



Nauru Photo: AFP or licensors

Every Life Matters.
Review of DFAT Health Investments to Nauru

FINAL REPORT

30 November 2022

**Specialist
Health
Service**

Strategic input on health to the Australian Government

Executive Summary

Background: Since 2009, the Government of Australia (GoA) has been providing funding of about AUD 2million per year to support Nauru's health sector. DFAT commissioned an independent review of Australia's support to the Nauru health sector for the period 2018 - 2022. This review provides an analysis and assessment of the overall performance of Australia's bilateral, regional and global investments to Nauru. Outcomes from the review will inform the design of Australia's next health partnership with Nauru.

A Review Team - comprising a Team Leader experienced in health system reviews, a health specialist with knowledge of the Nauru health sector and an experienced gender, disability and social inclusion (GEDSI) adviser - was commissioned from August to November 2022. The review was guided by 15 Key Evaluation Questions (KEQs) focusing on the review period (2018-2022) and future DFAT support to the Nauru health sector. Analysis was informed through over 150 key documents comprising regional and Nauru health sector reports, policies, strategies and other key documentation, and available program and health sector data. Information was further collected and verified through semi-structured consultations with over 60 key informants via remote interviews and an in-country visit, inclusive of DFAT personnel based in Nauru, the Pacific region and Canberra, the Nauru Ministry of Health and Medical Services (MHMS), other relevant government agencies, past and present technical advisers, and other development agencies and sectoral stakeholders.

Context: Nauru faces a triple health burden of non-communicable diseases (NCDs), communicable diseases and the health impacts of climate change, and demonstrates concerning indicators relating to social determinants of health, such as education, employment, environment. Nauru has one of the lowest life expectancies and highest premature mortality in the Pacific and one of the highest rates of diabetes in the world. The health system suffers from leadership, planning and service delivery challenges impacted by widespread vacancies, chronic absenteeism and inadequate performance and data management systems. Nauru is also a remote location, with limited transport options.

DFAT Support: The largest proportion of DFAT health investment to Nauru during the review period has been through the bilateral Nauru Health Support Program (NHSP) to strengthen health system management, primary health care and response to NCDs. DFAT's bilateral support consisted of three main components:

- (i) The Nauru Health System Support Project (NHSSP) was delivered between July 2019 - June 2022 by a Managing Contractor, Palladium, with the objectives of supporting the MHMS to strengthen health information systems, logistics management, planning, budgeting, performance management and operational systems and to improve community-based primary health care (PHC).
- (ii) WHO received a grant (November 2018 - October 2022) with the aim of strengthening the MHMS' NCD prevention and management at multiple service levels and including support to a multisectoral NCD Taskforce and Healthy Islands approach.
- (iii) A Direct Funding Agreement (DFA) with MHMS to address COVID-19 preparedness and clinical care priorities, including support for infection prevention and control (IPC), equipment and training.

Many of DFAT's global and regional investments also contributed to health sector outcomes in Nauru during the review period. Support to WHO, UNFPA, SPC, and the Centre for Health Security (through the Health Security Initiative (HSI) for the Indo-Pacific Region) and Office of the Pacific (OTP) contributed to strengthened infection prevention and control, anti-microbial resistance surveillance, health information systems, laboratories, disease surveillance and response, field epidemiology training and deployment of health security technical resources. The Regional Vaccine

Access and Health Security Initiative (VAHSI) also provided support to Nauru for vaccine access and rollout. The Pacific Clinical Services and Health Workforce Improvement Program (funding to SPC, FNU and RACS) provided education and training for 24 Nauruan health workers, and RACS provided four Visiting Medical Teams (VMT) with 233 patient consultations.

Key Findings and Lessons Learned: Given the country and health context, all DFAT investments during the period were assessed as **highly relevant** to the needs and strategic priorities of the Nauru health sector, being closely aligned with Nauru's strategic development priorities (within the *Nauru National Sustainable Development Strategy 2019-2030*, the *National Health Strategic (NHS) Plan 2016-2020* and the *Nauru NCD Strategic Action Plan 2015-2020*), and with Australia's *Aid Investment Plan for Nauru*. The Review Team concluded that all DFAT-supported health investments in Nauru aligned with Government of Nauru (GoN) and GoA strategic priorities for health improvement.

A particular challenge to assessing **effectiveness** against planned outcomes however was the lack of monitoring and data management systems, and in particular, limited means through which to collect data against identified indicators. Future design needs to include contextually relevant and verifiable indicators, and only those that are linked to the new *NHS* and *NCD Strategies 2021-2025*.

DFAT's bilateral investments through NHSP were determined by the Review Team to be 'mostly effective', in that they all contributed to at least partial achievement of intermediate and end-of-program outcomes, making an essential contribution to the management and strengthening of the health sector through improved delivery and coverage of preventive and clinical health services. Both NHSP and WHO contributed to partial achievement of all but one end-of-program outcome. The NHSP was the first in the Pacific to provide bilateral funding to WHO to implement and report against specific EOPOs. WHO's convening power and recognised technical credentials for supporting NCD programming have led to demonstrated progress in key areas of NCD clinical care and increased focus on prevention and screening. However, they were not able maintain support for the NCD Taskforce and Healthy School programs while advisers were out of the country during COVID-19. Future support for this modality should be based on an assessment of their Completion Report.

It is acknowledged that disruptions associated with COVID-19 travel restrictions and in-country preparedness and response efforts were a considerable factor in achieving progress, however slow inception (that resulted in missed opportunities later) and selection of some advisers could have been better managed by the implementing agencies. Absence of advisers in-country during COVID-19 exacerbated limited progress made initially, and this was not improved through remote support.

A particular highlight of DFAT support during the review period was Nauru's multisectoral preparedness and response to COVID-19, which was impressive for a country with a small population, significant co-morbidity and economic reliance on international connections. DFAT's support to preparedness and response plans, and establishment and technical assistance to the COVID-19 Task Force and establishment of the Tamanu and Tupaia data management systems (used to great effect during the pandemic) demonstrate exceptional coordination and effectiveness. These are stand-out achievements from Australia's combined health investments to Nauru.

Effective delivery of DFAT support to the Nauru health sector suffered from **efficiency challenges**. The number, relatively small size and disparate funding and support mechanisms across DFAT's global, regional and bilateral support can prove difficult for the DFAT Post and the MHMS to oversee, monitor, report against and manage. The Review Team experienced significant difficulties locating a single, streamlined mechanism or platform with oversight of DFAT's many regional funding and support modalities, and especially the extent to which these can be assessed as having reach and impact in individual countries, such as Nauru. DFAT Post in Nauru has few staff to oversight the multiple streams of support to Nauru.

Efficiency and sustainability and the extent to which the MHMS can absorb and utilise support are impacted by high rates of vacancies, absenteeism, and staff turnover within MHMS. Sustainable health reform depends on the capacity, motivation and leadership of key individuals responsible for delivery or oversight of particular programs, units or services, and management development will need support in the transition phase and future investment.

Program governance was a challenge for the NHSSP, which was slow to start and stalled during COVID-19 and did not include DFAT regional or other development partners. Given the small population and limited transport routes to Nauru, better coordination between health and human development partners is suggested for future support.

Australia's investments supported **GEDSI** through collaboration with the Department of Women's and Social Development Affairs (WASDA) to integrate GEDSI considerations in the MHMS strategies and supported the Department of People Living with Disability (DPLWD) to conduct research on barriers for people with disabilities to access health services. While some GEDSI capacity building with MHMS was undertaken, MHMS awareness of GEDSI and its relevance to health is still low. There is limited evidence of NHSSP supporting MHMS to collect and analyse disaggregated data in a systematic way. Partnerships with WASDA and DPLWD should improve response to GEDSI, to ensure women and people with disabilities can actively participate in program activities and in the design of future health programming. Ongoing support will need to be provided to further strengthen and operationalise GEDSI within the Republic of Nauru (RON) Hospital and Community and Public Health.

Key Recommendations: Continuing key components from the NHSP and finalising urgent infrastructure during the Nauru Transition Health Phase to 2024 is critical to maintaining gains made in the review period. The future health design should continue to focus on targeted health system strengthening for PHC and NCDs, but within a broader human development approach, inclusive of culture, gender, and disability. This approach can more explicitly address key development challenges (such as youth unemployment, quality of education, inequalities and poverty, mental health, climate change impacts) and support the *National Sustainable Development Strategy* while still supporting the health sector and *NHS (2021-2025)* and the *Nauru NCD Strategic Action Plan (2021-2025)* with the potential to include more development partners.

DFAT-funded regional programs have mixed reach into Nauru, and it is timely to review models while HSI and the Office of the Pacific are being re-designed or restructured. Smaller populations and health sectors may not benefit as much if funding or support is provided based on population size, yet their needs might be greater and they may have more limited human resources for health. The review team found this to be the case in Nauru. Any future bilateral programming should ensure that there is an agreed coordination and communication process with regional programs.

Along with SPC, the UN and other development partners, a model for how to provide support to islands with smaller populations could be considered for discussion at the next Pacific Heads of Health and Health Ministers meetings. The potential to share resources, technical support and lessons learned between air-linked countries to Nauru (Kiribati, FSM, Fiji) could be considered in the transition phase and in the future design. The new GoN could be supported to revitalise a Development Partner Coordination mechanism to ensure coherence across sectors relevant to human development. Given the extent of Australia's involvement in the health sector relative to other agencies, DFAT can play a leading role in supporting the MHMS to revitalise a Health (or Human) Development Partners Forum for coordination, joint planning and enhanced policy dialogue.

The MHMS Director of Finance is skilled and has demonstrated motivation to work closely with the Ministry of Finance Planning and Aid Division. It is an opportune moment to identify and plan future financial management support to strengthen MHMS oversight of government and development partner support funds with a view to re-assessing capacity to program DFAT funds through

government systems (on plan and on budget). An element of performance-linked ('bonus') funding could also be considered for future health programming to ensure progress against key objectives.

Existing MHMS Health Executive meetings that report regularly to the new Minister for Health provide an opportunity to include reporting on DFAT funded progress and align with NHS and Annual Operating Plans (AOPs). Regular (possibly monthly) meetings with DFAT Second Secretary, a new Development Specialist and the MHMS Health Executive could provide a forum where concerns on progress can be raised and worked on jointly.

With a new Minister for Health who is actively engaged and keen to progress reforms, there is an opportunity to set up new mechanisms to support improved communication and coordination with development partners. An Annual Health Review chaired by the Minister, and including all development and DFAT regional partners, could review and reflect on progress and identify gaps for partners to support. A similar process could be held in March to plan for the next Financial Year. This process could be trialled in the transition phase with DFAT support, and development partner engagement could be scheduled into joint in-country visits.

The Review provides strategic recommendations for DFAT (see table below) and considerations for the future design (see Table 6) and includes priority activities for MHMS and the transition phase (see Table 7 and Table 8).

Strategic Recommendations for DFAT

No.	Strategic Recommendation
1	Initiate discussions with UN MCO on future Nauru programming (especially WHO, UNICEF and UNDP) and support the new GoN Health Minister to strengthen and prioritise a Health (or Human) Development Partner Coordination mechanism to ensure coherence across sectors and discuss opportunities for a joint approach. This may include tying funding disbursements to implementers' active engagement in coordination activities in future
2	Develop a new DFAT Pacific Health Strategy to address the current Pacific context and challenges, and include specific strategies for the smaller island states
3	Develop a Joint Options Paper with SPC, UN and other development partners on meeting health needs of small island states to present at Pacific Health Minister's and other fora
4	Improve coherence and consistency between DFAT bilateral and regional programs through revision of communication and coordination protocols and the review of models while DFAT sections and investments (HSI, Office of the Pacific – OTP) are being re-designed or restructured
5	Increase the number of DFAT Scholarships targeted at health and social services (if possible) for the next 3-5 years to continue to build local capacity and future localisation of key senior positions.
6	Increase MHMS capacity to improve support for gender-based violence victims/survivors. Health sectors play a critical role in responding to GBV. Victims/survivors need to access comprehensive health services, including medical treatment, emergency contraception, and mental health care. Training for MHMS staff, in particular nurses and clinicians, should be provided to increase their awareness and knowledge about GBV and to improve the quality of care for GBV victims/survivors.
7	Support MHMS to collect and analyse GEDSI data. The NHS highlights the importance of GEDSI data and information to identify enablers and barriers to universal health coverage. Future investments need to work with MHMS staff to ensure GEDSI data are included in information managements systems so health policies and practices are able to respond to the different needs of women and men from different contexts and backgrounds

Contents

1. Background	1
1.1. Introduction and objectives	1
1.2. Country context	1
1.2.1. Health challenges	1
1.2.2. Health service delivery	2
1.2.3. Health system management	3
1.3. Overview of Australian health investments in Nauru covered by this review	4
1.3.1. Bilateral Health Programs	4
1.3.2. Regional Health Programs	5
1.3.3. The Indo-Pacific Health Security Initiative (HSI)	6
1.3.4. Vaccine Access and Health Security Initiative (VAHSI)	6
1.3.5. Global Health Programs	6
2. Approach and methodology	7
2.1. Purpose and scope	7
2.2. Methodology and data collection	7
2.3. Data analysis	7
2.4. Ethical considerations	7
2.5. Limitations and constraints	8
3. Findings and analysis	8
3.1. Relevance	9
3.2. Key Achievements	9
3.3. Challenges	13
3.4. Key Findings against Key Evaluation Questions	14
3.5. Recommendations for Future-focused Key Evaluation Questions	23
3.6. What did not work well in NHSP	30
4. Strategic Recommendations for DFAT and Considerations for the Future Design	31
5. Priority Activities for MHMS and Transition Phase	33
6. Annexes	36
Annex 1: Terms of Reference – Nauru health sector evaluation	36
Annex 2: Investments Identified for Review	47
Annex 3: Other DFAT Pacific Programs and Analysis of Reach to Nauru	48
Annex 4: Findings addressing Key Evaluation Questions	56

Annex 5: Reflections on Future Health Programming	78
Annex 6: Stakeholders and Key Informant Consultations.....	92
Annex 7: Documents Reviewed in the Evaluation.....	92
Annex 8: Gender Equality, Disability, and Social Inclusion	97

Acronyms

Acronym	Description
ACU	Acute Care Unit
AHC	Australian High Commission
AOP	Annual Operational Plan
AusP3	Australia-Pacific Partnerships Platform
BES	Beyond Essential Systems
CHPP	Community Health Project Plan
CHS	Indo-Pacific Centre for Health Security
COVID-19	Coronavirus disease 2019
DFAT	Department of Foreign Affairs and Trade
DFA	Direct Funding Agreement
DMS	Director of Medical Services
DPLWD	Department of People Living with Disability
DPS	Division of Pacific Technical Support (WHO)
EOPO	End of Program Outcome
ESKD	End-stage kidney disease
FNU	Fiji National University
FSM	Federated States of Micronesia
GBV	Gender-based violence
GEDSI	Gender Equality, Disability and Social Inclusion
GoA	Government of Australia
GoN	Government of Nauru
HSI	Health Security Initiative (HSI) for the Indo Pacific Region
ICT	Information and Communication Technology
IO	Intermediate Outcome
IPC	Infection Prevention and Control
KEQ	Key evaluation question
KRA	Key Results Area
LIMS	Laboratory Information Management System
LMIS	Logistics Management Information System (mSupply)
MCO	Multi-Country Office
MEL	Monitoring, evaluation and learning
MHMS	Ministry of Health and Medical Services

Acronym	Description
NCD	Non-Communicable Disease
NHPTI	Nauru Health Professionals Training Institute
NHS	Nauru Health Strategy (NHS) 2021-2025
NHSP	Nauru Health Support Program
NHSSP	Nauru Health System Support Project (Palladium)
NIHP	Nauru Improved Health Program (2009-2019)
NPF	Nauru Police Force
NSDS	National Sustainable Development Strategy 2019-2030
NTHP	Nauru Transitional Health Package
OMR	Overseas Medical Referrals
OPD	Organisations of People with Disabilities (previously DPO)
Pac-EVIPP	Pacific Evidence Informed Policy and Programs
PAD	Planning and Aid Division
PCSHWIP	Pacific Clinical Services and Health Workforce Improvement Program
PICTs	Pacific Island Countries and Territories
PLWD	People Living with Disability
RACS	Royal Australasian College of Surgeons
RIS/PACS	Radiology Information Systems/Picture Archiving and Communication System
RMI	Republic of Marshall Islands
RON Hospital	Republic of Nauru Hospital
RN	Registered Nurse
SHIP-DDM	Strengthening Health Interventions in the Pacific – Data for Decision Making
SHS	Specialist Health Service
SOP	Standard Operating Procedure
SPC	The Pacific Community
TGA	Therapeutic Goods Administration
VAWC	Violence against women and children
VMT	Visiting medical team
WASDA	Department of Women's and Social Development Affairs
WHO	World Health Organization

Review of Nauru Health Programs

1. Background

1.1. Introduction and objectives

Australia has an enduring interest in promoting the health of the people of Nauru and seeks to strengthen Nauru's health systems, including service delivery. Australia's Department of Foreign Affairs and Trade (DFAT) provides support to Nauru's health sector through bilateral, Pacific regional and global programs. Australia's support is aligned with the Government of Nauru's (GoN) *National Sustainable Development Strategy 2019-2030* (NSDS) and Government of Australia development policies (currently in review)¹. The recent visits in October 2022 to Nauru by the Deputy Prime Minister and Minister for Defence, Richard Marles and Foreign Minister, Penny Wong, are testament to the strategic importance of Nauru and the Pacific.

The Government of Australia (GoA) commissioned an independent review of Australia's support to the Nauru health sector from 2018 to 2022. The review provides an analysis of Australia's bilateral, regional, and global investments to Nauru and assesses the overall performance of these health investments, taking into consideration DFAT's aid quality criteria with a focus on effectiveness, efficiency, gender equality, disability and social inclusion (GEDSI), and risks and safeguards. Outcomes from the review will inform the design of Australia's next health partnership with Nauru.

1.2. Country context

Nauru is one of the world's smallest independent states with a land area of only 21 square kilometres. It is located in the Pacific Ocean and has a projected population of 12,688 in 2022². At the 2011 census, over half (57 per cent) of the total population was under the age of 24 and only 3 per cent were aged 60 years and above. A mini census in 2019³ determined that the majority of the population is Nauruan (95.4%), followed by i-Kiribati (2.1%), Fijian (0.7%), Tuvaluan (0.4%), Chinese (0.3%), Australian and New Zealand (0.2%) and other countries (0.8%). This may include an unspecified number of refugees and asylum seekers in the community and fly-in, fly-out Regional Processing Centre contractors.

1.2.1. Health challenges

The health of the population of Nauru gives cause for grave concern; Nauru has the second highest premature death rate in the Pacific⁴. Nauru faces a triple health burden of non-communicable diseases (NCDs), communicable diseases and the health impacts of climate change⁵. In addition, indicators relating to the social determinants of health - such as education, employment, environment - and lifestyles are concerning. NCDs present the most urgent danger to the health and well-being of the population, and to the health system's ability to meet essential service needs. NCDs are the main cause of premature mortality and morbidity in the country, contributing to shorter life expectancy compared with other countries in the region⁶. The 2017 independent review

¹ Prior to the COVID-19 pandemic, consultations were under way to update the *Health for Development Strategy*. Although the *Strategy* appears to have been superseded by aspects of *Partnerships for Recovery*, its principles continue to provide context and guidance for DFAT-funded programs at the country level – especially for health policy, system strengthening and financing, work force development and sector coordination.

² [World Population Review](#)

³ [Nauru Mini Census Fact Sheet](#)

⁴ NCD Road Map Report, 2014, p.59 (RMI is the highest)

⁵ The effects of climate change with rising sea levels, changes to weather patterns and scarcity of water and fertile soil impact on food security and disease vectors.

⁶ Nauru MHMS, 2022; Nauru Health Strategy 2021-2025; MHMS.

of the Nauru Improved Health Program (NIHP) found the current and potential future burden resulting from NCDs was the major challenge for future health status; that assessment remains the same in 2022.

High prevalence of risk factors such as tobacco and alcohol use, unhealthy diets and lack of physical activity contribute to high rates of obesity, diabetes and hypertension. Diabetes and hypertension are estimated to be prevalent in a quarter of the adult population, while 20 per cent of Nauruans are overweight and 70 per cent considered obese⁷. Risk factors for NCDs suggest that the health status is unlikely to improve in the short term and, indeed, may worsen given international evidence of a trans-generational effect on population health.

Prevalence of cancers and mental health conditions have not been adequately quantified, but anecdotally appear to be both under-reported, and on the rise for adolescents and young adults. It is acknowledged that these conditions have significant influence on morbidity and mortality in Nauru. Communicable diseases such as tuberculosis, Hansen's disease (leprosy) and trachoma are experienced amongst population clusters, and adherence with treatment regimens remains a challenge. Outbreaks of vector-borne diseases such as dengue are a seasonal concern.

Despite impressive, near-universal immunisation coverage, child mortality targets remain elusive for Nauru⁸. Most pregnant women give birth in the presence of a skilled health professional, most attend at least one antenatal care visit, and maternal deaths are rare. At 36 per cent⁹, contraceptive prevalence is low, and the unmet need for family planning is high among younger women, with teenage pregnancy rates among the highest in the Pacific. Violence against women and children (VAWC) continues to have a significant impact on the population; half of all women ever partnered report to have experienced violence from their partners¹⁰. While the law and justice sectors are making gains to safeguard women and girls from violence, the health sector is yet to adequately respond to VAWC. Sexually transmitted infections are prevalent throughout the population¹¹.

1.2.2. Health service delivery

The Ministry of Health and Medical Services (MHMS) offers primary health care prevention, referral and some clinical services, delivered through District Health Workers and Nurses in communities, (and in future from two decentralised Wellness Centres). Basic primary and secondary care diagnostic, clinical services, and public health programs for a broad range of communicable diseases and NCDs are offered from the Naoero Public Health Centre and also at the Republic of Nauru (RON) Hospital Outpatients Department. Some tertiary diagnostic, clinical, surgical and in-patient services are offered from RON Hospital¹², while more complex, specialist clinical care is provided through intermittent visiting medical teams (VMTs) - mostly from Australia and Taiwan, and formal and informal Overseas Medical Referrals (OMR) to Australia, New Zealand, Fiji and Asia.

OMR remains a significant drain on annual health sector budgets with the small islands of Tuvalu, Nauru, Federated States of Micronesia (FSM) and Republic of the Marshall Islands (RMI) the highest spenders in the Pacific¹³ (Figure 1). Nauru's referral policy and criteria for OMR was relaxed in 2017; and with COVID-19 restrictions to VMTs, OMR spending in Nauru in 2021-22 increased to AUD 11.2million (Figure 2). Procurement and management of essential medicines and clinical

⁷ Nauru MHMS, 2022; Nauru Health Strategy 2021-2025; MHMS

⁸ UNICEF, 2017; *Situation Analysis of Children in Nauru*; UNICEF, Suva.

⁹ Nauru Bureau of Statistics, *Republic of Nauru Demographic and Health Survey 2007*; Nauru Bureau of Statistics, Secretariat of the Pacific Community (sic), Macro International Inc.

¹⁰ Department Of Women's Affairs, 2014; *Nauru Family Health and Support Study: an exploratory study on violence against women*; Nauru Ministry of Home Affairs.

¹¹ MHMS, 2016 Nauru Global AIDS Progress Report reported that of the 84per cent of Nauru population tested for chlamydia, 21per cent tested positive p.14

¹² While the Review Team was in Nauru there was no contracted Obstetrician/Gynaecologist at RON Hospital

¹³ Source: OMRS Financing, WHO Regional Office for Western Pacific, February 2019

commodities have also presented ongoing challenges for Nauru, however recent system innovations and targeted procurement are gaining traction in terms of reliability and cost efficiency.

Figure 1: OMRS spending in selected PIC, 2017. Source: WHO OMR Policy Brief, 2017. Graphic: SHS

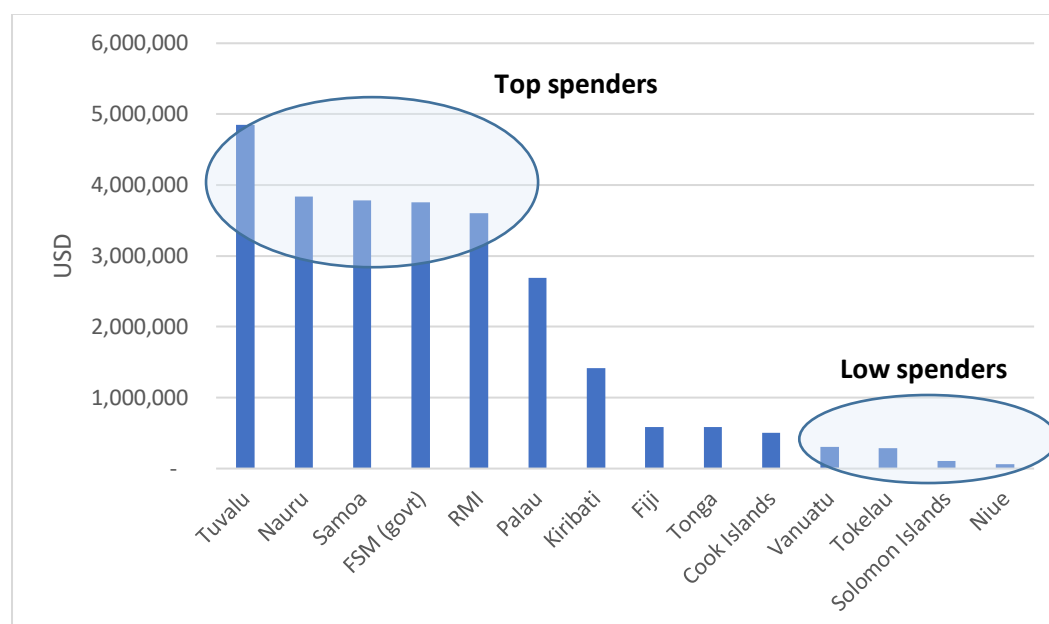
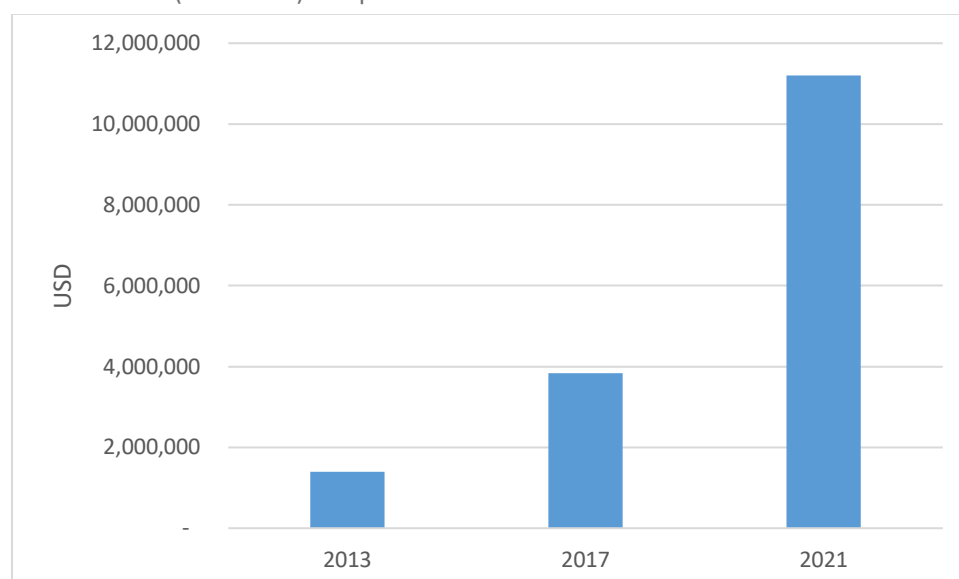


Figure 2: OMRS spending in Nauru, 2013, 2017, and 2021. Source: WHO OMR Policy Brief, 2017 and Nauru MHMS (2021 data). Graphic: SHS



1.2.3. Health system management

Recent restructures to health system management and service delivery have had mixed outcomes. At the senior executive management level, the Secretary for Health is supported by a Deputy Secretary. During the review period 2018-2022, that position has been filled by two international advisers on contract. The current Deputy Secretary (recruited through DFAT's Centre for Health Security) provides strong mentoring and support to the Secretary, Directors and middle-level managers across the RON Hospital and Naoero Public Health Centre.

A new President, Cabinet and Minister for Health were sworn in on September 29, 2022, with the new Health Minister taking an active interest in addressing challenges and prioritising system improvements. This presents a positive opportunity for future DFAT health programming. The

MHMS Health Executive Team (comprising the Secretary for Health, the Deputy Secretary and seven Directors) meets every two weeks for collaborative decision-making and management of the sector, prior to meeting with the new Health Minister.

The onset of the COVID-19 pandemic and associated travel restrictions resulted in a sharp decrease in the number of visitors entering the country, the introduction of strict quarantine measures, and restricted social engagement. All these factors impacted the national economy. For much of 2022, Nauru has dealt with rolling out vaccination and the rapid spread of COVID-19 in June which affected nearly half of the population¹⁴. This significantly impacted the capacity of the health system to maintain delivering essential services, both acute, emergency care, and ongoing identification and management of NCDs such as diabetes and hypertension.

1.3. Overview of Australian health investments in Nauru covered by this review

From 2009-2019, Australia supported the health system in Nauru through the Nauru Improved Health Program (NIHP) which expended around AUD 20 million over the decade. It was implemented through Direct Funding Agreements (DFAs) with GoN and technical assistance. The last independent review of Australia's bilateral health investments, undertaken in late 2017 (covering the period 2014 to 2017) found a significant lack of capacity, including for planning within the MHMS, and concluded that the DFA had not been an effective modality, with slow progress on achieving health objectives. DFAT also co-funded the Australian Department of Immigration and Border Protection/Australian Border Force to redevelop the RON Hospital following a fire in 2013.

1.3.1. Bilateral Health Programs

Since the commencement of the NHSP, DFAT has provided nearly AUD 2 million annually for health through a range of investments in Nauru, mostly through bilateral funds (Figure 3).

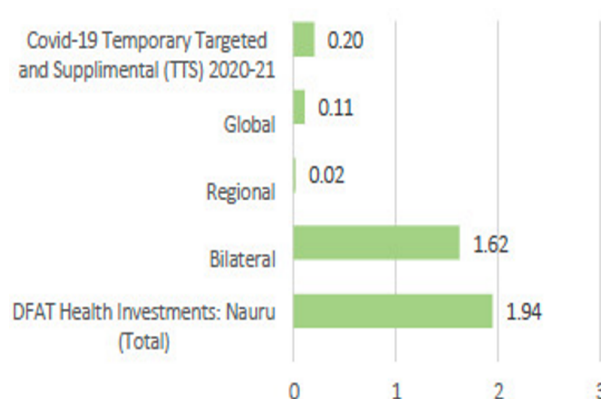


Figure 3: DFAT health investments to Nauru 2020-21 (AUD \$ million)

Source: Australian Department Budget Summary 2021-2022 and the Embargoes Australia's Official Development Assistance statistical summary 2020-21. "green book". Note: 2020-21 includes COVID-19 Temporary Targeted and Supplementary (TTS) 2020-21

DFAT and the GoN designed a new Nauru Health Support Program (NHSP - up to AUD 8.4 million from 2018 to 2022) to strengthen the health system and tackle NCDs. DFAT's bilateral support had two major components:

- A contract with Managing Contractor, Palladium to deliver the Nauru Health System Support Project (NHSSP) commenced in July 2019 and ended on 30 June 2022. This was intended to support the MHMS to strengthen health information systems, logistics management, planning,

¹⁴ [WPRO Covid Dashboard](#)

budgeting, performance management and operational systems and improve community-based primary health care (PHC).

- A grant to WHO that commenced in November 2018 and ended on 31 October 2022. This focused on improving prevention and management of NCD and addressing NCD risk factors through a multisectoral NCD Taskforce and actions.

The conclusion of the NHSP offers an opportunity to assess the effectiveness of Australia's total support to the Nauru health sector since 2018, and to consider future directions for sectoral support aligned with the new *Nauru Health Strategy (NHS) 2021-2025*.

Additional support was mobilised during 2019 and 2020-2021, including for COVID-19 preparedness. During 2018 and 2019, prior to the pandemic, the following activities were also supported by the bilateral program in parallel to NHSP design and early implementation:

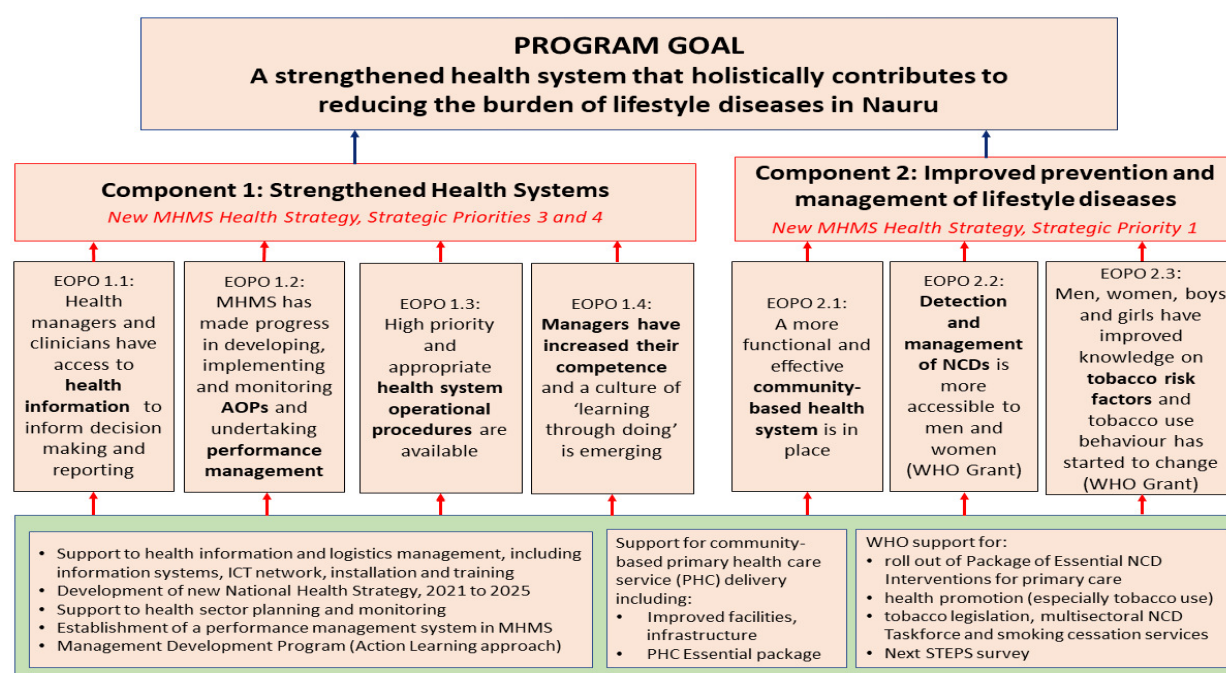
- Development of an options paper for Australian support for health security in Nauru
- Technical support for development of an all-hazards public health emergency preparedness and response plan in collaboration with WHO
- Technical support for infection prevention and control between April and August 2019 to support institutional reform in the management of Infection Prevention and Control (IPC)

The following activities were added during 2020-2021 in response to the COVID-19 pandemic, subsequent to the design of NHSP, and funded bilaterally, in parallel to NHSP:

- Procurement of medical equipment and fit-out of the Acute Care Unit (ACU) – through a DFA (AUD1.4m).
- Provision of a Senior Public Health COVID-19 Response Adviser, together with a Deputy Health Secretary and a Director of Medical Services for MHMS (funded by the bilateral program, recruited with CHS support).

Figure 4 summarises the areas of support within each NHSP component and how they align with the new *National Health Strategy (NHS) 2021-2025*. There were seven end-of-program outcomes in the original design, which also aligned with the (previous) *National Health Strategy 2016-2020*.

Figure 4: Summary of activities supported by NHSP, aligned with the NHS 2021-2025



1.3.2. Regional Health Programs

This review includes analysis of Australian support for several regional Pacific programs, with each providing varying levels of support to Nauru (see Annex 3 for detail on regional health programs). Funding is provided through different mechanisms to:

- UNFPA (in addition to core funding) for reproductive health commodities for the Pacific
- WHO (in addition to core and bilateral funding) for the Division of Pacific Technical Support (DPS) that provides technical and logistical support on COVID-19 health sector response, including to Nauru
- Pacific Medicines Testing Program, which allows a National Pharmacy access to Australia's Therapeutic Goods Administration (TGA) laboratories for testing the quality and safety of medicines and other items (such as masks)
- Funding to SPC through the Office of the Pacific (OTP) to support the Public Health Division business plan, as well as funding for two long-term technical specialists in IPC and Epidemiology Training and the Pacific Evidence Informed Policy and Programs (Pac-EVIPP)
- SPC for the Pacific Clinical Services and Health Workforce Improvement Program (PCSHWIP) to support Fiji National University (FNU) to deliver undergraduate and postgraduate education and training relevant to Pacific Island Countries and Territories (PICTs) health workforce needs, burden of disease and epidemiological patterns, and Royal Australasian College of Surgeons (RACS) to provide specialist VMTs and clinical mentoring.

1.3.3. The Indo-Pacific Health Security Initiative (HSI)

The Indo-Pacific Centre for Health Security (CHS) was established in 2017 to implement the Australian Government's Health Security Initiative (HSI) for the Indo Pacific Region and now sits as a branch in DFAT's Global Health Division. The Initiative aims to inform evidence-based planning, help prevent avoidable epidemics, strengthen early detection capacity, and support rapid, effective national and international outbreak responses. In 2020-22, CHS extended support to Pacific health ministries, including Nauru, to strengthen health systems including in infection prevention and control, anti-microbial resistance surveillance, health information systems, laboratories, surveillance and response, field epidemiology training and deployment of health security technical resources as required. The design is underway for a new five-year regional initiative.

1.3.4. Vaccine Access and Health Security Initiative (VAHSI)

The Regional Vaccine Access and Health Security initiative directs AUD 200 million to the Pacific to support vaccine access and rollout needs. The approach is holistic, with funding to procure and deliver COVID-19 vaccines and support related technical assistance in nine PICTs including Nauru. Nauru receives assistance through sharing Australian vaccine doses, Australian funded doses through the COVAX initiative, partnering with UNICEF to procure and deliver additional doses, and provide end-to-end support in rolling out the COVID-19 vaccines. End-to-end support includes technical support through partnerships with the TGA and Australian Universities, and support for cold chain equipment, logistics, risk communications and demand generation, reaching vulnerable populations, and training and staffing of vaccination teams.

1.3.5. Global Health Programs

Nauru benefits to some degree from Australia's investments in core funding to WHO, UNFPA, UNAIDS and the Global Fund (see detail in Annex 3). **WHO** has a Nauru Country Cooperation Strategy 2018-2022 and provides USD 100,000/year for MHMS requests. The **Global Fund** finance a multi-country TB/HIV grant in the Pacific (USD 10.2m) that supports 11 PICTs including Nauru with funding for HIV prevention and treatment, health system strengthening and TB care and prevention. Nauru received AUD 115,000 from that grant over 2018-2022, and a proportion of an additional USD 3.6m in 2020-2021 to 11 PICTs to respond to COVID-19.

Australia provides funding to **UNICEF** for the introduction of human papillomavirus, pneumococcal conjugate virus and rotavirus vaccines to Nauru (CHS funding plus USD 150,000 from the bilateral

program to sustain vaccine introduction in 2022). In addition to their support for the COVID-19 response, UNICEF has maintained access to the Vaccine Independence Initiative (VII) for vaccine procurement and with DFAT support, Multiple Indicator Cluster Survey (MICS). The **Gavi COVAX** Advance Market Commitment (AMC) provides COVID-19 vaccines, cold-chain equipment, and technical assistance to developing countries including Nauru. The **UNFPA** Supplies program improves access to sexual and reproductive health services and family planning commodities and pre-positioned essential supplies access to the Pacific, post-disaster, including to Nauru.

2. Approach and methodology

2.1. Purpose and scope

A comprehensive Review Plan was agreed prior to the Review Team mission, based on the Terms of Reference for this review (Annex 1). The purpose of this independent review is to assess whether a selected list of Australia's health sector investments in Nauru – bilateral, regional, and global – over the period 2018-2022, were effective, efficient and appropriate. The investments to be included in the evaluation were identified by DFAT and are listed in Annex 2 of this document.

The review seeks to understand what did and didn't work well; what was achieved with this investment; what results are likely to be sustained; and what lessons and recommendations can support future health programming. Findings and analysis will inform the Nauru Transitional Health Package (NTHP) and future health programming to 2030. A set of key evaluation questions were posed, with detailed analysis included at Annex 4 and 5.

2.2. Methodology and data collection

The evaluation approach was participatory and consultative to ensure transparency and independence. Key stakeholders such as DFAT, MHMS, advisers and other stakeholders were engaged from the start and throughout the review process to ensure findings and recommendations are accepted and owned by GoN, implementing partners and DFAT.

To address the Key Evaluation Questions (KEQs), a wide range of information sources was used, to gain as comprehensive a picture as possible in the limited timeframe. The methodology involved a combination of qualitative and, where possible, quantitative methods - document review, secondary analysis of program data and progress reports, review of key health and well-being indicators, key informant and stakeholder consultations, field visits and group discussions. Open-ended questions and semi-structured interviews and group discussions were used to address the KEQs and to explore and gain insight into the 'why' and 'how' questions. Observations, interviews and discussions were conducted in the RON hospital and Public Health Department to gain insights from staff.

2.3. Data analysis

Time was allocated for regular summarising, review and analysis among the Review Team. This is an important element in synthesising and analysing data and information and identifying areas for follow-up. The Review Team completed in-depth analysis of consolidated data at the end of data collection to prepare preliminary findings. Initial findings and recommendations were tested and discussed at the in-country debrief session and Aide Memoire soon after. This process aimed to clarify the accuracy of the findings and ensure that the recommendations are feasible, implementable, and likely to lead to sustained outcomes.

2.4. Ethical considerations

The Review adhered to the Australasian Evaluation Society's (AES) Guidelines for the Ethical Conduct of Evaluations. A Review Plan was developed for transparency. Findings have been discussed and presented in an accountable and transparent manner. Participants received an explanation of the purpose of the review and how the information they provided would be used. Verbal consent was

given. No participants requested anonymity, however any quotes in the findings are de-identified, including not referring to their positions, as that would clearly identify them.

2.5. Limitations and constraints

The Review Team experienced few of the anticipated limitations and constraints outlined in the Review Plan. The team was fortunate that all key stakeholders were available (except for the long-term MHMS Adviser Dr Kieren Keke), and all scheduled meetings were able to be conducted while in-country. Staff and key informants were willing to be interviewed and consultations were not impacted by COVID-19.

The time available for document review and for in-country consultations was limited. Original plans for a seven-day interview schedule in country were reduced to six days due to quarantine restrictions, resulting in a tight schedule of interviews each day. The team's GEDSI Adviser was unable to travel to Nauru to be part of the consultations due to conflicting travel commitments. This resulted in the inability to consult with a wider range of individuals and non-government organisations (NGOs) due to the heavy interview schedule of the review team¹⁵.

The Review team were unable to determine the final achievements against EOPOs for the WHO-led NCD prevention and management component under NHSP because WHO had not completed their contract at the time the review was conducted. WHO NCD team were in-country for two weeks (September 29-October 13) conducting training, clinical audits and consultations as their final inputs under the contract. Their completion report was not finalised at the time of this review. The Review Team requested advance findings from WHO to assess progress towards their End of Program Outcomes (EOPOs). To date, this has not been provided. Nonetheless this review includes observations from the Public Health Division site visit, key informant interviews and data from previous progress reports to assess this component.

Prior to visiting Nauru, the Review Team reviewed over 30 key documents and conducted 13 key informant interviews, with more included later. In-country consultations were undertaken in Nauru from 29 September to 6 October 2022 (Annex 6 and 7). While in Nauru, the team conducted over 38 key informant interviews with senior staff at the MHMS and held a group discussion with Public Health program coordinators, advisers and met with representatives from three other Government Departments – Ministry of Finance, Planning and Aid Division (PAD), Department of Women's and Social Development Affairs (WASDA), and the Department of People Living with Disabilities (DPLWD) and the Deputy Chair of the COVID-19 Taskforce and had several discussions with the WHO team.

Table 1. Summary of data collection methods and sample sizes

Method	Numbers	Data collection strategy
Key informant interviews	DFAT, CHS, SPC, FNU, WHO, ex advisers >30 MHMS staff n=23 Key stakeholders Nauru n=15	Virtual interviews Semi-structured interviews Open-ended questions
Clinic and outreach observations	Wellness Centres (2) Naoero Public Health Division clinics RON Hospital wards and units	Structured observations
Group discussion	Public Health n=8	Open ended questions
Documents reviewed	150+ [30 prior to Nauru review mission]	Thematic analysis to address KEQ

3. Findings and analysis

¹⁵ Ideally service users of the health system, including local women and men, people with disabilities, and other marginalized groups, or relevant women's organisations, organisations of people with disabilities (OPDs) and relevant NGOs – would be interviewed to understand their experiences of and barriers to access to health care provision

Findings are based on observations from site visit to facilities in Nauru, an analysis of over 150 documents and over 60 key informants who provided input to the Review (Table 1).

A significant constraint to a comprehensive, evidence-based review of health sector progress was the absence of a contextually relevant monitoring and evaluation framework (MEF). The NHSP design proposed a detailed MEF with EOPOs, Intermediate Outcomes (IOs), Outputs and Indicators through which to guide and measure program delivery. The Implementing Partners (Palladium and WHO) drew on the MEF in the design while preparing the final MEFs covering the EOPOs they were delivering. However, the means for collecting and reporting against almost all of these indicators were not in place at the commencement of the program. As such, neither targets nor baseline data were established. It is assumed that the NHSSP and WHO had intended to establish systems and mechanisms to strengthen MHMS data collection and reporting (such as electronic health information systems and patient records) during the course of NHSP implementation, but for various reasons these processes and systems were not completed.

As a result, it was not possible for the Review Team to make a comprehensive assessment of progress against the Intermediate Outcomes identified in the NHSP MEF. In the absence of indicator data, the Review Team focused on the EOPOs, and triangulated findings with key informants from within Nauru - MHMS, external government agencies - and donor/technical agencies across the region, to verify details in NHSSP, WHO and MHMS reports.

3.1. Relevance

Given the country and health context (outlined in the Background section), the NHSP was highly relevant to the Nauru health sector. It supported the high-level *Nauru National Sustainable Development Strategy (NSDS) 2019-2030*, National Development Priority of 'Improved health and well-being' and in the initial period for this review (2018-2022) was aligned with the *National Health Strategic Plan 2016-2020* KRAs and the *Nauru NCD Strategic Action Plan (2015-2020)*.

The NHSSP then supported development of the new *National Health Strategy (NHS) 2021-2025*. DFAT (bilateral and regional) investments aligned with Strategic Priority (SP) 1 focused on health service delivery; SP 2 on partnerships; SP 3 on leadership and good governance; SP 4 on corporate services; and SP 5 on health professional training and development. The NHSP also supported the MHMS to develop the *Nauru NCD Strategic Plan 2021-2025* with its focus on improving prevention, detection and management of NCDs, with support to MHMS from WHO.

The NHSP and other DFAT regional programs also aligned with the GoA's *Aid Investment Plan for Nauru*, which included a strategic priority of progressing health and education outcomes. If Nauru is to meet the ambitious targets of the *NHS 2021-2025* and *NSDS* by 2030 (with some targets to 2037), the MHMS will continue to need support from all development partners for a longer timeframe than the three years that was the actual timespan of the NHSSP.

The Review Team found no evidence of DFAT-supported health investments in Nauru which did not align with GoN or GoA strategic priorities for health improvement and strengthened health system management. All DFAT (bilateral and regional) investments during the period were highly relevant to the needs and strategic priorities of the Nauru health sector.

3.2. Key Achievements

Based on documented achievements in progress reports, key informant interviews and the Review Team's observations, NHSP directly contributed to some progress against the four key results areas (KRA) of the *NHS 2016-2020* (Annex 4). Most of the high-level EOPOs in the NHSP Monitoring and Evaluation framework were at least partially achieved (see Table 4 and Annex 4 for detail). Support for the strengthening and expansion of the Logistics Management Information System (LMIS) mSupply has been a stand-out success of DFAT support during the period. Table 2 presents other

highlights of bilateral and regional investments, with deeper analysis against EOPOs and IOs addressed in the KEQ sections following and a detailed analysis at Annex 4.

Table 2. Highlights of NHSP Achievements

Leadership and management

- ✓ A well-functioning MHMS Health Executive – now meeting regularly and with the new Minister for Health; with local, young and committed Directors who are being well mentored by the current Deputy Secretary – *‘[The Deputy Secretary] is always there if I have an urgent question, but he doesn’t just fix the problem for me – he leads me to find the answer’.*
- ✓ Health sector planning with Standard Operating Procedures (SOPs) and Guidelines have been drafted, and AOP processes are improving – *‘[The Health Planner adviser] spent time working with me to help me understand what was needed in an AOP; before I was just told to do it with nobody to ask.’*
- ✓ Advisers supported MHMS to develop and endorse a comprehensive *Nauru Health Strategy (NHS) 2021-2025* that is the core planning document for MHMS. It establishes the strategic direction, areas of investment, implementation framework and resources required for the health sector over the next five years
- ✓ Inclusion of GEDSI considerations in the Nauru Health Strategy 2021-2025 and Annual Operating Plan 2022-2023
- ✓ Current advisers are working closely with local counterparts and mentoring 1:1, addressing their challenges rather than just training large numbers with uncertain learning outcomes

Health information and logistics systems

- ✓ NHSSP LMIS Adviser initiated a major overhaul of pharmacy store inventories, expirations and systems, resulting in substantial savings; and trained 16 pharmacy and laboratory staff in mSupply system
- ✓ The laboratory system has been integrated into mSupply but is waiting on a new warehouse facility to safely store lab supplies before proceeding with staff training and setting up inventory systems
- ✓ Beyond Essential Systems (BES) have developed individual health records; key informants reported that these have been used effectively to manage COVID-19 testing and vaccination towards the end of NHSSP, and have enabled provision of internationally accepted certificates¹⁶
- ✓ Tupaia, along with other data sources, was used during the COVID-19 response to communicate immunisation and testing data to the population through public announcements from the President and the COVID-19 task force¹⁷

Community and Public health

- ✓ Community Health services are being energised by a recently devised Community Health Project Plan (CHPP). This Plan is informed through District Health Profiles that highlight disease prevalence and service need. Essential Services Packages and Models of Care have been established but further training and implementation support is needed
- ✓ Community health staff are conducting integrated visits to communities – for example, communicable diseases team are joining with immunisation teams, and there are efforts towards decentralised service delivery with the recent re-opening of the Wellness Centres
- ✓ Evidence of improvements in NCD management for patients, through clinical audit of files
- ✓ Study undertaken on the barriers for people with disabilities in accessing health services in Nauru. The study provides important baseline data for the impact of future program support and can inform design of future health investments
- ✓ Development of forms for Public Health teams that can be imported into Tamanu, using Patient Identity code.

¹⁶ [Beyond Essentials](#)

¹⁷ [Beyond Essentials](#)

Highlights of achievements from other DFAT funded health support to Nauru (detailed in Annex 3) are summarised in Table 3 below. Regional programs also provided multiple inputs to Nauru during the pandemic.

Table 3. Achievements from other DFAT-funded health support

✓	HSI supported recruitment and deployment of three long-term advisers (DMS, Deputy Secretary and Public Health COVID-19 Adviser)
✓	HSI funded two regional advisers (IPC and Field Epidemiology) who provided some support to Nauru
✓	Funding to UNICEF for the introduction of HPV, PCV and rotavirus vaccines (through CHS funding, and USD 150,000 from bilateral program to sustain vaccine introduction in 2022): 245 girls administered a first dose of HPV vaccine in December 2021. Second dose administration began in June 2022. These vaccination efforts are currently being supported by complementary funding provided by Rotary through UNICEF Australia. DFAT funding will allow extension beyond 2022.
✓	IPC preparedness training and pre-positioned supplies resulted in an excellent COVID-19 response during the June 2022 outbreak. <i>'[The COVID-19 Adviser] wasn't in-country at the time, but she had done so much work to prepare us that we felt ready and able to implement what we had learned from her'</i>
✓	Acting Director of Medical Services (DMS) and Matron demonstrated the effectiveness of preparedness and capacity development activities during the COVID-19 outbreak through stepping-up and leading the response well after all advisers had left the country (or remained at home); they pivoted well to train volunteers as staff became ill and rosters needed to be continually adjusted to provide basic care to patients
✓	COVID-19 outbreak response by Hospital, Public Health staff and volunteers was impressive due to preparedness training and mentoring. Vaccination was rapidly initiated in the community by Community/Public Health teams as a result of training and pre-positioning of vaccines
✓	Funding of technical support from regional partners such as WHO and SPC, and supply of new GeneXpert testing machine and cartridges, PPE and other medical equipment
✓	In 2021-22, Australia supported the delivery of 19,170 vaccine doses to Nauru, including 1,000 vaccination doses from its domestic supplies through UNICEF supply chain. Through this mechanism and COVAX (partially supported with Australian assistance), 25,570 doses were donated to Nauru. By the end of 2021, 65 per cent of the total population had received one dose, while 63 per cent were fully vaccinated. As of 27 October 2022, 99 per cent of the population had received at least 1 dose of COVID-19 vaccine, and 73 per cent are considered fully vaccinated.
✓	Support for COVID-19 vaccinations funded through VAHSI and delivered either through UNICEF's global procurement, or dose-sharing of Australian-manufactured Vaxzevria vaccine
✓	TGA Pacific Medicines Testing Program of 32 items resulted in detection of six failed products, which has led to a new MHMS system of quarantining items until they have passed testing
✓	SPC's Public Health Division spent €26,910 [approximately AUD 44,000] to support Nauru health-related activities: training, procurement and technical support. Most of the Nauru expenditure supported training in Critical Care Nursing and for seven participants in the Strengthening Health Interventions in the Pacific – Data for Decision Making (SHIP-DDM) Epidemiology Program
✓	RACS provided four VMTs in the period with 233 patients receiving specialist consultations and four surgical treatments; 33 clinicians have been mentored or received training.
✓	Australia Award Pacific scholarships supported seven Nauruans to complete under- and post-graduate training in nursing, public health and medical sciences in Fiji (FNU CMNHS) and nine to Australia during 2018-22. Recent graduates have taken-up key posts within the MHMS, including as the Director of Nursing Policy and Standards, a senior midwife in the maternity unit, and one in Health Promotion
✓	FNU CMNHS (with some regional funding from DFAT) provided undergraduate and postgraduate health professional training for 24 Nauruans from 2019-2022.

3.3. Challenges

The period 2018-2022 was a challenging time for project implementation, commencing with delays to NHSSP's inception phase (July-Dec 2019) due to elections in Australia, followed soon afterward by elections in Nauru. This generated a change in Nauru Government, and a reorganisation of human resources at MHMS, including appointment of a new Minister, Secretary and Director of Medical Services (DMS), none of whom had been involved in the initial planning for NHSP, and as such were not fully briefed on the program's goal, logic and proposed outcomes¹⁸.

The new senior appointments generated instability and uncertainty within MHMS. Significant engagement issues were experienced by NHSSP following the appointment of an expatriate DMS/Deputy Secretary of Health in 2019, and the subsequent appointment of nine expatriate staff (known and connected to the new DMS)¹⁹. It was in this dysfunctional environment that NHSSP attempted to establish and influence governance systems and relationships, with only limited effect.

In early 2020, the COVID-19 global pandemic seriously impacted implementation of the NHSP when all advisers left the country as border closures and travel restrictions were mandated. Most NHSSP advisers worked remotely for over a year, while others did not return. WHO's advisers attempted remote support to Nauru for over two years, only returning for a short input in September 2022.

In March 2021, following a prolonged period of dysfunctional and fractious management, the ten expatriate medical staff, including the DMS/Deputy Secretary resigned *en masse*, resulting in a short period of insufficient clinical care until DFAT provided support for a new international DMS and a separate recruitment of Deputy Secretary. This presented an opportunity for NHSSP to re-establish its relationship with MHMS, and the pace of activities increased, however the delays at the beginning of the project left limited time to truly embed the new systems and practices (such as newly developed SOPs, AOPs and strategies) into MHMS operations.

Outside of these external factors, implementing agencies also share some responsibility for limited performance. The NHSSP recruited some advisers during the period who were not suited to working in Nauru, resulting in their inputs ending abruptly, while others proved simply to be ineffective. Recruitment of advisers also appeared to be a challenge for the managing contractor, who was unable to fill some key adviser positions following COVID-19. There was surprise and concern expressed by some MHMS key informants at the abrupt departure of WHO advisers when COVID-19 was announced as a pandemic, who were then slow to return to Nauru; this created tensions with some key MHMS staff not happy with this perceived abandonment by advisers.

RACS has communicated that it was difficult until recently to engage the MHMS for appropriate planning and preparation ahead of VMTs, however some MHMS clinical managers (and indeed RACS themselves) have suggested that the guidance and support from RACS to encourage MHMS to advocate for, and request VMTs could be strengthened.

Any progress made was impacted by high rates of staff vacancies, absenteeism, and staff turnover within MHMS²⁰. A key lesson learned is that adviser support needs to be provided in-country. Neither NHSSP nor WHO were able to progress project activities effectively through remote support, with many confirming that attempts to deliver training and consultations via online platforms were met with reduced attendance and/or technical/connection difficulties. By contrast, initiatives which

¹⁸ Key informants within MHMS senior management reported to have been unclear of what NHSSP was supposed to be doing for some time after it commenced operations, and of their own role in engaging with the project.

¹⁹ A number of key informants reported that the new appointments proved disruptive to the overall governance and management of the health sector, reflecting disparate priorities of the individual appointees which did not always align with strategic priorities of the sector, and side-lined senior and mid-level national health sector managers.

²⁰ Reports indicate that only 4 of 11 health information management positions that report to the Director of Medical Services were filled; vacancies included the Chief Information Officer. Staff attendance in the Pharmacy store and dispensary was a particular concern and as low as 17 per cent. This led to a decline in the inventory management of the stock and impacted negatively on the inventory management system. The overall MHMS vacancy rate is approximately 40 per cent (i.e., only around 60 per cent of the establishment is filled).

benefitted from constant support, such as strengthening and expansion of mSupply through the LMIS Adviser, proved extremely successful, as has recent support from BES to improve hardware and software solutions through the provision of longer-term advisers who understand the Nauruan context, and are willing to invest in building working relationships with counterparts.

3.4. Key Findings against Key Evaluation Questions

The Terms of Reference for the Review (Annex 1) specified six key evaluation questions (KEQs) that are addressed in detail in Annex 4, with key findings against each KEQ provided below.

1. *To what extent have DFAT's investments made a **strategic contribution** towards helping achieve the outcomes of the MHMS' Health Strategies and Plans, including Nauru's NCD Strategic Action Plans?*

The extent to which DFAT's investments in the Nauru health sector from 2018-2022 made a strategic contribution to outcomes was impacted by the absence of strategic, evidence-informed health sector planning. Due to delays in finalising and releasing the *Nauru Health Strategy (NHS) 2021-2025* and *Nauru NCD Strategic Action Plan (2021-2025)*, the period for this review (2018-2022) was largely guided by the *National Health Strategic Plan 2016-2020* and the *Nauru NCD Strategic Action Plan (2015-2020)*. The NHSP EOPOs aligned with and supported NHS 2016-20, largely in Key Results Areas (KRA) 1 and 2, and to a lesser extent 3 and 4 (see Table 4 and Annex 4 for KRA progress).

Advisers under NHSP made a substantial contribution to strengthening the health sector strategic framework through facilitating the development of new, evidence-based NHS and NCD strategies, and through guiding and linking operational planning to these. It is noted, however, that these gains were made only in the last 8-12 months of the program, leaving little time for NHSSP and WHO advisers to support the MHMS to operationalise these strategies/plans.

NHSSP advisers supported the development of the new *Nauru Health Strategy (NHS) 2021-2025*. This document is comprehensive and ambitious and founded on a detailed evidence-base derived from multiple sources across the sector. It is an improvement on the previous Strategy as it articulates high-level costings, and some guidance for the development of costed AOPs, linked to a comprehensive monitoring and evaluation framework which establishes targets and potential data sources, and lists of proposed interventions. These substantial improvements to the *NHS 2021-2025* will contribute to an overall, strengthened sectoral strategic framework.

It should be noted however, that the breadth and ambition of the new strategy, and the limited means through which to collect and analyse data for monitoring progress and reporting on effectiveness will continue to pose a challenge to the MHMS.

WHO and SPC supported the development of a practical *NCD Strategic Action Plan 2021-2025*, endorsed by the NCD Taskforce in October 2022. This document sets out targets and a strategic multisectoral approach to tackling NCDs in Nauru that will continue to need support in the future. Given the breadth of strategic focus, inclusive of sectoral governance and system strengthening, public health programming, clinical care and improved data collection, analysis and reporting, the MHMS will likely require support in the next two-three years in order to operationalise and monitor progress against the new strategies and plans. Unfortunately, many of the actions recommended from the previous NCD Strategic Action Plan have been carried over from the 2015-2020 NCD Plan, indicating a lack of action and cross sectoral commitment to tackling NCDs.

2. *How **successful** have the investments been in achieving their stated **outcomes**? What has been NHSP's progress in achieving its end-of-program outcomes and intermediate outcomes?*

Success has been hard to achieve given the unprecedented challenges and setbacks from early implementation (see Section 3.3). Nonetheless, between 2021 and 2022, NHSP (inclusive of both NHSSP and WHO) managed to reverse stagnant progress and commence momentum towards the intermediate and end-of-program outcomes. Table 4 provides a summary of progress against EOPOs

with full detail and analysis at Annex 4. In all cases, the EOPOs are at best only partially achieved, however current focused support towards agreed priorities, delivered by experienced advisers will continue this momentum. A challenge for this ongoing support will be to foster ownership and stewardship of progress within MHMS clinical and community health staff.

Table 4: Summary of NHSP Progress against EOPOs (Annex 4)

Expected Outcomes	Assessment	Assessment description	Status Summary (end June 2022)
EOPO 1.1: By 30 June 2022, health managers and clinicians have access to timely, relevant, and user-friendly health information to inform decisions and reporting [NHSSP]	Partially Achieved	A number of health information management systems (HMIS - such as Tamanu, Tupaia and mSupply) have been established, with some staff trained and systems in use across some locations/programs, while further expansion and consolidation is required. Other proposed systems have not yet been introduced (LIMS, RIS/PACS, CanReg). The Health Information Unit has not been formally established or staffed.	The rollout of new HMIS supported by Australia began in March 2021; by June 2022, there had been some improvement, but the HIU was not functional (many vacancies). An HMIS TWG was formed and is now a MHMS Standing Group. NHSSP assisted MHMS to strengthen the ICT network, HMIS and LMIS, including the installation of the Master Patient Index (PMI) and immunisation module in Tamanu (including 35 staff and volunteers trained for COVID-19 testing and vaccination tracking), the installation of Tupaia and upgrading mSupply.
IO 1.1: HMIS and LMIS are functional; staff are trained HMIS and LMIS use; HIU capacity is strengthened	Partially Achieved	Underway	Establishment of 16 data entry forms to capture clinical and public health information, and to prepare other datasets for merging across to Tamanu. A NHSSP LMIS Adviser supported the Chief Pharmacist to oversee expansion of mSupply across MHMS; training of 16 pharmacy, stores, laboratory and health service staff; stores management systems overhauled; expired stock removed; stock-outs prevented; SOPs established and well utilised; procurement systems overhauled saving MHMS hundreds of thousands of dollars (AUD448,000 in 2022).
EOPO 1.2: By 30 June 2022, MHMS has made progress in developing, implementing, monitoring and evaluation of Annual Operational Plans (AOPs), and undertaking performance management [NHSSP]	Partially Achieved	AOPs were developed in the final 8 months of NHSSP, following drafting of the NHS 2021-2025 (not formally endorsed until early 2022), and there was little opportunity to align AOPs with the new strategic objectives.	Despite slow initial progress, there is evidence of improved health sector planning: draft SOPs and Guidelines have been developed, and AOP processes are improving with support from advisers and Deputy Secretary of Health for 2022-23 AOP.
IO 1.2a: AOPs being approved and used in alignment with GON timeframes and standards	Partially Achieved	MHMS senior managers report being unprepared to direct AOP development without technical support or guidance.	Performance management systems and 'culture' was not achieved by the end of NHSSP and will need attention in the transition.

Expected Outcomes	Assessment	Assessment description	Status Summary (end June 2022)
IO 1.2b: Health staff have clear work objectives linked to the AOP and performance appraisals		Performance management systems are weak and controlled centrally by GoN; there is little opportunity or mandate for MHMS to performance manage its personnel.	
EOPO 1.3: By 30 June 2022, high priority and appropriate health system Standard Operating Procedures (SOPs) are available [NHSSP]	Partially Achieved	SOPs were developed in the final 2 months of NHSSP, and although well received by MHMS management, there was little opportunity to train and operationalise these guidance documents.	Some SOPs and guidelines developed in final months of NHSSP, including patient referral and admission, management of laboratory specimens, IPC, mortuary management, information and record management, patient referral and care planning, human resources and performance management.
IO 1.3: SOPs included in AOP and workplans, and are being developed by line-managers	Partially Achieved	There has been no opportunity to date to include the new SOPs in AOPs and workplans.	Drafts well received, however more work is required to bring them to completion, endorsement and implementation. NHSSP adviser support for RON Hospital Operations remain inadequate; failing infrastructure and biomedical equipment, and inadequate systems for requesting, logging and tracking maintenance support.
EOPO1.4: By 30 June 2022, managers have increased their competence and a culture of 'learning through doing' is emerging [NHSSP]	Not achieved	EOPO was not addressed under NHSSP as originally intended due to repeated delays, and eventual agreement (between DFAT and the Managing Contractor in late 2021) to remove this from the NHSSP scope. NHSSP articulated that MHMS counterparts were not available to progress this, and delays associated with absent advisers shortened the time available to progress this.	Not achieved
IO 1.4: A cadre of future health managers have improved management competencies in keeping with organizational need and context	Not achieved	Not achieved	Not achieved
EOPO 2.1: By 30 June 2022, a more functional and effective community-based primary health (PHC) system is in place [NHSSP]	Partially/ Minimally achieved	The CHPP has been finalised and released by the MHMS following consultation for its development, however, there appears to be only minimal understanding of the proposed models of care and essential packages of services amongst public health and RON Hospital personnel.	Progress was made from mid-2021, with consultation for, and development of the Community Health Project Plan (CHPP); finalised in Quarter 1 2022, leaving little time to sensitise sector and staff to the Model of Care and Essential Services Packages.

Expected Outcomes	Assessment	Assessment description	Status Summary (end June 2022)
IO 2.1: Community-based health services delivery has been strengthened	Partially/Minimaalu achieved	The Wellness Centres are (recently) opened, but not efficiently staffed, nor offering comprehensive services. These facilities are not fit for purpose in accordance with the CHPP; they require substantial upgrade and/or re-building. Staff and communities are yet to fully understand and embrace the model.	The Wellness Centre PHC facilities are not fit-for-purpose, with few patients attending, despite being staffed by well qualified nurses. Wellness Centre infrastructure works stalled with NHSSP's inability to present a viable alternative to demountable/container structures for consideration by DFAT and MHMS.
EOPO 2.2: By end October 2022, timely, effective and cost-efficient detection and management of NCDs is more accessible to men and women [WHO]	Tentatively achieved – to be confirmed	Preliminary, reported results of outputs suggest significant increase in identification and management of women and men with NCD risk factors, in accordance with NCD PEN protocols. Further, outcomes-focused reporting will confirm actual progress against EOPO.	WHO advisers made progress in supporting roll-out of NCD PEN prior to the COVID-19, but progress slowed under remote support for two years (until advisers returned in October 2022). Staff trained on NCD PEN SOPs.
IO 2.2: Men and women at elevated risk are being identified and managed according to PEN protocols	Tentatively achieved – to be confirmed	Underway	A remote audit of clinical files in May 2022 showed improvement in key indicators of standards of care - WHO reports improvements to the numbers of target populations screened: 62% (of adults over 30 years of age) from a baseline of 0%, and cardiovascular disease risk assessment to 87.5% from a 0% baseline in 2019. 67% of registered individuals with diabetes mellitus received comprehensive foot examination within the last 12 months (compared to 0%) in the previous audit. Patient-held booklets developed and printed; unclear how much they are being used; some community nurses reported no awareness of the booklets. These represent preliminary results (mostly outputs); next NCD STEPS and Global School Health Surveys (scheduled for 2023) will provide a more accurate picture of progress against the EOPO.
EOPO 2.3: By end October 2022, men, women, boys and girls have improved knowledge on risk factors of NCDs and tobacco use behaviour has started to change [WHO]	Partially achieved	Efforts to reform tobacco control legislation have not been fully concluded, and the NCD Task Force has been inactive since before the mid-2022 COVID-19 outbreaks.	(end May 2022): Amendments to Tobacco Control Amendment Bill in 2019, and a Cabinet submission re-drafted in 2021; this has not progressed. Tobacco tax instituted July 2020 and data shows a decline in imports. Progress on Tobacco Control legislation, enforcement and hypothecation will be provided in the WHO completion report.

Expected Outcomes	Assessment	Assessment description	Status Summary (end June 2022)
<p>IO 2.3a: Men, women, boys and girls are being targeted with activities to adopt healthier lifestyles</p> <p>IO 2.3b: The NCD task force is taking a multisectoral approach to addressing NCD risk factors</p>	Partially achieved	Early data on NCD risk factor awareness suggests reasonable outcomes from supported multi-media Accampaigns and awareness.	<p>NCD lifestyle risk factor awareness through Health Promotion Unit and the District Health Workers; mDiabetes Project has launched six social media videos (mid 2021) with support from Digicel Nauru. KAP survey in October 2021 found moderate rates of knowledge about harmful effects of smoking. Tobacco cessation training for staff; 146 clients registered for Quit Smoking clinic. Interventions to be measured through the STEPS and Global School Health Surveys (scheduled 2023).</p> <p>Progress on the multisectoral NCD Taskforce and Health Promoting Schools network were to be revitalised in October 2022 (report pending). A NCD Strategic Action Plan 2021-2025 has recently been endorsed by the NCD Taskforce.</p>

3. How successful has DFAT been in supporting Nauru's COVID-19 response?

Nauru's multisectoral preparedness and response to COVID-19 was impressive for a country with a small population, significant co-morbidity and economic reliance on international connections. Prior to June 2022, Nauru had experienced only three confirmed cases of COVID-19, which were identified in quarantine and remained isolated for their infectious period. Under strict entry criteria requiring travellers to show proof of full vaccination, and to undergo mandatory, managed quarantine on arrival, international travel to Australia recommenced late in 2021. Nauru experienced no increase in cases until the Omicron variant was identified in the population on 19 June 2022, after which a rapid escalation saw confirmed COVID-19 cases reach 4,618 by 20 August 2021. Further spread was limited through a rapid, comprehensive vaccination campaign, on already high vaccination coverage rates. Only one death was recorded, of a woman with significant co-morbidities.

The success of Nauru's COVID-19 preparedness and response can be strongly attributed to the broad political and government-wide leadership of, engagement in, and cross-sectoral resource allocation to the COVID-19 Task Force. Additionally, many within the Task Force, across government and especially within the health sector, identify support from DFAT advisers as having been fundamental to the country's readiness to respond to the outbreaks in mid-2022. In particular, the efforts of the Public Health COVID-19 Response Adviser (recruited with CHS support through the HSI under DFAT's bilateral program) were identified as being crucial to the establishment and effective implementation of the national response. Key informants (MHMS and COVID-19 Taskforce) reported that the adviser worked tirelessly across all programs, units and departments of the MHMS, and as a special adviser to the COVID-19 Task Force, to facilitate consultative development of COVID-19 preparedness and response SOPs, implementation guidance, IPC guidelines and quarantine, isolation and case management guidance and protocols. She also facilitated group training and 1:1 follow-up training and mentoring and worked collaboratively across the MHMS to conduct simulations for detection, isolation and response. The success of these efforts is evident in the performance of MHMS staff during the outbreak, well after the adviser's scheduled departure.

With many health staff falling ill during the outbreak and rosters proving impossible to fill, the Acting DMS and Matron worked with the Nauru Health Professional Training Institute (NHPTI) and IPC nurse to train volunteers on IPC and provide basic care for patients.

The roll-out of Tamanu for COVID-19 and other immunisations enabled digitised vaccination certificates for COVID-19, essential for travel. The Tupaia platform was used effectively during the COVID-19 response to communicate immunisation and testing data to the population through public announcements from the President and the COVID-19 task force.

Support from the DFAT-funded Deputy Secretary for Health, and the NHSSP LMIS Adviser were also instrumental in facilitating procurement of consumables and supplies for the COVID-19 response effort. A DFAT bilateral DFA (AUD 1.4m over two years) also contributed to the multisectoral COVID-19 response, through procurement of medical equipment and consumables, support for IPC, diagnostics and education and training, and the renovation and fit-out of the ACU at RON Hospital, which was used as a COVID-19 isolation facility throughout the pandemic.

Other indirect DFAT support to Nauru's COVID-19 preparedness and response efforts included:

- HSI supported technical advice, recruitment and deployment of three long-term advisers (DMS, Deputy Secretary and Public Health COVID-19 Adviser)
- Funding of technical support from regional partners such as WHO and SPC, and supply of new GeneXpert testing machine and cartridges, PPE, RATs and other medical equipment
- Support for COVID-19 vaccinations funded through VAHSI and delivered either through UNICEF's global procurement, or dose-sharing of Australian-manufactured Vaxzervria vaccine
- In 2021-22, Australia supported the delivery of 19,170 vaccine doses to Nauru, including 1,000 vaccination doses from its domestic supplies through UNICEF's supply chain. Through these mechanisms and COVAX (partially supported with Australian assistance), 25,570 doses were donated to Nauru. MHMS reports that by the end of 2021, 65 per cent of the total population had received one dose, while 63 per cent were fully vaccinated²¹. No wastage was reported in Nauru during 2021; Australia is closely coordinating with other development partners and MHMS to mitigate risk to wastage by avoiding over-supply and providing assistance on cold-chain management.

Prior to the pandemic (2018 and 2019), DFAT had already supported national preparedness for emerging infectious diseases in Nauru, which later informed early COVID-19 preparedness work:

- Development of an options paper for Australian support for health security in Nauru
- Technical support (from WHO) for an all-hazards Public Health Emergency Preparedness and Response Plan
- Technical support for IPC; institutional reform in the management of IPC (April-August 2019).

*4. To what extent have the **modalities** used for DFAT support impacted on the **effectiveness and efficiency** of health support to Nauru, and what lessons have we learned?*

Following the 2017 review of DFAT's health sector support to Nauru, it was determined that direct funding from DFAT through GoN financial systems had not proven to be an effective modality. It was recommended that alternative means of providing bilateral support be trialled, most notably through funding a system strengthening program (NHSP), delivered by a Managing Contractor (for NHSSP) and a support project led by a credentialed technical agency (WHO for NCD prevention and management). Beyond bilateral funds and assistance, the Nauru health sector also benefitted from a range of DFAT-funded global and regional development modalities, comprising technical and/or material and procurement assistance from different implementing agencies. A full description of the range of funding modalities to the Nauru health sector is presented in Annex 3.

Through a variety of funding and support mechanisms (bilateral, regional and global), DFAT funding has continued to make a significant, effective contribution to the management and strengthening of the health sector, and the improved delivery and coverage of preventive and clinical health services

²¹ As of 27 October 2022, 99 per cent of the population had received at least 1 dose of COVID-19 vaccine, and 73 per cent are considered fully vaccinated.

to the people of Nauru. The Review Team conclude that NHSP's EOPOs were at least partially achieved (with one exception), although much of the progress has been made only in the last 12 months (see Challenges). This limited progress does not necessarily indicate ineffectiveness of bilateral funding, but rather slow provider ability to deliver results - given the context of disruptions at project commencement, and response to COVID-19.

The NHSP was the first program to provide bilateral funding to WHO to implement and report against EOPOs. Without the unprecedented pandemic, there would be a clearer assessment of the effectiveness of this modality. However, it is clear that WHO convening power and recognised technical credentials for supporting NCD programming have led to progress in key areas of NCD clinical care and increased focus on prevention and screening. Support for UN agency and program-specific projects, such as the WHO NCD Pacific unit, can harness a wide range of technical expertise as well as utilise the internal resources of the partner agencies. Such joint UN programs may be more technically and financially efficient and are worth consideration in the future design.

At a regional level, investments offer reasonable value for money for DFAT support to achieve substantial reach across the region. However, the extent to which individual countries benefit from direct interventions is dependent on a number of factors, including need, the providers' motivation to visit and support, and in-country capacity to advocate for, receive and respond to support. In Nauru's case, the review period has seen only minimal engagement or direct benefit from some regional investments, with limited VMTs, clinical mentoring and specialist medical equipment from RACS (through PCSHWIP), and exclusion from DFAT's Transformative Agenda and support to IPPF. Other regional investments have been better utilised by Nauru, such as support to COVID-19 vaccinations, quality reviews of pharmaceuticals and supplies (through the Pacific Medicines Testing Program), training for Nauruan health professionals through SPC, UNFPA supplies and other WHO inputs (detailed in Annex 3).

From an efficiency perspective, the number, relatively small size and disparate funding and support mechanisms can prove difficult for DFAT Post and the MHMS to oversee, monitor, report against and manage. It was challenging for the Review Team to gather information and data from all the multiple DFAT investments. There is no single, streamlined mechanism or platform through which to access details of the many funding and support modalities offered in the region, and especially the extent to which these can be assessed as having reach and impact in individual countries, such as Nauru.

The DFAT Post in Nauru has few staff to manage the multiple requests from a range of GoN departments, not only Health, and to review multiple reports and monitor progress; they have limited capacity to maintain an awareness of the myriad funding streams and programs. There has been concern expressed (from DFAT and the MHMS) that the multiple modalities lack efficiency, and have, at times resulted in some support mechanisms being under-utilised, especially when MHMS staff have had other competing responsibilities or more visible options for resourcing.

Throughout the NHSP, the extent to which the MHMS could absorb and utilise support depended on the capacity, motivation and leadership of key individuals responsible for delivery or oversight of particular programs, units or services. Within this environment, willingness of key staff to advocate for, and support delivery of assistance has been a key factor in some investments working well, while others (particularly the larger, bilateral investments with multiple streams of support, such as those delivered through the NHSP managing contractors and technical agencies) have faced implementation challenges.

Within the foreseeable future, the MHMS will likely continue to experience widespread vacancies across key management and service delivery positions, and this will impact the extent to which larger, consolidated investments will be supported and utilised. Further work to strengthen systems and foster collective appreciation of, and engagement in strategic and operational planning within MHMS, will help the Ministry recognise the range and modalities of investments it has at its disposal, that can be used to plan, schedule and track grants and disbursements. Closer, regular engagement

between the MHMS and DFAT Post perhaps through facilitation from the Deputy Secretary for Health will help both parties to maintain oversight and track multiple investments.

*4. How effectively are **governance** systems working with MHMS, DFAT and partners and how can these be improved?*

The Program Steering Group (PSG) was the primary governance mechanism for the NHSP and included senior representatives from MHMS, Ministry of Finance (Planning and Aid Division) and DFAT. Other development partners (apart from WHO as an implementing agency) were not included. The NHSSP Managing Contractor was required to establish, coordinate and support the PSG. An inaugural meeting was held in November 2019, but the second meeting was not convened for 16 months (in March 2021) due to COVID-19 priorities and absence of advisers. Over the final year, three additional meetings were held which essentially provided updates but did not act as a forum for strategic planning, review and problem solving. Active participation was challenging as WHO and some advisers were attending online. The inability to gain active engagement during the pandemic was experienced in many PICTs and many Ministries of Health have expressed how pressured they felt with competing demands and urgent priorities during the pandemic.

Other DFAT sections (CHS, OTP and GHD) that were providing funds to the Nauru health sector, especially related to COVID-19 preparedness and response, were not included in the NHSP PSG meetings, nor was there active participation from other health development partners such as UNICEF, WHO DPS and SPC. While it is acknowledged that the PSG was primarily a mechanism for overseeing the NHSP, it is unclear whether DFAT, MHMS, NHSSP and WHO engaged in any other, expanded forums for strategic sectoral oversight. Given the small population and limited transport routes to Nauru, it is important that health and human development partners better coordinate their efforts in future. In Nauru the COVID-19 Taskforce became the *de facto* forum for coordinating development partner inputs to the pandemic preparedness and response.

5. To what extent have Australia's health investments supported gender equality, disability inclusion and social inclusion and other cross-cutting areas? What has been the performance of these investments regarding improved GEDSI outcomes? What lessons can be learned for future programming?

Gender equality, disability and social inclusion was an important component of the NHSP and highly relevant to the work supported by the program. GEDSI support by DFAT's regional investments was limited and no real evidence of support was found. The document review and consultations suggest that while some GEDSI work had been initiated in other countries as part of the regional programs, such as RACS conducting a gender and disability analysis in some countries, this was not done in Nauru. The findings indicate that some organisations, such as UNFPA have a Gender Equality Strategy that informs their work; however, there is limited evidence to suggest that a GEDSI focus was included in Nauru activities.

A GEDSI Strategic Action Plan was developed by NHSSP in 2020 to guide the program in mainstreaming gender equality, disability and social inclusion across activities. The Plan provided a GEDSI analysis of Nauru and outlined the key challenges and opportunities relevant to the program. It identified key actions to improve participation and access of target groups, including women from different age groups and people with disabilities. However, the activities outlined were overly ambitious and the GEDSI Action Plan was updated and revised in July 2021 to ensure its alignment with NHSSP, MHMS, and DFAT's requirements.

The Action Plan included deliverable actions to support MHMS' GEDSI-related work including: capacity development for NHSSP staff to promote GEDSI awareness and action; GEDSI integrated into HMIS training, analysis, reports; strengthen MHMS ability to apply a GEDSI lens to strategic planning and HR management including women's leadership opportunities; strengthen MHMS response to GBV and child protection; Wellness Centre operational policies understand and meet

needs of target groups; capacity development for Wellness Centre staff on a range of priority health issues impacting target groups; and research to assess barriers to access for people with disabilities to health services. Of these seven activities, one was achieved (disability research); two activities had limited achievement (strengthen MHMS to apply GEDSI lens, and Wellness Centre policies met needs of targeted groups); and four activities were not achieved (capacity development of NHSSP staff, GEDSI integrated into HMIS training, analysis, strengthen MHMS response to GBV and child protection, and capacity development for Wellness Centre staff).

An international GEDSI STA was appointed in January 2020 who was responsible for leading the implementation of GEDSI activities; however, the adviser provided limited in-country or remote support to the program, resulting in a lack of practical support and guidance for the program and MHMS. In September 2021, an in-country GEDSI Coordinator was recruited who was able to progress some activities and develop partnerships with relevant government stakeholders, including WASDA, DPLWD, and the Nauru Police Force (NPF) towards the end of the program; the in-country position was a critical factor in accelerating the GEDSI-focused activities.

The GEDSI Coordinator was able to initiate discussions with MHMS on the implications of gender equality, disability and social inclusion on healthcare access and health outcomes. As NHSSP did not provide support or training opportunities to MHMS to support them in applying a GEDSI lens to their strategic planning or HR management processes, the discussions facilitated by the GEDSI Coordinator enabled GEDSI considerations and the role of women in health to be highlighted in MHMS' planning process. As a result of these discussions, GEDSI considerations have been included in the Nauru Health Strategy and Annual Operating Plan 2022-2023.

The GEDSI Coordinator engaged with WASDA and DPLWD on the development of GEDSI-Sensitive Patient Referral Guidelines and Standard Operating Procedures for processing GBV victims/survivors through the health system. While this is a significant achievement, healthcare workers have not been trained on using the Guidelines and SOPs and have received little or no training on GBV awareness. WASDA receive approximately 10 cases of violence per month at the Safe House and take women to hospital only if they have injuries, as most staff do not understand the reporting processes or confidentiality requirements. WASDA had trialled a system to have a point person to receive and support women experiencing GBV in the hospital; however, this person was not interested in the role and victims/survivors were sent to the maternity ward where they were reportedly poorly treated by nurses. Training of healthcare workers in appropriate management of and care for victims/survivors of GBV is necessary and needs to involve WASDA, as they are the main point of contact for GBV.

The GEDSI Coordinator also engaged with local women's organisations and OPDs, including the Nauru People with Disability Organisation; however, this engagement was limited. The Secretary of the DPLWD indicated to the Review Team that the Nauru People with Disability Organisation had disbanded due to a period of inaction. The team's consultations with WASDA and DPLWD indicate that both government departments require better engagement and communication with MHMS to improve health services for women, people with disabilities, and people from marginalised communities.

NHSSP supported research on the barriers for people with disabilities in accessing health services in Nauru. While people with disabilities were not part of the research team, the Secretary of DPLWD, who is a person with a disability, was engaged in the research. The study found that people with disabilities are not frequent users of healthcare services due to a range of factors including attitudes of healthcare workers, communication barriers, health centre/hospital not accessible for all people with disabilities, and poor knowledge of health workers regarding the needs of people with disabilities. As disability data in Nauru is limited or outdated, this study establishes a baseline for the impact of future program support on health outcomes, policy development, planning and service delivery and provides important information to inform the design of future investments to address

the barriers for people with disabilities in accessing healthcare. A practical example cited to the Review Team was the lack of allied health services and difficulty in getting physiotherapy treatment.

Some capacity building of nurses and nurse aides was conducted as part of larger training packages. GEDSI was integrated into topics such as service delivery and human resourcing. However, MHMS awareness of GEDSI and its relevance to health is difficult to determine, as the trainings were conducted towards the end of the program and did not provide ongoing knowledge or skills development. Addressing gender, disability and social inclusion issues related to health requires individuals to understand the reality of gender inequalities and social exclusion within their communities and workplace before they are able to identify inequalities and exclusion within the health system and how it operates. Given the limited understanding about GEDSI in MHMS, this will take time and significant resourcing to increase knowledge and skills of frontline healthcare workers in particular, and MHMS staff in general, to ensure health services are equitable and inclusive.

NHSSP assisted MHMS to strengthen its Health Management Information System (HMIS) and train staff to use Tamanu and Tupaia systems. The Health Management Information System (Tamanu) has the potential to collect sex disaggregated data. Both the NHS and CHPP include sex and disability disaggregated data and a gender and disability analyses. However, there is little evidence that NHSSP supported MHMS to collect and use disaggregated data in a systematic way; this is an area which should be prioritised in future support to MHMS.

The Community Health Project Plan (CHPP) has a strong GEDSI focus and outlines key outputs related to improving community health services for survivors of GBV, people with disabilities, and mental health clients. Community health activities will require ongoing support during the transition program to strengthen and further the integration of GEDSI considerations into the operationalisation of the CHPP.

3.5 Recommendations for Future-focused Key Evaluation Questions

In addition to the KEQ, recommendations on a set of questions focused on future health support to Nauru are summarised below and detailed in Annex 5. Recommendations for the future focused KEQs presented here include both the transition phase and future design.

6. *How can DFAT support MHMS to improve performance and sustainability of the health system and health service delivery including pandemic preparedness and response (considering the COVID-19 context)?*

To improve performance and sustainability of the health system, support needs to be directed to key areas of MHMS business, including:

- Strengthened management and leadership
- Improvements to corporate services, especially human resource functions
- Strengthened clinical services management, especially standardising care and management
- Improved Public and Community Health through new Model of Care
- Preparedness and response to COVID-19 and other emerging infectious diseases.

Improved MHMS system performance will best be achieved through greater, regular, sustained engagement with MHMS in the development and ongoing monitoring of development partner assistance, so that the features and modes of delivery continue to meet the agreed priorities of the MHMS. This will require discussing the capacity development needs of the MHMS with the Health Executive Team, and determining if there is a need for short-term, in-line support while identified Nauruans are being upskilled and trained. An updated Health Workforce Plan should be the basis for this discussion.

A critical constraint is that currently there are insufficient qualified and experienced health workers in Nauru to fill existing vacancies. While there are a few on scholarships, and there are plans to train more nurses in Nauru for the Nauru health system, staffing will remain insufficient for a basic,

essential health system now and for at least the next five years. A ‘twin-track’ approach of training lower-level cadre locally, along with regional higher education aimed at specific senior positions, is recommended to address sustainability of gains.

There are limited options to provide support to MHMS to enhance performance without a change to GoN Central Human Resource processes (relating to recruitment for vacant positions, local salaries, demotivation and turnover of staff).

Bold leadership from a new Minister for Health and a united Health Executive Team could influence positive change through demonstrating commitment to health sector reform focused on improving performance. The current MHMS Directors show potential and with good mentoring could revitalise their Divisions – but they need support to take on such leadership roles. A Management Development process would be beneficial to reinforce a supportive organisational culture and working environment.

Support for pandemic/infectious diseases preparedness and response will continue to be needed in the short-term, however with a view to continuing system strengthening. In the (expected) final stages of the COVID-19 Task Force, support is needed for the MHMS to develop a Bed Plan to utilise the well-equipped ACU (refitted with DFAT funds) for critical care patients, including SOPs and protocols for rapid transfers of patients to other wards, should a COVID-19 patient require admission.

7. How can the performance of Australia’s current health investments be improved to maximise their impact? For example, related to strategic focus, technical advice, policy dialogue, modality or governance arrangements, GEDSI, risk management systems, development partner coordination or MEL.

The impact of Australia’s health sector investments to Nauru can be improved through a focus on:

- Improved governance and coordination of development partner investments
- The models and processes for recruitment and management of technical advisers
- Realistic and achievable monitoring evaluation and learning (MEL) frameworks

The *Nauru Health Strategy (NHS) 2021-2025* and supporting AOPs provide the sound basis for assessing performance of MHMS Divisions. Strengthening regular monitoring and reporting will help to ensure progress remains on track and will provide a framework to guide implementing agencies. In the longer term, the AOP could be used to assess performance of individuals, programs and units within the MHMS. There may be a need for targeted support for M&E, such as facilitated annual review and reflection workshops – that can feed into Joint Planning processes. In addition, the MHMS has identified a need to strengthen Planning processes and have identified a local position of Health Planning Officer who could be an ideal counterpart for the recommended Planning Adviser position to work with during the transition.

Governance arrangements must be realistic and established with firm commitment from all relevant stakeholders. Depending on the intent of the governance mechanism (e.g. Health Executive Team meeting weekly or fortnightly prior to meetings with the Minister, or high-level quarterly or six-monthly), meetings need to be well supported by all relevant partners, and must be led by MHMS, through clear agendas, assuming chairing roles and being proactive in requesting and responding to requests for accountability. Commitments to engage must be maintained at all levels (and not delegated to those with limited authority), and focus should remain both on evidence-based performance assessments, and critical decision-making to confirm or alter direction of investments.

Technical advisers need to have identified counterparts who can be the focus of skills transfers and capacity development. It would be useful for advisers to jointly develop Capacity Development Plans early in their engagement with counterparts, taking into account that many staff have multiple jobs that would be done by separate individuals in larger health systems.

As proposed in the NTHP, in the short term, the adviser support model through multiple recruitment and support mechanisms has proven effective when the MHMS determines and prioritises the support required and engages in activity/intervention planning. This adviser support is most effective and sustainable where there is a local counterpart to work with and mentor. Previously, this support has been accessed through entities such as CHS and AusP3 and has placed dedicated, long-term/in-country advisers to provide mentoring and support, and in some cases, in-line roles. The value of these advisory positions is highly dependent on the right selection of long-term adviser matched with a local counterpart who is willing and interested to learn together. There are limited numbers of local staff with the skills to fully take over management of the health system at this stage. It will take time and workforce planning for the localisation change. Supportive and skilled advisers can fill a workforce gap in the meantime, while actively supporting skills development in counterparts and teams.

The **MEL frameworks** developed for bilateral investments under NHSP were comprehensive, but in most cases identified targets and indicators which were beyond the health sector's capacity to verify. Future MEL frameworks need to be realistic and cite only data collection systems and indicators that are available. They should be developed in full consultation with MHMS, sectoral stakeholders and implementing agencies to ensure outcomes are achievable (and measurable) in the given period and should also consider capacity and resource constraints.

Future health program MEL should be co-designed and aligned as far as possible with GoN and MHMS established systems, processes and core health indicators, and should reflect the strategic priorities of *Nauru's National Sustainable Development Strategy 2019-2030* and MHMS's current NHS and NCD strategies. For example, the new NCD Strategy includes a number of targets that will require support to achieve. This will avoid duplication or collecting data which does not have validity beyond the support period, while promoting the use and improvement of existing systems and collection methods. National counterparts should be involved in analysing information, generating findings and making recommendations. Joint annual planning processes provide transparency and an opportunity for Divisions to understand the bigger picture and present on their work to colleagues, encouraging a more collaborative mindset.

Understanding of **GEDSI** within the health system is at a low base and will require strong advisory support to an identified and specific GEDSI position in the MHMS to ensure the principle of 'no one left behind' is understood. This position should work closely with WASDA and DPLWD and community groups to ensure there is appropriate consultation, engagement and complaints monitoring.

8. How should Australia's investment in Nauru's health sector be refocused and/or refined to ensure maximum strategic impact with the resources available for health up to 2030?

WHO health system 'building blocks' continue to provide a useful framework to assess gaps and determine where to focus investments²². In Nauru the focus on health system strengthening, leadership and management and improving PHC and NCD care are still valid and constitute 'unfinished business'; these will continue to need support as described in the Nauru Transitional Health Package (NTHP) under three or four components (to be advised when the design of the transitional package is finalised): improved health information systems and logistics; governance, accountability and performance; community-based care and emergency preparedness and response. At the same time, there are also urgent health infrastructure investments that need to be fast-tracked, working with Ministry of Finance Planning and Aid Division to finalise a Capital Investment and Financing Plan.

While the health system will continue to require strengthening to make an impact on the health of Nauruans, a more comprehensive approach could be considered in future health programming, that

²² Used in Nauru NCD Strategic Action Plan 2021-2025, p.24

includes a focus on broader determinants of health. Globally, it has been recognised that there is a strong investment case for a focus on early childhood development²³ and adolescents and young adults²⁴ - to improve population health. Nauru has a high proportion of young people, facing multiple challenges.

Seeking to comprehensively address the social, economic and environmental determinants of health is a complex undertaking, requiring far more than merely setting up a multisectoral committee. The new Minister for Health with a three-year term (at least) may be interested in leading a more inclusive approach to improving health, along with the new President who has taken on several key portfolios. This 'human development' approach, inclusive of culture, gender, and disability, can more explicitly address key development challenges (such as youth unemployment, quality of education, inequalities and poverty, mental health, climate change impacts) while still supporting the health sector and NHS and NCD strategies.

A design team can test the GoN appetite for this broader approach early in 2023 and take time to co-design such an initiative. Other development partners, in particular UN agencies that have limited reach into Nauru (UNICEF, UNDP, UNFPA) plus WHO DPS (who are already committed to a broader community-based approach to NCD prevention and management in Nauru) could be included in the design and potentially pool funds and technical support.

Initially, revitalising a high-level Development Partner Forum to discuss needs and opportunities with relevant Ministers would be a good first step. Discussions with SPC on Options Papers to present at the next Pacific Heads of Government and Heads of Health meetings could include how best to provide support to smaller and more remote PICTs.

Working collaboratively across sectors is critical and a strong Minister and Secretary for Health could re-energise the multisectoral NCD Taskforce and development partner coordination. A presentation to Parliament on progress against the NHS and NCD Strategies and alignment to the *National Sustainable Development Strategy* could increase awareness on how critical the situation is in Nauru and that urgent action is needed across all Ministries to improve the health and wellbeing of the population. There is a need to develop a more enabling environment for policy dialogue including future legislative changes and budget support to tackle NCDs from a life-course perspective.

9. Is there any scope to improve the consistency and coherence between DFAT's bilateral and regional investments, including those funded through the Indo-Pacific Centre for Health Security's investment through HSI 2.0?

It is critical to improve coherence and consistency between DFAT bilateral and regional programs. Efforts to do this have already commenced with regular fortnightly meetings with Post – that will hopefully continue as an effective communication mechanism. DFAT-funded regional programs have mixed reach into Nauru (see Annex 3), and it is timely to review models while DFAT sections and investments (HSI, Office of the Pacific – OTP) are being re-designed or restructured. Smaller populations and health sectors may not benefit as much if funding or support is provided based on population size, yet their needs might be greater, and they also have more limited human resources for health than larger PICTs. This is certainly the case in Nauru. Given lessons learned from the recent pandemic, it was suggested by key informants that it is timely for DFAT to outline a new Pacific Health Strategy taking into account the ODE evaluation of Pacific health support.

²³ Moore TG et al, 2017 The First Thousand Days: An Evidence Paper – Summary. Centre for Community Child Health, Murdoch Children's Research Institute.

²⁴ The case for investing in adolescent and young adult health is strong. Economic modelling shows a 10-fold return on adolescent health investment, including addressing NCDs. Improving youth health delivers immediate and downstream benefits of reduced adolescent and later-life morbidity, improved productivity and economic participation in their prime years, and the best possible start for the next generation – 'the triple dividend'. Sheehan P, Sweeny K, Rasmussen B, Wils A, Friedman HS, Mahon J, et al. Building the foundations for sustainable development: a case for global investment in the capabilities of adolescents. *Lancet*. 2017;390(10104):1792–806

Along with DFAT Office of the Pacific, SPC, UN and other development partners, a model for how to provide support to islands with smaller populations could be considered for discussion at the next Pacific Heads of Health and Health Ministers meetings. In a small island like Nauru, it is impossible for any single development partner to do it all. Development partners need work together to develop a model to coordinate their inputs and efforts. The potential to share resources, technical support and lessons learned between air-linked countries to Nauru (Kiribati, FSM, Fiji) could be considered in the transition and a future design for Nauru.

On a practical level any future bilateral programming should ensure that there is an agreed coordination and communication process with regional programs – for example, who should receive information and requests? What is the role of advisers – can they be routinely copied into emails? What feedback processes are there from countries to regional programs? For example, any fails identified through the TGA testing scheme should be communicated to other PICTs who are using the same supplier or have the same failed batch in stock.

10. What scope is there to capitalise on successful investments across other sectors, and to promote synergies between the health program and other areas of the aid program?

Nauru is covered by a Multi-Country Office (MCO) of the UN Resident Coordinator for Palau, FSM, RMI, Nauru, and Kiribati, which was formally established on 1 October 2021, following the appointment of the UN Resident Coordinator. Nauru receives the lowest budget allocation of all the PICTs covered by the UN Pacific Strategy (1 per cent of total), and Nauru's UNPS budget expenditure reduced from AUD 1.2m in 2018 to AUD 56k in 2020²⁵. Given that the UN has had some presence in Nauru since 1984, including several relevant agencies for human development, it is prudent to gauge the level of in-country support and resources that can be provided to Nauru and ensure improved coordination and collaboration in the future design. In addition, Nauru has limited staff capacity to participate in various regional meeting and often miss out on opportunities for improved coordination and networking.

The new GoN could be supported to revitalise a Health (or Human) Development Partner Coordination mechanism to ensure coherence across sectors. Given the extent of Australia's involvement in health relative to other organisations, DFAT can play a leading role in supporting the MHMS to revitalise a Development Partners Forum for coordination, joint planning and, ultimately, enhanced policy dialogue. This could ideally be a role for the new Health Minister to initiate.

Nauru imports all its food, which is expensive. Given climate change, food security and supply are concerns in many PICTs, including Nauru. DFAT is supporting an Atoll Food Futures (AFF) program which has great potential to revitalise home kitchen gardens that have apparently gone 'out of fashion' and seen to be only for 'the poor'. The AFF Live and Learn specialists are planning a scoping mission to Nauru before the end of 2022. Their findings could feed into future DFAT health and education programming, including linking more closely with the Australian agriculture sector. This is an opportunity for DFAT to support multisectoral activities, especially between health and education sectors where there are currently DFAT investments (see below).

11. What are the potential options for priority investment areas and possible objectives for Australia's next phase of bilateral health investments?

As discussed earlier, a continued focus on targeted health system strengthening for PHC and NCDs, but within a broader, multisectoral human development approach - similar to that being developed in Samoa (see below) - could be considered for the next phase of bilateral health investments. This broader approach would support the GoN *National Sustainable Development Strategy* to meet the 2030 Sustainable Development targets, as well as the NHS and NCD strategies, and has the potential to include more development partners.

²⁵ UN Pacific Strategy (UNPS) 2018-2022 final evaluation report, April 2022 p.34

The **goal and objectives** for such a future investment, if a human development approach is supported, would be to *accelerate progress towards improved human development outcomes for all Nauruans*, reflected in improved learning outcomes *for all* and improved prevention, control and management of communicable and non-communicable diseases. The focus would be on three areas where DFAT is already invested in - **health, education, gender, disability, social inclusion (GEDSI)** and possibly a new focus on **food security/nutrition**. The theory of change and more achievable EPOs should be co-designed with GoN to ensure alignment with NSDS, NHS and NCD strategies.

If there is no appetite for this multisectoral human development approach, then designing joint education and health projects to incorporate nutrition (including food security and supply given climate change concerns) should be considered. Priorities remain to continue the focus on health workforce development and more clearly addressing GEDSI.

12. What options exist for how (mechanism) bilateral support can be delivered to Nauru's health sector in the next phase? For example, what funding modalities and governance arrangements should be considered given MHMS and DFAT capacity and strength of the health system?

In the short term, it is unlikely that the MHMS is ready to resume bilateral support through a DFA, at least until investment governance arrangements are well established alongside financial management and planning capability. Similarly, the managing contractor model has proven problematic for the delivery of DFAT's bilateral assistance in the period, including having to deal with multiple managing contractors at the same time. The design team should determine with DFAT and GoN whether a human development, social inclusion Facility model²⁶ under one Managing Contractor may provide a more effective, efficient delivery mechanism, at least across health and education portfolios, while also weighing up the transaction costs of such a modality. The Review Team note that progress is being made in the current transition phase **without** a managing contractor. However, this is putting a lot of burden on Post for program management, including to ensure coherence and coordination between the various transition activities and implementing partners.

As noted, the current MHMS Director of Finance is highly skilled and has demonstrated motivation to work closely with the Ministry of Finance Planning and Aid Division. It is likely a good time to engage with the MHMS to identify and plan future financial management support to strengthen MHMS oversight of government and development partner support funds with a view to re-assessing capacity to program DFAT funds through government systems (on plan and on budget). An element of performance-linked funding or 'bonus funding' could also be considered for future health programming to ensure progress against key objectives (currently proving successful through DFAT bilateral investments in Kiribati).

Existing MHMS Health Executive Team meetings that report regularly to the new Minister for Health provide an opportunity to include reporting on DFAT funded progress as it will align with NHS and AOPs. Regular (possibly monthly) meetings with DFAT Second Secretary, a new Development Specialist (to be recruited) and the MHMS Health Executive Team could provide a forum where concerns on progress can be raised and worked on jointly. This will test the capacity of the MHMS to report against objectives.

13. What are the development partner coordination modalities that MHMS and DFAT could consider during a new design?

If improved engagement and coordination with other development partners is the goal, then a different mechanism and TOR need to be designed in the future phase of support. With a new Minister for Health who is actively engaged and keen to progress reforms, there is an opportunity to set up new mechanisms to support improved communication and coordination. A Health Review

²⁶ For example, a Human Development Social Inclusion (HDSI) Facility has recently been co-designed in Samoa with the GoS and DFAT, and is at near final stage of Investment Design.

(around September each year), possibly chaired by the Minister, and including all development and DFAT regional partners, could review data and reflect on progress and identify gaps for partners to support. A similar process could be held in March to plan for the next Financial Year. This process could be trialled in the transition phase with DFAT support, and development partner engagement could be scheduled into joint in-country visits.

14. How should future health investments in Nauru better support and focus on gender equality, disability inclusion and social inclusion (GEDSI) and other cross-cutting areas? What specific approaches need to be integrated into the design and future programming to improve GEDSI outcomes through health investments? How should DFAT approach GEDSI in the design of Australian funded future health investments to Nauru?

While there has been some progress in mainstreaming GEDSI in MHMS strategies and activities, there are still significant gaps in addressing GEDSI across the broader health system. A more systematic approach is required to support and strengthen GEDSI within MHMS systems to develop the foundations for GEDSI in MHMS, on which further GEDSI work can then be progressively built.

MHMS have a very basic appreciation of GEDSI and it will take time to develop understanding of GEDSI and its relevance to improving health outcomes. Staff require a deeper understanding of GEDSI concepts and the implications of gender inequality, disability and social exclusion on health outcomes for women and men, and people from marginalized groups. Ongoing trainings should target information that highlights the relevance of GEDSI to different areas and roles, such as nursing staff, doctors, and HMIS staff. It will be important that WASDA and DPLWD are involved in the training, who can provide culturally-informed approaches and knowledge. In addition, collaborations with local women's organisations, Organisations of People with Disabilities (OPDs) and relevant NGOs should be sought to support the development and implementation of trainings.

The NHS 2021-2025 references the appointment of a GEDSI position to lead and promote GEDSI mainstreaming within MHMS systems and practices. This position will be essential to progress the integration of GEDSI in MHMS. As GEDSI is a new concept for both MHMS and Nauru more broadly, it is recommended that the GEDSI Focal Point position be supported by an international GEDSI STA during the transition phase and considered for inclusion in future programming.

Mainstreaming GEDSI across health systems requires a comprehensive understanding of the differences between and among women and men from diverse backgrounds, including people with disabilities and other marginalised groups and how cultural factors can create barriers in accessing and receiving health care services. A comprehensive GEDSI analysis should be undertaken as the first step in mainstreaming GEDSI. This information is important for facilitating the integration of GEDSI in health activities. The analysis should include existing GEDSI data, including the findings from the NHSSP disability study, and consult with a diverse range of individuals including women and men, people with disabilities, individuals from marginalized groups, local women's organisations, OPDs, and other local and international NGOs working in this area. This analysis is important for informing how health activities are planned and implemented and potential opportunities and risks for activities to contribute to gender equality, disability and social inclusion.

The health sector plays a critical role in responding to and supporting victims/survivors of GBV; however further investment is required to increase staff awareness and knowledge about GBV and to improve the quality of care for GBV victims/survivors. Clinicians and nurses need to be trained on using the newly-developed GEDSI Sensitive Patient Referral Guidelines and Standard Operating Procedures for responding to GBV cases within the health system. The training could be conducted with WASDA and NPF as they are the primary contacts for GBV.

The NHS highlights the importance of GEDSI data and information to identify enablers and barriers to universal health coverage. Future investments should work with MHMS staff to ensure GEDSI data are included in health information management systems to enable MHMS policies and practices to better respond to the different needs of women and men, people with disabilities, and people from

marginalized groups. MHMS should be supported to review existing data collection sources and surveys to identify areas where GEDSI can be included in data collection systems and analyses.

WASDA and DPLWD are key government stakeholders for advancing national priorities with regard to GEDSI. It will be important for future programs to establish strong partnerships and coordination between MHMS, WASDA, and DPLWD to address GEDSI issues in the health system. WASDA and DPLWD should play a key role in supporting MHMS to improve the capacity of MHMS staff in GEDSI, improving support services for women, people with disabilities, and people from marginalized groups to access GBV, mental health, and specialised and allied health services. Building partnerships with local women's organisations, OPDS, and relevant civil society organisations will be important in supporting GEDSI activities (see Annex 8).

3.6 What did not work well in NHSP

The Review Team identified aspects of the NHSP which did not work well as summarised below; these are further detailed under KEQs and in Annex 4. In terms of DFAT regional programs, a key concern was that RACS was unable to provide VMTs to Nauru during COVID-19 and only returned in June 2022, contributing to the high budget allocations for OMR in 2021.

Human resourcing

- The delayed inception of NHSP resulted in advisers not having been in place long enough to have established trust, working relationships and MHMS ownership of reforms and interventions prior to the COVID-19 pandemic
- Remote support proved only partially useful to strengthen local capacity; this is partly a result of the delayed inception and slow commencement of some NHSP advisers, and partly due to an absence of identified, continuous MHMS counterparts
- Recognition that relationships with counterparts are critical, and that some advisers (both within NHSSP and direct recruitment of senior clinical managers) were not suited to working in Nauru. This points to the need for strengthened recruitment systems and practices, and empowering MHMS counterparts to make informed contributions to adviser selection processes
- Performance management systems are not yet functioning within MHMS and Central Government Human Resource Management Units. Absenteeism remains a major challenge to health sector performance and needs to be addressed with Central Human Resources Management as a matter of urgency
- Limited awareness and understanding of GEDSI in MHMS staff and the relevance of GEDSI to health outcomes and no dedicated position to lead and promote GEDSI within the MHMS

Health Information Systems

- There is no functioning Health Information Unit (HIU) and vacancies remain high. A functioning, staffed, and equipped HIU was a key output and intermediate outcome identified within the NHSSP MEF, however the absence of prioritisation of the HIU resulted in limited gains for the establishment of improved health information systems. NHSSP had limited impact in digital health until the COVID-19 vaccination and outbreak, nearing the end of the NHSP.
- While BES (sub-contracted by NHSSP) made gains with the establishment and roll-out of the Tamanu (patient data management software) and Tupaia (a data collection, analytic and visualization platform) systems, this progress was achieved only in the last 12 months of the NHSSP. The lesson learned is that major changes are not a quick fix, and it will take some time and further technical support to transform existing paper-based systems to fully meet EOPO
- Community health and NCD tracking systems are not yet operating, resulting in unreliable patient tracking through paper-based registers. There is no recall system in place as yet.

- Procurement and contracting of the LIMS and Radiology Information Systems/Picture Archiving and Communication System (RIS/PACS) was stalled over concerns that there was little time remaining under NHSSP to procure and support effective establishment of the systems, and because the Tamanu platform was not ready to integrate the new systems. This is included for re-visiting in the AOP for 2022-23.
- Limited/no GEDSI-disaggregated data yet to inform policies and programs about the specific needs of women and men, people with disabilities, and people from marginalised groups

Models of Care

- The Model of Care and continuity of care between RON Hospital and community health had not been clarified, nor had staff been trained to implement it; improved discharge planning and referral systems are critical
- The Wellness Centre model of care is not yet operating and requires a phased approach to staffing and facility improvement. In their current form, these centres are unlikely to meet the requirements of an expanded, integrated, decentralised service model
- The health system is not reaching all potential users, including the most vulnerable. There was limited engagement from the MHMS with people with disabilities and the Department of Women's and Social Development Affairs (WASDA) to identify and plan for meeting their needs. As such, the health system is not achieving accessibility targets within the *NHS (2021-2025)*

NCD Case Management and Health Promotion

- NCD screening is opportunistic and did not take a population-based approach. As a result, detection and diagnosis of cases is not optimal. The small and relatively accessible population should be conducive to more comprehensive screening coverage
- The case management processes for patients with diagnosed NCDs and the protocols for follow-up of patients who fail to attend routine monitoring appointments are not clear
- The NCD Taskforce was inactive for prolonged period with weak cross sectoral engagement to address lifestyle and NCD risk factors
- Community-based and School Health Promotion activities stalled during the absence of WHO advisers and need revitalising

Health Infrastructure

- Limited storage and insufficient infrastructure, in particular the urgent need for an integrated warehouse facility to house the National Medical Store and associated pharmacy services
- Inadequate and inappropriate infrastructure means that Wellness Clinics are not fit for purpose and able to deliver services in accordance with the CHPP. A viable alternative to demountable/container structures, with enough space to provide primary care and screening is required
- Systems for requesting, logging and tracking maintenance support for failing infrastructure and biomedical equipment at RON Hospital remain inadequate and require urgent attention. These should be developed as electronic systems that offer transparency and accountability to RON Hospital managers.

4. Strategic Recommendations for DFAT and Considerations for the Future Design

Based on the review and findings against the Key Evaluation Questions (KEQs), a summary of strategic recommendations for DFAT (Post, OTP and GHD) are summarised in Table 5, below.

Table 5: Summary of Strategic Recommendations for DFAT

No.	Strategic Recommendations for DFAT
1	Initiate discussions with UN MCO on future Nauru programming (especially WHO, UNICEF and UNDP) and support the new GoN Health Minister to strengthen and prioritise a Health (or Human) Development Partner Coordination mechanism to ensure coherence across sectors and discuss opportunities for joint approach. This may include tying funding disbursements to implementers' active engagement in coordination activities in future
2	Develop a new DFAT Pacific Health Strategy to address the current Pacific context and challenges, and include specific strategies for the smaller island states
3	Develop a Joint Options Paper with SPC, UN and other development partners on meeting health needs of small island states to present at Pacific Health Minister's and other fora
4	Improve coherence and consistency between DFAT bilateral and regional programs through revision of communication and coordination protocols and the review of models while DFAT sections and investments (HSI, Office of the Pacific – OTP) are being re-designed or restructured
5	Increase the number of DFAT Scholarships targeted at health and social services (if possible) for the next 3-5 years to continue to build local capacity and future localisation of key senior positions.
6	Increase MHMS capacity to improve support for gender-based violence victims/survivors. Health sectors play a critical role in responding to GBV. Victims/survivors need to access comprehensive health services, including medical treatment, emergency contraception, and mental health care. Training for MHMS staff, in particular nurses and clinicians, should be provided to increase their awareness and knowledge about GBV and to improve the quality of care for GBV victims/survivors.
7	Support MHMS to collect and analyse GEDSI data. The NHS highlights the importance of GEDSI data and information to identify enablers and barriers to universal health coverage. Future investments need to work with MHMS staff to ensure GEDSI data are included in information managements systems so health policies and practices are able to respond to the different needs of women and men from different contexts and backgrounds

Nauru is country with a small population and DFAT investments in health are large if compared with similar programs in larger PICTs, however there is a price to providing a basic essential health system regardless of population size. Strengthening health systems is a long-term project that requires support to multiple components or building blocks; success is highly dependent on the country context. DFAT invested AUD 8 million over four years to the NHSP (plus regional and global investments) into Nauru. How much to invest in the system in future is ultimately a political decision for the GoA, however, there needs to be a realistic assessment made of what is feasible to achieve in four years within the capacity of the country. Key lessons learned from the NHSP include:

- The timeframe for the future investment could be a four plus four-year design (with flexibility beyond 2030), to allow for system changes that take time, and to embed the changes for sustainability while the local workforce strengthens
- MHMS and GoN should be fully engaged during the design process and essentially co-design the next phase, to support a smoother inception
- Targets and indicators need be realistic, achievable and able to be measured through existing systems – and linked to NSDP, NHS and NCD strategies
- Recognition that relationships with counterparts are fundamental, and MHMS involvement in selection of qualified, experienced advisers suited to working in Nauru is critical

- If a Managing Contractor implementation model is selected, ensure there is a clear plan for recruitment of local and international staff able to start early in the Program, and that there are local counterparts to work with.

In practical terms, the Design Team needs to consider new approaches to strengthening population health beyond the health system, acknowledging that NCD risk factors will require behavioural change (within a supportive environment). These approaches go beyond what health services traditionally provide and recognise that change needs to be encouraged in the critical early years and adolescence. This requires more than what the Health Promotion staff currently provide, and more of a joined-up human development, multisectoral and inclusive approach. Table 6 below outlines design considerations for DFAT and MHMS on the future design. It includes considerations to inform the design approach and focus.

Table 6: Considerations for Future Design

No.	Design Approach
1	Initiate high-level discussion with Health Minister, GoN on future co-design
2	Hold high-level discussions with other development partners, in particular UN MCO (UNICEF, WHO, UNFPA, UNDP) on design of future support to Nauru NSDS with a view to joint planning and sharing of resources
3	Include a GEDSI Specialist in the Design Team to ensure strong integration of GEDSI considerations across the design (engage with local women and men, people with disabilities, and marginalised groups to ensure their voices and lived experiences are addressed in the design).
4	Adopt a broad Human Development approach aligned with NSDS (that could include multisectoral budget support) while still focusing on health system strengthening for PHC and NCDs aligned with NHS and NCD strategies
5	In discussion with GoN, consider what financial management support MHMS/MoF needs for DFAT to provide future funds through government systems via a DFA. This could include an element of performance-linked funding or 'bonus funding' for future programming to ensure progress against key objectives
6	Focus on First 2000 days (early childhood) and adolescents and young adults (linking with UNICEF and education sector) and consider a Youth consultation to identify how to address youth concerns
7	Follow up Atoll Food Futures Nauru scoping to determine what support can be provided and if feasible, how to fund it
8	Include technical assistance and/or documented guidance to operationalise and monitor progress against the NHS 2021-2025 and AOPs and Nauru NCD Strategic Action Plan (2021-2025)
9	Integrate a comprehensive GEDSI Analysis to understand differences between and among women and men, girls and boys and cultural factors that may create barriers for women and men from diverse backgrounds, including women and men with disabilities, in accessing and receiving health care services. The analysis should adopt an intersectional approach. A comprehensive GEDSI analysis is the first step in mainstreaming GEDSI across future investments.

5. Priority Activities for MHMS and Transition Phase

Based on extensive document review, key informant interviews and observations of health facilities and life in Nauru, a summary of priority activities for MHMS and for the Transition Phase are summarised in the tables below for Health Executive Team consideration.

Table 8: Priority Activities for MHMS consideration

No.	Design Approach
1	Review WHO completion report health promotion and NCD detection and clinical management inputs – agree on WHO inputs during transition period
2	Fast track procurement and build for Wellness Centres and RON Warehouse Facility
3	Identify and address gaps in operations and ensure SOPs are developed, disseminated and training delivered.
4	Commence population-based NCD screening model with training for Public Health staff - in the next 6 months
5	Convene a working group of key clinicians and managers to review, revise and confirm the Community Health Project Plan and Model of Care, including referral and discharge planning
6	Review and confirm the role and scope of practice of District Health Workers with clinicians, Nurse Managers and Health Promotion
7	Develop a medium to long-term Health Workforce and Training Plan including analysis of staff workloads and impact of absenteeism, with strategies identified to address short and long term staffing needs with a focus on the localisation of senior positions and phasing out the need for some international adviser positions as and when possible
8	Repurpose the well-equipped ACU for regular utilisation through development of a Bed Plan that includes transfers of any patients to other wards, should a COVID-19 patient require admission to the ACU
9	Ensure Public Health Division has a plan to order timely supplies so that there are no stockouts (e.g HbA1C diagnostic test for NCD clinic patients). Introduce mSupply to PHD
10	Analyse the pilot of Patient EMR in dental clinic and work with BES advisers on expanding to other PHD clinics
11	Review requests for biomedical repairs and maintenance and whether they have been met within a specified timeframe
12	Review in consultation with DPLWD, rehabilitation services and provision of physiotherapy for people living with disability (PLWD) – clinic and outreach
13	Review Wellness Centre staffing models and patient load
14	Review OMR cases and criteria to ensure that clinical assessments are followed

The transition phase should show further progress towards achieving the NHSP EOPOs, although DFAT is finalising an interim support package with slightly less ambitious EOPOs. Based on Review findings, several areas to support emerged for MHMS and DFAT consideration and prioritisation that are not included in the description of the Transitional Health Package accessed by the Review Team. Table 9 below summarises these priorities. If these are not achievable during the transition phase, they are considerations for the design team.

Table 9: Priority Activities for Transitional Health Package phase

No.	Design Approach
1	Develop TOR for GEDSI focal point position in staff establishment and recruit urgently. Budget for GEDSI STA support for the MHMS GEDSI focal point, including support for the development of a series of GEDSI training packages to strengthen the knowledge and capacity of MHMS to understand GEDSI concepts and the relevance of GEDSI to health outcomes. Trainings should also focus on key areas such as improving quality of care to GBV victims/survivors and people with disabilities

No.	Design Approach
2	Deliver a sustained program of health sector-focused leadership and management training with sustained, in-country technical support ideally during the transition phase
3	Provide support for a Planning Adviser to the newly created MHMS position of Health Planning Officer. This position could potentially be combined with the planned Performance Adviser supporting MHMS monitoring and evaluation
4	Support Human Resource Division to analyse absenteeism in specific units and departments and develop an action plan
5	Support Health Executive Team and Minister to present a case for reform to recruitment processes to Central Human Resources
6	Continue support to managers to utilise data for reporting, aligned with AOP activities and linked to performance management
7	Finalise tenders and contracting for LIMS and RIS/PACS – to enable linking to Tamanu system
8	Analyse Nurse Training plans and consider future support for NHPTI to increase local training for Enrolled and Registered Nurses
9	Develop a plan for End-Stage-Kidney-Disease with expert advice, relevant for the limitations in Nauru dialysis unit
10	DFAT Post to consider allocating additional funds to RACS to increase targeted VMTs to Nauru
11	Engage with people with disabilities, including for mental health and psychosocial services to understand their needs and how best to meet them

6. Annexes

Annex 1: Terms of Reference – Nauru health sector evaluation

1. Position Title

Nauru health sector evaluation team

2. Team Members/ days

Team Leader (up to a maximum of 40 days)

Health Specialist (up to a maximum of 35 days)

GEDSI & health specialist (up to a maximum of 28 days)

3. Program

Nauru Post

4. Classification of role as specified under safeguarding policies

Working with children ☐

Contact with children ☒

Working with Vulnerable Adults ☐

Contact with Vulnerable Adults ☒

Nil (*Desk based no travel* and/or no access to personal data or images of children/vulnerable adults)
☐

5. Location/s

Desk based ☐

Desk Based with possible domestic travel ☐

Desk based with possible international travel ☒

6. Travel

Travel is required

If travel is required, list the country below and select security level for destination countries below based on smart traveller website: <http://www.smarttraveller.gov.au/>

7. Travel Details

Nauru N/A

DFAT Smarttraveller does not issue travel advice for Nauru. However, AHC has confirmed that there is no undue risk associated with travel to Nauru.

Currently, the borders to Nauru are open. The possibility of in-country consultations will take into consideration quarantine requirements.

It is anticipated that the team will need up to 10 working days in country to conduct consultations.

8. Term

Work to be conducted between 15 August 2022 – 15 November 2022.

9. Reporting to

The adviser will report to:

SHS: Jessica Gillmore, Director SHS, Jessica.Gillmore@shsglobal.com.au

DFAT: Andrew Hodges, Deputy High Commissioner, andrew.hodges@dfat.gov.au

10. QA conducted by

DFAT ☐ If this box is checked, once the adviser is contracted, DFAT will liaise directly with the adviser, manage their performance, and QA all deliverables. SHS will provide logistical and administrative support only.

The adviser/s will submit the agreed deliverables to DFAT, copying SHS Advice Desk (AdviceDesk@shsglobal.com.au) on the dates specified in section 15, below, unless other arrangements are confirmed in writing.

SHS ☒ If this box is checked, SHS quality assures all the deliverables prior to submitting them to DFAT for their review, unless agreed by SHS in writing. SHS will provide technical, logistical and administrative support.

The adviser/s will submit the agreed deliverables to the SHS Task Lead copying SHS Advice Desk (AdviceDesk@shsglobal.com.au) on the dates specified in section 15, below, unless other arrangements are confirmed in writing. The designated SHS Task Lead will liaise with the adviser to ensure that the final output meets DFAT requirements.

When SHS has QA responsibilities, deliverables should be submitted to the SHS no fewer than three (3) working days before the agreed deadline for submission to DFAT to allow for this process. Draft outputs are not to be circulated beyond key counterparts until final versions have been approved by the SHS.

11. Background

The Republic of Nauru faces significant health issues. There is a general picture of high rates of Non-Communicable Diseases (NCDs), including cardiovascular disease, respiratory disease, and diabetes, leading to high rates of premature death. Endemic infectious diseases continue to pose a threat to health security with, for example, regular outbreaks of dengue fever. Tuberculosis is a persistent issue. Chronic diseases worsen vulnerability to communicable diseases.

The high rates of non-communicable and persistent infectious diseases are set within the context of a population with high expectations of access to quality health care services. Overseas Medical Referrals (OMRs) place a high burden on the Government's budget. Air links mean that Nauru is only a flight or two away from emerging regional and global health threats, including COVID-19. Low health system capacity limits Nauru's ability to respond to acute public health events and increases vulnerability to threats to its health security.

Australia has an enduring interest in promoting the health of the people of Nauru. Australia seeks to strengthen Nauru's health systems and service delivery. DFAT provides support to Nauru's health sector through bilateral, Pacific regional and global programs (see Attachment 1). All investments

are guided by the *Partnerships for Recovery: Australia's COVID-19 Development Response 2020-2022* which focuses on three areas: health security, stability, and economic recovery.

Nauru receives assistance for vaccination support through both DFAT's Canberra-based CHS (primarily through VAHSI) as well as OTP Pacific Health Unit's UNICEF investment towards strengthening systems for the sustainable introduction of new vaccines, specifically HPV.

In response to COVID-19, Australia has provided Nauru with testing cartridges, medical equipment, PPE, vaccine supplies, priority equipment and technical advice via a COVID-19 Adviser supporting the Nauru COVID-19 Taskforce. However, this pivot of MHMS resourcing and diverted effort to respond to COVID-19 constrain MHMS' ability to progress non-COVID health reforms (such as responding to NCD burden) as well as strengthening its overall system capacity.

DFAT's bilateral support was through the Nauru Health Support Program (NHSP - up to \$8.4 million from 2018 to 2022) which had two components:

- a grant to WHO that commenced in November 2018. This focused on improved prevention and management of NCDs, including support for Nauru's community based primary health care system and NCD risk factors;
- a contract with Palladium to deliver the Nauru Health System Support Project (NHSSP) which commenced in 2019. This supported the MHMS to strengthen health information systems, logistics management, planning, budgeting, performance management and operational systems.

Palladium's contract concluded on 30 June 2022 and the WHO grant expires on 31 October 2022. The conclusion of NHSP offers an opportunity to assess the effectiveness of Australia's total support to the Nauru Health Sector since 2018, and to consider future direction of sectoral support in accordance with the proposed Nauru Health Strategy (2021-2025). The last independent review of Australia's bilateral health investments was undertaken in late 2017 and covered the period 2014 to 2017.

In addition, Nauru's health sector receives DFAT support through a number of regional and global initiatives, detailed in the Nauru Country Fact Sheet, provided with these Terms of Reference.

12. Purpose and objectives

The purpose of this independent evaluation is to assess whether a selected list of Australia's health sector investments – bilateral, regional and global – from 2018 to 2022 in Nauru were effective, efficient and appropriate. The investments to be included in the review have been identified by DFAT and are listed in Annex 2 of this document.

The evaluation will seek lessons from the listed investments, in particular the Nauru Health Support Program. For regional/multi-country investments, the team will determine how investment directly impacts Nauru and to what extent the people of Nauru benefit from these types of investments.

The evaluation will provide the Government of Nauru (GoN) and DFAT with recommendations on how to improve the performance of Australia's future health sector investments in general, including how effectively these investments have supported Gender Equality, Disability and Social Inclusion (GEDSI) outcomes, and how to support the Ministry of Health and Medical Services (MHMS) Nauru's new Health Sector Strategy (2021-2025).

The review is required to collect evidence of, and analyse, lessons learnt (including evidence of what has worked and what did not work well). The findings will inform the design of a strategic, multi-year approach to future Australian-funded investments in Nauru.

The objectives are:

- To undertake an independent evaluation of the performance of all Australia's health investments to Nauru over the period 2018-2022, including bilateral, regional and global investments, including investments funded by DFAT's Centre for Health Security (CHS).
- Based on the evaluation's findings, provide recommendations on:
 - the focus of Australia's future bilateral health investments for the period 2024 to 2030, with a specific focus on the period up to 2025 (in alignment with the new Nauru Health Strategy 2021-2025), and in consideration of GoN and MHMS strategic priorities from 2026 to 2030, including any recommendations on the design approach to these future investments, and

how Australia's transitional health support plan (July 2022 to December 2023) can be improved to ensure maximum impact with current investments

13. Duty Statement

- **SCOPE**

The team will review the overall performance of selected Australian health investments to Nauru from 2018 to 2022. The review should include consideration of DFAT's aid quality criteria with a strong focus on efficiency, effectiveness, gender equality, disability and social inclusion (GEDSI), and monitoring and evaluation.

Past DFAT Support to MHMS

Specific questions for consideration include:

- To what extent have DFAT's investments (see Annex 2) made a strategic contribution towards helping achieve the outcomes of the MHMS' Health Strategies and Plans, including Nauru's NCD Strategic Action Plans?
- How successful have the investments been in achieving their stated outcomes? What has been NHSP's progress in achieving its end-of-program outcomes and intermediate outcomes?
 - What has or has not worked well (and why)? What lessons can be learnt as well as any key barriers/obstacles?
 - Assess the adequacy of the MEL system, including lessons learned for future programming.
- How successful has DFAT been in supporting Nauru's COVID-19 response?
- To what extent have the modalities used for DFAT support impacted on the effectiveness and efficiency of our health assistance to Nauru, and what lessons have we learned?
- How effectively are governance systems working with MHMS, DFAT and partners and how can these be improved?
 - How have DFAT investments taken into account current and future planned health support by Nauru's other health development partners, including UNICEF, WHO, SPC?
 - How effective are development partner coordination efforts?

- To what extent have Australia's health investments supported gender equality, disability inclusion and social inclusion and other cross-cutting areas? What has been the performance of these investments regarding improved GEDSI outcomes?

Future DFAT support to MHMS

The evaluation should allow the team to draw conclusions on the suitability of Australia's health sector support and recommend a way forward for DFAT's future bilateral support to Nauru's health sector. The team is required to reflect on investment improvements and how future health investments can be more focused and strategic given health needs, the operating context and MHMS and DFAT capacity.

Specific questions will include:

- How can DFAT support MHMS to improve performance and sustainability of the health system and health service delivery including pandemic preparedness and response (considering the COVID-19 context)?
- How can the performance of Australia's current health investments be improved to maximise their impact? For example, related to strategic focus, technical advice, policy dialogue, modality or governance arrangements, GEDSI, risk management systems, development partner coordination or MEL.
- How should Australia's investment in Nauru's health sector be refocused and/or refined to ensure maximum strategic impact with the resources available for health up to 2030?
- Is there any scope to improve the consistency and coherence between DFAT's bilateral and regional investments, including those funded through the Indo-Pacific Centre for Health Security's investment through HSI 2.0?
- What scope is there to capitalise on successful investments across other sectors, and to promote synergies between the health program and other areas of the aid program?
- What are the potential options for priority investment areas and possible objectives for Australia's next phase of bilateral health investments?
- What options exist for how (by what mechanism) bilateral support can be delivered to Nauru's health sector in the next phase? For example, what funding modalities and governance arrangements should be considered given MHMS and DFAT capacity and strength of the health system? What are the development partner coordination modalities that MHMS and DFAT could consider during a new design?
- How should future health investments in Nauru better support and focus on gender equality, disability inclusion and social inclusion (GEDSI) and other cross-cutting areas? What specific approaches need to be integrated into the design and future programming to improve GEDSI outcomes through health investments? How should DFAT approach the design of Australian funded future health investments to Nauru?

EVALUATION APPROACH AND METHOD

In undertaking the evaluation, it is expected the team will:

- Conduct a thorough desk review of relevant documentation.
- Develop a review plan, maximum 10 pages in length, to be submitted for agreement with DFAT prior to the commencement of the review activities. The review plan will include methodology and report outline, indicate how the specific questions listed in the "Scope"

section will be addressed and identify key respondents and further documentation as required.

- Undertake one in-country visit to consult with DFAT Post in Nauru and GoN representatives including MHMS (ensuring the involvement of the MHMS Adviser, Dr Keke) and PAD, and Taiwan development partners in Nauru.
- The team will also conduct remote consultations with DFAT staff in Canberra responsible for DFAT regional programs covering Nauru and CHS initiatives. Other stakeholders to be consulted include relevant TA service providers for the NHSP and the Transitional program of health support. In addition, consultations will include relevant development partners such as MFAT, JICA, India, multilateral agencies WHO, UNICEF and UNFPA, and regional partners SPC and IPPF.
- Develop an aide memoire (in the form of a presentation) summarising the key findings and recommendations to be presented during a debrief with key stakeholders.
- Draft a review report for DFAT and the MHMS detailing the key findings and recommendations. The report should be no more than 30 pages (excluding executive summary and annexes). An executive Summary of 2-4 pages should be provided. The report will align with DFAT's Monitoring and Evaluation Standards and follow DFAT's Ethical Research and Evaluation Guidance which applies to all DFAT-funded activities that involve research or evaluation with human participants.
- Provide a final review report incorporating stakeholder feedback. Coordinated feedback from DFAT and other stakeholders will be provided within an agreed timeframe of receipt. The Final draft of the report will be due 15 November.
- The team will also be required to submit background data and information, references used and analysis to inform the design

Team composition and roles and responsibilities

The review team will consist of a Team Leader with evaluation expertise, a Health Specialist and a GEDSI specialist. One of DFAT's Senior Health Adviser's will be included in the team as the Health Specialist. A senior MHMS representative will be nominated as a primary resource person to the team. This representative will be well positioned to provide contextual understanding and MHMS views on DFAT's earlier support and how DFAT could best support the sector in the future, particularly in ensuring the recommendations align with MHMS's strategic goals and other relevant national policies and commitments.

Team leader will be responsible for leading on all aspects of the review including:

- Reviewing key documents
- Developing the review methodology and plan including key review questions and working with DFAT Post to finalise the stakeholder list;
- Leading consultations with DFAT and other stakeholders in-country and remotely;
- Drafting and finalisation of all deliverables required under the review;
- Managing the inputs of the Health Specialist and GEDSI specialist;
- Presenting findings from desk review of documentation and consultations (aide memoire)
- Delivering key deliverables on time for SHS review (prior to submission to DFAT) and DFAT review

Health Adviser will provide the following inputs:

- Reviewing key documents
- Technical and contextual knowledge of Australian support to Nauru's health sector and the Nauru operating context
- Technical input on the review approach and methodology (review plan) and key findings from consultations (Aide Memoire)
- Technical input to the draft review report and advice on feedback as required to finalise the review report
- Participate in stakeholder consultations
- Other support as requested by the Team Leader

GEDSI and Health Specialist will provide the following inputs:

- Reviewing key documents
- Technical input on GEDSI to the review approach and methodology
- Technical input to the draft review report findings and recommendations and addressing any feedback on the report to ensure GEDSI is fully considered and addressed
- Participate in stakeholder consultations
- Other support related to GEDSI as required by the Team Leader

The team will report on a regular basis to the Deputy Head of Mission, Australian High Commission Nauru.

The Evaluation will be published on the DFAT website, as per the DFAT Evaluation Policy. Publication will consider any sensitivities in the public version of the report.

14. Performance Outcomes and Deliverables, with dates

Indicative date	Milestone	Verification indicator
29 August	1. Draft review plan	Acceptance by DFAT
9 September	2. Final review plan	Acceptance by DFAT
30 September	3. Aide memoire	Acceptance by DFAT
17 October	4. Draft review report	Acceptance by DFAT
15 November	5. Final review report	Acceptance by DFAT

15. Reporting and Payment

Payment milestones

The advisers will submit an activity report and invoice at the following points

- Acceptance by DFAT of [Milestone 2]
- Acceptance by DFAT of [Milestone 5]

16. Deliverable Published

Yes ☒

No ☐

17. Policy context

Advisers are expected to align their work with *DFAT's Partnerships for Recovery: Australia's COVID-19 Development Response 2020-22* and to incorporate the priorities of DFAT's cross-cutting strategies *Gender Equality and Women's Empowerment Strategy (2016)* and *Development for All 2016-2020 Strategy for Strengthening Disability-Inclusive Development in Australia's Aid Program*. Advisers should seek advice from the DFAT commissioning area about the most appropriate ways to align the tasks to these policies. Advisers should also discuss whether there are other DFAT policies relevant to this task.

18. Conditions

Conditions of engagement may include completing and signing the following documents:

- The Deed of Confidentiality
- The Declaration of Adviser Status
- Safeguarding Code of Conduct

As per DFAT requirements, an Adviser Performance Assessment (APA) for each member of the review team will be undertaken at completion of the assignment.

Key Selection Criteria: Team Leader

Required experience	<ul style="list-style-type: none">• At least 10 years' experience conducting health sector reviews, evaluations and designs, including Pacific and/or developing country experience and experience in leading review or evaluation teams• Demonstrated experience in quantitative and qualitative data analysis, synthesis and reporting for evaluation.
Required qualifications and skills	<ul style="list-style-type: none">• Post graduate qualification in Evaluation, or equivalent experience• High level analysis and written skills.• Leadership and team management skills
Cultural & language requirements	<ul style="list-style-type: none">• Excellent interpersonal and communication skills, including a proven ability to liaise and communicate effectively with multi-cultural colleagues.
Desirable experience	<ul style="list-style-type: none">• In country experience in Nauru and familiarity with Nauru's health sector• An understanding of Australia's aid program and its policy settings

Key Selection Criteria: Health Specialist

Required experience	<ul style="list-style-type: none">• Knowledge and context of Australian support to Nauru's health sector, including in-country experience• A strong understanding of Pacific region health system and service delivery issues including capacity building, health workforce, health financing, procurement and health information expertise.• Demonstrated experience with different aid modalities, including sector budget support
Required qualifications and skills	<ul style="list-style-type: none">• relevant higher degree in public health, health systems management or other health related fields

Cultural & language requirements	<ul style="list-style-type: none"> Excellent interpersonal and communication skills, including a proven ability to liaise and communicate effectively with multi-cultural colleagues.
Desirable experience	<ul style="list-style-type: none"> An understanding of Australia's aid program and its policy settings

Key Selection Criteria: GEDSI and Health Specialist

Required experience	<ul style="list-style-type: none"> Demonstrated competence in reviewing and analysing both qualitative and qualitative data through a gender and social inclusion lens Demonstrated understanding of the gendered impacts of both health issues and health interventions
Required qualifications and skills	<ul style="list-style-type: none"> Post graduate degree in Gender, GEDSI or related field, or equivalent experience
Cultural & language requirements	<ul style="list-style-type: none"> Excellent interpersonal and communication skills, including a proven ability to liaise and communicate effectively with multi-cultural colleagues.
Desirable experience	<ul style="list-style-type: none"> In country experience in Nauru and familiarity with Nauru's health sector

Annex A: Table of indicative inputs

Task	Team Leader	Health Specialist	GEDSI Adviser
Document review and initial briefings	3	3	3
Develop review plan and discuss with stakeholders – Review plan to be endorsed by DFAT prior to commencement of consultations	4	2	1
Consultations with DFAT, MHMS, NHSP, and other development partners (including travel to Nauru for 10 days of consultations and remote consultations)	18	18	18
Report writing and presentation of findings	10	8	5
Revisions to report (including responding to comments)	5	4	1
Total	40 days	35 days	28 days

Annex B: Investment to be covered in this review

Investment number	Investment name
INM621	Nauru Health Support Program
INN721	Strengthening systems for sustainable introduction of new vaccines (Kiribati and Nauru)
INM486	UNFPA Supplies Multiyear Contribution
INM621	Nauru Health Support Program - 18A598: Improved NCD Prevention and Control in Nauru - 73210/8

Investment number	Investment name
INK721	Pacific Regional Health Investment (activity 22A005, 69294/62), Support to SPC Public Health Division
75185	Tupaia – Partnership for health information for health security and disaster preparedness – core funding (Australia)
69294/41	The Pacific Community (SPC) - Strengthening clinical capacity and capability to respond to COVID-19
73210/25 + 73210/22 + 73210/18	World Health Organization Western Pacific Regional Office
21A117 and 21A118	Vaccine Access and Health Security Initiative (VAHSI)
INK933	Pacific Clinical Services and Health Workforce Improvement Program. This includes: <ul style="list-style-type: none"> • FNU CMNHS providing undergraduate and postgraduate education and training relevant to PIC health workforce needs, burden of disease and epidemiological patterns • Royal Australasian College of Surgeons (RACS) providing visiting specialist medical teams and clinical mentoring
INN636	Pacific Medicines Testing Program: access to Australia's Therapeutic Goods Administration (TGA) laboratories for testing the quality and safety of medicines

Annex C: Key documents

- Nauru Country Fact Sheet
- NHSP IMRs (INM621)
- NHSP design documents
- NHSP completion report
- Other NHSP outputs.

IMRs and other outcome documents for:

Investment number	Investment name
INN721	Strengthening systems for sustainable introduction of new vaccines (Kiribati and Nauru)
INM486	UNFPA Supplies Multiyear Contribution
INK721	Pacific Regional Health Investment (activity 22A005, 69294/62), Support to SPC Public Health Division
75185	Tupaia – Partnership for health information for health security and disaster preparedness – core funding (Australia)
69294/41	The Pacific Community (SPC) - Strengthening clinical capacity and capability to respond to COVID-19
73210/25 + 73210/22 + 73210/18	World Health Organization Western Pacific Regional Office
21A117 and 21A118	Vaccine Access and Health Security Initiative (VAHSI)

- Nauru Sustainable Development Strategy 2019-2030 (plus NSDS KPIs)
- Nauru Health Strategy 2021-25
- Nauru Ministry of Health and Medical Services Annual Operating Plan 2022-23.
- Nauru 2022 Census reports (if available).

Annex D: Key stakeholders

- DFAT staff in Nauru
 - Head of Mission, Deputy Head of Mission, Health Program staff.
- DFAT staff in Canberra
 - Bilateral desk
 - Regional programs (OTP)
 - Other health initiatives (CHS).
- GoN representatives:
 - MHMS
 - MHMS Adviser, Dr Keke
 - Ministry of Finance Planning and Aid Division
 - Department of Women's and Social Development Affairs
 - Department of People Living With a Disability.
 - Department of Education and Training.
- Relevant TA service providers for the NHSP staff and the Transitional program of health support
 - Beyond Essentials
 - Cardno (Various programs, covering Dep Sec, Dir Med Services, Community Health Adviser)
 - Palladium (NHSSP teams)
 - WHO.
- Relevant development partners
 - Bilateral – Taiwan, NZ MFAT, India, Japan
 - Regional – SPC
 - Global – WHO, UNICEF, UNFPA, and IPPF.
- Other health providers in Nauru

Annex 2: Investments Identified for Review

Investment number	Investment name
INM621	Nauru Health Support Program
INN721	Strengthening systems for sustainable introduction of new vaccines (Kiribati and Nauru)
INM486	UNFPA Supplies Multiyear Contribution
INM621	Nauru Health Support Program - 18A598: Improved NCD Prevention and Control in Nauru - 73210/8
INK721	Pacific Regional Health Investment (activity 22A005, 69294/62), Support to SPC Public Health Division
75185	Tupaia – Partnership for health information for health security and disaster preparedness – core funding (Australia)
69294/41	The Pacific Community (SPC) - Strengthening clinical capacity and capability to respond to COVID-19
73210/25 + 73210/22 + 73210/18	World Health Organization Western Pacific Regional Office
21A117 and 21A118	Vaccine Access and Health Security Initiative (VAHSI)
INK933	Pacific Clinical Services and Health Workforce Improvement Program. This includes: <ul style="list-style-type: none"> • FNU CMNHS providing undergraduate and postgraduate education and training relevant to PIC health workforce needs, burden of disease and epidemiological patterns • Royal Australasian College of Surgeons (RACS) providing visiting specialist medical teams and clinical mentoring
INN636	Pacific Medicines Testing Program: access to Australia's Therapeutic Goods Administration (TGA) laboratories for testing the quality and safety of medicines

Annex 3: Other DFAT Pacific Programs and Analysis of Reach to Nauru

Investment name	Program Description and Reach to Nauru
UNFPA Supplies Multiyear Contribution	<p>DFAT has invested \$14.09 million over four years (March 2018-March 2022) and a further \$14.8 million (March 2022-December 2025) to support the global UNFPA Supplies program, which operates in 48 countries. In 2021, UNFPA Supplies developed a Pacific-specific strategy for the 14 PICTs in the south Pacific. UNFPA Supplies complements other DFAT investments in SRHR including \$1.15 million for the Indo-Pacific SRHR COVID-19 response (June 2021-August 2023), annual funding for the Transformative Agenda (\$7.5m) and annual Pacific core funding of \$1m to IPPF as well as core funding to UNFPA (\$9.24m), of which a small amount supports the Pacific sub-regional office (PSRO). Nauru was not a focus country for the DFAT funded Transformative Agenda or for IPPF (DFAT Pacific and core funding).</p> <p>UNFPA has provided support to the Ministry of Health and Medical Services in Nauru since 2008. Through the UNFPA Supplies Partnership, UNFPA supplies Nauru with reproductive health commodities to ensure availability of a wide range of contraceptive choices in support of Universal Health Coverage. Between 2019-2021, an average of USD 1,000 worth of commodities per year was donated by UNFPA. From 2019 through to 2021, the contraceptives distributed by the Nauru central warehouse to lower levels are estimated to have protected a total of 1,163 couples, preventing 243 unintended pregnancies, averting 1 maternal death and preventing 25 unsafe abortions, with total savings of USD 29,459 and 7.1 return on investment. In addition to providing continued support with the supply of contraceptives, UNFPA's plans for further support include conducting a Health Facility Readiness and Service Availability Assessment (already conducted in nine countries in the Pacific), and the provision of technical support and capacity building on quantification and supply chain improvements.</p> <p>Value of commodities supplied by UNFPA to Nauru (USD):</p> <p>2018 - 1,331.95</p> <p>2019 - 2,301.50</p> <p>2020 -</p> <p>2021 - 1,853.60</p> <p>TOTAL - 5,487.05</p> <p>Note: No commodities were supplied to Nauru in 2020 as quarterly reports were not submitted by the country for Q1 and Q1 2022 in order to conduct the quantification of needs in time for distribution prior to the end of the year (COVID-19 related delays).</p>
Pacific Medicines Testing Program: access to Australia's	<p>The Therapeutic Goods Administration (TGA), as part of the Australian Department of Health, supports the Department's strategic priorities for an affordable, accessible, efficient and high-quality health system. It achieves this through effective regulation that maintains and improves the health and safety of the Australian community, while reducing compliance burdens. The TGA's International Engagement Strategy 2021-2025 describes how working with international regulatory counterparts will benefit Australians through a</p>

Investment name	Program Description and Reach to Nauru
Therapeutic Goods Administration (TGA) laboratories for testing the quality and safety of medicines	more globally aligned regulatory framework. Reduced regulatory burden on industry, a fit for purpose regulatory system that is responsive to the latest regulatory science developments and enhanced global identification of safety signals leads to improved access to the latest health products and better safeguards for the Australian community. Through the Pacific Medicines Testing Program (PMTTP), the Therapeutic Good Administration (TGA) tests samples of medicines/therapeutic goods from 12 PICs and Timor-Leste for quality assurance. Testing focuses on NCD treatments, antibiotics, therapeutic goods for COVID-19 (such as facemasks), as well as suspected substandard medicines related to an adverse event/problem. Quality testing informs PIC decisions about recalling medicines or changing suppliers for medicines that fail quality standards. Each country can send up to five samples each year, through a credit-based voucher system. Phase 2 of the PMTP has increased the number of samples tested annually from 5 to 8 for each participating country. Nauru has sent 32 samples for testing in the period 2017-18 to 2022-2023 with six failures (mostly from India).
Strengthening systems for sustainable introduction of new vaccines (Kiribati and Nauru) UNICEF	This Project supports introduction of HPV vaccine into Kiribati, as well as catch up campaign for measles. Key results include: National capacities enhanced to strengthen immunization policy and legislation in Kiribati and Nauru ; Health system capacities strengthened to deliver quality immunization services that are adapted to climate change in Kiribati and Nauru; and Caregivers in Kiribati and Nauru have improved knowledge and skills to adopt recommended immunization practices. In Nauru bilateral DFAT funding finalised introduction of pneumococcal, rotavirus and HPV vaccination into schedule. In Nauru, 245 girls were administered the first dose of HPV vaccines in December 2021. The administration of the second doses began in June 2022. These vaccination efforts are currently being supported by complementary funding provided by Rotary through UNICEF Australia. DFAT funding will allow extension beyond 2022. This is due to the overall delay in the introduction of new vaccines, caused by the prioritisation of COVID-19 vaccination, including paediatric Pfizer vaccines, by the Ministry of Health.
Pacific Regional Health Investment (activity 22A005, 69294/62), Support to SPC Public Health Division (PHD)	DFAT provides core support of \$3m per year (June 2021-June 2024) to SPC's Public Health Division (PHD) to implement their Business Plan focussing on four pillars: Health Governance; NCD Prevention and Control; Epidemiology Surveillance, Preparedness and Response to communicable diseases; and Clinical Services. SPC PHD supports 22 PICTs (DFAT support for 14 PICs) to improve disease surveillance and response and provides high quality technical assistance on non-communicable diseases (NCD) prevention and control; communicable disease surveillance and response; and clinical services across the region. PHD also works to strengthen regional health governance and policy by convening key regional meetings. Support to Nauru included Trainings, Procurement and Technical support. <u>Trainings</u> <ul style="list-style-type: none"> - SPC convened the Pacific Heads of Nursing and Midwifery meeting (PoHNM). At this meeting postgraduate nursing trainings were discussed, and Nauru has sent in their list of earmarked nurses to be trained - Supported the enrolment of nurses into the Graduate Certificate in Critical Care Nursing by the Australian College of Nursing - SPC supported and assisted with International Air Transport Association (IATA) training for shipment of infectious substances - SPC provided support through enrolment of 7 participants under the Strengthening Health Interventions in the Pacific – Data for Decision Making (SHIP-DDM) Epidemiology Program

Investment name	Program Description and Reach to Nauru
	<p><u>Procurement:</u> SPC facilitated the procurement of Rapid Antigen Test (RAT) Kits to Nauru</p> <p><u>Technical Support by SPC</u> included:</p> <ul style="list-style-type: none"> - biomedical assistance towards Nauru - assistance by reviewing and conducting gap analysis on Nauru Liquor Control Act - support to Nauru for the development of M&E framework for national NCD plan - MANA Dashboard support and through the review of indicators, assisted Nauru in addressing NCD policy/legislation gap - Nauru also committed to act on these identified gaps as well as provide updates for MANA Dashboard - 7 Nauru nationals support on improvement projects and operational researchers under the SHIP-DDM Program <p>As of 11th October 2022, SPC's Public Health Division (PHD) had spent €26.91K and committed an additional €5.22K to support Nauru health-related activities. A large proportion of the Nauru health-related expenditure relates to training in the areas of Critical Care Nursing and Strengthening Health Interventions in the Pacific – Data for Decision Making (SHIP-DDM) Epidemiology Program.</p>
SPC – Strengthening clinical capacity and capability to respond to COVID-19 (HIS/CHS)	<p>DFAT funded SPC for \$3m over 2 years, with a no-cost extension to end June 2023 for Pacific Evidence Informed Policies and Programs (Pac-EVIPP) to strengthen PICT's response to COVID-19. In addition, \$1.3m over 3 years was provided to support 2 long-term specialists in SPC's health division: one for Infection Prevention and Control (IPC) and an Epidemiologist-Training.</p> <p>For Nauru, 7 students participated in Postgraduate Certificate in Field Epidemiology on Health Information Systems (February 2022) and undertook Systems Improvement Projects.</p>
Pacific Clinical Services and Health Workforce Improvement Program (FNU)	<p>Fiji National University (FNU) at the of Medicine, Nursing and Health Sciences (CMNHS) FNU CMNHS is working to address the diverse health workforce training needs across 14 PICs, in collaboration with SPC and FNU. CMNHS also partners with Pacific Ministries of Health, through various MOUs, to ensure its programs and courses are relevant to the changing disease burdens and health workforce needs across the region. The College includes schools of: medical science; health sciences; dentistry and oral health; nursing; public health and primary care. DFAT funded \$200k/year (2018-Jan 2022) for the Office of the Associate Dean Regional (Dean's position and support staff) to support Pacific regional students. Phase 2 of the PCSHWIP is currently under contract negotiation but will continue support for Regional Office to support Pacific students studying in Fiji, as well as connecting students with their High Commissions in Fiji.</p> <p>For Nauru: 10 in 2019 – 3 Bachelor Health Service Management (BHSM); 1 MBBS; 1 Certificate in Clinical Laboratory Technology; 1 Master HSM; 2 PGD in HSM; 1 Bach Physiotherapy; 1PGD oral surgery.</p> <p>7 in 2020 – 2 BHSM; 1 Bach Physiotherapy; 1 Bachelor Medical Lab Science; 1 Master HSM; 2 PGD in NCD.</p> <p>5 in Semester 2 2021: 5 students were enrolled (all DFAT) 2 for MPH in NCD, 1 PGD in PH, 1 PGD in NCD and 1 in Nursing.</p> <p>In 2022, 2 undergraduate Nursing; 2 graduated with PGD in NCD and will also graduate with MPH in NCD, 1 graduated with PGD in HSM and Master in HSM, 1 in PGD in PH programme expected to graduate at the end of this semester 2.</p>

Investment name	Program Description and Reach to Nauru
Pacific Clinical Services and Health Workforce Improvement Program (RACS)	<p>The Royal Australasian College of Surgeons (RACS) provides visiting medical teams (VMTs) and continuing professional development for Pacific clinicians to improve quality and accessibility of clinical and surgical care in 11 Pacific islands countries. RACS also works with senior clinicians to improve the service quality and contributes to courses at the Fiji National University (FNU). RACS' Pacific Islands Program (PIP) aims to increase access to surgical care across 11 Pacific Island countries by providing education and training to Pacific surgeons, nurses and other health workers and by supporting surgical teams to deliver surgeries locally, in collaboration with SPC and FNU. DFAT funded \$7.5m (2017-2022) in phase 1 and is currently in contract negotiation for phase 2.</p> <p>Nauru has had 4 VMTs (Phase 1 2017-22); a total of 233 patients received specialist consultations and 4 surgical treatments; 33 clinicians have been mentored or received training. In June 2022, a VMT conducted 27 consultations and completed vascular surgery on 4 patients. AV fistulas were scheduled for 15 dialysis patients, but the team had to leave due to the COVID-19 outbreak. The remaining patients were to be rescheduled to February 2023 however some were deemed urgent and will either be sent for OMR or a VMT from Taiwan has scheduled to come in December 2022.</p>
Health information and surveillance – core funding to Beyond Essential Systems (BES)	<p>DFAT has invested AUD15.9 million over 5 years in Beyond Essential Systems (BES) as core funding support – to assist health authorities across 10 PICTs improve health system data collection, storage and display and inform decision making. EOPOs include: Improved information systems for public health decision making in partner countries; Improved access and use evidence for policy and other decision making to strengthen response to disease threats. The investment has been amended six times. \$5.1m allocated to health system strengthening; COVID-19 \$4.5m and vaccine delivery \$2.6m. In addition, BES receives specific implementation projects in some countries through the addition of bilateral program and VAHSI funds, including to Nauru. BES also provides support to other CHS partnerships with Ministries of Health including to Nauru MHMS. The Palladium contract for ICT in Nauru was taken on directly by BES from July 1st 2022.</p> <p>Nauru has been using Tamanu for COVID-19 vaccines and is expected to scale this out to be the national EMR, with Tupaia implementation as well. Online training was provided in 2021 by BES to 36 health workers on Tamanu vaccination module and 6 health workers on Tamanu Patient Registration Refresher. In Nauru, Tamanu has been used to record individual COVID vaccination details including generating an internationally recognised vaccination certificate allowing for international travel. Tupaia is an aggregate data display platform using mapping lead visuals and is being used to show visuals, including for the Nauru COVID-19 Taskforce and for the President to present daily reports to the community.</p>
Health Security Initiative for the Indo-Pacific Region	<p>The Initiative as launched in late 2017 included six specific and substantial commitments:</p> <ul style="list-style-type: none"> • a \$75 million Product Development Partnerships (PDP) Fund to support portfolio investment in research and development for drugs, diagnostics and vector control technologies relevant to malaria, tuberculosis and other infectious diseases • a \$20 million contribution to the World Health Organization's Health Emergencies Program to strengthen its capacity to assess countries' compliance with the 2005 International Health Regulations (IHR), monitor infectious disease threats and support national and regional responses to outbreaks

Investment name	Program Description and Reach to Nauru
	<ul style="list-style-type: none"> • a \$16 million “Stronger Systems for Health Security” applied health systems research grants program, with proposals to be jointly selected by DFAT and the National Health and Medical Research Council (NHMRC) • a \$17 million regional regulatory strengthening partnership between DFAT and Australia’s national medicines regulatory authority, the Therapeutic Goods Administration. • a new Health Security Corps within the Australian Volunteers program, which would see up to 20 Australian public health specialists placed in capacity-building roles in Southeast Asia and the Pacific each year; and • a whole-of-government Indo-Pacific Centre for Health Security within the Department of Foreign Affairs and Trade, with a mandate to deliver the above commitments, develop a strategic program of further investments to strengthen regional health security, and pursue the interests of Australia and the Indo-Pacific region in relevant multilateral processes and for a. <p>CHS provides overall management, including managing global, regional and domestic contracts. Posts manage in-country partnerships, with CHS, SMD and OTP support. In liaison with CHS, geographical divisions and partner governments, Posts select partners that best meet each country’s context and needs.</p> <p>CHS funds an IPC Advisor who supports Nauru; and CHS through Cardno facilitated recruitment for the key positions in the MHMS- Deputy Secretary, Director of Medical Services and Senior Public Health Adviser. Recently CHS has instituted fortnightly meetings with each country - DFAT Post, CHS country focal point and Technical Pacific Health Lead and OTP sometimes (recent restructure has led to changes) - providing updates and a good problem-solving space. Nauru Post has participated in these regular meetings.</p>
Vaccine Access and Health Security Initiative (VAHSI)	<p>Commencing in 2021, Australia is assisting 18 countries in Southeast Asia and the Pacific to access safe, effective and affordable COVID-19 vaccines through the Regional Vaccine Access and Health Security Initiative (VAHSI). Australia has committed a AUD1.36 million comprehensive package of support over 2020-21 to 2022-23 for Nauru’s COVID-19 vaccine rollout, drawing on the regional VAHSI and the bilateral development program. Australia’s direct support to Nauru is complemented by regional assistance and \$215 million contribution to the COVAX Advance Market Commitment (AMC), which supports equitable global access to safe and effective COVID-19 vaccines. Nauru entered AMC as a self-funded country (Australia later reimbursed Nauru’s AMC subscription). The first 10,000 vaccine doses delivered to Nauru were supplied through AMC. Australia supplied further COVID-19 vaccine doses from Australian supplies and worked in partnership with the Nauru MHMS to bolster systems for vaccine delivery. A total of 25,570 doses were donated to Nauru from a range of donors in 2021 and 2022. In 2021-22, Australia supported the delivery of 19,170 vaccine doses to Nauru – including 1,000 vaccination doses from its domestic supplies through UNICEF’s supply chain. Nauru’s COVID-19 vaccine rollout commenced in April 2021. By the end of 2021, 65% of the total population had received one dose, while 63% were fully vaccinated. As at 27 October 2022, 99% of the population had received at least 1 does of COVID-19 vaccine and 73% are considered fully vaccinated. No wastage was reported in Nauru during 2021. Australia is closely coordinating with other development partners and MHMS to mitigate risk to wastage by avoiding over-supply and assisting with cold-chain management. The TGA Regulatory Strengthening Program provided advice to Post and MHMS on expiry dates and AZ as a booster third dose.</p>

Investment name	Program Description and Reach to Nauru
	<p>In June 2021, drawing on VAHSI and bilateral funding, Australia established a \$7.9 million partnership with UNICEF (2021-22 to 2022-23) to strengthen COVID-19 vaccine delivery in Pacific countries. Through this partnership, a broad range of activities in Nauru (June-December 2021) were supported including:</p> <ul style="list-style-type: none"> • vaccine management (including forecasting based on countries' absorptive capacity), receiving vaccines at port, transportation, and distribution of vaccines in-country; and, • Stock-taking and vaccine warehouse support. <p>15 health workers (13 women, 2 men) completed training in COVID-19 vaccine administration, handling, and cold-chain management. 6 MHMS staff (2 women/4 men) completed online Tamanu patient registration refresher training provided by BES 21 people completed training (15F/6M).</p> <p>By the end of 2021, COVID-19 vaccinations were being recorded in the DFAT-funded electronic medical record Tamanu, with implementation funded by the bilateral program.</p> <p>VAHSI also offers funding for Vaccine Delivery Support Funds including for routine immunisation and Nauru Post has been notified that about \$35k is available if the country can identify a need.</p>
Australia Award Pacific scholarships	<p>Australia Award Pacific scholarships supported 7 Nauruans to complete under- and post-graduate training in nursing, public health and medical sciences in Fiji (FNU CMNHS) and 9 to Australia during 2018-22. Recent graduates have taken-up important posts within the MHMS, including as the Director of Nursing Policy and Standards, as a senior midwife in the maternity unit and within the Health Promotion Unit</p>
World Health Organization (DPS) Pacific Action Plan for COVID-19 preparedness and response (phase 1); COVID-19 Pacific Health Sector Support Plan (phase 2)	<p>WHO receives core funding from DFAT and provides a wide range of Technical Assistance and support to PICs. In 2020 to 2022, DFAT and NZ MFAT, in partnership with other UN and development agencies funded WHO Division for Pacific Technical Support (DPS) to strengthen core public health and clinical services to quickly detect, trace, test and treat cases of COVID-19 the Pacific. The Action Plan has resulted in the setting up of a Joint Incident Management Team (JIMT) and a coordinated and coherent delivery of technical and logistical support to PICs.</p> <p>Nauru has received around AUD 100,000 a year from WHO for 'Strengthening Health System and Public Health Programs Communicable Disease, NCD, and Environmental Health.' WHO has also increased support for the COVID-19 response and is a provider of technical assistance and implementation support for the UNDP's COVID-19 Support Project. In phases 1 and 2, Nauru received training (on IPC, SOPs, case management, preparedness and response) and supplies including PPE (gloves, goggles, masks, gowns), GeneXpert machine and cartridges and an External Quality Assessment of laboratory. Country requests from Nauru were received; 7 were completed (with 3 in process pending) – for case management, laboratory support, surveillance and supplies. Support was also provided to Nauru's COVID-19 Taskforce to develop outbreak response plans and community engagement communication strategies, which were well implemented during the 2022 outbreak. An eco-friendly hospital waste management system was also procured through other funding sources.</p>

Investment name	Program Description and Reach to Nauru
Global Fund (managed through UNDP for 11 PICs)	<p>Funding support provided to Nauru MHMS during 2018-2022 for a total of AUD 115,565</p> <p>2018 – AUD 16,997.74 USD 12,380.00</p> <p>2019 – AUD 26,408.00 USD 18,059.95</p> <p>2020 – AUD 7,298.22 USD 4,902.44</p> <p>2021 – AUD 39,499.90 USD 29,704.79</p> <p>2022 – AUD 25,361.19 USD 17,935.25</p> <p>TOTAL – AUD 115,565.05 USD 82,982.43</p> <p>Programmatic results 2018-2022:</p> <ul style="list-style-type: none"> ➤ Advocacy and awareness activity during World AIDS Day (WAD) and managing to deliver targeted HIV/STI interventions and reaching key affected populations, including the Men who have sex with Men (MSM), transgender (TG) and female sex worker (FSW) population. ➤ 100% of PLHIV on ART ➤ 100% of TB treatment success rate of all forms of TB ➤ Capacity building trainings to Health Care Workers on HIV/STI telemedicine, Stigma and Discrimination and TB telehealth, policies, and guidelines. ➤ Life- saving TB/ HIV/ STI medicines, HIV/ Syphilis rapid diagnostic tests, TB diagnostic cartridges and Lab consumables along with medical instruments delivered to Nauru. Provided support to TB patients and People Living with HIV resulting in 100% treatment adherence. Key and vulnerable population Program which includes, Female Sex Workers (FSWs), Transgenders (TGs) and Men Who Have Sex with Mem (MSM) reached with HIV/ STI prevention package and testing services. ➤ UNDP in partnership with UNAIDS undertaking initiative to Re-estimate the Population Size for MSMs, TGs FSW, seafarers and prisoners across all 11 GF supported MWP countries in order to ensure resources are appropriately targeted and improve grant performance management. ➤ Ongoing remote HIV patient monitoring / case surveillance including <ul style="list-style-type: none"> • monitoring patient treatment regimens • monitoring patient CD4 count and viral load • Making reporting improvement recommendations based on monitoring data ➤ Engage and partner with community organizations to provide education and involve in community campaigns to raise awareness and reduce stigma. ➤ Strengthen surveillance, data management and information technology.

Investment name	Program Description and Reach to Nauru
	<ul style="list-style-type: none"> ➤ Provision of regional technical assistance to HIV clinicians and health care workers in through ongoing telemedicine and clinical management support of PLHIV patients. ➤ Provision of regional technical assistance by WHO on TB support to clinicians, health care workers through telemedicine and clinical management support. ➤ Development of Nauru National HIV/STI Strategic Plan 2022-2027 ➤ Development of Nauru M&E Strategy
World Bank – PNG & Pacific Islands Umbrella Facility multi donor trust fund	<p>DFAT funding to the World Bank (PPIIUF and Advance UHC) aims to strengthen public financial management in the health sector in selected PICs. The program of Pacific Advisory Services and Analytics (PASA) works to strengthen PICTs’ planning and budget implementation and to explore options for improving efficiency and equity of resource allocation in the health sector.</p> <p>Nauru is not eligible as it has recently been re-classified as a high-income country</p>
International Planned Parenthood Federation (IPPF) Niu Vaka Pacific strategy	<p>IPPF works with governments, faith based and civil society organisations to address sexual and reproductive health and rights. In the Pacific and PNG IPPF supports nine ‘family health associations’ (or Member Associations) which are local non-government organisations. IPPF Pacific funding is co-contributed from DFAT Pacific regional and gender program funds. Pacific regional health contribution is \$500k per year with \$18.9m (2019-22) for global strategic framework and related Pacific strategy. Pacific regional Niu Vaka II Strategy is being finalised and the contract negotiated by DFAT GHD. Funding from OTP VQS to increase.</p> <p>Currently there is no IPPF Member Association in Nauru.</p>

Annex 4: Findings addressing Key Evaluation Questions

Key Evaluation Questions	Findings
<p>Q1. To what extent have DFAT's investments (see Annex) made a strategic contribution towards helping achieve the outcomes of the MHMS' Health Strategies and Plans, including Nauru's NCD Strategic Action Plans</p>	<p>Health Sector Planning: EOPO 1.2</p> <p>The extent to which DFAT's investments in the Nauru health sector from 2018-2022 have made a strategic contribution to outcomes is impacted by the absence of strategic, evidence-informed health sector planning.</p> <p><i>Sectoral strategic and operational planning:</i> The sectoral, strategic direction during the period was led by the <i>National Health Strategic Plan 2016-2020</i>, which sets out the MHMS' priority areas of operation. It is founded on available data derived from national surveys (such as the national census and Demographic and Health Surveys), and to a lesser extent, some hospital data, but does not set specific targets, nor does it identify key indicators for measuring change. It does articulate an intention to use AOPs to guide implementation, and to monitor and report progress against these.</p> <p>Following the period of the <i>Nauru Health Strategic Plan 2016-2020</i>, there was a gap in the health sector's strategic framework as the country prepared for COVID-19. Absence of a DFAT-funded Planning Adviser (through NHSSP) in 2020 and much of 2021 only saw a new <i>National Health Strategy 2021-2025</i> completed late in 2021; it was not endorsed/released until mid-2022. This new <i>Strategy</i> is comprehensive and ambitious, and is founded on a detailed evidence-base derived from multiple sources across the sector. The new <i>National Health Strategy 2021-2025</i> is an improvement on its predecessor as it articulates high-level costings, and some guidance for the development of costed AOPs, linked to a comprehensive monitoring and evaluation framework which establishes some targets and potential data sources, and lists proposed interventions.</p> <p>Based on review and some key informant views, the <i>Nauru Health Strategy 2021-2025</i> appears ambitious in scope; many of the proposed targets are beyond what the sector is likely to achieve in the period, and many indicators are beyond the capacity of the sector's data collection systems.</p> <p>A key issue in planning and monitoring is the link between the <i>Nauru Health Strategy 2021-2025</i> and Annual Operational Plans (AOPs). Many senior managers across the MHMS articulated that the support they received from DFAT advisers to develop AOPs in 2021 was highly valued, however the abrupt departure of the NHSSP Planning Adviser early in 2022 left an absence of guidance and materials to support ongoing AOP development, monitoring and reporting. While the <i>Nauru Health Strategy 2021-2025</i> does provide some guidance, it is not sufficiently specific and focused to be a practical guide for Directors and managers.</p> <p>The AOPs for 2022-23 are comprehensive documents that clearly identify outputs and key activities; the intention of the Health Executive is that they are used within each Division/Department to foster accountability for delivery. The Public Health Division does a step-down quarterly plan and has developed a quarterly reporting template. The issue however, is that there is a weak 'culture of reporting' against AOPs in the MHMS, and improvement will require sustained effort from Directors and Managers. It is unlikely that users will be willing/able to familiarise themselves with the content to use them regularly for monitoring and</p>

Key Evaluation Questions	Findings
	<p>reporting, at least not without support from planning managers, officers, advisers and documented guidelines and reference materials.</p> <p>In summary while the strategic framework for the sector has improved on paper, with support from advisers, the breadth and ambition of the new <i>Nauru Health Strategy 2021-2025</i>, and the limited means through which to collect and analyse data for progress monitoring and reporting of effectiveness will continue to pose a challenge to the MHMS. This will need to be addressed in the Transitional Health Program.</p>
	<p>MHMS Health Priorities:</p> <p>Due to the delay in finalising and releasing the <i>National Health Strategy 2021-2025</i>, the period for this review (2018-2022) was mostly guided by the four Key Result Areas (KRAs) of the <i>National Health Strategic Plan 2016-2020</i>.</p> <p><i>KRA 1: Health Systems: To strengthened health system capacity and capability to meet health service needs, demand and expectations</i></p> <p>The NHSP identified strengthened MHMS leadership and management as a priority for DFAT investment during the period, however planned interventions (in line with EOPO 1.4) through NHSSP were later dropped from the scope following a delayed project commencement (due to a national election, initially, followed by reported challenges experienced by MHMS leaders to comprehend the project design and start-up requirements), and subsequent difficulties in recruiting and placing key advisers before, and during COVID-19. Proposed management development programs and structured mentoring systems were not initiated through the NHSSP.</p> <p>Despite the challenges, recent restructures to health system management and service delivery have had mixed outcomes. At the senior, executive management level, the Secretary for Health is supported by a Deputy Secretary; during the period, the position has mostly been filled by expatriates, with varying degrees of success or disruption depending on personalities and agendas. The current expatriate Deputy Secretary (recruited through DFAT's Centre for Health Security under AusP3) provides excellent, facilitatory mentoring and support to the Secretary, Directors and middle-level managers across the RON Hospital and Naoero Public Health Centre. The current appointment of Deputy Secretary for Health is considered an excellent outcome from DFAT's investment, although it is acknowledged that the leadership and governance development challenges within the MHMS are beyond the capacity of any single individual.</p> <p>DFAT support to clinical services management has made a modest contribution, with a number of expatriates placed into senior line positions such as the Director of Medical Services (DMS), again with varying degrees of success or disruption, depending on personalities and agendas. The most recent, DFAT-funded expatriate in this position was reported to have provided suitable clinical governance through an authoritarian approach, but their style was considered inappropriate and culturally insensitive, and they demonstrated an absence of leadership during the COVID-19 outbreaks of 2022. The current Acting DMS is a local, early-career</p>

Key Evaluation Questions	Findings
	<p>doctor who provided valued leadership and enhanced teamwork during the COVID-19 outbreak when many advisers were not in-country. The DMS is a critical position to implement the NHS, and many essential activities and outcomes are the responsibility of the DMS; the position is currently under recruitment (at November 2022).</p> <p>There has been limited DFAT-funded support to health financial management in the period, although bilateral funding through a Direct Funding Agreement (DFA) of AUD 1.4m over two years supported the MHMS to procure medical equipment and consumables, and strengthened IPC, diagnostics, education and training and the establishment of the impressive Acute Care Unit. This proved essential to Nauru's impressive COVID-19 preparedness and response efforts.</p> <p>Human resources management and systems development support (through NHSSP) was disrupted during COVID-19 and did not recommence due to recruitment challenges faced by the managing contractor. The advisory support provided (in the first half of 2021) only had minimal impact during the period. Vacancies across the MHMS staffing structure and chronic absenteeism amongst various staffing cadres continue to impact effective management and delivery of health services. The current staffing structure is reported to be too ambitious in terms of numbers of staff required within a limited human resourcing pool and lacks flexibility to enable re-purposing of staff from areas of lower to higher need.</p> <p>Considerable DFAT investment has been directed to strengthening health information management and systems in the period. A functional, dedicated Health Information Unit has not yet been established, however a competent Medical Records officer in RON Hospital, and a Public Health Statistician at Naoero Public Health Centre respectively provide adequate summaries of patient admissions and discharges, and public health program output (and some outcomes).</p> <p>Much of the investment during the period has been for the establishment and roll-out of electronic patient record systems. NHSSP employed a HMIS Adviser who left during COVID-19, provided some remote support, and did not return. The rollout of the Tamanu EPRS system in late 2021 was implemented by Palladium under the bilateral program, with some support from Beyond Essential Systems (BES). BES was contracted through NHSSP initially, and more recently under bilateral arrangements through CHS and the Health Security Initiative. Initial support for HMIS proved less effective than anticipated due to the long absence of the technical adviser (during and following COVID-19), and difficulties engaging MHMS staff through remote training and system support. This was rectified from March 2022, with 3 visits from BES advisers. Long-term adviser and technical support in-country did not happen until a separate contract was agreed from July 2022. The individual health record was used effectively to manage COVID-19 testing and vaccination towards the end of NHSSP, and its scale-up is continuing. The Tupaia system is being established alongside Tamanu, to assist MHMS to visualise and present de-identified health, disease and risk factor data against geographical and other grouping parameters; which was highly valued in presentations by the President during the COVID-19 outbreak in June 2022.</p> <p>After a period of disuse, individual Health ID cards are being re-issued without photos, and with options to collect and track multiple names for individuals (a practice of individuals identifying under different names and combinations has previously resulted</p>

Key Evaluation Questions	Findings
	<p>in duplicated individual health records). These changes because of stakeholder consultation will contribute to more accurate, and easily managed population health data sets and tracking of patient management.</p> <p>Plans to establish a Laboratory Information Management System (LIMS), and a Radiology Information System/Picture Archiving and Communication System (RIS/PACS) under NHSSP did not progress during the period. MHMS was reportedly not suitably informed by the Project about the rapid market assessment and tender procurement undertaken late in 2021, and the Ministry determined that, given the lack of transparency associated with the tender, it was unwilling to take-on the cost liabilities involved. A Cancer Registration system (CanReg) was also identified for progression (supported through WHO), however this has not progressed due to a WHO Adviser reportedly advising the MHMS to continue using an Excel spreadsheet instead (it is unclear from whom this advice was delivered, however WHO in Suva have confirmed that CanReg may be too comprehensive and difficult to maintain given the relatively small cancer patient load in Nauru).</p> <p>Management development, improved human resource systems and using data to present reports will need to be addressed in the Transitional Health Program.</p> <p><i>KRA 2: Primary Health Care and Healthy Islands:</i> To strengthen and improve community preventive and health care services under the principles and concepts of primary health care and healthy islands</p> <p>Public Health Division support through NHSSP commenced in May 2021; with consultation for, and development of the Community Health Project Plan (CHPP). This was finalised in Quarter 1 of 2022, leaving little time in which to sensitise the sector and staff to the Model of Care and Essential Services Packages included.</p> <p>The CHPP outlines the essential and life-course packages and interventions for all of the key strategic public health programs prioritised within the <i>National Health Strategic Plan 2016-2020</i> and articulates the model of care for community/zone nursing, inclusive of referral pathways, integrated care between public health and RON Hospital, patient/client management systems and staffing and resourcing needs. The proposed PHC approach promotes the concepts of Universal Health Coverage (UHC), consistent with the Government of Nauru's Healthy Islands commitments.</p> <p>The CHPP also sets-out the rationale and implementation plan for the Anibare and Yaren Wellness Centres, envisaged as community-based hubs for increased access to public health and screening programs, and for referral to secondary and tertiary services at RON Hospital. The Wellness Centres are not currently fit for purpose, and require considerable facility upgrades to meet the CHPP's vision for delivery of an essential package of primary health care services. Efforts to address infrastructure needs at the Wellness Centres did not progress adequately during the period, largely due to the Managing Contractor not providing an architect or plan for the facilities until near the end of NHSSP. DFAT's commitment to the Wellness Centre upgrades remain unfulfilled during the period.</p>

Key Evaluation Questions	Findings
	<p>Regardless of fitness of the facility and very low usage by the community, the Wellness Centres have staff allocated to them (an expatriate Nurse Practitioner and Registered Nurse); an issue that should be considered in the Transitional Health Program. In addition, successful implementation of the CHPP will require further work to promote and build ownership and understanding of the CHPP amongst senior and middle-level sector managers, and to some extent, the community. Engagement and investment in the model of care, cooperation and patient care planning across tertiary, secondary and primary care levels and user acceptance of multiple levels of service delivery will be possible only if there is collective understanding of the benefits to the sector through integrated resource sharing and early interventions to prevent disease progression. The level of detail in the CHPP dictates that it may need to be broken down into targeted messages and packages of information for key audiences but also joint clinical/public health workshops to develop shared understanding.</p> <p><i>KRA 3: Curative Health Services:</i> To provide high quality clinical care and services to meet the needs and expectations of patients and that are in line with the policies and resources of the Ministry.</p> <p>DFAT's health sector support has not been specifically focused on the delivery of clinical services, however the appointment of expatriate advisers in the role of Director of Medical Services (DMS) has sought to improve the planning, scheduling and quality of medical and nursing services within RON Hospital. The various Directors of Medical Services have worked with the Chief Matron to develop integrated patient management and flow systems and processes, however the extent to which these are disseminated and put into practice is not clear. Efforts to engage in collaborative discharge planning between RON Hospital and Naoero Public Health Centre only recently began in October 2022 with a series of workshops facilitated by the CHA Adviser and other Directors.</p> <p>DFAT support to specialist clinical and diagnostic services has mainly been provided through the Pacific Clinical Services and Health Workforce Improvement Program (PCSHWIP), which supports the Royal Australasian College of Surgeons (RACS) to provide visiting medical teams (VMTs) to Nauru. VMTs were not consistently implemented during the period due to border closures and travel restrictions associated with COVID-19 both within Australia and Nauru, and reportedly perhaps because of a limited advocacy on Nauru's part to submit suitably detailed clinical requests. The period has seen four VMTs visit Nauru to deliver specialist consultations to 233 patients, including four who underwent vascular surgical procedures; the latter took place during an urgent specialist vascular surgical VMT in mid-2022 following a lengthy absence, however the mission was forced to conclude early (with still 15 more surgical patients on the list) due to the COVID-19 outbreak in Nauru. A return visit to complete the list is under consideration for late 2022, or early 2023 however it appears that Taiwan will respond with a VMT in December. In addition to conducting clinical assessments and some surgeries, the VMTs also provided clinical mentoring and training to 33 Nauru-based clinicians.</p> <p>While the investment in VMT support has made important contributions to the MHMS' clinical care priorities, there is potential for greater services and overall clinical gains if the support from RACS and other clinical advisers is broadened to building the capacity of the Director of Medical Services to prioritise more effectively, advocate and appropriately document requests (with improved</p>

Key Evaluation Questions	Findings
	<p>diagnostics and patient planning) for VMTs. Given the reality of limited surgical capacity in Nauru, and the highest use of expensive Overseas Medical Referrals (OMR) there will be an ongoing need for VMTs, and with additional funding, more could be scheduled; to be considered in Transitional Health Program.</p> <p>DFAT support to the RON Hospital Pharmacy/National Medical Store has made a significant contribution to health sector and clinical improvement during the period. An NHSSP Logistics Management Information System Adviser worked closely with and supported the Chief Pharmacist to oversee the re-installing and expansion of the mSupply system across MHMS computers, and training of 16 pharmacy, stores, laboratory and health service staff in its use. Stores management systems were overhauled; stock counts and accurate inventories were established and linked to mSupply and expired stock was removed and replaced (effectively putting an end to previously frequent stock-outs). SOPs for pharmacy management and pharmaceutical dispensing were established and are being well utilised.</p> <p>Procurement systems were overhauled with a view to prioritising value for money and quality products, and preferred suppliers were established through addition of a pharmaceutical Tender Evaluation module within mSupply, effectively saving MHMS hundreds of thousands of dollars (AUD448,000 in 2022). A key to this success was to support the integrity and authority of the Chief Pharmacist position to provide impartial and effective management of the national drug and consumables supply, and to protect the position from political interference.</p> <p>DFAT regional support to the maintenance and supply of quality medicines and medical consumables in Nauru is provided through the Pacific Medicines Testing Program, which allows the National Pharmacy access to Australia's Therapeutic Goods Administration (TGA) laboratories for testing the quality and safety of medicines. Countries are eligible to send a specified number of samples each year; Nauru has sent samples every year: 2017-18 six samples all passed; 2018-19 eight samples with one fail; 2019-20 five samples with one fail; 2020-21 five samples with four fails; 2021-22 three samples all passed, and five samples have been sent in 2022-23.</p> <p>Establishment of medical and pharmaceutical storage remains a significant challenge; the current storage infrastructure is inadequate, with unstable flooring, leaking ceilings and inadequate space (resulting in boxes of items being stored in public thoroughfares) leaving supplies vulnerable to weather, theft and interference (both from humans and vermin). A dedicated, suitable facility is urgently required for a National Medical Store.</p> <p>Nauru's impressive Medical Laboratory team benefitted from DFAT support during the period through the procurement of new laboratory equipment and consumables, purchased through the Direct Funding Agreement (AUD 1.4m over two years), and through regional COVID-19 response support (inclusive of two ISTAT blood gas Point of Care Analysers, associated consumables and quarterly training for staff). The Laboratory Manager has requested the implementation of mSupply system to cover laboratory supplies and consumables. mSupply has been installed, however, training has stalled due to storage issues for the stock. Full implementation is unable to proceed until a sufficient storage area is obtained to allow effective inventory control management. As an interim measure, all Laboratory procurement is conducted in mSupply to allow for tracking of the items and cost management,</p>

Key Evaluation Questions	Findings
	<p>but no consumption data will be available until Inventory management processes are in place. As mentioned, plans to support the procurement and establishment of a Laboratory Information Management System have not progressed during the period. This tender and procurement process for LIMS is important to address in the Transitional Health Program, and a quick resolution sought.</p> <p><i>KRA 4: Support Services and Networking:</i> To support the clinical and health programme role and functions of the Ministry through a robust health administration and management system.</p> <p>DFAT has supported health system administration and operations management through specific adviser support, such as through the Deputy Secretary for Health, and a selection of NHSSP advisers including hospital operations, planning and health systems, human resources management and performance management systems.</p> <p>Support to human resources management and planning has had limited success; NHSSP advisers were forced to work remotely during COVID-19, and later NHSSP was unable to recruit replacement advisers to the roles. Staff shortages, position vacancies and slow/ineffective, central-government-controlled recruitment remain chronic issues facing the MHMS, as are absenteeism and limited internal capacity, systems or authority through which to conduct performance management and/or disciplinary action.</p> <p>Following eight months of NHSSP adviser support in 2019-2020, RON Hospital Operations remain inadequate, with failing infrastructure and biomedical equipment, and inadequate systems for requesting, logging and tracking maintenance support (although it is noted that MHMS Annual Reports present maintenance request and completion data, it is reported that many requests are not documented, and therefore are not reflected in these results). Immediately following the period of support from the NHSSP Hospital Operations adviser, 47% of logged maintenance requests were not completed²⁷. The Ministry introduced outsourcing of maintenance to a private company, to be reviewed by the new Minister.</p> <p>In the final months of the NHSSP, advisory support saw consultative development and drafting of SOPs and/or guidelines for health system operations, including patient referral and admission, laboratory specimens' management, IPC, mortuary management, information and record management, patient referral and care planning, human resources and performance management. These draft documents have been well received, however more work is required to bring them to completion, endorsement and implementation. The Transitional Health Program will need to identify with MHMS Health Executive Team and new Minister of Health the priority management and administrative changes to support.</p>

²⁷ MHMS Annual Health Report: July 2019 – June 2020.

Key Evaluation Questions	Findings
	<p><i>Progress against the Nauru NCD Strategic Action Plan (2015-2020):</i> The MHMS identified specific strategies for addressing NCDs during the period, which had been progressing well in the lead-up to COVID-19, due to the collective efforts of the NCD Unit in the Public Health Division, and WHO.</p> <p>Efforts to improve leadership and governance for NCD prevention and control saw the re-establishment of and building of political support for the National NCD Task Force. WHO worked to support the MHMS, through the leadership of the Minister, to draw in all relevant sectors to engage in NCD prevention and control efforts, including the review and re-drafting of tobacco control legislation. Within the health system, WHO supported the MHMS to deliver system-wide uptake of agreed NCD PEN protocols, and to initiate comprehensive prevention, screening, diagnosis, and clinical management of NCDs and their risk factors.</p> <p>Many of these interventions slowed or stalled in the face of COVID-19 preparedness and response efforts when WHO advisers were repatriated from Nauru and all national efforts and political focus were directed to the crisis. An assessment of the outcomes achieved through these efforts is due soon after this Review is released. A critical appraisal of the final results and subsequent, MHMS-led actions are to be prioritised early in the Transitional Health Program.</p>
<p>Q2. How successful have the investments been in achieving their stated outcomes?</p> <p>What has been NHSP's progress in achieving its end-of-program outcomes and intermediate outcomes?</p>	<p>Component 1: Strengthened health systems</p> <p><i>EOPO 1.1:</i> By June 30 2022, health managers and clinicians have access to timely, relevant and user-friendly health information to inform decisions and reporting</p> <p>In recognition of the absence of reliable, secure and usable data (patient contacts, service delivery and population health and wellbeing), DFAT support to the Nauru health sector sought to prioritise the establishment and/or revitalisation of electronic data and reporting systems with which senior and unit/program managers across the health sector could make informed, evidence-based decisions for resource allocation to prioritised need. Systems targeted included a comprehensive Health Information Management System (including Tamanu, PatisPLUS and CanReg), a Logistics Management Information System (mSupply), and Laboratory Information Management System (LIMS), a Radiology Information System/Picture Archiving and Communication System (RIS/PACS). A data visualisation and reporting system (Tupaia) was also identified for introduction during the period to assist MHMS with its reporting and communication initiatives, which were prioritised within the <i>National Health Strategic Plan 2016-2020</i> to promote understanding and acceptance amongst health sector stakeholders and foster a culture for evidence-based decision-making.</p> <p>NHSP experienced a slow initial start in 2018-19, followed by delayed progress during COVID-19 as advisers were located offshore and attempting to work remotely (except for the ICT adviser who remained in Nauru until October 2021 and returned in April 2022 for a few months). After return of some advisers in mid-2021, some success was achieved with ICT hardware installation and expansion and consolidation of some electronic health information management systems (mSupply, Tamanu and Tupaia). Other planned system reforms (LIMS, RIS/PACS) did not progress during the period, largely due to tendering and procurement concerns.</p>

Key Evaluation Questions	Findings
	<p>CanReg is waiting on advice from WHO to proceed and requires someone to transfer data from Xcel spreadsheets to the CanReg system; with small numbers this may not be a good investment of time.</p> <p>Establishment of an electronic, individual patient health record (using Tamanu) was slow to get moving during the period, due to an absence of dedicated staff to staff a Health Information Unit. Despite efforts to encourage and support MHMS in recruiting appropriate staff, the Health Information Unit was not formally established during the period. Health Information Management System advisers were also absent for a lengthy period during COVID-19, resulting in loss of skills following training delivered early in the period, and without identified Health Information Unit counterparts in place, efforts to operate remotely proved ineffective.</p> <p>Following border re-opening in 2022, BES (through NHSSP) placed advisers and support staff in MHMS and have made significant progress in establishing ICT hardware and cabling to facilitate expansion of electronic systems. Training of 35 staff and volunteers on the use of Tamanu has seen the system being used to manage community-based COVID-19 testing and vaccination interventions. The Tamanu system was not operational in RON Hospital units or Public Health by the end of the NHSSP.</p> <p>Other achievements include the establishment of 16 data entry forms to capture clinical and public health information, and to prepare other datasets for merging across to Tamanu. For example, the Medical Records officer in RON Hospital maintains patient admission, bed occupancy and service data through a limited data set (maintained on a series of spreadsheets), enabling such information to be reported annually by the MHMS. Efforts are underway to merge these datasets with newly entered data on the Tamanu system, and in Public Health, there is an intention to merge historical program data across to the Tupaia system to better track patient service and screening, and to report on program coverage.</p> <p>Tupaia itself has been demonstrated effectively during the COVID-19 response to communicate immunisation and testing data to the population. Respondents highlighted the effectiveness of this tool to inform public announcements from the President and the COVID-19 task force. Further expansion of the Tupaia system across public health programs is scheduled and should be prioritised within the Transitional Health Program, along with mobile applications to record population based NCD risk screening.</p> <p>Support for the strengthening and expansion of the Logistics Management Information System (mSupply) has been a stand-out success of DFAT support during the period (see KRA 3). The NHSSP Logistics Management Information System Adviser was embedded in the Pharmacy Unit of RON Hospital (also the National Medical Store), and through system expansion (both in terms of the number of users and terminals, and in scope), training of staff, electronic stock management and revitalisation and reforms to procurement systems and processes, the National Medical Store no longer experiences stock outs and expiration of medicines (chronic issues at the commencement of the period); in addition the new systems have demonstrated significant savings for MHMS procurement budgets.</p> <p>There was little progression of planned interventions to establish a LIMS and RIS/PACS during the period, due to delayed procurement which was left too late to be implemented during the NHSSP contract. There is currently no schedule in place to</p>

Key Evaluation Questions	Findings
	<p>reignite exploration of appropriate systems but could be considered during the Transitional Health Program. Similarly, the CanReg system was not progressed during the period; WHO (which supports the system) has reportedly advised the MHMS to continue use of an Excel spreadsheet given the relatively small cancer patient load in Nauru.</p> <p><i>EOPO 1.2: By June 30 2022, MHMS has made progress in developing, implementing, monitoring and evaluating AOPs and undertaking performance management</i></p> <p>Health planning capacity within the MHMS was assessed as weak at the commencement of the NHSP, with limited capacity to direct funding against strategic priorities and operational plans. Support to strengthen evidence-based priority setting and health planning, monitoring, and reporting was identified as an important priority of support under the Program, however slow progress in the initial stages of the NHSSP, and inaction during COVID-19 (when advisers were forced to work remotely) resulted in only moderate progress against this EOPO.</p> <p>Following a gap in strategic direction after the conclusion of the <i>National Health Strategic Plan 2016-2020</i> in the middle of Nauru's COVID-19 preparedness and response efforts, NHSSP advisers worked well with the MHMS to establish a new, evidence-based <i>Nauru Health Strategy (NHS) 2021-2025</i> which articulates a link between strategic priorities and the development, implementation, and monitoring of AOPs. MHMS senior managers have confirmed their satisfaction with the new <i>NHS's</i> development and finalisation, and with DFAT advisers' assistance to work with them to develop AOPs in 2021. Unfortunately, the abrupt departure of the NHSSP planning adviser early in 2022 left an absence of documented guidance and materials to support ongoing AOP development, monitoring and reporting, and some managers feel unsure about how to proceed with monitoring and reporting against the AOP. Efforts by a dedicated NHSSP adviser late in the project generated several draft guiding documents and SOPs which may, once finalised and well disseminated, assist managers in their planning and reporting, and potentially linking staff performance to AOP implementation, however further work will be required in the Transitional Health Program before this EOPO is fully realised.</p> <p><i>EOPO 1.3: By 2021, high priority health system operational functions are implemented</i></p> <p>At the commencement of the period, there was a recognised lack of operational systems across all areas, including finance, planning, procurement, human resources, risk management including health and safety, service quality, facilities and asset management, complaints and incident management and communication systems. As with EOPO 1.2, moderate progress was made in this area; most of the relevant progress was achieved in the final 12 months of implementation, leaving little time to train staff in their use.</p> <p>NHSSP advisory support in the final months of the project saw consultative development and drafting of SOPs and/or guidelines for health system operations, including patient referral and admission, laboratory specimens' management, IPC, mortuary management, information and record management, patient referral and care planning, human resources and performance</p>

Key Evaluation Questions	Findings
	<p>management. These draft documents have been well received, however more work is required to bring them to completion, endorsement, and implementation. Similar advisory support to key technical areas saw relevant SOPs developed in the final 6-8 months of the period for community health, mSupply, the Tamanu health information management system and IPC.</p> <p>NHSSP adviser support for RON Hospital Operations in 2019-2020 appears inadequate given failing hospital infrastructure and biomedical equipment, and inadequate systems for requesting, logging, and tracking maintenance support. It is unclear why this position was not re-ignited following post-COVID-19 border re-opening.</p> <p><i>EOPO 1.4: By June 30 2022, managers have increased their competence and a culture of 'learning through doing' is emerging</i></p> <p>This EOPO was not addressed under NHSSP as originally intended due to repeated delays, and eventual agreement (between DFAT and the Managing Contractor in late 2021) to remove this from the project's scope. NHSSP articulated that MHMS counterparts were not available to progress this, and delays associated with absent advisers (due to COVID-19 and other issues) shortened the time available to progress this.</p> <p>Most levels of MHMS management (from the Secretary down) communicated the need for leadership and management training and support to expand their professional/technical expertise to improve capacity for sectoral management, which should be addressed in the transition and future phases.</p>
	<p>Component 2: Improved prevention and management of lifestyle diseases</p> <p><i>EOPO 2.1: By June 30 2022, a more functional and effective community-based health system is in place</i></p> <p>It was an intention of the NHSP to relieve the service strain on RON Hospital through strengthened primary health services delivered at the community level, both through integrated public health program outreach and basic clinical and screening services delivered from community-based Wellness Clinics. Moderate progress has been made towards this EOPO, largely due to the late commencement of the NHSSP Community Health Adviser (CHA) following COVID-19 border closures. Since commencing in mid 2021, the CHA progressed consultative development of a comprehensive Community Health Project Plan (CHPP). This was finalised in Quarter 1 of 2022, leaving little time in which to sensitise staff about the Model of Care and Essential Services Packages presented.</p> <p>The CHPP sets-out the rationale, intervention types, target populations and service levels for a range of disorders, particularly for NCDs and their risk factors, drawing on the NCD PEN protocols and guidance to direct screening and diagnostic activities, clinical management, and referral. The CHPP also describes the model of care for community/zone nursing, inclusive of referral pathways, integrated care between public health and RON Hospital, patient/client management systems and staffing and resourcing needs and sets out the rationale and implementation plan for the Anibare and Yaren Wellness Centres as community-based hubs for increased access to public health and screening programs, and for referral to secondary and tertiary services at RON Hospital.</p>

Key Evaluation Questions	Findings
	<p>The Wellness Centres are not currently fit for purpose, however, and require considerable facility upgrade and expansion to meet the CHPP's vision for delivery of an essential package of primary health care services. Efforts to address infrastructure needs at the Wellness Centres did not progress adequately during the period, partly due to incompatible expectations between the MHMS and NHSSP, resulting in inadequate budget allocation to the facility upgrades; the two parties were unable to reach agreement on the needs and type of infrastructure required, and DFAT's commitment to the Wellness Centre upgrades remains unfulfilled.</p> <p>Given the finalisation and release of the CHPP in the final months of the NHSP, further work will be required in the Transitional Health Program to promote and build ownership and understanding of the Plan amongst senior and middle-level sector managers, and the community. Engagement and investment in the model of care, cooperation and patient care planning across tertiary, secondary and primary care levels and user acceptance of multiple levels of service delivery will require collective understanding of the benefits to the sector through integrated resource sharing and early interventions to prevent disease progression.</p> <p><i>EOPO 2.2: By end October 2022, timely, effective and cost-efficient detection and management of NCDs is more accessible to men and women</i></p> <p>Led by WHO under a bilateral DFAT grant, this EOPO enjoyed moderate success prior to COVID-19, but limited data is available upon which to assess performance in the final 18 months. Further to the direction and guidance within the CHPP (see EOPO 2.1), WHO were tasked with preparing and supporting the Nauru health system to deliver comprehensive prevention, screening, diagnosis and clinical management of NCDs and their risk factors in accordance with the <i>Nauru NCD Strategic Plan 2021-2025</i> which articulates the system-wide uptake of agreed NCD PEN protocols²⁸.</p> <p>WHO advisers were making reasonable progress in supporting the introduction and roll-out of NCD PEN prior to the COVID-19 pandemic, at which time they were forced to withdraw from Nauru, and to provide remote support. They did not return for nearly two years (until October 2022 for a short input). Following the development and training of all staff on NCD PEN SOPs by May 2022, WHO reported improvements to the numbers of target populations screened - 62% (of adults over 30 years of age up to May 2022) from a baseline of 0%, and CVD risk assessment to 87.5% from a 0% baseline in 2019. A remote audit of clinical files in May 2022 showed improvement in key indicators of standards of care. CVD risk recorded in patient files increased from 29% to 62.5%. Remarkably, 67% of registered individuals with DM received comprehensive foot examination within last 12 months (compared to</p>

²⁸ WHO's PEN includes analysis of factors that contribute to the rising trends of NCDs and NCD risk factors and are key barriers to NCD prevention and control. These include social, political, economic, environmental, epidemiological and behavioural factors. PEN expands on the importance of health systems strengthening, the role of primary health care in detection and management of NCDs and the rationale and evidence base for the core set of NCD interventions. The *Pacific NCD Roadmap* provides the Pacific direction to understanding the factors that have led to and sustain the NCD crisis. It includes further analysis as to why the Pacific is facing an NCD crisis and why a multisectoral response is required.

Key Evaluation Questions	Findings
	<p>0%) in the previous audit. Patient-held booklets have been developed and printed, but it is unclear how much they are being used, with some community nurses reporting that they were not aware of the booklets. It is acknowledged that these results offer intermediate outcomes only, and the next NCD STEPS and Global School Health Surveys (scheduled to take place in 2023) will provide a more accurate picture of progress against the EOPO.</p> <p><i>EOPO 2.3: By end October 2022, men, women, boys and girls have improved knowledge on risk factors of NCDs and tobacco use behaviour has started to change</i></p> <p>Also implemented by WHO under the bilateral DFAT grant, this EOPO reported moderate success prior to COVID-19, such as the supporting the drafting of amendments to the Tobacco Control Amendment Bill in 2019, and re-drafted Cabinet submission in 2021, however this has not progressed since then. A tobacco tax of 20% was instituted July 2020 and tobacco import data shows a decline in imports (pending Tobacco Tax impact assessment at the end of project). Progress on Tobacco Control legislation, enforcement and hypothecation will be provided in the WHO completion report.</p> <p>NCD lifestyle risk factor awareness has been driven through engagement with the Health Promotion Unit and District Health Workers; the mDiabetes Project has seen the production and launching of six videos (in mid 2021) which, with support from Digicel Nauru can be accessed, free-of-charge, via blanket SMS messaging. The KAP survey in October 2021 (n=200) found that 75.5% of respondents knew what the effects of smoking are. Only 16.3% had not heard about the effects of smoking. When asked whether smoking is harmful to people nearby, 55% responded with a definite yes, and 40.5% responded with a probably yes. Tobacco cessation training for staff was started and 146 clients were registered for Quit Smoking clinic (at April 2022). The KAP survey found that 30% had never heard about cessation services in Nauru. The success of tobacco interventions, and the extent to which different population groups have been exposed to and understand tobacco risk factors and behaviours will be measured through the STEPS and Global School Health Surveys, currently scheduled in early 2023.</p> <p>Establishment and ongoing performance of the multisectoral NCD Task Force has seen some self-direction amongst Nauru stakeholders, however stalled during and since the COVID-19 outbreaks in mid 2022, with the Task Force no longer meeting regularly. The WHO mission in October 2022 sought to revitalise the NCD Taskforce and Health Promoting Schools network, and results on that will be available soon.</p>
Q3. How successful has DFAT been in supporting Nauru's COVID-19 response?	<p>Nauru's multisectoral preparedness and response to COVID-19 was impressive for a country with a small population, significant co-morbidity, and economic reliance on international connections.</p> <p>Prior to June 2022, Nauru had experienced only three confirmed cases of COVID-19, which were identified in quarantine and remained isolated for their infectious period. With strict entry requirements requiring travelers to show proof of a full course of vaccinations, and undergo mandatory, managed quarantine on arrival, international travel to Australia recommenced late in 2021. Nauru experienced no increase in cases until the Omicron variant was identified in the population on 19th June 2022, after which a</p>

Key Evaluation Questions	Findings
	<p>rapid escalation saw COVID-19 cases peak at 4,610 by 20th August. Further spread was limited through a comprehensive vaccination campaign resulting in over 24,000 doses given. Only one death was recorded in a woman with significant co-morbidities.</p> <p>While the success of Nauru's COVID-19 preparedness and response can be strongly attributed to the excellent, broad political and government-wide leadership of, engagement in and cross-sectoral resource allocation to the COVID-19 Task Force, there are many within the Task Force, across government and especially within the health sector who identify support from DFAT advisers as having been pivotal to the country's readiness to respond to the outbreaks in mid-2022.</p> <p>In particular, the efforts of the Public Health COVID-19 Response Adviser (recruited with CHS support through the HSI under DFAT's bilateral program) were routinely identified as being crucial to the establishment and effective implementation of the national response. It is reported that the Adviser worked tirelessly across all programs, units and departments of the MHMS, and as a special adviser to the COVID-19 Task Force, to facilitate consultative development of COVID-19 preparedness and response SOPs, implementation guidance, IPC guidelines and quarantine, isolation and case management guidance and protocols. She also facilitated group training and 1:1 follow-up training and mentoring, and worked collaboratively across the MHMS to conduct detection, isolation and response simulations. The success of these efforts are evident in the performance of MHMS (IPC, clinical and community outreach) staff during the outbreak, that was after the departure of the adviser.</p> <p>Support from the DFAT-funded Deputy Secretary for Health, and the NHSSP Logistics Management Information System Adviser were also instrumental in facilitating procurement of consumables and supplies for the COVID-19 response effort. DFAT bilateral direct funding (AUD 1.4m) over two years also contributed to the multisectoral COVID-19 response, through procurement of medical equipment and consumables, support for IPC, diagnostics and education and training, and the renovation and fit-out of the Acute Care Unit at RON Hospital, which was used as a COVID-19 isolation facility throughout the pandemic.</p> <p>The roll-out of Tamanu for COVID-19 and other immunisations enabled digitised vaccination certificates for COVID-19, essential for travel. Tupaia was used effectively during the COVID-19 response to communicate immunisation and testing data to the population through public announcements from the President and the COVID-19 task force.</p> <p>Other areas of indirect DFAT support to Nauru's COVID-19 preparedness and response efforts included:</p> <ul style="list-style-type: none"> • Funding of technical support from regional partners such as WHO and SPC, and supply of testing cartridges, medical equipment, PPE supplies. • Funding to UNICEF for the introduction of HPV, PCV and rotavirus vaccines (through CHS funding, and USD 150,000 from the bilateral program to sustain vaccine introduction in 2022). • Support for COVID-19 vaccinations funded through VAHSI and delivered either through UNICEF's global procurement, or dose-sharing of Australian-manufactured Vaxzevria vaccine.

Key Evaluation Questions	Findings
	<ul style="list-style-type: none"> In 2021-22, Australia supported the delivery of 19,170 vaccine doses to Nauru, including 1,000 vaccination doses from its domestic supplies through UNICEF's supply chain. Through these mechanisms and COVAX (partially supported with Australian assistance), 25,570 doses were donated to Nauru. By the end of 2021, 65% of the total population had received one dose, while 63% were fully vaccinated. As at 27 October 2022, 99% of the population had received at least 1 dose of COVID-19 vaccine, and 73% are considered fully vaccinated. No wastage was reported in Nauru during 2021; Australia is closely coordinating with other development partners and MHMS to mitigate risk to wastage by avoiding over-supply and providing assistance on cold-chain management. <p>An important factor is that prior to the pandemic (2018 and 2019), DFAT had already supported national preparedness for emerging infectious diseases in Nauru, which later informed early COVID-19 preparedness work:</p> <ul style="list-style-type: none"> Development of an options paper for Australian support for health security in Nauru. Technical support (from WHO) for an all-hazards Public Health Emergency Preparedness and Response Plan. Technical support for IPC; institutional reform in the management of IPC (Apr-Aug 2019).
<p>Q4. To what extent have the modalities used for DFAT support impacted on the effectiveness and efficiency of our health assistance to Nauru, and what lessons have we learned?</p>	<p>Following the review of DFAT's health sector support to Nauru in 2017, it was determined that Direct Funding from DFAT through Government of Nauru financial systems had not proven to be an effective modality, due to poor health system planning and capacity to develop and monitor budgets linked to implementation schedules. It was recommended that alternative means of providing bilateral support be trialed, most notably through funding a system strengthening program (NHSP), delivered by a Managing Contractor (for NHSSP) and a support project led by a credentialed technical agency (WHO for NCD prevention and management). Beyond bilateral funds and assistance, the Nauru health sector also benefitted from a range of DFAT-funded global and regional development modalities (see Annex X), providing a range of technical assistance from different implementing agencies.</p> <p>Bilateral programs:</p> <p>Although the NHSP model has not proven to have achieved outcomes to the extent originally envisaged in the program design, this can partially be attributed to the unprecedented disruption of the COVID-19 pandemic on sectoral plans during the period. Border closures and the duties of care that contractors/technical agencies have to their deployed staff created a vacuum of technical support and guidance as advisers returned to their home bases; at the same time, Nauru health staff were fully engaged with COVID-19 preparedness and response measures, leaving little attention and resources to divert to pre-pandemic system priorities.</p> <p>Both NHSSP and the WHO Project advisers were absent during the COVID-19 border closures in Nauru (with exception of NHSSP ICT Adviser, who remained in-country until November 2021), but there was some question from GoN about the slow return to Nauru of advisers and support staff from both agencies after the immediate emergencies had subsided in the region. To MHMS staff, there appears to have been no sense of urgency for implementers and advisers to return to Nauru to re-ignite their</p>

Key Evaluation Questions	Findings
	<p>implementation plans, and this was not well received. This could be attributed to a failure of the funding mechanism and contracting arrangements – that DFAT had limited ability to demand action from contracted agencies.</p> <p>While the DFA model was evaluated as having limited effectiveness in Nauru in the past, there was some success in utilising this modality to support national COVID-19 preparedness and response measures. It appears that the well-recognised, urgent need of being prepared for COVID-19 outbreaks, a declared national emergency and the presence of strong, multisectoral leadership through the COVID-19 Task Force was sufficient to drive planning and timely funds disbursement during the period, in such a way that had not been possible under MHMS leadership in former ‘non-pandemic times’.</p> <p>Some senior MHMS managers identified that they were not fully aware of NHSSP’s aims and processes at the commencement of the project and did not feel able to engage in planning and discussions at that time. There is a suggestion that the managing contractor was not willing to acknowledge MHMS’ authority and the need to take ownership over project implementation. Likewise, the Public Health Division has expressed frustration at not being aware of, or in control of WHO’s project inputs.</p> <p>These examples, and the success of the COVID-19 DFA when managed by the motivated, multisectoral COVID-19 Task Force, demonstrate that more support may need to be provided to MHMS, perhaps by DFAT Post, the Senior Health Adviser, or embedded advisers such as the Deputy Secretary for Health to ensure an enabling environment that invites and encourages MHMS engagement, leadership and control over DFAT bilateral health sector investments.</p> <p>In summary, bilateral funding models should, if well managed by the implementing agencies, and with open dialogue and joint planning with MHMS, be an effective modality that can hold implementers to account. This requires greater engagement between and willingness of the MHMS and implementers in the finalisation of implementation plans, and regular governance mechanisms.</p> <p>Regional programs:</p> <p>DFAT supports a number of health system strengthening and technical assistance agencies and programs in the region that benefit Pacific Island Countries to varying degrees (see Annex X for a summary of DFAT regional investments to Nauru). On the whole, these investments offer reasonable value for money for DFAT support to achieve substantial reach across the region, but the extent to which individual countries benefit from direct interventions is dependent on a number of factors, including need, the provider’s motivation to visit and support, and in-country capacity to advocate for, receive and respond to support.</p> <p>DFAT regional investments have:</p> <ul style="list-style-type: none"> • Improved reproductive commodities supplies to Nauru (UNFPA). • Seen the introduction of HPV vaccines and strengthening of national immunisation schedules (UNICEF) • Strengthened SPC’s support to Nauru to improve disease surveillance and response, provide technical assistance on NCD prevention and control and communicable disease surveillance and response.

Key Evaluation Questions	Findings
	<ul style="list-style-type: none"> • The Centre for Health Security, through the Health Security Initiative for the Indo-Pacific Region delivers strengthened health security through high-level policy, research and support to national legislation, and through a range of in-country support mechanisms, such as long- and short-term technical assistance (including the Deputy Secretary for Health, and Director of Medical Services, and BES, which are highly valued by MHMS). Decisions on the types of investments and activities directed to Nauru are made through collaboration between the CHS, Nauru Post and the MHMS. • Establishment and roll-out of electronic health information management systems (BES) to collect, collate and report health service and disease prevalence data (discussed in detail in Section 2 above – these have generated significant support from MHMS and DFAT in Nauru). • Supported testing and quality assurance of medicines and clinical commodities (Australian Therapeutic Goods Administration – TGA) to assist Nauru to verify its supplies and maintain quality of procurement processes. Nauru has utilised this service well, having sent 32 samples for testing in the past six years, which identified six items that failed. • Through PCSHWIP, supported around 24 Nauruan students to undertake tertiary study at the Fiji National University’s College of Medicine, Nursing and Health Sciences across disciplines such as medical science; health sciences; dentistry and oral health; nursing; public health and primary care. DFAT support through the Office of the Dean included pastoral care and mentoring to encourage undergraduate students through their studies, in order to prevent high attrition rates amongst students from PICTs. • Through its scholarships and Australian Leadership Awards, supported 7 Nauruans to complete under- and post-graduate training in nursing, public health and medical sciences in Fiji (FNU CMNHS) and 9 to Australia during the period. Recent graduates have taken-up important posts within the MHMS, including as the Director of Nursing Policy and Standards, as a senior midwife in the maternity unit and within the Health Promotion Unit. DFAT scholarship support is highly valued amongst Nauruans across all sectors, and the subsequent competition for places poses a challenge for a health sector desperate to improve and professionalise its clinical workforce. • Through the PCSHWIP, supported RACS to provide four VMTs to Nauru to deliver specialist consultations to 233 patients, including four who underwent vascular surgery. VMTs are an essential component in efforts to reduce Nauru’s unsustainable reliance on overseas medical referrals for specialist care, and to provide specialist clinical mentoring and professional development to clinicians. The number and effectiveness of VMTs could be strengthened through additional support to MHMS to prioritise needs, schedule and prepare for VMTs with suitable diagnostics and care planning. <p>Global Programs: DFAT supports global organisations and initiatives to strengthen health security and outcomes in the region. In many cases, this assistance is through core funding that supports technical organisations to deliver their work, and is difficult to quantify at a country level, or against deliverables. DFAT’s contribution to global organisations is an important means through which Australia advocates for improved health outcomes and directed technical support to the most vulnerable:</p>

Key Evaluation Questions	Findings
	<ul style="list-style-type: none"> • Core funding to WHO assists the technical agency to support PICTs to address priority health needs across a broad range of technical specialities, including both non- and communicable diseases, through development of technical guidelines and resources, delivery of training or provision of legislative support. During the period, DFAT resourcing to WHO's Division for Pacific Technical Support sought to strengthen core public health and clinical services in PICTs to quickly detect, trace, test and treat cases of COVID-19. Nauru received training (on IPC, SOPs, case management, preparedness and response) and supplies including PPE (gloves, goggles, masks, gowns), a GeneXpert machine and cartridges and an External Quality Assessment of the medical laboratory. An eco-friendly hospital waste management system (Ecosteryl) was also procured through other funding sources. Support was also provided to Nauru's COVID-19 Taskforce to develop outbreak response plans and community engagement communication strategies, which were well implemented during the 2022 outbreak. • DFAT provides core funding to UNFPA's global UNFPA Supplies program, which operates in 48 countries (\$14.09m from 2018 to 2022). In 2021, UNFPA Supplies developed a Pacific-specific strategy, which has benefited Nauru by providing essential reproductive health and family planning commodities which were not previously been prioritised within national pharmaceutical procurement. • DFAT contributes financially, and through governance support to the Global Fund for Tuberculosis, HIV and Malaria (GFATM). GFATM has contributed AUD115, 565 worth of support to Nauru in the period (from multiple development partner sources, not exclusively DFAT) for tuberculosis and HIV/STI programming inclusive of awareness, prevention and treatment interventions, engagement and coordination with civil society and key target groups, development of, and training in clinical and programming protocols and guidelines, and improved systems and processes for collecting, analysing and reporting data. <p>Lessons learned:</p> <p>Through a variety of funding and support mechanisms, DFAT has continued to make a significant contribution to the management and strengthening of the health sector, and the improved delivery and coverage of preventive and clinical health services to the people of Nauru. However, there are very few staff in Nauru Post to be able to manage the multiple requests from a range of GoN departments, not only Health, as well as to review multiple reports and monitor progress. There has been some concern expressed (from DFAT and others working in the Nauru health sector) that the number, relatively small size and disparate types of funding and support mechanisms can be difficult for the DFAT Post and the MHMS to oversee, monitor, report and manage. At times this has resulted in some support mechanisms being under-utilised, especially when MHMS staff have had other competing responsibilities or more visible options for resourcing (for example, some regional agencies have cited lack of requests from the MHMS as a reason for having been slow to re-commence engagement following the COVID-19 crisis).</p> <p>During the period, the extent to which the MHMS can absorb and utilise support has often depended on the capacity, motivation and leadership of key individuals responsible for delivery or oversight of particular programs, units or services. Within this environment, willingness of key staff to advocate for, and support delivery of assistance has been a key factor in some investments working well, while others (particularly the larger, bilateral investments with multiple streams of support) faced implementation</p>

Key Evaluation Questions	Findings
	<p>challenges. Examples of this can be seen within the NHSSP, where specific areas of support, such as the establishment and strengthening of mSupply and the introduction of the Tamanu system have been well supported, and consequently progressed, while planned reforms to human resources management and leadership initiatives faced more complex barriers and were not adequately supported or progressed.</p> <p>It was also evident that investments were well utilised and supported when there was a clear, collective understanding of their importance. The successful use of the DFA mechanism to address the urgent, collective recognition of the COVID-19 threat was a clear example of this, where previous efforts to utilise DFA for health sector support had not proven successful.</p> <p>The Nauru NHSP was the first to provide bilateral funding to WHO to implement and report against EOPOs. Without an unprecedented pandemic, there would be a clearer assessment of this modality. Support for UN agency and program-specific projects, such as the WHO NCD program, can harness global, regional or Australian technical expertise and resources of the partner agencies. Such joint UN programs may be more technically and financially efficient and are worth consideration in the future design.</p> <p>While it is understood that multiple, relatively small investments comprising bilateral, regional, and global funding arrangements can be difficult for DFAT and MHMS to oversee and manage, this mixed-investment approach is likely to remain the most effective means of progressing sectoral reforms and assistance in the short term. Within the foreseeable future, the MHMS will likely continue to experience widespread vacancies across key management and service delivery positions, and this will impact the extent to which investments will be supported and utilised.</p> <p>Further work to strengthen systems and foster collective appreciation of, and engagement in strategic and operational planning within MHMS will help the Ministry recognise the range and modalities of investments it has at its disposal, that can be used to plan, schedule and track grants and disbursements. Closer, regular engagement between the MHMS and DFAT Post perhaps through facilitation from the Deputy Secretary for Health will help both parties to maintain oversight and track multiple investments.</p>
<p>Q5. How effectively are governance systems working with MHMS, DFAT and partners and how can these be improved?</p> <p>1. How have DFAT investments taken into account current and future</p>	<p>The Program Steering Group (PSG) was the primary governance mechanism for the NHSP and included senior representatives from MHMS, Ministry of Finance (Planning and Aid Division) and DFAT. Other development partners (apart from WHO as an implementing agency) were not included. The role of the PSG was to review progress and approve annual work plans and was scheduled to be three-monthly. The NHSSP Managing Contractor was required to establish, coordinate and support the PSG. An inaugural meeting was held in November 2019 but the second meeting was not convened until March 2021 due to COVID-19 priorities and absence of advisers. Over the final year, three additional meetings were held which essentially provided updates but did not act as a forum for review and discussion, although active participation was challenging as WHO and some advisers were</p>

Key Evaluation Questions	Findings
<p>planned health support by Nauru's other health development partners, including UNICEF, WHO, SPC?</p> <p>2. How effective are development partner coordination efforts?</p>	<p>attending by zoom. Other DFAT funded agencies that were providing funds into Nauru health sector, especially related to COVID-19 preparedness and response, were not included in the NHSP PSG meetings.</p> <p>While the PSG meetings were well attended and structured, they did not succeed, in the initial stages of the program, to foster understanding and ownership of the projects amongst some senior MHMS managers, who reported to be unaware of the aims and implementation plans of the projects. Frequent adviser and team leader changes within NHSSP did not help to correct this limited understanding and coordination, nor did the disruptions associated with COVID-19.</p> <p>The PSG did prove successful in linking NHSSP with the WHO NCD prevention and management initiative and helped to communicate the joint role the two projects had in progressing the EOPOs of the NHSP. There is no clear indication that the PSG improved coordination with other development partners supporting the Nauru health sector, although it is noted that SPC did attend some meetings through a virtual link. In general, health sector development partner coordination, and in particular forward communication amongst development partners of impending in-country visits and activities is not strong.</p> <p>Aside from the PSG, quality assurance of project reports and deliverables was managed through review by the DFAT Senior Health Adviser, who would make comments and recommendations to DFAT Post prior to the latter's acceptance and approval. NHSSP expressed that this multi-stage system of submission, review, feedback, amendment, resubmission, review, approval was very time consuming and impacted the contractor's payment disbursements for deliverables.</p> <p>On receiving an 'Investment requiring improvement' rating, efforts were made to circumvent these delays, and to ensure deliverables were submitted in accordance with DFAT requirements, through the convening of weekly meetings in the final 12 months of NHSSP. These informal, weekly meetings with documented activity briefs held between NHSSP, DFAT Post, and the Deputy Secretary for Health proved an effective mechanism for informing DFAT in advance of planned submission of deliverables, and emerging challenges that may impact delivery of planned activities.</p> <p>The structure of a PSG is considered an added burden to many Pacific government Ministries, as they create additional meetings to attend and report to. It would be preferable in the Transitional Health Program and future phases to discuss options with the MHMS on how to provide reporting within existing MHMS systems. The MHMS, nor any other GoN departments, do not currently have any quarterly reporting requirements, and it has been said that the 'culture of reporting' does not yet exist in Nauru.</p> <p>Development partners are currently not well coordinated. If engagement and improved harmonisation with other development partners is the goal, then a different mechanism and TOR need to be designed in the future phase of support.</p>
<p>Q6. To what extent have Australia's health investments supported gender equality, disability</p>	<p>The Nauru Health Support Program (NHSP) has had a greater focus on GEDSI than other Australian-funded health investments in Nauru. The two components of NHSP integrated a GEDSI focus to some degree.</p>

Key Evaluation Questions	Findings
<p>inclusion and social inclusion and other cross-cutting areas?</p> <p>What has been the performance of these investments regarding improved GEDSI outcomes?</p>	<p>WHO: WHO have conducted capacity building of medical, nursing and health promotion staff who have predominantly been women. Health promotion videos were developed which integrated a gender focus to show different behaviours of tobacco use common to women and men; the content was based on discussions with men and women in communities to understand gender-specific behaviours related to smoking. WHO addressed several challenges regarding people with disabilities' access to healthcare, including providing flexible-clinic hours, mobile services and shifting clinics to community outreach clinics. Training of health staff included a disability focus. However, it is unclear whether this training has been effective in increasing awareness of health staff regarding disability or improved services for people with disabilities. Health Promotion Officers, who are predominantly women, have been trained to deliver NCD-related information to communities. WHO's reporting on GEDSI has been constrained by limited GEDSI data in MHMS's Health Information System. WHO has used data from the NCD STEPS and Global School Health Survey to inform program design; however, this did not provide reliable data related to services and accessibility to services by gender.</p> <p>Nauru Health System Support Project: GEDSI was considered an important component of NHSSP and highly relevant to the work supported by the program. An international GEDSI STA was appointed in January 2020 who developed the program's GEDSI Strategic Plan to guide the program in GEDSI mainstreaming across activities. However, the activities outlined in the Plan were overly ambitious and the GEDSI Strategic Plan was updated and revised in July 2021 to ensure it aligned with NHSSP, MHMS, and DFAT's requirements. The GEDSI STA was not in-country due to COVID-19; this resulted in a lack of practical support and guidance for the program and MHMS regarding GEDSI. An in-country GEDSI Coordinator was recruited on a part-time basis, who was able to progress some activities and develop partnerships with relevant government stakeholders, including Department of Women's and Social Development Affairs (WASDA), Department of People Living with Disability (DPLWD), and Nauru Police Force (NFP). The presence of the GEDSI Coordinator in country boosted the progress of GEDSI in the program. Areas of progress include:</p> <ul style="list-style-type: none"> • Consulting with MHMS during the planning process contributed to GEDSI considerations being included in Nauru Health Strategy (NHS) and Annual Operating Plan 2022-2023 and the inclusion of a MHMS GEDSI Focal Point position in the NHS; this role will be essential for supporting and leading GEDSI in MHMS. • Collaborated with WASDA to develop GEDSI-Sensitive Patient Referral Guidelines and Standard Operating Procedures for responding appropriately to GBV victims/survivors in health system. This is a significant achievement; however health workers have not been trained to use the Guidelines and SOPs and have received little training on response to GBV. • NHSSP worked with DPLWD to conduct research on barriers for people with disabilities in accessing health services in Nauru. The study establishes a baseline for the impact of future program support on health outcomes of people with disabilities, and provides important information to inform future investments. • Some capacity building of nurses and nurse aids was conducted with regard to GEDSI; GEDSI was integrated into topics delivered as part of a larger training package. However, MHMS awareness of GEDSI and its relevance to health is lacking.

Key Evaluation Questions	Findings
	<p>Significant resourcing and time will be required to increase the knowledge and skills of healthcare workers to ensure equity and inclusion in health services.</p> <ul style="list-style-type: none"> • Community Health Project Plan (CHPP) has a strong GEDSI focus which has contributed to an evidence base for maternal and community health via surveys and community profiles; development of Patient Referral Guideline and SOPs that support needs of GBV survivors, people with disabilities and mental health client referrals and pathways; and an increase in the number of women screened for cervical cancer. Future investments will need to provide significant support to strengthen and further integration of GEDSI into operationalisation of the CHPP, given MHMS' limited capacity in GEDSI. • While NHSSP has assisted MHMS to strengthen its Health Management Information System, there is little evidence that NHSSP supported MHMS to collect and use disaggregated data in a systemic way. The inclusion and analysis of sex and disability disaggregated data needs to be included in health assessments, frameworks and tools to understand GEDSI issues and ensure MHMS initiatives are equitable and inclusive. This should be a priority for future programs.

Annex 5: Reflections on Future Health Programming

Additional Questions re future thinking	Findings
<p>How can DFAT support MHMS to improve performance and sustainability of the health system and health service delivery including pandemic preparedness and response (considering the COVID-19 context)?</p>	<p>There are limited options to provide support to MHMS to enhance performance without a change to GoN Central Human Resource processes (relating to local salaries, demotivation and turnover of staff, recruitment for vacant positions). Bold leadership from a new Minister for Health and a united Health Executive Team could influence positive change through demonstrating commitment to health sector reform focused on improving performance. The MHMS Directors show potential and with good mentoring could revitalise their Divisions – but they need support to take on such leadership roles. A Management Development process would be beneficial to create a supportive organisational culture and working environment.</p> <p>Improved MHMS system performance will best be achieved through greater, regular, sustained engagement with MHMS in the development and ongoing monitoring of development partner assistance, so that the features and modes of delivery continue to be acceptable to, and meet the agreed priorities of the MHMS.</p> <p>Support needs to be directed to key areas of MHMS business, inclusive of:</p> <ul style="list-style-type: none"> • Strengthened management and leadership • Improvements to corporate services • Strengthened clinical services management • Improved Public and Community Health • Preparedness and response to COVID-19 and other emerging infectious diseases. <p><i>Management and leadership strengthening at the Executive and senior management levels.</i> Interventions should continue to work with the Executive and the next layer of management (for longer-term investment in future leaders) to establish a collective recognition of the need for, and to establish policies and procedures for comprehensive sectoral oversight.</p> <p>A sustained program of health sector-focused leadership and management training should be identified from those which have proven effective in the region, and with sustained, in-country technical support, adapted for the Nauru context in order to i) build a team approach to strengthening leadership and guiding the health sector to align with strategic directions (as identified in the <i>Nauru Health Strategy 2021-2025</i>), and ii) encourage further establishment and utilisation of structured, scheduled management processes. The latter will draw upon emerging health sector output and disease data (through strengthened data management systems such as Tamanu and Tupaia) and promote a strengths-based approach that encourages managers of services, programs, and units to identify and address performance blockages. Essential to strengthening overall management processes and capacity will feature in ongoing support to promote engagement in, and utilisation of the AOP and management SOPs.</p> <p>This approach would address a missed opportunity under NHSSP (following the agreed removal of EOPO 1.4), and would address the potential periodic absence of counterparts by focusing on a broader group of senior and middle-level managers (the latter to ensure</p>

Additional Questions re future thinking	Findings
	<p>sustained leadership capacity as a counter to Nauru's high attrition rates at all levels). The approach would require adoption of aspects of Adaptive Management, which does not aim to establish a fully programmed schedule of leadership and management training and interventions over a number of years, but rather seeks to move with the direction of sector developments, and the needs of management and leadership teams. This adaptive, learning-by-doing approach is difficult to deliver without appropriately skilled and dedicated advisers who are willing to understand and engage in the Nauru health sector but has demonstrated greater sustainability of leadership and management reforms than simply selecting and implementing a generic training program with little contextual relevance to Nauru's unique health sector²⁹.</p> <p>Corporate systems improvement, inclusive of strengthened, structured human resources management and development, systematic operations and transparent procurement, and robust financial management which supports and promotes MHMS oversight of development partner investments and facilitates implementer accountability.</p> <p>The MHMS currently faces challenges in its efforts to address chronic, widespread vacancies across the sector; central government-led human resources management, and especially recruitment moving too slowly to affect improvements to health system performance (both in terms of filling vacancies and strengthening performance of existing staff), however there is interest from the new Minister for Health (and a clear need) for MHMS to expedite these issues through establishment/strengthening of a Human Resources Management Unit with capacity and mandate to take-on recruitment as an urgent priority. This may require approval from Central HR to devolve recruitment processes to MHMS, but this has apparently been taken on by other Ministries. Support is likely to be needed from dedicated advisers and a number of MHMS administration staff for a designated period (1-2 years) to help establish a Recruitment Initiative/Project under the Director of Human Resources (and with support and monitoring oversight of the MHMS Executive through a standing agenda item at regular meetings) which would: establish systems for rapid development of recruitment schedules; develop and approve position descriptions; conduct market assessments and processes for timely recruitment of expatriate staff; and streamline interview, selection and recruitment processes.</p> <p>Alongside expedited recruitment processes, the Human Resources Unit would lead analysis to determine the 5–10-year sector workforce need, and to schedule output based training targets against which to seek development partner support. The current, twin-track approach to nursing training, which offers up-skilling, bridging training for the existing nursing workforce (through the Nauru Health Professional Training Institute) should continue, while at the same time the MHMS should determine and access potential development partner support to encourage graduates through formal registered nurse training in Fiji, Australia and elsewhere (where training aligns with service standards and provision in Nauru) over a sustained period. A further aspect should see workforce planning drawing on development partner support for post-graduate nursing training in priority disciplines such as dialysis, midwifery and oncology.</p>

²⁹ "Australia-Indonesia Partnership for Justice 2 (AIPJ2) is an example of a high performing program using a MEL framework which is simple, iterative and adaptive that supports the implementation of this iterative and adaptive program ... uses the framework to drive program improvements, ensuring that best practice is shared and operational policies and practices are being sharpened", Dr David Carpenter, Cardno Development Effectiveness Unit Review, 2019.

Additional Questions re future thinking	Findings
	<p>A similar approach should be applied to medical and allied health staff (inclusive of physiotherapy, medical laboratory, radiology and biomedical technician staff), resourced through an agreed sharing of government budgets and regional development partner support, and utilising proven mentoring and professional development systems (through institutions such as Fiji National University's College of Medicine, Nursing and Health Sciences and SPC) to offer online professional development, and scheduled, supported clinical placements with suitable institutions in the region, not only in Australia and New Zealand, but in comparable health settings such as in Papua New Guinea and Fiji (where local capacity supports this). Australian and GoN scholarships could be earmarked for health disciplines, and careers in health promoted to secondary school students through a dedicated careers expo aligned with DFAT Education Programs to promote science and maths.</p> <p>Attention needs to be paid to ensuring staff returning from training overseas are encouraged and supported to remain in their roles, to capitalise on the investment in their training. Returnees will benefit from mentoring and support from their managers, and regular feedback on their performance (for which managers may require capacity development). Managers should recognise and create opportunities for returnees to apply their new skills and learning to new initiatives, and work to establish career progression plans for them.</p> <p>These approaches would seek to reduce absenteeism amongst staff returning from overseas training; a formal analysis across the wider health workforce may assist sectoral understanding of other reasons for absenteeism and to develop strategies to address these. This could possibly be a task/project for a recent returning graduate, with support from Director of HR and advisers.</p> <p>The Operations Division has undergone some reform in the recent past, particularly for procurement for pharmaceutical and medical supplies. These reforms should continue to be expanded throughout the system to further promote cost savings, time efficiencies, acquisition of quality products/services and transparency in engaging suppliers. At a facility operations level (for RON Hospital, Naoero Public Health and the Wellness Centres), reforms to systems (with a preference towards e-systems) for requesting, logging, tracking and completing maintenance and infrastructure improvement jobs are an urgency, and investment in additional, skilled staff in operations management and biomedical engineering should be prioritised. An urgent infrastructure needs assessment is required, and priorities established for immediate attention in the next 2-3 years. An immediate and urgent need is the design and contracting of a RON Hospital warehouse facility (as the National Medical Store) to prevent further damage and/or loss of medical equipment, drugs, and supplies.</p> <p>Financial oversight of DFAT support is a priority for the MHMS. With the exception of COVID-19 support, past initiatives programmed through DFA have not been well utilised, perhaps partly due to limited awareness, oversight and/or capacity of the MHMS financial management unit, or perhaps because ultimate responsibility for managing the grants lies with the Ministry of Finance's Planning and Aid Division (PAD). The current MHMS Director of Finance is highly skilled and has demonstrated motivation to work closely with the PAD; it is likely a good time to engage with the MHMS to identify and deliver financial management support to strengthen MHMS oversight of government and development partner support funds with a view to re-assessing capacity to program DFAT funds through government</p>

Additional Questions re future thinking	Findings
	<p>systems (on plan and on budget). An element of performance-linked funding or ‘bonus funding’ could also be considered for future health programming to ensure progress against key objectives³⁰.</p> <p><i>Clinical services and management:</i> Support for improved systems, guidance and resourcing is urgently required to support high-potential, early-career individuals who have been tasked with managing various components of the system, with only limited mentoring and coordination. Technical assistance and ongoing mentoring and support processes to strengthen clinical services management should prioritise comprehensive diagnostics and treatment, and patient continuum of care following discharge from hospital.</p> <p>A key objective for future support should be to reduce reliance and expenditure on overseas medical referrals (OMR), and to re-direct a proportion of OMR budget allocation to strengthen in-country clinical services. Developing a better understanding of, and setting clear selection criteria (through evidence-based diagnostic assessments of clinical need and prognosis) will go some way to managing OMR budgets; this will require broad political will to institute changes to OMR criteria and redirect OMR budgets to in-country clinical services.</p> <p>Another opportunity for reducing OMR expenditure is to scale up VMT support from RACS and other clinical advisers with additional budget above the regional allocation. MHMS should advocate for broader support from RACS to include building the capacity of the Director of Medical Services to prioritise more effectively, advocate for and appropriately document requests (with improved diagnostics and patient planning) for VMTs.</p> <p>Urgent recruitment of expatriate clinical specialists in paediatrics and obstetrics and gynaecology should commence immediately to fill current vacancies. This ‘quick-fix’ would ensure these important specialties are available in Nauru, however further support for workforce recruitment and staff development would be needed in the medium-term. In the longer-term, Pacific Ministers of Health could consider a range of alternative regional solutions to reduce brain drain, such as rotating Pacific clinicians at higher salary levels while maintaining their substantive positions in their home base countries.</p> <p>Progress by the Director of Nursing Policy and Standards and the Director of Medical Services on developing clinical standards and SOPs for nursing and other specialties during the final months of NHSSP require further support from dedicated clinical management advisers (and engagement with cross sectoral counterparts such as WASDA and DPLWD) to facilitate their finalisation, dissemination and the establishment of monitoring and adherence protocols. This should include reforms to national nursing and clinical practice registration, which is urgently needed to progress professional accreditation discussions with tertiary training institutions in the region.</p> <p>Diagnostics can be improved with support to expand the medical laboratory capacity and range of services offered, and to re-ignite progress towards achieving ISO accreditation. Not only would accreditation seek to enhance the quality and quantity of clinical diagnosis for Nauru,</p>

³⁰ This modality has shown some success in Samoa where the World Bank (and now DFAT Post and NZMFAT) and MoH are implementing a performance-based funding model with six disbursement-linked indicators.

Additional Questions re future thinking	Findings
	<p>but as one of the few accredited facilities in the region, may be able to partially self-fund its operations by providing accredited laboratory services to neighbouring, air-linked countries such as Kiribati, the Federated States of Micronesia and Tuvalu.</p> <p>Allied health services such as physiotherapy, mental health, podiatry/foot care and prosthetics/orthotics are insufficient to meet the needs of a community experiencing high rates of diabetes-related, lower limb amputations, and levels of disability amongst the general population. Both clinic- and community-based rehabilitation and treatment services are urgently needed to address the individual, household and population development implications of un-supported disabilities. The current physiotherapist is not providing regular care for patients in urgent need of support, and the reasons for this need to be addressed by the new DMS, as it is impacting negatively on patient care and outcomes.</p> <p>Urgent assistance to staffing, equipment and supplies for the renal dialysis unit is required to prevent untimely deaths of patients with end-stage kidney disease. Recent acquisitions of radiology equipment, such as a mammography unit, are likely to result in increased diagnoses of cancer. The Pharmacy at RON Hospital has the capacity to provide chemotherapy by the Chief Pharmacist, but it will require additional infrastructure/equipment to scale-up the new service.</p> <p>Public and Community Health: DFAT support should prioritise MHMS commitments in line with the Community Health Project Plan (CHPP) and the <i>Nauru NCD Strategic Action Plan 2015-2020</i>, which call for enhanced, comprehensive, dedicated public health programs and services that treat and manage communicable and non-communicable conditions identified from population-based screening and/or post-discharge referral from RON Hospital.</p> <p>Support to the MHMS (perhaps through a working group comprising Executive members and Public Health and RON Hospital clinicians and managers) is required from the Community Health Adviser in 2022 to work through the CHPP and seek consensus and confirmation on: referrals and treatment protocols; the proposed model of care; the roles and scope of practice of the District Health Workers (DHWs); and a schedule of priorities to be addressed during the next 2-3 years. Upon agreement from MHMS, this might include services being delivered from improved, dedicated facilities such as Naoero Public Health Centre and the Wellness Centres at Yaren and Anibare (initially).</p> <p>MHMS should consider complementing public health services with an approach to community care that is driven by strengthened ranks of community-based nurses and DHWs to build upon existing community profiling to work within and expand detailed knowledge of community and individual service needs. The role and scope of practice for DHWs needs be agreed within the Public Health Division, as there is a tension between a community/village health worker model, or as support staff to the PHD. DHWs currently report to Health Promotion, but they are frequently called-on by clinical teams to support screening, and to work in clinics. Public health program staff and DHWs will need to complete training on SOPs for disease prevention, health promotion and care seeking messages, and regular screening activities to identify and refer clients/patients to appropriate diagnostic and clinical management at the Wellness Centres and Naoero Public Health Centre. This community model is feasible (given Nauru's uniquely small and easily accessible population) to establish a deep understanding of health and service needs down to household and individual levels that will inform service delivery and patient care.</p>

Additional Questions re future thinking	Findings
	<p>As soon as available, there is a critical need to review WHO's health promotion and NCD detection and clinical management inputs from the period. The October WHO mission planned to implement remaining activities for health promotion training and support, and to conduct a clinical audit of NCD patient files to check on clinical management. The analysis and report will not be available before this Review is completed, and the results will require appraisal by the DFAT Nauru Senior Health Adviser to determine how to progress improvements to the national response to NCDs. WHO remains committed to providing ongoing support for NCD prevention and management, however their resources are limited without additional bilateral funding; the level of support should be agreed to in the Transitional Health Program and for future health programming.</p> <p>The impressive national approach led by the COVID-19 Taskforce provides an excellent model for how NCDs should be addressed – i.e. as a national crisis. For example, the scaling-up of NCD screening, identification and management has not kept pace with the increasing disease burden, nor likely to have had much impact on morbidity and mortality. It will be necessary to confirm with WHO the progress and influence of the multisectoral NCD Taskforce, and to explore opportunities to leverage the lessons learned from the COVID-19 Taskforce, which achieved impressive outcomes through responding to a health crisis considered by all to be urgent. Applying similar urgency, response milestones and population awareness about the equally critical NCD crisis may be an effective approach to more rapid progress.</p> <p>COVID-19 Preparedness and Response: Forth-coming DFAT advisory support for IPC and public health responses to COVID-19 should continue to review, revise and strengthen health system preparedness in readiness for emerging strains. This is to include ongoing support to IPC Focal Points to conduct audits, regular refresher training and to ensure sufficient stocks are well maintained. In the (expected) final stages of the COVID-19 Task Force, support is needed for the MHMS to develop a Bed Plan to utilise the well-equipped ACU (refitted with DFAT funds) for critical care patients, including SOPs and protocols for rapid transfers of patients to other wards, should a COVID-19 patient require admission.</p>
How can the performance of Australia's current health investments be improved to maximise their impact? For example, related to strategic focus, technical advice, policy dialogue, modality or governance arrangements, GEDSI, risk management systems, development partner coordination or MEL	<p>Impact of Australia's health sector investments to Nauru can be enhanced through focus and improvements on key, demonstrated approaches, including:</p> <ul style="list-style-type: none"> • Improved governance and coordination of development partner investments. • The models and management of technical assistance • Realistic and achievable monitoring and evaluation frameworks. <p>Governance, transparency and development partner coordination:</p> <ul style="list-style-type: none"> • A presentation to Parliament on NCDs and Healthy Island progress could be scheduled to increase awareness on how critical the situation is in Nauru and develop a more enabling environment for policy dialogue including legislative changes and budget support • Health sector investments to Nauru would be strengthened through improved governance and oversight of the MHMS, and agreed clarity on what is expected from, and achieved through interventions. This requires proactive engagement with a broader selection of MHMS senior and middle-level managers to determine sectoral priorities, and support at the Executive level to establish and utilise data

Additional Questions re future thinking	Findings
<p>a. What has or has not worked well (and why)? What lessons can be learnt as well as any key barriers/obstacles?</p> <p>b. Assess the adequacy of the MEL system, including lessons learned for future programming.</p>	<p>analysis and appraisal systems and templates. Key to this is for technical assistance and development interventions to be adaptive; to respond to changing, evidence-based directions (within an agreed, broad strategic results framework)</p> <ul style="list-style-type: none"> • DFAT health sector support can be improved through greater engagement in, ownership and oversight of various bilateral and regional support modalities: • Greater openness and accountability from implementing agencies to MHMS senior and middle-level managers will ensure broader awareness of proposed interventions (important for sustainability and engagement when senior managers move-on to other roles), and aim to foster a culture of monitoring and critically appraising implementing agencies' performance. • Governance arrangements must be realistic, and established with firm commitment from all parties. Depending on the intent of the governance mechanism (e.g. Health Executive Team meeting weekly or fortnightly prior to meetings with the Minister), or high-level quarterly/six-monthly, meetings need to be well supported by all relevant partners, and must be well led by MHMS. Commitments to engage must be maintained at all levels (and not delegated to those with limited authority), and focus should remain both on evidence based performance assessments, and critical decision-making to confirm or alter direction of investments. • Investment performance, inclusive of risk management, should not be confused with performance and risk management issues facing implementing agencies. While the latter may be a key component of discussion between an implementing agency and DFAT, these matters are not to be confused with the overall, collective governance of the investment, and the need for all parties to be aware of issues affecting delivery. • The Nauru Health Strategy 2021-2025 and supporting AOPs provide the sound basis for assessing performance of Divisions. Strengthening regular, periodic monitoring and reporting will help to ensure progress remains on track, and will provide a framework to guide implementing agencies. In the longer term, the AOP could be used to assess performance of individuals, programs and units within the MHMS. • Promoting an Adaptive Management or Action Learning approach to resource allocation which responds to the direction of sector developments, and the needs of management and leadership teams. This adaptive, learning-by-doing approach can generate longer-term, sustainable results, but requires support from appropriately skilled and dedicated advisers who are willing to understand and engage in the Nauru health sector. <p>Technical Assistance and Activities:</p> <ul style="list-style-type: none"> • Technical assistance needs to have established counterparts who can be the focus of skills transfers and capacity development. It would be useful for advisers to jointly develop Capacity Development Plans early in their engagement with counterparts, taking into account that many staff have multiple jobs that would be done by separate individuals in larger health systems. Staff with clinical and managerial responsibilities are particularly stretched and, understandably, often prioritise patients over systems change. It is important to not overload counterparts with information or meetings.

Additional Questions re future thinking	Findings
	<ul style="list-style-type: none"> Combining the Adaptive Management approach to align with the strategic direction of the <i>Nauru Health Strategy 2021-2025</i>, and using the AOP to guide implementation plans and monitor performance should encourage a more responsive and accountable approach to determining adviser supports, and ensure adviser inputs remain relevant and strategically focused. Aside from COVID-19, a number of implementing agencies have cited a reason for their limited engagement with the MHMS as being a lack of requests for assistance from the Ministry. Given the constraints associated with chronic vacancies, regularly changing management staff, poor communications infrastructure and limited oversight of the broad range of technical assistance on offer, it can be difficult for already stretched managers to communicate their needs to the appropriate agencies. Improved reach and coverage of support from agencies tasked with supporting the Nauru health sector would therefore benefit from more pro-active attempts to maintain communication and coordination with MHMS, inclusive of more frequent in-country visits, and where necessary, to assist with mentoring and support of senior managers to identify and articulate needs and requests for assistance. This will likely result in increased, appropriate requests, more targeted, responsive technical assistance and a more engaged, coordinated and collaborative MHMS during field visits and activities. <p>Monitoring, Evaluation and Learning:</p> <ul style="list-style-type: none"> The absence of dedicated data collection staff, systems and capacity has been challenging for maintaining oversight of investment performance. On the one hand, the historical lack of systems and data have inhibited a culture of seeking evidence to inform progress and decision-making. Similarly, absence of systems to monitor performance has resulted in little value placed on strategic direction and targets. With the establishment of a realistic <i>Nauru Health Strategy 2021-2025</i>, and recent developments to improve health information management systems (such as Tamanu and Tupaia), there are new and emerging opportunities to collect, analyse and report performance against targets. The MEL Frameworks developed for bilateral investments under NHSP were comprehensive, but in most cases identified targets and indicators which were beyond the health sector's capacity to verify. Future MEL Frameworks need to be realistic, cite only data collection systems and indicators that are available, and be developed in full consultation with MHMS, sectoral stakeholders and implementing agencies to ensure outcomes are achievable in the given period, and considering capacity and resource constraints. Future health program MEL should be co-designed and aligned as far as possible with GoN and MHMS established systems, processes and core health indicators, and should reflect the strategic priorities of <i>Nauru's National Sustainable Development Strategy 2019-2030</i> and MHMS's current NHS and NCD strategies. This will avoid duplication or collecting data which does not have validity beyond the support period, while promoting the use and improvement of existing systems and collection methods. As far as possible, country partners should be involved in analysing information, generating findings and making recommendations. Joint annual planning processes provide transparency and an opportunity for Divisions to understand a bigger picture and present on their work to colleagues, encouraging a more collaborative mindset.

Additional Questions re future thinking	Findings
<p>How should Australia's investment in Nauru's health sector be refocused and/or refined to ensure maximum strategic impact with the resources available for health up to 2030?</p>	<div data-bbox="577 296 1167 676"> </div> <p>WHO health system 'building blocks' still provide a useful framework to assess gaps and where to focus investments³¹. In Nauru the focus on health system strengthening, leadership and management, improving PHC and NCD care - is still valid and 'unfinished business' and will continue to need support as described in the Nauru Transitional Health Program (NTHP) three components: improved health information systems, logistic; governance, accountability and performance; and community-based care and emergency preparedness and response. At the same time, there are also urgent health infrastructure investments that need to be fast-tracked, working with MoF PAD to finalise a Capital Investment and Financing Plan.</p>

³¹ Used in Nauru NCD Strategic Action Plan 2021-2025, p.24

Additional Questions re future thinking	Findings
	<div data-bbox="539 293 1305 903"> <p>The diagram, titled "Determinants of health", illustrates a holistic model of health. At the center is a node labeled "Health" with an icon of people dancing. Nine other nodes are arranged around it, each connected by a line. These nodes are: "Employment" (worker icon), "Income & Social Status" (money icon), "Gender" (men and women icon), "Environment" (trees and people icon), "Healthy Child Development" (child playing icon), "Education" (school bag icon), "Culture" (people in traditional dress icon), "Health Services" (doctor and patient icon), and "Social Support" (group of people icon). The entire diagram is set against a blue background with a white horizon line.</p> </div> <p>While the health system building blocks will continue to require strengthening, to make an impact on the health of Nauruans, a more comprehensive approach could be considered in future health programming, that includes a focus on broader determinants of health (see Figure). Globally it has been recognised that a focus on early childhood development and adolescents and young adults have the potential to improve population health. Addressing health determinants more comprehensively requires more than setting up a multisectoral committee.</p> <p>It is a more difficult project, however there is a new Minister for Health with a three-year term (at least) who may be interested in leading a more inclusive approach to improving health, along with the new President who has taken on several key portfolios. This 'human development' approach, inclusive of gender, culture and disability, can more explicitly address key development challenges (such as youth unemployment, quality of education, inequalities and poverty, mental health, climate change impacts) while still supporting the health sector and NHS and NCD strategies.</p> <p>A design team can test the GoN appetite for this broader approach early in 2023 and take time to co-design such an initiative. Other development partners, in particular UN agencies that have limited reach into Nauru (UNICEF, UNDP, UNFPA) plus WHO DPS (who are already committed to a broader community-based approach to NCD prevention and management in Nauru) - could also be included in the design</p>

Additional Questions re future thinking	Findings
	and potentially pool funds and technical support. Working collaboratively across sectors is critical and a strong Minister and Secretary for Health could re-energise the multisectoral NCD Taskforce and development partner coordination. Initially revitalising a high-level Development Partner Forum to discuss needs and opportunities with relevant Ministers would be a good first step.
<p>Is there any scope to improve the consistency and coherence between DFAT's bilateral and regional investments, including those funded through the Indo-Pacific Centre for Health Security's investment through HSI 2.0?</p> <p>What scope is there to capitalise on successful investments across other sectors, and to promote synergies between the health program and other areas of the aid program?</p> <p>What are the potential options for priority investment areas and possible objectives for Australia's next phase of bilateral health investments?</p>	<p>DFAT funded regional programs have mixed reach into Nauru, and it is timely to review models while agencies are also being re-designed or restructured (e.g. HSI, Office of the Pacific). Smaller populations and health sectors may not benefit as much if funding or support is provided based on population size, yet their needs might be greater with limited human resources for health. Along with SPC and UN and other development partners, a model for how to provide support to islands with smaller populations could be considered for discussion at the next Pacific Heads of Health and Health Ministers meetings. The potential to share resources, technical support and lessons learned between air-linked countries to Nauru (Kiribati, FSM, Fiji) could be considered in the transition and a future design.</p> <p>Nauru is covered by a Multi-Country Office (MCO) of the UN Resident Coordinator for Palau, the Federated States of Micronesia (FSM), Republic of Marshall Islands (RMI), Nauru, and Kiribati, which was formally established on 1 October 2021, following the appointment of the UN Resident Coordinator. Nauru receives the lowest budget allocation of all the PICs covered by the UNPS (1% of total), and Nauru's UNPS budget expenditure reduced from \$1.2m in 2018 to \$56k in 2020. Given that the UN has had a presence in Nauru since 1984, and includes many relevant agencies for human development, it will be important the gauge the level of support that can be provided to Nauru and ensure coordination and collaboration in the future design. The new GoN could be supported to revitalise a Development Partner Coordination mechanism to ensure coherence across sectors.</p> <p>Nauru Post has very few staff, while still managing relatively large budgets and investments, and dealing with multiple requests. Issues for Post include the pressures that multiple, relatively small investments comprising bilateral, regional and global funding arrangements make it difficult for DFAT and MHMS to oversee and manage, yet this mixed-investment approach is likely to remain the most effective means of progressing sectoral reforms and assistance in the short term. Within the foreseeable future, the MHMS will likely continue to experience vacancies across key management and service delivery positions, and this will impact the extent to which investments will be supported and utilised.</p> <p>The extent to which the MHMS can absorb and utilise support has depended on the capacity, motivation and leadership of key individuals responsible for delivery or oversight of particular programs, units or services. Within this environment, willingness of key staff to advocate for, and support delivery of assistance has been a key factor in some investments working well, while others (particularly the larger, bilateral investments with multiple streams of support) have faced implementation challenges.</p> <p>Further work to strengthen systems and foster collective appreciation of, and engagement in strategic and operational planning within MHMS will help to ensure the Ministry recognises the range and modalities of investments it has at its disposal, and can use this to plan, schedule and track grants and disbursements. Closer, regular engagement between the MHMS and DFAT Post (perhaps through facilitation from the Deputy Secretary for Health) will help both parties to maintain oversight and track multiple investments.</p>

Additional Questions re future thinking	Findings
	<p>Any future bilateral programming should ensure that there an agreed communication process with regional programs - e.g. who should receive information and requests. What is the role of advisers – can they be routinely copied into emails? What feedback processes are there from countries to regional programs; e.g. any fails from the TGA testing scheme should be communicated to other PICTs who are using the same supplier, or have the same failed batch in stock.</p> <p>As discussed earlier, a broader human development approach is worth consideration in the next phase of bilateral health investments. If there is no appetite for this, then at least design joint education and health projects with consideration for food security and supply (given climate change concerns).</p>
<p>What options exist for how (by what mechanism) bilateral support can be delivered to Nauru’s health sector in the next phase? For example, what funding modalities and governance arrangements should be considered given MHMS and DFAT capacity and strength of the health system?</p>	<p>In the short term, it is unlikely that the MHMS is ready to resume bilateral support through a DFA, until such a time as investment governance arrangements are well established. Investing in such arrangements through more open, transparent dialogue with a broader range of MHMS senior and middle-level managers has been described above as a key strategy for strengthening engagement and oversight of DFAT’s health sector support, and this should be prioritised in the coming months, along with continued support for health sector planning, data collection and monitoring, and reporting.</p> <p>As proposed in the NHTP, in the short term, the adviser support model (through mechanisms such as CHS, SHS and AusP3) which places dedicated, long-term/in-country advisers into mentoring and support, and in some cases, in-line roles has proven effective when the MHMS determines and prioritises the support required, and engages in activity/intervention planning. This adviser support is most effective and sustainable where there is a local counterpart to work with and mentor.</p> <p>As noted, the current MHMS Director of Finance is highly skilled and has demonstrated motivation to work closely with the PAD; it is likely a good time to engage with the MHMS to identify and plan future financial management support to strengthen MHMS oversight of government and development partner support funds with a view to re-assessing capacity to program DFAT funds through government systems (on plan and on budget). An element of performance-linked funding or ‘bonus funding’ could also be considered for future health programming to ensure progress against key objectives.</p> <p>The MHMS should therefore be engaged and supported immediately to determine priorities for adviser assistance, with an emphasis on continuing with current, successful support (such as the Deputy Secretary for Health, Community Health Adviser, Logistics Management System Adviser, COVID-19 advisers and Health Information Management Systems support). Thinking more broadly, MHMS might consider additional technical assistance for: health sector planning; SOP development, finalisation and implementation; human resources management and recruitment; operations management. Managing and coordinating a disparate group of advisers in the Transitional Health Program can be challenging, and will require improvements to MHMS-led governance and oversight, using the agreed strategic and realistic MEL Framework to establish and monitor implementation and performance.</p> <p>Existing MHMS Health Executive meetings that report regularly to the new Minister for Health provide an opportunity to include reporting on DFAT funded progress as it will align with NHS and AOPs. Regular (possibly monthly) meetings with DFAT 2nd Secretary and new</p>

Additional Questions re future thinking	Findings
<p>What are the development partner coordination modalities that MHMS and DFAT could consider during a new design</p>	<p>Development Specialist (to be recruited) and the MHMS Health Executive, where concerns on progress can be raised and worked on jointly is preferable, to a model that only focuses on targets not being met. This will test the capacity of the MHMS to report against objectives.</p> <p>If improved engagement with other development partners is the goal, then a different mechanism and TOR need to be designed in the future phase of support. With a new Minister for Health who is actively engaged and keen to progress reforms, there is an opportunity to set up new mechanisms to support improved communication and coordination. A Health Review (around September), possibly chaired by the Minister, and including all development partners, could review data and reflect on progress and identify gaps for partners to support. A similar process could be held in March to plan for the next Financial Year. This process could be trialed in the Transition phase with DFAT support, and development partner engagement could be scheduled into joint in-country visits.</p>
<p>How should future health investments in Nauru better support and focus on gender equality, disability inclusion and social inclusion (GEDSI) and other cross-cutting areas?</p> <p>What specific approaches need to be integrated into the design and future programming to improve GEDSI outcomes through health investments?</p> <p>How should DFAT approach the design of Australian funded future health investments to Nauru</p>	<p>Key areas and approaches to strengthen GEDSI outcomes in future investments and support GEDSI objectives of the NHS 2021-2025 include:</p> <ul style="list-style-type: none"> • Support the establishment and recruitment of a MHMS GEDSI position. This role is critical for leading the promotion and mainstreaming of GEDSI in MHMS systems and practices. The position may benefit from the support of an international GEDSI STA. • Conduct a comprehensive GEDSI analysis to understand differences between and among women and men, girls and boys and cultural factors that may create barriers for women and men from diverse backgrounds in accessing and receiving health care services. A GEDSI analysis is the first step in mainstreaming GEDSI across future investments. • Build capacity of MHMS staff in GEDSI as it is a relatively new concept for MHMS; MHMS staff therefore require an understanding of GEDSI concepts and the implications of gender inequality, disability and social exclusion on health outcomes for women and men from diverse backgrounds. Disability awareness training should be provided to MHMS staff, in particular nurses and clinicians, to address stigma and negative attitudes towards people with disabilities and improve communication between health workers and people with disabilities. • Increase MHMS capacity to improve support for gender-based violence victims/survivors. Training for MHMS frontline staff, should be provided to increase awareness and knowledge about GBV and improve responsive care for GBV victims/survivors. This training should be conducted in collaboration with WASDA and the NPF, who are the primary contacts for GBV. • Support MHMS to collect and analyse GEDSI data to enable health policies and practices to better respond to the different needs of women and men from diverse backgrounds. Future investments should support MHMS to review existing surveys, health facility and relevant data sources to identify areas where GEDSI can be included in data collection systems and analyses. • Develop partnerships with WASDA and DPWLD to advance gender equality, disability and social inclusion priorities and address GEDSI issues in health system. WASDA and DPWLD should play a key role in improving MHMS systems and practices, including increased capacity of health staff in GEDSI, GEDSI data collection, improving support services for women and people with disabilities with regard to GBV, mental health, and accessing health services. Collaborations with local women's organisations and OPDs, which have local knowledge and established relationships with diverse women and men in communities, should also be sought to support the development and implementation of trainings

Additional Questions re future thinking	Findings
	<ul style="list-style-type: none"> • Provide ongoing GEDSI support to Community Health to further integrate and strengthen the existing GEDSI focus as it will require significant support to operationalise GEDSI within the CHPP during the transition program and future investments. It will be important to integrate key GEDSI messages into trainings to ensure relevance of GEDSI to different topics is continually reinforced and discussed. • Mainstream GEDSI in MHMS policies and practices to ensure they respond to the different needs of women and men. A review of activities and policies from a GEDSI perspective will contribute to improved health care accessibility, appropriateness and responsiveness. • Future design work to be guided by NHSSP's disability study findings and recommendations to ensure the barriers for people with disabilities in accessing health services are considered and addressed in future programs.

Annex 6: Stakeholders and Key Informant Consultations

DFAT Post

Name	Position	Location
Dr Helen Cheney	Head of Mission	Nauru
Andrew Hodges	Deputy Head of Mission	Nauru
Mathew Kerwin	2nd Secretary Development	Nauru
Rene Dube	Health and Infrastructure Officer	Nauru

DFAT regional and global programs

Name	Position	Location
Natalie McKelleher	Assistant Director Pacific Health Unit (OTP)	Canberra
Paulini Nainima Dr Frances Bingwor	Fiji Post (lead coordinator Pacific regional health)	Fiji
Kat Knope Chloe Damon	Adviser Centre for Health Security CHS focal point for Nauru	Canberra

Executive team

Name	Position	Location
Chanda Garabwan	Secretary of Health (current administration)	Nauru
Andy O'Connell	Deputy Secretary (DFAT funded expat)	Nauru
Giedo Garabwan	Director of Human Resources	Nauru
Anushka Cook	Director of Finance	Nauru
Iloi Rabuka Rosieli	Director of Training & Development (Acting)	Nauru
Dr David Bill	Director of Medical Services (Acting)	Nauru
Moralene Capelle	Director of Nursing	Nauru
David Dowiyogo	Director of Health Operations	Nauru
Stacey Cain	Director of Public Health	Nauru
Trixie Fritz	Chief Matron RON Hospital	Nauru

Other key informants

Name	Position	Location
Don Kadir	Deputy Director - NCD	Nauru
Christabel	Health Promotion Officer	Nauru
Roxyanna Kepea	Assistance Medical Records Manager	Nauru
Litiana Raikuna	Statistician	Nauru
Tomasi Marovia	Pharmacist	Nauru
Shanyko Benjamin Karen Tai	Lab Manager (lab info system - NHSSP) Junior Laboratory Scientist	Nauru
Elizabeth Giouba, Knighton Dowabobo	IPC Supplies manager	Nauru

Govt Nauru Departments

Partner	Name	Position	Location
COVID-19 Taskforce	Angelo Dimapilis	Chair Taskforce	Nauru

Partner	Name	Position	Location
Ministry of Finance	Samuel Grundler, Kristina Pawliw Georgina	Planning and Aid Division (PAD)	Nauru
Dept of Women's & Social Development Affairs (WASDA)	Livai Sovau (Mr) Joy Heine, Marjorie Kari	Legal Adviser (WASDA) CEO? Counsellor	Nauru
Department of People Living with Disabilities	Riddell Akua	Secretary DPLWD	Nauru

Relevant TA Service Providers for NHSP and Transitional Program of Health Support

Partner	Name	Position	Location
Beyond Essential	Michael Nunan	CEO Beyond Essential System (BES)	Australia
Beyond Essential	Ashley Allchurch	Adviser mSupply/Pharmacy - previous NHSSP	Nauru
Beyond Essential	Regina Akacich Templa Tau	Project Manager & Tamanu lead IT support	Nauru
Cardno (funded by Post)	Andy O'Connell	Deputy Secretary	Nauru
Cardno (funded by Post)	Vicky Assenheim	Community Health Adviser - previous NHSSP	Nauru
Cardno (funded by Post)	Lou Carrington	Outgoing COVID-19 Adviser - key informant	Australia
Palladium (NHSSP)	Anthony Carrigan	previous Contractor Representative	Australia
Palladium (NHSSP)	Tarla Steffens	Senior Project Manager	Australia
Palladium (NHSSP)	Shivnay Naidu	HMIS adviser (NHSSP)	Fiji
Palladium (NHSSP)	Clare Whelan	Health Systems & Team Leader (NHSSP)	Tonga
Palladium (NHSSP)	Alumita Lekenaua	GEDSI Coordinator (part-time)	Nauru
WHO Grant	Dr Tomo Kanda	Pacific NCD and Health through the Life-Course, Division of Pacific Technical Support	Fiji
WHO Grant	Dr Luisana Manoa	Technical Officer NCD	Remote
WHO Grant	Saula Volavola	Technical Officer Health Promotion	

Relevant Development Partners

Partner	Name	Position	Location
Regional SPC	Salanieta Saketa	Research & Evaluation/Nauru Focal Point	Fiji
Regional SPC	Silina Motofaga	SPC Team Leader, Clinical Services Program, Public Health Division	Fiji
Royal Australian College of Surgeons	Robyn Whitney Philippa Nicholson	RACS - Program and Operations Manager RACS Global Health - Head	Australia
Fiji National University (FNU)	Dr Timaima Tuiketei	College of Medicine, Nursing & Health Sciences	Global
Uni Fiji	Prof Shaista Sheema	Vice-Chancellor	Fiji
WHO	Dr Subhash Yadav	Nauru Country Focal Point	Fiji
UNICEF	TBC	New Vaccines (Post & Canberra funded)	Global
UNFPA PSRO	Josephine Chu	Reproductive health commodity supplies (RHCS) Data management analyst	Global

Partner	Name	Position	Location
UN Women	Sarika Chand	Gender equality	Global
UNDP	TBC	Nauru COVID-19 project support	Global
ADB	Camilla Solomon	Country Officer	Global

Annex 7: Documents Reviewed in the Evaluation

Nauru Health Project Documents and Reports:

- Nauru Country Fact Sheet
- Nauru Development Cooperation Factsheet (DFAT)
- Nauru health investments factsheet (DFAT)
- NHSP IMRs (INM621)
- NHSP design documents (3)
- NHSP completion report 2022
- NIHP Review 2017
- NHSP Implementing partner reports – Palladium/WHO
- Other NHSP reports – IPC and Preparedness & Response reports
- NHSP reports – Public Health/COVID-19 Adviser
- NHSP Adviser TOR and workplans (DMS/Dep Sect)
- Transition health program – BES reports

Government of Nauru related Documents:

- Nauru 2022 Census Report
- Nauru DHS Report 2007
- Nauru Health Strategy 2021-25
- Nauru NCD Strategic Action Plan 2021-2025 (draft)
- Nauru Ministry of Health and Medical Services Annual Operating Plan 2022-23
- MHMS Annual Health report 2019-20
- MHMS National Strategic Plan
- MHMS/WHO. NCD Risk Factors STEPS
- MHMS National Gender Implementation Plan, Health Sector
- Nauru Sustainable Development Strategy 2019-2030 (plus NSDS KPIs)
- Nauru Family Health Support Survey 2014

DFAT documents (CHS and other regional investments):

IMRs and other outcome documents for:

- TGA – Pacific Medicine Testing Program
- World Health Organization Western Pacific Regional Office
- Vaccine Access and Health Security Initiative (VAHSI)
- Health Security Initiative for the Indo-Pacific Strategic Framework 2019-2020

Guidelines and Frameworks

- UNICEF Strengthening systems for sustainable introduction of new vaccines (Kiribati and Nauru)
- UNFPA Supplies Multiyear Contribution to Pacific Reproductive health commodities
- Beyond Essential Systems - Tupaia – Partnership for health information for health security and disaster preparedness – core funding (Australia)

- The Pacific Community (SPC) - Strengthening clinical capacity and capability to respond to COVID-19 and PacEVIPP
- Pacific Regional Health Investment (activity 22A005, 69294/62), Support to SPC Public Health Division PCSHWIP (RACS/FNU)
- Framework of Action for Revitalization of Healthy Islands in the Pacific. WHO/SPC
- WHO WPRO: UHC and SDG country profile Nauru 2018
- WHO Nauru Country Cooperation Strategy 2018-2022
- UNICEF Situation Analysis of children in Nauru 2017
- WHO Monitoring and Evaluation of health systems strengthening: an operational framework

Annex 8: Gender Equality, Disability, and Social Inclusion

Introduction

Nauru's health sector receives DFAT support through a number of regional and global initiatives. DFAT has commissioned a review to assess whether Australia's health sector investments from 2018 – 2022 were effective, efficient, and appropriate. The gender equality, disability and social inclusion (GEDSI) Annex considers how these investments have supported GEDSI outcomes, and provides recommendations for future support for Nauru's Ministry of Health and Medical Services' (MHMS) Health Sector Strategy (2021-2025). The Annex focuses primarily on DFAT's bilateral support, the Nauru Health Support Program (NHSP). Limited GEDSI data did not allow for a review of DFAT-funded regional and global health initiatives in Nauru.

The key GEDSI considerations of this Annex are:

- To what extent have Australia's health investments supported gender equality, disability inclusion and social inclusion and other cross cutting areas? What has been the performance of these investments regarding improved GEDSI outcomes?
- How should future health investments in Nauru better support and focus on gender equality, disability inclusion and social inclusion (GEDSI) and other cross-cutting areas? What specific approaches need to be integrated into the design and future programming to improve GEDSI outcomes through health investments?

GEDSI Development Context

Gender

Nauru has a population of 11,550 (5,871 males; 5,679 females).³² Nauru is a patriarchal society but follows a matrilineal system for the transfer of family land. Land and other assets are inherited by both sons and daughters, but daughters can pass on their rights over property to their children without family consent.³³

Generally, women are not involved in decision-making processes in political and public life. Women can express their opinion in public meetings but men will make the decisions related to public matters.³⁴ Following the 2019 election, two women were elected to the Nauruan Parliament. While women are represented in the public service, most women occupy lower-level positions and there are inequitable levels of pay for male and female staff doing equivalent work with equivalent qualifications.³⁵ Women's multiple responsibilities for childcare and households make it difficult for women to dedicate the time required for more senior roles; these responsibilities are not acknowledged or supported by government policy.

There are limited sources of employment in Nauru for both males and females with 2019 census data indicating that only 52% of the population were employed.³⁶ Women experience challenges in accessing employment in the formal economy with only 30% and 12% of women aged 15-59 years employed in formal government and private labour force jobs compared to 46% and 23% of men.³⁷ The lack of economic opportunities is a constraint to supporting families, which has contributed to a

³² The Republic of Nauru Department of Finance. (2020) [Nauru Statistics](#)

³³ [ADB](#). (2017) Poverty, Social and Gender Assessment for Nauru Port Development Project

³⁴ [ADB](#). (2017) Poverty, Social and Gender Assessment for Nauru Port Development Project

³⁵ Secretariat of the Pacific Community. (2015) Stocktake of the gender mainstreaming capacity of Pacific Island Governments: Nauru, Noumea: Secretariat of the Pacific Community.

³⁶ The Republic of Nauru Department of Finance. (2020) [Nauru Statistics](#)

³⁷ [Nauru Bureau of Statistics and UNDP Pacific](#), Nauru Hardship and Poverty Report: Analysis of the 2012/13 Household Income and Expenditure Survey

rise in gambling, increased truancy of children from school, and high rates of teenage pregnancy.³⁸ Women are more likely to live in poverty than men with 17.7% of female-headed households living below the basic needs poverty line and 7.5% are highly vulnerable to poverty in comparison to 16.3% and 5.5% of male-headed households.³⁹

There is a lack of knowledge about sexual and reproductive health issues, including birth control and prevention of sexually transmitted infections among adolescents and the general population. DHS data indicates that 24% of married women in Nauru have an unmet need for family planning.⁴⁰ Data shows that unmet family planning needs were higher among younger women with 37% of women aged 20-24 having an unmet need for family planning. Only 8.5% of girls aged 15-19 years use any method of contraception, while 3.8% used a modern method of contraception.⁴¹ Women tend to have children at a young age with 22% of adolescent girls giving birth before the age of 18 years.⁴² Girls who get pregnant are not required to leave school; however, many do leave as a result of family and community pressure.⁴³ Data indicates that between 2014-2020, 27% of adolescent girls and 12% of adolescent boys were married by the age of 18 years.⁴⁴ Research has shown that early marriage reduces the likelihood that married women will have equal decision-making power with regard to using contraception and family planning.⁴⁵ The maternal mortality ratio is zero and all pregnant women are reported to give birth with a skilled health professional in health facilities.

There are more women (55%) registered as having diabetes than men (45%) in Nauru. This can be attributed to more women being diagnosed due to women going for screening more than men. Generally, women and girls care for family members with NCDs, with some giving up employment or stop attending school to provide the care required.⁴⁶ Older women often face the double burden of living with an NCD whilst also caring for family members with NCDs.

There are high rates of violence against women in Nauru. Research indicates that 48.1% of ever-partnered women who participated in the study have experienced physical and/or sexual violence by a partner at least once in their lifetime.⁴⁷ There were 46.6% of ever-partnered women who had experienced physical violence and 20.6% of ever-partnered women who had experienced sexual violence at least once in their lifetime; 25.4% of ever-pregnant women reported experiences of physical violence in at least one pregnancy. Most women do not report incidences of violence with approximately 68% of women who experienced violence not seeking help from formal services or authorities such as police or health centres; approximately 29% of women who experienced partner violence never disclosed the violence to anyone, including family and friends.⁴⁸ Women who report

³⁸ Secretariat of the Pacific Community. (2015) Stocktake of the gender mainstreaming capacity of Pacific Island Governments: Nauru, Noumea: Secretariat of the Pacific Community.

³⁹ UNICEF. (2017) Situation Analysis of Children in Nauru, Suva: UNICEF Pacific Office.

⁴⁰ Nauru Bureau of Statistics, SPC and Macro International Inc. (2007) Nauru 2007 Demographic and Health Survey, Noumea: The Pacific Community.

⁴¹ Nauru Bureau of Statistics, SPC and Macro International Inc. (2007) Nauru 2007 Demographic and Health Survey, Noumea: The Pacific Community.

⁴² UNICEF. (2021) The State of the World's Children 2021: On My Mind – Promoting, protecting and caring for children's mental health, New York: UNICEF.

⁴³ Secretariat of the Pacific Community. (2015) Stocktake of the gender mainstreaming capacity of Pacific Island Governments: Nauru, Noumea: Secretariat of the Pacific Community.

⁴⁴ UNICEF. (2021) The State of the World's Children 2021: On My Mind – Promoting, protecting and caring for children's mental health, New York: UNICEF.

⁴⁵ [Plan International](#). (2015) Getting the Evidence: Asia Child Marriage Initiative

⁴⁶ DFAT. (2018) Design Document: Nauru Health Support Program.

⁴⁷ [Nauru Ministry of Home Affairs](#). (2014) Nauru Family Health and Support Study: An exploratory study on violence against women

⁴⁸ [Nauru Ministry of Home Affairs](#). (2014) Nauru Family Health and Support Study: An exploratory study on violence against women

violence may be stigmatised by the community and are at risk of further violence from perpetrators, making it difficult for women to leave abusive situations.⁴⁹

There are gender disparities in education with the gender parity index for primary school enrolment being 0.92, indicating that there are more boys enrolled in primary school than girls in 2015.⁵⁰ While there is gender parity in lower secondary, there are more females than males enrolled in upper secondary school (gender parity index 110). The 2011 census highlights that a larger proportion of boys (5%) than girls (3%) aged 13-18 years had never attended school or had left school prematurely (30% males; 25% females).⁵¹ Literacy and numeracy rates are low with only 18.9% of boys aged 11 years and 33.1% of girls achieving the appropriate literacy level.⁵² In 2003, 67% of women were enrolled in preliminary, foundation, and vocational degree and continuing education courses; however success rates are low (10%) with withdrawal from courses due to issues related to internet accessibility, financial difficulties, and power outages.⁵³

Disability

There is limited data available on disability in Nauru. The Government of Nauru has committed to support the rights of people with disabilities by signing the United Nations Convention on the Rights of Persons with Disabilities in 2012. The Government developed the Nauru National Disability Policy in 2015 and has also established a number of support systems for people with disabilities including disability pensions, modification of houses and special schools. The 2019 Mini Census indicates that 2.5% (252 people) of the Nauruan population has a disability.⁵⁴ MHMS data (2016) estimates that there were 260 people with severe physical disabilities, caused predominantly by NCDs (46%) and congenital abnormalities (38%). Census data (2019) indicates that 3.9% of the population aged five years and above has some difficulty in seeing and 3.4% of the population have mobility difficulties; however, there is a higher prevalence of the population with mobility issues (1.1%) who experience difficulties and 0.5% of the population who cannot care for themselves at all.⁵⁵ Disability prevalence rates are higher among women (3% women; 2% men). The prevalence of disability is higher among people aged 50 years and older (9.5%), which may be due to health problems and functional limitations related to an ageing population.⁵⁶

Census data shows that 13.5% of the total number of people with disabilities (252) had attained primary level education, 63.1% had completed secondary education, and 1.2% had obtained higher education.⁵⁷ The data indicates that 15.1% of people with disabilities have had no education at all compared to 5.4% of people without disabilities. Children with disabilities have limited opportunities to participate in mainstream education due to social attitudes which force parents to enrol their children in the special needs school.⁵⁸ However, few children with disability attend the special school regularly due to poor transportation options to the school and the reportedly poor quality of education provided.

⁴⁹ Secretariat of the Pacific Community. (2015) Stocktake of the gender mainstreaming capacity of Pacific Island Governments: Nauru, Noumea: Secretariat of the Pacific Community.

⁵⁰ UNICEF. (2017) Situation Analysis of Children in Nauru, Suva: UNICEF Pacific Office.

⁵¹ Nauru Bureau of Statistics, SPC and Macro International Inc. (2007) Nauru 2007 Demographic and Health Survey, Noumea: The Pacific Community.

⁵² Nauru Bureau of Statistics, SPC and Macro International Inc. (2007) Nauru 2007 Demographic and Health Survey, Noumea: The Pacific Community.

⁵³ UNICEF. (2017) Situation Analysis of Children in Nauru, Suva: UNICEF Pacific Office.

⁵⁴ The Republic of Nauru Department of Finance. (2020) [Nauru Statistics](#)

⁵⁵ SPC. (2020) Disability in Nauru, Noumea: Statistics for Development Division (SDD), The Pacific Community.

⁵⁶ SPC. (2020) Disability in Nauru, Noumea: Statistics for Development Division (SDD), The Pacific Community.

⁵⁷ SPC. (2020) Disability in Nauru, Noumea: Statistics for Development Division (SDD), The Pacific Community.

⁵⁸ UNICEF. (2017) Situation Analysis of Children in Nauru, Suva: UNICEF Pacific Office.

Healthcare for people with disabilities is limited due to a shortage of trained specialists including speech therapists, mental health professionals and psychologists.⁵⁹ A lack of data and analysis and limited awareness of healthcare workers about the needs and circumstances of people with disabilities contributes to poor healthcare outcomes for people with disabilities in Nauru.

Nauru Health Strategy 2021-2025

GEDSI is a cross cutting theme throughout the Nauru Health Strategy (NHS). MHMS's commitment to GEDSI is to ensure equal rights, responsibilities and opportunities of women and men, girls and boys in Nauru in all their diversity, irrespective of age, ethnicity, disability, political affiliation, socioeconomic background, religion and sexuality. The NHS recognises that gender and socioeconomic factors intersect with a range of other demographic factors to produce differential health outcomes for women, men, boys and girls. MHMS has identified GEDSI issues affecting service quality, health access, health system outcomes, and a need to better understand the health status of women, men, girls and boys to improve GEDSI mainstreaming in health policies and strategies, and through service delivery to strengthen health systems, and improve access to and quality of primary health care.

The MHMS' approach to GEDSI includes:

1. Increasing availability of quality data and information to identify enablers and barriers to UHC facing specific groups such as youth, people living with disabilities and the elderly
2. Building the capacity of healthcare professional to better respond to the needs, interests and rights of certain groups, such as youth, elderly, people with disabilities, women and children who are survivors of gender-based violence
3. Improving the access of women, men, boys and girls to quality healthcare services through the public health, hospital and Wellness Centres
4. Strengthening the health sector response to gender-based violence through survivors-centred care, screening tools and interview protocols with the goal of establishing a 'one stop shop'
5. Advocating for a GEDSI positive healthcare sector through the identification of GEDSI champions and by demonstrating zero tolerance for harmful attitudes, stereotypes and norms which pose an obstacle to the goal of GEDSI.

The GEDSI approach outlined in the NHS is essential for strengthening GEDSI in health services and will provide a good foundation on which to develop and strengthen equitable and inclusive health systems. However, a review of program documentation and in-country consultations indicate that MHMS have a very basic understanding of GEDSI. It will take time to build a more sophisticated understanding of GEDSI and its relevance to health outcomes. Achieving the GEDSI objectives outlined in the NHS will require significant support from a GEDSI Adviser with the skills and knowledge to support and guide this work.

GEDSI in DFAT-funded Health Investments in Nauru

A review of documentation and consultations indicate that there has been limited integration of GEDSI into the regional and global investments. In comparison, the Nauru Health Support Program (NHSP) has had a greater focus on GEDSI than other Australian-funded health investments in Nauru. NHSP comprised of two components: WHO grant focusing on NCDs; and the Nauru Health System Support Project (NHSSP). The two components are discussed separately with regard to GEDSI.

⁵⁹ UNICEF. (2017) Situation Analysis of Children in Nauru, Suva: UNICEF Pacific Office.

- **World Health Organisation**

WHO conducted capacity building of medical, nursing and health promotion staff who have predominantly been women. Videos were developed for the health promotion campaigns that integrated a gender focus to show different behaviours of tobacco use that are common to women and men; the content of the videos was based on focus group discussion with men and women to understand gender-specific behaviours related to smoking. The design of the NCD program addresses the health care needs of people with disabilities to ensure diabetes is assessed and managed among people with disabilities. People with disabilities' access to healthcare was addressed by providing flexible clinic hours, mobile services and shifting clinics to community outreach clinics. Training for health staff integrated a disability focus in the curriculum and included content on the healthcare needs of people with disabilities. However, it is unclear whether this training has been effective in increasing awareness of health staff regarding disability or improved services for people with disabilities.

WHO's health promotion activities have utilised women to deliver NCD-related information to communities. WHO's approach is to work with community to identify relevant approaches and community strengths. The Health Promotion Officers (HPOs) and District Health Workers (DHWs) are predominantly women, are trained to deliver information to community women and men. Consultation with WHO suggests that this has been an effective approach to communicating information to communities about NCD prevention and control, as well as providing women with increased access to health information and potential opportunities to elevate women's status in communities. However, it is unclear whether the health promotion activities delivered by HPOs and DHWs include information specific to the different gender-related risk factors for NCDs, despite specific questions about this during the team's consultation with WHO.

WHO's reporting on GEDSI has been constrained by limited GEDSI data in the Health Information System. WHO used data from the NCD STEPS and Global School Health Survey to inform program design; however, this did not include reliable data related to services and accessibility to services by gender. A KAP Survey was initiated to understand knowledge of tobacco risk factors and tobacco use behaviours among men, women, girls and boys; this was planned to start in June 2021. The Global School Health Survey implemented late 2021 collected data on knowledge, attitudes and practices on health topics including tobacco and other NCD risk factors amongst 12-17-year-old school children in Nauru; all data collected are disaggregated by gender, however that survey encountered sample size problems with many children not attending school due to COVID-19 concerns. The survey findings were unavailable at the time of this review.

- **Nauru Health System Support Project**

Gender equality, disability and social inclusion was an important component of the Nauru Health System Support Project (NHSSP) and highly relevant to the work supported by the program. A GEDSI Strategic Action Plan was developed in 2020 to guide the program in mainstreaming gender equality, disability and social inclusion across activities. The Plan provided a GEDSI analysis of the Nauru and outlined the key challenges and opportunities relevant to the program. The Plan identified key actions to improve participation and access of target groups, including women from different age groups and people with disabilities. However, the activities outlined were overly ambitious and the GEDSI Action Plan was updated and revised in July 2021 to ensure its alignment with NHSSP, MHMS, and DFAT's requirements. The Action Plan included deliverable actions to support MHMS' GEDSI-related work including: capacity development for NHSSP staff to promote GEDSI awareness and action; GEDSI integrated into HMIS training, analysis, reports on GEDSI; strengthen MHMS ability to apply a GEDSI lens to strategic planning and HR management including women's leadership opportunities; strengthen MHMS response to GBV and child protection; Wellness Centre operational policies understand and meet needs of target groups; capacity development for Wellness Centre staff on a range of priority health issues impacting target groups; and research to assess barriers to

access for people with disabilities to health services. Of these seven activities, one was achieved (disability research); two activities had limited achievement (strengthen MHMS to apply GEDSI lens, and Wellness Centre policies met needs of targeted groups); and four activities were not achieved (capacity development of NHSSP staff, GEDSI integrated into HMIS training, analysis, strengthen MHMS response to GBV and child protection, and capacity development for Wellness Centre staff). The activities are discussed in more detail below.

GEDSI in NHSSP was led by an international GEDSI STA, appointed in January 2020, who was responsible for the implementation of the GEDSI Action Plan and leadership on targeted GEDSI activities. Unfortunately, the Adviser did not undertake any in-country inputs due to COVID-19, and provided limited remote support, resulting in a lack of practical support and guidance for the program and MHMS in integrating GEDSI considerations in identified areas. In September 2021, an in-country GEDSI Coordinator was recruited, who was able to progress some activities and develop partnerships with relevant government stakeholders, including Department of Women's and Social Development Affairs (WASDA), Department of People living with Disability (DPLWD), Nauru Police Force (NPF), and relevant local NGOs. While there was a significant gap in support for GEDSI prior to the recruitment of the in-country position, the presence of the GEDSI Coordinator was an important factor in accelerating the GEDSI-focused activities towards the end of the program.

As the concept of GEDSI is relatively new for MHMS, the GEDSI Coordinator was able to initiate discussions with MHMS with regard the implications of gender equality, disability and social inclusion on healthcare access and health outcomes. As NHSSP did not provide support or training opportunities to MHMS to support them in applying a GEDSI lens to their strategic planning or HR management processes, the discussions facilitated by the GEDSI Coordinator enabled GEDSI considerations and the role of women in health to be highlighted in MHMS' planning process. As a result, GEDSI considerations have been included in the Nauru Health Strategy and Annual Operating Plan 2022-2023. As part of this planning, a GEDSI Focal Person position was included in the NHS to lead GEDSI mainstreaming and activities. While this role has not been filled to date, this dedicated GEDSI role will be essential for supporting and leading on mainstreaming GEDSI in health policies, projects, and practices and to develop and maintain relationships with key stakeholders including DPLWD and WASDA, and the Nauru Police Force (NPF).

Collaborations and partnerships: NHSSP's GEDSI Coordinator collaborated with a range of government departments to identify opportunities for strengthening GEDSI in health. The Government of Nauru's Ministry of Women and Social Development Affairs (WASDA) and the Department of People Living with Disability (DPLWD) are key government stakeholders for advancing national gender equality and disability inclusion priorities. The GEDSI Coordinator engaged with WASDA on the development of the Nauru Health Strategy and the development of GEDSI Sensitive Patient Referral Guidelines and Standard Operating Procedures for processing GBV victims/survivors through the health system. While this is a significant achievement, healthcare workers have not been trained on using the Guidelines and SOPs and have received little or no training on GBV awareness. WASDA receive approximately 10 cases of violence per month at the Safe House and take women to hospital only if they have injuries, as most staff do not understand the reporting processes or confidentiality requirements. WASDA had trialed a system to have a point person to receive and support women experiencing GBV in the hospital; however, this person was not interested in the role and victims/survivors were sent to the maternity ward where they were reportedly poorly treated by nurses. Training of healthcare workers in appropriate management of and care for victims/survivors of GBV is necessary and needs to involve WASDA, as they are the main point of contact for GBV.

NHSSP supported MHMS to partner with the Department for People Living with Disabilities to conduct research on the barriers for people with disabilities in accessing health services in Nauru. While people with disabilities were not part of the research team, the Secretary of DPLWD, who is a

person with a disability, was engaged in the research. The study found that people with disabilities are not frequent users of healthcare services due to: attitudes of healthcare workers impact on the willingness of people with disabilities to engage with healthcare services; communication barriers limit people with disabilities using healthcare services; health centre/hospital not accessible for all people with disabilities; transportation barriers; and barriers such as inconvenient scheduling of appointments, insufficient time allocated for examinations, and poor knowledge of the needs of people with disabilities. As disability data in Nauru is limited or outdated, this study establishes a baseline for the impact of future program support on health outcomes, policy development, planning and service delivery and provides important information to inform the design of future investments to address the barriers for people with disabilities in accessing healthcare. As indicated in the study, the research findings can also support the implementation of DFAT's disability strategies by providing information and evidence to support the development and revision of operational policies and procedures, improving knowledge, and understanding about the barriers people with disabilities experience in accessing and participation in health initiatives. To date, MHMS has little engagement with DPLWD. DPLWD visit the homes of people with disabilities to check up on their health and mobility issues and inform MHMS if specific care requirements are needed; community health nurses generally do not provide health care for people with disabilities in the communities as most people with disabilities would go to the hospital if healthcare was needed. Communication and coordination between MHMS and DPLWD will be important to improve healthcare provision for people with disabilities in future programs.

Capacity building in GEDSI: Some capacity building of nurses and nurse aides was conducted as part of larger training packages. GEDSI was integrated into topics such as service delivery and human resourcing. However, MHMS awareness of GEDSI and its relevance to health is lacking, as the trainings were conducted towards the end of the program and did not provide ongoing knowledge or skills development with regard to GEDSI. Addressing gender, disability and social inclusion issues related to health requires individuals to understand the actuality of gender inequalities and social exclusion within their communities and workplace before they are able to identify inequalities and exclusion within the health system and how it operates. Given the limited understanding about GEDSI in MHMS, this will take time and significant resourcing to increase knowledge and skills of healthcare workers in particular, and MHMS staff in general, to ensure health services are equitable and inclusive.

NHSSP's GEDSI STA undertook a GEDSI Health Check of all NHSSP staff to assess internal progress against GEDSI commitments identified in the NHSSP GEDSI Strategic Plan. The Health Check suggests that progress had been made in integrating GEDSI in internal and external strategies, policies and plans and in the allocation of resources. Some progress had been made in the monitoring and evaluation of GEDSI and that NHSSP collected and analysed and reported on sex disaggregated data. The Health Check indicated that there was little or no progress on promoting GEDSI through social media and communication materials and staff had limited involvement in GEDSI training. This last point is supported by the findings from the document review and consultations, which suggest that NHSSP staff did not receive GEDSI training to increase GEDSI awareness; this was a deliverable outlined in the GEDSI Action Plan.

GEDSI mainstreaming:

- Community Health Project Plan (CHPP): There is a strong GEDSI focus integrated into the CHPP. Key GEDSI outputs of the Community Health Project include the development of a Patient Referral Guideline and SOPs that support the needs of survivors of GBV, people with disabilities, and mental health client referrals and pathways for acute care and continuity of care; an evidence base for maternal health and community health via the completion of surveys and community profiles; support for the Public Health team to undertake community outreach activities; and an increase in the number of women screened for cervical cancer. Community

health activities will require ongoing support to strengthen and further the integration of GEDSI considerations into the operationalisation of the CHPP during the transition phase.

- GEDSI data: Disaggregated data, including sex, disability, and age is essential for improving health outcomes for women, people with disabilities, and the elderly. NHSSP assisted MHMS to strengthen its Health Management Information System (HMIS) and train staff to use Tamanu and Tupaia systems. The Health Management Information System (Tamanu) collects sex disaggregated data. Both the NHS and CHPP include sex and disability disaggregated data and a gender and disability analyses. Data related to the number of males, females, youth and people with disabilities with an elevated risk of NCDs, males, females and people with disabilities who express satisfaction with services, and number of females being screened for cervical cancer will be collected through the community-based health system in the near future.

However, there is little evidence that NHSSP supported MHMS to collect and use disaggregated data in a systematic way; this is an area which should be prioritised in future support to MHMS. The inclusion and analysis of sex and disability disaggregated data should be included in health assessments, frameworks and tools to be able to understand GEDSI issues and ensure MHMS initiatives are gender, disability and socially inclusive. Similarly, there is a need to improve disability-related data. NHSSP relied on data from the Disability Register for people receiving financial support to inform activity planning; this information is held by DPLWD. It is critical that sex and disability disaggregated data, indicators and other demographic information are collected, analysed and included in health data collection systems to ensure planning, design, and implementation of policies and projects are equitable and inclusive.

- GEDSI mainstreamed in key operating plans, frameworks and strategies: GEDSI considerations were included in NHSSP's Capacity Development Framework and HMIS Capacity Development Strategy and its implementation. GEDSI considerations were included in Strategic and Operations Plans, SOPs and guidelines; NHS workshops and plans; NHMS 2021-2022 AOPs; Public Health AOPs; patient referral and care guidelines; and GBV/IPV screening tools. This was partially achieved through discussions with MHMS and partners about GEDSI barriers and challenges with regard to health services.

Improving GEDSI Outcomes in Future Health Investments

As outlined above, there has been some progress in mainstreaming gender equality, disability and social inclusion in areas such as community health and relevant MHMS strategies; however, there are significant gaps in addressing GEDSI issues across the broader health system. While GBV is an important focus for the GEDSI component and needs to be a focus in future programs, investments to date have focused predominantly on GBV and overlooked other important areas of gender equality/GEDSI in MHMS, such as supporting the collection and analysis of GEDSI disaggregated data, increasing health staff knowledge about GEDSI and its relevance to healthcare access, service delivery and health outcomes, and integrating GEDSI in policies and practices to ensure an equitable and inclusive health systems. The following recommendations outline key areas and approaches to strengthen GEDSI outcomes in future investments and support MHMS' GEDSI approach and objectives of the NHS 2021-2025.

- ***Support the recruitment of the MHMS GEDSI Focal Point.*** This role is important for leading the promotion and mainstreaming of GEDSI in MHMS systems and practices. This position may need the support of an international GEDSI STA. Depending on the GEDSI experience of the GEDSI Focal Point, the GEDSI STA may need to provide an initial training package for the Focal Point to ensure they have the required awareness and knowledge to lead the GEDSI work in MHMS. The GEDSI STA would need to provide ongoing coaching and mentoring for the Focal Point. The GEDSI STA should work with the GEDSI Focal Point to identify realistic activities that are informed by a GEDSI analysis and priority program areas outlined in the NHS. The GEDSI

activities should be outlined in annual GEDSI Action Plans and monitored and evaluated regularly to assess effectiveness and enable improvements and/or changes to be made to activities where required.

- **Conduct a comprehensive GEDSI Analysis** to understand differences between and among women and men, girls and boys and cultural factors that may create barriers for women and men from diverse backgrounds, including women and men with disabilities, in accessing and receiving health care services. The analysis should adopt an intersectional approach. A comprehensive GEDSI analysis is the first step in mainstreaming GEDSI across future investments. The information is important for facilitating the integration of GEDSI in program activities and increasing the effectiveness of the program. The analysis should be informed by existing GEDSI data and consultations with women and men from diverse backgrounds and contexts, as well as local women's organisations, Organisations of People with Disabilities (OPDs), and local and international NGOs working in this area. The analysis is important for informing how health projects are planned and implemented and highlighting potential opportunities, challenges and risks for activities to contribute to gender equality, disability and social inclusion outcomes.
- **Build capacity of MHMS staff in GEDSI.** GEDSI is a relatively new concept for MHMS. MHMS staff therefore require an understanding of GEDSI concepts and the implications of gender inequality, disability and social exclusion on health outcomes for women and men from diverse backgrounds. Trainings could be conducted separately with each area of the health system; trainings should provide targeted information that highlights the relevance of GEDSI to different areas and roles, such as nursing staff, doctors, and HMIS staff. This training should be conducted regularly to refresh and strengthen knowledge and skills, as well as ensuring knowledge and skills remain relevant and up-to-date. The training should be conducted in collaboration with WASDA and DPLWD who can provide culturally-informed approaches and knowledge with regard to addressing inequalities within the health system. Collaborations with local women's organisations and OPDs, which have local knowledge and established relationships with diverse women and men in communities, should also be sought to support the development and implementation of trainings.
- **Increase MHMS capacity to improve support for gender-based violence victims/survivors.** Health sectors play a critical role in responding to GBV. Victims/survivors need to access comprehensive health services, including medical treatment, emergency contraception, and mental health care. Training for MHMS staff, in particular nurses and clinicians, should be provided to increase their awareness and knowledge about GBV and to improve the quality of care for GBV victims/survivors. In addition, clinicians and nurses need to be trained to use the GEDSI Sensitive Patient Referral Guidelines and Standard Operating Procedures for responding to GBV victims/survivors through the health system. It is important that this training be conducted in collaboration with WASDA and the NPF, who are the primary contacts for GBV.
- **Support MHMS to collect and analyse GEDSI data.** The NHS highlights the importance of GEDSI data and information to identify enablers and barriers to universal health coverage. Future investments need to work with MHMS staff to ensure GEDSI data are included in information managements systems so health policies and practices are able to respond to the different needs of women and men from different contexts and backgrounds. This will require future investments to support MHMS to review existing surveys, health facility and relevant data sources to identify areas where GEDSI can be included in data collection systems and analyses. The collection and analysis of GEDSI data is critical to the mainstreaming of GEDSI into policies, practices, and activities.

- ***Develop partnerships with WASDA and DPWLD to advance gender equality, disability and social inclusion priorities.*** WASDA and DPWLD are key government stakeholders for advancing national priorities with regard to GEDSI. Future programs should support the establishment of strong partnerships and coordination between MHMS, WASDA, and DPWLD in order to address GEDSI issues in the health system. WASDA and DPWLD should play a key role in improving MHMS systems and practices, including increased capacity of health staff in GEDSI, GEDSI data collection, improving support services for women and people with disabilities with regard to GBV, mental health, and accessing health services. In addition, taking a multisectoral approach will contribute to more effective and sustainable GEDSI outcomes. Engaging with other ministries such as the Ministry of Education would provide increased opportunities to improve health of children and young adults, such as implementing Comprehensive Sexuality Education (Family Life Education) and continuing to provide health promotion activities in schools. Building partnerships with local women's organisations, DPOs, and other relevant civil society organisations will be important to identify and support initiatives that address GEDSI issues in healthcare services. Building these relationships should be considered in both short-term and long-term initiatives.
- ***Mainstream GEDSI in MHMS policies and practices.*** Work with MHMS staff to integrate GEDSI-related data in the development and/or review of policies and projects to ensure that these respond to the different needs of women and men from diverse backgrounds. Reviewing and adapting activities and policies through a GEDSI lens will contribute to improved health care accessibility, appropriateness, and responsiveness.
- ***Support Community Health Adviser to strengthen the integration of GEDSI in Community Health Project.*** The Community Health Project Plan has a strong GEDSI focus integrated into project activities and approaches. Ongoing GEDSI support should be provided to the Community Health Adviser to further integrate and strengthen a GEDSI focus in the CHPP in the transitional phase program and future investments. Key GEDSI messages could be integrated into various community health trainings to ensure relevance of GEDSI to different topics is continually discussed and reinforced.