

# **SCHEDULE TO THE NAURU-AUSTRALIA PARTNERSHIP FOR DEVELOPMENT**

## **Partnership Priority Outcome 3: A cost-effective health system which delivers improved health outcomes**

### **PARTNERSHIP FOR DEVELOPMENT BETWEEN THE GOVERNMENT OF NAURU AND THE GOVERNMENT OF AUSTRALIA**

The Nauru - Australia Partnership for Development was formalised by President Marcus Stephen and Prime Minister Kevin Rudd during the Pacific Forum Leaders' Meeting held in Cairns in August 2009. The Partnership for Development Initiative, a series of Partnerships between Australia and PNG and other Pacific Island Nations, including Nauru, represents a new era of development co-operation between parties. The initiative provides the guiding and practical framework for the Implementation of the Port Moresby Declaration that the Australian Government announced on 6 March 2008.

The Nauru - Australia Partnership for Development is founded on the principles of mutual understanding, mutual respect and mutual responsibility for improved development outcomes. The Partnership reflects the shared vision of the two governments to work together to meet the common challenges and to improve the quality of life of all Nauruans. Specifically, the Partnership seeks more rapid progress towards poverty reduction and the other Millennium Development Goals by 2015. To this end, the Nauru-Australia Partnership has identified an initial five priority outcomes that will help improve living standards in Nauru. This Schedule sets out Priority Outcome 3: A Cost-Effective Health System Which Delivers Improved Health Outcomes.<sup>1</sup>

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<sup>1</sup> The other Priority Outcomes are: 1) More Efficient and Accountable Public Sector Management; 2) Improved Education 4) Reliable and Cost Effective Provision of Essential Infrastructure and Services; 5) Increased Private Sector Growth

## **Nauru-Australia Partnership for Development**

### **Partnership Priority Outcome 3: A Cost-Effective Health system that delivers improved health outcomes.**

#### **1. Aim of the Partnership**

The Government of Nauru and the Government of Australia have agreed to pursue significant measurable progress towards the achievement of a cost-effective health system which delivers improved health outcomes in Nauru by 2015.

To this end, the Partnership will provide fundamental support to the implementation of the Department of Health (DOH) Strategic Health Plan 2010-15 and the Annual Operational Plans, to guide the implementation of the National Sustainable Development Strategy (NSDS) 2005-2025. SOP priorities (and Priority Outcome 3 in the Partnership) are:

- Strengthening health system management, in particular budget prioritisation, strategic planning, infrastructure redevelopment and improved health statistics (noting governance and human resource).
- Reduced prevalence of non-communicable diseases (NCDs) and sexually transmissible infections (STIs) through more effective preventive and public health programs
- Improving Maternal and Child Health (MCH) outcomes by addressing child nutrition and improving access to and quality of ante- and post-natal care

Poor health is both a cause and a consequence of poverty. Basic health care, and equitable access to it, directly improves quality of life (the end objective of development). It is also important to achieving an economically productive society. Promoting basic health addresses MDG5 (improving maternal health) and MDG 6 (combating HIV/AIDS, malaria and non-communicable diseases). In Nauru's case, progress against cardio-vascular disease, diabetes, and sexually transmissible diseases has been mixed.<sup>2</sup> This MDG focus is consistent with SOP priorities, and with the joint resolve acknowledged in the Partnership by the Government of Nauru (GoN) and the Government of Australia (GoA) to accelerate progress towards achieving the Millennium Development Goals (MDGs).

The 2009 review of Nauru's National Sustainable Development Strategy (NSDS) noted that progress in the health sector had been relatively steady.<sup>3</sup> The GoN provides health services under a relatively centralised system based around the Republic of Nauru Hospital (RONH), combined with some clinical outreach. In a

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<sup>2</sup> SPC "MDG Update, 9 April 2010", cited in AusAID Annual Program Performance Review (APPR) 2009, AusAID, p. 7.

<sup>3</sup> Republic of Nauru (2009) "National Sustainable Development Strategy 2005-25 Review", October.

small island setting, with a population estimated in 2009 at 14,019,<sup>4</sup> this centralised health service delivery model has been able to achieve excellent coverage for some aspects of health service delivery and considerable achievements have been made by DOH: for example, Nauru continues to maintain community based maternal and child health care programs. As a result, childhood vaccination rates are close to 100%, and almost all births take place in the RONH under the care of a skilled birth attendant. With one doctor and 9.8 nurses for every 1,000 people, the health work force provides better *per capita* population coverage than in most other Pacific countries. Other important sectoral gains include the MOH's implementation in 2009 of a successful whole-of-organisation reform, the establishment of a Health Practitioners' Board, finalisation of an NCD Action Plan and completion of critical refurbishment works at Nauru major health facilities, including renovations to the pharmacy and construction of a new dental clinic.

Major challenges nevertheless remain. Current life expectancy at birth in Nauru – 55.2 years for males and 57.1 years for females – is the second-lowest in the Pacific after Papua New Guinea (PNG). The main causes of morbidity and mortality in Nauru are non-communicable diseases (NCDs), particularly cardiovascular disease, diabetes and other chronic diseases. The 2004 STEPS survey found that almost one in four adults was on treatment for diabetes or had impaired glucose tolerance, rising to almost half of those aged 55 years or above. Contributing risk factors include a high prevalence (80%) of overweight or obesity, low participation in physical activity, and extremely low consumption of the recommended daily intakes of fresh fruit and vegetables. Around half the adult population either drinks alcohol and/or smokes tobacco, and mean daily *per capita* consumption (12 standard drinks, 20 cigarettes) is high. Almost 20% of the population has elevated blood pressure or serum cholesterol.

The 2007 *Demographic and Health Survey* (DHS) found mixed results for maternal and child health (MCH) outcomes. The infant mortality rate (IMR), in particular, has increased since the mid-1990s, when it was estimated at 12.5 and 21.4 per 1,000 live births for the Nauruan and non-Nauruan populations, respectively. For the 5-year period preceding the *Survey*, neonatal mortality (rate 27 per 1,000 live births) was the major contributor to the estimated IMR of 38 per 1,000. Maternal deaths are rare.

Newly recognised or emerging health issues for Nauru include: rheumatic heart disease; gynaecological and other malignancy; sexually transmissible infections (STIs), high rates of genitourinary tract infection in pregnant women; a high prevalence of anaemia of unknown origin; malnutrition and trachoma among school-aged children. Lack of local capacity is also a constraint to improved health outcomes - in the absence of formal health worker training on Nauru the work force is almost entirely dependent on expatriate staff for positions that require post-secondary education and training. Improvement seems likely given that there are Nauruan students studying towards graduate health qualifications abroad. Fifteen Nauruan medical students are currently training in Cuba, an important bilateral partner in human resources for health (HRH).

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<sup>4</sup> [Central Intelligence Agency](https://www.cia.gov/library/publications/the-world-factbook/geos/nr.html) (2009). "Nauru". [The World Factbook](https://www.cia.gov/library/publications/the-world-factbook/geos/nr.html). <https://www.cia.gov/library/publications/the-world-factbook/geos/nr.html>, cited in Wikipedia, retrieved 29 January 2011.

In the spirit of the *Paris Declaration on Aid Effectiveness* and the *Accra Agenda for Action*, and as set out in the *Partnership for Development*, both Governments are actively promoting co-ordination between development partners engaged in the health sector, particularly Australia, New Zealand, Republic of China (Taiwan), and multilateral and inter-governmental agencies like WHO, Secretariat of the Pacific Community (SPC), UNICEF and UNFPA. Collaborative analytical and design work, delegated aid delivery, pooled funding, and joint monitoring for the health sector are all consistent with the Cairns Compact and will contribute towards reduced aid fragmentation and ease the burden of aid administration on the GoN. Noting the heavy reliance of Nauru's economy on donor funding, harmonisation is critical. For example, in the health sector high levels of donor funding is earmarked for specific diseases such as HIV/AIDS, risking the diversion of GoN's own resources away from basic public health to areas such as tertiary health care,<sup>5</sup> which is likely to reduce the longer term sustainability of basic health gains in Nauru. A better co-ordinated donor response, working in true partnership with GoN, will ensure issues like these are identified and addressed as they arise.

The Partnership also seeks to align with the Australian aid program's policies on gender and disability. As yet there is no formally agreed gender specific focus in the bilateral program, though specific services target maternal health, cervical and breast cancer. Gender and disabilities inclusive approaches will be considered and developed in the sector, beginning with the appropriate disaggregation of data, and drawing on the expertise of local health workers in particular to draw out any hidden areas of gender-based and disability discrimination. For example, high rates of alcohol use are usually correlated with family violence – the extent to which this is the case in Nauru is an important health (and justice) sector consideration.

#### Examples of New Activities in Strategic Plan 2010 - 2015

- a. Health Research
- b. Pharmaceutical manufacturing for medicine availability
- c. Legislation - Pharmacy Bill
- d. Health Legislation Enforcement Unit
- e. Microbiology services
- f. Hydrotherapy services for rehabilitation
- g. Radiology information system
- h. Prosthesis services – for disable people
- i. Medical waste management

## 2 Costing and Timeframe

Total programmed health expenditure (from all sources) for 2009-10 is AUD 5,668,525 (a 4.1% increase over 2008-09) – this is about 17% of the national budget, and 12% of gross domestic product (GDP). Annual *per capita* expenditure on health in 2009/10 will be just over USD 600, which is relatively high by Pacific standards (range USD 34 in PNG to USD 690 in Palau). Local and expatriate salaries comprise a relatively low 53% of the health budget.

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<sup>5</sup> AusAID *Quality at Implementation Report for Nauru Health Program 2010* [check final date]

Public health (primary and preventive health care) represents 10.2% of overall health expenditure, but is funded almost entirely from donor allocations; these, in turn, are often earmarked for specific diseases (e.g. HIV, tuberculosis [TB] or NCDs). Public health accounts for just 0.6% of GON allocations for health in 2009-10.

Tertiary health services available to Nauruan citizens include haemodialysis for chronic renal failure, international referral for medical or surgical treatment (subject to specified selection criteria) and services provided by visiting specialist teams and individuals. The costs of these services in 2009-10 are estimated at AUD 1.321 million, or 23.3% of total health expenditure (29.3% if public health expenditure is excluded) – again, relatively high compared with other Pacific countries. An Overseas Referral Committee actively manages patient referrals, and 2009-10 has seen good compliance with agreed policies, guidelines and selection criteria.

Table 1 presents the costing and financial implications of meeting the health sector priorities set out in this document. These estimates will be revised to reflect any changes made by the Government of Nauru during approval processes for the SOP. Efforts are underway to better link NSDS sectoral priorities and budget allocations, including for the health sector.

Indicative AusAID funding for Nauru's health sector is a minimum of AUD 14.1m (to be jointly agreed annually) across the initial 5 years of the partnership. Moreover, proposal for additional funding support to meet the funding gaps in the strategic plan is outlined in Table 2. The revised funding level would mean a minimum health sector budget of AUD 15.45m for 5 years.

**Table 1: Cost Analysis of Strategic Plan by Year and Source (Australian \$)**

Source	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	Total
Total Funding / Requirement	<b>\$6,000,723</b>	<b>\$6.651M</b>	\$6.8 M	\$6.8 M	\$6.8 M	\$33M
Govt. of Nauru	\$3,076,411	\$3,381,634	\$3.4m	\$3.4m	\$3.4m	16.7M
Govt. of Australia <b>Error! Bookmark not defined.</b>	\$2,804,312	\$2,750,755	\$2.840m	\$2.905	\$2.840	14.1M
Other Donors	\$120,000	\$518,598	\$218,598	\$40,000	\$40,000	937K
Funding Gap	0	0	\$341,402	\$460,000	\$520,00	1.32M

**Table 2: Recommended Funding Contribution Under AusAID**

	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	Total

AusAID	<u>\$2,804,312</u>	<u>\$2,750,755</u>	\$3.18M	\$3.36M	\$3.36M	\$15.45M
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Given Nauru's limited resources and capacity for revenue generation, it is unlikely that GON will be able to sustain any domestic increases in health funding in the foreseeable future. An important challenge will be to derive broader health system benefits from more efficient and flexible use of disease-specific funding from regional and global donors. To limit the growth of costs for tertiary services relative to primary and preventive care, the DOH and the Overseas Referral Committee are actively seeking greater cost-effectiveness by referring patients to Fiji or India (instead of Australia or New Zealand).

Furthermore, the Ministry of Health is pursuing a Multipurpose Health Facility to replace the Republic of Nauru Hospital. Current health service provision is disjointed with public health and dialysis services separated from the main hospital. Support for the planning stage for new Multipurpose Health Facility development has been provided in the 2010/2011 financial year allocation.

Attached (**Annex 2**) is an indicative list of AusAID-funded activities under the Partnership summarised by year and objective.

### 3. Measurement

Nauru and Australia will jointly monitor health sector performance under the *Partnership* using the 28 quantitative and qualitative indicators and targets set out in **Table 2** (below). All quantitative indicators listed in the table are based on data that the DOH is already collecting, either routinely or in the course of regular surveys like the *Demographic and Health Survey*. They reflect targets and milestones in the DOH *Strategic and Operational Plan* for the focal areas of Australian support; many are also included for reporting against the MDGs.

As is the case in other sectors, the collection of accurate data remains a challenge. The Health Information System (HIS) has sought technical assistance from the HIS Knowledge Hub at the University of Queensland, so that the Nauru HIS is now able to generate useful morbidity and mortality reports. However, the overall system for information management remains somewhat fragmented. Where quantitative indicators are not available (or appropriate), performance monitoring will be on the basis of additional contextual information gleaned elsewhere, for example the Safe Motherhood Committee, mortality case reports and individual sub-sectoral plans (like the HRH 'road map').

**Table 2. Indicators and Targets**

Indicator	Baseline	Short-term targets	Medium-term targets
	2010	2012	2015
<b>Development Objective 1 – Strengthening health system management, in particular budget prioritisation, strategic planning, infrastructure redevelopment and improved health statistics</b>			
Indicative annual costing of DOH <i>Strategic and Operational Plan</i> , 2010-15 completed	Draft <i>Strategic and Operational Plan</i> , 2010-15 in	Costing of 5-year <i>Strategic and Operational Plan</i> completed by	Completion of costed 5-year <i>National Health Strategic Plan</i> ,

Indicator	Baseline	Short-term targets	Medium-term targets
	2010	2012	2015
	place, not costed	2011	2015-16 to 2019-20
Detailed annual work plan and budget, costed by output	Not yet available	Annual work plan and detailed budget completed by 31 March each year	Annual work plan and detailed budget completed by 31 March each year
Total health expenditure as a proportion of Government expenditure	17%	18%	<b>19%</b>
Progress against <i>HIS Strategic Action Plan</i>	<i>HIS Strategic Action Plan</i> in place but not costed	<i>HIS Strategic Action Plan</i> costed by end 2012; progress against 5 new outcome areas reported annually	<i>HIS Strategic Action Plan</i> fully implemented
Progress against HRH 'Road Map'	10-Year Plan for Specialty Nurse Education included in <i>Nursing Services Review</i> (2008)	HRH 'Road Map' 2010-19 completed for all cadres within DOH by end of 2011; report progress annually	Reduced proportion of nurse specialist positions occupied by expatriate employees; report progress annually against other positions
Progress against infrastructure, utilities and maintenance plan	No <i>Plan</i> in place	<i>Plan</i> in place by 30 June 2011	Report progress annually against <i>Plan</i>
Annual review of development effectiveness			
<ul style="list-style-type: none"> <li>Proportion of donor-funded health expenditure reflected and reported on-budget in annual work plan</li> </ul>	90% (estimated)	95%	100%



Indicator	Baseline	Short-term targets	Medium-term targets
	2010	2012	2015
<ul style="list-style-type: none"> <li>Improved performance relative to <i>Paris Declaration</i> harmonisation and alignment matrix</li> </ul>	—	Report annually in conjunction with annual work plan and budget	Report annually in conjunction with annual work plan and budget
<b>Development Objective 2 – Reduced prevalence of NCDs and STIs, through more effective preventive and public health programs</b>			
Proportion of all-sources health expenditure allocated to public health (primary and preventive care)	10.2%	12.5%	15%
<p>NCDs and other chronic diseases</p> <ul style="list-style-type: none"> <li>Prevalence of diabetes</li> <li>Prevalence of physical inactivity</li> <li>Death rates associated with chronic diseases (Death Rate due to diabetes and related complications)</li> <li>Amputations and rates per 1,000 among diabetic patients aged 15-64 years</li> <li>Projected number of patients expected to commence haemodialysis over next 5 years (rolling indicator)</li> <li>Prevalence of obesity by age group and sex</li> </ul>	<p>M 16.1% F 16.3% (Refer STEPS for age-specific rates)</p> <p>TBA</p> <p>9 / (3,899 x 0.227) = 10.17 / 1,000</p> <p>40</p> <p>M 82.1% F 82.2% (Refer STEPS for age-specific rates)</p>	<p>2% reduction to baseline</p> <p>TBA</p> <p>&lt;10 / 1,000</p> <p>No increase</p> <p>5% reduction relative to baseline</p>	<p>5% reduction to baseline</p> <p>TBA</p> <p>&lt;7.5 / 1,000</p> <p>No increase</p> <p>12.5% reduction relative to baseline</p>
<p>Infectious diseases</p> <ul style="list-style-type: none"> <li>Proportion of pregnant women testing positive for <i>Chlamydia</i></li> <li>Number of reported cases of HIV infection</li> <li>Proportion of surveyed individuals with clinical signs of trachoma</li> <li>Prevalence of tuberculosis</li> <li>Proportion of tuberculosis cases detected and cured according to regionally-recommended TB control (DOTS) strategy</li> </ul>	<p>32%</p> <p>0</p> <p>30%</p> <p>056/000</p> <p>90%</p>	<p>&lt;30%</p> <p>0</p> <p>&lt;10%</p> <p>No increase</p> <p>100%</p>	<p>&lt;15%</p> <p>0</p> <p>&lt;5%</p> <p>Decrease</p> <p>100%</p>



Indicator	Baseline	Short-term targets	Medium-term targets
	2010	2012	2015
Sexual and Reproductive Health			
• Contraceptive prevalence rate among females aged 15-19 and 15-49 years	15-19: 3.8% 15-49: 18.5%	5% increase	10% increase
• Teenage fertility rate	14.2%	12%	10%
• Condom use at last sexual encounter with non-regular partner	M 16.7% F 9.8%	18%	20%

Development Objective 3 – Improving MCH outcomes, by addressing child nutrition and improving access to and quality of ante- and post-natal care			
Prevalence of underweight children under 5 years of age	M 6.9% F 2.9%	Decrease	Decrease
Neonatal mortality rate	28 / 1,000	<20 / 1,000	<15 / 1,000
Infant mortality rate	38 / 1,000	<30 / 1,000	<20 / 1,000
Under-5 mortality rate	38 / 1,000	<32 / 1,000	<22 / 1,000
Proportion of 2-year-old children immunised against measles	95.4%	98%	100%
Proportion of 2-year-old children fully immunised according to national EPI schedule	85.5%	90%	98%
Maternal mortality			
• Number of maternal deaths	0-1	0	0
• Maternal mortality ratio	0-333	0	0

Indicator definitions are at **Annex 3**. All indicators will be disaggregated by gender, and consider disability, where possible. The implementation strategy focuses on the needs of all Nauruan citizens and residents: men and women, boys and girls, able and disabled. Although gender equity is not a separate indicator in the performance assessment framework, survey and programmatic data will be disaggregated by sex where available and appropriate; indicators like contraceptive prevalence rate, teenage fertility rate and maternal mortality are gender-specific. Periodic qualitative and contextual evaluations will also consider gender-related impact of the health *Partnership*.

Provision of services for disabled children and adults is a high priority in the *NSDS* and is also flagged for support under the *Partnership* (in collaboration with the education sector). Outreach services funded under the health *Partnership* will

continue to reach disabled individuals, either at home (through outreach by the medical and physiotherapy teams) or in collaboration with the *Able / Disabled Centre*. In the longer term, any newly-constructed health facility will include disabled access in its design.

The cost of monitoring and evaluation of progress against Partnership targets will be met through AusAID's broader Program Monitoring Group (PMG) which has a mandate for M&E across all Partnership priority areas. Health sector funding under the Partnership will not generally be diverted to M&E programs. M&E costs are estimated at 5% of operational costs in years when surveys (e.g. DHS, STEPS) may be needed; this will help GON to contribute to the costs of those surveys, which are routinely supported by various donors and technical agencies. As data collection for other indicators in the performance assessment framework is already occurring routinely, the cost of M&E in those 'non-survey' years is limited to around 2.5%.

While quantitative evidence of reduced morbidity and mortality and improved budget allocations are important, the DOH and its partners also need to understand any constraints to progress and their implications, in order to prioritise future *Partnership* activities to improve future performance and effectiveness. This is the function of the qualitative aspects proposed under the performance assessment framework.

Qualitative data include reporting against the HRH, HIS and infrastructure plans. Progress against overall DOH and Partnership targets will also be reviewed regularly in the course of the annual Nauru –Australia Partnership Talks, the bi-annual development partner 'round table' and the DOH five yearly strategic planning cycle.

From the point of view of the DOH *Strategic and Operational Plan* and budget, there will be two critical review points over the next 5 years – the first involves determining readiness to move from the transitional phase into full implementation of the *Partnership* arrangements, and the second will be towards the end of current phases of funding for Global Fund HIV and TB projects and the SPC-WHO NCD Framework. More detailed, joint evaluations will be needed as these milestones approach, and should replace separate donor- and agency-specific review missions.

The findings and recommendations of the second evaluation, to be undertaken around March 2013, will be reported to all stakeholders through the DOH. It will not only guide activity development and planning for the 2013-14 and 2014-15 annual implementation cycles; it will also function as a mid-term review of the health components of the Partnership, inform decisions about the next 5-year *Strategic Plan* and the concurrent second phase of the health-related Partnership arrangements, and assist decisions about pooling of any other donor funds with Australian resources, e.g. in a joint donor account. It is also proposed that a participatory, multi-stakeholder review be undertaken towards end of current phases of Global Fund and SPC-WHO NCD funding.

#### **4. Implementation**

A health sector analysis undertaken by SPC in 2009 summarised the important steps needed to improve health outcomes in Nauru: a strong and relentless focus on NCDs, sexual and reproductive health (SRH) and safe motherhood; improved primary and, particularly, secondary prevention of NCDs (i.e. ensuring optimal control, preventing or providing early interventions for complications), which will protect the health budget against impending demands from those with established

disease; responding to emerging and re-emerging infectious diseases; and a long term focus on strengthening HRH and health information management.

To address these substantial challenges and guide the implementation of the *NSDS* in the health sector over the next 5 years, the DOH is developing a *Strategic and Operational Plan, 2010-15*. The *Plan* addresses key elements of the *NSDS* on institutional and health system reform, including human resources and infrastructure. It also guides the fundamentals of health service delivery: preventive health; the management and control of communicable and non-communicable diseases; and SRH and MCH. The *Plan* is supported by a *NCD Action Plan*, a draft *Reproductive Health Policy and Strategy* and a *Health information System Strategic Action Plan*. It is proposed that this 5-year period be divided into two phases – a preparatory (or transitional) phase from mid-2010 to mid- or late-2011, leading into a phase of full implementation through to mid-2015.

These policy developments and strategies represent a considerable step forward in defining the necessary actions, behaviours, values and resources that will be needed by the health sector to address the challenges of poor health outcomes and the deterioration in some health indicators since the mid-1990s. The *Nursing Services Review* of 2008 also provided a 10-year projection of specialised nursing work force needs to gradually free Nauru from a dependence on expatriate registered nurses and midwives; a similar 'road map' is needed for other cadres of HRH (including senior decision-makers and supporting administrative staff).

The SPC report recommended that Government and development partners establish an appropriate forum for constructive, multi-partner policy dialogue and to monitor the most appropriate types and levels of technical and financial support to help Nauru to meet the Millennium Development Goals (MDGs) and the broad aspirations of the *NSDS*. While the *NSDS* defines a role for a National Development Committee, the *Strategic and Operational Plan* has not yet identified a preferred forum for interfacing with development partners active in the health sector. Without this, there is an ongoing risk that donor assistance will remain supply driven and not well aligned with national priorities and realities, policies and plans.

Based on the challenges and priorities discussed in the previous section, Australian assistance will concentrate on the following areas within the *Strategic and Operational Plan*:

**1. Strengthening health system management, in particular budget prioritisation, strategic planning, infrastructure redevelopment and improved health statistics**

Support through the *Partnership* will focus on strengthening and streamlining management and strategic planning within the health sector; this will include maintaining critical leadership functions within the DOH and providing well targeted technical support to assist decision-making in public health, health system development and management, and health financing and financial management. Technical assistance will be available to assist with review (and revision as may be necessary) as well as costing of the 5-year *Strategic and Operational Plan*, developing and providing support for an infrastructure redevelopment plan, and for validating resource allocations against *NSDS* and other priorities. The HRH 'road map' will be developed and implemented, with a longer term view to reducing the reliance on expatriate clinical staff. It is likely that technical assistance would be maintained for further development, extension and integration of the HIS.

## **2. *Reduced prevalence of NCDs and STIs through more effective preventive and public health programs***

Support will focus on the work of the public health team to increase public awareness, primary prevention and behaviour change in relation to these high-prevalence health problems. Noting the importance of preventing or providing early interventions for complications of chronic diseases, the Governments of Nauru and Australia will support the public health team in strengthening secondary prevention in relation to NCDs (in clinical, public health and community settings), and to ensure consistent surgical and medical management of complications should they occur.

## **3. *Improving MCH outcomes by addressing child nutrition and improving access to and quality of ante- and post-natal care***

Support for improved MCH outcomes will also focus on both clinical and public health interventions. In collaboration with the education sector and other development partners, early work on developing a sound nutritional base, growth monitoring, immunisation and the control of prevalent communicable diseases like trachoma among school-aged children will be maintained; extending the reach of these programs to children in the “gap” between infancy and school entry will make an important contribution to early childhood development. In addition to primary and preventive interventions (such as improving awareness and utilisation of antenatal services), support will also be available to strengthen hospital-based approaches to safe motherhood (including prevention and management of premature labour and delivery) and neonatal and early childhood care.

The *Partnership* document also makes reference to improved performance relative to other priorities identified in the SPC health sector analysis (*Framework of Priorities in Health*). This includes whole-of-government approaches, inter-sectoral collaboration and harmonisation, which are cornerstones of the *NSDS* and for which the health sector is well placed to take a leadership role.

### **Transitional Phase**

The focus of health system management, budgeting and strategic planning during the *Transitional Phase* will be on developing a medium term expenditure framework for the 5-year *Strategic and Operational Plan*. As part of this process, consideration may be given to the definition and analysis of priorities within the *Plan* and the strategic basis for addressing them, and the basis for inclusion in the plan of routine processes that, while supportive of the strategic plan, may belong more appropriately in an annual work plan (AWP), as well as the role definition for technical units, or an individual job description.

In the meantime, Australian support would be maintained under present arrangements between GON and AusAID. This has seen the Australian program of support effectively delivered as discrete projects funded through the MOU; expenditure monitoring, reporting and acquittal processes are in place and are apparently working effectively, and it will be simplest to maintain this process until the end of the initial *Transitional Phase*.

Policy dialogue between partners and consideration of AWP and detailed budgets (based on the costed 5-year *Plan*) would take place around March or April each year (commencing towards the end of the initial transitional year), prior to Cabinet submission.

Funding support for the **Secretary of Health and Medical Services** (SHMS) position, and **Health Educator** will be maintained. The Health Educator will seek accreditation with a regional School (e.g. Solomon Islands or Kiribati) so that nursing trainees can undertake supervised final year placements in Nauru. Funding support may also be available for **other in-line or advisory functions** as set out in the 5-year *Strategic and Annual Operational Plan*.<sup>6</sup>

Both the Ministry and AusAID have re-examined the ToR for the 'Planner' position to highlight the importance of the 'Health Administration' aspect of the role, while still retaining strategic planning functions. The ToR has more accurately reflect the inline nature of the position's responsibilities, and additional flexibility should be built-in to permit the position to take on ad-hoc responsibilities such as responding to infrastructure / logistics crises. The ToR should recognise that overall responsibility for strategic planning outcomes rests with the Secretary for Health.<sup>7</sup>

GoN and GoA agree to the establishment of a Program Monitoring Group for Nauru, comprising a small group of individuals who are available to provide consistent technical support and policy advice – either collectively or individually – to the GON and core in-line personnel in all priority sectors under the Partnership. The PMG's role would be to provide a point of technical reference, back-up support and advice to the government departments including DOH and local and in-line managers; their input would be especially important during the initial transitional year and around the time of key reviews or evaluations (see below). Costs will not be deducted from the PPD allocation for health.

The Governments of Australia and Nauru will promote coordination and regular opportunities for dialogue between development partners active in the health sector. Stakeholder meetings should coincide with Nauru's bi-annual donor roundtable meetings and the DoH 5 year strategic planning cycle, so that findings and recommendations can be appropriately fed in. Greater coordination between major development partners in the health sector (and also other sectors that are linked to health outcomes through the *NSDS*): New Zealand, Republic of China (Taiwan), and multilateral and inter-governmental agencies like WHO, SPC, UNICEF and UNFPA are critical to the success of all health sector initiatives. It would assist GoN and development partners to move towards a single policy framework, common budget and disbursement mechanisms, and integrated approaches to M&E in the health sector.

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<sup>6</sup> These positions may be filled using *Partnership* resources or with the support of an Australian or other volunteer program (e.g. Australian Youth Ambassadors for Development, United Nations Volunteer).

<sup>7</sup> Country Program Report Pacific Review of Adviser Positions funded by the Australian Aid Program Nauru.

## Annex 1

### **Nauru-Australia Partnership Priority Outcome 2: A cost-effective health system which delivers improved health outcomes**

**Joint Commitments:** The *Partnership* will support implementation of Nauru's Health Sector Strategy to deliver improvements in health outcomes, with an emphasis on:

- Strengthening health system management, in particular **budget prioritisation, strategic planning, infrastructure redevelopment and improved health statistics;**
- **Reduced prevalence of NCDs and STIs** through more effective preventive and public health programs; and
- **Improving MCH outcomes** by addressing child nutrition and improving access to and quality of ante- and post-natal care.

#### **Target Results:**

- Reduced rate of infant, under-5 and maternal mortality;
- 10% reduction in incidence of NCDs by 2015;
- Reduced sexually transmitted infections;
- Reduced nutritional deficiencies in children;
- Increased percentage of the health budget allocated to preventive health care; and
- Improved performance against the WHO Framework of Priorities in Health in the Pacific.

## Annex 2

The following table lists indicative activities by area of focus for each development objective during the first two years of full implementation under the partnership (2011-13).

As much as possible, these indicative activities have been aligned with relevant sections and activities in the 5-year *Strategic and Operational Plan*. (Details are subject to review and revision once the 5-year *Plan* and medium term expenditure framework are finalised).

Areas of support within 5-year DOH <i>Strategic and Operational Plan</i>	Included areas of support through the <i>Partnership</i> for health (indicative)	Potential AusAID, whole-of-government and external collaborations
<b>Development Objective 1 – Strengthening health system management, in particular budget prioritisation, strategic planning, infrastructure redevelopment and improved health statistics</b>		
<b>Health sector management, governance, policy development, strategic planning and budget prioritisation</b>	<b>Strengthen, streamline, maintain and support key management and strategic planning functions within the health sector through:</b> <ul style="list-style-type: none"> <li>• Maintaining SHMS position</li> <li>• Maintaining support for strategic planning function</li> <li>• Providing non-salary support for the 'high potential candidates' scheme</li> <li>• Providing technical assistance (including for policy development) through TAG</li> </ul>	Pacific Senior Health Officials Network (PSHON) AusAID Pacific Branch AusAID Health Resource Facility
	<b>Strengthen budget analysis and prioritisation functions within the health sector through:</b> <ul style="list-style-type: none"> <li>• Maintaining support for strategic planning function</li> <li>• Providing technical assistance through TAG</li> </ul>	<i>Partnership</i> outcome area 1 (Ministry of Finance) AusAID Health Policy and Finance Knowledge Hub (Nossal Institute)
<b>Human resource development, work force planning, capacity development and training</b>	<b>Strengthen HRH analysis, planning and projections through:</b> <ul style="list-style-type: none"> <li>• Development of HRH 'Road Map' (inclusive of all cohorts of DOH personnel)</li> <li>• Maintain technical support for Health Practitioner Registration Board</li> </ul>	Pacific HRH Alliance (WHO South Pacific) AusAID HRH Knowledge Hub (University of NSW) PSHON
	<b>Facilitate off-shore education, training and other types of capacity development for medical students and other categories of health worker</b> <ul style="list-style-type: none"> <li>• Facilitation of regional networking, affiliation and accreditation</li> <li>• Providing non-salary support for placements, scholarships and in-country courses as required</li> <li>• With other Pacific Island countries who have medical students in Cuba, Fiji and other common locations, contributing to the costs of maintaining a support officer to provide mentoring, counselling and pastoral care to students</li> </ul>	Regional School of Nursing (e.g. Kiribati, Solomon Is, Fiji) Strengthening Specialised Clinical Services in the Pacific (SSCSiP) team in Fiji Other Pacific Island country Ministries of Health Cuban Humanitarian Mission Fiji School of Medicine Australia-Pacific Technical College (APTC) WHO
	<b>Facilitate in-country education, training and other types of capacity development for</b>	Pacific HRH Alliance (WHO South Pacific)



Areas of support within 5-year DOH <i>Strategic and Operational Plan</i>	Included areas of support through the <i>Partnership for health</i> (indicative)	Potential AusAID, whole-of-government and external collaborations
	<b>doctors, nurses and other categories of health worker</b> <ul style="list-style-type: none"> <li>• Maintaining Health Educator position until localisation achieved</li> <li>• Facilitation of regional networking, affiliation and accreditation</li> <li>• Providing non-salary support for distance education scholarships and in-country courses as required</li> <li>• Support continuing professional development (CPD) schemes</li> </ul>	AusAID HRH Knowledge Hub (University of NSW) SSCSiP team in Fiji Royal Australasian College of Surgeons (RACS; for specialised clinical courses, e.g. trauma and burns management)
<b>Infrastructure development and upgrading</b>	<b>Regular maintenance of health infrastructure:</b> <ul style="list-style-type: none"> <li>• Providing technical support for health facility utilities and maintenance (e.g. through in-line function, volunteer program, etc)</li> <li>• Maintaining support for infrastructure redevelopment planning</li> <li>• Maintaining biomedical engineering (BME) support</li> </ul>	<i>Partnership</i> outcome area 4 (essential infrastructure and services) SSCSiP team in Fiji RACS (for BME linkages) Royal Adelaide Hospital (for hyperbaric medicine linkages)
	<b>Health facility redevelopment:</b> <ul style="list-style-type: none"> <li>• Support for well-sequenced, evidence-based options and feasibility studies and planning for health facility redevelopment</li> </ul>	<i>Partnership</i> outcome area 4 (essential infrastructure and services)
<b>Health information management</b>	<b>Support implementation of <i>HIS Strategic Action Plan</i> through:</b> <ul style="list-style-type: none"> <li>• Maintaining regular technical assistance through strategic partnerships</li> <li>• Providing infrastructure, software and networking support as defined in <i>HIS Strategic Action Plan</i></li> </ul>	AusAID HIS Knowledge Hub (University of Queensland) Australian Institute of Health and Welfare PSHON
<b>Development partner coordination</b>	<b>Establish regular development partners forum with other for policy dialogue and collaborative planning and budgeting:</b> <ul style="list-style-type: none"> <li>• Support for annual National Health Conference</li> <li>• Support for health donors' round table (at least annual, with more prominent donors potentially meeting more regularly)</li> </ul>	Aid Management Unit (Department of Finance) Multilateral (e.g. UN agencies), bilateral (e.g. AusAID, Taiwan, NZAID) and inter-governmental (e.g. SPC) partners
<b>Inter-sectoral and civil society collaboration and coordination</b>	<b>Establish, support or maintain regular forum for central agencies to meet and undertake policy dialogue in relation to <i>NSDS</i>:</b> <ul style="list-style-type: none"> <li>• Support (in conjunction with other sectoral <i>Partnership</i> interventions) for National Development Committee</li> <li>• Identify and support opportunities for civil society engagement</li> </ul>	Aid Management Unit Central agencies Non-Health line ministries AusAID <i>Partnership</i> programs working in other sectors Civil society representative groups

Areas of support within 5-year DOH <i>Strategic and Operational Plan</i>	Included areas of support through the <i>Partnership for health</i> (indicative)	Potential AusAID, whole-of-government and external collaborations
<b>Medical Products and Technology</b>	<ul style="list-style-type: none"> <li>Support pharmaceutical manufacturing to cater for better patient care</li> </ul>	Aid Management Unit Central agencies Business Traders
<b>Medical Services</b>	<ul style="list-style-type: none"> <li>Support District Community Centre to serve as outlet for community health services</li> <li>Support and strengthen health research capabilities of the Ministry</li> </ul>	Aid Management Unit Central agencies Civil society representative groups Pacific Health Research

Areas of support within 5-year DOH <i>Strategic and Operational Plan</i>	Included areas of support through the <i>Partnership for health</i> (indicative)	Potential AusAID, whole-of-government and external collaborations
<b>Development Objective 2 – Reduced prevalence of NCDs and STIs, through more effective preventive and public health programs</b>		
<b>Strengthen response and interventions on NCDs</b>	<b>Support implementation of public health aspects of <i>NCD Action Plan</i>:</b> <ul style="list-style-type: none"> <li>Maintaining support for health promotion activities and interventions</li> <li>Providing support for non-salary recurrent costs associated with community-based primary care outreach</li> <li>Augmenting resources for community-based small grants schemes</li> <li>Maintaining support for healthy lifestyles campaigns and initiatives</li> <li>Maintaining support for school nutrition programs, and extending support to early childhood nutrition</li> <li>Providing periodic technical assistance (as required) through TAG</li> </ul>	Government of Republic of China (Taiwan) Agriculture sector SPC and WHO Possible collaboration with International Labour Organization (although Nauru not a member state)
	<b>Support implementation of clinical services aspects of <i>NCD Action Plan</i>:</b> <ul style="list-style-type: none"> <li>Providing technical and other support as required to standardise and strengthen medical and surgical management of diabetic and other peripheral vascular disease</li> <li>Providing technical and other support as required to standardise and strengthen secondary prevention of diabetic and other chronic disease complications</li> <li>Ensuring cost-effective laboratory services of appropriate standard are available to support clinical management and secondary</li> </ul>	SSCSiP team in Fiji RACS (for surgical management and secondary prevention linkages) SPC, WHO and Pacific Paramedical Training Centre (PPTC) for laboratory services SSCSiP team in Fiji RACS (for BME linkages) Royal Adelaide Hospital (for hyperbaric medicine)

Areas of support within 5-year DOH Strategic and Operational Plan	Included areas of support through the Partnership for health (indicative)	Potential AusAID, whole-of-government and external collaborations
	prevention	linkages)
	<ul style="list-style-type: none"> <li>• Exploration of feasibility of telepathology services, with support for establishment and non-salary recurrent costs as appropriate</li> <li>• Explore feasibility of implementing hyperbaric oxygen therapy for patients with peripheral vascular disease and other indications</li> </ul>	
	<b>Support development of clinical and rehabilitative services for people with disabilities:</b> <ul style="list-style-type: none"> <li>• Providing technical and other support as required to standardise and strengthen physiotherapy, occupational therapy and community-based services for people living with disabilities</li> <li>• Explore feasibility of linkages with disability services in Australia or neighbouring Pacific Island countries; if feasible, support training, infrastructure and non-salary recurrent cost support</li> </ul>	Education sector <i>Partnership</i> outcome area 4 (improved education)
<b>Strengthen response and interventions on sexual and reproductive health</b>	<b>Maintain support for prevention and treatment of STIs, including HIV infection, through:</b> <ul style="list-style-type: none"> <li>• Maintaining support for unfunded areas of public health programs addressing HIV and STI awareness</li> <li>• Maintaining support for unfunded areas of public health programs addressing teenage fertility and pregnancy</li> <li>• Maintaining support for unfunded areas of HIV-related counselling and testing services</li> <li>• Ensuring cost-effective laboratory services of appropriate standard are available to support diagnosis and management of STIs</li> </ul>	SPC (HIV-STI Response Fund)  UNFPA, UNICEF and WHO  SPC, WHO and PPTC for laboratory services
<b>Environmental Health</b>	<ul style="list-style-type: none"> <li>• Expand and strengthen food safety control including the enforcement of the Food Safety Regulation</li> <li>• Maintain and strengthen pollution control measures especially sewerage and medical waste management</li> <li>• Support the role and functions of the enforcement unit of the Ministry</li> </ul>	WHO, SPC  WHO, SPC   Justice Department, Business Sector
<b>Healthy Islands / Health Promotion</b>	<ul style="list-style-type: none"> <li>• Strengthen health promotion and health protection initiatives under the healthy island banner</li> <li>• Support the Healthy Island Council and its role and function</li> </ul>	WHO / SPC  Health Promotion Foundations

Areas of support within 5-year DOH <i>Strategic and Operational Plan</i>	Included areas of support through the <i>Partnership for health</i> (indicative)	Potential AusAID, whole-of-government and external collaborations
<b>Diagnostic services</b>	<ul style="list-style-type: none"> <li>• Explore and support microbiology diagnostic capability at RON</li> <li>• Strengthen blood bank services to incorporate voluntary blood donor services including related support mechanisms</li> <li>• Strengthen radiologic and scanning services to cater for breast examination and diagnosis</li> <li>• Strengthen radiology services to include Radiological Information System (RIS)</li> </ul>	<p>WHO / SPC / GF</p> <p>NGOs, Business Houses</p> <p>WHO, Radiology Support Network, Cancer Societies</p>

Areas of support within 5-year DOH <i>Strategic and Operational Plan</i>	Included areas of support through the <i>Partnership for health</i> (indicative)	Potential AusAID, whole-of-government and external collaborations
<b>Development Objective 3 – Improving MCH outcomes, by addressing child nutrition and improving access to and quality of ante- and post-natal care</b>		
<b>Strengthen response and interventions on early childhood clinical care</b>	<p><b>Improve neonatal (including care of premature and other seriously ill babies) and early childhood through:</b></p> <ul style="list-style-type: none"> <li>• Improved case management</li> <li>• Providing improved facilities in neonatal nursery and post-natal ward as required</li> <li>• Strengthening community awareness and follow-up during the neonatal period</li> <li>• Promoting and improving timeliness of childhood vaccination</li> <li>• Promoting and improving primary care management of childhood diarrhoea and acute respiratory infection</li> </ul>	<p>SSCSiP team in Fiji</p> <p>UNICEF</p> <p>WHO</p>

Areas of support within 5-year DOH <i>Strategic and Operational Plan</i>	Included areas of support through the <i>Partnership for health</i> (indicative)	Potential AusAID, whole-of-government and external collaborations
Promote production and consumption of nutritious foods, especially in settings of early childhood care and schools	<p><b>Support improved production of, access to and consumption of healthy and nutritious foods, including through:</b></p> <ul style="list-style-type: none"> <li>• Support for implementation of nutrition components of <i>NCD Action Plan</i></li> <li>• Extending coverage of school nutrition program to include early childhood years between infancy and school entry</li> </ul>	<p>Non-Health line ministries, especially Education and Agriculture</p> <p>SPC (Health and Lands / Agriculture)</p> <p>Government of Republic of China (Taiwan)</p>
Strengthen response and interventions on safe motherhood	<p><b>Improve access to and utilisation of quality contraceptive services through support for:</b></p> <ul style="list-style-type: none"> <li>• Improved reproductive health commodities management</li> <li>• Promoting knowledge of, access to and utilisation of modern contraceptive methods</li> </ul>	UNFPA
	<p><b>Improve access to and utilisation of quality ante- and post-natal care through support for:</b></p> <ul style="list-style-type: none"> <li>• Promotion of ante- and post-natal care through community-based approaches</li> <li>• Strengthening linkages between community- and hospital-based care</li> <li>• Strengthening health worker awareness and skills in prevention, detection and management of premature labour</li> </ul>	<p>SSCSiP team in Fiji</p> <p>UNFPA</p> <p>WHO</p> <p>Possible institutional linkage with Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and College of Midwives</p>
	<p><b>Improve quality of intrapartum and perinatal obstetric care through:</b></p> <ul style="list-style-type: none"> <li>• Maintaining support for non-salary recurrent costs associated with improving obstetric and labour ward services, including through telemedicine linkages as appropriate</li> <li>• Providing support (including non-salary recurrent costs) for strengthening and maintaining safe blood transfusion services, including short courses in immunohaematology as required</li> </ul>	<p>SSCSiP team in Fiji</p> <p>Possible institutional linkage with RANZCOG and College of Midwives</p> <p>PPTC for laboratory-related capacity development</p>

### Annex 3

#### Health Indicators: Definitions, Data Sources and Frequency

Indicator	Formulation	Source	Frequency
Proportion of donor-funded health expenditure reflected and reported on-budget in annual work plan [modified MDG 8 indicator]	Numerator: Total value in AUD of donor-funded health expenditure included in AWP and budget  Denominator: Total funding to health sector in AUD derived from non-GON sources for the financial year	Aid Management Unit, Department of Finance	Annual
Proportion of all-sources health expenditure allocated to public health (primary and preventive care)	Numerator: Public health (primary and preventive care) budget from both GON and donor sources  Denominator: Total health sector budget from both GON and donor sources	DOH, Aid Management Unit, Department of Finance	Annual
Prevalence rate of diabetes	Numerator: Number of surveyed individuals with a single fasting blood glucose level $\geq 7\text{mmol/L}$ or already on treatment for diabetes x 100  Denominator: Total number of surveyed individuals	Public Health Unit: • programmatic (mini-STEPS) survey • STEPS survey	<ul style="list-style-type: none"> <li>• Annual (programmatic)</li> <li>• Once in 5-year cycle (STEPS)</li> </ul>
Prevalence rate of physical inactivity	Numerator: Number of surveyed individuals reporting no physical activity in the week before the survey x 100  Denominator: Total number of surveyed individuals	Public Health Unit: • programmatic (mini-STEPS) survey • STEPS survey	<ul style="list-style-type: none"> <li>• Annual (programmatic)</li> <li>• Once in 5-year cycle (STEPS)</li> </ul>
Death rates associated with chronic diseases	<b>Death rate of diabetes related complications</b>	• <b>Record sections RON</b>	<b>Annual</b>
Amputations and rates per 1,000 among diabetic patients aged 25-64 years	Numerator: Number of amputations performed for peripheral vascular disease of other indications identified in case records as a complication of diabetes among patients aged 25-64 years x 1,000  Denominator: Estimated total number of individuals aged 25-64 years with diabetes	Numerator: RONH operating theatre register  Denominator: Public Health Unit, STEPS survey	Annual
Projected number of patients expected to commence haemodialysis over next 5 years (rolling indicator)	Numerator only: Number of individuals with serum creatinine $>400\text{ }\mu\text{mol/L}$ on at least two different tests at least one month apart  .	RONH reno-vascular clinical register	Annual
Prevalence of obesity by age group and sex	Numerator: Number of surveyed individuals with body mass index $\geq 30$ , stratified by age group and sex x 100  Denominator: Total number of surveyed individuals	Public Health Unit: • programmatic (mini-STEPS) survey	<ul style="list-style-type: none"> <li>• Annual (programmatic)</li> <li>• Once in 5-year cycle</li> </ul>

Indicator	Formulation	Source	Frequency
		• STEPS survey	(STEPS)
Proportion of pregnant women testing positive for <i>Chlamydia</i>	Numerator: Number of pregnant women testing positive for genital <i>Chlamydia</i> on antigen-based testing of endocervical swab or PCR of urine specimen x 100  Denominator: Total number of pregnant women screened	Public Health Unit and Antenatal Clinic records	Annual
Number of reported cases of HIV infection [adapted MDG 6 indicator]	Numerator only: Number of individuals in whom HIV screening test <u>and</u> confirmatory test are both reactive	Public Health Unit records	Annual
Proportion of surveyed individuals with clinical signs of trachoma	Numerator: Number of surveyed individuals with clinical signs of trachoma x 100  Denominator: Total number of surveyed individuals	Public Health Unit records	Annual survey in high-priority districts to a total of 5 years; then stratified random sample in all districts two years after program completion
Number and prevalence rate of tuberculosis [MDG 6 indicator]	Numerator: Number of individuals with diagnosis of TB confirmed by sputum microscopy x 100,000  Denominator: Total population	Public Health Unit records	Annual
Proportion of tuberculosis cases detected and cured according to regionally-recommended TB control strategy [MDG 6 indicator]	Numerator: Number of new, registered individuals with diagnosis of TB confirmed by sputum microscopy who were cured or in whom a full course of DOTS was completed x 100  Denominator: Number of individuals with diagnosis of TB confirmed by sputum microscopy	Public Health Unit records	Annual
Contraceptive prevalence rate among females aged 15-19 and 15-49 years [MDG 5 indicator]	Numerator: Number of surveyed females who reported using any modern form of contraception x 100, stratified by age group (15-19 and 15-49 years)  Denominator: Number of surveyed females aged 15-19 and 15-49 years	DHS	Once in 5-year cycle
Teenage fertility rate	Numerator: Number of surveyed females aged 15-19 years who reported either being currently pregnant or had already given birth to a child  Denominator: Number of surveyed females aged 15-19 years	DHS	Once in 5-year cycle
Condom use at last sexual encounter with non-regular partner [MDG 6 indicator]	Numerator: Number of surveyed individuals aged 15-24 years who had two or more sexual partners in the last 12 months and reported using a condom during most recent sexual intercourse with a non-regular partner x	DHS or second generation surveillance	Once in 5-year cycle



Indicator	Formulation	Source	Frequency
	100 Denominator: Number of surveyed individuals aged 15–24 years who had two or more sexual partners in the last 12 months, stratified by sex		
Prevalence of underweight children under 5 years of age [MDG 1 indicator]	Numerator: Number of surveyed individuals aged <5 years whose weight-for-age is less than minus two standard deviations from the median for the NCHS/WHO reference population x 100 Denominator: Number of surveyed individuals aged <5 years, stratified by sex	Public Health Unit records STEPS	<ul style="list-style-type: none"> <li>• Annual (programmatic)</li> <li>• Once in 5-year cycle (STEPS)</li> </ul>
Neonatal mortality rate	Numerator: Number of registered deaths in the first 28 days of life x 1,000 Denominator: Number of Live births	Vital registration data, RONH records DHS	<ul style="list-style-type: none"> <li>• Annual (programmatic)</li> <li>• Once in 5-year cycle (DHS)</li> </ul>
Infant mortality rate [MDG 4 indicator]	Numerator: Number of registered deaths in the first year of life x 1,000 Denominator: Number of Live births	Vital registration data, RONH records DHS	<ul style="list-style-type: none"> <li>• Annual (programmatic)</li> <li>• Once in 5-year cycle (DHS)</li> </ul>
Under-5 mortality rate [MDG 4 indicator]	Numerator: Number of registered deaths in the first 5 years of life x 1,000 Denominator: Number of Live births	Vital registration data, RONH records DHS	<ul style="list-style-type: none"> <li>• Annual (programmatic)</li> <li>• Once in 5-year cycle (DHS)</li> </ul>
Proportion of 2-year-old children immunised against measles [modified MDG 4 indicator]	Numerator: Number of surveyed children aged 18-29 months who have received at least one dose of measles vaccine x 100 Denominator: Number of surveyed children in the population who are aged 18-29 months at the time of data collection [NB Nauru schedule = 2 doses of measles-containing vaccine at 12 and 15 months]	Public Health Unit records DHS	<ul style="list-style-type: none"> <li>• Annual (programmatic)</li> <li>• Once in 5-year cycle (DHS)</li> </ul>
Proportion of 2-year-old children fully immunised according to national EPI schedule	Numerator: Number of surveyed children aged 18-29 months who have received all scheduled doses of EPI vaccines x 100 Denominator: Number of surveyed children in the population who are aged 18-29 months at the time of data collection	Public Health Unit records DHS	<ul style="list-style-type: none"> <li>• Annual (programmatic)</li> <li>• Once in 5-year cycle (DHS)</li> </ul>
Maternal deaths and mortality ratio [MDG 5 indicator]	Numerator: Number of women who die from any cause related to or aggravated by pregnancy or its	RONH records	Annual

Indicator	Formulation	Source	Frequency
	<p>management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy x 100,000</p> <p>Denominator: Number of Live births</p>		

## Annex 4

### Acronyms

AUD	Australian dollar
AusAID	Australian Agency for International Development
AWP	Annual Work Plan
BME	Biomedical engineering
DHS	Demographic and Health Survey
DOH	Department of Health
GDP	Gross Domestic Product
GON	Government of Nauru
HIS	Health Information System
HIV	Human immunodeficiency virus
HRH	Human resources for health
IMR	Infant mortality rate
PNG	Papua New Guinea
M&E	Monitoring and Evaluation
MCH	Maternal and child health
MDG	Millennium Development Goals
MOU	Memorandum of Understanding
NCD	Non Communicable Disease
NGH	Nauru General Hospital
NSDS	National Sustainable Development Strategy
PPTC	Pacific Paramedical Training Centre
RACS	Royal Australasian College of Surgeons
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RONH	Republic of Nauru Hospital
SHMS	Secretary for Health and Medical Services
SPC	Secretariat of the Pacific Community
SRH	Sexual and reproductive health
SSCSiP	Strengthening Specialised Clinical Services in the Pacific
STI	Sexually transmissible infections
TAG	Technical Advisory Group
TB	Tuberculosis
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USD	United States dollar
WHO	World Health Organization