

Independent Performance Assessment

Solomon Islands - Health Sector Support Program 2016

29 May 2017

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Acronyms

ADT	Admissions, discharges and transfers
AUD	Australian dollar
AOP	Annual Operational Plan
CIS	Core Indicator Set
DHIS	District Health Information Software
DFA	Direct Funding Agreement
DFAT	(Australian) Department of Foreign Affairs and Trade
DP	Development Partner
DPCG	Development Partner Coordination Group
EU	Delegation of the European Union
FHC	Family Health Committee
FR	Financial Report
GBV	Gender Based Violence
HFCS	Health Facility Costing Study
HIS	Health Information Systems
HR	Human Resources
HRF	Health Resource Facility
HRM	Human Resources Management
HSSP	Health Sector Support Program
ICTSU	ICT Support Unit of Solomon Islands
IPA	Independent Performance Assessment
JPA	Joint Performance Assessment
JAPR	Joint Annual Performance Review
JD	Job description
JICA	Japan International Cooperation Agency
LMEA	Line Ministry Expenditure Analysis
MDPAC	Ministry of Development, Planning and Aid Coordination
MHMS	Ministry of Health and Medical Services
MPS	Ministry of Public Service
NHSP	National Health Strategic Plan
NMS	National Medical Stores
MOFT	Ministry of Finance and Treasury
NCD	Non Communicable Disease
NRH	National Referral Hospital
OPD	Outpatient Department
PA	Partnership Arrangement (between MHMS and DPs)
PCU	Partnerships Coordination unit
PFC	Planning and Finance Committee
PFM	Public Finance Management
PHD	Provincial Health Director
PLA	Performance Linked Aid
PLF	Performance Linked Funding

PS	Permanent Secretary
RAC	Risk and Audit Committee
RDP	Role Delineation Policy
SBA	Skilled Birth Attendant
SIG	Solomon Islands Government
SLMS	Second Level Medical Store
SPC	Secretariat of the Pacific Community
SWAp	Sector Wide Approach
TA	Technical Assistance
ToR	Terms of Reference
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
US	Under-secretary
WHO	World Health Organization

REQUEST:

Support the Ministry of Health and Medical Services of the Solomon Islands to assess its own and SWAp partners' performance against the 2016 Health Sector Support Program performance indicators, present findings and assist with finalising the 2017 performance indicators.

Independent Performance Assessment Report Solomon Islands Health Sector Support Program 2016

Executive Summary

Since 2008, the Solomon Islands Ministry of Health and Medical Services (MHMS), with support of development partners, has led a Sector-wide approach (SWAp) to the delivery of health services in Solomon Islands. Sixteen development partners including Australia are aligning their support with the Solomon Islands National Health Strategic Plan 2016-2020.

Australia is the lead donor in the Solomon Islands health sector, with its main bilateral assistance provided through the Health Sector Support Program. Under phase 3 of the Health Sector Support Program (HSSP3), Australia is providing AUD 66m over four years (2016 – 2020) for direct budget support, performance linked funding and technical assistance. The overall program goal for HSSP3 is to improve the access and quality of universal health care in Solomon Islands.

Under HSSP3, up to 25% of budget support is subjected to Performance Linked Funding (PLF) against a set of annually agreed performance indicators applied at both national and provincial level programs. Fifty per cent (50%) of the PLF is available for allocation to provincial health service delivery and fifty per cent (50%) to national programs/reforms. The PLF payment each year is triggered by an Independent Performance Assessment of the previous year's mutually agreed performance indicators. In addition, Development Partners are assessed for their performance mutually agreed against performance indicators.

The independent assessment of progress against the PLF indicators is presented at the MHMS's Joint Annual Performance Review (JAPR) in April/May each year. The present report reflects the results of the independent performance assessment for 2016. The report was tabled at the JAPR on 1 May 2017.

The following tables and figures show key assessment results for the major implementation categories at the national (Table 1) and provincial (Table 3) levels, performance scores for the payment-linked indicators at national (Table 2) and provincial (Table 4) levels, and performance scores per province (Table 5 and Figure 1) and payment levels. Table 6 summarises the performance results for Development Partners.

For 2016, the total amount available for disbursement as Performance Linked Funding is AUD2,614,000, or AUD1,307,000 each for national and provincial levels. The performance payments to be disbursed have been calculated by multiplying the indicator performance scores by the weight assigned to each indicator. The resulting percentage was multiplied by the total amount of money available. The

performance payment for each indicator was rounded to the nearest dollar and then summed to derive a total amount.

The final amount to be disbursed is AUD 1,912,410 or approximately 73% of the total amount available. The payment for national performance indicators are AUD 887,889 (approximately 68%) and the payment for provincial performance is AUD 1,024,521 (approximately 78%).

Table 1 Key Performance Assessment Results by Category and Indicator, National 2016

National			
Category	Indicator	Category Weight	Key Assessment Factors
INPUT			
Budget	N 1. % Solomon Islands Government (SIG) recurrent health budget (276) allocated to Provinces (including payroll) is no less than 37% of total recurrent budget in 2016.	20%	Fully met
PROCESS			
Health Reform & Human Resources	N 2.1 MHMS senior management job descriptions incl. tasks, responsibilities and reporting lines have been prepared as part of new MHMS structure by end of the year N 2.2 National Role Delineation Policy Action Plan has been prepared and approved by Executive by the end of 2016 N 2.3 % of Committee meetings held against set targets each year (also PHD representation where specified in ToR) N 2.4 % of MHMS counterpart positions that MHMS has completed recruitment processes for within 8 weeks of a position being vacant.	20%	Sr. Management job description prepared; organogram has not been endorsed by Cabinet. RDP Action Plan not prepared; Task Group finalised the RDP document. Family Health Committee (FHC), Planning and Finance Committee (PFC) and Risk and Audit Committee (RAC) not held against annual targets. No evidence of PHD presence (required for FHC, PFC). No evidence on completed recruitment process within 8 weeks (from advertisement to submission to MPS) of three remaining NHMS vacant counterpart positions.
Health Information Systems	N 3.1 % of ADT summaries entered into the electronic system at the National Referral Hospital (NRH) since the implementation of the system N 3.2 Scope work undertaken to provide for gender based violence (GBV) data integration into DHIS and other relevant clinic reporting processes N 3.3 Feasibility assessment on introduction of Electronic Patient Management System at minimum of one secondary hospital(s) undertaken before year end	20%	All patient admission, discharges and transfers (ADT) summaries entered into the electronic system at NRH since 10 Sept 2016 No assessment report available on GBV data collection potential at clinic and hospital and integration into DHIS. GBV indicators reviewed and proposed for the DHIS, GBV Clinical guidelines developed. Cabling assessment/plan available, but no full feasibility assessment report on introduction of electronic patient management system available
Public Finance Management	N 4. % of activities of the PFM roadmap that have been prioritised and conducted before end of 2016	20%	PFM Roadmap work packages included in divisional Annual Operational Plans (AOPs) and partly addressed through AOP implementation.
OUTPUT/OUTCOME			
Services	N 5.1 Non communicable diseases (NCD): Number of hospitals that have held at least one diabetes clinic per week in 2016. N 5.2 % Second Level Medical Stores (SLMS) having sufficient essential drugs available for distribution to health facilities without interruption during the year N 5.3 Number and per capita outpatient department (OPD) consultations in 2016	20%	Self-reporting evidence of NCD clinics including diabetes services available for 5 out of 7 hospitals; data are consistent but incomplete, and no mechanisms was established to consistently collect NCD service data (weekly) in these hospitals. Average in stock rate of 90% reduced with 10% due to localised stock-out problems and supply chain inefficiencies. Indicator has changed due to indicator validity and data availability issues. The target to increase OPD consultations in 2016 has been met- The total increase has been 14% without NRH and 22% with NRH OPD data included in DHIS.

Table 2 National payment-linked performance indicators and performance payment 2016

Payment-linked performance indicator	Weight	Relative weight	Score performance	Resulting payment score	Performance payment (AUS\$)
NATIONAL	Allocation: \$1,307,000				
N 1. % SIG recurrent health budget (276) allocated to Provinces (including payroll) is no less than 37% of total recurrent budget in 2016.	20%	1	100%	20.0%	\$261,400
N 2.1 MHMS senior management job descriptions incl. tasks, responsibilities and reporting lines have been prepared as part of new MHMS structure by end of the year	20%	1/4	50%	2.5%	\$32,675
N 2.2 National Role Delineation Policy Action Plan has been prepared and approved by Executive by the end of 2016		1/4	10%	0.5%	\$6,535
N 2.3 % of Committee meetings held against set targets each year [also Provincial Health Direct representation where specified in ToRs)		1/4	36%	1.8%	\$23,526
N 2.4 % of MHMS counterpart positions that MHMS has completed recruitment processes for within 8 weeks of a position being vacant		1/4	0%	0.0%	\$0
N 3.1 % of patient ADT summaries entered into the electronic system at the National Referral Hospital since the implementation of the system	20%	1/3	100%	6.7%	\$87,133
N 3.2 Scope work undertaken to provide for gender based violence data integration into DHIS and other relevant clinic reporting processes		1/3	50%	3.3%	\$43,567
N 3.3 Feasibility assessment on introduction of Electronic Patient Management System at minimum of one secondary hospital(s) undertaken before year end		1/3	75%	5.0%	\$65,350
N 4. % of activities of the PFM roadmap that have been prioritised and conducted before end of 2016	20%	1	64%	12.8%	\$167,296
N 5.1 NCD: Number of hospitals that have held at least one diabetes clinic per week in 2016.	20%	1/3	50%	3.3%	\$43,567
N 5.2 % SLMSs having sufficient essential drugs available for distribution to health facilities without interruption during the year		1/3	80%	5.3%	\$69,707
N 5.3 Number and per capita outpatient consultations in 2016		1/3	100%	6.7%	\$87,133
Total performance payment					\$887,889

Table 3 Key Performance Assessment Results by Category and Indicator, Provinces 2016

PROVINCES			
Category	Indicator	Category Weight	Key Assessment Factors
INPUT/PROCESS			
Planning & Monitoring	P 1.1 % of AOPs and budgets submitted by 30 September	Pre-condition 50%	Fully met
	P 2.1% of outstanding imprests that are more than 90 days overdue from specified retirement date at 31 December		Outstanding imprests over 90 days overdue for the total of all provinces is 24%. Only Choiseul and Makira provinces score under 10%. Reporting overall satisfactory. Timeliness has only been measured for DHIS reporting.
OUTPUT			
Outreach	P 3. Annual % increase of outreach activities	25%	Outstanding performance of Honiara City Council and Malaita Province on all three selected outreach activities: satellite clinics, vaccination visits and school health visits. Choiseul experienced underperformance on all three.
OUTCOME/IMPACT			
Services & Health Status	P 4. Number of maternal deaths, infant mortality, child mortality, contraceptive contacts, skilled birth attendance	25%	While the number of maternal deaths decreased, infant and child death increased. All provinces increased on contraceptive contacts likely due to Jadelle implant program. Skilled birth attendance only increased significantly in Renbel province.

Table 4 Provincial payment-linked indicators and performance payment 2016

Payment-linked performance indicator	Weight	Relative weight	Score performance	Resulting payment score	Performance payment (AUS\$)
PROVINCIAL	<i>Allocation:</i> \$1,307,000				
P 1.1 % of AOPs and budgets submitted by 30 September	Pre- condition		100%		
P 2.1 % of outstanding imprests that are more than 90 days overdue from specified retirement date at 31 December	50%	1/4	74%	9.2%	\$120,728
P 2.2 Completion on timely reporting for various reports per year		3/4	99%	37.1%	\$484,535
P 3. Annual % increase of outreach activities	25%	1	64%	16.0%	\$208,832
P 4 Number of maternal deaths, infant mortality, child mortality, contraceptive contacts, skilled birth attendance	25%	1	64%	16.1%	\$210,427
Total performance payment					\$1,024,521

Table 5 Performance scored and payments by Province, 2016

Province	PROVINCIAL SCORES				PROVINCIAL PERFORMANCE		
	OUTSTANDING IMPRESTS (status)	REPORTING (status)	OUTREACH * (progress)	IMPACT/ OUTCOME* (progress)	HSSP Performance Grant (AUD)	Weighted overall score (% of total available)	Performance payment (AUD)
	P 2.1 (weight=12.5%)	P2.2 (weight=37.5%)	P 3 (weight=25%)	P 4 (weight=25%)			
Central	69%	98%	50%	64%	82,127	74%	60,547
Choiseul	100%	98%	0%	64%	93,095	65%	60,832
Guadalcanal	83%	98%	50%	64%	191,670	76%	144,850
Honiara CC	85%	99%	100%	64%	54,204	89%	48,003
Isabel	52%	99%	53%	64%	106,007	73%	77,367
Makira	100%	99%	70%	64%	114,042	83%	94,798
Malaita	72%	100%	100%	64%	315,389	88%	275,998
Renbel	32%	100%	43%	88%	22,090	74%	16,431
Temotu	74%	99%	43%	64%	85,223	73%	62,344
Western	59%	99%	60%	64%	243,153	75%	183,351
TOTAL	74%	99%	64%	64%	1,307,000	78%	1,024,521

* progress measured on the basis of annual percentage change in 2016 compared to 2015

Figure 1 Provinces, weighted overall score, 2016

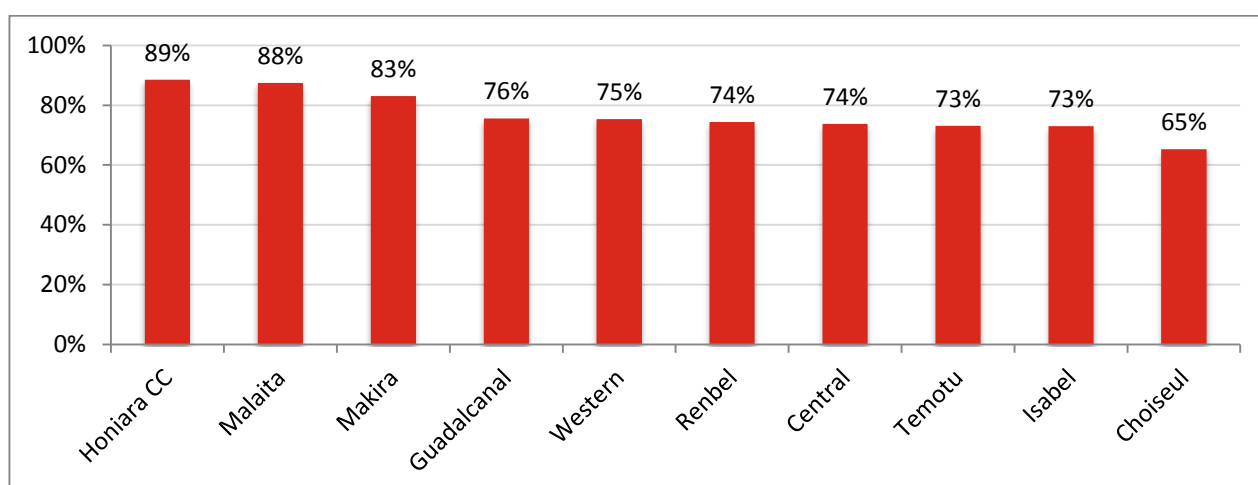


Table 6 Development Partner Performance Indicators and Assessment, 2016

	Type of indicator	Target	Key Assessment Factors
ALIGNMENT	<p>DP1.1 Proportion of non-Technical Assistance (TA) Development Partner (DP) funding on budget and on system.</p> <p>DP1.2 Funding inputs are announced at the SIG budget launch (July) and appropriated through the regular SIG budget process (appropriated in November).</p> <p>DP 1.3 Only the HSSP SWAp account is used with no separate bank accounts in operation (on-system).</p>	All signatories to the Partnership have advised 2016 inputs prior to Planning Development Partner Coordination Group (DPCG) (July 2016)	<p>Sixteen DPs are signatories of the Health SWAp. DFAT and EU are 100% on budget and on system, followed by the Joint UN (85%) and UNFPA (50%). For others the percentages are yet unknown: WHO and UNICEF contribute \$1.7 and \$1.9 million. Other SWAp partners are not on budget, but some non-SWAp organisations are, like the Global Fund (\$8.1 million).</p> <p>All funding inputs have been announced at the SIG budget launch (July) and appropriated through the regular SIG budget process (appropriated in November).</p> <p>Six development partners use the bank accounts in operation (MHMS SWAp development partners' account).</p>
PREDICTABILITY	<p>DP2.1 DP payments are made on time (as long as SIG has fulfilled reporting requirements) and in accordance with commitments (no intra-year changes).</p> <p>DP2.2 DP's provide 4 year budget projections to assist Ministry's long term planning activities.</p>	All signatories to the partnership	<p>WHO, Joint UN, UNFPA and the EU all provided payments on time with no major intra-year changes, such as the use of advance or contingent warrants to enable appropriation.</p> <p>DFAT and UNICEF payments were not made on time. For DFAT this was due to the delay in the execution of the HSSP3 Direct Funding Arrangement (January 2017) and a delay in making the first payment under HSSP3 whilst decisions about Australian-funded advisers in Ministry of Finance and Trade (MoFT) were being resolved.</p> <p>Longer term budget projections made in 2016 for 2017 and beyond (4 years) were only provided by DFAT.</p>
OWNERSHIP	DP3.1 Program related technical cooperation supported by development partners that has been cleared by MHMS.	100%	Technical cooperation offered by HSSP SWAp partners are administratively processed by MHMS and only implemented in cooperation with MHMS.

Performance indicators for 2017 are proposed. They are an initial draft to be used as a basis for further development in consultation with MHMS and other development partners. The proposed indicators draw on several lessons which have been learned from the present 2016 IPA: performance indicators could improve on their SMART formulation, target setting and/or criteria for payment. In addition, the indicators could be better used as carrots and sticks for improved management. This requires informing health managers at national and provincial levels about the performance indicators, being as transparent as possible about definitions, targets and financial consequences.

It is recommended that quarterly monitoring mechanisms be established. It is furthermore suggested to initiate the IPA process and agree on performance indicators for 2018 in July/August 2017 while AOPs for 2018 are being developed. This would increase ownership and integration of the performance indicators into the planning and monitoring process and contribute to accountability and transparency.

1. Introduction

Since 2008, the Solomon Islands Ministry of Health and Medical Services (MHMS), with support of development partners, has led a Sector-wide approach (SWAp) to the delivery of health services in Solomon Islands. Sixteen SWAp partners including the Australian Government¹ are aligning their support with the Solomon Islands National Health Strategic Plan 2016-2020.

Australia is the lead donor in the Solomon Islands health sector, with its main bilateral assistance provided through the Health Sector Support Program. Under phase 3 of the Health Sector Support Program (HSSP3), Australia is providing AUD 66m over four years (2016 – 2020) for direct budget support, performance linked funding and technical assistance.

The overall program goal for HSSP3 is to improve access to quality universal health care in Solomon Islands. The three program objectives include:

- improved quality and quantity of primary health care;
- stronger health systems to support service delivery; and
- implementation of priority reforms to ensure sustainable service delivery.

Under HSSP3, up to 25% of budget support is subjected to Performance Linked Funding (PLF) against a set of annually agreed performance indicators applied at both national and provincial level programs. Fifty per cent (50%) of the PLF is available for allocation to provincial health service delivery and fifty per cent (50%) to national programs/reforms. The PLF payment each year is triggered by an Independent Performance Assessment (IPA) of the previous year's mutually agreed performance indicators. The independent assessment of progress against the mutually agreed PLF indicators is presented at the MHMS's Joint Annual Performance Review (JAPR) in April/May each year.

Objectives and scope of work

A draft of this report was prepared in advance of the Joint Annual Performance Review (JAPR) to provide the findings of an assessment, conducted independently, on 2016 performance against the agreed set of *national indicators* and *provincial indicators*. It recommends the levels of performance for payment to the national level and the provinces as set out in clauses 26 to 36, particularly 34-36 of the HSSP3 Direct Funding Agreement between Solomon Islands Government (SIG) and the Government of Australia. Furthermore, the report reflects the findings on the performance of SWAp partners in the last year against jointly agreed *development partner indicators* and the SWAp Partnership Agreement signed in 2016. In addition, 2016 indicators were reviewed and a set of draft performance indicators and targets (milestones) for 2017 are recommended for review by the MHMS and Australian Government staff. These draft performance indicators are listed in Annex 9. They are an initial draft to be used as a basis for further development in consultation with MHMS and other development partners.

¹ Development partners who are signatories in the Solomon Islands health SWAp include: World Health Organization (WHO), World Bank, Secretariat of the Pacific Community (SPC), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), Government of Japan, Delegation of European Union, Korean International Cooperation Agency (KOICA), Government of the Republic of China (Taiwan), Fred Hollows Foundation New Zealand, World Vision Solomon Islands, Red Cross Solomon Islands, Save the Children Solomon Islands, New Zealand Government and Kaohsiung Medical University.

This report on 2016 performance against the previously agreed to indicators will contribute to the broader sector review undertaken by SIG and Development Partners (DP) at the JAPR.

Methodology

The assessment consisted of a desk review of documents (see Annex 1) and information from relevant stakeholders, including MHMS Executive, a Provincial Health Director and selected National Directors or their deputies, Australian Department of Foreign Affairs and Trade (DFAT), Delegation of the European Union (EU), Japan International Cooperation Agency (JICA), Secretariat of the Pacific Community (SPC), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank and World Health Organization (WHO). See Annex 2 for a complete list of persons met.

Sources of information differed from one indicator to another, with the main sources being the MHMS 2016 Core Health Indicator Descriptive and Statistical Reports, and the Health Information Unit and Finance Unit standard reports. The Line Ministry Expenditure Analysis (LMEA) provided some information on DP funding flows.

A participatory and iterative process guided the performance review. Apart from exchanging facts and views with the many officers at MHMS, there were meetings with the Permanent Secretary (PS) and Under Secretaries (US), and debriefing meetings with the MHMS Executive and DFAT. In these meetings findings and recommendations were shared and discussed.

2. Program Performance Assessment

The list of 2016 performance indicators in Annex 3 as provided with the ToR of the consultancy has been used for the review. While the calculation of most indicators was straightforward, some indicators were not SMART² formulated. The report highlights related measurement difficulties. The assessment findings are presented here.

Overarching indicator

One overarching indicator is included but is not directly associated with performance funding: 'The Solomon Islands Government will allocate at least 10% of domestically sourced revenue to the recurrent health budget for 2016.' Meeting the indicator is a condition for funding. The percentage of domestically sourced revenue allocated to health was 12.6 % in 2016 (Revised budget 2016; Source: MoFT AX System).

2.1. National indicators

National indicators refer to the budget, health reform, health information system, public financial management and service outcome and impact.

INPUT - Budget

Indicator N1: *Percentage SIG recurrent health budget (276) allocated to Provinces (including payroll) is no less than 37% of total recurrent budget in 2016.*

Key achievements: The percentage of the SIG total recurrent health budget (276) allocation to provinces including payroll in 2016 for the year 2017 has been 37.7%. Provincial malaria grants (previously held

² SMART: specific, measurable, achievable, relevant and time bound

under the budget of the National Program) and the deliberate strategy of funding malaria grants from the 276 budget rather than the 376 budget helped maximise the provincial allocations under the 276 budget. Source - 2017 Recurrent Budget (see also Annex 4).

Recommendation: -

Performance payment score: 100 % (weight 20%)

PROCESS – Health Reform and Human Resources

Indicator N 2.1: MHMS senior management job descriptions incl. tasks, responsibilities and reporting lines have been prepared as part of new MHMS structure by end of the year

Indicator description/interpretation: The indicator is similar to the one in 2015 and last year's description still applies: 'The functional responsibilities of each Division (including provincial health services) are documented and all Senior Managers have approved Job Descriptions, which set out reporting lines, roles and responsibilities.' MHMS senior management includes MHMS Executive (PS, US) and Directors, Heads of Divisions, and Provincial Health Directors. The indicator requires that the new structure (organogram) is endorsed by Cabinet. The disbursement linked condition is a pro rate score for all JDs prepared (weight 50%) and an Organogram endorsed (50%).

Key achievements: The organogram and affiliated roles and responsibilities have been designed including supporting functional responsibilities for the Divisions. Job descriptions have been prepared for Under Secretaries, Directors and Provincial Health Directors (PHD). This is all part of the restructuring of the MHMS, which is linked to the Role Delineation Policy for which approval by the Cabinet is pending. Only after approval will JDs for other senior management like Heads of Division be made final. A 50% score applies because functional responsibilities are present but the organogram has not been endorsed by Cabinet.

Areas for improvement: The final approval of the newly designed institutional set-up was expected before the launch of the SIG budget in July 2016. However, similar to the 2015 IPA, has not yet been endorsed by Cabinet.

Recommendation: In order to generate evidence of its efficiency and effectiveness, the implementation of the restructuring of the health workforce requires monitoring and evaluation. It is expected that by the next JAPR in April 2018 the results of its implementation during the second half of 2017 may be presented. (This is a recommendation repeated from last year's IPA report (2015)).

Performance payment score: 50% (weight ¼ of 20%)

Indicator N 2.2: National Role Delineation Policy Action Plan has been prepared and approved by Executive by the end of 2016

Indicator description/interpretation: Disbursement linked condition is 100% payment on approved Role Delineation Policy (RDP) Action Plan by Executive (evidenced).

Key achievements: The 2015 IPA recommended to put more energy in the RDP: 'the Executive takes immediate action on the revival of the RDP and its testing. Implementation experiences should be documented and discussed MHMS wide and with DPs and put on the agenda of all Committees as a recurrent item for monitoring and follow-up.' To that end an Action Plan for the implementation of the

RDP Policy was envisaged before year end. Evidence of an approved Action Plan was not received by the consultant.

In 2016 the development of the RDP policy was supported by a newly formed Task Group chaired by the Undersecretary Health Care, and consisting of the Director Policy and Planning, Director Nursing, Director Human Resources, PHD Guadalcanal and the HSSP Senior Advisor/Team leader. The Task Force concluded that the RDP Policy document was too descriptive and efforts should be directed to developing a real policy document. Many amendments were made to the document but no action plan was prepared.

A score as low as 10% applies because in 2016 an action plan was not produced, however the set-up of a Task Group did pave the way for amendments to the policy document and further planned actions in 2017. At the start of 2017 (February) a scoping mission supported by WHO assisted the Task Force, which resulted in a final RDP document that will be presented at the National Health Conference in May 2017. Thereafter it will be sent to Cabinet.

Recommendation: Prepare a RDP multi-year Action Plan for national and provincial level prioritised activities, and realistically plan according to budget available. Follow-up on all other recommendations made by the WHO Team in their Mission Report on the Role Delineation Policy (RDP) and Service Delivery Packages (#MR17005)³.

Performance payment score: 10% (weight ¼ of 20%)

Indicator N 2.3: Percentage of Committee meetings held against set targets each year (also Provincial Health Director (PHD) representation where specified in the terms of reference (ToR)

Indicator description/interpretation: Committee meetings of a) Family Health Committee, b) Planning and Finance Committee, and c) Risk and Audit Committee held against set annual targets (incl. frequency of meetings and presence of PHDs where relevant) as per the ToR of those Committees.

Key achievements:

- a) *Family Health Committee* The ToR of the Family and Health Committee (FHC) indicates that quarterly meetings are to be held. In 2016 the Committee met 3 times, in January (no minutes received), May (minutes) and August (minutes). According to the ToR a 'nominated Provincial Health Director (rotational)' is a core member. The 11 core members (MHMS 7, DPs/other 4) are expected to attend all meetings.

In the May meeting 6 core members participated (total participants 8), in the meeting of August 3 core members participated (total 4 participants). In none of the meetings was a PHD present. The August meeting had no Quorum as the ToR requires that at least half of the members (core and co-opted members) should be present.

All in all the FHC ends up with low score. Two meetings (minutes received) out of 4 (50%) and no presence of PHD (reduction of 10%) make a sub-score for FHC of 40%.

³ WHO Mission Report 18-25 February 2017; Team members: Dr. Vivian Lin, Director, Division of Health Systems, Mr. Luke Anthony Elich, Technical Officer, Dr Jun Gao, Coordinator, Ms. Anna Alexandra Maalsen, Technical Officer.

- b) *Planning and Finance Committee* The ToR of the Planning and Finance Committee (PFC) indicates that monthly meetings are to be held. The PFC has met twice in 2016, on 5 July and 15 September to endorse the budget. Minutes of meetings are available.

The reason for not having more meetings originates in a dispute on the Public Financial Management (PFM) Roadmap and the roles and responsibilities of the Committee as compared to the delegation of the Under Secretary Administration and Finance. The Planning and Financing Committee ToR was tabled at the Senior Executive meeting held on 16 August 2016. A team of DFAT and WB TA also filed comments. However, the issue has remained unresolved for the time being.

A sub-score for PFC applies of 2 meetings out of 12 (17%).

- c) *Risk and Audit Committee* The ToR of the Risk and Audit Committee indicates (by word of the Manager Internal Audit) that monthly meetings are to be held. However, in 2016 the Committee met 6 times, every two months. It seems that this frequency is a workable solution to participant's schedules, but this should be reflected in a revised ToR (not received). Minutes of meetings are available.

A sub-score for RAC applies to 6 meetings out of 12 (50%).

Recommendations: It is recommended that

- i) the MHMS Executive decides on the final ToR for the PFC at the first Executive Meeting after the JAPR 2017. It is recommended that the PFC meetings will start again on a monthly basis. PHD representation should be ensured;
- ii) the FHC meets quarterly and ensures quorum and PHD presence; and
- iii) the RAC amends the ToR.

Performance payment score: 36% $[(40+17+50)/3]$ (weight ¼ of 20%)

Indicator N 2.4: *Percentage of MHMS counterpart positions that MHMS has completed recruitment processes for within 8 weeks of a position being vacant*

Indicator description/interpretation: Number of Adviser counterpart positions (as identified in Adviser Terms of Reference) that have been advertised, interviewed for and recommendations sent to Ministry of Public Service (MPS) within 8 weeks of position being vacated. Register to be maintained by Human Resources Management Adviser. Proportional payment on target achieved.

Areas for improvement: In 2016 three new recruitments were due out of 9 positions. The 6 positions already in place include three Provincial Advisor counterpart positions and counterparts for the Technical Advisors at the National Medical Store, the NVBD Program, and the Provincial Finance team (filled late in 2016).

Three other important counterpart positions had to be filled in 2016. These are counterparts for the Procurement Technical Adviser (*Procurement Manager*), the Public Financial Management Specialist (*Financial Controller*) and the Infrastructure Technical Adviser [position filled up until 30 June 2016 and soon to be filled again] (*Infrastructure /Facility and fleet Manager*). Two of these positions have been vacant for the last two years. This is contrary to the requirements of the Health Direct Funding Agreement and also to Ministry of Development, Planning and Aid Coordination's (MDPAC) own

requirements. It is also a concern in the context of the HSSP3 design, which identifies these three advisory roles as core positions.

In 2016 the three counterpart roles were advertised (Procurement Manager, Financial Controller and National Facilities and Fleet Manager). Selections were made for the Facilities and Fleet Manager and Financial Controller roles, but the recommendations were not accepted by the PS and therefore not progressed through to the MPS. Although the Procurement Manager position was also advertised, interviews were not conducted for the position. Action is still yet to be taken to progress recruitment of the three counterpart roles. This indicator will have a 0% score.

It is acknowledged that the recruitment process is an arduous task requiring cumbersome administrative requirements that are outside the influence of MHMS. Nevertheless, the MHMS needs to progress those recruitment processes that are within its powers and responsibility in a timely fashion.

Recommendation: It is recommended that highest priority will be given by the MHMS Executive to the fill the three counterpart positions as soon as possible.

Performance payment score: 0% (weight ¼ of 20%)

PROCESS - Health Information System

Indicator N 3.1: *Percentage of patient ADT summaries entered into the electronic system at the National Referral Hospital since the implementation of the system.*

Indicator description/interpretation: Number of patient admissions, discharges and transfers (ADT) summaries entered into the electronic system at the NRH since implementation of the system / Total number of patients at NRH since implementation of the system (x 100).

Key achievement: The launch of the electronic ADT system was on 10 September 2016. The NRH Statistics Department confirms that all in-patients have been entered into the system. In total 25,701 admissions and 25,258 discharges were entered into the system since its inception. The Information Communication Technology Support Unit (ICTSU) has been supporting NRH with funding from WHO. The advantage of a local company is instant support and no licensing costs/constraints. Current data entry is done by medical record staff, not yet by the ward staff. The development of the system is a good step forward in resolving data quality and coverage issues, and working towards a more robust and sustainable information system.

Areas for improvement: The electronic system has been concentrating on in-patients so far. ICTSU is working on the out-patient system. Other pending activities include the reporting system, the networking (extra computers and cabling in the wards) and data validation issues. In addition, it will help when the wards receive full rights to the system and an appropriate interface has been designed and installed.

Recommendation: The recommended next steps for the NRH electronic system would be – inter alia – to link with the laboratory, to link the outpatient department, to create ownership of the electronic system at NRH, and to increase human resource (technical HIS) capacity in running the data system, data analysis and strengthening the medical reporting.

Performance payment score: 100% (weight 1/3 of 20%)

Indicator N 3.2: Scope of work undertaken to provide for gender based violence (GBV) data integration into DHIS and other relevant clinic reporting processes

Indicator description/interpretation: Assessment conducted to identify GBV data collection potential at clinic and hospital and integration into DHIS, and documented with recommendations.

Key achievements and areas for improvement: In 2016 MHMS developed with support from WHO draft clinical guidelines 'Policy and Clinical Protocols for Minimum Standards of Treatment of Survivors of Sexual and Gender Based Violence' (MHMS, Dec 2016).

However, no assessment was conducted to identify GBV data collection potential at clinics and hospitals and integration into DHIS, and document with recommendations. Despite this, GBV indicators have been proposed to be included in the next update of DHIS:

- Sexual violence against women aged 18 and above
- Physical violence against women aged 18 and above (by an intimate partner or family member)
- Child sexual abuse (below 18 years of age)
- Child physical abuse (below 18 years of age)
- Numbers of women subjected to violence who receive comprehensive health services (SafeNet Referral made)

Because of this partial implementation a score of 50% applies.

Performance payment score: 50% (weight 1/3 of 20%)

Indicator N 3.3: Feasibility assessment on introduction of Electronic Patient Management System at minimum of one secondary hospital(s) undertaken before year end.

Key achievements: A feasibility assessment report on the introduction of Electronic Patient Management System at secondary hospital(s) that was undertaken before year end was not available, but a cabling assessment/plan was shared. In addition, an update report on the progress of installing an electronic system at Gizo Hospital (Western Province) and Kiluufi Hospital (Malaita province) was received.

Recommendation: The disbursement linked indicator for 2017 would need to assess the progress made on the completion of the electronic patient management system including its functionality at least at one secondary hospital.

Performance payment score: 75% (weight 1/3 of 20%)

PROCESS - Public Financial Management

Indicator N 4: Percentage of activities of the PFM Roadmap that have been prioritised and conducted before end of 2016.

Indicator description/interpretation: Number of selected activities of the PFM roadmap that have been completed in 2016 / Number of selected activities in PFM roadmap for 2016 (x100). Proportional payment on target achieved.

Key achievements: The Public Financial Management Roadmap – Phase II for the period 2016 to 2020 has been used to inform and populate Annual Operational Plans (AOPs) for Finance, Policy and Planning, Human Resources, Procurement and other divisions. As such, one of the recommendations of the IPA

2015 report was responded to, namely the clear and proper assignment of Roadmap actions to designated organisational bodies and positions. The PFM Roadmap itself is not used and not much 'owned' by MHMS, instead the AOPs are the operational tools.

For the purpose of the present indicator N4, the finance team has been asked to check activities implemented in 2016 that could be categorised under the Roadmap. The Roadmap shows that most activities listed have implementation components or work packages in 2016, but it does not specify exactly what these activities in 2016 would entail. It is therefore difficult to compare implementation against plan. Nevertheless, a reasonable attempt was made.

More than half of the work packages in the Roadmap have been addressed, more or less, although it might be that not enough information was available for certain activities. This translates into a score of 64%, meaning that out of the 36 work packages 23 showed evidence of activities in 2016. See Annex 5 for an account of each work package.

Recommendation: Assign the Policy and Planning Division to monitor Roadmap work packages and actions and report on these in the Planning and Finance Committee regularly, at least quarterly. This would entail linking Roadmap work packages to AOPs and/or corporate plans, monitoring the AOPs and/or corporate plans, and reviewing Roadmap work packages to ensure they continue to be relevant.

Performance payment score: 64% (weight 20%)

OUTPUT/OUTCOME - Services

Indicator N 5.1: NCD: Number of hospitals that have held at least one diabetes clinic per week in 2016

Indicators description/interpretation: At least 48 diabetes clinics held at each of 7 hospitals in 2016.

Qualitative assessment, self- reporting by PHD. Cut-off point for payment = in 7 hospitals. (48 weeks allows for 4 week reduction in services during December/January). Remark: 7 hospitals not defined/named.

Areas for improvement: The method of data collection is through self-reporting by the PHD and Non-communicable Disease (NCD) Coordinator. Only for the purpose of the IPA 2016, PHDs were requested one and a half weeks before the JAPR to send the necessary information. It would have been better if this had been initiated earlier in order to establish the data collection mechanisms and have, for example, quarterly reporting on this indicator. No action was taken to establish such a mechanism.

Responses have been received from only 5 hospitals: Kilu'ufi Hospital (Malaita), Gizo Hospital (Western Province), Lata Hospital (Temotu), Kirakira Hospital (Makira) and Taro Hospital (Choiseul).

Key achievements: For Kilu'ufi Hospital it was reported that a special diabetes clinic was held weekly. In the other hospitals, a NCD clinic is open 5 days a week. The NCD clinics are run by an NCD Officer/Coordinator and refers patients to the Doctor's clinic at the hospital if required. In Taro Hospital the patient is seen by the Medical Officer the same day. In Temotu the NCD clinic is in a separate building outside Lata Hospital.

In general, NCD (including diabetes) services are provided as both special clinics and as part of the hospital general outpatient services. Quoting the Under Secretary Health Care 'all provinces have an NCD coordinator who would usually run the NCD (mainly diabetes and/or hypertension) clinic within the hospital setting. These clinics are not for diabetes only. How often these clinics open for business each

week varies by province. Apart from these dedicated NCD clinics, diabetes and other NCDs also get seen in the general outpatient clinics.'

Given above information, although not fully evidenced, it may be concluded that NCD services are provided to diabetes patients by the NCD Officer and/or a Medical officer. If this was done every week of the year (48 weeks) in 2016 is still to be verified, but is not within the scope of the IPA. Not all hospitals have responded promptly.

The self-reported data are consistent but incomplete, and no mechanism was established to consistently collect NCD service data in these hospitals. Therefore a scoring of 50% has been applied.

Recommendations: The indicator should be reviewed and a data collection mechanism needs to be developed. NCD clinics instead of diabetes clinics should be used. Self-reporting can be done (start early) but integrating the data collection in routine monitoring systems would be better.

Performance payment score: 50% (weight 1/3 of 20%)

Indicator N5.2: Percentage SLMSs having sufficient essential drugs available for distribution to health facilities without interruption during the year

Indicators description/interpretation: The list of indicators in Annex 3 defines this indicator as the 'Number of Second Level Medical Stores (SLMSs) having sufficient essential drugs available for distribution to health facilities without interruption during the year / Number of SLMSs in the country (x 100). The list also gives a target percentage of 90%. The term 'sufficient' needs to be defined. In addition, the data do not support the measurement of 'without interruption'. Therefore it was agreed between partners and in consultation with the National Medical Store (NMS) that this indicator will be measured in three ways, using the following methods:

1. Calculate the average percentage of stock-outs for the SMLs. This is a figure routinely provided by NMS.
2. Calculate on the basis of SMLS spot-check data
 - a. Percentage medicine spot checks that indicate a stock out by SLMS
 - b. Percentage SLMS spot checks finding that a medicine is out of stock by medicine

Spot check data collected by NMS provide point data and not period data, i.e. an out of stock indication for a medicine shows only that the drug is out of stock at the time of measurement and does not indicate how long the drug has been out of stock at the SLMS. In total 46 spot checks were conducted in 13 SMLSs in 8 provinces during 2016. Guadalcanal and Honiara City Council are not included as they obtain their drugs directly from NMS.

Key achievements: Average availability of drugs at SLMSs in 2016 was 90.3%, so the average stock out level was 9.7% (indicator 1).

Figure 2 and 3 show the results for indicator 2a and 2b. Figure 2 shows SLMSs that score over 10% on medicine checks that indicate a stock out for that medicine. This means for example that at SLMS Nila in Western Province one in four medicines (25%) that have been checked were out of stock at the time of the check (denominator is 111 medicine spot checks – 37 essential medicines x 3 checks of Nila SLMS in 2016).

Figure 3 shows the percentage of SLMS spot checks per medicine out of stock. For example, Magnesium Sulphate was out of stock in one of three spot checks (33%) done at SMLSs during 2016.

Figure 2 Percentage medicine spot checks that indicate a stock out by SLMS (>10%)

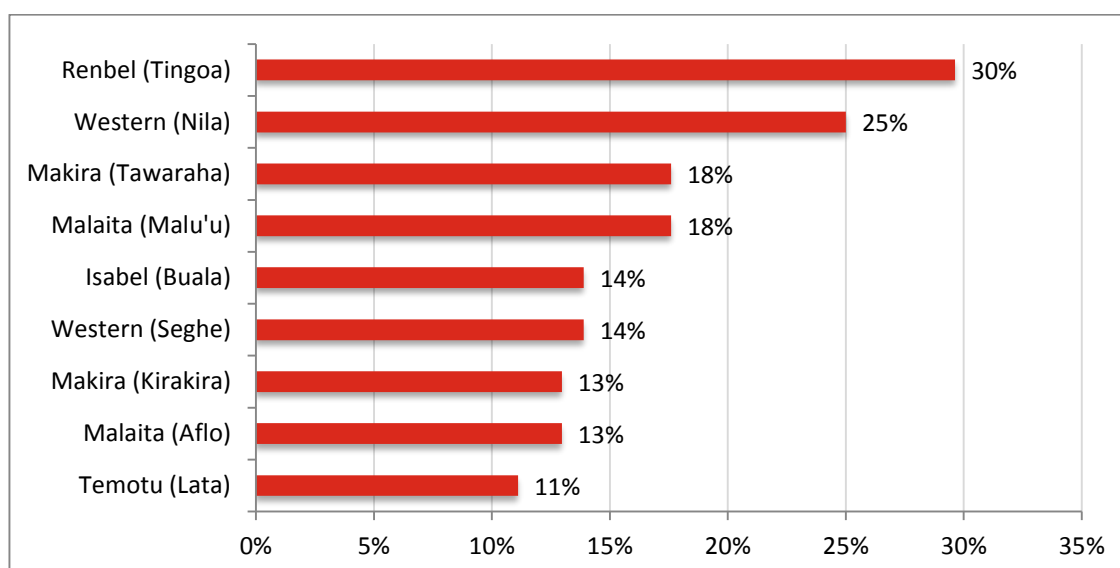
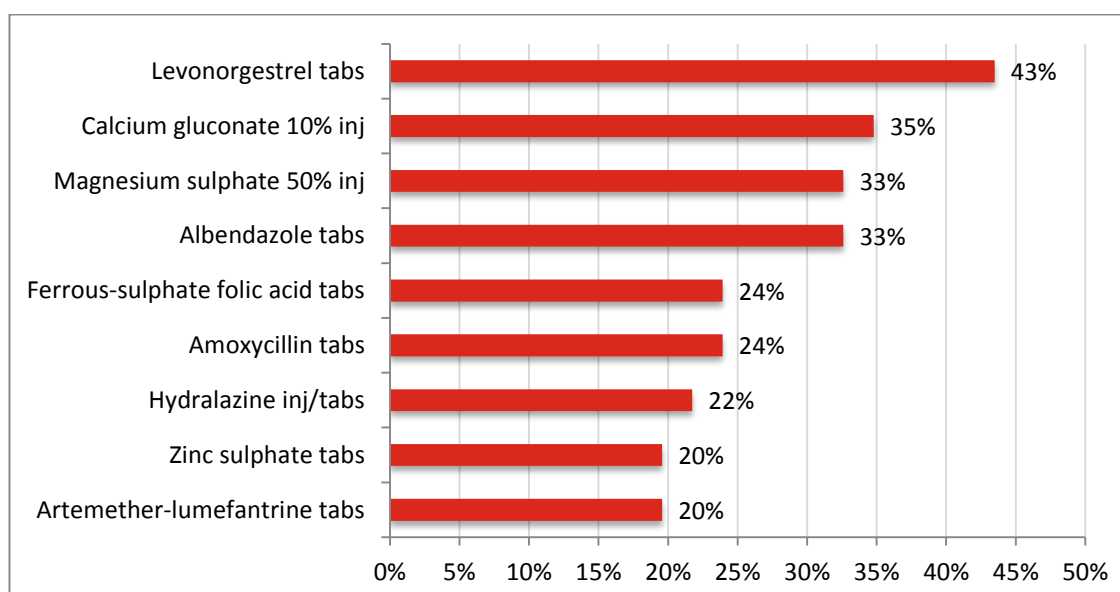


Figure 3 Percentage SLMS spot checks finding a medicine is out of stock by medicine (>20%)



Areas for improvement: Figure 2 and 3 clearly indicate areas for improvement: certain SLMSs have a higher frequency of medicines out of stock and some medicines are more often out of stock. However, the data do not give the full picture. For example, medicine might not be available at a SLMS but could be available at the clinics because they have all just been distributed.

It should be noted that MHMS internal audits conducted in 2016 have highlighted that medicines in several occasions have been distributed that are not requested and/or that are near expiry. The consequence is that facilities may be overloaded with drugs they do not need [e.g. Choiseul Province] and/or with drugs that are expired. This causes a wastage of drugs [see internal audits for Malaita, Western Province, and Renbel Province]. This is an unfortunate situation that requires attention.

The new version of mSupply Mobile was rolled out to 6 SLMSs in 2016 and comprehensive information would be available for these 6 stores for the 4th quarter. In 2017 mSupply will be rolled out to more stores. However, mSupply records the amount of stock sent to each SLMS but it does not accurately reflect stock levels in the provinces.

Although the average in stock rate target of ninety per cent in the SLMSs is achieved, the overall score of 100% is reduced by 20 percentage points due to above described problems in the system. Therefore a score of 80% applies.

Recommendations: The following recommendations are (partly) taken from the MHMS internal audit reports:

- a) Introduce and implement an effective system to monitor supply of drugs/vaccines via SLMSs down to facilities and create a true output based distribution system.
- b) NMS should not supply drugs that are near expiry to those SLMSs that do not have a high turnover rate; NMS should not send out quantities of drugs that have not been ordered by SLMS staff.
- c) NMS to collect data on the value and quantities of drugs which are destroyed because of expired dates.
- d) Link mSupply and DHIS; mSupply to also record duration of stock-out.

Performance payment score: 80% (weight 1/3 of 20%)

Indicator N5.3: Number and per capita outpatient consultations in 2016

Indicators description/interpretation: Number of visits for ambulant care, not including immunisations, for the total population (including repeat visits) in number and per capita. The benchmark set for the indicator was 'to increase outpatient consultations', a specific target for 2016 was not defined. Proportional payment on target achieved is therefore calculated as a 100% score.

Key achievements: DHIS routine data indicate a major uptake of outpatient visits by almost one quarter (22%) from 998,238 OPD in 2015 to 1,213,162 OPD in 2016, which is a per capita increase from 1.7 per capita in 2015 to 2.1 in 2016. This increase is partly due to the inclusion of NRH data for the first time. Without NRH OPDs included in 2016 the total OPD would be 1,133,162, which means an increase of 14%. Thus 8% of the total OPDs now reported in the DHIS are OPDs reported by NRH. The dengue outbreak may also have increased outpatient visits.

The inclusion of immunisations and dressing would increase the outpatient consultations per capita to 3.0, which was the target set for the MDGs.

Areas for improvement: -

Recommendations: In terms of measurement and payment score calculation for the indicator, define an annual target that is aligned to the estimates in the National Health Strategic Plan 2016-2020.

Performance payment score: 100% (weight 1/3 of 20%)

2.2. Provincial indicators

Provincial indicators measure performance at three levels. At input/process level the indicators relate to planning and monitoring, at output level they concern outreach services, and at outcome/impact level they assess reproductive and child health.

INPUT/PROCESS – Planning and Monitoring

Indicator P1.1: Percentage of AOPs and budgets submitted in accordance with MHMS timelines

Indicators description/interpretation: Number of Annual Operational Plans and budgets submitted by 30 September / total number of AOPs and budgets submitted.

Key achievements: All provinces submitted draft costed Annual Operational Plans (AOP) for 2017 before 30 September 2016. This achievement can be considered the result of efforts over a number of years to improve the operational planning and budget systems. The AOPs have a uniform format, and connect action to objective, performance indicator and budget allocation. The AOP format also includes a column to register gender integration.

Areas for improvement: Although all provinces submitted draft costed AOPs before 30 September 2016, these first drafts were not all of sufficient quality according to MHMS financial unit. But as ceilings for the budgets were only received in November this did not affect the process much. Based on the ceilings further iterations continued being part of the improvement process for the AOPS/budgets.

Recommendation: It is recommended to initiate the process of submission of and communication on AOPs well in advance of the deadline of 30 September, so that near final draft AOPs are available by 30 September and not first drafts.

Monitoring of AOPs should not only be done on the funds expended, but also on the content of activities. The Planning and Policy Division would have the task to organise this.

Performance payment score: 100% - conditional indicator for all other provincial indicators

Indicator P2.1: Percentage of outstanding imprests that are more than 90 days overdue from specified retirement date at 31 December

Indicators description/interpretation: Value (volume) of outstanding imprests 90 days overdue (where salary deduction has not been initiated) / Total value (volume) of outstanding imprests (where salary deduction has not been initiated) x100%. The target for provinces is to achieve less than 10% outstanding imprests 90 days overdue.

A salary deduction is considered to be initiated if the province has sent the salary deduction request to the MHMS or if the first deduction from salary of DWE staff retirement date is two weeks after activity completion.

The payment score is calculated as the inverse of the (volume) indicator. If the percentage outstanding imprest is lower than 10%, the score is 100%.

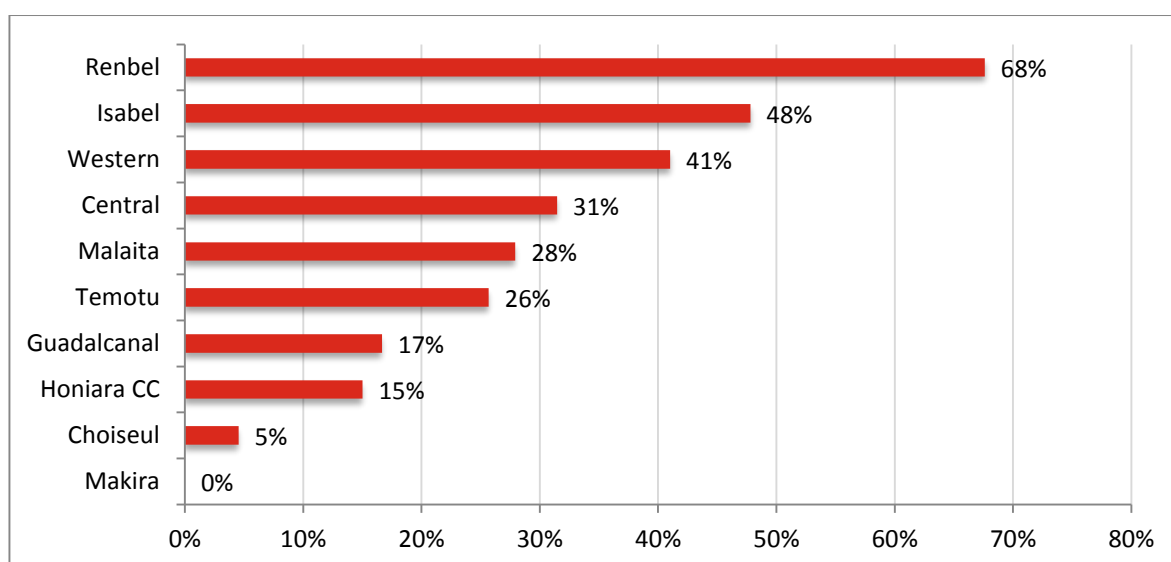
In addition, the number of outstanding imprests 90 days over against the total number of outstanding imprests has been calculated. This has been done to take away any confusion over the indicator, as the numerator of the indicator in the Performance Indicator 2016 list refers to a number.

Key achievements: The year 2016 shows a large difference between budget and execution. Observing the volume of outstanding imprests >90 days in the Table 7 below, only two provinces have achieved the target of less than 10% (Choiseul and Makira, see Table 7 fourth column and Figure 4). The total of outstanding imprests over 90 days overdue for all provinces is 24%.

Table 7 Outstanding imprests over 90 days

Province	Volume			Number		
	Total OS Imprests	Imprests >90 Days less Salary Deductions	Percentage Imprests >90 Days less Salary Deductions	Number OS Imprests	No. Imprests >90 Days less Salary Deductions	Percentage Imprests >90 Days less Salary Deductions
Central	\$ 138,152	\$ 43,463	31%	33	4	12%
Choiseul	\$ 63,900	\$ 2,910	5%	20	2	10%
Guadalcanal	\$ 647,423	\$ 107,906	17%	85	23	27%
Honiara CC	\$ 430,814	\$ 64,707	15%	51	38	75%
Isabel	\$ 130,275	\$ 62,275	48%	18	4	22%
Makira	\$ 466,828	\$ -	0%	52	0	0%
Malaita	\$ 1,418,322	\$ 395,965	28%	289	96	33%
Renbel	\$ 237,376	\$ 160,485	68%	17	10	59%
Temotu	\$ 150,787	\$ 38,728	26%	26	4	15%
Western	\$ 94,230	\$ 38,640	41%	18	8	44%

Figure 4 Outstanding imprests over 90 days (volume)



Recommendations: On the basis of 2016 volume data, it is recommended to take immediate action to reduce the value of the outstanding imprests in Renbel Province, Isabel Province, Western Province, Central Province, and Temotu Province. In addition, Honiara City Council, Renbel Province, and Western Province showing relative high numbers of outstanding imprests 90 days overdue should put effort into reducing these numbers.

Performance payment score: 74% (weight 1/4 of 50%)

Indicator P2.2: Completion on timely reporting for various reports per year

Indicators description/interpretation: MHMS only started registering the actual dates of incoming monthly bank reconciliations in 2016. Progress reports against AOPs have been added as a sub-indicator in 2016 – they should be submitted via the PHD to the MHMS Executive. The reference period for DHIS reports received is 6 weeks after the month. Health facilities that are closed have not been included in the calculation.

No official reference period has been stated for financial reports, bank reconciliations and AOP progress reports. Therefore timeliness cannot be taken into consideration in this IPA.

Reports [required number]:

- a. Financial reports [4 per year]
- b. Bank Reconciliations [12 per year]
- c. Progress Reports against AOPs [quarterly – 2 in 2nd half 2016]
- d. DHIS Reports [12 per year]

Key achievements: The achievements have been considerable. All provinces have successfully submitted 4 quarterly financial reports and 12 bank reconciliations. All provinces sent progress reports every quarter. These so called AOP Activity reports include a column on gender. With an average score of 95% in 2016 and 92% in 2015, DHIS reporting has maintained the same high level of last year, which was a substantially increase over 2014.

Recommendation: Include in 2017 timeliness component of the indicator by clearly stating deadlines for submissions of financial reports, bank reconciliations and AOP progress reports.

Table 8 Reporting – Composite indicator score P2.2

Percentage timely* reporting - 2016				Composite Indicator Score
Financial Reports (quarterly)	Bank Reconciliation (monthly)	Progress reports against AOPs (quarterly)	DHIS reporting (monthly)	
100%	100%	100%	95%	99%

* timeliness only applies to DHIS reporting

Performance payment score: All provinces, composite indicator score is 99%. For composite indicator scores by province see Table 5 in the Executive Summary. The method of calculation is described in Annex 6. (weight ¾ of 50%)

OUTPUT – Community Outreach

Indicator P3: Annual % increase of outreach activities

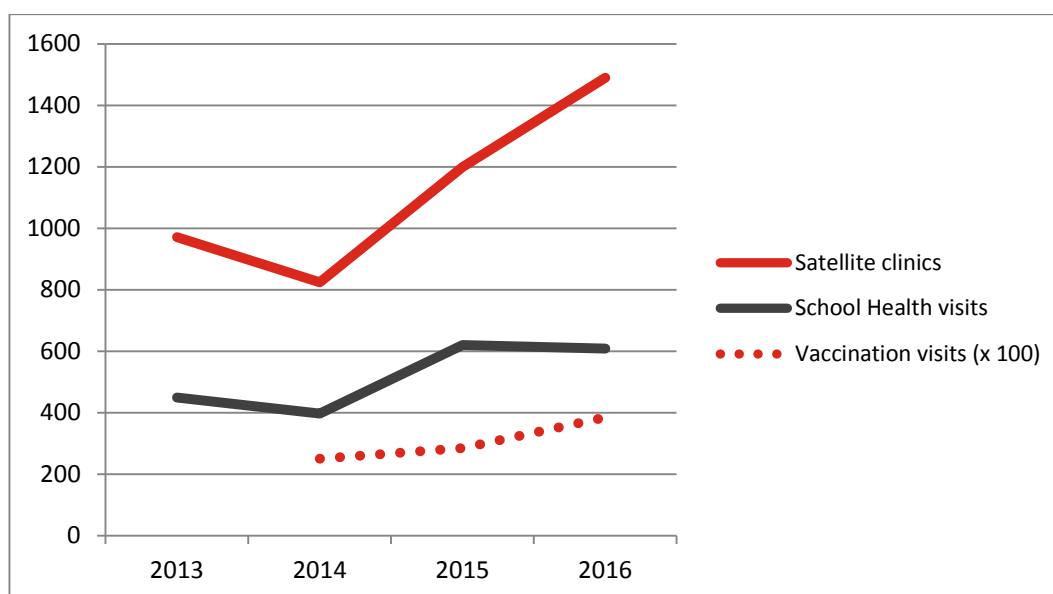
P3.1 Visits to schools

P3.2 Satellite clinics

P3.3 Vaccination visits

Indicator description/interpretation: The composite indicator measures three activities. Data are derived from DHIS. DHIS data do not reflect the quality of the activity. Additional outreach activities are included in the discussion below.

Figure 5 Outreach activities 2013 – 2016 (source: DHIS)



Key achievements: Figure 5 shows a general upward trend in reported satellite clinics and vaccination visits after 2014. Vaccination visits include routine and school vaccinations. The national upward trend in Figure 5 is not mirrored in most provinces. There is large variation between years and provinces. Therefore for purpose of payment score calculation at provincial level the smoothed trend was used comparing the average for vaccination visits in 2014 and 2015 with the average for 2015 and 2016.

For all the three selected outreach activities Honiara City Council and Malaita Province scored best with an increase over 2015 shown for all three activities. Makira, Guadalcanal, Western Province, and Central Province increased on their vaccination visits, but did not improve on satellite clinics. Isabel, Temotu and Renbel Provinces increased the number of satellite clinics but did not improve on vaccination visits.

Areas for improvement: Except for Honiara City Council and Malaita Province, none of the provinces showed a change over 2014/15. Choiseul experienced decreases in all three outreach activities.

Recommendation: Cited from the 2015 IPA: ‘... because the quality of outreach activities is not measured, it is not known what potential effect this could have on the health of the population. For planning this is important information. Therefore, it is recommended to consider an indicator that links an outreach activity to its intended output, for example, ‘annual % change in the proportion of vaccination outreach visits against vaccination prevalence’. In the Solomon Islands this would make

sense as gaps in immunisation coverage are frequently responded to by massive campaigning in remote areas.

Table 9 Outreach services – Composite indicator score P3

National Annual Percentage Change - 2016			Composite Indicator Score
Satellite clinics	Vaccination visits*	School visits	
24%	25%	-2%	64%

* Vaccinations routinely collected and in schools. Average of 2014-2015 compared with average 2015-2016 due to large fluctuations between years

Performance payment score: All provinces, composite indicator score is 64%. For composite indicator scores on indicator P3 by province see Table 5 in the Executive Summary. The method of calculation is described in Annex 6 and the table with provincial level indicators and the composite indicators is in Annex 7.

OUTCOME/IMPACT – Services and Health Status

Indicators

P4.1: *Number of Maternal deaths (CIS 1)*

P.4.2: *Number of death of children 0-11 months (nominator of CIS 2)*

P.4.3: *Number of death of children 0-59 months (nominator of CIS 3)*

P.4.4: *Number of family planning contacts (x1000) (CIS 4)*

P.4.5: *Percentage of deliveries that are attended by a skilled health personnel (inverse CIS 28)*

Indicator description/analysis/interpretation: The selected core indicators consist of three impact indicators (= measuring health status; CIS 1, 2, 3) and two outcome indicators (= measuring health behaviour; care seeking and risk avoiding; CIS 4, 28). Impact and outcome indicators are by their nature also determined by factors outside the realm of health sector efforts, like economic or political factors. The use of provincial level data will yield variations that cannot be explained by factors that can be solely attributed to service delivery or preventive actions alone.

National, not provincial, data have been used for the analysis of the three impact indicators. Data disaggregated by province have been used for analysing the two outcome indicators. This method has been applied because the outcome indicators are considered to be less influenced by confounding factors and more representative of tangible services delivered, i.e. contraceptive counselling and skilled birth attendance.

Key achievements: For the three impact indicators – number of maternal deaths, number of deaths of children 0-11 months and number of deaths of children 0-59 months - we observe an opposite pattern compared to 2015. Infant and child mortality increased compared to the previous year (both +12%), explained as being mainly due to outbreaks of malaria, dengue and diarrhoea. Maternal mortality decreased (-25%) to pre-2015 levels. However, infant and child mortality did not reach the 2014 peak.

While 2015 showed a modest increase in 'contraceptive contacts' per 1,000 population, in 2016 these contacts increased by about one third, likely due to the accelerated Jadelle implant program⁴.

⁴ MHMS, HIS Quarterly Updates 4th Quarter 2016

Hardly any annual change was noticed in the number of skilled birth attendance in the provinces, except for Renbel Province (increase with 22 per cent).

Areas for improvement: Although the number of maternal deaths decreased, safe motherhood continues to require utmost attention. The practice of reporting may have improved, but the numbers are small and the change may not be statistically significant.

Table 10 Outcome/Impact – Composite indicator score P4

National annual percentage change - 2016					Composite Indicator Score
Maternal mortality	Infant mortality	Under 5 mortality	Contraceptive contacts	Skilled birth attendance	
-25%	12%	12%	32%	1%	64%

Performance payment score: All provinces composite indicator score for P4.1 to P4.5 is 64%. For composite indicator scores on indicator P4 by province see Table 5 in the Executive Summary. The method of calculation is described in Annex 6 and the table with the national and provincial level indicators and the composite scores are in Annex 8.

3. Development Partner Assessment

The following performance-linked indicators to assess Development Partner's (DP) practices related to alignment, predictability and ownership in the SWAp are not associated with performance linked funding. The forum to discuss these partnership indicators is the Development Partners' Co-ordination Group (DPGC).

Sixteen development partners are signatories in the Solomon Islands health SWAp, they include: Australian Government (DFAT), World Health Organization (WHO), World Bank, Secretariat of the Pacific Community (SPC), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), Government of Japan, Delegation of European Union, Korean International Cooperation Agency (KOICA), Government of the Republic of China (Taiwan), Fred Hollows Foundation New Zealand, World Vision Solomon Islands, Red Cross Solomon Islands, Save the Children Solomon Islands, New Zealand Government and Kaohsiung Medical University. Contributors to the Joint UN program on RMNCAH are WHO (lead), UNICEF and UNFPA.

3.1. Alignment

Indicator DP1.1: Proportion of non-TA DP funding on budget and on system.

Table 11 shows the main contributors to the HSSP3 SWAp. These DPs, except for the World Bank, had their funding on budget and on system. On-budget means on the 376 budget or the 476 non-appropriated budget. On-budget and on-system means the 376 budget. For DFAT, EU, UNFPA, KOICA and Joint UN the percentage is known, for WHO and UNICEF only the nominator is known. DFAT and EU are 100% on budget and on system, followed by Joint UN and UNFPA. UNICEF also provides non appropriated support (for example procurement) which UNICEF operates itself. All other HSSP3 SWAp development partners are not on budget.

The Global Fund, which operates outside the SWAp, is on budget/on system and supports with \$8.1 million. Global Fund provides most of its funding through the Health Development Partners Account

(376), however there is a substantial portion of procurement performed for the National Vector Borne program outside of the system.

Table 11 Alignment of Development Partners under the Health SWAp

Development Partners Performance Indicators	Health SWAp signatories							
	DFAT	WHO	Joint UN	UNICEF	UNFPA	KOICA	EU	World Bank
DP1.1 Proportion of non-TA DP funding on budget and on system (for 2016)	100%	\$1.7 million	85%	\$1.9 million	50%	18%	100%	N/A
DP1.2 Funding inputs are announced at the SIG budget launch (July) and appropriated through the regular SIG budget process (appropriated in November) (as part of 2017 budget)	✓	✓	✓	✓	✓	✓	✓	N/A
DP 1.3 Only the HSSP SWAp account is used with no separate bank accounts in operation (on-system) (for 2016)*	✓	✓	✓	✓	✓	✓	✓	N/A

Source: WB Financial Specialist 29 April 2017 UNFPA only directly uses the SWAp account for Australian Government bilateral funding for upscale of the Jadelle contraceptive implants.

Note: The 2016 DP indicators refer to the HSSP SWAp account, however since more donor partners are using the account it should be recognised as a development partners' account. HSSP is the Australian government bilateral program with the Solomon Islands.

Indicator DP1.2: Funding inputs are announced at the SIG budget launch (July) and appropriated through the regular SIG budget process (appropriated in November).

All funding inputs have been announced at the SIG budget launch (July) and appropriated through the regular SIG budget process (appropriated in November).

Indicator DP 1.3: Only the SWAp account is used with no separate bank accounts in operation (on-system).

Six of the 16 SWAp partners (as shown in Table 11) are using the SWAp account and some of those six partners have also been using a second separate account. UNICEF had a separate bank account, but stopped using it in 2016. UNFPA also has a separate bank account for some of their funding, in addition to using the SWAp account for the upscale of Jadelle implants. Among organisations not part of the health SWAp, some use the SWAp account and others do not. The Global Fund uses the SWAp account but it does procurement separately as a 476 non appropriated expenditure. GAVI does not use the SWAp account for any purpose.

3.2. Predictability

Indicator DP2.1: DP payments are made on time (as long as SIG has fulfilled reporting requirements) and in accordance with commitments (no intra-year changes).

In 2015 only DFAT made payments in accordance with commitments without intra-year changes (DP 2.1). In 2016 this has changed: WHO, Joint UN, UNFPA and the EU all provided payments on time with no major intra-year changes in accordance with their commitments, although advance warrants were given.

In contrast, DFAT and UNICEF payments were not made on time. The reasons DFAT payments were not made on time was due to the delay in the execution of the HSSP3 Direct Funding Arrangement (January 2017) and delay in making the first payment under HSSP3 whilst decisions about Australian-funded advisers in MoFT were being resolved. Whilst the letter from MHMS requesting the release of the HSSP3 payment was dated 24 January 2017, the signed release letter of HSSP3 funds to MHMS was dated 2 March 2017.

Table 12 Predictability of Development partners

Development Partners Performance Indicators	Health SWAp signatories								GF
	DFAT	WHO	Joint UN	UNICEF	UNFPA	KOICA	EU	World Bank	
DP2.1 DP payments are made on time (as long as SIG has fulfilled reporting requirements) and in accordance with commitments (no intra-year changes) (for 2016)	x	✓	✓	x	✓	✓	✓	N/A	✓
DP2.2 DP's provide 4 year budget projections to assist Ministry's long term planning activities (2016 for 2017+ budget)	✓	x	x	x	x	x	x	x	x

Indicator DP2.2: DPs provide 4 year budget projections to assist Ministry's long term planning activities.

Longer term budget projections made in 2016 for 2017 and beyond (4 years) were only provided by DFAT. EU and GF are multi-year programs.

3.3. Ownership

Indicator DP3.1: Program related technical cooperation supported by development partners that has been cleared by MHMS

A register of Technical Assistance is kept by the SWAp Coordinator at the WHO Office. The register contains TA that has been administratively processed by MHMS. The major development partners in the SWAp providing TA (DFAT, WHO and World Bank) confirm that technical cooperation offered is only implemented in cooperation with MHMS. Smaller development partners in the SWAp and non SWAp technical cooperation may not always be following this process, but this was out of the scope of the IPA for verification.

4. Set of performance indicators and key milestones 2017

The following sections describe the lessons that have been learned on the formulation and application of the payment of payment-linked performance indicators for 2016, actions recommended on the process for the IPA 2017 and 2018, and the draft list of performance indicators and their targets for 2017. The draft list is provided in Annex 9. It is expected that they will be the basis for on-going development based on consultation between MHMS and other development partners.

4.1. Lessons learned

Indicator formulation

The formulation of payment-linked indicators is under continuous development. The indicators could improve on their i) SMART formulation, ii) target setting and/or iii) criteria for payment. Some suggestions are given here to take into account:

- Describe the criteria for performance as much as possible, for example, describe what is exactly meant by 'level of satisfaction' or 'timeliness'.
- Include targets that can realistically be achieved within a year. This would also include avoiding the measurement of performance that is too dependent on external factors and can hardly be influenced by health programs or the MHMS. For example, avoid including indicators dependent on actions to be taken by MPS or MOFT.
- It would be better if provinces could set hard annual targets, rather than just aiming at a mere increase from last year, for example setting the target for immunisations. Setting targets requires joint planning and thinking ahead on the feasibility of actions planned.

Indicators for management

Many of the respondents (health managers) who were interviewed for the IPA were not or not fully aware of the existence and content of the payment-linked indicators. That is a missed opportunity, because the DLIs are then not used for management purposes, neither as 'stick' nor as 'carrot'. It is assumed that using a performance indicator as stick would trigger staff to comply and work towards a common goal, while using performance indicators as carrot would make staff aware of the financial benefits of performing.

It will be important to create awareness about the payment-linked indicators among health managers for the remainder of 2017, but also for the year 2018. It is suggested the MHMS health managers and DPs jointly formulate 2018 indicators in July/August 2017 when AOPs are being prepared for the next year. This approach would generate transparency for 2018 performance expectations and create ownership of performance requirements while addressing NHSP strategic objectives.

Indicator quarterly monitoring

In previous years the IPA reviewed the performance on payment-linked indicators annually. However, within a management results-based framework that creates transparency and ownership within MHMS Divisions and Provinces, it is suggested that in addition to the annual monitoring of payment-linked performance indicators at the JAPR, most of the indicators could be monitored on a quarterly basis. The Partnerships Coordination Unit (PCU) at MHMS could play a pivotal role in organising the quarterly monitoring in the several forums, like the regular meetings of the MHMS Executive, Committees and the DP Coordination Group.

4.2. Recommended process for IPA 2017 and IPA 2018

Taking into account above lessons learned, the following actions are proposed for the design and implementation of the payment-linked performance indicators for 2017 and for 2018:

- May 2017: Prepare indicator list during IPA 2017 (as SMART as possible) – IPA TA, Exec, PCU, DFAT, others.
- May 2017: Prepare list of necessary reference documents and/or develop data collection mechanisms for verification of the indicators - by Planning Division/PCU.
- Quarterly (Jul '17, Oct '17, Jan '18, Apr '18, etc.): Organise collection of necessary reference materials (assessment reports, minutes of meetings, register reports, other evidence) and collect on a quarterly basis - by Planning Division/PCU:
- Organise quarterly monitoring meetings on the payment-linked indicators, which could be connected to Executive and Committee meetings (FPC, PFC, other). As a matter of routine, all indicators should also be reported at the DPCG meetings (2 times held in between JAPRs).
- Aug 2017: Develop the indicators for 2018; include new indicators (e.g. on GBV (referrals, incidence), facility out of stock medicines, facility amenities like water supply, sanitation, etc.) that can be derived from the new HIS monthly data collection formats; collection of these data will likely be functional from January 2018 onwards. The only drawback for using new indicators is that there is no baseline yet. A flexible approach to setting and adjusting targets for these new indicators would need to be applied.
- Aug 2017 planning process: Integrate 2018 DLIs in AOPs for 2018.
- March 2018: send all documentation to the IPA 2017 assessor for review well in advance of the actual assessment in-country before the JAPR in April/May 2018.

4.3. Proposed performance indicators and key milestones 2017

Based on the 2016 performance indicators a set of 2017 performance indicators has been drafted and were discussed in a meeting with the MHMS Executive and DFAT on 4 May 2017. Some 2016 indicators were regarded feasible and relevant for use in 2017. They remained unchanged or had minor adjustments. Some indicators were feasible but not relevant anymore in 2017, they were replaced by new ones. Some indicators required more specificity and SMART formulation. They have been reformulated or are still in the process of formulation.

The proposed set of performance indicators can be found in the table in Annex 9. The table consists of the following categories for national and provincial indicators:

- a. Payment-linked performance indicator* – the name of the indicator
- b. Category – at national level: budget, health reform, management, health information, service quality and coverage; at provincial level: budget, finance & reporting, outreach, services
- c. Weight – the relative weight of a category
- d. Nominator and denominator – if applicable
- e. Description/remarks* – notes for clarification or further description of the indicator
- f. Target – the target set for 2017

- g. Means of verification* – the source of information, and/or the mechanisms for data collection
- h. Performance-linked condition – the condition for payment and/or payment calculation method

* The marked (*) categories apply to the performance indicators for the Development Partners.

Annex 1: Reference documents

Australian Government (2013) AusAID Agreement No. 64501: Direct Funding Agreement between Government of Australia and Government of the Solomon Islands in relation to the Solomon Islands Health Sector Support Program 2012-2016

Design document: Health Sector Support Program 3, Solomon Islands: 2016 – 2020

Development Partner Indicators – personal communication with Adrian Koochew, Public Financial Management Specialist, World Bank, Honiara, Apr 2017

Health Fact Sheet Solomon Islands 2016.

Health Sector Perspectives, Presentation at Friends and Budget Support Meeting 23 November 2016

Health Technical Assistance Inventory Framework

Independent Performance Assessment, Solomon Islands – Health Sector Support Program 2015. Specialist Health Services, 27 April 2016

Ministry of Health and Medical Services (2016) National Health Strategic Plan 2016-2020.

Ministry of Health and Medical Services (2017) Statistical Health Core Indicator Report, Solomon Islands 2016, 12 April 2017

Ministry of Health and Medical Services, Role Delineation Policy for Solomon Islands Health Facilities and Service Delivery Packages, DRAFT April 2017.

Ministry of Health and Medical Services. Annual Operational Plans 2016, 10 Provinces

Ministry of Health and Medical Services. Annual Operational Plans 2017, 10 Provinces

Ministry of Health and Medical Services. HIS Quarterly Updates, Solomon Islands. 2nd Quarter 2016

Ministry of Health and Medical Services. HIS Quarterly Updates, Solomon Islands. 3rd Quarter 2016

Ministry of Health and Medical Services. HIS Quarterly Updates, Solomon Islands. 4th Quarter 2016

Ministry of Health and Medical Services. Human Resource Management Roadmap 2017 - 2018

Ministry of Health and Medical Services. Internal Audit Annual Plan 2016/2017

Ministry of Health and Medical Services. Internal Audit Annual Report 2016

Ministry of Health and Medical Services. Internal Audit Provincial Reports 2016.

Ministry of Health and Medical Services. Joint Annual Performance Review, Meeting Minutes, 21 April 2016

Ministry of Health and Medical Services. Monthly Provincial Report Register 2016, incl. Monthly Bank Reconciliations

Ministry of Health and Medical Services. Partnership Coordination Unit Terms of Reference, April 2017

Ministry of Health and Medical Services. Public Financial Management Roadmap – Phase II, 2016 to 2020.

Ministry of Health and Medical Services. Recurrent Estimates Budget Paper, Year 2017

Ministry of Health and Medical Services. Terms of Reference MHMS Family Health Committee, Planning and Finance Committee.

Minutes of MHMS & DPs meetings, incl. Family Health Committee, Planning and Finance Committee, Risk and Audit Committee, Development Partnership Coordination Group, 2016

National Medical Store. Data on SLMS stock out 2016 – personal communication with Susie Lake, Technical Advisor NMS.

WHO (2017) Mission Report (MR17005): Role Delineation Policy and Service Delivery Packages in Solomon Islands, 18-25 February 2017.

Annex 2: List of persons met

Dr. Steve Aumanu, CEO, NRH

Dr. Nemia Bainivalu, Under Secretary Health, MHMS

Brendan Beak, Technical Advisor Finance, MHMS

Albino Bobogare, Director MVBP

Polini Boseto McNeil, Program Specialist, UNFPA

Roger Butterick, Sr. Consultant / TA Team Leader, MHMS

Dr. Tenneth Dalipanda, Permanent Secretary, MHMS

Gina De Pretto, First Secretary, High Commission Australia
Brendan Beak, Deputy Financial Controller, MHMS

Ivan Ghemu, Director Planning & Policy, MHMS

Dilip Hensman, Health Information, WHO

Dr. Sevil Huseynova, WHO Representative Solomon Islands

Chris Iduramoa, Internal Auditor, MHMS

Lani longi-Stowers, SWAp Coordinator, WHO

Dr. Greg Jilini, Under Secretary Health Care, MHMS

Bakai Kamoriki, Chief Medical Statistician, MHMS

Dr. Geoff Kenilorea, Director NCD, MHMS

Adrian Koochew, Public Financial Management Specialist, World Bank

Michael Larui, National Directing of Nursing, MHMS

Yvonne Lipa, Provincial Finance, MHMS

Ernest Mac, Chief Policy Officer, MHMS

James Osiramo, Financial Controller (Ag), MHMS

Francis Otto, Manager Internal Audit, MHMS

Richie Rummery, PACTAM Provincial Finance Specialist, MHMS

Dr. Ross Seyha, VBD Specialist, WHO

Melissa Stutsel, Counsellor, High Commission Australia

Shadie Taragwanu, Hospital Information Manager, NRH

Ben Ulley, Legal Advice Officer, MHMS

Nashley Vozoto, GBV program Officer, MHMS

DP partners in a separate DP meeting

Annex 3: Payment-linked performance indicators 2016

NATIONAL

Performance indicator	Weight	Numerator/ Denominator	Description/remarks	Target	Means of verification	Payment-linked conditions
The Solomon Islands Government will allocate at least 10% of domestically sourced revenue to the recurrent health budget for 2016	Pre-condition		If the 10% is not met no PLA applies in 2016.	10%	Budget	Condition for payment, meeting cut-off point
N 1. % SIG recurrent health budget (276) allocated to Provinces (including payroll) is no less than 37% of total recurrent budget in 2016.	20%	SIG recurrent health budget allocated to provinces/ SIG recurrent budget allocated to health care		37%	Budget	Condition for payment, meeting cut-off point
N2.1 MHMS senior management job descriptions incl. tasks, responsibilities and reporting lines have been prepared as part of new MHMS structure by end of the year	20%		Senior management include: MHMS Executive (PS, US), Heads of Divisions, Provincial Health Directors Assumption is that new structure (organogram) is endorsed by Cabinet	100%	Evidence of all new JDs	Pro rata score for all JDs prepared (50%); Organogram endorsed (50%) <i>(Weighing ¼ of 20%)</i>

Performance indicator	Weight	Numerator/ Denominator	Description/remarks	Target	Means of verification	Payment-linked conditions
N 2.2 National Role Delineation Policy Action Plan has been prepared and approved by Executive by the end of 2016	20%		Feasibility assessment in pilot facilities of RDP informs action plan.	Action Plan approved	RDP Action Plan and evidence of approval by Executive	100% on approval by Executive <i>(Weighing ¼ of 20%)</i>
N 2.3 % of Committee meetings held against set targets each year [also PHD representation where specified in TORs]		Number of Committee meetings per year (with PHD representation where relevant)/ Target number of Committee meetings (with PHD representation where relevant)	Meetings of: a) Family Health Committee b) Planning and Finance Committee c) Risk and Audit Committee # PHD presence in committees to be reported as well where relevant	Meeting frequency as per terms of reference for each Committee Committees where ToRs specify PHDs membership - representation as per terms of reference	Number of meetings List of participants	Proportional payment on target achieved (average of the three Committees) PHD presence used as weight for score <i>(Weighing ¼ of 20%)</i>
N 2.4 % of MHMS counterpart positions that MHMS has completed recruitment processes for within 8 weeks of a position being vacant		Number of Adviser counterpart positions that have been advertised, interviewed for and recommendations sent to MPS within 8 weeks of position being vacated /Total Number of counterpart vacancies	Counterpart position = position identified in Adviser Terms of Reference	100%	Register to be maintained by Human Resources Management Adviser	Proportional payment on target achieved <i>(Weighing ¼ of 20%)</i>

N 3.1 % of patient ADT summaries entered into the electronic system at the National Referral Hospital since the implementation of the system	20%	Number of patient ADT summaries entered into the electronic system/ Total number of patients since implementation of the system	ADT = admission, discharge, transfer	100%	Electronic system	Proportional payment on target achieved <i>(Weighing ¼ of 20%)</i>
N 3.2 Scope work undertaken to provide for gender based violence data integration into DHIS and other relevant clinic reporting processes			Assessment conducted to identify GBV data collection potential at clinic, hospital and DHIS levels.	Assessment conducted and documented with recommendations	Report with recommendations	100% on completion of report <i>(Weighing ¼ of 20%)</i>
N 3.3 Feasibility assessment on introduction of Electronic Patient Management System at minimum of one secondary hospital(s) undertaken before year end			HIS = hospital information system Assessment builds on electronic ADT system at NRH	Sec. HIS assessed & documented	Assessment report on subject	100% score when achieved <i>(Weighing ¼ of 20%)</i>
N 4 % of activities of the PFM roadmap that have been prioritised and conducted before end of 2016	20%	Number of selected activities of the PFM roadmap that have been completed in 2016/ Number of selected activities in PFM roadmap for 2016.	PFM = Planning and Finance Management	100% of activities that have been selected for 2016	List of prioritised roadmap activities	Proportional payment on target achieved <i>(Weighing ¼ of 20%)</i>
N 5.1 NCD: Number of hospitals that have held at least one diabetes clinic per week in 2016.	20%	Number of diabetes clinics held	48 weeks allows for 4 week reduction in services during December/January	At least 48 diabetes clinics held at each of 7 hospitals in 2018	Qualitative assessment, self-reporting by PHD	Cut-off point for payment = in 7 hospitals

						<i>(Weighing 1/3 of 20%)</i>
N 5.2 % SLMSs having sufficient essential drugs available for distribution to health facilities without interruption during the year		Number of SLMSs having sufficient essential drugs available for distribution to health facilities without interruption during the year/Number of SLMSs in the country		90%	Medical stores reports/ database	Proportional payment on target achieved <i>(Weighing 1/3 of 20%)</i>
N 5.3 Number and per capita outpatient consultations in 2016		Total number of outpatient consultations/Number of SLMSs in the country	See CIS #25 Total number of outpatient consultations in hospitals and Area Health Centres Total population: calculate and estimate catchment area population	Increase in raw number and per capita OPD consultations since 2015	DHIS Population data	Proportional payment on target achieved <i>(Weighing 1/3 of 20%)</i>

PROVINCIAL

Performance indicator	Weight	Numerator / Denominator	Description/ remarks	Target	Means of verification	Payment-linked conditions
P 1.1 % of AOPs and budgets submitted by 30 September	Pre-condition	Number of AOPs and budgets submitted by 30 September Total number of AOPs and budgets submitted	Number of AOPs with gender integrated (in order to get a baseline and targets will be set in 2017)	100%	Financial controller files	Pre-condition for payment
P 2.1 % of outstanding imprests that are more than 90 days overdue from specified retirement date at 31 December	50%	Number of outstanding imprests 90 days overdue (where salary deduction has not been initiated) Total value of outstanding imprests (where salary deduction has not been initiated)	Measurement by province Salary deduction has been initiated if: <ul style="list-style-type: none"> PS has approved for staff on Establishment First deduction from salary of DWE staff retirement date is two weeks after activity completion. 	Less than 10%	Financial files	Proportional payment according to % outstanding imprest >90 days retirement <i>(Weighing 1/4 of 50%)</i>
P 2.2 Completion on timely reporting for various reports per year		Number of reports submitted per year Required number of reports submitted per year	Reports [required number]: <ul style="list-style-type: none"> a. Financial reports [4/yr] b. Bank Reconciliations [12/yr] c. Progress Reports against AOPs [quarterly - 2 in 2nd half 2016] d. DHIS Reports [12/yr] 	100% Progress reports against AOPs should be submitted via PHD to MHMS Executive	MHMS policy & planning annual report	Proportional payment on target achieved <i>(Weighing 3/4 of 50%)</i>

Performance indicator	Weight	Numerator / Denominator	Description/ remarks	Target	Means of verification	Payment-linked conditions
P 3. Annual % increase of outreach activities	25%	Difference between the number of outreach activities in present year and previous year Number of outreach activities in previous year	Composite indicator on outreach activities, to include: P 3.1 visits to schools P 3.2 satellite clinics P 3,3 vaccinations visits	At least 5% increase as compared to 2015	DHIS	Payment on the basis of summed scores (%decrease=1, %increase=+1 or no change $\pm 5=0$) divided by number of items * 1.00%) Proportional payment on target achieved
P 4.1 Number of maternal deaths	25%		See CIS #1	Over 5% decrease as compared to 2015 actual	P 4.1- facility date DHIS Otherwise survey data	Payment on the basis of summed scores (% decrease = -1, % increase +1 or no change $\pm 5=0$) divided by number of items* 100% Proportional payment on target achieved
Infant mortality rate		P 4.2 Number of deaths of children till months/ Number of live births	See CIS #2	Over 5% decrease as compared to 2015 actual	P 4.2 - facility date DHIS Otherwise survey data	
Child mortality rate		P 4.3 Number of deaths of children 0-59 months / Number of live births	See CIS #3	Over 5% decrease as compared to 2015 actual	P 4.3 - facility date DHIS Otherwise survey data	
Rate of Contraceptive contacts		P 4,4 Number of 'family planning' contacts (x 1000) Total population	CIS #4 Contacts = FP service provided	Over 5% increase as compared to 2015	DHIS	

P 4.5 % of deliveries that are attended by a skilled health personnel		Number of deliveries attended by skilled health personnel Total number of deliveries	Indicator is the inverse of Core Indicator Set #28	Over 5% increase as compared to 2015	DHIS	
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DEVELOPMENT PARTNERS

Performance indicator	Weight	Numerator / Denominator	Description/ remarks	Target	Means of verification	Payment-linked conditions
DP1.1 Proportion of non-TA DP funding on budget and on system. DP1.2 Funding inputs are announced at the SIG budget launch (July) and appropriated through the regular SIG budget process (appropriated in November). DP 1.3 Only the HSSP SWAp account is used with no separate bank accounts in operation (on-system).	n/a	n/a		DP1.1 target: 100% of non-TA funding All signatories to the Partnership have advised 2016 inputs prior to Planning DPCG (July, 2015)	DP1.1 Proportion of non-TA DP funding on budget to be tracked through the SWAp secretariat. SIG Budget and LMEA update	n/a
DP2.1 DP payments are made on time (as long as SIG has fulfilled reporting requirements) and in accordance with commitments (no intra-year changes). DP2.2 DP's provide 4 year budget projections to assist Ministry's long term planning activities	n/a	n/a		All signatories to the partnership	SIG Budget and LMEA update	n/a
DP 3 Program related technical cooperation supported by development partners that has been cleared by MHMS	n/a			Register of cleared technical cooperation		n/a

Annex 4: SIG recurrent budget (276), provincial allocation

Budget allocations in 2017 (276) to Provinces / Provincial Activities				
Province name (\$m)	Source	Payroll	Grants	Total
Central Province	2017 Budget	4.3	3.0	7.3
Choiseul Province	2017 Budget	5.0	2.9	7.9
Guadalcanal Province	2017 Budget	9.2	7.4	16.6
Isabel Province	2017 Budget	5.9	2.8	8.7
Makira Ulawa Province	2017 Budget	7.1	4.9	11.9
Malaita Province	2017 Budget	16.2	11.6	27.8
Temotu Province	2017 Budget	6.1	3.3	9.4
Western Province	2017 Budget	11.8	11.1	22.9
Honiara City Council	2017 Budget	8.7	4.0	12.7
Rennel & Bellona	2017 Budget	1.2	0.8	2.0
Total direct provincial expenditure		75.5	51.8	127.3
Determination of provincial allocation				
Total provincial allocation		127.3		
Total MHMS recurrent budget		337.4		
Total provincial allocation from recurrent (SIG) budget		37.7%		

Annex 5: Implementation in 2016 of PFM Roadmap as linked to AOP

Performance Area	No.	Work Package	2016				
			Planned for 2016				AOP actions 2016*
			Q1	Q2	Q3	Q4	
1. Planning and Budgeting	1.1	National Health Sector Strategic Plan				X	o
	1.2	Planning and Finance Committee	X	X	X	X	
	1.3	Annual Budget Timetable and Ceilings		X			o
	1.4	Budget Training		X			o
	1.5	Development Partner Participation		X	X		o
	1.6	Annual Budget Submission			X		o
	1.7	Annual Operating Plans		X			o
	1.8	Project Implementation Plans		X			
	1.9	Medium Term Expenditure Pressures	X				o
	1.10	Standard Cost of Services			X	X	o
	1.11	Performance Linked Funding (HSSP)			X		
	1.12	Medium Term Expenditure Framework/ Program Budgeting	tbd	tbd	tbd	tbd	
Performance Area	No.	Work Package	2016				
			Planned for 2016				AOP actions 2016*
2. Budget Execution	2.1	Human Resources	X	X			o
	2.2	Finance Unit	X	X			o
	2.3	Procurement	X	X	X	X	o
	2.4	Asset Management	X	X	X	X	
	2.5	Inventory Management (National Medical Stores)					o
	2.6	Imprest Management					o
	2.7	Headquarters Bank Accounts	X	X	X	X	
	2.8	Provincial Bank Accounts	X	X	X	X	o
	2.9	Delegation (??)			X	X	
	2.10	Virements, Advance Warrants and Supplementary Appropriations	X	X			o
3. Accounting and Reporting	3.1	Monthly Financial Reporting	X	X	X	X	o
	3.2	Quarterly AOP Reporting					o
	3.3	Combined HIS/Financial Reporting					o

	3.4	Annual Closing of Accounts				X	
	3.5	Annual Report	X	X			o
	3.6	IFMIS/ SIGConnect	tbd	tbd	tbd	tbd	
Performance Area	No.	Work Package	2016				
			Planned for 2016				AOP actions 2016*
4. Internal Control and Assurance	4.1	Internal Audit Charter	X	X			
	4.2	Annual Internal Audit Plan				X	o
	4.3	Audit and Risk Management Committee	X	X	X	X	o
	4.4	Internal Audit Unit	X	X	X	X	o
	4.5	Investigations	X	X	X	X	o
5. External Scrutiny and Audit	5.1	Office of the Auditor General			X		
	5.2	HSSP Audit			X		
	5.3	MHMS Response				X	
Total of 36 Roadmap activities that required attention in 2016			23				
			Roadmap implementation level 2016				
			64% ((23/36)*100)				

*NOTE: See for details on 2016 activities the complete table in the file <PFM Roadmap with links to 2017 AOPs_JAPR2017.docx>

Annex 6: Performance & performance-based payment calculations, Provincial indicators

Calculation of composite indicator scores

The following methods were used for the indicators on Reporting, Outreach and Impact/Outcome:

A. [IMPRESTS] The score is 100% minus the actual percentage of value 90 days overdue. When actual percentage is less than 10% the score is 100% (target set at <10%).

B. [REPORTING] Composite indicator score calculation method: individual provincial scores are weighed with provincial HSSP allocation grants and weighted for 'reporting'; subsequently the sum of provincial performance amounts are divided by the total provincial allocation.

C. [OUTREACH] Composite indicator calculation method: for each province the annual percentage of change was calculated; a percentage higher than 5% yielded a score of +3 for vaccination visits, +2 for satellite clinics, and +1 for school health visits. A percentage less than -5% scores 0 and between -5% and 5% scores 0.6. The 3 scores were summed for each province and divided by 6 (maximum score is 6), times 100%. The composite indicator score in the table is then calculated from the individual provincial scores, weighted by provincial HSSP allocation grants and 'reporting'; the sum of provincial performance amounts are divided by the total provincial allocation.

D. [IMPACT/OUTCOME] Due to the low numbers of maternal deaths and consequent large variation effects, it was decided to first calculate a national base score. Contraceptive contacts and skilled birth attendants were considered being the most suitable for weighting the provincial score, because their performance in terms of service outputs is most tangible. Infant and child mortality were not considered for that reason. Composite indicator calculation method: a national score was calculated using all 5 indicators (a percentage increase from 2015 to 2016 higher than 5% yielded a score of +1, less than 5% increase was given a score of 0). The 5 scores were summed and divided by 5, times 100%. This national score was used as basis for the calculation of provincial scores, using the indicators contraceptive contacts and skilled birth attendants. For each province the annual percentages of change for these two indicators were calculated and scored (a percentage higher than 5% yielded a score of 1, less than 5% scores 0). This provincial score was multiplied by an adjustment factor of 0.6. The composite indicator score for each province is then calculated from the national indicator score plus the adjusted provincial score multiplied by the national score. These composite provincial scores are weighted by provincial HSSP allocation grants and 'reporting'; the sum of provincial performance amounts are divided by the total provincial allocation.

Annex 7 Calculation of P3 scores

P3. Outreach activities (satellite clinics + healthy village activity + school visits + village health committee) increased on 2015 levels.														
	Satellite clinics				Vaccination visits (on tour and in schools)				School visits				Total rating	Composite Indicator Score
Province	2015	2016	annual % change	Rating	Avg 2014- 2015	Avg 2015- 2016	% change	Rating	2015	2016	annual % change	Rating		
Central	35	32	-9%	0	1,004	1,161	16%	3	32	30	-6%	0	3	50%
Choiseul	57	48	-16%	0	1,377	1,162	-16%	0	42	36	-14%	0	0	0%
Guadalcanal	229	182	-21%	0	5,114	7,240	42%	3	140	99	-29%	0	3	50%
Honiara	147	173	18%	2	3,838	4,977	30%	3	76	105	38%	1	6	100%
Isabel	89	141	58%	2	1,560	1,626	4%	0.6	66	66	0%	0.6	3.2	53%
Makira	259	257	-1%	0.6	2,552	4,259	67%	3	51	52	2%	0.6	4.2	70%
Malaita	178	424	138%	2	6,780	7,949	17%	3	75	100	33%	1	6	100%
Renbel	23	25	9%	2	-	-		0.6	4	0	-100%	0	2.6	43%
Temotu	36	57	58%	2	1,228	1,188	-3%	0.6	44	36	-18%	0	2.6	43%
Western	146	151	3.4%	0.6	3,257	3,894	20%	3	90	85	-6%	0	3.6	60%
Avg score	1,199	1,490	24%		26,708	33,453	25%		620	609	-2%			64%
Notes on scoring change of 2016 indicator from 2015: Satellite clinic rating: If annual change from 2015 to 2016 is greater than 5%, rating = 2; if annual change is between -5% and 5%, rating = 0.6; if annual change is less than -5% (negative), rating = 0. Vaccination visits rating: If change from 2014-15 to 2015-2016 is greater than 5%, rating = 3; if change is between -5% and 5%, rating = 0.6; if change is less than -5% (negative), rating = 0. School visits rating: If annual change from 2015 to 2016 is greater than 5%, rating = 1; if annual change is between -5% and 5%, rating = 0.6; if annual change is less than -5% (negative), rating = 0. Total rating: Sum of ratings for satellite clinics, vaccination visits and school visits, possible range 0 to 6. Composite indicator score: Percentage of total rating out of the total possible score of 6.														

Annex 8: Calculation of P4 scores

P4. Consolidate annual performance improvement across select core Indicators (CIS 1-5)

National indicators												
					2015	2016	% change	Rating				
No of maternal deaths (CIS 1)					24.0	18.0	-25%	1				
Infant mortality rate (CIS 2)					16.9	18.9	12%	0				
Under 5 mortality rate (CIS 3)					21.2	23.8	12%	0				
Number of contraceptive targets (CIS 4)					2,647	3,402	29%	1				
Average of provincial % of deliveries with skilled birth attendants (inv of CIS 28)					83	85	3%	0				
National composite rank (sum of ratings/5)									0.4			
Provincial indicators												
	Contraceptive contacts (CIS 4)				Skilled birth attendance (inverse of CIS 28, %)				Provincial score (ratings for CIS 4 and CIS 28)	Adjustment factor (0.6)	Composite score	
Province	2015	2016	% change	Rating	2015	2016	% change	Rating				
Central	333	364	9%	1	77	78	1%	0	1	0.60	64%	
Choiseul	159	211	33%	1	89	90	1%	0	1	0.60	64%	
Guadalcanal	183	251	37%	1	68	69	1%	0	1	0.60	64%	
Honiara	522	747	43%	1	0	1	0%	0	1	0.60	64%	
Isabel	436	556	28%	1	91	90	-1%	0	1	0.60	64%	
Makira	277	321	16%	1	86	87	1.2%	0	1	0.60	64%	
Malaita	176	242	38%	1	81	85	5%	0	1	0.60	64%	
Renbel	52	73	40%	1	74	90	22%	1	2	1.20	88%	
Temotu	281	349	24%	1	87	84	-3.4%	0	1	0.60	64%	
Western	228	288	26%	1	93	93	0%	0	1	0.60	64%	
Total score for P4											64%	
Notes												
Ratings for individual indicators: Percentage increase from 2015 to 2016 of greater than 5%, rating equals 0, if increase less than 5% or a negative change, rating = 0. (For maternal deaths a positive increase is a decline in number of deaths.)												
Composite score: Equals the national score plus the adjusted provincial score weighted by the national score.												

Annex 9: 2017 Payment-linked performance indicators 2017 (draft 12 May 2017)

NATIONAL							
Performance indicator	Cat.	Weight	Nominator / Denominator	Description/ remarks	Target	Means of verification	Payment-linked conditions
The Solomon Islands Government will allocate at least 10% of domestically sourced revenue to the recurrent health budget for 2017 (276 out of national ledgers 2)	Budget	Pre-condition		If the 10% is not met no PLA applies in 2017.	10%	Budget	Condition for payment, meeting cut-off point
N 1. % SIG recurrent health budget (276) allocated to Provinces (including payroll) is no less than 37% of total recurrent budget in 2016.	Budget	20%	SIG recurrent health budget allocated to provinces / SIG recurrent budget allocated to health care	276 – provincial grants, payroll or other recurrent expenditures and national program provincial allocations	37%	Budget	Condition for payment, meeting cut-off point
N 2.1 MHMS Organogram has been submitted to the Ministry of Public Services for endorsement (official submission before end 2017).	Health Reform	20%			MHMS Organogram submitted to MPS	Official letter to MPS by MHMS Executive requesting endorsement of MHMS Organogram	100% upon target achieved <i>(Weighing 1/2 of 20%)</i>
N 2.2 National RDP Action Plan has been prepared and endorsed by the Executive by the end of 2017.				Action Plan specifies activities and their cost estimates	National RDP Action Plan and Budget approved by MHMS Executive in 2017	Documented National RDP Action Plan and Budget, and evidence of	100% upon target achieved <i>(Weighing 1/2 of 20%)</i>

						approval by the MHMS Executive	
N 3.1 % of activities in Corporate AOPs which are related to work packages in the PFM roadmap that have been conducted in 2017	Management Human Resources	20%	Number of activities in Corporate AOPs which are related to work packages in the PFM roadmap that have been conducted in 2017 / Number of prioritized work packages in the PFM roadmap in 2017	Corporate AOPs include: Finance, Planning, Human Resources, Audit, etc. PFM = Planning and Finance Management	100% = work packages in the PFM that are prioritized in 2017 can be all linked to implemented activities in AOPs in 2017	List of prioritized PFM work packages for 2017, and List of implemented activities in AOPs that can be linked to the PFM work packages in 2017	Proportional payment on target achieved (Weighing 1/3 of 20%)
N 3.2 % of meetings of Executive and Committees held against set targets on frequency, quorum and PHD presence (where relevant) in 2017			Number of Executive or Committee meetings per year with sufficient quorum (and PHD representation where relevant) in 2017/Committee meetings (and PHD representation where relevant) as per TORs in 2017	Meetings of: a) Executive b) Family Health Committee c) Planning and Finance Committee d) Risk and Audit Committee # PHD presence in committees to be reported where relevant Meetings without sufficient quorum do not count	100% = all meetings conducted with sufficient quorum as per TOR for the Executive or Committee in 2017 Committees where TOR specifies PHD membership: representation as per terms of reference.	Minutes of meetings List of participants	Proportional payment on target achieved (average of all meetings per TORs) PHD presence used as weight for score (Weighing 1/3 of 20%)

N 3.3 % of MHMS vacant counterpart positions that MHMS has completed recruitment processes for within 8 weeks of a position being vacant			Number of vacant Adviser counterpart positions that have been advertised, interviewed for and recommendations sent to MPS within 8 weeks of position being vacated / Total number of counterpart vacancies	Counterpart position = position identified in Adviser Terms of Reference	100% = all vacant counterpart positions with completed recruitment process within 8 weeks before submission to MPS	Register to be maintained by Human Resources Management Adviser	Proportional payment on target achieved <i>(Weighing 1/3 of 20%)</i>
N 4.1 National Referral Hospital *INDICATOR to be defined	Health information	20%					<i>(Weighing 1/3 of 20%)</i>
N4.2.a % Nurses trained in the care of GBV clients as per GBV AOP in 2017			Total number of Nurses trained in GBV before end 2017 / Number of Nurses planned to be trained as per GBV AOP 2017 (40)	No of Nurses planned to be trained = no identified in the GBV AOP (40 in 2017)	100%	GBV Coordinator training records	Proportional payment on target achieved <i>(Weighing 1/6 of 20%)</i>
N4.2.b % Family Health Committee meetings during 2nd half 2017 in which MHMS GBV Statistical Reports have been presented and discussed			No of Family Health Committee meetings during 2 nd half 2017 in which MHMS GBV Statistical Reports have been presented and discussed / No. of Family Health Committee meetings during 2 nd half 2017		100% for (2 nd half 2017) Condition is that at least 2 quarterly FHC meetings are held in the 2 nd half of 2017; otherwise indicator will be omitted and indicator N4.2.a will weigh 1/3 of 20%	Agenda and Minutes of FHC meetings	Proportional payment on target achieved <i>(Weighing 1/6 of 20%)</i>
N 4.3 % functionality of an Electronic Patient Management System (PMS) in one secondary hospital(s) in 2017			Number of functional criteria for an electronic PMS met in one secondary hospital before end 2017 / Total number of functional criteria for an electronic PMS in one	A functional electronic patient management system complies to	100% = all functional criteria have been met before end 2017	Assessment report that describes the level of functionality of the electronic	Proportional payment on target achieved <i>(Weighing 1/3 of 20%)</i>

			secondary hospital before end 2017	the following criteria: <i>Criteria to be added</i>		PMS in one secondary hospital by year end	
N 5.1 % hospitals that have held at least one NCD clinic per week with a minimum of 48 weeks in 2017	Service quality and coverage	20%	Number of secondary hospitals that conducted NCD clinics every week for 48 weeks in 2017 / Seven secondary hospitals that conduct NCD clinics every week for 48 weeks in 2017	NCD clinic is organized by the NCD Coordinator or Doctor at or next to the secondary hospital Note: 48 weeks allows for 4 week reduction in services during December / January	all 7 secondary hospitals conduct NCD clinics at least every week during 48 weeks of the year 2017	NCD reporting form that compiles weekly number of NCD clinics in secondary hospitals <i>NCD report form needs to be designed by HIS and collected through NCD Coordinators</i>	Proportional payment on target achieved <i>(Weighing 1/3 of 20%)</i>
N 5.2a % average stock-out level of critical drugs and goods at SLMSs, deducted by % essential medicines that show spot-check out-of-stock levels at SLMSs over 25% in 2017.			No of stock-out critical drugs and goods at SLMSs / No. of critical drugs and goods that should be available at SLMS Resulting % will be deducted by % essential medicines that show spot-check out-of-stock levels at SLMSs over 25%		On average max. 10% out of stock level of critical items at SLMS and no essential medicines with over 25% spot-check out-of-stock level)	Medical Stores report (assessed quarterly using a standard basket of goods)	Proportional payment on target achieved <i>(Weighing 1/6 of 20%)</i>
N 5.2b % SLMS orders received by National Medical Stores according to predefined schedule			No. of SLMS orders received by National Medical Stores according to schedule / No. of SLMS orders scheduled		At least 40% of orders by SLMS are received on schedule		Proportional payment on target achieved <i>(Weighing 1/6 of 20%)</i>

N 5.4 Number and per capita outpatient consultations in 2017			Total number of outpatient consultations / Total population	See CIS # 25	At least 5% increase in number of OP consultations compared to 2016	DHIS Population data	Meeting cut-off point <i>(Weighing 1/3 of 20%)</i>
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PROVINCIAL							
Performance indicator	Cat.	Weight	Nominator / Denominator	Description/ remarks	Target	Means of verification	Payment-linked conditions
P 1 % of draft AOPs and budgets submitted by 30 September	Budget	Pre-condition	Number of draft AOPs and budgets submitted by 30 September / Total number of AOPs and budgets submitted	Submit a final AOP and budget is only possible until the budget ceiling is announced – in 2016 this was in November	100%	Financial controller files	Pre-condition for payment
P 2.1 % of outstanding imprests that are more than 90 days overdue from specified retirement date at 31 December	Finance & reporting	50%	Value of outstanding imprests 90 days overdue (where salary deduction has not been initiated) / Total value of outstanding imprests (where salary deduction has not been initiated)	Measurement by province Salary deduction has been initiated if: <ul style="list-style-type: none"> • PS has approved for staff on the Establishment • First deduction from salary of DWE staff retirement date is two weeks after activity completion 		Financial files	Proportional payment according to % outstanding imprest >90 days retirement (Weighing 1/4 of 50%)
P 2.2 Completion on timely* reporting for various reports per year * PERIOD 1 JULY – 31 DECEMBER 2017: all reports submitted within 45 days of the end of the month or quarter (timeliness does not apply for first half year 2017)			Number of reports submitted within 45 days* of the end of the month or quarter, per year / Required number of reports submitted within 45 days* of the end of the month or quarter, per year	Reports to be submitted [required number]: a. Quarterly financial reports [4/yr] b. Monthly Bank Reconciliations [12/yr] c. Quarterly Progress Reports against AOPs [4/yr]	100%	Financial controller files MHMS policy & planning annual report Progress reports against AOPs to be submitted via	proportional payment on target achieved (Weighing 3/4 of 50%)

				d. Monthly DHIS Reports [12/yr]		PHD to MHMS Executive	
P 3. Annual % increase of outreach activities	Outreach	25%	Difference between the number of outreach activities in present year and previous year / Number of outreach activities in previous year	Composite indicator on outreach activities, including sub indicators: a. visits to schools b. satellite clinics c. vaccinations visits	At least 5% increase per sub indicator per province as compared to 2016	DHIS	Payment on the basis of summed scores per province divided by number of sub indicators x 100% Proportional payment on target achieved
P 4 Annual change in selected service indicators	Services	25%		a. Measles immunization rate b. Number of family planning contacts c. Number of deliveries by skilled birth attendant	At least 5% increase per sub indicator per province as compared to 2016; or if threshold is reached. <i>Level of threshold still under discussion.</i>	DHIS, NRH database	Payment on the basis of summed scores per province divided by number of sub indicators x 100% Proportional payment on target achieved

DEVELOPMENT PARTNERS		
Performance indicator	Description/Remarks	Means of verification
DP1.1 Proportion of non-TA DP funding on budget and on system. DP1.2 Funding inputs are announced at the SIG budget launch (July) and appropriated through the regular SIG budget process (appropriated in November). DP 1.3 Only the HSSP SWAp account is used with no separate bank accounts in operation (on-system).	DP1.1 target: 100% of non-TA funding All signatories to the Partnership have advised 2016 inputs prior to Planning DPCG (July, 2015)	DP1.1 Proportion of non-TA DP funding on budget to be tracked through the SWAp secretariat. SIG Budget and LMEA update
DP2.1 DP payments are made on time (as long as SIG has fulfilled reporting requirements) and in accordance with commitments (no intra-year changes). DP2.2 DP's provide 4 year budget projections to assist Ministry's long term planning activities.	All signatories to the partnership	SIG Budget and LMEA update
DP 3 Program related technical cooperation supported by development partners that has been cleared by MHMS	Register of cleared technical cooperation	

Annex 10: Terms of Reference

Title

Independent Performance Assessment of HSSP 2016 Performance Indicators – Solomon Islands

Background

Health is a priority focus of the Government of Australia's Solomon Islands Aid Investment Plan 2015/6-2018/19; Australia has a long term commitment to the sector to help save lives.

The goal of the third phase of the Health Sector Support Program (HSSP3) is to improve access to quality universal health care in Solomon Islands. Achieving the overall goal of HSSP3 needs outcomes in three main areas:

- improved quality and quantity of primary health care services;
- stronger health systems to support service delivery;
- implementation of priority reforms to ensure sustainable service delivery.

This goal is consistent with the commitment of the National Development Strategy 2015 – 2035 and the National Health Strategic Plan 2016-2020 to achieve Universal Health Coverage.

To progress towards the goal, Australia will work in partnership with SIG and with other development partners, as described in the Partnership Arrangement between Solomon Islands Government and Development Partners in the Health Sector-Wide Approach 2016-2020. Australia is the largest donor in the sector. Other development partners include WHO, World Bank, SPC, JICA, UNICEF and UNFPA.

In March/April 2017 the Solomon Islands Government (SIG) will convene the Joint Annual Performance Review (JAPR) with development partners. A key component will be to measure SIG's performance over the last year against the National Health Strategic Plan (NHSP), the core indicator set and the development partners/SIG jointly agreed national and provincial performance indicators. A further component of the JAPR meeting will be to review the performance of SWAp partners – development partners and the MHMS – against jointly agreed milestones for 2016.

A funding recommendation will be provided which will inform levels of performance linked funding provided by development partners, including Australia. SWAp Partners are looking to continuously improve the performance linked component of the HSSP program, including its value to MHMS. A secondary objective of this assignment is to provide a recommended schedule of performance indicators for 2017 (to be measured in 2018). This should align with the National Health Strategic Plan monitoring and evaluation framework.

It should be noted this cycle has a 20:80 ratio of performance linked aid (approximately AUD2.6 million) to core budget support but in future years this will grow to 25:75.

Objective

SHS will recruit, manage and quality assure the work of a specialist consultant.

The consultant will be engaged to support the MHMS assess its own, and SWAp partners' performance, including preparing a report, delivering presentations and assisting MHMS with finalising the 2017 performance indicators.

The consultant will be engaged to:

- help the Ministry assess and report on its progress against the jointly agreed performance indicators (as set at Attachment B) to highlight progress in 2016 on institutional reforms and service delivery results and progress against operational plans and strategies in the NHSP;
- help the Ministry assess the performance of SWAp partners and provide a briefing to the Ministry on key findings to assist them at JAPR deliberations.
 - This will include: (i) proportion of development partners' (DP) funding on plan, on budget and on system increased (ii) DP funding inputs announced in the SIG budget launch and appropriated through regular SIG budget processes (iii) use of the Health SWAp account with no separate bank accounts in operation (iv) timely DP payments and in accordance with commitments (no intra-year changes) (v) proportion of DP technical cooperation inputs with all steps in MHMS clearance process completed;
- prepare a draft set of jointly agreed performance indicators for 2017, based on report recommendations, and in close cooperation with MHMS; and
- make recommendations on performance payment for 2016.

Scope

The scope of the appraisal is set out in clauses 9.1-9.11 of the Direct Funding Agreement (Attachment A). The consultant will travel to Honiara by 17 April and present the first draft of their report to MHMS and GoA by 26 April. The findings will be presented at the JAPR on 1 May.

The consultant will be responsible for performance outcomes listed below.

1. Preparation and document review. *(2 days)*
2. Travel in country for up to 18 days to work with the MHMS Executive to review MHMS sector performance against jointly agreed performance indicators for 2016 (Attachment B) as well as development partner performance. *(up to 18 days in country and 4 days travel)*
- 2a. Prepare a brief report for MHMS and DFAT on 2016 performance including:
 - i. recommendation on the performance payment for 2016 to be paid immediately after the JAPR;
 - ii. performance of SWAp partners against the development partner indicators in the 2016 indicator matrix (Attachment B) and the Partnership Arrangement between Solomon Islands Government and Development Partners in the Health Sector-Wide Approach 2016-2020, and areas for improvement; and
 - iii. prepare a draft set of achievable set of milestones for 2017, in alignment with NHSP.
- 2b. Liaise and work in close cooperation with MHMS to assess performance and discuss the main findings and recommendations with SIG and partners as required and in advance of the JAPR.
- 2c. Prepare and deliver a 5-10 minute presentation for the MHMS executive prior to the JAPR.
- 2d. Prepare and deliver a 5-10 minute presentation of findings at the JAPR:
 - i. tabling of the report of progress against the performance matrix;
 - ii. outlining areas of strengths and weaknesses and areas of opportunity for improvement for MHMS and partners;
 - iii. outlining 2016 performance payment recommendation;
 - iv. outlining of recommended key performance milestones for 2017; and

- v. recommending how the process can be continually improved including tracking tools for MHMS Executive/donors quarterly meetings.
- 2e. Follow-up with MHMS executive and DFAT on issues raised during the JAPR in order to confirm findings and data. *(up to 2 business days (of the 18 days in-country) are to be scheduled following the JAPR for this task)*
- 3. Finalise report, including an annex of the 2017 performance matrix. *(up to 3 days)*

Methodology

The review will include a desk analysis of performance evidence generated in 2016 and findings will be confirmed by consultations in country. Provincial travel is not envisaged, however a visit to Guadalcanal and Honiara City Council clinic is likely. The consultant will refer to any available reviews or reports in assessing performance and assess the feasibility of next year's indicators. The consultant's analysis will factor in any mitigating circumstances (including the need to respond to natural disasters and major disease outbreaks) and their report will outline key achievements, areas for improvement and a recommendation on the performance component. The consultant's report on the selected indicators will contribute to the broader sector review undertaken by SIG and development partners at the JAPR.

Deliverables

- Draft report (up to 20 pages including annexes) to be tabled at the JAPR to DFAT by 24 April.
- Presentation to the MHMS executive prior to the JAPR by 26 April. (Adviser will send to SHS 24 April)
- Presentation on the findings to MHMS and donors at the JAPR on 1 May
- Final report to DFAT by 15 May 2017. (Adviser will send to SHS 12 May)

Duration and Phasing

- Preparation and document review *(2 days)*
- In country travel including preparation of draft report and presentations *(up to 18 days in country and up to 4 days travel)*
- Finalise report *(up to 3 days)*

Team composition

- A health expert with specific technical expertise including knowledge and experience of SWAps, including performance-linked funding.

Communication and reporting

- Client Area contact – Gina De Pretto,
- SHS Lead – Maia Ambegaokar, Director SHS

Budget

- Up to 27 days at C4 (AUD933per day). Travel to Solomon Islands.

Attachments from client

- Attachment A – Clauses 9.1-9.11 of the Direct Funding Agreement
- Attachment B – 2016 Performance Indicator

Attachment A – Clauses 9.1-9.11 of the Direct Funding Agreement

Performance Linked Funding (Performance Component)

- Performance Component payments will be triggered by an Independent Performance Assessment of mutually decided Performance Targets.
- Performance Targets will be jointly determined by the Participants and tabled at the Joint Annual Performance Review (JAPR). Participants will determine in advance targets related to emergency responsiveness which can be used to replace annual targets in the event of a designated emergency.
- A draft Indicative Schedule of Performance Targets is provided in Annex 2, Table 3. The final Schedule of Performance Targets will be developed following completion of the NHSP monitoring and evaluation framework (expected by the end of 2016). The Final Schedule of Performance Targets will reflect indicators in the monitoring and evaluation framework. Participants will jointly reassess and amend the Schedule prior to the JAPR and any amendments will form an integral part of this Arrangement. In this regard, a formal amendment to this Arrangement will not be necessary.
- Independent Performance Assessment results will be a standing agenda item at the JAPR.
- The performance cycle will start at the JAPR where draft Performance Targets are tabled and end at the following year's JAPR where the results of the Independent Performance Assessment are reported. The period of measurement for each Performance Target will be jointly determined by Participants.
- Performance Component funds will be paid into the CBSI Health SWAp Deposit Account as a lump sum payment after the Independent Performance Assessment is tabled.
- Unless otherwise mutually decided by the Participants, Performance Component funds will be appropriated in the SIG Budget for the fiscal year through SIG's regular budget process and reflected in the relevant Costed Annual Operational Plans.
- Fifty (50) per cent of the Performance Component funds will be allocated to the provinces. The remaining fifty 50 per cent of the Performance Component funds will be earmarked for other Core component activities and be subject to SIG's budget allocation process. All Performance Component funds are to be reflected in the relevant costed Annual Operational Plans.
- The Independent Performance Assessment will determine the Performance Component after balancing both quantitative and qualitative indicators of performance. Unless otherwise mutually decided between the Participants, the default amount will equal the weight of the group of Performance Targets which have been achieved multiplied by the total Performance Component (the total available for potential award is an indicative A\$10.7 million over four years). Each indicator within a group will have equal weight unless otherwise determined between the Participants. The Independent Performance Assessment qualitative assessment will moderate the final Performance Component payment outcome.
- In the event that only some of the Performance Targets are achieved in a group, or a Key Performance Target is only partly achieved, a pro rata performance payment will be paid for that group of Performance Targets. The assessment will factor in other qualitative indicators related

to performance, for example, Ministry effort, any acts of God (such as natural disasters and disease outbreaks) or other extraneous, mitigating circumstances related to achieving the Performance Targets.

- The selection of an Independent Performance Assessment team and the terms of reference will be mutually decided by the Participants. Other Development Partners in the health SWAp will be invited to participate in the assessment, including the development of the terms of reference. If SIG is unsatisfied with the results of the Independent Performance Assessment, it will inform GoA in writing and in that event GoA will make a final determination. The Independent Performance Assessment will be funded from Program Management Costs.