

Samoa Health Design

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**Specialist
Health
Service**

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Acronyms & Abbreviations

ADB	Asian Development Bank
AIP	Aid Investment Plan
DFAT	Australian Government Department of Foreign Affairs and Trade
EOPO	End of program outcome
GOS	Government of Samoa
HPAC	Health Program Advisory Committee
HIP	Health Investment Plan
HIS	Health Information System
HSP	Health Sector Plan
ICM	In-country mission
IHME	Institute of Health Metrics and Evaluation
ILP	Institutional Linkages Programme
IPPF	International Planned Parenthood Foundation
M&E	Monitoring and evaluation
MWCSD	Ministry of Women, Community and Social Development
MOH	Samoa Ministry of Health
NCD	Non-communicable disease
NGO	Non-government organisation
NHS	Samoa National Health Service
NOLA	National Organisation for People with Disabilities
NZ MFAT	New Zealand Ministry of Foreign Affairs and Trade
PACTAM	Pacific Technical Assistance Mechanism
PFM	Public Financial Management
SHFA	Samoa Family Health Association
SHS	Specialist Health Service
SPP	Queensland Government Department of Health and Samoa Ministry of Health Strategic Partnership Program
SRH	Sexual and Reproductive Health
STI	Sexually transmitted infection
SWAp	Sector Wide Approach

TA	Technical assistance
TOR	Terms of reference
TTM Hospital	Tupua Tamasese Meaole National Hospital
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
WHO	World Health Organization

A. Investment Design Title

Start date: July 2016 End Date: June 2021	
Total proposed funding allocation: AUD 1-2 Million per year (total less than 10Million)	
Investment Concept (IC) approved by: Not Applicable	IC Endorsed by AIC: NA
Quality Assurance (QA) Completed: Peer Reviewed	

B. Executive summary

Samoa's health sector is relatively well-resourced, accounting for around 7.2 per cent of GDP in 2014 and this trend has continued into the 2017/18 financial year. Health outcomes showed good results in several important areas. The 2014 NCD Risk Factors STEPS Survey confirmed that between 2002 and 2013 the smoking rate fell by one third, alcohol consumption decreased, and both the numbers engaging in physical activity and the extent of that activity grew. Samoa has either achieved or is on track to meet internationally agreed targets for infant and under five mortality rates, maternal mortality, skilled birth attendance, HIV prevalence and TB treatment. Infant mortality has fallen from 37 per 1000 live births in 1981 to 15 in 2014; under-five mortality rate was 24.7 per 1000 live births in 2006 and 20 in 2014 and in most years since 2000 maternal mortality has been between ≤two deaths.

Nevertheless, a number of major health challenges continue to confront the country. Non-communicable diseases (NCDs) have become the top disease burden for Samoa. Based on the 2014 STEPS survey, 28.9% of the population are hypertensive and 24.8% have diabetes. Two thirds of those found to have high blood pressure were not being treated with medication while a similar proportion of smokers had not been advised to quit by a doctor or other health worker in the preceding 12 months.

Despite a long-standing commitment to the principles of primary health care and equity of access for all Samoans, it is clear that effective diagnosis and early intervention services, especially at district level, are not adequately addressing the community's needs and that Samoa's resources are overwhelmingly targeting secondary and tertiary health care at the expense of primary health care.

A 2011 report states that "Samoa has the highest prevalence of sexually transmitted infections (STIs) in the Pacific region" (Government of Samoa, Ministry of Health, 2011) yet sexual and reproductive health (SRH) services are not reaching those in most need. The teenage pregnancy rate is high at 67 live births per 1,000 women aged 15-19 in 2014. The prevalence rate for chlamydia in 2015 was estimated to be 26 per cent (albeit based on a sample of just one per cent of the population), which the World Health Organization (WHO) reports to be "high". Thirty-five per cent of married women are reported to have expressed an unmet need for family planning.

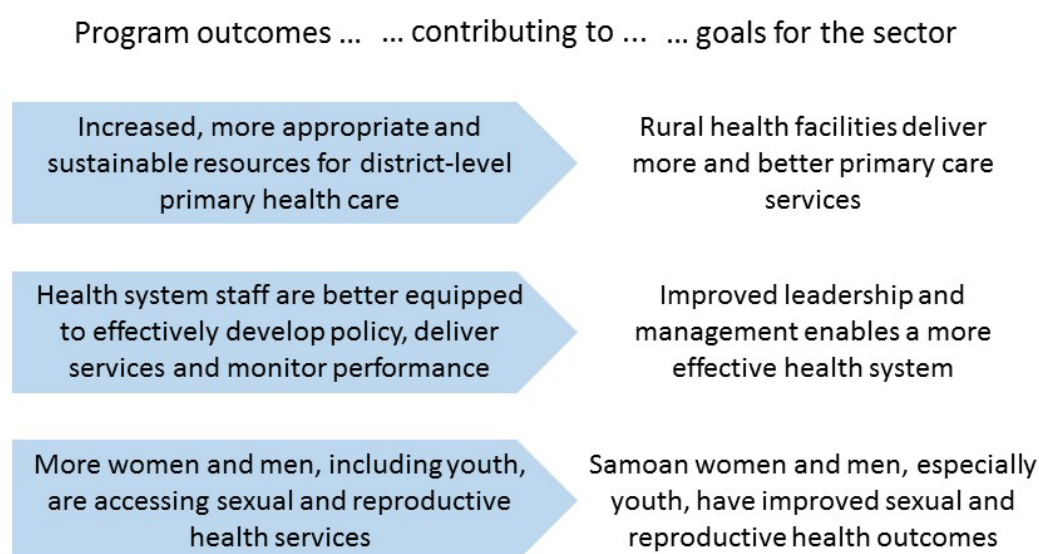
In addition, infectious diseases continue to be a concern for Samoa. More recently there has been a rise in vector borne diseases including dengue and is said to be a direct consequence of climate change. Emerging and reemerging communicable diseases adds to Samoa's burden of diseases.

There are potentially many reasons why Samoa's health system is not delivering outcomes in line with the inputs and opportunities that are available. The fact that institutional arrangements are still evolving can be a significant constraint. There is also strong evidence that lack of a comprehensive national health information system inhibits evidence-based planning, resource allocation and performance monitoring across the system as a whole, while inadequacies in clinical and managerial information systems result in inefficiencies at the service level.

In light of the above, and in line with strategies and objectives of Samoa's Health Sector Plan (2008 - 2018) (HSP), Australia will support Samoa's health sector to:

- help equip the health system to identify the population's health priorities, to allocate resources in ways which best address those needs and to monitor the impacts of those allocation decisions;
- support delivery of primary care and SRH services close to where people live, work, study and play; and
- strengthen the efficiency and effectiveness of health institutions in line with their legislated roles.

The design identifies three specific goals for the Samoa Health Program and proposes a specific outcome that the program should seek to deliver in support of each of those goals:



The goals of the program contribute to the following goals of the Samoa HSP (2008-2018):

Goal 1: Rural health facilities deliver more and better primary care services

(HSP Goal: To improve access and strengthen health care delivery in Samoa)

Goal 2: Improved leadership and governance enables a more effective health system.

(HSP Goal: To strengthen regulatory governance and leadership role of the Ministry of Health (MOH))

Goal 3: Samoan women and men, especially youth, have improved sexual and reproductive health outcomes.

(HSP Goal: To improve access and strengthen health care delivery in Samoa)

In order to achieve **increased, more appropriate and sustainable resources for district-level primary care** the program will:

- work with the World Bank and the health sector to develop and finalise a primary health care program to support improvements at rural health facilities (district level facilities);
- work with the health sector to assist with their surveillance efforts through the provision of an epidemiologist;
- provide expert assistance to establish the new procurement unit at NHS and assist staff to acquire skills and improve systems which can identify what medicines and equipment are required, to procure them in the most cost-effective manner, and to ensure they are distributed and used appropriately; and
- continue to support the NHS biomedical engineering service.

The program will help **health system staff to be better equipped to effectively develop policy, deliver services and monitor performance** by:

- commissioning an expert consultancy to carry out a cost-benefit appraisal of options for a national health information system, and depending on the appraisal, contributing towards the cost of a recommended solution;
- continuing to fund the strategic partnership program between senior officials in Queensland Health and MOH to foster dialogue and two-way learning on issues of mutual interest; and
- if requested, providing analytical, fact-finding or other appropriate support to a future review of, or plan for, Samoa's health sector.

To help **more women and men, including youth, access sexual and reproductive health services** the program aims to:

- strengthen the Samoa Family Health Association (SFHA) by assisting with strategic planning to improve its internal systems and processes and plan to deliver more accessible services; and
- provide support for implementing new and/or better SRH services, particularly in extending services to Savaii; and
- provide support on sustainability of the services, which may include renovations to the SFHA headquarters.

The program will run from 1 January 2017 (after official end of SWAp) to the end of June 2021, with a budget of up to AUD\$1 to 2 million per year and with a total funding envelop of not more than AUD\$10 million. It will work with and through a number of government, non-government organisations (NGO), multilateral and contract managing partners, which might include:

- MOH, The World Bank and WHO Samoa – to scope, develop and implement a primary health care program to address NCDs and in doing so supporting improvements at district level;
- MOH and ADB – for scoping, and potentially providing support for implementation of a new, national health information system;
- SFHA – by providing technical assistance and, potentially, subsequent financial support through the International Planned Parenthood Federation (IPPF);

- Ministry of Finance – for providing appropriate support to a future review of, or plan for, Samoa’s health sector; and
- DFAT Managing Contractors and existing panels – for the procurement of advisers and contractors for the management and administration of programs.

Funding of partner organisations will be dependent on implementation of previously recommended improvements to financial management systems and processes.

There will also be opportunities for private sector participation in undertaking a cost-benefit assessment of options for health information systems as well as possible involvement in developing and delivering various health services at district level.

All components will be expected to address issues of gender equality and be responsive to the needs of people living with disabilities. In that context, the role of SFHA, the need for district-level primary health care services to be accessible and responsive to all members of the community, and the importance of gender disaggregated health information and statistics are particularly significant aspects of the program.

The existing Health Program Advisory Committee (HPAC) - chaired by the Chief Executive Officer of Samoa’s Ministry of Foreign Affairs and Trade - will oversee the program including participation in regular reviews of progress. The committee will also continue to ensure alignment within the program and coordination with other development partners’ inputs.

A number of risks have been identified and assessed including potential risks to delayed implementation due to the merger of the NHS and MOH. Risk management, overseen by the HPAC, will ensure that no risks pose an undue threat to the program’s ability to meet its objectives.

The design document provides the overarching framework articulating where Australia’s funding will be provided to Samoa’s health sector from 2017 to 2021 and will be monitored through an overarching Performance Assessment Framework. Where appropriate, in line with the goals of this design, specific designs are developed as part of separate processes. For example, separate designs are anticipated to be developed for the following programs:

- Sexual and Reproductive Health Program with Samoa Family Health Association in partnership with IPPF (partner led);
- Strategic Partnership Program between Samoa Ministry of Health and Queensland’s Department of Health (partner led);
- Health Information System Program (Ministry of Health/ADB led); and for a
- Primary Health Care Program (Ministry of Health/World Bank led)

C. Analysis and Strategic Context

Country/Regional and Sector Issues

Samoa has achieved relatively good social, economic and health outcomes. The 2015 Human Development Index ranked Samoa at 105, close to Fiji (ranked 90) and Tonga (ranked 100) and significantly higher than Vanuatu (134) and Kiribati (137). Furthermore, the health system is relatively well funded and the country’s geography and climate are generally benign – though the latter will

change over time as the impacts of climate change continue to manifest. Life expectancy at birth is higher and the infant mortality rate lower in Samoa than in most comparable Pacific countries. The population is relatively well educated (with an adult literacy rate of 98.9 per cent) and the ratios of doctors and nurses to population, while not high, are broadly in line with those to be found in similar countries. While disasters are an ever-present risk, preparedness and response capacities are adequate, though they may be stretched as extreme weather events increase in frequency and intensity.

Investments over a number of years by Government and development partners have enabled Samoa to establish a strong foundation on which to continue building its health sector. A number of significant infrastructure projects have been completed to provide modern facilities for both clinical, administrative and support services. The recent Sector Wide Approach (SWAp) (2008 – 2016) supported extensive upskilling of staff from across the sector while past and current scholarship programs provide Samoan health professionals with further training opportunities. Partnerships between Samoan Government entities (MOH and NHS) and overseas counterparts (Queensland Health and Counties Manukau District Health Board respectively) are helping to further strengthen institutional arrangements.

Samoa's health system has made progress in several important areas. Nevertheless, a number of major challenges, most notably in the area of prevention and treatment of NCDs, continue to confront the sector.

Adding to the challenges, late in 2017, the Samoa Cabinet issued a conveyance for the remerger of the National Health Service with the Ministry of Health. The Honorable Minister of Health, Tuitama Leao Dr. Talalelei Tuitama assured that the merger will lead to better primary health care services and will also sharpen the focus and finances on services as opposed to the current situation where the "total expenditure for health is about 80 percent personnel and 20 percent on services" (Samoa Observer 22 January 2018). The health sector are now working through the merger and this is expected to have some impact on future designs.

Health challenges

Non-communicable diseases

In common with many other Pacific island countries, Samoa faces a major challenge as a result of increasing prevalence of NCDs.

Samoa has had some successes in respect of NCD risk factors. The smoking rate fell by one third between 2002 and 2013, alcohol consumption has decreased, and both the numbers engaging in physical activity and the extent of that activity has risen.

On the other hand, the 2014 STEPS survey revealed that 85 per cent of adults, aged 18-64, were overweight or obese and the prevalence of raised blood glucose/diabetes in that age group was 46 per cent. The US-based Institute for Health Metrics and Evaluation (IHME) estimates that one in six deaths in Samoa during 2013 was attributable to diabetes (Institute for Health Metrics and Evaluation).

Diabetes is not the only NCD affecting Samoa. According to the WHO *Country Cooperation Strategy for Samoa 2013-2017*, "Over the past two decades, Samoa has witnessed almost epidemic rises in coronary heart disease, stroke, high blood pressure and mature-onset diabetes".

The 2014 STEPS survey found that half of the participating adult population, aged 18-64 years, was at high risk of developing an NCD by virtue of having at least three of five risk factors, and fewer than one per cent had no risk factors present.

Many people with NCD risks are not receiving the health care they need. Three quarters of those aged 18-64 years had never had their blood sugar measured by a doctor or health worker and 71.7 per cent had never had their blood pressure measured by a doctor or health worker. Of those found to have high blood pressure, two thirds were not being treated with medication while a similar proportion of smokers had not been advised to quit by a doctor or other health worker in the preceding 12 months.

The negative health impacts of NCDs on individuals and families are obvious. Diabetes related amputations more than doubled in number, from 49 to 105, over the period 2006-14, whilst the median age of such amputations is now 50, which suggests a growing impact on economically active members of the community potentially leading to reduced worker productivity and diminished household savings.

The broader economic burden of NCDs can also be significant. Dialysis for patients with diabetes related kidney failure was estimated to cost the Government of Samoa (GOS) US\$38,686 per patient per year in 2010/11.

Sexual and reproductive health

Perinatal mortality rates in Samoa are low but other aspects of SRH are less satisfactory.

The adolescent birth rate fell from 46 births per 1,000 women aged 15-19 in 2001 to 29 in 2006 but subsequently increased again to 39 in 2011 (UNFPA, 2015). In 2014, according to the recent Demographic and Health Survey, 6.7 per cent of women aged 15-19 had had a live birth (Samoa Bureau of Statistics, 2015). While there may be some inconsistencies in data, the underlying trends are worrying. More generally, 35 per cent of married women are reported to have expressed an unmet need for family planning (Samoa Bureau of Statistics, 2015).

In 2015 the prevalence of chlamydia in Samoa was estimated (albeit on the basis of a very small survey) to be 26 per cent (Government of Samoa, Ministry of Health, 2016). That could be attributable, in part at least, to the fact that “condom use rates are generally low, mostly due to lack of awareness and access, and lack of acceptance of condoms” (Samoa Bureau of Statistics, 2015).

Other communicable diseases

Communicable diseases are estimated to account for 20 per cent of the Samoa’s burden of disease (Institute for Health Metrics and Evaluation).

Cases of trachoma were recently identified among primary school aged children on both of Samoa’s main islands; sepsis is reportedly common; there are cases of leprosy reaching advanced stages before detection; dengue is on the rise with the Ministry of Health confirming an outbreak in November 2017 and new viruses such as zika and chikungunya pose a constant threat and may become more prevalent due to the changing climate.

Disasters and emergencies

Samoa is exposed to a number of environmental hazards including cyclones, volcanic eruptions and tsunami, all of which are rated as presenting “extreme” levels of risk in the country’s National Disaster

Management Plan (Government of Samoa, 2011). A major tsunami in September 2009 directly affected more than 4,500 people while Cyclone Evan, which crossed Samoa in December 2012, resulted in 14 deaths and extensive damage.

Samoa is likely to experience an increase in strong storms as climate change impacts intensify. Longer-term climatic trends will also affect Samoa's health system. Climate change is projected to result in an increase in the number of extremely hot days and a reduction in the number of cool nights (Australian Government, 2011). Rainfall patterns are likely to change, with more extreme rainfall events and drier dry seasons. This has implications for agriculture and, therefore, nutrition, as well as an increasing likelihood of flooding, leading to an increase in water- and vector-borne diseases (World Health Organization, 2015).

Alongside exposure to environmental hazards Samoa also shares with other Pacific countries the risks posed by pandemics and other public health emergencies.

Health system

Appendix A provides an overview of Samoa's health system by reference to the six "building blocks" as identified by WHO (World Health Organization, 2007). At the operational level, "business as usual" continues until further notice on the outcomes of the merger are conveyed. The current objectives for the national *Health Sector Plan 2008 – 2018* (Ministry of Health, 2008) are:

1. Improve and strengthen people centred health services
 - a. Health protection
 - b. Health promotion and primordial prevention
 - c. Health care service
2. Effective and efficient human resources for health
3. Strengthen health information development and management
4. Improve health sector financial management and predictability
5. Strengthen governance and leadership
6. Ensure appropriate medical products and technology
7. Continuous management of disaster preparedness and response

Gender and women's health

In 2014, Samoa ranked 97 out of 155 countries and territories on the UNDP Gender Inequality Index.

Women are relatively well represented at senior levels in the bureaucracy but less so on boards of state-owned enterprises, in leadership at the village level and at senior levels in churches and in parliament.

In 2013, Samoa introduced a quota for women's political representation. Legislation introduced also protection against sexual harassment and gender discrimination in the workforce. However, domestic violence is a concern. A survey conducted in Samoa in 2000 found that 20 per cent of all women surveyed had experienced sexual violence at some point in their lifetime while 41 per cent of women with an intimate partner who were surveyed had experienced physical violence at the hands of that partner (World Health Organization, 2005).

The National Policy for Women of Samoa 2010–2015 (Ministry of Women, Community and Social Development, 2010) identifies a need for health promotion for women to address NCDs and the need

for increased collaboration with health service providers to address women's vulnerability to cancers and the debilitating effects of violence.

Disability

The *Samoa National Policy on Disability 2011 – 2016* has as one of its seven strategic core outcome areas “provision of support, health services and assistive devices”. The policy's objectives also include “Accessible, quality and affordable health service for urban and rural based people with disabilities and their families”. It encompasses mental illness together with physical, sensory and intellectual disabilities.

A National Platform of Action for young people with disabilities, hosted by National Organisation for People with Disabilities (NOLA) in 2016, recommended that Government improve accessibility to health services, including access to mobility devices and primary health care, for young people with disabilities. It noted that disability is often under diagnosed or poorly diagnosed and that there are few mental health services and few allied health specialists to support rehabilitation. It was also not clear whether the free medical health care scheme for people with disabilities has been rolled out. Youth leaders urged the Government to improve access to health services, including access to sexual and reproductive health and rights and urged the community to implement the recently developed Community Based Rehabilitation Action Plan.

NCDs are a cause of disability, due to the fact that foot ulcers, which are one of the most common complications of uncontrolled diabetes, can become infected and, if untreated, may in turn result in the need to amputate the affected limb. It has been estimated that as many as one in six Pacific people who have diabetes may require amputation.

Development Problem/Issue Analysis

The key challenge now for the health sector in Samoa is to capitalise fully on past investments (including the recent health SWAp) and to achieve outcomes that are in line with the opportunities and resources available. That means pursuing both allocative efficiency (directing funds to activities where they will deliver the best return on investment), and technical efficiency (ensuring that the system delivers value, monies are well-spent and services well-managed).

Australia is well-placed to support Samoa in meeting that challenge. While there are many partners with obvious strengths in clinical aspects of health care, Australia has particular expertise in governance, planning and management of health services in a system which relies extensively on public funding and government-run hospitals and community health services. Australia has also made significant investments in health information systems and gained experience of both successful and less successful approaches, which could be of relevance to Samoa. By focusing on such aspects, the impact of the Australian Department of Foreign Affairs and Trade's (DFAT) engagement with Samoa will be optimised.

In terms of **allocative efficiency**, the need to strengthen and improve access to primary care (notably in respect of NCDs and SRH) is clear and aligns well with GOS strategies and also with DFAT's Pacific Health Strategy (2018-2030). The issue is not just one of financing, however. Since its establishment, the NHS has focused much of its attention on hospital services and, in particular, services at the two main referral hospitals. Primary and community-based health services have struggled to capture adequate resources.

Such concerns are not unique to Samoa and other countries in the Pacific are also currently struggling to develop effective approaches to tackling the problems of NCDs through better prevention and early intervention.

The program will take a staged approach to addressing the above challenges and will include the following:

DFAT will support the development of the World Bank led Primary Health Care Program with Samoa. In November 2017 a World Bank team conducted a Samoa Health Project Identification Mission and agreed with the health sector on the project development objective “To strengthen NCD control in Samoa through enhanced health promotion and disease prevention as well as establishing people-centered disease management with strengthened primary health care”. The World Bank design mission to further develop and finalise a five year, ten million USD program is planned for early 2018. Support to the PHC program will be in areas where Australia is best placed to provide assistance and a final decision on this will be made in the coming months.

Ongoing investments to support pharmaceutical and biomedical supplies and services and others (including the recent proposal for an Epidemiologist), means there will be a relatively strong focus on TA anticipated during the early stages of the program. Procurement and Public Financial Management (PFM) TA will also help to ensure that any remaining financial risks, as highlighted in recent DFAT reports (DFAT, 2014), are effectively managed and necessary remedial measures are put in place prior to adopting partners’ financial systems and processes.

It is anticipated that use of TA in the manner outlined will impact positively to build capacity both in individual counterparts and in the organisations in which TA personnel operate. Experience to date with DFAT-funded TA for biomedical engineering in NHS has demonstrated what can be achieved at the individual level when committed TA work with and mentor Samoan counterparts. At the same time, the knowledge and experience that good TA can bring to their host organisations can leave a lasting legacy of improved systems and processes. Accordingly, the performance of TA personnel will be assessed in terms of their impact on improving organisations, systems and processes, as well as building the capacity of individual counterparts.

Whilst it is proposed that DFAT procure the agreed adviser positions, the health sector will be fully involved in choosing the TA, and with their counterparts responsible for their management.

The challenges Samoa faces in respect of **technical efficiency** stem to a large extent from the absence of a comprehensive health information system. This limits both the extent to which services can be planned to meet the population’s evolving needs and the scope for effective monitoring of the volumes, costs and effectiveness of services once they have been delivered. Better information would help to ensure the right services were being delivered, in the right places, in the most cost-effective manner.

Weaknesses in health information systems and logistics management systems also mean that senior officials have had limited opportunities to develop or apply skills in evidence-based policy formulation and planning.

Past and current investments

Health sector-wide approach

In 2008, Australia, together with New Zealand, the World Bank, UNFPA, UNICEF and WHO, established a SWAp to health sector development in Samoa. The main focus of the SWAp was to support implementation of the Government's *Health Sector Plan 2008-2018* (HSP). Its total cost to date has been US\$31 million of which Australia has contributed AUD\$18.6 million.

A number of other reviews carried out over the lifetime of the SWAp (Davies, 2013) (Specialist Health Service, 2016) (World Bank, 2016) identify positive outcomes including: less duplication; new policies; significant additional infrastructure; quick and flexible response to the tsunami and cyclone; and staff training.

However, those positives were outweighed by significant areas of concern including:

- a disconnect between stated health priorities (especially prevention of NCDs) and actual resource allocation¹;
- failure to develop and implement a comprehensive health information system which has had 'knock-on' adverse impacts on the ability to acquire and analyse health sector activity data for performance monitoring purposes;
- a focus on infrastructure with concerns relating to quality, major cost overruns, slow progress with three key projects and low allocation to maintenance; and
- mixed and adverse trends on key strategic health issues (such as reproductive health, STIs, immunisation, and NCDs).

Australia and New Zealand continued to support the SWAp during 2016 to allow completion of outstanding work on infrastructure developments.

Other current DFAT support for health

The health SWAp has accounted for the majority of Australia's support for the sector in Samoa over recent years. Additional bilateral assistance has been provided by means of:

- the Samoa/Queensland Strategic Partnership Programme (SPP) - which was established in 2015 to be implemented over three years to foster dialogue and two-way learning on issues of mutual interest between MOH and the Queensland Government Department of Health;
- a biomedical engineer – who provided technical assistance and supported upskilling for counterparts in NHS on a full-time basis for one year up to January 2016 and is now providing part-time support on a fly-in / fly-out basis over two years;

¹ It has been suggested that significant funding by PR China for development of the new Tupua Tamasese Meaole National Hospital (which was not foreseen in HSP) distorted spending priorities and weakened the focus on primary/ preventive services as envisaged by the SWAp. The proportion of total NHS funding spent at the hospital is estimated to have increased from 22 per cent to 32 per cent over the life of the SWAp (Specialist Health Service, 2016).

- a nutrition specialist – who has been providing TA and supporting upskilling for counterparts in MOH on a full-time basis since August 2014 with the assignment completing in August 2016; and
- under the Samoa Disability Program, the Samoa Integrated Mobility Device Services project - a four-year collaboration between the NHS, NOLA and Motivation Australia launched in 2014 to improve access to mobility devices for people with a physical disability and deliver a diabetic foot clinic service at the Tupua Tamasese Meaole National Hospital (TTM Hospital).

In addition, Australia's pacific regional health program is an important complement to its bilateral investments and has also played a significant role in supporting health functions in Samoa.

Other development partners

Details of other development partners and their contributions to Samoa's health sector are set out in Appendix B.

Lessons learned

Aspects of the SWAp approach which have worked well should be maintained. They include:

- aligning support with the overall direction of development for Samoa's health sector;
- focusing on GOS plans and priorities;
- adopting a broad approach to performance monitoring across the sector as a whole (including the contributions of NGOs);
- coordinating with other partners (notably New Zealand Ministry of Foreign Affairs and Trade (MFAT) and UN agencies); and
- maintaining the HPAC as the forum to coordinate development partners and programs for the sector.

Evidence provided by previous activities, as outlined above, points to a number of factors to be considered:

- primary care at district level, and especially services to tackle NCDs, remains a critical priority;
- weaknesses in information systems are a barrier to effective management and monitoring at both clinical/operational (NHS/health facility) and strategic (MOH/national) levels;
- weaknesses in systems and staff capacity mean the anticipated benefits of separating MOH and NHS have not yet been fully realised;
- there may be scope for NGOs and the private sector to play a greater role in the system; and
- use of government systems remains a goal but according to a recent assessment of national systems, should not be pursued until certain steps are taken to mitigate identified risks.

DFAT undertook a review of financial management capability and capacity, together with associated risks and benefits, in MOH, NHS and SFHA (DFAT, 2014). The review acknowledged some benefits but

also identified a number of significant risks associated with DFAT channelling funds through health sector agency systems and procedures. It recommended that DFAT should not conduct a future program of support to the agencies concerned until a framework to implement relevant risk mitigation measures is agreed with GOS and those measures are implemented in a number of critical areas. A future assessment will be needed to provide an update of the current situation.

Strategic setting and rationale for Australian/DFAT engagement

The case for Australia to continue investing in health in Samoa is strong.

The recent 2017 Australia Foreign Policy White Paper articulates a stepup in the Pacific region with the Pacific Development Framework 2018 articulating Australia's commitment to support better health outcomes as one of five key priorities of focus for the Pacific. The DFAT development policy set out in *Australian aid: promoting prosperity, reducing poverty, enhancing stability* reaffirms the connections between health, education and economic growth. It states "We will invest in health—particularly health systems—so that women, men and children can access better health and live healthy and productive lives" (DFAT, 2014).

Increasing movement of people to, from and within the Pacific region brings with it a growing risk of communicable diseases reaching Australia. Thus, an effective public health system in Samoa can also protect Australia and Australians against communicable disease.

The DFAT *Aid Investment Plan Samoa: 2015-16 to 2018-19* (AIP) defines, as one of three strategic priorities, "To progress health and education outcomes" and, in the case of health, signals a commitment to improving the quality of the health system including health information" (DFAT, 2015).

In addition, the AIP states that all investments in Samoa "will address issues of gender equality, inclusion of people with disability and climate change resilience" and that "Australia will also continue to support Samoa to prepare for, and respond to, natural disasters".

The design's focus on health systems and, in particular on prevention, primary care and institutional strengthening, aligns well with the targets set out in *Making Performance Count: Enhancing the accountability and effectiveness of Australian aid performance framework* (DFAT, 2014) and also aligns strongly with the 2018-2030 Pacific Health Strategy (See Appendix C).

Private sector engagement and innovation

Private sector engagement

Private sector involvement in Samoa's health sector is limited to the provision of locally-sourced inputs of non-specialist goods (e.g. foodstuffs) and services (e.g. tradespeople).

Future opportunities for private sector engagement may, however, arise in areas such as:

- supply of professional services, hardware, software and training in connection with development of health information systems;
- outsourcing some clinical or support roles to private providers (while maintaining government funding);

- innovative arrangements to distribute medicines, commodities and other supplies for both NHS and SFHA;
- deployment of technological solutions that use mobile devices to facilitate interactions with health professionals for people living in outlying districts (telemedicine, remote ordering of supplies, patient reminders and recalls etc.)

Innovation

In addition to any innovations that might stem from private sector engagement as outlined above, the SPP that brings together Queensland Health and MOH is an innovative arrangement on the part of DFAT. Although it has elements in common with the pre-existing NZ MFAT-funded Institutional Linkages Programme (ILP) between NHS and Counties Manukau District Health Board it represents a first on the part of MOH and is considered to have great potential.

D. Investment Description

Program logic and expected outcomes

This section builds on the contextual analysis above to set forth the goals, program logic and anticipated outcomes for DFAT's Samoa Health Program, presented diagrammatically in Figure 1 (at page 14).

Goals and outcomes

The program will contribute to three long-term goals to be achieved beyond the life of the program:

1. Rural health facilities deliver more and better primary care services
2. Improved leadership and management enables a more effective health system
3. Samoan women and men, especially youth, have improved SRH outcomes

The program will contribute to these goals through three end-of-program outcomes (EOPOs):

1. Better resourcing and approaches for district-level primary care
2. Health system staff are better equipped to effectively develop policy, deliver services and monitor performance
3. More women and men, including youth, are accessing SRH services

A series of intermediate outcomes and outputs contribute towards these EOPOs. The hierarchy of outcomes is summarised in the program logic diagram

Figure 1: Program logic



End-of-program outcome 1 - Better resourcing and approaches for district-level primary health care

The first long-term goal to be achieved beyond the life of the program is NHS delivering more and better primary health care services at the district level.

EOPO 1 will contribute to that goal through increased, more appropriate and sustainable resources and better approaches for district-level primary health care.

The inputs required from this investment to achieve this outcome are detailed under “Delivery Approach” below. In summary, they focus on:

- Work with the World Bank and health sector to develop and implement tailored approaches for improved district level primary health care services;
- improving pharmaceutical and biomedical procurement and supply systems and sustaining progress in strengthening biomedical engineering in NHS.
- Improving surveillance at the Ministry of Health in order to improve information and therefore better targeting of programs (health promotion included).

The program will contribute to achieving EOPO 1 through three intermediate outcomes:

- As determined by the new Primary Health Care program, the MOH/NHS explores and replicates effective approaches for delivering district level primary health care (e.g PENfa included);
- health services, including primary care services, have access to the supplies and equipment they need to be effective; and
- health services, including primary care service have access to surveillance information to better inform and target effective and efficient interventions

End-of-program outcome 2 – Health sector staff are better equipped to develop policy, deliver services and monitor performance

The second long-term goal that will be achieved beyond the life of the program is improved leadership and management that enables a more effective health system.

EOPO 2 will contribute to this goal through health sector staff being better equipped to effectively develop policy, deliver services and monitor performance. That will be achieved through:

- support to identify and, if appropriate, implement health information systems;
- ongoing efforts to foster mutual learning and exchange between MOH officials and their counterparts in Queensland’s Department of Health; and
- if requested by GOS, support for further sector-wide planning and/or institutional review initiatives.

The following intermediate outcomes will contribute to achievement of EOPO 2:

- senior leaders and managers have access to reliable information and analysis to inform policy and oversight;
- the health workforce has access to information required to plan, deliver and monitor services; and

- health sector institutional arrangements are better adapted to Samoa's health needs.

End-of-program outcome 3 - Improved access to sexual and reproductive health services

The third long-term goal that will be achieved beyond the life of the program is Samoan women and men, especially youth, have improved SRH outcomes.

The key input in this case will be provision of consultancy support to enable SFHA to develop and implement strategic and operational plans, which will better define its role, improve its internal systems and processes and equip the Association to deliver more accessible services. Additional funding will subsequently be provided to support development of more/better SRH services to address unmet needs.

EOPO 3 will contribute to this goal through more women and men, including youth, accessing SRH services and through improving resourcing and approaches to primary health care at the district level, which includes SRH services.

The program will contribute to EOPO 3 through the following intermediate outcomes:

- SFHA has improved organisational performance;
- SFHA services are delivered in locations and in ways that are affordable, accessible and appropriate; and
- SFHA implements innovative solution(s) to improve SRH service delivery.

Delivery approach

This section of the design first outlines the range of modalities that will be adopted and the basis on which they have been selected before continuing to describe in detail the specific activities that will be undertaken in three core program components. Each component aligns closely with one of the EOPOs detailed in the theory of change although each will also deliver some whole-of-sector benefits.

Modalities

In considering a preferred delivery approach, the design has been informed by:

- experience with the recent health SWAp (2008 – 2016);
- the recent review of financial management capability and the reservations expressed regarding use of health sector agency systems and procedures (DFAT, 2014);
- the scope for greater recognition and involvement of NGOs and civil society organisations in Samoa's health sector;
- concerns expressed regarding the effectiveness of skills/knowledge transfer and sustainability of technical assistance in the Samoan context (e.g. in the recent World Bank Implementation, Completion and Results Report (World Bank, 2016));
- the Australian Government's development policy as detailed in *Australian aid: promoting prosperity, reducing poverty, enhancing stability* (DFAT, 2014);
- the principles set out by the Paris Declaration on Aid Effectiveness (OECD, 2005); and
- considerations of risk minimisation and value-for-money.

Previous reviews have identified a number of weaknesses in the SWAp approach and noted the extent to which inadequacies in alignment with GOS strategies and shortcomings in information systems inhibited effective management and oversight of achievements.

The risks of over-reliance on **technical assistance**, as noted in the recent World Bank Implementation, Completion and Results Report and by other commentators in a more general context are recognised and, as a result, the design anticipates limited use of long-term TA. However, in the early stages of the program, some technical assistance is viewed as important:

- to establish or maintain key systems and processes which will be employed in connection with planned moves to use of government systems during later stages of the program;
- to build capacity in individuals and organisations and to help establish robust systems prior to later-stage investments;
- in the specific case of procurement-related TA, to ensure the successful commissioning of the new pharmaceutical warehouse funded under the health SWAp;
- In the specific case of biomedical-related TA, to ensure the sustainability of biomedical equipment, especially that procured under the SWAp; and
- In the specific case of epidemiology TA, to ensure the sustainability of surveillance efforts to ensure targeted interventions at district level which will ensure protection of population health.

The relevant host organisation should be involved in selection of TA personnel. Host organisations are expected to have suitable counterparts in post to ensure effective capacity building can occur.

TA will be sourced in line with DFATs procurement guideline (2016).

Australia remains committed to transitioning, over time, to provision of **unearmarked sector budget support** for health in Samoa. Any decision to adopt unearmarked sector budget support will ultimately be dependent on DFAT gaining assurance that the sector has met certain criteria.² The reservations previously expressed regarding reliance on use of health sector agency systems and procedures preclude any immediate moves in that direction. However, it is anticipated that there may be scope for some use of earmarked budget support to MOH and/or NHS for the procurement of the Inventory management system for the Pharmaceutical Warehouse.

Finally, specific **project funding** will be employed for the following areas of activity: the MOH/Queensland SPP; consultancy support for organisational strengthening and service delivery, a sexual and reproductive health program in partnership with IPPF and SFHA; and any Australian investment in health information systems and primary health care.

² The following criteria are widely recognised as being significant for successful adoption of sector budget support:

- Well-defined national sector policies/strategies
- Institutional setting, leadership and capacity for implementation of the sector strategy
- Sector and donor coordination
- Mid-term budgetary perspectives for sector policy implementation based on sector budget analysis and sector allocations in Medium Term Expenditure Frameworks
- Monitoring of sector policy implementation and in particular the development of Performance Assessment Frameworks
- A system of efficient and effective PFM (or a credible program is in place to address weaknesses is in place)
- Existing and projected macro-economic framework in which sector policies will be implemented

Component descriptions

Component 1 - Better resourcing and approaches for district-level primary health care

Three key areas of activity, involving support to NHS and MOH, are proposed under this component.

1.1 *Tailored approaches for district-level primary health care*

The program will seek to support the World Bank and health sector in developing and implementing measures to enhance primary care. Australia will provide support where there is alignment with policy and where there is added value for Australia to invest.

From 2018, funding of up to AUD\$500,000 per year will be committed and available to fund the expenses associated with implementing improved approaches to district-level primary health care. Australia's support will be in line with agreement between the World Bank and Samoa on which areas Australia will fund as part of Australia's support to the new Samoa primary health care program. Funding is planned to be channelled through the World Bank.

1.2 *Epidemiology support*

With vector borne diseases on the rise and posing a high risk to population health. The support of an Epidemiologist will assist the MOH strengthen its surveillance efforts. As a result, the MOH will be better able to effectively and efficiently target public health interventions at district level and contribute to protection of public health.

1.3 *Pharmaceutical and biomedical procurement*

Services throughout the system require reliable access to essential medicines together with other supplies and equipment. The health SWAp has funded the commissioning and construction of a new pharmaceutical warehouse in Apia while DFAT has previously supported a full-time biomedical engineer to provide technical support and capacity building for counterparts in NHS.

Further time-limited specialist support is proposed in order to ensure that the full benefits of recent investments in infrastructure and equipment under the SWAp are realised and sustained. Specifically, the program will fund:

- a two year full-time pharmaceutical procurement specialist;
- a one year full-time biomedical equipment procurement specialist; and
- continuation (over two years, on a part-time, fly-in/fly-out basis) of TA by a biomedical equipment engineer to support maintenance of equipment and further capacity building for NHS personnel.

Each TA will be expected to develop and implement plans to transition responsibilities to their counterparts. DFAT's Panels will be utilised for the recruitment and management of the advisers.

Component 2 - Health system staff are better equipped to effectively develop policy, deliver services and monitor performance

The focus of activities under this component of the program will be on establishing an effective, fit-for-purpose health information system and supporting measures to strengthen institutional arrangements in the health sector.

2.1 Health information system

Inadequacies in information have been highlighted as a fundamental challenge for Samoa's health sector. The lack of comprehensive, reliable and contemporary information systems has been cited as creating barriers to:

- identification of health needs, service planning and performance monitoring/reporting at a national level;
- maintenance of, and access to, medical records by service providers working across the sector;
- day-to-day planning, management and monitoring of clinical activity, financial budgets and human resources; and
- monitoring and evaluation of the effectiveness of development partners' investments in the sector.

Samoa's need for more and better information encompasses many aspects of clinical and management information. As such, it extends beyond the scope of a health information system which focuses primarily on providing "reliable and timely information on health determinants, health system performance and health status" (World Health Organization, 2007).

Access to significant funding from the Asian Development Bank (ADB) provides an opportunity for Samoa to make significant progress towards the development of a much-improved national health information system.

A number of technological solutions have been proposed to meet Samoa's health information system needs but the design team considered that their costs appeared to be very high in relation to the scale of Samoa's health system and that there would be merit in considering a more diverse range of potential approaches to meeting the country's needs.

The need for caution in planning investments in health information systems is reinforced by the fact that numerous countries, including the UK, Netherlands and Germany have struggled to implement large-scale health information systems (Kaplan & Harris-Salamone, 2009). There have also been "ongoing implementation concerns" with Australia's planned national personally-controlled electronic health record system (Partel, 2015).

Australia has signalled a willingness to contribute to the development of systems that will address the current inadequacies in information systems across Samoa's health system. Prior to committing significant resources (up to AU\$3 million over the life of the program) DFAT will, however, seek to ensure that both the technological solution(s) and the implementation approach(es) proposed for health information systems are fit-for-purpose.

In order to do so, a cost-benefit review will be commissioned to address the following issues (as a minimum):

- health and health service management information needs³;
- information system(s) scope and architecture(s);
- preferred technological approach(es);
- estimated costs (and affordability in the Samoan context);
- project design, governance and management;
- sustainability;
- procurement arrangements; and
- risks and risk management.

The review will be conducted by an independent, specialist consultant or consultancy firm with strong knowledge of the health information system market and the ability to draw on international practical experience of health information system design, implementation and governance. Draft terms of reference for the review are attached at Appendix I and will build on support provided by WHO.

2.2 Strategic partnership program

Operationalising the institutional reforms which took place in Samoa some ten years ago has not always been straightforward and there is still a lack of clarity about aspects of the current arrangements and how they can best be employed to address the country's health needs.

The MOH has done much to fulfil its role in setting strategic directions and developing policy but has been hampered both by limitations of current health information systems and availability of key skills and capabilities in the workforce. The latter situation is not unique to Samoa. For example, similar challenges arose following the introduction of a purchaser/provider arrangement in the British NHS where most senior staff had gained experience in service delivery and few had the expertise needed to operate effectively as funders/commissioners of health services.

The SPP between Samoa's MOH and Queensland Department of Health has been operating since July 2015. It is a collaborative arrangement that seeks to build knowledge and capability in targeted areas.

A comprehensive design for the SPP was prepared in 2015 and anticipates that Australia will continue to support the program with Queensland Health meeting its own staff costs, through to June 2018 (DFAT, 2015).

Three initial focus areas for the SPP have been established. They reflect perceived gaps identified by MOH where there is corresponding expertise within the Queensland Department of Health:

- governance and leadership - particularly in areas of health systems, strategic planning, quality assurance, and managing health system complaints and grievances;
- public health - including improved collection, analysis and reporting of epidemiological data and improved public health laboratory services; and
- health information - to complement the ADB-funded initiative in strengthening health information systems management and development.

³ It is anticipated that information needs will largely be identified using a 'normative' approach and by drawing analogies with other, similar health systems. A detailed information needs analysis is not considered to be necessary.

An M&E framework for the SPP has been developed to assess progress and guide an end-of-program review of achievements (Schierhout, 2015). It has been noted that the SPP has helped to establish dialogue between the two parties, while also providing opportunities for DFAT to gain insights into the issues they face.

A 2017 presentation to MOH staff by a Queensland Deputy Director-General reportedly generated significant interest in the ‘purchaser’ role. There is scope to re-focus SPP away from largely technical exchanges, as have dominated the program to date, and seek to establish dialogue on issues that are more concerned with sector-wide dynamics and design. Extending the scope of the program to include representatives from Samoa’s Ministry of Finance may also be beneficial.

2.3 Support for sector-wide renewal

Australia will also consider supporting any initiatives that the GOS may choose to undertake with a view to improving institutional arrangements or confirming the strategic direction of the country’s health sector.

Support might include providing analytical or fact-finding assistance (possibly drawing further on expertise sourced from the Queensland Department of Health). Alternatively, if the GOS was formally to establish a more fundamental review of the sector, as has been commonplace in other countries in recent years, then Australia could provide support to the review process as required.

Component 3 - More women and men, including youth, are accessing sexual and reproductive health services

The third component of the program seeks to enhance access to SRH services for all Samoans by assisting the SFHA in strategic and business planning and offering subsequent financial support for new or improved facilities and/or services.

DFAT will initially fund an organisational review and strengthening consultancy to advise SFHA on issues such as:

- clarity of the SFHA’s role, direction and priorities including the respective contributions of SFHA and NHS in delivering SRH services;
- approaches to fundraising, financial management, contract management and monitoring and reporting;
- modes and locations of delivery to ensure services are affordable, accessible and appropriate (including whether expanding mobile clinic services in Savai’i remains a priority and the need for, and nature of, new clinic facilities in Apia); and
- opportunities to adopt innovative, technology-based solutions to improve improving the reach, accessibility, acceptability and/or quality of services (e.g. providing advice over the internet or enabling internet-ordering of family planning products).

It is envisaged that issues such as those above would be addressed in a strategic plan which would form the basis for further, ongoing support to enable SFHA to implement new systems, processes, models of service delivery and any necessary supporting infrastructure or other capital investments.

At this stage it is proposed that support to SFHA be provided by a volunteer through Australian Volunteers for International Development but other options may need to be considered.

Resources

The total budget for the program is between AUD\$1 to AUD\$2 million per year, over 5 years, running from 1 July 2016 to 30 June 2021, with a total envelope of funding of no more than AUD\$10 million.

Table 1: Summary program budget).

In addition to this funding, DFAT will commit resources by way of the Counsellor for Development and the Senior Program Manager for Health and Disability at Post (estimated to total one full time equivalent (FTE)) to undertake aid-related diplomacy, high-level oversight and strategic direction setting for the program, and manage its evaluation.

If applicable, DFAT will also provide expertise through its Samoa Economic Reform Program and (Canberra) Public Financial Management (PFM) team to support the health sector in meeting the preconditions to receive and manage DFAT funds identified in the recent PFM review (DFAT, 2014).

It is also expected that GOS and SFHA will commit their own resources to complement program activities, either through providing sufficient human resources to participate in activities or co-funding key initiatives. This will be negotiated between DFAT, GOS and SFHA on a case-by-case basis, although the Procurement Arrangements section outlines key stop/go points in the program which rely on GOS commitment of its own resources.

Table 1: Summary program budget

	2016/17 (actual)	2017/18	2018/19	2019/20	2020/2021	Total Total
Component One						
Technical Advisers	\$751,766.76	\$700,000	\$700,000	\$400,000	\$400,000	\$2,951,767
District-level Primary Health Care approaches	\$0	\$0	\$500,000	\$500,000	\$500,000	\$1,500,000
Procurement improvements (Inventory Management System)	\$0	\$500,000	\$0	\$0	\$0	\$500,000
Component Two						
HIS Options Paper and possible HIS support	\$291,583	\$0	\$1,000,000	\$1,000,000	\$1,000,000	\$3,291,583
MOH/QLD Health Strategic Partnership	\$96,422.54	\$110,000	\$80,000	\$80,000	\$80,000	\$446,423
Additional Responsive Adviser request from GoS	\$0	\$0	\$20,000	\$20,000	\$20,000	\$60,000

(including Policy research, analysis & dialogue)						
Component Three						
SFHA services design and implementation	\$377,377	\$214,504	\$204,060	\$204,060	\$0	\$1,000,000
Support to DFAT Apia Post						
Independent evaluations, reviews, assessments, Advisers including for Public Financial Management & design	\$40,603.49	\$30,000	\$30,000	\$30,000	\$30,000	\$160,603
Total (up to amount)	\$1,557,752.79	\$1,554,504	\$2,534,060	\$2,234,060	\$2,030,000	<u>\$9,910,377</u>

E. Implementation Arrangements

Implementation plan

A detailed implementation plan in the form of a GANTT chart is set out in Appendix F

Procurement Arrangements

There are a number of channels through which support and advisory staff for the program could be procured and their contracts subsequently managed. They include the DFAT Aid Advisory Service, DFAT's Specialist Health Service (SHS), through PACTAM administered by Scope Global for long-term advisors, through Scope Global and AVI for recruitment of Volunteers etc.

Appointments will be based on the terms of reference in Appendix I. Noting that the TORs will be finalised in consultation with the health sector and the MOF. TORs that are not currently attached are available on request.

An agreement between DFAT and the Queensland Department of Health has already been signed, and will remain as the contractual basis for the SPP.

All procurement under the program will comply with the Australian Government's Commonwealth Procurement Rules and DFAT's Aid Adviser Remuneration Framework.

Subject to satisfactory remedial actions being taken to address identified shortcomings, the financial management and procurement systems, SFHA through IPPF may receive a grant to implement measures to improve the location and mode(s) of delivery for its services.

Should Australia agree to support implementation of a health information system following completion of the cost-benefit and options analysis, a grant to the ADB is earmarked to support recommendations of the analysis for procurement of an inventory management system for the national pharmaceutical warehouse and support for implementation of Samoa's HIS project.

Contingent on the outcomes of the World Bank led design for Samoa's new Primary Health Care program, a grant is also earmarked to assist implementation of the program.

A DFAT assessment of financial management systems (DFAT, 2014) made a number of recommendations for improvements which MOH, NHS and SFHA would need to implement before

they could receive and manage grants directly. The program will provide unallocated TA support funding of up to \$40,000 per year for short-term TA to support implementation of the recommended improvements. This funding can also be used for other adviser support as necessary to ensure successful program implementation. In addition, DFAT's PFM and Procurement Team may be able to provide assistance. This is done in recognition of Australia's commitment to strengthening and preparing the health sector to receive possible future budget support.

There will be a number of performance triggers for program expenditure, as detailed in Table 2.

Table 2: Performance triggers for program expenditure

EOPO	Expenditure item	Triggers required
1	Possible grant to the World Bank to support implementation of tailored approaches for district-level primary health care (PHC)	World Bank has effectively designed a range of approaches to be tested/ implemented. NHS/MOH has provided the human resources needed to implement the approaches. Endorsement by HPAC of the new PHC program.
	Support for technical advisers	Advisers procured inline with DFAT procurement guidelines and with close collaboration with appropriate health sector personnel. Assurance for counterparts for advisers to work with.
2	Grant to support establishment of health information system.	Completion of health information system cost-benefit and options analysis. DFAT agreement to support implementation.
	Grant to support initial recommendations of the cost benefit analysis	Agreement between DFAT and implementing partner(s) MOH commitment of funding and human resources for HIS establishment and operation. Endorsement by HPAC of the new HIS Project.
	Support to analysis etc. for institutional and/or strategic reviews	Policy dialogue between DFAT and key leaders including at the HPAC to identify appropriate support.
3	Grant to SFHA through IPPF for improving location and/or delivery mode of its services	Approval by DFAT of improvements to SFHA financial and governance systems and processes .
	Grant to SFHA through IPPF to implement SRH service delivery solutions	Approval by DFAT of a consolidated proposal for a SRH program.

Note that additional triggers for tranche payments will be provided within the specific project designs and agreements.

Monitoring and evaluation

M&E will focus on how well the program is achieving its end-of-program and intermediate outcomes. By doing so it will enable those responsible for implementation to refocus or vary effort within the overall program depending upon what is working and what is not, how well partner agencies are performing and any changes in policy or the broader contextual environment.

Purpose

The Samoa Health Program M&E has three purposes:

- reporting and accountability – establishing whether program funds are being used and managed effectively and efficiently to achieve program outcomes;

- program adaptation and improvement – providing information that can inform program management decisions to continually improve performance and ensure the program remains relevant; and
- learning and dissemination – generating knowledge on how and why a change has occurred which may inform the program and other stakeholders’ approaches.

M&E audience

The Samoan Government, implementation personnel and DFAT require information on:

- the ongoing relevance of program activities and outcomes;
- progress towards achieving program outcomes and any unexpected benefits and challenges arising;
- key performance issues and how they are being managed;
- sustainability of program outcomes;
- implementation progress against annual work-plans and budgets; and
- value-for-money considerations and lessons learned.

DFAT also requires information to feed into annual Aid Quality Checks, Aid Program Performance Reports and DFAT Performance Framework reporting.

The HPAC brings together key counterparts under the program and is responsible for monitoring overall performance of the health sector. The Committee should thus be provided with information about program progress, coordination among Samoan stakeholders, lessons learned and implications for the development and implementation of Samoan health policy. HPAC is also an appropriate conduit for reporting to Ministers and Cabinet.

Secondary audiences for M&E are IPPF, SFHA, Queensland Department of Health, other stakeholders in the Samoan health sector and other donors working in the Samoan health sector. They are most likely to be interested in knowledge and learnings generated from the program which may inform their own programming.

Principles

Principles for the M&E activities inform how the M&E activities will be delivered. They include:

- user focused – all data that are collected should meet the needs of the primary audience, inform learning and/or support accountability, decision making or program management;
- performance focused – the M&E activities support reporting on, and the management of, the performance and outcomes of the program rather than seeking to provide situational results;
- partner driven and strengthening partner systems by using them – wherever possible GOS and partner data and systems should be used, especially at the goal and EOPO level (which will become easier if and when a health information system is established and operational);
- on-going relevance - ensuring ongoing relevance of the M&E plan through an annual review and update that coincides with the Annual Work Plan; and

- gender and social inclusion - collecting data disaggregated by sex and capturing data relating to people with a disability will ensure a more accurate representation and interpretation of the program and its impacts.

Key questions

The M&E should focus on key questions of effectiveness, efficiency and sustainability as follows:

- How effective is the program in progressing towards its EOPOs and intermediate outcomes and what factors are enabling or inhibiting this? In particular:
 - To what extent and how is the program contributing to better resourcing of district health services and how is that contributing to better access to health services?
 - To what extent and how is the program contributing to evidence-based decision-making by key health personnel?
 - To what extent and how is the program improving access to sexual and reproductive health services, especially for currently under-served groups?
- How efficient are the program activities? In particular:
 - What is the quality of key analytical and other reports produced and how are they influencing GOS decision-making?
 - Are activities being implemented as planned and to budget?
 - Where unit costs of outputs can be derived or estimated how do they compare with benchmarks from other sectors/countries?
- How sustainable and enduring are the outcomes of the program likely to be? What are the early signs of sustainability? In particular:
 - What are the levels of GOS ownership?
 - To what extent are GOS and SFHA scaling up or adopting service delivery models trialled under the program?
 - Are the technologies and systems introduced appropriate to the Samoan context and end users?
 - To what extent is GOS contributing its own resources?
 - What are the levels of motivation and incentives to continue the benefits beyond the life of the program?

Mid-term evaluation

In addition to the ongoing monitoring against the indicators (set out below), a mid-term evaluation will be required for each individual design and fed into a mid term review for this design. All mid-term evaluations should focus on whole of program level assessment of the performance of the program.

Performance indicators

The program logic provides the initial framework for M&E, with indicators linked specifically to the outputs, intermediate outcomes, and EOPOs.

The M&E framework has been designed to measure outcomes that can be realistically achieved within the timeframe of the program, as well as progress towards goals that may be achieved within a few years beyond the life of the program. The indicators have been selected to ensure data can be obtained from existing GOS data sources or generated by program staff. Early in implementation, DFAT's health program manager should progress to finalise the M&E framework, including refining indicators to ensure relevance as activities are finalised and verifying the quality and availability of GOS data sources.

Baseline data will be collected as program mobilisation advances. Given that the program operates in a changing context, the M&E frameworks and plans will be reviewed on an annual basis to ensure that they continue to produce useful results and findings.

The full M&E framework is attached at Appendix G.

Implementation

DFAT's senior program manager for health will be responsible for overseeing and managing program-wide M&E. Their role will include finalising and if necessary updating the M&E framework and the key evaluation questions in this design as well as clarifying responsibilities and timing for data collection, analysis and reporting.

Sustainability

As noted previously, health accounts for a significant share of both GDP and total government spending in Samoa. Thus, the scale of the proposed program is such that it should complement rather than substitute or supplement GOS resourcing for the sector and so in this context issues of sustainability are not considered to be of concern.

Also, Samoa has a history of stable and democratic government with sound public service institutions and systems underpinned by strong community solidarity. The program will thus be implemented in a low risk socio-political environment.

Use of TA in the program will ensure that key systems and procedures are established to ensure effective management of services and resources as and when they come on stream. Those arrangements will largely be institutionalised within the respective organisations and thus likely to endure beyond the lifetime of the program.

The requirement for an expert cost-benefit analysis as a pre-condition for DFAT to invest in health information systems is also intended to ensure the sustainability of any such system which is developed with Australia's support. On the other hand, if a system is implemented which Australia is unwilling to support then any risk to sustainability will be independent of the program (although 'second order' impacts of a significant health information system failure might range from financial losses through to service disruptions which in turn may flow through to subsequent requirements for development partner support).

In addition to support for organisational strengthening, DFAT's ongoing involvement with SFHA should also help to reinforce the role of a key NGO in Samoa's health sector and, as a result, add a degree of diversity to institutional arrangements. That, in turn, will impact positively on sustainability by helping to make the system somewhat more robust and enhancing consumer choice.

Gender equality

The program's approach to achieving gender equality and women's empowerment will be through a specific component dedicated largely to women's health (Component 3), as well as mainstreaming gender throughout the program.

Component 3 seeks to ensure health services better meet the needs of women, young women and people living with a disability through enhancing SFHA's organisational capacity and delivery of SRH services.

A focus on gender equality and women's empowerment will be integrated into both of the other components. Some examples of how this will be done are outlined below, but each implementation lead will be required to develop specific strategies to promote gender equality through their work:

Component 1:

- Encouraging health service providers to consider the gender implications of the tailored approaches for district primary health care resourcing. For example, considering gender balance in the allocation of human resources, the different incentives required for women and men to work at the district level, whether resourcing is meeting the health needs of women (such as proper resourcing for SRH and maternal health services).
- Considering gender outcomes and implications, including how effectively the resourcing is meeting women's and men's needs and whether women and men are accessing primary health care services.
- Where possible, encouraging equal numbers of men and women to participate in activities (e.g. mentoring, training, workshops, recruitment) supported by the pharmaceutical and biomedical equipment procurement and biomedical maintenance specialists.

Component 2:

- Ensuring any development of a health information system includes generation of gender-disaggregated data and skills to analyse and report on the gender implications of those data.
- Any modifications to health sector institutional arrangements consider gender implications. For example, ensuring women are actively involved in discussions that women's health needs are considered in any structural decisions, recruitment encourages women to apply for positions, training has equal gender participation etc.

A gender focus will also be integrated into program operations. The terms of reference (TORs) for all positions recruited through the program will include responsibilities for promoting gender equality and require all positions to have an understanding of gender equality issues and be gender sensitive.

M&E data collected under the program will be gender disaggregated and analysis and reporting on those data will consider gender outcomes and implications.

Disability inclusiveness

Disability-inclusive development will be promoted across the program's three objectives, as follows:

Component 1:

- Decreasing the incidence of NCD-related disabilities, through improved resourcing for and access to NCD prevention services.
- Improving access to health care services for people living with a disability, through improved resourcing and approaches for these services.

Component 2:

- Ensure any development of a health information system includes generation of relevant data on people living with a disability and skills to analyse and report on the implications of those data for the health needs of people living with a disability as well as prevention of disability.
- Any modifications to institutional arrangements consider implications for people living with a disability. For example, ensuring people with a disability are actively involved in these discussions; that people with a disability's needs are considered in any structural decisions, recruitment considers how to encourage people living with a disability to apply for positions, training promotes participation of people with a disability.

Component 3:

- Ensuring support for SFHA encourages consideration of people living with a disability's access to SRH services.

Where feasible and relevant, the program will collect data related to people living with a disability and will ensure analysis and reporting on those data considers outcomes and implications for people living with a disability.

Support for disability inclusiveness will be included in the responsibilities for TORs for each position to be recruited under the program.

Private sector and innovation

The proposed health information system is the main area where extensive private sector engagement is anticipated. The initial cost-benefit appraisal of technological options will be undertaken by a private sector consultant and, if DFAT agrees to support the project thereafter, there is likely to be substantial private sector involvement in development and delivery of the preferred solution together with training and support.

Further opportunities for private sector engagement which may arise as a result of the design include:

- Encouraging outsourcing some clinical or support roles to private providers under the primary health care program as part of exploring possible new delivery arrangements for primary health care services at district level;
- private sector involvement in innovative arrangements to distribute medicines, commodities and other supplies for both NHS and SFHA might be an option;
- technological solutions that employ mobile devices to facilitate interactions with health professionals for people living in outlying districts (telemedicine, remote ordering of supplies, patient reminders and recalls etc.).

Climate change

Samoa is susceptible to a number of environmental hazards, including earthquakes (and subsequent tsunami), tropical cyclones, floods and droughts, which have the potential to impact significantly on the country's health system. Samoa developed a National Adaptation Program of Action in 2005 under the UN Framework Convention on Climate Change. The National Adaptation Program of Action ranked priority sectors based on an assessment of climate change risks and the need for support for adaptation. Health was considered a top priority, ranking third (Government of Samoa, 2005). Subsequently, the Samoan MOH developed a Climate Adaptation Strategy for Health (Ministry of Health, 2013). The Strategy highlights the need to continue investments in primary health care and essential public health services to help increase the resilience of the population to climate change impacts. Significant strengthening of Samoa's health system will be required to ensure it can effectively cope with direct climate change impacts related to the increasing incidence of extreme weather, as well as more indirect impacts, like increasing spread of water- and vector-borne diseases and malnutrition.

DFAT's investments in Samoa's health system will help build the resilience of the system to the impacts of climate change. This in turn helps increase the resilience of the Samoan people. One specific anticipated benefit of DFAT's proposed investment in district-level primary health care services is a stronger disaster response capacity at the local level.

Risk Management Plan

DFAT Post will manage the Samoa Health Program and the Senior Health Program Manager is expected to maintain an up-to-date risk register throughout the program and will be required formally to review and update the register on a quarterly basis (or more frequently if necessary). An initial draft risk register is attached at Appendix H.

Risk management, and review of the risk register (including the initial draft), will also be a standing item for consideration at the regular meetings of the HPAC.

Safeguards

Child protection

Samoa has demonstrated a high level of commitment to international agreements regarding protection and promotion of children's rights.

Specific Child protection risks that arise in connection with delivery of services under the program will be addressed via existing professional regulation and disciplinary procedures.

Environmental risks

The design does not create any additional environmental risks.

Displacement risks

None identified.

Resettlement risks

None identified.

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