no more than 30 pages in length (excluding executive summary and annexes). An executive Summary or 2-4 pages should be provided. The draft will be delivered to the program manager, the Australian Aid Program in Honiara and the Senior Health Specialist Canberra, by July 2015. Feedback from the Aid Program and other stakeholders will be provided within one week of receipt.
4. Consultants should be prepared to submit data and analysis upon request.
5. **Second and final draft report/annexes** – as above, revised to incorporate stakeholder feedback. The Final draft of the report will be due to HRF by July .

The final evaluation report will be made publicly available (upon agreement with SIG).

Key Reference Documents

- a. Foster, Higgins Program Management Review, (December 2013)
- b. Thomas and Duituturaga, Gender Equity and Social Inclusion Review, (April 2014)
- c. DFAT, Health Sector Investment Plan (draft) (October 2014)
- d. MHMS, Core indicator Report (2015, 2014, 2013)
- e. HSSP2 Direct Funding Agreement (March 2013 and January 2014)
- f. AusAID HSSP Design Strategy and Implementation Document (2012-2016) – *the package includes the AusAID DSID, MHMS National Health Strategic Plan, MHMS Core Indicator Set, Concept Note, Program Delivery Plan, Malaria Support Plan, Risk Register, Procurement Plan, Partnership Arrangement, Subsidiary Arrangement, Assessment of PFM Systems;*
- g. GoA-SIG Partnership for Development and Health Performance Assessment Matrix
- h. DFAT, Performance Linked Aid Schedule (2012-2015)
- i. Independent Performance Assessment (April 2013, April 2014 and March 2015)
- j. AusAID HSSP Program Implementation Document (2008-2012)
- k. DFAT Quality at Implementation reports (2013, 2014) and Aid Quality Report (2015)
- l. Assessment of National PFM Systems – Solomon Islands (Higgins, 2011)
- m. AusAID Health Sector Procurement Assessment and Audit Report (2011)
- n. MHMS Updated PFM Roadmap
- o. MHMS Updated HIS Roadmap
- p. MHMS Updated HRH Roadmap
- q. World Bank Public-Private Options Paper (2013)
- r. World Bank Health Financing Options Report (2011)
- s. Monash University, Health Facilities Costings Study (2015)
- t. AusAID / WHO Strengthening SWAp Governance and Technical Cooperation Report (2012)
- u. AusAID Partnership for Development Report 2010-12
- v. MHMS: Role Delineation: Policy (2013)
- w. Malaria Program Review (2013)
- x. MHMS RWASH Strategic Plan (2015-2020)
- y. MHMS Child Health Strategic Plan (2011-15)
- z. MHMS Infrastructure Report 2012
- aa. World Bank NRH Retention and Private Options Report (2012)
- bb. Core Economic Working Group Matrix (Revised, 2013)

- cc. SIGOV Delivery Strategy
- dd. 2012, 2013, 2014 and 2015 SIG Budgets
- ee. MHMS quarterly expenditure reports
- ff. MHMS Resource Allocation Formula
- gg. MHS Operational Plans (2014)
- hh. MHMS Financial Procedures Manual (Updated Dec 12)
- ii. MoFT Procurement Manual (Updated April 13)
- jj. Tyson S, HSSP Progress Report, 2012.
- kk. AusAID Executive Minute, Ex-ante controls policy for working in partner systems in Melanesia, October 2013

Annex 2 – Program of in-country visits

Date	Time	Activities	Venue	Confirmed
Thursday 18 June 2015	4:30	Arrival in Honiara	Honiara International Airport	Confirmed
Friday 19 June 2015	9.00 – 9.30	Brief meet and greet with DFAT Minister Counsellor <i>(Sue Connell)</i>	DFAT Map room	Confirmed
	9.30 – 10.30	Meeting with DFAT health team <i>Provide content of program to the team</i>	DFAT Map room	Confirmed
	10.45 – 11.00	Courtesy call on Hon Minister for Health <i>(Dr. Tautai Agikimua Kaitu'u)</i>	MHMS, Minister's Office	Confirmed
	11.00 – 12.00	Meeting with MHMS Executive <i>(Dr Dalipanda, Permanent Secretary)</i>	Permanent Secretary's Office, MHMS Compound	Confirmed Contact: Daisy Kapu (7677216)
	12:30 – 1:30	Lunch Meeting with SIG – ICTSU, Strategic adviser <i>(Beau Tydd)</i>	Breakwater	Confirmed
	1.30 – 2.30	Meeting with Maternal and Child Health team <i>(Kathleen Gaporongo)</i>	Reproductive Health conference room, MHMS Compound	Confirmed

Date	Time	Activities	Venue	Confirmed
	2.45 – 3.45	Meeting with SWAp secretariat and Civil Registration <i>(Lani Stowers-longi)</i>	WHO Library	Confirmed
	4.00 – 5.00			
Saturday 20 June 2015	9.00 – 4.00	Good Samaritan Hospital and	Field Visit	Confirmed
Sunday 21 June 2015				
Monday 22 June 2015	8.30 – 9.30	Meeting with Policy and Planning team <i>(Ivan Ghemu, Policy and Planning, Delilah Lowe, Chief Planning Officer & Wayne Murray, Senior health adviser)</i>	EHD Conference room, MHMS Compound	Confirmed
	9.30 – 10.30	Meeting with Procurement team <i>(Tim Hales & Ellison Gauwane)</i>	EHD Conference room, MHMS Compound	Confirmed
	10.30 – 11.30	Meeting with Infrastructure specialist <i>(Mike Green)</i>	EHD Conference room, MHMS Compound	Confirmed
	12.00 pm – 13:00 pm	LUNCH BREAK		
	1.30 – 2.30	Meeting with National Referral Hospital (NRH) executive <i>(Rooney Jagili, NRH Superintendent, Jane Tait (Hospital Administrator & Jack Atomea (NRH Hospital Secretary)</i>	NRH Conference Room	TBC

Date	Time	Activities	Venue	Confirmed
	2.30 – 3.00	Walk through of National Referral Hospital		
	3.30 – 4.30	Meeting with Guadalcanal Provincial Health Authority <i>(Dr Joel Denty, Provincial Health Director & Rita Fahy, Provincial finance support adviser)</i>	DFAT Coral room	Confirmed
Tuesday 23 June 2015	8.00 – 9.00	Meeting with DFAT Counsellor, Service Delivery + health team <i>(Kirsten Hawke & Health team)</i>	Breakwater	Confirmed
	9.45 – 10.15	Meeting with Accountant General, Ministry of Finance and Treasury <i>(Paula Uluineceva)</i>	DFAT small conference room	Confirmed
	10.30 – 11.30	Teleconference with World Bank team <i>(Susan Ivatts, Health specialist & PFM specialists: Maude Ruest, Tony Higgins, Bob Flanagan & Margaret Kisi)</i>	World Bank conference room	Confirmed
	11.30 – 12.00	Meeting with MFT FMSS (Financial Management Services Section) <i>(Lizzie Enoka)</i>	DFAT small conference room	Confirmed
	12:00 - 13:00	LUNCH BREAK		
	1.15 – 2.15	Meeting with Malaria team <i>(Albino Bobogare, Director NVBDCP, Leonard Boaz & Malaria adviser, Tony Patridge)</i>	3 rd Floor, Tongs Building	Confirmed
	3.30 – 4.30	Meeting with Rural WASH team <i>(Tom Nanau, Director EHD, Bryce McGowan WASH Team Leader & Isabel Ross (Sanitation)</i>	MHMS EHD Conference room, MHMS Compound	Confirmed

Date	Time	Activities	Venue	Confirmed
		<i>adviser)</i>		
	8.00 – 9.00	Meeting with WHO Country representative <i>(Audrey Aumua & Chloe Damon, WHO RMNCH technical officer)</i>	Breakwater	Confirmed
Wednesday 24 June 2015	9:00 – 11.30	Focus group session with National Program Directors <i>(Malaria, MNCH, RWASH, NCD, Health promotion, HIV, TB, Mental Health, Eye, Social Welfare, Nursing, CBR, Medical Lab & Imaging and NRH Directors)</i>	DFAT Large conference room	TBC
	12:00 - 13:00	LUNCH BREAK		
	13:00 – 14:00	Check-in Domestic Airport Depart Honiara	Domestic terminal, Henderson	
	14:25	Arrive Kira Kira, Makira Province See separate program Wednesday 24 – Friday 26 June 2015 - Makira province		
Provincial trip:	Wednesday to Friday KiraKira, Makira province	Wednesday – pm – Kirakira Thursday – Whole day – Kirakira Friday – am (kirakira) pm (Honiara)		
Saturday 27 June 2015	8:00 - 4:00 pm	Reporting writing		

Date	Time	Activities	Venue	Confirmed
Sunday 28 June 2015	8:00 - 9:00 pm	Opportunity for Day trip to Tulagi, Central Islands (Visit Tulagi hospital and Second Level Medical Store) – see separate program		
Monday 29 June 2015	8.30 – 9.30	Meeting with National Medical Stores <i>(Willie Horoto, NMS Manager & Susie Lake, NMS adviser)</i>	National Medical Stores	Confirmed
	9.50 – 10.50	Meeting with Internal Audit team <i>(Neville Moo & Francis Otto)</i>	MHMS conference room, MHMS Compound	Confirmed
	11:00 - 12:00	Meeting with UNICEF <i>(Y Kang, Head of Country office, Ibrahim Dadari, EPI specialist & Winston Pitakomoki, Health officer)</i>	UNICEF Conference Room, Level 2, City Centre Building	Confirmed
	12:00 – 1.00	LUNCH BREAK		
	1.30 – 2.30	Meeting with Ministry of Finance and Treasury, Procurement and Payments <i>(Anna Halea, Assistant Accounting General & Fiona Stanley)</i>	DFAT Small conference room	Confirmed
	2.45 – 3.45	Meeting with Ministry of Finance and Treasury, Budget section <i>(Norman Hiropuhi, Director, Coswal, Deputy Director & Brendan Nerdal, Budget Adviser)</i>	DFAT Small conference room	TBC
	4.00 – 5.00			
Tuesday 30 June 2015	8.00 – 9.00	Meeting with DFAT Economic and Governance team <i>(Clair Cochrane and Kelly Vuanivono)</i>	DFAT small conference room	Confirmed

Date	Time	Activities	Venue	Confirmed
	9.00 – 10.00	Meeting with Public Service <i>(Nego Sisiolo, Permanent Secretary)</i>	DFAT Small conference room	Confirmed
	10.00 – 11.00	Meeting with MHMS Finance team <i>(Yvonne Lipa (Ag Financial Controller) and Michael Wyatt (Deputy Financial Controller))</i>	DFAT Small conference room	Confirmed
	11.00 - 12:00	Meeting with Ministry of Finance and Treasury, Procurement section <i>(John Masa and Ricardo Aquino, Procurement Adviser)</i>	DFAT Small conference room	TBC
	12.00 – 1.00	LUNCH BREAK		
	1.30 – 2.30	Meeting with MHMS HR team (Dorothy Kiko & Cat Hockings)	DFAT Small conference room	TBC
	2.45 – 3.45	Meeting with MFT Internal Audit team <i>(Chris Ward and Bradley Lenga)</i>	DFAT Small conference room	Confirmed
	4.00 – 5.00	Meeting with Communication for Development (C4D) Adviser, Jacinta Issacs	DFAT Small conference room	TBC
	Wednesday 1 July 2015	8.30 – 9.30	Meeting with World Vision <i>(Janes Ginting, Country Manager)</i>	DFAT Small conference room
10.00 – 11.00		Meeting with Save the Children <i>(Shiv Nair, Country Manager)</i>	DFAT Small conference room	TBC

Date	Time	Activities	Venue	Confirmed
	11.15 – 12.15	Meeting with Seif Ples (Kim Abbey, Clinic Manager)	Seif Ples clinic, Rove	Confirmed
	12.150 – 13.15	LUNCH BREAK		
	1.30 – 2.30	Meeting with Secretariat of Pacific Community (SPC), Manager, Country office (Mia Rimon)	DFAT small conference room	Confirmed
	2.45 – 3.45	Meeting with EU (Pavlos Evangelidis, Head of Development Cooperation)	EU conference room	TBC
	4.00 – 5.00			
Thursday 2 July 2015	8.00 - 9.00			
	9:00 – 10:30	Meeting with UNFPA Country representative (Polini McNeil)	UNFPA Conference Room, Level 2, City Centre Building	Confirmed
	11.00 – 12.00			
	12.00 – 1.00	LUNCH BREAK		
	1.00 – 2.00			
	2.00 – 3.00	Debrief with MHMS executive	TBA	TBA

Date	Time	Activities	Venue	Confirmed
	3.00 – 4.00	Debrief with DFAT health team	DFAT Large conference room	TBA
Friday 3 July 2015	9.00 – 11.00	Debrief with all stakeholders who have met with the team	DFAT Large conference room	TBA
	11.00 – 12.00			
	Depart Honiara for Brisbane			

Annex 3 – Decadal trends – health status changes

Core Indicators	1990	2006/7	2012/14	
	(UNICEF /WHO)	(DHS+ DHIS '12)	(MHMS /DHIS '14)	
# of maternal deaths		34	13	Good progress
Maternal Mortality Rate	320	184	110	Good progress
Infant Mortality Rate	32	26.1	24	Small progress
Neonatal Mortality Rate	16	16.8	11	Good progress
Under 5 Mortality Rate	39	37.2	30	Small progress
Contraceptive Prevalence Rate		27.3	27	No progress
Skilled Birth Attendance		84.5	89	Continuing Good
Malaria Incidence Rate		140	44	Good progress
% of 1 yr old children immunized against measles		79	95	Good progress
Improved Sanitation		19	20	Minimal Change
Diarrhoea incidence		48	34.2	Progress
Under-weight children (<2)		12	12	No progress
% malnourished (stunted) (<5)		32.8	33	No progress
% women overweight		30	44	Worsening
% men overweight		24	31	Worsening
Tuberculosis treatment success rate		93	85	Continuing Good
Tuberculosis notification rate		78	63	Progress

Decadal indicators were chosen based on the availability of data from about 2006/7 to compare with 2012/14 data (or as close as possible to give a 10 year perspective)

Annex 4 – Application of the Australian Aid Policy tests to health

Aid Policy Tests	This means that DFAT Health diplomacy and investments will....	Considerations/criteria	Findings for HSSP2
<p>Pursuing national interest and extending Australia's influence</p>	<ul style="list-style-type: none"> • prioritise low and lower middle-income countries in the Indo-Pacific Pacific region • reflect Australia's broader strategic and political priorities and comparative advantage (e.g. geographic proximity and priority relationships) • promote regional security, stability and prosperity through addressing health related development and economic risks 	<ul style="list-style-type: none"> • Are public health issues, antimicrobial resistance in the region and future epidemics a potential threat to Australia's interests? • Can Australia be a significant and valuable health player in the region? • Does the investment benefit DFAT's priority countries in the Indo-Pacific region? Does it benefit countries in Southeast Asia and the Pacific in particular? • Is health a priority sector in the relevant DFAT country and regional Aid Investment Plans? • Does the investment prevent or mitigate a public health threat to Australia, to the region, and globally? • Does the investment prevent health-related instability in the region and thereby contribute to economic and human development? • Does the investment promote a regional solution to cross-border disease threats, such as antimicrobial resistance in the region? 	<ul style="list-style-type: none"> • Not significantly – except for malaria where HSSP2 has supported efforts in malaria elimination. • YES. Australia is THE significant and valuable player and the SI SWAp is a flagship program of support • YES. Specifically the Pacific • YES • NO. May reduces Solomon Islanders coming to Australia for treatment. • YES. HSSP2 has been a major contributor to the RAMSI led stabilisation mission. • NO
<p>Impact on promoting growth and reducing poverty</p>	<ul style="list-style-type: none"> • target health system constraints to address countries' priority health challenges including 	<ul style="list-style-type: none"> • Is poor health limiting partner countries' progress with economic growth and poverty reduction? • Does the investment focus on benefitting the poor? Who will benefit? What is the evidence for this? (e.g. 	<ul style="list-style-type: none"> • YES. See world Bank and IMF studies. • YES - focus on poor. All population will benefit with focus on provincial

Aid Policy Tests	This means that DFAT Health diplomacy and investments will....	Considerations/criteria	Findings for HSSP2
	<p>tackling diseases and establishing social safety nets that target the poorest and most vulnerable populations</p> <ul style="list-style-type: none"> influence countries' domestic policy and resource allocation across sectors to maximise health impact for the poor maximise the potential of the private / non-state sector at the national, regional and global level to achieve better population health effectively address gender equality and empowerment of women and girls 	<p>Demographic and Household Survey data, global literature)</p> <ul style="list-style-type: none"> Is the health issue being addressed known to impact economic growth (e.g. the impact of illness and death on economically active adults)? How will this investment affect out-of-pocket health expenditure? Will the investment strengthen the performance of the health system or its component building blocks? Does the investment reflect the partner government's own health sector priorities? What is the evidence? Is it backed up by burden of disease analysis? Is it backed up by the partner government's own budget allocation? Can DFAT's engagement leverage additional public spending and/or make its allocation more efficient? Does the investment consider the role of the private sector (e.g. better regulation of the private sector; increased use of social marketing expertise, leveraging additional public sector finance)? Does the investment have the potential to empower women and girls and contribute to gender equality? What is the evidence for this? (e.g. Demographic and Household Survey data, global literature) 	<p>level – i.e. poorest. See DHS, WB Studies and RAMSI peoples survey.</p> <ul style="list-style-type: none"> YES. Program addresses whole of health and focuses flexibly on greatest burden of disease issues. POSITIVE. Maintain Status Quo. Studies show low level out of pocket expenditure on health YES. Main focus of support. Significant systems support. YES. Evidence in Health Strategic Plan, MTEF, and extensively throughout project documentation. SIG has fulfilled 12% of GDP to health commitment as agreed. YES. See point above and recommendation to increase to 15% YES where possible, but private sector at present <u>very</u> small in Solomon Islands health sector. YES. See DHS, RAMSI Peoples survey, Program consultancy reports. Government reports.

Aid Policy Tests	This means that DFAT Health diplomacy and investments will....	Considerations/criteria	Findings for HSSP2
<p>Australia's value-add and leverage</p>	<ul style="list-style-type: none"> • respond flexibly to country/regional context, priorities and needs • use the most effective multilateral and bilateral aid modalities to contribute to sustained population health • ensure appropriate levels of financial and technical resources to have an impact • capitalise on Australia's comparative advantages across government and non-government sectors to draw upon Australian expertise 	<ul style="list-style-type: none"> • Can Australia be a significant and valuable health security player in the region? Globally? • Is the proposal adequately cognisant of the roles and responsibilities of other players in the health sector? Does DFAT have a particular contribution to make? • Is DFAT making its contribution in the most appropriate way? Are proposed partner organisations known to be effective? • Is DFAT's contribution significant enough to make a difference? • Can DFAT's engagement influence global funders to increase their aid effectiveness and to increase their investment in DFAT's priority focus on regional health security, and in our priority countries? • Can DFAT's engagement leverage the private sector to contribute more and to develop innovative ways to improve health? • Can DFAT's engagement leverage other streams of development finance? • Does the investment present an opportunity for DFAT to deploy its stated world-class expertise in health systems, regulation, research, prevention and disease control and address its stated priorities. 	<ul style="list-style-type: none"> • YES. Proven See RAMSI. Main donor in Solomon Islands. • YES. Australia main player in health in Solomon Islands. DFAT leading the DP partnership. • YES. SWAp internationally recognised to be highly appropriate. Partner organisations effective. • YES. Without DFAT contribution health services in SI would be severely compromised • YES. The Solomon Islands SWAp is an approach that should be further studied and the approach disseminated. • Yes, but most likely cautiously and not in the medium term. Approaches to engage the food sector have been made. • YES. HSSP2 is designed to be an appropriate approach for all DPs • YES. Across all the stated areas of expertise. This is already been evident and support to malaria particularly displays this approach.

Aid Policy Tests	This means that DFAT Health diplomacy and investments will....	Considerations/criteria	Findings for HSSP2
<p>Making performance count</p>	<ul style="list-style-type: none"> • be designed and managed by staff with skills to be able to influence health policy outcomes • demonstrate a clear results focus backed by high calibre M&E systems • work with partners who have the capacity to deliver, measure and be accountable for results • generate the evidence to improve multilateral/bilateral effectiveness for health • support sharper program focus and consolidation 	<ul style="list-style-type: none"> • Can DFAT make a 'real-world' difference in the health sector and demonstrate that it has done so? • Does DFAT have the capacity and expertise to deliver the investment? • Are the proposed interventions recognised to be cost-effective? Do they invest in 'best-buys'?¹⁰¹ • Do the investments have a strong monitoring and evaluation framework in place, or planned, with appropriate indicators, baseline data and targets? • Can opportunities be taken to support national health information systems? E.g. disease data, surveillance, civil registration and vital statistics. • Do partner organisations have the capacity to report against monitoring and evaluation frameworks? • Does DFAT have the means to harvest and share the lessons of the investment for future practice? • Does the investment contribute to consolidation or fragmentation of DFAT's portfolio? 	<ul style="list-style-type: none"> • YES. Clearly so. This is the whole approach of the support. • YES. Proven over 8 plus years of support. • YES. WHO is an active technical partner in the program. • Yes. But this aspect continues to be improved. M&E is through SIG systems and is a work in progress • YES. Done and part of ongoing support (see point above). Improvements in vital statistics also. • YES. All should report through SIG. All report through DHIS. • Possibly. This needs planning and additional resources but is important • CONSOLIDATION. Very much so. This has been a feature of HSSP2

¹⁰¹ World Bank Disease Control Priorities Project; WHO-CHOICE www.who.int/choice/results

Annex 5 – People met

Acting Provincial Health Director,	Central Province
Albino Bobogare	Director, NVBDCP
Alby Lovi	NHPD
Angellah Kingmele	DFAT
Anna Halea	Assistant Accountant General
Audrey Aumua	WHO Country Representative
Beau Tydd	Strategic adviser, SIG-ICTSU
Bob Flanagan	World Bank (via teleconference)
Bradley Lenga	Director, Internal Audit MFT
BrendanNerdal	Budget Adviser
Bryce McGowan	WASH Team Leader
Chantelle Boland	DFAT
Chloe Damon	WHO RMNCH technical advisor
Chris Ward	MFT Internal Audit Team
Clair Cochrane	DFAT Economic and Governance Team
Claude Posala	Eye Division
Curtis Beneteti	Bauro Accounts, Makira Hospital
Dave Kelly	DFAT
Dr Dalipanda	Permanent Secretary, MHMS
Dr Tautai Agikimua Kaitu'u,	Hon Minister of Health and Medical Services MHMS
Ellison Gauwane	Director, Procurement
Fiona Stanley,	Accountant Technical Adviser
Francis Otto	National Audit Team
Geoff Kenilaren	NCD Division
Glen Homby	Primary Health Officer
Honry Kako	STI/HIV Unit
Ibrahim Dadari	EPI Specialist, UNICEF
Isabel Ross	Sanitation Advisor
Ivan Ghemu	Director, Policy and Planning
Jacinta Issacs	Communication for Development Adviser
Jack Atomea,	NRH Hospital Secretary

Jacob Makini	RWASH/EHD
James Ginting	Country Manager, World Vision
Jane Tait	NRH Hospital adviser
Joan Ahikan	Social Welfare Division
Joel Denty	Provincial Health Director, Guadalcanal
John Harara	Acting Provincial Health Director, Makira-Ulawa Province.
Kathleen Gapirongo,	Acting Director Maternal and Child Health
Kelly Vuanivono,	DFAT Economic and Governance Team
Kirsten Hawke	DFAT Counsellor, Service Delivery
Lani Stowers-longi,	SWAp Secretariat and WHO adviser
Lizzie Enoka	MFT Financial Management Services Section
Margaret Kisi	World Bank
Mathew Fehre	DFAT (via Teleconference)
Maude Ruest	World Bank, PFM
MCH/HIV Officer	Tulagi
Melody	Midwifery Director, Makira
Melville Moo	Audit Adviser, MHMS
Mia Rimon,	Manager, Country Office, SPC
Michael Larui	National Head of Nursing
Michael Wyatt	Deputy Financial Controller
Mike Green	Infrastructure specialist
Natalina Hong	DFAT
Neville Moo	National Audit Team, adviser
Noel Itogo	NTP Program
Norman Hiropuhi	Director, MFT, Budget Section
Nurse Aide	Kerepe Health Clinic, Ugi Island
Nurse in Charge	Kerepe Health Clinic, Ugi Island
Nurse in Charge	Maonosugu Health Clinic, Makira
Nurse-Superintendent	Good Samaritan Hospital
Nursing Director	Tulagi Hospital
Paula Uluineceva	Accountant General, Ministry of Finance and Treasury
Pedical Toganne	Emergency Department
Polini McNeil	Country Manager, UNFPA

Prudence Reveli	DFAT
Ram Onotalda	Mental Health
Rebecca Dodd	DFAT Health Adviser (via Teleconference)
Registered nurse in charge	St Clares Clinic Area Health Clinic, Tarbawara
Ricardo Aquino	Procurement Adviser, Ministry of Finance and Treasury
Richard Bontjer	DFAT (via Teleconference)
Rita Fahy	Provincial Finance Support Advisor, Guadalcanal and Honiara
Rooney Jagili	NRH Superintendent
Shiv Nair	Country Manager, Save the Children, AU
Sue Connell	DFAT Minister Counsellor
Susie Lake	Adviser National Medical Stores
Tim Hales	Adviser procurement/contracts
Timmy Manea	NPSD - Pharmacy
Tom Nanau	Director, EHD
Tony Higgins	World Bank (via Teleconference)
Tony Partridge	Malaria Advisor
Wayne Murray	Senior Health Advisor
Willie Horota	Manager National Medical Stores
Y Kang	Head of Country Office, UNICEF
Yvonne Lipa	Acting Financial Controller, MHMS

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Annex 7 – Evaluation Plan

Provided as a separate document.

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