Australian Government
AusAID

Quality at Entry Report and Next Steps to Take before Tendering for Tibet Health Personnel Capacity Building Program

A: AidWorks details			
Initiative Name:	Tibet Health Personnel Capacity Building Program		
AidWorks ID:	INJ808	**Total Amount:**	A$10 million
Start Date:	2011	**End Date:**	2016

B: Appraisal Peer Review meeting details	
Initial ratings prepared by:	Beijing Post
Meeting date:	16 November 2010
Chair:	• Sun-Hee Lee, A/g Assistant-Director General
Peer reviewers providing formal comment & ratings:	• Benedict David, AusAID Principal Health Adviser • Brian Hearn, OSO Manager • Graham Rady, Asia Program Quality and Development
Independent Appraiser:	• Guo Yan, Professor , Peking University Health Science Centre
Other peer review participants:	AusAID Canberra: • Beth Slatyer, HHTG • Pamela Larkin, PAS • Danielle Sever, A/g Director, NAS • Nicole Tyrie, NAS • Russell Harwood, NAS Consultants: • Kirsty Dudgeon, former First Secretary, Beijing (was on recall to duty as a design team member) • Alison Heywood, Design Team Leader AusAID Beijing: • Grant Morrison, First Secretary • Linna Cai, Senior Policy Officer • Chen Wei, Program Officer Chinese Ministry of Commerce: • Luo Yu, First Secretary • Guo Jie, Program Officer

C: Safeguards and Commitments *(new!)* ***completed by Activity Manager***		
Answer the following questions relevant to potential impacts of the activity.		
1. Environment	Have the environmental marker questions been answered and adequately addressed by the design document in line with legal requirements under the *Environmental Protection and Biodiversity Conservation Act*?	*Yes*

C: Safeguards and Commitments *(new!)* *completed by Activity Manager*		
2. Child Protection	Does the design meet the requirements of AusAID's Child Protection Policy?	*N/a*
3. Imprest Account	Does the business case and risk assessment support the use of an imprest account as the most efficient, effective and ethical use of Commonwealth funds in accordance with the Commonwealth Financial Framework and AusAID policy?	*N/a*

D: Initiative/Activity description	
4. Description	The Government of Australia has provided assistance to Tibet Autonomous Region (TAR) since 1991. The most significant investment made by AusAID was the Tibet Health Sector Support Program (THSSP) with a total budget of $19.3 million, finished in June 2010. The TAR Government made numerous requests that Australia stay engaged in the health sector. AusAID conducted a scoping mission in November 2009 and a design mission in July 2010. The new $10m five-year program will focus on health human resource management practices at strategic and operational levels of the health sector in TAR, and on priority technical and clinical practices of the existing workforce in pilot sites. It includes two components: Health Human Resource Management and Technical and Clinical Practices. Under Component 1, at Regional level, a Bureau Management Human Resource Development Program (BMHRDP) will be conducted for senior managers of Tibet Regional Bureau of Health (TRBH) and directors of institutions under direct leadership of TRBH. Follow-up support will include a formal learning set approach, input to the implementation of the 12th Five Year Human Resource Plan for TAR (2011-2015), the establishment of an annual HHR Forum and support for human resource policy research projects. At prefecture and county level, similar activities will be conducted for managers of the health system. Under Component 2, guidelines will be developed for model county hospitals and township health centres to specify their functions and staffing profiles. Formal training programs, on-the-job reinforcement of skills and knowledge, and continuing education will be provided to technical and clinical staff in identified priority areas in selected prefectures. A capacity building program for the rapid containment of infectious diseases will also be delivered. In addition, laboratory staff from all prefecture CDCs will receive training to improve their skills.
5. Objectives Summary	**Program Goal:** To improve the health of the people of Tibet. **Program Purpose:** More efficient and better quality health service delivery **Objectives:** • *Component 1*: Improved HR management practices at the strategic & operational levels. Key outcomes: 1. Senior managers at regional level turning the 12th Five Year Tibet Health Human Resources Plan into implementable strategies 2. At regional level managers display improved HR skills and practices 3. At prefecture and county level managers display improved HR skills and practices • Component 2: *Improved priority technical & clinical practices of the workforce in pilot sites.* Key outcomes: 1. Improved functioning of prefecture CDC laboratories 2. Pilot county hospitals and township health centres providing better health services 3. Improved capacity to contain infectious disease outbreaks.

E: Quality Assessment and Rating			
Criteria	**Assessment**	**Rating (1-6) ***	**Required Action**
6. Relevance	• The design targets the TAR's top priority for Australian assistance and a clear national development priority for China which no other donor is addressing. It will help implement national and regional government policies eg. *Suggestions of the State Council on Deepening the Health Care System Reform* and the *12th Five Year Plan for Tibet HHR Development.* • It is in line with AusAID's Health Strategy and China Country Strategy (2006 – 2010). • The design's approach, modality and financing arrangements are based on context specific analysis and six year's' experience of working this sector in the TAR through the THSSP.	6	
7. Analysis and Learning	• The design is firmly based on analysis of the successes and limitations of the recently completed THSSP and it proposes the logical next step in building sustainable capacity of the sector. i.e. targeting HR and working within the TRBH, which THSSP was unable to do. • The main lessons learned from THSSP such as being counterpart driven, flexible annual planning, using Chinese experts, and approaches to capacity building and M&E are reflected in the design. Lessons from international experience on staff retention and incentives will also be factored into the annual HR Forum and management training. • The design team has taken into account available information on institutional, financial and human resource issues in the TAR. It acknowledges that it will only be able to influence other supply side aspects of the health system indirectly. • The relative paucity of data and analysis on HR needs in the TAR means that indicators, outputs and the identification of program partners need more specificity. This can only be remedied by a thorough verification exercise on mobilisation when the program will have resources in the TAR to check these against reality. Modifications can then be incorporated into the first annual work plan.	5	

E: Quality Assessment and Rating			
8. Effectiveness	• The Objectives for this Program are clear and measurable through the outcome indicators. • Under Component 2, there may be a risk of too much reliance on the train-of-trainer modality, which was not fully tried and tested under THSSP. The Component has identified several provider partners. More provider partners and training methodologies can be identified during the implementation of the program. • Partnerships have been identified with TRBH, and relevant divisions within it, as well as the Regional Personnel Bureau and the Regional Education Bureau. The contribution of each will need to be teased out early in program implementation. • The design gives prominence to the partnership with the TRBH. A major difference between this design and the THSSP is that the new program aims to work from within the TRBH and all the program's HR, clinical and technical capacity building should be integrated within the TRBH's annual HRD program of work. Several indicators have been set up to measure TRBH's engagement. Soon after mobilisation, the M&E team of the program should agree with TRBH an indicator to measure the extent to which the new program is absorbed into TRBH's own planning processes. • The main reason why Tibet has such poor health indicators is not poverty but the geographic dispersal of the population and the low capacity of the health workforce. The program will principally target the rural population, which is generally poorer than the urban population in Tibet, and pilot sites will include at least one chosen because it services a very poor demographic. The most efficient and effective strategy for the program to contribute to poverty alleviation will be for it to work through the TRBH to raise the quality of health services and encourage increased access. • The spread of risks and mitigation strategies is generally realistic although lack of strong leadership by TRBH is the largest risk and mitigation will have to be elaborated soon after mobilisation when working relationships with the Bureau are more clear. The risk that sufficient, experienced trainers will not be available is also real and the mitigation strategy should be further strengthened at the initial stage of implementation.	5	

E: Quality Assessment and Rating			
9. Efficiency	• As noted above, training needs analysis will should be done immediately on mobilisation. Work will also need to be done to identify appropriate and available partners for training delivery. This will inform the first annual work plan. • The capacity building approach is comprehensive and builds on successful capacity building approaches developed under THSSP such as work-based projects. It also uses Chinese and where possible Tibetan technical assistance rather than international. This is more acceptable to Tibetans, it has shown to save money and time, and generally produce more sustainable results. • Roles and responsibilities of program management partners are identified to the extent they can be at this stage. • Activities appear adequately and appropriately resourced – based on THSSP costs and data provided by the Ministry of Health's HR Centre. • The proportion of costs going to management will always be high for any program operating in the TAR. 33.2% of the indicative budget goes to management costs. This is broadly consistent with the THSSP but needs to be looked at again when developing tender documents.	5	
10. Monitoring and Evaluation	• Program oversight and management arrangements - six monthly and annual reports, annual PCC, three TAGs, an IPR and an ICR - are appropriate. • The Logframe and Program Monitoring Tool (PMT) provide a reasonable outline of what will be assessed, by whom, when and how (including baselines). The annual planning process will allow for continuous modification improvement to these documents. The PMT will need further work soon after mobilisation. The program also needs to incorporate gender indicators. • The M&E Framework will also need to be operationalised soon after mobilisation. The Program will aim to use as much as possible the existing information system of TRBH and part of the capacity building approach will be to improve this system. However, the lack of available health data in the TAR, and the unreliability of some of the available data, means that much indicator related information is likely to be qualitative rather than quantitative. The data collection and survey work of THSSP and the qualitative approaches it adopted did yield useful performance information and the new program will use these approaches. However, TRBH will need to make its Health Information Systems more available to this program than they were to THSSP.	5	

E: Quality Assessment and Rating

11. Sustainability	• Incorporation of the THSSP experience gives this program good prospects for sustainability. It will inherit a reservoir of good will towards Australia within the TAR health sector and the design addresses what the TRBH wants it to. • If expectations can be met and early successes achieved, significant parts of the TAR health workforce should benefit from skill transfers that can translate into better health outcomes. The challenge will be the extent to which TRBH is able to institutionalise improved management practices that can shape the future of the sector. This will depend on a range of factors, some of which will be beyond the control of the program.	5	
12. Gender Equality	• At activity level, gender disaggregated data will be collected and analysed. Training content and the selection of participants will pay attention to inequalities, bias and special needs within the health system. Intermittent gender specialist inputs could be engaged from the program's Component 2 unallocated short term adviser budget line. • Because MCH is a priority of the TAR health system, program capacity building will inevitably address aspects of it, and this should contribute to improvements in MCH indicators, at least in pilot sites.	5	

* **Definitions of the Rating Scale:**			
Satisfactory *(4, 5 and 6)*		***Less than satisfactory*** *(1, 2 and 3)*	
6	Very high quality; needs ongoing management & monitoring only	**3**	Less than adequate quality; needs to be improved in core areas
5	Good quality; needs minor work to improve in some areas	**2**	Poor quality; needs major work to improve
4	Adequate quality; needs some work to improve	**1**	Very poor quality; needs major overhaul

F: Next Steps

Provide information on all steps required before tendering	Who is responsible	Date to be done
1. Distribute the PDD to the Chinese Ministry of Commerce (MOFCOM) for endorsement. This will be on the understanding that it would only proceed if it is consistent with a new China Australia Country Strategy.	Post & Desk	End March
2. Send Minsub to Minister for approval	Post & Desk	When appropriate in context of development of a new China Country Strategy
3. Seek FMA Reg 9/10 Approval	Post & Desk	Within one week after receipt of Minister's Approval
4. Sign MOU with MOFCOM	Post	Within one month after receipt of FMA Reg 9/10 Approval
5. Hand Procurement over to PAS	Post	Within one week after signing of MOU

G: Other comments or issues

- In accordance with the recommendations of the Appraisal Peer Review meeting on 16 November 2010 (refer to the attached Minutes of the meeting), the design team made substantial revisions to the design document. On 11 January 2011, Beijing post distributed the revised design document and an updated QAE to the peer reviewers for final comments. No substantive suggestions for further improvement of the design or the QAE were received from peer reviewers.

H: Approval

On the basis of the final agreed Quality Rating assessment (E) above:

☑ **QAE REPORT IS APPROVED**, **FINAL PDD IS CLEARED,** and authorization given to proceed to **the Next Steps (F)** above.

☐ **NOT APPROVED** for the following reason(s):

Sun-Hee Lee, A/g Assistant-Director General	signed:	13/4/2011 < date >