AIDE MEMOIRE

SAMOA HEALTH SWAP PROGRAM
Joint Review Mission
21 October to 1 November, 2012

INTRODUCTION

1. The Joint Review Mission took place from 21 October to 1 November, 2012. It comprised representatives from the Government of Samoa (GOS), the New Zealand Aid Programme (NZAP), Australian Agency for International Development (AusAID), the World Bank (WB), the World Health Organization (WHO) and the United Nations Population Fund (UNFPA).

2. The Mission members thank the staff of the Ministry of Health, and the National Health Services for their time and cooperation with the Mission. In particular the Mission thanks Ms. Noumea Simi (ACEO, Aid Coordination, Ministry of Finance) and Ms. Palanitina Toelupe (Director General of Health, Ministry of Health) for chairing meetings and for their kind cooperation during the Mission.

3. The Health SWAp program is in its fourth year with another year to closing (December 31, 2013). The program of work (PoW) was revised and approved in September 2012, fully programming the SWAp the financial envelope and the ability to deliver in the timeframe remain questions at the time of the Mission.

4. The objectives of the Mission were:

a) To review the status of implementation and procurement and agree to the priorities and a realistic schedule for the remaining period of the SWAp. The priorities which have been established in the reprioritised PoW (Health Advisory Committee (HAC) approved, Sept 2012).
b) To review the financial status of the SWAp including current expenditure and commitments, the approved programme, and available funds, and agree on an approach that will allow the delivery of a sound SWAp within budget.
c) To engage on key policy issues related to:
    i. Strategic approaches to prevention and treatment of NCDs.
    ii. Primary Health Care service delivery issues.
    iii. Health financing.
d) To finalize and agree on a detailed roadmap which provides for evaluation and completion of the existing SWAp and planning and design for a post-SWAp environment.

KEY ACTION AND AGREEMENTS REACHED DURING THE MISSION

5. During the previous Mission in March 2012, a number of activities were identified for action. All of these were completed, except for the repair to incinerators which is now included in the new list of actions below:

FOLLOW-UP ACTIONS

Action #	Action	By Whom	By When	Completion Status
1	GoS to finalise shortfall analysis and submit any request to DPs.	MoF	To be determined	Ongoing
2	The financial and procurement supervision mission would work through the PoW and procurement plan to confirm estimates of the final outputs and any savings from removed or deferred work	MoH/DP	December 5, 2012	Pending
3	Completion of the evaluation for the Health Care Waste Management truck (due to non-responsiveness of bids).	MOH/NHS	November 15, 2012	Pending
4	Extension of the Biomedical Engineer for NHS. a. NHS/MOH to revise the TORs and the contract and send a request to the WB for no objection (copying DPs). WB to provide the no objection.	NHS/MOH WB	November 7, 2012 November 8, 2012	The DPs approval was provided during the Mission. Done and WB no objection provided on 10/31/2012.
5	No Objection on the revised Health Information System (HIS) TORs.	DPs/WB	November 5, 2012	NoObj provided on 11/12/2012.
6	Transition plan for transfer of equipment to new hospital.	MOH/NHS	November 2012	Pending
7	Maintenance & Operating Plan and budget line item.	MOH/NHS	March 2013	Ongoing
8	Discussion of new infrastructure and links to PHC program.	MOH/DP	Ongoing	Ongoing
9	Revision to TORs on the HSP and SWAp evaluation would be conducted by the Sector and sent for NOL.	MOH/DP	November 2012	NoObj provided on 11/15/2012.

Action #	Action	By Whom	By When	Completion Status
10	AusAID will provide a TA to assist in the situational analysis and other key activities as directed.	MOH/AusAid	November 15, 2012	Pending
11	The health financing report commissioned by the DPs would now be resent to the Ministry of Finance, copied to the Ministry of Health, to finalize prior to dissemination.			Pending
12	Submit to WB for comments the revised design of the PHC/Warehouse/Orthodic package (review of design and functionality).	MOH/NHS	December 6, 2012	Pending
13	MOH officials to inform the World Bank alignment of the report with the Government's existing strategies for health promotion and reduction of NCDs.	MOH	December 15, 2012	Not yet Due

STATUS OF IMPLEMENTATION AND PROCUREMENT

Overall Implementation Progress

6. Overall implementation progress has proceeded relatively well with some 68% of the Programme of Work estimated to be completed. Since the previous Mission, key design work and specifications have been developed for a number of critical infrastructure and equipment items. Of the high value procurement items identified in the last two Missions, all have progressed except for the design of MTII Hospital, although the Health Information Systems faced a false start with the ending of the initial contract in this area.

7. Of critical current concern is the emergence of a budgetary issue which is causing a number of large procurement items in Component 2 to be put on hold. During the Mission, the sector tabled a list of procurement items which are at the launch of bids or evaluation/contract signing stages and for which the detailed design and costings have resulted in significant revision in the expected cost. The cost increase would significantly exceed the available SWAp funds by around USD 9.4million (excluding additional funds for new equipment for the hospital). The programme cannot move forward until a way forward on this budget shortfall is agreed upon. The list of items and revised cost estimates is provided in Annex 6.

8. The GoS advised the DPs that based on discussions during the mission it expected to submit a request for additional funding to expand the funding of the SWAp to take account of the shortfall. Before considering the specific overruns on existing PoW items, the mission noted that there appeared to be the possibility of savings elsewhere in the PoW where items were no longer progressing or might come in under budget, and there was a need to revisit the expected outputs of the SWAp. Specific savings from the Poutasi hospital (SAT$ 1.8m) if not relocated, and from the Health Information System (SAT$ 2m) if SWAp does not cover implementation, in addition to the lower priority of the Lufilufi staff quarters (SAT$ 400,000) could also offset the total shortfall. The DPs also noted the possibility that some items be removed from the SWAp programme and deferred to future support.

9. It was agreed:

- The GoS would finalise shortfall analysis and submit any request to the DPs (Action 1). It was also recognized that any request to the DPs for additional funding for the PoW overrun would require more detail, rationale, shift in and justification on the scope of each activity with major overruns as there have been some revisioning of the work (Action 1).
- The financial and procurement supervision mission would work through the PoW and procurement plan to confirm estimates of the final outputs and any savings from removed or deferred work (Action 2).

Project Objective

10. The objective of the Project is to *improve access to, and utilization of effective, efficient and quality health services to improve the health status of the Samoan population.* Progress is being made to achieve the Project Objective, in improving access through the deployment of General Practitioners to rural areas, the deployment of auxiliary nurses, strengthening service delivery, increased communication of health risks for the Samoan population, and improved outreach. An updated result matrix reporting against the PAD indicators was provided to the mission. Due to the infrequency of data collection, some

indicators have not changed since the March mission. Others have been modified based on routine data collection for specific locations of intervention (i.e. Hospitals) but data on a number of such indicators remains incomplete without details of information from outlying health facilities.

11. **Component 1: Health Promotion and Prevention.** The component has progressed satisfactorily. Legislation on the establishment of the Health Promotion Foundation has been developed but further consultations will be undertaken prior to it being ratified (expected date December 2012). Dissemination and reinforcement of health messages will be under the aegis of this Foundation, linking primary and secondary care delivery of services. Other activities have been completed or are ongoing, such as the small grants to increase physical activity and dietary changes, tobacco control and prevention, and promotion on communicable diseases, environmental health, HIV and STIs, training on Infant Young Child (IYCF), multi-sectoral collaboration (school nutrition standards), social marketing, prevention and control, and health care waste management. In addition much work has been done on policy documents/legislation on breast milk substitute, food and nutrition, physical activity guides, primary healthcare model, and Non-Communicable Diseases (NCDs).

12. **Component 2: Enhancement of Quality Health Care Service Delivery.** The component activities are moving forward, but less satisfactorily due to significant delays encountered in implementation. Activities to improve oral health improvements have been largely implemented. The health care waste management (HCWM) program is also well underway, apart from a need to complete the evaluation for the HCWM truck (Action 3). The Rheumatic Heart Disease (RHD) screening and control activities have been significantly delayed due late delivery of the RHD vehicle and the echo-cardiogram (being procured through UNOPS). The curricula for nurses training had also encountered several months of delay but have now been reviewed and will be launched soon. Activities in Neo-natal and cervical screening, detection of breast cancer, capacity building for healthcare professionals and emergency and relief management are still pending. The sector has experienced intermittent support in the biomedical area, critical to definition of key equipment needs.

13. The Mission agreed to extend the contract of the prior biomedical engineer TA to ensure that the equipment required meets the specifications needed and to support the transition planning (Action 4) Remaining activities in the component are still under the procurement process or have not been launched and center on key infrastructure and equipment purchases outlined “Implementation Progress”.

14. **Component 3: Strengthening Policy, Monitoring and Regulatory Oversight of the Health System.** The component is delivering on its outputs in general. The DPs appreciated receiving the Annual Progress Report and the amount of work that went into this report. Though the Annual Progress report is rich in information, it could be strengthened by being more succinct and would greatly benefit from the inclusion of progress and performance indicators, which would bolster the descriptive information. From discussions and the Policy Discussion Day, there has been quite a lot more substantial progress by the Sector which is not reflected in the report, and it would be useful to add in this information. In addition, the policy papers developed could enrich the exchanges.

15. The Health Information System (HIS) consultancy was recently cancelled due to the selected consultant not being able to meet the required reporting standards of the Program. Given the strategic importance of the HIS, it has been agreed that the development of the scoping and the plan is critical prior to investment in the HIS system, therefore, SWAp financing will focus on the first phase of the HIS, with further development over time with support from the DPs, to ensure that Samoa obtains reliable and more evidenced-based data for decision making and strategy development. The HIS terms of reference (TORs) have been revised with a more realistic scope of work and a functional and responsive HIS will be developed over a period of time which will go beyond the current SWAp timeframe. The HIS TORs have been approved by the DPs and received the World Bank’s no objection (Action 5).

Overall Risk

16. The key risks to the programme at this stage are that activities in the program will not be completed within the current programme timeframe and budget. Upward revisions to the expected cost of several large procurement packages have meant the programme cannot proceed to tender and contract this work until the budget shortfall is addressed. This is putting further pressure on the implementation schedule.

FIDUCIARY STATUS AND PROGRAM OF WORK

Procurement

17. The Mission noted inconsistencies between the current Procurement Plan and the PoW and requested the procurement plan be reviewed and updated to clearly show the progress of activities (Plan, Revised, and Actual). In addition, the costs will be aligned with the PoW.

18. On the operational side, procedures will be strengthened to ensure that there is improved processing of procurement packages. The MOH/NHS will follow-up with the World Bank on procurement packages which have been officially submitted within two weeks of submission. The World Bank will apply the regulation standards to respond to procurement packages.

19. As for Terms of Reference (TORs), and as a reminder, all consultant TORs will need to be cleared by the Bank. The MOH/NHS will submit the draft TOR to the DPs, and the Lead DP will consolidate comments from all partner DPs, and submit the comments to the MOH/NHS. The MOH/NHS in turn will then submit the final TORs to the Bank for no objection.

Expenditure Update

Table 1. Total Expenditures and Commitments at 30 September 2012 and the POW estimates

Components	Currently Costed Program	Actual Expenditures	Committed	Balance remaining (budget less (exp + commitmt)
Component 1	9,698,064.55	6,519,164.57	994,872.96	2,184,027.02
Component 2	42,918,902.44	12,754,741.81	4,755,496.11	25,408,664.52
Component 3	21,063,633.84	13,054,460.43	4,985,771.16	3,023,402.25
Total SAT	73,680,600.83	32,328,366.81	10,736,140.23	30,616,093.79
Total USD				US$13,495,574.14

Financial Management

20. The November 18, 2011 World Bank letter will apply with regard to sitting fees of the Samoa Parliamentary Advocacy Group for Healthy Living (SPAGHL). The Mission assessed the Financing Agreements for both IDA 47210 and 44320 are exclusive of taxes. However, it is virtually impossible to monitor as all payments are co-financed by funds from NZAid, AusAID and GOS. The GOS funds are the government's contribution to the payment of taxes; in reality some purchases are subject to VAGST at 15% and other payments are not subject to VAGST (i.e. wages, professional fees, transport allowances). It is recommended the World Bank team discuss this matter with the Legal and Disbursement Departments of the World Bank and inform government of next steps and amendments required.

21. A **transaction review** was conducted for the period from March to September 2012. Documentation was reviewed for a sample of transactions with a 100% review of the expenditure for reasonableness. The documentation was adequate for all transactions reviewed and the testing was quite limited as this has not been high risk area. The following transactions were queried for reasonableness and the response is also included:

- Payment to Adele Keil in June $3,545.92 which was paid from MOF payroll. It was explained that this person was a consultant not a salary earner but at the end of the project they would become an employee of MOH.
- Flowers $2,380 July – hire of pot plants and flowers for MOH health exhibition.

22. An asset register is maintained by the project and this was reviewed although time did not permit any verification of assets against the register; however, a reconciliation was done back to the expenditure in the testing period and no issues were identified. There are a large number of assets purchased by the project (over 350) and these are handed over to the respective entity at time of procurement. The issue of assets not being included in the assets register as raised in the 2010/11 audit has now been addressed.

23. **IFR Review – Budget**. The budget for the IFR changes each quarter as it is based on the Financial Package Matrix, which outlines the estimated cost in SAT of all program expenditure since inception. The budget changes occur as the Matrix is amended according to the Health Advisory Committee meeting which may reprioritize the future expenditures. It will also be changed when the contract amount is signed. Hence the budgeted amount changes, though by a relatively small amount each IFR. It is recommended that a copy of this Matrix be attached to the IFR to enable users to identify how the budget is calculated. There may be a delay in the updating of new contracts due to updating of the procurement plan.

- Commitments are a formula from estimated cost less actual and the brief testing of outstanding contracts indicated this is a reasonable estimate of the current unpaid contracted amounts.
- Commitments and budget calculations will be reviewed in future implementation reviews although no material issues were identified in this review.

24. **Revision to Percentage Costs per DP** – changes to contributions from each pooled partner and the likely total pool of funds has meant that the percentages currently used to apportion expenditure in the Interim Financial Reports need to be revised. The Financial Supervision Mission notes the following expected percentage contributions of each partner which will need to be factored in to the final expenditure allocations.

Source of Finance	IDA	AusAID	NZAid	GoS
Funds not yet Disbursed	$3,058,197	$4,773,000	$5,312,897	$336,795
Balance in DA 30 Sept	($285,393)	$2,080,067	$973,254	$396,943
Total	$2,772,804	$6,853,067	$6,286,151	$733,738
% per source of funding	17%	41%	38%	4%
Current % allocation	25%	45%	24%	6%

Projected Overrun on agreed Programme of Work

25. As noted above, during the Mission, a meeting with the NHS Board and Management highlighted a number of areas in which the actual cost of existing items in the PoW is likely to substantially exceed the original estimates.

26. The largest overruns relate to the pharmaceutical warehouse, primary health care centre, and orthotics workshop (additional SAT $5.78m required), the MT2 hospital (additional SAT $2.5m), and laundry equipment (additional SAT $0.6m). In total, the overrun identified on items already in the PoW amounts to USD 9.33m. During discussions, the NHS proposed to remove the MTII hospital extensions from the list if these could be picked up in subsequent support, which would bring the shortfall down to around USD 6.8m.

27. Additionally, revised estimates of the total medical and non-medical equipment required for the new Hospital amount to just over SAT $6m. All of these revised costs add to an existing projected overrun on the SWAp envelope of some USD $1.8m (around SAT $4m).

28. The DPs propose to treat the equipment for the new Hospital separately from the PoW over-runs. The hospital equipment needs are immediate and urgent and the full list was not originally part of the intended SWAp PoW. A request has been made by the Health Advisory Committee and was reiterated by the Mission, for a full proposal on the safe and effective transitioning of services from the old to the new hospital including all equipment, technical support, and other transition costs so that the matter can be considered appropriately. It was agreed that:

- GoS would urgently complete work on the proposal for support to the Hospital transition and submit this via MoF to the DPs for their consideration (Action 6).

29. The mission noted a number of strategic issues related to the current scale of secondary and tertiary healthcare investment being made by both the GoS itself through concessional loans and requested of the SWAp. These relate to two main issues:

- The intended place and role of the central hospital facilities in Apia and Tuasivi within Samoa's primary health care model; and
- The ongoing maintenance of both infrastructure and equipment throughout the health sector, and in particular the quality of planning, management, and resourcing of a maintenance programme commensurate with the scale of Samoa's capital investment.

30. The mission noted the active analytical and planning work underway within the NHS and the importance placed on this by the Board. It noted that the SWAp partners including the GoS believe it is now critical that:

- The National Health Service complete and fully cost its maintenance plan for both infrastructure and equipment within the health service and incorporate a suitable annual programme and budgetary provision within its budget beginning 2013/14, with MoF agreement.
- The NHS reviews the quality of budget estimates for major equipment and infrastructural items and takes steps to strengthen capacity and systems to ensure more reliable initial estimates and contingencies.
- The NHS develop a detailed plan and performance framework that ensures that the new hospital and the services it prioritizes are in line with the health policy to increase resourcing of promotion and prevention work and to focus on primary health care.

RESULTS MONITORING AND REPORTING

31. The result matrix was provided to the Mission. Progress is being made against activities on the ground. For example, current information shows updated data for Rheumatic Heart Disease (RHD) with the increase in cases reflecting the improved reporting arising from screening work. Perinatal mortality rates, while not yet national, show signs of steady improvement. While the DPs noted immunization coverage has increased (45% 2008 compared with 67% in 2011) the challenge remains to sustain this improvement via the health system. It was noted that antenatal visits which were expected to increase have dropped from the baseline – 61% in 2008, to 58% in FY 2010/11). The mission was informed that the new Primary Health Care Policy will be addressing these issues through General Practitioners and auxiliary nurses.

32. The MoH also reported that a decision had been made to now produce an annual report on all the indicators of annual frequency at the timing of performance reporting to the Ministry of Finance. This should strengthen the regularity of feedback on the Sector M&E framework. The STEPS survey that is to be carried out during the first quarter of 2013 will be critical to updating data on non-communicable disease indicators which are measured intermittently.

33. As regards data collected through larger less frequent surveys, the STEPS survey is expected to deliver a new body of data that will be able to be compared against earlier STEPS data and provide some trend information. Data from Village Health Fairs provide useful information on rates as found during the village based process and progress with regard to health promotion. However, as they do not follow a specific sampling methodology these indicators are not directly comparable standardized data.

34. Given the growing and concerning issues around NCDs, it would be useful to strengthen a more coordinative approach to data collection and the registration and sharing of information between services and regulatory bodies. This could also inform the medical profession on other needs that are evolving due to NCDs (prevention measures to limit surgical amputation, disability equipment).

SAFEGUARDS

35. Following up on the March 2012 aide-mémoire, the mission was informed that the Health Care Waste Management (HCWM) framework has been revised (comments were submitted by the Bank in July 2012, but no response has been received to date), and staff trained on HCWM. The appropriate supplies and protective gears have been received, distributed, and are in place. However, the mission visited the MT2 Savaii hospital, and only one of the two incinerators is functional. The second incinerator needs to be fixed urgently to comply with the March 2012 mission aide-mémoire, and this current aide-mémoire.

36. With regard to the relocation of the Poutasi District Hospital, this activity will depend on the outcome of Samoan Cabinet discussions and decisions on the overrun of the SWAp budget. In the event this activity proceeds, the safeguard triggers (including resettlement) will apply.

FUTURE PLANNING – POST SWAP

37. Discussions were held on the draft roadmap provided by the GoS and the feedback provided by the Development Partners. It was agreed that:

- The Review of the Health Sector Plan and the Review of the Health SWAp were to be progressed as a single exercise that would provide:
    - An updated situational analysis of the health sector
    - A mid-term review and revisions to the Health Sector Plan
    - Reflections and learning from the contribution of the Health SWAp

- This work would be led by the consultant currently being recruited by the Health Sector with the support of a Health Evaluation Specialist provided by AusAID. The latter consultant will focus on an evaluation of the SWAp as a management tool for improving the harmonisation and alignment of aid to the health sector. No objection was received to the revised TORs for the MTR of the HSP (Action 9). AusAID will provide a TA to assist with the SWAp evaluation and they will develop the ToR for the consideration by the other partners (Action 10).

38. A revised draft of the road-map was circulated for further discussion, incorporating specific stages for the conceptual development and design of a post-SWAp engagement.

39. GoS noted the inclusion of provision for sector level PFM and Procurement assessments and indicated that it found these to be burdensome exercises and it would rather undertake such assessment centrally via the Ministry of Finance's own PFM and procurement strengthening programme. It was agreed to defer this issue to discussions between MoF and the relevant DPs.

ANALYTICAL WORK

40. **Analytical work on health financing options in Samoa.** At Government's request, the World Bank undertook a review in 2011 of current and future health financing options in Samoa. The review assessed eight options for making health expenditure more effective, efficient, equitable and sustainable. The eight options assessed are:

- increasing government expenditure via increased general taxation;

- increasing government expenditure via deficit financing; increasing the share of government expenditure to health; increasing external and donor financing; increasing specific taxes;
- mobilising additional non-government resources via insurance (including social health insurance, community, and private insurance);
- increasing cost-recovery measures; and
- increased efficiency.

41. The review concluded that the most strategic health and financing gains would come from improving efficiency of expenditure, including through an increased allocation of resources to preventive services. Increasing taxation on tobacco would simultaneously improve health outcomes and Government's overall revenue. It was agreed:

- The health financing report would now be resent to the Ministry of Finance, copied to the Ministry of Health, to finalize prior to dissemination (Action 11).

42. **Economic costs of Non-Communicable Diseases (NCDs).** The World Bank provided an overview of why and how it was engaging with NCDs[1] as a development issue globally, and then presented the results of a rapid stocktake on the economic cost of NCDs in three countries of the Pacific: Samoa, Tonga and Vanuatu. There are four main messages from the rapid stocktake.

First, NCDs are already significant, accounting for 70% of deaths, and risk factors feeding a future pipeline of NCDs.

Second, costs of treating NCDs are often high, especially if neglected in early stages of the disease.

Third, the combination of these two factors (high prevalence of NCDs as well as high costs) will put large financial strain on already tight budgets (limited 'fiscal space').

Fourth, there are implications for Ministers of Health as well as Ministers of Finance. For example, more effective primary and secondary prevention can simultaneously reduce adverse health outcomes as well as financial costs; raising taxes on tobacco simultaneously raises revenues for government while reducing uptake by the young and poor.

43. The World Bank invited comments on the report, and asked for suggestions for any follow up work. Ministry of Health officials and DP welcomed the report, noting it provided a good evidence base for future planning and health financing. This is especially important as Government and development partners are now considering strategic health financing options when the current SWAP expires at the end of 2013. Ministry officials welcomed the emphasis in the report on the importance of promotion and preventive services, noting these are already priorities being supported under the *Samoa Health Sector Plan 2008-2018,* although acknowledging more needed to be done to enhance and strengthen those activities. Government officials also expressed support for the focus in the report on promotive and preventive health services for adolescent and pregnant females, and the attention given in the report to multi-sectoral approaches. MOH officials explained they would need some more time to consider how the findings and recommendations of the report could align with the Government's existing strategies for health promotion and reduction of NCDs.

[1] The main NCDs are heart and circulatory disease; diabetes, cancers, and chronic respiratory problems.

LIST OF ANNEXES

ANNEX 1

RESULT MATRIX

	IMPACT INDICATORS				
	Baseline	**New Data**	**Update Data: as of November 2012**	**Definition & Frequency of Reporting Update**	**Data Source / Comments**
Control of non-communicable diseases • Prevalence of Diabetes (25-64yrs) *(Goal: declining rate)*	**2002 STEPS Survey: 21.5%** **VHF Covered 16 villages** **(**2817 sample size)	**Awaiting STEPS Survey 2013**	• DHS 2009 did not cover prevalence of NCDs including diabetes • **11.3% (15 Years +)** covered 155 villages 23,302 people registered (at nurse clinics) Source: (*Village Health Fair 2010/2011*)	***Defn:*** Estimate of proportion of population who have diabetes (fasting glucose level is greater than or equal to 6.1 mmol/L (110mg/dl) ***Freq:*** by the end of Year 5 Notes: Diabetes measured as whole blood capillary reading of >=11.0 mmol/L	DHS does not covered prevalence of NCDs Village Health Fair Report (2010/2011**)** **Next STEPs currently in Planning Stages.** **Data Collection target**

					in March 2013
Improved maternal and child health • Perinatal mortality Rate *(Goal: declining rate)*	**23.9 per 1000 live births** **(All public health facilities – 2008)**	**21.7 per 1000 live births** **(All public health facilities – 2009)** **Perinatal mortality rate according to DHS 2009 is 37**	18.8 per 1000 live births *(TTM, MTII & District Hospitals 2011)* Source: -PATIS/MOH/NHS -Community Nursing Integrated Services Rural Areas	***Defn:*** "Deaths occurring during late pregnancy (at 24 completed weeks gestation and over), during childbirth and up to seven completed days of life" ***Freq:*** Annual & 3-5yrs ***Defn:*** **"**A Death occurring in the first year of life."	Sourced from all births in public health facilities. Does not include births by TBAs or outside of the public health facilities. Improvements to Sector Wide Health Information System scheduled under SWAP should see 100% coverage of all birth sources by end of Year 5 Current efforts coordinated by the

• Infant Mortality Rate (IMR) • Maternal Mortality Rate (MMR)	Infant Mortality Rate 2001 = 19.3 per 1000 live births (*Source: National Census Report 2001)* **2001** = 0.9 per 1000 live births (*Source: TTM, MTII & all public health facilities)*	**per 1,000 births** Infant Mortality Rate 2006 = 20.4 per 1000 live births (*Source: National Census Report 2006)* **2006 = 0** (*Source: TTM, MTII & all public health facilities)*	Infant Mortality Rate 2011 = 15.6 per 1000 live births (*Source: National Census Report 2011)* 2011 = 0.4 per 1000 live births (*Source: TTM, MTII & all public health facilities)*	***Note: This does not include stillbirths, which should be included in Perinatal Deaths*** ***Freq:*** 3-5yrs ***Defn:*** The Death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. ***Freq:*** 3-5yrs	Statistics Bureau to coordinate national births and deaths data will improve coverage. • National Census does not include Perinatal Mortality • National Census 2011 did not covere Maternal Death

Universal access to reproductive health services • Adolescent birth rate *(Goal: declining rate)*	**28.6 annual births per 1000 women aged 15-19 yrs (*Samoa Census 2006)***	**38.1 births per 1000 women aged 15-19 yrs (*Year 2008 births @ public health facilities and 15-19yrs age group)*** **Adolescent birth rate 44 per 1,000 women age 15-19 (*DHS 2009*)**	26.5 births per 1000 women aged 15-19 yrs (*Year 2011 Births @ TTM, MTII & all public health facilities- age group 15-19yrs*) Source: -PATIS/MOH/NHS -Community Nursing Integrated Services Rural Areas **39 births per 1000 women aged 15-19yrs (*National Census 2011 Report*)**	***Defn:*** The adolescent birth rate measures the annual number of births to women 15 to 19 years of age per 1,000 women in that age group. It represents the risk of childbearing among adolescent women 15 to 19 years of age. It is also referred to as the age-specific fertility rate for women aged 15-19. ***Freq:*** Annual	Figures are sourced from 2 different information sources- publically funded hospitals (which does not capture babies born out of public hospitals) and the National Census Reports.

Control of Communicable diseases • Incidence of water-and-food borne infections **i. Diarrhoea**	**Diarrhoea & Gastroenteritis in <5yr olds presenting to TTM and MTII Hospitals (2008): 1,962**	**Diarrhoea & Gastroenteritis in <5yr olds presenting to TTM and MTII Hospitals (2009): 2,157**	**Diarrhoea & Gastroenteritis in < 5 Yrs old presenting to TTM and MTII Hospitals 2010 = 2,280** Diarrhoea & AGE in children < 5yrs 2011 for TTM, MTII & all public health facilities= 2056 *Source:* *-PATIS/MOH/NHS* *-Community Nursing Integrated Services Rural Areas*	**Annual & 3-5yrs**	Presentations (outpatients/admissions) due to diarrhea and gastroenteritis of all children under 5 yrs old to TTM and MTII hospital; The 2011 figure includes data from the 6 District Hospitals.
ii. Typhoid	**Cases of clinically suspected Typhoid (2008): 771*** *(Source: PATIS)*	**Cases of clinically suspected Typhoid (2009): 606** *(Source: PATIS)*	Cases of clinically suspected Typhoid in TTM, MTII & all public health facilities in 2011= 562 *Source:* *-PATIS/MOH/NHS* *-Community Nursing*	**Annual**	Cases of clinically diagnosed typhoid diagnosed at TTM, MTII and all rural public health facilities hospitals.

(Goal: declining number) **iii Compliance to National Drinking Water Standards**		**DHS 2009 = 1594**	*Integrated Services Rural Areas* • Samoa Water Authority (SWA) Treatment Plant compliance to National Drinking Water Standards (NDWS) – 90.1% (Jan-June 2012) • SWA Boreholes Endpoint compliance rate to NDWS – 30% (Jan-June 2012) • Independent Water Scheme compliance rate to NDWS – 0% (Jan-Jun 2012) • Bottled Water Companies compliance to NDWS – 100% (Jan-Jun 2012) *Source: - MOH* - *Scientific Research of Samoa (SROS)* • 36% of the Schools visited comply with Sanitation Standards from Jan to Jun 2012.		Strengthening the communication between the Villages and MOH & SWA must be addressed Achievements by Water Bottle Companies Is a reflection of the regular monitoring role of the MOH The SPAGHL (Samoa Parliamentary Advocacy Group Health

iii Compliance to Sanitation Standards			*Source: Ministry of Health* 63% of the lab confirmed typhoid cases were investigated from Jan-June 2012 *Source: - Ministry of Health* - *National Laboratory (NHS)* 63% of the lab confirmed typhoid cases were investigated from Jan-June 2012 *Source: - Ministry of Health* - *National Laboratory (NHS)*		Leadership) is currently leading the inspections of schools and recommends health issues for improvement to the Cabinet for action The Ministry of Health is still facing with challenges of the typhoid contact tracing implementation.

iv Typhoid Investigation					
Injury Prevention • Injuries in children (under 15yrs) *(Goal: declining number)*	**367 (under 15yrs admission)** **(*TTM & MTII)*** ***FY 2008/2009***	**346 (under 15yrs admissions)** **(*TTM & MTII)*** ***FY 2009/2010***	310 (under 15 yrs) Admissions to TTM, MTII & all public health facilities 2011 *Source:*	**Annual Reports sourced from PATIS.**	**The 2011 figure includes information from the 6 publicly funded District hospitals.** There has been a multi

			-PATIS/MOH/NHS *-Community Nursing Integrated Services Rural Areas.*		sectoral campaign on injuries from government ministries and corporations.
RESULT INDICATORS					
People aged 25-64yrs overweight or obese	**85.2%** **(*2002 STEPS Survey)***	**Awaiting STEPS 2013**	**86.4% for overweight and all obese. (Overweight – 26.0% and obese – 46.7%; morbidity obesity is 13.7%)** **(*Village Health Fair 2010/2011)***	**Survey conducted every 3-5yrs**	Update to be provided by the end of Year 5 through the STEPS survey. DHS not suitable to update this indicator.
Percentage of children under I year received at least one dose of measles vaccine	**45%** **(*2008 EPI coverage)***	**48% (*MMR Campaign 2009)*** ***2009 EPI Report***	**62% (Expanded Program on Immunization (*EPI) 2010)***	**Annual & 3-5yrs**	Source: National EPI programme, NHS.

		53.6% (48.0% male; 58.5% female) of children one year of age immunized against measles - (*DHS 2009)*	67% Coverage (2011) *Source: National EPI Program*		
Improved Medical Waste	**2008:** HCW Monitoring visits at all HCW *Generation Sources in Upolu & Savaii (Monthly, Bi annual*) HCW Trainings for Nurses Doctors Vet Clinics and NGOS health care providers in the Private Sector.	**2010:** HCW Monitoring Visits of HCW *Generation Sources (Monthly, Bi Annual)* Review of NHCWMP by Mark Hodges (*Consultant) August 2010*	Compliance to Treatment and Final Disposal of HCW Standards = 90% (2012) Compliance to Disposal of HCW at disposal standards = 80% (2012) *Source:* *-Health Care Waste Management Unit (MOH) 2012* - **Distribution of colour coded bins to all health sector service providers** - **Segregation in Savaii has become more**	**Annual**	**Health Care Waste Management Audit Reports)**

	Train of Trainers Programme for three days in April 2008	HCW Trainings for health care staffs in Upolu & Savaii (2)	**effective due to availability of colour coded bins** - **Collection, transportation and disposal also has improved with availability of collection vehicle** - **Still need improvements in most of these areas to maintain/sustain effective collection, coding and disposal of all health care waste especially for services provided outside of public hospitals e.g. private clinics etc…**		
Antenatal care coverage for at least 3 visits	**61%** **of AN mothers seen at TTM had at least 3 visits (*2008*)** *Source: PATIS*	**51%** **at least 3 visits** **of all antenatal mothers seen at TTM hospital (*2009*)** *Source: PATIS*	60% of antenatal mothers at least 3 visits for Antenatal care at TTM, MTII & all public health facilities *Source:* *-PATIS/MOH/NHS* *-Community Nursing Integrated Services Rural*	**Annual**	**PATIS** **CHNIS** **MOH** **NHS** **Much work is going**

		DHS 2009: • **Antenatal care coverage (at least one visit) – 92.7** • **Antenatal care coverage (four visits) – 58.4**	*Areas*		**into advising mothers of the need to attend** antenatal clinics and current efforts for a PHC Facility under SWAp funding at the NHS Motootua Compound will help especially for the growing Apia Urban population.
Proportion of Rheumatic Heart Disease (RHD) patients complying with treatment (12/12 months)	**<u>Compliance to IM Penicillin:</u>** 2008 = 84% **<u>New RHD</u>** **2008 = 55**	**<u>Compliance to IM Penicillin:</u>** 2009 = 81% **<u>New RHD</u>** **2009=49**	**<u>Compliance to IM Penicillin:</u>** 2010 = 86% **<u>New RHD</u>** **2010 = 117**	**Annual compliance rates**	**RHD Program Database** **NHS** **MOH**

	<u>New ARF:</u> 2008 = 13 *Source: Rheumatic Fever Database (NHS)*	**<u>New ARF:</u>** 2009 = 17 **DHS 2009 findings also reveals that RHD is the same across the lowest – highest wealth quintile; but it is common in women between ages 15-49 (0.7) compared to men for the same age group (0.4)**	**2011 = 155** **<u>New ARF:</u>** 2010 = 21 2011 = 55 *Source: Rheumatic Fever Database (NHS)*		**Figures have increased for new cases captured due to the wider screening programs currently being undertaken with funding through the SWAp program.**
Number of reported drug stock-outs by facility		**Not Available**	March 2012 = 2% stock out from all public health rural facilities	**NHS Pharmacy Division**	Currently putting in place strategies in order to efficiently track stock outages as part of usual

			March 2012 = 95% availability of essential medicines at all public health facilities at any one time *Source: Pharmacy/NHS*		key performances indicators for stock management. It is expected that the Health Information system strengthening planned with funding from SWAp will significantly improve ability to record stock out.

Component 3:	Baseline	UPDATE	Frequency and reporting	Data collection instruments	Responsibility for data collection
Staff mix and distribution according to national standards	Interim database for HRH for the health sector in place as a starting point in identifying staff gaps by facility and qualification Numbers of APCS issued by the Registrar Healthcare Professionals are as follows: <u>2012 (Calendar Year)</u> Doctors Employed at: NHS-39; Private Sector-31;OUM-4;	- The staff mix and distribution is based on the national health service demand. - The National Health Service , Samoa's major healthcare service provider bases their staff mix and distribution on service demand at the TTM Hospital, MTII Hospital as well as District Hospitals (3 on Savaii and 3 on Upolu) - Due to continuous shortage of doctors and nurses, NHS has contracted the private GPs to assist their workforce in the District Hospitals on a weekly basis. - The Integrated Community Health Services at NHS	Annual	Listed Annual Practicing Certificates for each cadre of legally mandated healthcare profession is sourced from the Registrar Healthcare Professionals lists of issued APCs.	Ministry of Health and Sector Partners

Component 3:	Baseline	UPDATE	Frequency and reporting	Data collection instruments	Responsibility for data collection
	MOH-3 Dentists-18 (2 in Private sector, 1 in NGO Clinic, 15 at the NHS) Pharmacists-15 - (8 NHS-7 Private Sector) <u>Nurses 2011-2012 FY</u> RNs 205; 63 NS including MWs; ENs 51 (*As of 20 March 2012*) <u>Distribution</u>: NHS – 122 RNs; 84 NS (including MWs) 83 ENs NUS- 2 RNs 5 NS	provides staff mix using a multidisciplinary team approach that consists of nurses, doctors, dentists, allied health etc to provide health services in the rural areas. - It is a legal requirement that every nurse, doctor, dentist and pharmacist must be registered and hold a current Practicing Certificate issued by the Registrar Healthcare Professionals.			

Component 3:	Baseline	UPDATE	Frequency and reporting	Data collection instruments	Responsibility for data collection
	NKFS 12 RNs; 5 NS NGOs 6 RNs, 3 NS, 1 EN Private Sector 2 NS MOH 3 NS RN-Regsitered Nurse NS- Nurse Specialist including Midwives EN- enrolled Nurse				
Evidence of performance monitoring leading to policy and	Monitoring and Evaluation Framework developed. All health professions have developed standards to guide and for all to	The Health Sector M&E Framework and Indicators was Officially Launched in Dec 2011. The M&E indicators are		Health Sector Plan Corporate Plans	MOH

Component 3:	Baseline	UPDATE	Frequency and reporting	Data collection instruments	Responsibility for data collection
regulatory action to improve health services	comply with.	divided under 7 long term outcomes based on priority areas of the health sector plan. MOH is responsible with monitoring the implementation of the M&E Operational Manual and update of indicators. All Healthcare Professional standards are in place. Implementation and compliance is being monitored by healthcare professional councils, and the Registrar HCPs mainly through the formal complaints process mandated by the HCPR& Standards Act 2007. All staff in the MOH has their performance appraised annually using the Public Service Commission appraisal system.		Professional Standards	

Component 3:	Baseline	UPDATE	Frequency and reporting	Data collection instruments	Responsibility for data collection
Demonstrated outcomes of training plan by component	• All DHS trainings (local and overseas) including training on Situational Analysis have all been crucial in the development of the DHS from its initial stages to its final stage of report writing. As an outcome of the recent DHS report writing training staff will now be focusing on a Service Performance Assessment in due time. • M&E Framework for the Ministry of Health and the health sector development was led by the trainees of the Monitoring and Evaluation study tour in NZ in 2009.	All staff involved in the DHS trainings funded under SWAP were involved with the DHS field work, data cleaning and report writing with technical assistance from Samoa Bureau of Statistics, Macro International, and UNFPA. The DHS report was launched in August 2010 and findings of the DHS has since been used to provide baseline data for some M&E indicators, and also used for policy development and planning. Staff who attended this training was heavily involved with the development of the Health Sector M&E Operational Manual through a consultative	Ongoing	DHS Survey Health Plans Census Health Sector	MOH

Component 3:	Baseline	UPDATE	Frequency and reporting	Data collection instruments	Responsibility for data collection
	• Health Information Management Training enabled participating staff to develop and establish basic database for general health information suitable to the local context. A Health information session was also conducted to collect the necessary data to establish a health sector information taskforce with its role focusing on the improvement of the Health Information System. • HRH related trainings equipped staff to develop the HRH Country Profile for Samoa and HRH Database for the Health sector as well as the discussion of the progress of the HRH Policy and POA Implementation. An output of this discussion is the	process with all health partners and stakeholders. Selective members of the Health Sector Information/ICT Taskforce conducted a study visit to Auckland NZ in July 2011 to observe and discuss the HIS improvement project for Samoa with the NZ ICT Health Board and selective IT Vendors in NZ together with selective NZ health care service providers. A report was submitted to Cabinet through the Director General of Health and received approval. One of the recommendations in the report is for a TA to be brought on board to conduct a scoping exercise for the whole health sector information system requirements as well as identifying specifications.	Ongoing Ongoing	Plan Corporate Plans Services Standards PATIS/CHNIS System	MOH MOH

Component 3:	Baseline	UPDATE	Frequency and reporting	Data collection instruments	Responsibility for data collection
	establishment of a HRH Taskforce for the Health sector. • Data Analysis/Coding has improved the quality of coding capacity of staff. Monitoring of this capacity is regularly carried out through data generated from PATIS.	The HRH Taskforce was only established during preparation work for the interim database. The taskforce was inactive ever since, as we await the establishment of the HRH information system. However, the HRH information system or database, is now included in the scoping exercise and identification of specifications of the HIS improvement project. Data Analysis training was conducted with technical assistance from the Health Information System knowledge hub QUT (AusAID funded). This training involved majority of staff from NHS and selective	Ongoing	Consultations HRH registers HRH Policy and Plan of Action	MOH

Component 3:	Baseline	UPDATE	Frequency and reporting	Data collection instruments	Responsibility for data collection
		staff from MOH. The training helped the staff involved in identifying gaps with the coding process, and also the staff is now able to utilize data from PATIS for analysis and decision making.		PATIS/CHNIS Information System NHS Record Section Community Nurses TBAs register	MOH
Health Expenditure as percentage of total govt. expenditure	FY 1998-1999: 16.9% FY 2000-2001: 17.7% FY 2002-2003: 18.1% FY 2004-2005: 16.7% FY 2006-2007: 13.8%	FY 2010-2011: 12.4% FY 2011-2012: 16%	Annual	GOS Budgets and accounts National Health Accounts	MOF (budget estimates) MOH(NHAs)

Component 3:	Baseline	UPDATE	Frequency and reporting	Data collection instruments	Responsibility for data collection
	FY 2008-2009: 17.4% FY 2009-2010: 12.6%				
Stakeholders participation in programme planning and implementation reviews	• Health Sector partners both private and public attended the Health Summit that was held in March 2009. In addition, MOH facilitated the National Health Forum in December 2009 to review the implementation of health reforms, and health sector partners were also involved.	- Participation of Health Sector partners and stakeholders in programme and planning has very much improved over the years since the launching of the Health Sector Plan 2008-2018. - The Ministry of Health has been conducting Annual Health Forums since 2008 where all health sector partners actively participate in discussing and presenting their views on the various themes for these annual forums. - The Year 2011 experienced a change in the way these forums are conducted, in that the MOH prepare papers	Annual	Annual Health Forum Reports Consultation reports Minutes of Public Health Sector Management Meetings	MOH & Development Partners

Component 3:	Baseline	UPDATE	Frequency and reporting	Data collection instruments	Responsibility for data collection
		on different health issues and each health partner or organization provided interventions in relation to the papers provided. The Ministry of Health continues to develop policies and plans using a consultative approach, where all health partners and stakeholders participate. The Ministry of Health also coordinates monthly public health sector management meetings.			
Disaggregation of data by sex, age and domicile enhances planning for services		Data from the existing health information systems PATIS and CHNIS are disaggregated by sex, age and region. This is the same with data from health surveys such as STEPS, DHS and Second Generation Survey for STIs.	Annual & every 3-5yrs	CHNIS, PATIS reports, POW, health surveys and censuses.	MOH and all health sector partners

Component 3:	Baseline	UPDATE	Frequency and reporting	Data collection instruments	Responsibility for data collection
MOH Financial Audits submitted on time and action plan agreed for resolving outstanding issues	Yr 1, 2, and 3 completed Submitted unqualified report with few minor management and administrative outstanding issues.	Internal MOH Audit Processes as Follows: Pay-Roll: Carried out every year at the end of the FY (up to date) Procurement and Payment Audit: Carried out every year at the end of the FY Receipt and Banking: Carried out every year at the end of the FY (up to date) Audits of GF and Response Fund project: Every two years (up to date) Audit of the Petty Cash: Yearly (up to date)	Annual	MOH Internal Audit Reports SWAP Accounts Section Reports Audit Office	MOH, Audit Office, SWAp DPs

Component 3:	Baseline	UPDATE	Frequency and reporting	Data collection instruments	Responsibility for data collection
		Audit of Below the line items e.g. DAS Clinic: Yearly (up to date) Outside Audits by Audit Office- Carried out Yearly (up to date)			
DHS and other statistical reports completed within stated timeframe and made public.	• DHS preliminary report is complete. • DHS final report 1st draft was ready on 19th February 2010	DHS Report completed and officially launched in August 2010. The DHS is carried out every 5 years. The Village Health Fair (NCD Screening) Report is also completed and was officially launched in Dec 2011 during the Annual Health Forum.	Annual & every 3-5yrs	DHS, STEPS, HIES, MOH reports	GOS, MOH, DPs

Component 3:	Baseline	UPDATE	Frequency and reporting	Data collection instruments	Responsibility for data collection
		MOH Annual Report for FY 09/10 has been submitted to Parliament and the FY 2010/2011 is near completion. All these reports are made available to the public through distribution during launching, and also on MOH website.			
Percent health sector budgets and disbursements conform to policy objectives and HSP priority areas		SWAP: Yr 2 = 70% Yr 4 = 90% All activities funded under SWAP follow the health sector priorities as articulated in the	Annual	NHA	MOH, NHS

Component 3:	Baseline	UPDATE	Frequency and reporting	Data collection instruments	Responsibility for data collection
		HSP.			
Share of annual outpatient visits by poorest quintile of population (indicator of equity of access – HIES)	DHS and STEPS Survey which haven't been finalized	Data from PATIS not complete to provide a full analysis for this indicator. However, findings of the DHS 2009 shows that 9% of households in the lowest wealth quintile have a member aged 25 or older diagnosed with diabetes compared with 29% of households in the highest wealth quintile. Similarly, 12% of the poorest households reported having at least one member aged 25 or older ever diagnosed with hypertension compared with 25% of those in the wealthiest households.	Annual & every 3-5 years	HIES, DHS, NHS monitoring reports	GOS, MOH, NHS facilities
MTEF and related procurement plan updated and adjusted based on recommendations from sector	Completed	The Second MTEF is completed and was launched together with the M&E Operational Manual in Dec 2011.		MTEF reports, procurement plans, Review reports	MOH, DPs

Component 3:	Baseline	UPDATE	Frequency and reporting	Data collection instruments	Responsibility for data collection
reviews		The MTEF is reviewed by CSD based on sector developments and evolving needs when needed.			
Key sector partners' corporate plans and government investments aligned with HSP priorities.	Aligned with Health Sector Plan Government investment also aligned with HSP since HSP aligned with SDS	The key health entities (MOH, NHS, NKFS) have corporate plans in place. The MOH Corporate plan 2007-2010 review has completed, and a new corporate plan is near finalization. All these corporate plans objectives and key strategic areas derive from and are linked to the priority areas and key sector goals in the Health Sector Plan 2008-2018. The mid term review of the Health Sector Plan 2008-2018 is in progress.	Every 3-4 years.	Corporate Plans Review reports	MOH and all health sector partners

Component 3:	Baseline	UPDATE	Frequency and reporting	Data collection instruments	Responsibility for data collection
Percentage of SWAp program funds released according to agreed schedule		Disbursement as of September 2012 for the SWAp Program 43.9% of total budget not including commitments.	Annual	MOH Financial Reports	GOS, MOH, DPs

ANNEX 2

SITE VISIT SAVAII

The mission visited Savaii: visits included the Rural District Hospitals (RDH) and MTII Savaii Hospital on Saturday October 27, 2012.

Sites visited were the Rural District Hospitals of Fualalo, Safotu, and the MTII Savaii Hospital of Tuasivi.

We thank the authorities for the kind cooperation and logistics in organizing this site visit, and the host village of Manase for their warm welcome.

The main findings of the visit are as follows:

- With regard to NCDs, there appears to be poor compliance of medicine dispensed.
- Patients tend to return to get a refill on their prescription; however, they also tend to return much earlier as their medicine has been used up.
- Due to legislation, certain drugs cannot be stored at the Rural District Hospitals and require a prescription from a doctor.
- The RDH holds only the essential drugs. However, there are occasional stock-outs which require patients to return to get a refill on their prescriptions. They may also choose to go directly to the MTII hospital, as the doctors are available full time, and patients can take care of medical services and drug prescription/availability at the same time.
- Doctors visit the RDH twice a week for NCD related services (check-up and follow-up, medicine prescription), and for special cases (there is a weekly visit by a doctor for those cases).
- Outreach services are screening for diabetes, providing EPI, antenatal care, blood pressure, PSI.
- Patients who are bed ridden are taken careof by the outreach services.
- There is a progressive trend of seeing younger patients with diabetes (as young as 18) requiring insulin (these are also mainly women).
- There has been an increase in amputations below the knee, requiring an increase in crutches, wheelchairs, and rehabilitation.

ANNEX 3

PROCUREMENT

Procurement Plan Update. **The mission requested that the procurement plan be updated to reflect the original, current, and actual dates and costs.** This information is even more relevant as the project moves into its final year of implementation, to enable an accurate assessment of fund availability to meet all commitments. **The HSCRM Division will update the procurement plan every 3 months, and revise dates and prior review requirements based on the new thresholds as agreed with the Bank.**

Activities on the Critical Path**. Annex 4** below provides the estimated timelines for the major activities yet to be procured. Fully equipping the new facilities with furniture and the required equipment to make them functional will go beyond the grant closing date of December 31, 2013. The mission recommends that MoH considers options to address this issue, such as splitting of contract packages, and moving high value items (such as the warehouse) to a post-SWAP program. Further, cost estimates for the major critical items yet to be procured can only be finalized once the works designs have been completed and the equipment lists have been prepared. **HSCRM Division will closely follow-up on all critical activities, regularly updating the estimates in the procurement plan.**

Status of Contracts signed with DRC, International: The mission was informed that all goods on these contracts have now been received. There are still a number of waste bins yet to be delivered to end-user sites, and the mobile x-ray vans have yet to be commissioned. Bids for the HCW truck are under evaluation. **The MoH will report to the DPs as soon as all goods have been commissioned and are in operation, and will provide the final distribution list.**

Procurement Post Review. A post review was carried out in July 2012 by the Bank's procurement specialist. No serious issues were found however, it was noted that contract awards have not been regularly published. As soon as the information is published, the HSCRM Division will forward to the DPs the list of all publications. **The HSCRM Division will forward to the Bank the updated list of all contracts awarded up to October 31, 2012 prior to the next post review scheduled to be carried out in early 2013.**

TABLE 1::AGREED ACTIONS		
Action	**By Whom**	**By When**
Program Implementation		
1. Forward updated procurement plan to DPs, with revised thresholds, dates, and estimates	SCU	Jan 22, 2013 & every 3 months thereafter
2. Report to DPs on procurement activities on critical path.	SCU	Dec 1, 2012 & every 3 months thereafter
3. Forward to the Bank the updated list of awarded contracts.	SCU	Jan 31, 2013
4. Forward list of contract award publication to the DPs.	SCU	Feb 15, 2013

ANNEX 4

PLANNED PROGRAM OF COMPLETION OF CIVIL WORKS

contract no.	Activity	No. of days		Date:	
		Planned	Actual	Planned	Actual
QCBS.1 SP6.09.B1	**Design & Supervision for PHC, Warehouse, Orthotics: QCBS**				
	Draft contract with Attorney General's office review	10	15		2-May-12
	Seek cabinet approval	7	14		2-May-12
	World Bank approval of draft contract	7	10		23-Apr-12
	Signing of contract	2	10		23-May-12
	Develop designs & tender documents	150		20-Oct-12	
	World Bank approval of bidding documents	7		27-Oct-12	
SP6.09.B2	Construction of the PHC, Warehouse, Orthotics, MTII Works - 3 lots: ICB				
	Publish Invitation to Bid (SPN) - ICB (mini of 6 wks)	2		29-Oct-12	
	Preparation and submission of bids	42		10-Dec-12	
	Evaluate bids	14		24-Dec-12	
	World Bank approval of evaluation	7		31-Dec-12	
	Seek Tenders Board approval of evaluation	5		5-Jan-13	
	Seek Cabinet approval of evaluation	5		10-Jan-13	
	Award and prepare contract	2		12-Jan-13	
	Seek Attorney General's Office for review	10		22-Jan-13	
	Signing of contract	2		24-Jan-13	
		272	49		
	Supervision of PHC, Warehouse, Orthotics Bldg	12 months		24-Jan-14	
		537	573		
	DEFECTS LIABILITY PERIOD	12 months		24-Jan-15	
QCBS.1 SP6.09.B7	**Design and supervision of MTII Savaii Hospital extension & renovations: SSS**				
	Negotiations with firm for contract variation	5		30-Jun-12	26-Oct-12
	World Bank approval of Draft contract variation	7		2-Nov-12	
	Seek Tenders Board approval of contract variation	5		7-Nov-12	
	Seek Cabinet approval of contract variation	5		12-Nov-12	
	Seek Attorney General's Office review	10		22-Nov-12	
	Signing of contract variation	2		24-Nov-12	
	Develop designs & bidding documents	120		24-Mar-13	
	World Bank approval of bidding documents	7		31-Mar-13	
		161	0		
SP6.09.B8	**Construction of the MTII Hospital extension & renovations : ICB**				
	Publish Invitation to Bid (SPN) - ICB (mini of 6 wks)	2		2-Apr-13	
	Preparation and submission of bids	42		14-May-13	
	Evaluate bids	14		28-May-13	
	World Bank approval of evaluation	7		4-Jun-13	
	Seek Tenders Board approval of evaluation	5		9-Jun-13	

	Seek Cabinet approval of evaluation	5		14-Jun-13	
	Award and prepare contract	2		16-Jun-13	
	Seek Attorney General's Office for review	10		26-Jun-13	
	Signing of contract	2		28-Jun-13	
		89	**0**		
	Construction of MTII Savaii Hospital	**6 months**		**25-Dec-13**	
	DEFECTS LIABILITY PERIOD	**12 months**		**25-Dec-14**	
B6.01	**Construction of 3 dental static clinics: NCB SAT827,082.30**				
	World Bank approval of bid evaluation				7-Mar-12
	Seek Cabinet approval	7	15		28-Mar-12
	Draft contract for Attorney General's Office review	10	15		16-Apr-12
	Signing of contract	2	20		3-May-12
	Actual construction of works	180		**30-Oct-12**	
		199	**50**		
	DEFECTS LIABILITY PERIOD	**12 months**		**30-Oct-13**	
SP6.09.B13	**Relocation and construction of Poutasi District Hospital: ICB**				
	Revisit existing drawings and scope of works for relocation	10	30		13-May-12
	To amend the drawings according to Architect (WB recommendations	30	90		13-Aug-12
	Finalise bidding documents and designs	20	30	13-Sep-12	
	World Bank approval of designs & bidding documents	7		20-Sep-12	
	Publish Invitation to Bid (SPN) - ICB (mini of 6 wks)	2		22-Sep-12	
	Preparation and submission of bids	42		3-Nov-12	
	Evaluate bids	14		17-Nov-12	
	World Bank approval of evaluation	7		24-Nov-12	
	Seek Tenders Board approval of evaluation	5		29-Nov-12	
	Seek Cabinet approval of evaluation	5		4-Dec-12	
	Award and prepare contract	2		6-Dec-12	
	Seek Attorney General's Office for review	10		16-Dec-12	
	Signing of contract	2		18-Dec-12	
		96	**0**		
	Construction of Poutasi District Hospital :	**12 months**		**18-Dec-13**	
	DEFECTS LIABILITY PERIOD	**12 months**		**18-Dec-14**	
SP6.09.B19	Supervision of construction works of Poutasi District Hospital: CQS				
	Develop TOR	3		1-Nov-12	
	World Bank approval of TOR	7		8-Nov-12	
	Seek expressions of interest from firms - CQS	14		22-Nov-12	
	Evaluation of EOIs	5		27-Nov-12	
	Seek Tenders Board approval of selection	5		2-Dec-12	
	Issue RFP to selected firm to prepare proposal	14		16-Dec-12	
	Evaluate proposal	14		30-Dec-12	

	Seek Tenders Board approval of contract award	5		4-Jan-13
	Negotiate and prepare contract	14		18-Jan-13
	Seek AG's Office for contract review and clearance	10		28-Jan-13
	Signing of contract	2		30-Jan-13
SP6.09.B11	Construction of Lufilufi Nurse's Quarters : NCB			
	Develop designs for Nurse's Quarter	30	45	30-Sep-12
	Develop bidding documents	10	25	25-Oct-12
	Seek World Bank approval of bidding documents	7	10	5-Nov-12
	Advertise	2	2	7-Nov-12
	Prepare and submission of bids	30	30	7-Dec-12
	Evaluate bids	5	10	17-Dec-12
	Seek World Bank approval of evaluation report	7	10	27-Dec-12
	Seek Tenders Board approval of evaluation report	5	15	9-Jan-13
	Seek Cabinet approval of evaluation report	5	5	14-Jan-13
	Draft contract for Attorney General's Office review	10	15	29-Jan-13
	Signing of contract	2	5	5-Feb-13
		113	172	
	Construction works of Lufilufi Nurse's quarters	6 months	6 months	30-Aug-13
	DEFECTS LIABILITY PERIOD	6 months	6 months	28-Feb-14
	Supply & Installation of Non-medical Equipment: ICB			
	Prepare schedule of requirements, specifications & draft bidding documents & forward to World Bank			1-Aug-13
	World Bank approval of bidding documents	7		8-Aug-13
	Publish Invitation to Bid (SPN) - ICB (mini of 6 wks)	2		10-Aug-13
	Preparation and submission of bids	42		21-Sep-13
	Evaluate bids	14		5-Oct-13
	World Bank approval of evaluation	7		12-Oct-13
	Seek Tenders Board approval of evaluation	5		17-Oct-13
	Seek Cabinet approval of evaluation	5		22-Oct-13
	Award and prepare contract	2		24-Oct-13
	Seek Attorney General's Office for review	10		3-Nov-13
	Signing of contract	2		5-Nov-13
		96	0	
	Supply & Installation:	6 months		4-May-14
	WARRANTY PERIOD	12 months		4-May-15
	Supply & Installation of Medical Equipment-Phase B			
	Prepare schedule of requirements, specifications & draft bidding documents & forward to World Bank			1-Oct-13
	World Bank approval of bidding documents	7		8-Oct-13
	Publish Invitation to Bid (SPN) - ICB (mini of 6 wks)	2		10-Oct-13
	Preparation and submission of bids	42		21-Nov-13
	Evaluate bids	14		5-Dec-13
	World Bank approval of evaluation	7		12-Dec-13
	Seek Tenders Board approval of evaluation	5		17-Dec-13
	Seek Cabinet approval of evaluation	5		22-Dec-13
	Award and prepare contract	2		24-Dec-13
	Seek Attorney General's Office for review	10		3-Jan-14
	Signing of contract	2		5-Jan-14

	96	0	
Supply & Installation:	6 months		4-Jul-14
WARRANTY PERIOD	12 months		4-Jul-15

ANNEX 5

FINANCIAL MANAGEMENT

October 30-31, 2012

Objective and scope of review – A review of the implementation of the financial management (FM) arrangements of the Samoa Health Sector Management Program Support and compliance with the financial covenants under the Financing Agreement was conducted on October 30 & 31 2012 at the Ministry of Health by the Bank's FM Specialist Stephen Hartung. The objective of the review was to ensure that the FM arrangements for the IDA credit and other donor funds are adequate for the successful achievement of project development objectives. The mission generally covered the following: (1) review of the project's financial management system through (a) discussions with Project Staff and the Ministry of Finance, (b) review of and analysis of IFR for March to June 2012 review and (c) inspection of selected expenditures as to eligibility and adequacy of supporting documents and compliance with policies and procedures under the Project; (2) review of financial reports and books of accounts; (3) review of the status of the actions taken to the recommendations in the past missions; and (4) review of compliance with the financial covenants under the credit and grant agreements.

Project Description –The project is financed from IDA USD 6million equivalent, increased from USD 3 million; NZD6 million, increased from NZD2.4, AusAID $12.6 US increased from 4.5M and GOS1.5M. Funds are pooled and hence no donor funds specific expenditure with the exception of the GoS which funds specific positions within the MoH which contribute to the project. Initially the prorata allocation of funds are as follows: AusAID45%, IDA 25%, NZAid 24% and GoS 6%.
The objectives of the Health Sector Management Program Support Project for Samoa is to improve the effectiveness of the Government of Samoa ("GoS") in managing and implementing the Health Sector Plan 2008-2018 (HSP) using results from sector performance monitoring. There are three components to the project.

a) The first component is health promotion and prevention. It aims to support the transformation of the health sector towards a health and wellness model from a narrower medical orientation. Health promotion is at the centre of Ministry of Health's effort to reorient the sector to a wellness focus.
b) The second component is the enhancement of quality health care service delivery. It aims to support improving the various dimensions of the quality of health care, particularly at the primary care level. The following areas will be supported:
    i. Dissemination of, and staff training, on the clinical standards and protocols for disease management adapted to the Samoan context;
    ii. Upgrading the skills of the health workers;
    iii. Improving reproductive, maternal and child health services to reduce post-natal morbidity among women and reduce neonatal mortality among babies;
    iv. Improving primary health care and community health outreach through integrated health services;
    v. Improved forecasting of pharmaceuticals requirements, procurement, storage, distribution and use through upgraded warehouse and inventory management system.
c) The third component is the strengthening policy, monitoring, and regulation in the health sector. The following areas will be supported:
    i. Implement human resources development strategy for the health sector, including Human Resources database creation, development of multi-skilled nurses and credentialing

system, and development of a bachelor of health science program in the national university of Samoa;

ii. Monitoring and evaluation through use of improved information systems including analysis and reporting, structured survey instruments and annual joint health sector reviews, and

iii. Public private partnership framework for service delivery through competitive contracting with large Non-government organisations and the private sector.

Status of disbursement –Total disbursements for the IDA funds are shown in the table below as of October 28 2012**,**

Source of funds	Loan Amount in XDRs	Amount disbursed	% of funds disbursed.
IDA 44320	1,900,000	1,896,634	99.8%
IDA 47210	2,000,000	0	0%

The closing date for the project is December 31, 2013. IDA 44320 is almost fully disbursed but there has been no disbursement in the IDA 47210. The September 2012 IFR indicates nearly $1.5million will need to be advanced based on the six month projection.

Overall financial management system rating – The FM rating as remains as **Moderately Satisfactory** mainly due to the unresolved issue of the sitting fees. IFRs are up to date and the general quality of documentation retention is excellent.

Adequacy of accounting staff and maintenance of accounting records – The Financial section for this project consists of Darryl Anesi (program accountant) and Richard Titimaea Tafua (Component 2 assistant) who helps with the accounts and Mareta Sefo (Component 3 assistant). Darryl has the skills to maintain an adequate set of accounts and now that he has successfully completed his Masters Degree there should be sufficient FM resources to maintain the accounts and complete the FM requirements of the project. FM implementation reviews will continue to be conducted at least every 6 months.

Internal Controls – There is segregation of incompatible duties and responsibilities. Levels of review and approvals were considered adequate to provide reasonable assurance that the policies and procedures for recognition and recording of assets, revenues and expenses are generally complied with. The Program Operations Manual covers the internal control requirements of the project.

Follow up from previous mission issues

a) Acquittals were reviewed to determine if the Accountable Advances were adequately controlled. There had been 5 accountable advances since the previous mission in March 2012 and a 100% review was conducted. No material issues were identified.

b) Reconciliation to MOF records. As part of the accounting process, prior to the preparation of the IFRs all transactions are entered from the Finance One printout supplied by MOF and checked against the documentation maintained by MOH. While this system is quite comprehensive IFR does not have an actual reconciliation back to the Finance One records so errors may go undetected. **Hence it is recommended that a formal reconciliation is prepared between the totals of the Finance One print outs and the actual amounts entered into the quarterly expenditure for the IFR.** The reconciliation could take the following format:

Finance One Print out totals
Month 1
Month 2

Month 3

Total Amount of Finance One Print Outs

Plus any interest/revenue included in the print outs

Plus any expenditures not included or understated

Less any expenditures incorrectly included or overstated

Amended Finance One Print Out Total

Plus Central Bank Transactions

Month 1

Month 2

Month 3

Total Central Bank Transactions

Total Transactions for Quarter

Less Amount entered into IFR

Discrepancy

c) As requested in the previous mission MoH are now keeping hard copies of the Registers provided by the MoF. These were checked during the review.

d) The IFR cumulative expenditure in US$ formula included both sum of Cumulative Expenditure and Cumulative Commitments, multiplied by a variable exchange rate. This has now been amended.

Issues identified during this review

Sitting fees – A letter was sent by the Bank to the Ministry of Finance on November 8, 2011 which outlined that civil servant sitting fees are ineligible and prior expenditures need to be refunded. The letter also stated that sitting fees for Parliamentarians were also deemed ineligible but as this was not specifically stated in the legal agreements the ineligibility would only apply to those payments made after the date of the abovementioned letter.

The sitting fees for civil servants (CEOs) were refunded for the meetings of November 29, 2011, February 2,8 2012, March 8th and 15th, 2012. The total amount refunded was 4,250WST. Sitting fees that were incurred in meetings on 28 May 2011, 16 September 2010, October 8, 2010, December 6, 2010, November 3, 2011, November 10, 2011, November 15, 2011 and November 2,1 2011 were not refunded.

At the time of this review no Parliamentarian sitting fees have been refunded. The total amount of sitting fees needs to be determined based on the Civil Servant sitting fee dates identified above and also the total amount of parliamentary sitting fees since November 8, 2011. These amounts then need to be reversed out of the project records. Hence the government will need to replenish the DA with the amount and take this expense out of the reports. This transaction needs to be reflected in the December report along with the basis of the calculation.

Taxes -The Financing Agreements for both IDA 47210 and 44320 are exclusive of taxes. Hence taxes should not be paid from this source of finances. This is virtually impossible to monitor as all payments are co-financed by funds from NZAid, AusAID and GOS. The GOS funds are supposed to be the government's contribution to the payment of taxes but in reality some purchases are subject to VAGST at 15% and other payments are not subject to VAGST (i.e. wages, professional fees, transport allowances). It is recommended there are discussions with GoS on how to rectify the current position and this may include amending the donor Financing Agreements and or increasing the GoS contribution.

Transaction Review – A transaction review was conducted for the period from March to September 2012. The review checked the documentation for a sample of transactions and there was a 100% review of the expenditure for reasonableness. The documentation was adequate for all transactions reviewed and the testing was quite limited as this has not been a high risk area. The following transactions were queried for reasonableness and the response is also included and no action is required:

- Payment in June: $3,545.92 which was paid from MOF payroll. It was explained that this person was a consultant not a salary earner but at the end of the project they would become an employee of MOH.
- Flowers 2,380 July – hire of pot plants and flowers for MOH health exhibition.

Assets Register - An asset register is maintained by the project and this was reviewed although time did not permit any checking of assets against the register; however a reconciliation was done back to the expenditure in the testing period and no issues were identified. There are a large number of assets purchased by the project (over 350) and these are handed over to the respective entity at time of procurement. The issue of assets not being included in the assets register as raised in the 2010/11 audit has now been addressed.

IFR Review – Budget. The budget for the IFR changes each quarter as it is based on the Financial Package Matrix, which outlines the estimated cost in SAT of all program expenditure since inception. The budget changes occur as the Matrix is amended according to the Health Advisory Committee meeting which may reprioritize the future expenditures. It will also be changed when the contract amount is signed. Hence the budgeted amount changes, all be it by a relatively small amount for each IFR. It is recommended that a copy of this Matrix is attached to the IFR to enable users to identify how the budget is calculated. There may be a delay in the updating of new contracts due to updating of the procurement plan.

- Commitments is a formula from estimated cost less actual and the brief testing of outstanding contracts indicated this is a reasonable estimate of the current unpaid contracted amounts.

- Commitments and budget calculations will be reviewed in future implementation reviews although no material issues were identified in this review.

Available Funds – Based on the September IFR there has been 28,972,412 SAT expended and a budget of 72,942,466 SAT meaning the amount still to be expended on this project is 43,970,053 SAT or at current exchange rate as at 30 September USD 19,588,658. In addition there was at 30 September an estimated 3,325,649 SAT (which includes interest) in the DA. The donor funds available as at 30 September 2012 based on the information provided by NZAid and updating of IDA of available IDA funds based on current (November 15 exchange rate of SDR to USD) the current amounts still remaining to be disbursed are as follows;

- World Bank IDA US$3,058,197
- AusAID US$4,773,000
- NZAid US$5,312,897
- Balance of DA US$1,481,576

  Total US$14,625,670

… which equals a short fall of US$4,962,988. It should be noted that there is also another US$336,795 of funds to be contributed by the GOS as part of their agreed contribution of US$1,500,000. Based on the information provided there are currently insufficient funds to cover the projected budget, however there are adequate funds to cover the commitments shown in the September IFR of US$11,091,187.

Adjustment of Donor Contributions. - The future contribution per donor is based on the funds yet to be expended plus the nominal amount as shown in the September IFR. The table below shows the amount in USD for each source of finance.

Source of Finance	IDA	AusAID	NZAid	GoS
Funds not yet Disbursed	$3,058,197	$4,773,000	$5,312,897	$336,795
Balance in DA 30 Sept	($285,393)	$2,080,067	$973,254	$396,943
Total	$2,772,804	$6,853,067	$6,286,151	$733,738
% per source of funding	17%	41%	38%	4%
Current % allocation	25%	45%	24%	6%

Referring back to part 8 (b) of this report, currently the donor agreements do not fund taxes. To compensate for this it was agreed the GoS would provide 6% funding to cover the VAGST which was estimated as the average amount of tax that would be payable at the preparation stage of the project. However the VAGST has risen from 10% to 15%. Given that other donors have increased their contribution, the 4% GoS contribution is no longer consistent with the contribution required to cover taxes. Hence it is recommended that either the donor legal agreements be amended to include payment of taxes or that there is negotiation with the GoS to increase their contribution commensurate to the estimated amount of tax paid through project transactions.

Compliance with the financial covenants – (a) ***Interim Financial Reports*** - The IFR for June 2012 has now been cleared and the September IFR which is not due till November 15 was being worked on during the review. (b) ***Audited project financial statements*** - The 2011/12 audited financial statements are due on 31 December 2012. At the time of the review the financial statements had not been submitted to the audit office.

Summary of action plans:
Below is a list of the actions required as a result of the Implementation review:

	Actions	Responsible	Due Date
1.	Repayment of the sitting fees for the civil servants and parliamentarians.	Project Manager and Project Accountant.	30 November 2012.
2.	Use of reconciliation sheet included in section 7 of this report to ensure accuracy of IFRs to MOF records.	Project accountant	To be implemented for the December 31 2012 IFR.
3.	Submission to the World Bank of 2011/12 project Audited Financial Statements.	Project Accountant/ Samoa Audit Office	31 December 2012.

ANNEX 6

TABLES LIST OF PROJECTED OVERRUNS/POTENTIAL ADDITIONAL REQUESTS

Act#	Activity	Budget Estimate	Actual Budget/ Revised	Budget Shortfall
1	HCW Truck	150,000	238,864	88,864
2	Extension TA Biomedical Engineer	119,818	331,107	211,289
3	Construction (3 bldgs) PHC, Warehouse, Orthotics	12,000,000	17,789,703.14	5,789,703.14
4	Laundry Equipment	185,000	791,356	606,356
5	Renovation & extension of MT2 Savaii Hospital	1,500,000	4,000,000	2,500,000
6	Hospital medical equipment package for phase B	7,620,657	9,554,217	1,993,560
7	Emergency generator for Savaii hospital	200,000	430,000	230,000
8	Non-medical equipment for new hospital (new)	0	3,771,425	3,771,425
TOTAL		21,775,475	36,906,672	15,491,197 11,719,772 (minus #8)

ANNEX 7

LIST OF PERSONS MET

MINISTRY OF FINANCE (MOF)	
Peseta Noumea Simi	Assistant Chief Executive Officer, Ministry of Finance Health Advisory Committee Chairperson
Oscar Malielegaoi	
MINISTRY OF HEALTH (MOH)	
Palanitina Tupuimatagi Toelupe	Director General, Chief Executive Officer
Pelenatete Stowers	Assistant Chief Executive Officer, Nursing and Midwifery
Frances Brebner	Registrar
Ualesi Falefa Silva	Assistant Chief Executive Officer, HPPS & CFP 1
Gaualofa Matalavea Saaga	Assistant Chief Executive Officer, HSCRM
Sarah Faletoese Su'a	Assistant Chief Executive Officer, SDPD
Sosefina Talauta Tualaulelei	Assistant Chief Executive Officer, CSD
Darryl Anesi	Program Accountant
Richard Tafua	Accountant
Violet Aita	Procurement Specialist
Victoria Ieremia Faasili	Principal Component Assistant
NATIONAL HEALTH SERVICE (NHS) OF THE MINISTRY OF HEALTH	
Tupuola Koki Tuala	NHS Board Chairman
Leota Laki Sio	General Manager
Kassandra Betham	SWAp Manager / CFP2
NEW ZEALAND AID PROGRAM	
Pete Zwart	Manager New Zealand Aid Program (Samoa)
Marion Clark	Development Manager Health New Zealand Aid Program (Wellington)
Christine Sa'aga	Development Programme Coordinator (Samoa)
AUSTRALIAN AGENCY FOR INTERNATIONAL DEVELOPMENT - AusAID	
Megan Counahan	Health Specialist (Samoa)
Erica Reeve	
UNITED NATIONAL FUND FOR – UNFPA	
Virisila Raitamata	UNFPA Representative (Fiji)
WORLD HEALTH ORGANIZATION – WHO	
Dr. Yang Baoping	WHO Representative
WORLD BANK	
Eva Jarawan	Lead Health Specialist (Washington)

Eileen Brainne Sullivan	Health Specialist (Washington)
Ian Anderson	Consultant: Non-Communicable Diseases
Stephen Hartung	Financial Management Specialist (Sydney)
Miriam Witana	Procurement Specialist (Sydney)
Maeva Natacha Betham Vaai	Liaison Officer (Samoa)