

Tonga Health Systems Support Program Phase 2 (THSSP2)

Mid-term evaluation report

25 April 2019

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Acronyms

ADB	Asian Development Bank
AGO	Auditor General's Office
AUD	Australian Dollar (currency); unless indicated otherwise, "\$" is used in the text
BCC	Behaviour change communication
CEO	Chief Executive Officer
COPD	Chronic obstructive pulmonary disease
CPU	Central Procurement Unit (Ministry of Finance)
DFAT	Government of Australia Department of Foreign Affairs and Trade
FMIS	Financial management information system
FY	Fiscal year
GBD	Global Burden of Disease (Institute for Health Metrics and Evaluation)
GoT	Government of Tonga
GSHS	WHO Global School-based Student Health Survey
Hala Fononga	National strategy for the prevention and control of NCDs 2015-2020 (‘Hala Fononga ki ha Tonga Mo’ui Lelei’ translates as ‘The path to good health’)
HIV	Human immunodeficiency virus
HR	Human resources
JICA	Japan International Cooperation Agency
KPI	Key performance indicator
M&E	Monitoring and evaluation
MoF	Government of Tonga Ministry of Finance (formerly Ministry of Finance and National Planning)
MoH	Government of Tonga Ministry of Health
NCD	Non-communicable disease
NCD-MAP	Multi-sector action plan on control and prevention of NCDs
NHDC	National Health Development Committee
NHSP	National Health Strategic Plan
NPO	National Planning Office (Prime Minister's Office)
ODE	DFAT Office of Development Effectiveness
PASA	World Bank Pacific Health Analytical and Advisory Services program
PEN	WHO Package of Essential NCD Interventions
PFM	Public financial management
PSC	Public Service Commission
SDG	Sustainable Development Goals
SHS	Specialist Health Service
SPC	The Pacific Community
STEPS	WHO STEPwise Approach to Surveillance
T2DM	Type 2 diabetes mellitus
TSDF II	Tonga Strategic Development Framework 2015-2025
THSSP1	Tonga Health Systems Support Program Phase 1
THSSP2	Tonga Health Systems Support Program Phase 2
TongaHealth	Tonga Health Promotion Foundation
TOP	Tongan Pa'anga (currency)
ToRs	Terms of reference
WHO	World Health Organization

Executive Summary

Overview of findings

The design of THSSP2 appropriately addresses the most significant health issues for Tonga, and implementation has largely delivered according to the design. The intended modality of "on plan, on budget, on system" was appropriate in terms of good development practice, but ambitious considering the limitations of elements of the Tonga public service, and this led to the use of some parallel systems for THSSP2. The Mid-Term Evaluation Team considers that the original design concepts are sound for a sector program, and that future work continue to focus on strengthening this approach, including improvements to: core planning and budgeting functions; effective governance and monitoring and evaluation, gender and social inclusion; and coordinating support to the Government of Tonga's medium term priorities in the sector.

Background

Since 2009, Australia has invested in Tonga's health sector through the Tonga Health Systems Support Program. Phase 1 (THSSP1) of the Program (2009-2015) aimed to improve community health services and deliver preventative health measures, while focusing on halting the rise in prevalence of non-communicable diseases (NCDs) and their risk factors. THSSP Phase 2 (THSSP2) commenced in March 2015, with continued support focused on preventive health services. THSSP2 is designed around funding of the annual work-plans of the Ministry of Health (MoH) and Tonga Health Promotion Foundation ('TongaHealth'). There is a direct funding agreement with the Ministry of Finance (MoF) and the MoH, for the MoH, and a funding agreement with TongaHealth. The NCD prevention component of THSSP2 is specifically designed to support the *National Strategy for the Prevention and Control of NCDs 2015-2020* ('Hala Fononga'). The total THSSP2 budget is \$17.3 million over five years (2015-20), including \$3.3 million in DFAT regional Disability-inclusive Development (DID) funding.

The purpose of the mid-term evaluation was to obtain information on the performance of Australian-funded support to the health sector through THSSP2. This information will be used to improve Australia's support to the MoH and TongaHealth and, subsequently, the delivery of Tonga's National Health Strategic Plan 2015 – 2020. It will also be used to inform consideration of any future Australian support to the health sector. The evaluation approach reflected the program design, with five high-level program targets and the intention that progress would be measured using the THSSP2 Monitoring and Evaluation Framework (M&E Framework).

Progress

High-level program targets

The THSSP2 Design Document sets five high-level program targets. Although available information on the population health program targets was limited, the evaluation found:

1. Signs of early progress towards achieving the following population health targets:
 - the rate of NCD-related premature mortality had not risen;
 - behavioural risk factors relating to tobacco and alcohol use had fallen amongst adolescents.
2. Key progress towards health systems targets:

- the development of the Package of Essential Health Services (PEHS): an MoH policy framework, at final draft stage, that commits to mainstream NCD management into primary health care;
- strengthening of the MoH organisational structure by consolidating administrative support functions into a Corporate Services Division.

Health services

The evaluation considered that the areas of progress in health services with the greatest overall significance were:

1. The development and ongoing implementation of Tonga's multi-sector action plan for NCD prevention and control, which positions Tonga as a regional leader, with signs of early progress previously described.
2. NCD management has continued to improve (as a largely vertical program).
3. The scope of the vision of the PEHS, embracing many of the priorities advanced by THSSP2 including (in addition to the mainstreaming of NCD management), the mainstreaming of services such as mental health, a commitment to provide a consistent range and level of services in all health facilities including outer islands, a commitment to a disability-inclusive approach, and a commitment to progress gender equality.

Health systems strengthening

The evaluation considered that the areas of achievement in health systems strengthening with the greatest overall significance were:

1. GoT has maintained its level of financing for the health sector, and MoH's budget for the Public Health Division has increased as a percentage of the total MoH budget.
2. MoH and TongaHealth have largely met their high-level accountability requirement (eg budget commitments) but key elements of program level accountability have been weak (eg no annual reporting or overall program oversight meetings and delayed financial reporting).
3. THSSP (through both phases) has been successful in establishing an agenda for more effective use of GoT health sector resources. The MoH has successfully developed key change agendas supported under THSSP including the establishment of a Corporate Services Division and the development of the PEHS.

In addition to the areas above, THSSP2 has supported the establishment of a national disability-inclusive health oversight mechanism inclusive of persons with disability organisations has successfully been established.

Progress in priority and strategic areas

The terms of reference (ToR) for the evaluation required the evaluation team to examine several priority and strategic areas. The key findings are summarised here under three major themes: (i) health services (ii) health systems strengthening and (iii) general and cross-cutting priorities:

Theme 1: Health services

NCD prevention and health promotion activities

TongaHealth, a statutory agency, acts as the secretariat for Hala Fononga (the National Strategy for the Prevention and Control of NCDs 2015-2020). The statutory health promotion fund provides an effective mechanism for pooling GoT and THSSP2 funds in support of Hala Fononga, and for sequestering GoT's funding commitment for health promotion from the wider health sector budget. TongaHealth's primary role is as a grant manager rather than an implementer.

In line with Hala Fononga, TongaHealth coordinates a multi-sector action plan for NCD prevention and control (NCD-MAP). The concept of a multi-sectoral approach to NCDs has only recently been recognised globally and positions Tonga at forefront of multi-sectoral approach implementation. This is strategic for Australia because it is supporting other Pacific countries to respond to similar NCD problems.

Coordinated work and consistent focus has turned NCDs into a whole of community issue. A formal independent review of Hala Fononga is scheduled to take place shortly after the THSSP2 mid-term evaluation. To achieve changes in population risk factors, there is a need for ongoing refinement of TongaHealth's systems including strategic prioritisation of areas for grant application, increased attention to healthy eating, local research, innovation and advocacy.

Primary health care and NCD services

THSSP2 has invested to further develop initiatives established during THSSP1. For example, the Vaiola Hospital Diabetes Centre, with THSSP2 support, has worked to improve patient-centred care to achieve a lower level of defaulters and greatly improved management of diabetic patients. The deployment of a cadre of NCD nurses has improved access to and quality of NCD management.

The PEHS provides an effective framework for mainstreaming services such as NCD management and mental health into primary health care. The impact of PEHS now depends on an effective rollout strategy that will need to be planned and resourced. The World Bank will commence a health facility costing and benchmarking exercise that will help inform the roll-out of the PEHS, including developing financing guidelines by 2020-21. Sources of finance for the additional costs of achieving PEHS service benchmarks have not been identified.

The PEHS signals that NCD services will be effectively 'mainstreamed' into universal health coverage. The capacity of the nursing workforce to deliver elements of the PEHS requires training and supervision, and clarification of nursing roles.

The MoH has recently changed the reporting lines of the nursing workforce of the Community Health Section within the Public Health Division. A number of respondents reported this has contributed to a lack of clarity of roles between reproductive health, NCD and general nurses. Nurse-delivered NCD outreach services are complicated by the limited prescribing privileges of nurses and supervision by hospital-based medical staff (at the time of the evaluation, MoH had plans to review prescribing arrangements in 2019).

Feedback from pharmacy staff and nurses suggests improvements in availability of essential NCD medicines between 2016 and 2018 (there were no reports of stock outs in the previous year). 2017 and 2018 stock reports from Vaiola Outpatient Dispensary show all essential NCD medications in good supply.

Theme 2: Health systems strengthening

Governance and strategy

The National Health Development Committee (NHDC) had not provided program oversight as intended in the program design, but the TongaHealth Board had oversighted TongaHealth operations. The National NCD Committee (NNCDC) had not met regularly to oversight the multi-sectoral action plan on NCDs (NCD-MAP). The capacity of the MoH to budget, plan, and administer its resources was limited according to delegations from central government agencies (e.g. to manage public finances, manage staff, and set public policy). The evaluation team did not encounter any evidence that the newly established MoH Corporate Services Division had begun to have an impact on institutional performance.

MoH strategic planning capacity had improved according to ratings issued by the MoF and recorded in the program Monitoring and Evaluation (M&E) Framework. Despite these ratings, the evaluation found that the health sector does not have an expressed medium-term strategic direction. As the largest bilateral donor in the health sector, DFAT is challenged to optimise the strategic impact of its investments given the lack of clarity about the medium-term strategic direction of the sector.

Public financial management

Pre-conditions in the THSSP2 Design Document that Government of Tonga (GoT) maintains its level of financing for the health sector, and that MoH's budget for the Public Health Division (excluding donor funds) increases as a percentage of the total MoH budget, have been met. MoH and TongaHealth have also largely been accountable, as far as this can be assessed, against GoT requirements and Department of Foreign Affairs and Trade (DFAT) indicators in the THSSP2 M&E Framework. Financial reporting has been consistently delayed.

The THSSP2 Design Document states that program delivery '*will be organised around the funding of the annual work-plans of the Ministry of Health and TongaHealth... with involvement from DFAT in agreeing areas for funding*'. Early attempts to integrate THSSP2 annual planning with MoH planning were unsatisfactory as the MoH budget prioritisation process was not considered robust. In response, a parallel annual planning process was instituted by DFAT, meaning that whilst THSSP2 is 'on system', it is 'off plan'. DFAT has little in the way of an agreed sector strategic framework by which to assess funding applications other than the five high-level program targets and professional judgement.

THSSP2 has been successful in getting program funds 'on system' i.e. program activities have been successfully funded and implemented through GoT systems (i.e. MoH and TongaHealth), and program procurement (goods and services, infrastructure) occurs through GoT systems. THSSP2 is also 'on budget' with funds appearing in GoT budget records, but as per above is not integrated with the MoH planning process.

Monitoring and performance

The THSSP2 M&E Framework contains 76 indicators which are not well harmonised with other M&E frameworks used in the health sector. The THSSP2 M&E Framework does not adequately represent the program design and many of the indicators are not routinely collected. Each of the indicators from the various frameworks reflects some interesting aspect of the health sector, but not all indicators are strategic. Practical, strategic information for MoH and DFAT management is needed.

Independently of other components of the program, the THSSP2 Design Document reserves \$1 million over the five years of the program for performance-based payments to the MoH. The evaluation team considered that there was no evidence of the payment having a motivational effect.

Theme 3: General and cross-cutting priorities

Capacity development

The THSSP2 Design Document states that ‘THSSP2 has a strong focus on systems improvement, supported by TA’. In the context of a centralised system of government, the institutional capacities of MoH and TongaHealth are largely dependent on the central GoT agencies and therefore outside of the ‘reach’ of THSSP2. DFAT is intended to be instrumental in capacity building through the strategic and annual planning processes, but weak program oversight by the NHDC, the lack of an agreed sector strategic plan, and the use of a parallel annual planning process for THSSP2 funds has limited the ability of DFAT staff to directly engage with and influence the direction and use of GoT health sector resources.

Despite the challenging context, there was evidence that THSSP (both phases) has been successful in establishing an agenda for more effective use of GoT health sector resources. The THSSP2 program targets provide evidence that GoT support for health has been maintained and MoH support for public health has actually increased. It appeared to the evaluation team that key actors within the MoH have taken ownership of the agenda introduced through THSSP. Some program initiatives have provided ‘seed funding’ for improvements that are strategic and may be sustainable under GoT funding (for example, the costs of developing the PEHS document under Phase 2, and training of the first cohort of NCD nurses under Phase 1). Other program-funded investments supplement GoT funding for ordinary service delivery, for example, paying for specialist outreach travel to outer islands and salary supplementation. The capacity development potential of the two key long-term advisers has been diminished by: the parallel THSSP2 annual planning process (not integrated with MoH planning); MoH staff changes and vacancies (the MoH THSSP2 co-ordinator for 50% of the program to date, the retirement of the Principal Administrator requiring the adviser to act in-line, and the lag time of more than a year between establishing the Director of Corporate Services position and filling it); and high staff turnover within TongaHealth.

Overall, the evaluation team considered that actual progress in capacity development was reasonable given the context, and that expectations about changing capacity in functions largely controlled by central government agencies may have been unrealistic in the original program design.

Disability, including mental health

Disability-inclusive health is a \$3.3 million component funded under the DFAT regional Disability-inclusive Development (DID) initiative. Implementation of the DID-funded initiative is overseen by a Steering Committee led by MoH. However, there is limited decision-making authority held by this committee as all activities were fully planned at the beginning of the initiative. Awareness raising workshops have been conducted for the MoH and TongaHealth leadership groups to prepare for subsequent activities, including the mainstreaming of disability into regular health worker practice. The draft PEHS, which is expressly disability-inclusive, establishes a framework for universally available mental health services in the future. At DFAT’s request, THSSP2 refurbishment of the national psychiatric inpatient facility (ward) at Vaiola Hospital has been delayed by around 18 months due to a long lag in DFAT’s engagement of an architect to quality assure the proposed design. At the time of the mid-term evaluation, an M&E framework for the disability-inclusive health component was not in place.

Disadvantage, including remoteness

With 75% of the national population on Tongatapu, Tonga has less of a challenge in providing universal health coverage than many other Pacific Island countries, but the evaluation team did find some evidence of ongoing disadvantage due to remoteness (for example, reduced access to some

NCD medications). The draft PEHS is the main development supported under THSSP2 that potentially addresses disadvantage due to remoteness.

Gender equality

National outcome C of the TSDF II is ‘human development with gender equality’. The evaluation team observed indications of equal employment opportunity in the Tongan public service and availability of gender disaggregated health and disability information is generally good. THSSP2 annual funded activities are required to consider gender. Female participation has been good in health promotion activities such as Fiefa sports but, because of underlying gender differences in NCDs and NCD-related disability, it is appropriate to develop some strategic targeting of gender in NCD management and health promotion activities.

Human resources for health

A major issue for the MoH and DFAT throughout both phases of THSSP has been the inability of GoT to provide regionally competitive remuneration for some specific positions for highly qualified medical professionals (“Critical Staffing Deficiencies”), leading to high-cost, unsustainable topping up of salaries by DFAT. The arrangement was carried over into THSSP2 despite the fact that the medical specialist positions being supported are in acute clinical care and not directly related to the high-level targets of THSSP2. DFAT advised the evaluation team that it intended to phase out support for medical specialist remuneration by the end of THSSP2. This will require agreement to be reached between MoH, Public Service Commission and the Remuneration Authority to be able to pay increased rates (“Scarcity Allowance”) so that specialist positions are competitively remunerated from the GoT budget.

Program implementation issues

Despite the intention of the THSSP2 program design to integrate into MoH’s own annual planning process, this has not been achieved and a project-like planning arrangement persists. Also, THSSP2 inherited legacy investments that are not necessarily consistent with the five high-level program targets.

The Clinical Services Division of MoH has to date received around 57% of THSSP2 investment in the MoH: 17% being for clinical services activities related to the THSSP2 high-level targets and around 40% for acute hospital care that is not consistent with the priorities expressed in the THSSP2 Design Document. The investment in acute hospital care is not precluded in the design, although some logical connection with progress towards the five high-level program targets would be reasonably expected. This substantial program investment is unmeasured in the M&E Framework. The evaluation team concludes that the large investment in acute clinical care represents dilution of the strategic intent of the THSSP2 program design.

Recommendations

Recommendation	Responsibility	Priority	Timeframe
<i>Program targets and direction</i>			
1. Australian aid health sector support maintains consistent priorities at least until the end of THSSP2.	DFAT	High	Immediate ratification, with effect 2019/20 annual plans
2. THSSP2 annual planning be specifically aligned with the operationalisation of the PEHS.	MoH/DFAT	High/ Medium	2019/20 onwards

Recommendation	Responsibility	Priority	Timeframe
3. THSSP2 annual planning continues in parallel with MoH annual planning until the end of Phase 2, and that future Australian aid works towards integrated MoH/THSSP annual planning.	MoH/DFAT	High/ Medium	2019/20 onwards
Program oversight and engagement			
4. THSSP2 program oversight is re-assigned to the MoH level for the remainder of Phase 2.	MoH	High	Immediate
5. THSSP2 progress reporting and acquittal procedures be simplified.	DFAT/MoH	Medium	2019/20 onwards
6. The criteria for the performance-based payment be simplified, worded more explicitly, and focused on fewer themes.	DFAT	Medium	Before 2019/20 year
Program performance measurement			
7. DFAT adopts a more pragmatic approach towards THSSP2 performance measurement for the remainder of Phase 2.	DFAT	High	2019/20 onwards
NCD prevention			
8. TongaHealth's grant application and management processes and systems be simplified and streamlined to the extent possible.	TongaHealth	Medium	Before end of phase 2
9. TongaHealth proactively encourages grant applications based on strategic relevance.	TongaHealth	High/ Medium	From 2019/20 onwards
10. TongaHealth supports and facilitates local research to inform and evaluate health promotion messages and focus (healthy eating, health-promoting churches and NCD control).	TongaHealth	Medium	Initial steps taken before end of phase 2
NCD management and universal health coverage			
11. The planning for the PEHS rollout considers the role of nurses, particularly in relation to NCD control.	MoH	Medium	Before end of phase 2
Health sector management			
12. Future Australian aid health sector designs reflect the underlying need to strengthen core government functions.	DFAT	Medium	Future health sector designs
Disability-inclusive health			
13. Disability-inclusive health activities are captured in program performance measurement.	DFAT/MIA	Medium	Before end of 2019
14. The participation of persons with disability in oversight of the disability-inclusive health component is facilitated by supplementary opportunities for dialogue.	DFAT/MIA	High	From 2019/20 onwards

Recommendation	Responsibility	Priority	Timeframe
<i>Gender and social inclusion</i>			
15. (a) TongaHealth encourages gender-differentiated health promotion activities where appropriate, and (b) MoH develops gender-differentiated NCD interventions where appropriate.	TongaHealth	High/ Medium	Before 2020/21
	MoH	Medium	Before 2020/21
16. Low socio-economic status be included as one of the determinants of disadvantage in future Australian aid health sector support.	DFAT	Medium	Future health sector designs
<i>Technical assistance for remainder of Phase 2</i>			
17. Long-term technical assistance for the remainder of Phase 2 focuses on supporting progress towards the recommendations above, where appropriate.	DFAT/MoH/ TongaHealth	High	Immediate (for TA work plans)

1. Introduction

1.1. Health in Tonga

Tonga has a population of 100,745 (2016 census preliminary count), with around 74% of the national population residing on the main island of Tongatapu. The 2016 population census shows that, since 1996, life expectancy for men has fallen by five years for males to 65 years, and by three years for females to 69 years.

As at 2016, the infant mortality rate was 7.4 per 1,000 live births, the total fertility rate was 3.3, and 31.9% of married women of reproductive age used modern contraceptives (Ministry of Health, 2018). Rates of emigration are very high, with an annual net outwards migration rate of 17.8 per 1,000 (2017 estimate: CIA, 2018). The population growth rate is estimated to be -0.1% (CIA, 2018). The percentage of literacy, immunisation, deliveries with a skilled birth attendant, and access to water and sanitation are all at, or close to 100% (Ministry of Health, 2018; Rodney A, Hufanga S, Sausini Paasi S, Vivili P, 'Ahio T and Hufanga M, 2015).

Tonga has one national referral hospital (Vaiola), four district hospitals (Niu'eiki, Niu'ui, Prince Wellington Ngu, and Likamonu), and 14 Community Health Centres (seven on Tongatapu, seven on other islands). There were 71 doctors and 454 nurses working in Tonga as at end of 2016. Services are funded through general taxation and are free at a point of delivery. Pharmaceuticals are free if dispensed at health centres.

The growing prevalence of non-communicable diseases (NCDs) is a national health crisis: driving up mortality rates and health system costs. The four primary NCDs are heart disease, type 2 diabetes mellitus (T2DM), chronic obstructive pulmonary disease (COPD) and cancer (Institute of Health Metrics and Evaluation, 2017; WHO, 2017). The prevalence of all NCDs was estimated to be 7% in 1973, 15% in 1999 and 18% in 2004 (Government of Tonga, 2011). By 2012, the World Health Organization (WHO) STEPwise approach to Surveillance ('STEPS') survey found that the prevalence of specific NCDs amongst adult Tongans had increased to 22% for diabetes, 28% for hypertension and 49% for elevated blood cholesterol.

The primary NCDs share four behavioural risk factors: unhealthy diets, physical inactivity, alcohol and tobacco use, as well as the intermediate risk factor of overweight/obesity. The 2012 STEPS survey concluded that 98.7% of the population are at moderate or high risk of NCDs (displaying at least one risk factor), with 61% at high risk (three to five risk factors). Key findings in the 2012 STEPS survey (for adults age 25-64 years) were:

- 90.7% of the adult population is overweight or obese (67.6% obese)
- 73.1% are not meeting fruit and vegetable intake guidelines
- 23.7% have low levels of physical activity
- 26.7% are daily smokers.

The 2017 WHO Global School-based Student Health Survey (GSHS) shows that it is not only adults at a high risk of NCDs, with adolescents (age 13 years onwards) showing an increase in behavioural risk factors since 2010. Left unaddressed, the potential future burden of NCDs in this younger population already at high risk threatens to overwhelm the health system and impact on the social and economic development of Tonga.

As the first Pacific country to release a national NCD strategy in 2004, Tonga has been a leader in strategic and policy direction within the region. However, NCDs are a chronic, whole of society issue that require long lasting and efficient health and societal action to effectively control and prevent.

1.2. The Tonga Health Systems Support Program (THSSP)

The Australia-Tonga Aid partnership, as documented in the Aid Investment Plan (AIP), sets the strategic framework for the provision of Australian bilateral aid to Tonga. There is one objective for the health sector: [a] **more effective, efficient and equitable health system**. ‘Australia is promoting a more effective, efficient and equitable health system in Tonga, with a focus on reducing the health and economic burden of NCDs.’

Since 2009, Australia has invested in Tonga’s Ministry of Health (MoH) through the Tonga Health Systems Support Program. Phase 1 (THSSP1) of the Program (2009-2015) aimed to improve community health services and deliver preventative health measures, while focusing on halting the rise in prevalence of NCDs and its risk factors. The program also supported improvements in primary health care services to a common national standard, a skills development twinning arrangement with Ballarat’s St John of God Hospital, provision of critical clinical positions, and mentoring and training to support the operation of Vaiola Hospital. THSSP1 also supported Tonga to build a cadre of specially trained NCD nurses to improve the treatment of NCDs. The nurses are stationed at health and diabetes centres across Tonga, including all outer island groups.

THSSP Phase 2 (THSSP2) commenced in March 2015, with Australia agreeing to continue its support to Tonga’s health sector in order to improve health service delivery, in particular preventive health services. THSSP2 is designed to support the Government of Tonga (GoT) strategy and planning for the health sector by providing support to MoH and TongaHealth to improve health service delivery, with a strong focus on NCDs. The program is aligned to the Tonga Strategic Development Framework II, the National Strategy to Prevent and Control NCDs 2010 – 2015, and the MoH Corporate Plans 2015-2020. The THSSP2’s overarching objective is for a more effective, efficient and equitable preventative and primary care service for the Tongan population.

THSSP2 was designed to be organised around funding of the annual work plans of the MoH and TongaHealth. 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. Funding occurs under a direct funding agreement with the Ministry of Finance (MoF), for the MoH, and a funding agreement with TongaHealth. THSSP2 also funds technical assistance, procured directly by DFAT, and program management.

In the parlance of international development program design, THSSP2 is designed to be ‘on budget’ and ‘on system’ i.e. program activities are budgeted as part of the annual work plans for the MoH and TongaHealth, and program funds are managed and expended through GoT financial systems or TongaHealth grants. THSSP2 was also designed to be ‘on plan’, to the extent that MoH and TongaHealth annual planning flows from the relevant medium-term strategic plans.

Compatibility with Government of Tonga priorities

THSSP2 is broadly supportive of the health outcomes of the *Tonga Strategic Development Framework 2015 -2025* (TSDF II) and the goals of the *Tonga National Health Strategic Plan 2015-2020*.

Pillar 2 “social institutions “of the TSDF II sets out the following health outcomes:

- Outcome 2.5: Improved health care and delivery systems (universal health coverage): Improved, country-wide, health care systems which better address the medical conditions becoming more prevalent in Tonga so hastening recovery and limiting pain and suffering.
- Outcome 2.6: Stronger integrated approaches to address both communicable and non-communicable diseases: A stronger and more integrated approach by all parts of society, to address communicable and non-communicable disease, significantly cutting the rate of these diseases and the burden they place upon communities and the economy.
- Outcome 2.7: Better care & support for vulnerable people, in particular the disabled: Better care and support for vulnerable people that ensures the elderly, the young, disabled and others with particular needs continue to be supported and protected despite shrinking extended families and other changing social institutions.

The relevant parts of the Tonga National Health Strategic Plan are set out in Table 1 below.

Table 1: Tonga National Health Strategic Plan 2015-2020: key result areas and goals

Key Result Area	Goal
KRA 1: SERVICE DELIVERY	To provide the best attainable quality health care services through promotion of good health, reducing morbidity, disability and premature (death) mortality.
KRA 2: HEALTH WORKFORCE	To provide the best attainable human resource services and workforce systems that can serve the best attainable quality health care services.
KRA 3: INFRASTRUCTURE, MEDICAL PRODUCTS AND TECHNOLOGY	To provide the best attainable infrastructure, medical products and technology that is needed to deliver the entire minimum required health care services in Tonga.
KRA 4: LEADERSHIP AND GOVERNANCE	To provide efficient and effective leadership and governance systems that would produce and deliver the best attainable health care services to the people of Tonga.
KRA 5: INFORMATION, RESEARCH, POLICY AND PLANNING	To provide the best attainable policy and planning services that is guided by credible information and research to ensure the cost effectiveness of health care services in relation to health needs and problems of Tonga.
KRA 6: HEALTHCARE FINANCE	To improve financial support for efficient implementation of health services in Tonga.

The NCD prevention component of THSSP2 is very specifically designed to reflect (and support) the *National Strategy for the Prevention and Control of NCDs 2015-2020* ('Hala Fononga').

Table 2: National Strategy for the Prevention and Control of NCDs 2015-2020: vision, goals and key result areas and goals

VISION:	Stronger integrated approaches to address non-communicable diseases result in reduced premature death, illness and disability
GOALS:	Positive trends in Tonga's performance against a relevant NCDs environment policy index that measures key influences like funding and resources, health-in-all-policy, leadership and governance
	Positive trends in the effectiveness of NCDs related multi-sectoral partnership in delivering against NCDs strategy goals
OUTCOMES:	1: Tongan infants (age 2 and under) have a healthier start to life
	2: Tongans are leading healthier lifestyles (with a focus on children and adolescents)
	3: Improved early detection, treatment and sustained management of people with or at high risk of NCDs
	4: Strengthened monitoring and surveillance supports evidence-based action

THSSP2 targets

The original THSSP2 program design identified five outcome targets to be achieved by the end of program:

- 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 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 program targets were subsequently refined in June 2017, as indicated below:

- 1) Rate of premature deaths and preventable disability related to NCDs has not risen.
- 2) Fall in percentages of population at high risk of developing NCDs.
- 3) Develop and implement a plan with strategies to increase NCD management as part of universal health coverage leading to efficiencies and budget cost savings through the program.
- 4) Strengthened health system management (including public financial management) of budgeting, planning, reporting, implementation and procurement.
- 5) Increased equity of access for poor and marginalised groups, including people with disability, to MoH services and TongaHealth activities.

THSSP2 budget

THSSP2 was designed with an overall budget of \$10 million over the five years July 2015 to June 2020. The budget was allocated as \$6.8 million for MoH and TongaHealth, \$1.0 million for performance-based payments to MoH and the remainder for Post program management costs. Technical assistance was to be funded out of the MoH/TongaHealth allocation.

The total investment was increased by variations in August 2016 and October 2017 to a total of \$17.3 million. The variations added \$3.3 million in DFAT regional Disability-inclusive Development (DID) funding, increased the total amount of bilateral funding, and modified the performance-based payment component. The final budget includes:

- a direct funding agreement with MoH (\$10.75 million) supporting a range of NCD prevention and treatment services, as well as systems strengthening support to improve planning and budgeting for sustainability, and including a component earmarked for disability-inclusive health (\$3.3 million) for service accessibility, community-based rehabilitation, and mental health. Funded activities are negotiated each year against MoH management plans.
- a direct funding agreement (\$2.1 million) with TongaHealth to support national cross-sectoral action and coordination on the national NCD strategy
- technical assistance costs (approximately \$1.9 million), and
- Post program management costs and audit (approximately \$1.5 million).

THSSP2 is by far the largest donor program in the health sector. The average annual budget of THSSP2 is equivalent to 13.5% of the GoT budget allocation for health in 2017-18.

Governance, management and staffing

The National Health Development Committee (NHDC) is the highest governance structure in the MoH and is chaired by the Minister. The THSSP2 Design Document intended that the NHDC and the TongaHealth Board would be the peak governance bodies for the program: approving annual work plans of program-funded activities and monitoring quarterly reports. DFAT was to be included in dialog around the work plans and would have final approval regarding activities to be funded.

The Post program management structure is one Australian Public Service position (Second Secretary Development) funded from program funds and two Program Managers in nationally-engaged positions. Under the terms of an Agreement between DFAT and MoH, MoH is obliged to fund and staff two program support positions, a project coordinator and a finance (accounts) officer, as a precondition for THSSP2 funding.

At the time of the midterm evaluation, two long term technical assistance positions were funded out of program funding: a health planner and a health promotion/NCD specialist. A long-term procurement and contracts specialist was deployed to the MoH under the DFAT economic governance program.

1.3. Australian aid strategic priorities

In addition to the directions of Australia's country program in Tonga, this mid-term evaluation is intended to determine the extent of consistency of THSSP2 with the broader policy directions and strategies for Australian aid. Relevant key DFAT policy documents include *Making Performance Count* (2014), *Health for Development Strategy* (2015), *Gender Equality and Women's Empowerment Strategy* (2016), and *Development for All* (2015).

Making Performance Count sets out the purpose of Australia's aid program: promoting Australia's national interests by contributing to sustainable economic growth and poverty reduction. The 10 targets are:

- 1) Promoting prosperity
- 2) Engaging the private sector
- 3) Reducing poverty
- 4) Empowering women and girls
- 5) Focusing on the Indo-Pacific region
- 6) Delivering on commitments
- 7) Working with the most effective partners
- 8) Ensuring value-for-money
- 9) Increasing consolidation
- 10) Combatting corruption

The targets for Australian aid described in *Making Performance Count* are reflected in the evaluation framework for this mid-term evaluation.

The contribution that health programs make towards enabling development is the subject of DFAT's Health for Development Strategy 2015-2020. In the health sector, Australia's highest priority for aid is to work towards strengthened, resilient public health systems as a foundation for country and regional health security and prosperity.

DFAT's *Gender Equality and Women's Empowerment Strategy* integrates gender equality into Australia's aid program and requires that at least 80% of development investments effectively address gender equality issues. In addition to the aid program, gender is simultaneously addressed through diplomatic, trade and DFAT internal corporate policy.

Development for All is intended to address barriers that limit the extent to which people with disability can enjoy the benefits of development. The strategy has a twin-track approach which seeks to mainstream the participation of people with disabilities whilst concurrently targeting some initiatives specifically to benefit people with disabilities. Under the strategy, Australia also assists beneficiary countries to ratify and implement the Convention on the Rights of Persons with Disabilities.

1.4. Complementary evaluations

This THSSP2 mid-term evaluation occurred immediately prior to the mid-term evaluation of '*Hala Fononga*', the National Strategy for Prevention and Control of Non-Communicable Diseases 2015-2020. Although the THSSP2 evaluation team had expected to be informed by and coordinate with the NCD strategy review, no findings were available from the NCD strategy review in time for incorporation in the THSSP2 evaluation.

The DFAT Office of Development Effectiveness (ODE) is conducting a strategic evaluation of DFAT's bilateral Pacific health investments over 2008-17. Case studies in Tonga, Fiji and Solomon Islands will investigate factors affecting the effectiveness of health system strengthening investments, with particular attention to the following activities:

- 1) Strengthening health information systems
- 2) Strengthening the health workforce to improve access to, and the supply of, health services

- 3) Strengthening financial planning and management for health service delivery
- 4) Strengthening the management of pharmaceutical supplies

The entry point for the case studies are activities funded through bilateral investments, but the ODE will also examine complementary activities funded through regional programs. The findings and recommendations will not be specific to any investment or country. The ODE evaluation team visited Tonga prior to the THSSP2 mid-term evaluation, and some of the ODE's insights were considered in the THSSP2 evaluation.

2. Evaluation Methods

2.1 Evaluation purpose

The purpose of this mid-term evaluation is to obtain information about the implementation of Australian-funded support to the health sector. This information will be used to improve Australia's support to the MoH and TongaHealth and, subsequently, the delivery of Tonga's National Health Strategic Plan 2015 – 2020. This will be the first evaluation of THSSP2.

The specific objectives of this mid-term evaluation are:

- 1) To review and document the performance of THSSP2 over the period 2015 – 2017, including the program's achievement against agreed performance benchmarks to inform the 2018-19 Performance Based Payment.
- 2) Based on the review findings, provide recommendations for improvements that could be made by partners in the remaining implementation period to June 2020.
- 3) Provide advice on options for future support to the health sector in Tonga beyond June 2020, and in particular if the THSSP2 delivery modality is still appropriate.
- 4) Make recommendations for analytical products to be commissioned to inform a future health program design.

The full Terms of Reference for the mid-term evaluation are at **Annex A**.

2.2 Evaluation scope and methods

The evaluation was undertaken by a three-person team: a team leader/evaluation specialist, a health financing specialist, and an NCD service delivery specialist. An evaluation methodology was developed by the team in advance and documented in an Evaluation Plan that was reviewed and endorsed by the Australian High Commission Nuku'alofa. The terms of reference (ToR) provided for 12 calendar days in Tonga but due to international flight schedules the team spent only ten calendar days in country (one team member arriving in the afternoon a day before the other two members). Seven working days were spent meeting relevant stakeholders and sourcing data for measuring program performance, the weekend was used for analysis, team discussion and preliminary writing, and on the final working day the team provided a departure debriefing for stakeholders.

The evaluation approach reflected the program design, with five high-level program targets and the intention that progress would be measured using an extensive THSSP2 Monitoring and Evaluation Framework (M&E Framework). The indicators in the M&E Framework are a mixture of qualitative

and quantitative measures, including some sentinel events. In the program design concept, actual activities were intended to be planned annually and not individually monitored. The evaluation approach therefore relied on obtaining source data for populating the M&E Framework.

Document review

A background set of documents relating to THSSP2 was shared with team members in advance of their travel to Tonga. Documents included relevant GoT plans and strategies, MoH plans and strategies, and the original program design document. The document review formed the basis of pre-travel planning, including a comprehensive request for additional documents that was submitted to DFAT prior to the country visit. In response to the request, DFAT was able to provide financial reports and acquittals, and DFAT aid quality checks. However, additional documents that needed to be obtained from MoH and TongaHealth were not provided prior to the country visit. A full list of documents reviewed can be found at **Annex B**.

Consultations

The evaluation team conducted consultations using a semi-structured, open-ended interview technique. This meant that consultations began in a broadly uniform manner and then ‘drilled down’ into the subject material that was relevant to the participants. Consultations were not intended to be the sole data collection approach for the evaluation because, as explained above, the program design concept was to monitor progress towards five high-level program targets using the M&E Framework. A full list of people consulted is provided at **Annex C**.

The dominant challenge of the review was the extensive amount of source data for the M&E Framework that remained outstanding when the country visit began. There was a tension between the need to conduct consultations that engaged in discussion at a strategic level, whilst simultaneously making arrangements about how to collect large amounts of detailed operational-level data. The team members jointly attended meetings of strategic or common relevance, and separately attended meetings relating to their primary areas of professional responsibility as set down in the ToR.

Each team member was responsible for recording and collating information relating to their primary area of professional responsibility. Discussion of each day’s findings took place after office hours and on the weekend. Due to the limited duration of the country visit and the unavailability of source data, the team was unable to complete the full synthesis during the visit.

Site visits

The review team met with MoH officers in locations including the MoH headquarters building, Vaiola Hospital, and the Queen Salote Institute of Nursing and Allied Health. Meetings with TongaHealth officers took place in the TongaHealth offices. Two members of the team conducted site visits to two health facilities, Niu’ui Hospital and Foa Health Centre, in Ha’apai district (an outer island group). Consultations with central government agencies, other development partners, non-government organisations, persons with disability groups, technical advisers and DFAT Post took place in a range of locations around Nuku’alofa.

2.3 Limitations

The Evaluation Plan was designed on the assumption that source data would be available for the indicators in the Program M&E Framework and that this would be the principal evidence base for the evaluation. A written request for all of the source documents cited in the M&E Framework was submitted through DFAT Post two weeks prior to the country visit so that these could be made ready

before or during the visit. On the day of commencement of the country visit, the evaluation team raised the need for M&E Framework source data in person with the MoH Chief Executive Officer (CEO).

During the country visit, the evaluation team found that many of the source documents were not ready and so the team made collection of M&E indicators the focus of interviews with informants. The team continued to follow-up requests for data by email for two weeks after the country visit. At the completion of the evaluation process, a considerable amount of source data nominated in the M&E Framework remained unavailable, as detailed in **Annex D**. In some instances, the evaluation team reverted to available alternative forms of information to measure program impact and progress.

At the time of this report, the overall stats of data availability was as follows:

- the majority of financing and PFM indicators had been satisfactorily determined, with data obtained from MoF, MoH and TongaHealth reports and official records (these data sources are subject to audit);
- the majority of population health status indicators had been determined, drawing on MoH annual reports although without external validation of data;
- only a relatively small proportion of service delivery-related indicators had been determined, with data obtained from MoH internal operating databases and without external validation;
- the majority of THSSP2 M&E indicators relating to TongaHealth had been provided directly by TongaHealth (these indicators are subject to review and verification by the TongaHealth board).

3. Evaluation Findings

3.1 High-level program targets

This section of the report considers signs of early progress towards the high-level program targets and speculates on end-of-phase outcomes.

The THSSP2 Design Document sets intentionally ambitious targets for a five-year program (i.e. 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) because it describes the current population of Tongans as already being a ‘time-bomb’ in terms of having extremely high probability of developing NCDs and the urgent need for a ‘generational shift’.

Target 1: Rate of premature deaths and preventable disability related to NCDs has not risen

Data on NCD-related program impact and outcome measures was not available from in-country sources. Global Burden of Disease (GBD) estimates for 2017 show a reduction in NCD related premature mortality of 2.9% in comparison to 2010 (536.5 deaths per 100,000 in 2017; 552.5 per 100,000, 2010). Ischaemic heart disease, diabetes and stroke remain the leading causes of death. GBD estimates are based on modelling and need to be interpreted with caution, particularly in light of the known limitations in accuracy of Tonga’s mortality data on which this modelling process is based.

The THSSP2 Design Document defines preventable disability as diabetic retinopathy, and diabetes-related limb amputation and renal failure. Since data on diabetic retinopathy and renal failure is not routinely collected, only limb amputation is measured in the M&E Framework. MoH annual reports indicate that the combined number of admissions to the Vaiola Hospital surgical ward for diabetic foot ulcers and cellulitis of the lower limb (a proxy measure of limb amputation) increased by only 1% in 2016 (164 admissions in 2016; 159 admissions in 2015). Diabetic foot ulcer was the leading single cause for admissions to the surgical ward.

Overall it appears that target 1 may be achieved with respect to halting the rise in deaths related to NCDs. The results for preventable disability are less certain because at the start of THSSP2 there was a segment of the population with pre-existing undiagnosed NCDs or with imminent NCDs because of lifestyle risk factors (hence the ‘time-bomb’ reference in the Design Document).

Target 2: Fall in percentages of population at high risk of developing NCDs

High risk of NCDs is defined as displaying between three and five risk factors (smoking, overweight/obesity, low fruit and vegetable intake, physical inactivity and/or raised blood pressure). Adult data from the 2016 STEPS survey was not yet available but data from the 2017 GSHS showed evidence of a reduction in some behavioural risk factors amongst 13- 15-year-old students:

- 7% reduction in current smokers (from 21.6% in 2010 to 14.6% in 2017)
- 14.3% reduction in exposure to second hand smoking (from 65.4% to 51.1%)
- 6% reduction in current users of alcohol (from 16.4% to 10.4%)

The 2017 GSHS also found evidence of an increase in physical inactivity and obesity:

- 6.2% reduction in those meeting the physical activity guidelines (from 25.6% to 19.4%)
- 1.4% reduction in those attending physical education classes on ≥ 3 days a week (from 24.4% to 23%).
- 4.8% reduction in the overall proportion of the population classified as overweight and/or obese (although within this a 3.1% increase in obesity).

It is difficult to predict changes in risk factors in the adult population based on a survey of adolescents. The evidence about the impact of health promotion on risk behaviours was an evaluation of the 2016 anti-tobacco campaign which identified a 3.5% reduction in the proportion of adults who were current smokers following the campaign (University of Sydney, 2016). The reduction in smoking and alcohol risk factors for adolescents does appear to reflect positively on past health promotion efforts.

Target 3: Develop and implement a plan with strategies to increase NCD management as part of universal health coverage leading to efficiencies and budget cost savings through the program

At the time of the mid-term evaluation, the MoH was nearing publication of the Package of Essential Health Services (PEHS). The development of the PEHS is a substantial point of progress which should be applauded. It represents, amongst many things, a policy commitment to mainstream NCD management into primary health care. The PEHS also helps to identify service gaps. The baseline survey completed for the PEHS shows that most key heart disease and diabetes management interventions are being delivered, though areas such as lifestyle counselling and diabetic foot care require attention. The survey also found essential services for COPD and cancer management/prevention are not currently present in the majority of primary health care facilities. The evaluation team found evidence (i.e. reported by health workers) of improvements in NCD

management arising from initiatives in THSSP1 that have been supported and maintained in THSSP2, notably the Diabetes Centre and NCD Nurses program, both aided by improvements in the availability of essential NCD medicines. PEHS is a long-term target document which will not be fully realised for some years to come, but ongoing measurable progress towards PEHS standards is expected during the remainder of THSSP2.

Target 4: Strengthened health system management (including public financial management) of budgeting, planning, reporting, implementation and procurement

The MoH budgets, plans, manages and reports on its public resources to the extent that delegations from the central government agencies (National Planning Office, Ministry of Finance, Public Service Commission) allow. The centralisation of GoT public administration functions, and weaknesses in these core government functions, limits what can be expected in terms of THSSP2 impact (see later in this report for details). The MoH has strengthened its organisational structure by consolidating administrative support functions into a Corporate Services Division, and this has the potential to strengthen health system management functionality in the future. Prospects for strengthening MoH planning and reporting before end-of-phase are intrinsically linked with THSSP2 implementation issues and are the subject of specific recommendations contained later in this report.

Target 5: Increased equity of access for poor and marginalised groups, including people with disability, to MoH services and TongaHealth activities

Awareness raising initiatives had been delivered under THSSP2 to prepare the MoH and TongaHealth leadership groups for disability-inclusive health and raise the profile of mental health. The draft PEHS is expressly disability-inclusive and establishes a framework for universally available mental health services in the future. Evidence (i.e. reported by health workers) suggested that THSSP2's continued support for the activities of NCD nurses had maintained an improved level of access to and quality of NCD services in the outer islands districts where those nurses were posted (improved access was initially evidenced in a Phase 1 evaluation of the NCD outreach program). It was also reported by health workers and partially substantiated by the PEHS baseline survey that availability of NCD medications in hospital dispensaries in the outer islands had improved. Overall, it appears likely that THSSP2 will contribute towards increased equity of access for disadvantaged groups. M&E needs to be strengthened to ensure that improvements arising from disability-inclusive health activities are adequately measured: specific recommendations are contained later in this report.

3.2 Progress

The second component of the evaluation examines progress in priority or strategic areas. The ToR for the mid-term evaluation identifies the following six priorities:

- governance, strategic planning, process efficiency, linkages with other donor and DFAT regional programs, and decision making (within both GoT and DFAT systems);
- planning and budgeting (including health expenditure policy, finance and accounting processes);
- primary care service delivery including early detection and management of NCDs, procurement and stock/asset management;
- NCDs prevention and health promotion activities provided by both MoH and TongaHealth;
- monitoring including National Health Indicators, monitoring and evaluation framework and performance-based funding;

- capacity development, including technical assistance.

The evaluation team included a further four strategic issues:

- disability, including mental health
- disadvantage, including remoteness
- gender
- human resources.

Table 3 summarises the most significant points of progress identified during the evaluation, with reference to the priority areas listed above. Table 3 also sets out the structure for the remainder of Section 3.2 and is intended to be interpreted in conjunction with the detailed description and discussion on progress that follows the table. Note that the discussion in Section 3.2 refers back to the program design concept, described in Section 1, that THSSP2 is designed to be ‘on budget’ and ‘on system’.

Table 3: Overview of Progress in Priority Areas

<i>Theme Group</i>	<i>Priority Areas</i>	<i>High-level Comments [1]</i>
HEALTH SERVICES THEMES		
NCD prevention	<ul style="list-style-type: none"> • Health promotion • NCD risk factors • Challenges 	<p>Tonga’s multi-sector action plan for NCD prevention and control positions Tonga as a regional leader.</p> <p>There is promising evidence of early progress in reducing some lifestyle risk factors for NCDs.</p>
Primary health care	<ul style="list-style-type: none"> • Detection and management of NCDs • Package of Essential Health Services • Workforce • Management arrangements for service provision • NCD medications availability and provision 	<p>NCD management has continued to improve (as a largely vertical program).</p> <p>The development of the PEHS is a commendable achievement that provides a vision for the future of the national service delivery system.</p> <p>The PEHS provides a framework for mainstreaming services such as NCD management and mental health into primary health care.</p>
HEALTH SYSTEMS STRENGTHENING THEMES [2]		
Governance and strategy	<ul style="list-style-type: none"> • Governance • Strategic planning • Development partner coordination 	<p>Oversight of THSSP2 by the NHDC has not been achieved as intended in the program design.</p> <p>Oversight of the multi-sector action plan for NCD prevention and control by the NNCD is not to the standard envisaged in Hala Fononga.</p>
Public financial management	<ul style="list-style-type: none"> • Health expenditure policy • Annual planning • Budgeting and accounting • Procurement • Audit 	<p>GoT has maintained its level of financing for the health sector, and MoH’s budget for the Public Health Division has increased as a percentage of the total MoH budget.</p> <p>MoH and TongaHealth have largely met GoT and DFAT accountability requirements, except for consistent delays in financial reporting.</p>

Monitoring and performance	<ul style="list-style-type: none"> Monitoring and evaluation frameworks Performance-based aid 	Monitoring and evaluation in the health sector is problematic, with an excessive number of indicators that exceeds the availability of MOH data or capacity to report, and this adversely affects monitoring and evaluation arrangements for THSSP2.
GENERAL AND CROSS-CUTTING THEMES		
Capacity development	<ul style="list-style-type: none"> GoT central agency support DFAT engagement Technical assistance 	<p>THSSP (both phases) has been successful in establishing an agenda for more effective use of GoT health sector resources.</p> <p>The MoH has taken ownership of key change agendas introduced through THSSP including the PEHS.</p>
Disability, including mental health		A Tongan national disability-inclusive health oversight mechanism inclusive of persons with disability organisations has successfully been established.
Disadvantage, including remoteness		The PEHS is a formal policy commitment to provide a consistent range and level of services in all health facilities, including outer islands.
Gender		The PEHS includes a formal policy commitment to progress gender equality.
Human resources		THSSP2 funding prioritisation has not been achieved as intended in the program design, primarily due to historical issues arising from the inability of GoT to provide regionally competitive remuneration for highly qualified medical professionals.

Notes:

1. Due to limited space, abbreviations are defined in the text that follows and not in the table.
2. Themes that formed part of the evaluation and that are categorised as health systems strengthening: these groupings are not intended to represent the WHO 'building blocks' of health systems strengthening.

3.2.1 NCD prevention

Health promotion

Health promotion was reported as a key weakness in Tonga during THSSP1. The Tonga Health Promotion Foundation ('TongaHealth') was established by the *Tonga Health Promotion Act 2007* to administer the statutory health promotion fund. Under the Act, TongaHealth is responsible for making grants to support health promotion and relevant research, and consultation across government ministries. TongaHealth is neither part of nor responsible to the MoH: it is accountable to the Minister of Health through its own Board. TongaHealth acts as the secretariat for Hala Fononga (the National Strategy for the Prevention and Control of NCDs 2015-2020). THSSP2 contributes towards the implementation of Hala Fononga through a funding agreement with TongaHealth. The MoH Health Promotion Unit is one of the grantees of TongaHealth.

The evaluation team considered that the statutory health promotion fund provided an effective mechanism for pooling GoT and DFAT (THSSP2) funds in support of Hala Fononga, and for sequestering GoT's funding commitment for health promotion from the wider health sector budget (and in particular, away from spending on acute clinical services). It was apparent that TongaHealth's primary role as a grants manager rather than an implementer was widely misunderstood, even amongst key external stakeholders. Within TongaHealth itself, there had been a period of staff turnover preceding the mid-term evaluation and some staff saw their role as a deliverer of traditional health promotion activities such as mass media campaigns. A new CEO with an aid

coordination background had recently been appointed, and the organisation was in a 'catch-up' phase.

In line with Hala Fononga, TongaHealth coordinates a multi-sector action plan for NCD prevention and control (NCD-MAP). The NCD-MAP recognises that the causes and solutions for the NCD crisis extend well beyond the health sector. By working to bring together other government sectors, NGOs and community groups, the NCD-MAP endeavours to form a whole-of-society response to NCDs. While the concept of a multi-sectoral approach to NCDs was formally recognised by the world's health ministers in 2011 (First Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease Control, Moscow, April 2011), actually implementing a multi-sectoral approach is an emerging field that has only gained real traction since 2015.

Sitting at the forefront of multi-sectoral approach implementation gives Tonga the chance to be a regional and world leader. This is strategic for Australia because it is supporting other Pacific countries to respond to similar NCD problems. As a joint funder of the NCD-MAP with GoT, THSSP2 has been instrumental in enabling multi-sector partnerships to gain momentum and initiate actions. Of note are:

- Working relationships between TongaHealth and 14 grantee partners, including essential government departments, civil society and church groups. For example, the anti-tobacco campaign included mass media messages, legislative measures and taxation reforms.
- Partnership with the MoH Health Promotion Unit has resulted in effective planning and delivery of high-quality mass media campaigns (this was an area of concern within THSSP1 as funding was frequently diverted away from health promotion towards clinical care).
- Three years of the national anti-tobacco campaign based on local research included a high-quality evaluation which showed a 3.5% reduction in smoking. The mass media approach included television, radio and social media, as well as billboards and posters.
- A range of physical activity programs at the community and workplace level that have been supported by multi-sector partners and achieved high levels of participation.
- The provision of technical advice to TongaHealth through THSSP2 has assisted in the implementation of high-quality interventions – including the recent work with the Ministry of Revenue & Customs to increase taxation of sugar-sweetened beverages. The evaluation noted that the focus to date has been on imported rather than domestic products.

There is a general consensus that coordinated work and consistent focus has turned NCDs into a whole-of-community issue. Even the terminology has changed from Mahaki ikai pipihi ('disease not communicable') to Mahaki I 'oe To'onga moui ('disease of lifestyle'): emphasising that NCDs are linked to behaviours and can be prevented through healthy actions. A formal independent review of Hala Fononga is scheduled to take place shortly after the THSSP2 mid-term evaluation.

NCD risk factors

There are signs of early progress with the NCD-MAP. As reported under 'High-level program targets', there is evidence from the GSHS that health promotion activities have contributed to a reduction in smoking and alcohol use amongst adolescents. In accordance with the multi-sectoral approach, the health promotion interventions to reduce tobacco use included mass media campaigns, legislation to increase taxation (imported tobacco products only), and statistical measures to improve measurement of smoking behaviour (National Statistics Department: 2016 census).

A healthy eating campaign is planned for 2019 with a focus on sugar, fat and salt. Grant projects have to date tended to focus on promoting fruits and vegetables, which are worthy areas of focus, but when targeted in isolation, may not be sufficient to shift obesity rates. There is a need for local research to identify the priority dietary factors that influence obesity and NCDs in Tonga, such as excessive consumption, feasting and portion sizes that may be missed without attention to the cultural context.

Much work has been done to promote physical activity and change community perceptions, but data is not yet available to demonstrate the impact of this on habitual physical activity. Programs such as Fiefia Sports are popular in both Tongatapu and Ha'apai, and have shown consistent gains in attendance numbers. Program focus on physical activity by TongaHealth, MoH and Ministry of Internal Affairs (MIA) has contributed to a changed perception of physical activity in the community with reports (from multiple sources) suggesting visible changes in the number of people exercising. However, program reports for these activities focus on attendance and have not utilised the opportunity to measure programs' impact on self-reported physical activity levels. Despite Hala Fononga focusing on increasing the provision of physical activity in schools, it appears that no grants have been commissioned to support work this area. As previously reported, the GSHS also shows a slight reduction in the proportion of adolescents participating in school physical education activities.

Though there has been limited work to address alcohol, teenagers have shown a reduction in use. The GSHS showed that 14.0% of 13-17 years old currently drink alcohol and 13.2% had drunk to the point of drunkenness (this was two times higher in males). In comparison to 2010, the proportion of 13-15-year olds who were current drinkers dropped by 6% (from 16.4% to 10.4%). To help address alcohol use TongaHealth has partnered with the Ministry of Police, Tonga National Youth Congress and the Salvation Army. This work has focused on supporting the Liqueur Licensing Act and increasing awareness of alcohol-related harms. Latest reports from TongaHealth's grant tracker show there have been delays in community collaboration with police to enhance enforcement and raise awareness of alcohol legislation. Reports by TongaHealth officers and Board members suggest an increase in alcohol use following Tropical Cyclone Gita.

Challenges for Hala Fononga

To achieve changes in population risk factors, there is a need for strategic prioritisation of areas for grant application (the current approach is almost 'first come, first served', so long as it fits within Hala Fononga). Although there has been encouraging early progress (reported in the previous section), more advanced actions are needed to result in a meaningful reduction in NCD risk factors, particularly in the area of healthy eating. Re-establishing activities proposed in the THSSP2 Design Document, such as advisory committee meetings to steer high-level strategy discussion, might be effective; there are also some practical tools which could help advance action. The first example is to issue guidelines for grant applications which clearly state preferred higher priority activities (currently the only guidance given to potential applicants is a draft grant agreement). The second example is to develop policy briefs for individual ministries and NGOs that outline each organisation's specific role in creating healthy environments, overview of progress/activity so far, and potential strategies for the future (taken from the Hala Fononga activities), and providing advice on relevant equity issues, thus creating a roadmap for that specific ministry or NGO's activity.

Research, innovation and advocacy are needed to ensure sustainable results and local relevance. Grant allocation to fund research that informs healthy eating initiatives is encouraged to ensure the priority areas/behaviours and beliefs in Tonga are addressed. Specific examples of locally-relevant behaviours that arose during the evaluation included the role of feasting and portion sizes, as well as beliefs around traditional medicines hindering NCD control measures in the outer islands.

The health-promoting churches initiative provides an ideal base for both research and message sharing. The church is a focal point of Tongan society with the church network reaching over 90% of the population. The health-promoting churches initiative has generated promising initial action and strengthened multi-sector relationships. However, there is a lack of data available from this program to assess progress and strategically advance the initiative.

In addition to strategic and technical challenges, the evaluation team observed that TongaHealth faces challenges with its grant administration systems. Arrangements that seem practical when there are only two or three grants suddenly become unsustainable when the number of grants increases to the current 18. Challenges include:

- the grant application process is excessively complex and does not facilitate grant applications (the TongaHealth CEO intends to streamline the process)
- grant reporting is too complicated and the figures show timely reporting is slipping (this is related to growth in the number of active grants)
- grantee indicators (reporting and disbursement) were not readily available (the evaluation team had difficulty collecting these)
- monitoring and evaluation efforts have lapsed as the result of staff turnover (hopefully the incoming staff can address this)
- data from M&E frameworks that were built into grant agreements was not available (specified pre/post surveys and health measurements that were planned to be conducted would have been useful for the evaluation team)

There is a disconnect between TongaHealth and DFAT in reporting requirements for THSSP2 funds. TongaHealth endeavours to meet financial reporting requirements set out under previous DFAT agreements whereas DFAT is seeking 'richer' data and conceptual details. The grant tracker, as well as catching-up on outstanding annual reports (which are near completion), will help. A planning session between the new staff members to clarify needs and capacity is recommended.

For the year 2017/18, GoT changed arrangements for how funding flowed to TongaHealth. Rather than flowing directly to TongaHealth from MoF, funds for TongaHealth now pass through the MoH. Since the MoH Health Promotion Unit is a grantee of TongaHealth, TongaHealth funding that is earmarked for the Health Promotion Unit is retained within the MoH and does not pass through the TongaHealth mechanism.

3.2.2 Primary health care

Detection and management of NCDs

Positive improvements in NCD care were evident and linked to THSSP initiatives (phases 1 and 2). For example, reports from the Vaiola Hospital Diabetes Centre indicates that, with THSSP2 support, the Centre has worked to improve patient-centred care to achieve a lower level of defaulters (i.e. to reduce the number of diabetics who cease or skip treatment) and greatly improved NCD management of diabetic patients. The provision of an HBA1c machine has allowed for assessment of long-term diabetes management, and verbal reports suggest the average HBA1c levels of patients has fallen from 11 to 8 mmol/mol. These are substantial improvements, and the Diabetes Centre is encouraged to publish these reports. It is also advised to apply lessons learned from the Diabetes Centre in improving the care of diabetic patients to services around the country.

The evaluation team heard positive reports on the NCD nurses (trained under THSSP1 and further supported under THSSP2). Seventeen (17) of the 20 NCD nurses trained remain in practice and

appear to show good leadership in NCD care with patients enjoying smoother care pathways and referrals. MoH staff suggested that this has improved reporting of NCD data (not viewed by the evaluation team) and there is a widespread desire to expand the NCD nurse program by repeating the course for new cohorts of NCD nurses, and expand their skills and abilities in conducting research, leadership and prescribing rights. Within the community setting of Ha'apai the benefit of the NCD nurse was very apparent with well-structured clinics and home visits easing the doctors' workload and providing the NCD nurse with a great sense of pride and responsibility where she would persist with contacting defaulters and motivating patients with poor control as well as running exercise programmes for patients. There is interest in training more NCD nurses with content extending into research, leadership and management.

Package of Essential Health Services (PEHS)

The PEHS document, at pre-publication final draft stage at the time of the midterm evaluation, specifies:

- the health services that are considered 'essential' at each delineation level of the referral system, and
- the delivery system inputs (infrastructure, drugs and equipment) needed to provide these services.

The document includes a description of how services will be made accessible to the most remote island communities, and how gender and disability-inclusion will be mainstreamed. The MoH intends to proceed with publication of the PEHS as a formal policy statement in early 2019. The development of such a policy document is one of the identified objectives of THSSP2, and THSSP2 annual funding has supported the consultation processes leading to the current draft document.

The PEHS indicates that NCD management will be mainstreamed into primary health care. The PEHS incorporates the core interventions in the WHO Package of Essential NCD Interventions (PEN) and 'best buy' cost-effective interventions for NCD control. The PEHS provides direction to broaden services from the sole focus on diabetes (T2DM) and heart disease to include cancer and COPD. This aligns to international guidelines and the Sustainable Development Goals (SDGs). This is a positive move for Tonga where COPD, in particular, has a substantial impact on premature death and disability. It has also raised the profile of mental health and promotes a lifecycle approach to NCD prevention via the inclusion of 'First 1000 days' components. For the control of diabetes and heart disease, the PEHS and a revision of the essential drugs list (EDL), promote consistent service provision and reduce the likelihood of medication shortages. The PEHS provides a framework for improving NCD management by informing planning, financing and monitoring. The impact of PEHS now depends on official publication and an effective rollout strategy. THSSP2 funding has been instrumental in supporting the PEHS development.

Although THSSP2 M&E Framework data on current NCD management (including the number of health centres screening for NCDs plus new cases of diabetes (T2DM) and hypertension) were not available, the PEHS baseline survey provides a snapshot of service availability and gaps for all NCDs. The baseline survey shows that essential services for COPD and cancer management/prevention are not currently present in the majority of primary health care facilities. Most key heart disease and diabetes management interventions are being delivered, though areas such as lifestyle counselling and diabetic foot care require urgent attention in all health facilities.

Full achievement of the standards in the PEHS has significant workforce, infrastructure, equipment, training, and supervision costs that are as yet unknown. In 2019 the World Bank will commence a

facilities costing exercise that is expected to provide financing guidelines by 2020-21. Sources of finance have not been identified. Given that the PEHS is the vehicle for achievement of the THSSP2 high-level target *‘develop and implement a plan with strategies to increase NCD management as part of universal health coverage leading to efficiencies and budget cost savings through the program’*, financing of the PEHS has become a strategic concern for THSSP2.

Workforce

Although Tonga enjoys a relatively higher workforce density of doctors and nurses in comparison to other Pacific Island countries, the allied health workforce is limited with only one physiotherapist and three nutritionists/dietitians providing secondary health care services at Vaiola Hospital. Capacity for the provision of specialised ‘healthy lifestyle’ interventions and NCD-related rehabilitation services in primary health care is therefore limited and relies heavily on the nursing workforce. The PEHS signals that strengthening of NCD services (including counselling on healthy lifestyles for primary prevention) will be effectively ‘mainstreamed’ into universal health coverage but the capacity of the nursing workforce to deliver these specialised lifestyle interventions and rehabilitation elements of the PEHS is uncertain. The evaluation team concurred with various parties (including nurses) who expressed concern that nurses will be potentially overburdened with counselling requirements to cover NCDs, gender-based violence and mental health.

The PEHS baseline survey and interviews with nurses indicate that further training of nurses is needed in order to develop capacity to deliver the services indicated in the PEHS. Key areas linked to the quality of NCD management include the delivery of behaviour change interventions for reducing risk of NCDs and improving management. Options such as motivational interviewing and behavioural activation should be explored, as well as the availability of regional tools for patient counselling such as those produced by The Pacific Community (SPC). Training also needs to ensure local relevance in relation to both lifestyle factors and medication use. A key factor to address is the influence of traditional medicine on adherence to recommended drug therapy. This was considered by informants at Niu’ui Hospital to be a determinant of poor NCD control in up to 40% of NCD cases in Ha’apai and was identified by the 2015 Health System Review as a core source of out-of-pocket expenses. Improvement in diabetic foot care in order to prevent disability is also a priority area, nurses in more remote settings highlighted that this training needs to account for different resource availability for procedures, and patient circumstances in areas away from Nuku’alofa.

Reports from nurses and development practitioners suggest the nursing workforce has been very prompt with reporting and taking up new technologies in their reporting, no data on this was available for the review team to assess this, suggesting a gap in the central collation of this data.

Management arrangements for service provision

Outreach services for the proactive management of NCDs are key to improving health outcomes. Without outreach, there was potential for NCD patients to delay travel to health facilities for wound examinations or to obtain medication refills. The ability of nurses to effectively deliver community outreach services is a concern as the current model of supervision means that nurses who work in the community are supervised by hospitals and community health centres and are frequently ‘pulled back’ to the health facilities. This undermines universal health coverage (and the THSSP2 high-level target of reducing health system costs) and contributes to patient preferences to bypass community facilities and go direct to hospitals. The evaluation team noted that the THSSP2 M&E Framework has no indicators that reflect on the numbers of NCD patients who are managed in the community, rather than attending a health centre or hospital.

During the visit, nurses voiced concerns that the recent restructuring (which places nurses under the direction of medical officers) meant there is no nursing authority to advocate for the needs and concerns of nurses. Nurses felt that having a head nurse would increase nurses' power to 'push back' against requests to revert to facility-based care. Also, the creation of a new cadre of NCD nurses under THSSP1, and a recent MoH restructure which divided the nursing workforce within the Public Health Division by establishing a new Community Health Section had resulted in a divide between reproductive health, NCD and general nurses, who had previously worked together harmoniously.

Delivery of effective community outreach services is further complicated by the limited prescribing privileges of nurses. NCD patients may receive nursing services in their homes but be required to attend hospitals to obtain prescription-only medications. Prescribing limitations further contribute to patient preferences to go directly to hospitals and larger health centres. MoH has indicated its intention to review prescribing arrangements in 2019.

NCD medications availability and provision

Feedback from pharmacy staff and nurses suggests improvements in availability of essential NCD medicines between 2016 and 2018. Specifically, there were no reports of stock outs in the previous year. While the review team was not able to meet key the chief pharmacist, the 2017 and 2018 stock reports from Vaiola Outpatient Dispensary support this finding of no stock outs, with all essential NCD medications in good supply.

Information on the rates of NCD patient defaulters was not available. Feedback suggested that waiting times for prescription refills was an influence on both defaulters and non-compliance with medications. Suggestions to improve this include (i) separation at hospitals of patients waiting for consultations and those simply seeking repeat medications, (ii) increased prescribing privileges of nurses, and (iii) coordinated prescription times for NCD related medicines (metformin reportedly runs on monthly prescriptions, while statins run on fortnightly prescriptions). The MoH indicated that a review of prescribing rights and needs is due for 2019 and hopes to investigate these issues further.

The tracer drug checklist that measures availability of essential non-expired medicines shows good availability of oral hypoglycaemic agents and metformin for diabetes (T2DM) management. For management of heart disease, angiotensin-converting enzyme (ACE) inhibitors and atenolol show generally good coverage though both drugs are absent in the Niuaus (outer islands) health centre. Data on insulin appears to be missing from the tracer drug checklist. Captopril (for hypertension) should be in all health settings though some gaps are evident.

The evaluation team was unaware if reviews or audits had been undertaken into the appropriateness of prescribing practices. At a policy level, the Essential Drug List and the PEHS reflect best practice in the use of NCD medications.

3.2.3 Governance and strategy

Governance

The THHSP2 Design Document intended that program governance would be incorporated into GoT health sector governance arrangements. As explained in Section 1, the NHDC was to be the peak governance body for the overall program: approving annual work plans of program-funded activities and monitoring quarterly reports. DFAT was to be included in dialogue around the work plans and would have final approval regarding activities to be funded. For various reasons, the NHDC has not met regularly and has not performed the program oversight function envisaged in the program design. At the time of the mid-term evaluation, the NHDC had met only once or twice in the previous

12 months, and it had not discussed THSSP2 at its meetings. The current Minister for Health holds two ministerial portfolios concurrently, and it appears that there is little likelihood of re-establishing regular NHDC meetings.

The TongaHealth Board (appointed by the Minister) has provided regular oversight to the operations and finances of TongaHealth. However, the National NCD Committee (NNCDC) and the various cross-sector and other committees engaged in NCD prevention have not met regularly as planned.

GoT ministries, in general, do not meet on a regular basis (at CEO level or officer level) to coordinate the executive management of government, consider new policy and support Cabinet decision-making. The MoH budgets, plans, manages and reports on its public resources to the extent that delegations from the central government agencies (National Planning Office, Ministry of Finance, Public Service Commission) allow. The Joint Policy Reform Program of economic and public sector reform that is funded by DFAT, the ADB, EU and World Bank aims to strengthen the management of public finances, policy formulation and coordination, and other public sector management. This will eventually benefit the MoH but progress will be slow and results are unlikely in the short term (ADB, 2017).

Weaknesses of the core government functions greatly limit what can be expected in terms of MoH, and by extension THSSP2, performance in the form of strengthened health system management, including planning, financial management, implementation, monitoring, health information, procurement and human resources. The MoH has very recently strengthened its organisational structure by consolidating administrative support functions into a Corporate Services Division, and this has the potential to strengthen health system management functionality in the future. Given that the new Corporate Services Division is yet to have an impact (the evaluation team did not encounter any claims or evidence of improved performance arising from the restructure), governance is considered to be in much the same state at the time of the mid-term evaluation as it was at the beginning of THSSP2.

In Section 2.3, the evaluation team observed that a significant proportion of the measures in the THSSP2 M&E Framework could not be obtained or were not readily accessible (i.e. the raw data exists in patient databases, but the summary level indicators are not on hand). This indicates that executive-level decision making is currently not well supported by formal information sources (although it may be using informal sources). THSSP2 is predicated upon a model of efficient use of health sector resources informed by evidence in a transparent process. Therefore, the absence of information support contributes to weakness in governance at the operational ministry level.

Strategic planning

The National Planning Office (NPO) assists the Prime Minister's Office to provide leadership and direction in whole-of-government policy development, and to facilitate implementation of government priorities and projects. Recent reforms have increased the NPO's level of consultation with line ministries regarding budget formulation and corporate planning and monitoring, supporting more credible annual budget formulation.

Although the NPO is assigned a most important task in support of improved public service performance and social and economic growth and development, it has few staff and is not supported by any cross-ministry policy coordination and policy advisory committee. Cabinet does not appear to be supported by any CEO level public service management committee.

Government policies and priorities are explicit and are broadly reflected in the budget. Policy priorities are established in the TSDF II. The allocations in the national budget are reasonably well

aligned with the priorities set out in the TSDF II. A government-wide national corporate planning exercise that commenced 2014/15 is still being developed. Higher-level impact and sector outcome statements have been established but are yet to be fully translated into ministry/agency outputs and activities and linked to inputs. Ongoing inputs and activities do not, therefore, have a framework for prioritisation, and resultant M&E indicators can be too numerous to measure. The generation of national and sector statistics is also poorly developed, in part because there is minimal policy demand for such information. According to the Asian Development Bank (ADB), corporate plans are also not costed nor are they linked to budgets (the MoH has records of historical recurrent expenditure but these records are not used to develop forward estimates). It is unclear whether outer island and national programs develop costed annual operational plans to inform the budget.

There is no regular or systemic review of health system performance by GoT: the legislature and senior executive do not demand reports. MoH Annual Reports are infrequent (reports for 2015 and 2016 were shared with the evaluation team but are yet to be published, and reports for 2017 and 2018 have not been prepared). MoH management meetings are also irregular and there is no demand for information for governance. There are no regular reviews of health sector performance by the health sector stakeholders (including Development Partners). In addition, there has previously been very limited information for MoH management from the centralised GoT financial management information system (FMIS) with very little access for operational ministries (see section 3.1, target #4). The WHO reports that ‘the current method of resource allocation and purchasing is not conducive to improving efficiency and better data is required to assess the levels of efficiency in service provision and resource allocation in Tonga.’ ADB has prepared a project to support the MoH design and implementation of a hospital HIS, while DFAT’s Innovation Exchange is supporting a public health HIS.

The THSSP2 M&E Framework (indicator 5.7) measures MoH corporate planning performance in terms of ratings given by MoF: these were ‘red’ 2016/17, ‘green’ 2017/18 and ‘green’ 2018/19. Therefore, the official program M&E indicator would suggest that MoH planning capacity has improved significantly. The then MoF rating scale (which has recently been abandoned by MoF) was based on characteristics such as correct categorisation of outputs and activities, measurable indicators and linkage with the TSDF II. The definition of a ‘green’ rating is “more than adequate, you might provide a comment on how it could be further improved, but for now it is sufficient”. Given the discussion in the preceding paragraphs, the evaluation team questions the meaningfulness of the MoF ratings awarded to MoH, considering the low utility of the corporate planning currently undertaken by MoH.

The evaluation team was also concerned about the apparent lack of cross-linkage between the MoH corporate plan and the National Health Strategic Plan 2015-2020 (NHSP 2015-20), and the budgeting process. The key result areas of the NHSP 2015-20 were provided in section 1.2.1. (Table 1). The NHSP 2015-20 states in its title that its goal is to achieve universal coverage but within the document there is not a comprehensive, holistic vision of what this will look like. The main future-oriented statements are contained within each individual key result area. The NHSP includes relatively detailed indicators and outputs (labelled as “targets” in the document) for each key result area, on the understanding that these will inform the MoH Annual Management Plans (annual budget process). Since operationalisation of the NHSP is not explained within the NHSP itself, this partly explains the subsequent lack of cross-linkage with the MoH corporate plan and the annual budgeting process. Most significantly, the NHSP does not indicate how outputs will be financed.

Overall, it was evident that MoH had invested considerable resources and effort over recent years in developing the NHSP and the corporate plans, but the evaluation team had concerns about

excessive complexity of the documents, thereby reducing “user friendliness”, and the extent to which the plans reflected actual capacity to implement. This is a thorny issue in development practice because nations have an understandable desire to aspire to rapid development, but the members of the evaluation team felt personally that setting overly ambitious goals contributes to a sense of under achievement and undermines staff confidence. Both the NHSP and the PEHS signal the desire of the MoH to strengthen the health system at the primary health care level, but (from the documents) it was unclear to the evaluation team how this would be progressed.

Development partner coordination

DFAT is by far the largest bilateral donor in the health sector. The UN system development partners active in the health sector (WHO, UNFPA, UNICEF) and World Bank, ADB and SPC, are managed regionally (WHO and UNFPA have in-country offices). The evaluation team met with the New Zealand Deputy High Commissioner, who expressed New Zealand’s interest in supporting activities in the health sector, the WHO resident technical officer, and the UNFPA resident officer. The World Bank was consulted remotely following the country visit (details of the World Bank Pacific Health Analytical and Advisory Services (PASA) program are provided later in this report). The evaluation team did not meet with any other development partners but did note that the ADB is about to commence an ehealth project and an immunisation project, and JICA has donated medical equipment.

In some other Pacific Island countries, peak sectoral coordination forums have had some success in aligning host government and development partners in working towards an agreed sectoral strategy. The World Bank is familiar with and supportive of sector-wide coordination models, and is playing a key role in supporting better oversight over development partner contributions under the PASA work plan. A previous WHO country representative did organise regular development partner meetings, but the arrangement lapsed when that person was posted elsewhere. Since Tonga has only DFAT as a major bilateral partner, the MoH may not perceive potential benefits in improving donor coordination. The smaller donors may be satisfied to identify niche roles for themselves and have little to gain from sector coordination. Given the number of partners working vertically in the sector, better coordination could only serve to improve management and use of all resources available to the health sector. However, DFAT has a particular interest as a major donor needing clarity about the medium-term strategic direction of the sector in order to optimise the strategic impact of its investments.

3.2.4 Public financial management

Health expenditure policy

The THSSP2 Design Document was particularly concerned that GoT maintain its level of financing for the health sector, and that MoH’s budget for the Public Health Division (excluding donor funds) increases as a percentage of the total MoH budget. These two critical commitments have been met: MoH’s share of the total GoT budget increased from 12.9% in 2015-16 to 13.2% in 2017-18, and the MoH budget allocation for the Public Health Division increased from 8.3% in 2015-16 to 12.8% in 2017-18 (refer **Annex D** for detailed financial performance measures).

Other health sector financing targets (i.e. commitment of public finances) in the THSSP2 M&E Framework have mostly been met. See the following:

Targets fully met:

- Funding has been channelled through existing MoH financial processes (see comments on accountability below).

- Each year MOH has expensed more than 70% of its budget, however actual expenditure has exceeded budget by at least 9% each year, possibly indicating poor alignment of planning and financial management.
- TongaHealth disbursed 73% of DFAT grant funds on time over FY 15/16 and FY 16/17.
- Total funding sources and funding available for NCD prevention and control have increased.
- The percentage of overall health budget allocated to Health Planning and Information Services has been maintained but significantly increased in absolute terms.

Targets partially met:

- TongaHealth administrative costs as a percentage of DFAT grant funds have decreased although an increase is budgeted for the current fiscal year (FY).
- Percentage of total budget allocated for strategic priority areas has varied by allocation and year but has been maintained overall.

Targets not met or unknown:

- MoH expenditure on innovation and young people has not been adequately defined for measurement as an indicator.
- The reporting and timely acquitting of TongaHealth National NCD Strategy grantees has worsened over the past three years.

Refer to **Annex D** for full details of health sector financing performance measures and relevant data issues.

The issue of accountability has to be viewed at a number of levels. The THSSP2 triggers of GoT expenditure on the health sector and MoH expenditure on the Public Health Division have been met. MoH and TongaHealth have also largely been accountable as far as this can be assessed against the other indicators laid down in the THSSP2 M&E Framework concerning other commitments of public funds.

The area where THSSP2 has not achieved the desired level of accountability is in meeting timelines for the submission of published accounts; these are commonly delayed. The MoH is accountable to GoT in terms of the requirement to follow the policies, guidelines and procedures laid down under the *Public Finance Management Act, 2002*. MoH and TongaHealth accounts may be late, and they may require extra time in reconciliation, but this is typical of the rest of government and is not the sole responsibility of MoH or TongaHealth. Delays in submitting accounts are also due to delays in (i) annual reporting by MoH and TongaHealth senior management, (ii) sign off of the accounts by the Minister of Health and the TongaHealth Board, (iii) the Auditor-General's audits.

Annual planning

The THSSP2 Design Document states that program delivery *'will be organised around the funding of the annual work-plans of the Ministry of Health and TongaHealth... with involvement from DFAT in agreeing areas for funding'*. Regarding the annual work plans, the Design Document states that plans are *'developed by sections within the MoH'* and *'the allocation decisions are made by the NHDC 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 Health Planning Unit within the MoH is responsible for coordinating the preparation of the divisional annual plans, which form the basis of the annual MoH budget submission to MoF. Sections

are required to develop annual plans ('annual management plans') with reference to the five-year National Health Strategic Plan and the three-year MoH Corporate Strategic Plan. In practice, the majority of the GoT budget for health is expended on salaries and wages, and funds for operating expenses are limited. This scenario, common in other Pacific Island countries, curtails the service delivery capacity of the ministry. In addition, divisional budgets usually exceed the overall MoH financing envelope and there is considerable compromise exercised between MoH and MoF in the final budget submission to MoF.

MoH annual planning capacity at the time of the design of THSSP2 is not documented, but it appears that the transition from Phase 1 ('off budget, off system') to Phase 2 ('on budget, on system') was not well managed, and early attempts to integrate THSSP2 annual planning with MoH planning were unsatisfactory. The evaluation team was told that the MoH was unable to demonstrate that proposed program expenditure was consistent with the five high-level program targets of THSSP2. Overall, it appears that the MoH made final budget allocation decisions to balance the competing priorities of divisions and prominent individuals, rather than to reflect priorities expressed in printed documents. The MoH Executive group was not regarded as making strong, strategic decisions in the budget process. The evaluation team is mindful this situation is not unusual in small countries.

In response to what DFAT regarded as inadequate MoH planning capacity, a parallel annual planning process was instituted by DFAT and the THSSP2 MoH health planning technical adviser was required to administer the process. MoH does not, either as a whole or by division, undertake a planning exercise to the level necessary to properly inform service implementation, address priorities, or coordinate with donors, other ministries, or sector stakeholders. Planning is conducted without consultation of MoH divisions or outer islands management. Planning is not well connected to budget, which is developed based on historical budget allocations and similarly without consultation.

At the time of the mid-term evaluation, the THSSP2 budgeting process required that MoH sections seeking DFAT funding were required to make a written application, and these applications were subsequently screened by the adviser for consistency with the high-level program targets of THSSP2 and strategic and technical merit. The MoH endorses applications and the final decision on funding is made by DFAT Post. This parallel arrangement means that whilst THSSP2 funds are 'on system', and 'on budget' (reflected in budget books), they are 'off plan', resembling a project delivery approach.

DFAT's decision to plan activities parallel to the MoH budget was a risk management response to reduce the perceived possibility of program investment in areas not consistent with the high-level program targets and investment in activities of 'low yield'. By instituting an application-driven process for MoH funding, DFAT inadvertently duplicated the weakness that already existed in the TongaHealth grant-making process, in that the funder is passively funding applications without giving a clear message to applicants about where the funder's preferred priorities (other than the very generalised direction of the five high-level program targets). Furthermore, in the absence of a clear strategic plan for the health sector, DFAT has very few points of reference by which to determine and evaluate priorities. It is important to note this process was underway at a point in the program when the NHDC oversight was not operational and MoH-DFAT strategic dialogue was not optimal. The mid-term evaluation observed that the program activities selected through this process had been carefully considered. However, the parallel planning process did serve to accentuate the strategic difference between the design of THSSP2 and its implementation.

DFAT has accepted responsibility for the strategic identification of THSSP2 activities, but these are delivered through the MoH with little DFAT control over the quality of implementation. From the perspective of risk, the parallel process has averted the risk of poorly considered program activities

(due to limited MoH planning capacity) but it has achieved this by transferring the risk to itself. The THSSP2 Design Document states that ‘responsibility for achieving the THSSP2 targets is shared amongst the MoH, TongaHealth, DFAT and (to a lesser extent) many other stakeholders in Tonga’ but the parallel arrangement tends to undermine this sharing of responsibility. Annual program activities are not based on the ‘quality annual plans’ envisaged in the program design, but discrete funding applications. DFAT has little in the way of a strategic framework by which to assess funding applications other than the five high-level program targets and the professional judgement of the adviser and Post.

DFAT Post is also scrutinising activity-level records, acquittals and reports *post hoc*, which ensures good financial compliance but doesn’t contribute proactively to good planning or good program monitoring. Given that the previous DFAT Assessment of National Systems (ANS) assessment determined that financial governance was adequate for an ‘on system’ approach, it would be a better use of DFAT resources to rely on GoT acquittal processes and periodic audit, so that more attention could be given to monitoring at the program and outcome level.

Budgeting and accounting

THSSP2 was designed with a clear intention to be on ‘on budget’ and ‘on system’. The program has been successful in getting program funds ‘on system’, i.e. program activities have been successfully funded and implemented through GoT systems. THSSP2 procurement (goods and services, infrastructure) also occurs through GoT systems. However, while THSSP2 is ‘on budget’ with funds appearing in GoT budget records, as per above it is not ‘on plan’.

It was anticipated under THSSP2 that: (i) a new MoH budget structure would reflect the programs/sub-programs of the MoH linking plans to budgets; (ii) The SunSystems FMIS would enable full program and sub-program analysis, linking GoT local funds (recurrent) and donor expenditure; (iii) a new financial procedures manual would be developed; and (iv) the SunSystems FMIS would be fully functional and used by MoH.

To date, there has been little progress towards these budget and FMIS reform objectives, and MoH finances remain as difficult to manage today as at the time of THSSP2 design. While there have been some changes to the budget structure and improvements in corporate planning, MoH plans remain insufficiently linked to the budget. The SunSystems FMIS, including recently added Vision reporting software, is hosted and managed by MoF. Operational ministries, including MoH, have limited access to SunSystems and cannot access Vision reporting, which has resulted in MoH supplementing SunSystems with Quickbooks (accounting software) and Excel spreadsheets. MoH has found it difficult to meet GoT and DFAT deadlines, and the limited transport and telecommunications with the outer islands reportedly continues to delay internal accounting. SunSystems was not operational for much of 2017. The new financial procedures manual has also not yet been developed. MOH and World Bank agree that (2018): ‘*Current systems, processes, and arrangements related to the MoF ... and MoH FMIS hamper MoH’s ability to produce regular, timely and quality financing reports to inform resource allocation.*’

The transition from THSSP1 to THSSP2 was reportedly difficult for MoH as THSSP1 Project Management Unit staff did not pass on systems knowledge to MoH staff before leaving. Essential financial documents also went missing. Additional ongoing PFM system problems are in compliance, overly complicated and unnecessary signature processes, the ad hoc manual delivery of records to MoF, duplication of data, and shortage of qualified accounts staff. The payroll continues to be managed by spreadsheet. The MoH Director of Corporate Services has only recently been appointed.

As noted, the MoH is receiving assistance from the World Bank to help strengthen health financing, including PFM. The World Bank PASA 2018-2022 program is a multi-year regional activity (across five Pacific Island countries) and the PFM/health financing components of the PASA Tonga work program are funded by DFAT. The PASA work program for Tonga has two main foci, related to providing technical and analytical assistance to:

- help MOH in its tracking and managing of health financing pressures to the health sector (this includes conducting a health facility costing and benchmarking exercise to help inform the phased implementation of the PEHS); and
- assist MOH monitor activity and budget implementation.

The emphasis of PASA's health expenditure trend analysis is to assist MoH, MOF and other relevant ministries to have access to the best possible information to make decisions on, and monitor, resource allocation and use through the annual planning and budgeting process. This includes supporting MoH to track medium-term health financing pressures arising from the transitions from donor funding support for tuberculosis, human immunodeficiency virus (HIV) and immunisation programs, and to inform the budget process accordingly. The health facility costing and benchmarking exercise is expected to be completed in time to inform the 2020-21 MoH annual budget submission.

In relation to administrative and operational aspects of MoH PFM capacity, the MoF is concerned that MoH lacks internal PFM controls, accounts reconciliation is delayed, hiring and rehiring of staff is often late, and there is excessive expenditure on overtime. While these accounting issues are experienced across the whole of government, MoH PFM issues are more visible because of the size and nature of the work of the ministry.

Despite the fact that to date it has proved to not be possible to fully integrate THSSP planning and budgeting with the MoH plan and budget process, this remains a desirable objective in the interests of health sector capacity building, donor coordination and sustainability. The evaluation considers that future health sector support should continue to work towards budget integration but with more realistic expectations about the pace of change. Full integration is not achievable during Phase 2.

Procurement

There were central government reforms of public procurement immediately before the commencement of THSSP2 including revised Procurement Regulations, establishment of a Central Procurement Unit (CPU) within MoF, and strengthened enforcement. Despite these improvements, GoT procurement continues to be confronted by many difficulties. Controls on procurement are relatively restrictive (the threshold for independent procurement at agency level is very small), contributing to a lack of compliance, which is seldom penalized. However, bribery and collusion between bidders is believed to be scarce and incidences of major corruption are rare.

The THSSP2 Design Document envisaged participation by MoH procurement staff in relevant training under the Economic and Public Sector Reform (EPSR) Program. DFAT is supporting technical assistance within CPU and, under DFAT's economic governance program, a long-term procurement and contracts adviser has been deployed within the MoH procurement unit. From the MoH perspective, procurement remains highly problematic because of extensive delays at CPU in processing procurement requests. The evaluation team was shown examples including the annual bulk drug order which had been waiting six months at CPU without action. This is sensitive for THSSP2 because stock-outs in drugs and medical supplies had occurred prior to THSSP2 and improving access to NCD drugs is a priority.

From the perspective of the CPU, operational ministries are not adequately planning procurement, and there is a lack of internal and inter-agency coordination of procurement. These capacity gaps result in late ordering and breaches of procedures and regulations. A review of procurement notes that, in most cases, divergence from regulations is thought to have reflected inadequate capacity rather than fraud or misappropriation.

DFAT expects that its funded advisers cooperate to expedite procurements that are DFAT-funded or otherwise strategic to DFAT. The head of CPU reported that the DFAT CPU adviser also provides general capacity building which benefits all procurement indirectly. The evaluation team understands the short-term practicality of requiring DFAT advisers to expedite DFAT-related procurement, but it probably reduces sustainable capacity development in the longer term.

Financial Audit

A DFAT Assessment of National Systems (ANS) update review was undertaken in March 2015 to prepare for THSSP2 to be delivered using an 'on system' approach.

As assessed under the THSSP2 M&E Framework, auditing indicators are problematic for MoH and TongaHealth. The THSSP2 Design Document envisaged that program funds expended through MoH systems would be audited as part of the annual audit of MoH undertaken by the Auditor-General's Office (AGO). However, it was acknowledged that the AGO had capacity constraints that would be assisted by broader programs such as from the Pacific Association of Supreme Audit Institutions. The AGO does not publish specific audits, only its Annual report, the most recent of which was 2015/16. There is no effective mechanism to ensure follow up on audit issues relating to specific ministries.

According to the Design Document, there were insufficient funds for audit under THSSP1 and funding for annual external audit was to be top-sliced from the THSSP2 budget, thus protecting the funds from other uses.

There has only been one audit of THSSP2 accounts to date; that is for the period 1 January 2015 to 31 December 2015. The auditors recorded that: *'(i) the financial assistance to MoH and THSSP acquittal report was not accurate, valid and complete; (ii) the financial assistance to MoH and THSSP grant has not been managed in accordance with the terms and conditions of the agreement; (iii) the systems and processes used for procuring services and goods with program financial management procedures, procurement processes and relevant legislation were not managed properly as the amount of transactions without procurement documents is material; and (iv) the general management of the funds was not effective.'* Further, although the budget and statement of corporate intent have been submitted on time over the past four FYs, the annual reports and audits of account have been late. Non-compliance with financial policies is not known, as the audits have not been published for the past three FYs.

3.2.5 Monitoring and performance

Monitoring and evaluation frameworks

Tonga had 18 national health indicators for 2011-2015 (as reported in the MoH Annual Report 2015). For the subsequent five-year period, the National Health Strategic Plan 2015-2020 sets out over 200 key performance indicators (KPIs) and an M&E Framework containing 38 national health indicators. The MoH Corporate Plan 2016/17 – 18/19 uses the same 38 national health indicators as the National Health Strategic Plan. The MoH Corporate Plan 2017/18 – 19/20 does not use the 38 national health indicators and reverts to KPIs. The MoH Annual Report 2016 uses neither national health indicators nor KPIs and instead reports against a sub-set of the SDGs and the Healthy Islands

Indicators. There is also a separate higher-level corporate planning M&E Framework at the GoT level.

This is an indicator-dense context, especially so given the population size of Tonga. The THSSP2 M&E Framework contributes a further 76 indicators. There is some commonality between the THSSP2 M&E Framework, national health indicators and the MoH KPIs but they are not harmonised. The THSSP2 M&E Framework is divided into two components: one part monitors the program overall and the other part monitors TongaHealth. Since THSSP2 activities are planned annually, activities are not directly tracked because the program design envisaged that annual program-funded activities would be consistently and strategically related to the five program outcome targets.

The THSSP2 M&E Framework does not demonstrate a theory of change. This lack of a vertical examination of the logical relationship (between inputs and activities – outputs – outcomes – impact) constrains the use of the framework for evaluation purposes. The framework focuses heavily on NCDs but the program objective of contributing to a ‘more effective, efficient and equitable health system’ is largely unmeasured. Furthermore, many of the indicators are not routinely collected and require interrogation of health information systems and administrative records. The evaluation team spent a considerable part of the country visit working with MoH and TongaHealth staff to manually examine administrative records to collect indicators.

One-tenth of the THSSP2 M&E indicators are sourced from the 4-yearly STEPS survey. Results of these surveys are published by WHO two to three years after data collection, with the 2016 survey results expected in 2019, and the next survey due in 2020. STEPS is highly relevant to THSSP2, but because of the time delay, it is impractical for M&E purposes for a five-year program. Only the 2016 survey results (reflecting the first year of THSSP2) will be available during the life of the program. The 2020 survey (reflecting four years of THSSP2 implementation) will not become available until two to three years after THSSP2 ends.

Some of the THSSP2 M&E indicators draw on hospital activity data. The MoH advised that the quality of ICD10 coding for Vaiola Hospital is doubtful for earlier years, and for procedures and comorbidities (the focus of coding is to record the reason for admission). It is understood that there is little capture of activity data for district hospitals. There are initiatives underway, the ADB ehealth project on hospital activity data and the DFAT Innovation Exchange-funded *Fanafana Ola* project on DHIS2, that will improve data quality and ease of access to data in the future, but for the time being the value of these indicators is questionable.

The TongaHealth section of the M&E Framework replicates TongaHealth’s own corporate M&E Framework, and it contains some institutional performance measures (e.g. number of staff undergoing staff appraisal) that provide evidence about the quality of internal corporate functions of TongaHealth. The measures have meaning for TongaHealth, but they have no direct relationship with DFAT’s investments. There is an implied logic that if TongaHealth is a robust corporate entity, then it will competently perform its role as a funds manager and grant administrator. The evaluation team agrees that indicators do reflect a desired corporate behaviour, but the indicators do not belong in the program M&E Framework.

The full THSSP2 M&E Framework containing indicators collected for or during the mid-term evaluation is at **Annex D**. Overall, the size and complexity of the THSSP2 M&E Framework defeated collection given the limited capacity available. The evaluation team discussed the matter frankly with the MoH CEO who said that the many indicators all appeared to be relevant. It is true that each of

the indicators from the various frameworks reflects some interesting aspect of the health sector, but clearly not all indicators are strategic.

Given that a majority of the indicators from the many frameworks described in this section are not available in a timely manner, this is *de facto* proof that MoH, TongaHealth and DFAT are making management decisions without reference to these indicators. The lack of an evidence base contributes to a weakness in governance (although the use of informal information channels cannot be discounted). In the opinion of the evaluation team, there is a gulf between contemporary best practice in management where a 'dashboard' (a motor vehicle metaphor) provides top management with the essential few indicators, and international development, where comprehensive indicator sets are the norm (metaphorically closer to the cockpit instrumentation of a jumbo jet). The evaluation considers that there has been a failure to separate large, comprehensive data sets which are used for post hoc technical analysis of health systems from practical, strategic information for management.

The *Fanafana Ola* project arose from a THSSP2-supported MoH pilot project in 2016-17. The pilot project worked with the MoH reproductive health program to test the possibility of rolling out DHIS2 as a public health information system. The success of the pilot allowed DFAT Tonga to bid internally for Innovative Exchange support for the full DHIS2 roll out. This achievement is described under Monitoring and Evaluation because it was a "work in progress" at the time of the evaluation. Assuming that future use of DHIS2 is good and that this information helps to inform future decision-making, this has the potential to be a significant health systems strengthening result for THSSP2.

Performance-based aid

Independently of other components of the program, the THSSP2 Design Document reserves \$1.0 million over the five years of the program for performance-based payments to the MoH. The Design Document establishes that the NHDC will oversight the performance-based payments arrangement. Performance-based payments are to be allocated in two ways:

- Up to \$600,000 allocated by a small team of three to four senior managers including DFAT representation, meeting annually in April, based on the MoH Annual Management Plans and quarterly monitoring reports.
- Up to \$400,000 based on the findings of the mid-term evaluation and the end-of-program evaluation. The process for awarding the \$400,000 to be agreed in advance of the mid-term evaluation by a panel chaired by the Minister of Health.

The Design Document sets out eight indicators for the mid-term payment, which are additional to and independent of the 76 THSSP2 M&E Framework indicators, 200+ National Health Strategic Plan KPIs, and 38 national health indicators. The indicators for the mid-term payment are not defined using explicit language, and so it appears that the Design Document anticipated that any subjectivity would be managed through NHDC dialogue. The indicators reflect managerial processes such as regular meetings, production of reports, production of THSSP2 M&E data, and progress in areas such as disability and GESI.

In practice, the NHDC has not provided program oversight and there has not been committee or panel discussions on the mid-term payment. It appears that the process by which the MoH and DFAT were intended to discuss the payment was probably as critical to 'incentivisation' as the payment itself. The evaluation team considered that there was no evidence of 'incentivisation' having occurred, most likely due to:

- the confounding and counterproductive effect of having far too many indicators to measure sector performance (see **Annex D**)
- a lack of dialogue between MoH and DFAT on performance and performance-based payments, and
- the general failure of THSSP2, in design and implementation, to reflect available capacity (as detailed under ‘Strategic planning’ and ‘Annual planning’).

3.2.6 Capacity development

The THSSP2 Design Document implies health sector capacity development under the program will occur through three mechanisms – GoT central agency support; direct DFAT engagement; and technical assistance.

GoT central agency support

In relation to health systems strengthening, the THSSP2 program design is only able to directly address the capacity of individuals within MoH and TongaHealth. In the context of a centralised system of government, the institutional capacities of MoH and TongaHealth (to a lesser extent because it is not a line ministry, but it is subject to the same public accountability requirements and it exists within the public sector culture) are dependent on the central agencies (MOF, NPO, and PSC), as described earlier in this report. The THSSP2 Design Document acknowledges that ‘for systems to improve in the MoH improvements also need to be made in other ministries and agencies, notably the Ministry of Finance.’ With regard to institutional capacities, for whatever historical, political, social, and cultural reasons, there is not a strong culture of inter-ministry working. Discussions between DFAT and the evaluation team have recognised these system constraints and the potential contribution of DFAT’s general government activities such as the Joint Policy Reform Program – but this will take time to show benefits.

DFAT engagement

The THSSP2 design appears to intend that DFAT is central to the capacity building process. The design states:

‘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.’

As argued above, the limited functioning of the NHDC in a program governance role has limited the degree to which this form of capacity building engagement has occurred directly. Similarly, the lack of a clear link between the sector strategic plan and budgeting, and the development of a parallel annual planning process for THSSP2 funds has limited the ability of DFAT staff to directly engage with and influence the direction and use of GoT health sector resources. Despite the fact that DFAT’s engagement has not been possible in the manner envisaged in the original Design Document, there is evidence of a positive impact of Australian aid through both phases of THSSP on improving how health sector resources are deployed:

- MoH has sustained and increased GoT-financed budget allocations for the Public Health Division over the duration of THSSP2 to date
- key decision-makers in the health sector have actively engaged in discussion on THSSP2 priorities such as strengthening the referral system and improving NCD management, and
- the MoH has developed the PEHS, which represents the formal policy adoption of many of the key priorities of THSSP2.

In the absence of dialogue at the NHDC level, it must be assumed that this positive impact is the result of multiple concurrent leverage points including the ‘demonstration effect’ of program funding support (which gives the MoH decision-makers the opportunity to see for themselves the benefits of some novel service initiatives), the work of embedded technical advisers, and ongoing informal dialogue between MoH and DFAT. The role of program-funded annually planned activities on strengthening health sector capacity is unclear in the design: do these activities simply increase service delivery capacity by increasing available finance or are they intended to have a sustainable transformative impact?

The evaluation team found that program funding (both phases) has been instrumental in strengthening services for the management of diabetes and this has had a demonstration (or ‘proof of concept’) effect, in so far as the developments have been widely acknowledged within the sector as being successful. Some other program initiatives have provided ‘seed funding’ for strategic developments that may be sustainable in the future under GoT funding (for example, the costs of developing the PEHS document under Phase 2, and training of the first cohort of NCD nurses under Phase 1). These ‘transformative’ investments can be contrasted with program-funding that simply supplements GoT funding for ordinary operational service delivery, for example, paying for specialist outreach travel to outer islands, or salary supplementation.

The conclusion is that there is evidence that Australian aid has had a positive impact in the health sector generally, but the midterm evaluation was not designed to determine the extent to which each individual annually-planned program-funded activity has contributed to capacity development. Some of the implementation issues in program funding are described in the next section (subchapter 3.3). The arrangement set out in the THSSP2 Design Document, of integrated MoH and THSSP planning and budgeting, with DFAT dialogue at the NHDC level, remains an attractive concept that is simply not achievable at this point.

Technical assistance

The THSSP2 design establishes two central long-term advisory roles: a MoH health planner and a TongaHealth health promotion and NCD strategy specialist. Short term technical advisory roles are contemplated but not specified in the design. At the time of the mid-term evaluation, there was also a DFAT-funded long-term procurement and contracts adviser supporting the MoH, under DFAT’s economic governance program. The health planner adviser is engaged through the Pacific Technical Advisory Mechanism Phase 2 (PACTAM2) and the NCD strategy specialist, currently engaged through the Specialist Health Service (SHS), will transfer to PACTAM2 later in 2019.

All roles have a capacity building requirement, however the capacity development potential of the health planner has been diminished by the requirement for that person to administer the parallel THSSP2 annual planning process. This oversight role of the THSSP2 program has become embedded in the adviser’s role particularly due to an extensive period of working in the in-line role as head of corporate services. The evaluation team understood that due to the period of high staff turnover within TongaHealth, the capacity development potential of the TongaHealth adviser has also been

diminished by the necessity of performing in-line roles (the adviser acted as CEO during a period when the CEO role was vacant). The evaluation team was not in a position to directly evaluate the capacity building achievements of the individuals who hold the advisory roles.

3.2.7 Disability, including mental health

The original THSSP2 design addressed disability only as a cross-cutting issue, but the Design Document does acknowledge enthusiasm (at that time) to progress disability issues. Subsequent to the original design, DFAT and MoH successfully bid for an additional \$3.3 million from the DFAT regional Disability-inclusive Development (DID) initiative for a disability-inclusive health component within THSSP2. This component is separate to other THSSP2 activities and is overseen by a steering committee led by the MoH and including representatives from the Ministry of Internal Affairs (which has the portfolio responsibility for disability), disabled persons' organisations, and the WHO. Activities for the full duration of THSSP2 have been planned in advance under a separate process involving disabled persons organisations, with technical assistance support. The evaluation was limited in its enquiries into the disability-inclusive health component because attempts to meet with MIA were unsuccessful. Persons with disability organisations gave their time enthusiastically for which the evaluation team is grateful.

The disability-inclusive health component of THSSP2 has a 'twin tracks' approach, with one stream of activities intended to build awareness and transform the health system over time to become disability inclusive, and a separate stream of activities designed to target rapid improvements in disability-specific services, for example, mental health disability and community-based rehabilitation.

Awareness raising workshops have been conducted for the MoH and TongaHealth leadership groups to prepare for subsequent activities, including the mainstreaming of disability into regular health worker practice. As a policy development, the draft PEHS, which is expressly disability-inclusive and establishes a framework for universally available mental health services in the future, is the 'crowning achievement' in disability-inclusive health to date. At the time of the mid-term evaluation, the NGO Motivation Australia was supporting MoH to establish an expanded rehabilitation department at Vaiola Hospital. This is a 3-year project to renovate a service and workshop building and establish an expanded rehabilitation and mobility device service. This component is also improving the collection of information on disability.

Given that the disability-inclusive health component began a year later than THSSP2, at the time of the mid-term evaluation there had been relatively little time to complete targeted disability-specific service initiatives. Initiatives undertaken to date include improving physical access to some health facilities and the procurement of a wheelchair-accessible vehicle for Vaiola Hospital. A pilot program of community-based rehabilitation (CBR) was underway, but the evaluation team was unable to meet with the MIA officer coordinating the pilot.

Mental health services are a priority of the disability-inclusive health component. A national mental health conference was held, legislation was reviewed, and a mental health strategy was drafted (which remains only at draft stage at this time). The key development was intended to be the refurbishment of the national psychiatric inpatient facility (ward) at Vaiola Hospital, but at DFAT's request this has been delayed by around 18 months due to DFAT's engagement of an architect to quality assure the proposed design.

It was reported to the evaluation team that there are no other major development partners working in the disability sphere and GoT services for the disabled are not very advanced. Therefore, persons

with disability in Tonga have relatively few community and social support services, and they have priorities in their daily living needs that are beyond the scope of the THSSP2 disability-inclusive health component. This was a contextual factor that influenced how people with disability responded to the evaluation team during discussions on disability-inclusive health. Representatives of persons with disability organisations reported that they considered that some of DFAT's initiatives had been of relatively low priority. An example given of a simple, practical immediate priority for persons with sight impairment was the need for Braille labelling of medicines.

Persons with disability reported to the evaluation team that they often found it difficult to effectively participate in steering committee processes because they felt under-informed relative to the GoT officials who organised the committees. There was a clear willingness to participate and the evaluation team concluded that future committee and consultation processes would benefit from taking care to make the discussion accessible to lay people.

Despite the excess of M&E elsewhere in the health sector, the evaluation team was concerned to note that the disability-inclusive health component is virtually unmeasured. It understood that the steering committee was responsible for developing an M&E framework, but at the time of the mid-term evaluation a framework was not in place.

Overall, there was clear evidence that THSSP2 had supported advocacy for persons with disability, and that strategic work in legislation, policy and information was underway. The greatest risk for DFAT is that of poor visibility of its efforts due to an almost complete absence of outcome measurement. The “twin tracks” approach appeared to the evaluation team to be appropriate to the context, and the team did not have sufficient knowledge of other country examples to make a comparison. The evaluation team was advised of tensions between MoH and MIA in oversight of the disability-inclusive health component, but was unable to explore this further due to the lack of discussion with MIA. The evaluation team did note that having the disability-inclusive health component activities fully planned in advance seemed to be at odds with the THSSP2 principle of flexible annual planning, but had no means by which to determine the merits or otherwise of this arrangement.

3.2.8 Disadvantage, including remoteness

By regional standards, Tonga has achieved good population coverage with 95% of the population within a one hour walk of a health facility. However, this measure of proximity is an incomplete measure of access because the availability of qualified health workers, drugs and other medical supplies and equipment may be a problem in remote areas. With 75% of the national population on Tongatapu, Tonga has less of a challenge in providing universal health coverage than other Pacific Island countries, but the evaluation team did find some evidence of ongoing disadvantage in remote areas (for example, some NCD medications were not available in the Niuas). The evaluation team was unable to obtain information on the resourcing of remote health centres or indicators that demonstrate differences in quality of care.

Tonga has made excellent progress since 2010 in reducing out-of-pocket expenditure for health care, though users continue to bear indirect costs such as transport and time away from employment (Rodney et al, 2015; Levisay, 2014). By supporting strengthening of service provision in rural and remote areas, and thereby reducing the need for patients to travel to Nuku'alofa, it is likely that THSSP (Phases 1 and 2) has indirectly helped to minimise patient out-of-pocket expenditure on transport but there was no data by which to confirm this. The evaluation team met with staff at Niu'ui Hospital (Ha'apai District) and was advised about the eligibility criteria for GoT-funded patient transport to Nuku'alofa for pregnant women at risk. During the Niu'ui Hospital visit, the evaluation

team also learnt that the influence of traditional medicine is a factor in poor adherence to recommended drug therapy and a cause of out-of-pocket expenses (a claim supported by the 2015 Health System Review and nurses on Tongatapu). The evaluation team did not have any available evidence to determine if traditional medicine is also an issue in other outer islands or in urban areas.

The draft PEHS is the main development supported under THSSP2 that potentially addresses disadvantage due to remoteness. Given that PEHS is a policy document only, an option is for DFAT to expedite the practical impact of the PEHS in outer islands by using THSSP2 funds to address gaps in medical/clinic equipment in remote areas. The risk of this approach is that medical/clinic equipment will not directly lead to improved services unless there is adequate staffing, managerial and clinical supervision, and adequate drugs and other medical supplies. In locations where an NCD nurse is posted, this option is attractive because the deployment of NCD nurses has already been shown to improve NCD services.

During consultations, several different informants independently suggested to the evaluation team that there may be unrecognised disadvantage in communities with relatively low socio-economic status on Tongatapu. The evaluation team was unable to investigate this further, but it is a reasonable possibility. It is therefore important that THSSP2 does not overlook urban and peri-urban communities.

3.2.9 Gender

National outcome C of the TSDF II is 'human development with gender equality'. The evaluation team observed indications of equal employment opportunity in the Tongan public service with female chief executives in at least two of the ministries/agencies consulted, and many sections and units headed by female staff. The MoH and TongaHealth have majority female workforces typical of the health sector: 674 out of a total of 987 MoH staff members were female (2016). The number of female senior managers is a better indicator of equal employment practices: at the time of the evaluation two of the six MoH divisions were headed by women. The evaluation team found that availability of gender-disaggregated health and disability information is generally good: data in the main MoH databases is gender-disaggregated and the formal MoH reports presented to the team indicated gender where appropriate. The two main sources of information on NCDs, the STEPS and the GSHS, are fully disaggregated by gender and age.

Considerations of gender are mainstreamed into the design of THSSP2. The mechanism for this mainstreaming is to require that annual funded activities have gender aspects. The evaluation team felt that this approach was broad without necessarily being strategic: simply counting the number of plans with gender aspects (as required under the THSSP2 M&E Framework) doesn't reflect the substance or the impact of the activities. Although TSDF II represents a formal GoT commitment to gender equality, the evaluation team considers that cross-cultural promotion of gender equality is a complex area.

The THSSP2 Design Document recognises that NCDs affect females and males differently (both directly and indirectly). Care-seeking behaviour is known to be different between the genders and this will affect outcomes. NCD-related disability amongst male income earners will have economic and social impact upon women and children. THSSP2 support for early detection and management of NCDs therefore may have indirect gender benefits. With the exception of gestational diabetes, the evaluation team did not find evidence that NCD management activities supported by THSSP2 have reached the level of refinement that is differentiating interventions by gender.

Health promotion on NCD risk factors has to date been limited in addressing gender differences. While there is no information available on the number of female participants in the Fiefia sports program, it is evident that gender has been a large consideration with inclusive sports activities and female/male role models elected. Implementation of Hala Fononga is jointly funded by GoT and DFAT, and to simplify the different accountability requirements, TongaHealth funds support for community groups (including female sports clubs) from the GoT side of its budget. In light of the high prevalence of obesity seen in Tongan women, specialised health promotion activities would be strategic. Given the dramatically higher rates of smoking amongst males, mass media anti-tobacco campaigns are probably benefitting males.

In addition to improvement of services on gestational diabetes under THSSP2, DFAT regional support will soon be strengthening sexual and reproductive health through the UNFPA 'Transformative Agenda'. DFAT regional support to the International Planned Parenthood Federation is already resulting in training for MOH health workers on gender-based violence.

As has been repeated at length throughout this report, the draft PEHS is prominent because it makes a policy commitment on and sets standards for reproductive health and gender-based violence services. However, the PEHS baseline survey indicates that access to gender-based violence services is currently poor to non-existent in the public system. The Tonga Family Health Association and several other agencies provide gender-based violence support in Nuku'alofa.

Overall, DFAT advocacy on gender (through THSSP2) was clearly evident. Actual improvements in services were in a few niche areas such as gestational diabetes, and the most significant development, the PEHS, will not have a practical effect for some time to come. The evaluation team considered that the evidence in Tonga of gender differences in NCD presentations and risk factors means that it is appropriate to develop some gender-differentiated interventions in NCD prevention and control.

3.2.10 Human resources

The THSSP2 Design Document states that good systems for human resources (HR) would contribute greatly to the success of the program, but otherwise is silent on HR issues. The management of public service personnel is centralised under the control of the Public Service Commission (PSC), including public sector remuneration. The centralised system of personnel management leaves little room for operational ministries such as MoH to manage personnel for the particular needs of their sectors.

A major issue for the MoH and DFAT throughout both phases of THSSP has been the inability of GoT to provide regionally competitive remuneration for highly qualified medical professionals, leading to topping up of salaries by DFAT. The evaluation team understood that during THSSP1, DFAT budget support had funded salary supplements for identified positions of critical shortage, and that this was a 'legacy investment' that pre-dated THSSP. The arrangement was carried over into THSSP2 despite the fact that the medical specialist positions being supported are in acute clinical care and not directly related to the high-level targets of THSSP2. There is no simple resolution. Medical specialists are internationally mobile and the small population size of Tonga means that some medical specialists are sole providers in their specialty. DFAT is conscious of the sensitivity of the situation and has worked directly with the PSC to ensure that GoT mechanisms for supplementing positions of critical shortage are fully exploited. DFAT advised the evaluation team that it had a strategy to phase out support for medical specialist remuneration by the end of THSSP2. The evaluation team is mindful that DFAT Post will remain exposed to lobbying and it may be helpful to preclude this type

of expenditure in future health program designs (assuming a continuing focus on NCD prevention and management in primary health care).

Another unaddressed but strategic issue has been the excessive use of overtime in the MoH, which may mask underlying workforce shortages, or it may be a *de facto* device for health workers to supplement their base salaries. Excessive overtime reduces the amount of funds available to support MoH operations, and yet it is not acknowledged in the planning and budgeting that is central to the design of THSSP2. The MoH has a draft Health Workforce Strategic Plan 2016-2020 that contains some useful actions to improve staff supervision and performance management. In the longer term, the PSC is considering decentralising personnel management which might lead to useful flexibility at operational ministry level, but MoH has not demonstrated the ability to link strategic planning to budgeting, therefore it seems unlikely to address the overtime issue.

In the experience of the evaluation team, there are other workplace practices and behaviours that may be overlooked. Excessive overtime is already an issue; the accompanying issue is excessive absenteeism (whether due to formal sick leave or unexplained absence). Supervision practices in hierarchical societies are not well understood by people from other cultures. These issues are well beyond the remit of THSSP2 to address, but they do actively affect the ability of THSSP2 to achieve its stated objectives.

3.3 Program implementation issues

The third component of the evaluation considers the performance of THSSP2 performance through the lens of how THSSP2 has been implemented to date.

3.3.1 Program activities and investments

As per the ‘annual planning’ section in 3.2 above, despite the intention of the THSSP2 program design to integrate into MoH’s own annual planning process, this was not achieved, and the project-like planning arrangement persists. Also, as explained under ‘Human Resources’, THSSP2 inherited legacy investments that are not necessarily consistent with the five high-level program targets. Table 4 shows actual program expenditure to date, examples of types of activities and approximate allocations by MoH division.

Table 4: THSSP2-funded MoH activities, 2015/16-2017/18 in Tongan Pa’anga (TOP) currency

<i>Division</i>	<i>Examples of activities supported</i>	<i>2015/16 (TOP)</i>	<i>2016/17 (TOP)</i>	<i>2017/18 (TOP)</i>
Clinical services	Clinical medical specialists, biomedical engineering, hospital twinning programs, digital radiography, medical equipment	1,386,688	1,561,000	1,416,000
Community health (part of Public Health)	Primary health care, infrastructure, diabetes services including outreach, NCD nurses, transport assets	677,200	203,000	40,000
Public health (other than Community Health)	Infrastructure, health promotion, technical assistance	393,368	187,000	881,000
Corporate services	Planning, health information systems, training, workforce planning	275,000	168,122	426,000
Sub-total		2,732,256	2,119,122	2,763,000
Disability-inclusive health		-	1,050,000	1,691,500

Notes:

(1) Allocations by division are approximate because each year’s budget was presented differently.

(2) The Public Health Division for 2017/18 is not comparable with prior years because it includes funding for Hala Fononga activities passing directly to MoH from DFAT, bypassing TongaHealth.

(3) Program funding for Nursing and Dental Divisions has been consolidated into the division most closely relating to the expenditure type e.g. NCD nurses and dental outreach visits have been added into Community Health.

Due to changes in the budgeting format between 2015 and 2016, presenting the financial data consistently for each program year is not precise. The key observation from Table 4 is that 57% (TOP 4,363,688 million) of total investment in the MoH (TOP 7,614,378 million) for the program to date was in support of the Clinical Services Division. After adjusting for clinical services that directly relate to THSSP2 priorities (such as NCD management or medical specialist outreach to outer islands), there is a net investment in clinical services in the order of 40% of program funding to the MoH that does not directly correspond to THSSP2 high-level targets. This 40% investment is almost entirely at Vaiola Hospital in acute medical services, medical imaging, biomedical engineering and medical equipment procurement. This means that to date THSSP2 has divergent investment priorities to those expressed in the THSSP2 Design Document.

The largest investment in clinical services has been for hospital-based positions of critical shortage described previously under 'Human Resources'. Other large investments have included procurement of a digital medical imaging (radiography) system for Vaiola Hospital and continuation of the longstanding twinning relationship with St John of God Hospital, Ballarat, Australia. The St John of God arrangement is focused on hospital-related functions (e.g. hospital infection control, intensive care, nursing middle management, engineering, psychiatry, and pharmacy). The clinical services investments have generalised health system benefits and the mid-term evaluation is not intended to evaluate the program activity by activity. The original THSSP2 Design Document has a 'conceptual' design, with five high-level program targets, that are not investment themes, with resource allocation driven by annual planning of activities. Strictly speaking, the investment in clinical services is not precluded in the design, although some logical contribution to progress towards the five high-level program targets would be reasonably expected. The THSSP2 M&E Framework is not designed to measure progress in acute clinical care, so this substantial program investment is unmeasured.

The rather broad spread of annual program activities does tend to mitigate concerns about potential 'verticalism' of the focus on NCDs (although it is unclear if the spread is intended to strengthen the wider health system in a strategic manner). The effectiveness of aid programs that focus on a single health issue, for example communicable diseases, tends to plateau at some stage if the overall health system is not adequately addressed. In this case, the evidence is that THSSP2 annual activities have not been as intensely focused on NCDs as the design suggests. The dilemma is that, as discussed under 'annual planning', the investments in clinical services have no guiding strategic framework.

Overall, the evaluation team concludes that in the context of the limited effectiveness of the program governance structure through the NHDC, and insufficient MoH planning capacity, the large investment in acute clinical care represents dilution of the strategic intent of the THSSP2 program design. The increase in the program budget (since the original Design Document) from bilateral aid has been offset by the separate clinical services legacy commitments being rolled into THSSP2. The level of DFAT funding for acute clinical care is such that a sudden withdrawal would be disruptive to the Tongan health care system and probably negatively affect the relationship between DFAT and the sector. To reinforce the focus of Australian aid health sector support on the priorities expressed in the THSSP2 Design Document, progressive reduction over time in funding support for acute clinical care is the preferred direction. DFAT has already facilitated engagement between the MoH

and PSC with a view to reducing dependence on donor funding for salary supplementation for positions of critical shortage.

3.3.2 Relationships

Given the limits of the THSSP2 governance arrangement, the relationship between the MoH and DFAT Post is critical. The evaluation team observed that, although the relationship is cordial, DFAT has been relatively unsuccessful in initiating strategic dialogue and in obtaining program performance data. In the absence of a routine platform for policy discussion (which the NHDC was intended to provide), much of the focus of the relationship appears to be on reporting and acquittals of funding, rather than activities that advance the intended collaboration on higher level strategic policy and health sector advancement.

The factors that are likely to contribute to good engagement between the MoH and DFAT include:

- health professional expertise within DFAT to enable communication at a technical level
- good interpersonal relations between the individuals and effective cross-cultural communication
- leverage obtained from the donor's financing support for the health sector, and
- a relationship of mutual respect which may in part reflect the equivalence of the status of the parties.

The Second Secretary position was created for the purpose of providing health professional expertise and is funded from the program budget. The design of THSSP2 contemplates DFAT engagement at the level of the Minister for Health (chair of the NHDC) and possibly this is an overly ambitious requirement of the design (although the Minister's non-availability has been partly due to pragmatic issues - the workload of two portfolios). If all development partners were to operate through one official coordination point with the health sector (for example, a joint MoH/development partner forum), this may be more likely to attract the Minister's interest. The evaluation team did not investigate the factors related to engagement in depth and cannot comment further, except to recommend that the design of future health sector support should critically review the viability of the shared planning approach.

During the country visit, it was suggested to the evaluation team that the MoH, which was previously accustomed to project-style aid delivery, did not initially understand the new delivery model for THSSP2 and therefore failed to take advantage of the opportunity to direct THSSP2 for its own strategic benefit. This is plausible because THSSP2 is a relatively complex program in practice and has undergone multiple revisions since the original design document (as detailed in this report). The evaluation team did find a lack of understanding in some areas, for example, a surprisingly large number of key informants did not properly understand the role of TongaHealth as a statutory fund manager and grants coordinator. At the time of the evaluation, there was no single document available that explained the current iteration of the program and the evaluation team felt that preparation of a short succinct document would assist in engagement with the MoH and other key stakeholders.

Within DFAT Post, a large part of the work of the locally-engaged program managers involves post hoc reviewing of acquittal documentation. Given that MoH has already been assessed by DFAT ANS as suitable for 'on system' management of DFAT funds and the midterm evaluation has found that MoH largely meets DFAT accountability requirements, the evaluation team considers that such intensive scrutiny of expenditure in a low risk setting is not making the best use of the program

managers. Furthermore, given the MoH's chronic problems with timely financial reporting (for largely contextual reasons explained previously), this creates a lot of problems for DFAT that might be avoidable if a simpler acquittal regime was possible. The evaluation team was unable to determine what alternatives might be possible under DFAT corporate policy but is aware that in the Solomon Islands health sector-wide approach that DFAT funds are "expensed" at the point of transfer to the beneficiary. If acquittals for the Tonga health sector program could be simplified in a similar way, this would give the program managers more time to engage proactively with the MoH and TongaHealth in planning and implementation.

THSSP2 has relatively few program-funded technical advisers, and these are engaged through PACTAM, which is designed for in-line roles (i.e. supervised by GoT officials), and SHS. There is potential confusion around accountability when in-line advisers are required to act as gate-keepers for DFAT funding. Several MoH informants described the MoH PACTAM adviser as being part of DFAT: a significant misperception given that the MoH role is designed to (and does) broadly support the MoH across all funding sources. To give DFAT-funded advisers the best prospects for success, it is important that they are perceived to be in the service of their beneficiary organisation.

3.4 DFAT's strategic evaluation questions

This section of the evaluation summarises the key findings in terms of the key evaluation questions set by DFAT in the evaluation terms of reference. These are presented in Table 5.

Table 5: Key findings in response to key evaluation questions

	DFAT <i>Health for development</i> strategic priorities	Considerations for THSSP2
Relevance Extent to which activity is suited/appropriate to the priorities and policies of target group Are the program's five key development outcomes still relevant and appropriate? Is the program theory of change still appropriate?	There is unassailable evidence that NCD prevention is the most relevant health priority for Tonga, and that partnership with Australia has been beneficial. Early intervention and effective management of NCDs is important for reducing the burden of ill health arising from NCDs. There is evidence of a need to continue to address disadvantage related to gender, remoteness and disability; and possibly also communities within Tonga of relative socio-economic disadvantage.	THSSP2 is well aligned with the <i>National strategy for prevention and control of NCDs</i> , but at the level of planning and budgeting, MoH's own strategic directions are not explicit and, as a consequence, THSSP2 activities are potentially not strategic. Effective management of NCDs relies on an overall well-functioning health care system. There is evidence of expenditure spread broadly across the sector but unclear if this is designed for system-wide impact. With the exception of NCD prevention, the THSSP2 theory of change is not clearly expressed or widely understood. The program M&E Framework does not fully reflect program objectives and the theory of change. For a program that has a strong focus on planning and budgeting, the theory of change does not adequately take account of core government functions and the way they limit what is possible for the MoH to achieve.
Effectiveness A measure of the extent to which an aid activity attains its objectives and manages the risks.	As the first Pacific country to release a national NCD strategy in 2004, Tonga has been a leader in NCD strategic and policy direction within the region.	Not all of the necessary components for the implementation of an effective health sector program are in place. MoH medium-term strategic directions are not explicit. THSSP2 is not integrated with MoH planning and budgeting process. DFAT has endeavoured to risk manage

	DFAT Health for development strategic priorities	Considerations for THSSP2
<p>To what extent and in what ways is THSSP2 achieving progress against defined program targets as set out in the design document?</p> <p>Are the necessary components for the implementation of an effective health sector program (e.g. a platform for high-level policy dialogue, quality annual management plans, integrated budgets and systems for MoH and THSSP2 funds) in place?</p> <p>What factors are influencing the achievement or non-achievement of targets?</p>	<p>There is evidence of practical improvements in NCD service delivery, but the program M&E indicators do not yet indicate improvements in NCD health outcomes. THSSP2 has been instrumental in the development of a MoH policy framework (PEHS) to improve universal health coverage (including NCD management) but implementation (as required by the program targets) will likely need to be supported to the end of the Phase and beyond.</p>	<p>the threat of poor strategic relevance of program activities by strengthening its parallel planning process, effectively transferring risk from MoH to DFAT. On the TongaHealth side, the Board has provided high-level governance but the NNCD has not provided direction for the NCD-MAP.</p> <p>TongaHealth performance has been affected by a period of high staff turnover and excessively complex grants administration processes.</p> <p>The program has a performance-based incentive which appears to be not understood by all parties and has been ineffective in driving performance.</p>
<p>Efficiency Qualitative and quantitative measure of outputs in relation to inputs (including resource inputs)</p> <p>Is the investment making appropriate use of resources to achieve targets?</p> <p>Is program governance, donor coordination and management appropriate for achieving the program targets?</p> <p>Is the Monitoring and Evaluation system fit for purpose and generating information which is being used by management for decision-making, learning and accountability purposes?</p>	<p>The 'conceptual' design of THSSP2 around high-level targets and an annual planning process does not connect inputs with program outputs and outcomes.</p> <p>This design has the advantage of being highly flexible. However, with an absence of high-level MoH/ DFAT joint program oversight, no explicit MoH medium-term strategic direction, and MoH capacity issues in planning, determination of appropriate annual activities is a major design weakness. DFAT has established a parallel planning process which duplicates MoH planning.</p> <p>The NHDC has not met regularly and has not performed the program oversight function envisaged in the program design. The TongaHealth Board has provided regular oversight to the operations and finances of TongaHealth. However, the National NCD Committee and the various cross-sector and other committees engaged in NCD prevention have not met regularly as planned.</p> <p>THSSP2 has 5 high-level program targets: 3 of which are expressed in explicitly measurable terms. However overall the M&E Framework is not contextually appropriate. A majority of</p>	<p>THSSP2 activities are planned and budgeted in parallel to MoH systems. The main barriers to integration have been poor shared understanding of the program design, a lack of an explicit MoH medium-term strategic direction and MoH capacity issues in planning.</p> <p>In the absence of an explicit sector strategy, THSSP2 has generally succeeded in investing in activities that sensibly contribute to the program high-level objectives. THSSP2 has clearly contributed to the strengthening of prevention and control of NCDs. The impact of current health promotion approaches is likely to plateau without investment in local research and innovation, and targeted grant-making.</p> <p>The program M&E Framework is not harmonised with GoT M&E Frameworks, which may undermine government efforts.</p> <p>The program M&E Framework poorly reflects program objectives and, with the exception of NCD prevention, the M&E Framework does not reflect the theory of change. Disability-inclusive health is completely unmonitored.</p> <p>The program M&E Framework has minimal direct relationship with program-funded activities, and some program investments are entirely unmonitored</p>

	DFAT Health for development strategic priorities	Considerations for THSSP2
	the performance measures cannot be readily sourced from MoH and/or TongaHealth information systems. A significant number of performance measures are based on manual audit of operational records. Overall, the M&E Framework has to date provided no effective guidance to MoH and/or DFAT on annual program planning and delivery.	
Impact Is there evidence of the program contributing to improved health status of the target population, including for women, people with disability and those living in the outer islands? Are there any unintended consequences of program activities?	The THSSP2 Design Document sets intentionally ambitious targets for a five-year program (i.e. 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) because it describes the current population of Tongans as already being a 'time-bomb' in terms of having extremely high probability of developing NCDs and the urgent need for a 'generational shift'.	Overall it appears the target of halting the rise in deaths related to NCDs may be achieved. The results for preventable disability are less certain because at the start of THSSP2 there was a segment of the population with pre-existing undiagnosed NCDs or with imminent NCDs because of lifestyle risk factors.
Sustainability Will the benefits of the investment be sustained beyond the life of the Australian investment? Which factors constrain/facilitate sustainability?	<p>The NCD prevention component of THSSP2 was designed to be well integrated into Tongan systems and, in terms of what is achievable in aid program design, is highly sustainable.</p> <p>NCD management aspects of THSSP2 align well with implied MoH NCD priorities, but sustainability may be an issue due to lack of domestic financing.</p> <p>Although gender is a TSDF II objective, there is little to show GoT ownership of THSSP2 initiatives on disadvantage related to gender, remoteness and disability. Sustainability appears to be poor without continued DFAT advocacy and support.</p>	<p>From design, THSSP2 was aligned with the <i>National strategy for prevention and control of NCDs</i>. The strategy is semi-dependent on THSSP2 for financing, but the strategy is 'owned' by GoT and there is no indication that the strategy would be abandoned if DFAT withdrew support (it appears likely that implementation would continue with GoT funding, albeit at a slower rate). The failure of the NNCD to meet regularly is regarded by the evaluation team as regrettable but not inconsistent with the Tongan public sector generally. TongaHealth does face ongoing challenges in identifying, commissioning and grant-managing high-impact health promotion investments.</p> <p>Potentially sustainable are the service delivery-related initiatives to address disadvantage related to gender, remoteness and disability incorporated in the draft PEHS. These will depend heavily on DFAT financing for rollout.</p>
Gender equality and social inclusion	THSSP2 has provided a vehicle for advocacy for gender-equality and social inclusion.	<p>Under the regional Disability-inclusive Development initiative, THSSP2 has incorporated a sub-component that appears to be contributing positively to the engagement of people with disability in Tonga. There are no measures in the program M&E Framework to reflect this.</p> <p>At the mid-term stage, there is little measurable benefit from program activities for women, the disabled and other disadvantaged groups.</p>

	DFAT Health for development strategic priorities	Considerations for THSSP2
		Program inputs do appear rational but have addressed necessary precedent issues, for example the MoH draft PEHS, ratification and application of the Convention on the Rights of Persons with Disabilities. It is highly likely that the program will have measureable impact in the longer term.
Risk management What else is at stake? And Safeguards <ul style="list-style-type: none"> • Child protection • Displacement and resettlement • Environment • Other 	THSSP2 activity planning has the unintended consequence of transferring public policy risk from MoH to DFAT. THSSP2 support for universal health coverage improves resilience to natural disasters, displacement and resettlement.	DFAT has endeavoured to risk manage the threat of poor strategic relevance of program activities by strengthening its parallel planning process. It is highly desirable to increase the engagement of MoH in THSSP2 activity planning and to demonstrate greater alignment between the program and MoH medium-term strategic direction. At the de-briefing session, the mid-term evaluation team was advised that there had been some preliminary investigations on risks to health due to climate change.
Innovation and private Sector Innovative development approaches?	THSSP2 goods and services, and infrastructure procurement is delivered through GoT systems and engages private sector suppliers. THSSP2 has effectively capitalised on initiatives emerging from DFAT's innovationXchange.	The Tupaia initiative (developed through DFAT's innovationXchange) has provided strategic support for advancing universal health coverage.

4. Recommendations

Section 4 presents the team's recommendations, including a brief rationale for each recommendation. Table 6 at the end of this section provides a summary of the recommendations, including the relative priority of each recommendation and the recommended timeframe for giving effect to each recommendation.

Program targets and direction

1. *It is recommended that Australian aid health sector support maintains consistent priorities at least until the end of THSSP2.*

THSSP2's five high-level development targets are still relevant and appropriate. To provide adequate time for health promotion on NCDs to begin to demonstrate changes in lifestyle risk behaviours and strengthening of universal health coverage (in the form of roll-out of the PEHS), continuity and consistency of direction is important. Tonga's efforts in society-wide reduction of lifestyle risks of NCDs have the potential to inform other Pacific Island Countries.

2. *It is recommended that THSSP2 annual planning be specifically aligned with the operationalisation of the PEHS.*

THSSP2 lacks a mechanism that links the annual planning of program activities to the MoH's strategic direction: this is partly because the MoH does not have an explicit medium-term

strategic plan that adequately links to budgeting and operational planning vision (the Corporate Plan and Budget 2017-2020 is operational rather than strategic). The choices are:

- i. To work towards a Tonga health sector medium-term strategic plan (such a document is unlikely to be completed before end of Phase 2; therefore, this option does not address the need for practical direction during Phase 2), or
- ii. To complete Phase 2 based on the understanding that the MoH's interest in finalising and rolling-out the PEHS constitutes the medium-term strategic direction for the health sector.
- iii. To operate without a strategic direction for the remainder of Phase 2 and encourage MoH to take greater responsibility for annual planning of program activities subject to clear conditions on uses of funds.

The evaluation team recommends option ii as the preferred option. The PEHS is the MoH's current approach for moving towards universal health coverage and strengthening service provision, including NCD management. The PEHS is a product of THSSP2 and the roll-out of PEHS aligns with THSSP2 program targets. DFAT may proactively identify some priorities e.g. procurement of replacement/missing minor clinical equipment to ensure that all primary health care facilities can provide a basic range of services. If there was satisfactory progress for the remainder of Phase 2 and MoH remained enthusiastic about the PEHS, any future Australian support could move towards integrated MoH/program budgeting based on the PEHS and informed by the World Bank PASA costing of the PEHS.

3. *It is recommended that THSSP2 annual planning continues in parallel with MoH annual planning until the end of Phase 2, and that future Australian aid works towards integrated MoH/THSSP annual planning.*

Recognising MoH capacity issues and the fact that there is only one full budget cycle remaining in Phase 2, the evaluation team cannot see value in changing THSSP2 budgeting arrangements. It is therefore recommended that the parallel annual planning arrangement continue until end of the current phase, and be integrated into the MoH budgeting process in the longer term. Future DFAT support should be based upon a Tonga health sector medium-term strategic plan and sector coordination model consistent with recommendations 2 and 3.

Program oversight and engagement

4. *It is recommended that THSSP2 program oversight is re-assigned to the MoH level for the remainder of Phase 2.*

The NHDC has proven to be an inappropriate body for THSSP2 program oversight and high-level policy dialogue. Under the circumstances, a small committee comprising the CEOs of MoH and TongaHealth, DFAT, and MoF (aid coordination) will provide DFAT with a more practical device for oversight. As already stated in recommendation 3, it is desirable to progress towards a sectoral coordination forum in any future Australian support inclusive of all development partners. (Recommendation 5 is not intended to address MoH governance more broadly although the section on 'Governance' in sub-section 3.2 does describe whole of GoT issues concerning the frequency of meetings at executive level.)

5. *It is recommended that THSSP2 progress reporting and acquittal procedures be simplified.*

The current situation in which MoH is failing to provide agreed information for quarterly progress reports and M&E Framework indicators is unacceptable. Clearly THSSP2 contributes to

the situation with an excessively complex M&E Framework (see recommendation 9 below) and progress reporting requirements that don't reflect actual capacity to report. For the remainder of Phase 2 it is recommended that progress reporting be simplified and that there be investigation of ways to simplify the acquittal process (to reduce the time that DFAT Program Managers spend on post hoc reviewing of acquittal documentation).

6. *It is recommended that the criteria for the performance-based payment be simplified, worded more explicitly, and focused on fewer themes.*

The evaluation found that the performance-based payment had been ineffective as an incentive, and attributed this outcome in part to the complexity of the criteria (the other main contributing factor being the lack of DFAT engagement with the NHDC). Two or three criteria would be preferable to the current eight. MoH compliance with the simplified progress reporting and performance monitoring (recommendations 5 and 7) should be a criterion.

Program performance measurement

7. *It is recommended that DFAT adopts a more pragmatic approach towards THSSP2 performance measurement for the remainder of Phase 2.*

The evaluation team considered that there is a need to be more pragmatic about program M&E to ensure that MoH and DFAT receive practical and timely information on program performance. At the same time, there is a requirement to continue to capture progress towards long-term changes in NCD risk factors using the periodic STEPS surveys for which reporting is typically extensively delayed. The midterm evaluation was extremely challenged by the task of collecting performance measures that were simply not readily available. It is recommended that one of the following options be adopted for the remainder of THSSP2:

- Retain the existing M&E Framework in its entirety and commission a dedicated data collection consultancy prior to the end of program evaluation
- Identify around 20 feasible and relevant measures out of the M&E Framework and discontinue the remainder
- On the assumption that Australian aid health sector priorities will remain constant in the medium-term, commission a new M&E Framework that is more practical and aligned with the roll-out of the PEHS, existing GoT indicators and the MoH's capacity to report.

NCD prevention

8. *It is recommended that TongaHealth's grant application and management processes and systems be simplified and streamlined to the extent possible.*

TongaHealth has had institutional performance difficulties from time to time and this is likely to recur given the low capacity context and the limited availability of candidates for key roles such as finance and M&E. Furthermore, the existing grant application process is complex and potentially discourages applications. Simplification of procedures will reduce risk associated with institutional capacity and facilitate applications.

9. *It is recommended that TongaHealth proactively encourages grant applications based on strategic relevance.*

TongaHealth's existing grant application process is essentially passive and does not identify the areas that are most strategic for implementing Hala Fononga. As part of the streamlining process described in recommendation 10, application procedures could be modified to indicate

priority areas and facilitate applications in these areas. This process could also review the extent to which applications understand and address issues of equity including gender and disability. This recommendation will need to be revisited based on the findings of the independent review of Hala Fononga.

10. *It is recommended that TongaHealth supports and facilitates local research to inform and evaluate health promotion messages and focus (healthy eating, health-promoting churches and NCD control).*

TongaHealth has tended to support fairly traditional health promotion approaches, for example, mass media campaigns that have been shown elsewhere in the world to have a limited long term impact (the impact of repeated mass media campaigns tends to “plateau” over time and their cost-benefit decreases). Some of the current approaches may have been adopted from other cultures (Australia and New Zealand) and may not be ideal for Tonga. A stronger focus on health promotion research and innovation would help to ‘localise’ health promotion approaches. An increase in formal publication would serve to complement the research orientation and raise the regional profile of TongaHealth’s work.

NCD management and universal health coverage

11. *It is recommended that the planning for the PEHS rollout considers the role of nurses, particularly in relation to NCD control.*

The recent MoH restructure and the introduction of the NCD nurse cadre has resulted in some instability (and possibly insecurity) regarding the future role of nurses. The rollout of the PEHS is likely to add to the instability, given the necessity to expand nursing roles, and PEHS implementation may be impeded if nursing roles remain unclear. Areas that require further consideration include leadership, prescribing privileges, training, and skills for delivering lifestyle interventions.

Health sector management

12. *It is recommended that future Australian aid health sector designs reflect the underlying need to strengthen core government functions.*

Core government functions (planning, public financial management, procurement, personnel management and auditing) all require strengthening in both central and line agencies. The Joint Policy Reform Program of economic and public sector reform will require a long-term, ten to twenty-year political commitment, as well as technical assistance, to yield improved government. The expectations of aid programs in individual operational ministries should reflect the reality of the whole-of-government.

Disability-inclusive health

13. *It is recommended that disability-inclusive health activities are captured in program performance measurement.*

The disability-inclusive health component of THSSP2 does not have corresponding M&E measures. Notwithstanding recommendation 7 above (to simplify the existing whole-of-program M&E Framework), some practical measures are recommended to ensure that improvements in access to health services for persons with disability are captured in future program evaluations.

14. *It is recommended that the participation of persons with disability in oversight of the disability-inclusive health component is facilitated by supplementary opportunities for dialogue.*

The persons with disability organisations consulted during the evaluation did not have a high level of awareness of the program ‘architecture’ (i.e. design documents and work plans, prior consultation, DFAT corporate procedures) behind the various DFAT initiatives. They also indicated that they found it difficult to engage during formal meetings with GoT officials and DFAT officers because they felt under-informed. The impression the evaluation team obtained was that persons with disability are keen to engage and might benefit from some supplementary opportunities for discussion and consultation.

Gender and social inclusion

- 15. It is recommended that (a) TongaHealth encourages gender-differentiated health promotion activities where appropriate, and (b) MoH develops gender-differentiated NCD interventions where appropriate.**

Given that there are gender differences in NCDs, and that NCD-related disability has social and economic consequences for women and children, there is a case for beginning to develop gender-differentiated interventions.

- 16. It is recommended that low socio-economic status be included as one of the determinants of disadvantage in future Australian aid health sector support.**

The evaluation team heard that socio-economic disadvantage is a driver of health ‘underservicing’ in Tonga, independently of geographic isolation. The available data indicates that out-of-pocket expenses in Tonga are low by regional standards so ‘cost’ is unlikely to be the explanation for this claim. It is conceivable that health care-seeking behaviour and responses to public health messages are negatively affected by low socio-economic status.

Technical assistance for remainder of Phase 2

- 17. It is recommended that long-term technical assistance for the remainder of Phase 2 focuses on supporting progress towards the recommendations above, where appropriate.**

The major tasks/themes for the MoH Health Planning Adviser are: to support improved core planning, budgeting and execution (including rollout and operationalisation of the PEHS); allowing better coordination and integration of THSSP2 annual planning and budgeting; and assist the World Bank PASA program to identify medium-term expenditure ‘pressure points’ for the health sector.

The major tasks/themes for the TongaHealth NCD Strategy Implementation Adviser are to: simplify and streamline grant application and management processes and systems to the extent possible; modify grant application procedures to indicate priority areas (the most strategic areas in Hala Fononga) and facilitate grant applications in these areas; and encourage gender-differentiated health promotion activities where appropriate.

Table 6: Summary of final recommendations, including prioritisation and timeframes

Recommendation	Responsibility	Priority	Timeframe
<i>Program targets and direction</i>			
1. Australian aid health sector support maintains consistent priorities at least until the end of THSSP2.	DFAT	High	Immediate ratification, with effect 2019/20 annual plans

2. THSSP2 annual planning be specifically aligned with the operationalisation of the PEHS.	MoH/DFAT	High/ Medium	2019/20 onwards
3. THSSP2 annual planning continues in parallel with MoH annual planning until the end of Phase 2, and that future Australian aid works towards integrated MoH/THSSP annual planning.	MoH/DFAT	High/ Medium	2019/20 onwards
Program oversight and engagement			
4. THSSP2 program oversight is re-assigned to the MoH level for the remainder of Phase 2.	MoH	High	Immediate
5. THSSP2 progress reporting and acquittal procedures be simplified.	DFAT/MoH	Medium	2019/20 onwards
6. The criteria for the performance-based payment be simplified, worded more explicitly, and focused on fewer themes.	DFAT	Medium	Before 2019/20 year
Program performance measurement			
7. DFAT adopts a more pragmatic approach towards THSSP2 performance measurement for the remainder of Phase 2.	DFAT	High	2019/20 onwards
NCD prevention			
8. TongaHealth's grant application and management processes and systems be simplified and streamlined to the extent possible.	TongaHealth	Medium	Before end of phase 2
9. TongaHealth proactively encourages grant applications based on strategic relevance.	TongaHealth	High/ Medium	From 2019/20 onwards
10. TongaHealth supports and facilitates local research to inform and evaluate health promotion messages and focus (healthy eating, health-promoting churches and NCD control).	TongaHealth	Medium	Initial steps taken before end of phase 2
NCD management and universal health coverage			
11. The planning for the PEHS rollout considers the role of nurses, particularly in relation to NCD control.	MoH	Medium	Before end of phase 2
Health sector management			
12. Future Australian aid health sector designs reflect the underlying need to strengthen core government functions.	DFAT	Medium	Future health sector designs
Disability-inclusive health			
13. Disability-inclusive health activities are captured in program performance measurement.	DFAT/MIA	Medium	Before end of 2019
14. The participation of persons with disability in oversight of the disability-inclusive health component is facilitated by supplementary opportunities for dialogue.	DFAT/MIA	High	From 2019/20 onwards
Gender and social inclusion			
15. (a) TongaHealth encourages gender-differentiated health promotion activities where appropriate, and (b) MoH develops gender-differentiated NCD interventions where appropriate.	TongaHealth	High/ Medium	Before 2020/21
	MoH	Medium	Before 2020/21

16. Low socio-economic status be included as one of the determinants of disadvantage in future Australian aid health sector support.	DFAT	Medium	Future health sector designs
<i>Technical assistance for remainder of Phase 2</i>			
17. Long-term technical assistance for the remainder of Phase 2 focuses on supporting progress towards the recommendations above, where appropriate.	DFAT/MoH/ TongaHealth	High	Immediate (for TA work plans)

5. Future Australian aid support

This section contains suggestions for future health sector support and possible areas of analysis that might inform future DFAT health program design. Indicative outlines of ToRs are contained in **Annex E**.

5.1 Future health sector support

As previously stated, Tonga's efforts in society-wide reduction of lifestyle risks of NCDs are of global significance. The learning process that Tonga is undertaking with respect to lifestyle is directly relevant to and can inform other Pacific Island Countries where DFAT is a major partner in the health sector. On this basis, the evaluation team considers that it is highly desirable that Australia's partnership with Tonga on NCD prevention is long term.

The team also considers that it is highly desirable that Tonga and the Australian aid program work toward a health sector coordination model based on a medium-term sector strategy to be developed by GoT that is agreed by all development partners, and that forms the basis for the involvement of all development partners in the sector. An 'ideal' scenario based on precedents in other Pacific Island countries is for a medium-term sector strategy to be developed by GoT that is agreed by all development partners. Under GoT arrangements, this would require leadership in the planning process from the National Planning Office (Prime Minister's Office). It would not be possible to complete a medium-term sector strategy during Phase 2, but discussions can commence now about the possibility of developing a plan for any future Australian support. It appears likely that the World Bank PASA costing of the PEHS will partially fulfil the need for an expenditure framework.

The evaluation team's recommendations in Section 4 are supportive of progressive movement of Australian aid support towards a future health sector program that is fully embedded in the host government institutions and systems. In the team's view, this will maximise GoT and MoH ownership, and improve prospects of sustainability.

Table 7 examines the changes that have occurred since THSSP2 was designed and how these have contributed to a context that is now more conducive for an embedded aid modality. Note that although positive developments have occurred, as stated several times in the main report, expectations of the pace of change have to be realistic in small nations and capacity will vary over time due to competing priorities and as key staff members move on.

Table 7: Analysis of ‘readiness’ for embedded health sector support

	Status at time of THSSP2 design	Developments since commencement of THSSP2
‘On plan’	<p>At the time of the THSSP2 design, the medium-term health sector plans that were in place did not indicate clear strategic directions. For this reason, the THSSP2 Design Document is not strongly connected to any GoT strategic frameworks, and the design relies on ‘quality annual plans’. This aspect of the design has resulted in problems for DFAT because DFAT is having to identify prudent and relevant annual activities without a guiding document agreed by both DFAT and MoH.</p>	<p>The development of the PEHS provides a tangible strategic direction for the health sector that is consistent with THSSP priorities, and Recommendation #2 connects program annual planning to operationalisation of the PEHS for the remainder of Phase 2 as a pragmatic measure.</p> <p>The full rollout of the PEHS is yet to be planned. If an explicit rollout plan was developed and formally endorsed by MoH, this would be an ideal framework for any future Australian support. The World Bank-supported health facility costing and benchmarking exercise, and WHO support on health workforce planning, will help MOH identify financing needs.</p> <p>The PEHS begins to provide a clearer vision of the future than is contained in the existing health sector medium-term strategy (National Health Strategic Plan). This links to discussion earlier in this report on the desirability of a clear medium-term sector strategy that forms the basis for the involvement of all development partners in the sector. With the National Health Strategic Plan expiring in 2020, there is the opportunity for DFAT and MoH to have discussions with NPO about the next sector plan.</p> <p>In conclusion, although the existing health sector strategic plan is somewhat unclear in how universal health coverage will be achieved, there is considerably greater documentation of sector priorities agreed by both MoH and DFAT (and other development partners) than existed at the time when THSSP2 was designed.</p>
‘On system’	<p>There was a DFAT ANS update review at the time of the THSSP2 design that verified that GoT/MoH systems were ready for managing DFAT funds: therefore, in principle the ‘on system’ criterion was already addressed at that time.</p> <p>The World Bank PASA program and the midterm evaluation have since found that</p>	<p>DFAT is funding the World Bank PASA program which is assisting MoH to identify and manage medium-term expenditure pressures. WB is also conducting a health facility costing and benchmarking exercise to help inform the PEHS rollout. This should improve MoH planning, budgeting, and execution monitoring capacity but centralised control of the FMIS by MoF will continue.</p>

	Status at time of THSSP2 design	Developments since commencement of THSSP2
	although financial governance risk is acceptable to DFAT, the highly centralised control of the FMIS by MoF means that MoH financial reporting and budgeting capacity remains limited.	<p>The Joint Policy Reform Program (funded by DFAT, ADB, EU and World Bank) is expected to improve the issues with centralised control of the FMIS but over a longer term.</p> <p>In summary, the evaluation team has no evidence to suggest the DFAT ANS assessment that this a low risk financial governance context has changed (noting that DFAT will conduct an ANS update in early 2019), and an 'on system' modality continues to be viable, although timely financial reporting will continue to be a problem.</p>
'On budget'	The THSSP2 Design Document assumed that planning of annual program activities would be integrated (or highly connected with) MoH budgeting for the GoT budget. This is one of the areas where the implementation of THSSP2 was unable to progress as intended. THSSP2 annual funding is recognised in the GoT budget notes but the planning process remains separate.	<p>Recommendation #3 recommends that future Australian aid works towards integrated MoH/THSSP annual planning. In the context of an evaluation report that makes repeated comments about avoiding unrealistic expectations, it behoves the evaluators to take heed of their own advice. Therefore, although the evaluation team would prefer this happen as soon as possible, it is not desirable to force the issue prematurely.</p> <p>To actions to strengthen the 'on budget' approach include resolution of program oversight arrangements, and confirmation that the MoH will continue to focus on the rollout of the PEHS. Other factors include maturation of the newly-formed Corporate Services Division and the future of health planning technical assistance.</p>

The modality of THSSP Phase 2 is very different from Phase 1 and the evaluation team heard there was a significant loss of impetus when the Phase 1 project officers departed. The approach recommended for future DFAT health sector support is simply a logical and gradual progression from Phase 2, learning from the aspects of the THSSP2 design that were difficult to achieve in practice.

5.2 Possible areas for analysis

The evaluation team has in its general recommendations (Section 4) recommended that DFAT maintains a degree of consistency until the end of phase. This same philosophy applies to the deployment of technical assistance: in the team's view, a sudden change in the technical assistance arrangements or a surge in short term deployments has the potential to be disruptive. The MoH should be given final determination over whether the recommendations put forward in this section should be acted upon.

The analytical products suggested below have relevance to both Phase 2 and future sector support, and so it is not meaningful to list them under one particular phase or the other. The suggestions have been devised with a view to future DFAT health sector support, but these suggestions are not exclusive and might also be picked up by other development partners. Comments are provided at the end of each described product on how it relates to the phases of DFAT sector support. A more detailed description of the products is provided in **Annex E**.

Service system mapping and PEHS gap analysis

A baseline survey has been completed for the PEHS and the findings will be included in the published policy document. The baseline survey indicates the status of service provision at each health facility but it doesn't document the reasons behind the status ratings. The evaluation team heard that in some instances the lack of a single item of equipment was enough to cause a facility to be rated lower than it might otherwise have been.

The PEHS policy document includes a short-term plan (a sort of 'next steps' plan), but the entire rollout remains largely unplanned. It would be extremely timely to document the existing service system very specifically to guide the PEHS rollout and THSSP2 investments (as per recommendation 2): for each individual facility this would document staffing, major infrastructure, transport assets, major and minor medical equipment, communications equipment, etc. The mapping would also document the interconnection with national systems such as medical supply logistics and supervision, and any issues arising. The mapping would be prioritised to focus initially on facilities in the outer islands and the locations on Tongatapu earmarked to become community health centres.

Discussions suggest that much of this information is already held within MoH, which means that the amount of field travel needed might be relatively modest. The task would therefore be largely about assisting the MoH Divisions to organise their existing information and documenting this clearly. The UNFPA Transformative Agenda will be undertaking a baseline survey on sexual and reproductive health in 2019. This might be an opportunity to gather additional information and reduce travel costs by combining site visits. The UNFPA survey is likely to address the maternal health and gender-based violence components of the PEHS while the service system mapping could focus on the NCD, rehabilitation and mental health sections. The mapping would also serve as a form of review of the nursing structure.

This analytical product has equal relevance to Phase 2 and beyond. For Phase 2, it represents completion of the body of policy and planning activity associated with the PEHS. Since it would inform the PEHS rollout and improve the quality of planning of the rollout, this product would contribute to future DFAT health sector support (assuming that the PEHS rollout remains the central strategic direction of MoH).

Quality assurance for management of NCDs

Given the past THSSP investment (both phases) in NCD management, it is prudent to periodically review the technical quality of care for the four major conditions (diabetes (T2DM), heart disease, cancer and COPD). Subject to the agreement of the Director of Clinical Services (Medical Superintendent), this would link through the PEHS from Vaiola Hospital down to all referral levels of the service system, and would compare actual practice with the relevant MoH treatment guidelines. If this review is structured around the PEHS, it helps to inform the rollout and it establishes a review/audit model that potentially can be repeated at regular intervals. This product is also mindful of the fact that the evaluation has elsewhere recommended to reduce funding for clinical services, so this is an appropriate balancing investment.

If there are limited resources for this review, an option would be to scale back to focus on one major condition at a time, and have a four-yearly rolling program of review i.e. one of the four major conditions each year. Once the generic aspects of the audit process are established, it should be relatively straightforward to substitute a different set of treatment guidelines in the following year's review (although different clinicians would be involved at the hospital end of the review).

This analytical product can be seen to be providing reassurance about the sustainability of the improvements in NCD management achieved in Phase 1 and 2. The establishment of the generic audit methodology creates a resource for the future.

Health workforce

The MoH draft Workforce Strategy contains a number of generalised recommendations regarding the establishment of a MoH HR Information System. The Workforce Strategy does not contain a detailed plan. There are two quite separate bodies of work relating to the HR Information System (1) setting up the system for personnel management functions, and (2) documenting formal qualifications and in-service training undertaken, to guide workforce development planning.

The second body of work is essential for the rollout of the PEHS and links to Recommendation #11. It would be possible to combine the two activities: a once-off audit of credentials to be uploaded into a future HR Information System, combined with a more strategic examination of competencies in relation to the roles required under the PEHS.

This product completes Phase 2 activities in relation to strengthening capacity for MoH management of the health workforce, and informs the quality of planning for the PEHS rollout that is expected to be central to future DFAT health sector support.

Health promotion research

Recommendation #10 states that 'it is recommended that TongaHealth supports and facilitates local research to inform and evaluate health promotion messages and focus (healthy eating, health-promoting churches and NCD control)'. The objective is to increase the local relevance of health promotion approaches and raise the regional profile of TongaHealth's work. It is unlikely that the THSSP2 long-term adviser will have a relevant research background or, given the other responsibilities of the role, sufficient ability to work meaningfully in this area. Therefore, some short-term focused support is recommended, partly analytical in terms of identifying opportunities for research and partly capacity building in terms of fostering local research skills. A local partner such as the Queen Salote Institute should be involved in the fostering of local research skills. The work should focus on healthy eating as this is a high priority lifestyle risk factor that is resistant to change, and tobacco use has previously been researched. Reinforcement of the multi-sector approach (trade policy, food industry, health promotion settings) is important.

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Annex A: THSSP2 Mid-term Evaluation Terms of Reference

Purpose

These Terms of Reference set out the requirements for a Midterm Evaluation of the Tonga Health Systems Support Program Phase 2 (THSSP2). They encompass the requirements for both an independent progress report (which asks is the program being implemented as planned) and an evaluation. The evaluation will focus on progress – positive, negative, intended and unintended – at an outcome level and seeks to understand observed performance, test continued relevance, and make recommendations for course corrections during the remainder of THSSP2 and future support to the health sector in Tonga.

Background

Context

The Kingdom of Tonga is an archipelago of 169 islands of which 36 are inhabited. Tonga is scattered over a vast area of the Pacific Ocean about 700,000 square kilometers. The islands are divided into three main groups – Tongatapu / Eua, Vava'u and Ha'apai. As of January 2017, the population of Tonga was estimated to be 107,000 people. At the last Census (2017), the population number was falling, mainly due to migration. Australia's interests in Tonga are defined by the Foreign Policy White Paper, which includes prioritising the achievement of sustainable development goals across the Pacific through genuine partnerships with Pacific governments. Australia currently invests around \$30 million per year through its aid program comprising around \$17 million administered bilaterally, and \$13 million through regional and global programs. Bilateral investment is prioritised under the three pillars of the current aid investment plan (AIP): Economic governance and private sector development; Strengthened health systems; and Skills development. The AIP will be renewed in 2019.

Non-communicable diseases (NCDs), such as diabetes and cardiovascular disease are endemic in Tonga and present a large and increasing risk to sustainable development. Health expenditure is skewed towards hospital and tertiary care, with few Tongans accessing affordable health care in their local communities.

Tonga Health Systems Support Program (THSSP)

Since 2009, Australia has invested in Tonga's Ministry of Health through the Tonga Health Systems Support Program. Phase 1 (THSSP1) of the Program aimed to improve community health services and deliver preventative health measures, while focusing on halting the rise in prevalence of NCDs and its risk factors. The program also supported improvements in primary health care services to a common national standard, a skills development twinning arrangement with Ballarat's St John of God Hospital, provision of critical clinical positions, and mentoring and training to support the operation of Tonga's major hospital. Australia also supported Tonga to build a cadre of specially-trained NCD nurses to improve the treatment of NCDs. The nurses are stationed at health and diabetes centres across Tonga, including all outer island groups.

Phase 2 of the Tonga Health Systems Support Program (THSSP2) commenced in March 2015, with Australia agreeing to continue its support to Tonga's health sector in order to improve health service delivery, in particular preventative health services. In an effort to seek a consolidated approach, Australia provides programmatic support through grants to Tonga's Ministry of Health, a health

promotion NGO (Tonga Health), and technical assistance. Funding has also been allocated for program management.

THSSP 2 is designed to support the Government of Tonga's (GOT) own strategy and planning for the health sector by providing support to its Ministry of Health and Tonga Health to improve health service delivery, with a strong focus on non-communicable diseases (NCDs). The program is aligned to the Tonga Strategic Development Framework II, the National Strategy to Prevent and Control NCDs 2010 – 2015, and the MOH Corporate Plan 2015-2020. The THSSP 2's overarching objective is for a more effective, efficient and equitable preventative and primary care service for the Tongan population. The program aims to reduce the prevalence of NCD risk factors, strengthen health systems and increase equity of access to health services. Tonga Health Systems Support Program 2 has identified five key development outcomes:

- 5) rate of premature deaths and preventable disability related to NCDs has not risen;
- 6) fall in percentages of population at high risk of developing NCDs;
- 7) develop and implement a plan with strategies to increase NCD management as part of universal health coverage leading to efficiencies and budget cost savings through the program;
- 8) strengthened health system management (including public financial management) of budgeting, planning, reporting, implementation and procurement; and
- 9) increased equity of access for poor and marginalised groups, including people with disability, to MoH services and Tonga Health activities.

The total planned value of this investment is \$17.3 million over 5 years, starting in 2015. Expenditure to date has been just over \$9 million. Activities funded under THSSP2 are:

- A direct funding agreement with MOH (\$A10.8M, for years 2015 to 2020) provides support to a range of NCD prevention and treatment services, as well as systems strengthening support to improve planning and budgeting for sustainability. This amount also includes a component of (\$A3.3M, for 2015 to 2020) earmarked for disability inclusive health including service accessibility, community-based rehabilitation, and mental health. Funded activities are negotiated each year against MOH management plans. Currently, the program supports the MoH's major reform for achieving effective, efficient and equitable preventative and primary care- the Package of Essential Health Services.
- A funding agreement (\$A2.1M, for years 2016 - 2020) with the independent Tonga Health Promotion Foundation (THPF) to support national cross-sectoral action and coordination on the national NCD strategy. Australian funding supports THPF to provide grants to a range of recipients to conduct NCD-prevention activities across a range of sectors, as well as supporting core organisational functions including program management and monitoring and evaluation.
- The organisational funding agreements are supported by two long-term technical advisers and some additional short-term contracted advice as needed (approx. \$A1.9m). A Health systems support and planning manager to support improved planning, budgeting and monitoring cycles is currently in place at MOH, and a NCDs/Health promotion adviser is currently working with THPF.
- The program also meets support costs of approximately \$A1.5m for post managements costs and audit costs.

In addition, the program has set aside \$400,000 of the direct funding for performance based funding for the MoH based on the achievement of targets, the findings of the independent progress report, and the extent to which the recommendations of the independent progress report are met. This mid-term evaluation is the trigger for a decision on the first tranche (\$200,000) of this performance-based funding.

Linked Evaluations/Reviews

This THSSP2 evaluation will occur at the same time with the national review of Tonga's NCD strategy to be conducted by Tonga Health Promotion Foundation. The evaluation team will be expected to coordinate with the NCD strategy review including by conducting joint meetings with stakeholders or discussing findings if appropriate. The Tonga Health evaluation will focus on reviewing the National NCD Strategy, and the success of Tonga Health Promotion Foundation in implementing and coordinating it. The THSSP2 evaluation will draw on this as appropriate and complement it with an evaluation of THSSP2 support to the provision of clinical and public health NCD services.

DFAT's Office of Development Effectiveness (ODE) is also conducting a strategic evaluation of DFAT's bilateral Pacific health investments over 2008-17. Case studies in Tonga, Fiji and Solomon Islands will investigate factors affecting the effectiveness of health system strengthening investments, with particular attention to the following activities:

- Strengthening the Health Information System
- Strengthening the health workforce to improve access to, and the supply of, health services
- Strengthening financial planning and management for health service delivery
- Strengthening the management of pharmaceutical supplies

The entry point for the case studies are activities funded through bilateral investments but the evaluation team will also examine complementary activities funded through regional programs. The findings and recommendations will not be specific to any investment or country. However, the evaluation team is expected to be in Tonga prior to the THSSP2 evaluation, and some of team's the insights of the effectiveness and sustainability of DFAT investments over the ten years may be relevant to this evaluation.

Purpose and Objectives

The purpose of this Midterm Evaluation is to provide to the Ministry of Health Executive Team and Ministry of Finance and National Planning, The Board of Tonga Health Promotion Foundation (Tonga Health) and DFAT with information about the implementation of DFAT funded support to the health sector. This information will be used to improve Australia's support to the MOH and Tonga Health and, subsequently, the delivery of Tonga's National Health Strategic Plan 2015 – 2020.

This will be the first review of THSSP2.

The objectives of this Midterm Evaluation are:

1. To review and document the performance of THSSP2 over the period 2015 – 2017, including the program's achievement against agreed performance benchmarks to inform the 2018/19 Performance Based Payment.
2. Based on the review findings, provide recommendations for improvements that could be made by partners in the remaining implementation period to June 2020.

3. Provide advice on options for future support to the health sector in Tonga beyond June 2020, and in particular if the THSSP2 delivery modality is still appropriate.
4. Make recommendations for analytical products to be commissioned to inform a future health program design.

Key evaluation questions

Relevance

- Are the program's five key development outcomes still relevant and appropriate?
- Are the program activities and outputs consistent with the achievement of these development outcomes?
- Is the program theory of change still relevant and appropriate?

Effectiveness

- To what extent and in what ways is THSSP2 achieving progress against defined program targets as set out in the design document?
- Are the necessary components for the implementation of an effective health sector program (e.g. a platform for high-level policy dialogue, quality annual management plans, integrated budgets and systems for MoH and THSSP2 funds) in place? If not, why not and how is this affecting the program?
- What factors are influencing the achievement or non-achievement of the targets?
- To what extent do the performance-based incentives drive overall performance?

Efficiency

- Is the investment making appropriate use of resources to achieve targets?
- Is program governance, donor coordination and management appropriate for achieving the program targets?
- Is the Monitoring and Evaluation system fit for purpose and generating information which is being used by management for decision-making, learning and accountability purposes?

Impact

- Is there evidence of the program contributing to improved health status of the target population, including for women, people with disability and those living in outer islands?
- Are there any unintended consequences of program activities?

Sustainability

- Will any benefits of the investments be sustained beyond the life of Australian investment? Which factors constrain/facilitate sustainability?

Cross Cutting Issues

- Do program planning, implementation and governance processes include meaningful opportunities for the involvement and consideration of women, people with disability and currently underserved groups?
- Are women, the disabled and disadvantaged benefiting from project activities proportionate to their need?
- Does the program adequately identify and respond to current and emerging risks to health due to climate change? What more could future support do?

Priority areas in which to focus these questions include:

1. Planning and budgeting (including influencing health expenditure policy, finance and accounting processes);
2. Governance, strategic planning, process efficiency, linkages with other donor and DFAT regional programs, and decision making (within both GoT and DFAT systems);
3. Primary care service delivery including early detection and management of NCDs, procurement and stock/asset management;
4. NCDs prevention and health promotion activities provided by both MoH and TongaHealth (as informed by the NCD Strategy review);
5. Monitoring including National Health Indicators, Monitoring and evaluation framework and performance based funding;
6. Capacity development, including technical assistance.

Review Team

The review team will comprise three members covering the following expertise:

- Team Leadership/representation/negotiation/political acumen;
- Health systems strengthening including governance, supply chain, and working in partner government systems preferably in the Pacific;
- Capacity development approaches at an institutional, organisational and individual level, including technical assistance;
- Health financing, including sector budget support, pool funds, and performance based funding approaches;
- Monitoring and evaluation including theory of change, indicator and target setting and performance based funding approaches;
- Primary care service delivery including planning, quality, accessibility, and monitoring with a particular focus on NCD detection and management.
- Gender equality, disability and social inclusion strategies and measurement.

This will result in a team with the following configuration:

- Team Leader/Evaluation Specialist;
- A Health Financing Specialist; and
- An NCD Service Delivery Specialist.

Roles, responsibilities and requirements of the team¹

Team Leader/Evaluation Specialist

Duties

- plan, guide and develop the overall approach and methodology for the evaluation, including developing and submitting an evaluation plan to DFAT;
- be responsible for managing and directing the evaluations activities, representing the review team and leading consultations with government officials, other stakeholders and DFAT;
- lead the team's analysis, findings and recommendations related to the Program's performance in:
 - governance and planning;
 - monitoring and evaluation/theory of change;
 - capacity development
 - gender equity and social inclusion
- lead and compile inputs from team members to complete the assessment of the program against the Performance Based Funding benchmarks;
- be responsible for managing, compiling and editing inputs from other team members to ensure the quality of reporting outputs;
- be responsible for producing an aide memoire, and draft and final Midterm Evaluation Report.

Qualifications/Experience

- program review/evaluation of health projects and programs in an international development context (preferably in the areas of health sector strengthening/ partner government implementation in the Pacific);
- experience in health program review and strategy development, preferably for DFAT or similar bilateral aid organisation;
- extensive (+15 years) experience in health sector strengthening/capacity building/monitoring and evaluation and/or institutional strengthening in a development context;
- an understanding and relevant experience of assessing gender equality and social inclusion in health policies and programs; and
- excellent interpersonal, cross-cultural, facilitation, representation, negotiation and written skills.

¹ Indicative at this stage may vary depending on profile of final team.

Health Financing Specialist

Duties

- contribute to the development of the evaluation methodology with a particular emphasis on the assessment of the program's resource allocation, budgeting, expenditure, reporting and accountability;
- lead the team's analysis, findings and recommendations of the Program's performance in:
 - resource allocation and budgeting – equity, efficiency and link to outcomes;
 - financial management – efficiency, effectiveness, accountability;
 - flow of funds within MoH and service delivery units;
 - building/supporting GoT budgeting and financial management capacity and
 - providing consideration of gender equity and social inclusion.
- contribute to the analysis, findings and recommendation related to:
 - the assessment against the performance-based funding benchmarks.
- provide written input as required from the team leader toward the aide memoire and a draft and final Midterm Evaluation Report.

Qualifications/Experience

- post-graduate qualifications in accounting, financial management, applied public sector health economics, or equivalent experience;
- extensive (+10 years) senior level health financing/budgeting experience, preferably in a low-middle income country setting, preferably in PNG/Pacific;
- understanding of financing institutional development in low or middle income countries context, including sector budget support and pool financing arrangements;
- excellent interpersonal, cross-cultural, communication and written skills.

NCD Service Delivery Specialist:

Duties

- contribute to the development of the evaluation methodology with a particular emphasis on the assessment of the program performance in strengthening the delivery of NCDs services;
- lead the team's analysis, findings and recommendations of the Program's performance in:
 - planning for an appropriate package of essential health services (including NCD's) at the primary and referral / secondary level services;
 - providing appropriate inputs for primary and secondary services to deliver quality services (including NCDs), including to remote and difficult to reach areas and groups;
 - the availability of appropriate medicine and supplies at the primary and secondary level (including for NCDs), and addressing any supply chain constraints;
 - providing consideration of gender equity and social inclusion and

- supporting appropriate health promotion and healthy public policies to address NCDs.
- contribute to the analysis, findings and recommendation related to:
 - the assessment against the performance-based funding benchmarks.
- provide written input as required from the team leader toward the aide memoire and a draft and final Midterm Evaluation Report.

Qualifications/Experience

- post-graduate qualifications in public health, or health service management or equivalent experience;
- extensive (+10 years) senior level health service delivery experience, preferably involving NCDs in a low-middle income country setting, preferably in the Pacific;
- understanding of service delivery institutional development in low or middle income countries context;
- excellent interpersonal, cross-cultural, communication and written skills;
- relevant clinical qualifications and experience would be an advantage.

The consultants will report to the Second Secretary Development, Australian High Commission Tonga.

Review method (including inputs and timeframe)

The review process will take up to 31 days for the Team Leader, Health Financing Specialist and the NCD Service Delivery Specialist team members. The review will commence no later than 22nd October 2018 with the final report completed by 11th February 2019.

In undertaking the review, it is proposed that the team will:

- Consult with DFAT program staff, health advisors and team members of linked evaluation teams.
- Conduct a desk review of relevant documentation, including but not limited to documents included in the reading list attached.
- Develop an evaluation plan, which will include methodology and report outline, indicate how the specific questions listed in the 'Scope' section will be addressed and identify key respondents and further documentation as required. It is expected the Program's Monitoring and Evaluation Framework will form part of the evaluation plan and methodology but not be the only source of program performance measures.
- Undertake one in-country visit to gather data in line with the review methodology.
- Develop an aide memoire summarising the key findings and recommendations to be presented at the debrief with key stakeholders in Tonga.
- Draft a report for DFAT and the MoH detailing the key findings and recommendations.

The proposed inputs by activity is as follows:

Appendix A: Proposed inputs by activity

Dates	Activity	Location	Maximum No of Days		
			Team Leader	Health financing specialist	NCD Service Delivery Specialist
22 October - 1 November 2018	Background reading / /Briefing/Review plan	At base	Up to 3 days	Up to 3 days	Up to 3 days
22 October - 8 November 2018	Preparation/Submit of Evaluation Plan	At base	Up to 2 days	Up to 2 day	Up to 2 day
17-18 November	Travel to Tonga		Up to 2 days	Up to 2 days	Up to 2 days
19-30 November	On-island mission. Stand Up Steering Committee	Tonga	Up to 12 days	Up to 12 days	Up to 12 days
30 November	Aide Memoire presentation findings & preliminary recommendations	Tonga			
1-2 December	Travel to base location		Up to 2 days	Up to 2 days	Up to 2 days
1 December– 20 December	Finalise written inputs and submit draft Report to DFAT by 20 th December	Base location	Up to 7 days	Up to 7 days	Up to 7 days
21 January 2018	Receipt of coordinated feedback from Steering Committee /Peer Review and DFAT/ MOH on draft report (4 weeks)	Via email			
11 February 2019	Respond to feedback, finalise inputs as required and submit final Report by 11 February 2019	Base location	Up to 3 days	Up to 3 days	Up to 3 days
Total			Up to 31days	Up to 31 days	Up to 31 days

Outputs

The following deliverables are to be delivered:

Indicative Date	Milestone	Verifiable Indicator
1 November 2018	Evaluation Plan	Acceptance by DFAT as per specifications below
30 November 2018	Aide Memoire	Acceptance by DFAT as per specifications below
20 December 2018	Draft Evaluation Report	Acceptance by DFAT as per specifications below
11 February 2019	Final Evaluation Report	Acceptance by DFAT

- a) **An evaluation plan** – maximum 10 pages in length, to be submitted for agreement with DFAT prior to in-country mission.
- b) **Aide Memoire presentation findings and preliminary recommendations** by 30 November 2018.
- c) **First draft report/annexes** – overall evaluation report no more than 30 pages in length (excluding executive summary and annexes). An executive Summary of up to 5 pages should be provided. The draft will be delivered to DFAT no later than 20th December 2018. Coordinated feedback from the DFAT and other stakeholders will be provided within four weeks of receipt. Consultants should be prepared to submit data and analysis upon request.
- d) **Phone feedback session with stakeholders on the first draft report** in January 2019.
- e) **Final draft report/annexes** – as above, revised to incorporate stakeholder feedback. The final report should include an annex with Terms of Reference for required technical assistance for the remainder of the program to June 2020. The Final draft of the report will be due by 11th February 2019.

All deliverables should have regard to the relevant quality requirements set out in the DFAT Monitoring and Evaluation standards.

Key reference documents include:

- MOH Corporate Plan & Budget 18/19
- DFA + Amendments (MOH and THPF)
- THSSP2 design and M&E Framework
- Performance Based Funding Benchmarks
- Annual management plans (MOH and Tonga Health)
- Annual reports (MOH and Tonga Health)
- Quarterly reports (MOH and Tonga Health)
- Financial acquittals and audits (MOH and Tonga Health)
- Adviser contracts and reports
- Internal DFAT annual program quality reviews (2015 to 2018)
- THSSP1 evaluation
- DFAT's Making Performance Count framework
- DFAT's Gender equality and women's empowerment strategy
- Integrating Gender, Equity and Social Inclusion in the Health Sector: A Strategy Paper for DFAT in the Pacific
- H4D Strategy, draft Pacific Health Strategy, Indo-Pacific Health Security Initiative
- DFAT Monitoring and Evaluation Standards (July 2018)

- World Bank Pacific Health Program of Advisory Services and Analytics 2018-2022 Tonga work plan documents
- WHO country support agreement
- National Health Development Committee TORs
- Package of Essential Health Services framework

Annex B: Bibliography

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Full year 15-16 THSSP1 costed

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The University of Sydney, TongaHealth and Australian Aid (2016). An evaluation of the ‘Tuku Ifi Leva 2016’ second-hand smoking mass media campaign in the Kingdom of Tonga. Prevention Research Collaboration.

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Palu E & Ford A (2016). Funding Proposal: Working together for disability inclusive health services in Tonga

Disability Inclusive Health Implementation Plan 2016-2020

Annex 1 Activity details

Annex 2: Budget breakdown

Annex 3: CBM-NOSSAL THSSP2 disability options paper

Disabilities Inclusive Health- Activities status of implementation plan as at 11th October 2018.

Mines R (2028). Tonga Rehabilitation and Mobility Project Progress Report June 2018. Motivation Australia.

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Government of Tonga (2013). Tonga Health Strategic Health Communication Framework for NCD Control 2013-2018.

Tonga Health Promotion Foundation Act, 2007 (2016 consolidation)

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Asia Pacific Observatory on Health Systems and Policies. The Kingdom of TongaHealth System Review. Health Systems in Transition. Vol 5, No 6 2015.

Annex C: List of informants

The people and organisations consulted for the midterm evaluation are listed in the table below. If an individual was consulted in different capacities, that person is listed twice. Follow-up/repeat meetings are not recorded in the table.

Date consulted	Name	Position / title	Organisation	Contact details
15-Nov-18	Jeanie McKenzie	PACTAM Adviser (NCDs / health promotion)	TongaHealth	jeanie.mckenzie@hotmail.com
19-Nov-18	Ofa Mafi	Program Manager TongaHealth	Australian High Commission	ofa.mafi@dfat.gov.au
20-Nov-18	Andrew Ford	High Commissioner	Australian High Commission	andrew.ford@dfat.gov.au
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	Dr Amelia Tu'ipulotu Afuha'amango	Chief Nursing Officer	Ministry of Health	amyafuhaamango@gmail.com
	Julie Bowen	PACTAM Adviser (health planning)	Ministry of Health	juliebowen@outlook.com.au
	Patinia Patelisio	Public Health Division	Ministry of Health	
	Dr Susitina Piukala	A/g Chief Dental Officer	Ministry of Health	
	Ofeina Filimoehala	Chief Executive Officer	TongaHealth	ofeina.filimoehala@tongahealth.org.to
	Monica Tu'ipulotu	Project Coordinator	TongaHealth	monicat@tongahealth.org.to
	Dr Ofa Tukia	Medical Officer In-charge, NCD/Health Promotion	Ministry of Health	o.tukia@gmail.com
	Fusi Kau	Supervisor, Nurse Practitioners	Ministry of Health	
	Manafonu Siola'a	Supervisor, Sexual & Reproductive Health Nurses	Ministry of Health	
21-Nov-18	Semisi Fukofuka	Director Corporate Services	Ministry of Health	sfukofuka@health.gov.to
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Date consulted	Name	Position / title	Organisation	Contact details
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22-Nov-18	Amelia Tu'ipulotu	Deputy Director Budget and Finance	Ministry of Health	ameliahalakiumatatumitupou@gmail.com
	Mita	Accounts Officer (DFAT)	Ministry of Health	
	Dr Peter Mellon	PACTAM Adviser (procurement & contracts)	Ministry of Health	pjmellon@aol.com
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	Pisila Otunuku	Head, Central Procurement Unit	Ministry of Finance	potunuku@finance.gov.to
	Rheema Misser	Disability advocate	Naunau 'o e 'Alamaite Tonga (NATA)	rhemamisser@yahoo.com
	Ofa Leka	Representative	Tonga Vision Impairment Association	mr.ofa.leka@gmail.com
	Una	Support worker	Naunau 'o e 'Alamaite Tonga (NATA)	
	Makeleta Siliva	Deputy CEO, Treasury	Ministry of Finance	msiliva@finance.gov.to
	Losa Makakaufaki	Senior Accountant, Development		
23-Nov-18	Rev Dr Tu'ipulotu Katoanga	Chair	Board of Directors, TongaHealth	
	Dr Amelia Afuha'amango	Member	Board of Directors, TongaHealth	
	Ofeina Filimoehala	Secretariat	Board of Directors, TongaHealth	
	Dr Siale 'Akau'ola	Chair	National NCD Committee	
	Alifaleti Fonua	Representative, Ministry of Education & Training	National NCD Committee	
	Manaia Halafihi	Deputy CEO, Ministry of Agriculture	National NCD Committee	
	Ana Ika	Chief Economist, Project & Aid Management Division, Ministry of Finance	National NCD Committee	ebaker@finance.gov.to
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	Onetoto 'Anisi	Acting CEO, Ministry of Internal Affairs	National NCD Committee	

Date consulted	Name	Position / title	Organisation	Contact details
	Emele Latu	Program Manager, Civil Society Forum of Tonga	National NCD Committee	
	Rev Lilo	Ministry of Internal Affairs	National NCD Committee	
	Sunia Soakai	Deputy Director, NCD Program	The Pacific Community (SPC)	
	Elena Procuta	Deputy High Commissioner	New Zealand High Commission	Elena.Procuta@mfat.govt.nz
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26-Nov-18	Maureen Perrin	Associate Managing Partner	Gevity Consulting Inc	mperrin@gevityinc.com
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	Dr Veisia Matoto	Director, Community Health	Ministry of Health	matotov@gmail.com
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	Elisi Tupou	Country Representative	UNFPA	tupou@unfpa.org
27-Nov-18	Walter Hurrell	Chief Information Officer, Health ICT and Data Management	Ministry of Health	shurrell@health.gov.to
	Lia Maka	Commissioner	Public Service Commission	
	Tilema Cama & colleagues	Principal	Queen Salote Institute of Nursing & Allied Health	tilimacama@yahoo.co.nz
	Various	Nursing officers	Queen Salote Institute of Nursing & Allied Health	
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	Dr Reynold 'Ofanoa	Chief Medical Officer (Public Health)	Ministry of Health	reynoldofanoa@gmail.com
28-Nov-18	Inaise	Senior Nurse In-charge	Niu'ui Hospital, Ha'apai	
	Soko	Senior Midwife	Niu'ui Hospital, Ha'apai	
	Dr Lander	A/g Medical Officer In-charge	Niu'ui Hospital, Ha'apai	
	Mele	Senior NCD Nurse	Niu'ui Hospital, Ha'apai	
	Pesi Baker	Aid Coordination	Ministry of Finance	

Date consulted	Name	Position / title	Organisation	Contact details
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29-Nov-18	Rhona McPhee	Deputy High Commissioner	Australian High Commission	rhona.mcphee@dfat.gov.au
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Meetings requested but not held				
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	Dr Tevita Vakasiuola	Medical Officer In-charge	Niu'ui Hospital, Ha'apai	

Annex D: THSSP2 performance measured using the M&E framework

Red: not expected to meet target	Amber: progressing but below target	Green: on target	Not coloured: insufficient data
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#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2			Year 3	
1.0: Health system performance indicators											
1.1	PERFORMANCE : THSSP 2 funding is channelled through regular MOH financial processes	DFAT, Ministry of Finance and MOH will monitor the THSSP 2 funding to ensure the efficiencies of harmonising financial processes	Maintained or increased	As reported by DFAT, MOH and MOF	Yes 2015/16	FY 16/17 Yes Funding has been channelled through regular MOH financial processes		FY 17/18 Yes Funding has been channelled through regular MOH financial processes		FY 18/19 (to date) Yes Funding has been channelled through regular MOH financial processes	
1.2	PERFORMANCE : Budget allocated to MOH and TongaHealth (considered separately) as a percentage of total government budget, in %	Budget refers to an estimate of funding available to MOH and TongaHealth (excluding donor funds) and the expenditure planned for the period. Numerator: Budget allocated to MOH (in local currency excluding donor funds)	Maintained or increased	MOH and Ministry of Finance annual report & Budget papers NB: Figures extracted from budget papers and Deputy Director Budget and Finance own files.	MOH: 9.7% TH: 0.17% (2015/2016) MOH: 9.8% TH: 0.16% (2016/2017) NB: Base Year figures (2015/16 and 2016/17) as at M&E	Budget allocations to MOH and THPF (TOP)	FY 15/16 (Provisional)	FY16/17 (Provisional)	FY 17/18 (Revised Estimate)	FY 18/19 (Estimate)	
						MOH % of local fund (excl. donor funds)	12.99	13.1	13.2	10.9	
						MOH estimate of MOH local fund, TOP (excl. donor funds)	11.57	11.42	11.30	11.70	
						TongaHealth % excl. donor funds	0.20	0.22	0.23	0.22	

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2		Year 3	
		Denominator: Total government budget (in local currency excluding donor funds) x 100 Numerator: Budget allocated TongaHealth (in local currency excluding donor funds) Denominator: Total government budget (in local currency excluding donor funds) x 100 <i>NB: Funding available to MOH and TongaHealth is defined as 'Government Local Fund' in the Program Budget of the Government of Tonga'. This excludes 'budget support'.</i>			<i>Design do not agree with the same FY figures as at the Mid-Term Review. This is likely as government budget figures are commonly subsequently revised.</i>					
1.3	PERFORMANCE : Budget allocated to public health division as a	Budget refers to allocated amount in the past financial year and	Maintained or increased	MOH annual report <i>NB: Allocation to public health division</i>	10% (2015/2016)	Budget allocation to public health (TOP m), excluding donor funds	FY 15/16	FY 16/17	FY 17/18 (provl)	FY 18/19 (est)

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2		Year 3	
	percentage of total MOH budget, in %	excludes donor funds. Public health refers to preventative health care. Numerator: Budget allocated to public health division (in local currency excluding donor funds) Denominator: Total MOH budget (in local currency excluding donor funds) x 100		is not stipulated in the national budget documents. Public Health allocations had to be adjusted to remove costs of nurses working in other divisions of MOH. Figures are therefore extracted from Deputy Director Budget and Finance own files.	NB: Base Year figure as at M&E Design does not agree with the same FY figure as at the Mid-Term Review. This is likely as government budget figures are commonly subsequently revised.	Public Health Division % of MOH excl. donor funds	8.29	7.56	12.80	15.67
1.4	PERFORMANCE : Latest annual report made available to the public	Report refers to MOH's annual report published on the Ministry's website and/or in print form for public consumption by March of each year. The report should include information on indicators for monitoring MOH's corporate plan and THSSP's	Published online or in print form by March of each year.	MOH annual report	Last report published, (2011/12)	2015 released to Evaluation Team (not published on website as at 6-12-18)	2016 released to Evaluation Team (not published on website as at 6-12-18)		2017 not prepared	

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
		over-arching objectives						
1.5	PERFORMANCE : Health facilities maintaining and reporting up-to-date records of screening and management of diabetes based on quarterly data, in %	Health facilities refer to all 4 hospitals and Health clinics in the country. Annual reports are to be compiled on the basis of calendar year. Numerator: Number of health facilities maintaining and reporting up-to-date records of screening and management of diabetes in the country based on quarterly data Denominator: Total number of facilities in the country x 100	100%	Community health, MOH To come from NCD nurse reports and community health centre reports	2015 89%			Feedback from health workers suggests improvements. Reports not sighted.
2.0: Decrease in percentage of population at high risk of developing a NCD, for both males and females.								
2.1	OUTPUT: Completion of a fully costed 2015-2020 National NCD Strategy and	The National NCD Strategy guides government and nongovernment evidence-based actions to		National NCD Strategy document	Completed (2015/2016)	National NCD Strategy 'Hala Fononga' completed in 2015, including M&E framework, and launched by Prime Minister in Feb 2016.		World Bank to undertake costing.

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
	M&E Framework	prevent, treat and management NCDs according to the different needs by gender, location and, where possible, disability.						
2.2	OUTCOME: Adults with 3 or more NCD risk factors, %	Adults refer to population aged 25 – 64 years. A person is considered to be at risk if they have three or more of the following risk profiles: is current smoker, is overweight (i.e. has BMI ≥ 25 Kg/m ²), has raised blood pressure (i.e. SBP ≥ 140 and/or DPB ≥ 90 mmHg or currently in medication), consumed less than five combined servings of fruit and vegetables per day, and performs low level of activity (i.e. ≤ 600 MET	Halt the increase	STEPS 2012, 2016 and 2020	STEPS 2012 Data 25-44 years Males: 51.7% Females: 55.4 % Both sexes: 52.8 % 45-64 Males: 64.7% Females: 75.0 % Both sexes: 66.9 %	-	Data collection completed for 2016 STEPS survey. Report is due for publication in early 2019.	-

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
		minutes per week) Numerator: Number of adults aged 25-64 years with 3 or more NCD risk factors Denominator: Total number of adults aged 25-64 years						
2.3	OUTCOME: Prevalence of overweight and obesity in adolescents, %	This indicator captures NCD risk in adolescents. Adolescents refers to population aged 13-17 years. A person is overweight if their BMI is ≥ 25 Kg/m ² or obese their BMI is ≥ 30 Kg/m) Numerator: Number of adolescents whose BMI is ≥ 25 Kg/m ² (for prevalence of adolescents who are overweight). Number of adolescents aged	Halt the increase	GSHS 2016 and 2020 <i>Note: The GSHS measures adolescent BMI as (overweight: $>1SD$ from median for BMI by age and sex, Obese $>2SD$). Numerator and denominator need to reflect the use of a GSHS sample as opposed to full population statistics.</i>	13 – 17 Males: Data from GSHS 2016 Females: Data from GSHS 2016 Both sexes: Data from GSHS 2016	-	Data collection completed for 2016 GSHS.	Adolescents, GSHS 2017 All adolescents (13-17 years), OVERWEIGHT (OBESE) Male: 48.2% (21.4%) Female: 63.3% (27.9%) All: 55.7% (24.6%) Rating: This is a high level of overweight and obesity, and an increase in obesity for 13-15 year olds since 2010. No direct programmes to reduce adolescent obesity, coupled with lower physical activity rates compared to 2010, mean figures are unlikely to decline.

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
		13-17 whose BMI is ≥ 30 Kg/m ² (for prevalence of adolescents who are obese Denominator: Total number of adolescents aged 13-17						
2.4	OUTCOME: Prevalence of current tobacco use among adults and adolescents	Tobacco use defined as those who currently smoke Numerator: Number of people currently smoke Denominator: Total number of people (for the defined age group)	Halt the increase	STEPS 2014, 2016 and 2020 GSHS 2016 and 2020	13 – 17 Males: Data from GSHS 2016 Females: Data from GSHS 2016 Both sexes: Data from GSHS 2016 18 – 24 Males: Data from STEPS 2016 Females: Data from STEPS 2016 Both sexes: Data from STEPS 2016 25-44 Males: 40.9% Females: 14.5 % Both sexes:		Adolescents: Data collection completed for 2016 GSHS. Adults: Data collection completed for 2016 STEPS survey. Report is due for publication in early 2019.	Adolescents: GSHS 2017 % who currently used any tobacco 13-15 years Male: 28.0% Female: 8.4% All: 18.5% 16-17 years Male: 42.5% Female: 17.0% All: 29.2% All 13-17 year olds Male: 32.4% Female: 11.2% All: 21.9% results For the 13-15 year age group, the percentage reporting they are current smokers has shown a marked 7% reduction since 2010, particularly in female students who reported a 17% reduction. This is also true for second hand smoking with 14.3% fewer 13-15 year old students reporting people have smoked in their presence. Adults: awaiting STEPS survey though feedback from

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
					27.4 % 45-64 Males: 44.6% Females: 8.0 % Both sexes: 25.3 %			TongaHealth officers and NNCD members suggests slight improvements. This is supported by evaluation of the anti-tobacco campaign which identified a 3.5% reduction in smoking
2.5	PROCESS: Number of media awareness campaigns for NCD prevention conducted or commissioned	This indicator captures the part of the activities planned by TongaHealth and the National NCD Strategy as well as any by MOH. Media campaigns may include all forms of media and may be stand-alone or multipronged programs.		MOH and TongaHealth program records <i>Note: There is no overall report that captures these measures and links to the August 2017 timeline. Results taken from available TongaHealth and HPU grant reports.</i>	Data to be reported no later than August 2017		2016 Anti-tobacco Campaign Fiefia Sports media awareness (MOH/MIA) Alcohol related harm awareness (Salvation Army/TNYC)	<ul style="list-style-type: none"> 2017 and 2018 Anti-tobacco Campaigns Fiefia Sports media awareness (MOH/MIA) Alcohol related harm TV series (commissioned by TH) Commissioned for 2019: Healthy eating campaign with focus on sugar, salt and fat through television ads. TV Exercise Series also noted in grant tracker. <p>Rating: no target set for indicator. High quality smoking campaigns delivered, and physical activity campaigns continue to strengthen in their coverage. Progress in healthy eating campaigns not sufficient to impact on behaviour-though planned for 2019.</p>
2.6	INTERMEDIATE OUTCOME: Knowledge of	Target population refers to population	Increase	Pre/post survey for	Data to be provided as surveys	-	This indicator is not routinely collected in population surveys or	

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
	target population towards the health risks of physical inactivity, poor diet, smoking and alcohol misuse, %	<p>aged 18 years or over who benefited from targeted health promotion interventions on key NCD risk factors.</p> <p>Numerator: Number of adults aged 18 or over years who knew (or are aware) of the given NCD risk factor of interest.</p> <p>Denominator: Total number of adults aged 18 years or over who benefited from targeted health promotion interventions on key NCD risk factors.</p>		selected programs	completed. Data for pre survey for anti-tobacco campaign available late 2016.		campaign surveys. 2016 campaign evaluation of 'Tuku Ifi Leva 2016' anti-tobacco campaign available. The evaluation reports on awareness of the campaign and its key messages, as opposed to awareness of smoking as an NCD risk factor.	
3.0: Downward trend in the rates of premature deaths and preventable disability related to NCDs in men and in women.								
3.1	OUTCOME: Incidence of GDM among pregnant women, in %	Gestational diabetes mellitus (GDM) refers to glucose intolerance that has its onset (or	Reduction	RH Nurse data	7.1 % (2015)	2016 study reported 8.4% of pregnancies affected by GDM	Systematic screening introduced on Tongatapu	Information (from health workers) suggests systematic screening was rolled out in 2016 and screening data is collected by RH nurses and reported to the GDM taskforce. GDM screening

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
		is first diagnosed) during pregnancy. Numerator: Number of pregnant women diagnosed with GDM Denominator: Total number of pregnancies in the year x 100						guidelines received but report with incidence data not sighted, nor reported in MoH annual report. NCD Strategy review reports on broader GDM.
3.2	IMPACT: All-cause mortality rate between ages of 30 and 69 years (probability of dying between 30 and 69 years per 1000 population)	The probability that a person aged 30 years in a given year or period will die before reaching her/his 70 th birthday, if subject to age-specific mortality rates of that period. The quantity is estimated from all cause-specific mortality life table. It requires combining cause of death and population data by age, and applying life table technique.	Halt the increase	Vital registration <i>Note: The THSSP2 and NCD Strategy target is a reduction in NCD related (not all cause) premature mortality. This also aligns to the SDG indicator routinely collected by the MoH</i>	2010-2014 Females: 668.0 per 1000 Males: 545.8 per 1000 Both sexes: 613.8 per 1000		Indicator should be revised to reflect THSSP2 target which aims to reduce NCD related premature mortality. This matches SDG indicator 3.4.1 and is planned for inclusion in MoH Annual Reports. Data from SDG trackers suggest a slight reduction between 2010 and 2017 (536.5 deaths per 100,000 in 2017 vs 552.5 deaths per 100,000 (95% CI 512.4-596.3 in 2010) Source: https://vizhub.healthdata.org/sdg/	

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
3.3	IMPACT: People with lower limb amputation as a percentage of total hospital admissions at Vaiola Hospital, per 100000	Lower limb amputation covers the following ICD-10 codes [Block 1484, 44370-00, 44373-00, 44367-00, BLOCK 1505, 44367-01, 44367-02, BLOCK 1533, 44338-00, 44358-00, 90557-00, 44361-00, 44364-00, 44364-01, 44362-02 Numerator: Patients with diabetes who had lower limb amputations in a given year Denominator: Total number of hospital discharges in the year x 100000	Reduction	The M&E Framework intended that this measure be sourced from the electronic patient activity database. During the evaluation, MoH advised that ICD10 coding for surgical procedures was too unreliable to provide representative data. The evaluation team made enquiries about access to data from a manual audit of amputations.	2010-2014 Both sexes: 15.3 per 100000 population	Not available	Not available	Not available
4.0: NCD management as part of Universal Health Coverage leads to cost savings in hospitals.								
4.1	INTERMEDIATE OUTCOME: Standards for essential NCD care established	Approval of an essential package of services, including evidence-based	One-off	MOH	Essential package of services being developed, not yet			'Package of Essential Health Services' (PEHS) document at final drafting stage 2018; baseline readiness survey complete. Feedback (from health workers) suggests the guidelines for

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
	in all health care facilities	NCD care for health centres, along with a mechanism to monitor the capabilities of health facilities to provide the care			approved (2015-16)			diabetic care are having a beneficial effect on standards of care though these were not sighted.
4.2	OUTPUT: Health centres implementing PEN (adapted) as a percentage of total facilities, in %	PEN (adapted) refers to a package of essential NCD interventions delivered through primary health care according to Tonga's health systems context. Numerator: Number of facilities implementing PEN (adapted) in a given year Denominator: Total number of facilities in the country in a given year x 100	Increase	The M&E Framework intended that this measure be sourced from Community Health and MOH administrative records. The WHO PEN model has since been absorbed into the PEHS.	Will not be available until the essential package is determined and facility survey has been conducted			This indicator is reliant upon and incorporated in the PEHS. The PEHS baseline study indicated that NCD services are not reliably available at all health facilities. The baseline indicated that the best performance was in availability of drugs for cardiovascular conditions, diabetes and prevention of acute rheumatic fever.
4.3	OUTCOME: Ratio of new NCD cases to 1000 population	This indicator may initially rise as improved care results in cases being detected earlier. Both	Initially increase as a result of earlier detection,	Community health, MOH	2014 (Only for 7 clinics in Tongatapu Island) 3.9 per 1000			New and existing cases of all NCDs reported by NCD nurses around the country but the number of new cases is not reported in the MoH annual

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
		diabetes and hypertension (cardiovascular disease) are included because many people have both conditions. The data provided do not double count individuals. Numerator: Number of new cases (diabetes and/or hypertension) identified by NCD nurses and clinics in one year Denominator: Current population estimate of the mid-year population	and then decline		Diabetes (including diabetes and hypertension) 2.3 per 1000 Hypertension - including diabetes and hypertension 2.3 per 1000			report and relevant quarterly reports not accessible.
4.4	OUTCOME: Default rate as % of all registered people with NCD, %	NCD register refers to data on demographic characteristics, risk factors and clinical measurements for every NCD (i.e. diabetes and hypertension) in the country.	Reduction	Community Health, MOH	2014 (Only for 7 clinics in Tongatapu Island) Females: 5.4 % Males: 6.4 % Both Sexes: 5.8 %			Information (from health workers) suggests this measure is captured by NCD nurses but report not accessible.

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
		Defaulters are those NCD patients who are in the NCD register but fail to visit NCD centres for health monitoring and management of diabetes or hypertension Numerator: Number of defaulters in a given year Denominator: All registered people with diabetes and hypertension in a given year x 100						
4.5	IMPACT: Average length of hospital stay due to medical and surgical conditions, mean	Length of hospital stay refers to the total number of days spent in hospital due to medical and surgical conditions. The data presented cover ONLY the main hospitals in the country. Numerator: Total number of days spent in hospital	Reduction	Electronic medical record <i>In the absence of HIS data, MoH Annual Reports were used</i>	2015 Females: 13.93 days Males: 12.59 days Both Sexes: 13.19 days	2015: Average length of stay for Vaiola Hospital: Medical ward 5.1 days (all) Surgical ward was 8.0 days (all) (Source: MoH Annual Report 2015)	2016: Average length of stay for Vaiola Hospital: Medical ward 5.1 days (all) Surgical ward was 8.5 days (all) (Source: MoH Annual Report 2016)	Not available

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
		due to medical and surgical conditions in a given year Denominator: Total number of discharges in the year x 100						
4.6	IMPACT: Potentially preventable hospital admissions related to NCDs (as defined by MOH) per 1000 of all hospital discharges, ‰	Potentially preventable hospital admissions refer to NCD admissions that could have been handled at lower level facilities as defined by the MOH essential service provision, and include the ICD AM diagnoses codes provided on the footnote. Numerator: Total number of hospital diagnosis with the ICD AM codes in a given year Denominator: Total number of hospital discharges in the year x 1000	Reduction	Electronic medical record During the evaluation, MoH advised that ICD10 coding was too unreliable to provide representative data. Furthermore, the M&E Framework does not define admission types that could have been handled at lower level facilities.		2015: 124 discharges from Vaiola Hospital surgical ward related to diabetic foot ulcers (Source: MoH Annual Report 2015)	2016: 134 discharges from Vaiola Hospital surgical ward related to diabetic foot ulcers (Source: MoH Annual Report 2016)	Not available

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2			Year 3	
5.0: Strengthened health system management, including planning, financial management, implementation, monitoring, health information, procurement and human resources (HR). (Note: stronger health systems benefit both service delivery and the delivery of aid, which is why there are outcome indicators related to both.)											
5.1	OUTPUT: % of facilities that have a cardio-vascular disease risk register	Cardio-vascular risk register refers to a risk register created and actively used by the facility to individually register patients by level of CVD risk and their socio-demographic characteristics Numerator: Number of facilities that have a CVD risk register Denominator: Total number of facilities in the country in a given year x 100	Maintain	Community health, MOH	2015 100%						
5.2	OUTPUT: % of actual expenditure compared to total MOH budget	Numerator: Actual expenditure in the year (in local currency) Denominator: Original budget in a given year (in local currency) x 100	MOH expends at least 70 % of planned budget	MOH Financial reports NB: Figures extracted from budget papers and Deputy Director Budget and	2015/2016 91.7 NB: Base Year percentage as at M&E Design does not agree with the same FY percentage as at the	Actual v budgeted expenditure (TOP, m)	FY 15/16	FY 16/17	FY 17/18 Revised Actual by Dec	FY 18/19 To date	
						MOH actual: budget %	109	110	112	27 (1 st quarter)	

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
				<i>Finance own files.</i>	<i>Mid-Term Review. This is likely as government budget figures are commonly subsequently revised.</i>			
5.3	OUTPUT: % of AMPs completed and reported	AMP refers Annual Management Plan by each of the divisions of MOH and TongaHealth Numerator: Total number of AMP activities completed and reported for the year Denominator: Total number of AMP activities planned for the year x 100	At least 80% of annual activities from AMP completed and reported	MOH monitoring reports, HR information systems and DFAT	77% of planned activities completed 18% of planned activities partly completed 2015/2016	2016 not available		
5.4	OUTPUT: % of planned AMP activities completed within 5% of planned budget	Numerator: Number of planned activities completed within 5% of budget Denominator: Total number of	At least 70% of planned activities are completed within budget	MOH monitoring reports, HR information systems and DFAT	39% 2015/16	2016 not available		

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
		planned activities						
5.5	OUTCOME: % TongaHealth / National NCD Strategy grantees reporting and acquitting on time against agreed grant agreement work plans	<p>Numerator: Number of grantees reports that report and acquit on time against agreed grant agreement work plans</p> <p>Denominator: Total number of grantees</p>	<i>What is the target?</i>	<p>TongaHealth Grantee Reports</p> <p><i>As reported in TongaHealth M&E Framework</i></p>	2015-16 data to be provided no later than August 2017	<p>Jan 2015-June16: Staff recruitment.</p> <p>Oct-Dec 2016 100% All program and financial quarterly reports submitted on time</p>	<p>Jan-Mar 2017 92% progress reports received 21% financial acquittal received</p> <p>Apr-Jun 2017 14% financial acquittal received on time* <i>*Ministry financial processes take longer, especially over financial year - 30 days after quarterly period seems to be unattainable for most.</i></p> <p>July-Sep 2017 46%</p> <p>Oct-Dec 2017 38%</p>	<p>Jan-Mar 2018 0% - still awaiting acquittals from 8 projects</p> <p>Apr-June 2018 Partners have until end of July to acquit</p>
5.6	OUTPUT: % of essential NCD medicines available at the Central Pharmacy	<p>Essential NCD medicines refer to a collection of 46 medications listed on the country's essential drug list.</p> <p>Numerator: Number of essential NCD medicines available at the</p>	Maintain or increase	Central Pharmacy (mSupply)	June 2016 91.3 %			

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
		Central Pharmacy as of June 30th Denominator: Number of all essential NCD medications listed on the country's essential drug list x 100						
5.7	OUTPUT: Quality of MDA Corporate Plans	Quality of MDA corporate plan refers to a planning quality ranking accorded by the Ministry of Finance	Improvement	Budget Statement <i>Prime Minister National Planning Office and annual budget</i>	2016/2017 -2 <i>NB: Corporate Plan ratings have been colour coded since FY 16/17</i>	'Red'	'Green'	'Green'
6.0: 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 THSSP 2 are gender, geographic equity, and inclusion of disabled and mentally ill people)								
6.1	OUTCOME: Service readiness of Vaiola Hospital Psychiatric Ward, (index of service readiness)	Service readiness refers to the overall availability and functionality of all the tracer items such as basic amenities, equipment, diagnostic	Improvement	Assess to be conducted as part of improving the mental health unit	Draft plan for Vaiola mental health unit hospital completed	Delayed	Delayed	Delayed

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
		capacity, essential medicines and tools that are deemed necessary to provide mental health services for the population. Numerator: Total number of tracer items in the facility that are available and functional at the time of review Denominator Total number of all tracer items that are deemed necessary to provide mental health services to the population x 100						
6.2	INTERMEDIATE OUTCOME: Percentage of annual plans which reflect relevant GESI considerations and report outcomes.	Plans refer to annual plans of MOH Numerator: Total number of AMPs that reflected and reported GESI outcomes in a given year Denominator Total number of	Increase	MOH annual plans	23.2% 2015-16		Unable to ascertain GESI implications based on level of detail contained in MoH Corporate Plans 2016/17-2018/19 and 2017/18-2019/20	Unable to ascertain GESI implications based on level of detail contained in MoH Corporate Plans 2016/17-2018/19 and 2017/18-2019/20

#	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
		AMPs for the year x 100						

TongaHealth M&E Framework

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3								
Institutional strengthening and health promotion																
Strategic priority 1: TongaHealth is an organisation of operational excellence, reliability, transparency and ethical practice																
Maintain a high standard of governance, probity and risk management																
1	OUTPUT: Updated risk register and risk mitigation plan in place and reviewed quarterly	Measured by quarterly update of risk register and risk mitigation		TongaHealth Risk Register and Risk Mitigation Plan	Risk register developed but not yet finalised (2016)	Risk register developed but not yet finalised (2015-16)	Currently being reviewed for submission to the board (2016-17)	Yet to be updated (2017-18)								
2	OUTPUT: TongaHealth administrative costs as an overall percentage of DFAT grant funds	Numerator: Amount of TongaHealth administrative costs Denominator: Total TongaHealth Budget x 100 NB: The following problems were encountered in evaluating this indicator: (i) Grant funds = total DFAT provision or DFAT+? (ii) Does the denominator refer to grant funds only or total budget as stated above? (iii) What is the definition of administrative costs? = Program 1: Leadership and Policy Advice or are administrative costs equal to that applicable to DFAT grants only or all administrative costs?; (iv) What is the target? and (v)		TongaHealth financial report NB: Figures extracted from TongaHealth Finance Manager’s own files.	Data for 2015/2016 to be provided following NNCDL approval of financial report, expected December 2016	<table><tr><th>FY 15/16</th><th>FY 16/17</th><th>FY 17/18 (budget)</th><th>FY 18/19 (budget)</th></tr><tr><td>64</td><td>41</td><td>45</td><td>78</td></tr></table>			FY 15/16	FY 16/17	FY 17/18 (budget)	FY 18/19 (budget)	64	41	45	78
FY 15/16	FY 16/17	FY 17/18 (budget)	FY 18/19 (budget)													
64	41	45	78													

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
		<i>Given the variability in annual allocations due to roll-overs and delayed accounting should the baseline be better compared with subsequent averages?</i>						
3	OUTPUT: Compliance to legislative and DFAT contractual requirements	Compliance to legislative and contractual requirements measured by: <ul style="list-style-type: none"> Budget and Statement of Corporate Intent submitted to Minister on time (1 June before new financial year) Annual Report published on time (31 March of following financial year) Audit of accounts conducted on time (31 December of following financial year) 	All submitted on time	Budget and Statement of Corporate Intent, TongaHealth Annual Report, audit of accounts <i>NB: FY is July 1 to June 30. Annual report is to be published by 31 March of following FY (e.g. 31 March 2017 for FY 15/16 accounts). Audit is to be ready in December of the following FY? (This would have to be FY two years removed e.g. December 2017 for FY 15/16 accounts). TongaHealth report that the audit meets DFAT requirements, not GOT requirements</i>	Budget and Statement of Corporate Intent submitted for 2016/2017 on 8 July 2016. Annual Report not published (due 31 March 2017). Audit of Account for 2015/2016 not yet due (due 31 December 2016).	Performance is mostly off track. See footnote		

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
4	OUTPUT: % DFAT grant funds dispersed on time TongaHealth	Numerator: Amount of DFAT grant funds dispersed on time TongaHealth Denominator: Total DFAT grant funds TongaHealth x 100	70%	TongaHealth financial report <i>NB: As advised by TongaHealth CEO. Awaiting more information from Project Coordinator</i>	2015/2016 Data to be provided no later than August 2017	Reported as 70% for FY 15/16 and FY 16/17 but insufficient data to confirm. See footnote.		
5	OUTCOME: # non-compliances to financial policies	The number of non-compliance to financial policies noted in the independent audit. This indicates compliance to recognised financial policies and procedures.	Zero non-compliances	Annual audit report <i>NB: Uta'atu & Associates conducted the 2014/15 audit but their services were not available after FY 14/15. Obtaining audit quotes for a new auditor delayed further audit. The Government auditor was selected. Audit for 15/16 did not commence until April 2017. The 15/16 audit has been completed. Audit for FY 16/17 submitted in September 2017 with audit fieldwork completed but</i>	<i>Baseline is audit from end of last project, 2014-15</i> 2 non compliances (2014/2015): (1) Twelve planned and budgeted activities were not initiated and seven planned and budgeted activities were partially implemented; and (2) Several assets with fully expired costs continued to be depreciated	Insufficient data. See footnote.		

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
				<i>final report still not produced. Annual report for FY 15/16 is now with the Minister of Health.</i>				
Invest in building the capability of staff in both skill development and in modelling our organisational values and behaviours.								
6	OUTPUT: % staff that undergo a documented annual performance appraisal	Numerator: Total number of annual performance appraisals conducted Denominator: Total number of staff who are eligible for an annual performance appraisal	100%	TongaHealth HR records	Performance appraisal template completed. Report for 2015/2016 to be provided no later than August 2017. Baseline for 2014/15 was 80% - 4/5 staff.		100% of appraisals due (i.e. 12 months post recruitment) (2016-17)	86% (6/7) of appraisals due (2 staff still on probation) (2017-18)
7	OUTPUT: % of activities delivered as per the TongaHealth 'Staged capacity development' plan in increase the capacity of TongaHealth and its board and staff	Numerator: Number of activities delivered as per the TongaHealth 'Staged capacity development' Denominator: Total number of activities in the TongaHealth 'Staged capacity development'		TongaHealth program records	Plan finalised for five years. 24 capacity activities listed for 2016. Implementation started in 2016/2017 and will be reported in first annual report August 2017.	39% of activities delivered (2016)	32% planned activities delivered (2017)	
8	OUTCOME: % of 'staged capacity development' activities delivered that achieved the outcome indicators are	Reporting on the outcome achieved for each staged capacity development activity conducted in the reporting period		TongaHealth program records	Outcome indicators have been included in the plan for each activity. Reporting will be done in first		80% (8/10) (2016-17)	80% (8/10) (2017-18)

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
	described in the TongaHealth 'Staged capacity development' plan				annual report August 2017			
Commit to Transparency								
9	OUTPUT: % of business plans and workplans, M&E frameworks, and annual reports made publicly available on TongaHealth website	Numerator: M&E frameworks, and annual reports available on TongaHealth website Denominator: Total number of M&E frameworks, and annual reports X 100 Note that this indicator depends on the completion of the documents – indicator #11		TongaHealth website	Documents not yet finalised (see indicator #11)	National NCD Strategy (including M&E framework) published; 2015-16 annual report finalised but not published	2016-17 annual plan published; 2016-17 annual report finalised but not published	2017-18 report not yet prepared
Communicate effectively								
10	OUTPUT: % of communication activities planned in the annual communications strategy	Numerator: Number of planned communication activities completed Denominator: Number of communication activities listed in the annual communications plan x 100		TongaHealth program records and communication activities	2016-17 Communication Strategy completed. The strategies notes that in 2015-16 nine key communication activities were completed.	2015/16, nine key communication activities were completed		Communications strategy was not finalised for 2017/18
Measure and report our performance against agreed indicators								
11	OUTPUT: TongaHealth has an up to date M&E Framework and annual business plan	TongaHealth M&E Framework and TongaHealth annual business plan developed on time		TongaHealth program records	M&E Framework in development and work plan awaiting approval from board.	National NCD Strategy (including M&E framework) launched February 2016	2016-17 annual plan published	

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
12	OUTPUT: % of actions listed in the annual business plan completed on time	Numerator: Number of activities from the TongaHealth annual business plan delivered within the defined time Denominator: Total number of activities in the TongaHealth annual business plan x 100		TongaHealth program records	34 action listed in 2015-16 business plan; by April 2016 17 complete and 6 nearly complete. Full report to be provided no later than August 2017.	-	95.6% (22/23) 2016-17	87.5 % (21/24) 2017-18
13	OUTCOME: NCD Prevention activities implemented and reported against as a percentage of all NCD planned activities for that year, %	Health promotion activities refer to NCD promotion activities identified in the NCD Strategy. These health promotion activities may also be in the TongaHealth annual business plan. Numerator: Number of health promotion activities planned, implemented and reported for the year Denominator: Total number of NCD health promotion activities planned in the year x 100	At least 80 % is implemented and reported against	TongaHealth program records	Data to be reported no later than August 2017	100% (2 NCD prevention activities funded: 2016 Anti-tobacco campaign and pilot remote patient monitoring) 2015-16	95% (20 of 21) grants implemented and reported. One grant cancelled. 2016-17	100% (16 of 16) grants implemented 2017-18
14	PROCESS: Number of media awareness campaigns for NCD prevention conducted or commissioned	This indicator captures the part of the activities planned by TongaHealth and the National NCD Strategy. Media campaigns may include all forms of media and may be stand-alone or multipronged programs.		TongaHealth program records Note: no target set for this indicator	Data to be reported no later than August 2017	(1) 2016 Anti-tobacco Campaign (2) Fiefia Sports media awareness (MOH/MIA) (3) Alcohol related harm awareness	(1) 2017 Anti-tobacco Campaign (2) Fiefia Sports media awareness (MOH/MIA) (3) Alcohol related harm TV series	(1) 2018 Anti-tobacco Campaign (2) Fiefia Sports media awareness (MOH/MIA) (3) Alcohol related harm TV series (commissioned by TH)

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
						(Salvation Army/TNYC)	(commissioned by TH)	(4) Healthy Eating Campaign commissioned
Strategic Priority 2: Maximise the impact of the NCD strategy through effective planning, co-ordination, harmonisation of activities and funding, and monitoring and evaluation.								
Strengthen co-ordination of NCD prevention and control								
15	OUTPUT: % of attendance by nominated representative for National NCDs governance and Advisory Committee meetings	Numerator: Number of nominated representatives in attendance Denominator: Total number of nominated representatives x 100	80%	National NCD Committee / Advisory Committee minutes	In 2015-16: National NCD Governance Committee: 86%, Physical Activity Advisory Committee: 535, Healthy Eating Advisory Committee: 75%, Tobacco Control Advisory Committee: 80%, Alcohol Harm Reduction Advisory Committee: 80%	2016 Advisory Committee meetings - 50% of nominated representatives attended	2017 Advisory Committee meetings - 48% of nominated representatives attended	2018 0% (Mid-term evaluation meeting attended by representatives of 8/11 organisations of the NNCD)
16	OUTCOME: % planned NCD Governance and Advisory Committee meetings held with minutes from meetings prepared and distributed.	Numerator: Number of meetings held with minutes and actions from previous meeting provided Denominator: Total number of meetings planned x 100%	2 NCD Governance and 4 Advisory Committee meetings held per year	National NCD Committee / Advisory Committee minutes	NCD Governance Meetings: 100% (2/2) Advisory Meetings 50% (2/4)	2016 - 100% of NNCD and advisory committee meeting minutes prepared and distributed	2017 - 100% of NNCD and advisory committee meeting minutes prepared and distributed	0%
17	OUTCOME: Satisfaction rating from partners,	Tool for satisfaction rating to be developed and results reported	Maintenance or improvement	TongaHealth satisfaction rating tool developed with 11 questions	Draft satisfaction rating tool developed. Pre-test in late 2016.		Grant recipient satisfaction	Survey not yet conducted

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
	including grantees (obtained at end of agreement if shorter than 12 months or annually)		in satisfaction rating	measuring dimensions of satisfaction.	Results reported no later than August 2017.		survey yet to be conducted. Tool has been developed.	
Increase investment in the reduction and management of NCD's								
18	OUTCOME: # of partners contributing to NCD prevention and control in Tonga and their contribution	Partners include government ministries, civil society and nongovernment organisations, churches, private enterprises and community groups. Partners may be receiving grants from TongaHealth or a Ministry or participating in another way such as membership in Advisory Committees.	Expand the pool of multi-sectoral partners and their involvement in NCD prevention and control	TongaHealth and the National NCD Strategy	2015/16 results to be reported no later than August 2017	11	14	14
19	OUTCOME: Total funding and source available for NCD prevention and control	Total funding available for NCD prevention and control	Maintain or expand the resources, including new sources of funding	Annual budgets <i>NB: The level of DFAT funding has been impacted by rollover from THSSP 1 and subsequent delayed acquittals. NCD funding is received from the Government of Tonga, DFAT/ TongaHealth, WHO, UNFPA, World Diabetic</i>	\$1,815,480; Government: \$688,108, DFAT: \$1,127,372 (2015/2016)	Some progress in terms of sources of funding but total funding by FY unclear.		

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
				Foundation, and Japan Aid.				
Maintain efficient and effective grants management								
20	OUTPUT: % of grants that are up to date in the grant management cycle	<p>The grant tracker will outline the major activities to be done for managing a grant from establishment to completion, including key deliverables and risk management activities.</p> <p>Numerator: Number of grants which are activities are up to date in grant management tracker</p> <p>Denominator: Total number of grants x 100</p>		TongaHealth grants tracker	Grant tracker draft developed. Baseline for 2015-16 grants to be provided no later than August 2017.			<u>As at June 2018:</u> 72.7% (8 in progress, 3 delayed active grants) <u>As at Nov 2018:</u> Grant tracker shows 17 grants: 2 completed, 2 delayed and 13 in progress
Develop health promotion capacity and skills transfer								
21	OUTPUT: # of TongaHealth funded workshops/trainings/placements and number of participants	<p>Total number of TongaHealth funded workshops/trainings/placements</p> <p>Total number of participants</p>		TongaHealth	<p>0 (2015/2016)</p> <p>0 (2015/2016)</p>	TongaHealth provided support, set up and ran the National NCD Summit in June 2016	<p>3 sessions with all current grant recipients on grant requirements.</p> <p>Total number of participants: 52</p>	None
22	OUTCOME: % of participants indicating positive outcomes from the training	<p>Numerator: % of participants indicating gains in knowledge, skills or attitude</p> <p>Denominator: number of participants surveyed</p>	80% of participants surveyed	Pre- and post training surveys to be conducted for at least half of training activities	0 trainings done in 2015/16	-	No pre-post training surveys undertaken however the training evaluation form has been developed and will be used for all future	N/A

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
							trainings/workshops	
23	OUTCOME: % Dr Tapa scholars working in health promotion in Tonga	Numerator: Number of Dr Tapa scholars who have completed their studies who are working in health sector in Tonga Denominator: Total number of Dr Tapa scholars who have completed their studies in the year		TongaHealth	Data for 2015/2016 to be provided March 2017	20% (1 of 5 scholars working in NCD health promotion)	20% (1 of 5 scholars working in NCD health promotion) No new scholars from previous year.	20% (1 of 5 scholars working in NCD health promotion) No new scholars from previous year.
Health Promotion activities are sensitive to gender equity and social inclusion (GESI)								
24	OUTPUT: % of grantee work plans that document GESI considerations	Numerator: Number of grantee work plans that document GESI considerations Denominator: Total number of work plans x 100		TongaHealth grantee work plan	No work plans developed for the 2 grantees (2015/2016)	Only 2 grants, no work plans developed	86% - GESI considered and mentioned in grant agreements of 12 of 14 grants	100% - GESI section included in all grant agreements
Support Innovation								
25	OUTPUT: % of DFAT grant funding retained to respond to and support innovation	Numerator: Budgeted grant funding allocated to innovation (to be defined in grant guidelines) Denominator: Total budgeted grant funding (in local currency)		TongaHealth financial records <i>NB: Expenditure on innovation has not been defined.</i>	0% (0/2) (2015/2016)	The indicator cannot be measured.		
26	OUTCOME: # of new/emerging technologies being used as part of NCD	Total number of activities incorporating new/emerging technologies being implemented as part of National NCD Strategy annual work plan		TongaHealth program records	Two activities on website using ICT. To be reported in March 2017.	-	(1) First 1000 days SMS messaging (2) Remote Patient monitoring	(1) DFAT Launch Legends pilot - children's App (2) Promoting awareness through Facebook (Anti-

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
	strategy annual work plan						project using tablets (3) Census using tablets (4) Promoting awareness through Facebook (Anti-tobacco campaign, Fiefia Sports)	tobacco campaign, Fiefia Sports)
Ensure investment in well evidenced and prioritised interventions								
27	INTERMEDIATE OUTCOME: % TongaHealth budget allocations aligned to strategy priority areas	<p>Priority areas defined as young people, healthy eating, and tobacco control.</p> <p>Numerator: Budget allocation to priority areas (in local currency)</p> <p>Denominator: Total budget (in local currency) x 100</p>		<p>TongaHealth financial and program records</p> <p><i>NB: the following issues were apparent with this indicator: (i) How was the base year (15/16) estimated to be 17.5%? (ii) Was the target to maintain or increase the proportion of the budget allocated to strategy priority areas? (iii) Given the variability in annual allocations due to rollovers and delayed accounting</i></p>	17.5% (2015-16)	The target is not known. Allocations to strategic priority areas fluctuates but has been maintained overall. See footnote.		

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
				<i>should the baseline be compared with subsequent averages? and (iv) no budget has been allocated for young people.</i>				
Strategic Priority 3: Build the evidence base for NCD prevention and control in Tonga, and the region								
Ensure regular reporting against the NCD strategy monitoring and reporting framework								
28	OUTCOME: % grantees reporting and acquitting on time against agreed grant agreement work plans	Numerator: Number of grantees reports that report and acquit on time against agreed grant agreement work plans Denominator: Total number of grantees	<i>What was the target?</i>	TongaHealth Grantee Reports	2015-16 data to be provided no later than August 2017	If target is 100% reporting and acquitting on time then performance has declined. Each grantee report defines times for reporting and acquitting. TongaHealth Annual Report for 16/17 reports 100% grantees reporting and acquitting on time against agreed grant agreement from October to December 2016; January to March 2017: 92% progress reports received and 21% financial acquittals received; April to June 2017: 14% financial acquittals received on time.		
Work collaboratively to translate evidence into policy and practice								
29	OUTPUT: # of publications in relation to Tongan NCD prevention and control	Publications refer to journal articles, policy briefs, conference presentations, reports or any other publication that can inform policy development in Tonga Total number of publications in relation to the Tongan NCD prevention and control		TongaHealth Note: no target set for this indicator and reporting does not include details of the actual publication	Online article: 31 pages, 5 Online document (pdf), 1 Journal article	1	3	1
30	OUTCOME: % of grants and commissioned projects with M&E or research component	Numerator: Number of grants and projects with M&E or research component Denominator: All grants and projects managed by TongaHealth		TongaHealth	National NCD strategic priority area	-	95% (18/19) 14 with M&E framework included in grant agreements and	100% All new grants included M&E framework

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
							one developed since signing + 4 (research component)	
31	OUTCOME: Examples of use of commissioned research and evaluation for improvement in NCD activities and policies	Descriptions of how research and evaluation has been used, including evidence in minutes, proposals and policies		TongaHealth	Three reports completed to inform the National NCD Strategy. 2015-16	(1) 2016 Anti-tobacco Evaluation by Sydney Uni (completed) (2) 2017 Anti-tobacco Evaluation. Fieldwork by Statistics Dept. (commissioned)	(1) 2017 Anti-tobacco Campaign Evaluation analysis by University of Sydney (2) Reports for Phase One and Phase Two of campaign completed	
Ensure M&E activities are sensitive to gender equity and social inclusion (GESI)								
32	OUTPUT: % of results of TongaHealth supported surveys able to be disaggregated by sex, disability, location	Numerator: Number of TongaHealth supported surveys with results able to be disaggregated by gender, disability, location Denominator: Total number of TongaHealth supported surveys		TongaHealth	100% - 1 survey (anti-tobacco) conducted (2015/2016)		100% - 2016 anti-tobacco survey (Sex and location but not by disability) Census data on kava and tobacco use disaggregated by gender and location	Global School Health Survey (GSHS) data disaggregated by sex only
Monitoring National NCD Strategy strategic priorities								
Outcome 1: Tongan infants (age 2 and under) have a healthier start to life								
Halt the number of babies exposed to the risk of being born to a mother with diabetes (Type 2 or GDM)								
33	OUTCOME: Incidence of GDM among pregnant women, in %	Gestational diabetes mellitus (GDM) refers to glucose intolerance that has its onset (or is first diagnosed) during pregnancy.	Reduction	RH nurses data	7.1% (2015)	See indicator 3.1	See indicator 3.1	See indicator 3.1

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
		<p>Numerator: Number of pregnant women diagnosed with GDM</p> <p>Denominator: Total number of pregnancies in the year x 100</p>						
Increase in the number of babies exclusively breastfed until 6 months								
34	OUTCOME: % babies exclusively breastfed under 6 months of age	<p>Numerator: Number of babies aged 6-12 months of age who were exclusively breastfed until 6 months of age</p> <p>Denominator: Total number of babies aged 6-12 months</p>	Increase	<p>RH nurses data</p> <p>Note: taken from MoH annual reports</p>	Tongatapu: 58%, 'Eua: 74%, Vava'u 56%, Niuas 57% (2014)	2015: not included in annual report	2016: 65.4%	
Improve awareness and attitudes about breastfeeding along with complementary feeding until age 2								
35	INTERMEDIATE OUTCOME: Knowledge of target population towards the 'First 1000 days' key messages, %	<p>Target population refers to mothers who benefited from the 'First 1000 days' intervention.</p> <p>Numerator: Number of pregnant women and mothers of infants less than 24 months of age who knew (or are aware) of the 'First 1000 days' key messages.</p> <p>Denominator: Total number of pregnant women and mothers of infants less than 24 months of age who benefited from the 'First 1000 days' key messages x 100</p>	Increase	TongaHealth - Program pre/post survey	Project underway			

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
Outcome 2: Tongans are leading healthier lifestyles								
36	OUTCOME: Prevalence of overweight and obesity in adolescents and adults	<p>Adolescents refers to population aged 13-17 years. Adults a persons aged 18 years and older. A person is overweight if their BMI is ≥ 25 Kg/m² or obese their BMI is ≥ 30 Kg/m²</p> <p>Numerator: Number of people whose BMI is ≥ 25 Kg/m² (for prevalence of overweight). Number of people whose BMI is ≥ 30 Kg/m² (for prevalence of obesity)</p> <p>Denominator: Total number of people (for the defined age group)</p>	Decrease	STEPS 2014, 2016 and 2020 GSHS 2016 and 2020	<p>13 – 17 Males: Data from GSHS 2016 Females: Data from GSHS 2016 Both sexes: Data from GSHS 2016</p> <p>18 – 24 Males: Data from STEPS 2016 Females: Data from STEPS 2016 Both sexes: Data from STEPS 2016</p> <p>25-44 Males: 57.6% Females: 77.3 % Both sexes: 67.5 %</p> <p>45-64 Males: 56.2% Females: 78.2 % Both sexes: 67.9 %</p> <p>Overweigh 13 – 17 Males: Data from GSHS 2016</p>		GSHS and STEPS survey data collected in 2016	<p><u>Adolescents:</u> See indicator 2.3</p> <p><u>Adults:</u> awaiting STEPS 2016 survey due early 2019</p>

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
					<p>Females: Data from GSHS 2016 Both sexes: Data from GSHS 2016</p> <p>18 – 24 Males: Data from STEPS 2016 Females: Data from STEPS 2016 Both sexes: Data from STEPS 2016</p> <p>25-44 Males: 86.5% Females: 93.4 % Both sexes: 89.9 %</p> <p>45-64 Males: 89.0% Females: 95.1 % Both sexes: 92.3 %</p>			
More Tongans are meeting the WHO Global Physical Activity Guidelines								
37	OUTCOME: Prevalence of insufficiently physically activity	Insufficient physical activity defined as less than 150 minutes of moderate or 75 minutes of vigorous physical activity per week for adults and less than 60 minutes of moderate to vigorous daily activity for adolescents	Decrease	STEPS 2014, 2016 and 2020 GSHS 2016 and 2020	13 – 17 Males: Data from GSHS 2016 Females: Data from GSHS 2016 Both sexes: Data from GSHS 2016		GSHS and STEPS data collected in 2016	<p><u>Adolescents aged 13-17 years</u> GSHS 2017: Male: 80.5% Female: 82.9% All: 81.7%</p> <p><u>Adults:</u> awaiting release of STEPS survey in early 2019</p>

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
		<p>Numerator: Number of people who do insufficient physical activity</p> <p>Denominator: Total number of people (for the defined age group)</p>			<p>18 – 24 Males: Data from STEPS 2016 Females: Data from STEPS 2016 Both sexes: Data from STEPS 2016</p> <p>25-44 Males: 15.0% Females: 30.8 % Both sexes: 23.0 %</p> <p>45-64 Males: 15.3% Females: 33.5 % Both sexes: 25.0 %</p>			
Reduce Alcohol related harm								
38	OUTCOME: Prevalence of heavy episodic drinking among adolescents and adults who are current drinkers	<p>Heavy episodic drinking defined for men as 5 or more or more drinks on any day in the past 7 days and for women as 4 or more drinks on any day in the past 7 days</p> <p>Numerator: Number of people who have had heavy episodic drinking in the past 30 days</p> <p>Denominator: Total number of people who drank alcohol in the previous 30 days (for the defined age group)</p>	Decrease	<p>Primary source: STEPS 2014, 2016 and 2020 GSHS 2016 and 2020</p> <p>Note: Heavy episodic drinking is not reported in the GSHS</p>	<p>13 – 17 Males: Data from GSHS 2016 Females: Data from GSHS 2016 Both sexes: Data from GSHS 2016</p> <p>18 – 24 Males: Data from STEPS 2016 Females: Data from STEPS 2016 Both sexes: Data from STEPS 2016</p>		GSHS and STEPS data collected in 2016	<p>Adolescents aged 13-17 years who currently drink alcohol, GSHS 2017: Male: 19.6% Female: 8.3% All: 14.0%</p> <p>Adults: awaiting release of STEPS survey in early 2019</p>

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
					25-44 Males: 66.3% Females: 38.9 % Both sexes: Not available 45-64 Males: 41.5% Females: 21.7 % Both sexes: Not available			
Reduce Tobacco related harm								
39	OUTCOME: Prevalence of current tobacco use among adults and adolescents	Tobacco use defined as those who currently smoke Numerator: Number of people currently smoke Denominator: Total number of people (for the defined age group)	Decrease	STEPS 2014, 2016 and 2020 GSHS 2016 and 2020	13 – 17 Males: Data from GSHS 2016 Females: Data from GSHS 2016 Both sexes: Data from GSHS 2016 18 – 24 Males: Data from STEPS 2016 Females: Data from STEPS 2016 Both sexes: Data from STEPS 2016 25-44 Males: 40.9% Females: 14.5 % Both sexes: 27.4 %			See indicator 2.4

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
					45-64 Males: 44.6% Females: 8.0 % Both sexes: 25.3 %			
Tongans are eating a healthier diet								
40	INTERMEDIATE OUTCOME: Knowledge of target population towards the health risks of physical inactivity, poor diet, smoking and alcohol misuse, %	Target population refers to population aged 18 years or over who benefited from targeted health promotion interventions on key NCD risk factors. Numerator: Number of adults aged 18 or over years who knew (or are aware) of the given NCD risk factor of interest. Denominator: Total number of adults aged 18 years or over who benefited from targeted health promotion interventions on key NCD risk factors.	Increase	Pre/post survey for selected programs	Data to be provided as surveys completed. Data for pre survey for anti-tobacco campaign available late 2016.			See indicator 2.6
41	OUTCOME: Prevalence of persons consuming less than five total servings of fruit and vegetables per day		Decrease	Primary source: STEPS 2014, 2016 and 2020 GSHS 2016 and 2020 <i>Note: GSHS does not collect this indicator</i>	13 – 17 Males: Data from GSHS 2016 Females: Data from GSHS 2016 Both sexes: Data from GSHS 2016 18 – 24 Males: Data from STEPS 2016		Data collection completed for 2016 STEPS survey.	Awaiting publication of 2016 STEPS survey results in early 2019

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
					<p>Females: Data from STEPS 2016 Both sexes: Data from STEPS 2016</p> <p>25-44 Males: 73.1% Females: 72.9 % Both sexes: 73.0 %</p> <p>45-64 Males: 71.1% Females: 75.3% Both sexes: 73.3 %</p>			
42	OUTCOME: Mean population intake of salt (sodium chloride) per day in grams in persons aged 18-24	The method of determining salt intake can vary. Methods include collection of 24-hour urine or sport urine for sodium excretion or food frequency surveys. Definition to be updated once method for STEPS defined.	Decrease	STEPS Gap 2016 and STEPS 2020	Survey (STEPS Gap) to be completed			Interviews with key informants suggest STEPS 2016 did not include the STEPS Gap survey or any measure of mean salt intake
Outcome 3: Improved early detection, treatment and sustained management of people with or at high risk of NCDs								
People with, or at high risk of, NCDs are staying healthier for longer								
43	OUTCOME: Ratio of new NCD cases to total population	This indicator may initially rise as improved care results in cases being detected earlier. Both diabetes and hypertension (cardiovascular disease) are included because many people have	Initially increase as a result of earlier detection, and then decline	Community health, MOH	<p>2014 (Only for 7 clinics in Tongatapu Island)</p> <p>3.9 per 1000</p>			See indicator 4.3

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
		<p>both conditions. The data provided do not double count individuals.</p> <p>Numerator: Number of new cases (diabetes and/or hypertension) identified by NCD nurses and clinics in one year</p> <p>Denominator: Current population estimate of the mid-year population</p>						
44	OUTCOME: Default rate as % of all registered people with NCD, %	<p>NCD register refers to data on demographic characteristics, risk factors and clinical measurements for every NCD (i.e. diabetes and hypertension) in the country.</p> <p>Defaulters are those NCD patients who are in the NCD register but fail to visit NCD centres for health monitoring and management of diabetes or hypertension</p> <p>Numerator: Number of defaulters in a given year</p> <p>Denominator: All registered people with diabetes and hypertension in a given year x 100</p>	Reduction	Community Health, MOH	<p>2014 (Only for 7 clinics in Tongatapu Island)</p> <p>Females: 5.4 %</p> <p>Males: 6.4 %</p> <p>Both Sexes: 5.8 %</p>			See indicator 4.4
Outcome 4: Strengthened monitoring and surveillance supports evidence based action								

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3		
45	OUTPUT: % of overall health budget allocated to Health Planning and Information Services	Budget refers to allocated amount in the past financial year and excludes donor funds.	Maintain or increase	MOH Annual Budget NB: The following concerns were evident with this indicator: (i) The estimate for health planning and information services (HPIS) for 2014/15 would appear to be excessive at 8% of total budget; (ii) Donor funds are assumed to equal the total development budget; (iii) HPIS data is only available up to FY 16/17 as HPIS was incorporated under Corporate Services from FY 17/18.	8.08% (2014/2015)	Budget allocation for HPIS excluding donor funds (TOP m)	FY 14/15	FY 15/16	FY 16/17	FY 17/18
		% of total MOH budget allocated to HPIS, excl. donor funds				1.67	1.78	2.25		
46	OUTCOME: % of NCD Strategy M&E framework indicators reported against	Numerator: Number of NCD Strategy M&E Framework indicators reported on (Indicators from Outcomes 1-4 in this framework) Denominator: Total number of NCD Strategy M&E framework indicators x 100	To be determined	TongaHealth M&E team Note: Indicators 1-4 in this framework are not included in the NCD strategy M&E framework. May be more relevant to the	To be reported in the 2015/2016 TongaHealth Annual Report, no later than August 2017					

Indicator number	Indicator name	Definition	Target	Data source/s used for midterm evaluation	Baseline	Year 1	Year 2	Year 3
				<i>NCD strategy review</i>				
47	OUTPUT: # NCD program/project intervention independently evaluated and reported	Total number of NCD program/projects that have had an independent evaluation conducted and reported	To be determined	Evaluation Reports	0 (2015/2016)		2016 Anti-tobacco campaign evaluated by University of Sydney	2017 Anti-tobacco campaign evaluated by University of Sydney

Notes to tables:

1.2

Budget allocations to MOH and THPF (TOP)	FY 15/16 (Provisional)	FY16/17 (Provisional)	FY 17/18 (Revised Estimate)	FY 18/19 (Estimate)
Total government local fund, TOP, (excl. donor funds)	217,890,283	227,106,700	264,560,300	321,646,000
MOH local fund, TOP (excl. donor funds)	28,309,746	29,679,586	35,002,500	35,218,800
MOH % of local fund (excl. donor funds)	12.99	13.1	13.2	10.9
MOH estimate of MOH local fund, TOP (excl. donor funds)	11.57	11.42	11.30	11.70
TongaHealth TOP excl. donor funds	450,000	500,000	600,000	700,000
TongaHealth % excl. donor funds	0.20	0.22	0.23	0.22

According to the Staff Report for the 2017 IMF Article IV consultation the FY18/19 budget is expansionary and the fiscal position is projected to weaken. The FY 18/19 budget reflects spending pressures from (i) wage increases; (ii) a reform of public sector employment categories; and (iii) the government's infrastructure development strategy.

1.3

Budget allocation to public health (TOP m), excluding donor funds	FY 15/16	FY 16/17	FY 17/18 (provl)	FY 18/19 (est)
Public Health Division, TOP excl. donor funds (assuming all development budget is donor funded)	2,502,700	2,463,455	4,985,000	6,711,100
Total MOH budget, TOP excl. donor funds (assuming all development budget is donor funded)	30,197,500	32,596,200	38,943,800	42,832,000
Public Health Division % of MOH excl. donor funds	8.29	7.56	12.80	15.67

5.2

Actual v budgeted expenditure (TOP, m)	FY 15/16	FY 16/17	FY 17/18 Revised Actual by Dec	FY 18/19 To date
MOH actual expenditure (provisional outcome), TOP	32,852,267	35,821,439	43,794,139	11,772,025
MOH budget expenditure (original budget), TOP	30,197,500	32,596,200	38,943,800	42,832,000
MOH actual: budget %	109	110	112	27 (1 st quarter)

2.

TongaHealth administrative costs as % of DFAT grants (or budget?) (TOP)	FY 15/16	FY 16/17	FY 17/18 (budget)	FY 18/19 (budget)
TongaHealth total administrative costs	360,425	390,210	380,471	533,923
TongaHealth total grant funds including costs of administering grants	566,857	941,299	853,168	684,426
TongaHealth DFAT grant funds excluding DFAT funded TongaHealth administration	791,849	577,111	625,766	567,351
TongaHealth DFAT grant funds, including DFAT funded TongaHealth administration	839,708	638,916	674,472	650,000
TongaHealth admin/ total DFAT grant funds %	64	41	45	78

3.

Compliance to legislative and DFAT contractual requirements	FY 15/16	FY 16/17	FY 17/18	FY 18/19
Budget and Statement of Corporate Intent submitted to Minister on time (1 June before new financial year)?	Submitted on time			
Annual Report published on time (31 March of following financial year)	Not yet published		Not yet due	
Audit of accounts conducted on time (31 December of following financial year)? (1)	Completed Sept 17	Completed, awaiting management letter	Not yet due	

4.

Timely disbursement of grant funds	FY 15/16	FY 16/17	FY 17/18	FY 18/19 To date
TongaHealth grant funds actually disbursed on time (by end June)				As of 21.11.18 grant funds not recd.
Total TongaHealth grant funds disbursable				
% disbursed on time/ disbursable	70%	70%	Not known	

5.

Compliance with financial policies	FY 14/15	FY 15/16	FY 16/17	FY 17/18
Number of non-compliances to financial policies	2	With the Minister of Health	Should be available last week of November 2018.	Not yet available Waiting on TongaHealth Board to clear. Aiming for December 2018.

19.

Funding available for NCD prevention and control	FY 15/16	FY 16/17	FY 17/18	FY 18/19
Government funding	688,108	500,000	600,000	700,000
DFAT funding	1,127,372	638,917	674,472	650,000
Total funding	1,815,480	1,138,917	1,274,472	1,350,000

27.

Budget for strategy priority areas (TOP)	FY 15/16	FY16/17	FY 17/18	FY 18/19
Budget allocated for young people	No budget allocation for young people			
Budget allocated for healthy eating	191,722	224,000	160,500	220,500
Budget allocated for physical activity	191,722	128,000	98,000	20,000
Budget allocated for tobacco control	168,645	10,000	140,000	170,000
Budget allocated for alcohol reduction	35,000	70,000	110,000	60,000
Total budget allocated for priority areas	587,089	432,000	508,500	470,500
Total budget allocation	875,518	725,440	833,585	786,726
% of total budget allocated for strategic priority areas	67	69	61	60

45.

Budget allocation for HPIS excluding donor funds (TOP m)	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19
Budget allocated for HPIS, excl. donor funds	470,106	538,700	734,800	HPIS merged into Corporate Services from FY 17/18	
Total MOH budget, excl. donor funds	28,066,893	30,197,500	32,596,200		
% of total MOH budget allocated to HPIS, excl. donor funds	1.67	1.78	2.25		

Annex E: Analytical products

Outlines of major tasks/themes for analytical products to inform future health sector program design.

Service system mapping and PEHS gap analysis

In consultation with the MoH Divisions and based on the structure of the PEHS, for each individual health facility, document:

- staffing
- major infrastructure
- transport assets
- major and minor medical equipment
- treatment guidelines and tools (patient information, education and communication materials)
- communications (equipment/devices, network connectivity, etc)

For each individual health facility, document:

- medical supply logistics
- referral arrangements for diagnostic services
- clinical supervision (including vertical program structures, if applicable)
- managerial supervision
- reporting arrangements (tablet, paper, etc)

Order of work to focus initially on facilities in the outer islands and the locations on Tongatapu earmarked to become community health centres. Subject to final agreement on the scale and scope of this activity, coordinate a comprehensive audit of all PEHS elements within health facilities OR priority PEHS themes determined by the MoH (which must include NCD prevention and management).

Field travel as required.

Document findings in a simple electronic file format (e.g. Excel spreadsheet) for handover to MoH. Upload into Tupaia platform where relevant.

Provide a written report including narrative.

Quality assurance for management of NCDs

In consultation with the MoH Divisions and based on the structure of the PEHS, develop a simple audit model using indicators of quality of care for the four major NCD conditions (diabetes (T2DM), heart disease, cancer and COPD). Indicators should encompass responsible staff, medication supply, monitoring of patient progress, management of defaulters, tools/guidelines for patient care, referral pathways and patient satisfaction.

Pilot test the audit using MoH staff as auditors.

Subject to final agreement on the scale and scope of this activity, coordinate a comprehensive audit at all health facilities OR a selective audit that includes at least one health facility from every level of the

referral system AND one complete outer islands district AND the Tongatapu facilities earmarked to become Community Health Centres.

Document findings in a simple electronic file format (e.g. Excel spreadsheet) for handover to MoH.

Provide a written report including narrative, including recommendations for continuing professional development.

Health workforce

In consultation with the MoH Divisions, for each individual MoH employee document:

- formal academic qualifications
- in-service training undertaken within the past 5 years
- competencies with respect to the requirements of the individual's current role as indicated by the PEHS

Document findings in a simple electronic file format (e.g. Excel spreadsheet) for handover to MoH and future uploading to an HR Information System.

Provide a written report including narrative, including recommendations for continuing professional development.

Health promotion research

Working jointly with TongaHealth and the MoH:

- Identify existing bodies of work with a focus on NCDs that are suitable for publication and support local staff to prepare and submit for publication (for example, progress in patient care within the diabetes centre)
- Identify opportunities for local research into health promotion approaches and message content (focusing on healthy eating, health-promoting churches, and approaches to addressing beliefs on traditional medicines in order to improve NCD control).
- Identify Tonga-specific approaches to marketing of improved diet.
- Capacity building in research skills (with emphasis on the nursing workforce and monitoring of TongaHealth grants to encourage locally produced and owned research).
- Reinforcement of the multi-sector approach (for example, through the publication of research into the impact of different sectors on NCD risk factors).