

Final Report

**Independent Evaluation of the Tertiary Health
Pacific Islands Program (PIP) and Strengthening
Specialised Clinical Services in the Pacific
(SSCSiP)**

Beth Plowman

11 November 2015



Content

| Chapter | Title | Page |
|----------------|--|-------------|
| | Executive Summary | 5 |
| | Recommendations | 10 |
| 1. | Introduction | 13 |
| 1.1 | Background | 13 |
| 1.2 | Objectives of the evaluation | 14 |
| 1.3 | Conducting the evaluation: approaches, methods and sources | 15 |
| 1.4 | Limitations of the evaluation | 16 |
| 2. | Strengthening Specialised Clinical Services in the Pacific | 17 |
| | Objective 1: Evaluate SSCSiP against quality criteria including relevance, efficiency, effectiveness, sustainability, gender equality, monitoring and evaluation | 17 |
| | Sub-objective 1.1: Assess the continued relevance of the SSCSiP in regards to program design, needs of the population in PICTs and other investments in specialised clinical services. | 17 |
| | Sub-objective 1.2: Assess the effectiveness and efficiency of the SSCSiP in relation to its performance against design, needs of the population of PICTs, and previous external assessments | 25 |
| | Sub-objective 1.3: Assess the performance of SSCSiP in regards to sustainability, monitoring and evaluation and gender equality | 29 |
| 3. | Pacific Islands Program/Royal Australasian College of Surgeons | 33 |
| | Objective 2: Evaluate PIP including against quality criteria including relevance, efficiency, effectiveness, sustainability, gender equality, monitoring and evaluation | 33 |
| | Sub-objective 2.1: Assess the continued relevance of the Pacific Islands Program / RACS in regards to program design, needs of the population in PICTs and other investments in specialised clinical services | 33 |
| | Sub-objective 2.2 Assess the effectiveness and efficiency of the PIP in relation to cost-effectiveness, equity of access, clinical governance safeguards, strategic planning, health systems strengthening, and gender equality. | 44 |
| 4. | Conclusions | 54 |
| 5. | Recommendations | 56 |
| | Annex 1: Terms of Reference | 59 |
| | Annex 2: Evaluation Objectives, sub-objectives and key questions | 74 |
| | Annex 3: Individuals interviewed | 77 |

| | |
|---|-----|
| Annex 4: Interviewees by type of organisation | 81 |
| Annex 5: Documents reviewed | 82 |
| Annex 6: SSCSiP result hierarchies per original design document and revised M&E Plan | 89 |
| Annex 7 Achievements by project outcome 1 (SSCSiP) | 91 |
| Annex 7: Achievements by project outcome 2 (PIP) | 93 |
| Annex 8: Project responses to IPR recommendations | 95 |
| Annex 9: Surgical procedures performed by country and type | 97 |
| Annex 10: Analysis of gender distribution in PIP service delivery and training activities | 99 |
| Annex 10: Ratio of women to men receiving consultation or surgery by PIP | 102 |
| Annex 11: In-country training conducted by PIP | 104 |
| Annex 12: Risk management | 105 |
| Annex 13: PIP measures of success categorised by results level | 107 |

Acronyms

| | |
|----------|--|
| AUD | Australian Dollar |
| AusAID | Australian Agency for International Development |
| BEMI | Bio-medical Engineering Maintenance Initiative |
| CCrISP | Care of the Critically Ill Surgical Patient |
| CHIPSR | Centre for Health Information, Policy and Systems Research |
| CMNHS | College of Medicine, Nursing and Health Sciences (FNU) |
| CPD | Continuing professional development |
| DaCT | Development and Coordination Team |
| DFAT | (Australian) Department of Foreign Affairs and Trade |
| EMST | Emergency Management of Severe Trauma |
| ENT | Ear Nose and Throat |
| FNU | Fiji National University |
| HR | Human Resources |
| HRH | Human Resources for Health |
| IPR | Independent Progress Review |
| M&E | Monitoring and Evaluation |
| MFAT | Ministry of Foreign Affairs and Trade (New Zealand) |
| MMED | Masters of Medicine |
| MoH | Ministry of Health |
| NZMTS | New Zealand Medical Treatment Scheme |
| O&G | Obstetrics and Gynaecology Unit |
| OECD/DAC | Organisation for Economic Cooperation and Development/Development Assistance Committee |
| PACTAM | Pacific Technical Assistance Mechanism |
| PICTs | Pacific Island Countries and Territories |
| PIP | Pacific Islands Program |
| POLHN | Pacific Open Learning Health Net |
| RACS | Royal Australasian College of Surgeons |
| RCEM | Royal College of Emergency Medicine |
| RHP | Regional Health Program |
| SCS | Specialised Clinical Services |
| SPC | Secretariat of the Pacific Community |
| SRG | Stakeholder Reference Group |
| SSCSiP | Strengthening Specialised Clinical Services in the Pacific |

| | |
|-------|--------------------------------|
| StAG | Strategic Advisory Group |
| ToR | Terms of Reference |
| UNFPA | United Nations Population Fund |
| VMT | Visiting Medical Team |
| VT | Visiting Teams |
| WHO | World Health Organization |

Executive Summary

Background

In the Pacific regional context, countries with small populations have limited capacity to sustainably provide the full range of health expertise, functions and services necessary to improve health outcomes to desired levels. In this setting, regional health development investments can effectively complement country-level activities. To that end, the role of Australia's regional aid program is to improve health outcomes in the Pacific and to drive more effective regionalism in health through supporting targeted regional functions that complement country-level actions. One important area of Department of Foreign Affairs and Trade (DFAT) regional investment is in specialised clinical services¹, an area in which few Pacific Island countries can achieve economies of scale in service delivery.

Currently, these investments are organised under two complementary projects. The Strengthening Specialised Clinical Services in the Pacific (SSCSiP) project began in 2010 to assist Pacific Island countries to strengthen their capacity to plan and implement specialised services and to improve coordination of specialised teams from overseas. The second project, Tertiary Health Pacific Islands Program (PIP) has been funded by AusAID/DFAT and implemented by the Royal Australasian College of Surgeons (RACS) since 1995. This project delivers specialised clinical support and capacity development in surgery and associated clinical areas such as nursing and anaesthesia for 11 Pacific countries.

Continued support for 'tertiary care policy, technical support, capacity building and provision' and 'specialised health worker training' is a key aspect of DFAT's Regional Health Program Delivery Strategy 2013-2017. DFAT commissioned this evaluation to provide up-to-date information about the performance of these investments. This evaluation feeds into an on-going design process for the next stage of DFAT's investment in specialised clinical services (SCS) in the Pacific.

Purpose and methods

The overall purpose of the evaluation was to assess:

- progress towards the programs' stated objectives and outcomes as they approach completion;
- action related to issues identified in previous evaluations and performance assessments and any needs for further action.

The evaluation was also tasked with formulating recommendations to help inform DFAT on continued support for specialised clinical services and health workforce development in the Pacific region during the period 2016-2020.

¹ Specialised services involve a level of clinical support beyond that primary care workers and include: surgery, internal medicine, paediatrics, anaesthetics and trauma/critical care, obstetrics and gynaecology, orthopaedics, urology, cardiology, cardiac surgery, gastroenterology, ophthalmology, specialist dental services, mental health, management of chronic diseases, plastic and reconstructive surgery, neurology, radiology and rehabilitation medicine/services.

The evaluation was structured around two objectives in which each project was assessed against quality criteria including relevance, efficiency, effectiveness, sustainability, gender equality, monitoring and evaluation (M&E).

The evaluation's approach was primarily summative albeit with elements of forward-looking learning for the next program design cycle. A mix of methods and tools were used including structured document review, interviews and group discussions with key stakeholders, secondary data assessment, and country and site visits. Between 20 July and 14 August, visits to Fiji, Samoa and the Solomon Islands allowed face-to-face interviews on both an individual and group basis, site visits to hospitals and clinics, and identification, review and collection of materials.

Key Findings

Strengthening Specialised Clinical Services in the Pacific

The three functions performed by SSCSiP at the level of objectives remain important areas of need in the Pacific region (i.e. support for planning and managing SCS; strengthened country-level Human Resources for Health planning and capacity; and stronger regional coordination and networking). At issue is the relative emphasis which has been accorded between the three objectives as well as the balance of support for the sub-outcomes under each. The project's role in medical education and training (i.e. as a "gap-filler") for individuals, while responsive to country requests, has resulted in a relatively greater focus on the building of individual capacities than system capacities.

The SSCSiP model is best described as a demand-driven model in which Pacific Island countries request support for a range of services and support related to SCS. One advantage of the current model is that it provides "one-stop shopping" across specialties. Three aspects emerge as short-comings. Firstly, for countries to benefit from SSCSiP support, key individuals must be knowledgeable of the range of services and support available. The evaluation found that in many cases, interviewees were not aware of the support available including tools and templates on the project's website. A second short-coming to the current model arises from the demand-driven nature which results in the project taking a responsive stance rather than a pro-active and more strategic position. With its heavy emphasis on medical training, an unintended consequence of the model is the burden placed on countries when their specialist clinical staff are overseas for extended periods of time for training. Finally, important elements of project implementation are, in essence, country-specific in nature and do not fully reflect the regional mandate of the project.

Findings on project effectiveness should take into account the fact that strengthening of SCS is a long-term endeavour and is currently at a relatively early stage of implementation. There is movement in the direction of more demand-driven services in the region. However, the contribution of SSCSiP to this change is difficult to pinpoint. Clearly, support for the position of SCS Coordinators and assorted tools and templates has been positive. However, there is high turn-over in the SCS Coordinator positions and little seems to be done to maintain contact and to assess the needs of

new incumbents. Several interviewees with responsibilities relevant to SCS were unaware of the tools and templates designed to support their work and available on the project's website.

Progress is reported in the management and coordination of Visiting Medical Teams (VMTs) but these services are still a long way from being entirely demand-driven. There is little indication that VMTs are driven by any evidence-based assessment of population need, there is little, if any, data on equity considerations, and limited progress in systematically monitoring patient outcomes (an exception is initial work on post-operative morbidity in several countries). Decision-making on overseas referrals varies widely by country and in most cases, has political influences which make it difficult for an external actor to intervene. The prime achievements in this area are analyses conducted by the Centre for Health Information, Policy and Systems Research (CHIPSR). As mentioned above, the project has been actively involved in the provision of assistance for training opportunities. While efforts are underway to create a map of clinicians on a country-by-country basis, to date, it isn't clear when or how these maps could be used to identify and meet capacity building needs.

Management of the project at the Fiji National University College of Medicine, Nursing and Health Sciences (FNU CMNHS) was raised as an issue by many stakeholders. Issues revolved around the transparency of decision-making and the need for more independence for governance vis-à-vis the Secretariat. In Stakeholder Reference Group (SRG) meetings (2012 and 2013) appeals were made to provide clearly defined eligibility criteria and funding guidelines to all countries. While there were both advantages and disadvantages of the FNU location identified during the evaluation, the evaluation found that the frustration with decision-making processes perceived to benefit Fiji has serious consequences for the project.

The project should be credited with developing what is, on paper, a solid M&E Plan. The project reports difficulty in acquiring requested data from the countries. As a result, many of the monitoring tools included in the M&E Plan have not been made fully operational. Elements of the M&E Plan are conceptually sound but in practical terms cannot be implemented. In contrast to PIP reporting, which disaggregates all variables by sex, there is no gender-disaggregated reporting in the SSCSiP materials. Indeed, SSCSiP reporting is notably devoid of gender considerations. This lack of focus on issues of gender has been noted in the past (i.e. Independent Progress Review 2011 and the 2014 Quality at Implementation Report).

Pacific Islands Program

In examining questions related to the continued relevance of PIP objectives to the needs of countries in the region, the evaluation found that the three objectives differ in terms of their continued relevance (i.e. improved clinical health outcomes through service delivery; capacity-building for individuals; and support capacity for health planning as requested). The first objective, service delivery is highly relevant. In the eyes of the Ministries of Health (MoHs) and service providers interviewed, the real value of the PIP is in its provision of services.

During the period 2012 to 2015, the PIP conducted 3,559 surgical procedures across 10 countries and in 14 areas of specialty. The majority of these services were ophthalmologic, followed by plastic and reconstructive procedures, and ear, nose and throat. It is not possible to estimate the degree to which the number of specific surgical procedures (e.g. urology versus vascular surgery) are associated with need in terms of burden of disease. As a measure of met need, a Lancet Commission on global surgery proposed a surgical volume indicator (i.e. procedures done in an operating theatre per 100,000 per year) with a goal established for 2030 goal of 5000 surgical procedures per 100,000. The evaluation adapted² the surgical volume indicator to estimate the magnitude of PIP contributions on a population basis. PIP surgical procedures represent, on average, 16 procedures per 10,000 population in the countries served.

The second objective (strengthened capacity of individuals to provide specialised medical and health support service) is of continued relevance albeit differences in the type of capacity strengthening provided may be needed. The project takes a tiered approach with in-country and regional workshops followed by more intensive continuing professional development (CPD) and overseas training (e.g. in-country workshops reach large number of beneficiaries, are aimed at more general audiences than specialist clinicians and in a broader range of topics). It is worth noting that several of the top five forms of in-country training are not directly related to specialist clinical care and may be provided by other actors in the region (e.g. UNFPA, World Health Organization (WHO) for intrapartum care). The leading form of in-country training is Essential Pain Management which accounts for 45 per cent of all in-country training activities. Over the course of a PIP VMT visit, hands-on training can take the form of attachments. These attachment experiences are valued by the Pacific clinicians and can lead to mentoring over the course of repeat visits and through communication between visits. Surgical providers interviewed also spoke highly of the type of skill upgrading that occurs during the visits which include clinical training and mentoring, tutorials, lectures and grand rounds.

The final objective, to promote and support capacity for health planning and management as requested by the MoH and/or SSCSiP, seems far less relevant than the preceding two objectives. Indeed, the perception among some involved in PIP is that responsibility for this area has been transferred out of PIP to SSCSiP. It stands outside the unique skills and expertise of the implementing agency and MoHs in the region do not consider PIP as a source for support of this type.

The evaluation also examined whether PIP was “fit for purpose” including consideration of value for money. The value for money model utilised concepts of economy, efficiency, effectiveness and cost-effectiveness based on a stepwise progression (e.g. inputs, processes, outputs, etc.). In regards to economy, the evaluation found that the relationship with RACS, as implementer, brings a multiplier effect to the investment of the Government of Australia. Specifically, through the provision of volunteer surgical services³, every AUD invested by DFAT into PIP

² One adaptation was to use 10,000 as the population base given the small populations in the region.

³ This figure should be considered an underestimate as RACS also negotiates reduced prices on procurement of supplies and equipment as well as outright donations. These elements have not been fully costed.

generates an additional 75 cents of in-kind services volunteered by RACS Fellows. The efficiency of PIP (the relationship between inputs and outputs) was roughly calculated as AUD per consultation and to surgical procedure. It was found that consultations were provided at a cost of AUD 736 for each, and surgical procedures at AUD 2,759 each. If the DFAT investment were considered alone, there would be far fewer consultations (7,585 rather than 13,333) and surgeries (2,023 rather than 3,559). One could conclude that the efficiency of converted input to outputs is enhanced by approximately 43 per cent through the use of RACS as implementer of PIP. Moving across the model to effectiveness and cost-effectiveness becomes increasingly difficult. The evaluation was not able to generate valid estimates of an individual project's contribution to what are jointly achieved, longer-term results. It is possible to estimate the total number of consultations and surgical procedures provided through PIP visits per 10,000 population in the countries served. However, drawing out the relationships between outputs and outcomes is not possible.

In examining “fit for purpose”, it was assumed that purpose referred to the provision of specialised services as identified and prioritised by the MoH through a purely demand-driven model. If this is the case, then RACS is not a particularly relevant option. It is difficult to envision a scenario in which SCS could be both entirely voluntary and demand-driven. As voluntary services, there are concessions made in timing and other aspects of VMT management to accommodate their provision. One senior Pacific clinician interviewed articulated perhaps the best case scenario with regards to the balance between supply and demand. He said: *“The PIP VMTs are more streamlined now. They used to come as generalist surgeons, now we have a roster of patients for a specific type of specialty and they send a team specifically for that; they are also always checking how the situation on the ground is changing; how our needs evolve; what training needs may be coming up.”*

In regards to health workforce planning and training, PIP supports MoHs to determine needs in specialty areas covered by the VMTs often on an individual basis through working side-by-side during the course of a visit. At completion of a visit, training needs are clearly identified in the end-of-visit report. It is difficult to know whether and how these training needs are translated into action. There were mixed reports among those interviewed as to whether the end-of-visit reports are distributed within a country. Nonetheless, for the identification of these quite specific training needs of individual surgeons, RACS is well-positioned and has a comparative advantage.

The evaluation examined gender dimensions of both services provision and training activities. VMT screening and surgical cases are said to be based on severity of illnesses, quality/safety considerations and services that can be provided in the local hospital setting. In this scenario gender considerations would not necessarily weigh in determining who is seen and served. However, analysis performed for this evaluation found that there are differences by gender that may not be fully explained by objective criteria for screening and surgical cases. At an aggregate level, there are balanced distributions in the numbers of males and females consulted and provided with surgical care. When examined by specialty area, there are some specialties where men and women are equally represented among those consulted and surgical cases. However, there are a number of areas where the representation of males

relative to females is quite skewed. DFAT has acknowledged an important gap in existing knowledge regarding the initial selection of patients to be screened by PIP, whether and how gender equality principles may be accounted for in this process. Indeed, the lack of information seems to be a basic barrier to understanding and addressing issues of equity of access. Ideally, variables related to equity of access (e.g. age, sex, region of residence, distance of residence to facility, cost of travel, etc.) should be available in patient records. The evaluation was not able to examine this issue in greater depth but flags it as a potential area for further careful analysis.

In general, PIP does an excellent job of defining measures of success for each objective and associated outcome. A number of monitoring formats have been developed, made operational and are reported in semi-annual and annual reports. Several of the measures used at output level pose challenges (i.e. role of Pacific clinicians during surgical procedures and increased skills, confidence and application at three months post-training). In regards to outcomes, the monitoring tool being used is the recently developed beneficiary study. Based on the review of the Tonga report, the value of this instrument seems limited primarily due to the fact that the individuals selected were not representative and findings can only be considered anecdotal of the entire population of beneficiaries.

In discussing sustainability, several high-level Pacific clinicians spontaneously said that the support of PIP/RACS will be needed some time into foreseeable future. RACS is consistent in placing emphasis on the provision of clinical services. As found in the evaluation, the provision of these services, via VMTs, has an important capacity-building element, particularly when RACS surgeons are working side-by-side with their Pacific colleagues. While difficult to quantify, this form of upskilling was consistently mentioned by the Pacific clinicians interviewed. Obviously, this form of skills-building is sustainable when it can be provided by Pacific clinicians themselves without the presence of the VMTs.

Recommendations

For SSCSiP

1. DFAT should carefully examine the balance of effort that is devoted to building individual versus systems capacities and providing country-specific assistance versus strengthening regional mechanisms. Going further, DFAT should build into the design, mechanisms and incentives to ensure that the desired balance is more likely to be achieved (e.g. countries must first have a multi-year SCS human resources (HR) plan in place before submitting requests for individual training – ideally these would be part of broader HR planning, and not siloed to SCS).
2. As implemented, several areas of SSCSiP focus do not fully represent the intent of regional programming. In the future, DFAT should examine the relationship between regional investments (e.g. developing common standards) and country-specific investments (e.g. getting newly agreed standard adopted into country practice). Moreover, some activities, appropriately regional in nature, have gone unaddressed. In a resource constrained environment, a regional initiative should

- focus more exclusively on those aspects of strengthening SCS that serve regional as opposed to individual country needs.
3. Recognising the burden placed on countries by clinicians seeking advanced training, DFAT should invest in a thorough examination of the possibilities of remote and/or on-line training courses. While it is said that “training a surgeon takes 10 years”, when staff are away for extended periods of time in training, the ability of Pacific country to provide SCS is severely affected.
 4. Project funding for use as gap-filling is widely appreciated throughout the region and the project should be commended for its approach to cost-sharing with MoHs. However, the project should “ring-fence” this component in order to avoid becoming a project primarily for the support of ad-hoc, individual capacity-building. Where support for training is granted, it should be clearly linked to information on the SCS needs of the country. DFAT should examine the potential of tapping into bilateral mission training funds for scholarships and training as a potential means of meeting these needs.
 5. An important contribution of SSCSiP has been through the analytical work carried out by CHIPSR. Quality, independent work of this nature is a tremendous value-added for the project and an area into which few other agencies would venture. DFAT should find ways to expand this aspect of the project’s operations.
 6. While needs for SCS differ substantially by country, respondents from across countries consistently cited the need to provide nurses with access to specialised clinical training in addition to access to training currently provided to surgeons. In addition, the area biomedical services is an enormous and under-addressed issue across the region. DFAT should extend its offerings to nurses in priority areas of specialised services and incorporate biomedical support into bilateral programs of assistance albeit with a systems-wide emphasis on primary, secondary and tertiary services.

For PIP

7. Looking forward to a diminished resource envelope, DFAT should prioritise PIP’s real strength and value which is the provision of SCS accompanied by hands-on training that occurs during the course of a visit.
8. In certain specialty areas, PIP/RACS should be strongly encouraged to engage in more region-wide coordination and to adapt its VMTs accordingly (e.g. other actors have expanded service provision in ophthalmology). In some areas of specialty, services available through other actors may have expanded to the point that it no longer need be a PIP/RACS lead specialty. At the same time, other areas, such as cardiac surgery, is greatly needed yet requires very large teams and more specialised equipment. In these areas, PIP/RACS should expand partnerships with others to expand service offering through more joint efforts.
9. PIP/RACS training at country and regional level should be increasingly focused on a) country-identified areas of need, and b) in topic areas which RACS is uniquely positioned to provide. In sum, DFAT might be better served to expect less capacity-building activities from PIP but more higher-value, specialised skills building. Pacific clinicians expressed their clear preference for attachment training – seen as high-value training with cascading effects when the surgeon returns to his/her country.

10. Data reviewed for this evaluation suggest that there may be some underlying, systematic gender bias affecting who gets screened and eventually treated by the PIP VMTs. DFAT should find a means of complementing PIP/RACS skill set in order to better understand and address this issue, if it is occurring.
11. Finally, PIP/RACS should be commended for attempting to gauge the impact to beneficiaries of receiving VMT services. However, the approach adopted appears to generate data which are only slightly better than anecdotal. This problem could be addressed through the creation of a system to monitor patient outcomes – an initiative outside of PIP/RACS expertise. DFAT may consider funding analysis which would allow countries, PIP/RACS and others to estimate surgical need by country, specialty and procedure so that met and unmet need can be better gauged. Analytical resources, such as those found in FNU's Center for Health Information, Policy and Systems Research, will be needed to address this data gap.

1. Introduction

1.1 Background

This evaluation was undertaken at the request of the Australian Department of Foreign Affairs and Trade (DFAT) to help inform the design process for the next phase of Australian investment in Specialised Clinical Services (SCS) and Health Workforce Development in the South Pacific planned for 2015.

In the Pacific context, countries with small populations do not have the capacity to sustainably provide the full range of health expertise, functions and services necessary to improve health outcomes to desired levels. In this setting, there is a case for regional investment that complements country-level activities. To that end, the role of Australia's regional aid program in improving health outcomes in the Pacific is to drive more effective regionalism in health through supporting targeted regional functions that complement country-level actions. One important area of DFAT regional investment is in SCS, an area in which few Pacific Island countries can achieve economies of scale in service delivery.

Currently, these investments are organised under two complementary projects, Strengthening Specialised Clinical Services in the Pacific (SSCSiP) and the Tertiary Health Pacific Islands Program (PIP). PIP has been funded by AusAID/DFAT and implemented by the Royal Australasian College of Surgeons (RACS) since 1995. This program delivers specialised clinical support and capacity development in surgery and associated clinical areas such as nursing and anaesthesia for 11 Pacific countries. The value of the investment is *AUD 8,970,905* inclusive of extension funding. SSCSiP began in 2010 to assist Pacific Island countries to strengthen their own capacity to plan and implement more specialised services and to improve coordination of assistance of specialised care provided from overseas. The SSCSiP investment is *AUD 4,392,000*. Table 1 below summarises basic characteristics of the two projects.

Table 1: Summary variables for PIP and SSCSiP projects

| | PIP | SSCSiP |
|---------------------------|--|---|
| Implementer | RACS | FNU/CMNHS |
| Duration | Since 1995, current phase March 2011 -April 2016 | 2010 – June 2016 |
| Coverage | 11 countries | 14 countries |
| Scope | <ul style="list-style-type: none"> provides specialised clinical support capacity development in surgery as well as other clinical areas | <ul style="list-style-type: none"> supports Pacific Island countries' capacity to plan and deliver specialised services and improved coordination of assistance for specialised clinical care. |
| Budget¹ | AUD 8,970,905 | AUD 4,392,000 |

The Regional Health Program Delivery Strategy 2013-2017⁴, continues DFAT's support for 'tertiary care policy, technical support, capacity building and provision' and 'specialised health worker training' as key areas for future regional investment. The existing investments that were due to end during 2015 have been extended until early 2016 to allow time for a design process to be undertaken. It is important that up-to-date information about the performance of existing investments, operating context, and gaps feeds into the design process.

1.2 Objectives of the evaluation

Per the original Terms of Reference (Annex 1), the overall purpose of the evaluation is to assess:

- progress towards the programs' stated objectives and outcomes as they approach completion;
- actions related to issues identified in previous evaluations and performance assessments and the need for further action if required; and

The evaluation is also tasked with providing recommendations formulated to help inform DFAT on continued support for specialised clinical services and health workforce development in the Pacific region during the period 2016-2020.

DFAT monitoring and evaluation (M&E) guidance⁵ outlines three functions of evaluation: management, accountability and learning. Of these three, this exercise is primarily intended to support DFAT management by providing evidence and an analysis of performance to guide future decisions about new and existing investments. The main audience for the evaluation findings and recommendations is DFAT, particularly decision-makers involved in the development and management of Pacific regional health programming. Other audiences include DFAT missions throughout the Pacific region as well as governments of Pacific countries and implementers of the projects (i.e. College of Medicine, Nursing and Health Sciences (CMNHS) and RACS)).

The overarching objective for this task is to evaluate two distinct yet related DFAT-funded projects: SSCSiP and PIP. In practical application, this single objective has been broken down into two separate objectives which are none-the-less closely related. These two are as follows:

⁴DFAT Pacific Regional Health Program Delivery Strategy 2013 – 2017 December 2013.

⁵DFAT M&E Standards, June 2014

Objective 1: Evaluate SSCSiP against quality criteria including relevance, efficiency, effectiveness, sustainability, gender equality, monitoring and evaluation.

Objective 2: Evaluate PIP against quality criteria including relevance, efficiency, effectiveness, sustainability, gender equality, monitoring and evaluation.

These projects are to be evaluated using commonly applied evaluation criteria including: relevance, efficiency, effectiveness, sustainability, gender equality, M&E. These criteria are briefly summarised in Table 2.

Table 2: Evaluation criteria and intended application⁶

| Criteria | Summary description |
|---------------------------|---|
| Relevance | Are the objectives of SSCSiP and PIP still consistent with the needs of the Pacific Islands Countries and Territories (PICTs)? In sum, is this still the right thing to do? |
| Effectiveness | Have the projects' intended results been achieved? |
| Efficiency | Do the investments in SSCSiP and PIP/RACS make appropriate use of DFAT's and counterparts' time and resources to achieve objectives? |
| Sustainability | Will the benefits of the DFAT contribution continue after the investment has ceased? How likely are the benefits of SSCSiP and PIP/RACS to be continued over the long-term? |
| Monitoring and evaluation | Have the projects' developed and used an M&E system to measure implementation and progress towards intended results? |
| Gender | Have gender concerns been effectively integrated into the projects? |

The original Terms of Reference (ToRs) had a very large number of wide ranging questions which could not have been addressed adequately with the time and resources available. Therefore, DFAT carried out a prioritisation process which focused the exercise considerably. Sub-objectives and priority questions for each objective appear in Annex 2. This report is structured by the evaluations' objectives and sub-objectives. Evaluation questions appear in the text as sub-headers.

1.3 Conducting the evaluation: approaches, methods and sources

The overall approach was guided by the need to ensure that the evaluation is relevant and directly useful for DFAT in program design, to ensure that the evaluation is rigorous and evidence-based and to conduct and complete the assignment within the designated time-frame. The evaluation was primarily summative albeit with important elements of forward-looking learning for the next program design cycle. A mix of methods and tools were used including structured document review, interviews and group discussions with key stakeholders, secondary data assessment, and country and site visits.

⁶ Descriptions are drawn from DFAT M&E guidance as well as the OECD/DAC Glossary of Key Terms in Evaluation and Results Based Management.

A total of 85 individuals were interviewed. Most interviews were conducted face to face during country visits. A small number were by phone. Detailed notes were taken during all interviews. The full list of interviewees is provided in Annex 3, the number of interviewees by type of organisation in Annex 4, and list of documentation consulted in Annex 5. The field work portion of the evaluation started in Melbourne with a day of interviews at RACS. Country visits to three countries were an important element of the methodology. Between 20 July and 14 August, visits to Fiji, Samoa and the Solomon Islands allowed face-to-face interviews on both an individual and group basis, site visits to hospitals and clinics, and identification, review and/or collection of materials. Each country visit culminated in a debriefing with DFAT mission and country stakeholders. An Aide Memoire including a summary of activities and observations was prepared upon completion of each country visit.

1.4 Limitations of the evaluation

An important limitation was evaluation's inability to reflect the widely varied settings within the region. This was addressed, in part, by reaching out to interviewees in some of the smaller countries for phone interviews. For the PIP/RACS component of the evaluation, RACS managers were interviewed but not members of the visiting teams. Another important limitation was the lack of country documentation available for review. Much of the information that was hoped for was simply unavailable (e.g. records and of reports of Visiting Medical Teams (VMTs), patient demographics and outcomes). Finally, the work as envisioned in the Evaluation Plan was for a two person team (Team Leader and Specialist) working in tandem. However, early during country visits the Specialist departed the team. From that point forward, the work was carried out by the Team Leader who was joined by a DFAT staff member for the duration of the travel. Acknowledging these limitations, every effort was made to bring forth salient findings and conclusions based on evidence collected and professional judgements.

2. Strengthening Specialised Clinical Services in the Pacific

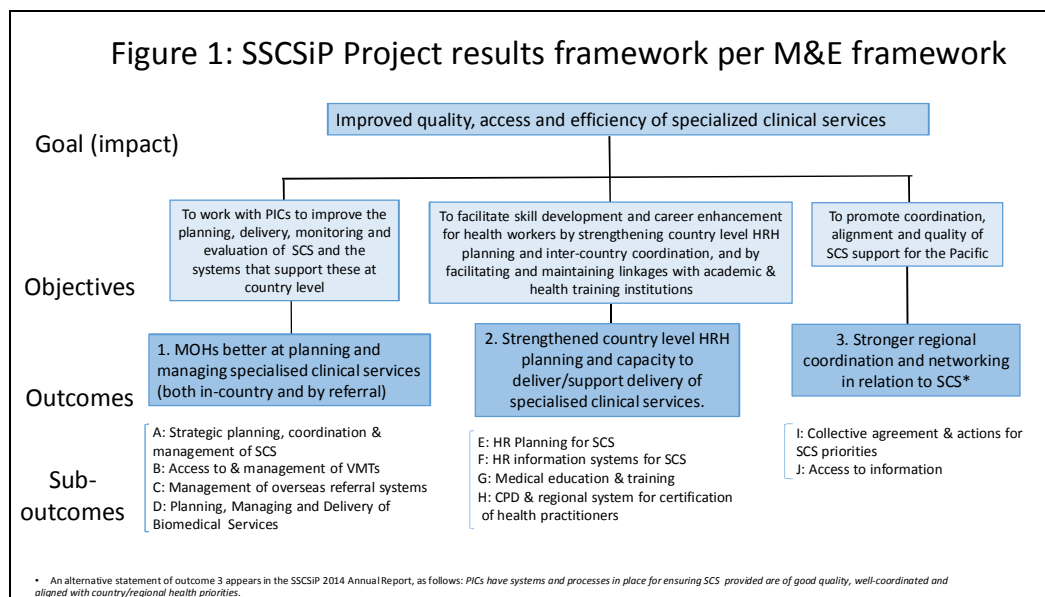
Objective 1: Evaluate SSCSiP against quality criteria including relevance, efficiency, effectiveness, sustainability, gender equality, monitoring and evaluation

Sub-objective 1.1: Assess the continued relevance of the SSCSiP in regards to program design, needs of the population in PICTs and other investments in specialised clinical services.

1.1. To what extent are SSCSiP's objectives and functions, as currently performed, relevant given the health development context in the Pacific region (noting their role has evolved over time)?

1.2. Are current SSCSiP functions more relevant to some Pacific Island Countries and Territories (e.g. Melanesia, micro-states) than others?

The results hierarchy for the SSCSiP projects changed between the original agreement and the M&E plan/framework⁷. For the purposes of comparison, the depiction of those two results hierarchies appear in Annex 6. This assessment will follow the revised set of objectives and outcomes to answer the questions for this sub-objective of the evaluation (Figure 1 below).



In regards to the relevance question, the three functions being performed by the SSCSiP at the level of objectives remain an important area of need in the Pacific region. Indeed, these findings should be viewed in light of the fact that as a demand-driven model with capacity development components, it is still at a relatively early stage of implementation. At issue is the relative emphasis which has been accorded

⁷ SSCSiP. M&E Plan. 27 September 2014.

⁸ SSCSiP. Progress Report for the period January-December 2014.

between the three objectives, the balance of support for the sub-outcomes under each as well as the relevance of a regional versus country-specific program of support. In Table 2 below, the relevance of each sub-outcome is ranked along with summary observations.

At the level of sub-outcome, it is possible to differentiate some degree of relevance. For example, under the first outcome (i.e. support for planning and managing SCS, sub-outcome B includes both access to and management of VMTs. Based on interviews conducted in three countries, it did not seem necessary for SSCSiP to address issues of access in terms of VMTs reaching the country. Most Pacific Island countries had their own established relationships with other countries (e.g. New Zealand, Taiwan), RACS or other specialty colleges based in Australia or New Zealand, individual hospitals and non-governmental organisation. Specifically related to PIP, VMTs, specialist clinicians and managers from individual countries dialogue directly with RACS. Due to these networks, the support that SSCSiP provided in regards to access would be minimal. This dynamic was recognised in the original Program Design Document which noted that as relationships and capacities are developed, countries would increasingly dialogue directly with VMTs as providers of SCS.

At a regional level, there continues to be a relevant role in coordinating VMTs to achieve economies of scale particularly in regards to services such as cardiac surgery (e.g. services that require large teams of specialists and adequate facilities). Implementation of this role would require a strong coordination function across countries and possibly with different providers/organisations, and willingness of countries to negotiate around a range of issues of including timing, location, transportation, patient selection and follow-up care. Pooling patients across countries for these types of services is not typically performed by VMTs. In addition, a regional perspective could identify specialty areas which may be in relative “over supply” with an eye towards re-directing VMT resources to areas of unmet need.

Also under the first outcome, is a sub-outcome related to management of overseas referral systems. Most countries have existing systems for handling overseas referrals. Moreover, these systems often operate with a degree of political influence. It would be exceedingly difficult for an outside party to intervene directly in these systems and drivers of decision-making. However, it is entirely relevant and appropriate for SSCSiP to play an analytical function as it has through the Center for Health Information, Policy and Systems Research (CHIPSR). Examining the sometimes fraught issues of overseas referral (e.g. access and cost) in a rigorous and objective manner is a highly relevant and important role for SSCSiP to play.

Finally, under the first objective, the results framework includes a sub-outcome related to planning, managing and delivery of biomedical services. With the transfer of some functions of the previous Biomedical Engineering Maintenance Initiative (BEMI project), this sub-outcome has come to focus heavily on delivery of technical assistance. The areas of planning and managing for biomedical services remain an outstanding need in the region. This unmet need can be largely addressed via country-specific mechanisms. The relevant regional role is then focused on the

development of standards of practice and uniform qualifications for personnel. Biomedical services was one of two areas in which there was widespread agreement that much more needed to be done (the other area was support for nurses which is addressed below).

Under the second objective (i.e. country-level Human Resources for Health (HRH) planning and capacity), some, but not all, of the sub-outcomes remain relevant. For example, while Human Resource (HR) planning for SCS is an area of need, work on HR information systems for SCS should only be undertaken as part of larger information system design and management as opposed to a stand-alone system. Moreover, there are other entities that are more suited to this role. The sub-outcome related to medical education and training has become an issue of concern to many of those interviewed. SSCSiP has stepped in to play the role of “gap-filler” when an individual student falls short of funding or when their funding is delayed. The provision of SSCSiP funding in these cases was seen by some as flexible and valuable and thus represents a distinct demand. As a result, the focus on individual capacities has out-weighted those related to systems capacities. There are numerous other organisations which make funding available for medical training. For example, in the three countries visited, DFAT scholarships personnel were largely unaware of the need for continued medical education and training. In addition, while the requests are transmitted through Ministries of Health (MoHs), requests are not typically associated with any form of needs assessment or SCS workforce planning. The provision of gap-filling scholarships does not represent a function unique to SSCSiP. Other avenues could be found or its presence in the project limited so as not to overshadow other relevant areas.

As expressed by interviewees, needs for specialised clinicians differ by country (i.e. one country’s priority need might be for a Pathologist and another country’s priority need might be for an Anaesthetist). However, across countries there was broad agreement on the need to upskill nurses in much the way that surgical staff have benefitted from project activities (both SSCSiP and PIP). Surgeons sometimes expressed this need in terms of service provision teams wherein a surgeon doesn’t work in a vacuum but as a member of a team in which other members need to be supported to expand and improve their skills as well. This need can be addressed through country-specific (e.g. scholarships) rather than regional mechanisms.

Finally, in regards to the third outcome (i.e. stronger regional coordination and networking), access to information has become a valued function for the project. For example, a HR manager in one country commented on the efficiency of disseminating job announcements through SSCSiP to reach a regional audience as opposed to paying for newspaper advertisements. The sub-outcome related to collective agreement and actions for SCS priorities is fairly narrowly focused on SSCSiP SRG meetings. These meetings have provided a forum for MoHs to consider collective areas of need and to prioritise SCS issues for SSCSiP (e.g. approaches to upgrade skills of Cuban-trained graduates). The function is relevant but perhaps under-exploited given the types of discussion which could be held in the forum. In particular, given the expertise and authorities of the membership, it would

be more relevant for the SRG to focus strategically on collective and regional need and less on the SSCSiP workplan.

Table 3: Continued relevance of SSCSiP key functions (revised results framework)

| Sub-outcome | Continued Relevance | | | Observations |
|---|---------------------|---|---|---|
| | H | M | L | |
| Outcome 1: MoHs better at planning and managing specialised clinical services (both in-country and by referral) | | | | |
| A: Strategic planning, coordination & management of SCS | ✖ | | | Highly relevant, while others may address general health sector workforce planning, no other actor in this space for SCS. |
| B: Access to & management of VMTs | | ✖ | | Relevant but countries have little need for SSCSiP to work on <i>access to VMTs</i> ; regionally more could be done to rationalise under-supplied specialty areas (e.g. cardiac surgery). |
| C: Management of overseas referral systems | | ✖ | | Relevant, but highly contextual and with political dimensions; objective analysis is particularly relevant. |
| D: Planning, Managing and Delivery of Biomedical Services | ✖ | | | Highly relevant; regional support for development of standards but on-going functions should be performed on a country-specific basis. |
| Outcome 2: Strengthened country level HRH planning and capacity to deliver/support delivery of specialised clinical services. | | | | |
| E: HR Planning for SCS | ✖ | | | Highly relevant. |
| F: HR information systems for SCS | | | ✖ | Little current relevance – countries have far greater need for basic HR planning and eventually HR information systems. |
| G: Medical education & training | | ✖ | | Gap-filling funding is valued but not explicitly linked to HR workforce planning. Other actors operate in this space. |
| H: Continuing professional development (CPD) & regional system for certification of health practitioners | ✖ | | | Highly relevant |
| Outcome 3: Stronger regional coordination and networking in relation to SCS | | | | |
| I: Collective agreement & actions for SCS priorities | ✖ | | | Highly relevant |
| J: Access to information | ✖ | | | Highly relevant |

Functions performed by SSCSiP vary in their relevance across Pacific Island countries. The determining factors appear to be health systems capacity of the country and relationships with other partners. The evaluation was unable to delineate the precise determinants of these differences. If considered systematically, the relevance of specific objectives would be assessed for each country (e.g. Tonga may have a well-functioning overseas referral process but need to have support for biomedical services). Perhaps the greater issue is not relevance of the functions

across countries but the ability of countries to access the available services. This emerged as an issue of concern as it represents an “uneven playing field” in countries knowledge of and ability to access SSCSiP services. This issue is examined further under evaluation sub-objectives 1.3 and 1.4.

1.3. Are there other, more efficient models of providing or supporting those SSCSiP objectives/functions? If so, what are those other models?

1.4. Of those functions with continued relevance, which SSCSiP functions (including those performed by the Development and Coordination Team (DaCT) are most cost-effective and efficient as regionally-provided support?

The SSCSiP model is perhaps best described as a demand-driven model in which Pacific Island countries request support for a range of services and support related to SCS. One advantage of the current model is that it provides “one-stop shopping” across specialties. The model has two areas which emerged as short-comings. Firstly, for countries to benefit from SSCSiP support, key individuals must be knowledgeable of the range of services and support available. The evaluation found that in many cases, interviewees were not aware of the support available including tools and templates on the project’s website. This was a particular concern for staff performing SCS-related tasks such as the SCS Coordinators who were unaware of the project’s support.

The model depends on comprehensive information dissemination so that there is an “even playing field” for all countries. Interviewees with regional perspectives felt it important to point out that SSCSiP did quite well in some countries and not in others. This was not simply a matter of larger versus smaller countries but also whether existing country capacities were such to effectively tap into the services available. Interviewees in several countries expressed the opinion that they were not getting their share of resources and requested better allocation of resources (e.g. through a pre-determined allocation for countries to be used for their areas of need and priority).

A second short-coming to the current model arises from its demand-driven nature. This results in the project taking a responsive stance rather than a pro-active and more strategic position. For example, it appears unlikely that countries in the region would request support to examine and manage their overseas referral programs for reasons mentioned above (i.e. long-standing agreements between countries and institutions with some political overtones). In contrast, many requests are made for support for medical education and training. As a result, the capacity-building elements of the project are more focused on the individual rather than the system.

There are other models for the delivery of the services now covered by SSCSiP. For example, much of the support provided by the project is essentially technical assistance which could be provided by any number of development consulting firms, universities or Pacific Technical Assistance Mechanism (PACTAM)⁹. Dispersal of funding for interim scholarships could be integrated into DFAT’s larger scholarships

⁹ In Samoa, an Australian biomedical engineer was serving as a PACTAM volunteer had made considerable progress in planning and management of those services in addition to mentoring promising younger Samoans in the unit.

programs. It is however, difficult to determine if those other models are more efficient as a) those alternative models will differ by objective/function and b) it is not possible to estimate the required input levels – a variable needed to consider and compare efficiency.

Several methods could be employed to mitigate these shortcomings. As mentioned above, one would entail an up-front allocation or earmarking of resources to individual countries for them to use for a variety of SCS strengthening inputs. This would help to eliminate the perception that not all countries are getting their “fair share” of the project’s resources. In terms of the demand-driven nature of the project, it might be possible to more actively guide or direct countries by establishing a series of benchmarks. For example, requests for SCS training should be linked to a SCS HR workforce plan. Therefore, in order for countries to access the training fund, they would first need to develop their SCS HR workforce plan, linked to a broader health HR plan, which, of course, would also be supported by the project. Similar benchmarks could be used to incentivise certain of the project’s products which are otherwise of low demand.

Many noted the tremendous burden on countries when their specialist clinical staff are overseas for extended periods of time for training. The Stakeholder Reference Group (SRG) (2015) urged that, to the extent possible, training institutions should deliver postgraduate studies in-country due to the shortage of clinicians. Several noted alternative training models based on on-line training. Many respondents mentioned the training available through the Pacific Open Learning Health Net (POLHN) although most also noted that its content are directed more towards public health. Several courses more relevant to specialist skills and adjunct services were discussed as well. One model cited was with the Royal College of Emergency Medicine (RCEM) which offers diplomas through an 18 month course. In these types of courses, the trainees work under a supervisor who is a Fellow of the college, conduct course work on-line, and their skills are reviewed through visits from RCEM to the training site. Several other forms of graduate level course were mentioned during the interviews as well (e.g. a Masters of Medicine (MMED) program for orthopaedics). For adjunct services, one respondent cited the Wellington-based Pacific Paramedical Training Centre for courses including laboratory management. This two year course is, again, largely completed on-line with occasional travel needed for testing and skills assessment. Given the remoteness of countries in the region and impact on services when specialised clinical staff are away for extended period, these types of courses should be pursued vigorously in future DFAT investments.

Some, but not all, of SSCSiP functions are best performed as regionally-provided support. To provide context for the following section, Pacific regionalism¹⁰ has been described as *“the expression of a common sense of identity and purpose, leading progressively to the sharing of institutions, resources and markets, with the purpose of complementing national efforts, overcoming common constraints, and enhancing sustainable and inclusive development within Pacific countries and territories and for the Pacific Region as a whole”*.

¹⁰ Pacific Islands Forum Secretariat. 2014. The Framework for Pacific Regionalism.

A set of criteria to gauge regionalism has been agreed by the Pacific Islands Forum Leaders¹¹ and used to prioritise initiatives which were expected to meet one or more of the following at a sub-regional or regional level, in support of national priorities and objectives:

- Establish a shared norm or standard
- Establish a common position on an issue
- Deliver a public or quasi-public good which is regional (or sub-regional) in scope
- Realise economics of scale
- Overcome national capacity constraints
- Complement national governments where they lack capacity to provide national public goods like security or rule of law
- Facilitate economic or political integration.

In Table 4, the functions performed by SSCSiP are assessed with referenced to these criteria.

Table 4: Regional aspects of SSCSiP functions (revised results framework)

| Sub-outcome | Regional-level support |
|--|--|
| A: Strategic planning, coordination & management of SCS | Development of common tools and templates (e.g. position descriptions for SCS Coordinators, ToRs for VMTs) are appropriate as regionally-provided support helping to create a common platform for practice |
| B: Access to & management of Visiting Teams (VTs) | Economies of scale <i>could</i> be achieved through regional coordination of VMTs in certain specialties (over- and under-supplied) |
| C: Management of overseas referral systems | Primarily a country-level function |
| D: Planning, Managing and Delivery of Biomedical Services | Development of common tools (e.g. Pacific Biomedical Standards, training programs) are appropriate as regionally-provided support |
| E: HR Planning for SCS | Development of common tools (e.g. planning guidelines, methods of estimating SCS need) <i>could</i> be provided on a regional basis |
| F: HR information systems for SCS | Primarily a country-level function |
| G: Medical education & training | Primarily a country-level function |
| H: CPD & regional system for certification of health practitioners | Contributes to shared standards for clinical competencies |
| I: Collective agreement & actions for SCS priorities | Contributes to shared position on priorities/issues related to SCS |
| J: Access to information | Region-wide dissemination of information is efficient and represents a public good |

¹¹ Ibid.

As per Table 4, some of the sub-outcomes can be considered as having a basis for regionally-provided support particularly those involving the development of agreed standards and approaches. However, the implementation of those newly developed standards and approaches lies in the realm of country programming. This suggests that these functions are relevant as regionally-delivered for a limited period (during development) and then should be subject to “hand-over” for full implementation by countries and their development partners.

However, effective “hand-over” of regionally-agreed standards in the forms of tools and templates requires recognition on the part of countries and their development partners of the integral role of specialised clinical services in the broader health system. Advocates call for a comprehensive view that recognises the role of surgical care as part of a larger health system in which performance is determined by critical interrelationships¹². The programmatic challenge is for surgical services to integrate into the broader health system along with methods for measuring their performance. Therefore for development effectiveness, regional efforts to strengthen specialised clinical services should be complemented by country programs ready to integrate and encourage the uptake of regionally-agreed standards and positions.

1.5. What process(es) is used by SSCSiP to determine PICTS needs and demands and to ensure alignment with PICTs priorities? Which in-country stakeholders do they engage with? Which regional stakeholders do they consult and in what manner?

There are several means through which SSCSiP engages with PICTs. One method is through the SRG which provides coordination and oversight. The SRG meets annually to review project progress and workplans. Substantive presentations are made on a number of activities that the project is involved in developing. The SRG generates recommendations for priorities in the further development of SCS. Recommendations are generated for both SSCSiP and for countries. However, the number of recommendations far out-numbers those that can be practically acted upon. The process of determining priorities among the recommendations is not clear.

Otherwise, the project acts in a responsive modality by receiving requests for support from countries, reviewing and determining whether they will be able to fulfil the request. The Strategic Advisory Group (StAG) plays a role in making these determinations. The majority of requests coming from countries are for short-term training opportunities or gap-filling support for medical education and training (e.g. as reported at the 2012 SRG meeting, about 49 per cent of the requests were for short-term training). Up to 2015, the SRG endorsed the need for a regional funding mechanism to support clinical capacity building when all other funding options are exhausted.

Not all requests from countries are resourced. For example, despite requests from countries, the scheduling of a workshop on HR planning for SCS was delayed due to budgetary constraints. Such a workshop was held in October 2014 and participants included seven countries which had expressed need for assistance in this area (Fiji, Kiribati, Solomon Islands, Vanuatu, Tuvalu, Samoa, Cook Islands). Unfortunately,

¹² H. T., P. Donkor, A. Gawande, D. T. Jamison, M. E. Kruk, and C. N. Mock, editors. 2015. Essential Surgery. Disease Control Priorities, third edition, volume 1. Washington, DC: World Bank. doi:10.1596/978-1-4648 -0346-8. License: Creative Commons Attribution CC BY 3.0 IGO.

also due to budgetary constraints, the project has not been able to expand on this effort with additional countries nor provide follow up support to those that attended. As a result, the process has lagged in some countries (e.g. in Samoa, despite good efforts to use the templates and to create a plan, there is a need for more support and assistance to see the work through to completion).

1.6. Is there potential for duplication between SSCSiP's current purpose/objectives, goals, roles, responsibilities and functions and those of PIP? If so, to what extent might such duplication actually occur?

There is limited potential for overlap or duplication between the purpose/objectives of SSCSiP and PIP. The primary objectives of the two investments differ sufficiently to avoid overlap. The two projects coordinate on training and capacity-building opportunities by sharing information on the planned events and identification of potential participants. In some regional workshops, both projects provided support for individuals to attend (e.g. a PIP-funded Emergency Management of Severe Trauma course was supported by SSCSiP with coordination and logistic support). In addition, SSCSiP has funded participants to attend PIP-funded training courses in the region. The form of coordinated support was not provided during in-country training and very rarely for CPD and overseas training. There seems to be a number of missed opportunities for each of the projects to reinforce the work of the other. For example, as will be described below, PIP VMTs end-of-visit reports provide good insight into the CPD needs of specific individuals and, in some cases, raise issues with equipment, supplies or facility conditions. Ideally, SSCSiP would routinely receive and review these reports and possibly contextualise them with an eye to addressing stated needs.

Sub-objective 1.2: Assess the effectiveness and efficiency of the SSCSiP in relation to its performance against design, needs of the population of PICTs, and previous external assessments

1.7. To what extent have the objectives and outcomes of SSCSiP, as per the original design document, been achieved? To what extent and with what quality has SSCSiP supported PICTs to plan for clinical services tailored to country need in terms of levels, category of specialty, and functional area? Is this an appropriate function to be performed regionally?

The extent to which objectives and outcomes have been achieved against the original design document is considered below. As noted above, the objectives and outcomes for SSCSiP were changed and submitted in the M&E Plan. However, per the evaluation's ToRs, in this section, the extent of achievement for each of the sub-outcomes of the original Design Document are presented (Table 5 and Table 6). More detailed version of the same tables appear in Annex 7, Tables 1 and 2.

Table 5: Summary of achievements under Outcome 1 (original Program Design Document)

| Outcomes anticipated | Extent of Achievement |
|--|---|
| <p>Outcome 1.1 – visiting specialised clinical services are demand-driven and planned and visiting service providers have access to the resources required for conduct of services (e.g. staff, clinic space, theatre time)</p> | <p>There is movement in the direction of more demand-driven services in the region. However, the contribution of SSCSiP to this change is difficult to pinpoint. Support for the position of SCS Coordinators and assorted tools and templates have been positive. However, there is turn-over in the SCS Coordinators and little seems to be done to maintain contact and to assess the needs of new incumbents. There was little evidence that the project supported better resource planning.</p> |
| <p>Outcome 1.2 – programs of visiting teams and individuals addressing the needs of participating countries are coordinated across the Pacific & provided in an efficient and effective manner</p> | <p>Certain countries are recipient to a very large number of VMTs and, at times, the ability of the MoH and clinical staff to coordinate and them is limited. Other countries have far fewer teams and the task of coordinating them is more manageable.</p> <p>Requests for VMTs made to SSCSiP come from smaller and less capacitated countries. A driver of VMTs is often based on past patterns (legacy-type visits) as opposed to evidence-based assessment of population need. Coordination of VMTs occurs at the level of individual countries and not at the level of the region. Support to upskill returning Cuban-trained doctors was an important regional need and added on to the project's responsibilities.</p> |
| <p>Outcome 1.3 – adjunct services to support specialised services (e.g. biomedical equipment, diagnostic services) are available and generally strengthened</p> | <p>Support for adjunct services is largely limited to biomedical support. Tools and forums developed include National Equipment Management Plans, Equipment Committees and Pacific Biomedical Standards. However, significant gaps exist in many adjunct services.</p> |
| <p>Outcome 1.4 – patient outcomes (short and medium-term) are assessed and deemed satisfactory</p> | <p>With the exception of examining post-operative morbidity in several countries, there has been limited (if any) progress in systematically monitoring patient outcomes.</p> |
| <p>Outcome 1.5 – where necessary, off-shore referral for specialised clinical care is cost-efficient, and consistent with agreed medical and equity guidelines</p> | <p>Decision-making on overseas referrals varies widely by country. In most cases, it is a politically-tinged process and difficult for an external actor to intervene. The prime achievement in this area are the analysis conducted by CHIPSR.</p> |

The longer-term vision for Objective 1 encompassed three elements. These were met to varying degrees as described below.

Countries will increasingly liaise directly with service providers, informing them of patient lists and identifying specific needs for clinics. There is significant progress towards this vision.

The role of the DaCT will be to confirm readiness for the clinical visit and ensure that the full range of pre-requisites for visiting services are available locally. This long-term vision was not met and indeed, seems to be beyond the scope of the project's activities.

Where needed, the DaCT can continue to advise on value-for-money assessments and maintain a role in procurement issues. There was limited progress towards this vision notably in the analytical work sub-contracted to CHIPSR and the biomedical equipment staff member.

Table 6: Summary of achievements under Outcome 2 (original Program Design Document)

| Outcomes | Achievement |
|---|--|
| Outcome 2.1 – Improved planning capability to meet specialised clinical service needs, maintain appropriate balance b/w primary and more specialised services, strengthen referral networks from peripheral to central locations, and ensure fair and equitable prioritisation of specialised services | <p>The project has not kept pace with the needs of capacity building around SCS. Notably, turn over in the SCS Coordinator positions have not been tracked or new incumbents supported.</p> <p>A set of tools and templates were developed to support planning for SCS and are available on the project's website. Many interviewees with responsibilities relevant to SCS were unaware of these tools. There have been no assessments of balance between primary and specialised services or referral networks.</p> |
| Outcome 2.2 – Increased knowledge and skills of health workers to provide and/or support quality specialised clinical services in each country | <p>The project has been actively involved in the provision of assistance for training opportunities. Requests for training support were sent by MoHs to the DaCT – despite that the project was not originally set up to respond to requests for training support. While efforts are underway to create a map of clinicians on a country-by-country basis, to date, it isn't clear that DaCT has utilised these maps to identify and meet capacity building needs.</p> |
| Outcome 2.3 – Established linkages to support health workers' development and institutional strengthening | <p>The project has supported regional associations of clinical specialists. Capacity development frameworks have been developed as well as efforts to link newly practicing specialists with mentors and structured supervision. Support is for basic secretariat functions as well as training and development of training standards.</p> |

The longer-term vision for Objective 2 encompassed five elements. These were met to varying degrees as described below.

Stakeholders recognise that strengthening the workforce, systems and institutions are long-term tasks. Stakeholders interviewed appreciated that these types of capacity building are long-term endeavours but their exposure to these process had been limited.

Based on first two years of activities (2010-2012), plans for longer-term approaches were to be developed to address these needs. These approaches were to include:

a) *Strengthening of medical, nursing and allied health councils in each country.* There was little, if any, action to achieve this vision.

b) *Supporting governments to project workforce needs.* There was limited progress made towards this vision. A 2014 workshop on HRH planning principles and concepts was attended by representatives from Fiji, Solomon Islands, Vanuatu, Samoa, Kiribati, Tuvalu, Cook Islands, and Niue. In at least one of these countries, the evaluation found that the HR plans for SCS was not yet finalised. More support for the process beyond the workshop would have been beneficial.

c) *Further development of specialist associations and facilitating regular meetings and linkages with Australian and New Zealand professional bodies.* For a number of specialist associations, this vision has been achieved albeit through joint efforts of a number of partners (i.e. SSCSiP cannot be credited with these achievements alone). Leading examples are the World Gastroenterology Organisation with a training program based in the FNU CMNHS and the Pacific Eye Care Society both based in Suva. SSCSiP also supports other regional specialist organisations that are in earlier stages of development including societies of anesthesiology and internal medicine.

1.8. How has management of SSCSiP, particularly by CMNHS, impacted on achievement of objectives and outcomes? What are advantages and limitations arising from this arrangement?

There are some clear benefits to locating the project at the Fiji National University (FNU) College of Medicine, Nursing and Health Sciences (CMNHS). Notably, there is close proximity to the leading medical training institution in the region. A very high percentage of specialised clinicians in the region have trained at some point at the FNU CMNHS. In addition, Fiji serves as a regional hub for which travel is more convenient compared to other locations in the region.

However, the management of SSCSiP by the FNU CMNHS has created some anger and frustration throughout the region. Senior clinical service managers in several countries felt that Fiji benefits disproportionately from the arrangements. (e.g. “*Fiji benefits the most*”, “*we do not get our fair share of it*” “*Decisions that FNU makes are not in the interest of this country*”). Specific instances also generated anger. While the evaluation was not able to fully vet these instances among all actors, they dealt with situations in which students sent to FNU were either not placed in the agreed-upon course of study or specialist clinicians were being used to staff Suva’s Colonial War Memorial Hospital because their classes were cancelled due to a university problem.

Issues were raised with the transparency of decision-making and the need for more independence for governance vis-à-vis the Secretariat. In SRG meetings (2012 and 2013) appeals were made to provide clearly defined eligibility criteria and funding guidelines to all countries. These issues may have contributed to a closed door session at the SRG (2014), in which members expressed their preference that a regional program to support SCS be continued and absorbed by the Secretariat of the Pacific Community (SPC). In this scenario, the directors of clinical services would provide an independent governance mechanism for SCS in the Pacific.

While there were both advantages and disadvantages of the FNU location identified during the evaluation, the evaluation found that the disadvantages, particularly, anger and frustration at decision-making processes perceived to benefit Fiji, has serious consequences for the project.

1.9. To what extent have issues highlighted and recommendations made in the Independent Progress Report (IPR) (2011) been addressed with specific focus on SSCSiP's strategic planning.

The majority of issues highlighted in the IPR do not appear to have been addressed. (Annex 8). It is suggested that reasons underlying the limited level of response to the identified issues is discussed at a project reference group meeting.

Sub-objective 1.3: Assess the performance of SSCSiP in regards to sustainability, monitoring and evaluation and gender equality

1.10 To what extent are the monitoring and evaluation approaches used by SSCSiP appropriate and effective? Are activities linked to higher outcomes? To what extent can SSCSiP assess the cost-effectiveness of its support?

SSCSiP has faced challenges in its M&E function. The post of M&E Officer went unfilled for most of the project's life cycle. With an unsuccessful search for an M&E Officer candidate, the project took several approaches to fill that gap. One was to have external support provided through short-term technical assistance to develop the project M&E Plan. In addition, the project provided additional training for the Health Planning Officer so that he could assume some of the responsibilities of the M&E Officer. This was a diversion from the original design, in which the Health Planner was meant to work with countries on health and HR planning, and the M&E Officer was intended to work at the level of the project. Despite these challenges, early in the project, there were well-conceived efforts to develop information on the basic specialised clinical situation through country-specific specialist clinical situation analyses. Some follow-up has been published in the SSCSiP 2013 Report which included country-specific "clinical services at a glance" summaries.

The project should also be credited with developing what is, on paper, a solid M&E Plan. The plan is thoughtful and well-structured and includes a program theory of change as well as a results framework. Annexes include tabulation of progress markers for each outcome area with markers identified at the level of activities, outputs, intermediate outcomes and end-of-program outcomes. Also annexed to the document are reporting templates in order to collect the underlying data required to generate performance measures.

To date, monitoring data are reported in the annual reports. This primarily comprises activity-level reporting against the outcomes and sub-outcomes as described in the M&E Plan. The reports use a traffic light system for project self-assessment of progress during the reporting period.

The project reports difficulty in acquiring requested data from the countries. As a result, many of the monitoring tools included in the M&E Plan have not been made fully operational. In sum, elements of the M&E Plan are conceptually sound but in practical terms cannot be implemented. This presents a problem for the project in its ability to link activities to outputs and higher level outcomes. As a further consequence, SSCSiP does not have the data required to provide a valid estimate of cost-effectiveness.

1.11. In regards to gender equality, to what extent is gender equality considered in SSCSiP activities? Is the gender-focus considered to be appropriate?

In contrast to PIP reporting, which disaggregates all variables by sex, there is no gender disaggregated reporting in the SSCSiP materials. Indeed, SSCSiP reporting is notably devoid of gender considerations. A review of documents including the 2014 Annual Report, Briefing Note prepared for the independent evaluation, report on scholarships from 2008-2013, and a sponsorship information for post graduate clinical and Bachelor of Medicine and Bachelor of Surgery programs at FNU in 2012, found that consideration is made of gender equality. The 2012-2013 Annual Report makes a brief reference to gender which seems to place the onus of gender consideration on countries rather than the project; as follows: *“Few countries were able to point out any equity or gender-sensitive practices, outcomes or benefit, suggesting that there may be were little awareness among PIC MoH that equity and gender-related benefits are sought by SSCSiP”*

This lack of focus on gender has been noted in the past. For example, the IPR (2011) suggested a less than clear denotation for gender by noting that: “some evidence that gender issues are present in their thinking”. More recently, the 2014 Quality at Implementation Report also found that gender and equity issues have not been a key consideration of the project. To some extent, it seems that SSCSiP passes on the responsibility of gender-sensitivity to the countries supported (e.g. to improve reporting and disaggregation of data) without practicing it themselves.

1.12. To what extent are SSCSiP-related functions currently being undertaken at the country level and at the regional level? Would countries be ready to take over planning and management of SCS as planned? Do they have the policies and governance/ financing frameworks in place to do so? Provide commentary on:

- Implications of the current status quo on sustainability.
- Functions which were to be transferred to PICTS as per the original design document - which ones were or were not transferred, and why.
- Which functions could be appropriately absorbed at the country level.
- How successfully PICTs are undertaking those functions that have transferred across, and how could/should DFAT further support PICTs undertake these functions.

Based on the efforts of the project, along with those of PIP, progress has been made planning and managing SCS and in capacity-building at the level of the individual, and to a lesser extent systems (e.g. biomedical support). This movement should be considered as nascent with some areas likely solidified well enough to sustain (e.g. the role of SCS Coordinator) while others may wither without concerted, on-going attention (biomedical services).

The functions of the SCS coordinator appear well embedded in MoHs and the project should be credited with negotiating country ownership of these posts and “hand over” of funding responsibilities. In addition, through the project’s efforts at least one country has established its first ever biomedical position. Again, the project provided interim support for the salary while the MoH formalised the position with the Ministry of Finance and public service office. The position is now fully funded by the Tuvalu MoH.

Several lessons emerge about successfully transferring products (e.g. templates). The first is that it is insufficient to have a one-off training/workshop opportunity and expect then tools to be fully incorporated into the MoH system. An example was provided above of the SCS HR planning – an effort which was under-budgeted and therefore not seen through to satisfactory completion. When introducing new processes or building systems capacities, the project should plan and budget accordingly to provide on-going support, both remotely and face-to-face too ensure successful transfer. It is important too that the proposed capacity development activities are supported at the right levels, include the right participants, are properly aligned with country HR strategy and processes, and, where possible, integrated with other trainings, rather than being stand-alone. Another issue that arose with the project was its ability to anticipate and mitigate the effects of staff turn-over. In several cases, turn-over of staff in the role of SCS Coordinator was disruptive and poorly handled. In several countries, it was reported that SCS Coordinators have left the posts with no form of hand-over or formal briefing for the new incumbent. SSCSiP should also be tracking the individuals in those key positions on an on-going basis to ensure that needed support and guidance is provided. Many of the new SCS Coordinators had no knowledge of the suite of tools and templates prepared by the project to support their job functions. The biomedical support area stands out as having maintained very close and collaborative relationship with countries in the region and was able to effectively identify and target areas of needs.

Progress has been made in countries’ ability to plan and manage SCS. However, most countries in the region could not continue to make progress without further support. As mentioned above, the SSCSiP implementation has emphasised the building of individual clinical capacities rather than systems capacities. There is much still to be done in the areas of for example, policies, governance, and financing frameworks to support SCS in the region. On the plus side, in the countries visited, a clear organisational structure exists for the management of SCS. These structures, which may have pre-existed SSCSiP, can serve as the centre point for strengthening systems.

Looking forward, if DFAT wants to build the capacity of individuals, it should continue what it is doing; however, if the goal is to build the capacity of systems, then there is more direction and incentivising needed to make that happen. The design of the project was clear in its intent to strengthen systems for improved SCS planning, management and coordination. However, as implemented (i.e. as a responder to country requests based on a menu of services), the project has moved in the direction of support for short- and long-term training with far less emphasis on systems strengthening. Possible reasons contributing to this direction are outlined above. An additional contributing factor may have been the nature of the organisation managing the project – essentially the core business of a university is training provision, and this type of institution may perhaps be less well equipped to drive system strengthening, and the higher level stakeholder engagement and leadership that this requires.

3. Pacific Islands Program/Royal Australasian College of Surgeons

Objective 2: Evaluate PIP including against quality criteria including relevance, efficiency, effectiveness, sustainability, gender equality, monitoring and evaluation

Sub-objective 2.1: Assess the continued relevance of the Pacific Islands Program / RACS in regards to program design, needs of the population in PICTs and other investments in specialised clinical services

2.1. To what extent are the services and functions provided by PIP still relevant to the Pacific region?

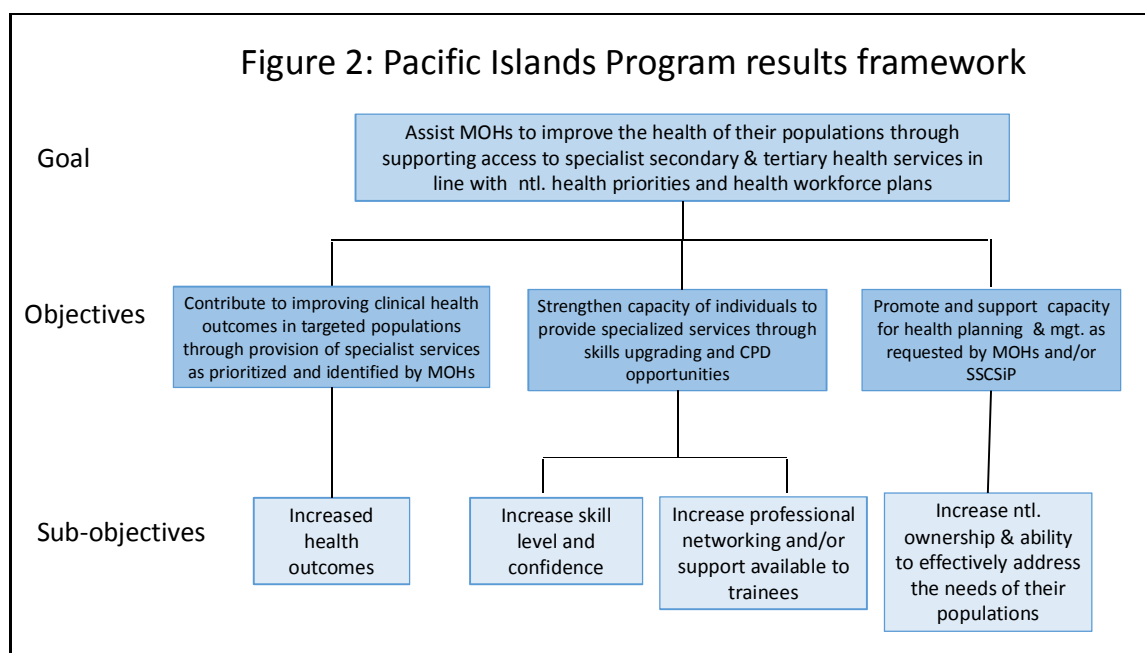
Relevance of the PIP is considered here in relation to the project's design, the needs of the countries in the region and the other investments in SCS.

In terms of the original design, the project logframe (depicted in Figure 2) set out three objectives to meet the goal of assisting *MoHs to improve the health of their populations, through supporting local access to specialist secondary and tertiary health services, in line with national health priorities and health workforce plans for development*. The goal of the project remains highly relevant as challenges in the region to health and well-being and needs for continued access to SCS remain largely unchanged. The countries of the region continue to struggle with a heavy burden of non-communicable disease, health expenditure levels remain constant or declining and there is only a slowly expanding pool of specialist clinicians.

In examining questions related to whether the objectives of the PIP are still consistent with the needs of countries in the region, the evaluation found that the three objectives differ in terms of their continued relevance. The first objective, contributing to improved clinical health outcomes in targeted populations through provision of specialist services as prioritised and identified by MoHs, is highly relevant.

In the eyes of the MoHs and service providers interviewed, the real value of the PIP is in its provision of services. Most envisioned that the need would not diminish at any time in the near future. In addition to general shortages of surgical staff, these respondents pointed to the fact that many surgical staff are still young and acquiring experience thus the ability to work alongside the RACS teams is valuable in that regard. In addition, it is appreciated that the RACS teams will sometimes provide services in areas which are more difficult to reach and therefore underserved.

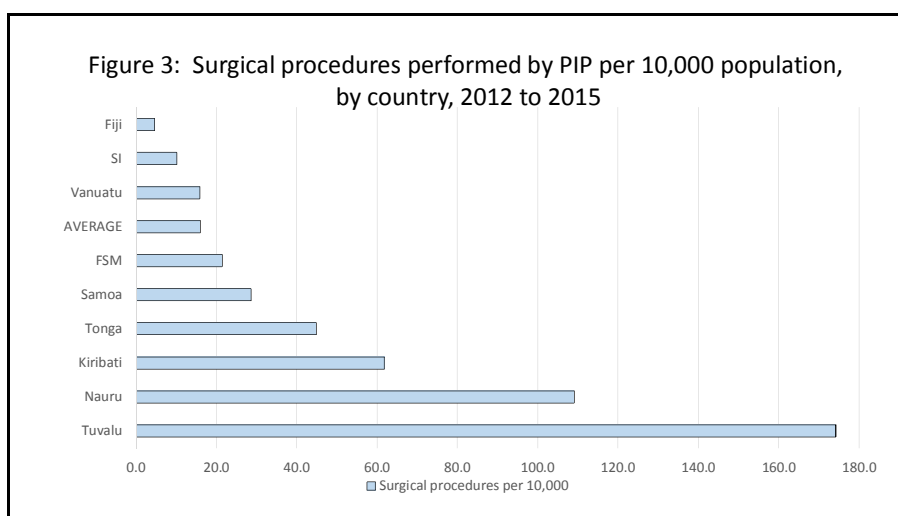
During the period 2012 to 2015, the PIP conducted 3,559 surgical procedures slightly more than a comparable period from 2007 to 2010 (Annex 9 Tables 1 and 2). These services were provided across 10 countries and in 14 areas of specialty. The majority of these services were ophthalmologic (1012 or 28 per cent of the total), followed by plastic and reconstructive procedures (682 or 19 per cent) and ear, nose and throat with 559 procedures accounting for 16 per cent of the total. Patterns in the provision of some of these surgical services will be addressed further in a section below.



It is not possible to estimate the degree to which the number of specific surgical procedures (e.g. urology versus vascular surgery) are associated with need in terms of burden of disease. As a measure of met need, a Lancet Commission¹³ on global surgery proposed a surgical volume indicator defined as procedures done in an operating theatre per 100,000 per year. The goal established for 2030 goal is 5000 surgical procedures per 100,000. The evaluation adapted the surgical volume indicator to serve as a means of estimating the magnitude of PIP contributions on a population basis. The data presented below are adapted to the smaller populations of Pacific island countries (i.e. per 10,000 versus 100,000) and uses data for a three year period.

PIP-provided surgical procedures represent an average of 16 surgical procedures per 10,000 population in the countries served with a range from 4.6 in Fiji to 174.2 in Tuvalu (Figure 3). It is important to note that several of these countries (e.g. Nauru, Tuvalu) have very small populations and therefore skew the analysis towards higher rates of procedures per population.

¹³ Meara JG, Leather AJM, Hagander L. Lancet Commission. 2015. Global Surgery 2030: evidence and solutions for achieving health, welfare, and economic development. The Lancet. Published Online. April 27, 2015. [http://dx.doi.org/10.1016/S0140-6736\(15\)60160-X](http://dx.doi.org/10.1016/S0140-6736(15)60160-X)



The second objective (*strengthened capacity of individuals to provide specialised medical and health support services through skills upgrading and continued professional development opportunities*), is of continued relevance albeit with differences by type of capacity strengthening. These efforts can be seen as a tiered approach with in-country and regional workshops followed by more intensive CPD and overseas training. Table 7 below provides information on the number of these types of events as well as numbers of participants.

Table 7 Types of training activities conducted by PIP, 2012-2015

| Types of capacity building | Number | Participants |
|------------------------------|--------|--------------|
| In-country workshops | 66 | 1191 |
| Regional training workshops | 17 | 245 |
| CPD activities | 12 | 152 |
| Overseas training activities | 8 | 22 |

PIP-supported in-country training workshops reach the greatest number of participants. These workshops are typically aimed at more general audiences than specialist clinicians, cover a broader range of topics (e.g. intrapartum care), and are short training activities typically of two days duration. In-country trainings occur most frequently in Fiji (32 per cent). A total of 17 topics were covered by in-country workshops albeit with heavy emphasis on several topics (Annex 11). The leading topic of in-country training is Essential Pain Management which account for 45 per cent of all in-country training activities. Other leadings topics for training in-country are intrapartum care (16 per cent), Ponseti workshop (eight per cent) and primary trauma care (seven per cent). It is worth noting that several of the top five forms of in-country training are not directly related to specialist clinical care and may be provided by other actors in the region (e.g. UNFPA, WHO for intrapartum care). When queried on the selection of topics, some respondents pointed to an established pattern of these topics being offered with little discussion (e.g. as one respondent said: *“its just*

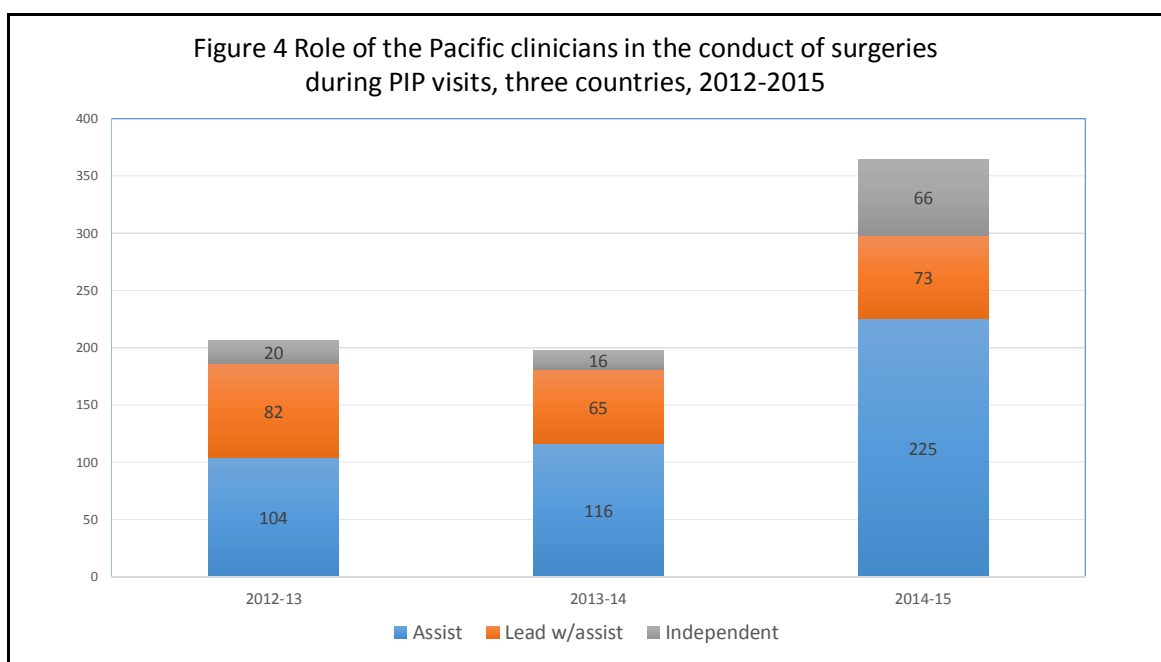
an on-going thing” before offering her opinion of what would be more a relevant and useful topic).

The second leading form of training is through regional courses which intended to deliver more specialised training content. These are primarily held in Fiji as it serves as a transport hub for many points in the Pacific Islands. PIP-supported regional courses often complement training delivered through FNU. Courses such as Care of the Critically Ill Surgical Patient (CCrISP), Emergency Management of Severe Trauma (EMST), and Emergency Management of Severe Burns for both service providers and instructor’s courses are conducted annually as part of the FNU training program for doctors.

Hands-on training also takes the form of attachments over the course of a PIP visit. These experiences are highly regarded by the clinicians and can lead to mentoring over the course of repeat visits and through communication between visits. In several cases, Pacific clinicians noted that capacity-building efforts were mixed depending on specialty area and emphasised the importance of identifying the local counterpart in advance and deciding on the skills to be enhanced and roles to be played (e.g. assisting, leading, etc.). Between 2012 and 2015, there were six or seven such attachments each year and, on average, these attachments last seven to eight days. In order of frequency, these attachments occur in Fiji (7), Vanuatu (5), Solomon Islands (5), Federated States of Micronesia (3) and Samoa (1). It is not clear why these attachments do not occur in each of the countries visited by PIP.

Surgical providers interviewed also spoke highly of the type of skill upgrading that occurs during the visits. To better quantify this type of activity, the evaluation examined a set of end-of-visit reports from the three countries visited (17 reports from all VMT in the three countries during 2014). The reports provide an adequate summary of the types of training that occurred during visits with categories including: clinical training and mentoring, tutorials, lectures and grand rounds. The number and topic for each activity is noted. Of the 17 VMT reports, 14 identified clinical training and mentoring as part of the visit, nine identified tutorials, eight identified lectures, and seven identified grand rounds. Moreover, nine of 17 reports identified individuals for on-going mentoring and support on a one-on-one basis after the conclusion of the VMT.

While the overall effect of this type of skills building is difficult to quantify, RACS has developed a means of tracking the involvement of the Pacific clinicians in surgeries carried out during PIP visits. These categories comprise the Pacific clinician assisting during surgery, taking the lead with RACS assistance during the surgery or independently leading the surgery. Data for the three countries visited are shown in Figure 4 below. While these data highlight general trends over time, it is difficult to discern clear patterns for several reasons. Primarily, these data reflect a dynamic situation in which (a) new, recently accredited surgeons are joining the work force; and (b) types of surgeries being conducted differ over time. Typically more routine surgeries would eventually be conducted in-country outside of the VMT allowing the VMT to concentrate on more difficult surgeries or those where skills need strengthening.



Finally, training attachments can also occur in a second location in which trainees have one-on-one hands-on mentoring and support with a surgeon, anaesthetist or specialist nurse as a complement to their ongoing training. Attachments enable the trainees to learn and practise new skills in a supportive environment before returning to their home country. Training attachments involve relatively few participants given the specialised and targeted nature of these activities.

The final objective, *promote and support capacity for health planning and management as requested by the MoH and/or SSCSiP*, seems far less relevant than the preceding two objectives. Indeed, the perception among some involved in PIP is that responsibility for this area has been transferred out of PIP to SSCSiP. Very little, if any, support of this nature is requested of the PIP.

In sum, the goal remains highly relevant as does objective 1 on service provision. Moving forward, direct service provision, with its attendant skills building, should serve as the prime objective. Objective 2 remains relevant with important differences within that set of activities. In the future, the topics of training provided should be carefully selected and demonstrably aligned with stated needs of MoHs and surgical providers in the area of SCS. This finding relates specifically to the subject matter covered in the trainings. The form of training (in-country, regional workshops, overseas, etc.) should be determined based on topics of greatest demand. Finally, objective 3 (support for capacity in health planning and management) is not directly relevant. It stands outside the unique skills and expertise of the implementing agency. MoHs in the region do not consider PIP as a source for support of this type. Looking forward to a reduced resource environment, the evaluation findings clearly point to continued emphasis on direct service provision and skills upgrading and transfer through hands-on opportunities particularly through clinical attachments.

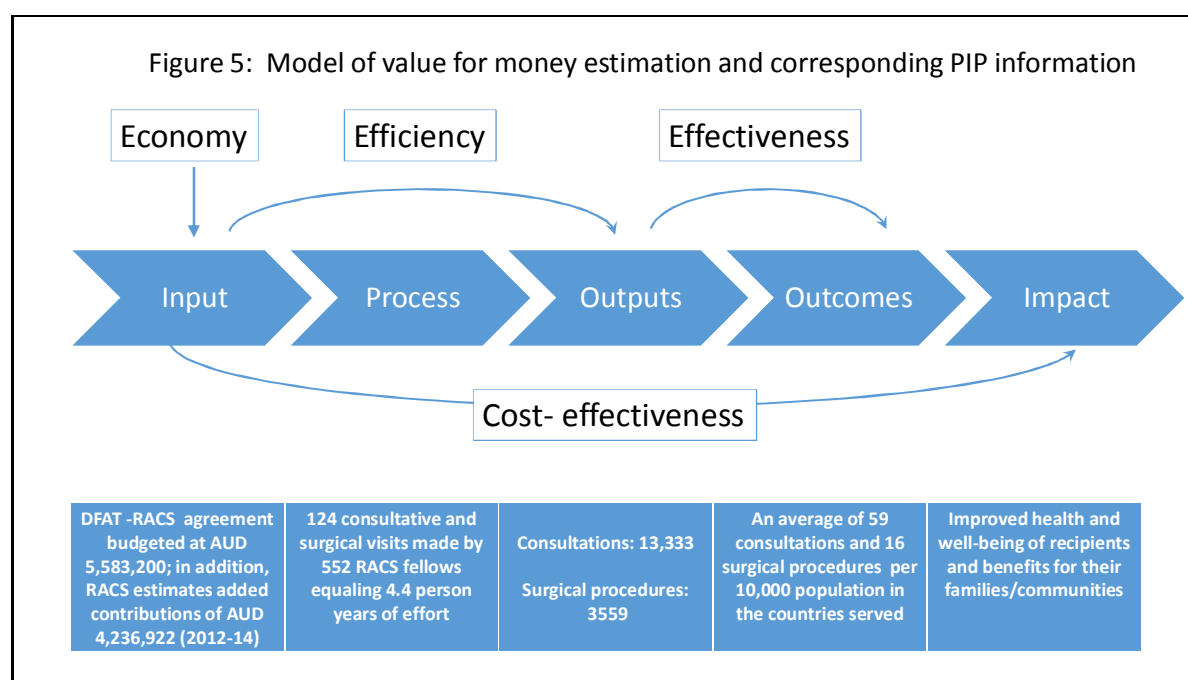
2.2a) Given the relevance of the services and functions performed, what are options for service providers? How might services providers be assessed as “fit for purpose”?

This section builds on the previous in that it considers the following PIP functions to be relevant:

- direct service provision with attendant hands-on skills building
- capacity-strengthening albeit with an increased focus on subject matter which is directly linked to stated needs and priorities of the MoHs.

The underlying assumptions of the Theory of Change for DFAT’s regional health strategy¹⁴: clearly still pertain, notably that “given their size, Pacific Island countries do not have the capacity to sustainably *provide the full range of health functions and services necessary to improve health outcomes to desired levels, hence there is a case for regional investment and collective action that complements country-level activities*”. Accordingly, under the objective of *selected specialised services provided regionally*, DFAT’s regional health strategy includes an intervention area related to tertiary care policy, and capacity building.

As depicted In Figure 5, the evaluation adapted and applied a model of value for money to the PIP¹⁵. All data used in this exercise is project reported. The model is premised on a stepwise progression using systems logic (e.g. inputs, processes, outputs, etc.). Value for money concepts (economy, efficiency, effectiveness and cost-effectiveness) are derived from the relationships between these elements in the systems logic. For the PIP, these are described below.



¹⁴ Australian Government. DFAT. 2013. Pacific Regional Health Program Delivery Strategy 2013-2017. December 2013.

¹⁵ Department of International Development. 2011. DFID’s approach to value for money. July.

In regards to *economy*, we see that the relationship with the RACS brings a multiplier effect to the investment of the Government of Australia. Specifically, through the provision of volunteer surgical services¹⁶, Every AUD invested by DFAT into PIP generates an additional 75 cents of in-kind services volunteered by RACS fellows. No form of independent verification of this estimate was conducted.

The *efficiency* of PIP is estimated as a function of inputs to outputs. Through a crude calculation of AUD to consultations and to surgical procedures, we see that this volume of consultations were provided at a cost of AUD 736 for each and surgical procedures at AUD 2759 each. If the DFAT investment were considered alone, there would been far fewer consultations (7585 rather than 13,333) and surgeries (2023 rather than 3559). One could conclude that the efficiency of converted input to outputs is enhanced by approximately 43 per cent through the use of RACS as implementer of PIP.

It becomes increasingly difficult to move across the model and provide estimates of any validity regarding the contributions of individual projects to what are larger, longer-term results. Looking at outcomes, it is possible to estimate the total number of consultation and surgical procedures provided through PIP visits per 10,000 population in the countries served. However, drawing out the relations between outputs and outcomes is not possible.

In a very rough estimation, it is possible to look at the number of surgical procedures performed through PIP visits with the total number that might be expected per 10,000. Recent information from Australia¹⁷ suggests the 522 surgical procedures are performed per 10,000 while WHO¹⁸ reports that, based on data from 56 countries, an average of 400 procedures are performed per 10,000 population. More recently, a Lancet Commission¹⁹ concluded that, based on analysis from 21 regional groupings, somewhere between 300 and 600 surgical procedures per 10,000 was an estimate of total need. These figure would suggest that, depending on the country, the PIP visits represent either a minor (three per cent) to major (34 per cent) of total need in the population. This analysis suggests that the PIP has an established platform to provide services at some scale and the professional network to arrange for the delivery of those services within the countries served.

Clearly there are other options for the provision of similar surgical services in the countries in the region and there is some potential for duplication around specific specialities. Indeed, some MoHs appear inundated with visiting teams and struggle to coordinate these on an on-going basis. However, many of the other teams are single focus (e.g. Pacific Eye Institute for ophthalmology, Interplast for plastic and reconstructive surgery, Adventist Development & Relief Agency International Open Heart for cardiac surgery, etc.) as opposed to RACS which seems better able to provide “one stop shopping” for a variety of clinical specialities.

¹⁶ This figure should be considered an underestimate as RACS also negotiates reduced prices on procurement of supplies and equipment as well as outright donations. These elements have not been fully costed.

¹⁷ Australian Government. Australian Institute of Health and Welfare. Australia's Hospitals 2013-2104. At a glance.

¹⁸ WHO, 2009. WHO guidelines for safe surgery.

¹⁹ www.thelancet.com. Published online April 27, 2015.

Perhaps the option with the closest profile to the PIP is the New Zealand Medical Treatment Scheme (NZMTS²⁰). Funded by the New Zealand Ministry of Foreign Affairs and Trade (MFAT) and implemented by a private contractor, the NZMTS provides visiting teams and an overseas medical referral scheme. It seeks to (a) increase opportunities to access secondary and tertiary treatment not normally available in the home country, (b) provide access, and where appropriate, provide services according to need, that are not otherwise available; and (c) maximise opportunities for capacity-building through activities such as structured training and/or on-the-job training. Five countries in the region participate in NZMTS (Fiji, Kiribati, Tonga, Tuvalu and Vanuatu). The NZMTS has worked with a budget of about 1.35 million NZD per annum equivalent to approximately AUD 1.195 million. Both projects provide specialist clinicians' services on a voluntary or pro-bono basis.

Table 8 below provides a limited assessment of the two projects, PIP and MTS, with comparison of volume of VMT visits as well as associated costs.

²⁰ Blick G and J Smith. 2015. Evaluation of the New Zealand Medical Treatment Scheme. Sapere Research Group. 13 March.

Table 8: Comparison of regional projects providing visiting medical teams²¹

| Project | Period under review | # of VMT visits | % of VMT with a single person | Cost per | | | Mgt. fee |
|------------|---------------------|-----------------|-------------------------------|------------|------------------------------|------------------|----------|
| | | | | Team | Drugs, supplies, consumables | Surgical patient | |
| PIP | 2012-2015 | 117 | 7% | AUD 22,424 | AUD 8981 | AUD 1042 | <10% |
| MTS | 2011-2014 | 86 | 45% | AUD 11,200 | -- | AUD 449 | 22% |

Table notes:

Currency conversions (from NZ dollar to AUD) made with www.xe.com/currencyconverter; 18 September 2015.

Figures are averaged across the period under review – a three year interval for both.

PIP figures are inclusion of a) team visit/mobilization packaged fixed fee and b) drugs/medical supplies and consumables. MTS figures are assumed to be team visit only.

Management fees are expressed as a percentage of the total project budget.

PIP costs shown in Table 8 can be broken down by VMT members as well as the drugs, medical supplies and consumables that they carry with them. In contrast, the MTS figures appear to account for team-associated expenses only. Therefore data on costs per surgical patient (i.e. AUD 1,042 and AUD 449) may not be directly comparable. Table 9 below provides further details on PIP costs in these two expenses categories per team and per surgical patient.

Over a comparison period time (three years), the PIP provided a significant larger number of visits building on their long-standing arrangement with countries in the regions. On average, the PIP teams comprised four individuals. Visits by solo clinicians made up 45 per cent of the MTS VT visits, compared to 7 per cent of PIP VMT visits. Given that the PIP teams are substantially larger, it is to be expected that the associated costs are higher. The average cost of MTS team is AUD 11,200 compared to AUD 22,424 for PIP.

Table 9: PIP/RACS costs for surgical teams and services, by category, 2012-2015

| Costs per | VT mobilisation | Drugs/medical supplies, consumables | Total |
|------------------------|-----------------|-------------------------------------|------------|
| Team | AUD 22,424 | AUD 8981 | AUD 31,405 |
| Surgery patient | AUD 747 | AUD 295 | AUD 1042 |

There are several factors which would elevate the costs of the PIP teams. As mentioned above, the average team size is significantly larger than those of MTS.

²¹ BAP note: Need to check with RACS if there is a fee built into the VMT mobilisation, packaged fixed fee category

The nature of the surgeries conducted could also have an impact on costs although it was not possible to compare the specific types of surgeries between the two projects. PIP is active across 11 countries, whereas MTS is active in five. Finally, as noted above, PIP costs are inclusive of both team member expense as well as drugs and medical supplies.

These data provide an indication of the costs and outputs associated with both projects. It is not possible for the evaluation to draw definitive conclusions regarding cost effectiveness of the models. Additional data would be required minimally - the number of surgeries by type, patient risk factors including age, sex and stage of presentation and surgical outcomes. It is notable that the RACS fixed management fee for PIP is less than 10 per cent of the total project budget whereas the private contractor responsible for the NZMTS has a fixed management fee equal to approximately 22 per cent of the project budget.

2.2b) In regards to coordination of visiting medical teams, including Australian colleges and Pacific clinical services organisation, what are potential options and what is the relevance of RACS²² vis-à-vis those other options?

The coordination of VMTs is carried out through the MoH with close collaboration with a tertiary hospital in each country. Other options to this arrangement were not explored during the evaluation as this coordination mechanism is at the heart of both SSCSiP and PIP. The coordination of VMTs through an office in the MoH or NHS represents movement towards a country-owned process which, over time, can help to ensure that such visits are demand- rather than supply-driven.

It is in this regard that the “fit for purpose” question becomes relevant. If “purpose” is intended to be provision of specialised services as identified and prioritised by the MoH through a purely demand-driven model, then RACS is not a particularly relevant option. It is difficult to envision a scenario in which SCS could be both entirely voluntary and demand-driven. As voluntary services, there are concessions made in timing and other aspects of VMT management to accommodate their provision. If the model were to be entirely demand-driven, then a contractual rather than voluntary labour force would be more “fit for purpose”. One senior Pacific clinician interviewed articulated perhaps the best case scenario with regards to the balance between supply and demand. He said: *“The PIP VMTs are more streamlined now. They used to come as generalist surgeons, now we have a roster of patients for a specific type of specialty and they send a team specifically for that; they are also always checking how the situation on the ground is changing; how our needs evolve; what training needs may be coming up”*

2.3a) To what extent does PIP support MoHs and other relevant stakeholders to determine health workforce and training needs?

2.3b) To what extent does and in what manner does PIP helps to address those needs?

2.3c) To what extent does RACS have a comparative advantage in the area of health workforce and training needs?

²² Note that RACS provides medical indemnity to PIP visiting teams, including other colleges. This was a key consideration in selecting RACS to implement the current phase of PIP.

PIP supports MoHs to determine health workforce and training needs in those areas of specialty covered by the VMTs. These needs are identified oftentimes on an individual basis as a results of the VMT working side-by-side with Pacific clinicians during the course of a visit. In a few cases, needs may be described at a facility level. At the completion of a visit, training needs (as perceived by the visiting specialists) are identified in the end-of-visit report. Examples of needs as identified in those reports appear below:

- “It is important that Dr. P. moves forwards to complete the MMED Anaesthesia in Fiji. Her current participation in a one-in-two roster makes this difficult to achieve. The burden of call was substantial and must represent a disincentive to provide anaesthesia services in the Solomon Islands.”
- “Dr M. is hoping to pursue anaesthetic training through the Fiji training programme. This must be strongly supported. Arrangement could be made for Dr M. to spend an attachment in Australia as part of his postgraduate training.”
- “Dr. J. should be targeted for highly specialised paediatric training at the University of Papua New Guinea or equivalent elsewhere.”
- “Registrars Dr S. and Dr. K.: Hand/Plastic Surgery attachment to Australian/NZ Plastics unit.”
- “There is an unsustainable shortage of junior medical staff to support the two consultants at Honiara - there is now only one very junior registrar attached to the obstetrics & gynaecology O&G) unit. In the medium term, the new medical interns coming from Cuba are likely to result in more work for the consultants because of increased requirements for training and supervision. Thus there is an urgent requirement for middle grade (registrar) staff in the O&G unit and a need for a third or fourth consultant to assist in clinical work, teaching and outreach surgical visits. In the short term, hospital admin probably needs to place another Papua New Guinea graduate into the O&G unit – they are likely to have the skills to do a lot of the basic obstetric workload. If local staff are not available, in the medium term (one to three years) a request could be made by the O&G unit and ministry for assistance from DFAT for recruitment of such staff.”

The recommendations of the visiting surgeons with regards to health workforce and training needs in their area of speciality would need to be considered by each MoH in the light of HR processes in-country, competing demands for resources, ability to cover for staff away for extended periods, and other factors. Capacity-building needs are also identified in reports prepared by the Pacific clinicians upon completion of a VMT. One such report is prepared at the completion of a clinical attachment – again during the course of a VMT. The Pacific clinicians who participate in the attachments are asked to identify and/or rate the achievement of educational objectives during the attachment, confidence/ ability to perform independently, as well as their perceived need for future training. A second form of post-visit feedback is completed by staff from the hospital which received the VMT. Through these reports, staff are asked to reflect on visit completed, to identify ways that they may adjust or adopt processes, protocols or practices as a result of the VMT visit, and to identify priorities for future PIP visits including learning opportunities.

The extent to which these identified training needs are translated into actions is difficult to determine. Similarly, the extent to which the VMT end-of-visit reports are contributing to a more strategic assessment of health workforce and training needs with a whole-of-system perspective by MoHs is not known. There were mixed reports among those interviewed as to whether the end-of-visit reports are received and/or distributed within a country. Several of the Pacific clinicians interviewed who should have seen the end-of-visit reports reported that they had not received them. Even in cases where the end-of-visit report is received, there is no structure in place to review and act. Much of the follow-up action to be taken would be the responsibility of the MoH and not RACS to pursue. In some cases, VMT members would look prospectively at clinical training needs for specific individuals from one visit to the next. At the highest level, their observations deal with the operations of a single facility (i.e. more work load than work force). In terms of actual workforce planning (e.g. the number of gynaecologists needed on a population basis) RACS has no comparative advantage. In sum, RACS provides an assessment of training needs for individuals but not priorities in training based on country surgical plans and needs.

For the identification of these quite specific training needs of individual surgeons (for example related to their career development), RACS is well-positioned. They may be less well positioned to identify skills gaps and training priorities in relation to identified surgical priorities in the countries. Because of their long-established presence and high-regards for their skills, the observations of VMTs from RACS would likely carry more weight than those of other VMT providers. To that extent, RACS have a comparative advantage. Further, if countries used a more structured approach to review the end-of-visit reports and considered them in decision-making, then RACS would bring a distinct value-added to the equation. At current, this is a missed opportunity.

Sub-objective 2.2 Assess the effectiveness and efficiency of the PIP in relation to cost-effectiveness²³, equity of access, clinical governance safeguards, strategic planning, health systems strengthening, and gender equality.

2.4) Assess the value for money derived from DFAT-funded regional services and support provided by PIP to PICTs

2.5) To what extent does PIP ensure equity of access in the support provided, either in training or service delivery? To what extent are these efforts appropriate to the need?

2.6) What are barriers to achieving equity of access? In the next phase of support, what approaches and practices might PIP employ to ensure equity of access?

In regards to individuals' access to service, PIP is at least one step, and likely several steps removed from the decision-making process that brings surgical candidates to the VMT. Individuals with relevant conditions may first be evaluated in their region of residence. In advance of a visit, central-level clinicians (located based on the national

²³ Please note that the cost-effectiveness element of this question is addressed under question 2.1b above.

referral hospital or similar tertiary care facility) might ask regional hospitals about candidates or may simply draw from their own surgical backlogs.

VMTs provide basic commentary, via the end-of-visit reports, on the nature of the screening process conducted in country albeit with emphasis on clinical aspects of cases and not equity concerns. Of the seventeen end-of-visit reports reviewed, issues of access were only addressed in one, as follows: *“There were more patients planned to attend the Gizo outreach however poor weather and rough seas in the immediate days preceding the visit meant that patient numbers were lower than expected”*. The VMT spend a limited amount of time in country – typically one week with the majority of their time devoted to hands-on patient care. It is unrealistic to believe that VMTs could play a greater role in ensuring equality of access.

Lack of information makes it difficult to assess and if needed, re-dress, equity issues. Ideally, variables related to equity of access (e.g. age, sex, region of residence, distance of residence to facility, cost of travel) should be available in patient records. This evaluation did not have scope to examine the availability and content of such records. In a first step, determining equity of access is an analytical task. With a protocol or template that has been tested and revised, it is conceivable that the Specialist Clinician Services Coordinator could compile the required information on a regular basis. At a minimum, that type of information is required to inform any decision and action on ensuring equity of access. Accepting that patient information systems may be weak, nonetheless as far as possible, from a health systems strengthening perspective, it would be preferable to avoid or at least minimise any parallel record keeping systems. Health facilities should ensure appropriate use of existing health information systems, including for patients receiving care from VMTs. This is important to re-inforce existing systems, and also to facilitate greater follow up and continuity of care after the VMTs have left the country.

Another means of encouraging equity of access is the provision of services outside of the main or major urban areas. However, the poor infrastructure including transportation and facilities limits provision of visiting teams' services to many communities (e.g. outer islands or remote locations). Pacific clinicians interviewed provided a varied picture of VMT willingness to make clinical visits to outer islands or outlying districts. In at least one case, VMTs were unwilling to travel to underserved region (due to difficulties in transport and poor quality accommodations). None the less, the country tertiary care managers were keen to get VMTs to this remote yet heavily populated region. In this country, many of those interviewed spoke openly about the preference of the VMTs to travel to another region of the country where there was a more recently built hospital and excellent recreational opportunities (i.e. diving). Looking forward, PIP should examine more systematically the possibilities of extending the coverage of VMT services to other regions in order to offer greater equity of access.

2.7) To what extent are clinical governance safeguards employed by RACS based on DFAT's guidance on clinical safeguards?

RACS has developed risk management matrices for the global health program as well as for each funded program. Therefore PIP has a risk management matrix which, for each identified risk, provides an assessment of its probability of occurring,

its impact and an overall risk assessment. Each identified risk is also accompanied by actions for mitigating the risk and the responsible actors. Relevant portions of the PIP risk management matrix appear in Annex 12. Risks assessed as high which have implications for clinical safeguards include inadequate post-operative care, lack of equipment and supplies for surgeries undertaken and inadequate patient pre-screening. A surgical safety checklist, adapted from Australian practice, is used for all PIP visiting teams.

Based on interviews and document review, the evaluation concludes that RACS is particularly mindful of these risks and that mitigating actions are integrated throughout program materials to the extent possible. In comparison with DFAT guidance on clinical governance safeguards²⁴, PIP appears to be compliant and in many areas embodies standards with far greater depth and specificity than that provided in the Guidance.

2.8) To what extent are there unintended consequences of providing specialised clinical services through visiting teams to health sector financing?

Per the Evaluation Plan, this question was intended to examine issues regarding increased demand for specialised clinical services and/or pressures to increase spending on hospital services or re-direct resources from lower levels of the health systems. The evaluation found that the presence of VMT, per se, did not have these unintended consequences. Interviews with the RACS team did reveal isolated instances when countries would request either equipment, technology or services which could not be adequately maintained or safely provided. The RACS global health team turns down those requests.

In interview Pacific health personnel raised some concerns relating to equalising the training and up-skilling available to nursing staff vis-à-vis the surgeons. In each of the countries visited, both nursing and medical staff raised this as an issue. As aptly stated by several Pacific surgeons interviewed: “*we cannot have specialist services without specialist nurses*” and “*any specialty needs the support structure around it (e.g. nursing, radiographers); they need to evolve as well; we don’t work in a vacuum.*”

Another unintended consequence is the burden on the receiving facilities operations during VMTs. This burden is not due to PIP alone, it results from the cumulative number of visiting teams. Perhaps the most disruptive are those VMTs which come through political channels (e.g. Ministry of Foreign Affairs) with little (if any) involvement and knowledge in the MoH and hospital. However, even well-coordinated VMTs can place a burden on hospitals in resource-scarce environments. Typically, VMTs require a ward and beds which can then limit the beds available for other patients. In at least one hospital, a Bed Manager was hired to deal with this issue. Most respondents saw two sides to the issue, on one hand, the number of VMTs is disruptive to the patients because of the bed block; but at the same time, their services were needed. In one country, it was reported that the shortage of beds

²⁴ Ollier L. 2015. Guidance Note on incorporation of Clinical Governance in the management of contracts and programs involving clinical service delivery. Health Resource Facility. Mott MacDonald (Mott MacDonald Australia Pty Ltd). 12 January.

creates a situation where prior to a VM, patients are discharged early or transferred to another facility. It was further described that for non-acute cases, typically five persons would be waiting for a bed while during VMTs, there would be anywhere between 12 and 25 persons waiting for a bed.

2.9) To what extent are the monitoring and evaluation approaches and practices used for PIP appropriate and effective? Is there evidence of management follow-up action taken as a result of M&E?

PIP has developed an M&E framework which spans the project's impact, objectives and outcomes. Each level has a set of "measures of success" as well as type of M&E tools to be used and unit responsible. The evaluation used the measures of success and depicts them across a standard M&E results framework (i.e. inputs, processes, outputs, outcomes and impact). The evaluation finds that PIP does very well in measuring at lower levels of results – notably processes and outputs. However, as was found during the IPR (2011), at the higher levels (outcomes and impact), monitoring is more difficult and quite limited. It should be noted that PIP is engaged in project monitoring and not evaluation.

It is also important to note that PIP can be held accountable for the results produced at the levels of processes and outputs with stated assumptions and risks. However, at the level of outcome and impact, results are achieved through joint efforts of the project and other partners, most notably actors in the national health care system.

Annex 13 presents the measures of success by standard M&E results framework. Points pertaining to its appropriateness and effectiveness appear below.

- In general, PIP does an excellent job of defining measures of success for each objective and associated outcome. A number of monitoring formats have been developed, made operational and are reported in semi-annual and annual reports. Particular note should be made on the reporting of numbers of consultations and surgical procedures performed by each specialty team disaggregated by gender and with post-operative complications flagged.
- Among the process measures, the majority are collected, tabulated and reported. A few are collected but do not appear among the tabulations in the routine reports (e.g. # and specialty of ongoing mentoring relationships, # and types of other informal training provided (i.e. lecture, grand rounds, tutorials, other)
- Among the output measures, those dealing with the direct service provision are very good. Several related to the role and participation of Pacific clinicians in pre-screening, diagnosis and involvement in surgical procedures are also quite useful with one caveat. The indicator related to the degree of involvement in surgical procedures (assisting, lead with VMT assist and conduct independently reflects the intent of PIP to increase the enhance skills and confidence during the hands-on portions of the VMT. However, the indicator is influenced by a number of variables which makes it difficult to track over time and interpret. For example, the indicator will be influenced by the entry of young surgeons into the pool as well as the types of specialties and procedures performed during any one visit. In short, one cannot track in a linear fashion at a country or across the region. It may be more appropriate to track this measure for a core set of surgical procedures. Interviewees spoke of procedures which the VMTs used to perform but can be

conducted by Pacific clinicians. Likewise, certain types of cases previously required overseas referral and can now be handled by Pacific clinicians in their home countries. It may be more indicative of increased skill to select a set of “sentinel” procedures for each specialty and then track Pacific clinicians’ involvement using the same rating: assist, lead with VMT assist and perform independently.

- The measure related to Pacific clinicians having increased skills, confidence and application three months after PIP training (clinical visit, workshop or training attachment) also poses challenges. For many forms of training, this type of measure is monitored through pre-and post-training knowledge testing and ideally, with a follow-up visit to the trainees’ work site for observation of the skills in use. PIP-supported training is too varied to use this standard approach to monitoring increased skills. In a few instances, pre- and post-training knowledge testing is done as well as self-reported feelings of confidence.
- In regards to outcomes, the monitoring tool being used is the recently developed beneficiary study. Based on review of the Tonga report, the value of this instrument seems limited primarily due to the fact that the individuals selected were not representative and findings can only be considered anecdotal of the entire population of beneficiaries. It is not recommended that beneficiary survey be conducted on a representative sample as the costs would be prohibitive.
- Rather than collecting information from individual beneficiaries, PIP might consider examining its impact on a population basis. This would require country-by-country estimates of population-based need for specific types of surgical procedures and the degree to which PIP VMTs address that need. With data on the surgical procedures performed by age and sex, a modelling exercise may be able to provide population-level estimates of likely health outcomes achieved at the level of the population.
- DFAT should determine what degree of outcome-level reporting is essential. Bearing in mind that VMTs come for brief periods and the benefits derived may accumulate over several years, it will be difficult and costly to try to monitor outcomes through any form of follow-up of beneficiaries.

There appear to be important questions pertaining to the VMTs that are not addressed by PIP monitoring or other forms. Perhaps foremost among these is equity. Information on the age, gender, residence, employment, income and ethnicity of the patients could be collected during the consultation process or as patients advance to surgery. Other variables may be of interest as well (e.g. distance/time/cost to travel to facility). This would not be needed for 100% of patients but a sub-set of patients in a manner considered an appropriate random sample.

2.10) To what extent have improvements been made since the 2011 IPR, with a focus on implementing methods to measure:

- Changes in skills, competencies, and confidence of training beneficiaries;
- Longer term outcomes and the impact of the program; and
- Impact of donated equipment on clinical services

Table 9: Status of issues identified in IPR regarding measurement methods

| Issue identified | Changed made since IPR and current status |
|--|--|
| Changes in skills, competence and confidence of training beneficiaries | A variety of tools are utilised to gauge changes in skills and confidence. Many are self-reported and with no form of objective assessment against standards. |
| Longer-term outcomes and the impact of the program | A beneficiary study protocol has been developed and tested in several countries. |
| Impact of donated equipment on clinical services (sustainability of recurrent costs, maintenance issues, and availability of local clinical skills for use) | RACS has a donation policy. However, they do not track the impact of donated equipment. Assessing only their own contributions would likely not be useful to countries which receive donations (many of questionable value) from many sources. |

2.11. In regards to sustainability, to what extent is the support provided by PIP, including its capacity building component, sustainable?

- Of this, assess the level of capacity building support provided by PIP and the appropriateness of the capacity building approach used to maximise sustainable outcomes.
- Provide commentary on the level and approach to capacity building PIP should employ in a potential next phase of support, including whether more support should be provided to particular countries or sub-regions.

In a spontaneous manner, several high-level Pacific clinicians said that the support of PIP/RACS will be needed some time into the foreseeable future. RACS is consistent in placing emphasis on the provision of clinical services. As found in the evaluation, the provision of these services, via VMTs, have an important capacity-building element particularly when Australian surgeons are working side-by-side with their Pacific colleagues. While difficult to quantify, this form of upskilling was so consistently mentioned by the Pacific clinicians interviewed as to be without doubt. Obviously, this form of skills-building is sustainable when it can be provided by Pacific clinicians themselves without the presence of the VMTs.

It is difficult to state that there is specific capacity-building “approach” used by PIP. The PIP offers and/or supports a number of differing types of trainings (e.g. in-country and regional), as well as continued professional development and overseas training. VMTs also identify specific training needs of Pacific colleagues, and recommend individuals for support to complete training. In each country visited, Pacific clinicians and nursing staff emphasised the importance of attachments to either Australia or New Zealand of relatively short duration as well as longer-term placement of Australasian professional in Pacific institutions for an extended period. This was deemed particularly important where a speciality was not available in-country while an incumbent was away for training.

This evaluation questions the overall value and unique advantage of certain types of training offered through PIP. The extent of training on essential pain management does not seem to be a distinctly expressed need of Pacific clinicians nor a unique advantage of PIP/RACS to provide. Likewise, training in intrapartum care does not seem to be a unique specialty for the PIP and is likely provided by other organisations including UNFPA, WHO and United Nations Children's Fund (UNICEF).

Looking forward, one model for PIP would be to focus on quality of trainings rather than quantity. Rather than conducting a large number of trainings in-country on topics such as essential pain management, it may be better to focus on providing a high-quality attachment opportunity to fewer individuals or placing an individual with strong skills building experience in one of the countries for a period of several months. Irrespective of approach taken, there is a strong need to better target capacity development initiatives, basing this targeting on an objective assessment of existing capacity in relation to need – this would include an assessment of training needs, and possibly also could consider needs for other aspects of capacity development in relation to provision of SCS – for example, systems, tools, information flows.

2.12) To what extent is gender equality considered in PIP activities? Have gender equality considerations been handled appropriately?

This section examines the extent to which PIP activities – both clinical services as well as training/capacity-building – are distributed in regards to gender.

The Independent Progress Review (2011)²⁵ found that PIP took purposive approach to monitor gender equity in its activities. Among these were the reporting template for clinical visits that requires VMTs to provide sex-disaggregated data for both consultations and surgeries as well as training opportunities of all types (i.e. in-country, regional and CPD). The IPR also pointed to RACS use of reports of positive discrimination to promote access to training opportunities for female health workers.

This evaluation found that PIP made substantial improvements in their recording of sex as a variable for both patients consulted and treated. As seen in Table 10, The percentage of consultations which lacked sex disaggregated data fell from 35 per cent in the 2007-2010 to seven per cent during the most recent phase. Likewise, the percentage of surgical procedures lacking sex disaggregated data fell from 21 per cent (2007-2010) to less than one per cent in the most recent period.

Table 10: Consultations and surgical procedures where sex was not recorded, 2007 to 2010, and 2012 to 2015

| Events lacking sex-disaggregated data | | |
|---------------------------------------|-----------|-----------|
| | 2007-2010 | 2012-2015 |
| <i>Consultations</i> | 35% | 7% |
| <i>Surgeries</i> | 21% | <1% |

²⁵ Campbell J, Braithwaite JA, Buchan J and J McKimm. 2011. Pacific Tertiary Health Program – Phase III Bridging/Transition Phase ('Pacific Islands Project'). Independent Progress Report. 4 November. AusAID Health Resource Facility.

The distribution of consultations and surgeries between males and females changed slightly between the period 2007 to 2010 and 2012-2015. While consultations have remained roughly equal between the sexes, a pattern continues in which surgical procedures skew slightly in favor of males (Table 11 below).

Table 11: Consultations and surgical procedures by sex, 2007 to 2010, and 2012 to 2015

| | Consultations | | Surgical Procedures | |
|-----------|---------------|------------|---------------------|------------|
| | Male | Female | Male | Female |
| 2007-2010 | 4517 (49%) | 4784 (51%) | 1589 (57%) | 1198 (43%) |
| 2012-2015 | 6120 (50%) | 6226 (50%) | 1885 (54%) | 1629 (46%) |

As pointed out by several sources^{26,27}, the types of services provided by the VMTs are influenced by population health needs, national priorities and requests, communication and mobilisation efforts. Screening for treatment by the VMT is based on severity of illnesses, quality/safety considerations and services that can be provided in the local hospital setting. These factors all have a bearing on the final numbers of male and female patients who will receive care. In sum, the case is made that clinical case diagnosis and not gender considerations determine who is seen and served. However, analysis performed for this evaluation found that differences that may not be fully explained by objective criteria for screening and surgical cases. The analysis conducted for the evaluation appears in Annex 10. Key points in regards to gender include the following:

- When presented as ratios (i.e. male data are set at a value of 1 and female data appear as a proportional amount above or below 1), male and female participation in surgical consultation is quite equal (See Table 12 below)
- In contrast, surgical procedures show that more males than females receive treatment. For every 100 males receiving surgery, there are only 86 corresponding females. Surgical specialities which are sex-specific (i.e. O&G and urology) have been removed from these analyses.

Table 12: Ratios of male to female consultations and surgical procedures, 2007 to 2010 and 2012 to 2015 (Crude rates)

| | Consultations | Surgeries |
|-----------|---------------|-----------|
| 2007-2010 | 1:1.06 | 1:1.75 |
| 2012-2015 | 1:1.02 | 1:1.86 |

Table Notes: Date for 2007-2010 is from the IPR 2011 (Table 1, page 5) and is assumed to include all surgical procedures. Data for 2012-2015 are drawn from PIP/RACS reports and exclude the categories of O&G and urology.

²⁶ Ibid.

²⁷ Government of Australia. AusAID. 2013. Quality at Implementation Report for INJ833 Tertiary Health-Pacific Island Project. Approval date: 15 March.

- When examined further by disaggregating by surgical specialty, we can see the specialties/procedures which may be more likely to be performed on one sex over another (e.g. orthopaedics).
- In four areas, *consultations* are provided on nearly equal basis (cardiac, ENT, plastics/reconstructive and vascular). In one area, ophthalmology, women are more likely than men to have a consultation (i.e. for every 100 men, there 122 women who receive a consultation). In three other specialty areas, men out-represent women as individuals who receive a consultation. In descending order, these are: gastroenterology (80 women for every 100 men), neurosurgery (71 women for every 100 men), orthopaedics (67 women for every 100 men) and paediatrics (48 girl children for every 100 boy children).
- As with consultations, there are specialty areas in which the male to female ratios of surgical cases are somewhat similar (i.e. ENT, ophthalmology, plastics and reconstructive. In the area of neurosurgery, women are far more likely than men to received surgery (122 women for every 100 men). In the remaining specialty areas, men are more likely to receive surgery than women. These include: cardiac (100 men to 43 women), orthopaedics (100 men to 48 women), paediatrics (100 boy children to 62 girl children) and vascular (100 men to 34 women).

The potential for such differentials was recently acknowledged by DFAT²⁸. They noted an important gap in knowledge regarding the initial selection of patients to be screened by PIP, whether and how gender equality principles may be accounted for in this process. Based on the above, it appears the same concerns extend beyond selection for consultation and into selection for surgery, in which the RACS teams would be more involved.

The evaluation also examined the available data on training. The aggregate data show that more women have benefitted from PIP training than men. During the period, 2012-2015, 1000 women participated in training activities compared to men (576 men). However, on closer look, it seems that men have a greater diversity of training opportunities than do women. Key points are:

- Women are far more likely to participate in in-country workshops (81 per cent of all female participants compared to 56 per cent of male participants). One reason for this is the fact that the nursing profession is overwhelmingly female and is the targeted audience of in-country training.
- Twenty percent of male trainees were engaged in CPD activities or overseas training compared to only five per cent of the female participants.
- Regional training opportunities accounted for 20 per cent of the male training opportunities and 13 per cent of the female training opportunities.

These figures should be viewed in light of the fact that a far greater percentage of Pacific specialist clinicians are male than female. Where appropriate to do so, RACS reports that they target and support women and other marginalised groups to ensure they benefit from training opportunities provided through PIP. RACS also notes that it

²⁸ Government of Australia. DFAT. 2014. Quality at Implementation Report. Tertiary Health-Pacific Island Project. Approval date: 14 March.

is limited by the candidate selection process of hospitals and MoHs which may hinder its ability to further support female candidates.

There are greater numbers of male than female PIP volunteers participating in the project (291 males and 202 females). There are significant disparities by professional area, for example, 157 male surgeons to seven female surgeons and 72 male anaesthetists to 15 females. This is unsurprising given the gender profile of the Australia-based workforce – in Australia, males are disproportionately represented in the surgical profession, and females disproportionately represented in nursing.

4. Conclusions

The two regional projects remain largely relevant to the needs of the countries in the region. In some areas, relevance has changed when compared to the original project. These areas of exception occur where either: a) a result area has been raised to the level of outcome when its relevance suggests that it should appear lower in the results hierarchy (e.g. the third objective in the PIP results framework) or b) in implementation, the balance of effort between outcomes has skewed in a manner that certain sub-outcomes have to represent an overly-prominent role vis-à-vis other sub-outcomes (e.g. sub-outcome on medical education and training in the SSCSiP results framework).

It is clear that considerable thought went into the creation of the two projects and in the manner in which they were to complement one another. The models (fit for purpose) being utilised to implement the projects have significant benefits but also come with unanticipated disadvantages.

SSCSiP has adopted an approach in which a menu of services and products are available for countries in the region to request and use. While this approach was designed to as a response to the widely varied needs of the countries in the region, it also has negative implications. Among these is the fact that specialised clinicians and managers in-country must have sufficient knowledge of the project and its offerings in order to request support. Without this, a situation arises in which those ‘in the know’ can more effectively access support. Responding to requests also means that clinical specialists will turn to the project for support in continued training of individual clinicians. Indeed, the flexibility of the project to consider and support these types of requests was frequently cited as a strength of the project. It seems far less likely that requests would be made for systems strengthening elements such as human resource planning or value-for-money analysis. *Requests received by the project have the endorsement of the MoH but are not necessarily based on any form of longer-term planning or needs assessment.* Finally, the project has developed a number of tools and templates which are appropriately aimed at improved coordination and management of VMTs. However, there appears to be little in the way of active promotion. Many individuals interviewed who could have benefited from these tools were unaware of their existence. As a result, these materials have not had the impact that they might have achieved with more consistent dissemination, on-going support and dialogue. The evaluation did not identify instances of SSCSiP actively interfacing with broader health workforce development initiatives. Owing to the broad scope of the evaluation, the evaluation also did not include detailed consideration of the potential of SSCiP to do so in the future – as discussed in Section 5, this potential could be considered in the design phase. For the PIP, there has been discernible movement towards a more “demand-driven” approach and all interviewees recognise a continued need for the PIP VMT services. However, in many cases, the content and timing of VMTs may be more driven by established patterns (e.g. ophthalmology team comes every October) than current need. The repeat patterns allow RACS volunteer surgeons to develop professional relationship with county clinicians which can span years and can incorporate skills building in a phased approach. On the negative side, there may be less room for countries to obtain the specialist skills that they actually need from the PIP/RACS. Moving more

towards a demand-driven model would require a better understanding of what is actually needed (i.e. types of specialties, service accessibility, and equity including gender considerations). Meeting the need for greater understanding of demand was one of the core reasons for establishing a health planning function in SSCSiP – but as outlined below, this aspect of SSCSiP has been relatively weak, or at least has not been implemented as intended.

The PIP model has also incorporated a stronger emphasis on capacity-building through a tiered approach of in-country, regional, overseas and professional development opportunities. While these capacity-building activities are appreciated in general, their value to Pacific clinicians comes nowhere close to the value of the VMTs/service provision. Moreover, Pacific clinicians were far more attuned to the unique form of hands-on upskilling that occurs throughout the PIP VMT visits. Similar to the situation described above, the training agenda is also at least partly driven by established patterns rather than current need, making it less useful than it otherwise might have been.

It is difficult to imagine another service provider who could work as extensively and as efficiently as RACS for the purpose of VMTs. In contrast, the current form of capacity-building that PIP engages in does not seem uniquely suited to RACS. It seems that other agencies and organisations could conceivably provide the same.

On the other hand, the functions of SSCSiP could be performed through other modalities. In particular, important areas of SSCSiP current work does not fully reflect the regional intent of the project. As currently implemented, there are some significant disadvantages in locating the project at FNU. Senior clinicians throughout the region noted that countries benefitted differentially from the project. Those who felt that they were not getting their fair share were quite vocal, were less willing to cooperate with project requests for information and, in general, questioned their further involvement. Thus, these disadvantages seem substantive enough to impact on the project's implementation. Moreover, when compared with elements of the long-term vision for the project (as per the original Design Document), the project is not viewed as having the expertise and skills needed to perform more strategic functions. For example, one stated long-term vision for SSCSiP was that the DaCT, as needed, would advise on value-for-money assessments and maintain a role in procurement issues. With the exception of the work sub-contracted to CHIPSR, few would turn to the DaCT for advice on value-for-money considerations.

For each project, issues of equity including gender consideration continue to represent a distinct challenge. Each project has conducted valuable M&E initiatives but neither has established what could be considered a comprehensive and systematic approach.

5. Recommendations

Based on the findings and conclusions, there are potentially a large number of recommendations. In light of DFAT's current need for information for the re-design process, this section is limited to a small number of highest priority and actionable recommendations for each project.

Strengthening Specialised Clinical Service in the Pacific

1. In determining priorities for the new project, DFAT should carefully examine the balance of effort that is devoted to a) building individual versus systems capacities; b) providing country-specific assistance versus strengthening regional mechanisms; and c) short-term versus long-term results. Going further, DFAT should build into the design, mechanisms to ensure that the desired balance is more likely to be achieved. For example, countries should first have assessed their training needs and used these to guide requests for individual training. A multi-year SCS HR plan should be in place ideally within the context of an overall multi-year HR for health plan. Project work in the area of HR planning should be developed as a multi-year effort with stable budget allocations to see the work through with on-going support as opposed to a one-off workshop and template. Another example comes in the form of regional SCS governance via the SRG. This group should be convened in a manner in which regional SCS priorities are given priority over and above a recounting of the project's progress and review of its workplan. This re-configuration may require different ToRs, strong leadership/chairperson and some dedicated budget.
2. As implemented, several areas of SSCSiP focus do not fully represent the intent of regional programming. In the future, DFAT should examine the relationship between regional investments (e.g. developing common standards) and country-specific investments (e.g. getting newly agreed standard adopted into country practice). Moreover, some activities, appropriately regional in nature, have gone unaddressed (for example helping to achieve greater economies of scale through regional coordination of VMTs in certain specialties of over- and under-supply). In a resource constrained environment, a regional initiative should focus more exclusively on those aspects of strengthening SCS that serve regional as opposed to individual country needs. DFAT bilateral programs should be encouraged to take a comprehensive view of health sector programming which includes a role for specialised clinical care.
3. Recognising the burden placed on countries by clinicians seeking advanced training, DFAT should invest in a thorough examination of the possibilities of remote and/or on-line training courses. Throughout the region, it was acknowledged that "training a surgeon takes 10 years". When staff are away for extended periods of time in training, the ability of Pacific country to provide SCS is severely affected. Several respondents spoke persuasively on courses that were available on a remote/on-line basis with combination of study and supervision in their home country with occasional travel for the purposes of

testing. This model is far better suited for many countries in the region and should be pursued in order to establish it as a viable means of furthering medical education. As per the recommendation above, these efforts should be informed by evidence generated through training needs assessment.

4. Provision of financial support as a gap-filling measure is widely appreciated by clinicians throughout the region. The project should be commended for its approach to cost-share with MoH. However, in a resource constrained environment, this is one aspect of the project that should be shifted to other actors. For example, DFAT should examine the potential of tapping into bilateral mission training funds for scholarships and training as a potential means of meeting needs in the areas of SCS training. If this component is retained in the future, the project should “ring-fence” it in order to avoid becoming a project primarily for the support of ad-hoc, individual capacity-building. Where support for training is granted, it should be clearly linked to information on the SCS needs of the country.
5. An important contribution of SSCSiP has been through the analytical work carried out by CHIPSR. Quality, independent work of this nature is a tremendous value-added for the project and an area into which few other agencies would venture. DFAT should find ways to expand this aspect of the project’s operations. For example, in addition to the work that has occurred on overseas referrals, issues such as service accessibility and equity in the use of SCS could be a subject for multi-country research.
6. The project’s approach assumes that the needs of each country differ so greatly that a responsive, menu-type approach is the most suitable. This assumption holds for some but not all aspects of the project’s focus. Respondents from across countries repeatedly cited the need to provide nurses with access to specialised clinical training in addition to surgeons. DFAT should encourage the project to find means of extending its offerings to nurses in priority areas of specialised services. The intended role and function of nurses that might be trained through the future project would need to be clarified – for example, roles as “skilled assistants” to medical specialists, and/or alternate nurse-led approaches to aspects of specialised care. In addition, the area of biomedical services is an enormous and under-addressed across countries in the region. The biomedical support offered by the project has been well-appreciated. To the greatest extent possible, this form of support could be incorporated into bilateral programs of assistance albeit with a systems-wide emphasis on primary, secondary and tertiary services.

Pacific Island Project

1. PIP/RACS long-standing presence in the region is an important asset for the regional program. Looking forward to a diminished resource envelope, DFAT should prioritise PIP’s real strength and value which is the provision of SCS accompanied by hands-on training that occurs during the course of a visit.

2. In certain specialty areas, PIP/RACS should be strongly encouraged to engage in more region-wide coordination and to adapt its VMTs accordingly. For example, one area in which others have expanded their service provision is in ophthalmology. Through the work of organisations including the Fred Hollows Foundation and the outreach teams of the Pacific Eye Institute, available services may have expanded to the point that it no longer need be PIP/RACS lead specialty (i.e. in terms of numbers of patients). At the same time, other specialty areas, such as cardiac surgery, are greatly needed yet require very large teams and more specialised equipment. In this areas, PIP/RACS might look to expand its partnership with Open Heart International to expand its service offering through more joint efforts.
3. PIP/RACS training at country and regional level should be increasingly focused on a) country-identified areas of need, and b) in topic areas which RACS is uniquely positioned to provide (e.g. Care of the Critically Ill Surgical Patient or Emergency Management of Severe Trauma). In sum, DFAT might be better served to expect less capacity-building activities from PIP but more higher-value, specialised skills building. The training program should seek to include more opportunities for nurses in specialty training. Finally, numerous Pacific clinicians expressed their clear preference for attachment training – again seen as high-value training with cascading effects when the surgeon return to his/her country.
4. Data reviewed for this evaluation suggest that there may be some underlying, systematic bias affecting who (i.e. gender) gets screened and eventually treated by the PIP VMTs. DFAT should find a means of complementing PIP/RACS skill set in order to delve deeply into this issue for greater clarity and possible remedial action. Similarly, PIP/RACS is not the right institution to examine wider issues of equity but should be partnered with another group or organisation who could look into these issues with appropriate methods.
5. Finally, PIP/RACS should be commended for attempting to gauge the impact to beneficiaries of receiving VMT services. However, the approach adopted appears to generate data which is only slightly better than anecdotal. One means of overcoming this problem is through the creation of a system to monitor patient outcomes. However, developing such a system is outside of PIP/RACS expertise. Building on momentum behind a focus on essential surgical care, DFAT may consider investing in analysis which would allow countries, PIP/RACS and others to estimate the surgical need in-country by specialty and procedure so that they can better gauge the proportion of that need which is addressed.

Annex 1: Terms of Reference

1. Background

Healthy populations are fundamental to economic development in the Pacific and a focus for Australian contributions to reduce hardship and vulnerability in the region. Several countries in the Pacific region are below the minimum health workforce to population ratio determined by the World Health Organization (WHO) as necessary to achieve appropriate standards of universal primary health care (PHC) coverage – noting also that this formula is not ideally adapted to the needs of widely dispersed, small island populations.²⁹ Maintaining a workforce that is suitable for Pacific Island Countries needs (including being ‘fit for purpose’) – in terms of qualifications and size – is also a challenge.

While much of Australia’s investment in improving health outcomes is pursued bilaterally, appropriately targeted regional approaches have an important place in ensuring efficiency, effectiveness, and achieving economies of scale where feasible and appropriate. Regional investments in skilling the health workforce, providing access to specialist health services and working collectively on trans-boundary health challenges – including disease surveillance and policy responses to non-communicable diseases – all contribute strongly to Australia’s interests in the Pacific.

Previous Regional Health Program (RHP) investments in the area of specialised clinical services and health workforce development have tended to follow an “organic”, sometimes *ad hoc* evolution under a multi-project model. This has led to a fragmented collection of partially interdependent activities that do not clearly represent a strategic whole-of-system approach and have contributed to system inefficiencies. The majority of these investments have or are about to end.

In the Regional Health Program Delivery Strategy 2013-2017 (the ‘Delivery Strategy’), support for **‘tertiary care policy, technical support, capacity building and provision’** and **‘specialised health worker training’** has been identified as key area for future regional investment. The rationale for this is the need for support in Pacific Island Countries and Territories (PICTS) to determine a model of health service delivery that is affordable and sustainable in each PICT context. Helping countries determine what clinical services it makes sense to provide locally, versus what are more cost-effectively delivered by visiting teams and/or overseas providers, is a key consideration, and will differ from country to country. Most PICTs are already spending a significant (and, in many cases, an increasing) proportion of their health budgets on off-shore referrals and tertiary clinical services, not leaving much scope to investment in health workforce. DFAT is keen to support PICTs to manage their health expenditure more efficiently and effectively to achieve an appropriate and sustainable balance between primary and preventative health care and tertiary care, including management and development of the associated health workforce.

In noting the ad-hoc approach to investments in the past, a more strategic approach to Australian investment in Specialised Clinical Services and Health Workforce

²⁹ 2.3 (doctors, nurses and midwives) per 1000 people. Papua New Guinea: 0.54 per 1000; Samoa: 1.22 per 1000; Solomon Islands: 2.17 per 1000; and Vanuatu: 1.8 per 1000. Source: Updated data from WHO Country Health Information Profiles (CHIPS), 2011, and WHO HRH Profiles 2012-2013 where available.

11 November 2015

Development is required to ensure the best use of a finite amount of funding. The design process for this next phase of support is planned for 2015. Existing investments that were due to end during 2015 have been extended until December 2015 to allow time for this design process to be undertaken.

It is important to seek up-to-date information about the performance of existing investments before moving forward with the design process. This includes re-evaluating³⁰ some of the key investments in this area to understand past performance of DFAT-funded investments, operating context, gaps and future needs. Key investments are considered to be those with Fiji School of Medicine (FSMed), Pacific Tertiary Health Pacific Islands Project (PIPs; through the Royal Australasian College of Surgeons or RACS) and Strengthening Specialised Clinical Services in the Pacific (SSCSiP). Note that FSMed is currently undergoing a separate independent evaluation by DFAT.

2. Purpose, Objectives and Intended Use of the Evaluation

These Terms of Reference are for an independent evaluation of DFAT's SSCSiP and PIP investments.

The purpose of this assignment is to:

- i. Evaluate (as much as possible) the end-of-program progress towards the stated objectives and outcomes:
- ii. Follow-up on issues identified in previous evaluations and performance assessments³¹, including assessing if the issues remain or if further action is required.
- i. Building on i. and ii., provide recommendations as directed in the Key Evaluation Questions, to help inform DFAT when determining how it could/should support specialised clinical services and health workforce development in the Pacific region from 2016-2020.
- iii. Assess the clinical governance safeguards that these providers have in place, ensuring they are fit for purpose.

The findings of these evaluations will be used to inform the next phase of DFAT's support for specialised clinical services and health workforce development in the Pacific region, including the design of new investment/s in the second half of 2015.

The objectives for this task are to:

- ii. evaluate SSCSiP and PIP, including against (but not limited to) DFAT's quality criteria (relevance, efficiency, effectiveness, sustainability, gender equality, monitoring and evaluation); and

These objectives should be addressed with the awareness that the results of this review will inform future programming in this area.

3. Key Evaluation questions

³⁰ Note that a number of relevant evaluations were undertaken in 2011 to inform the development of the Delivery Strategy. These included evaluations of: FSMed; SSCSiP; Bio-medical Engineering Maintenance Initiative (BEMI); RACS. Two other relevant evaluations on the Kiribati Internship Program and Pacific Regional Blindness Prevention Program (PRBPP) are planned for 2015, although are being undertaken separately to this assignment.

³¹ Including Quality at Implementation reports (now known as Aid Quality Checks or AQC's)
11 November 2015

The independent evaluation team is required to evaluate the programs in a manner that meets the stated objectives of this Terms of Reference and includes consideration and rating of DFAT's quality criteria mentioned previously, with a strong focus on *relevance, effectiveness efficiency and sustainability*. The team is not expected to structure the entire evaluation explicitly around these criteria and is encouraged to take the evaluation approach that they feel is most appropriate to meet the stated objectives of this task.

The following Key Evaluation Questions are intended as a guide only. It is expected that the Evaluation Team will work with DFAT to refine these questions, based on the information needs for the next design phase, so that the evaluation is robust, appropriate and achievable.

Part 1 – Evaluation of SSCSiP

Relevance:

- Assess the continued relevance of the objectives and functions SSCSiP currently performs (noting their role has evolved over time) given the health development context in the Pacific region. Are these functions more relevant to some PICTS (e.g. Melanesia, micro-states) than others? Are they sustainable? What would the impact be on PICTs should funding cease? Provide commentary on whether there is another, more efficient model of providing or supporting those objectives/functions which are deemed necessary in the future.
- Assess the extent to which the activities currently performed by SSCSiP differ from those originally outlined in the design document and why that evolution has taken place? This includes assessing the unofficial functions³² provided by FSMed that are not funded through a specific mechanism, but that are in the specialised clinical services and health workforce development space.
- Assess the process through which SSCSiP determines PICTS needs and demands and ensures alignment with PICTs priorities. Which in-country stakeholder's do they engage with?
- Assess whether SSCSiP's current purpose/objectives, goals, roles, responsibilities and functions duplicate those of PIP, or whether there is potential for duplication?
- Assess the interface between SSCSiP and other functions played by FSMed (e.g. core FSMed work and special projects such as support to the Kiribati Internship Training Program).
- Assess what current SSCSiP functions (including those performed by the Development and Coordination Team; DaCT) are most cost-effectively and efficiently provided regionally? Provide commentary on:
 - the different needs in different sub-regions (e.g. due to economies of scale);
 - how existing relationships between some PICTS and other development countries such as France, USA, NZ affects need and demand for these functions across the region; and
 - how these functions would meet DFAT's strategic targets³³ for the aid program (particularly around aid for trade i.e. building productive

³² That is, those functions which FSMed perform but which are not included in their Strategic Plan or that which is not formally funded by DFAT or other partners.

³³ Strategic target technical notes are provided in reading list.

capacity, engaging the private sector, reducing poverty i.e. through promoting economic growth and empowering women and girls)?

- Assess the contribution of SSCSiP to risk pooling and risk management in access to and the delivery of specialised clinical services. For example, the risk of importation of multi-drug resistant organisms from India or Asia through patients returning after having invasive procedures.

Effectiveness and efficiency:

- Has the increased focus on specialised clinical services generated by SSCSiP had implications for health sector financing? For example, has it raised expectations about the level of clinical services countries should be providing, creating pressure to increase spending on hospital services and/or make it harder to re-direct resources to lower levels of health system?
- Assess whether the objectives and outcomes of SSCSiP, as per the original design document, have been achieved. This includes the following:
 - a. The extent and quality of SSCSiPs support to PICTs for the planning of clinical services, including at the regional/national/facility/team or individuals level as well as in the categories of specialty, resource management (staff, facilities, equipment and supplies) and patient screening. Is this an appropriate function to be performed regionally?
 - b. How SSCSiP has assisted with the elevation of clinical services management as a key priority in PICTs and the region? What are the implications of clinical services not being a regional priority?
 - c. Have the capacity building efforts in PICTs been effective?

Provide commentary on how management of SSCSiP, specifically by FSMed, has impacted on achieving these objectives and outcomes, including whether there are any advantages and limitations arising from this arrangement.

- Assess the extent to which the issues highlighted and recommendations made in the Independent Progress Review (IPR) in 2011 have been addressed, with a focus on SSCSiP's strategic planning.
 - a. appropriate setting and articulating the SSCSiP scope and role/responsibility,
 - b. long and short term planning and implementation processes;
 - c. the use of country and regional governance mechanisms, such as the Heads of Health, Strategic Advisory Group (StAG) and Stakeholder Reference Group (SRG)?
 - i. The use of and interaction between SSCSiP's governance mechanisms (e.g. SRG) and key PICTs mechanisms (e.g. clinical committees³⁴)? Provide commentary on the advantages and disadvantages to current approaches and the opportunities and barriers, including of having a dedicated regional clinical governance mechanism?
 - ii. Expansion of the StAG to include the necessary skillsets?³⁵
 - iii. Resolution of potential conflicts of interest in terms of StAG membership?³⁶
 - iv. Communication and linkages between SRG and StAG.

³⁴ The 2011 MTR noted that PICTs clinical committees could become the Specialised Clinical Services Committee (currently under SSCSiP), given they hold most of the authority in this area, although the current focus of PICT clinical committees is on off-shore referrals.

³⁵ The 2011 MTR noted that the TAG consisted of clinicians only and not others with valuable expertise in planning, capacity building and M&E.

³⁶ The 2011 MTR noted that FSMed staff and health specialists who play a role in FSMed were on the TAG.

- v. The structuring of the SRG so that it allows for dynamic, discursive and meaningful analysis and discussion, including on more strategic matters (instead of operational matters)?³⁷
- d. Reducing the duplication of the scholarship and off-shore medical referrals systems set up by SSCSiP, parallel to that of PICTS.
- e. The approach to capacity building, including: defining and measuring what improved PICT planning capacity looks like; setting appropriate strategies based on this (using a broader definition of capacity building than just skills development and scholarships – including items such as roles, systems, tools, structures, facilities, workloads and leadership); planning and implementing at the country and regional level (including how the former links feeds into the latter). Further, how does their capacity building link in with national competency frameworks and continuing professional development plans?;
- f. SSCSiP data needs and use of the PICT situational analysis undertaken by SSCSiP;
- g. financial management decisions against the core program to ensure the best use of funding sources.
- Assess the extent and appropriateness to which SSCSiP is:
 - a. ensuring equity of access in training provided; and
 - b. promoting equity in service delivery.

Provide commentary on approaches and practices to ensuring equity of access that SSCSiP could implement in a potential next phase of support.
- Are there possible conflicting priorities (such as public health versus hospital care, or the trade-offs between quality and affordability) considered? Provide commentary on how DFAT can further promote a sustainable and demand driven model in a possible next phase of funding.
- Assess the level and appropriateness of clinical governance safeguards employed by SSCSiP, using DFAT's guidance on clinical safeguards.
- Assess DFAT's management of the program and provide commentary on how this can be improved.

Monitoring and Evaluation:

- Review the appropriateness and effectiveness of monitoring and evaluation approaches used by SSCSiP, including how activities are being linked to higher outcomes, the extent to which SSCSiP assess the cost-effectiveness of its support, and the *use* of monitoring and evaluation information.

Gender Equality:

- Determine the extent to which gender equality is considered in SSCSiP activities and assess whether this is appropriate.

Sustainability

- What SSCSiP-related functions are currently being undertaken at the country level and at the regional level? Provide commentary on:
 - the implications of the current status quo on sustainability.
 - the functions which were to be transferred to PICTS as per the original design document³⁸ - which ones were or were not transferred, and why.

³⁷ The 2011 MTR noted that country representatives suggested a less formal forum instead of the structured SRG meeting for these reasons.

- which functions could be appropriately absorbed at the country level.
- how successfully PICTs are undertaking those functions that have transferred across, and how could/should DFAT further support PICTs undertake these functions.

Part 2 – Evaluation of PIP

Relevance:

- Assess whether the services and functions provided by PIP is still relevant to the Pacific region.
- Assess whether RACS is still the relevant provider for PIP³⁹.
- Assess the process through which PIP determines PICTS needs and demands and ensures alignment with PICTs priorities. Which in-country stakeholder's do they engage with? Are there possible conflicting priorities (such as public health versus hospital care, or the trade-offs between quality and affordability) considered? Provide commentary on how DFAT can further promote a sustainable driven model in a possible next phase of funding.
- Assess whether PIP purpose/objectives, goals, governance structures, roles, responsibilities and functions duplicate those of SSCSiP, or whether there is potential for duplication, or to what extent they are complementary? Provide commentary on the quality of interaction between PIP and SSCSiP at the regional level and in countries served by both investments, and the impacts of PIP and SSCSiP's covering different countries in the Pacific.
- Assess whether/how PIP promotes preventative care in its activities, and whether this is an appropriate role for PIP and RACS (instead of Ministries of Health or in-country development partners)?
- Assess whether and how PIP supports Ministries of Health to determine health workforce and training needs and the extent and manner in which it helps to address those needs (including standards/protocols, competencies and licencing, career advancement, continuing professional development and the acquisition of specific skills, given RACS comparative advantage in these areas)? Assess RACS comparative advantage and value-add in this area.
- Is RACS still the most relevant coordinating body for visiting medical teams, including coordinating with other Australian colleges and Pacific clinical organisations?

Effectiveness:

- Assess the cost-effectiveness of (DFAT-funded) regional services and support provided by PIP to PICTS. Provide commentary on whether RACS the most cost-effective provider of these services, as well as a comparison with other visiting team models in the region such as the New Zealand Medical Treatment Scheme which is implemented by Health Specialists Limited⁴⁰.
- Assess the extent to which the issues highlighted and recommendations made in the Independent Progress Review (IPR) in 2001 have been addressed, with a focus on PIP/RACS's strategic planning for PIP.

³⁸ The design document outlined that DaCT will gradually/eventually be absorbed into national health system functions. For example, after the first two years, PICTs will increasingly liaise directly with service providers

³⁹ Note that RACS provides medical indemnity to PIP visiting teams, including other colleges. This was a key consideration in selecting RACS to implement the current phase of PIP.

⁴⁰ Note that an evaluation of the NZ Medical Treatment Scheme was undertaken in 2014.

- a. Linkage of RACS's purpose to the stated goals and objectives of PIP and definition/articulation of the added value of PIP/RACS to the Pacific region.
 - b. Quality of planning and communication with Ministries of Health to determine national priorities and need for visiting teams and the roles/responsibilities of national counterparts.
 - c. Review of the governance model so that it includes PICT representation and a member with knowledge of the Australian Governments aid effectiveness, results-based programming and M&E requirements and methods.
 - d. Strengthened connections and coordination with other organisations providing visiting clinical services, including those provided by other countries such as New Zealand, Taiwan and Cuba.
- Provide commentary on the appropriate timeframe for a potential next phase of support to PIP so that long-term planning can be undertaken.
 - Assess the extent and appropriateness to which PIP is ensuring equity of access⁴¹ to support provided (either in training or service delivery). Provide commentary on the barriers to achieving equity of access and what approaches and practices to ensuring equity of access that PIP could implement in a potential next phase of support.
 - Assess the level and appropriateness of clinical governance safeguards employed by RACS, using DFAT's guidance on clinical safeguards.

Efficiency:

- What are the implications for health sector financing of providing specialised clinical services through visiting teams? For example, does it raise expectations about the level of clinical services countries should be providing, creating pressure to increase spending on hospital services and/or make it harder to re-direct resources to lower levels of health system? Or does it relieve budgetary pressures by providing a service that Governments would otherwise have to pay for directly?
- Assess the extent to which RACS is aware of, and responsive to, the realities of providing high-end services in low-resource environments. What is its approach, and how does it review the effectiveness of this approach?
- Assess the level of coordination of PIP/RACS visiting teams, including with PICTS priorities and schedules and other foreign medical teams (e.g. New Zealand, Taiwan)
- Assess the extent to which improvements have been made to the operational management of visiting teams, including (but not limited to): pre-visit communications and patient screening; developing training and development based on country/health worker needs and the competency frameworks for the specialty; availability of in-country equipment and supplies as well as the transportation/customs clearance of imported medical equipment/supplies; and post-operative care.⁴²
- Assess DFAT's management of the program and provide commentary on how this can be improved.

⁴¹ Equity of access includes consideration of gender, locality (rural vs urban), regional (small island state vs larger PICs), disability, income status etc.

⁴² The 2011 IPR noted issues with organising visits and transportation of medical equipment, relying on personal networks and relationships to resolve issues, rather having set procedures which prevent issues arising in the first place.

Monitoring & Evaluation:

- Assess the appropriateness of the monitoring and evaluation approaches and practices used for PIP. Assess the extent to which improvements have been made since the 2011 IPR, with a focus on implementing methods to measure:
 - a. changes in skills, competence and confidence of training beneficiaries;
 - b. longer-term outcomes and the impact of the program;
 - c. the impact of donated equipment on clinical services (sustainability of recurrent costs, maintenance issues, and availability of local clinical skills for use).
- Assess how performance targets or indicators are being linked with overseas referrals?

Gender Equality:

- Determine the extent to which gender equality is considered in PIP activities and assess whether this is appropriate.

Sustainability:

- Assess the level of sustainability of the support provided by PIP, including its capacity building components.
 - a. Of this, assess the level of capacity building support provided by PIP and the appropriateness of the capacity building approach used to maximise sustainable outcomes⁴³. Provide commentary on the level and approach to capacity building PIP should employ in a potential next phase of support, including whether more support should be provided to particular countries or sub-regions.
- How critical has been the support from SSCSiP to ensure the success of PIP and Australian-funded visiting teams? Are there other ways in which this function could have been better performed?
- What is the level of knowledge of and support for the PIP visiting teams from DFAT bilateral aid programs and heads of missions? In a reduced aid budget scenario that would impact the Regional program's capacity to support PIP to continue to service the numbers of Pacific countries it currently does, to what extent would Pacific bilateral programs see value in co-funding the investment?
- Is PIP adopting a health systems strengthening approach? How has this been translated into its program activities?

4. Key management decisions that the evaluation findings will inform

As stated previously, these evaluations (in addition to the separate evaluation on FSMed and other background analysis) will be used to inform the next phase of DFAT support to specialised clinical services and health workforce development. Based on this, the following management decisions will be required:

- How well the current investments and partners are performing.
- Given the present context and finding of the evaluation:
 - a. are the existing functions fulfilled by SSCSiP and PIP still relevant, and are there other functions that need to be addressed;
 - b. which existing functions should continue after 2015 (under SSCSiP and PIP, or under a different model);

⁴³ This includes looking at any support provided for national competency frameworks and continuing professional development plans.

- c. of these, which ones should DFAT support in the future; and
- d. has RACS and FNU been effective partners.
- Based on the above, what functions/activities, models, partners and delivery modalities should DFAT support in the next phase.

5. Evaluation team

The evaluation team should comprise of:

| Description | Role | Qualifications/experience required |
|-----------------------------|--|---|
| Team Lead | - Manage and direct the evaluation activities, represent the team and lead consultations with government officials and other donor agencies. | Appropriate evaluation qualifications, with approximately 15 years' experience in evaluation and monitoring and evaluation. |
| | - Plan, guide and develop the overall approach and methodology for the evaluation, including preparation of the evaluation work plan. | |
| | - Manage, allocate, compile and edit inputs from other team members to ensure the quality of outputs – including on any aide memoirs, evaluation materials, draft and final evaluation report. | Knowledge of the Pacific aid environment would be highly desirable but not mandatory. |
| | - Represent the team in peer reviews, if required. | Human Resources for Health knowledge would be advantageous. |
| Team Member - consultant | - Provide sufficient health expertise and knowledge to the team, including inputting health knowledge and expertise where necessary and as directed by the Team Lead. | Minimum of 9 years clinical specialised service experience in remote and/or under-resourced settings. |
| | - Provide assistance during evaluation activities, as directed by the Team Lead. | A strong background in undergraduate and/or internship training, clinical workforce capacity development and CPD mechanisms, clinical governance and knowledge of regulatory, registration and accreditation mechanisms, is preferable. |
| | - Provide technical health input into, and quality assure, the robustness of findings in the draft and final reports | Knowledge of the Pacific aid environment (including around health service delivery, broader |

| Description | Role | Qualifications/experience required |
|-----------------------------------|---|---|
| | as directed by the Team Leader. | health workforce development and small island developing states) would be highly desirable. |
| Team Member - DFAT representative | <ul style="list-style-type: none"> - Provide input (dialogue, analysis and writing) as necessary, to be determined in consultation with the team lead. - Provide advice, relevant documentation from DFAT and an understanding of DFAT processes; - Engagement of senior DFAT officials and other government officials in the evaluation and design process, as is required. | - |

In addition to the evaluation team, the following members will be required to provide technical inputs and advice as outlined under **7. Evaluation Timeframes and Methods**.

These members are a part of DFAT's Reference Group for Specialised Clinical Service and Health Workforce (Reference Group), rather than the evaluation team. The Reference Group for Specialised Clinical Service and Health Workforce is an advisory group convened by DFAT to inform and provide technical expertise. Members include the DFAT Regional Health Team, DFAT Pacific Division Health Specialist and two consultants with expertise in specialised clinical services and health workforce development.

These members of the Reference Group may also provide quality assurance and technical oversight to the development of analytical pieces of work undertaken by DFAT or others to support the evaluation process.

| Description | Role |
|--------------|--------------------------------------|
| Rob Condon | Consultant - Public Health Physician |
| James Buchan | Consultant – Health Workforce expert |

6. Quality Assurance Requirements

The draft evaluation report will be reviewed by DFAT prior to finalisation. Specific areas to be reviewed are:

- Compliance with this Terms of Reference and evaluation plan prepared by the Team Leader
- Alignment with DFAT's Monitoring and Evaluation Standards
- The quality of the evaluation content – assessed through a peer review (including by relevant DFAT officers and the Reference Group⁴⁴ for the Specialised Clinical Services and Health Workforce).

⁴⁴ Membership of the Reference Group consists of the DFAT Regional Health Team, DFAT Pacific Division Health Specialist and the two consultants outlined above that have expertise in specialised clinical services and health workforce development.
11 November 2015

7. Evaluation Method and Timeframes

The evaluation is expected to commence on **15 June 2015** with the final report completed prior to **9 October 2015**.

| Activity | Completion date/s (approx.) | Indicative number of days | | | | Team Outputs |
|---|-----------------------------|---------------------------|-----|---|---|---|
| PREPARATION PHASE | | | | | | |
| Desk review of relevant documentation and relevant follow up teleconferences ⁴⁵ . | 15-19 June 2015 | 3 | 3 | 0 | 0 | - |
| Virtual briefing of evaluation team in CBR with DFAT and the Reference Group, including a discussion on the guiding Key Evaluation Questions in this ToR. For the Reference Group members, this will require travel to CBR for one day. | 22 June 2015 | 1 | 1 | 1 | 1 | - |
| Evaluation team planning meeting (location/format to be determined by evaluation team). | 23 June 2015 | 1 | 1 | 0 | 0 | - |
| Team to prepare and submit to DFAT a draft evaluation work plan, including: <ul style="list-style-type: none">- Confirmed evaluation questions- Proposed process for evaluation including schedules of any evaluation mission/s (see stakeholder consultation section)- Outlining the methodology, how the specific evaluations questions will be addressed, and identify key respondents and further documentation as required- Stakeholder consultation including PICTS to be visited. | 24 June – 8 July 2015 | 3 | 3 | 0 | 0 | Draft Evaluation Work Plan (max 10 pages) due 8 July 2015 |
| Feedback provided by DFAT and | 9-17 July | 3 | 1.5 | 1 | 1 | Final |

⁴⁵ The evaluation team should teleconference with the relevant New Zealand Ministry of Foreign Affairs and Trade regarding the Medical Treatment Scheme evaluation which was released in April 2015.

| Activity | Completion date/s (approx.) | Indicative number of days | | | | Team Outputs |
|---|------------------------------|---------------------------|----------|---|---|---|
| the Reference Group for the Specialised Services and Health Workforce, with a teleconference between DFAT and the evaluation team to discuss final evaluation questions. | 2015 | | | | | Evaluation Work Plan Due 17 July 2015 |
| Evaluation work plan finalised prior to in-country visits. | | | | | | |
| Undertake in-country visits to meet with DFAT staff, implementing organisations, key development partners and beneficiaries as appropriate. Tentative travel schedule is: | | | | | | |
| - Melbourne: 20 July | | | | | | |
| - Fiji: 21 to 30 July | 20 July – 14 August 2015 | 25 (TBC) | 25 (TBC) | 0 | 0 | (Evaluation Mission) |
| - Samoa: 31 July to 6 August | | | | | | |
| - Solomon Islands: 7 to 13 August | | | | | | Aide Memoires |
| This may include the presentation of an Aide Memoire on the findings and points for team discussion to DFAT post on the final day of each country mission. | | | | | | |
| Preparation and submission of one draft evaluation report (with separate sections for each evaluation). | 15 August – 1 September 2015 | 5 | 3 | 0 | 0 | Draft Independent Evaluation Report (max 25 pages) due 1 September 2015 |
| Preliminary DFAT feedback provided on draft evaluation report with suggested changes considered and amended if appropriate. | 2 September 2015 | 1 | 1 | 1 | 1 | Amendments made by OOB 7 September 2015 |
| Formal DFAT feedback on evaluation report provided (i.e. that from peer review) and | 7-11 September 2015 | 2 | 1 | 1 | 1 | Final Independent Evaluation |
| 11 November 2015 | | | | | | |

| Activity | Completion date/s (approx.) | Indicative number of days | | | | Team Outputs |
|--|------------------------------|---------------------------|-----------|----------|----------|--|
| amendments made if appropriate. | | | | | | Report due 30 September 2015 |
| Virtual briefing to DFAT, Reference Group for the Specialised Clinical Services and Health Workforce and design team ⁴⁶ on the evaluation findings. For the Reference Group members, and possible the design team, this will require travel to CBR for one day. | No later than 9 October 2015 | 0.5 | 0.5 | 1 | 1 | Presentation of findings by 9 October 2015 |
| TOTAL NO. OF DAYS | | 44.5 | 40 | 5 | 5 | |

8. Stakeholders consultations to be undertaken

The evaluation team will be responsible for leading the agreed consultations with stakeholders. While the list of stakeholders to be consulted will be finalised in the agreed evaluation plan, it is anticipated that the following stakeholders will be consulted at a minimum:

DFAT staff

- DFAT staff at the posts (TBC; Fiji, Solomon Islands, Samoa)
- DFAT staff in Canberra, including:
 - o Rebecca Dodd, Director, Pacific Health Advice, Pacific Division
 - o Members of the Health, Education and Sport Section, Pacific Division

SSCSiP Stakeholders

- Fiji School of Medicine
- Relevant governance groups (e.g. SSCSiP SRG, SSCSiP TAG)
- SSCSiP in-country coordinators
- Relevant senior Ministries of Health of the following countries (TBC):
 - o Fiji
 - o Solomon Islands
 - o Samoa
- New Zealand Ministry of Foreign Affairs and Trade

PIP Stakeholders

- Relevant senior Ministries of Health of the following countries (TBC):
 - o Fiji
 - o Solomon Islands
 - o Samoa

⁴⁶ A design team will be engaged in July/August to undertake the design of Australia's future support to Specialised Clinical Services and Health Workforce. Note. the draft findings of the report submitted on 27 August will be provided to the design team for their background /preparation for the design.

- RACS (likely the Melbourne office)
- Health Specialists Limited, as the implementing partner of New Zealand's Medical Treatment Scheme
- Other relevant entities such as Taiwan's visiting medical team coordinator

Face to face consultations should be conducted. However, where not feasible, consultations can be conducted through tele-interviews.

9. Suggested reading

- RACS design document
- SSCSiP design document
- 2011 Independent Progress Report on SSCSiP
- Independent Progress Report – Pacific Tertiary Health Program – Phase III Bridging/Transition Phase (Pacific Islands Project)
- Synthesis of learning from Reviews of AusAID's Pacific Regional Health Programs 2010-2012
- Quality at implementation reports for SSCSiP and RACS
- DFAT Aid Policy
- DFAT's Health Strategy
- Strategic Target technical notes
- DFAT's Monitoring and Evaluation Standards
- DFAT Guideline: manage an evaluation
- Other documents as advised by DFAT
- New Zealand Medical Treatment Scheme Evaluation Report

Reference Guides

- Aid Programming Guide
- Regional Health Program Delivery Strategy
- Pacific Framework for Regionalism
- DFAT M&E Standards

Annex 2: Evaluation Objectives, sub-objectives and key questions

Objective 1: Objective 1: Evaluate SSCSiP against quality criteria including relevance, efficiency, effectiveness, sustainability, gender equality, monitoring and evaluation

| | |
|---|---|
| <p><i>Sub-objective 1.1: Assess the continued relevance of the SSCSiP in regards to program design, needs of the population in PICTs and other investments in specialised clinical services.</i></p> | <p>1.1 To what extent are SSCSiP's objectives and functions, as currently performed, relevant given the health development context in the Pacific region (noting their role has evolved over time)? To what extent are some functions more or less relevant given the changing context?</p> |
| | <p>1.2 Are current SSCSiP functions more relevant to some counties in the region than others (e.g Melanesia, micro-states)?</p> |
| | <p>1.3 Are there other, more efficient models of providing or supporting those SSCSiP objectives/functions currently undertakes? If so, what are those other models?</p> |
| | <p>1.4 Of those functions with continued relevance, which SSCSiP functions (including those performed by the DaCT) most cost-effective and efficient as regionally-provided support?</p> |
| | <p>1.5 What process(es) is used by SSCSiP to determine country needs and demands and to ensure alignment with country priorities? Which in-country stakeholders do they engage with? Which regional stakeholders do they consult and in what manner?</p> |
| | <p>1.6 Is there potential for duplication between SSCSiP's current purpose/objectives, goals, roles, responsibilities and functions and those of PIP? If so, to what extent has such duplication actually occurred</p> |
| <p><i>Sub-objective 1.2: Assess the effectiveness and efficiency of the SSCSiP in relation to its performance against design, needs of the population of PICTs, and previous external assessments</i></p> | <p>1.7 To what extent have the objectives and outcomes of SSCSiP, as per the original design document, been achieved? To what extent and with what quality has SSCSiP supported PICTs to plan for clinical services tailored to country need in terms of levels, category of specialty, and functional area? Is this an appropriate function to be performed regionally?</p> |
| | <p>1.8 How has management of SSCSiP, particularly by CMNHS, impacted on achievement of objectives and outcomes? What are advantages and limitations arising from this arrangement? To what extent has achievement of the objectives been affected by evolving focus of the project? To what extent and how has the SSCSiP implementing team managed competing demands e.g. priorities of the FNU?</p> |
| | <p>1.9 To what extent have issues highlighted and recommendations made in the IPR (2011) been addressed with specific focus on SSCSiP's strategic planning?</p> |
| <p><i>Sub-objective 1.3: Assess the performance of SSCSiP in regards to</i></p> | <p>1.10 To what extent are the monitoring and evaluation approaches used by SSCSiP appropriate and effective? Are activities linked to higher outcomes and managed accordingly? To what extent can SSCSiP assess the cost-effectiveness of its support</p> |

| | |
|--|---|
| <i>sustainability, monitoring and evaluation and gender equality</i> | 1.11 In regards to gender equality, to what extent is gender equality considered in SSCSiP activities? Is the gender-focus considered to be appropriate? |
| | 1.12 To what extent are SSCSiP-related functions currently being undertaken at the country level and at the regional level? Would countries be ready to take over planning and management of SCS as planned? Do they have the policies and governance/financing frameworks in place to do so? |

Objective 2: Evaluate PIP including against quality criteria including relevance, efficiency, effectiveness, sustainability, gender equality, monitoring and evaluation

| | |
|---|--|
| <i>Sub-objective 2.1: Assess the continued relevance of the Pacific Islands Project / RACS in regards to program design, needs of the population in PICTs and other investments in specialised clinical services</i> | 2.1 To what extent are the services and functions provided by PIP still relevant to the Pacific region? |
| | 2.2a Given the relevance of the services and functions performed, what are options for service providers? How might services providers be assessed as “fit for purpose”? |
| | 2.2b In regards to coordination of visiting medical teams, including Australian colleges and Pacific clinical services organisation, what are potential options and what is the relevance of RACS vis-à-vis those other options? |
| | 2.3a To what extent does PIP support Ministries of Health to determine health workforce and training needs? |
| | 2.3b To what extent does and in what manner does PIP helps to address those needs? |
| | 2.3c To what extent does RACS have a comparative advantage and value-added in the area of health workforce and training needs? |
| <i>Sub-objective 2.2 Assess the effectiveness and efficiency of the PIP in relation to cost-effectiveness, equity of access, clinical governance safeguards, strategic planning, health systems strengthening, and gender equality.</i> | 2.4 Assess the value for money derived from DFAT-funded regional services and support provided by PIP to PICTS. |
| | 2.5 To what extent does PIP ensure equity of access in the support provided, either in training or service delivery? To what extent are these efforts appropriate to the need? |
| | 2.6 What are barriers to achieving equity of access? In the next phase, what approaches and practices might PIP employ to ensure equity of access? |
| | 2.7 To what extent are clinical governance safeguards employed by RACS based on DFAT’s guidance on clinical safeguards? What form of guidance on clinical safeguards is most commonly used? |
| | 2.8 To what extent are there unintended consequences of providing specialised clinical services through visiting teams to health workforce development health sector financing? |
| | 2.9 To what extent are the monitoring and evaluation approaches and practices used for PIP appropriate and effective? Is there evidence of management follow-up action taken as a result of M&E? |

| | |
|--|--|
| | <p>2.10 To what extent have improvements been made since the 2011 IPR? with a focus on implementing methods to measure:</p> <ul style="list-style-type: none"> • changes in skills, competence and confidence of training beneficiaries; • longer-term outcomes and the impact of the program; • impact of donated equipment on clinical services (sustainability of recurrent costs, maintenance issues, availability of local skills for use)? <p>2.11 In regards to sustainability, to what extent is the support provided by PIP, including its capacity building component, sustainable?</p> <p><input type="checkbox"/> Of this, assess the level of capacity building support provided by PIP and the appropriateness of the capacity building approach used to maximise sustainable outcomes.</p> <p><input type="checkbox"/> Provide commentary on the level and approach to capacity building PIP should employ in a potential next phase of support, including whether more support should be provided to particular countries or sub-regions.</p> <p>2.12 To what extent is gender equality considered in PIP activities? Have gender equality considerations been handled appropriately?</p> |
|--|--|

Annex 3: Individuals interviewed

| Individual consulted | Position/Title | Organisation |
|------------------------|---|---|
| Sheona McKenna | Counsellor (health) | Australian High Commission |
| Paulini Sesevu | Senior Program Officer | Australian High Commission |
| Frances Bingwor | Program Officer | Australian High Commission |
| Solstice Middleby | Counsellor (Australian Aid Programs) | Australian High Commission |
| Rodney Yee | Senior Program Manager, Health - bilateral | Australian High Commission |
| Margaret Vuiyasawa | Suva bilateral health team | Australian High Commission |
| Marleen Nelisse | Regional Program Manager | Fred Hollows, New Zealand |
| Lily Anne Homasi | Senior Program Manager, Tuvalu | Australian High Commission |
| Rosalyn Morgan | Senior Manager Scholarships - Bilateral | Australian High Commission |
| Lorissa Hazelman | Program Manager-Australia Awards | Australian High Commission |
| Margaret Twomey | High Commissioner | Australian High Commission, Fiji |
| Rosemary McKay | Deputy High Commissioner and Counsellor Development | Australian High Commission, Samoa |
| Gardenia Elisaia | | DFAT Samoa |
| Kassandra Betham | | DFAT Samoa |
| Dr. Meciusela Tuicakau | Acting Permanent Secretary | Ministry of Health and Medical Services |
| Dr. Neil Murray | | Fred Hollows |
| Dr. Mundi | Outreach Program | |
| John Setzu | Program Medical Director | |
| Susan Ivatts | Senior Health Specialist | World Bank Pacific Department |
| Sinead Kato | | |
| Mabel Taoi | Project Coordinator | FNU/SSCSiP |

| Individual consulted | Position/Title | Organisation |
|----------------------|---|---|
| Dr. Berlin Kafoa | FNU/CMNHS Director Projects Unit | FNU/SSCSiP |
| Nehal Karpadia | Bio-Medical Engineer | SSCSiP/FNU |
| Sireli Kaloucara | Consultant, urologist | Head of Department General Survey, CWMH |
| Dr. Alan Biribo | Neurosurgeon | CMWH |
| Dr. Anaseini Cama | Prevention of Blindness Coordinator | International Agency for the Prevention of Blindness, Pacific Island Sub Region Secretariat |
| Dr. Jojani Malani | Associate Professor | FNU/CMNHS; World Gastroenterology Organization, International Medicine Society of the Pacific |
| Dr. Mai Ling Permal | Assistant Professor | FNU/CMNHS; World Gastroenterology Organization |
| Dr. Paula Vivili | Director, Public Health Division | Secretariat of the Pacific Community |
| Paulini Qica | Acting Head of S. | FNU College of Nursing |
| Senimela Hatogo | | FNU College of Nursing |
| Dolores Hill | | FNU College of Nursing |
| Dr. Ezekiel Nukuro | Technical Officer, Human Resources and Health Systems | World Health Organization, Suva |
| Dr. Eddie McCaig | Member, StAG and clinical advisor | FNU CMNHS |
| Dr Sereima Bale | Member, StAG and clinical advisor | FNU CMNHS |
| Dr. William May | Heads, Department of Medical Sciences, (acting) Dean, FNU | FNU |
| Dr. Leenu Maimanuku | | Oral Health Pacific Advisory Forum Meeting |
| Dr. Joan Lal | | Oral Health Pacific Advisory Forum Meeting |
| Dr. Luisa Cikamatana | Deputy Secretary Hospital Services | MoHMS |
| Dr. Wayne Irava | Coordinator, Center for | FNU |

| Individual consulted | Position/Title | Organisation |
|-------------------------------|--|---------------------------------|
| | Health Information, Policy and Systems Research | |
| Dr. Shyama Janaka Mahakalanda | Co-ordinator CHIPSR Nodal Hub | FNU |
| Margaret Leong | Manager, Nursing | CWMH |
| Dr. J. Tudravu | Medical Superintendent | CWMH |
| Manjula Lal | | MoHMS |
| Raymond St. John | SCS Coordinator | MoHMS |
| Dr. Anisi Kavoa | MMED, anaesthesia | FNU/CMNHS; CWMH |
| Rakei Kaarira | MMED, pediatrics | FNU/CMNHS; CWMH |
| A. Vakamoree | MMED, OB/GYN | FNU/CMNHS; CWMH |
| Ronal Kumar | MMED, surgery | FNU/CMNHS; CWMH |
| KiKi Maoate | PIP Project Director (volunteer) | RACS |
| David Watters | | RACS |
| Daliah Moss | Director, External Affairs | RACS |
| Lito de Silva | Manager, Global Health | RACS |
| Kate Newall | Senior Program Officer | RACS |
| Liz Mcleod | Chair, Sub-committee on M&E | RACS |
| Virisila Livicala | Bio-medical engineer | CWMH |
| Dr. Take Nasri | Director General | Ministry of Health, Samoa |
| Gaulofa Matalavea | Assistant Chief Executive Officer, Health Sector Coordination, Resourcing and Monitoring | Ministry of Health, Samoa |
| Leota Laki-Sio | General Manager | National Health Services, Samoa |
| Noel Kitto | Biomedical Engineer | National Health Service, Samoa |
| Dr. Ben Matalavea | Manager, Clinical Services | National Health Service, Samoa |
| Dr. Ponifasio Ponifasio | Head, Department of Surgery | National Health Service, Samoa |
| Dr. Penehuro Tapelu | Head, Department of Emergency and Outpatient Services | National Health Service, Samoa |

| Individual consulted | Position/Title | Organisation |
|-----------------------|---|--------------------------------|
| Dr. Francis Maru | Head, Department of Obstetrics and Gynecology | National Health Service, Samoa |
| Dr. Farah Maru | Head, Department of Pediatrics | National Health Service, Samoa |
| Dr. Tamara Nowell | Senior Medical Registrar | National Health Service, Samoa |
| Mr. Faleata Savea | Manager, Allied Health & Other Support Services | National Health Service, Samoa |
| Ms. Hinauri Leaupepe | Manager, Laboratory Services | National Health Service, Samoa |
| Ms. Leoti Lafoa'i | Manager, Human Resources | National Health Service, Samoa |
| Ms. Maatasese Matthes | Manager, Nursing and Midwifery | National Health Service, Samoa |
| Joan | Principle Nurse | TTM Hospital, Samoa |
| Iobi Batio | Senior Program Manager | DFAT Post Kirabati |
| Lavea'I Ioane | Development Program Manager | MFAT |

Annex 4: Interviewees by type of organisation

Table 1 Interviewees by type of organisation

| Organisation | Interviewees |
|--|--------------|
| DFAT (regional and mission staff) | 19 |
| Implementers (FNU/CMNHS and RACS) | 12 |
| MoH/NHS | 18 |
| Clinicians/hospital personnel | 24 |
| Regional partners (e.g. World Bank, World Health Organization, Fred Hollows Foundation, and professional associations) | 13 |

Annex 5: Documents reviewed

Anderson I. 2013. Health care financing in Vanuatu: Challenges and options. 2013 The International Bank for Reconstruction and Development / The World Bank.

Anderson I. 2013. Health care financing in Samoa: Challenges and options. 2013 The International Bank for Reconstruction and Development /The World Bank. September.

Blick G and J Smith. 2015. Evaluation of the New Zealand Medical Treatment Scheme. Sapere Research Group. 13 March.

Campbell J, Braithwaite JA, Buchan J and J McKimm. 2011. Strengthening of Specialized Clinical Services in the Pacific. September 21.

Campbell J, Braithwaite JA, Buchan J and J McKimm. 2011. Pacific Tertiary Health Program – Phase III Bridging/Transition Phase ('Pacific Islands Project'). Independent Progress Report. 4 November.

Department of International Development. 2011. DFID's approach to value for money. July.

Department of Foreign Affairs and Trade. 2013. Pacific Regional Health Program Delivery Strategy 2013 – 2017. December

Department of Foreign Affairs and Trade. 2014. Monitoring and Evaluation Standards. June.

H. T., P. Donkor, A. Gawande, D. T. Jamison, M. E. Kruk, and C. N. Mock, editors. 2015. Essential Surgery. Disease Control Priorities, third edition, volume 1. Washington, DC: World Bank. doi:10.1596/978-1-4648 -0346-8. License: Creative Commons Attribution CC BY 3.0 IGO.

Fiji Ministry of Health. Fiji specialised clinical services manual. 2013

Fiji Ministry of Health. Visiting team exit report form (Template).

Fiji Ministry of Health. Terms of Reference. Visiting Medical Teams Fiji (VMTF). No date.

Fiji Ministry of Health. Terms of Reference for Visiting Medical Teams (Template).

Fiji Ministry of Health. Check list for reviewing readiness for visiting teams (Template).

Fiji Ministry of Health. Debriefing report for visiting medical teams to local facility (Template).

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. 2011. Situational analysis of specialised clinical services in Niue-2010. August.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific . 2011. Situational analysis of specialised clinical services in Cook Islands -2010. August.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. 2011. Situational analysis of specialised clinical services in the Republic of Kiribati-2010. August.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. 2011. Situational analysis of specialised clinical services in the Republic of Naurui-2010. August.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. 2011. Situational analysis of specialised clinical services in the Solomon-2010. August.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. 2011. Situational analysis of specialised clinical services in Tokelau 2010. August.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. 2011. Situational analysis of specialised clinical services in the Kingdom of Tonga-2010. August.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. 2011. Situational analysis of specialised clinical services in Vanuatu-2010. August.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. 2012. Situational analysis of specialised clinical services in the Republic of Fiji – 2010-2012. April.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. SSCSiP Progress Report for the period January-December 2012.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. Mapping of clinician's profiles in 14 Pacific island Countries. 2012.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. 2013. Situational analysis of specialised clinical services in the Federated States of Micronesia-2011.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. 2013. Situational analysis of specialised clinical services in the Republic of the Marshall Islands-2011.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. 2013. Situational analysis of specialised clinical services in the Republic of Palau-2011.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. SSCSiP Annual Report. July 2012-June 2013.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. 2013. Pacific biomedical standards. Standards for Managing Biomedical Services in the Pacific Region.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. Report 2013.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. Monitoring and Evaluation Plan. 24/07/2014.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. Progress Report for the period January-December 2014.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. SSCSiP Progress & Narrative Report. July-December 2014.

Fiji National University. College of Medicine, Nursing and Health Services Sponsored students from 2008 to 2013. No date.

Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. Briefing Note for the independent review. No date.

Irava W. Comparing costs of cardiac treatment between government, private insurance, and visiting cardiac teams. Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. No date.

Irava W, Mahalakanda S, Prasad R. A Situational analysis and Assessment of the Overseas Patient Referral Systems in four Pacific Islands Countries. Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific No date.

Irava W, Mahalakanda S, Prasad R. A Situational Analysis and Assessment of the Overseas Patient Referral Systems in four Pacific Islands Countries. Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. Presentation. No date.

Strengthening of Specialized Clinical Services in the Pacific 2010-2014. 2010. Final Program Design Document. May.

SSCSiP-RACS-PIP. Joint Report. January-December 2013.

Kirition R. 2012. Sponsors for students enrolled in FNU's MBBS and Post Graduate Clinical Programs. Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. November 26.

Kirition R. A review of the cost, safety & quality of health care in Indian medical tourism hospitals. . Fiji National University. College of Medicine, Nursing and Health Services. Strengthening of Specialized Clinical Services in the Pacific. No date.

Government of Australia. AusAID. 2013. Quality at Implementation Report for INK590 Pacific Specialized Clinical Services. Approval date: March 15

Government of Australia. AusAID. 2013. Quality at Implementation Report for INJ833 Tertiary Health-Pacific Island Project. Approval date: 15 March.

Government of Australia. Department of Foreign Affairs and Trade. 2013. Pacific Regional Health Program Delivery Strategy 2013-2017. December 2013.

Government of Australia. AusAID. 2014. Quality at Implementation Report for INK590 Pacific Specialized Clinical Services Approval date: March 14.

Government of Australia. DFAT. 2014. Quality at Implementation Report. Tertiary Health-Pacific Island Project. Approval date: 14 March.

Government of Australia. Australian Institute of Health and Welfare. Australia's Hospitals 2013-2104. At a glance.

Grant Agreement Deed between Commonwealth of Australia and Royal Australasian College of Surgeons for Tertiary Health Services for Pacific Islands Countries. AUSAID Agreement 63683. 2012.

Meara JG, Leather AJM, Hagander L. Lancet Commission. 2015. Global Surgery 2030: evidence and solutions for achieving health, welfare, and economic development. The Lancet. Published Online. April 27, 2015. [http://dx.doi.org/10.1016/S0140-6736\(15\)60160-X](http://dx.doi.org/10.1016/S0140-6736(15)60160-X).

Mock CN, Donkor P, Gawande A, Jamison DT, Kruk ME, Debas HT. DCP3 Essential Surgery Author Group. 2015. Essential surgery: key messages from Disease Control Priorities, 3rd edition. Published Online February 5, 2015. [http://dx.doi.org/10.1016/S0140-6736\(15\)60091-5](http://dx.doi.org/10.1016/S0140-6736(15)60091-5)

Ollier L. 2015. Guidance Note on incorporation of Clinical Governance in the management of contracts and programs involving clinical service delivery. Health Resource Facility. Mott MacDonald (Mott MacDonald Australia Pty Ltd). 12 January.

Pacific Islands Forum Secretariat. 2014. The Framework for Pacific Regionalism.

Report Essential Pain Management (EPM) Workshops. National Referral Hospital, Honiara, Solomon Islands. Monday 31st June & Tuesday 1st July 2014.

Royal Australasian College of Surgeons. PIP End-of-Visit Reports:

- Urology, Solomon Islands, 13 - 22 March 2014
- Gynecology, Solomon Islands, 30 March – 08 April 2014
- General Surgery, Solomon Islands, 10 – 24 April 2014
- ENT surgery, Fiji, 23 – 27 June 2014
- ENT surgery, Solomon Islands, 17 – 31 July 2014
- Orthopedic surgery, Samoa, 07 - 17 September 2014
- Plastics and Reconstructive, Interplast Solomon Islands, 25 July – 08 August 2014
- Pediatrics surgery, Fiji, 21-26 September 2014
- Pediatrics surgery, Solomon Islands, 25 November - 03 December 2014

- Ophthalmology, Samoa, 17 – 21 March 2014
- Cardiac surgery, Open Heart International, Fiji, March 21 – April 6, 2014
- Plastics and Reconstructive, Interplast, Samoa, 19 October – 1 November 2014
- Plastics and Reconstructive, Interplast, Fiji, 02 - 15 November 2014
- ENT surgery, Samoa, 06 – 17 October 2014
- Paediatric Endocrinology, Fiji, Colonial War Memorial Hospital, Suva (28 – 30 April 2014), Lautoka Hospital, Lautoka (01 & 02 May 2014)
- Paediatric Nephrology, Fiji, Colonial War Memorial Hospital, Suva (14 – 16 July 2014), Lautoka Hospital, Lautoka (17 & 18 July 2014)
- Obstetrics and Gynaecology, Solomon Islands, Kilu'ufi Hospital, Auki, Malaita Province, 28 July – 02 August 2014

Royal Australasian College of Surgeons. PIP Training Attachment Reports (Template and Reports):

- Obstetrics and Gynaecology, Solomon Islands, Kilu'ufi Hospital, Auki, Malaita Province, April 22 to April 29 2015;
- Pediatric surgery, Vanuatu, 18 – 24 September;
- Orthopedics, Port Vila, 14 – 23 July 2014;
- ENT, Head and Neck surgery, Port Vila, 5th – 14th August 2014

Royal Australasian College of Surgeons. PIP Professional Development Activity Report (Template)

Royal Australasian College of Surgeons. PIP. Surgical Safe Checklist/Operations Records.

Royal Australasian College of Surgeons. PIP. Feedback Report. (Template and Reports):

- Orthopedics, Tupua Tamasese Meaole Hospital , Apia Samoa; 8th Sept – 17th Sept 2014
- Ophthalmology, Yap State, January 12-18, 2014
- Pediatric Surgery, CWMH, Suva, Fiji, 21 – 26 September 2014
- Renal, Narau, 4th – 11th July 2013
- ENT, Samoa, 6/10/14 - 17/10/14

Royal Australasian College of Surgeons. PIP. Serious Adverse Event Report. (Template)

Royal Australasian College of Surgeons Tertiary Health Services (Pacific Island Countries). AusAID Agreement 63683. Progress Report. July – December 2012.

Royal Australasian College of Surgeons. Tertiary Health Services (Pacific Island Countries). Agreement 63683. Year 1 Annual Report. July 2012 – June 2013.

Royal Australasian College of Surgeons. Tertiary Health Services (Pacific Island Countries). Agreement 63683. Progress Report. July – December 2013.

Royal Australasian College of Surgeons. Tertiary Health Services (Pacific Island Countries). Agreement 63683. Annual Report. July 2013-June 2014.

Royal Australasian College of Surgeons. Tertiary Health Services (Pacific Island Countries). Agreement 63683. Progress Report. June – December 2014.

Royal Australasian College of Surgeons. Tertiary Health Services (Pacific Island Countries). Agreement 63683. Annual Report. July 2014-June 2015.

Royal Australasian College of Surgeons. Pacific clinician involvement in surgeries conducted during PIP visits by country and reporting period. Prepared on request for evaluation. 2015.

Royal Australasian College of Surgeons. PIP information requested by DFAT review team. August 2015

Samoa National Health Services. Annual NHS Forum 2015. Clinical Health Services. Leituala Dr B Matalavea. 20th–22nd May 2015. Presentation.

Samoa National Health Services. Annual NHS Forum 2015. Surgery. Dr. Ponifasio Ponifasio. Head of Surgery. 20th–22nd May 2015. Presentation.

Sesuvu P, Austen A, Bingwor F. 2013. Synthesis of learning from reviews of AUSAID's Pacific regional health programs 2010-2012. AUSAID. Suva Post.

SSCSiP. Report of the 3rd SSCSiP Stakeholder Reference Group Meeting. 30th May-1st June 2012. Nadi Fiji.

SSCSiP. Stakeholder Reference Group Meeting. Meeting Recommendations. 2013.

SSCSiP. Stakeholder Reference Group Meeting. Meeting Recommendations. 2014.

SSCSiP. Stakeholder Reference Group Meeting. Meeting Recommendations. 2015.

SSCSiP. Project Mission Report. Perioperative Mortality Rate/Ratio calculation in a Pacific Island Setting: the case of Tonga. 28-31 January 2014.

Secretariat of the Pacific Community and WHO. 2013. Tenth Pacific Health Ministers Meeting. 26 June 2013. Apia, Samoa. 2–4 July 2013. Agenda Item 4: From Honiara to Apia: Report On Progress And Challenges.

Secretariat of the Pacific Community and WHO. 2013. Tenth Pacific Health Ministers Meeting. 2-4 July 2013. Apia, Samoa. Health Workforce Development in the Pacific.

World Health Organization. WHO guidelines for safe surgery 2009 : safe surgery saves lives. 2009. WHO/IER/PSP/2008.08-1E.

World Health Organization. 2013. Human Resources for Health. Country Profiles. Vanuatu.

World Health Organization. 2013. Human Resources for Health. Country Profiles. Kiribati.

World Health Organization. 2013. Human Resources for Health. Country Profiles. Tokelau.

World Health Organization. 2014. Human Resources for Health. Country Profiles. Tonga.

World Health Organization. 2014. Human Resources for Health. Country Profiles. Solomon Islands.

World Health Organization. 2009. WHO guidelines for safe surgery. www.thelancet.com. Published online April 27, 2015.

World Health Organization. Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage. Draft resolution proposed by Australia, Kenya, Monaco, Nigeria, Rwanda, Senegal, Ukraine, United States of America and Zambia. 2015. Executive Board. 136th session. Agenda item 10.1. EB136/CONF./1. 26 January 2015.

Annex 6: SSCSiP result hierarchies per original design document and revised M&E Plan

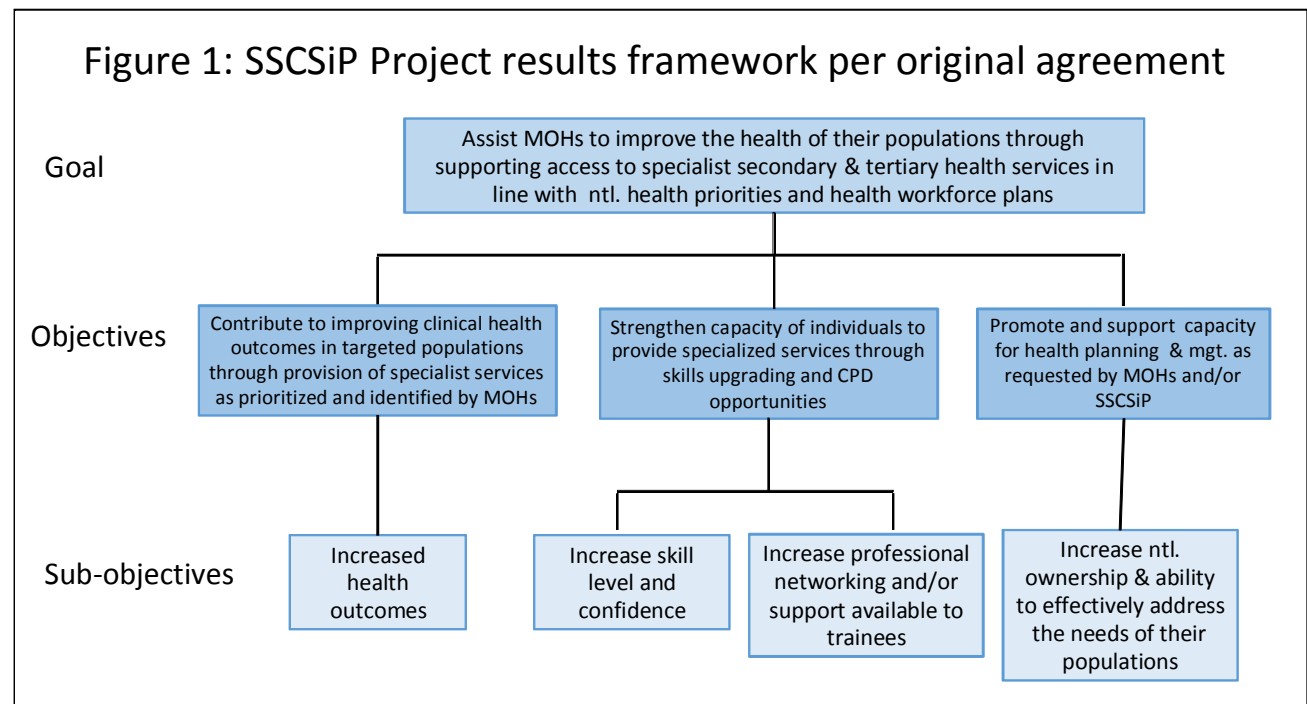
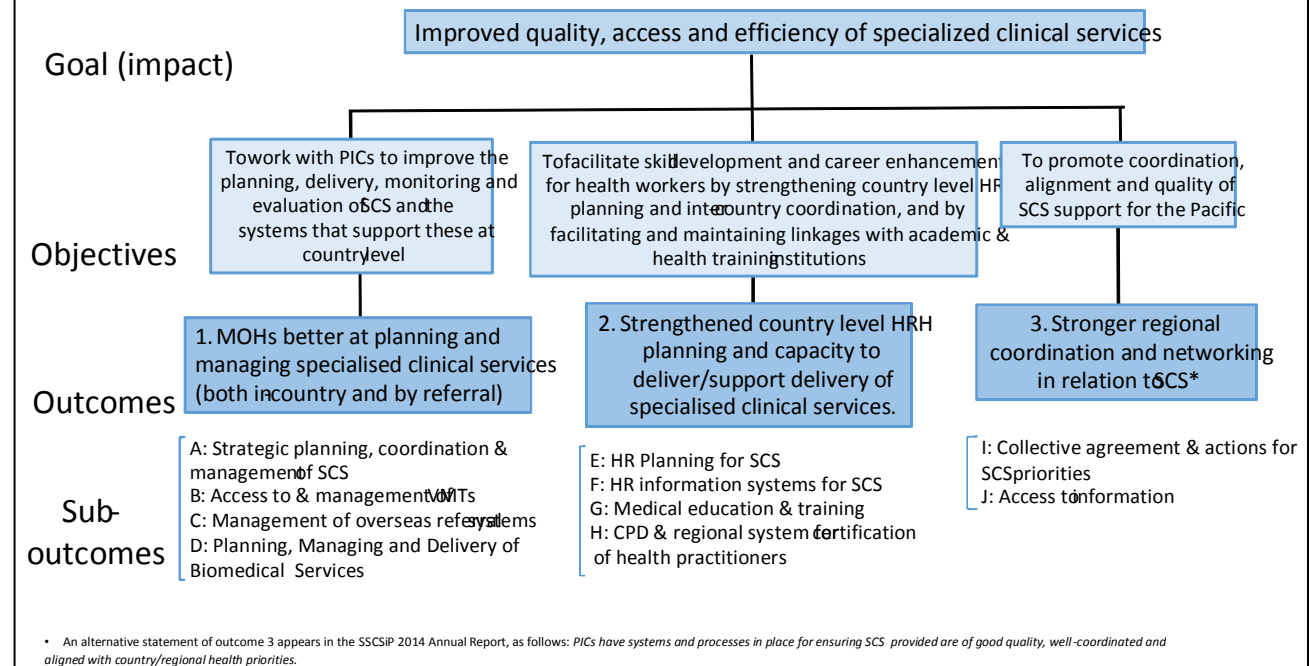


Figure 2:SSCSiP Project results framework per M&E framework



Annex 7 Achievements by project outcome 1 (SSCSiP)

Table 1: Outcome 1 and indicative activities (original Project Design Document)

| Outcomes anticipated | Indicative activities | Achievement |
|--|---|---|
| <p>Outcome 1.1 – visiting specialised clinical services are demand-driven and planned and visiting service providers have access to the resources required conduct of services (e.g. staff, clinic space, theatre time)</p> | <p>SCS Committees (created or already existed)</p> <p>SCS Committee use pre-agreed eligibility criteria</p> <p>Countries develop: rolling biennial plan and detailed annual activity plan; checklist to ensure readiness for visits</p> | <p>The majority of countries covered have some form of SCS Committee. In some cases, those forum were already in existence.</p> <p>Not clear that SCS Committees use pre-agreed eligibility criteria. Oftentimes patients seen by the VMTs were selected by surgeons based on the type of case.</p> <p>A range of tools developed for country use including activity plans and checklists. Countries use those tools at their discretion.</p> |
| <p>Outcome 1.2 – programs of visiting teams and individuals addressing the needs of participating countries are coordinated across the Pacific & provided in an efficient and effective manner</p> | <p>DaCT promotes equity of access to services</p> | <p>VMTs are increasingly demand-driven although PIP/RACS seems to be ahead of the curve.</p> <p>Not clear that needs of participating countries are coordinated across the region.</p> <p>The DaCT is not in a position to negotiate equity of access in services.</p> |
| <p>Outcome 1.3 – adjunct services to support specialised services (e.g. biomedical equipment, diagnostic services are available and generally strengthened</p> | <p>No indicative activities for this outcome but services provided for biomedical equipment maintenance</p> | <p>Support for adjunct services largely limited to biomedical support. A significant accomplishment was the development of a course for biomedical technicians at the Fiji National University.</p> |
| <p>Outcome 1.4 – patient outcomes (short and medium-term) are assessed and deemed satisfactory</p> | <p>DaCT assists with development of an M&E framework.</p> <p>DaCT provides/supports effective reporting, and regular evaluation of service quality, country planning and regional coordination</p> | <p>Little progress in monitoring patient outcomes in a systematic manner. The quality of patient information systems is lacking and information about patient outcomes would reside with individual clinicians. A recommendation from the SRG (2014) to develop a patient audit for both VMT and overseas referral patients seems to be unaddressed.</p> |

| Outcomes anticipated | Indicative activities | Achievement |
|---|---|--|
| Outcome 1.5 – where necessary, off-shore referral for specialised clinical care is cost-efficient, and consistent with agreed medical and equity guidelines | DaCT assists countries to ID appropriate locations for referral services and sources of visiting services | The prime achievement in this area are the analysis conducted by the Center for Health Information, Policy and Systems Research. |

Annex 7: Achievements by project outcome 2 (PIP)

Table 2: Outcome 2 and indicative activities (original Project Design Document)

| Outcomes | Indicative activities | Achievement |
|---|---|--|
| Outcome 2.1 – Improved planning capability to meet specialised clinical service needs, maintain appropriate balance b/w primary and more specialised services, strengthen referral networks from peripheral to central locations, and ensure fair and equitable prioritisation of specialised services | DaCT works with SCSC to develop planning skills | The project has not kept pace with the needs of capacity building around SCS. Notably, turn over in the SCS Coordinator positions have not been tracked or new incumbents supported. |
| | DaCT works with countries to ‘map’ national capacity for specialised clinical services and support provided to address service needs (map of national capacity, all-sources map of contributing services) | Efforts are underway to create a map of clinical services providers. Once completed and kept up-to-date, this could be an important planning tool. However not all countries are interested in complying with the initiative not seeing the value to them in doing so. |
| | | No assessments of overall service needs. |
| | Program effectiveness assessed through periodic audit of human resource capacity | With the exception of investigations into post-operative morbidity measurement, no further efforts have been made to assess human resource capacity. |

| Outcomes | Indicative activities | Achievement |
|--|---|---|
| <p>Outcome 2.2 – Increased knowledge and skills of health workers to provide and/or support quality specialised clinical services in each country</p> | <p>DaCT, specialist teams and country personnel use resources maps to ID CB needs for SCS; establish ways that these can be met through VTs and advocate for access to training opportunities (e.g. scholarships) .</p> <p>Visiting teams include senior personnel and consistent membership, use a variety of CB techniques to encourage skills transfer of skills and ID opportunities for post-graduate trainees and/or expatriate personnel to participate in visiting specialised service visits established</p> | <p>Not clear that DaCT has utilized country personnel maps to identify CB needs. In contrast, PIP/RACS gauges CB needs on an individual by individual basis for services provided through their VMTs.</p> <p>The project has been actively involved in the provision of assistance for training opportunities.</p> <p>Beyond the PIP/RACS VMTs, it isn't clear that CB needs are being negotiated in advance of team visits. SSCSiP has developed templates and checklists for these purpose but they seem to be largely unknown about country staff.</p> |
| <p>Outcome 2.3 – Established linkages to support health workers' development & institutional strengthening</p> | <p>Linkages developed through VTs and other programs (e.g. POHLN, PEI) to facilitate training and career mentoring in the Pacific</p> | <p>POHLN appears to be well-utilised across countries although it could expend its coverage even further. However, VMTs and SSCSiP have had little involvement.</p> <p>With the exception of support to regional clinical networks, there is little evidence that SSCSiP has engaged with other programs to facilitate training and career mentoring</p> |

Annex 8: Project responses to IPR recommendations

| Issue raised in IPR | Changes made and current status |
|--|---|
| Appropriate setting and articulating of SSCSiP scope and role/ responsibility | Articulating the scope and role/responsibility was achieved with the revised program design (M&E Plan) |
| long and short term planning and implementation processes | While articulated in paper in the revised program design, however, full enactment lacking |
| use of country and reg. governance mechanisms, such as Heads of Health, Strategic Advisory Group(StAG) and Stakeholder Reference Group (SRG) | As described in the Evaluation Report, more strategic use could be made of the SRG; other aspects of governance mechanisms (i.e. criteria for receiving funding) are still raised as issues by some country representatives |
| The use of and interaction between SSCSiP's governance mechanisms (e.g.SRG) and key PICTs mechanisms (e.g. clinical committees)? What are advantages and disadvantages to current approaches? What are opportunities and barriers including of having a dedicated reg. clinical governance mechanism? | There appears to be little interaction between SSCSiP and the clinical committees of individual countries. Interactions is primarily around requests for funding for training and CPD. |
| -Expansion of the StAG to include the necessary skillsets? | No significant change made. |
| -Resolution of potential Conflict of Interest in terms of StAG membership? | No significant change made. |
| -Communication and linkages between SRG and StAG. | No significant change made. |
| -Structuring of SRG to allows for dynamic, discursive and meaningful analysis and discussion, including on more strategic matters (as opposed to operational matters | Perhaps some movement |
| -Reducing the duplication of the scholarship and off-shore medical referrals systems set up by SSCSiP, parallel to that of PICTS | No outright duplication |
| -The approach to capacity building, including: defining and measuring what improved PICT planning capacity looks like; setting appropriate strategies based on this (using a broader definition of capacity building than just skills development | No |

| Issue raised in IPR | Changes made and current status |
|--|---------------------------------|
| and scholarships – including items such as roles, systems, tools, structures, facilities, workloads and leadership); planning and implementing at the country and regional level (including how the former links feeds into the latter). Further, how does their capacity building link in with national competency frameworks and continuing professional development plans?; | |
| -SSCSiP data needs and use of the PICT situational analysis undertaken by SSCSiP; | Unfortunately, no |
| -Financial management decisions against the core program to ensure the best use of funding sources. | No significant change made. |

Annex 9: Surgical procedures performed by country and type

Table 1: Total surgical procedures performed through the PIP, by country, 2007 to 2010, and 2012 to 2015

| Country | Number of surgical procedures | |
|--------------------------------|-------------------------------|-------------|
| | 2007-2010 | 2012-2015 |
| Cook Islands | 128 | 33 |
| Fiji | 516 | 406 |
| Kiribati | 396 | 642 |
| Federated States of Micronesia | 104 | 222 |
| Nauru | 54 | 110 |
| Samoa | 472 | 549 |
| Solomon Islands | 795 | 576 |
| Tonga | 543 | 474 |
| Tuvalu | 91 | 172 |
| Vanuatu | 320 | 408 |
| Total | 3428 | 3559 |

Table 2: Total surgical procedures performed through the PIP, by type, 2007 to 2010, and 2012 to 2015

| Type | Number of surgical procedures | |
|-----------------------|-------------------------------|-----------|
| | 2007-2010 | 2012-2015 |
| Cardiac surgery | 148 | 73 |
| ENT | 783 | 559 |
| Gastroenterology | 6 | 60 |
| General surgery | 22 | 160 |
| Laparoscopy | 5 | - |
| Neurosurgery | 44 | 40 |
| Obstetrics/gynecology | - | 168 |

| Type | Number of surgical procedures | |
|------------------------|-------------------------------|-------------|
| Ophthalmology | 982 | 1012 |
| Oral- Maxillofacial | 30 | 31 |
| Orthopedic | 439 | 299 |
| Pediatric | 100 | 189 |
| Plastic/reconstructive | 687 | 682 |
| Renal access/vascular | - | 12 |
| Screening-ortho | 1 | - |
| Urology | 145 | 243 |
| Vascular | 37 | 31 |
| Total | 3428 | 3559 |

Annex 10: Analysis of gender distribution in PIP service delivery and training activities

As seen in Annex 10 Table 1⁴⁷, data on the numbers of males and females are presented as ratios (i.e. male data are set at a value of 1 and female data appear as a proportional amount above or below 1). We see here that, in regards to consultation, male and female participation is quite equal. Indeed, females are slightly overrepresented (e.g. from 2012-2015, for every 100 males seen in consultation, there were 102 females seen). In contrast, surgical procedures show that more males than females receive treatment. For every 100 males receiving surgery, there are only 86 corresponding females. Surgical specialties which are sex-specific (i.e. obstetrics and gynaecology and urology) have been removed from these analyses.

Table 1: Ratios of male to female consultations and surgical procedures, 2007 to 2010 and 2012 to 2015 (Crude rates)

| | Consultations | Surgeries |
|-----------|---------------|-----------|
| 2007-2010 | 1:1.06 | 1:0.75 |
| 2012-2015 | 1:1.02 | 1:0.86 |

Table Notes: Data for 2007-2010 is from the IPR 2011 (Table 1, page 5) and is assumed to include all surgical procedures. Data for 2012-2015 are drawn from PIP/RACS reports and exclude the categories of obstetrics and gynaecology and urology.

Granted, as pointed out above, gender is not a factor in considering who is a candidate for surgery. However, the proportional difference in males versus females receiving services warranted a closer examination. Therefore, the data were examined with a further level of disaggregation by type of surgical specialty. This allows for further consideration of the types of specialties/procedures which may be more likely to be performed on one sex over another (e.g. orthopaedics). These data are presented, again as ratios, in Annex 10 Figures 1 and 2, by consultation and surgeries.

A number of types of consultations are provided on nearly equal basis. These include: cardiac, ENT, plastics/reconstructive and vascular. In one specialty area, ophthalmology, women are more likely than men to have a consultation (i.e. for every 100 men, there 122 women who receive a consultation). In three other specialty areas, men out-represent women in the pool of individual who receive a consultation. In descending order, these are: gastroenterology (80 women for every 100 men), neurosurgery (71 women for every 100 men), orthopaedics (67 women for every 100 men) and paediatrics (48 girl children for every 100 boy children).

The same analysis was carried further to examine patterns in regards to surgeries, again by area of specialty. As with consultations, there are a set of specialty areas in which the male to

⁴⁷ This analysis does not make direct comparison between time periods as the types of procedures differ.
11 November 2015

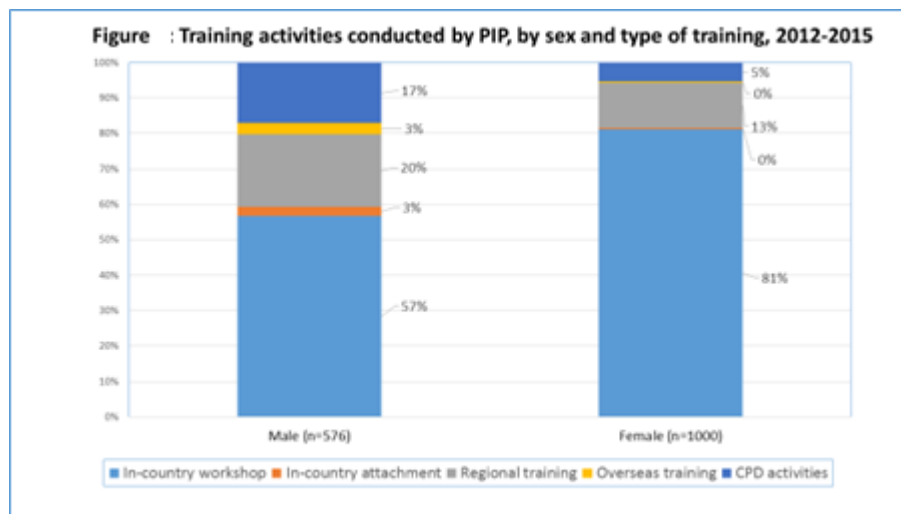
female ratios are somewhat similar. These include Ear Nose and Throat (100 men to 105 women), ophthalmology (100 men to 93 women) plastics and reconstructive (100 men to 91 women). In the area of neurosurgery, women are far more likely than men to received surgery (122 women for every 100 men). In the remaining specialty areas, men appears to be far more likely to receive surgery than women. These include: cardiac (100 men to 43 women), orthopaedics (100 men to 48 women), paediatrics (100 boy children to 62 girl children) and vascular (100 men to 34 women). While there may well be valid explanations for these differences in proportional representation in surgery (e.g. stage of disease, adequacy of facilities to perform needed procedures), the data available cannot provide further illumination.

The potential for such differentials was recently acknowledged by DFAT⁴⁸. They noted an important gap in existing knowledge regarding the initial selection of patients to be screened by PIP, whether and how gender equality principles may be accounted for in this process. Based on the above, it appears the same concerns extend beyond selection for consultation and into selection for surgery, in which the RACS teams would be more involved.

The evaluation also examined the available data on training. The aggregate data show that more women have benefitted from PIP training than men. During the period, 2012-2015, 1000 women participated in training activities compared to men (576 men). However, on closer look (Figure 1), it seems that men have a greater diversity of training opportunities than do women.

Women are far more likely to participate in in-country workshops (81 per cent of all female participants compared to 56 per cent of male participants). One reason for this the fact that the nursing profession is overwhelmingly female and the targeted audience of in-country training. Twenty per cent of male trainees were engaged in CPD activities or overseas training compared to only five per cent of the female participants. Regional training opportunities had better PIP-supported representation as these fora accounted for 20 per cent of the male training opportunities and 13 per cent of the females.

⁴⁸ Government of Australia. DFAT. 2014. Quality at Implementation Report. Tertiary Health-Pacific Island Project. Approval date: 14 March. 11 November 2015



These figures should be viewed in light of the fact that a far greater percentage of Pacific specialist clinicians are male than female. Where appropriate to do so, RACS reports that they target and support women and other marginalised groups to ensure they benefit from training opportunities provided through PIP. RACS also notes that it is limited by the candidate selection process by hospitals and MoHs which may hinder its ability to further support female candidates.

Indeed, a similar situation pertains the gender distribution of the PIP volunteers⁴⁹. Overall, there are 291 male volunteers to 202 females. However, significant disparities appear by professional areas with 157 male surgeons and seven female surgeons. Likewise, there are 72 male anaesthetist to 15 females. In the aggregate, these figures are, of course, offset by the number of female to male nurse volunteers which stands at 144 to 13.

⁴⁹ Data on PIP volunteers by profession and gender provided by RACS 04 August 2015.
11 November 2015

Annex 10: Ratio of women to men receiving consultation or surgery by PIP

Figure 1: Ratio of women to men receiving consultation by PIP, by specialty, 2012-2015

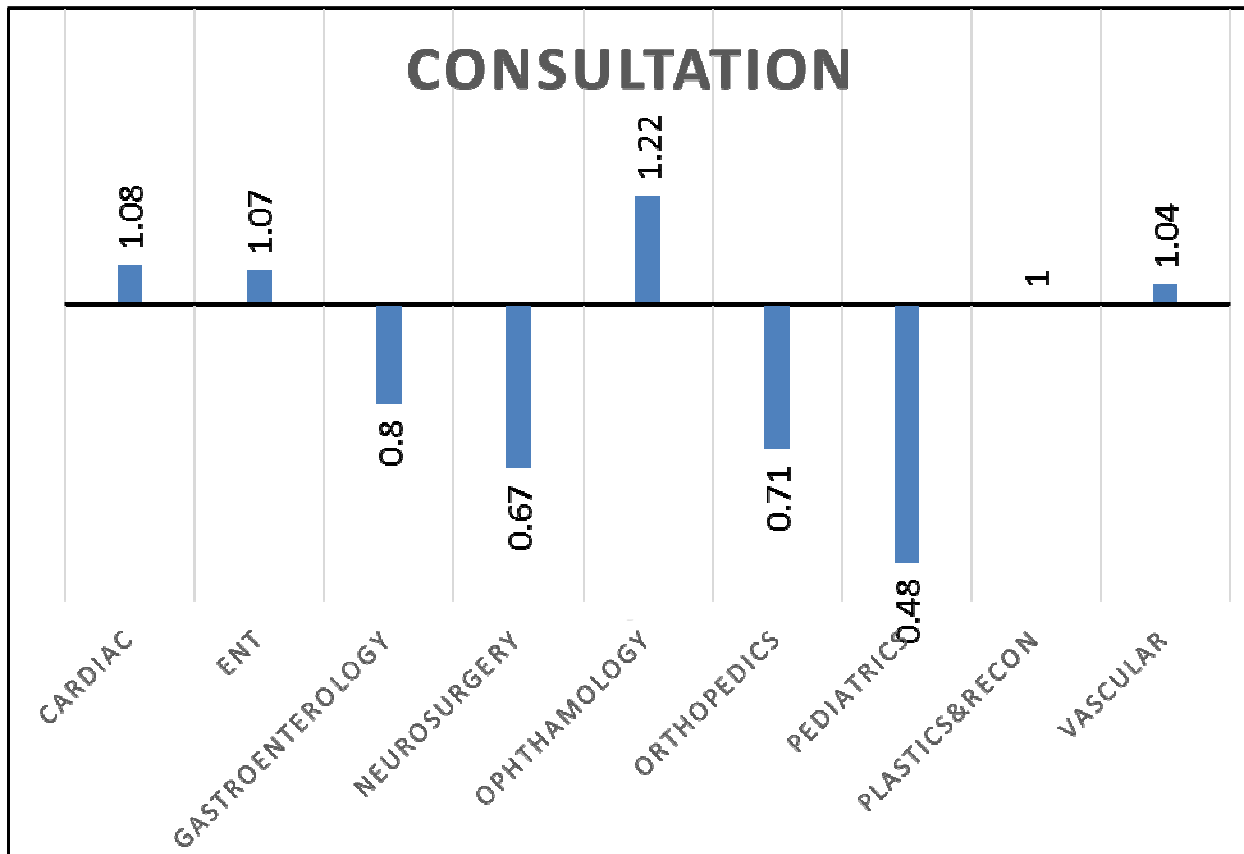
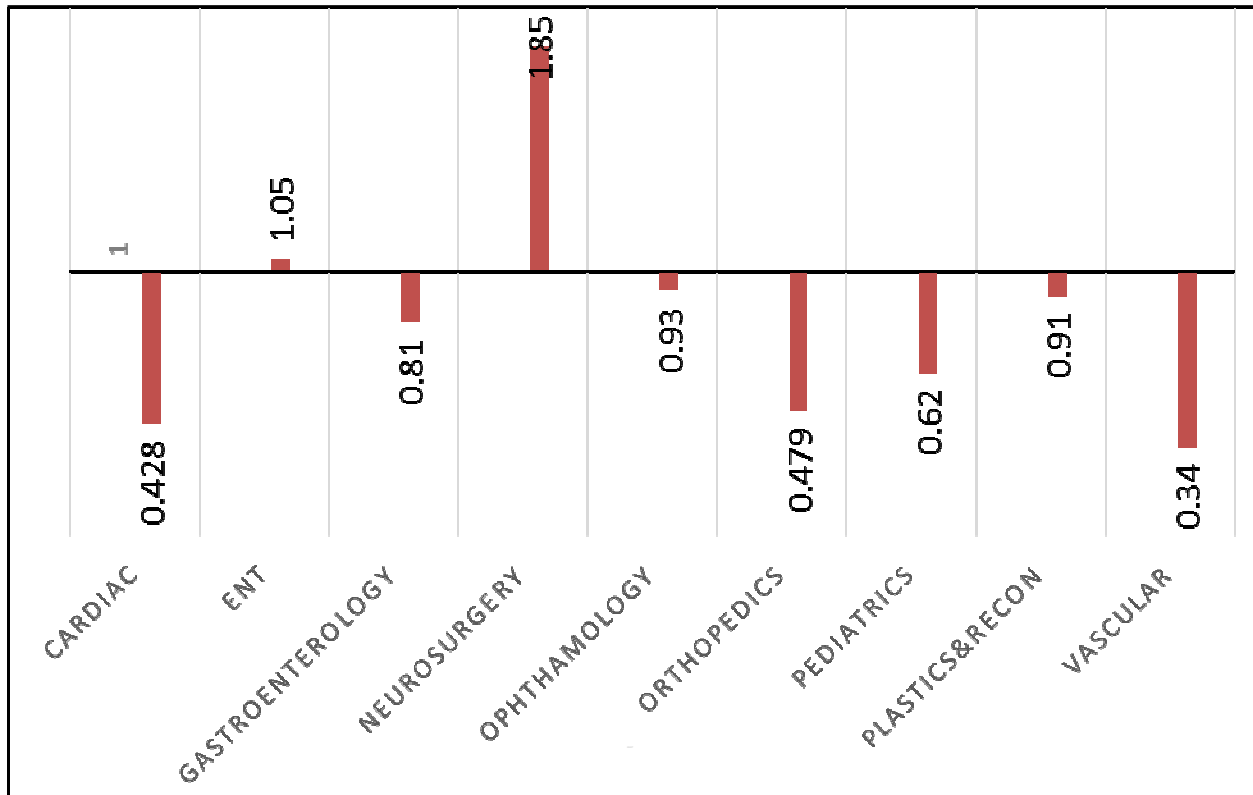


Figure 2: Ratio of women to men receiving surgery by PIP, by specialty, 2012-2015



Annex 11: In-country training conducted by PIP

Table 1: In-country training conducted by PIP by subject and number of participants, and as percent of all in-country training provided, 2012-2015

| | Workshops | Participants | % of total | |
|---|-----------|--------------|------------|-----|
| Essential Pain Management | 19 | 471 | 31% | 40% |
| Intrapartum care | 10 | 179 | 16% | 15% |
| Essential Pain Management – instructors workshop | 8 | 92 | 13% | 8% |
| Ponseti workshop | 5 | 46 | 8% | 4% |
| Primary trauma care | 4 | 113 | 7% | 9% |
| Nurses burns workshop | 2 | 58 | 3% | 5% |
| Ward Nurse training | 2 | 56 | 3% | 5% |
| Primary trauma care - instructors | 2 | 18 | 3% | 2% |
| Future leaders workshop | 1 | 26 | 2% | 2% |
| Primary emergency care of obstetric complications | 1 | 25 | 2% | 2% |
| Essential pain management - lite | 1 | 22 | 2% | 2% |
| Essential management of severe trauma | 1 | 16 | 2% | 1% |
| Nurses peri-operative workshop | 1 | 19 | 2% | 2% |
| Essential management of severe burns | 1 | 17 | 2% | 1% |
| Care of the Critically Ill Surgical Patient | 1 | 12 | 2% | 1% |
| Ultrasound workshop | 1 | 11 | 2% | 1% |
| Essential management of severe burns-instructors | 1 | 10 | 2% | 1% |

Note: Two types of training: cardiotelemetry and interpartum care – instructors workshop are not included in the table as there were no data available on numbers of participants.

Annex 12: Risk management

Table 1: Risk management issues, mitigating actions and responsibilities pertaining to clinical governance safeguards⁵⁰

| Risk | Mitigating action | Responsibilities |
|--|--|--|
| Lack of adequate post-operative aftercare for patients | <ul style="list-style-type: none"> PIP teams are instructed to avoid conducting procedures that require post-operative care beyond the skills and resources of the Pacific host-nation. Appropriate patients are selected by PIP teams in collaboration with the local clinicians. Pacific medical personnel are provided with appropriate post-operative care training and/or instruction as required, which they can deliver after PIP teams have departed Post-operative morbidity and/or mortality are documented through specific report templates. | RACS, Volunteer Team/Specialists Pacific MoHs/hospital authorities/medical staff/counterparts |
| Lack of necessary equipment and support facilities (e.g. x-ray and pathology) | <ul style="list-style-type: none"> Teams are advised to undertake procedures that can be safely delivered using materials and supplies available locally or brought by the visiting team | RACS, PIP volunteers, Pacific MoHs/medical personnel |
| Lack of adequate pre-screening of patients by Pacific clinicians in advance of visits | <ul style="list-style-type: none"> A communication link between visiting teams and relevant Pacific clinicians is established prior to each visit. This serves to discuss preliminary screening of patients/cases waiting. Teams are to dedicate time for pre-operative assessments and conduct clinics in between procedures. Pre-screening visits by an specialist will be arranged as required. PIP will monitor team reports for comment on screening and take action to remedy shortcomings when necessary | RACS, Pacific MoHs/Hospital authorities/medical Staff/counterparts |
| Lack of Pacific MoH and/or hospital budget to provide counterpart contribution in support of clinical visit and training initiatives | <ul style="list-style-type: none"> To minimise the cost burdens of visits, teams are provided with appropriate medical equipment and disposable supplies for the provision of services. | RACS |
| | <ul style="list-style-type: none"> Under the Program budget, funds are allocated for training initiatives to maximise opportunities for capacity development for Pacific clinicians | |

⁵⁰ Extracted from RACS/PIP Risk management Matrix. Updated January 2015.
11 November 2015

| Risk | Mitigating action | Responsibilities |
|---|--|---|
| Failure to document clinical visit and/or training outcomes, including receiving relevant feedback reports from Pacific clinicians | <ul style="list-style-type: none"> The responsibility of monitoring and auditing surgical patient outcome lies primarily with Pacific clinicians as there is no program management staff on the ground. Visiting teams are directed to collect immediate information but Pacific clinicians will be engaged for further information and/or follow-up. | RACS, PIP volunteers, Pacific medical personnel |
| Failure to identify appropriately qualified and experienced team members to deliver program activities | <ul style="list-style-type: none"> PIP maintains a database of potential volunteers. Visits are planned well in advance and program administration maintains a flexible approach enabling it to amend schedules as necessary in response to Pacific MoH/hospital requests and availability of volunteers. RACS/PIP also maintains strong relationships with a large number of specialist organisations and associations. This facilitates access to a wide range of specialists to provide program activities. In the event that the RACS and its partners are unable to deliver requested services, this would be clearly communicated to Pacific MoHs. | RACS |
| Failure of Pacific MoH/hospitals to act on recommendations of visiting teams | <ul style="list-style-type: none"> PIP will provide Pacific MoHs and medical personnel with the recommendations for them to implement at their discretion. PIP will provide support and advice where appropriate to support their development, as required. | RACS, Pacific MoHs/Hospital authorities |
| Equipment and disposable supplies provided to PIP teams will be inadequate to address local needs, including equipment being maintained at the required level | <ul style="list-style-type: none"> Equipment and supplies lists for specialist visits and training regularly updated in accordance with recommendations from previous visits and in consultation with Pacific medical personnel requirements | RACS |
| | | Pacific MoH/medical personnel |

Annex 13: PIP measures of success categorised by results level

| Inputs | Processes | Outputs | Outcomes | Impact |
|---|--|--|--|--|
| Financial reporting includes grant advances and claims/ acquittal by category of activity | <ul style="list-style-type: none"> - # and specialties of consultations provided - # and specialties of surgeries conducted - # and description of voluntary clinicians who offered their services - # of Pacific clinicians working with PIP teams during clinical visits - # and type of formal training courses conducted by PIP in-country - # of course participants - Improvement in clinical skills and knowledge of trainee medical personnel - # and specialty of supervisions/on the job trainings - # and specialty of ongoing mentoring relationships - # and types of other informal training provided (i.e. lecture, grand rounds, tutorials, other) - # and type of attachments - #, names and countries of personnel who attended conferences and type of conferences, funded by PIP - # and types of clinical visits with equipment and supplies provided - Appropriate and adequate supplies | <ul style="list-style-type: none"> - Immediate outcomes of surgical interventions (by # and specialty) conducted annually - # and specialty of peri-operative mortality annually - Pacific clinicians have increased capability to undertake patient pre-screening and diagnosis - Pacific clinicians (doctors) have increased capability to undertake medical procedures over time - Pacific clinicians have increased skills, confidence and application 3 months after PIP training (clinical visit, workshop or training attachment) - # of Pacific clinicians teaching and/or leading educational | Measure of (intermediate) health change/s as experienced by patients as a result of PIP assistance | <p>Has PIP increased access to, and contributed to, improving the capacity of health services in Pacific nations?</p> <p>Has PIP support improved the quality of life for targeted populations in the Pacific?</p> |

| Inputs | Processes | Outputs | Outcomes | Impact |
|--------|-----------------------------|--|----------|--------|
| | and equipment were provided | programs annually - # and types of educational programs led by Pacific clinicians | | |

This document is issued for the party which commissioned it and for specific purposes connected with the above-captioned project only. It should not be relied upon by any other party or used for any other purpose.

We accept no responsibility for the consequences of this document being relied upon by any other party, or being used for any other purpose, or containing any error or omission which is due to an error or omission in data supplied to us by other parties.

This document contains confidential information and proprietary intellectual property. It should not be shown to other parties without consent from us and from the party which commissioned it.

Mott MacDonald, Level 6, 224 Bunda
Street, Canberra, ACT 2601, Australia

T +61 6111 2725,
www.mottmac.com/health