

Independent Performance Assessment of the Solomon Islands Health Sector Support Program 2017

May 2018

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Acronyms

ADT	Admissions, discharges and transfers	MHMS	Ministry of Health and Medical Services
AUD	Australian dollar	MPS	Ministry of Public Service
AOP	Annual Operational Plan	NHSP	National Health Strategic Plan
CIS	Core Indicator Set	NMS	National Medical Stores
DHIS	District Health Information Software	MOFT	Ministry of Finance and Treasury
DFA	Direct Funding Agreement	NCD	Non Communicable Disease
DFAT	Australian Department of Foreign Affairs and Trade	NRH	National Referral Hospital
DP	Development Partner	OPD	Outpatient Department
DPCG	Development Partner Coordination Group	PA	Partnership Arrangement (between MHMS and DPs)
EU	Delegation of the European Union	PCU	Partnerships Coordination unit
FHC	Family Health Committee	PFC	Planning and Finance Committee
FR	Financial Report	PFM	Public Finance Management
GAVI	Gavi Alliance	PHD	Provincial Health Director
GBV	Gender Based Violence	PLA	Performance Linked Aid
HFCS	Health Facility Costing Study	PLF	Performance Linked Funding
HIS	Health Information Systems	PS	Permanent Secretary
HR	Human Resources	RAC	Risk and Audit Committee
HRM	Human Resources Management	RDP	Role Delineation Policy
HSSP	Health Sector Support Program	SBA	Skilled Birth Attendant
ICTSU	ICT Support Unit of Solomon Islands	SIG	Solomon Islands Government
IPA	Independent Performance Assessment	SLMS	Second Level Medical Store
JPA	Joint Performance Assessment	SPC	Secretariat of the Pacific Community
JAPR	Joint Annual Performance Review	SWAp	Sector Wide Approach
JD	Job Description	TA	Technical Assistance
JICA	Japan International Cooperation Agency	ToR	Terms of Reference
KOICA	Korean International Cooperation Agency	UNICEF	United Nations Children's Fund
LMEA	Line Ministry Expenditure Analysis	UNFPA	United Nations Population Fund
MDPAC	Ministry of Development, Planning and Aid Coordination	US	Under-secretary
MDSR	Maternal Death Surveillance and Response	WHO	World Health Organization

Executive Summary

This report measures performance against a set of key indicators that were agreed between the Solomon Islands Ministry of Health and Medical Services (MHMS) and the 15 Development Partners comprising the Solomon Islands Health Sector Wide Approach (SWAp).

Performance is quantified in three ways:

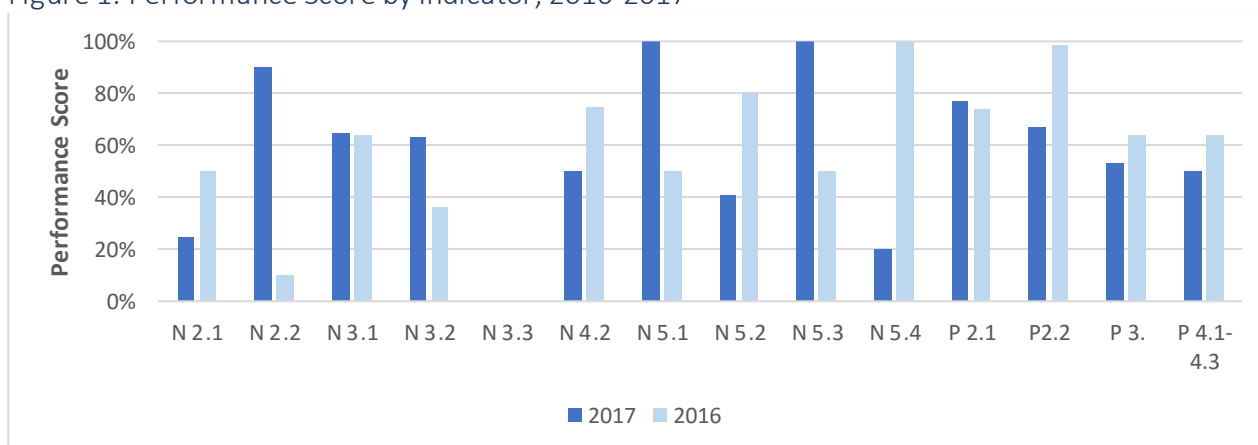
- 1) Met / Not Met – where the indicator requires a target to be fully achieved
- 2) Completed – where the indicator requires a task to be completed by a set point in time
- 3) Percentage – where the indicator measures proportional performance against the target

The performance payment for 2017 is recommended as \$1,742,305 (see Table 1). Overall, performance has declined from 2016. Though several indicators did improve between 2016 and 2017, particularly at the national level (see Figure 1).

Table 1: Performance Payment Summary by Category, 2017

Category	PLF Allocation (AUD)	Recommendation (AUD)	Proportion of PLF Allocation
Budget	\$271,000	\$271,000	100%
Health Reform	\$271,000	\$155,825	58%
Governance	\$271,000	\$115,627	43%
Health Information	\$271,000	\$203,250	75%
Service Quality and Coverage	\$271,000	\$176,828	65%
National Subtotal	\$1,355,000	\$922,530	68%
Finance and Reporting	\$677,500	\$470,863	70%
Outreach	\$338,750	\$179,538	53%
Services	\$338,750	\$169,375	50%
Provincial Subtotal	\$1,355,000	\$819,775	61%
TOTAL	\$2,710,000	\$1,742,305	64%

Figure 1: Performance Score by Indicator, 2016-2017



Development Partner Performance

Development partner performance relates to aid effectiveness principles and is assessed based on a set of indicators relating to alignment, ownership and predictability. Development partner performance is not linked to performance funding.

Table 2: Development Partner Performance Summary by Indicator, 2017

Disbursement linked indicator		Performance Score
DP1.1	All development partner contributions are “on plan”	Partially Met
DP1.2	All development partner contributions are “on budget”	
DP1.3	Development partners are “on system”	
DP1.4	Funding inputs are announced at the SIG budget launch (July) and appropriated through the regular SIG budget process (appropriated in November)	
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)	Partially Met
DP2.2	DP’s provide multi-year year budget projections to assist Ministry’s long-term planning activities	
DP 3.1	Program related technical cooperation supported by development partners that has been cleared by MHMS.	Partially Met
DP 3.2	Development partners regularly update TC inventory, including long and short term TA and volunteers	
Development Partner Performance		Partially Met

National Performance Summary

Performance at the national level achieved mixed results across the different categories (see Table 3). SIG did not meet the budget pre-condition because a mid year revised appropriation provided significant funding for scholarship to MEHRD and caused the proportion allocated to health from 12.9% in early 2017 to 11.8% by end of 2017. The dollar funding allocation to health did not change however, and health represented a proportion of 12.3% of the funding actually expended by SIG in 2017.

MHMS allocated 40% of the recurrent health budget to the provinces and exceeded the target of 37%. Governance and service delivery measures were also strong at the national level. Health information experienced some delays, reducing the scores in this area.

Table 3: National Performance Summary by Indicator, 2017

Disbursement linked indicator			Performance Score	Performance Payment
National Performance Summary				
Budget	Pre-Condition	The Solomon Islands Government will allocate at least 12.5% of domestically sourced revenue to the recurrent health budget for 2017	Not Met (11.8% revised)	N/A
	N 1.	% SIG recurrent health budget (276) allocated to Provinces (including payroll) is no less than 37% of total recurrent budget in 2017.	Met	\$271,000
Health Reform	N 2.1	MHMS restructure has been submitted to the Ministry of Public Services for establishment (official submission before end 2017)	25% Completed	\$33,875
	N 2.2	National Role Delineation Policy (RDP) Action Plan has been prepared and endorsed by Executive by the end of 2017.	90% Completed	\$121,950

Disbursement linked indicator			Performance Score	Performance Payment
Governance	N 3.1	% of activities in Corporate AOPs which are related to work packages in the PFM roadmap that have been conducted in 2017	65%	\$58,717
	N 3.2	% of meetings of Executive and Committees held against set targets on frequency, quorum and PHD presence (where relevant) in 2017	63%	\$56,910
	N 3.3	% of MHMS vacant counterpart positions that MHMS has completed recruitment processes for within 8 weeks of a position being vacant	0%	\$0
Health Information	N 4.1 (N 3.4)	% of NRH inpatient maternal deaths audited	100%	\$135,500
	N 4.2 (N3.5)	Scoping missions and implementation plans for Electronic Patient Admission, Discharge and Transfer Management System (ADT) completed for Kilu'ufi and Gizo hospitals by the end of 2017	50%	\$67,750
Service Quality and Coverage	N 5.1	% of hospitals that have held at least one NCD clinic per week with a minimum of 48 weeks in 2017	100%	\$67,750
	N 5.2	% average availability 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	41%	\$27,778
	N 5.3	% of health care providers trained in the care of GBV clients as per targets in GBV AOP in 2017	100%	\$67,750
	N 5.4	Number of outpatient consultations per capita in 2017 increased by at least 5% in each province	20%	\$13,550
National Total			63% ¹	\$922,530

Provincial Performance Summary

Provincial performance was varied across the indicators. All provinces submitted their draft AOPs before the cut-off date in September 2017, which was a pre-condition for performance payment. Provinces performed best on finance and reporting indicators, with a high proportion of provinces scoring well in regard to outstanding imprests. The relatively poor performance score for services resulted from the large number of provinces that failed to achieve increased immunisation, family planning coverage or skilled birth attendance rates. Only one province met the target for increased skilled birth attendance. Outreach services were similarly low compared to 2016, with three provinces failing to achieve increases in any outreach service delivery, and three more only seeing increases in one of the three outreach activities between 2016 and 2017.

¹ Performance Score is weighted and does not directly relate to the performance payment amount. Met and Completed are score at 100% and then weighted for overall performance score, Not Met is 0%. For weighted scores see Table 6.

Table 4: Provincial Performance Summary by Indicator, 2017

Disbursement linked indicator			Performance Score	Performance Payment
Provincial Performance Summary				
Finance and Reporting	P 1.1 Pre-Condition	% of AOPs and budgets submitted by 30 September	Met	N/A
	P 2.1	% of outstanding imprests that are more than 90 days overdue from specified retirement date at 31 December	77%	\$130,419
	P 2.2	Completion on timely* reporting for various reports per year (*3 rd and 4 th Quarters only)	67%	\$340,444
Outreach	P 3.	Annual % increase of outreach activities	53%	\$179,538
Services	P 4.1	Child Immunisation coverage	50%	\$169,375
	P 4.2	Family Planning Service contacts		
	P 4.3	Skilled Birth Attendance rates		
Provincial Total			69% ²	\$819,775

Achievements, Opportunities and Challenges

MHMS staff have increased their reporting against a number of indicators in 2017, with more data being more readily available. A range of systems have been established to record the information required, such as timely reporting and AOP submission. DHIS and the 2017 Health Core Indicators Statistical Report have been adapted to report on key health services, outcomes and some financial reporting. Similarly, the Consolidated Provincial 2017 Financial Statements Report provided key financial information to support the assessment. These are significant improvements, where incomplete reporting in the 2016 IPR prevented adequate assessment against several indicators (as noted through this report).

Future progress and improvement in routine collection and reporting of data is still required for several indicators. Where possible, recommendations have been made to improve the 2018 indicators and make it more efficient for MHMS to record and report the data. The development of a process for routine collection and reporting templates for the indicators which are lagging behind in collection would improve reporting, ensuring a more efficient process of assessing performance in 2018.

There is the potential for MHMS and Development Partners to agree to a standard template for reporting on key performance indicators and enable MHMS to compile the draft performance assessment report for independent appraisal each year (based on NHSP M&E Reporting where possible). This should be the aim of future reporting as it empowers MHMS to lead in performance assessment and reduces future reporting burden ahead of the Joint Assessment Appraisal Review Meetings each year.

To ensure an adequate reflection of the context of performance against each indicator, an iterative process of consultations with MHMS leadership and key program managers was used to draw out qualitative information and reflections that will guide future improvements in performance or improve the measurement of performance in 2018. The recommendations and results of this report have been shared with the MHMS Senior Executive and feedback was sought to ensure the report is fair and reflective of the strong work that was undertaken through 2017 by SIG.

² Performance Score is weighted and does not directly relate to the performance payment amount. Met is scored at 100% and then weighted for overall performance score. For weighted scores see Table 11.

1. Introduction

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:

1. improved quality and quantity of primary health care services;
2. stronger health systems to support service delivery;
3. 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.

1.1 Objectives and Scope

In April 2018 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 2017.

A funding recommendation will be provided which will inform levels of performance linked funding provided by 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 2018-2020 (to be measured in 2019-2021). This should include:

- Indicators from the National Health Strategic Plan monitoring and evaluation framework (NHSP MEF) that will be measured in each year across 2018-2020 (anticipated to be approx. 80% of PLF indicators);
- Indicators for priority policy reforms for 2018 (anticipated to be approx. 20% of PLF indicators), noting that new priority policy reforms for 2019 and 2020 will be set in future years.

It should be noted this cycle has a 22:78 ratio of performance linked aid (approximately AUD2.71 million) to core budget support but in future years this will grow to 25:75.

1.2 Methodology

This performance assessment was conducted primarily as a desk review of documents and information from the MHMS and Development Partners (see Annex 1), supported in close working collaboration by staff at the MHMS. In line with the information required for each indicator, key persons (listed at Annex 2) were consulted, including management, finance, health information and program staff at MHMS, DFAT Health Program staff and technical staff supporting program delivery from WHO and HSSP3. To help maintain consistency between the 2016 and 2017 performance assessments, a similar overall

methodology was used and several calculation methods were repeated (see calculations at Annex 7). Some limitations with the previous indicators and calculations became apparent during the 2017 assessment, including indicators that were fully met in 2016 and carried forward to 2017 to be fully met again; issues with using increasing outpatient consultations as a measure for health service utilisation (the two are not directly linked); and increases in health service provision that were impossible or very difficult to achieve in practice. Where possible, allowances were made to account for adequate performance when indicators were not appropriate, and each case is noted through the report.

The MHMS has invested a significant amount of effort into compiling the 2017 Health Core Indicator Statistical Report (CIS), which should be used as a companion document in reading the results of this performance assessment. The CIS was primarily used for selected statistical and health information derived from the DHIS2 health information system operated by MHMS. But a range of indicators required information beyond what was reported in the CIS and the source of data is identified for each indicator through this report. Namely, budget, finance and aid effectiveness measures required specific analysis, and was undertaken largely with the support of the budget and finance team in MHMS and with input from the World Bank.

In most cases, MHMS have prepared for the assessment by recording information on a set of templates. This was particularly useful for measuring the timeliness of reporting and AOP submission. Where information was recorded through the year, the process of reporting was more efficient. In some other cases, where information was not routinely collected, analysis was delayed while information was gathered from various sites nationally.

To ensure an adequate reflection of the context of performance against each indicator, an iterative process of consultations with MHMS leadership and key program managers was used to draw out qualitative information and reflections that will guide future improvements in performance or improve the measurement of performance in 2018. The recommendations and results of this report were shared with the MHMS Senior Executive and feedback was sought to ensure the report is fair and reflective of the strong work that was undertaken through 2017.

2. Program Performance Assessment

This report provides measures against performance for a set of key indicators that were agreed between the Solomon Islands Ministry of Health and Medical Services (MHMS) and the Development Partners participating in the Solomon Islands Health Sector Wide Approach (SWAp).

Performance is quantified in three ways:

- 1) Met / Not Met – where the indicator requires a target to be fully achieved
- 2) Completed – where the indicator requires a task to be completed by a set point in time
- 3) Percentage – where the indicator measures proportional performance against the target

This report provides the outcome for each indicator as well as some context on the factors that have influenced achievement and where improvements can be made in the future. Qualitative inputs from program areas were used to identify the influencing factors for each indicator, which were largely subjective but provided a good snapshot of how programs were managed and the factors that limited their effective implementation. Program managers and staff were able to provide some good suggestions for measuring future years performance based on their experience and were quite candid with regards to the limitations and challenges that are faced.

2.1 Development Partner Performance

Sixteen Development Partners are signatories in the Solomon Islands Health SWAp, they include:

- | | |
|---|--|
| 1. Australian Government | 9. Korean International Cooperation Agency |
| 2. World Health Organization (WHO) | 10. Government of the Republic of China (Taiwan) |
| 3. World Bank | 11. Fred Hollows Foundation New Zealand |
| 4. Secretariat of the Pacific Community (SPC) | 12. World Vision Solomon Islands |
| 5. United Nations Children's Fund (UNICEF) | 13. Red Cross Solomon Islands |
| 6. United Nations Population Fund (UNFPA) | 14. Save the Children Solomon Islands |
| 7. Government of Japan | 15. New Zealand Government |
| 8. Delegation of the European Union | 16. Kaohsiung Medical University |

Contributors to the Joint UN program on RMNCAH are WHO (lead), UNICEF and UNFPA. Non-SWAp partners in health include the Gavi Alliance and the Global Fund, and they have been referenced in this assessment to enable a reflection on their performance as significant development partners in the health sector.

Development Partner performance is assessed on a set of indicators related to alignment and ownership (being on plan, on budget and on system), and predictability (timely advice of inputs, consistent payment and multi year commitments). Development partner performance is not linked to performance funding.

DP1.1 All development partner contributions are “on plan”

DP1.2 All development partner contributions are on are “on budget”

DP1.3 Development partners are “on System”

DP1.4 Funding inputs are announced at the SIG budget launch (July) and appropriated through the regular SIG budget process (appropriated in November)

Major DP stakeholders in the SWAp were “on plan”, “on budget” and “on system”, though there is room for improved performance amongst other DP stakeholders. Alignment in this context requires DP activities to be included in AOPs for 2017, contributions to be included in the health (376) or non-appropriated (476) budgets, and development partner contributions to flow through the MHMS Development Partners

Account (or any other SIG account as decided by the Government and agreed by the Partner)³. Regrettably, most DPs were not able to provide their 2018 commitments prior to the 2017 DP Coordination Group (DPCG) Meeting. A score card for selected DP performance is reported in Table 5.

Performance Score: Partially Met

DP2.1 DP payments are made on time and in accordance with commitments

DP2.2 DP's provide multi-year year budget projections to assist Ministry's long term planning activities

All major DPs were able to provide their 2018 contributions in accordance with their commitments. However, there were issues with timeliness of payments and providing multi-year commitments. The combination of which caused uncertainty and delayed the implementation of activities in 2017.

Performance Score: Partially Met

Table 5: Development Partner Key Performance Assessment Results by Category, 2017

Performance Indicator		Selected SWAp Partners							Selected Non-SWAp Partners	
		DFAT	EU	UNFPA	UNICEF	WHO	KOICA	Joint UN	GAVI	Global Fund
DP 1.1	On Plan	✓	✓	✓	✓	✓	✓	✓	✓	✓
DP 1.2	On Budget	✓	✓	✓	✓	✓	✓	✓	✓	✓
DP 1.3	On System	✓	✓	✓	✓	✓	✓	✓	✗	✓
DP 1.4	Timely advice of 2017 Inputs	✓	✓	✗	✗	✗	✗	✗	✓	✓
DP 2.1	Timely and Consistent Payments	✓	✓	✓	✓	✓	✓	✓	✓	✓
DP 2.2	Multi-year Budget Projections	✓	✓	✗	✗	✓	✗	✗	✓	✓

Source: MHMS Partnership Coordination Unit (PCU) with support from the World Bank (as of 18 April 2018)

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

DP3.2 Development partners regularly update TC inventory, including long and short term TA and volunteers

MHMS reported that DPs do not always report in a timely way on Technical Advisors (TAs) timing or purpose (also raised in the 2016 IPR). MHMS should be advised of all incoming TAs engaged by DPs for health-related consultancies, including providing an advance copy of their Terms of Reference and a copy of their final mission reports. Timing of incoming TAs has competed with other MHMS commitments or crossed common leave periods (like Christmas / New Year period), which presents a burden on the MHMS and can affect the quality and outputs of the missions when counterparts are unavailable. The SIG Aid Management Policy requires that all Development Partners provide 6 months advance notice of planned TAs including the intended period in country and assignment objectives. The only DP that consistently follows this process is the World Bank.

³ DPs may also provide off-system support to the health sector for activities such as direct procurement, implementation or technical assistance, which is not captured in this performance assessment.

Performance Score: Partially Met – There is room for improvement in 2018.

2.2 National Performance

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

PLA Pre-condition: The Solomon Islands Government will allocate at least 12.5% of domestically sourced revenue to the recurrent health budget for 2017 (276 out of national ledgers 2)

Performance Linked Aid is contingent on SIG at least maintaining the annual allocation to the recurrent health budget (276) (proportionate to domestically sourced revenue only). In 2016, the performance measure required an allocation of at least 10%, and 12.6% was achieved. In 2017 the measure increased to 12.5% (in line with the Direct Funding Agreement with Australia). SIG initially allocated 12.9% of the national budget to the recurrent health budget in 2017. However, the budget was revised mid 2017 with an additional appropriation of \$254 million, almost 80% of which went to the Ministry of Education and Human Development for additional scholarships. This allocation significantly reduced the proportion of funds allocated to health, reducing from 12.9% to 11.8%, despite the dollar funding allocation to health remaining constant in 2017. By contrast, health represented 12.3% of actual recurrent SIG expenditure in 2017, better reflecting the original allocation.

Performance Score: Not Met – 11.8% of the revised 2017 national budget was allocated to health (276)

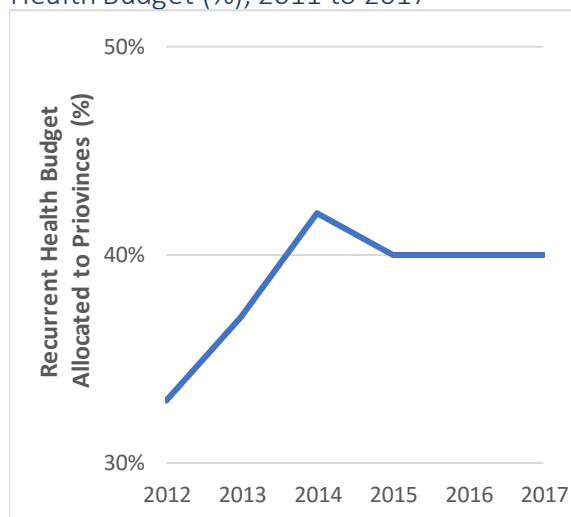
N 1. % SIG recurrent health budget (276) allocated to Provinces (including payroll) is no less than 37% of total recurrent budget in 2017

The proportion of the recurrent health budget (276) allocated to provinces was 40% in 2017, well meeting the target set of 37%. In fact, the provincial allocation increased from 33% in 2012, to 37% in 2013 and then has remained at 40%+ since 2014 (see Figure 2). This level of funding should be maintained or increased year on year to ensure ongoing development and growth of the health sector to meet need.

Performance Score: Met – The performance target of 37% of the recurrent health budget being allocated to provinces was exceeded.

Recommendation for 2018: The performance measure for allocation of the recurrent health budget to provinces should be revised to require at least year on year maintenance of the provincial allocation – for 2018 this would require at least 40% of the recurrent health budget to be allocated to provinces.

Figure 2: Provincial Allocation of the Recurrent Health Budget (%), 2011 to 2017



Source: Consolidated Indicators Statistical Report 2017

N 2.1 MHMS restructure has been submitted to the Ministry of Public Services for endorsement (official submission before end 2017)

The MHMS plans to fully restructure at the national and provincial levels, which requires a full mapping of the current roles and responsibilities, as well as how those roles and responsibilities will be restructured into a new organogram. Performance in the current indicator measures performance on submission of the

MHMS restructure to the Ministry of Public Services (MPS), but the indicator does not recognise the significance of this piece of work or properly value the steps and progress required in developing the submission.

Some progress was made in early 2017 on development of the new organogram and supporting materials. High level meetings between MHMS and MPS had also commenced to discuss the reforms required in implementing the Role Delineation Policy (RDP) and present the draft organogram. However, a gap in HR advisory support between March and September slowed progress, with subsequent changes requiring significant revisions once the new HR adviser commenced in September. The management restructure continues to be a priority for MHMS and further progress is planned in 2018 to implement the RDP.

At present, activities planned for 2018 are at the higher level, with the first step in implementation being the restructuring of the Corporate Services Division. Additionally, the RDP Implementation Plan includes restructure activities in two pilot provinces that also link with this indicator (see next indicator). In order to effectively measure and track performance in implementing the restructure, it is recommended that comprehensive and clear implementation plans are developed with clear milestones of progress and achievement for all facets of the restructure that will be action in 2018 and 2019.

Performance Score: Partially Completed - 25% - MHMS Restructure was not submitted to the Ministry of Public Services for endorsement before the end of 2017, but score recognises early work (50% in 2016)

Recommendation for 2018: Performance should be measured against progress in implementing the restructure as outlined in the RDP as planned in 2018 and 2019 (milestones to be developed when RDP and restructure implementation planning is finalised).

N 2.2 National Role Delineation Policy (RDP) Action Plan has been prepared and endorsed by the Executive by the end of 2017
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The Role Delineation Policy (RDP) outlines the human resources required to meet current and emerging health sector challenges and improve access to quality primary health care services across the Solomon Islands. The RDP is a key step in progressing the Solomon Islands towards universal health coverage and is aligned with the NHSP.

Progress in finalising, approving and implementing the RDP has not progressed as quickly as intended. However, the RDP Implementation Plan was endorsed by the MHMS Executive and will be the theme for the 2018 Solomon Islands Health Conference. Next steps will require approval of the RDP by the SIG Cabinet, endorsement of the restructure plan (see previous indicator) and then implementation. A comprehensive RDP Implementation Plan will be required to understand the challenges and map progress in 2018 and 2019.

Performance Score: Partially Completed - 90% - The Role Delineation Policy (RDP) Action Plan was prepared by the end of 2017, but endorsement by the MHMS Executive was delayed until the first Executive Meeting in February 2018 (10% in 2016).

Recommendation for 2018: The RDP's submission to cabinet is a significant event and could be used to measure progress in 2018. Additional measures linked with restructuring under the RDP to the zonal level (particularly doctors) should be considered for 2019 (when implementation plans are clear) as a measure of effective implementation.

N 3.1 % of activities in Corporate AOPs which are related to work packages in the PFM roadmap that have been conducted in 2017

The PFM Roadmap outlines a set of 5 Performance Areas (Planning and budgeting; budget execution; accounting and reporting; internal control and assurance; and external scrutiny and audit) and contains 36 activities (28 of which were included in 2017 AOPs and assessed against performance of this indicator) (see PFM Roadmap). MHMS reported that the Office of the Auditor General did not schedule or conduct an external audit in 2017.

Detailed information against progress in each of the PFM activity areas was not available for the assessment. Instead, the assessment relied on a subjective assessment of progress made through discussion with the MHMS Budget and Finance Team. Progress against achieving each indicator was assessed proportionally and assigned an indicative percentage score. Overall performance was assessed by averaging the percentage score for each of the 28 activities that were assessed (see calculations at Annex 7). The total score was 79% and a comparison between the PFM Roadmap Performance Areas is available in Table 6.

Table 6: Progress against Activities in the PFM Roadmap by Category, 2017

PFM Roadmap Performance Area	Score
Planning and Budgeting	79%
Budget Execution	61%
Accounting and Reporting	90%
Internal Control and Assurance	55%
External Scrutiny and Audit	0%
Average Total Score	65%

Performance Score: 65% - average partial performance (64% in 2016).

N 3.2 % of meetings of Executive and Committees held against set targets on frequency, quorum and PHD presence (where relevant) in 2017

Consistent convening of senior executive, planning and review committee meetings is a proxy indicator for functioning governance structures. MHMS performance by that measure has been moderate in 2017.

All Executive, Family Health Committee, and Planning and Finance Committee meetings were conducted as planned and in accordance with Terms of Reference (with quorum) (see Table 7). PHDs (at least one) were required to attend the Family Health, and Planning and Finance Committee meetings (rotating), and did so in each case (Guadalcanal PHD was vacant for part of 2017, but each meeting was still attended by at least one other PHD). The Risk and Audit Committee held 3 out of 6 bi-monthly meetings that were planned in 2017 and identified provincial travel as the main reason for half the meetings not being held.

Performance Score: 63% - weighted partial performance on 65% planned meetings conducted (4/5 of the score) and 55% PHD attendance when required (1/5 of the score) (36% in 2016).

Table 7: Meetings of the Executive and Select Committees, 2017

Meeting	Meetings Planned for 2017	Meetings conducted in 2017	PHD Attended (if Required)
Senior Executive	10	10	N/A
Family Health Committee	4	4	✓
Planning and Finance Committee	10	5	(only 1 Meeting)
Risk and Audit Committee	6	3	N/A

N 3.3 % of MHMS vacant counterpart positions that MHMS has completed recruitment processes for within 8 weeks of a position being vacant

A counterpart for the purpose of this study is a MHMS staff member position that is directly supported by a HSSP technical advisor. It is important that counterpart vacancies are minimised to ensure technical support is effective.

There were 3 counterpart roles that became vacant in 2013 and have remained vacant through 2017 – these were Financial Controller, Procurement Manager and Infrastructure Manager. The roles were advertised and interviewed in 2017, but recruitment outcomes could not be agreed. The positions remain vacant as of 24 April 2018.

Performance Score: 0% - 0 of 3 counterpart positions that were vacant at the start of 2017 have been filled (0% in 2016).

N 4.1⁴ % of NRH inpatient maternal deaths audited

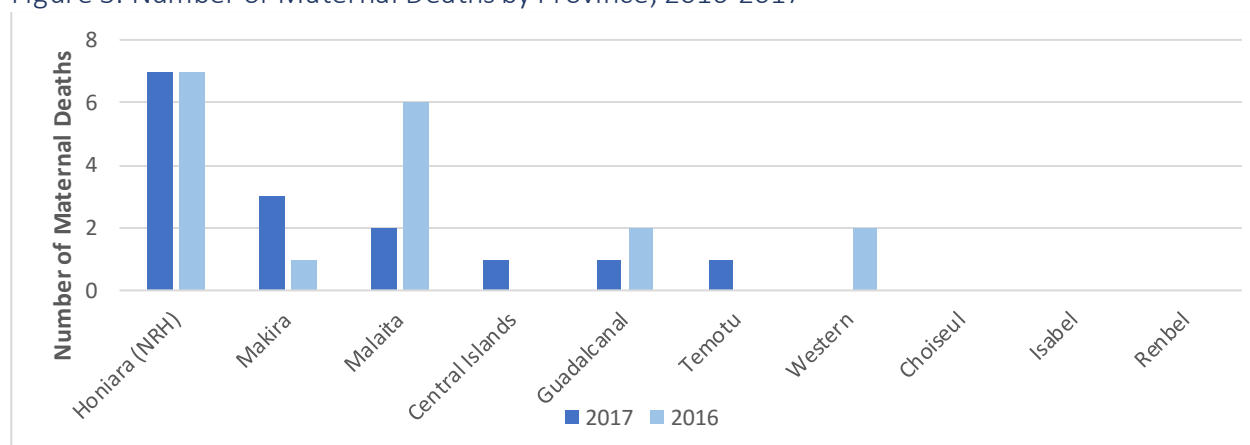
The Solomon Islands had a total of 15 maternal deaths in 2017, with 7 maternal deaths occurring at NRH (see Figure 3). Maternal death audits are currently only consistently completed at the NRH and were only routinely collected since 2016 (some maternal deaths that occurred in 2015 at NRH were audited). MHMS is implementing Maternal Death Surveillance and Response (MDSR) Reporting in 2018. MDSR reporting will be rolled out to enable investigation and reporting of key contributing factors and help improve service delivery and support. There is a need for training on MDSR Reporting to be conducted in 2018 to enable improved maternal death audits and reporting in all provincial hospitals and nationally.

Performance for this indicator in 2017 is measured on the proportion of maternal deaths at NRH where a maternal death audit was completed. Capacity at NRH is high and reporting is regularly and consistently reported. Provinces need support to build capacity and understand the importance of the information gained from regular reporting on maternal deaths.

Performance Score: 100% - all 7 maternal deaths at NRH in 2017 were audited.

Recommendation for 2018: Expand MDSR Reporting to all provincial hospitals in 2018 and measure performance on the proportion (%) of hospitals (NRH and Provincial) with staff trained in MDSR Reporting.

Figure 3: Number of Maternal Deaths by Province, 2016-2017



N 4.2⁵ Scoping missions and implementation plans for the Electronic Patient Admission, Discharge and Transfer Management System (ADT) completed for Kilufi and Gizo hospitals by the end of 2017

A scoping mission to Kilufi was completed in 2017, but the Gizo scoping mission did not progress in 2017. Both hospitals were connected to the SIG Connect Network by the ICTSU in 2017, however more funding is needed to connect all wards in both locations. Around half of the planned ADT work was completed.

⁴ This indicator was labelled incorrectly as N 3.4 in the 2017 set of performance indicators.

⁵ This indicator was labelled incorrectly as N 3.5 in the 2017 set of performance indicators.

Performance Result: 50% - partial performance in having undertaken one scoping mission and connecting both locations to SIG Connect in 2017 (75% in 2016).

Recommendation for 2018: Completed rollout of ADT in Gizo and Kilu'ufi remains a priority, alongside additional rollout locations planned for 2018 as a measure of performance (to be scoped). 2019 should consider progressive implementation of ADT and develop a measure to show ADT usage in locations where it has been connected.

N 5.1 % hospitals that have held at least one NCD clinic per week with a minimum of 48 weeks in 2017

The Solomon Islands is experiencing a 'double burden' of disease – rates of communicable disease that remain high and increasing rates of non-communicable diseases (NCDs), comprising diabetes, heart and respiratory diseases, cancers, and mental health conditions (NHSP). NCDs are a focus of the NHSP in Outcome Area 4 and the focus is on health promotion, legislative review (including limits on high calorie foods and beverages) and reducing preventable causes of blindness.

Data on NCD Clinic operation is not routinely collected, despite being recommended in 2016. A standard reporting process should be established to make reporting performance in 2018 more efficient. With improved reporting, it may also be possible (in future years) to collect and collate information on utilisation of NCD clinic services, main reasons for seeking preventive care and client demographic information for the DHIS, and improve measurement of the NCD burden in each province and at the national level.

Data collected by the NCD Program shows that every hospital conducted at least weekly NCD clinics in 2017 (see Table 8). Most hospitals operate NCD clinics more than once a week, with NRH and the Malaita and Western Province provincial hospitals operating full time. Data was complete in 2017, compared to 2016 where only 5 out of 7 hospitals were able to provide data.

Performance Score: 100% - every provincial hospital conducted at least weekly NCD clinics in 2017 (50% in 2016).

Recommendation for 2018: Consider expanding DHIS to capture data from NCD clinics to better understand NCD burden, drivers and treatments, with performance measured on reporting available in 2018. Data from the reports could be developed into a 2019 indicator, depending on system limitations.

Table 8: Operation of NCD Clinics Nationally, 2017

Province	Hospital/ Location	Weekly	No.	Staffing and Operation
Central	Tulagi	Yes	96	1 NCD nurse
Choiseul	Taro	Yes	240	1 NCD nurse
Guadalcanal	Good Samaritan	Yes	96	1 NCD nurse
Honiara	National Diabetes Centre (NRH)	Yes	240	1 Doctor, 5 staff; referrals; Full time
	Kukum Area Health centre	Yes	240	2 NCD nurses; Full time
Isabel	Buala Hospital	Yes	96	1 NCD nurse
Makira	Kirakira	Yes	96	1 NCD nurse
Malaita	Kilu'ufi	Yes	240	2 NCD nurses; Full time
	Atoifi	Yes	96	1 NCD nurse
Renbel	Tingoa	Yes	240	1 NCD nurse
Temotu	Lata	Yes	144	1 NCD nurse
Western	Gizo	Yes	240	1 NCD coordinator
	Helena Goldie	Yes	240	1 NCD nurses; Full time

Source: MHMS NCD Program, 2018

N 5.2 % average availability 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

Medical supplies are managed by a network of medical stores, with the National Medical Store located in Honiara and a further 15 Second Level Medical Stores (SLMS) in the Provinces. The Stores are progressively rolling out M-Supply, which is a software program used for pharmaceutical management. M-Supply is currently in the National Medical Store and 6 SLMSs. Rollout is in progress for Seghe and Nila SLMSs. Provinces with M-Supply are more likely to have provided stock information in 2017.

Medical supplies performance is assessed against the availability of critical drugs and goods (the standard basket of goods) and then the percentage of SLMSs that experienced spot-check stock-outs of essential medicines is deducted. This indicator was difficult to measure effectively due to incomplete stock records, but this will hopefully improve with the ongoing rollout of M-Supply at the SLMSs. Deducting the percentage of essential medicines that show spot-check stock-outs at SLMSs requires spot checks to have routinely taken place, which was not the case in 2017.

The 2017 assessment is based on incomplete information. 5 out of 15 SLMSs were able to provide complete 2017 stock availability data. 'No Data' was counted as 0% for the purpose of this assessment and significantly lowered the overall performance score. The average level of critical drugs and goods available at SLMSs varied (mostly due to 'no data') and averaged 57% across all SLMSs (see Table 9). 17% of SLMSs showed spot-checks stock outs >25% for 6 of the 36 essential medicines⁶ through 2017.

Performance Score: 41% (80% in 2016)

Recommendation for 2018: The availability of critical drugs and supplies at the service level should be used as the performance measure from 2018 onwards and is available in the DHIS.

Table 9: Availability of Critical Medical Supplies at Second Level Medical Stores, 2017

SLMS	M-Supply	Q1	Q2	Q3	Q4	Average Availability
Tulagi (Central)	✓	75%	97%	No Data	No Data	43%
Taro (Choiseul)	✓	70%	100%	100%	100%	93%
Buala (Isabel)	✗	50%	97%	No Data	No Data	37%
Susubona (Isabel)	✗	90%	97%	No Data	No Data	47%
Kirakira (Makira)	✓	75%	93%	No Data	No Data	42%
Tawaraha (Makira)	✗	90%	83%	No Data	No Data	43%
Afio (Malaita)	✗	90%	No Data	No Data	No Data	23%
Kilu'ufi (Malaita)	✓	45%	95%	100%	97%	84%
Malu'u (Malaita)	✗	95%	90%	93%	93%	93%
Lata (Temotu)	✓	60%	97%	No Data	No Data	39%
Tingoa (Renbel)	✗	86%	68%	No Data	No Data	38%
Gizo (Western)	✓	75%	97%	100%	97%	92%
Nila (Western)	In Progress	75%	93%	93%	79%	85%
Munda (Western)	✗	75%	97%	95%	No Data	67%
Seghe (Western)	In Progress	70%	76%	No Data	No Data	36%
Average Availability of Critical Drugs and Goods (Standard Basket) at SLMSs						57%
SLMSs with >25% Spot-Check Stock-Outs of Essential Medicines in 2017						17%
Performance Score						41%

Source: National Medical Store / M-Supply, 2018

⁶ Amoxycillin (tabs/caps); Artesunate (suppository/injection); Ferrous sulphate + folic acid (tabs); Morphine or pethidine (tabs or injection); Oxytocin or syntometrine (injection); and STI treatment packs.

N 5.3 % of health care providers trained in the care of GBV clients as per targets in GBV AOP in 2017

Gender based violence (GBV) is Outcome Area 7 of the NHSP and MHMS have committed to appointing a National Gender Focal Point. The MHMS developed draft clinical guidelines 'Policy and Clinical Protocols for Minimum Standards of Treatment of Survivors of Sexual and Gender Based Violence' in 2016 with the support of WHO.

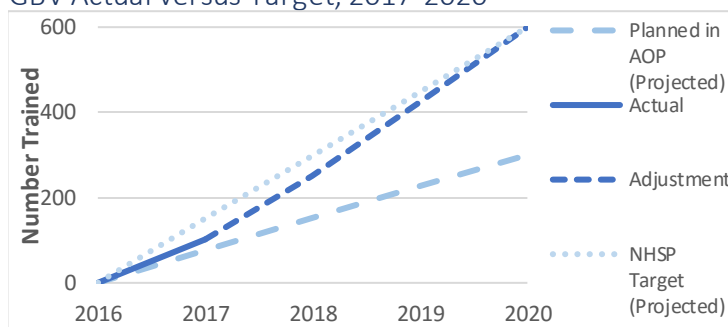
Part of the MHMS's commitment to addressing gender based violence through the health sector includes training health care providers in the care of GBV clients. WHO continues to provide ongoing technical support to MHMS in this area, and the MHMS is working with a range of development partners, service providers and staff across the health sector.

The NHSP and program target is 150 health care workers trained in the care of GBV clients each year by 2020. The 2017 GBV Program AOP planned to deliver training to 75 health care workers, half what is required to meet the 2020 target (see Figure 5). While 75 is achievable, it is not relative to the 2020 target and was easily exceeded. Training of health care workers will need to increase between 2018-2020 if the target is to be achieved - at least 150 in 2018, then 174 each year 2019-2020 (see Figure 4 – Adjustment).

Performance Score: 100% - A total of 102 health care workers were training in 2017 against the GBV AOP plan of 75 (50% in 2016).

Recommendation for 2018: The GBV performance target should be set relative to achieving the NHSP target of 150 per year until 2020.

Figure 4: Health Care Providers Trained in the Care of GBV Actual versus Target, 2017-2020



Source: WHO, 2018

N 5.4 Number and per capita outpatient consultations in 2017

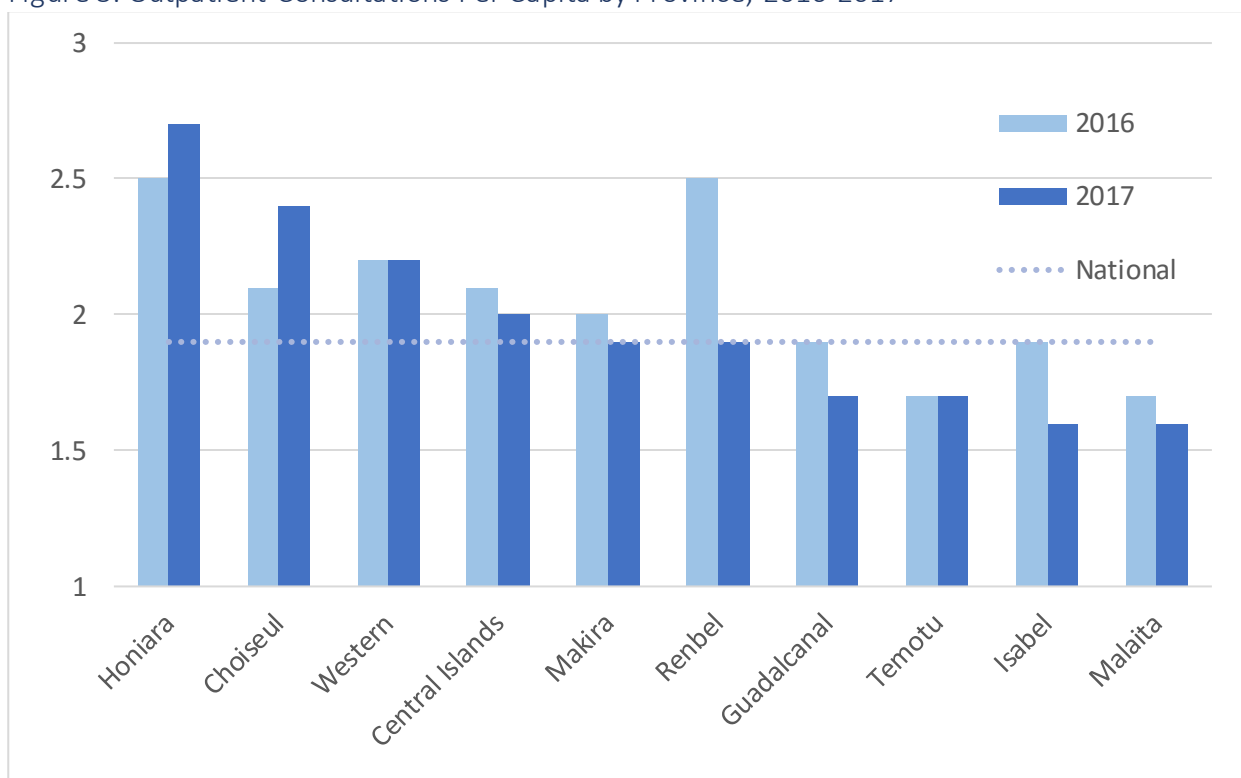
Information to assess this indicator is derived from the 2017 Core Indicators Statistical Report – Section 25, which assessed the number of visits for ambulant care, not including immunizations, for the total population (including repeat visits) per capita.

The target for this indicator assessed the number of provinces that achieved at least a 5% increase in outpatient consultations between 2016 and 2017. Only Choiseul and Honiara (including NRH) achieved the required increase in 2017. The remainder of the provinces either maintained their 2016 level (Western and Temotu) or consultations decreased (see Figure 5). This measure is also influenced by the number of people seeking treatment in any given year and does not necessarily relate proportionately to health service utilisation.

Performance Score: 20% – Honiara and Choiseul (Fully met - 100% in 2016, using different calculation).

Recommendation for 2018: Develop a more accurate indicator of service quality and coverage for 2018 performance assessment onwards based on the data currently available through the DHIS.

Figure 5: Outpatient Consultations Per Capita by Province, 2016-2017



Source: Consolidated Indicators Statistical Report 2017

2.3 Provincial Performance

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

P 1 % of draft AOPs and budgets submitted by 30 September

It is a pre-condition for payment of Performance Linked Aid that all provinces have submitted their draft AOPs for the following year by 30 September 2017. Drafts used as AOPs cannot be finalised until the budget ceiling is finalised for the year, which happened in November in 2016. In 2017, the budget ceiling was finalised before September, allowing the majority of Provincial AOPs to be approved before the end of September 2017 (see Table 10). More than half of the Provinces had their AOPs approved by the second draft, and Isabel and Western Provinces were approved on the first draft. This indicates a significant improvement in quality from 2016.

Performance is measured on all provinces having submitted their draft AOPs by 30 September 2017.

Performance Score: 100% - all provinces had submitted draft AOPs by the end of September 2017 (100% in 2016).

Recommendation for 2018: Submission of draft AOPs by the end of September is easily achieved. 2017 results showed that 9 out of 10 provinces had their AOPs approved by the end of September. As such, using approval instead of draft as a measure for performance in 2018 could be considered, with a caveat that measures submission of drafts if the annual budget ceiling is not finalised in time.

Table 10: Submission of Draft and Final Provincial AOPs, and Timeliness, by Province, 2017

Province	Draft Submission Date	Timely 1 st Draft Submission	Final Version Submission Date	Timely Final Draft Submission
Central Islands	28/09/2017	✓	Ongoing	✗
Choiseul	6/09/2017	✓	22/09/2017	✓
Guadalcanal	15/09/2017	✓	26/09/2017	✓
Honiara	15/09/2017	✓	30/09/2017	✓
Isabel	30/09/2017	✓	30/09/2017	✓
Makira	15/09/2017	✓	29/09/2017	✓
Malaita	11/09/2017	✓	28/09/2017	✓
Renbel	27/09/2017	✓	28/09/2017	✓
Temotu	19/09/2017	✓	29/09/2017	✓
Western	8/09/2017	✓	8/09/2017	✓
Submission of AOPs by 30 September 2017		10/10		9/10

Source: MHMS Finance Records, current as at 19 April 2018

P 2.1 % of outstanding imprests that are more than 90 days overdue from specified retirement date at 31 December

The Consolidated Provincial 2017 Financial Statements Report listed the total outstanding imprests at the end of 2017, as well as the proportion and value of those imprests that were more than 90 days overdue from the specified retirement date.

Performance is measured against the percentage of outstanding imprests value that is more than 90 days overdue – with a positive score derived by the percentage of outstanding imprest value that is not more than 90 days overdue and adding the 15% permitted by the indicator target (up to a maximum of 100% per province) (see Table 11). This is the same calculation that was used in 2016 and a comparison shows there was a modest improvement in performance against this indicator between 2016 and 2017.

Performance Score: 77% - average performance based on the proportion of outstanding imprest value that is greater than 90 days overdue (74% in 2016).

Recommendation for 2018: Performance would be better measured on the proportion of provinces where the percentage of outstanding imprests greater than 90 days overdue is less than the 15%. If this target were used in 2017, then only 10% of provinces would have achieved the performance measure.

Table 11: Provincial Performance Scores and Payment for Reporting Timeliness, 2017

Province	Outstanding Value End 2017	Outstanding Value >90 days	Proportion >90 Days	Performance Score
Central Province	\$678,017.19	\$387,822.85	57%	58%
Choiseul Province	\$50,560.00	\$25,690.00	51%	64%
Guadalcanal Province	\$423,461.50	\$238,818.50	56%	59%
Honiara City Council	\$131,920.80	\$62,892.30	48%	67%
Isabel Province	\$43,472.00	\$5,800.00	13%	100%
Makira Province	\$125,695.00	\$23,300.00	19%	96%
Malaita Province	\$242,208.00	\$99,073.00	41%	74%
Renbel Province	\$213,163.00	\$105,250.00	49%	66%
Temotu Province	\$185,310.00	\$34,510.00	19%	96%
Western Province	\$70,310.00	\$21,000.00	30%	85%
Total Outstanding Value	\$2,164,117.49	\$1,004,156.65	46%	
Average Performance Score:				77%

Source: Consolidated Provincial 2017 Financial Statements Report

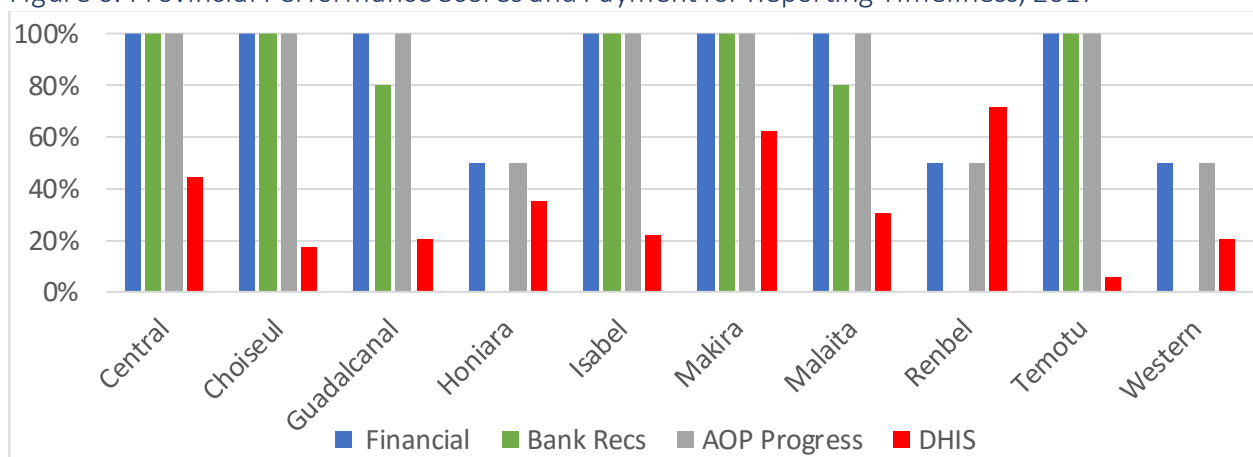
P 2.2 Completion of timely* reporting for various reports per year (*3rd and 4th Quarters only)

Data on the timely submission of reports was routinely collected in 2017, and available in the Consolidated Provincial 2017 Financial Statements Report, MHMS Finance Records and the DHIS for all provinces. This was a significant improvement on 2016, where timeliness could not be reported as the information had not been recorded.

Performance was measured on whether each kind of report was submitted within 45 days for each time it was due in 2017. The composite score was calculated on the proportion of reports of each kind that were submitted on time for all provinces and then averaged (see calculation at Annex 7). DHIS reports were least likely to be submitted on time by all provinces. Honiara, Renbel and Western Provinces were least likely to submit reporting on time (see Figure 6). Performance of individual Provinces is listed in Table 12.

Performance Score: 67% - composite partial performance on timely submission of selected reports (99% in 2016 – on submission only).

Figure 6: Provincial Performance Scores and Payment for Reporting Timeliness, 2017



Sources: Consolidated Provincial 2017 Financial Statements Report; MHMS Finance Records; DHIS

Table 12: Proportion of Provincial Reports Submitted by Type, 2017

Province	Financial Reports (quarterly)	Bank Reconciliation (monthly)	Progress reports against AOPs (quarterly)	DHIS reporting (monthly)	Average Score
Central	100%	100%	100%	45%	86%
Choiseul	100%	100%	100%	18%	79%
Guadalcanal	100%	80%	100%	20%	75%
Honiara	50%	0%	50%	35%	34%
Isabel	100%	100%	100%	22%	80%
Makira	100%	100%	100%	62%	91%
Malaita	100%	80%	100%	31%	78%
Renbel	50%	0%	50%	71%	43%
Temotu	100%	100%	100%	6%	76%
Western	50%	0%	50%	20%	30%
Consolidated Average Score:					67%

Sources: Consolidated Provincial 2017 Financial Statements Report; MHMS Finance Records; DHIS

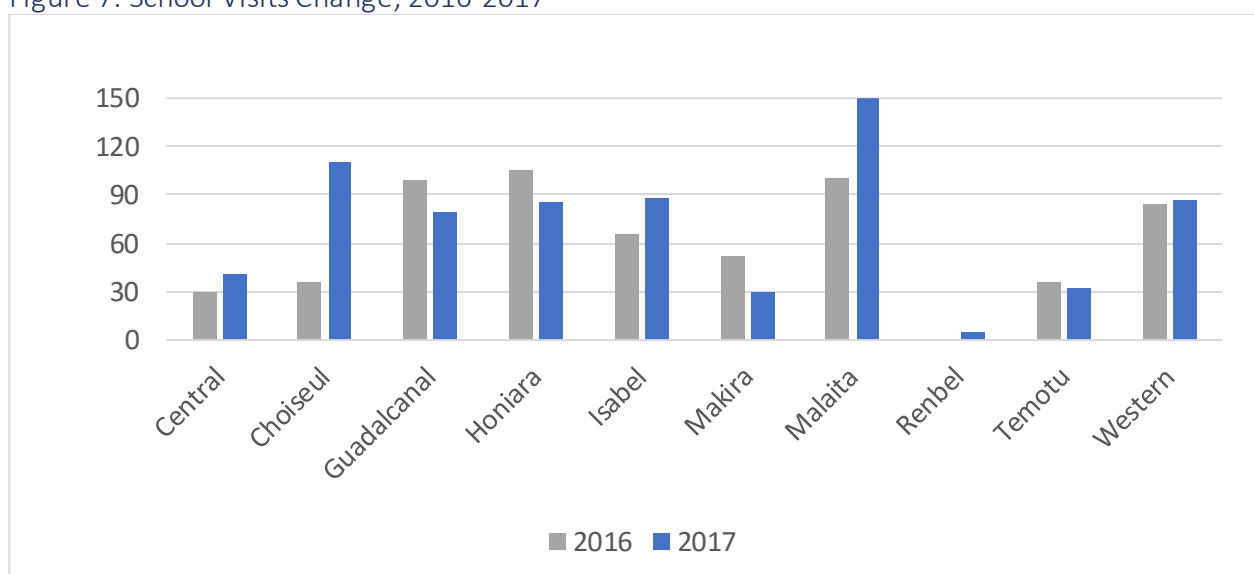
P 3. Annual % increase of outreach activities

Outreach activities are measured across provinces for visits to schools, vaccination visits (namely EPI in schools and on tour) and satellite clinics. All the information used to assess this performance indicator was compiled using the DHIS with the support of the Chief Medical Statistician. The DHIS information showed a general upwards trend across each of the outreach activities measured (see Figures 7-9).

Performance requires at least a 5% increase in each province for each of the outreach activities. This assessment used the same calculation method that was used in 2016, including the smoothing of year to year fluctuations in the number of vaccination visits (see calculation at Annex 7).

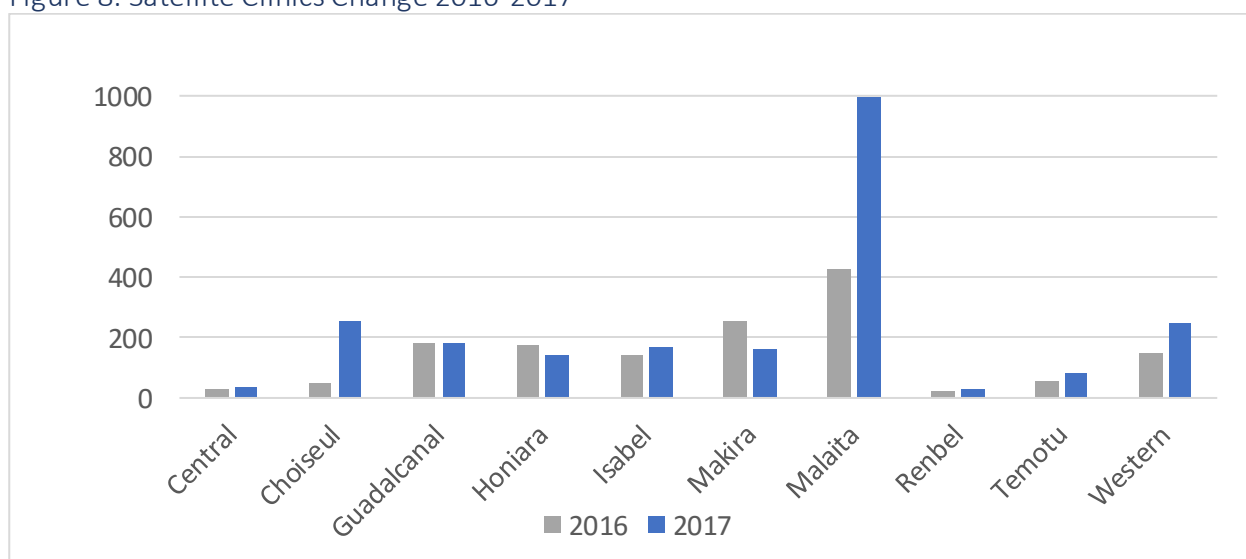
Performance Score: 53% - Composite partial performance across the three outreach services measured (64% in 2016).

Figure 7: School Visits Change, 2016-2017



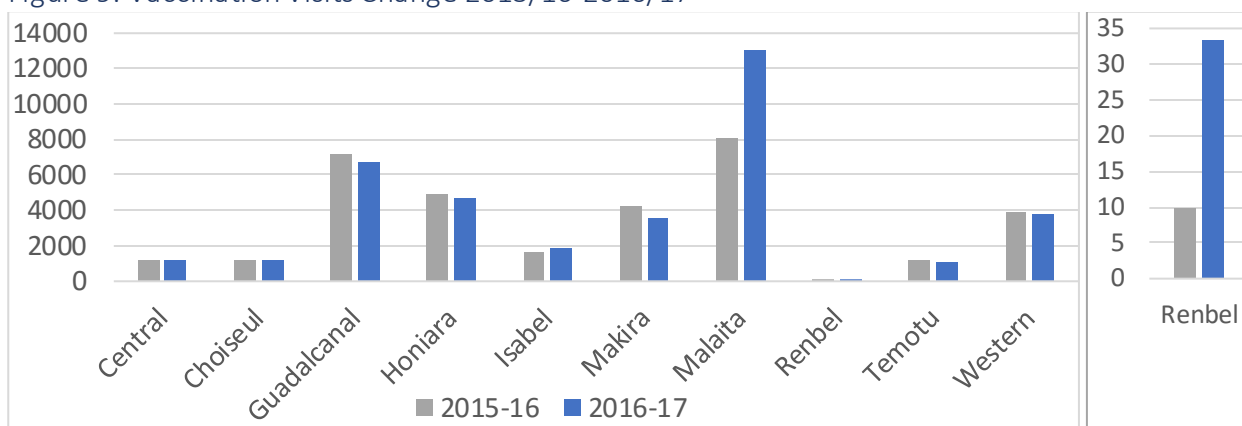
Source: DHIS

Figure 8: Satellite Clinics Change 2016-2017



Source: DHIS

Figure 9: Vaccination Visits Change 2015/16-2016/17



Source: DHIS

P 4.1 Child Immunisation coverage

P 4.2 Family Planning Service contacts

P 4.3 Skilled birth attendance rates

Child immunisation (MCV1 vaccination rate amongst children aged 12-59 months), family planning (contraceptive usage rates derived from the household survey) and skilled birth attendance rates are used as a proxy to measure overall health service performance at the provincial level. The data to assess these indicators was reported in the 2017 CIS. There have been increases (not always steady) in coverage, contacts and rates across each of the three selected health services indicators (see Figures 10-12). For a breakdown of provincial performance see the 2017 CIS sections 4, 7 and 28.

Performance was measured for each indicator as follows:

- 1) MCV1 vaccination: on the proportion of provinces that either maintained rates of at least 90%, or increased their rates by at least 5% if less than 90% between 2016 and 2017;
- 2) Contraceptive use: an increase in the proportion of family planning contacts per 1000 population between 2016 and 2017; and
- 3) Skilled birth attendance: at least a 5% increase in skilled birth attendance rates between 2016 and 2017.

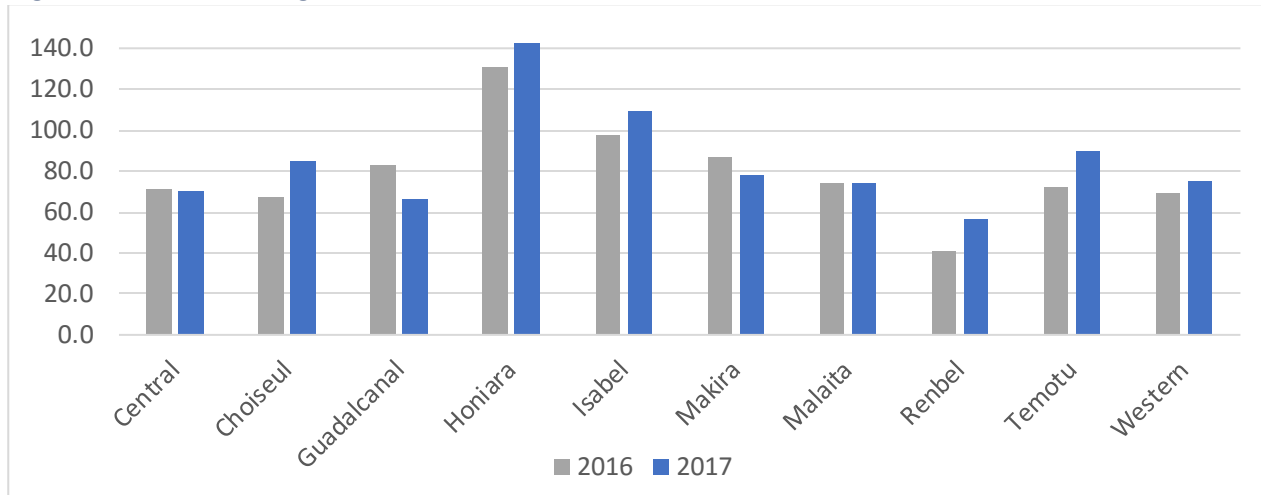
(Calculation is at Annex 7).

Choiseul, Honiara and Western provinces all maintained SBA coverage above 90% in 2017, but failed to achieve a 5% increase on 2016. Accepting that achieving a 5% increase is difficult from a base of 90% and impossible when the base coverage is already above 95%, a positive performance score was attributed for each of the three provinces that maintained coverage above 90%.

Performance Score: 50% - composite partial performance across the three health services measured (64% in 2016 – but for a different mix of health service indicators).

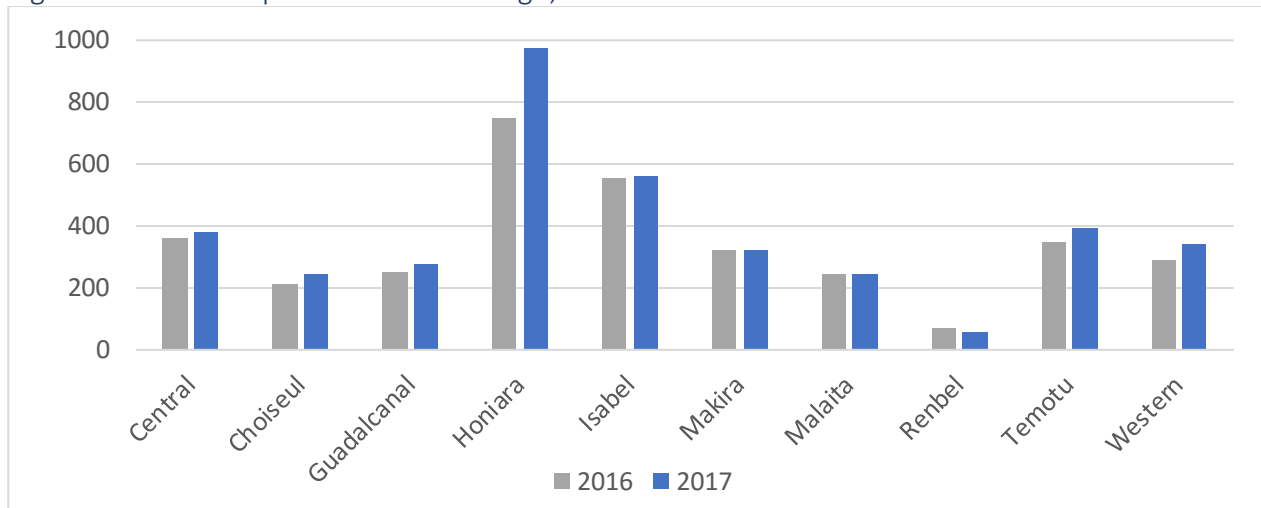
Recommendation for 2018: The target for SBA coverage should be at least a 5% increase on 2016 if less than 90% coverage already achieved; or coverage is maintained above 90%.

Figure 10: MCV1 Change, 2016-2017



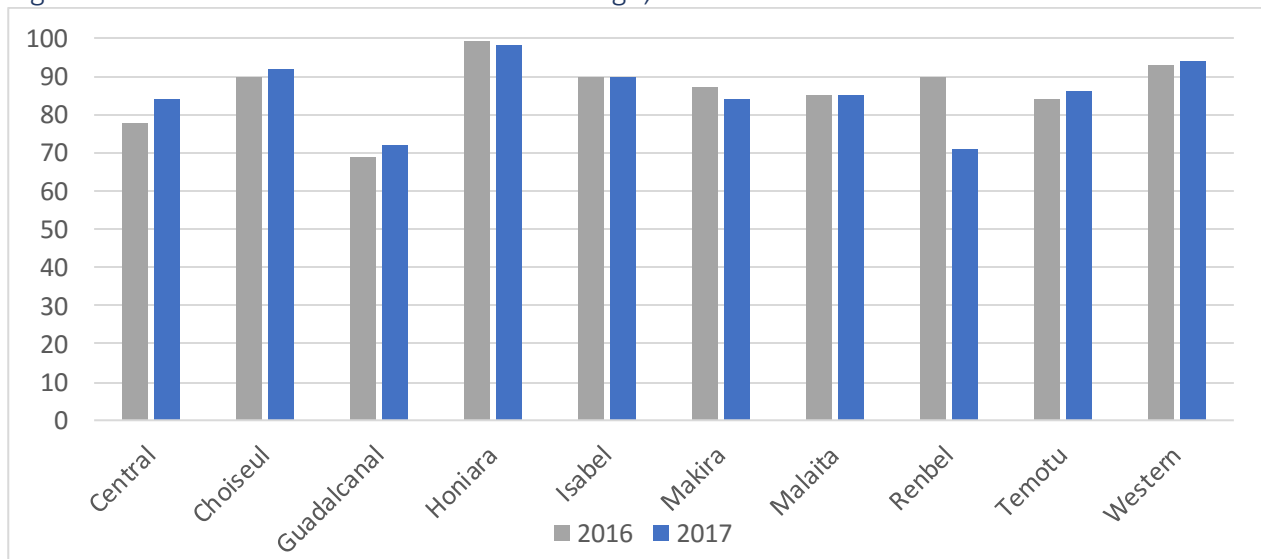
Source: Consolidated Indicators Statistical Report 2017

Figure 11: Contraceptive Contacts Change, 2016-2017



Source: Consolidated Indicators Statistical Report 2017

Figure 12: Skilled Birth Attendance Rates Change, 2016-2017



Source: Consolidated Indicators Statistical Report 2017

3. Future Performance Assessment

MHMS, with appropriate systems and support, could draft the 2018 performance assessment report using an agreed template. This streamlined process would require integration of more of the performance indicators into regular DHIS, financial reporting and M-Supply. Some targeted technical support through 2018 could assist MHMS to develop templates and integrate into existing reporting processes. It would provide the potential for a more routine performance assessment that could be independently appraised. Routine availability of the performance data would solve the problem of rushed data collection each year prior to the JAPR, which puts a lot of pressure on MHMS staff. Additionally, clear reporting templates and processes, that link with and draw from the NHSP M&E Framework (where possible) would enable more routine progress reporting to the MHMS Senior Executive and support efforts to motivate programs to increase performance where it is lagging.

The NHSP Monitoring and Evaluation Framework (MEF) was still being developed when this report was drafted. Where possible, the final version of the 2018 and 2019 performance indicators and milestones should seek to align with the NHSP MEF where practical. It is likely that health information and service delivery related measures will be reflected in the NHSP MEF and may need to be adapted to align with national reporting systems. Until the NHSP MEF is finalised, the indicators from 2017 have been updated and carried forward in the proposed indicators for 2018. This will allow comparison over time until the indicators can be better aligned with the NHSP going forward. A summary of how the existing indicator set could be further improved is listed at Table 13.

A detailed set of performance indicators and milestones for 2018 (that has been adjusted in line with the recommendations of this report) is provided at Annex 3.

With the forthcoming NHSP MEF, there is an opportunity to fully re-design the performance assessment framework with new and more appropriate indicators that better demonstrate progress and performance in the health sector. This should include the integration of responsibility for Development Partners, particularly where DPs provide funding or technical support to a program or outcome area being assessed. A re-design also provides the opportunity to re-focus where performance is measured, ensure both MHMS and DP priorities form part of the assessment and correct those indicators that are not directly linked to health outcomes or performance. Any re-designed performance assessment framework should take into account the lag in agreeing performance indicators for 2018 and adjust proposed indicators accordingly in the first year.

Table 13: Summary of Recommendations

Indicator	Recommendation for 2018
N 1.	The performance measure for allocation of the recurrent health budget to provinces should be revised to require at least year on year maintenance of the provincial allocation – for 2018 this would require at least 40% of the recurrent health budget to be allocated to provinces.
N 2.1	Performance should be measured against progress in implementing the restructure as outlined in the RDP as planned in 2018 and 2019 (milestones to be developed when RDP and restructure implementation planning is finalised).
N 2.2	The RDP's submission to cabinet is a significant event and could be used to measure progress in 2018. Additional measures linked with restructuring under the RDP to the zonal level (particularly doctors) should be considered for 2019 when implementation plans are clear as a measure of effective implementation.
N 4.1	Expand MDSR Reporting to all provincial hospitals in 2018 and measure performance on the proportion (%) of hospitals (NRH and Provincial) with staff trained in MDSR Reporting.

N 4.2	Completed rollout of ADT in Gizo and Kilu'ufi remains a priority, alongside additional rollout locations planned for 2018 as a measure of performance (to be scoped). 2019 should consider progressive implementation of ADT and develop a measure to show ADT usage in locations where it has been connected.
N 5.1	Consider expanding DHIS to capture data from NCD clinics to better understand NCD burden, drivers and treatments, with performance measured on reporting available in 2018. Data from the reports could be developed into a 2019 indicator, depending on system limitations.
N 5.2	The availability of critical drugs and supplies at the service level should be used as the performance measure from 2018 onwards and is available in the DHIS.
N 5.3	The GBV performance target should be set relative to achieving the NHSP target of 150 per year until 2020.
N 5.4	Develop a more accurate indicator of service quality and coverage for 2018 performance assessment onwards based on the data currently available through the DHIS.
P 1.	Submission of draft AOPs by the end of September is easily achieved. 2017 results showed that 9 out of 10 provinces had their AOPs approved by the end of September. As such, using approval instead of draft as a measure for performance in 2018 could be considered, with a caveat that measures submission of drafts if the annual budget ceiling is not finalised in time.
P 2.1	Performance would be better measured on the proportion of provinces where the percentage of outstanding imprests greater than 90 days overdue is less than the 15%. If this target were used in 2017, then only 10% of provinces would have achieved the performance measure.
P4.1 – 4.3	The target for SBA coverage should be at least a 5% increase on 2016 if less than 90% coverage already achieved; or coverage is maintained above 90%.

Annex 1: Reference Documents and Data Sources

Solomon Islands Budget 2017
MHMS Restructure Plan
PFM Roadmap
Consolidated Provincial 2018 Financial Report
Consolidated Indicators Statistical Report 2017
DHIS2
MHMS Financial Records
Development Partner Records
Program Reporting and Records

Annex 2: Key Contact Persons

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Mr Arnold Moveni Undersecretary Administration and Finance, MHMS

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Mr Dilip Hensman, WHO HIS Technical Officer

Dr Divi Ogaoga, Director of Maternal and Child Health, MHMS

Mrs Esther Tekulu, Budgeting and Reporting Accountant, MHMS

Ms Fiona Mulhearn, DFAT First Secretary Health

Mr Francis Otto, Manager Internal Audit, MHMS

Mr George Pego, Human Resources Manager, MHMS

Dr Greg Jilini, Undersecretary Health Care, MHMS

Dr Hayfa El Amin, WHO GBV Program

Mr Ivan Ghemu, Director Policy and Planning, MHMS

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Ms Vivian Yu, PFM Specialist Advisor

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Mrs Yvonne Lipi, Chief Accountant Provinces, MHMS

Annex 3: Proposed 2018 Performance-Linked Payment Indicators (Draft)

DEVELOPMENT PARTNERS		
Performance Indicator	Description/Remarks	Means of verification
DP1.1 All development partner contributions are “on plan”	100% of development partner contributions are on plan (included in AOPs)	Development Partner funding on budget to be tracked through the SWAp secretariat. SIG Budget and LMEA update PCU template for planned DP contributions.
DP1.2 All development partner contributions are on are “on budget”	100% of development partner contributions are on budget - 376 or non-appropriated 476	
DP1.3 Development partners are “on system”	100% of development partner 376 contributions flow through the MHMS Development Partners Account or any other SIG account as decided by the Government and agreed by the Partner	
DP1.4 Funding inputs are announced at the SIG budget launch (July) and appropriated through the regular SIG budget process (appropriated in November)	All signatories to the Partnership have advised annual inputs prior to Planning DPCG	
DP2.1 DP disbursements are made on time and in accordance with commitments	All signatories to the partnership	SIG 376 Budget compare with the MoFT actual receipts (or deposits into the Donor Partner Account).
DP2.2 DP’s provide multi-year year budget projections to assist Ministry’s long term planning activities.		Line Ministry Expenditure Analysis (LMEA) Development Partner Agreements, PCU records
DP 3.1 Program related technical cooperation supported by development partners that has been cleared by MHMS	Register of cleared technical cooperation maintained. 476NA template being developed that may also assist with tracking.	Technical cooperation register
DP 3.2 Development partners regularly update TC inventory, including long and short term TA and volunteers		

NATIONAL						
Performance Indicator		Performance Measure	Description/ Remarks	Target	Means of verification	PLF Allocation
N 1.1 Recurrent health budget (276) allocation is at least maintained in 2018	Budget	Percentage of National Budget Estimate allocated to Health (276) in 2018	If the 12.5% is not met no PLA applies in 2018	12.5%	2018 Budget – Summary of Total Expenditure Table	Pre-condition for PLF support
N 1.2 Proportion of the recurrent health budget allocated to the provinces is at least maintained in 2018		Percentage of Recurrent Health Budget (276) Allocated to Provinces in 2018	Core Indicator Report 2018 Maintain provincial allocation year on year	40%	2018 Budget	10% PLF on target achieved
N 2.1 MHMS Restructure Plan is implemented in 2018	Health Reform	Completion of the Corporate Services Restructure to zonal level in 2018	Milestones to be agreed once planning finalised	Completed	MHMS Restructure Plan	5% PLF on target achieved
N 2.2 National Role Delineation Policy (RDP) Action Plan has been implemented in 2018		RDP submitted for Cabinet approval by the end of 2018	2019: Percentage of Provinces with RDP defined workforce (milestones to be agreed once planning finalised)	Completed	RDP Reporting	Up to 5% PLF proportionally on target achieved if Cabinet approved
N 3.1 Implementation of the PFM Roadmap continues in 2018	Governance	Percentage of planned work packages in the PFM roadmap for 2018 that were completed	Refer to the PFM Roadmap and AOPs for areas responsible for each work package	100%	PFM Roadmap and applicable AOPs	Up to 3% PLA proportionally on target achieved
N 3.2 Functioning Executive and committee meetings in 2018		Percentage of selected meetings conducted according to their frequency in 2018 and attended by a PHD (if required) (for each type of meeting then averaged)	Performance measured on meetings of: a. Senior Executive b. Family Health Committee c. Planning & Finance Committee d. Risk & Audit Committee	100%	Minutes of meetings List of participants	Up to 3% PLA proportionally on target achieved
N 3.3 Proportion of MHMS vacant counterpart positions that remained vacant for more than 8 weeks in 2018		Percentage of counterpart positions that were filled within 8 weeks of becoming vacant in 2018	A counterpart position is an in-line advisory position funded through the HSSP	100%	Counterpart Position Register (see HRM)	Up to 4% PLA proportionally on target achieved

NATIONAL						
Performance Indicator		Performance Measure	Description/ Remarks	Target	Means of verification	PLF Allocation
N 4.1 Proportion of maternal deaths audited nationally in 2018	Health information	Percentage of hospitals (NRH and Provincial) with staff trained in MDSR Reporting		100%	Maternal Death Surveillance and Response Reports	Up to 4% PLA proportionally on target achieved
N 4.1 Electronic Patient Admission, Discharge and Transfer Management System (ADT) operational and in use at Gizo and Kilu'ufi Hospitals		Percentage of patients attending Gizo and Kilu'ufi Hospitals that are managed using ADT System	Completed installation and connection of the ADT system is required in Gizo and Kilu'ufi Hospitals to meet requirements of this indicator	100%	ADT	Up to 3% PLA proportionally on target achieved
N 5.1 NCD clinics are conducted weekly at all provincial hospitals in 2018	Service quality and coverage	Percentage of hospitals that held weekly NCD clinics in 2018	NCD clinic is organised by the NCD Coordinator or Doctor and on-site or near to provincial hospital	100%	NCD Program Reporting	Up to 3% PLA proportionally on target achieved
N 5.2 Proportion of primary health care facilities that have access to essential medicines		Percentage of essential medicines in stock at primary health care facilities, averaged over all facilities	Core Indicator Report 2018 Having better linkages between DHIS and mSupply will support routine data collection of this information.	80%	DHIS and M-Supply	Up to 4% PLA proportionally on target achieved
N 5.3 Health care providers are trained in the care of GBV clients in 2018		Percentage of health care providers trained in the care of GBV clients in 2018 against the annual quota (150 per year to 2020)	Annual quota is derived from the number of health care providers that should be trained in the care of GBV clients by 2020	100% of annual quota	GBV Coordinator training records	Up to 3% PLA proportionally on target achieved
N 5.4 Per capita outpatient consultations increase year on year		Percentage change in per capita outpatient consultations between 2017 and 2018.	Core Indicator Report 2018	At least 5% increase from previous year	DHIS Population data	3% PLA on target achieved

PROVINCIAL						
Performance indicator		Performance Measure	Description/remarks	Target	Means of verification	PLA Allocation
P 1. Timely submission of AOPs and budgets	Budget	All provinces have finalised AOPs and budgets by 30 September 2018	Where the budget ceiling is not finalised, then performance is measured on submission of draft AOP to MHMS by 30 September 2018	100%	Financial Controller Records	Pre-condition for PLA support
P 2.1 Proportion of imprests that are more than 90 days overdue at end of year	Finance & reporting	Percentage of provinces where imprests outstanding for more than 90 days are less than 15% of the total value of outstanding imprests	Each province that achieves the target will count towards proportional performance payment	15%	MHMS Consolidated Provincial 2018 Financial Report	8% PLA on target achieved
P 2.2 Timely completion of provincial financial, operational planning and health information reporting		Percentage of selected reports submitted within 45 days of the end of the reporting period for that report in 2018	Performance measured on: a. Quarterly financial reports b. Monthly Bank Reconciliations c. Quarterly Progress Reports against AOPs d. Monthly DHIS Reports	100%	DHIS; MHMS Consolidated Provincial 2018 Financial Report; MHMS Finance	Up to 18% PLA proportionally on target achieved
P 3. Outreach activities increase year on year	Outreach	Percentage of provinces that achieve at least a 5% increase in each of the selected outreach activities between 2017 and 2018	Performance measured on: a. visits to schools b. satellite clinics c. vaccinations visits	At least 5% increase from previous year for each outreach activity per province	DHIS	Up to 12% PLA proportionally on target achieved

PROVINCIAL						
Performance indicator		Performance Measure	Description/remarks	Target	Means of verification	PLA Allocation
P 4.1 Child Immunisation coverage at least 90% P4.2 Family Planning Service contacts increase year on year P4.3 All births are attended by a Skilled Birth Attendant	Services	Percentage of provinces where the number of children aged 12-59 mths receiving the MCV1 increases by 5%; or is maintained at 90%+ between 2017 and 2018	NHSP target is 90% by 2020	90%+ coverage maintained or coverage increased by 5%+ for provinces with less than 90% coverage	DHIS	Up to 12% PLA proportionally on target achieved
		Percentage of provinces where the total number of contraceptive contacts (all forms) seen at health facilities increases by at least 5% between 2017 and 2018	Number of family planning contacts per 1000 population	At least 5% increase in contraceptive contacts per 1000 population		
		Percentage of provinces where the number of births attended by a SBA increases by 5% when under 90%; or increases when already 90%+ between 2017 and 2018 ⁷	Number of deliveries by Skilled Birth Attendant (SBA). NHSP target by 2020 is 100%, but a rate of 90%+ is considered performance against this indicator	100%		

⁷ In 2017, this indicator required a 5% increase on previous year for all provinces, but this was difficult to achieve for provinces already with coverage of 90%+

Annex 4: 2017 Payment Linked Performance Indicators

NATIONAL								
Performance indicator	Cat.	Weight	Nominator / Denominator	Description/remarks	Target	Means of verification	Responsible officer	Payment-linked conditions
The Solomon Islands Government will allocate at least 12.5% of domestically sourced revenue to the recurrent health budget for 2017 (276 out of national ledgers 2)		Budget Pre-condition		If the 12.5% is not met no PLA applies in 2017.	12.5%	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 2017.	Budget	20%	SIG recurrent health budget allocated to provinces / SIG recurrent budget allocated to health care x 100	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 restructure has been submitted to the Ministry of Public Services for endorsement (official submission before end 2017).	Health Reform	20%			MHMS Restructure Proposal (with national and provincial Organograms) submitted to MPS by 31 December 2017	MHMS letter to MPS requesting endorsement of MHMS Restructure Proposal (with Organogram)		100% upon target achieved <i>(Weighing 1/2 of 20%)</i>
N 2.2 National Role Delineation Policy (RDP) Action Plan has been prepared and endorsed				Action Plan specifies activities, timeframes, responsibilities	National RDP Action Plan approved by MHMS Executive in 2017	Documented National RDP Action Plan evidence of		100% upon target achieved <i>(Weighing 1/2 of 20%)</i>

NATIONAL								
Performance indicator	Cat.	Weight	Nominator / Denominator	Description/remarks	Target	Means of verification	Responsible officer	Payment-linked conditions
by the Executive by the end of 2017.						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	Governance ⁸	20%	Number of activities in Corporate AOPs (HQ & Admin, Policy & Planning, HR, Internal Audit) which are related to work packages in the PFM roadmap that have been conducted in 2017 / Number of scheduled work packages in the PFM roadmap in 2017 x 100	Corporate AOPs include: Finance, Planning, Human Resources, Internal Audit, Procurement 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 scheduled PFM work packages for 2017, and List of implemented activities in AOPs that can be linked to the PFM work packages in 2017 AOP Activity reporting		Proportional payment on target achieved (<i>Weighting 1/5 of 20%</i>)
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 held per year with sufficient quorum (and PHD representation where relevant) in 2017 / Required number of meetings (and PHD representation where relevant) as per TORs in 2017 x 100	Meetings of: a) Senior 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 and other Committees in 2017 Committees where TOR specifies PHD membership: representation as per TORs.	Minutes of meetings List of participants		Proportional payment on target achieved (average of all meetings per TORs) PHD presence used as weight for score (<i>Weighting 1/5 of 20%</i>)

⁸ Note: there is an error with numbering of criteria for Governance and Health Information criteria (N3.1-N3.5 instead of N3.1-3.3 and N4.1-N4.2). Any resulting changes in weighting will need to be agreed by MHMS and DFAT during the assessment.

NATIONAL								
Performance indicator	Cat.	Weight	Nominator / Denominator	Description/remarks	Target	Means of verification	Responsible officer	Payment-linked conditions
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 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 x 100	Counterpart positions for core HSSPs Advisers. Counterpart position = position identified in Adviser Terms of Reference.	100% = all vacant counterpart positions with completed MHMS 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 1/5 of 20%</i>)
N 3.4 % of NRH inpatient maternal deaths audited	Health information	20%	The number of NRH inpatient maternal deaths audited / The total number of NRH inpatient maternal deaths x 100		100% (July–December 2017)	Maternal death audit reports.		Proportional payment on target achieved (<i>Weighing 1/5 of 20%</i>)
N 3.5 Scoping missions and implementation plans for Electronic Patient Admission, Discharge and Transfer Management System (ADT) completed for Kilufi and Gizo hospitals by the end of 2017				Scoping missions at Kilufi and Gizo hospitals conducted and scoping mission report with implementation plan for ADT roll-out completed.	100%	Scoping mission report with implementation plan for ADT roll-out		Proportional payment on target achieved (<i>Weighing 1/5 of 20%</i>)

NATIONAL								
Performance indicator	Cat.	Weight	Nominator / Denominator	Description/remarks	Target	Means of verification	Responsible officer	Payment-linked conditions
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 provincial hospitals that conducted NCD clinics every week for 48 weeks in 2017 / Seven provincial hospitals that conduct NCD clinics every week for 48 weeks in 2017 x 100	On-site or near to provincial hospital site NCD clinic is organised by the NCD Coordinator or Doctor Note: 48 weeks allows for 4 week reduction in services during December / January	100% (minimum of 48 clinics held at each of 7 provincial hospitals)	NCD reporting form that compiles weekly number of NCD clinics in provincial hospitals		Proportional payment on target achieved (<i>Weighing 1/4 of 20%</i>)
N 5.2 % average availability 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 available 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 min. 90% availability of critical items at SLMS and no more than 5% 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 1/4 of 20%</i>)
N5.3 % of health care providers trained in the care of GBV clients as per targets in GBV AOP in 2017			Total number of health care providers trained in GBV before the end of 2017/ Number of health care providers planned to be trained as per GBV AOP 2017 (40) x100	Number of health care providers planned to be trained = number identified in the GBV AOP (40 in 2017)	100% for (2 nd half 2017)	GBV Coordinator training records		Proportional payment on target achieved (<i>Weighing 1/4 of 20%</i>)

NATIONAL								
Performance indicator	Cat.	Weight	Nominator / Denominator	Description/remarks	Target	Means of verification	Responsible officer	Payment-linked conditions
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 1/4 of 20%</i>)

PROVINCIAL								
Performance indicator	Cat.	Weight	Nominator / Denominator	Description/remarks	Target	Means of verification	Responsible officer	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 x100	Submission of final AOP and budget is only possible after the budget ceiling is finalised – 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) x100	Measurement by province Salary deduction has been initiated if: <ul style="list-style-type: none"> List has been submitted to Finance Unit Imprest Accountant for PS approval for staff on the establishment PHD has approved salary deduction commencement for DWEs with outstanding imprests 	15%	Financial files		Proportional payment according to % outstanding imprest >90 days retirement (<i>Weighing 1/4 of 50%</i>)

PROVINCIAL								
Performance indicator	Cat.	Weight	Nominator / Denominator	Description/ remarks	Target	Means of verification	Responsible officer	Payment-linked conditions
P 2.2 Completion on timely* reporting for various reports per year <i>* 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)</i>			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]: d. Quarterly financial reports [4/yr] e. Monthly Bank Reconciliations [12/yr] f. Quarterly Progress Reports against AOPs [4/yr] g. Monthly DHIS Reports [12/yr]	100%	Financial controller files MHMS policy & planning annual report Progress reports against AOPs to be submitted via PHD to MHMS Executive		proportion al payment on target achieved <i>(Weighing 3/4 of 50%)</i>
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% Proportion al payment on target achieved

PROVINCIAL								
Performance indicator	Cat.	Weight	Nominator / Denominator	Description/remarks	Target	Means of verification	Responsible officer	Payment-linked conditions
P 4.1 Child Immunisation coverage	Services	25%	a. Total Number of children aged 12-59 mths receiving the MCV1 in 2017 / Total number of children aged 12-59 months x 100% - percentage change compared to 2016 data	Measles immunisation rates. (NHSP target by 2020 is 90%)	90%+ coverage maintained or increased coverage by 5% or more for provinces with less than 90% coverage.	DHIS, NRH database		Payment on the basis of summed scores per province divided by number of sub indicators x 100% Proportional payment on targets achieved
P4.2 Family Planning Service contacts			b. Total number of contraceptive contacts (all forms) seen at health facilities in 2017 per 1000 population –percentage change compared to 2016 data	Number of family planning contacts per 1000 population	At least 5% increase in contraceptive contacts per 1000 population			
P4.3 Skilled birth attendance rates			c. Number of births attended by skilled health personnel / Total number of births x 100% - percentage change compared to 2016 data	Number of deliveries by skilled birth attendant*. *Definition of skilled birth attendance as defined in DHIS2: all births in a health facility attended to by doctors, midwives, registered nurses and nurse aides. Births in villages (home births) and births before arrival are considered unskilled birth attendance. NHSP target by 2020 is 100%	At least 5% increase in skilled birth attendance			

DEVELOPMENT PARTNERS		
Performance indicator	Description/Remarks	Means of verification
DP1.1 All development partner contributions are “on plan” DP1.2 All development partner contributions are on are “on budget” DP1.3 Development partners are “on System” DP1.4 Funding inputs are announced at the SIG budget launch (July) and appropriated through the regular SIG budget process (appropriated in November).	100% of development partner contributions are on plan (included in AOPs) 100% of development partner contributions are on budget - 376 or non-appropriated 476 100% of development partner 376 contributions flow through the MHMS Development Partners Account or any other SIG account as decided by the Government and agreed by the Partner All signatories to the Partnership have advised 2017 inputs prior to Planning DPCG (July, 2017)	Development Partner funding on budget to be tracked through the SWAp secretariat. SIG Budget and LMEA update PCU template for planned DP contributions
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 multi-year year budget projections to assist Ministry’s long term planning activities.	All signatories to the partnership	SIG 376 Budget compare with the MoFT actual receipts (or deposits into the Donor Partner Account). Line Ministry Expenditure Analysis (LMEA) Development Partner Agreements, PCU records.
DP 3.1 Program related technical cooperation supported by development partners that has been cleared by MHMS DP 3.2 Development partners regularly update TC inventory, including long and short term TA and volunteers	Register of cleared technical cooperation maintained. 476NA template being developed that may also assist with tracking.	Technical cooperation register.

Annex 5: Clauses 9.1-9.11 of the Direct Funding Agreement

9. Performance Linked Funding (Performance Component)

- 9.1 Performance Component payments will be triggered by an Independent Performance Assessment of mutually decided Performance Targets.
- 9.2 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.
- 9.3 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.
- 9.4 Independent Performance Assessment results will be a standing agenda item at the JAPR.
- 9.5 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.
- 9.6 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.
- 9.7 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.
- 9.8 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.
- 9.9 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.
- 9.10 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.
- 9.11 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

Annex 6: Independent Assessor Terms of Reference, 2017

Title

Independent Performance Assessment of HSSP 2017 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:

4. improved quality and quantity of primary health care services;
5. stronger health systems to support service delivery;
6. 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 April 2018 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 2017.

A funding recommendation will be provided which will inform levels of performance linked funding provided by 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 2018-2020 (to be measured in 2019-2021). This should include:

- Indicators from the National Health Strategic Plan monitoring and evaluation framework (NHSP MEF) that will be measured in each year across 2018-2020 (anticipated to be approx. 80% of PLF indicators)
- Indicators for priority policy reforms for 2018 (anticipated to be approx. 20% of PLF indicators), noting that new priority policy reforms for 2019 and 2020 will be set in future years.

It should be noted this cycle has a 22:78 ratio of performance linked aid (approximately AUD2.71 million) to core budget support but in future years this will grow to 25:75.

Objective

The consultant will support the MHMS assess its own, and SWAp partners' performance, including preparing a report, delivering presentations and assisting MHMS with finalising the 2018 performance indicators.

The consultant will:

- help the Ministry assess and report on its progress against the jointly agreed performance indicators (as set at Attachment A) to highlight progress in 2017 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 against the Development Partner performance indicators (as set out at Attachment A) and provide a briefing to the Ministry on key findings to assist them at JAPR deliberations.
- prepare a draft set of jointly agreed performance indicators for 2018-2020 (consisting of indicators from the MHSP MEF for 2018-2020 and indicators of priority policy reforms for 2018), based on report recommendations, and in close cooperation with MHMS; and
- make recommendations on performance payment for 2017.

Scope

The scope of the appraisal is set out in clauses 9.1-9.11 of the Direct Funding Agreement (Attachment B).

The consultant will travel to Honiara by 16 April 2018 and present the first draft of their report to MHMS and GoA by 25 April 2018. The findings will be presented at the JAPR on 1 May 2018. *[Dates to be confirmed with MHMS]*

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 2017 (Attachment A) as well as development partner performance. *(up to 18 days in country)*
 - 2a. Prepare a brief report for MHMS and DFAT on 2017 performance including:
 - recommendation on the performance payment for 2017 to be paid immediately after the JAPR;
 - performance of SWAp partners against the development partner indicators in the 2017 indicator matrix (Attachment A) and the Partnership Arrangement between Solomon Islands Government and Development Partners in the Health Sector-Wide Approach 2016-2020, and areas for improvement; and
 - prepare a draft set of achievable set of milestones for 2018, 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:

- tabling of the report of progress against the performance matrix;
- outlining areas of strengths and weaknesses and areas of opportunity for improvement for MHMS and partners;
- outlining 2017 performance payment recommendation;
- outlining of recommended key performance milestones for 2018; and
- 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 2018-2020 performance matrix. (up to 3 days)

Approach

The review will include a desk analysis of performance evidence generated in 2017 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 *[Dates to be confirmed with MHMS]*

- Draft report (up to 20 pages including annexes) to be tabled at the JAPR to DFAT by 23 April. (Consultant will send to SIRF M&E facility by 20 April)
- Presentation to the MHMS executive prior to the JAPR by 25 April. (Consultant will send to SIRF M&E facility by 23 April)
- Presentation on the findings to MHMS and donors at the JAPR on 30 April.
- Final report to DFAT by 17 May 2018. (Consultant will send to SIRF M&E facility by 14 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)
- Finalise report (up to 3 days)

Annex 7: Calculations

N 3.1 % of activities in Corporate AOPs which are related to work packages in the PFM roadmap that have been conducted in 2017

% PFM Activity = number sub-activities completed / number of sub-activities x100

PFM Activity	Conducted	PFM Activity	Conducted	Activity	Conducted	Activity Number	Conducted
1.1	67%	1.8	75%	2.6	100%	3.5	75%
1.2	0%	1.9	100%	2.8	100%	3.6	100%
1.3	100%	1.11	100%	2.9	100%	4.1	0%
1.4	100%	2.1	33%	2.10	0%	4.2	0%
1.5	75%	2.2	50%	3.1	75%	4.3	75%
1.6	100%	2.3	90%	3.2	100%	4.4	100%
1.7	75%	2.4	19%	3.4	100%	4.5	100%
Total average score = sum % conducted / number of activities x100 = 72%							

P 2.2 Completion on timely* reporting for various reports per year (*3rd and 4th Quarters only)

Only for reporting period 1 July to 31 December 2017 (3rd and 4th Quarters only)

% Performance Score = Average % for all provinces

% Provincial Score = (1+2+3+4)/4

Where:

1 = (Number of Quarterly Financial Reports <45 days after end of quarter / 2 quarters) x100

2 = (Number of Monthly Bank Reconciliation <45 days after end of month / 6 months) x100

3 = (Number Quarterly AOP Progress reports <45 days after end of quarter / 2 quarters) x100

4 = (Number Monthly Provincial DHIS reports <45 days after end of month / 6 months) x100

P 3. Annual % increase of outreach activities

% Performance Score = Average % for all provinces

% Provincial Score = (1+2+3)/3 x100

Where:

1 = Number of visits to schools was at least 5% more than 2016? Yes=1 / No=0

2 = Number of satellite Clinics was at least 5% more than 2016? Yes=1 / No=0

3 = Number of vaccination visits was at least 5% more than 2016? Yes=1 / No=0

Visit types (all from DHIS):

- School Visits = School Health Visits
- Satellite Clinics = Satellite Clinics
- Vaccination visits = EPI in Schools and on Tour

<p>P 4.1 Child Immunisation coverage</p> <p>P 4.2 Family Planning Service contacts</p> <p>P 4.3 Skilled birth attendance rates</p>

Child Immunisation coverage = Total Number of children aged 12-59 mths receiving the MCV1 in 2017 / Total number of children aged 12-59 months

Family Planning Service contacts = Total number of contraceptive contacts (all forms) seen at health facilities in 2017 per 1000 population

Skilled birth attendance rates = Number of births attended by skilled health personnel / Total number of births

% Performance Score = Average % for all provinces

% Provincial Score = $(1+2+3)/3 \times 100$

Where:

1 = Child immunisation coverage increased by 5%+ between 2016 and 2017? Yes=1 / No=0

2 = Family planning service contacts increased by 5% between 2016 and 2017? Yes=1 / No=0

3 = Skilled birth attendance rates increased by 5% between 2016 and 2017? Yes=1 / No=0