

## Nauru Health System Support Project – Design Summary

*This document is intended to provide advice to the market about key elements of the design of the Nauru Health System Support Project (NHSSP). A more comprehensive design will be provided to those organisations successful at the Request for Expressions of Interest (REOI) stage and invited to participate in the subsequent Request for Tender (RFT).*

### Background and Context

Non-Communicable diseases (NCDs) are Nauru's most critical health issue. Nauru has high prevalence rates of cardio vascular disease, respiratory disease and, particularly, diabetes. NCDs are a major cause of premature death. Recent estimates suggest the probability of dying between the ages of 30 and 70 from one of the main NCDs is 71 per cent. Incomplete MHMS data from 2016 estimated there were 260 severely physically disabled people in Nauru, caused mainly by NCDs (46 per cent).

While patients with established pathology need specific management, crucially, much of the future burden of NCDs is preventable. The 2016 Non-Communicable Disease Risk Factors Survey (STEPS survey) (unpublished) did not show any significant improvements in key behavioural risk factors for NCDs. Indicators for predetermining conditions and lifestyle choices suggest that the health status is unlikely to improve and, indeed, may worsen given that there is international evidence of a trans-generational effect on population health.

Over 80 per cent of the population of Nauru is overweight or obese and over 95 per cent of the population eat a diet deficient in fruit and vegetables and high in salt, sugar and trans fats. With around half of the adult population using tobacco, Nauru has one of the highest rates of tobacco use in the Pacific Islands. How Nauru tackles the avoidable risk factors of poor nutrition, physical activity, tobacco and alcohol in the short-term, and how well its primary health care facilities manage NCDs to prevent or delay complications, will impact on the demand for health services and health costs in the long-term.

The extensive pressures placed on the health system in recent years, including the fire in 2013 that destroyed stores, pharmacy and medical records in the Republic of Nauru (RON) Hospital, have meant that capacity/capability remains low and health system development is a major challenge. This covers the whole range of systems, including planning, budgeting, performance management, computerised systems for procurement (supply chain management) and patient administration, and operational systems. Improvements are needed in the quality of both clinical and management information. Low systems capacity is increasing workload, increasing costs and, most importantly, affecting service delivery.

It is essential that high NCD rates are addressed as a priority due to the excessive costs of NCDs, both in terms of health sector spending and effects on economic productivity. The Nauru Health System Support Project (NHSSP or the Project) is designed to support the Government of Nauru to do as much as possible to tackle the NCD epidemic - preventing NCDs in the younger generation and managing existing NCDs as cost effectively as possible. The Project will build on Australia's comparative advantage built over many years of investing in health in the Pacific.

### Modalities

The NHSSP is part of an overarching Nauru Health Support Program (NHSP) which will deliver assistance to the Ministry of Health and Medical Services (MHMS) through two modalities:

- FA Managing Contractor (MC) for systems strengthening and reinvigorating community-based primary health (End of Project Outcomes 1.1, 1.2, 1.3, 1.4 and 2.1 – outlined below). The project will support the MHMS for an initial three years with an option to extend for up to an additional three years. The NHSSP will be firmly “on-plan”, so aligned with government policies and use government planning and monitoring systems.
- The NHSP will also be supported by a three-year grant agreement with World Health Organisation (WHO, Division of Pacific Technical Support team) to provide a package of support for NCDs prevention and management (End of Program Outcomes 2.2 and 2.3). This includes support to MHMS to roll out a Package of Essential Non-communicable Disease Interventions (PEN) for primary care in Nauru. The successful MC will need to work closely and collaboratively with the WHO to achieve the overall objectives.

## **Project Description**

### **Project Goal**

The overall goal of the Project is “a strengthened health system that holistically contributes to reducing the burden of life style diseases in Nauru”.

This is fully aligned with the Government of Nauru’s *National Sustainable Development Strategy 2005-2025* (NSDS) and MHMS’s *National Health Strategic Plan 2016-2020* (NHSP). The strategic priorities of Australia’s *Aid Investment Plan: Nauru 2015-16 to 2018-19* and DFAT’s *Health for Development Strategy 2015-2020* are also in line with the design. In addition, the cross-cutting aspects of the Project with a focus on gender and disability are intended to strengthen the health system for all Nauruans.

The Project has two components:

- Component 1: Strengthened health systems
- Component 2: Improved prevention and management of lifestyle diseases.

A pre-requisite for an effective and efficient NCD response in Nauru is a functioning health system, including at the primary health care level. The evidence that primary care can deliver better health outcomes at lower cost is strong. Scaling-up primary care for NCDs and health system strengthening are mutually reinforcing. A sustained, efficient response to NCDs requires well-functioning systems of planning, resource allocation, quality management, asset management, procurement and health information.

### ***End of Project Outcomes (Three years) for Component 1: Strengthened Health Systems***

*EPO 1.1 By 2021, health managers and clinicians have access to health information to inform decisions and reporting*

The health sector in Nauru is experiencing a lack of standardised data sets, inconsistent data collection and management processes, and unstructured reporting which culminates in little use of information for planning, operational management or monitoring. A Health Management Information System (HMIS) will both improve patient care and provide health managers with improved access to management information.

Supply chain management is also weak with spreadsheets being used for inventory management. There are frequent stockouts and costly urgent orders. A functioning Logistics Management Information System (LMIS) will provide data on usage and stock holding of medicines and health products, and support more efficient procurement.

The MC will procure and install a suite of health software systems and computer hardware to enable MHMS to collect, analyse and effectively utilise health data. Once rolled out, the HMIS will support

continuity of care between the RON Hospital, Public Health Centre and the community-based primary health clinics (the 'Wellness Clinics').

The proposed systems include *mSupply*, a Logistics Management Information System (LMIS) that had been used by MHMS for inventory management from 2008 to 2013. Following the fire at RON Hospital in 2013, the use of *mSupply* by MHMS has been restricted to pharmacy dispensing. The reintroduction of a fully functional *mSupply* system will ensure that a full inventory management system is operational. Its use should lead to a reduction in the frequency of stockouts.

As part of the HMIS, the *PATISplus* Patient Administration System will also be procured and implemented incrementally for registering, monitoring and producing patient reports. *PATISplus* will enable MHMS staff to access all the information about any previous treatment recorded in the system, including access to the Person Master Index that contains a record of any relevant alerts, including NCDs such as diabetes and rheumatic heart disease, as well as access to all laboratory and radiology results once associated information systems for the Pathology and Radiology functions are installed.

The *PATISplus* system was developed for use in Fiji, using DFAT funding and has been operating successfully for several years. A number of staff from the Ministry of Health and Medical Services (MHMS) staff who have worked in Fiji are familiar with *PATISplus*. It will require all patients to have a National Health Number. DFAT will clarify any legal issues with *PATISplus* software ownership (intellectual property) and discuss with Fiji's Ministry of Health as appropriate. The Project will also support improvements in the paper-based medical records management.

*DHIS2* is an open source application used extensively throughout the Pacific. It is proposed that *DHIS2* be implemented in Year Two of the Project. *DHIS2* will enable collection, analysis and reporting of aggregate public-health related population statistics from interventions that are not undertaken with individual patients. These include public health campaigns, school visits, survey results and so forth.

To ensure sustainability, the MHMS will need to establish a Health Information Unit (HIU) with responsibility for all health information collection and reporting functions within the MHMS. The role of the HIU will include responsibility for overseeing the health information systems as well as providing related Information and Communication Technology (ICT) support for MHMS staff. The HIU will provide a focal point for the skills transfer required. Appropriate training will be provided to all relevant MHMS staff – including those participating in the Management Development Program as appropriate – in the use and utility (monitoring, analysis and reporting) of the systems.

Achieving this EOPO will require three Long-Term Technical Advisers (LTTA) be engaged by the Contractor as follows: A Health Information Management System Adviser to support the roll out of the proposed HMIS application architecture; An LMIS Adviser to assist the MHMS and its staff to implement *mSupply* and; an ICT Support Manager to roll out the ICT needed for the HMIS and LMIS.

*EOPO 1.2: By 2021, MHMS has made progress in developing, implementing and monitoring Annual Operational Plans (AOPs) and undertaking performance management*

The MC will strengthen the planning process for the development of annual budgets and AOPs linked to the priorities in the NHSP. This will mean that the planning and budgeting processes can be linked, so that planning can be based on realistic budgets capturing all funding sources (GoN, DFAT and other donors). Support will be provided to ensure that the annual system of planning-budgeting-implementation-monitoring is functional for the MHMS. This will involve supporting MHMS to develop a Monitoring, Evaluation and Learning (MEL) Plan and system for the AOPs which will reflect core health indicators once developed and agreed. Having core health indicators will allow the MHMS to track progress of key health processes, outputs and outcomes and use the information to make resource allocation decisions. Over time it may be possible to link health outcomes to budget and financing information to better inform MHMS planning. The Project will ensure that gender,

disability and social inclusion issues are integrated into both the AOPs and the indicators, and that gender disaggregated data is prioritised.

The Project will also support the cascading of AOPs into performance management. This will allow the objectives, activities and budget in AOPs to be broken down to team and personal annual objectives, and to be reviewed regularly. Teams and individual staff members will then know what is expected from them to achieve the objectives in the AOP. The Management Development Program will support this by identifying development needs related to the objectives and meeting these through mentoring, coaching and some formal teaching if necessary. The information generated through the HMIS will help to provide line managers with the information they need to hold teams and individuals to account for implementation of AOPs.

The project requires a LTTA in Health Planning and Health Systems to be engaged by the MC to provide planning advice and to build planning capacity and systems. It is envisaged that MHMS will establish and recruit staff into a small Health Planning Unit (HPU) to facilitate the strengthening of the budget/AOP development as well as support line managers in undertaking performance management. The MHMS needs to fill the vacant Director Finance and Planning as this post will be the counterpart for the Health Planning and Health Systems Adviser.

*EOPO 1.3: By 2021, high priority and appropriate health system operational procedures are available*

The MC will support the development of health system Standard Operating Procedures (SOPs). It will work with the MHMS Executive to agree the list of needed SOPs (health systems) and to prioritise them, recognising that an incremental approach is needed. According to the prioritised timetable, the Project will support integration of the SOPs into the AOP and support individual leads on each SOP through, for example, suggesting writing formats and testing methods and implementation strategies. This will, in part, be done through Action Learning sets as part of the Management Development Program. It is recognised that it is unrealistic to expect development and implementation of all the health systems procedures required in three years.

The project requires the LTTA in Health Planning and Systems to ensure that the development of health systems functions is an integral part of the AOP. He/she will work closely with the LTTA Hospital Operations Manager who will support the MHMS to develop and implement the SOPs, including through training and processes for review and update. The LTTA Hospital Operations Manager is currently engaged by the Pacific Technical Assistance Mechanism (PACTAM) and it is envisaged that this contract would be “novated” to the Managing Contractor.

*EOPO 1.4: By 2021, managers have increased their competence and a culture of ‘learning through doing’ is emerging*

The project proposes the establishment of a Management Development Program. The aim of the Management Development Program will be to develop a small cadre of junior and middle managers, together with staff with the educational background and potential to become managers, so that they have demonstrable competence in a range of management functions and the potential to become future MHMS managers. Efforts will be made to ensure a balance of male and female staff participate in the Program.

This Management Development Program will seek to build competence using action learning methodologies supported by coaching and mentoring. It is not intended that it should be delivered as a formal academic training course as this would involve excessive absence from the workplace, can be more challenging for female participants and no suitable programs are available. Formal courses are also not appropriate where staff turnover is as high as it is in MHMS. The Management Development Program will aim to achieve a change in culture so that the MHMS becomes a learning organisation. It will focus on the development of identified competencies and learning from experience rather than just knowledge gained through courses. All the Project’s Technical Assistance (TA) will support the Management Development Program.

Delivery should involve a mixed approach including, for example:

- guided reading
- monthly teaching sessions delivered by a senior manager, TA, visiting expert and possibly through the Continuing and Community Education services offered by the University of The South Pacific in Nauru
- regular monthly facilitated action learning sessions (learning through doing, using real life situations that arise in day to day work)
- practicing management skills with support and coaching and documenting learning in personal learning logs
- mentoring (having a mentor who provides support and guidance)
- twinning (a distance relationship with a person undertaking a similar job in a similar regional setting).

The project proposes the MC both design the Management Development Program and, once agreed with MHMS, implement and monitor it. The MC will also be responsible for developing and monitoring a capacity development model to be adopted by all TA. This will include capacity development approaches and principles to be followed, including in support of the Management Development Program. The use of the TA model will be monitored to inform the MHMS and the Project's understanding about capacity development approaches within the health sector. This will be done in collaboration with WHO, as the other implementing partner of the Project.

### ***End of Project Outcomes (three years) for Component 2: Improved Prevention and Management of Lifestyle Diseases***

#### ***EOP2 2.1: By 2021, a more functional and effective community-based health system is in place***

In Nauru, primary health care services are either provided at the Out-Patient Department in the RON Hospital or at the Public Health Centre. Only one of the planned four community-based primary health 'Wellness Clinics' is currently operating (including, at a reduced level, providing dental services). The clinics operated from the Public Health Centre have low attendance and many registered patients are lost to follow-up. For example, around 70 per cent of the 870 registered diabetics do not attend for monitoring and/or treatment. There are community nurses and District Public Health Workers, but their effectiveness is compromised, including by lack of transport and poor allocation of responsibility for activities and accountability. Services related to mental health and disability are particularly under-developed. There is a general recognition that services need to be more available to the community and outreach needs to be prioritised. MHMS has divided the island into zones, the vision being that each zone has a functioning community-based primary health clinic.

The project proposes to strengthen and extend community-based primary health services in Nauru to deliver integrated primary health services locally and relieve the burden on the RON Hospital. In this way the community-based primary health 'Wellness Clinics', in line with the MHMS vision, will offer a range of services to the community in their zone, including through multi-purpose outreach and domiciliary visits. Services will be available to both adults and children and will include services for the prevention and management of NCDs.

Community-based primary health care services will be strengthened through a series of activities managed by the MC. The Project proposes a LTTA Community Health Adviser be engaged by the MC to develop and agree a cost-effective and realistically resourced Community Health Project Plan to strengthen community-based primary health service delivery. This plan will be based on an integrated model of care for community-based primary health services that will include a costed primary care essential package. The model will consider the structure, organisation and operations

of community health services, given the health needs of the population, affordability and feasibility of implementation. It will include the scope of the services to be provided, the shape of the delivery model (including outreach), referral protocols and links to public health and the RON Hospital, management systems, staffing needs (including training and supervision), and other resourcing requirements. It will consider gender, equity, disability and social inclusion. The LTTA Community Health Adviser will support the model's implementation and provide advice on technical and operational aspects of the community-based primary health activities.

It is anticipated that the model of care and the essential package will provide for the expansion of support for disability and mental health at the community level, as well as expanding the provision of Reproductive, Maternal, Newborn, Child, Adolescent health services through improving access to, for example, family planning, Ante Natal Care, Sexually Transmitted Infections, immunisation, cervical cancer screening services and early diagnosis of breast cancer. The model of care will also integrate with the gender-based violence services already being supported by DFAT.

Small scale infrastructure work will refurbish/expand the 'Wellness Clinics' and improve patient physical access and facilities, including improving privacy in consultation rooms and developing storage and toilet facilities. This includes the three 'Wellness Clinics' in containers and one existing building that has been donated by the community as a health clinic and requires refurbishment or replacement.

The Project also proposes continuing the payment of salaries for up to four GoN community health nurses (one per 'Wellness Clinic') as well as the provision of additional vehicles. The GoN will maintain the clinics and vehicles, provide the additional staffing required for the operation of the clinics, and the medicines and health products needed.

*EOPo 2.2: By 2021, detection and management of NCDs is more accessible to men and women*

WHO will be responsible for implementing a range of activities to achieve this EOPo and will be rolling out their PEN for primary care in Nauru.

*EOPo 2.3: By 2021, men, women, boys and girls have improved knowledge of tobacco risk factors and tobacco use behaviour has started to change*

WHO will be responsible for implementing a range of activities to achieve this EOPo

## **Resources**

The Activity Budget for the proposed initial three-year Project to be implemented through a MC is estimated at approximately AUD5.4 million.

### **Key Budget Assumptions**

DFAT's Australian High Commission (AHC) in Nauru has a contract with Palladium to provide comprehensive support services for MC deployees. The support services provided by Palladium includes shared housing for Long-Term and Short-Term Technical Advisers (LTAs and STAs); housing security services; and project vehicles consistent with the Adviser Remuneration Framework.

Given shipping costs to Nauru, the potential time and costs of a MC providing support services independently, the limited availability and costs of housing, the AHC Nauru envisages that the successful tenderer would utilise key services (LTAs and STAs housing, security, vehicles) provided via the Palladium contract. Therefore, in the Project (MC) Activity Budget no allowance had been made for LTAs and STAs housing/accommodation and security costs in Nauru.

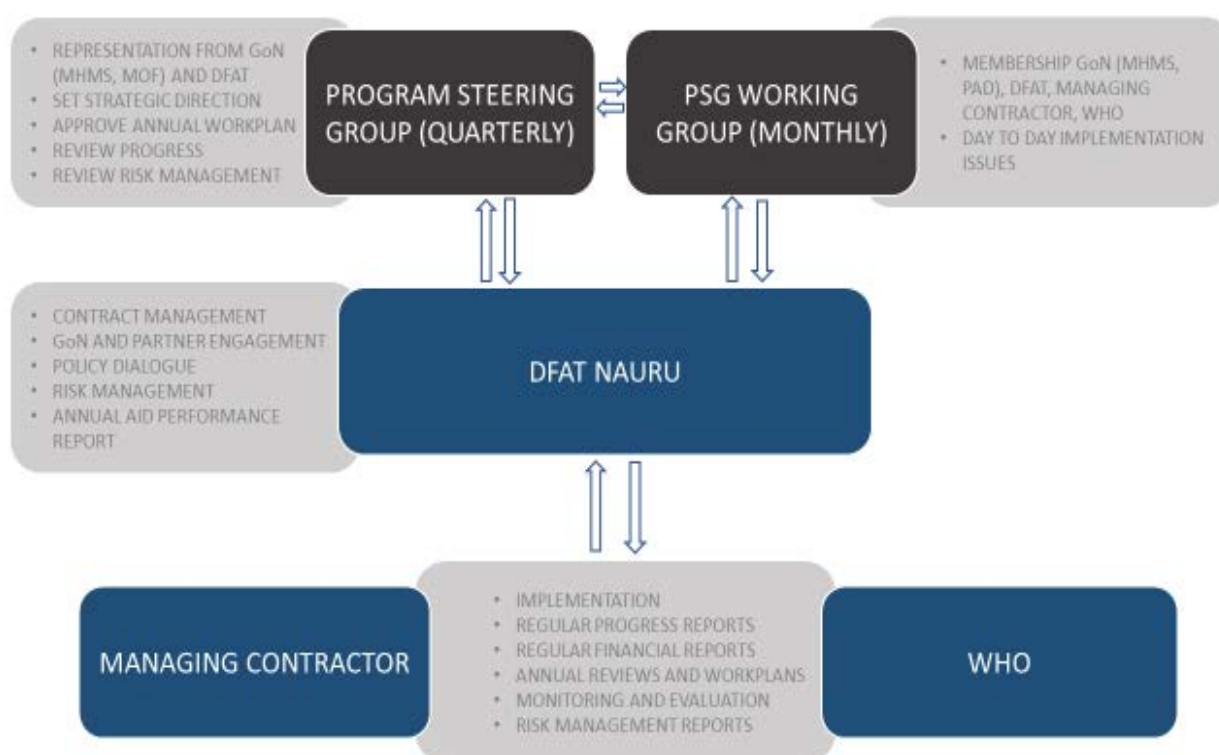
In addition, AHC Nauru, for similar reasons to that outlined above, has expressed a strong preference for the MC to maximise project management and administration functions and associated staff at their home base location, or possibly at an existing project management location elsewhere in the Pacific. This will minimise project management facilities and project management

staff based in Nauru. However, the AHC Nauru also indicated that, at a minimum, a MC would base a project liaison/coordination position in Nauru.

## Implementation Arrangements

### Management and Governance Arrangements and Structure

It is proposed that the primary governance mechanism for the Project will be a Project Steering Group (PSG). The PSG would be chaired by the Secretary MHMS and include senior management representatives from MHMS, Ministry of Finance (Planning and Aid Division) and DFAT. In addition, it is proposed that WHO attends the PSG (observer status) due to its role in delivering the Project's NCD component. It is envisaged that the PSG would initially meet at least quarterly and would have a standard agenda of key items to facilitate overall monitoring of progress.



**Figure 1: Governance Arrangements for the Nauru Health Support Project**

The PSG will also consider the establishment of a PSG Working Group at its initial meeting. A Working Group would meet monthly and discuss more operational day-t- day issues with the implementation of the Project. The governance arrangements envisaged for the can be seen in Figure 1. There is currently no forum for MHMS to coordinate with its health development partners. The MC may support the MHMS to operationalise a Partners Forum with a view to the Secretariat functions transitioning to the MHMS at the end of the Project.

The MC will be expected to provide regular, three-monthly, progress reports to the PSG. The MC will also provide annual plans to the PSG for approval, based on annual reviews against an agreed Monitoring, Evaluation and Learning Framework (MELF). Each Annual Plan will provide a fully-costed program of activities for the Project's coming financial year. Each Annual Plan will be integrated into the MHMS's AOP and budget with assistance from the LTTA Health Planning and Systems Adviser. The MC will be required to present a MELF to the PSG for approval.

## **Implementation Plan**

It is proposed that tenderers as part of their proposal provide a detailed Implementation Plan (Gantt chart and narrative) for the first six months of implementation of the Project. The Implementation Plan would indicate the tenderer's priority activities for the initial six months of implementation. The successful tenderer would be required to elaborate the Implementation Plan and submit it to DFAT and the PSG. The Implementation Plan would serve as an interim work plan until the (draft) Annual Plan for 2019-20 was developed.

The MC will be required to develop a Gender Action Plan. This will be informed by a gender analysis building on the analysis in the Project document. The gender analysis will consider the key challenges, opportunities and the gender equality context in Nauru relevant to Project implementation. This will include highlighting the key enablers and barriers to gender equality, women's participation and access to health services.

## **Risks**

The overall project risk is "Medium". The majority of the residual risks are rated as low or medium following appropriate mitigation measures. There are two residual risks that remain high: turnover of MHMS staff and a related risk on MHMS project counterparts. The underlying reasons for the high staff turnover are considered to be the "pull" factor of alternative (better paid) employment and "push" factors related to MHMS management. The project seeks to mitigate the "push" factors by improving the internal management of MHMS through a number of measures, including improved operational effectiveness, accountability and performance.

## **Safeguards**

### *Environmental protection*

There is a potential environmental risk associated with the proposed small-scale infrastructure for MHMS 'Wellness Clinics'. The main risk is the potential for asbestos to be identified in one of the clinics that requires refurbishment/expansion. The MC will be required to undertake an inspection of all clinics (including asbestos testing) and report to DFAT on the outcome. The MC will also be required to develop a proportional Environmental, Health and Safety Management Plan.

### *Children, vulnerable and disadvantaged groups*

To effectively manage risks to children, DFAT requires the commitment, support and co-operation of the implementing partners (contractor/subcontractors, WHO and GoN staff). Two LTTA positions will involve contact with children. One of the LTTA positions (Community Health Adviser) will be engaged by the MC. The MC will be required to develop a Child Protection Policy based on an assessment of child protection risks. The policy will meet the nine minimum standards of DFAT's Child Protection Policy. It will ensure its employees and subcontractors undertake activities in accordance with DFAT policies, including DFAT's Child Protection Policy, and ensure they are aware that they will be held accountable for compliance with the policies. The MC will be responsible for undertaking the necessary staff checks including police checks.

While the DFAT Child Protection Policy does not cover Government Partners, the GoN enacted child protection legislation in 2016. The legislation puts in place comprehensive measures to protect children from all forms of violence, neglect and exploitation.

In respect of vulnerable and disadvantaged groups, the MC will also be required to develop a Sexual Exploitation and Abuse (SEA) policy that will align with DFAT's SEA policy that is expected to be finalised in late 2018. The WHO SEA policy (2017) applies to all WHO staff.

### *LTTA Displacement and resettlement*

No displacement or resettlement issues were anticipated to arise from the NHSSP.



### *Indigenous peoples*

No indigenous peoples' issues were anticipated to arise from the NHSSP.

### *Health and safety*

Whilst the issue of medical waste was not considered by the project design team, MHMS advised that the Republic of Nauru Hospital is currently liaising with the Customs Department regarding the co-location of the hospital incinerator with a (new) incinerator proposed for the Customs Department. This would resolve some current (hospital) issues regarding smoke and maintenance.