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<b>A:</b>	<b>Tonga Health Systems Support Program 2</b>
<b>Start date:</b> July 2015	<b>End Date:</b> June 2020
<b>Total proposed funding allocation:</b> \$10,000,000	
<b>Investment Concept (IC) approved by:</b> Brett Aldam	<b>IC Endorsed by AIC:</b> NA
<b>Quality Assurance (QA) Completed:</b> Peer review + independent assessment	

## B: Executive Summary

### Problem to be addressed

The main problem addressed by the second Tonga Health Systems Support Program (THSSP2) is **non-communicable diseases** (NCDs). NCDs are a major cause of premature death in Tonga: in 2011 it was calculated that life expectancy had actually *decreased* by five years, largely due to NCDs.<sup>1</sup> The major risk factors for NCDs are poor diet, lack of exercise, smoking, alcohol misuse and obesity. It is a startling fact that in 2014 WHO concluded that **the *entire adult population* is at moderate to high risk of developing an NCD**. The Government of Tonga fully recognises the seriousness of its NCD situation describing it as a national crisis in the 2014 budget.

Given these enormously high levels of risk factors for NCDs, Tonga will have to work very hard even to stay still in terms of NCD rates in its population. However the issue must be tackled head-on, because NCDs are proving to have high costs in Tonga both in terms of health sector spending and the effects on economic productivity. THSSP2 is about doing as much as possible to tackle the NCD epidemic – preventing NCDs in the younger generation and managing existing NCDs as cost-effectively as possible.

### Description of THSSP2: areas to be funded

THSSP2 has four components:

- Management of NCDs in primary care: primary and secondary prevention
- Health promotion related to NCDs
- Health systems strengthening
- Support for mental health and disability services.

Together these components support the goal of the Ministry of Health's Corporate Plan – **Universal Health Coverage** (UHC) in Tonga. UHC is about ensuring that all people (men, women, boys and girls) obtain health services based on need and without suffering financial hardship when paying for them. In Tonga, a particular challenge is to provide a reasonable level of health services to people living on the most remote islands.

An important aspect of UHC is specifying what services will be provided at which level of the health system. A cost-effective response to NCDs requires that **primary health care facilities** provide screening (to identify the presence of NCDs or their risk factors), preventive activities (such as practical support to stop smoking) and sound management of existing NCDs to prevent them from escalating into much more serious conditions (such as diabetic-related blindness and amputations).

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<sup>1</sup> The literature is inconsistent about whether or not life expectancy has fallen, although the Ministry of Health accepts that it has. This inconsistency is discussed in the main text, Section C *The problem of NCDs*.

Nationally organized **health promotion** activities complement services provided in primary care facilities. Examples are media campaigns and programs which promote healthier lifestyles in other ways (e.g. improving diet through using more fresh, local foods). For NCDs, health promotion focuses on the four major risk factors of poor diet, insufficient exercise, smoking and alcohol misuse.

The support for **health systems strengthening** is important because a national health system does not operate as a series of discrete disease-specific packages: rather it consists of a number of health facilities and programs which rely on *systems* to provide them with the appropriate human resources, drugs and equipment, information etc. To improve the quality and sustainability of the NCD response in Tonga it is not enough to support just the narrow technical aspects directly related to non-communicable diseases. A sustained, efficient response to NCDs requires well-functioning systems of planning, resource allocation, asset management and procurement, for example. An important focus of THSSP2 is to use government systems and to strengthen them by so doing.

The relatively modest financial support for **mental health and disability services** was championed by the Ministry of Health, which recognized that these areas have been under-funded and even stigmatized in the past, even though they are vital in terms of both health and social inclusion.

Tonga is vulnerable to natural disasters and it is important that there is enough flexibility within THSSP2 to respond to **emergencies**. During THSSP1 the Flexible Fund was used to respond quickly to the effects of Tropical Cyclone Ian in 2014. In exceptional circumstances, an emergency meeting of the NHDC can be called (or at least as many members as are available in the circumstances) and recommendations made about funding for emergency needs. This provides a valuable response mechanism which is flexible and rapid. Assuming that both parties agree that the situation is indeed an “emergency”, funds can be re-directed quickly, with a later decision about whether this will ultimately be paid for through re-prioritisation of the existing THSSP2 budget or through a top-up from DFAT. This is an important part of overall disaster preparedness planning in Tonga.

## Targets

There are five targets (with associated outcome indicators) to be achieved by the end of THSSP2. Two are directly related to NCD risk factors and health status, one is about cost efficiencies and universal coverage:

1. Decrease in percentage of population at high risk of developing an NCD, for both males and females. (Risk factors are diet, inactivity, smoking and alcohol abuse.)

2. Downward trend in the rates of premature deaths and preventable disability<sup>2</sup> related to NCDs in men and in women.
3. NCD management as part of Universal Health Coverage leads to cost savings in hospitals.
4. Strengthened health system management, including planning, financial management, implementation, monitoring, health information, procurement and human resources.
5. Development of GESI as a cross-cutting issue: at least 80% of annual plans from the Ministry of Health and TongaHealth reflect GESI considerations. (The most relevant GESI considerations for THSSP2 are gender, geographic equity, and inclusion of disabled and mentally ill people.)

This is summarised into one over-arching objective (or vision): **a more effective, efficient and equitable health system which reduces the health and economic burden of non-communicable diseases in Tonga.**

The beneficiaries of THSSP2 are in a very real sense *all* Tongans, because all Tongans are at medium to high risk of developing an NCD. The younger generation will benefit most from preventive work; the older generation from the improved management of NCDs.

The first and second targets about NCDs and mortality are linked to the WHO Global NCD targets.

The reason for including the third and fourth targets (cost efficiencies and strengthened systems) is the significant economic and social burden of NCDs. It is vital that the Government of Tonga controls the escalating costs of NCDs. Cost efficiencies will be measured through management of NCDs in primary care: for example, reductions in amputations due to diabetic foot syndrome, reductions in hospital length of stay (due to better diabetic care) and fewer hospital admissions for preventable aspects of NCDs. Universal Health Coverage will be promoted through the development of an Essential Health Package for health facilities across Tonga. Endorsement of the Health Centre Operational Manual (currently in draft form and being reviewed) will also contribute to equitable health services.

Strengthened health systems will be measured through progress in the areas of planning, implementation, monitoring, and human resources, with particular interest in the area of public financial management and specifically in procurement. (In March 2015, Vaiola hospital experienced a 3-6 month stock-out due to improper planning leading to procurement delays.) Strengthening the processes around planning and budgeting should contribute to better and faster procurement.

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<sup>2</sup> Preventable disability for THSSP 2 is here defined as cases of diabetic retinopathy, limb amputation (related to lack of diabetic control) and different stages of renal failure (as per data collected by the Diabetes Clinic)..

The final outcome indicator reflects the importance of including gender, equity and social inclusion (including mental health and disability) as cross cutting issues around MOH and TongaHealth activities.

It is important to stress that responsibility for achieving the THSSP2 targets is shared amongst the Ministry of Health, TongaHealth, DFAT and (to a lesser extent) many other stakeholders in Tonga. THSSP2 works through the Ministry of Health's systems and relies on activities delivered by MoH staff. This is not a separate and discrete project which can achieve all its targets acting in isolation: the model of shared responsibility is integral to the design of THSSP2 because we know that separate projects about NCD will not be sustainable.

Another important point about the targets is to appreciate how ambitious it is for a five-year Program to aim for a downward trend in the rates of premature deaths and preventable disability and for a decrease in the percentage of population at high risk of developing an NCD. (Risk factors are diet, inactivity, smoking and alcohol abuse.) It is ambitious because the current population of Tongans is already a "time-bomb" in terms of having extremely high chances of developing NCDs. The really significant drops in NCD rates will not be possible until a generation of Tongans has adopted healthier lifestyles. The priorities at the moment are to make sure that this generational shift happens, and that the health sector is able to manage the inevitable NCD burden as cost-effectively as possible.

The target related to reduced premature death is deliberately ambitious. If nothing is done, NCD rates will soar; even reversing this upward-spiralling trend will be an achievement. It is vital that Tonga develops the decision-making processes and systems to tackle NCDs effectively. Without this, Tonga's overall development will be hampered by lost economic productivity through early deaths and chronic illness, and by escalating health care costs. Working through the hierarchy of outcomes described in Annex 12 entails focusing on doing the right kinds of things to reduce NCDs – for example prevented hospitalisations show that the systems are in place to manage NCDs more efficiently (thus avoiding public spending on these hospital stays). The targets are ambitious because Tonga needs to be ambitious in this area. However it is important that any evaluations of THSSP2 focus on whether the right things – and enough of the right things – are being done to tackle the NCD crisis. It is always a possibility that prevention and treatment activities are carried out extremely well, but that the damage already done to the health of middle-aged Tongans (in terms of unhealthy lifestyles) means that five years is too short to impact on rates of premature death.

### **Delivery approach**

The delivery approach is a **financing agreement based on high-quality annual plans**. The activities to be funded by THSSP2 will be described in the annual work-plans of the Ministry of Health and TongaHealth. (TongaHealth is a Foundation which serves as a funding and co-ordinating mechanism to pass on and manage grants to other organizations doing work in relation to NCDs.) Examples of the types of activity which might be funded are:

#### ***Non-Communicable Diseases***

- Mass (gender-targeted) campaigns related to smoking, exercise and diet.
- Annual audit of the quality of care for NCDs in all government health facilities.
- Improved services for diabetics in remote parts of Tonga.

### ***Health Systems Strengthening***

- Describe what universal health coverage means for all people (men, women, boys and girls) living on Tonga's smallest islands and begin to develop the appropriate services.
- Operationalise the Human Resource Strategy: this could involve activities such as strengthening hospital roster arrangements with a view to reducing overtime costs and increasing outputs, or improving opportunities for women in leadership positions.
- Develop the primary health care information system so that basic data on out-patient utilisation is collated regularly.
- Ensure that arrangements for procuring and distributing crucial supplies related to laboratories and pharmaceuticals are as robust as possible, so that (for example) there are not harmful stock-outs leading to emergency procurement at significantly higher prices.

### ***Mental health and disability services***

- Ensure that mental health and disability are included in an appropriate way in the curricula of health workers trained in Tonga.
- Develop a national strategic plan for the gradual expansion of disability-inclusive health, rehabilitation and mental health services in Tonga.
- Expand support for mental health at the community level.

THSSP will be organised around the funding of the **annual work-plans** of the Ministry of Health and TongaHealth.<sup>3</sup> This combines a government-led approach with support for systems strengthening, with involvement from DFAT in agreeing areas for funding and in monitoring achievements. A key aim of THSSP2 is to strengthen systems of planning, budgeting, financial management and reporting so that there is strong local capacity to sustain the response to the NCD crisis.

There will a Direct Funding Agreement (DFA) involving the Ministry of Finance and National Planning (MoFNP) and a grant agreement with TongaHealth: these will describe the modalities and payment schedules for THSSP2 as relevant to the Ministry of Health and TongaHealth. The DFA will be between DFAT and the MoFNP and the Ministry of Health as co-signatories on behalf of the Government of Tonga. (See Annex 9 for a draft DFA.) A separate grant agreement will be signed with TongaHealth. The separate agreements are to allow for flexibility and to mitigate the risk of funding delays to TongaHealth due to under-utilisation by the Ministry of Health or vice versa. Although the administered funds will be regulated through separate agreements, funding to the health sector will be considered as a whole over the five years of the program.

Financial management and procurement will follow Government of Tonga legislation and regulations, and TongaHealth's Administration Procedures Manual. Money will flow through to TongaHealth and through the Ministry of Finance and National Planning to the Ministry of Health.

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<sup>3</sup> A note on terminology: the Ministry of Health uses the term "Annual Management Plan (AMP)", but TongaHealth does not. AMP is used in the context of the Ministry; "work-plans", or simply "plans" is used when referring to both institutions.

The National Health Development Committee (the highest governance structure in the Ministry of Health) and the TongaHealth Board are the crucial **governance structures** for THSSP2. These two bodies will approve work-plans (and will actively use the quarterly monitoring reports as management tools to improve implementation. DFAT will be closely involved in the dialog around what is included in these work-plans. There will be a final stage of formal approval by DFAT of work-plans which are to receive DFAT funding.

A risk register has been completed for THSSP2.

## Resources for THSSP2

The overall **budget** is \$10 million over five years (July 2015-June 2020), broken down as follows:

- \$120,000 per year top-sliced for management costs (Post's time and travel, accountancy, audit etc.)
- Up to \$400,000 allocated to TongaHealth in the first year. Thereafter this allocation will be reviewed annually.
- \$1 million total reserved for performance based payments to Ministry of Health.

This leaves about \$6.4 million to be allocated against the Ministry of Health's Annual Management Plans (depending on the exact amounts allocated to TongaHealth in later years) to support NCD prevention and control, health systems strengthening and disability/mental health.

**Technical assistance** will be funded out of the \$6.4 million to support planning, public health and health promotion.

A well-documented risk to a donor which provides significant support to a particular sector is that the recipient government allocates fewer of its own resources to that sector, which it regards as being relatively well catered for. This compromises the intent of the donor, which wishes to provide *additional* resources to the sector. For this reason, there are two **pre-conditions**:

- The combined MOH plus TongaHealth budgets (excluding donor funds) as a percentage of the total government budget do not decrease (taking 2015 as the baseline).
- The MOH's budget for the Public Health Division (excluding donor funds) increases as a percentage of the total MOH budget (taking 2015 as the baseline).

The first condition reflects the Government of Tonga's overall commitment to the health sector; the second is about the funding of the most cost-effective services which should be available to all Tongans. (Public health, health promotion and primary care are all under the Public Health Division.) If these conditions are not met, DFAT may formally re-assess the level of its financial contribution to THSSP2.

## C: Analysis and Strategic Context



## Introduction

The design of the second Tonga Health Systems Support Program (THSSP2) brings together three broad themes: non-communicable diseases (NCDs), universal health coverage (which has strong links to equity and social inclusion) and systems strengthening. Extensive work was done to describe these issues and why they are important to Tonga. This analysis – which includes discussions of gender equality and disability inclusion – is presented in full in Annex 1. Further background information about the Tonga health sector is given in Annex 2, which reproduces the Executive Summary of the 2014 *Tonga Health Sector Analysis* commissioned by DFAT.

The main points from this detailed analysis are summarised here.

## Non-communicable diseases

### *The problem of NCDs*

Tonga has some of the best health indicators in the Pacific and has achieved substantial reductions in communicable diseases and maternal and child mortality.<sup>4</sup> **Non-communicable diseases (NCDs) are now the fastest-growing cause of morbidity and mortality, accounting for 75 per cent of all deaths; NCDs are also a leading cause of premature death and disability.**<sup>5</sup> In 2012 an article in *Population Health Metrics* stated that life expectancy had actually decreased by five years, largely because of NCDs.<sup>6</sup> This claim is contradicted by some international sources – for example UNDP's Human Development Index records a slight increase in life expectancy.<sup>7</sup> The Ministry of Health accepts the claim that there has been a fall, and this is also stated in the National NCD Strategy and World Bank publications.<sup>8</sup> Despite this lack of consensus (caused by incomplete reporting and small numbers), it is generally accepted that NCDs are the major health problem in Tonga.

Quantifying accurate future levels of NCDs is impossible. But it is widely accepted that – without drastic interventions – NCD rates will continue to rise. This expectation is based on two main facts – Tonga's current young population and the known high levels of risk factors for NCDs. Taken together, these two facts suggest that there could well be a significant increase in both

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<sup>4</sup> This section draws heavily on the DFAT-commissioned *Tonga Health Sector Analysis* which was part of the preparatory work for THSSP2 (Levisay A with Evans L, 2014). More primary references can be found in this document. The Executive summary is given in Annex 2.

<sup>5</sup> WHO, Asia Pacific Observatory on Health Systems and Policies: 10.

<sup>6</sup> Hufanga et al., Mortality Trends in Tonga: An Assessment Based on a Synthesis of Local Data, *Population Health Metrics* 10:14, 2012, 9-10.

<sup>7</sup> <http://hdr.undp.org/en/data>

<sup>8</sup> See for example, Anderson, I (2012) *The economic costs of NCDs in the Pacific Islands: a rapid stocktake of the situation in Samoa, Tonga and Vanuatu*.

the absolute numbers and the rates of people with NCDs as the current large generation of people under 30 years of age gets older. In 2014 WHO concluded that **the *entire adult population* is at moderate to high risk of developing an NCD.**

Rates of NCDs in women and men are not radically different, though the way in which the genders are affected by various risk factors does differ. Women, for example, are more prone to obesity; in contrast smoking rates are in the range of 42-48 per cent for men and 10-15 per cent for women.

Crucially, much of the future burden of NCDs is preventable. Primary prevention is about stopping the onset of the diseases in the first place; secondary prevention is about managing diseases well to prevent them from escalating into more serious manifestations.<sup>9</sup> How Tonga tackles the risk factors of nutrition, physical activity, tobacco and alcohol in the short term, and how well its primary health care facilities deal with secondary prevention, will impact on the demand for health services and health costs in the long term.

As discussed later in this document, the existing high levels of risk factors mean that Tonga will have to work hard merely to stand still in terms of NCD rates. In other words there are a lot of Tongans who will, almost inevitably, develop NCDs because of their lifestyles so far. It is vital that Tonga reverses the situation for the younger generation, but in the next decade NCD rates will include the generation who have already had unhealthy lifestyles. Keeping at the same levels of NCDs, or very modest reductions will actually be very positive achievements in Tonga, even if they do not immediately appear to be a dramatic return on a financial investment.

#### *Economic impact of NCDs*

The major health financing issue in Tonga is efficiency savings. In 2009 a World Bank review of health financing options in Tonga concluded that “Continuing to rely on general revenue financing while generating additional resources for the sector through efficiency savings is likely to be the most feasible and sustainable financing option for Tonga”.<sup>10</sup> For NCDs, expenditure more than trebles as care goes from health centres to out-patients at the main hospital, and increases a further nine-fold as treatment moves from out-patients to in-patient care. This is why it is so important to manage the clinical aspects of NCDs efficiently. (Anderson I, 2012).

As well as being expensive in terms of health care, NCDs lead to costs in terms of lost labour productivity because of high rates of premature mortality and morbidity. These issues were highlighted in the NCD Roadmap sponsored by the World Bank, DFAT, WHO, Government of New Zealand and the Secretariat of the Pacific Community:

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<sup>9</sup> The terminology here can be confusing. “Secondary prevention” – avoiding the escalation of existing NCDs – actually takes place in the *primary* health care setting.

<sup>10</sup> World Bank, *Financing Options for the Health Sector in Tonga*, 2009.

“The rising costs of (preventable) NCD treatment extend beyond the health sector, undermining national budgets and national investments. NCDs also impose large – but again often preventable – economic costs on individuals and the economy more broadly through death and disability of key skilled workers. Adverse social impacts occur when people – especially girls – are withdrawn from education or the workforce to become carers for those with NCD disabilities. Orphans and widows caused by premature NCD deaths are vulnerable to poverty and exploitation.”

#### *NCDs are a regional and national priority*

In 2014 the Government of Tonga participated in the Joint Forum Economic and Pacific Economic and Health Ministers which issued an Outcomes Statement which emphasised the high priority afforded to tackling NCDs. The Ministers committed to action in five broad areas: tobacco control, reducing harmful alcohol consumption, improving nutrition, strengthening evidence and improving the efficiency and impact of the health budget. The specific commitment in relation to the health budget was “re-allocating scarce health resources to targeted primary and secondary prevention of cardio-vascular disease and diabetes, including through the Package of Essential Non-Communicable Disease Interventions of ‘best buys’”.

Key documents from the Government of the Kingdom of Tonga – including the [draft] National Strategic Development Framework 2015–2025 and the Ministry of Health’s Corporate Plan - are equally clear about the importance of tackling NCDs.

The main focus of THSSP2 is support for NCD ‘best buys’, i.e. the health interventions which provide the most cost-effective ways of preventing and managing NCDs, as summarised in WHO’s Package of Essential Non-Communicable Disease Interventions (PEN). This focus is fully compatible with the recommendations of the Joint Forum of Economic and Health Ministers.

### Universal health coverage

In 2012 the United Nations General Assembly adopted a resolution that emphasized the importance of moving towards universal health coverage. The goal of universal health coverage (UHC) is to ensure that people obtain health services based on need and without suffering financial hardship when paying for them. There are three dimensions of UHC:

- the population which is covered: does everyone have access to appropriate health services?
- the services which are available: is a package of ‘best buys’ available to everyone who needs those services?
- the extent to which costs are pooled through taxation or health insurance: is health care free (or almost free) at the point of use?

The goal of the new Corporate Plan of the Ministry of Health in Tonga is “universal health coverage to improve accessibility to quality health services for better health impact and outcomes”, or in short “UHC for better health impact”. For Tonga, the key issues in moving towards universal health coverage are defining a package of services and specifying how this will be made available to people throughout Tonga. This should help to address the geographic and socio-economic inequalities in current service provision. By definition, the work on essential

health care services will also include consideration of services for people with disability or mental health conditions.

## Systems strengthening

A national health system does not operate as a series of discrete disease-specific packages: rather it consists of a number of health facilities and programs which rely on *systems* to provide them with the appropriate human resources, drugs and equipment, information etc. To improve the quality and sustainability of the NCD response in Tonga it is not enough to support just the narrow technical aspects directly related to non-communicable diseases. A sustained, efficient response to NCDs requires well-functioning systems of planning, resource allocation, human resources, asset management, procurement and health information, for example. An important focus of THSSP2 is to use government systems and to strengthen them by so doing.

The Ministry of Health's Corporate Plan shows an awareness of the importance of systems strengthening. The National Health Development Committee (NHDC) has also demonstrated its commitment to health systems strengthening by approving the DFAT Investment Concept Note in October 2014 (see Annex 3). This concept note gave the NHDC the choice of whether or not to include health systems strengthening as a significant part of THSSP2: the NHDC quickly agreed that this was a vital component.

To inform the design of THSSP2, an assessment of the MoH's PFM systems was undertaken at the end of 2013. This assessment identified several system weaknesses, along with the fiduciary risks resulting from those weaknesses. The report also included recommendations to mitigate the identified risks, and to inform the longer term systems strengthening objective of THSSP2. The Risk Matrix is provided at Annex 22, along with a response to how the recommendations regarding mitigation measures have been incorporated into the THSSP2 design.

The Ministry of Health does not work in isolation: for systems to improve in the MOH improvements also need to be made in other ministries and agencies, notably the Ministry of Finance and National Planning. It is hoped that improvements in the MOH will act as an influential demonstration for other ministries about what can be achieved within the Government of Tonga system.

## Gender equality and disability inclusion

Gender and disability are both highly relevant to the work supported by THSSP2. An important activity under THSSP2 is defining a "universal health coverage" package for *all* Tongans – poor and disadvantaged groups stand to benefit from this disproportionately because they are less likely to access health care for reasons of geography or disability, for example. The different barriers faced by men, women, boys and girls in accessing health information and services in Tonga are multiplied for those with disability, who also experience physical, communication and cultural barriers to access, and problems related to the suitability of services. (For example people with mental health conditions are often reluctant to visit health facilities because of the stigma attached to mental illness.) THSSP2 will seek to address these barriers by supporting

work on universal health coverage and by requiring MoH Annual Management Plans to show how they address gender, equity and social inclusion issues.<sup>11</sup> Provision of the package will be monitored, with the information disaggregated by gender and location.

### *Gender equality*

NCDs affect women and men differently and the response needs to be tailored accordingly. For example men are less likely to visit a health practitioner and there is a need for targeted interventions to improve male utilisation. A mass media campaign about tobacco use would benefit men more than women; in contrast a campaign promoting participation in netball would benefit mostly women and girls.

Designing and maintaining gender-appropriate responses require good data. Fortunately, the main sources of information on NCDs – facility information, Knowledge-Attitude-Behaviour Surveys and the five-yearly STEPS Survey – disaggregate most of their information by gender.<sup>12</sup> Although the quality of much of the data needs to be improved, there is a reasonably good foundation for the pursuit of gender equality.

### *Disability inclusion*

Rates of disability are on the rise in Tonga, meaning greater numbers of people with disability require health services. Therefore it is important to ensure that work on promoting universal coverage and addressing NCDs specifically considers the needs of people with disability and addresses barriers they face.

There is a strong link between the increase in rates of disability (including mental health conditions) in Tonga and the incidence of NCDs: for example amputations related to diabetic sepsis, paralysis relating to stroke and vision impairment due to diabetes. THSSP2 will contribute to preventing some of these conditions and limiting the disabling consequences of NCDs. Services for people with disability and mental health conditions are very limited in Tonga – even some highly cost-effective interventions (for example community-based rehabilitation) are not currently available. To complement the universal health coverage package, THSSP2 will make available seed money for disability and mental health services, in recognition that these are under-developed and at times stigmatised services. This design document deliberately does not specify a percentage of the budget to be spent on mental health and disability because this

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<sup>11</sup> A note on terminology: the Ministry of Health uses the term “Annual Management Plan (AMP)”, but TongaHealth does not. AMP is used in the context of the Ministry; “work-plans”, or simply “plans” is used when referring to both institutions.

<sup>12</sup> The WHO STEPwise approach to Surveillance (STEPS) of NCD risk factors is a standardized method for collecting, analysing and disseminating data in WHO member countries. By using the same questions and protocols, countries can use STEPS information not only for monitoring within-country trends, but also for making comparisons across countries.

depends on the quality of the relevant Annual Management Plans. The disability/mental health spending is intended to be catalytic – i.e. to raise the profile of these vulnerable groups, to support advocacy activities and to demonstrate what types of services are possible. The funds are certainly not intended for large-scale service delivery, for example for routinely prescribed psychiatric drugs. (See Annex 4 for Guidelines on the use of THSSP2 funds.)

## Development Problem/Issue Analysis

Previous sections, plus Annexes 1 and 2, describe the major health and health system issues to be addressed by THSSP2. In summary, the program will address the following development issues:

- *Health:* NCDs are a serious health problem. The Ministry of Health believes that NCDs have caused a *decrease* in life expectancy in Tonga.
- *Economic and social:* NCDs are costly to both government budgets and the economy more broadly. They have high social costs by imposing a heavy burden on (mostly female) carers and creating households which have lost their main income earner.
- *Country ownership and country systems:* THSSP2 is designed to ensure that decisions about resource allocation and the practicalities of implementation will be made by local organisations. This is vital for developing a sustained response to the NCD crisis.
- *Inclusion:* there is currently no comprehensive planning and prioritisation system which takes into account the health needs of *all* Tongans, regardless of gender, disability, geographical location or the nature of their health need. THSSP2 seeks to address this by supporting Universal Health Coverage and strengthening planning systems. Plans will be informed by information disaggregated by gender, with different services for females and males when appropriate. Information related to disabilities will also be improved.

There would be a number of dimensions to success for this investment:

- Essential health care services specified and their provision monitored, as per the current Corporate Plan. Information about gender, disability, geographical location and the types of services being used will enable consideration of gender, equity and social inclusion.
- Improved trends in key NCD indicators for women and for men. (As explained above, Tonga will have to work hard even to maintain stable rates of NCDs, so this is an ambitious – but necessary – aim.)
- Information available about the number and cost of prevented hospitalisations because of better out-patient management of NCDs. (This can start by focussing on particular types of hospitalisation, e.g. for amputations.)
- Annual planning-implementation-monitoring cycle functioning for the Ministry of Health, with the resulting information used to make resource allocation decisions. Towards the end of THSSP2 progress with this can be used to assess whether the Ministry may be ready to receive Sector Budget Support.
- Measurable population changes in knowledge, attitudes and behaviours around healthy living.
- Implementation of a multi-sectoral NCD National Strategy, with TongaHealth playing an effective leadership and co-ordination role.

- Basic disability and mental health services included in the essential services package and new resources available to expand service provision in these areas. (Funding from THSSP2 itself is marginal for these services; certainly not enough to develop a universal service.)
- The combined Ministry of Health + TongaHealth budgets (excluding donor funds) as a percentage of total government budget have not decreased and the MOH budget for the Public Health Division has increased as a percentage of the total Ministry budget. (These are the two pre-conditions for THSSP2.)

Taken together, these dimensions of success can be summarised as “**taking control of the NCD crisis**”. If its overall development is not to be jeopardised, Tonga needs to ensure that the younger generation have healthier lifestyles and that the health system deals with NCDs in a more cost-effective manner.

## Evidence-base/Lessons Learned

The Investment Design template now moves on to a section about how reference has been made to evidence and lessons learned from comparable programs. This section looks at this issue from a number of perspectives:

- lessons from THSSP1 and other aspects of the DFAT health portfolio in Tonga, including the Tonga Assessment of the Public Finance Management System in the Health Sector 2013
- lessons from the wider DFAT portfolio in Tonga, including the Tonga Education Sector Program and Assessments of National Systems (ANS) (2012 and draft 2015)
- relevant points from the work of other development partners in Tonga
- lessons from the DFAT health program in Solomon Islands
- global technical evidence about the control of NCDs
- other ways in which the Ministry of Health and TongaHealth use evidence.

### *Lessons from the existing DFAT health portfolio in Tonga*

DFAT is the largest development partner in Tonga in terms of financial support; THSSP1 accounts for most of DFAT’s current spending on health. The Independent Progress Report of THSSP1 is therefore an important source of lessons learned for THSSP2. These lessons are summarised in Table 1a, along with a description of how the lessons have been incorporated into the design of THSSP2.

**Table 1a Lessons Learned from THSSP1 and incorporated into the design of THSSP2**

THSSP1: issues from which lessons were learnt (as identified in Independent Progress Report)	Implications for design of THSSP2
There were problems with the health promotion work, largely because of lack of clarity about organisational roles and	There is now a signed Memorandum of Understanding which clearly describes the respective roles of the Ministry of Health and TongaHealth. (Annex 5)



THSSP1: issues from which lessons were learnt (as identified in Independent Progress Report)	Implications for design of THSSP2
responsibilities.	
The Flexible Fund was used in an ad hoc way, largely to support the main hospital. Spending was not based on work-plans and outputs.	All spending will be allocated against Annual Management Plans (AMPs). Priority will be given to spending on NCD prevention and treatment at the primary care level, as well as on health systems strengthening. Spending priorities will be an important aspect of the MOH/DFAT dialog about the AMPs; increasing the public health budget is a condition of DFAT funding.
The joint governance tended to focus on relatively minor problems and did not address strategic issues.	The National Health Development Committee will be involved in allocating THSSP2 resources and will thus have to make strategic resource allocation decisions. DFAT will be involved in these discussions and needs to approve the final AMPs which involve DFAT funding.
The Ministry of Health did not have good information about the budget and expenditure of THSSP1.	Finances will be managed using the same systems and categories as the Government of Tonga; information about THSSP2 budgets will be available alongside the information about MOH core funds.
The timing of surveys (especially STEPS) was crucial for monitoring outcomes.	STEPS has a history of long delays in publication. MOH and DFAT will work with WHO to emphasise the importance of timely publication. Government of New Zealand is also a useful channel of influence because it funds STEPS in the Pacific region.
Government systems tended to be by-passed, including systems for planning, budgeting and staff supervision.	THSSP2 will transition to an approach which will not use separate systems. There will not be a separate project office.
There was insufficient external audit.	Funding for annual external audit will be top-sliced from the THSSP2 budget, thus protecting the funds from other uses.
Implementation of the Program started too slowly: just 1% of the budget was spent in Year 1.	NHDC has been made aware in advance of the decisions it will have to make about funding; in the first year there will be two funding rounds (instead of the usual one) to allow for the fact that some work-plans may not have been ready in an appropriate format for the first round. Year 1 includes some continuity of funding from THSSP1, notably for Critical Staffing Deficiencies. This will help to spread the risk about low expenditure in Year 1. As described in Box 3, there have been a number of joint activities related to the design of THSSP2, so that all major stakeholders have had good opportunities to prepare for the start of the program in July 2015.
The Flexible Fund was used to respond quickly to Cyclone Ian in 2014.	The Design describes how funds could be allocated in an emergency. (See <i>Delivery Approach</i> section.)



Other DFAT-funded health programs are also relevant to THSSP2. For example there is concern that changes in how Critical Staffing Deficiency posts are funded will mean that clinicians lose out on stimulating contact with international colleagues: it will be important to work with regional programs such as those run by Fiji National University to explain the new arrangements and see if help may be available for the transition to ensure that the timing of clinician visits is appropriate and that priority needs are met.

The more co-ordination there can be with the Australian Volunteer Program and the Scholarships Program the better, as there are areas of THSSP2 which would greatly benefit from these inputs. The more that these programs complement each other, the greater the added value. The DFAT Health Program Manager will actively pursue opportunities for positive links between THSSP2 and the Volunteer and Scholarship programs.

Table 1b uses the same format as Table 1a to describe lessons learnt from the Assessment of National Systems (ANS), Assessment of the Public Finance Management (PFM) System in the Health Sector and the PFM Road Map. An Assessment of PFM systems in the Health Sector was undertaken in 2013, and an update to the ANS was conducted in March 2015: recommendations from the outcome of these assessments have implications on issues to be addressed with the Ministry. While the findings of the ANS are yet to be finalised, the preliminary findings, along with the findings of the 2013 Health Sector Assessment, have been incorporated in Table 1b and into the design of THSSP2. Annex 22 gives a complete list of risks identified and mitigation measures recommended in the PFM Assessment of the Health Sector, including a response regarding how the mitigations measures have been incorporated into THSSP2 design.

**Table 1b Lessons Learned from ANS, Assessment of the Public Finance Management (PFM) System in the Health Sector and PFM Road Map and incorporated into the design of THSSP2**

Issues from which lessons were learnt (as identified in ANS, Assessment of the Public Finance Management (PFM) System in the Health Sector and PFM Road Map)	Implications for design of THSSP2
National level Government of Tonga Procurement reforms under implementation (supported by DFAT) need to be supplemented by capacity-building support at the health sector level to ensure successful implementation.	Ensure participation by health sector procurement staff in relevant training under Economic and Public Sector Reform (EPSR) Program, and consider providing additional specific technical support to MoH through THSSP2 (Health Systems Strengthening component).
THSSP1 implemented outside of MoH finance system, therefore no consolidated financial reports prepared of total MoH resources (recurrent plus donor), and no linkage of costed AMPs to budgets. This limited the ability of the MoH to prepare high quality planning and budgeting documents, based on informed resource allocation decisions. MoH does not currently have access to the Vision reporting function of the Sun System, therefore it is unable to extract useful financial management information in a timely manner.	<p>THSSP2 will ensure that the new budget structure reflects the programs/sub-programs of the Ministry which are included in the annual work- plans and medium term corporate plans, enabling linkage of plans to budgets.</p> <p>The Sun system has the ability to separate out GoT expenditure from donor expenditure against the same overall budget structure, so that total budget/actual expenditure can be analysed for each sub-program and even activities under each sub-program. Critical system strengthening activity to include development of Financial Procedures manual to supplement existing Treasury Instructions, and roll-out and training in full functionality of Sun system to MoH, including budget coding and Vision reporting module – this is important so that MoH can extract reports directly from the system.</p> <p>These improvements in MoH must be done in the context of the broader Sun System and planning reforms being led by Ministry of Finance and National Planning (MoFNP). MoH should be considered a priority pilot ministry for this work, and if MoFNP funding is insufficient, additional support could be provided to MoH from THSSP2 resources (Health Systems Strengthening component).</p>

## Lessons from the wider DFAT portfolio in Tonga

The DFAT-funded education program TESP (Tonga Education Sector Program) has important lessons for THSSP2 about the challenges involved in using Government of Tonga systems. In fact the education program has not succeeded in its attempts to rely on GoT systems. The same format as used in Tables 1a and 1b was used to describe lessons learnt from TESP, based on discussions with the DFAT Education Program Manager. Perhaps the most important lesson was the need to ensure that work-plans are not too ambitious: one way of doing this is to assess the quarterly monitoring reports against the annual plan. The full table is shown in Annex 6.

**Other DFAT funding outside the health sector** is also relevant to THSSP2. Over 50% of the budget support to Tonga was used to fund Ministry of Health salaries in 2014/15. The Economic and Public Sector Reform Program (funded jointly with the ADB, EU and World Bank) aims to introduce just the type of budget and financial management improvements which would benefit the Ministry of Health. A potentially useful collaboration between THSSP2 and the Reform Program would be if the Ministry of Health was the pilot line ministry for an improved chart of accounts and clear roles and responsibilities in relation to financial management and reporting. The ANS update undertaken during this design process has highlighted the need for the Economic and Public Sector Reform Program and the THSSP2 design to have a more targeted approach to addressing procurement issues within the Ministry of Health. This includes capacity-building assistance to improve procurement planning, preparation of procurement proposals and technical specifications, and stock management.

The annual Tonga-Australia Partnership talks are an opportunity to bring together experience from the various programs, especially in the key areas of financial management and budget decision-making.

### *Relevant aspects of the work of other development partners in Tonga*

The work of other development partners is also related to THSSP2. Other development partners currently supporting the health sector are Australia, Japan, China, New Zealand, WHO, United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA). The International Planned Parenthood Federation (IPPF) provides support through its local affiliate, Tonga Family Health. Development aid to the health sector increased from approximately 8 million TOP in 2003/04 to over 11 million TOP in 2007/08, with the vast majority of spending being off-budget (not shown in the Ministry of Health's budget). A few large projects, notably THSSP1 and renovation of Vaiola Hospital, accounted for the bulk of the expenditure.

The **New Zealand** Government responded to two urgent health requests from the Government of Tonga in early 2015. The first was funding for the Tongan Red Cross Services Emergency Dengue Plan and the second was for the urgent procurement of essential drugs, following a stock-out of almost 80 percent of the drugs within the central government pharmacy. While not a large donor in the health sector in Tonga, New Zealand remains engaged and is flexible to mid-level requests for assistance. New Zealand also provides long-term support to Tonga through its medical transfers program.

The Tongan and Australian Governments both recognise the leading role of the **World Health Organization** as the primary specialised agency for health. They have re-affirmed its leadership and co-ordination role in promoting and monitoring global action against non-communicable

diseases in relation to the work of other relevant United Nations agencies, development banks and other regional and international organisations. Australia continues to support WHO's global role in establishing norms, standards and guidance – including in relation to the NCD response. DFAT's position is that the operationalization of global action plans requires adaptation to country contexts, including ensuring that relevant stakeholders at local level take the lead. A recent WHO consultation on PEN (the WHO package of essential NCD interventions) in Suva acknowledged that “countries were keen to adapt their approach to NCD management” – just one small and recent example of broader recognition within WHO of the need to tailor global work to country priorities. As the largest regional bilateral donor in health, with a major investment in NCDs, DFAT is continuing to work with WHO at different levels to ensure better co-ordination between stakeholders to make best use of our limited resources.

Whilst WHO has provided guidance on TongaHealth's statutory position in relation to Government, there has been no engagement with TongaHealth itself. The Country Liaison Office does not regard TongaHealth as a relevant government partner, despite WHO's global policy to support Health Promotion Foundations. This has raised issues related to co-ordination and duplication: DFAT will encourage WHO to become more involved with TongaHealth. Issues that could benefit from stronger WHO engagement include advice about evidence-based health promotion and harmonization and alignment of donor funding for health promotion related to NCDs.

In addition, WHO is supporting the development of a National Human Resources (HR) Strategy. At the time of writing, this document is due for imminent release. The translation of this Strategy into concrete plans is an important part of the Ministry's systems strengthening. HR plans should deal both with the main cadres of health worker (such as various types of nurses) and with succession planning for senior clinical and management posts.

The **Asian Development Bank** (ADB) supported the development of a submarine fibre- optic cable system in Tonga through the Tonga-Fiji Submarine Cable Project. To harness the increased capacity for Information, Communication and Technology (ICT), the Government of Tonga requested ADB to explore the potential to use electronic applications (“e-applications”) to improve delivery of vital social services such as health and education. One area of support is the preparation of an ICT Health Sector Policy that will set out in which areas e-applications can be developed to help the government achieve its national health objectives. A Health ICT Policy Expert has been recruited by ADB to undertake this work under the Pacific Information and Communication Technology (ICT) Investment Planning and Capacity Development Facility. The International Telecommunication Union (ITU) and the World Health Organization (WHO) will provide technical back-stopping over the course of the assignment. Reliable, timely health information is highly relevant to THSSP2: the Ministry of Health and DFAT will ensure that there is co-ordination between THSSP2 and the ADB's work on ICT in health. This is directly relevant to THSSP2's support for health systems strengthening. Indeed the ADB-funded TA has already provided useful inputs for THSSP2 by advising on the monitoring framework described here in Annex 12.

The **World Bank** undertakes valuable research in Tonga in the area of NCDs. Most recently in early 2015, the Bank produced a (DFAT-funded) paper comparing prices of pharmaceuticals/ medical supplies for a short-list of items predominantly used for dealing with NCDs. The prices were collected in late 2014. In most cases Tonga paid a higher price for the same pharmaceutical supplies than their Pacific Island neighbours. The aim of the paper was to stimulate discussion on practical actions countries might take to achieve better value for existing

health expenditure on essential medical supplies. The Bank has suggested that a more comprehensive comparison of a broader ‘basket’ of essential medical supplies could be completed in 2015 as part of follow-up action by the Pacific Heads of Health. This has natural synergies with this investment because pharmaceuticals and medical supplies are an important component in the overall cost of managing NCDs. The medical supplies comparison could be considered for funding by DFAT, if the Government of Tonga makes the appropriate request. DFAT is funding a Supply Chain Adviser for the Tonga health sector who will assess the potential usefulness of the comparisons work.

The **disability sector** in Tonga is small and lacks co-ordination.<sup>13</sup> The majority of services are provided by non-government organizations and supported by **church donations**. The Church of Jesus Christ of the Latter Day Saints (LDS) partnered with Motivation Australia in 2012 to organise training of medical professionals, care-givers and others on how to assess a person’s mobility needs, as well as how to assemble and use wheelchairs. In November 2013 the LDS Church provided a donation of 540 wheelchairs and 300 other mobility aids, some of which went to the Ministry of Health.

Until recently there was no clear ministry responsible for co-ordinating disability-related initiatives; however the new Disability Policy states that this role now sits with the Ministry for Internal Affairs. There is no co-ordinating mechanism between government and non-government services, nor within the non-government sector.

## Lessons from elsewhere

In terms of evidence from elsewhere, two areas of work have particularly informed the design of THSSP2: the WHO Package of Essential Non-communicable Disease Interventions and the DFAT-funded Solomon Islands Health Sector Support Program.

### *Lessons from the DFAT health program in Solomon Islands*

Through document review and a telephone conversation, details of the DFAT-funded **Solomon Islands Health Sector Support Program** (HSSP) were reviewed and lessons drawn to inform the design of THSSP2. The main points are summarised in the table below.

**Table 2 Lessons learnt from the Solomon Islands HSSP and applied to THSSP2**

Solomons Islands HSSP experience	Implications for THSSP2
The Solomon Islands program budget is eleven times bigger than THSSP2 and the level of	It is important that the Tonga program is kept reasonably simple and that it is appropriate to

<sup>13</sup> Information about disability services comes from documents by the CBM – Nossal Institute Partnership for Disability Inclusive Development.

engagement of other development partners (WHO, World Bank) is much higher.	the small size of Tonga. Expectations need to be realistic. As a donor, DFAT will be isolated on the NHDC.
Performance-based financing (PBF) incentives should go to the organisational sections which actually achieved the good performance; health facilities and other “frontline” institutions should be eligible to receive incentive payments.	The guidelines for PBF (Annex 7) stress the importance of incentive payments reaching the sections directly responsible for the good performance.
It takes time to improve planning and budgeting; this is an area where technical assistance (TA) is often valuable.	The five-year period of THSSP2 is about strengthening systems prior to possible Sector Budget Support. TA will be provided in the areas of planning, budgeting and financial management. There is flexibility around the duration of this TA.
Good systems for health information and human resources (HR) contribute greatly to the success of this kind of program.	Both of these areas are eligible for Health Systems Strengthening funding.  It is vital that a review of the Health Information System is undertaken; production and implementation of a Health Information Plan are indicators for THSSP2. THSSP2 funds could be used to support the MoH to collaborate with the ADB/WHO work under way (see section on <i>Relevant aspects of the work of other development partners in Tonga</i> ).  It is acknowledged that HR is an area of potential risk: the publication of the WHO-funded Human Resource Strategy will be an important step.

#### *Global technical evidence about the control of NCDs*

**PEN**, the WHO Package of Essential Non-communicable Disease Interventions for Primary Care (2010), is a prioritized set of cost-effective interventions that can be delivered to an acceptable quality of care in resource-poor settings. It defines minimum standards for the following NCDs: heart disease, stroke, cardiovascular risk, diabetes, cancer, asthma and chronic obstructive pulmonary disease. PEN acknowledges the wider health system and discusses the implications for health systems, using the same six health systems building blocks as the Ministry of Health in Tonga uses to structure its Corporate Plan. PEN can be a useful tool for countries working

towards Universal Health Coverage, as long as the PEN interventions are seen as an integral part of a wider package of primary care interventions.

It is important to acknowledge that PEN is not without its critics (particularly about the cardiovascular disease guidelines)<sup>14</sup> and that PEN is not an off-the-shelf protocol which can be applied in Tonga without adaptation. Decisions about who to screen and when, what risk thresholds to use and what treatments to provide greatly influence cost-effectiveness in any particular setting. Cost-effectiveness is also particularly sensitive to drug prices – the lower the prices achieved through the drug procurement process, the greater the potential cost-effectiveness. THSSP2 funds could be used to support the adaptation of PEN to Tonga’s particular circumstances; the TA in public health could assist this work.

#### *Other ways in which the Ministry of Health and TongaHealth use evidence*

Lesson-learning and reference to evidence do not only happen in the context of designing externally-funded programs. The Ministry of Health and TongaHealth also use international evidence. PEN has already been used in Tonga (for example to inform the NCD nurses’ training) and the national NCD strategic plan *Hala Fononga* is currently being developed through a process which explicitly acknowledges the importance of evidence (see Box 1).

#### **Box 1 Development of the National NCD Strategic Plan *Hala Fononga***

*The following extracts come from a paper presented to the TongaHealth Board.*

“The situation analysis is the ‘foundation piece’ for the development of the National NCD Strategy 2015-2020. The purpose of the situation analysis is to make evidence based recommendations on which target groups, target behaviours and approaches the National NCD strategy design should adopt to maximise reductions in NCDs in Tonga.”

“A panel of Tongan experts will be put together by TongaHealth to undertake the situational analysis. Extensive work will be done prior to convening the panel to produce a set of concise summary documents about obesity, alcohol and tobacco misuse, best international practice in relation to NCDs, STEPS findings and lessons learned from the previous *Hala Fononga* that will be used by the panel to make evidence-based recommendations. The panel’s recommendations will go to the relevant sub-committees and the National NCD Committee for approval.”

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<sup>14</sup> Wijemanne N Rannan-Eliya R (2014) *Policy Brief for DFAT on Support for Country Implementation of CVD Treatment and WHO-PEN*. Institute for Health Policy, Sri Lanka. HRF Help-desk Request.

## Strategic Setting and Rationale for Australian/DFAT engagement

The rationale for proposing the DFAT investment in THSSP2 is as follows:

- NCDs are the main health issue in Tonga and DFAT is the main donor; there is little other bilateral donor activity in this area.
- The NCD response requires health systems strengthening. Box 2 illustrates some of the systems activities which are a necessary part of providing interventions related to NCDs.
- Provision of primary health care is inconsistent across the country.
- Services related to mental health and disability are particularly under-developed.
- Tonga should be supported to make its own decisions about how to respond to the NCD crisis.
- Health services will be improved if there is more consideration of gender, equity and social inclusion, including disability inclusion.

Responding to this rationale, THSSP2 has four components:

- Management of NCDs in primary care: primary and secondary prevention
- Health promotion related to NCDs
- Health systems strengthening
- Support for mental health and disability services.

The program is designed to use existing Tongan decision-making bodies and to strengthen the systems of relevant government departments and TongaHealth.

### **Box 2: NCDs and health systems - health systems involved in the essential NCD package**

(Adapted from WHO PEN, 2010)

This Box gives examples of systems activities which are a necessary part of providing interventions related to NCDs. For example a primary health care facility relies on a good centralised system for procuring medicines.

**Human Resources:** adapt learning materials to train staff in the use of NCD technical protocols; organize and evaluate in-service training.

**Pharmacy:** procure and distribute medicines.

**Laboratory Services:** issue guidance on laboratory procedures; supply materials and reagents; undertake training and quality assurance.

**Medical Equipment:** procure and distribute appropriate equipment such as blood pressure measuring devices and nebulizers.

**Health Information:** specify the information needed to monitor and evaluate NCD activities and ensure that this information is collected, and can be used to inform evidence-based, gender-sensitive approaches.

**Nursing Services:** develop guidance on the role of nurses in integrated approaches to prevention and management of NCDs.



The key development objectives of THSSP2 are:

- Improved ability of men, women, boys and girls to participate in economic activity because of less premature mortality and serious chronic illness.
- Reduction in the economic burden of escalating NCDs, both on the Ministry of Health and the wider economy.
- Greater efficiency: some hospitalisation (and the related costs) avoided because of prevention and better management of early stage NCDs; more cost-effective NCD programs.
- Measurable population changes in knowledge, attitudes and behaviours around healthy living.
- A more equitable, gender-aware health service because of the definition of a primary care package and the monitoring of its implementation.
- Improved overall stewardship of the health sector, particularly in terms of the planning and budgeting cycle.
- In TongaHealth, an institution which can stimulate a truly multi-sectoral response to NCDs. (This aspect of the NCD response in Tonga has until now been particularly weak.)

Most of these objectives are reflected in THSSP's targets. However note that some of the objectives lie "above" the logical framework for the Program, notably improved economic activity and the burden of NCDs on the economy beyond the health sector. The targets for THSSP2 are:

1. Decrease in percentage of population at high risk of developing an NCD, for both males and females. (Risk factors are diet, inactivity, smoking and alcohol abuse.)
2. Downward trend in the rates of premature deaths and preventable disability<sup>15</sup> related to NCDs in men and in women.
3. NCD management as part of Universal Health Coverage leads to cost savings in hospitals.
4. Strengthened health system management, including planning, financial management, implementation, monitoring, health information, procurement and human resources.
5. Development of GESI as a cross-cutting issue: at least 80% of annual plans from the Ministry of Health and TongaHealth reflect GESI considerations. (The most relevant GESI considerations for THSSP2 are gender, geographic equity, and inclusion of disabled and mentally ill people.)

The full table of indicators for THSSP2 is given in Annex 12.

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<sup>15</sup> As stated mentioned in an earlier reference, preventable disability for THSSP2 THSSP 2 is here defined as cases of diabetic retinopathy, limb amputation (related to lack of diabetic control) and different stages of renal failure (as per data collected by the Diabetes Clinic)..

## Alignment of investments with Australia's aid policy framework

The Australian aid program has ten strategic performance targets. Table 3 shows how THSSP2 contributes to these targets. The table also includes a row on “innovative approaches”, which are a high priority for DFAT.

In addition, Australia's aid policy framework has four tests to guide strategic choices across the aid program (related to Australia's national interest, promoting growth and reducing poverty, value-added and leverage and making performance count). Annex 23 discusses THSSP2 in the context of these tests. These tests will be applied later in 2015 when the Aid Investment Plan for Tonga is developed.

**Table 3: Australian strategic performance targets and the design of THSSP2**

Australian strategic performance target	How incorporated into THSSP2
Target 1: promoting prosperity	<p><b>Prosperity:</b> Better health leads to growth in earning potential and income for individuals and households. Fewer NCDs and more equal access to health services should mean that more children live in economically secure and healthy families. Such children tend to have higher levels of educational attendance and better outcomes. Moreover, without successful prevention and management of NCDs, the cost of treating NCDs would outstrip the Ministry of Health's budget and place strains on the economy as a whole.</p> <p>There is not a large direct <b>aid-for-trade</b> component in THSSP2, though it will promote better procurement of pharmaceuticals and other medical supplies.</p>
Target 2: engaging the private sector	<p>The private health market in Tonga is small and there are limited opportunities to develop work with the sector. There will, however, be some engagement. Through the funding for TongaHealth work-plans, Post will look for opportunities to prioritise funding of health promotion activities implemented by the private sector: TongaHealth is able and willing to fund all kinds of organisations, both private and public. There will certainly be engagement at various stages of media campaign activities where it will be necessary to tender out contracts (research, media design and broadcast etc.). An example could be a health promotion campaign transmitted by a communications provider via text messaging.</p>
Target 3: reducing poverty	<p>There should be a reduction in the number of vulnerable people whose economic viability is jeopardised by premature death or heavy burdens of caring. Work on essential primary health care will mean better services for the poorest and most marginalized Tongans.</p>
Target 4: empowering women and girls	<p>The work on essential primary care will mean an enhanced role for professionals in primary care, very many of whom are women. In general, the health sector offers excellent opportunities for women to develop their leadership skills. Women and girls benefit disproportionately from population health improvements because they tend to be the main carers for the ill, which reduces their employment and education opportunities. Good health is a necessary, although obviously not sufficient, part of empowerment. The work on essential services should improve reproductive health services throughout Tonga: this is an important element in women taking control of their</p>

	<p>lives. Some aspects of NCDs disproportionately affect women – for example women are more likely than men to be obese in Tonga. Interventions about obesity will have aspects that are specifically targeted towards women: for example promoting netball or brisk walking, and not just football and rugby, as beneficial forms of exercise. Some messages and activities will be tailored specifically for women.</p> <p>Most data about NCDs is disaggregated by gender, as can be seen in the indicators selected for THSSP2. This makes it possible to target interventions appropriately and to monitor the impact on males and on females separately.</p>
Target 5: focusing on the Indo-Pacific region	Tonga is in the Indo-Pacific region.
Target 6: Delivering on commitments	<p>The Government of Tonga and TongaHealth will be clear about their obligations under THSSP2. Funds will be allocated based on Annual Management Plans and reports on the implementation of previous plans. Poor reporting or under-spending will lead to reduced levels of funding.</p> <p>10% of the THSSP2 budget is earmarked for performance related incentive payments.</p> <p>THSSP2 has pre-conditions related to the Government of Tonga showing a budgetary commitment to health in general, and public health in particular. If the conditions are not met, DFAT will formally re-assess its commitment to THSSP2 and may reduce its overall financial allocation to the Programme.</p>
Target 7: working with the most effective partners	The main partners are the Ministry of Health and TongaHealth. Performance and funding will be closely linked, as described for Target 6.
Target 8: ensuring value-for-money	<p>With its small number of program-specific staff and use of government systems, the delivery approach for THSSP2 offers good value-for-money.</p> <p>THSSP2 will promote and support cost-effective interventions related to NCDs: this will be based on good international evidence.</p> <p>THSSP2 will promote a more efficient Ministry of Health and should mean that savings are made from, for example, a reduction in the complications of diabetes which require hospitalisation. It will also promote improved management, including of human resources, which account for more than 50% of health expenditure.</p> <p>The design of THSSP2 has benefited from analytical work by the World Bank: in future, Tonga should be a source of important information about what works and what is cost-effective in terms of tackling NCDs in the Pacific.</p>
Target 9: increasing consolidation	<p>DFAT support to the health sector in Tonga is highly consolidated: THSSP2 will be the only significant bilateral health program. DFAT works in collaboration with other donors in the health sector including WHO, UNFPA and SPC and endeavours to co-ordinate efforts when possible.</p> <p>There will be strong links to other DFAT programs, notably Economic and Public Sector Reform; the Program Manager will actively look for opportunities to link with the DFAT Volunteer and Scholarship programs.</p>
Target 10: combatting corruption	<p>THSSP2 will conform to the Government of Tonga's public financial management rules and procedures, which have been carefully scrutinized and approved by DFAT.</p> <p>DFAT has put in place a Technical Advisor within the Central Procurement Unit to oversee all procurements funded through DFAT.</p>
Innovative approaches	Tonga is a front-runner in terms of its unequivocal acceptance of NCDs as a crisis which needs to be tackled.

Working through a Foundation such as TongaHealth is innovative in the Pacific as a vehicle to co-ordinate a multi-sectoral approach to addressing the NCD crisis, and there is Pacific-wide interest in its performance. **The WHO Western Pacific Regional Office advocates for health promotion foundations as a good mechanism for sustainable funding of health promotion activities.**<sup>16</sup>

The Ministry was unusual in pushing to use part of the available DFAT funding to support disability and mental health services, which tend to be neglected and stigmatized: this is a very positive attitude.

The design of the performance-based financing (PBF) is innovative in the way it tries to ensure that funds are potentially available to support both major senior-management decisions and smaller decisions made by front-line teams. This is only the second example of DFAT-funded PBF in the health sector in the Pacific.

## D: Investment Description

Both the Ministry of Health and the Ministry of Finance and National Planning have seen a draft of this design document and have been consulted about its contents. Prior to the design document, there have been a number of collaborative stages (including workshops) involving the Ministries of Health and Finance, TongaHealth and DFAT to discuss a broad range of options for THSSP2. These are described in Box 3. October 2014 was a particularly significant time in the design process, because this is when the Investment Concept Note for THSSP2 was approved by the National Health Development Committee and by the Australian High Commission in Tonga. This approval was a formal decision about both the components of THSSP2 and the delivery approach. The delivery approach – a Direct Funding Agreement with the allocation of funds based on high-quality annual plans – is described in the next section. The four components of THSSP2 are:

- Management of NCDs in primary care: primary and secondary prevention
- Health promotion related to NCDs
- Health systems strengthening
- Support for mental health and disability services.

THSSP2 will be a five year program starting in July 2015, meaning that it has the same timeframe as the Ministry of Health's Corporate Plan.

### Box 3 Joint design process – key dates

A number of steps have taken place to develop this design document for THSSP2. The process

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<sup>16</sup> [www.wpro.who.int/southpacific/programmes/healthy\\_communities/health\\_promotion/page/en/index1.html](http://www.wpro.who.int/southpacific/programmes/healthy_communities/health_promotion/page/en/index1.html)

has been a joint one, involving the Ministries of Health and Finance, TongaHealth and DFAT.

The following list of dates is how the Ministry of Health recently summarised the stages of joint design.

- Health System Review June 2014 (see Annex 2)
- Tonga Strategic Development Framework Review, October 2014
- National Health Development Committee agreed on next phase of DFAT funding, October 2014
  - Agreed priorities: NCDs, Health Systems, Mental Health and Disability, with focus on Gender, Equity and Social Inclusion.
  - Agreed modality: Direct Funding Agreement with the allocation of funds based on high-quality annual plans.
- Health Sector Development Aid Workshops, November 2014
- Outer Island Consultations, November 2014
- Planning Week, December 2014 (DFAT invited as observers for first time)
- Review of the first draft of Key Results Areas & Strategy and initial draft of the Corporate Plan, January 2015
- Consultation with Key Development Partners, January 2015
- THSSP Design Consultation, January/ February 2015
- Verification of THSSP2 design with Chief Executive Officers of Ministries of Finance and Health, February 2, 2015.

The activities to be funded by THSSP2 will be described in the annual work-plans of the Ministry of Health and TongaHealth. Because of this, this design document has more details about *how* funds will flow rather than *what* they will be used for. Box 4 is intended to give a flavour of what THSSP2 will fund: certain strategies such as the revised NCD Strategy (*Hala Fononga*) have not yet been finalised, so the examples below are for illustrative purposes only. It is important to stress that the choices of which activities to include in work-plans will be made by the Ministry and TongaHealth, following dialog with DFAT and with formal DFAT approval of work-plans which will receive DFAT funding. (Governance processes are described in more detail in the next section about the *Delivery Approach*.)

**Box 4 Examples of the kinds of activities which could be funded under THSSP2**

***Non-Communicable Diseases***

- Mass (gender-targeted) campaigns related to smoking, exercise and diet.
- Ensuring accessibility of NCD services and campaigns to people with a range of disabilities.
- Funding for community sports clubs for basic equipment.

- Funding to the Ministry of Agriculture, Food, Forests and Fisheries to promote the growing and use of vegetables.
- Annual audit of the quality of care for NCDs in all government health facilities.
- Improved services for diabetics in remote parts of Tonga.
- Establish international technical partnerships so that global and Pacific NCD guidelines can be adapted to provide maximum value for money in Tonga.

#### ***Health Systems Strengthening***

- Describe what Universal Health Coverage means for all people (men, women, boys and girls) living on Tonga's smallest islands and begin to develop the appropriate services.
- Operationalise the Human Resource Strategy: this could involve activities such as strengthening hospital roster arrangements with a view to reducing overtime costs and increasing outputs, succession planning for key posts (including the Critical Staffing Deficiency posts), or improving opportunities for women in leadership positions.
- Develop the primary health care information system so that basic data on out-patient utilisation is collated regularly.
- Ensure that arrangements for procuring and distributing crucial supplies related to laboratories and pharmaceuticals are as robust as possible, so that (for example) there are not harmful stock-outs leading to emergency procurement at significantly higher prices. (DFAT-funded TA is currently finalising a set of recommendations related to drug supplies.)
- Institutionalise systems for the maintenance and repair of medical equipment.
- Develop a Financial Procedures Manual to supplement existing Treasury Instructions.

#### ***Mental health and disability services***

- Ensure that mental health and disability are included in an appropriate way in the curricula of health workers trained in Tonga.
- Develop a national strategic plan for the gradual expansion of disability-inclusive health, rehabilitation and mental health services in Tonga.
- Expand support for mental health at the community level.
- Establish an Integrated Mobility Device Service.

The last four examples are taken from *Options for investment in disability and mental health support services for the Tonga Health Sector Development Program*, which was presented and discussed at a workshop in November 2014. The paper is given in Annex 8.

## **Delivery Approach**

As described in the previous section, a formal decision was made in October 2014 about the delivery approach for THSSP2. Out of three options described in the Investment Concept Note, the preferred delivery option was a **financing agreement based on high-quality annual plans**. Extracts from the Concept Note are provided in Annex 3; the key points from the section on delivery approaches are reproduced in Box 5 below. Design work in January/February 2015 elaborated on the details of the selected delivery option.

The choice of delivery approach was informed by lessons from THSSP1: one important lesson was that there were opportunities to work more through government systems and governance structures. Sector budget support as a delivery option was not supported because both the Ministry of Health and DFAT felt that government systems were not sufficiently robust to manage DFAT funding in this way. THSSP2 will strengthen systems of planning, budgeting, financial management and reporting, which could potentially be used in the future to manage budget support funds.

#### **Box 5 Delivery approaches for THSSP2: Key points from the Concept Note**

Three alternative delivery approaches are described:

- 1) sector budget support
- 2) project-style
- 3) a financing agreement based on high-quality annual plans.

The approaches vary in the extent to which they rely on government systems for planning, budgeting, implementation, financial management, reporting and monitoring.

Lessons from THSSP Phase I and from recent DFAT-funded reviews point towards a financing agreement based on strengthened annual plans as the preferred option. This combines a government-led approach with support for systems strengthening and with annual involvement from DFAT in agreeing areas for funding and in monitoring achievements.

There will be a Direct Funding Agreement (DFA) involving the Ministry of Finance and National Planning (MoFNP) and a grant agreement with TongaHealth: these will describe the modalities and payment schedules for THSSP2 as relevant to the Ministry of Health and TongaHealth. The DFA will be between DFAT and the MoFNP and the Ministry of Health as co-signatories on behalf of the Government of Tonga. (See Annex 9 for a draft DFA.) A separate grant agreement will be signed with TongaHealth (Annex 10). The separate agreements are to allow for flexibility and to mitigate the risk of funding delays to TongaHealth due to under-utilisation by the Ministry of Health or vice versa. Although the administered funds will be regulated through separate agreements, funding to the health sector will be considered as a whole over the five years of the program.

The overall budget is \$10 million over five years, broken down as follows:

- \$120,000 per year top-sliced for management costs (Post's time and travel, accountancy, audit etc.)
- Up to \$400,000 allocated to TongaHealth in the first year. Thereafter this allocation will be reviewed annually.
- \$1 million total reserved for performance based payments to Ministry of Health.

This leaves about \$6.4 million to be allocated against the Ministry of Health's Annual Management Plans (depending on the exact amounts allocated to TongaHealth in later years) to support NCD prevention and management, health systems strengthening and disability/mental health. This averages out at just over \$1.25 million per year, although the design is deliberately

flexible about how much is spent each year. The need for flexibility is particularly important in Year 1, when it is most difficult to estimate spending levels and some activities will be slow to start. We do, however, know that a much greater proportion of the budget will be spent on Technical Assistance in the earlier years than in subsequent years. A maximum of \$500,000 annually could be spent on three Technical Assistance posts during the first half of THSSP2:

- **A Health Systems Support and Planning Manager** (ca \$290,000 for one year). The overall purpose of this post is to support the Ministry of Health and TongaHealth to develop well-functioning cycles of planning-budgeting-implementation-monitoring.
- **An NCD/Health Promotion Strategic Adviser** for *Hala Fononga*, the NCD Strategy (ca \$150,000 per year). This post will support the planning, implementation and evaluation of health promotion activities, with close reference to international evidence about effectiveness.
- **A public/primary health consultant** (ca \$60,000 per year). The overall purpose of the post is to support the Public Health Division of the Ministry of Health to operationalise Universal Health Coverage at the primary care level. The public health specialist will report to the Head of the Public Health Division. TORs for these posts are given in Annex 11.

If necessary, these positions can be supplemented by short-term TA funded through the \$120,000 management costs per year. One possible need is for some financial management expertise to complement the skills of the Health Systems Support and Planning Manager. The job description for this post requires a very broad range of skills, which it might not be possible to find in one individual.

It is envisaged that there would be less need for Technical Assistance in the second half of THSSP2: however there is flexibility about this. The experience in Solomon Islands (where it took a longer duration of TA to improve planning processes than had initially been thought) is acknowledged. The Ministry of Health, TongaHealth and DFAT will discuss the need for TA as the Program develops – if necessary, more TA can be included in work-plans.

Table 4A shows the overall budget for Year 1 and shows how this might change in subsequent years. Table 4B breaks down the management costs. These are only indicative costs: figures can change depending on technical assistance and Post requirements throughout the life of THSSP2.

**Table 4A THSSP2 budget for Year 1 and indicative budget for subsequent years**

Item	Year 1	Years 2-5
Ministry of Health work-plans	Approximately \$1,000,000	Exact allocations will depend on performance and what remains from the items in the rows below. Amount available will rise if TA reduces over time.
TongaHealth work-plans	Approximately \$400,000	Exact allocations will depend on performance
Technical assistance	Approximately \$500,000	Need for ongoing TA will be assessed in Year 2. Spending



		may well decrease over time.
Management costs	Approximately \$120,000	Up to \$120,000 each year
Performance incentives	Up to \$120,000 at end of year	To total no more than \$1 million over the five years. Not spread evenly over the duration of THSSP2, as more allocated at time of Independent Progress Report and towards end of the Program.
<b>TOTAL</b>	<b>Approximately \$2,140,000</b>	<b>\$10 million over 5 years.</b>

**Table 4B: Breakdown of Management Costs (Indicative only)**

<b>Year</b>	<b>2015-16</b>	<b>2016-17</b>	<b>2017-18</b>	<b>2018-19</b>	<b>2019-20</b>
Research and Mid-term review			A\$100,000		A\$54,000
Internal Annual Audit of Program (TH and MOH)	A\$5,000	A\$5,000	A\$5,000	A\$5,000	A5,000
Short Term TA if required (TH financial consultant support, PFM support etc.)	A\$80,000	A\$60,000	A\$40,000	A\$41,000	A60,000
Post travel and management costs (if required for fieldwork, training etc.)	A\$20,000	A\$20,000	A\$10,000	A\$10,000	A\$10,000
Total	A\$105,000	A\$85,000	A\$155,000	A\$56,000	A\$129,000
<b>TOTAL COST</b>	<b>A\$530,000</b>				

The budget is allocated each year in March against work-plans (called “Annual Management Plans” (AMPs) in the Ministry of Health). The allocation decisions are made by the National Health Development Committee for the MOH funds and by the TongaHealth Board for TongaHealth’s funds, with DFAT present at both meetings for the relevant agenda items. The Annual Management Plans are developed by sections within the Ministry of Health and then collated into six divisional AMPs. The organisational structure of the Ministry is shown in Figure 1. AMPs will need to be submitted two weeks before NHDC and TongaHealth Board meetings to allow time for scrutiny.

There is already a system within the Ministry for quarterly reports based on AMPs. However the system does not work well and not all sections report. THSSP2 aims to support the improvement of the system in terms of completeness and in the way that the NHDC and divisional heads respond to the information about activities and expenditure in the quarterly reports. These

processes of planning, budgeting and reporting take time to develop – THSSP2 has a strong focus on systems improvement, supported by TA. This support is partly about the systems themselves, but is also about *what* is funded. DFAT will make the case for spending on evidence-based interventions that take into account the needs of males and females, the more remote communities in Tonga and people with disabilities.

DFAT will base its six-monthly tranche releases on the work-plans and the quarterly reports about activities and expenditure. Once the work-plans have been approved by the NHDC or TongaHealth Board, there will be a stage for formal DFAT approval. Although the content of the work-plans should already have been discussed thoroughly at this stage, this gives DFAT the formal opportunity to decline funding for anything which it deems unacceptable.

Throughout the process, DFAT staff will assure themselves that financial management is in accordance with the relevant Tongan and Australian legislation and rules, including the Public Governance, Performance and Accountability (PGFA) Act.

Tonga is vulnerable to natural disasters and it is important that there is enough flexibility within THSSP2 to respond to **emergencies**. As described in Table 1a, during THSSP1 the Flexible Fund was used to respond quickly to the effects of Tropical Cyclone Ian in 2014. In exceptional circumstances, an emergency meeting of the NHDC can be called (or at least as many members as are available in the circumstances) and recommendations made about funding for emergency needs. This provides a valuable response mechanism which is flexible and rapid. Funds can be re-directed quickly, with a later decision about whether this will ultimately be paid for through re-prioritisation of the existing THSSP2 budget or through a top-up from DFAT. This is an important part of overall disaster preparedness planning in Tonga. To ensure that this arrangement is not misused, the Ministry of Health and DFAT will need to agree at any emergency meeting that the circumstances are indeed exceptional and that it is reasonable to treat the situation as an emergency. This will be considered by DFAT on a case by case basis with approval required from appropriate delegate (as per the PGPA Act).

An innovative aspect of THSSP2 is that \$1 million (over the five years) of the budget will be reserved for **performance based payments** to the Ministry of Health. The money will be allocated in two ways:

- Up to \$600,000 allocated by a small team of 3-4 senior managers (including DFAT representation) meeting annually in April, based on the Annual Management Plans and quarterly monitoring reports.
- Up to \$400,000 based on the findings of the Independent Progress Report (IPR) in late 2017 and towards the end of THSSP2 in 2019/20 based on the extent to which the targets have been achieved and the recommendations of the IPR have been implemented.

Incentive payments can be made to divisions or sections (the divisions vary greatly in size) and all recipients will be encouraged to spend the money close to the “front line” – for example the Public Health Division could reward some well-performing health centres. Recipients will be asked to describe how the money will be used in a simple addendum to their annual work-plan. The subsequent quarterly report will record how the incentive payments have been used.

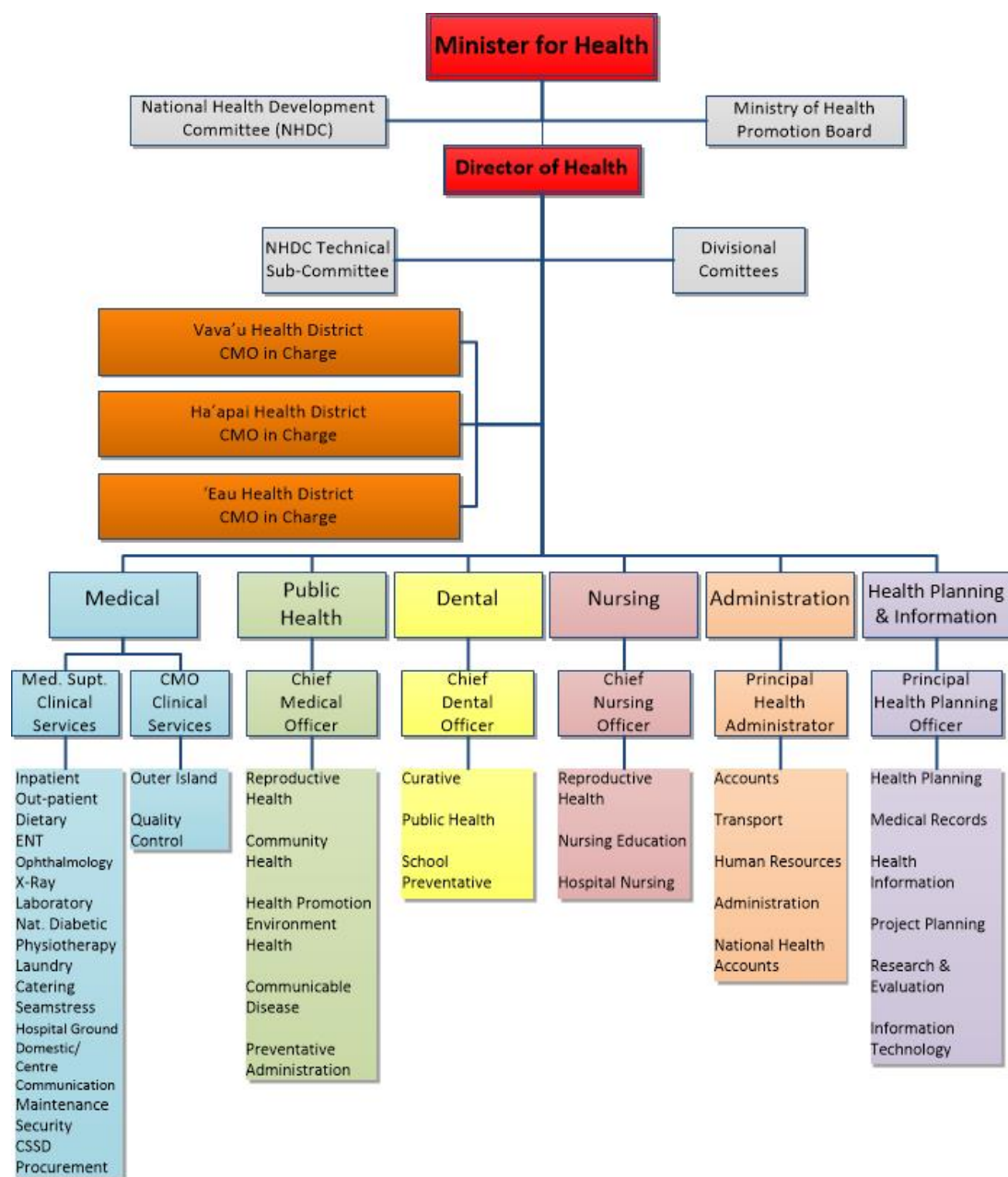
Draft guidelines for the allocation of performance-based payments are given in Annex 7.

Table 5 summarises the main planning, reporting and financing events in the annual calendar. Figure 2 presents key timings in the form of a flow diagram.

Although the bulk of DFAT funds go directly to only two organisations – the Ministry of Health and TongaHealth – many other organisations will benefit indirectly by receiving funds from TongaHealth and, to a lesser extent, the Ministry. TongaHealth is essentially a funding and co-ordinating mechanism which passes on grants to other organizations (government and non-government) doing work in relation to NCDs (see Figure 4 later in the document). The Ministry of Health also funds activities by other organisations, notably the St. John of God Hospital Ballarat, with which it has a long-standing twinning arrangement. Allocations to other organisations can take place as long as they are approved as part of a work-plan.

The inclusion of TongaHealth as a significant recipient of funds based on their plans is an innovative aspect of THSSP2. It is notoriously difficult to organise a multi-sectoral response to a health issue such as NCDs – Ministries of Health (which are often junior ministries) typically struggle with this aspect of their remit. The creation of a Foundation such as TongaHealth, with backing from the national Cabinet, is an attempt to tackle this challenge in a different way. After a faltering start, the role of TongaHealth has been formally clarified in a Memorandum of Understanding – THSSP2 offers TongaHealth the opportunity to demonstrate the extent to which it can interest other governmental and non-governmental institutions in contributing to the control of NCDs.

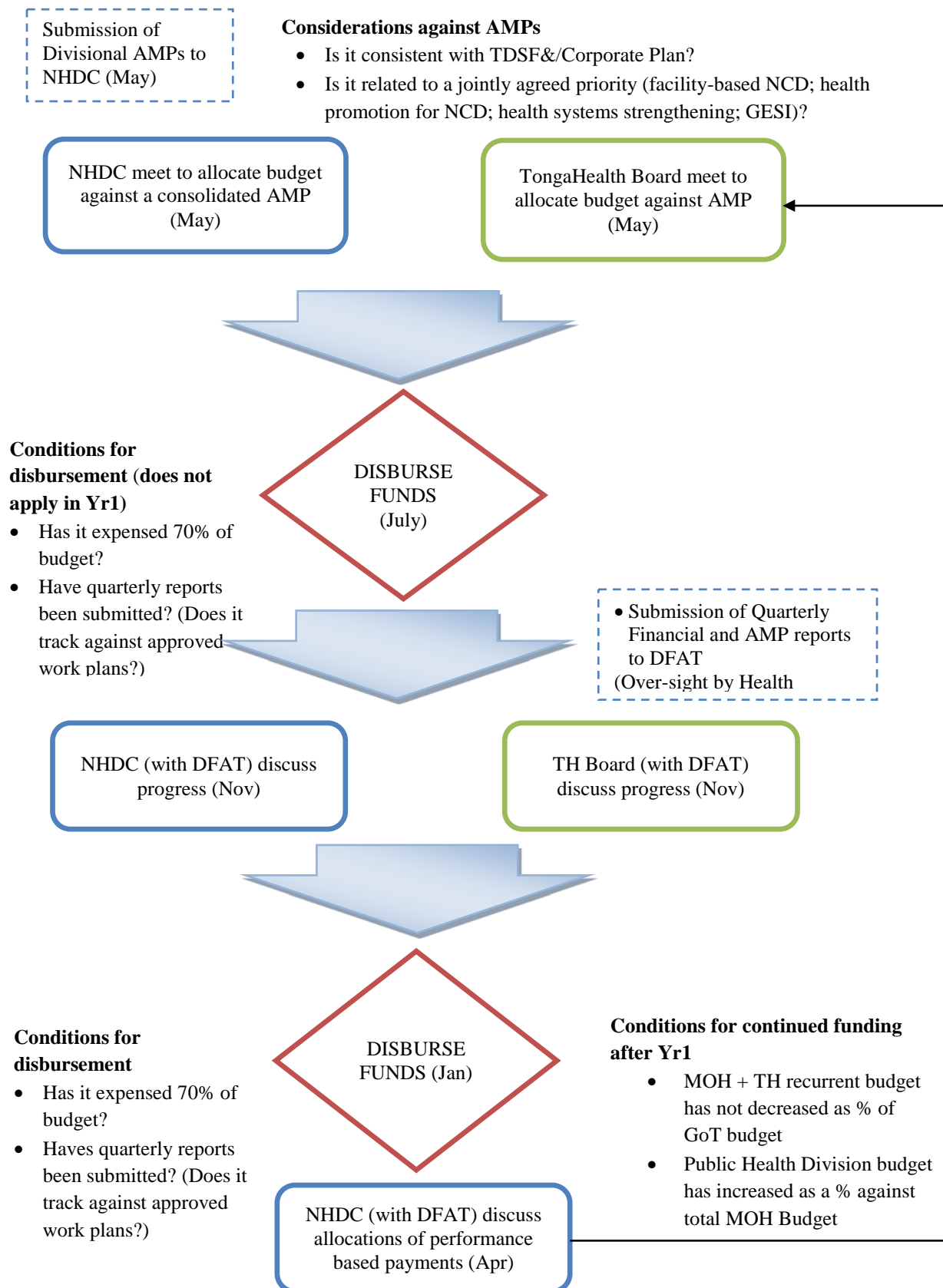
Figure 1 Organisational structure of the Ministry of Health



**Table 5 Planning, reporting and financing events in the annual calendar**

Tasks	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
NHDC discusses monitoring reports												
Panel decides Performance-Based payments for the year												
DFAT Funding Disbursements												
Financial acquittals and narrative reports (3 <sup>rd</sup> week of month)												
Procurement plan												
GOT to confirm budget for FY (relevant to conditions for funding)												
External Audits (for MOH and TongaHealth)												
MOH Planning Week (“Week of Love”)												

**Figure 2 Key timings**



## Resources

The budget has been described in the previous section. Procurement will be through standard Government of Tonga procedures. Specialist procurement (e.g. pharmaceuticals) would need to involve the appropriate professional. TA could be procured in a number of ways: directly, by the Ministry of Health or TongaHealth, through DFAT's Health Resource Facility or through the Pacific Technical Assistance Mechanism (PACTAM). Whichever route is used, the Ministry of Health and/or TongaHealth would need to be involved with the process and there would need to be agreed processes for the assessment and review of the recruits' work.

THSSP2 has implications for the staffing of the DFAT Post. THSSP2 aims to reform and strengthen critical functions related to the governance and management of the health sector, i.e., planning, budgeting and monitoring. As such, it will require sustained engagement from a number of people in the DFAT post. DFAT interlocutors will need the capacity and authority to discuss strategic issues with members of the MOH executive; to sustain a policy dialog about priorities, equity and the quality of management; and to review progress and work through the inevitable challenges as they arise. DFAT will regularly attend meetings of both the National Health Development Committee and the TongaHealth Board and will contribute to discussions about the direction of the work-plans and specific funding requests. DFAT will also be a member of the panel which will allocate performance payments each year. This work will need to be led by the locally-engaged (LES) Health Program Manager and the Second Secretary (Development), with support from the Head of Mission (HOM) and Deputy HOM as required, backed up with input by the Director, Pacific Health Advice based in Canberra. Support will also be provided as required by the Public Financial Management Advisory Services section, on the implementation of the PFM aspects of the program. It is anticipated that the Health Program Manager will need to spend 90% of her/his time on this investment, supported by the Second Secretary as 70% of their role. Engagement in the first year of the program will be particularly critical, as this investment represents a new way of working for post. While the implementation of the program will be supported by long-term TA, the ultimate responsibility for keeping the strategic intent of the program on track rests with DFAT: the Deputy High Commissioner, Second Secretary and Health Program Manager all have key roles in this regard. Heightened engagement in the first 12-18 months is anticipated.

## Program Logic and Expected Outcomes

This section begins by describing key features of the results chain: the full table of indicators is given in Annex 12. The section then moves on to describe the Program Logic underpinning THSSP2.

### *Indicators of results*

There are five targets (with associated outcome indicators) to be achieved by the end of THSSP2. Two are directly related to NCD risk factors and health status, one is about cost efficiencies and universal coverage, one is linked to system strengthening and one relates to addressing gender equity and social inclusion:

1. Decrease in percentage of population at high risk of developing an NCD, for both males and females. (Risk factors are diet, inactivity, smoking and alcohol abuse.)
2. Downward trend in the rates of premature deaths and preventable disability<sup>17</sup> related to NCDs in men and in women.
3. NCD management as part of Universal Health Coverage leads to cost savings in hospitals.
4. Strengthened health system management, including planning, financial management, implementation, monitoring, health information, procurement and human resources.
5. Development of GESI as a cross-cutting issue: at least 80% of annual plans from the Ministry of Health and TongaHealth reflect GESI considerations. (The most relevant GESI considerations for THSSP2 are gender, geographic equity, and inclusion of disabled and mentally ill people.)

This is summarised into one over-arching objective (or vision): **a more effective, efficient and equitable health system which reduces the burden of non-communicable diseases in Tonga.**

The first and second targets about NCDs and mortality are linked to the WHO Global NCD targets.

The reason for including the third and fourth targets (cost efficiencies and strengthened systems) is the significant economic and social burden of NCDs. It is vital that the Government of Tonga controls the escalating costs of NCDs. Cost efficiencies will be measured through management of NCDs in primary care: for example, reductions in amputations due to diabetic foot syndrome, reductions in hospital length of stay (due to better diabetic care) and fewer hospital admissions for preventable aspects of NCDs. Universal Health Coverage will be promoted through the development of an Essential Health Package for health facilities across Tonga. Endorsement of the Health Centre Operational Manual (currently in draft form and being reviewed) will also contribute to equitable health services.

Strengthened health systems will be measured through progress in the areas of planning, implementation, monitoring, and human resources, with particular interest in the area of public financial management and specifically in procurement. (In March 2015, Vaiola hospital experienced a 3-6 month stock-out due to improper planning leading to procurement delays.) Strengthening the processes around planning and budgeting should contribute to better and faster procurement.

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<sup>17</sup> As mentioned in an earlier reference, preventable disability for THSSP2 is here defined as cases of diabetic retinopathy, limb amputation (related to lack of diabetic control) and different stages of renal failure (as per data collected by the Diabetes Clinic)..



The final outcome indicator reflects the importance of including gender, equity and social inclusion (including mental health and disability) as cross cutting issues around MOH and TongaHealth activities.

When translating these overall objectives into specific THSSP2 indicators, care was taken to focus on indicators included in existing government plans whenever possible and to ensure that the indicators could actually be measured. Although the indicators do not directly match the Global NCD Action Plan (because it was not possible to guarantee that information about the global targets would be available with the frequency required for THSSP2 monitoring), the targets around NCDs have been aligned as closely as possible to global targets. Targets around NCD primary and secondary prevention have also been aligned to the extent possible with the WHO PEN package clinical targets, as well as the indicators in the relevant MOH section plans. The indicators included here together provide a good overview of Tonga's progress with tackling NCDs.

It is important to stress that responsibility for achieving the THSSP2 targets is shared amongst the Ministry of Health, TongaHealth, DFAT and (to a lesser extent) many other stakeholders in Tonga. THSSP2 works through the Ministry of Health's systems and relies on activities delivered by MoH staff. This is not a separate and discrete project which can achieve all its targets acting in isolation: the model of shared responsibility is integral to the design of THSSP2 because we know that separate projects about NCD will not be sustainable.

Another important point about the targets is to appreciate how ambitious it is for a five-year Program to aim for a downward trend in the rates of premature deaths and preventable disability and for a decrease in the percentage of population at high risk of developing an NCD. (Risk factors are diet, inactivity, smoking and alcohol abuse.) It is ambitious because the current population of Tongans is already a "time-bomb" in terms of having extremely high chances of developing NCDs. The really significant drops in NCD rates will not be possible until a generation of Tongans has adopted healthier lifestyles. The priorities at the moment are to make sure that this generational shift happens, and that the health sector is able to manage the inevitable NCD burden as cost-effectively as possible.

The target related to reduced premature death is deliberately ambitious. If nothing is done, NCD rates will soar; even reversing this upward-spiralling trend will be an achievement. It is vital that Tonga develops the decision-making processes and systems to tackle NCDs effectively. Without this, Tonga's overall development will be hampered by lost economic productivity through early deaths and chronic illness, and by escalating health care costs. Working through the hierarchy of outcomes described in Annex 12 entails focusing on doing the right kinds of things to reduce NCDs – for example prevented hospitalisations show that the systems are in place to manage NCDs more efficiently (thus avoiding public spending on these hospital stays). The targets are ambitious because Tonga needs to be ambitious in this area. However it is important that any evaluations of THSSP2 focus on whether the right things – and enough of the right things – are being done to tackle the NCD crisis. It is always a possibility that prevention and treatment activities are carried out extremely well, but that the damage already done to the health of middle-aged Tongans (in terms of unhealthy lifestyles) means that five years is too short to impact on rates of premature death.

As discussed, the indicators for THSSP2 capture the impact of activities by many organisations working together in partnership, notably the Ministry of Health, TongaHealth and DFAT. If DFAT

wishes to attribute any changes to its contribution, a method can be agreed with the Ministry of Health to do this. The general approach is to calculate the percentage of total Ministry of Health and TongaHealth expenditure funded by DFAT. This percentage is then taken as DFAT's contribution to the changes identified. This is obviously an over-simplification (wider forces are at work that influence, for example, obesity rates), but it is a reasonable one.

### *Program Logic*

Two diagrams are presented in Figure 3 to illustrate the overall logic underlying THSSP2. The first, more detailed diagram shows the levels of building blocks which gradually blend together into the five work-streams of THSSP2 (as reflected in the five indicators on the “targets” line of the diagram):

1. health promotion
2. management of NCDs
3. primary health care
4. health systems strengthening
5. GESI as a cross-cutting issue.

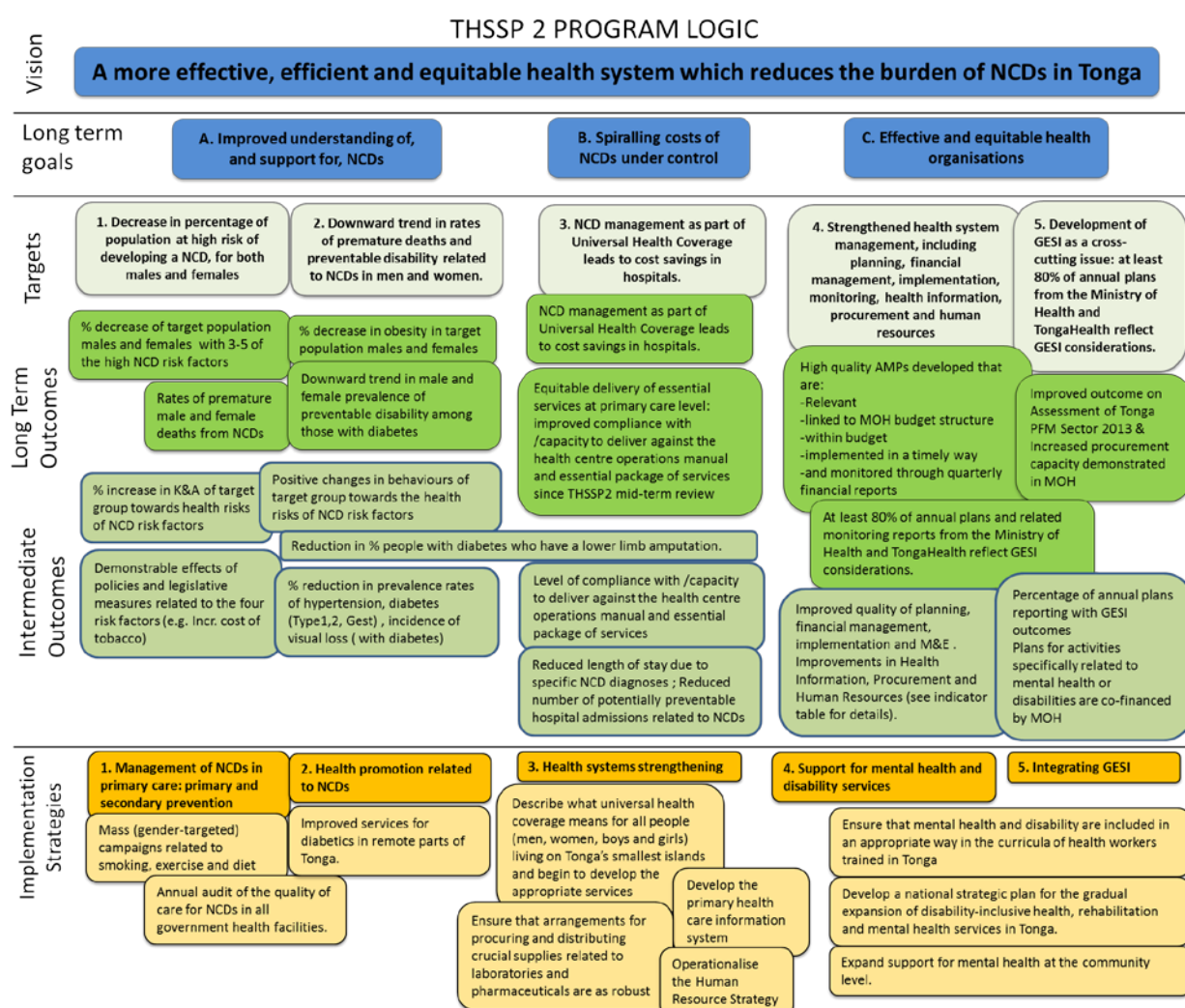
The first two work-streams – **health promotion** and **management of NCDs** – are evidence-based, prioritised technical responses to NCDs. The third – **primary health care** – is about ensuring that the NCD activities have an institutional home in health facilities. This is important for sustainability and to ensure that a focus on NCDs does not harmfully displace other priority interventions such as Maternal, Neonatal, Child and Reproductive Health. The other important part of the primary health care work is improving the capacity of primary care facilities to do their job properly. If primary care facilities are ineffective, some people miss out on services altogether and others go to hospitals, which are more costly.

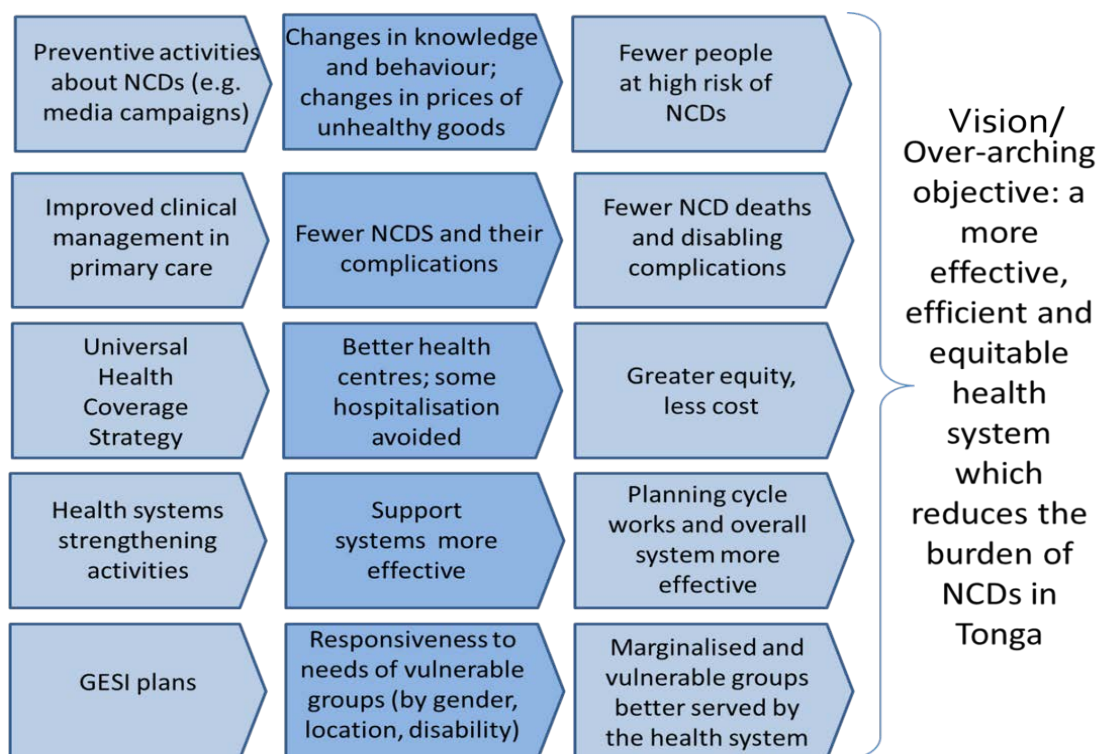
The delivery of health interventions relies on a number of support systems working effectively. These include planning, financial management, reporting, health information, procurement and human resources. A health service cannot be effective without all of these support systems working well. The fourth work-stream is about the **strengthening of these support systems**.

Groups in the overall population which use health services least can be the very groups which need the services most – examples are geographically isolated populations, people with disabilities, including mental illness and (in the Tongan context) middle-aged men who are reluctant to use health services, but who are at very high risk of developing NCDs. The fifth strand of work is about influencing ways of thinking so that activities are planned from the outset to be **inclusive and responsive to the needs of vulnerable groups (GESI)**.

THSSP2 is based on the assumption that these five strands of work are all necessary to achieve the vision of a more effective, efficient and equitable health system which reduces the health and economic burden of non-communicable diseases in Tonga. This is shown in a highly simplified form in the second diagram in Figure 3.

Figure 3 Depictions of program logic for THSSP2





The assumptions for each individual work-stream are:

1. Health promotion: activities lead to changes in behaviour significant enough to have a health impact (as well as changes in knowledge and attitudes), and the behavioural changes are measured and recorded.
2. Management of NCDs: the improvements in management of NCDs are enough to have an impact on mortality and disability, even though there is an underlying increase in the numbers of people with NCDs in the short-term (because of the ageing of people who have already behaved in a risky way). As discussed above, this is a deliberately ambitious assumption.
3. Primary health care: health care can improve in all facilities, including those which are currently the weakest; these improvements will reduce the projected number of hospitalisations because some complications will be prevented.
4. Health systems strengthening: working with the various support systems will have an overall effect on the functioning of the system in terms of having the right resources in the right places at the right time, meeting the most pressing health needs.
5. GESI as a cross-cutting issue: the design of THSSP2, plus continued advocacy by DFAT, will increase awareness of, and responsiveness to, the needs of vulnerable groups.

It is a DFAT requirement to have some form of independent evaluation at least once in the lifetime of a program. The most useful for THSSP2 would be to have an Independent Progress Report (IPR) mid-way through the Program in late 2017. The description above of the program logic will be referenced in the TOR for the IPR. Although it will be too early to analyse all the stages of the results chain, this will be a good opportunity to see if the underlying logic still appears sound half way through the implementation period.

The IPR will complement the annual Regular monitoring will be conducted annually against the Monitoring and Evaluation Framework, which will be reported to both DFAT and MOH management.

## **E: Implementation Arrangements**

### **Management and Governance Arrangements and Structure**

THSSP2 is considered as a whole but will be funded through a Direct Funding Agreement with Government of Tonga and a separate Grant Agreement with TongaHealth. The National Health Development Committee and the TongaHealth Board are the crucial governance structures for THSSP2.

The terms of reference and membership for the NHDC are given in Annex 4. Planning, budgeting and monitoring are already part of the existing TOR, though the nature of the decisions will change when THSSP2 is implemented. The main differences will be that there will be a much bigger non-salary recurrent budget to allocate and the Annual Management Plans should be more comprehensive (i.e. coming from all sections of the Ministry) and should include more details about planned activities and expenditure.

The main functions of the **NHDC** in respect of THSSP2 will be to:

- **Allocate funding** against AMPs and according to the agreed priorities for THSSP2, with DFAT participating in discussions (annually, and twice in year 1). Guidelines have been developed to assist with this process (see Annex 4; the guidelines can be adapted for use by TongaHealth).
- Receive, discuss and act on the **quarterly monitoring reports** about activities, achievements and finance from the six Divisions; thoroughly discuss any major problems with implementation and identify solutions. In collaboration with DFAT, funds can be removed from areas which are under-spent, or in other ways problematic and, if appropriate, allocated to another Division or Section.
- Regularly review and approve the **procurement plan** (which can be updated as frequently as monthly).
- Ensure that Ministry of Health funding is available for **activities to be continued after the end of THSSP1**, notably Critical Staffing Deficiencies and equipment maintenance.
- Ensure that gender, equity, social inclusion (**GESI**), **disability and mental health** are mainstreamed: in other words the access needs and barriers to inclusion of both women and men, and of vulnerable or marginalised groups including people with disability, are considered in planning and reporting, and not restricted to separate projects.
- Be aware of the **risk register** and discuss it at least quarterly, updating risks as appropriate and identifying mitigation measures, including the timing of these measures and who is responsible for implementing them.
- At least once per year discuss the **performance-based financing** scheme, comment on whether it is working well and, if appropriate, recommend possible changes to how the scheme operates.
- Ensure that collaboration and the division of labour with **TongaHealth** is effective. (The TongaHealth Board and NHDC have some members in common.)

Whilst the main discussions about THSSP2 will happen at the NHDC five times per year (at the budget allocation meeting and the four quarterly report discussions), important THSSP2 issues can be discussed at any of the NHDC's monthly meetings. In particular, financial information and procurement plans will be available monthly, and these should be reviewed at each meeting.

It is the responsibility of the Health Planning and Information Division to collate the quarterly reports for the NHDC, but Heads of Division remain responsible for the content of their reports. The Joint Budget Team, with membership from the Planning and Administration Divisions, advises the NHDC about priorities for funding.

Annex 4 includes TORs and membership for the MOH Budget and Finance Committee (B&FC), whose responsibilities include considering expenditure proposals, developing budget strategies and monitoring expenditure, and subsequently reporting up to the NHDC. If operating as intended, the B&FC will play a pivotal role in oversight and management of THSSP funding, which should be considered as part of the total resource envelope available to the MoH. The B&FC includes representation at the operational level from across the MoH, so it will also be an



important vehicle for promoting and implementing systems strengthening components of THSSP, including improved planning, budgeting and financial monitoring practices. It is important that the relative responsibilities of the NHDC and the B&FC are clear, including transparency regarding how the major decisions related to DFAT funds are made and monitored.

It is recognised that a lot is expected of the NHDC and that this is not without its risks. The NHDC is used to dealing with these *kinds* of issues, but perhaps not with the rigour that will be expected for DFAT funds. The TA posts funded by THSSP2, especially the Health Systems Support and Planning Manager, can support the Planning Division as it develops its role of Secretariat to the NHDC. (The Manager's TORs are given in Annex 11.) Funds from the Health Systems Strengthening component can be used, if appropriate, to help with measures to support the NHDC with the tasks listed above.

As outlined in the National NCD Committee/TongaHealth Memorandum of Understanding (Annex 5), it is the responsibility of the **TongaHealth Board** to approve TongaHealth annual plans and budget. Annex 13 gives the TOR for the TongaHealth Board. For DFAT funds, its role is comparable to that of the NHDC, although TongaHealth will not receive performance-related incentives. The Board's situation is similar to that of the NHDC: it has dealt with these *kinds* of issues before, but not necessarily at the scale of this DFAT funding. Moreover DFAT and the Board have not worked together before; this is different from the NHDC/DFAT partnership, which has had the opportunity to mature over time. The importance of the Board's role is recognised, and care will be taken to ensure that it receives appropriate support.

It is the responsibility of TongaHealth to make sure that the National NCD Committee (NNCDC) is kept informed of key decisions, and is given the opportunity to influence them. The NNCCDC consists of senior members of organisations that do work relevant to the major NCD risk factors – for example, the Ministry of Agriculture, which has clear links to nutrition.

The DFAT-funded Health Systems Support and Planning Manager will be assigned the role of THSSP2 liaison officer, so that there is a clear route for DFAT's communications with the Ministry and vice versa. The same applies to TongaHealth. Each organisation will be asked to name a counterpart for the Planning Manager.

## Implementation Plan

In October 2014, the Tonga National Health Development Committee made choices about the overall design of THSSP2, based on the Investment Concept Note. Since then, there have been a number of promising developments that show some commitment to strengthening the Ministry's planning cycle:

- Work-plans were discussed extensively at the Ministry's Planning Week in December 2014. For the first time, DFAT was invited to attend this week as an observer.
- Some significant organisational anomalies are being rectified, notably the management of primary health care facilities moving to the Division of Public Health.
- There have been detailed discussions about monitoring the Corporate Plan and THSSP2.

Year 1 will be a crucial year because of the new system of allocating DFAT resources according to work-plans and because the Ministry (and to a lesser extent TongaHealth) must begin to absorb activities funded under THSSP1, which are not priorities for THSSP2. For this reason, efforts have already begun to fill the TA posts as early as possible in THSSP2's lifetime: it seems reasonable to assume that the three full-time posts (Planning Manager, Public/Primary Health Consultant and NCD/Health Promotion Strategic Adviser) will all be filled within the first three months. Currently, the procurement of the Planning Manager is well under way and should be available to start mid-late June. The other two positions will be recruited through the Ministry of Health and will be subject to the Ministry's own procurement processes and procedures with DFAT support.

For the new system of resource allocation based on work-plans to begin, key steps need to be taken at the right time. Assuming that the DFAT budget release happens in July 2015, the NHDC can meet shortly thereafter and issue guidance to Divisions about budget ceilings for 2015/16. This in turn may lead to some revised Annual Management Plans. (Because AMPs have historically been written in the context of very small amounts of non-salary funding, it is only reasonable to provide guidance on the new financial situation.) The first round of funding decisions could be made around May. To allow for the fact that this is the first year of working in this way, a second round of funding decisions based on work-plans will be held in November 2015. (The situation for Tonga Health will be similar. For the first year it knows that its budget will be a maximum of \$400,000.)

To ensure continuity of funding and eventual absorption into the Ministry of Health budget, activities funded by THSSP1 that the Ministry intends to continue need to be included in Annual Management Plans. For some sections (e.g. biomedical engineering) this will be the first time they have written an AMP, and other sections will need to include items which previously THSSP1 provided without involving them in the procurement (e.g. drugs for the National Diabetes Centre). Much of the support for the new cadre of NCD nurses was also managed through THSSP1, so it is important that each function is included in the appropriate AMP: for example the information submitted by the NCD nurses on screening and other activities should be managed by the health information section. It is accepted that it will be too late in financial year 2015/6 to absorb some activities from THSSP1 into the Ministry's budget and that some of the Year 1 DFAT funds can be used to ensure that there is no break where continuity is important. THSSP1 funded a wide range of activities including drug procurement, laboratory supplies, equipment maintenance and a twinning arrangement: Year 1 can be used to ensure that funding for the critical inputs is incorporated in the MOH budget.

There are two particular areas of funding from THSSP1 that need to be managed carefully.

At the time of writing there are five **Critical Staffing Deficiency (CSD)** appointments. Over time, the CSD budget has been used to fund long-term employment and short-term locums. One effect of long-term Australian funding is that the full cost of the national hospital is not made clear to Cabinet and the Ministry of Finance and National Planning. Tonga is too small to be able to continuously fill all its specialist posts from within the country – even with excellent Human Resources planning, there is likely to be a long-term need for some international recruitment. Moreover such recruitment is technically valuable, because it allows for new ideas to be introduced.

Although Tonga has a good track record in the recruitment and management of individual CSD posts, there is a need for stronger HR planning for scarce skills and Government of Tonga funding needs to be secured, which will probably require discussion by the Cabinet. THSSP2 can support these HR activities through its Health Systems Strengthening component. Individual CSD posts need to be placed within wider plans for securing vital technical skills, including



consideration of local capacity-building requirements. These HR plans can be thought of as a longer-term “exit plan” for external CSD funding. Under THSSP2, CSD posts will only be funded as part of wider HR and capacity-building plans.

It is not only the posts supported by CSD funding which are important to THSSP2. Other senior management posts – for examples the Heads of Planning and Public Health – are crucial to the success of the Program. It is important that Human Resource plans think through succession planning for all key posts. In a country as small as Tonga it is always difficult to build resilience against the employment moves of individuals, but good planning has an important role to play.

For the **maintenance and repair of equipment**, the main issue is that there is no budget that is unambiguously allocated to the management of equipment. (The existing “maintenance” budget is in practice used as a general contingency fund.) AMPs need to be submitted through the Medical Division and the Ministry needs to develop the discipline of allocating sufficient funds for the upkeep of vital equipment.

The budget allocation for the Ministry of Health includes about \$420,000 to cover CSD posts. A practical advantage of the staged absorption of THSSP1 activities is that it spreads the risks for THSSP2. In year 1, a good percentage of funds will be used to continue with priority THSSP1 activities: this is relatively low risk. This acts as a counter-balance to the fact that in other respects year 1 is a high-risk year as the new system of allocating and managing funds is introduced.

In addition to these issues that have run over from THSSP1, there has recently been a renewed focus on **drug supplies**, following a period of serious stock-outs (for example problems with the continuous supply of insulin for diabetics). In the first half of 2015 the Government of Tonga requested the Governments of Australia and New Zealand to help with improving drug supplies. At the same time as THSSP2 was being designed, technical assessments were made of the drug supply situation and recommendations were being developed. Strengthening drug supplies is entirely compatible with the health systems strengthening aims of THSSP2 and critical for managing of NCD related illnesses. Requests for funding to implement the recommendations can be included in the Annual Management Plans which are the route to accessing DFAT funds for THSSP2. (There will be two rounds of funding in 2015/6, so there need not be long delays with this.) This is a high-profile issue in Tonga and, given that Government of Tonga itself initiated the process, it is reasonable to assume that the commitment to improving drug supplies will be sustained. As it also affects management of NCD related illnesses, it will also have implications for delivery against THSSP2 outcomes.

## Financial management arrangements

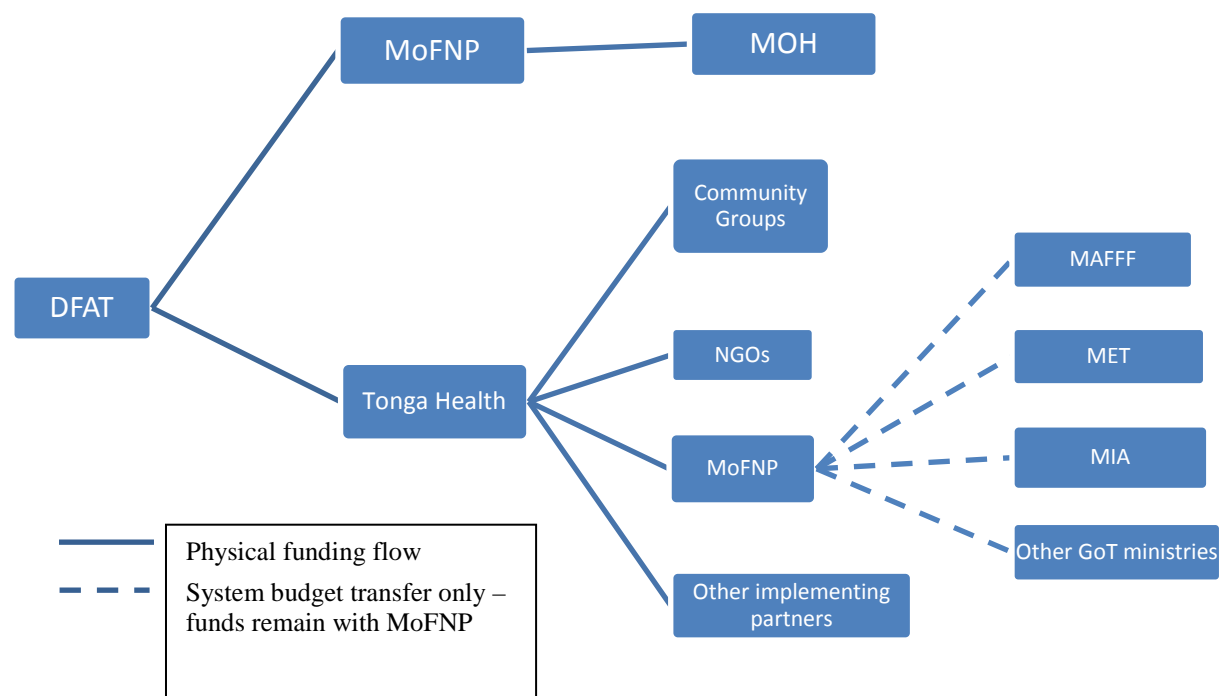
### *Funding flows*

THSSP2 funds will be deposited by DFAT into the Government of Tonga General Development Account and the TongaHealth account, both held at the Westpac Bank of Tonga. Per the Tonga Public Financial Management Act, all funds for activities to be implemented by the Ministry of Health will remain in this account and will be administered by the Ministry of Finance and National Planning (MoFNP), with payment processing undertaken by the MoH, as described below under ‘Responsibility for financial management’.

TongaHealth will oversee the implementation of THSSP2 activities through grants provided to a range of implementing partners, as illustrated in Figure 4. For grants to Government line ministries, payments must be deposited into the General Development account at the MoFNP,

which will subsequently allocate the relevant budget to the selected implementing ministry, with TongaHealth as the donor. For all other implementing partners, TongaHealth will provide a cheque to the selected partner (community groups, NGOs etc.), in accordance with the TongaHealth Grant Making Policy.

**Figure 4 - THSSP2 funding flows**



## Ministry of Health

### *Responsibility for financial management*

For the first year of the program (2015-16), all payments for the program will be managed by the Program Finance Officer, under the direction of the Deputy CEO for Administration. During this transition year, the Program Finance Officer should liaise regularly with the Accounts section under the Deputy CEO, Administration, to ensure consistency of budget structures and financial coding, and to enable consolidation with the whole of MoH financial management and reporting.

The Program Finance Officer will also work in close collaboration with the Project Co-ordinator who will provide oversight of DFAT funding within the Ministry of Health. It is a transition role intended to absorb and appropriately transition the previous role that the Program Central Unit (PCU) had managed through the Assistant Program Manager's role. Both roles will also work in close collaboration with the DFAT funded Health Systems Support and Planning Manager.

From 1 July 2016, it is expected that the position of Program Finance Officer will be transferred to the Accounts section under the Deputy CEO, Administration, with an additional MoH post created for this role. This approach was endorsed by the NHDC in March 2015.

The Program Finance Officer will liaise with the DFAT-funded Health Systems Support and Planning Manager, who will have oversight of how well the financial management arrangements are fitting into the planning cycle as a whole.

Payment approvals and processing procedures for activities funded by DFAT should be undertaken in accordance with the relevant Government of Tonga Public Financial Management legislation and regulations. Refer to the procurement section below for a detailed description of procurement arrangements for the program.

For the first year of the program, payment approvals and processing will be undertaken in accordance with the current arrangement for all donor programs in the Ministry of Health. The Head of Sections (HoS) and Head of Divisions (HoD) are responsible for developing their AMPs with associated budgets. When the activities are ready to be implemented, the HoS, with the endorsement of the HoD, writes to obtain approval from the CEO for implementation, with detailed costing. This approval is subsequently forwarded to the Program Finance Officer to process orders and payment vouchers, which are then endorsed by the Principal Health Planning Officer (PHPO) and finally approved by the CEO to proceed with the payment. After the first year of transition for the program, as noted above, the Program Finance Officer will shift to the Accounts section.

#### *Budget allocation and use of SUN accounting system*

An important change in the way that THSSP2 will be managed compared to THSSP1 is that the budget and expenditure allocation will be fully integrated with the existing budget structure of the MoH. Previously, under THSSP1, all funding was allocated to one activity in Program 6, Health Planning and Information, regardless of the specific activity which the funds were spent on. Detailed financial records were maintained using external accounting software – Quickbooks – thus creating a parallel financial system solely for management and reporting on THSSP1 funding. This limited the ability of the MoH and DFAT to perform timely analysis of THSSP1 expenditure to see if program funding was complementing or supplementing Government of Tonga recurrent expenditure.

In THSSP2, once activities from the MoH AMPs to be funded with DFAT funds are agreed between NHDC and DFAT, the detailed costing of those activities will be allocated according to the MoH budget structure and chart of accounts, and incorporated into the MoH Development Budget for submission to the MoFNP. In the instance where the activities to be funded under the program do not align with existing activity codes in the MoH budget structure, MoH is able to create the required activity codes in the relevant sub-program to enable effective monitoring and reporting of program activities.

For the first year of the program, while the new approach of incorporating THSSP2 into the MoH budget structure is first being implemented, the Program Finance Officer must continue the current practice of maintaining detailed financial records in Quickbooks, with monthly reconciliation to the information in the SUN system. Once it can be demonstrated that the coding structure can provide accurate monitoring and reporting on the use of DFAT funds, and that information between SUN and Quickbooks can be reconciled, the maintenance of financial records in Quickbooks will no longer be required.

Refer to Annex 14 for details of the existing MoH budget structure for 2014-15 financial year, noting that this may change slightly for 2015-16 and subsequent years.

In summary, the standard coding structure, with an example code for MoH, is as follows:

Ministry	Program	Sub-Program	Activity	Function	Location	Funding source	Cash/ In-kind	Natural account
X	X	XX	X	XX	X	XX	X	XXXX
15	2	01	4	74	1	00/10	0	1480
MoH	Preventative Health	Preventative Health	Health Promotion	Health	Tongatapu	GoT/ DFAT	Cash	Consultant & TA

All expenditure will be allocated to the relevant code according to the above GoT budget structure, with the DFAT funding being distinguishable from GoT recurrent and other donor funding through the funding source code. Where the funding source code is a donor code (i.e. anything other than '00'), the SUN system also requires an additional field to be entered with the relevant 'Project code'. Therefore, all funding for the program will be allocated against the existing code for DFAT funding source '10' and Project Code '044' for THSSP. Refer to Annex 15 for details of the different stages of the budget cycle when the relevant coding must be used.

#### *Procurement Arrangements*

For the first year transition phase of the program (2015-16), all procurement will be managed by the Program Co-ordinator, under the direction of the Deputy CEO, Health Planning and Information Systems. During this transition year, the Program Co-ordinator should liaise regularly with the Procurement section under the Deputy CEO, Administration, to enable consolidation and co-ordination with broader MoH procurement activity and planning.

From 1 July 2016, it is expected that the position of Program Co-ordinator will be transferred to the Procurement section under the Deputy CEO, Administration, with an additional MoH post created for this role.

In accordance with the existing arrangement between DFAT and the Government of Tonga (GoT) to abide by GoT Procurement legislation and regulations, the MoH (Program Co-ordinator) will be responsible for all procurement using DFAT funds under TOP 7,500. This threshold will be revised pending an update of GoT Procurement Regulations: this update as it has been approved by Parliament but has not been formally released.

The DFAT-funded Procurement Manager in the Central Procurement Unit at the Ministry of Finance and National Planning will be responsible for all Program procurement over TOP 7,500 in accordance with the established rules, procedures and legislation of the Partner Government and as may be amended from time to time. For the avoidance of doubt, MoH is not permitted to undertake any Program procurements over TOP 7,500.

The Program Co-ordinator shall prepare and submit to the NHDC a procurement plan including detailed coverage of all contracts for which procurement action is to take place in the first 12 (twelve) months of Program implementation. The Program Co-ordinator shall update procurement plans on a rolling basis throughout the duration of the Program, to ensure that the plan reflects current and planned procurement activities. This should be done on a monthly basis, and in time for the next meeting of the NHDC, by including contracts previously awarded and to be procured in the next 12 (twelve) months. All procurement plans and their updates or

modifications shall be subject to NHDC prior review and no objection before implementation. After no objection by the NHDC, the Ministry of Health shall arrange the publication on its external website of the agreed initial procurement plan and all subsequent updates.

DFAT may also review implementation of the Program procurement plan during informal meetings and discussions throughout the year, and discuss any issues arising with the Ministry of Health.

Both parties agree that a sample of procurements, whether valued under or over TOP 7,500, may be audited periodically, either independently by DFAT or by the Tonga Audit Office.

#### *Procurement of TA – DFAT direct procurement*

TA could be procured in a number of ways: directly, by the Ministry of Health, through DFAT's Aid Advisory Services Standing Offer (AAS), Health Resource Facility, or through the Pacific Technical Assistance Mechanism (PACTAM). The favoured mechanism would be for the Ministry (or TongaHealth) to do its own procurement if possible. Whichever route is used, the Ministry of Health/TongaHealth (as appropriate) and DFAT would need to be involved with the procurement process and there would need to be agreed processes for the assessment and review of the recruits' work.

#### *Financial reporting*

MoH will provide quarterly financial reports to DFAT on actual expenditure against the agreed budget for the activities agreed to be funded under THSSP2. These financial reports will accompany the narrative progress report against agreed indicators and activities.

If activities are coded appropriately using the MoH budget structure, as outlined above, the financial reports should be extracted directly from the SUN system, using the Vision reporting software. A sample financial report has been provided in Annex 16, based on the current MoH budget structure. MoH should review the suggested report format to ensure that it is appropriate to meet the financial reporting needs of the CEO and Heads of Divisions, and make any necessary changes. MoH must share the final report template with DFAT prior to the commencement of the program, to confirm that the format is also sufficient to meet the reporting requirements for DFAT funding. Over the course of the program, MoH will submit to DFAT the regular quarterly financial reports which are prepared for NHDC, to reduce the reporting burden on MoH. This shift will be dependent on an agreed format for the report, where DFAT funding can be clearly distinguished from MoH recurrent and other donor funding.

As mentioned above, one of the key components to be targeted under systems strengthening is improved financial management and reporting. One of the critical tools to achieve this will be for MoH to obtain relevant licenses and training for the Vision reporting software, which MoH do not currently have access to. MoFNP are currently in the process of scoping a SUN system upgrade, which will include consideration of the reporting functionality available to line ministries. Therefore any additional Vision software licences or training by MoH should be approved by MoFNP, and aligned with the timing and scope of the system upgrade being implemented. DFAT would be supportive of MoH funding software licenses and training for relevant MoH finance staff under the systems strengthening component of THSSP2, if MoFNP budget was not sufficient to include this cost for MoH.

It is hoped that MoH would have access to Vision by the end of the first year of THSSP2. Until this is achieved, MoH will need to rely on MoFNP Budget Division to provide the required report in the

agreed format. Once the report is designed and coded in Vision, the report can be easily extracted directly from the SUN system for the relevant reporting period.

#### *External Audit*

Consistent with all DFAT funded programs in Tonga, THSSP2 will be audited annually by an independent external auditor, which will be engaged by DFAT. The cost of the audit will be borne by DFAT, as part of the administrative budget for THSSP2 (i.e. as part of the \$120,000 per year top-sliced for management costs from the \$10 million total). The Terms of Reference for the audit will be drafted by DFAT, and shared and agreed with MoH and TongaHealth prior to commencement of the audit work, which should be completed by 31 December following the end of each financial year, for each year of the program.

It is envisaged that over the course of the program, THSSP2 will also be audited as part of the annual audit of MoH undertaken by the Tonga Audit Office (TAO). It is acknowledged that there are capacity constraints within the Tonga Audit Office, which will be the focus of support of broader programs such as from the Pacific Association of Supreme Audit Institutions (PASAI). Future reforms and capacity building activities will be carefully monitored as part of the broader interest in the TAO related to all DFAT-funded programs in Tonga.

### **TongaHealth**

#### *Responsibility for financial management*

The overall responsibility for the financial management of funding received by TongaHealth from DFAT will rest with the Financial Manager. At the time of the design mission, this role was vacant, but the CEO TongaHealth is in the process of recruiting someone to fill the position. TongaHealth uses MYOB accounting software to manage finances and prepare financial monitoring reports. As THSSP2 will significantly increase the level of funding and activities which TongaHealth will manage, it is essential that the two positions of a Financial Manager and Monitoring and Evaluation Manager are engaged under the program, prior to funding being released to TongaHealth. Technical assistance around coding and setting up of TongaHealth's financial system will need to be recruited to ensure their accounting system(MYOB) is configured in such a way as to enable effective monitoring and timely reporting of program expenditure against agreed activities. The identified technical assistance will be maintained on contract to provide intermittent ongoing assistance to TongaHealth during the inception phase of the program, to be reduced over time as financial processes operate effectively. A sample ToR for this assistance is provided at Annex 11D.

#### *Procurement arrangements*

All procurement by Tonga Health using THSSP2 funding will be undertaken in accordance with the Tonga Health Administration Procedure Manual (2014), the Tonga Health Financial Policy and the Tonga Health Grant Making Processes policy document. As part of, or in addition to the annual audit of Tonga Health, DFAT may request a sample of THSSP2 procurements to be audited, to verify compliance with relevant procurement procedures and policies.

#### *Financial reporting*

TongaHealth will submit quarterly financial reports to DFAT, detailing the actual expenditure against the agreed budget for THSSP2 activities. The format of the report will be agreed between DFAT and TongaHealth once the activities to be funded under the program have been confirmed, and in collaboration with the technical assistance to be provided for the MYOB software. Over

the course of the program, TongaHealth will submit to DFAT their regular quarterly financial report that they currently prepare for their Board, to reduce the reporting burden of producing separate financial reports for THSSP2 funding. However, this will depend on whether sufficient detail can be provided to meet DFAT's reporting requirements.

#### *Audit*

In accordance with the Administration Procedures Manual, an independent external audit firm audits TongaHealth annually, with the audit report presented along with the Annual Report and audit management letter to the TongaHealth Board. All DFAT funding provided to TongaHealth should be included in this audit process, with a copy of the overall audit report provided to DFAT.

Prior to the audit work being commissioned, DFAT should have the opportunity to review and comment on the audit Terms of Reference, to confirm that the proposed scope of the audit work will meet the necessary DFAT requirements.

### Disbursement triggers for the release of DFAT funds

There are three forms of disbursement trigger – pre-conditions, the trigger for the “routine” six-monthly disbursements and the disbursement of the performance-based incentives.

#### *Pre-conditions*

A well-documented risk to a donor that provides significant support to a particular sector is that the recipient government allocates fewer of its own resources to that sector, which it regards as being relatively well catered for. This compromises the intent of the donor, which wishes to provide *additional* resources to the sector. For this reason, there are two pre-conditions for disbursement:

- The combined MOH plus TongaHealth budgets (excluding donor funds) as a percentage of the total government budget do not decrease (taking 2015 as the baseline).
- The MOH's budget for the Public Health Division (excluding donor funds) increases as a percentage of the total MOH budget (taking 2015 as the baseline).

The Public Health Division's budget should be clear from the accounting codes: care needs to be taken that the definition is unambiguous. If the responsibilities of the Division change (for example this year the Division has become responsible for primary health care facilities), appropriate adjustments will have to be made.

The first condition reflects the Government of Tonga's overall commitment to the health sector; the second is about the funding of the most cost-effective services which should be available to all Tongans. (Public health, health promotion and primary care are all under the Public Health Division.) The point about accounting codes is to ensure that there is clarity about what needs to be measured and consistency over time. The importance of assigning budget conditions to particular accounting codes was learnt in THSSP1, where there was an ambiguous condition about funding for “preventive health services”.



The two pre-conditions appear as indicators in THSSP's monitoring framework. It would be appropriate to discuss the pre-conditions during the annual Tonga/Australia Partnership talks, as the overall allocation of resources is a Cabinet decision.

Information about the Government of Tonga's budget becomes available in June, so this would affect the subsequent bi-annual disbursement. DFAT views the pre-conditions extremely seriously. If they are not met (in other words, Government of Tonga's commitment to the health sector in general and public health in particular is not demonstrated through budget allocations), **DFAT will formally re-assess its commitment to THSSP2 and may reduce its overall financial allocation to the Programme.**

#### *Six-monthly disbursements*

The Ministry of Health and TongaHealth need to submit quarterly monitoring reports. The exact format of these reports needs to be agreed, but it would be based on the existing format for quarterly reports. The existing forms, plus comments about the format, are given in Annex 17. The weaknesses in the current format are recognised: it is part of the Health Systems Support and Planning Manager's terms of reference to work with MoH colleagues to improve the format, bearing in mind the importance of these reports for THSSP2. The aim is to minimise the extra workload, whilst providing DFAT with the information it requires. The monitoring reports would refer back to the work-plans, which were approved for funding and describe progress with activities, expenditure and, as appropriate, outputs. It is the responsibility of the recipients of funds (usually Heads of Division) to complete the quarterly reports and ensure that funds are properly accounted for.

Managers and the oversight bodies (the NHDC and TongaHealth Board) should use the quarterly monitoring reports to actively manage problem areas such as under-spending or a shift away from the original work-plans. Information from these reports may be used to re-distribute money or to halt some payments, particularly if a specific Division or Section is very under-spent or under-performing.

#### ***Performance incentives***

Of the \$10 million budget for THSSP2, \$1 million has been set aside for performance-based payments to the Ministry of Health (not to TongaHealth). It is proposed that the \$1 million is allocated as follows:

- a) Up to \$600,000 allocated by a Performance Payments Panel based on achievements related to the Annual Management Plans
- b) Up to \$400,000 for the Ministry of Health as a whole based on the achievement of targets and the findings of the Independent Progress Report (IPR) and towards the end of THSSP2 based on the extent to which the recommendations of the IPR have been implemented.

- a) *Up to \$600,000 allocated by a Performance Payments Panel*

It is proposed that the Performance Payments Panel consists of the Honourable Minister of Health, the Chief Executive Officer (CEO) of the Ministry and the DFAT First Secretary from the



Australian High Commission. Allocations will be made to divisions and sections – the Minister and the CEO both sit above this divisional structure.

The Panel would meet annually in about May. It would allocate up to \$120,000 per year, even though this means that THSSP2 will be finished when the final allocation is being spent in the second part of 2020.

Performance payments should be awarded as objectively as possible: this is fairer and allows staff to know what they are aiming for. A points system is suggested in Table 6 as a way of identifying divisions, sections or facilities worthy of receiving a payment. The Performance Payments Panel should discuss this proposal, adapt and approve it, and distribute information about the criteria throughout the Ministry. This should happen as early on in THSSP2 as possible.

**Table 6 Possible scoring system for incentive payments allocated by Performance Payments Panel**

<b>To what extent is/are.....</b>	<b>Maximum possible marks</b>
Good quality workplans prepared and reported on regularly?	15
Finances tracked adequately through the SUN system and information made available in a timely manner?	20
Information available to monitor THSSP's expected outputs, intermediate outputs and outcomes?	15
Regular meetings held by divisions/sections to discuss workplans, reports, budgets and risks?	10
Progress being made with strengthening the management of NCDs in all primary care and out-patient facilities?	10
Management improving in at least two systems areas? (Systems include health information, human resources, procurement etc.)	10
Activities identified and implementation begun to raise the profile of mental health and/or disability services?	10
GESI considerations mainstreamed into the work of divisions?	10
<b>TOTAL</b>	<b>100</b>

Incentive payments can be made to divisions or sections (the divisions vary greatly in size) and all recipients will be encouraged to spend the money close to the “front line”. Outer Island hospitals and primary care facilities should be eligible to receive payments. It is important that the Panel give brief reasons for their decisions, as this is an important element in strengthening the Planning Cycle.

As examples, the Panel could award performance payments in the following types of circumstances:

- If a Division's or Section's Annual Management Plans (AMPs) and quarterly reports are of a particularly high standard. This can apply to Divisions and Sections which are not necessarily recipients of large-scale DFAT funding – for example Dental Division or Paediatric Section.

and/or

- If a Division or Section has identified an appropriate new area of work, or an innovative way to work, and has implemented this convincingly in relation to the DFAT-supported

priorities of NCDs, Health Systems Strengthening (including Universal health coverage) and mental health/disability.

and/or

- If activities have been implemented particularly well or a difficult problem has been overcome in relation to the DFAT-supported priorities described above.

and/or

- If a Division or Section has shown particular initiative in working in partnership with another part of the Ministry (or another organisation) to improve the way in which a job is done in relation to one of the DFAT priorities.

For all of the above circumstances, the Panel should be satisfied that the area of activity is an appropriate, cost-effective priority (i.e. that the division/section is doing the right thing, in addition to doing it well.)

As a guide, overall payments could be up to a maximum of 75% of the initial activity cost funded by DFAT. (How this works out in practice depends on how many incentive awards will be made and the value of the activities being rewarded.) Lump sums could be agreed for Divisions or Sections that have produced excellent AMPs and monitoring reports, even though they are not major DFAT recipients. Payments should be thought of as a sliding scale, rather than as a binary yes/no decision. For example, if one division scored 50/100 according to the scoring described in Table 6 and another division scored 75/100, the second division would be awarded a relatively higher incentive payment.

Recipients will be asked to describe how the money will be used in a simple addendum to their annual workplan. The subsequent quarterly report will include reference to how the incentive payments have been used.

*b) Up to \$400,000 for the MoH as a whole, with decisions in 2017 and 2019*

Up to \$200,000 will be available for allocation to the MoH as a whole, based on the findings of the Independent Progress Report (IPR) in late 2017 and up to \$200,000 more towards the end of THSSP2 in 2019/20 based on the extent to which targets have been met and the recommendations of the IPR have been implemented.

The IPR will include Evaluation Criteria Ratings (scores). The amount of any performance payments will be based on these ratings and the extent to which the THSSP2 targets/outcomes/outputs have been achieved for the appropriate time period. An objective way of combining the scores and target-achievements will be agreed in advance of the IPR by the Performance Payments Panel (PPP). The payment should be available on a sliding scale, not as an all-or-nothing, win-or-lose incentive.

Similarly, the payment awarded in 2020 should be based on the extent to which the THSSP2 targets have been met, plus the extent to which the recommendations of the IPR have been implemented. Again, an objective way of combining the information about targets and recommendations will be agreed in advance by the PPP. Also again, the payment should be available on a sliding scale, not as an all-or-nothing incentive.

In general, the PPP should oversee the process for awarding this \$400,000.

Performance-based funding is a new way of working for the Ministry of Health and DFAT in Tonga, plus it is known from the experience of the DFAT-funded health program in the Solomon Islands that these kinds of schemes often need to be adapted in the early years to ensure that they function as intended. For these reasons, the NHDC and DFAT can discuss possible changes to the details of the scheme each year and can make minor adjustments if there is mutual agreement. In addition, TORs for the Independent Progress Review will include a thorough assessment of how well the performance-based funding is working.

The points above are presented in Annex 7 as draft guidelines for the allocation of performance-based payments.

## Monitoring and Evaluation (M&E)

The section above on *Program Logic and Expected Outcomes* described the program logic (or theory of change) and referred to the full monitoring framework of indicators in Annex 12.

A Performance Assessment Framework will be jointly developed by the Ministry of Health, TongaHealth and DFAT through the Implementation Phase of the program. Annex 18 gives the start of this M&E Performance Assessment Framework, which will be completed during Year 1 of THSSP2, guided by the Director of Planning and the TA Planning Adviser. Each indicator in Annex 12 will have a time frequency attached to it and the National Health Development Committee and TongaHealth Board will expect to see reports of progress against indicators according to this schedule. The DFAT Second Secretary and DFAT Health Program Manager will carefully scrutinise the quarterly monitoring reports to ensure that reporting is up-to-date. This will take some time to work smoothly: the TA Planning Adviser will support the process and stress the importance of incorporating indicators in plans and monitoring reports. The responsible Division in the Ministry of Health is Planning, which has responsibilities for both compiling the monitoring reports and providing information. Work at section level also needs to take place and the twinning partnership with the Saint John of God Hospital in Ballarat will provide the necessary support to ensure section and individual reports are reflective of Division and corporate plans.

The M&E Performance Assessment Framework describes who is responsible for collecting data and when. The main sources of data are:

- The Health Information System (including hospitals, primary care facilities and outreach)
- Reviews of health promotion campaigns to measure changes in knowledge, attitudes and behaviour.
- STEPs, the five-yearly survey of NCD risk factors.
- Analyses of the MOH Annual Management Plans and TongaHealth work-plans. These will initially be done by the Planning Adviser, but from year 3 onwards by the MOH (Planning Division) and TongaHealth respectively.

The Health Information System (HIS) is the most complex of the sources. The Asian Development Bank is in the early stages of support for health information: in co-ordination with this work, THSSP2 can fund HIS strengthening activities. An important activity in Year 1 will be to gauge what needs to be done to improve the capacity of the HIS.

In addition to the sources listed above, the Ministry of Internal Affairs, which is the implementing agency responsible for the National Disability Strategy, is gradually improving its database about disability.

There are important links between the Risk Register and monitoring: both will be discussed regularly at NHDC and TongaHealth Board meetings. For example, one risk is that the Health Information System (HIS) takes too long to produce consolidated information about primary health care activities. If the quarterly monitoring reports do not include the expected information, the Risk Register signals that it is time to think about what support is needed for the HIS: it is not just a matter of waiting for next time and hoping the information will appear. The mitigation strategies for this risk would then be worked out in detail and included in the relevant work-plan.

The Independent Progress Review of THSSP2 in late 2017 is an opportunity to scrutinise achievements in terms of outputs and outcomes and to interrogate the program logic to consider whether the thinking under-pinning THSSP2 is still valid. In particular, is there evidence that the Ministry of Health is making good decisions about resource allocation to improve NCDs and then effectively overseeing implementation?

The monitoring of financial information has been described above in the section on *Financial Management Arrangements*.

## Sustainability

**Sustainability is at the heart of the design of THSSP2. An apposite statement was made by the Joint Forum Economic and Pacific Economic and Health Ministers in 2014:**

**“NCDs already undermine social and economic development in the Pacific, and are financially unsustainable. NCDs impose increasingly large, yet often preventable financial costs on national budgets and the economy more broadly. Without decisive action, NCDs can undo the development gains of the last 20 years.”**

THSSP2 is about institutionalising the ability within Tonga to prevent and manage NCDs so that development gains are not undone. This is reflected in the targets for the Program, which include downward trends in premature deaths caused by NCDs, reductions in the proportion of Tongans at high risk of NCDs and savings in expensive hospitalisations through better management of NCDs in primary health care facilities. (It is more efficient to prevent an amputation than to fund the treatment costs.) Full details of the targets are given in Annex 12.

The strategies for achieving this sustained control over the NCD crisis are:

- Strengthening the technical response to NCDs so that the diseases are dealt with effectively and equitably throughout Tonga
- Strengthening management systems in the Ministry of Health so that it is a more responsible and efficient organisation
- Supporting TongaHealth with its work in preventing NCDs and promoting healthier individual behaviour and healthier public policies (e.g. in terms of enforcing no smoking rules).

All three strategies address significant reasons for the current NCD crisis – health interventions which are sub-optimal in terms of effectiveness and distribution, weak support systems and unhealthy behaviours.

In addition to these strategies, THSSP2's pre-conditions ensure that there is a strong focus on the Government of Tonga's financial commitment to the health sector. According to the latest National Health Accounts (2007/8), donors provided about 38% of total health expenditure. With percentages such as these, sustainability is always a challenge. However the two preconditions (see Box 6) are intended to protect government health expenditure as a whole, and particularly for the most cost-effective area of public health.

#### **Box 6 Pre-conditions**

The combined MOH plus TongaHealth budgets (excluding donor funds) as a percentage of the total government budget do not decrease (taking 2015 as the baseline).

The MOH's budget for the Public Health Division (excluding donor funds) increases as a percentage of the total MOH budget (taking 2015 as the baseline).

If the pre-conditions are not met, DFAT will formally re-assess its commitment to THSSP2 and may reduce its overall financial allocation to the Programme.

THSSP2 has a strong focus on capacity development, through the provision of TA; strengthening planning, financial management and reporting systems by using them; linking financial disbursements to the effective running of these systems; and rewarding good practice with performance payments. In addition, THSSP2 is linked to the Economic and Public Sector Reform Program, which aims to develop capacity in financial management and procurement across the Tongan public sector.

Capacity development is explicitly mentioned in the TORs of all three long-term TA posts (see Annex 11):

- Health Systems Support and Planning Manager: "Provide support in the development of a Staged Capacity Development Plan for the MoH".
- Technical support for *Hala Fononga* (NCD Strategy/Health Promotion): "Support CEO TongaHealth to identify capacity development needs for TongaHealth and where possible to link in with DFAT funded capacity development trainings with MOH."
- Technical support for public/primary health: "Provide support for Capacity Development Assessments (CDAs) linked to annual management plans as a first step in the development of a CDA for the Division. In general, the capacity-building element of this position is crucial."

A particularly challenging aspect of sustainability in Tonga is the funding of Critical Staffing Deficiency posts. THSSP2 will support the development of plans and budget structures to tackle the gradual transfer of responsibility for funding key skills to the Government of Tonga wherever possible.

## Gender Equality

The latest Tonga Strategic Development Framework is currently being prepared and is expected to include a strong statement about the importance of gender equality to Tonga's overall development. This complements the Revised Gender and Development Policy, which was launched in 2014.

In the policy dialogs related to THSSP2 DFAT will promote gender equality and other aspects of GESI. One idea is to advocate for "GESI champions" on the National Health Development Committee and TongaHealth Board.

The work on essential primary care will mean an enhanced role for professionals in primary care, very many of whom are women. In general, the health sector offers excellent opportunities for women to develop their leadership skills.

NCDs are not only a health issue, but also an economic and social problem which affects females and males differently. Women and girls are more likely to care for people with disabling advanced NCDs; orphans and widows caused by premature NCD deaths are vulnerable to poverty and exploitation. This program aims to prevent NCDs and manage early-stage disease efficiently: this has the potential to benefit women in terms of their own health, reduced responsibilities as carers and fewer occasions when women bear heavy economic responsibilities as the head of a single-adult household.

Considerations of gender are mainstreamed into THSSP2 because the work-plans that determine the allocation of funds will need to consider gender aspects. The review of work-plans and quarterly reports will include a gender-review: are gender differences properly reflected? Is information disaggregated by sex? If a service is less used by one gender, what is being done about that? Performance rewards can be made if there is particularly good work related to gender.

Good health is a necessary, although obviously not sufficient, part of empowerment. The work on essential services should improve reproductive health services throughout Tonga: this is an important element in women taking control of their lives. Good clinical management of NCDs is important for reproductive and maternal health: for example gestational diabetes needs to be diagnosed and managed appropriately. Work-plans will be scrutinised to ensure that they include gender-specific activities where relevant and to ensure that relevant information is disaggregated by gender.

NCDs affect women and men differently and the response needs to be tailored accordingly. For example men are less likely to visit a health practitioner and there is a need for targeted interventions to improve male utilisation. A mass media campaign about tobacco use would benefit men more than women; in contrast a campaign promoting participation in netball would benefit mostly women and girls.

An important activity under THSSP2 is defining a "universal health coverage" package for *all* Tongans – poor and disadvantaged groups stand to benefit from this disproportionately. This will be monitored, with the information disaggregated by gender, age, location and (as feasible) disability. Most data about NCDs is also disaggregated by gender, as can be seen in the

indicators selected for THSSP2. This makes it possible to target interventions appropriately and to monitor the impact on males and on females separately: inequalities can be identified and acted on.

## Disability Inclusion

The Investment Concept Note for THSSP2 is given in Annex 3. The NHDC of the Ministry of Health was given the choice of whether or not to include mental health and disability as eligible areas for THSSP2 spending. No additional money was involved, so including disability and mental health meant that the resources were spread more thinly. The NHDC strongly supported including mental health and disability in the program design: we believe that this is an unusually strong statement of support by a Ministry of Health.

In addition to the small amount of money directly available for disability and mental health services, efforts will be made to 'mainstream' disability where possible into much of THSSP2's work because (a) basic disability services should be part of the universal health coverage package for primary care and (b) much of the work on preventing NCDs and their most serious sequelae is about preventing disability (most notably amputations). Work-plans will be scrutinised to ensure that they have identified and reasonably addressed potential barriers for people with disability accessing health services/activities and to ensure that relevant information is being collected on their inclusion. An important part of the dialogue between the Ministry of Health and DFAT throughout THSSP2 will be about how GESI considerations, including disability, can become an integrated part of how the Ministry operates.

## Risk Management Plan

Table 7 shows the identified risks for THSSP2. This is simply a list – further details are given in the completed Risk Register in Annex 19 (EXCEL file). The risks cover the technical areas of the program (NCDs, Universal Health Coverage, health systems strengthening and GESI) as well as governance, workplans, financial management, procurement and the resources for THSSP2.

This analysis of risks will be shared with the NHDC and TongaHealth Board: they will both be asked to discuss them regularly and identify appropriate mitigation measures, specifying a timescale and who is responsible for implementing the response. In addition, the risks will be incorporated into the risk management tool for post (Post Risk Register), which is actively managed and updated quarterly.

In spite of the mitigation efforts described in the regularly-updated Risk Register, some residual risk will remain. This residual risk is about the effectiveness of the Ministry and TongaHealth and the relationships between these organisations and DFAT. The main strategies for dealing with these issues are building good working relationships, implementing the robust project management processes described in this document and monitoring progress systematically. There are already good relationships with the Ministry based on THSSP2; TongaHealth is a newer partner for DFAT.

<b>Table 7 Risks in THSSP2</b> (for full details see the Risk Register in Annex 19)



1. Reduction or loss of program funding due to pre-conditions and DFAT requirements not met.
2. Health outcomes related to NCDs do not improve.
3. Health promotion activities do not work or have less impact on NCD risk factors than expected.
4. Government Ministries do not include NCD-related activities in their work-plans.
5. Publication of the 2019 STEPS survey is delayed.
6. Operationalising the definition of Universal Health Coverage takes a long time to finalise.
7. Human Resource Strategy is weak, or MOH stakeholders feel insufficient ownership of it.
8. Health Information System slow to solve its problems with collating primary health care data.
9. Dependency on DFAT funding for Critical Staffing Deficiencies inadequately addressed.
10. Recommendations about drug procurement system are not accepted or implemented.
11. Staff are under-skilled in GESI analysis and the collection of disaggregated data.
12. MoH and TongaHealth unable to fulfil DFAT's requirements for GESI.
13. Implementing Capacity of TongaHealth (a new partner for DFAT) is over-estimated.
14. Relationships between the Ministry of Health and TongaHealth are unconstructive.
15. TongaHealth Board does not meet as scheduled or does not keep to fixed agenda items.
16. Difficult for DFAT to signal when TongaHealth Board decision could be an inappropriate use of DFAT funds.
17. MOH unable to carry out committed work-plans due to other commitments to other donors.
18. The NHDC does not meet as scheduled or does not keep to the fixed agenda items.
19. Difficult for DFAT to signal when it thinks an NHDC decision is inappropriate use of DFAT funds.
20. Work-plans are inadequate, meaning that spending is low and progress not as hoped.
21. Work-plans are inadequately tracked.
22. Lack of development partner co-ordination causes gaps or duplication.
23. Position of Program Finance Officer is not successfully integrated into MoH finance team.
24. MoH is not able to gain access to the Vision reporting module of the SUN accounting system.
25. Low procurement capacity leads to delays in program implementation and increased cost.
26. PFM and procurement activities not co-ordinated with PFM reform activities planned by MoFNP.
27. The overall THSSP2 budget is cut.
28. DFAT Post has insufficient resources to manage THSSP2.
29. Important permanent posts in the Ministry of Health are left vacant.
30. Environmental and resettlement safeguards are not fully implemented or are inadequate.
31. Child protection safeguards are not fully implemented or are inadequate.

## Private Sector

The private health market in Tonga is small and there are limited opportunities to develop work with the sector. There will, however, be some engagement. Through the funding for TongaHealth work-plans, Post will look for opportunities to prioritise funding of health promotion activities implemented by the private sector: TongaHealth is able and willing to fund all kinds of organisations, both private and public. There will certainly be engagement at various stages of



media campaign activities where it will be necessary to tender out contracts (research, media design and broadcast etc.). An example could be a health promotion campaign transmitted by a communications provider via text messaging.

## Safeguards

### *Environment and Resettlement Safeguards*

The main potential area where environmental issues could arise is with the construction or renovation of health infrastructure (clinics, hospitals etc.), including the removal of asbestos. Resettlement issues are unlikely as potential renovations will not lead to physical or economic displacement of people. A screening of the environmental risks and resettlement issues associated with this investment was undertaken by Post (Annex 20) in consultation with the Environmental and Social Safeguard focal point at Post. The risk categorisation for the potential for this initiative to have a significant negative environmental impact is limited and therefore, in alignment with the DFAT Environment Policy (2015), a full Environmental Assessment and Environment Management Plan was not required for this design. However as the systems strengthening approach aims to create improvements in procurement and infrastructure management within the Ministry of Health, there is potential to ensure that both resettlement and environmental protection safeguards are considered in this investment. This will be described and monitored through Annual Management Plans and reported through annual aid quality processes. Post will continue with engagement by both Post's Environmental and Social Safeguards focal point and the DFAT Infrastructure Adviser currently engaged in Tonga Post's infrastructure portfolio, as needed.

Environment and resettlement safeguards are included in the Risk Register (Annex 19).

### *Child Protection and Child Protection Safeguards*

To effectively manage risks to children, DFAT requires the commitment, support and co-operation of contractors and civil society organisations. Post will ensure all of the arrangements with contractors and civil society organisations under this investment meet the terms of DFAT's Child Protection Policy and ensure that partners are aware that they will be held accountable, through contracts, audits and spot checks, for complying with it. TongaHealth has successfully undergone DFAT's due diligence framework which requires all potential partners to be assessed for risks and strengths before agreements are entered into, and to ensure they are compliant with DFAT policy and standards. TongaHealth has developed a child protection policy (Annex 21) as a part of this process and compliance will be monitored by Post through annual performance assessments and the THSSP Independent Progress Report.

Where DFAT funds are being used to engage an organisation or individual sub-contractor such as PACTAM, Post will ensure the organisation or individual sub-contractor complies with the relevant child protection policy as a part of the standard recruitment process.

While the DFAT Child Protection Policy does not cover our Government Partners, Tonga is making progress in child protection. The Tongan Government ratified the Convention on the Rights of the Child (CRC) in 1995. More recently the Family Protection Bill was introduced in 2012 to deal with domestic violence (including against children) and to introduce the concept of protection orders. The Bill states that one of its aims is to enact provisions that are consistent with the CRC. The Act came into effect in 2014. Tonga Post is monitoring the implementation of the Act through the Pacific Women Shaping Pacific Development initiative.

Child protection safeguards are included in the Risk Register (Annex 19).