

Independent Progress Report of the Tonga Health Systems Support Program (THSSP)

Catriona Waddington
Rebecca Dodd

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AusAID HRF
HLSP in association with IDSS
GPO BOX 320
15 Barry Drive
Canberra City ACT 2601
Tel: +61 (2) 6198 4100
Fax: +61 (2) 6112 0106
www.ausaidhrf.com.au

Initiative summary

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Authors' details

Catriona Waddington is a health economist who specialises in health systems strengthening. She has 18 years of experience in development work in Africa, the Pacific, Eastern Europe and Asia. She is a non-executive director for the Shetland Island health service in Scotland, UK.

Rebecca Dodd is Senior Health Specialist at the AusAID Health Resource Facility in Canberra, Australia. She has 16 years' experience in international development, including 12 in international health.

Disclaimer:

This report reflects the views of the Evaluation team, rather than those of the Government of Australia or of the Government of Tonga.

Contents

Acronyms.....	iv
Executive Summary.....	v
Evaluation Criteria Ratings.....	x
1. Introduction	1
1.1 Health in Tonga	1
1.2 The Tonga Health Systems Support Program (THSSP)	2
1.2.1 Compatibility with Government of Tonga priorities	3
1.2.2 THSSP targets	4
1.2.3 THSSP budget	5
1.2.4 Staffing, governance and management	6
1.3 Aid effectiveness	8
2. Evaluation Purpose and Questions.....	8
2.1 Evaluation Scope and Methods	9
3. Evaluation Findings	10
3.1 Findings for Component 1: Prevention and Management of Non-Communicable Diseases.....	11
3.1.1 NCD Sub-component 1a: Legislative and fiscal change (2% of total budget; 1% of total THSSP spending so far)	12
3.1.2 NCD Sub-component 1b: Behaviour change/Health promotion (13% of total budget; 9% of total THSSP spending so far)	13
3.1.3 NCD Sub-component 1c: Primary/Community Care (25% of total budget; 7% of total THSSP spending so far)	15
3.1.4 NCD Sub-component 1d: Diabetes Centre and Outreach; other clinical priorities (6% of total budget; 8% of total THSSP spending so far)	18
3.1.5 Monitoring the NCD component	19
3.2 Findings for Component 2: Critical Staffing Deficiencies (6% of total budget; 19% of total THSSP spending so far)	20
3.3 Findings for Component 3: Flexible Fund (11% of total budget; 18% of total THSSP spending so far).....	23
3.4 Component 4: Hospital Twinning (2% of total budget; 3% of total THSSP spending so far)	24
3.5 Program Management (7% of total budget; 21% of spending so far).....	24
3.5.1 Aid Effectiveness	27
3.5.2 Donor co-ordination	28
3.5.3 Evaluation Criteria Ratings.....	30
3.5.4 Other aspects of equality.....	31
3.6 Next steps: beyond 2015.....	31
4. Conclusions and recommendations.....	33
4.1 Component 1: Prevention and Management of Non-Communicable Diseases	34
4.2 Component 2: Critical Staffing Deficiencies.....	36
4.3 Component 3: Flexible Fund	37

4.4 Component 4: Hospital Twinning	37
4.5 Program Management	38
<i>Annex 1: Health in Tonga</i>	<i>40</i>
<i>Annex 2: THSSP M&E framework.....</i>	<i>42</i>
<i>Annex 3: Terms of reference.....</i>	<i>46</i>
<i>Annex 4: Documents reviewed</i>	<i>55</i>
<i>Annex 5: People interviewed</i>	<i>58</i>
<i>Annex 6: Notes on the preventive health budget target.....</i>	<i>62</i>
<i>Annex 7: Progress with NCD workplan (Draft as of 26/02/2013)</i>	<i>67</i>
<i>Annex 8: Interview outline</i>	<i>75</i>

Tables, figures and boxes:

Table 1: Components of the Tonga Health Sector Support Program, 2009-2013	3
Table 2: MoH Corporate Plan priorities and the THSSP.....	4
Table 3: Targets for THSSP	4
Table 4: THSSP budget and expenditure.....	6
Table 5: Long-Term Staff employed by THSSP (i.e. 9 months +).....	7
Table 6: ‘Best buys’ in NCD control.....	12
Table 7: Curriculum for Diploma in Nursing: Prevention and Management of NCDs	16
Table 8: Aid effectiveness and THSSP	27
 Figure 1: Breakdown of spending from Flexible Fund (ca. AUD 730,000/TOP 1.2 million)	 24
 Box 1: What is meant by “annual audit and review”?	 32

Acronyms

AHPRA	Australian Health Practitioner Regulation Agency
AUD	Australian Dollars
ET	Executive Team
ET+	Executive Team Plus
FAR	Fixed asset register
GoA	Government of Australia
GoT	Government of Tonga
HPU	Health Promotion Unit
HR	Human resources
IPR	Independent Progress Report
JICA	Japanese International Cooperation Agency
KAP	Knowledge, attitude and practice
KRA	Key Results Area
MDG	Millennium Development Goal
MoFNP	Ministry of Finance and National Planning
MoH	Ministry of Health
NCD	Non-communicable disease
PACTAM	Pacific Technical Assistance Mechanism (AusAID)
PEN	Package of Essential NCD interventions
PSC	Public Service Commission
STEPS	WHO STEPwise approach to Surveillance of NCD risk factors
SWAp	Sector-wide approach
THSSP	Tonga Health Systems Support Program
TNQAB	Tonga National Qualifications and Assessment Board
TOP	Tongan pa'anga (currency)
TOR	Terms of reference
UNDP	United Nations Development Program
WHO	World Health Organization

Executive Summary

Background and context

Tonga has a population of just over 103 000. Since 2000 life expectancy has fallen by at least three years to 65 years for men and 69 for women. The fall is due to a growing problem of non-communicable diseases (NCDs) and their associated risk factors of smoking, alcohol consumption, physical inactivity and poor diet. A particular problem is obesity – in 2004 92 per cent of Tongans were overweight; 69 per cent were obese. Rates are higher in women than men.

The Tonga Health Systems Support Program (THSSP) is a four-year, four-component package of support. The total budget for the four years 2009-13 is AUD 7.5 million, making it by far the largest donor program in the health sector (equivalent to 11 per cent of the government health budget for 2012/3). The three main components are NCDs, critical staffing deficiencies and the Flexible Fund. There is also a small twinning program (2 per cent). Although it is called a Program, the four components in practice operate separately.

The objectives for THSSP are set out in two documents. The *2009 Australia-Tonga Partnership for Development* establishes the strategic focus:

- Halting the rise in prevalence of non-communicable diseases risk factors;
- Improving community health services;
- Increasing the budget utilised for preventative health.

The 2009 *Framework Design* states that THSSP's objectives are to enable the MoH to:

1. Implement its Corporate Plan to improve health service delivery systems;
2. Fund critical service delivery deficiencies;
3. Manage, utilise and report on AusAID funding using Government of Tonga (GoT) systems and strengthening them where necessary.

Implementation of the Program started slowly. Just 1 per cent of the budget was spent in Year 1; 16 per cent was spent in year 2 and a further 20 per cent in year 3. Projections for year 4 suggest that about 31 per cent of the total budget will be spent this year. By June 2013 (the end date of the program), it is estimated that 68 per cent will have been spent. The main reason for the slow start was the failure to recruit a program facilitator, who had the task of setting up the systems to start the program. After eighteen months, it was decided instead to employ two technical co-ordinators, who would be supported by the Strategic Health Advisor for Tonga, who is based in Australia. This has worked reasonably well.

THSSP funds a total of 23 staff: 15 working in line positions in the Ministry of Health (MoH) and 8 program staff. This is equivalent to 2.9 per cent of the total MoH workforce.

Evaluation Purpose, Scope and Methods

The objectives of the Independent Progress Review were:

- To review the progress of the Program against its original objectives;
- To assess the Program against AusAID's quality criteria;

- To assess the strategic value of the program vis-à-vis broader sector development and the degree to which it adheres to aid effectiveness principles;
- To provide recommendations on how AusAID support for the health sector in Tonga should be delivered beyond June 2013 (particularly the possibility of an extension, and the design of a second phase).

The evaluation was carried out by a two-person team who spent ten days in Tonga meeting relevant stakeholders. For many of the meetings the team was accompanied by the AusAID Strategic Health Advisor for Tonga. In addition to document review, budget analysis and site visits, the main methodology used was semi-structured interviews. Extensive interviews were carried out with staff from (amongst others) the Government of Tonga (Ministry of Health, Ministry of Finance and National Planning, Public Service Commission), Tongan NGOs, AusAID, THSSP and UNDP.

Frequent meetings were held with AusAID post throughout the two-week mission during which the team verified and 'tested' their emerging findings and ideas.

Findings

Three broad conclusions of the evaluation are:

The **NCD component** is highly relevant to Tonga's needs and has made a broadly promising start. Progress with institutionalising the new cadre of NCD nurses is impressive. The exception to the good progress is health promotion, which is largely stuck at the planning stage. This is a very serious concern: Tonga's life expectancy has dropped and strong health promotion is an important part of reversing this. Whilst it is too early to observe outcomes, the component has the potential to have a positive impact on NCDs and their risk factors, as long as there is strong quality assurance of activities – it is notoriously easy to spend significant amounts of money on ineffective health promotion activities. The timing of future surveys needs to be carefully planned so that outcome data *is* available by the time the Program ends in 2015.

The **Critical Staffing Deficiencies, Flexible Fund and twinning** components largely focus on hospital care. They have stronger government involvement in their management than the NCD component, got off to a faster start and have generally spent more of their budgets. Whilst all three components appear to make a positive (and much-appreciated) contribution to curative care, they do not operate in a framework of objectives and targets that allows for effectiveness to be gauged.

The joint **governance** of the Program does not focus on the big strategic issues – the focus tends to be on process issues and the Flexible Fund.

In terms of aid effectiveness, THSSP is a hybrid of programmatic features plus the use of government systems. The story of the NCD nursing cadre is a text book example of how working 'outside' the system can provide the space to develop and pilot innovative approaches, which can then be embedded in government structures. There are also examples of THSSP working through government systems, though the extent to which it *strengthens* these systems is less clear.

Next steps: beyond 2015

For AusAID support to the health sector after 2015 it is reasonable to surmise that the trend will be away from project-type support. There are two ways in which the period of the two-year THSSP extension can be used to prepare for the likely change in the way support is provided.

The first way is to move the Critical Staffing Deficiencies and Flexible Fund components towards a system of annual audit and review. These established components offer the opportunity to try out this new way of working in the context of familiar areas of spending.

The second way to prepare for the next phase of support is to commission analytic work which thinks about the overall “shape” of health services in Tonga and hence what areas might be priorities for international support. “Shape” refers to the packages of services provided by primary care facilities, district hospitals and Vaiola Hospital.

A logical follow-on from THSSP would be to support some activities through financial aid (budget support or something similar), whilst retaining some programmatic support to work in areas where the Ministry is expanding or changing the services which it provides. This takes on board the main lesson from THSSP: that programmatic support can work well to kick-start new ideas (e.g. the NCD nurses), but that the Ministry should be developing its own systems to deal with familiar areas such as critical staffing vacancies and recurrent budget support for non-salary expenditures. Programmatic support for new or fast-changing areas works well because it can generally implement changes faster than through government systems, and because it is a more appropriate way of managing technical assistance. So the first area of work described above would demonstrate how annual planning and review can replace detailed, hands-on program management, as long as it is clear in advance what outcomes are expected from the funding, who is accountable for the outcomes and how they will be assessed. The analytic work would inform decisions about what area to concentrate on to further develop the package of services provided by the Ministry.

Recommendations

The most important recommendations are given here. A full list of recommendations, with the additional level of detail necessary for those implementing the Program can be found in Chapter 4. As a general point, the Program needs to address **sustainability** in the next two years to ensure that key activities do not end when the Program ends.

Recommendation 1: Extend the current THSSP (all components) for two more years until June 2015 whilst retaining the initial budget of AUD 7.5 million.

As of December 2012 there was about AUD 3.6 million unspent; this will be about AUD 2.4 million by June 2013. Spending in 2012/13 will be about AUD 2.3 million. So with no additional budget, the Program would have to reduce annual costs below current levels for the two years of the extension. This may be difficult, especially given that the most expensive single procurement is yet to be made (a boat) and because of the recommendation to implement at least one significant health promotion campaign.

The reason for not recommending an increase to the budget at this stage is that there is confusion about the way the budget has been recorded. This led to an impression that more money was left in the budget than is actually the case. Given this lack of clarity, plus the fact that only 53 per cent of the budget had been spent by month 42 of a 48-month Program, it is not appropriate at this point to recommend additional funding. However a second recommendation recognises that more funds *may well* be needed.

Recommendation 2: Correct the procedures for presenting budgets and expenditure so that by June 2013 there is a clear picture of past expenditure, available budget and future spending plans. This information is required before AusAID can decide if

and when the budget should be increased. If AusAID is satisfied with the quality of the information provided, the review team would not object to an increase in the THSSP budget.

Recommendation 3: National NCD Committee to lead process of clarifying roles and responsibilities for health promotion and inter-sectoral activities related to NCDs. Involve the Cabinet to ensure high-level buy-in.

Recommendation 6: **URGENT!** Follow up on **formal approval for the new cadre** of NCD nurses with the Public Service Commission and Ministry of Finance. [By the time of the final version of this report, the authors had informally heard that this matter had been resolved and that the recruitment of NCD nurses could proceed.]

Recommendation 7: Establish an operational research program to assess the effectiveness of both the diploma training and the new nursing cadre itself.

Recommendation 10: Plan monitoring activities so that information on outcomes is available at the time of the end of the Program in June 2015; the timing of surveys, including STEPs and KAP studies, is crucial (transition advisor plus co-ordinator: behaviour change/health promotion).

Recommendation 11: Allow greater flexibility in the use of the 'Critical Deficiencies' budget, to respond to broader health workforce needs and continue to externally audit the component annually. The MoH and AusAID should jointly review audit results as part of a strategic discussion on progress with this component.

Recommendation 15: The Flexible Fund should be used for expenditures which are in line with Annual Management Plans (but not for salaries). The Fund will continue to be externally audited each year; the findings of the audit will be reviewed jointly by the MoH and AusAID as part of a strategic discussion on the use of the Fund. The "no objection" stage of decision-making should be removed, as should the rules specifying that purchases should be small-scale and urgent.

This recommendation has some element of risk for AusAID but it is potentially an important step towards the greater use of government systems in the future. The risk is moderate and manageable, and should be seen as a sensible step towards a different type of aid modality after 2015.

Recommendation 17: Employ a 'transition advisor' to manage the two-year extension phase. Key tasks will be to oversee the implementation of recommendations in this report and to engage with the MoH and AusAID at senior level to design the next program. Ensure that a 'Plan B' is in place in case recruitment is impossible or extensively delayed.

Recommendation 18: Strengthen the program's use of government procurement, budgeting and reporting systems where possible and strengthen the engagement of the executive in planning.

Recommendation 19: MoH ET (and then the ET+) to review the effectiveness of the program team, with a view to agreeing a freeze on the recruitment of additional staff.

Recommendation 21: Commission work on the overall "shape" of health services in Tonga and hence what areas might be priorities for international support. "Shape" refers to the packages of services provided by primary care facilities, district hospitals and Vaiola Hospital. The work would explore:

- The areas of greatest need where cost-effective interventions exist but are not currently being provided in Tonga. Areas to be explored included mental health, possible unmet need for contraceptives, cancer (the NCD nursing

curriculum covers some aspects of some cancers) and disability (mobility, blindness etc.).

- What hospital services should be provided at what level (district, national, overseas referral) to provide the best value for money?

This work would also facilitate a more systematic and transparent approach to the selection of specialties to be filled through the critical deficiencies fund and would complement work on appropriate service provision in health centres which is being done as part of the health centres' Operation Manual (AusAID in consultation with MoH).

Evaluation Criteria Ratings

Evaluation Criteria	Rating (1-6)	Explanation
Relevance (Does THSSP contribute to higher level objectives?)	5	NCD component very relevant to Tonga's needs and priorities and focuses on priority interventions. Other components fit in with Ministry of Health's Corporate Plan, but are not linked to an overall strategy about the future of hospitals.
Effectiveness (Is the Program on track to achieve its objectives?)	4	NCD component largely on track, although delayed because of slow start to Program. Exception is behaviour change/health promotion, which needs to begin implementing significant health promotion pack-ages. Too early to judge the quality and effectiveness of interventions – this is why there needs to be a focus on quality during the program extension. Implementation of other components proceeding smoothly. However, no specific targets set (e.g., in relation to mentoring outcomes or volume of services provided) so only qualitative judgements possible.
Efficiency (Is the Program managed to get the most out of inputs, including risk management?)	4	Program performance has improved substantially over the last two years, however there have been challenges, some of which remain. Poor management of facilitator recruitment meant long delay in start of project. Appointment of two program coordinators helped address this issue. Important to learn lessons from the failed recruitment process and consider the efficiency trade-offs: lack of flexibility in the salary package offered to the preferred candidates may have been a false economy, given the impact on program implementation. Delay in recruitment of anaesthetist suggests inefficiencies in recruitment which might be addressed with additional support. More flexible use of critical deficiencies budget, e.g., to offer additional training to mentees, might help maximise the impact of the training/mentoring program. Need to strengthen planning and budgeting processes: it was not clear at the time of the Review how much money was left in the budget.
Sustainability (Will benefits continue after funding has ceased? Government systems, ownership, phase-out strategy)	4	Generally strong Government ownership and well-aligned to national priorities. But high dependence on Program funding and management (especially on the work of the co-ordinators). Need to rigorously explore the (difficult) options related to the funding of long-term overseas specialists.
Gender equality (Does the Program advance gender equality and promote women's empowerment?)	4	Good involvement of women in responsible positions. The vast majority of the NCD nurses are likely to be women: this new cadre widens the opportunities of professional jobs for women. The two senior co-ordinator roles in the Program are both held by women. NCD work is highly relevant to the needs of women and girls, especially as they tend to be more overweight than males. All appropriate indicators are disaggregated by gender.

Rating scale:

Satisfactory	Less than satisfactory
6 Very high quality	3 Less than adequate quality
5 Good quality	2 Poor quality
4 Adequate quality	1 Very poor quality

1. Introduction

1.1 Health in Tonga

Tonga has a population of just over 103 000, with average life expectancy of around 67 years and infant mortality rate of 14.5 per 1,000 live births. About 70 per cent of the population live on the small (257 km²) main island of Tongatapu. The total fertility rate is 3.7 and 30 per cent of women of reproductive age use modern contraceptives; rates of emigration are very high, with an annual net migration rate of 15.1 per 1,000. The annual population increase was 0.2 per cent between 2006 and 2011. The percentage of immunisation, deliveries with a skilled attendant, and access to water and sanitation are all at, or close to 100 per cent. Annex 1 provides key indicators about health in Tonga, with comparisons to Australia, Japan and New Zealand.¹

Tonga has one main hospital (Vaiola) and three district hospitals. There are 14 health centres (seven on Tongatapu, seven on other islands) and 34 Reproductive Health Clinics. There are over 60 doctors and 350 nurses working in Tonga. Services are funded through general taxation and are free at a point of delivery. Pharmaceuticals are also free if dispensed at health centres.

The latest available Ministry of Health (MoH) Annual Report describes the growing concern with non-communicable diseases (NCDs):

“There are two major evidences suggested that NCD is a national emergency concern in Tonga. The prevalence of NCD was estimated to be 7% in 1973, 15% in 1999 and 18% in 2004. With reference to the Government Census in 1996, the life expectancy was 70 and 72 for male and female respectively. After a decade, the most recent Census in 2006 shows that life expectancy reduced by one 1 year for male (69 years) and no change for female (72 years). Recently in 2010, a new finding from a research conducted by the Ministry and the University of Queensland, Australia suggest that the life expectancy is even lower by at least three years for both males (65 years) and females (69 years).”

“STEPS” is a survey designed by the World Health Organization (WHO) to assess the prevalence of common NCDs and their risk factors in a population. The main risk factors are obesity, alcohol abuse, physical inactivity and smoking. The most recent STEPS information dates from 2004 and illustrates why NCDs and their risk factors – particularly obesity – are such a concern in Tonga:

- 44% had low levels of physical activity.
- 92% were overweight; 69% were obese.
- 7% consumed five or more servings of fruit and vegetable per day.
- 28% smoked tobacco daily.
- 13% were alcohol drinkers.
- Hypertension prevalence was 23%.
- The prevalence of raised blood glucose was 16%.
- 99.9% were at high or moderate risk of NCDs.

¹ All information from Ministry of Health Annual Report 2010, except for population and growth rate (Preliminary Findings of 2011 census, http://unstats.un.org/unsd/demographic/sources/census/2010_PHC/Tonga/release.pdf) and emigration rate (www.nationsencyclopedia.com/economies/Asia-and-the-Pacific/Tonga.html)

With the exception of significant shifts in the capital budget, Ministry of Health spending per capita has stayed reasonably stable since 2010, at about TOP 165 per capita (AUD 97). Since 2003/04, salaries have nearly doubled in absolute terms. To pay for this, non-salary operational spending is increasingly squeezed.²

1.2 The Tonga Health Systems Support Program (THSSP)

The *2009 Australia-Tonga Partnership for Development* establishes the strategic focus for THSSP and its objectives. It states that Australia's support to national health priorities will focus on:

- Halting the rise in prevalence of non-communicable diseases risk factors;
- Improving community health services;
- Increasing the budget utilised for preventative health.

Based on this, THSSP was designed as a four-year, four-component program which supports the Government of Tonga (GoT) to achieve its national health goals, with a particular focus on tackling the growing burden of NCDs and (to a lesser extent) hospital care. As specified in the *2009 Framework Design* (paragraph 48), the objectives of the THSSP are to enable the MoH to:

1. Implement its Corporate Plan to improve health service delivery systems;
2. Fund critical service delivery deficiencies;
3. Manage, utilise and report on AusAID funding using GoT systems, strengthening them where necessary.

The total THSSP budget is AUD 7.5 million over four years. The content of the Program is described in Table 1. The three main components are NCDs (46 per cent of the budget), Critical Staffing Deficiencies (21 per cent) and the Flexible Fund (11 per cent). There is also a small twinning program (2 per cent). Although it is called a Program, the four components in practice operate separately: nowhere during the design stage was a set of objectives developed which reflects what is to be achieved from the Program as a whole. The *Framework Design* objectives are merely descriptive; the *Partnership* objectives refer only to the NCD component, which directly accounts for less than half of the Program budget. The critical staffing deficiencies and Flexible Fund components operate without expected outcomes and targets.

² 2010 Public Expenditure Review and 2012/3 Government Budget.

Table 1: Components of the Tonga Health Sector Support Program, 2009-2013

Component number and title	Percentage of budget (1)	Description of main activities
1a. NCDs: legal and fiscal	2%	Review and improvement of laws and fiscal measures (taxes) relevant to NCDs.
1b. NCDs: behaviour change/health promotion	13%	Work on behaviour change activities related to NCDs and their risk factors.
1c. NCDs: primary/ community care	25%	Development of a new cadre of NCD nurses and production of an Operations Manual for primary care.
1d. NCDs: Diabetes Centre and outreach	6%	Support for the work of the national Diabetes Centre and its outreach activities (which reach all over Tonga)
2. Critical staffing deficiencies	21%	Fills critical staff vacancies. Employs senior clinical and non-clinical staff to work in Vaiola Hospital. Currently funds a surgeon, senior pathologist and biomedical engineer; an anaesthetist is being recruited.
3. Flexible Fund	11%	A cash fund for “unplanned small scale and/or urgent work”. Spending decisions made by the MoH Executive, called the ‘Executive Team’ (ET).
4. Hospital twinning	2%	Twinning between the main hospital in Tonga (Vaiola) and St John of God Hospital, Ballarat, Australia to support skills development and training. Twinning arrangement has been in operation for 20 years.

(1) The remaining 21% of the budget includes program management, TA, and some items where the categorisation is unclear.

1.2.1 Compatibility with Government of Tonga priorities

The objectives of THSSP – as defined in the *Partnership* document – are well aligned to government priorities. The Program supports all six of the Key Results Areas (KRAs) in the 2008/09 – 2011/12 MoH Corporate Plan, as shown in Table 2 below. The Corporate Plan has officially expired: however the review team was informed that the new Plan will have similar target areas. There has been a delay in producing the new Plan because of a change in the national template in order to link priorities more closely with budgets.

The importance of NCDs is reflected in Tonga's Strategic Development Framework (2011-2014). To follow this through, a multi-sectoral National Strategy to Prevent and Control NCDs 2010-2015 (*Hala Fanonga*) has been developed. As another way of demonstrating the importance of NCDs, Tonga created its own, Tonga-specific MDG – “Goal 6c: Have halted by 2015 and begun to reverse the incidence of NCDs”.

Table 2: MoH Corporate Plan priorities and the THSSP

MoH Key Results Area, Corporate Plan	THSSP contribution to the KRA
1. Build capability and effectiveness in preventive health services to fight the NCD epidemic and communicable diseases	All NCD components, particularly behaviour change/health promotion and development of NCD nurse cadre
2. Improve the efficiency and effectiveness of curative health service delivery	Critical deficiencies, Flexible Fund, twinning, diabetes outreach
3. Provision of services in the Outer Island Districts and Community Health centres	Development of NCD nurse cadre to be posted in all health centres and hospitals
4. Build staff commitment and development	NCD components on community/primary and behaviour change/health promotion have a strong element of staff development. Critical deficiencies work involves mentoring.
5. Improve customer service	An aspect of the work in hospitals and health centres. People with chronic NCDs will receive a better, more local service as the NCD nurses become established and are complemented by regular clinical outreach
6. Continue to improve the Ministry's infrastructure and ICT	Refurbishment of health centres. Support for health information system.

1.2.2 THSSP targets

The *Partnership* document specifies targets directly linked to the priorities described above. These targets are shown in Table 3.

Table 3: Targets for THSSP

Indicator	Baseline	Target	Method of verification
Target 1: Reduce the prevalence of smokers (aged 15-64) by 2% by 2015			- Census - STEPS Survey - Global Adult Tobacco Survey
% of population (aged 15-64) who are smokers	29 ³	27	
Males	46	44	
Females	12	10	
Target 2: Halt increase in prevalence of obesity by 2015 ⁴			STEPS Survey Rheumatic Heart
% of population (aged 25-64) who are obese (BMI>30kg/m2)	67 ⁵	65	

³ 2006 census.

⁴ There is clearly an inconsistency here. The narrative target was amended from "2% decrease in overall prevalence of obesity by 2015", but the 2015 target numbers have not been changed in the documentation to reflect this. Baselines are from 2004 figures.

⁵ 2004 STEPS Survey.

Males	56	54	Surveillance
Females	75	73	
Target 3: Budget for preventative health care reaches 10% of total public health operational budget by 2015⁶			Budget papers
% of total public health budget allocated to preventive health	5	10	
Target 4: Primary health care to all communities follow common national standards			
National standards approved and implemented by at least 10 of the 13 health centres			

Most of the sources of information in the right-hand column are not annual, except for rheumatic heart surveillance and budget papers. This poses challenges for monitoring Program effectiveness, as will be discussed in section 3.1.5 below (*Monitoring the NCD Component*).

This list of indicators was subsequently expanded into a Revised Monitoring and Evaluation Framework, which is shown in Annex 2. This framework retains targets 1-3, and adds further targets related to smokers who have given up, hospitalisation for diabetic sepsis and amputations, and percentages of undiagnosed or uncontrolled hypertension and diabetes in the population. The Framework also includes 17 intermediate indicators – 13 of them related to NCDs and 4 related to program management. The program management indicators focus on the role of the 'Executive Team Plus (ET+)', which provides oversight and governance of the program, and include number of meetings held and timely submission of reports including financial reports; there is also an indicator on progress towards program milestones.

1.2.3 THSSP budget

The total THSSP budget for the four years 2009-13 is AUD 7.5 million, making it by far the largest donor program in the health sector. Its average annual budget is equivalent to 11 per cent of the government health budget for 2012/13.⁷

Program spending was slow to start, but has been increasing:

2009/10	AUD 90,375 (1% of total budget)
2010/11	AUD 1,191,336 (16% of total budget)
2011/12	AUD 1,528,240 (20% of total budget)
2012/13	AUD 2,269,710, based on doubling the July-December spend (30% of total budget).

Both Tonga and Australia have fiscal years starting in July. Assuming that half of 2012/13's spending had been completed by December, 68 per cent of the budget will have been used by June 2013, when the Program is currently scheduled to end. The reasons for the slow start are discussed in the next section.

⁶ GoT 2008/9 Budget – there were no donor funds in the 5% public health budget and only some WHO funds in the total health budget for 2008/9.

⁷ 2012/13 MOH budget was TOP 28,619,885. THSSP is TOP 3,187,500 per year. 3,187,500 is 11% of TOP 28,619,885.

The budget and expenditure for THSSP are shown in Table 4. It is important to describe how this table was developed. No budget was available which showed the initial breakdown of funding amongst sub-components. Moreover, the budget information provided to the review team included errors, as planned expenditure was double-counted if it was not actually implemented in the first year that it was included in the annual budget. For this reason the budget columns in the table below should be seen as indicative, rather than exact. They were calculated by taking the current overall budget and using the same relative allocations to each component, scaled down to total the correct overall budget of AUD 7.5 million.⁸ The problem is particularly apparent for the “program management” line, which appears to be over-spent, probably because the budget breakdown provided to the review team did not fully account for spending by the AusAID Post (as opposed to through the MoH). Despite the problems, it is worthwhile using these budget estimates, because they give at least some indication of the relative sizes of the various sub-components.

These problems do not apply to the expenditure information, which is assumed to be accurate.

Table 4: THSSP budget and expenditure

Component	Budget 2009-13 (AUD)	Actual spending (AUD)					Remaining funds
		FY 09/11	FY 10/11	FY 11/12	FY 12/13 (Jul-Dec 12)	TOTAL	
Legislative & Fiscal Measures	133,213		0	21,015	25,462	46,477	86,736
Behaviour Change	1,003,369		0	187,302	178,270	365,572	637,797
NCD Primary Care	1,861,327		0	208,603	85,330	293,933	1,567,394
Diabetic & Outreach	478,441		0	94,834	202,945	297,779	180,662
Critical Deficiency	1,545,559		106,000	400,636	236,186	742,822	802,737
Flexible Fund	833,814		455,480	229,889	42,335	727,704	106,110
Twinning Program	146,290		0	50,398	63,190	113,588	32,702
Program Management	536,106	90,375	104,065	325,650	301,137	821,227	-285,121
Other	980,392		525,791	9,913		535,704	444,688
TOTAL	7,518,511	90,375	1,191,336	1,528,240	1,134,855	3,944,806	3,573,705

1.2.4 Staffing, governance and management

THSSP funds 23 staff in total: 15 working in line positions in the MoH and eight program staff (see Table 5). The MoH Annual Report 2010 states there were 799

⁸ Exchange rate of AUD 1 = TOP 1.7.

filled posts in the MoH – THSSP funded staff as a whole are thus the equivalent of 2.9 per cent of the total MoH workforce.

Table 5: Long-Term Staff employed by THSSP (i.e. 9 months +)

Component	Employee	Category M = line position in MoH P= program management staff
1a. NCDs: legal and fiscal	1 legal officer	M
1b. NCDs: behaviour change/health promotion	1 co-ordinator	P
	2 project officers	P
1c. NCDs: primary/community care	1 co-ordinator	P
	1 assistant	P
	4 NCD nurses (pilots)	M (positions pending approval by Public Service Commission)
	1 NCD nurse tutor	M
	2 IT operators	M
	2 mobility equipment and plaster technicians	M
1d. NCDs: Diabetes Centre and outreach	1 senior medical officer	M
2. Critical staffing deficiencies	1 surgeon	M
	1 pathologist	M
	1 biomedical engineer	M
	(1 anaesthetist – being recruited)	M
Program management	1 program management assistant	P
	1 program finance officer	P
	1 administrative officer	P

Strategic oversight of the program is provided by ET+ comprising of the MoH Executive, AusAID, two NGO representatives, the Ministry of Finance and National Planning (MoFNP) and the WHO country liaison officer, which meets every six months. Additional meetings between AusAID and the MoH Executive are held between the ET+ meetings, at three-monthly intervals.

Initially it was envisaged that a program facilitator would manage the start-up of the program. The slow start to spending was largely due to difficulties in recruiting this position. After two failed recruitment attempts, a Strategic Health Advisor for Tonga (Lynleigh Evans) was brought in on a short-term basis to kick-start the program and develop annual workplans and budgets. In this period it was agreed that two technical coordinators (Behaviour Change/Health Promotion and Community Health) and a program administrator be appointed instead of the facilitator. The team started in late January 2011 and reports to the THSSP Program Manager (who is also the MoH Principal Planning Officer). The Strategic Health Advisor continues to provide support on annual workplans, and has also lead two mini-reviews of the program (August 2011 and March 2012). Over the last two years, implementation has accelerated.

1.3 Aid effectiveness

In addition to specifying particular areas of work, the *Partnership* document also commits to furthering aid effectiveness principles. The *Partnership* refers to the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. The *Framework Design* translated aid effectiveness principles into a specific objective for THSSP: “to manage, utilise and report on AusAID funding using GoT systems and strengthen them where necessary.”⁹ The TOR confirm this commitment by stating “The program is in the process of a transition to a new approach, moving from project based support to program based support, as part of a deliberate strategy to improve Tonga’s systems by using them.”

The *Framework Design* describes a ten year period of support from Australia to the health sector – this THSS Program is the first phase. The design envisages that over time there will be a transition to sector budget support and, in parallel, a shift to a sector-wide focus which encompasses overall health sector priorities, and associated for systems for planning and resource allocation: “*The experience gained under the approach of this design will enable the MoH to learn by doing and continuously improve its systems, processes and understanding... In time, with the experience gained under this funding, Tonga may choose to bring all donor funding together with its own financing, under a SWAp... Australian support to the health sector in Tonga is based on a 10 year time frame, by the end of this period the desire from AusAID’s perspective is to have a true SWAp.*”¹⁰

2. Evaluation Purpose and Questions

The Independent Progress Review takes place at a time when the planned period for THSSP is coming to an end (June 2013). It is thus an opportune time to reflect on progress with current AusAID support; the main issues facing the health sector in Tonga; and the possibilities of a Program extension and a second phase.

The objectives of the evaluation are:

- To review the progress of the Program against its original objectives;
- To assess the Program against AusAID’s quality criteria (relevance, efficiency, effectiveness, impact, sustainability, gender equality and disability inclusive health measures, monitoring and evaluation framework, analysis and learning);
- To assess the strategic value of the program vis-à-vis broader sector development and the degree to which it adheres to aid effectiveness principles;
- Provide recommendations on how AusAID support for the health sector in Tonga should be delivered beyond June 2013, and particularly the possibility of a 1-2 year extension, and the design of a second phase thereafter.

In line with these objectives, detailed questions were developed by AusAID Tonga, relating to (i) a review of past/current implementation and (ii) reflections about the future. These are listed in the full TORs, which are presented in Annex 3. The evaluation team condensed this detailed list into two overarching questions which served to unify the various themes and help keep a focus on the overall purpose of the IPR:

⁹ Tonga Health Systems – Australian Support, Framework Design – August 2009; paragraph 48.

¹⁰ Paragraphs 55-57, Framework Design.

- To what extent is the THSSP (with its alignment to MoH plans and use of some MoH systems) contributing to the overarching objectives of:
 - halting the rise in prevalence of non-communicable diseases risk factors;
 - improving community health services;
 - increasing the MoH budget utilised for preventative health (so that AusAID support is additional, and not a substitute)?
- Using lessons from past performance, what recommendations are there for the future in terms of content, management and aid effectiveness.

2.1 Evaluation Scope and Methods

The evaluation was carried out by a two-person team (Catriona Waddington and Rebecca Dodd). In addition to preparatory work, the team spent ten days in Tonga meeting relevant stakeholders. For many of the meetings the team was accompanied by Lynleigh Evans, Strategic Health Advisor for Tonga. Benjamin Rolfe, AusAID Lead Pacific Health Advisor based in Canberra, also joined a small number of interviews and had extensive discussions with the team.

The methodology was explained in detail in the Evaluation Plan for the review – this was shown in advance to AusAID in both Canberra and Nuku'alofa. The time spent investigating the various components of THSSP broadly reflected their relative budget sizes (NCD 46%, critical staffing deficiencies 21%, Flexible Fund 11%). Because no specific issues were raised about the St John of God twinning arrangement (2%), this was not reviewed in detail. However, given that this twinning arrangement is more than 20 years old and has never been reviewed or evaluated in detail, we recommend that a proper review be done at some point during the two-year extension period.

The evaluation methods used were largely qualitative, though numerical analysis was done in some specific areas (particularly analysis of budget and staffing). Methods employed are set out below.

Document review

A comprehensive set of documents relating to THSSP was shared with the team in advance of their travel to Tonga. These included relevant GoT plans and strategies, design documents and agreements related to the program, implementation plans, the audit report, two six-monthly review reports and quarterly reports. Further documents, including the program budget and records of expenditure and the minutes from ET+ meetings were collected in Tonga. A full list of documents reviewed can be found at Annex 4.

Semi-structured interviews

Semi-structured interviews were the key analytic tool used during the review. A draft interview guide (Annex 8) was developed to provide the structure and helped to ensure a systematic approach to the topics. This list was matched in advance of each meeting to the specific interviewee. The “semi” (of “semi-structured”) reflects the fact that the team was interested in exploring respondents’ opinions and perceptions, as well as their ideas for the future. Individuals from the following organisations were interviewed by the team:

- Ministry of Health, led by the Honourable Minister
- Ministry of Finance and National Planning
- Ministry of Internal Affairs

- Public Service Commission
- National Qualifications and Assessment Board
- Health Promotion inter-sectoral sub-committees
- Tonga Health Promotion Foundation (TongaHealth)
- Tonga Family Health Association
- UNDP
- Australian High Commission
- AusAID
- THSSP.

Unfortunately the WHO Country Liaison Officer was on leave during the time of the review. A full list of people consulted is provided at Annex 5.

A major challenge of the review was ensuring that qualitative information was collected and analysed systematically, given the number of sub-components in THSSP and the large number of questions in the TOR. A division of labour between team members was agreed, with the two team members assigned lead responsibility for different areas of the review. The lead person led questioning (during interviews) relating to her particular area, as well as analysis and write-up. The division of labour was not absolute – indeed, both core team members were present during all interviews (except one) and both members collected and discussed information on all topics.

A second technique used by the team to ensure a systematic approach was regular collating and discussion of information. The team divided the write-up of interview notes according to their lead area, and then regularly discussed and categorised key points. Frequent meetings were held with AusAID post throughout the two-week mission during which the team verified and ‘tested’ their emerging findings and ideas.

Budget analysis

The following budgets were analysed: Ministry of Health, THSSP and details of the Flexible Fund. A specific analysis relating to the GoT preventive health budget was carried out, at the request of AusAID. This looked at current definitions and content of the preventative health budget line and whether these required review. A short paper on this issue was submitted to AusAID while in country (Annex 6).

Site visits (limited due to time constraints)

The review team visited two health centres on Tongatapu. Although there was insufficient time for visits to other islands, the team explored issues related to health service delivery in the islands with clinical staff who are currently, or were until recently, working there.

Limitations

The main limitation of the review was time – it takes time to understand the complexities of the sector in general and the Program in particular. The review team also had to deal with the reality that implementation was at too early a stage to demonstrate outcomes. An independent review is usually held in Year 4; in practice THSSP has only been active for just over two years.

3. Evaluation Findings

The findings of this review are discussed separately for each of the four components of the THSSP. Before discussing each separate component, it is important to state

the first recommendation of this report, namely *to extend the current THSSP for two more years until June 2015 whilst retaining the initial budget of AUD 7.5 million*. Awareness of this recommendation is necessary to understand the discussion below.

3.1 Findings for Component 1: Prevention and Management of Non-Communicable Diseases

The NCD component is the largest individual part of the THSSP. This section is organised as follows:

- objectives and targets for the component;
- relevance to health sector objectives in Tonga;
- progress with the four sub-components;
- monitoring the component.

All recommendations are then presented together in the very last section of this report.

As a general point, this component is still largely at the stage of activities and processes – it is too early to identify outcomes. This is largely because of the delayed start to the Program.

Objectives and targets for the NCD component

The NCD component is linked to the following objectives from the *2009 Australia-Tonga Partnership for Development*:

- halting the rise in prevalence of non-communicable diseases risk factors;
- improving community health services;
- increasing the budget utilised for preventative health.

Specifically, it has the following targets (see Table 3 above):

- 2% decrease in prevalence of smokers by 2015 (disaggregated by gender);
- halt increase in prevalence of obesity by 2015 (disaggregated by gender);
- 10% of recurrent budget allocation to preventive health care.

Relevance of the NCD Component to health objectives in Tonga – is it doing the right things?

Table 6 shows global best practice, as described in *The Lancet* in 2011. These immediate priority interventions are backed by good evidence about feasibility and effectiveness and have implementation costs which “are known and affordable in most countries.” They are the “best buys in NCDs” (i.e. the most cost-effective ways to spend money to reduce the burden of NCDs). A very large number of the “best buys” are included in THSSP plans, suggesting that the component as a whole is concentrating on the right activities and is highly relevant to Tonga's needs. Moreover, the four sub-components of the NCD work correspond neatly to the levels of interventions related to NCDs, from primary prevention (laws, health promotion), through secondary prevention (i.e. preventing conditions getting worse) to treatment. If implemented effectively, the component should make a strategic contribution to help achieve the outcomes of the MoH Corporate Plan, *Hala Fanonga* (the national NCD Strategy) and the Australia-Tonga Partnership.

Table 6: 'Best buys' in NCD control¹¹

Areas related to NCDs	Top priorities/Best buys
Tobacco use	Accelerated implementation of the WHO <i>Framework Convention on Tobacco Control</i> (which Tonga signed in 2003), including: <ul style="list-style-type: none"> • Raise taxes • Protect people from smoke • Warn people about dangers of smoking • Ban advertising and enforce this
Dietary salt	<ul style="list-style-type: none"> • Mass media campaigns • Voluntary action by food industry to reduce consumption
Obesity, unhealthy diet and physical inactivity	<ul style="list-style-type: none"> • Mass media campaigns • Food taxes • Subsidies • Labelling • Marketing restrictions
Harmful alcohol intake	<ul style="list-style-type: none"> • Tax increases • Advertising bans • Restricted access
Cardiovascular risk reduction	Combination of drugs for individuals at high risk of NCDs
Leadership	Individual champions need to take leadership roles at the national and international levels.

3.1.1 NCD Sub-component 1a: Legislative and fiscal change (2% of total budget; 1% of total THSSP spending so far)

The first NCD sub-component deals with legislative and fiscal (tax) issues. Legal and fiscal policies are relevant to NCDs because they affect access to healthy and unhealthy products. For example, laws can make tobacco smoking illegal in certain places and taxes can make cigarettes more expensive.

Reviews have been completed or almost completed on Tongan laws related to tobacco, alcohol, physical activity and food. This work illustrates the multi-sectoral nature of issues related to NCDs and the complexity of the required response. For example the review of alcohol laws discussed the following areas:

- licensing of places which sell alcohol, including night-clubs and shops;
- drink driving and breath-testing;
- duty free allowances;
- manufacture of intoxicating alcohol;
- age restrictions for drinking alcohol;
- drunk and disorderly behaviour in public places.

Similarly the review of laws on diet and physical activity identified issues that involved ten government ministries or departments (including Education, Internal Affairs,

¹¹ See Beaglehole R et al (2011) *Priority actions for the NCD crisis*. The Lancet Vol 377, page 1438.

Environment, Agriculture and the Police) and several other bodies including the Tonga Sports Council and the Markets Authority.

Two general issues have emerged out of the reviews:

- Whilst some legislation needs to be changed, the issue is just as often **enforcement of existing laws**.
- In most cases, the **responsibility for relevant legislation and its enforcement does not lie with the MoH**. For alcohol, for example, most enforcement is the responsibility of the police. The exception to this is tobacco, where the MoH *does* have a significant role.

In order to take forward the many recommendations of the legal reviews, THSSP funds a legal officer in the MoH. She works closely with the MoH's Principal Administrator and has managed to combine work on program-specific tasks with some other issues identified by the MoH (such as the legal standing of nurse-practitioners). New tobacco legislation has been prepared and is currently being reviewed. A proposal for a Compliance/Enforcement Unit related to tobacco control has been developed and is currently being considered. One person in this Unit will be a "cessation officer" responsible for providing support for people who want to give up smoking: this is an appropriate item for Program funding because of the huge importance of reducing levels of smoking.

Many of the recommendations from the legal reviews relate to sectors other than health. This includes some of the most important issues in public health terms – for example matters related to food and tobacco availability (see the "best buys"). The issue of inter-sectoral work is discussed in the section on NCD sub-component 2b below (behavioural change/health promotion), as it is an area which needs strengthening.

This sub-component is highly relevant to NCDs and has raised many relevant issues. The challenge now lies with implementation of existing plans and prioritising and implementing the recommendations of the legal reviews. Prioritisation should be based on likely effectiveness (see Table 6 on "best buys") and should reflect the situation in Tonga, particularly the fact that obesity is such a significant problem.

3.1.2 NCD Sub-component 1b: Behaviour change/Health promotion (13% of total budget; 9% of total THSSP spending so far)

The second NCD sub-component deals with behaviour change - a vital part of tackling NCDs. The NCD "best buys" include behaviour change activities related to smoking, diet and physical activity (see Table 6).

Tonga needs to have successful behaviour change/health promotion activities if it is to effectively tackle the rise in NCDs. (The term "health promotion" is used from now on.) Much of the health promotion work so far has been at the "organising" stage of planning, stocktaking and strategizing: this has resulted in overlapping plans.¹² There has been relatively little done in terms of substantive health promotion activities. This is because of unclear roles, i.e. who is responsible for what. Examples of this lack of clarity are:

- The MoH's Health Promotion Unit (HPU) and Tonga Health are conducting uncoordinated activities which overlap. For example, the review team went to one village which receives four visits per week from Nuku'alofa to conduct

¹² More details of the various plans etc. can be found in Annex 7 Progress Report prepared by the Strategic Health Advisor.

exercise classes, two from the HPU and two from TongaHealth. At the same time there are presumably villages which are receiving far less support.

- The Sub-Committees of the National NCD Committee (one each for alcohol, tobacco, exercise and food) want to have new TORs and are frustrated about lack of progress.

The problems with health promotion are well understood within the MoH. **It is important that this governance issue is tackled directly and as a matter of priority** so that the health promotion sub-component can move forwards and start substantive implementation. The National NCD Committee has a clear leadership role to play here: note that leadership is included as a “best buy” in Table 6 because it has such a crucial role to play. Time is relatively short if there are going to be some measureable outputs by the time the extended THSSP ends in mid 2015.

Looking at the “best buys” information makes clear what the priorities should be – there is (1) a need for large-scale health promotion activities related to diet, exercise and smoking; and (2) the Ministry of Health needs to have effective ways of working with other sectors to promote activities which are not in its jurisdiction, such as the availability and cost of unhealthy foods. (We saw above in the section on legislative change that most of the recommendations fall outside the mandate of the Ministry of Health.)

- (1) In terms of health promotion, it is time to prioritise one important message and implement a package of activities related to that message. The “package” would most likely consist of a mass media campaign with complementary activities in communities, workplaces, schools and churches and other relevant activities (for example related to the availability of unhealthy items relevant to the message). Given the severity of the obesity problem, the package should probably relate to diet and/or exercise. The situation related to knowledge, attitudes and practice needs to be assessed before and after implementing such a package: it is notoriously easy to spend significant amounts of money on ineffective activities.
- (2) The NCD Committee needs to lead work on re-thinking inter-sectoral activities and the role of the sub-committees. The sub-committee chairpersons appear committed to health promotion and should be involved in the process. Inter-sectoral work requires buy-in at a high level, including the Cabinet. It is important that Cabinet members are clear what their sector can contribute in relation to NCDs and the governance routes which are available to encourage implementation.

There are two reasons for inter-sectoral work. One is for the Ministry of Health to encourage ideas from other sectors related to NCDs and provide technical inputs to promote the effectiveness of these inputs. For example, the Ministry of Agriculture, Food, Forestry and Fisheries is interested in promoting a cookery book and cooking demonstrations. How important and effective are these activities; what helps to make them better? THSSP has funds available to support appropriate ideas from other sectors – it is important that these funds start flowing reasonably soon (based on workplans), as difficulties in accessing the money has been demoralising for other sectors.

The second reason for inter-sectoral work is for the Ministry of Health to encourage other sectors to implement activities which are known to be priorities for tackling NCDs. Examples are combating the commercialisation of locally grown tobacco and the availability of unhealthy foods such as mutton flaps and turkey tails.

Related to the unclear roles described above, there are also some overlaps in the international support provided through the THSSP. As part of its work on rationalising

the governance of health promotion, the NCD Committee should think about the best way of streamlining the technical assistance/twinning arrangements. (One stream of work focuses on a review of the National NCD Plan and capacity-building in the HPU, another focuses on development of a health promotion strategy. There appear to be overlaps between the two streams of work, for example in relation to governance). This is an important decision – given the drop in life expectancy, it is vital that Tonga has high-quality support for its health promotion activities.

Notwithstanding the criticisms of non-activity above, there are two areas where the sub-component has been active.

A lot of work is being done in schools, some of it supported and funded through THSSP. Clearly schools are an important place for health promotion, given the population profile of Tonga and the levels of childhood obesity. The Review Team was unable to investigate health promotion activities in schools directly, but it was clear that a lot is being done and the education sector fully recognises that it has an important role to play in relation to NCDs. Coordination is a priority, as there are a number of health promotion “providers” working in schools, including the HPU, TongaHealth and the Tonga Family Health Association. This again points to the importance of inter-sectoral work.

The other area where progress has been made in this sub-component relates to monitoring, notably work on STEPS and Knowledge, attitudes and practice (KAP) studies. Although this is discussed in another section of this report (see *Monitoring of the NCD component* below), it is important to recognise this as an achievement for this sub-component.

The importance of making progress with this sub-component cannot be stressed enough. Behavioural change in relation to the NCD risk factors is a significant part of Tonga’s overall socio-economic development.

3.1.3 NCD Sub-component 1c: Primary/Community Care (25% of total budget; 7% of total THSSP spending so far)

The third NCD sub-component is about strengthening activities at the primary health care level. The main activities are developing a new cadre of NCD nurses and (for the future) producing a practical Operations Manual for Health Centres. The Program also funds part of a national program on rheumatic heart disease.

As with the rest of the Program, the primary/community sub-component started slowly, with little obvious activity before 2012. During that time, there was considerable discussion on the best way to tackle NCDs at the primary level: eventually it was decided to develop a cadre of NCD nurses. The idea was for each health centre and hospital to have at least one NCD nurse. In the health centres, they would complement the work of the public health nurses, who are widely perceived as a successful and well-managed cadre who have done much to improve maternal and child health in Tonga. Since this decision was made, there has been considerable progress in the five areas described below.

i. Curriculum design

At the end of January 2013, an initial submission was made to the Tonga National Qualifications and Accreditation Board (TNQAB) for accreditation of an advanced diploma in NCD nursing. (The full title is “Nursing: Prevention and Management of NCDs.”) The TNQAB insists on high standards for submissions and, when necessary, employs an external specialist to compare the curriculum with international best practice and the requirements of the job for which the students are being prepared. Following minor amendments, the plan is to re-submit the application

for final approval in February/March 2013. The TNQAB was impressed with the first draft and gave every indication that the submission was likely to be approved.

The Diploma consists of two semesters, each of 15 weeks, with a clinical practice course at the end of each semester. The 11 units (all of which are compulsory) are shown in Table 7.

Table 7: Curriculum for Diploma in Nursing: Prevention and Management of NCDs

Module number	Title of Module	Number of credits
1	Diabetes (prevention, detection, management)	12
2	Cardiovascular disease (prevention, detection, management)	12
3	Asthma and chronic obstructive pulmonary disease (COPD: prevention, detection, management)	12
4	Cancer (prevention, detection, monitoring)	6
5	Obesity (prevention, reduction, impact)	6
6	Patho-physiology (signs, symptoms, investigations)	12
7	Patient education and health promotion	12
8	Evidence base for and from practice	12
9	Professional practice	12
10	Clinical practice 1	12
11	Clinical practice 2	12
Advanced Diploma		Total 120 credits

This curriculum is well matched to the NCD “best buys” (Table 6) and – with its module devoted to obesity – is targeted to meet the particular needs of Tonga.

It is planned that the first diploma course will have 20 students and will run from April to October 2013. The course will only be run every three years or so – Tonga’s small size means that an annual course is not necessary. The infrequent nature of the course means that there has to be a heavy reliance on teaching by clinicians who are not qualified trainers.

ii. Pilot nurses recruited and posted

In 2012, five qualified and experienced nurses were identified who were interested in becoming pilot NCD nurses. Because of the unclear status of the cadre at that time, most of them were recruited from outside government service. The five nurses were placed in health centres in ‘Eua (a separate island), and Mu’a, Kolonga, Houma and Nukunuku (all on Tongatapu and, by international standards, reasonably close to Nuku’alofa). The nurses were carefully briefed on their role but were not specialist NCD nurses and did not receive any formal training related to NCDs. Once posted, they were closely followed up, mainly by the Program Coordinator. The idea is that all five pilot nurses join the first diploma course when it is run in 2013.

Based on anecdotal evidence and interviews, the pilots have served their purpose in that they have:

- shown that nurses working in the community can identify a lot of people with, or at risk of, major NCDs;
- shown that NCD nurses can work well with, and be accepted by, the other staff in health centres;

- established the credibility of the cadre of NCD nurse in the eyes of much of the senior management of the MoH.

One specific issue that emerged from the pilot phase is transportation for the NCD nurses. Currently all the staff in a health centre share one vehicle. It may be advantageous for the NCD nurses to have their own transport: the most appropriate would be a small motorcycle/scooter. At present many of the nurses think that this is an unseemly mode of travel for women – the Program’s idea to offer the nurses a scooter on a voluntary basis seems to be a practical first step. Another idea is to include some training on riding and maintaining a scooter as part of the curriculum. The issue of transport should be investigated as part of the research into the effectiveness of NCD nurses – see *Recommendation 7* below.

Placing not-specifically-trained but well-motivated nurses in a clinical setting is an unusual way to pilot a new cadre (a more orthodox way might have been to train a small number of recruits). It appears, however, to have been a rather inspired decision, as it seems to have speeded up the acceptance of the new cadre.

iii. Verbal acceptance of NCD nurses as an official, financed cadre

Government and Program staff generally informed us that the NCD cadre “had been fully accepted by the Public Service Commission (PSC) and the Ministry of Finance and National Planning”. Our interviews with these bodies confirmed that they were well aware of – and supported – the development of the cadre. However **(as of late February 2013) the PSC was still awaiting the final paperwork from the MoH, which needed to be accompanied by a formal acceptance of funding commitments from MoFNP.** Every impression was given that final approval for the cadre would be granted: however it is **vitaly important that this formal process is completed as soon as possible.**¹³

If positive decisions from the TNQAB, PSC and MoFNP are made soon, this will be an impressively fast process of developing and institutionalising a new nursing cadre.

iv. Set of indicators agreed and adopted by national information system

The information to be collected by the NCD nurses has been agreed and is being piloted on a manual basis. The health information section of the Ministry led the development of this data set and plans to include its collection in the gradual computerisation of health information in Tonga. Over time, the data will provide valuable information about the incidence and prevalence of NCDs and their risk factors. It will be possible to compare data on NCD prevalence collected by the nurses with population-based information collected through surveys to estimate what proportion of cases the nurses are identifying.

v. Renovating/re-equipping health centres

There are plans to renovate and re-equip, as necessary, all 14 health centres in Tonga. The plans are that all the facilities will become wheelchair-accessible for the first time. Because disabled access is currently rare in Tongan buildings, this may have an important demonstration effect. Renovation work has begun in a few health centres. In the one partially-renovated health centre visited, patients were being seen in the Health Officer’s house whilst the renovations were being done (she came from the village so had somewhere local to live). For this reason, and also because it would be good for the graduating NCD nurses to move into refurbished buildings, the renovation should proceed as quickly as possible. The plan to employ a short-term construction supervisor is appropriate and sensible.

¹³ Subsequent informal e-mail correspondence in April 2013 suggested that this issue had been resolved.

Obviously the renovation work will benefit all staff and patients at health centres, not just the NCD nurses. There will be a better environment for curative care, visiting clinicians, and the work of the public health nurses.

Other activities in the primary/community sub-component

In addition to development of the NCD cadre, a significant activity in this sub-component is the development of **guidelines for primary care**. This manual was seen as an important part of the 2009 Partnership agreement and there are several targets related to establishing, enforcing and monitoring national standards (see Table 3). A table of contents for a Health Centre Operations Manual has been developed and there are plans to recruit a consultant to help with the writing. Contents include staff roles, operational issues and clinical guidelines. It is important that the manual is relevant and able to be updated regularly. To ensure its relevance, the consultant needs to be given enough time to become familiar with the working environment of health centres and the needs of their staff.

This sub-component also includes the purchase of a MoH **boat** for Ha`apai (Ha`apai is a group of islands in the central part of Tonga: 17 of the islands are populated). A scoping study has been conducted about the specifications and ownership of the boat. The option of sharing it with other Ministries was explored, but discounted. The specifications are stringent, partly because the challenging geography of the islands makes access difficult, and partly because of safety issues for passengers and crew. The purchase of this boat is an important step in improving access to some of the remotest communities in Tonga. At an estimated AUD 500 000 the boat is the most expensive single item in the THSSP budget (7 per cent of total budget). It is important therefore that this procurement is done with great care (commissioning a scoping study was appropriate), so that the boat will be able to improve access over a period of many years.

3.1.4 NCD Sub-component 1d: Diabetes Centre and Outreach; other clinical priorities (6% of total budget; 8% of total THSSP spending so far)

The fourth NCD sub-component supports the national Diabetes Centre and its outreach activities. The Diabetes Centre fulfils two functions – it provides secondary care for diabetics (and primary care for some people in Nuku'alofa) and also provides support to primary care facilities, including regular clinics in all health centres. Obviously these functions overlap: for example the new NCD Nurse Supervisor has a joint post with the Diabetes Centre.

THSSP supports both of the functions. It funds drugs and equipment for use in the Centre; it also funds a senior clinician who holds regular outreach clinics at all the health centres in Tonga. These diabetes clinics have an important role to play in contributing to the “best buy” of providing appropriate drugs for people at high risk of NCDs (Table 6). The clinics are also an important complement to the work of the pilot NCD nurses.

The sustainability of the outreach clinics is an important concern. The clinician is past retirement age and will need to hand over responsibility to other suitably-qualified clinicians. The funding of travel and accommodation for outreach also needs to be institutionalised – at present this is not funded through government systems (see Recommendation 9).

The funding of outreach is not just an issue for diabetes. THSSP was asked to fund allowances for MoH specialists to visit the outer islands to see patients and support clinical staff. This request was declined, as it went against Public Service Commission rules. However this is an important equity issue which the MoH needs to address.

A separate strand of work within this sub-component deals with mobility issues. Many, but by no means all, mobility problems are linked to NCDs, notably amputations due to diabetes. In 2010, 46 patients underwent 48 major (below or above-knee) amputations. 44 of them (95 per cent) were suffering from diabetic sepsis.¹⁴ Currently THSSP employs two mobility equipment and plaster technicians and supports the work of Motivation Australia. This clearly meets a need in Tonga for good-quality wheelchairs. However support for this particular part of the Program has never been considered strategically – how does this work on mobility compare with other unmet needs in Tonga, either directly related to disability (prosthetics or blindness, for example) or in terms of wider health issues? Recommendation 21 is about a systematic assessment of Tonga's health needs and priority services.

3.1.5 Monitoring the NCD component

Outcomes and targets

The achievements of the NCD component are monitored at two levels – overall outcome indicators and targets, and intermediate indicators.

Table 3 listed the targets for the Program. The main sources for the data on smoking and obesity are the STEPS surveys and (for smoking) the five-yearly census. Analysis of the 2011 national census is currently under way and results should be available later this year. It is not known when the next Global Adult Tobacco Survey (the other data source specified in Table 3) is scheduled.

STEPS surveys are a relevant and internationally-recognised method for collecting information on NCDs and their risk factors. However in practice there have been implementation problems. Although STEPS surveys in Tonga have been largely funded by AusAID, the analysis is managed by WHO. The results of the 2004 STEPS survey were not published until 2012 – an extraordinary and completely unacceptable delay. The MoH believes that the results of the 2012 survey will be available “some time in 2013”. It is not clear why analysis and publication takes so long, especially given Tonga's small size. Delays make the information much less useful and jeopardise any local ownership of the process. If STEPS is to be used to measure the outcomes of THSSP, there needs to be another survey in 2014 and a guarantee that results will be available within six months at the maximum. Without it, the STEPS information will only be for 2004 and 2011, which does not match with the duration of THSSP. A decision needs to be taken about whether the obesity and smoking targets will be measured through STEPS or through a locally managed survey.

The third target relates to the percentage of the recurrent budget allocation spent on preventive health care. There has been some confusion about this indicator; this is discussed in detail in Annex 6. The overall conclusion is that monitoring should focus on the simplest measure available, the percentage on prevention according to the government budget. Whilst imperfect, this measure can be used to raise the key policy issues – overall direction of spending and the salary/non-salary balance. Adopting a simple methodology enhances transparency and avoids distractions. The point of this target is to ensure that AusAID support does not displace the GoT's commitment to prevention. This support can be demonstrated by implementing the recommendations of this report, notably the employment and funding of NCD nurses and funding regular NCD outreach clinics.

¹⁴ MoH Annual Report 2010.

Intermediate indicators

The revised monitoring and evaluation framework (Annex 2) includes 13 intermediate indicators related to NCDs. These intermediate indicators are useful because there are so many different activities which are working together to achieve the same overall outcomes: the intermediate indicators can pick up the results of particular activities such as law enforcement or health promotion in schools, for example.

The Revised Framework still needs some work – dates need to be added for when baselines will be available and for targets. There needs to be some thought about what information will be available by the time THSSP finishes in mid 2015 and hence what surveys are required when. Although THSSP is part of a longer, ten-year period of support, it is reasonable to expect that there will be information on intermediate outcomes by the end of the extended Phase 1. In addition, the Monitoring Framework currently does not address the most significant issue for this component: *do health promotion activities change knowledge, attitudes and practice?* It is important that this question is addressed for the major health promotion activities through careful before-and-after assessments.

Conclusion about monitoring

If the NCD component is implemented as planned, and to a high standard, it has the potential to have a significant impact on NCDs and their risk factors. In particular, it is reasonable to be optimistic that the NCD nurses will bring about positive outcomes. Although not too much weight should be applied to it, anecdotal evidence already suggests that the nurses are able to identify new cases and improve compliance of existing cases. What is not yet clear is how effective the nurses will be in reducing obesity, smoking, alcohol consumption and physical inactivity.

More thought needs to be given about what information will be available in 2015 to assess the overall impact of THSSP. Census information is interesting in relation to smoking, but is unlikely to be available before 2017 at the earliest. STEPS provides good information, but in the past has been slow. The timing of the next Global Adult Tobacco Survey needs to be established. Most of the intermediate indicators do not yet have baselines. The two main options are either to have another STEPS in 2014, or to organise a specific survey that can investigate some of the aspects covered by STEPS.

3.2 Findings for Component 2: Critical Staffing Deficiencies (6% of total budget; 19% of total THSSP spending so far)

Rationale

This component of the Program has its roots in broader AusAID support to the provision of specialist clinical services across the Pacific, and is thus aligned to AusAID's long-standing regional support to hospitals and tertiary care. It is not strategically aligned to the NCD and community-health focussed targets of THSSP; however it *is* in line with THSSP's objective of strengthening the Tongan health system and is reflected in the program's second objective to: 'Fund critical service delivery deficiencies'. Further, rolling the critical staffing deficiencies program into THSSP (previously it was a stand-alone project) and making MoH responsible for its management should help strengthen planning and management of human resources and lead to better integration with broader health workforce development objectives.

Progress

Australia has supported the placement of long-term clinical specialists in Vaiola Hospital to meet critical staffing deficiencies for over a decade; previous to the

THSSP, specialists were deployed through AusAID's Pacific Technical Assistance Mechanism (PACTAM) program. Now, their recruitment and contracting is managed directly by the MoH. Currently, there is provision for four specialists of whom three are in post and one is in the process of being contracted (see Table 5).

Discussions with the MoH and with the specialists themselves suggest that this component fills an important gap in the provision of hospitals services. For this component to have maximum impact, its *recruitment, mentoring and supervision* elements must be implemented effectively. In particular, sufficiently senior staff must be contracted, who not only perform a clinical role but also have skills and experience to pass on their knowledge to local staff. The salary offered to visiting specialists is AUD 140,000, and the GoT also provides a living allowance of TOP 50,000 (just under AUD 30,000). This salary level was set by PACTAM over a decade ago and has not been increased since. There have been some concerns expressed that the salary level is now too low. An indication of this is that the anaesthetist post has been vacant for over a year, with the last incumbent resigning before the end of her contract and citing poor pay as the reason. MoH is open to raising the salary however it would like to retain the flexibility to negotiate on an individual basis. Their view is that to date the recruitment difficulties have been confined to a single position, so there is not yet a compelling case to raise the salary bar. At present, the three critical deficiency specialists in post have the appropriate experience to help build local staff capacity, however it is important to maintain this level of seniority if and when they move on. The salary levels may have to be reviewed at this time.

At present recruitment is supervised directly by the Medical Superintendent. An advertisement is posted through the relevant professional society, and through personal networks. Candidates that are registered to practise in Australia or New Zealand are preferred, as are those towards the end of their career who are more able to take on a mentoring role. Applications have been received from the Middle East and North Africa, but to date Tonga has been able to source specialists either from the Pacific region or from OECD countries. Application review and reference checks are done by the Medical Superintendent, and interviews take place only if there is more than one candidate. In practice, those recruited are often known personally to senior staff at Vaiola hospital.

Mentoring is an explicit part of the specialists' job description, and all visiting specialists to Tonga report that they are active in this area. The Bio Medical engineer and the Pathologist both have one Tongan staff that they mentor directly with the long-term goal of taking over the position currently being occupied. The surgeon mentors several staff through a weekly training session in the ward. Oversight and performance of the visiting specialists, including their mentoring, is done by the Medical Superintendent.

As outlined in a recent AusAID report,¹⁵ there are risks of medical misadventure associated with the deployment of medical specialists which, while small, could be further minimised by more rigorous recruitment procedures. These procedures will be even more important if and when candidates from countries without strong accreditation systems are considered. A suggested approach to strengthening recruitment procedures is outlined in the *Recommendations* section, based on current procedures. This brings together a number of practical activities, such as checking professional registers and police checks.

¹⁵ Hurley, D (2012) Pacific Medical Risk Management, AusAID Health Resource Facility.

Additional uses for the critical staffing deficiencies budget

Difficulties in recruiting an anaesthetist mean that the budget allocation for 'critical staffing deficiencies' is significantly underspent: of the AUD 1.5 million allocated to this component in over the four years, AUD 802,737 remained as of December 2012 (54 per cent) (see Table 4). The MoH indicates that it wishes to maintain the program of visiting specialists however it would also like flexibility to use funds to respond to other human resources (HR) and training needs. Examples of additional uses of the fund proposed by the MoH include:

- Supporting the development of paramedical training courses, e.g., for dental technicians, laboratory services, x-ray technicians. Several courses have already been developed, and now require external peer review, finalisation and accreditation through the newly-established Tonga National Qualifications Accreditation Board. There is a precedent for this kind of support – a Professor from Australia was funded by THSSP to assist with the development of the NCD nurses' curriculum.
- Short-term, specialist training for MoH staff, especially those being mentored by critical staffing deficiency specialists. While AusAID has other mechanisms to support long-term training, there are specific, short-term training needs that would contribute to the mentoring process.
- Purchase of additional equipment needed by visiting specialists to perform their work (a small amount of funding is already available for each person recruited in this scheme to use as they judge best).
- Bringing in trainers from overseas to support the mentoring and capacity development role.

Monitoring and outcomes

The monitoring and evaluation framework established for THSSP does not include any indicators or targets related to the critical staffing deficiencies component. This is a significant gap – and makes it very hard to judge whether this part of the program is delivering optimal results. For example, while each of the four positions funded under this component relates to a critical area in the provision of hospital services, there is no systematic approach to determining which positions are most needed. It is therefore impossible to know whether the clinical skills provided are aligned with greatest needs. Determining *what level and types of care Tonga can reasonably be expected to provide to its population*, given its population and national wealth, may be an important step in finding more long-term sustainable solutions to the gap in specialist services.

Equally, there should be some regular monitoring of both the clinical and capacity building aspects of the program. At present no specific targets have been set in this area and neither the clinical work nor the mentoring work of the visiting specialists is regularly evaluated. The Specialists themselves have raised this as an issue – for example, the Pathologist would like the laboratory at Vaiola hospital to benefit from independent quality audits, as happened in the past. Similarly, some monitoring is needed of the number of patients seen by the visiting surgeon and anaesthetist, and how this has affected overall hospital capacity – for example, are there fewer overseas referrals as a result? Such data is likely recorded through hospital systems: incorporating results into the program monitoring is desirable.

Is the critical staffing deficiencies component sustainable?

While Tonga has been successful in increasing the number of medical doctors, it has difficulty in retaining specialists, as do many Pacific Islands. The *Framework Design* indicates that the provision of visiting health specialists should be on a temporary

basis however it also notes that ‘more sustainable solutions to these challenges are desirable but it is likely that some funding of this type will be required for the medium terms’ (paragraph 75). This is because Fellowship-qualified Specialists can make the transition to practise in Australia and New Zealand, where salaries are much higher, quite easily. An indication of this is that, over recent years Tonga has trained two anaesthetists and two surgeons, but all are now working overseas. However, most medical doctors in Tonga are now trained at the Fiji School of Medicine whose Masters qualification does not enable them to work outside the Pacific region. This means that they cannot get the experience necessary to obtain a fellowship. Because of this ‘catch 22’ there is no obvious strategy for producing the next generation of Tonga specialists. Equally, even if Tonga is able to train *and retain* a particular specialist the small size of the population means that it is only ever likely to have one individual per speciality, a fragile situation for obvious reasons. This suggests that the solution to Tonga’s specialist deficiency does not (or not only) lie in ‘better HR planning’ and that a program to support long-term visiting specialists, like this critical deficiencies fund, is likely to be required for the foreseeable future.

Given Tonga’s small population, the challenge of retaining highly-specialist staff is not confined to the health sector. The Public Service Commission plans to explore innovative approaches to this problem (such as working with Australian- and NZ-based institutions to release Tongan staff for periods of employment in Tonga, keeping their position open) and would be interested in collaborating with the health sector on this issue. This could provide an opportunity to explore longer-term solutions to the staffing deficiencies from a whole of government perspective.

3.3 Findings for Component 3: Flexible Fund (11% of total budget; 18% of total THSSP spending so far)

Rationale

The Flexible Fund is to be used for “unplanned small scale and/or urgent work”, with decisions on its use made by the Executive Team. The Fund is worth AUD 250,000 per year and is usually all spent. The MoH values the Fund highly because it can be used for items where there are few alternative sources of funding, particularly given the squeeze on non-salary recurrent expenditure. Figure 1 shows the breakdown of expenditure. The vast majority of money is used for clinical equipment and related supplies. For example, some of the largest single items include:

- an X-ray machine for a hospital in the outer isles;
- intensive care beds and monitors;
- laboratory equipment and consumables.

The conditions for use of this Fund – unplanned small scale and/or urgent – are rather odd and indeed work against encouraging good planning. Most of the money is spent on equipment, where *planned* replacement and *planned* maintenance are preferable to “unplanned” and “urgent” purchases.

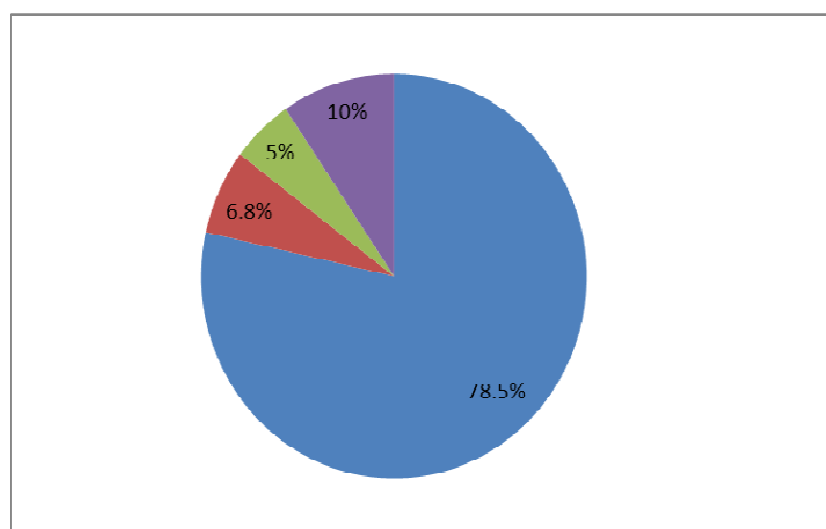
An external audit of THSSP was conducted in October 2012; it did not find any problems with the use of the Fund. The audit’s conclusion does, however, emphasise that the current conditions of use are unhelpful: “The Flexible Fund can be used for any purpose as long as it is classified as urgent.”¹⁶

Management of the Flexible Fund takes up a disproportionate amount of time and energy – both for the AusAID Post and for the MoH. Contested expenditures from

¹⁶ THSSP Audit Report for the period July 2009 – June 2012. `Uta`atu and Associates.

over a year ago are still discussed, even though the issues under dispute were not particularly serious. These contested expenditures led to the introduction of a “no objection” decision from AusAID for each expenditure.

Figure 1: Breakdown of spending from Flexible Fund (ca. AUD 730,000/TOP 1.2 million)



Equipment and related supplies: 78.5%; Hospital supplies (linen): 6.8%; Professional fees: 5%; Others: 10%.

Monitoring and outcomes

No particular indicators or targets are linked to the Flexible Fund, meaning that its use cannot be judged in strategic terms. The *Recommendations* responds to this by suggesting that spending is linked to the Ministry's Annual Management Plans.

3.4 Component 4: Hospital Twinning (2% of total budget; 3% of total THSSP spending so far)

As explained in the *Evaluation Scope* section, the hospital twinning component between St John of God Hospital, Ballarat, Australia and Vaiola Hospital, Nuku'alofa was not reviewed in detail because of its small size and because no specific issues were raised about the arrangement. Like the critical deficiencies work, the twinning is an 'add on' to the program, i.e., a previously stand-alone initiative that has been rolled into THSSP. Ministry of Health staff refer to this component very positively, and are clearly keen for it to continue. In addition to staff exchanges, Ballarat Hospital has provided Vaiola with valuable equipment. The twinning arrangement has been going for twenty years, a strong indication that it is valued by both hospitals; however it has never been formally evaluated.

3.5 Program Management (7% of total budget; 21% of spending so far)

Program leadership As discussed above, delays in the recruitment of a program facilitator led to delays in the establishment of the program. The engagement of two program coordinators, supported by a Strategic Health Advisor for Tonga, was a practical response to this situation. However it did mean that the Program lacked the intended leadership (beyond the sporadic support provided by the Strategic Health Advisor). The Program Manager is the MoH Principal Planning Officer, who is also responsible for a team of 30 staff in his own division. In practice, in the absence of a

THSSP counterpart, his role has been limited to ensuring that program procurements are in line with agreed annual workplans.

There are clear indications that the THSSP has lacked full-time leadership. Moreover leadership is still required to deal with the more challenging recommendations in this report and to ensure that there is a smooth transition to the next phase. There should not be a repeat of the start of THSSP, when little happened for 18 months. It is recommended that a “transition advisor” be recruited to provide leadership during the two-year extension. However it is recognised that this is risky because it is possible (given past experience) that either no-one is recruited or that there is a serious delay before someone is actually in post. It is therefore also recommended that a date is set when efforts to recruit the advisor end (say, end 2013). If recruitment has failed, the Strategic Health Advisor should lead discussions on how to deal with the transition to a new phase and the recommendations of this Review.

The main aspects of **program management** are described below. THSSP was established with a clear intention to use government systems where possible. In practice the Program is a hybrid of programmatic features and government systems, with patchy use of government systems. About 18 per cent of spending so far has been done directly by AusAID. In addition to the five members of Program staff who focus on specific NCD sub-components, there are three administrative staff with program management responsibilities (see Table 5).

The THSSP has a stand-alone **planning and budgeting** process. Annual workplans and budgets are developed with assistance from the Strategic Health Advisor in consultation with MoH and Program staff. At present there is no mechanism for integrating these into the annual management plans (AMPs) prepared by each of the MoH's six divisions. In early 2013 THSSP program management staff, along with representatives from other health donors, made a presentation to the MoH divisions as they embark on the process of revising their AMPs. This is positive, though given the relative size of the program stronger engagement may be warranted, beyond information sharing.

Financial management is, in effect, done by Program staff, but channelled through government systems. The exception to this is that about 18 per cent of the budget is retained by AusAID Post in Tonga to support external technical assistance and other costs. The Program is on-budget in that it appears in the overall MoFNP budget, but as separate external assistance rather than part of the MoH budget. Funds are channelled through the MoFNP: Australia and New Zealand are the only donors to do this (World Bank, ADB and EU do not). Funds are released by the MoFNP to the Program based on requests from Program staff.

The government Chart of Accounts is followed, but different software is used. Government uses the Sun System; the Program has recently moved from Excel to the Quick Books accounting tool. There was an initial effort by the Program to use Sun: a coding for the structure for the program was developed based on the Chart of Accounts which presented the project as a seventh division within the MoH budget. This coding was submitted to the department responsible within the MoH, but for unclear reasons was never sent on to the MoFNP for approval. There was also confusion over the cost of licences required to use Sun; THSSP staff understood that a minimum of six licences would need to be purchased, representing a significant cost for the Program. In fact, the GoT is already a licence holder and holds multiple licences; MoFNP confirmed to the evaluation team that it has a Sun licence available for use by the project.

Procurement of larger items is through the Ministry of Finance and follows GoT procedures. Items are authorised by MoH staff; Program staff handle the paperwork and facilitate the process. A Procurement Unit is in the process of being established

within the MoH, and once this is in place the Program will route purchases through it. The Program could explore whether some of its funds can be used to strengthen this new unit (See *Recommendations*).

The first external **audit** of THSSP was carried out in 2012 and produced a number of recommendations about procedures. The audit did not pick up the overall problem about relating expenditures to the total budget, probably because it focussed on expenditures. Both MoFNP and MoH welcomed the audit as a helpful source of advice on how to strengthen government procedures.

Program **reporting** is through quarterly reports, prepared by program staff, and six-monthly reviews (two have been carried out so far). The exception to the authorship by Program staff is the section on monitoring and health information, which is written by the MoH's senior information officer, demonstrating strong MoH ownership. The intended audience for these reports is AusAID and the MoH ET. The format for the reports is not user friendly: they are long, key points are buried, and issues requiring action from the MoH ET are not clear. A more accessible format would help facilitate more strategic MoH ET engagement in the program. Ways to make the report more accessible include:

- starting with a one-page summary of key issues and decision points;
- systematically reporting against annual objectives, with a focus on performance. Processes only need to be described when there is a particular point to make, for example when implementation has encountered an unforeseen difficulty;
- systematically reporting on implementation of decisions from the previous meeting;
- Including an expenditure table. Not necessary to describe each expenditure in detailed narrative form.

For Program **governance**, the ET+ is responsible for strategic oversight of THSSP and the MoH ET also discusses the program in its monthly meetings. This management model is conceptually sound in that it seeks to foster MoH ownership of the program and facilitate integration. However, in practice it does not appear to function as anticipated. A rapid review of ET+ minutes suggests that strategic-level discussion is limited and a disproportionate amount of time is taken up with the Flexible Fund and lower-level program management issues. Similarly, though the review team did not have sight of MoH ET minutes, it was reported to us that much discussion at this level also focuses on the Flexible Fund. The appointment of a senior staff dedicated to the program, along with removal of AusAID's no objection rule on the Flexible Fund, should create space for strategic level discussion and help ensure the management model works as originally envisaged. AusAID also holds bi-monthly meetings with THSSP staff; in future a facilitator may help to ensure that program meetings address day to day management issues, leaving space at the ET+ for strategic discussion.

Monitoring of most THSSP health outcomes will be through the health information system and existing survey instruments. This is the best example of the THSSP strengthening a system through using it. Working with the MoH officer responsible for health information, a system has been established to collect and process data from NCD nurses (e.g. on risk factors and prevalence) and integrate this into the existing hospital information system. This is the first step in computerising and integrating data from health centres and there is a long-term vision to integrate data collected by other staff working at this level. Some additional monitoring of behaviour change will be done through KAP surveys, though these should have usefulness beyond THSSP as they will give a sense of the combined impact of all health promotion activities.

THSSP **staffing** is described above (Table 5). The number of staff employed by the project is now relatively large, having grown quite rapidly over the last 12-18 months. Many staff are in line positions, which represents good practice in terms of ensuring close collaboration with MoH colleagues and integration of program activities. However, given the broader recruitment freeze across the public service, there are questions around the sustainability of these positions beyond the end of the program. While the Public Service Commission has been open to agreeing additional MoH staff in the form of the new NCD nursing cadre, it may be less sympathetic to additional management and administrative positions. A process to identify and agree the positions which are most critical to Tonga's NCD response over the longer-term, and to seek necessary budget and approvals for their establishment, should begin soon.

3.5.1 Aid Effectiveness

"Aid effectiveness" is about improving the way donor funding is organised and managed so that it has the maximum positive impact and achieves value for money. The TOR for this Review asked for an assessment of the degree to which the Program adheres to aid effectiveness principles. These principles (taken from the 2005 Paris Declaration) are:

- Ownership: The host government sets the agenda in terms of priorities.
- Alignment: Donors support local priorities and use local systems.
- Harmonisation: Donors co-ordinate, simplify procedures and share information to avoid duplication.
- Results: There is a focus on results and how they are managed, rather than on processes and procedures.
- Mutual accountability: Governments and donors are accountable to each other for results.

Table 8 sets out these principles and summarises relevant characteristics of THSSP in relation to each.

Table 8: Aid effectiveness and THSSP

Aid Effectiveness Principle	Relevant Characteristics of THSSP
Ownership	Generally strong ownership; the main challenge is institutionalisation of a govt-owned and run health promotion program. THSSP supports areas which MoH believes are important.
Alignment	Close alignment between THSSP and Govt priorities as set out in the national NCD strategy and MoH Corporate Plan. Use of govt systems is patchy at present and could be strengthened (especially procurement, planning and budgeting).
Harmonisation	Not a major issue given the limited number of health partners in Tonga. However there are overlaps in support to health promotion activities provided by different donors (and by different funding streams within AusAID).
Managing for Results	THSSP has clear targets and a monitoring framework for its NCD components. An evaluation framework is lacking for other components. There are no overarching targets / indicators that capture the combined

	impact of all components.
Mutual Accountability	<p>The ET+ provides a forum for AusAID and MoH to discuss the program at senior level. This has enabled MoH to express dissatisfaction with aspects of AusAID's management (e.g., the 'no objection' rule on the Flexible Fund). However, it does not serve as a forum for ongoing dialogue about important strategic issues.</p> <p>In terms of predictability, AusAID should aim for a smooth transition of support after 2015. The delays encountered at the start of THSSP should be avoided.</p>

AusAID has expressed concern that THSSP remains a 'project'; the review team agree that the NCD component is regarded by many stakeholders as a separate entity rather than part of the MoH. The other components are more fully integrated and are in effect managed by the MoH.

THSSP provides interesting lessons about aid effectiveness. On the one hand, the story of the NCD nursing cadre is a text book example of how working 'outside' the system can provide the space to develop and pilot innovative approaches, which can then be embedded in government structures. On the other hand, there are examples of THSSP working through government systems, though the extent to which it *strengthens* these systems is less clear.

3.5.2 Donor co-ordination

The overall donor landscape in the health sector is relatively uncomplicated, with a limited number of partners. Nevertheless, there are clearly some overlaps in the support provided by health partners, suggesting that co-ordination could be improved. AusAID is the main bilateral donor supporting health, though Japan and China are also active. China funds construction of health centres, which then require equipment and staff. This has implications for THSSP's support to primary health care; for example, AusAID has provided a pilot NCD nurse and equipment to a Chinese-built health centre in Tonga'tapu. Discussions with AusAID suggest that this complementary financing was not agreed in advance, pointing to the need for stronger planning and co-ordination, led by the Ministry of Health.

Japan International Cooperation Agency (JICA) runs a small training program for community health nurses. This has implications for THSSP's training of NCD nurses, who will be working alongside community nurses at health centres or providing back-up for them. To date, information exchange between JICA and AusAID has been good, with overall coordination managed by the Ministry of Health and including THSSP staff. Japan also provides volunteer clinical specialists at Vaiola hospital: a radiologist, medical technologist and a physical therapist. There are clear overlaps here with AusAID's support for critical staffing deficiencies. Finally, Japan supports Public Health promotion, which includes 'life-style related disease prevention' and a program of aerobics and physical education.

New Zealand funds the referral of critically ill patients to its hospitals. While New Zealand's support is not provided in the form of a traditional donor program, it does have co-ordination implications for THSSP and in particular the critical deficiencies fund. For example, a review of the types of cases transferred could help to inform the choice of visiting specialist.

Of the multilaterals, only WHO and UNDP have a presence at country level. WHO provides support on NCDs: for example, it is currently rolling out training on the essential package of NCD interventions (PEN). To date co-ordination with THSSP

and AusAID is reportedly good, however the timing of training is driven by WHO's regional program rather than Tonga's needs. UNICEF and UNFPA run programs from a regional base in Fiji to provide commodities (vaccines and contraceptives). The World Bank previously funded the establishment of a hospital information system but that project is now finished. The multi-laterals also provide important technical and analytical support through their regional programs – for example the World Bank study on the economic costs of the NCD epidemic in the Pacific was mentioned by the MoFNP, an indication of its influence.

There is some overlap between THSSP and programs funded by AusAID at regional level. In particular, the Australian Sports Outreach Program (ASOP), which provides approximately AUD 340,000 annually to promote netball among teenage girls in Tonga; and, AusAID's support to TongaHealth which is channelled through WHO and the Secretariat to the Pacific Community (SPC). Both these initiatives are repositories of health promotion expertise and support significant health promotion activities in Tonga. THSSP reports that it is making significant efforts to co-ordinate with ASOP, to ensure there is no major overlap in activities and that strategic health communication campaigns are complementary. Funds provided by AusAID to TongaHealth will cease in June 2013.

There are also overlaps between AusAID-funded support for clinical specialists in the Pacific and the critical deficiencies component of THSSP; these have been explored in detail in a previous report and will not be discussed further here.¹⁷

In summary, the main co-ordination issues are around support to NCDs, where there are overlapping mandates:

- between national agencies (the MoH and TongaHealth);
- with NGOs (Tonga Family Health Association, though primarily focussed on sexual and reproductive health, also works on obesity and physical activity as part of its school health program);
- between different AusAID-funded programs (THSSP and the regionally-funded Netball initiative);
- between AusAID and JICA's bilateral support to health promotion and nurse training, and between AusAID and China's support to strengthening of primary health care; and
- between THSSP and WHO, which has a mandate for setting norms and standards in NCD prevention and care.

At present there is no co-ordination mechanism for partners supporting the health sector. Until a year ago, WHO chaired a regular co-ordination meeting in the MoH, attended by the Director of Health, which served as a forum for information exchange. The major bilaterals and TongaHealth attended. This stopped when the senior WHO officer changed. Given the areas of overlap in partner support, and the potential for duplication, there may be a case for reviving this meeting. Consideration could be given to joint chairing by the MoH and one development partner on a rotating basis. Tonga's relatively small size and the limited number of partners mean that a light touch co-ordination mechanism is likely to be sufficient, focussed on information sharing as the previous meeting was. In time, the donor group could become involved in annual audit and review activities: ideally the annual reviews would include activities funded by other donors.

¹⁷ Hurley, D., *Op Cit.*

3.5.3 Evaluation Criteria Ratings

This section discusses the Program as a whole in terms of the AusAID evaluation criteria.

Evaluation Criteria	Rating (1-6)	Explanation
Relevance (Does THSSP contribute to higher level objectives?)	5	NCD component very relevant to Tonga's needs and priorities and focuses on priority interventions. Other components fit in with Ministry of Health's Corporate Plan, but are not linked to an overall strategy about the future of hospitals.
Effectiveness (Is the Program on track to achieve its objectives?)	4	NCD component largely on track, although delayed because of slow start to Program. Exception is behaviour change/health promotion, which needs to begin implementing significant health promotion packages. Too early to judge the quality and effectiveness of interventions – this will be the proof of whether the objectives of reducing NCDs will be achieved, and is the reason why there needs to be a focus on quality during the program extension. Implementation of other components proceeding smoothly. However, no specific targets set (e.g., in relation to mentoring outcomes or volume of services provided) so only qualitative judgements possible.
Efficiency (Is the Program managed to get the most out of inputs, including risk management?)	4	Program performance has improved substantially over the last two years, however there have been challenges, some of which remain. Poor management of facilitator recruitment meant long delay in start of project. Appointment of two program coordinators helped address this issue. Important to learn lessons from the failed recruitment process and consider the efficiency trade-offs: lack of flexibility in the salary package offered to the preferred candidates may have been a false economy, given the impact on program implementation. Delay in recruitment of anaesthetist suggests inefficiencies in recruitment which might be addressed with additional support. More flexible use of critical deficiencies budget, e.g., to offer additional training to mentees, might help maximise the impact of the training/mentoring program. Need to strengthen planning and budgeting processes: it was not clear at the time of the Review how much money was left in the budget.
Sustainability (Will benefits continue after funding has ceased? Government systems, ownership, phase-out strategy)	4	Generally strong Government ownership and well-aligned to national priorities. But high dependence on Program funding and management (especially on the work of the co-ordinators). Need to rigorously explore the (difficult) options related to the funding of long-term overseas specialists.
Gender equality (Does the Program advance gender equality and promote women's empowerment?)	4	Good involvement of women in responsible positions. The vast majority of the NCD nurses are likely to be women: this new cadre widens the opportunities of professional jobs for women. The two senior co-ordinator roles in the Program are both held by women.

		NCD work is highly relevant to the needs of women and girls, especially as they tend to be more overweight than males. All appropriate indicators are disaggregated by gender.
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Rating scale:

Satisfactory		Less than satisfactory	
6	Very high quality	3	Less than adequate quality
5	Good quality	2	Poor quality
4	Adequate quality	1	Very poor quality

3.5.4 Other aspects of equality

In addition to gender, the TOR asked for some discussion of how well equity measures related to disability and geography have been integrated into the program and how this could be improved.

For disability, the monitoring framework includes the number of hospital admissions and length of stay for diabetic sepsis and amputations, disaggregated by gender. It should be possible to monitor what effect the NCD nurses have on these indicators. This is an adequate reflection of disability issues for the current Program.

Geographical equity is an important issue for the outer islands and is not currently reflected in Program monitoring. It is recommended that:

- In 2015, the Program compares information provided by NCD nurses in Tongatapu with the information from nurses on the other islands.
- The Program records the visits to outer islands for NCD nurse supervision and diabetic clinics.

3.6 Next steps: beyond 2015

The TOR for this review asked the authors to think in broad terms about the second phase of support, beyond any extension to the current THSSP.

While this phase of THSSP comes to an end in 2015, the original design was based on a ten-year time frame, up until 2019. The next phase is likely to have a stronger focus on working through government systems, in line with the current trend in AusAID away from project-type support. The design for the next phase should focus on the governance of joint planning and review, as well as incorporating new areas of support based on analytic work. This implies major changes for the way in which AusAID support is provided. But it is appropriate – the critical deficiencies component in particular has shown that the Ministry is able and willing to manage donor funds. If there was to be such a change, the preparatory work would be organised by the AusAID Post in Nuku'alofa (obviously this discussion does not imply any commitment by AusAID).

There are two ways in which the period of the two-year THSSP extension can be used to prepare for the likely change in the way support is provided. The first way is to move the critical staffing deficiencies and flexible fund components towards a system of annual audit and review (see Box 1). These established components offer the opportunity to try out this new way of working in the context of familiar areas of spending and as such could pave the way for the possibility of wider budget support after 2015. This thinking is reflected in Recommendations 11, 14 and 15 below.

Box 1: What is meant by “annual audit and review”?

This report recommends that the critical deficiencies and flexible fund components move towards a system of annual audit and review. Key features of this are:

- Overall agreement about what the funds can and cannot be used for. **What are the component objectives and what (if anything) can the money specifically not be used for?**
- **Annual workplans stating the annual budget and specifying objectives for the components, how performance will be measured, and what reporting there will be. (Two possible examples of objectives and reporting: each clinical specialist will act as a mentor and provide a very brief annual report on progress with mentoring; ET will discuss all Flexible Fund spending and note decisions in minutes)**
- Independent audit conducted annually and report ready in time for annual review.
- **Annual review focuses on objectives and whether they have been achieved. Also discusses any “misuse” of funds – i.e. beyond the agreed scope for that component. This leads into discussion of next year’s objectives and any increase/decrease in the budget. The annual review could be conducted by ET+, though it would be a good idea to bring in a facilitator to ensure that the review is not just “business as usual”. The review is informed by reporting from the MoH against objectives, and by the report of the auditor.**

This cycle of annual audit and review differs in a number of ways from current practice. It has a stronger focus on strategy and performance, rather than processes, and replaces detailed quarterly discussions. The initiative to keep implementation moving lies firmly with the MoH.

The second way to prepare for the next phase of support is to think about the overall “shape” of health services in Tonga and hence what areas might be priorities for international support. “Shape” refers to the packages of services provided by primary care facilities, district hospitals and Vaiola Hospital. The planned manual for health centres is highly relevant. To complement the manual, a piece of work could explore:

- The areas of greatest need where cost-effective interventions exist but are not currently being provided in Tonga. Areas to be explored included mental health, possible unmet need for contraceptives, cancer (the NCD nursing curriculum covers some aspects of some cancers) and disability (mobility, blindness etc.).
- What hospital services should be provided at what level (district, national, overseas referral) to provide the best value for money?

This work would also facilitate a more systematic and transparent approach to the selection of specialties to be filled through the critical deficiencies fund. This thinking is reflected in Recommendation 21 below.

How would these two areas of preparation inform the design of support after 2015? A logical follow-on from THSSP would be to support some activities through financial aid (budget support or something similar), whilst retaining some programmatic support to work in areas where the MoH is expanding or changing the services which it provides. This takes on board the main lesson from THSSP: that programmatic support can work well to kick-start new ideas (e.g. the NCD nurses), but that the MoH should be developing its own systems to deal with familiar areas such as critical staffing vacancies and recurrent budget support for non-salary expenditures. Programmatic support for new or fast-changing areas works well because it can

generally implement changes faster than through government systems, and because it is a more appropriate way of managing technical assistance. So the first area of work described above would demonstrate how annual planning and review can replace detailed, hands-on program management, as long as it is clear in advance what outcomes are expected from the funding, who is accountable for the outcomes and how they will be assessed. The analytic work would inform decisions about what area to concentrate on to further develop the package of services provided by the Ministry.

4. Conclusions and recommendations

There are three broad conclusions about the THSSP:

- The **NCD component** is highly relevant to Tonga's needs and has made a broadly promising start. Progress with institutionalising the new cadre of NCD nurses is impressive. The exception to the good progress is health promotion, which is largely stuck at the planning stage. This is a very serious concern: Tonga's life expectancy has dropped and strong health promotion is an important part of reversing this. Whilst it is too early to observe outcomes, the component has the potential to have a positive impact on NCDs and their risk factors, as long as there is strong quality assurance of activities. The timing of future surveys needs to be carefully planned so that outcome data is available by the time the Program ends in 2015.
- The **Critical Staffing Deficiencies, Flexible Fund and twinning** components largely focus on hospital care. They have stronger government involvement in their management than the NCD component, got off to a faster start and have generally spent more of their budgets. Whilst all three components appear to make a positive (and much appreciated) contribution to curative care, they do not operate in a framework of objectives and targets that allows for effectiveness to be gauged.
- The joint **governance** of the Program does not focus on the big strategic issues – the focus tends to be on process issues and the Flexible Fund.

The recommendations reflect the broad conclusions described above. After each recommendation a job title is given in brackets. This is the suggested recommendation "owner". The point is not that this person has to implement the recommendation single-handedly: rather the "owner" should be responsible for ensuring that the recommendation (assuming it is adopted) is implemented. For a number of recommendations the owner is the "transition advisor". Recommendation 17 explains more about this post, which is intended to replace the never-filled facilitator position. If for some reason the transition advisor post is not filled, there should be discussions with the Strategic Health Advisor for Tonga to see which recommendations she can deal with: additional alternative arrangements would probably have to be made to ensure that all the adopted recommendations are implemented.

Because there are a relatively large number of recommendations, the priority ones are preceded by ****.

**** **Recommendation 1:** Extend the current THSSP (all components) for two more years until June 2015 whilst retaining the initial budget of AUD 7.5 million (*Transition advisor*).

Because the Program started slowly, many activities have started relatively recently and one important area (health promotion) is still largely at the planning stage. Additional time is needed to ensure that appropriate activities are implemented and their quality is properly assessed. Keeping the initial budget is recommended because as of December 2012, only 53 per cent of the budget had been spent - this is likely to reach about 68 per cent by the end June 2013, which is the official end-date of the Program.

As of December 2012 there was about AUD 3.6 million unspent; this will be about AUD 2.4 million by June 2013. Spending in 2012/13 will be about AUD 2.3 million. So with no additional budget, the Program would have to reduce annual costs below current levels for the two years of the extension. This may be difficult, especially given that the most expensive single procurement is yet to be made (a boat) and because of the recommendation to implement at least one significant health promotion campaign.

The reason for not recommending an increase to the budget at this stage is that there is confusion about the way the budget has been recorded. This led to an impression that more money was left in the budget than is actually the case. Given this lack of clarity, plus the fact that only 53 per cent of the budget had been spent by month 42 of a 48-month Program, it is not appropriate at this point to recommend additional funding. However a second recommendation recognises that more funds *may well* be needed.

**** **Recommendation 2:** Correct the procedures for presenting budgets and expenditure so that by June 2013 there is a clear picture of past expenditure, available budget and future spending plans. This information is required before AusAID can decide if and when the budget should be increased (*Strategic Health advisor and the MoH advisor*). If AusAID is satisfied with the quality of the information provided, the review team would not object to an increase in the THSSP budget. Any budget increase would not need to follow the current allocation amongst components: there should be flexibility about this.

4.1 Component 1: Prevention and Management of Non-Communicable Diseases

The legislative/fiscal change sub-component has embarked on interesting and relevant work; the challenge now is to prioritise and to ensure that other sectors are involved. There are no specific recommendations for this sub-component.

The behavioural change/health promotion sub-component needs to solve its governance issues and begin substantive implementation of large scale health promotion activities.

**** **Recommendation 3:** National NCD Committee to lead process of clarifying roles and responsibilities for health promotion and inter-sectoral activities related to NCDs. Issues include: to what extent does the MoH want to advise other ministries about things which need to be done (e.g. in relation to availability of unhealthy foods, alcohol and tobacco)? To what extent does MoH/THSSP want to respond to requests from other ministries for funding for activities which may or may not be priorities in overall public health terms? How can the Committee and Sub-committees secure and keep membership from other ministries that is senior enough to ensure that the (sub-)committees are effective? Involve the Cabinet to ensure high-level buy-in: NCDs are a national priority and it is appropriate that the Cabinet is aware of, and supports, the intersectoral response (*Co-ordinator: behaviour change/health promotion*).

Recommendation 4: Once the governance structure for the inter-sectoral work has been re-designed (previous recommendation), organise a high profile re-launch of the inter-sectoral work (*Co-ordinator: behaviour change/health promotion*).

Recommendation 5: HPU to lead the implementation of a coordinated package of activities related to one health promotion message. The quality of this work is important; the “before and after” situations need to be measured to assess effectiveness (*Co-ordinator: behaviour change/health promotion*).

In the community/primary care sub-component, progress with the NCD nursing cadre has been good. This now needs to be institutionalised and carefully monitored to ensure that the nurses really are having an impact on NCDs.

**** **URGENT! Recommendation 6:** Follow up on **formal approval for the new cadre** of NCD nurses with the Public Service Commission and MoFNP. (*Co-ordinator: primary care*). (By the time of the final version of this report, the authors had informally heard that this matter had been resolved and that the recruitment of NCD nurses could proceed.)

**** **Recommendation 7:** Establish an operational research program to assess the effectiveness of both the diploma training and the new nursing cadre itself (*Co-ordinator: primary care*).

The research should have both qualitative and quantitative aspects. Key questions include: did the Diploma prepare the nurses adequately for the job? Are the nurses able to alter the behaviour of clients in relation to primary and secondary risk factors? As well as assessing outcomes to the extent possible, the research should consider factors which contribute to (or detract from) the effectiveness of the nurses (for example teamwork, transport, computer literacy). It would be helpful if the research could comment on how many NCD nurses Tonga needs – what is a reasonable size of population for one nurse to cover?

Recommendation 8: Work towards sustainability of the NCD nurses when THSSP ends in mid 2015 – the nurses should be able to work effectively with as few external inputs as possible (*Co-ordinator: primary care*).

THSSP funds seven long-term posts and one short-term position as part of this sub-component: the co-ordinator, five nurses, one tutor and the (soon-to-be-engaged) construction supervisor. This raises important concerns about sustainability, even if it is confirmed that the nurses themselves will be paid by government from the time they graduate. The component is currently very dependent on the skills and energy of the Co-ordinator. The Co-ordinator should gradually reduce her level of involvement as THSSP draws to a close in mid-2015. Supportive supervision will be important for the future of the cadre. This will require appropriate transport/logistical support to reach *all* the NCD nurses; it is vital that nurses in the outer isles are well supported.

Sustainability is also a crucial concern for the Diabetes Centre/Outreach sub-component.

Recommendation 9: Ensure the sustainability of the diabetes outreach service in terms of staffing and funding (*Co-ordinator: primary care*).

Given the delayed start, it is understandable that there is as yet no evidence in relation to outcomes. By June 2015, however, there must be evidence on outcomes. The current monitoring framework (indicators with targets, plus intermediate indicators) does not make clear what information will actually be available by 2015.

**** **Recommendation 10:** Plan monitoring activities so that information on outcomes is available at the time of the end of the Program in June 2015; the timing

of surveys, including STEPs and KAP studies, is crucial (*Transition advisor plus co-ordinator: behaviour change/health promotion*).

4.2 Component 2: Critical Staffing Deficiencies

The MoH owns and largely manages this component. There needs to be greater clarity about objectives and some analytic work to consider the future of this type of support.

Recommendation 11: Allow greater flexibility in the use of the ‘critical staffing deficiencies’ budget, to respond to broader health workforce needs; continue to externally audit the component annually as part of THSSP’s annual independent audit (Medical Superintendent and, for the audit *Transition advisor*).

Clear criteria can be developed about what can be funded, for example, long-term degree training can be excluded. Oversight could be provided by the MoH Training Committee and spending should be in line with the health workforce plan. The external audit of the component can be combined with the audit of the Flexible Fund (Recommendation 15).

**** **Recommendation 12:** Make technical support available to the Medical Superintendent to assist with the search for visiting specialists, as required. To minimise the risk from medical misadventure related to deployment of medical specialists draft a protocol to guide the recruitment of specialists, based on current procedures (*Medical Superintendent*).

A suggested approach for the protocol is as follows:

- All candidates should have specialist qualifications (Fellowship) from Australia or New Zealand or equivalent country;
- If a Fellowship qualified candidate is not available, documented reasons for accepting equivalence must be provided;
- A search of the Australian Health Practitioner Regulation Agency (AHPRA) or equivalent register should be made to ensure the doctor is registered and has no conditions on their registration. An active web search should be done *in addition* to requesting a letter of good standing from the registration authority;
- Referees’ reports must be obtained even if only one candidate applies; telephone interviews are preferable to written reports.
- Once selected the candidate must be registered with the Tonga Medical Registration Board.
- A global police check should be performed.

Recommendation 13: In consultation with the Public Service Commission, commission a piece of analytic work on innovative approaches to the retention of specialist skills in Tonga, using the health sector as an example. This could include exploring the relative cost-effectiveness of recruitment from overseas versus training for local citizens (*Transition advisor*).

Recommendation 14: Incorporate into the THSSP monitoring framework indicators and targets on clinical and mentoring work of the clinical specialists employed under the critical deficiencies component of the program (*Transition advisor*). This is part of the move towards a greater focus on performance rather than processes – it is the *MoH’s* responsibility to propose targets and indicators and to report against them. AusAID’s focus should be on agreeing the targets and then ensuring that they are achieved, rather than on the details of how the component is managed.

4.3 Component 3: Flexible Fund

**** **Recommendation 15:** The Flexible Fund should be used for expenditures which are in line with Annual Management Plans (but not for salaries). The Fund will be externally audited each year (as part of the overall independent THSSP audit); the findings of the audit will be reviewed jointly by the Ministry and AusAID. The “no objection” stage of decision-making should be removed, as should the rules specifying that purchases should be small-scale and urgent (Transition advisor).

This recommendation needs some explanation. It is hoped that after the end of the recommended Program extension, AusAID support to the health sector will move towards a less project-type arrangement. In other words there will be less emphasis on the separate program management unit, and closer ways of working in terms of budgeting, planning, reporting and governance. AusAID oversight would become less hands-on and would focus on joint reviews of work carried out. (See Box 1.)

The recommendation to broaden the scope for the Flexible Fund needs to be seen in this context. It is a relatively modest move away from micro-management towards a more strategic focus on strengthening the Ministry’s systems – in this case, the relevant parts of the system are the Annual Management Plans and the response to external audits. A similar recommendation has been made for the critical staffing deficiencies funding, so it would make sense to combine the planning and review mechanisms for the two pots of money (see Recommendations 11 and 14).

For AusAID, there is a risk to making the fund more genuinely flexible. The Annual Management Plans are rather general and it may take time to develop them into useful spending guides. The risk is that funds will be used for items which are regarded as inappropriate – vehicles and overseas travel are seen as particularly sensitive areas of expenditure. These risks can be mitigated through discussions at the time that the recommendation is adopted (assuming it is) and by an annual review informed by an external audit, with clear follow-up actions agreed. (In extreme cases, it may be decided to disallow an expenditure.) Moreover the risk is moderate and manageable, and should be seen as a sensible step towards a different type of aid modality after 2015.

This recommendation is contrary to the recommendation of the 2012 Audit Report, which stated that the “no objection” from AusAID should be formally institutionalised as a stage in decision-making. However given that the audit found no problems with how the Fund had been used, and given that the Auditor was not asked in any way to think about aid modalities or government ownership, it is reasonable to contradict this recommendation. This highlights the need for future audits to be undertaken in the spirit of strengthening government systems: if something goes wrong, the immediate response should not be to set up a parallel system.

The “no salaries” condition is simply because of government rules and sustainability – the Flexible Fund is not an appropriate source of funding for salaries, which already account for a very large percentage of government spending.

4.4 Component 4: Hospital Twinning

This twinning program has operated for 20 years without formal review.

Recommendation 16: There should be a small-scale review of the twinning, at a convenient point during the extension phase, to look at its outcomes, relevance and sustainability (Transition advisor).

4.5 Program Management

Relatively little time is spent on joint MoH/Program planning, budgeting and discussion of strategic issues. Whilst government systems are sometimes used, there has not been much focus on strengthening them.

**** **Recommendation 17:** Employ a ‘transition advisor’; key tasks will be to ensure that the major challenges are dealt with in the extension phase and to engage with the MOH and AusAID at senior level to design the next program, including a possible transition to a new kind of funding such as budget support. (*MoH and AusAID*)

The number of recommendations from this report which have the transition advisor as their “owner” is an apt demonstration of why this position is required. In addition, it is important that there is a smooth transition to the next phase. AusAID support represents more than 10 per cent of MoH recurrent spending and there should not be a year-plus delay as there was at the start of THSSP.

A “Plan B” needs to be developed in case the advisor is not recruited, or is recruitment is unacceptably delayed. A date needs to be set when efforts to recruit the advisor end (say end 2013). If recruitment has failed, the Strategic Health Advisor should lead discussions on how to deal with the transition to a new phase and the recommendations of this Review.

Recommendation 18: Strengthen the Program’s use of government procurement, budgeting and reporting systems where possible and strengthen the engagement of the executive in planning (*Transition advisor*).

Examples of what this “strengthening” might look like include:

- Channel procurement through the MoH procurement unit once established, providing administrative and management support to the new unit as required. Specifically, support the development of an annual procurement plan for the MoH, as requested by MoFNP, which includes project procurement. Program staff and the MoH procurement unit could together discuss procurement of the Ha`apai boat as a case study, identifying what might have been different had MoH processes been used, as one means of establishing a working relationship.
- Adopt the Sun System for budgeting and reporting if an opportunity arises; provide quarterly budget and expenditure information to the MoH and MoFNP in the Sun format; ensure that any second phase of the project, beyond 2015, uses the Sun System.
- From June 2013 onwards, ensure that annual budgets and annual expenditure are set out in the same format, so that it is possible to track spending by program component against the annual budget. Ideally this format would also be the same as that used by the MoH.
- Establish a mechanism to integrate annual THSSP planning and budgeting (particularly for the NCD component) with the work of the ET and relevant MoH divisions.
- Review the format of the quarterly report to make it more user-friendly for the ET, clearly identifying issues for their discussion and decisions.
- Work with the MoH to make the ET+ meetings more strategic, through for example advance briefings with the Director of Health on key issues for discussion; and, a revised quarterly report format with decision points clearly highlighted.

AusAID may also wish to discuss with WHO and MOH the possibility of reviving the health sector co-ordination group, which WHO used to convene and chair.

Recommendation 19: MoH ET (and then the ET+) to review the effectiveness of the Program team, with a view to agreeing a freeze on the recruitment of additional staff. For staff in line positions funded by THSSP, agree which positions are likely to be required beyond the end of the program, and begin the process of establishing permanent positions (*Transition advisor*).

Recommendation 20: Geographical equity is an important issue for the outer islands and is not currently reflected in Program monitoring. It is recommended that:

- in 2015, the Program compares information provided by NCD nurses in Tongatapu with the information from nurses on the other islands;
- the Program records the visits to outer islands for NCD nurse supervision and diabetic clinics (*Transition advisor*).

**** **Recommendation 21:** Commission work on the overall “shape” of health services in Tonga and hence what areas might be priorities for international support. “Shape” refers to the packages of services provided by primary care facilities, district hospitals and Vaiola Hospital. The work would explore:

- The areas of greatest need where cost-effective interventions exist but are not currently being provided in Tonga. Areas to be explored included mental health, possible unmet need for contraceptives, cancer (the NCD nursing curriculum covers some aspects of some cancers) and disability (mobility, blindness etc.).
- What hospital services should be provided at what level (district, national, overseas referral) to provide the best value for money?

This work would also facilitate a more systematic and transparent approach to the selection of specialties to be filled through the critical deficiencies fund and would complement work on appropriate service provision in health centres which is being done as part of the health centres’ Operation Manual (*AusAID in consultation with MoH*).

Annex 1: Health in Tonga

Selected health related indicators of Tonga and neighbouring countries:

	INDICATORS	Japan	Australia	New Zealand	Tonga
		Demographic			
1	Estimated Population ('000)	127,692	21,542.49	4,268.9	103.1
2	Annual Population growth	...	1.71	1.00	0.3
3	Percentage of Population less than 4 years (per 100)	4.23	6.42	7.03	13
	Percentage of Population between 4-14 years (per 100)	9.21	12.83	13.81	25
	Percentage of population 65 years and over (per 100)	22.24	13.21	12.6	6
4	Percentage of urban population (per 100)	66.3	88.6	86.4	36
5	Rate of natural increase (per 1,000)	-1	6.9	8.2	19.9
		Health Status			
6	Crude Birth Rate (per 1,000)	8.6	13.7	14.91	25.4
7	Crude Death Rate (per 1,000)	8.8	6.6	6.67	5.5
8	Maternal Mortality Rate (per 100,000)	3.2	8.4	6.81	114.4
9	Life Expectancy (Male)	79.19	79	78	70
	Life Expectancy (Female)	85.99	83.7	82.2	72
10	Infant Mortality Rate (per 1,000)	2.6	4.2	4.8	14.5
11	Total Fertility Rate	1.34	1.93	2.15	3.7
		Socioeconomic			
12	Total Health expenditure, amount (in million US\$)	351,472.94	82,120	11,683.09	11
	total expenditure on health as % of GDP	8	8.71	8.90	3
	per capita total expenditure on health (in US\$)	2,750.8	3,886	2,763.26	105
13	Health workforce				
	Physicians (per 1,000)	2.18	2.93	2.33	0.53
	Dentists (per 1,000)	0.76	0.68	0.45	0.13
	Nurses (per 1,000)	9.66	8.79	10.03	3.27
		Primary Health Care Coverage			
14	Proportion of population with sustainable access to an improved water source	100	100	...	100
15	Proportion of population with access to improved sanitation	100	100	...	100
16	Immunization coverage				
	BCG	89.5	...	...	99.8
	DTP3	98.3	91.8	87	99.8
	POL3	94.7	91.7	87	99.7
	Measles	...	...	...	99.4

	INDICATORS	Japan	Australia	New Zealand	Tonga
	Hepatitis B III	...	94.4	88	99.7
17	Percentage of pregnant women immunized with tetanus toxoid 2	42.9	...	...	97.8
18	Percentage of pregnant women cared for by skilled health personnel	99.97	99.6	100	100
19	Percentage of women in the reproductive age group using modern contraceptive methods	43.9	65	72.0	29.8

Source: Ministry of Health annual Report 2010

Annex 2: THSSP M&E framework

Indicator	Methods/Verification	Baseline	Year 3 Actual	Year 3 Target	Year 4	Year 5 Actual	Year 5 Target
% of population (aged 15-64) who are smokers	Census STEPS survey Global adult tobacco survey (GATS)	29					27
- Males		46					44
- Females		12					10
% of total population aged 25-64 who are obese	STEPS survey Rheumatic Heart Surveillance	67					65
- Males		56					54
- Females		75					73
% of children aged 5-14 who are obese or overweight (Total)		From RH					TBD
- Males		From RH					TBD
- Females		From RH					TBD
Percentage of previous smokers who have not smoked in previous year.	KAP Survey	TBD		TBD			TBD
% of recurrent budget allocation to Primary and Preventive Health care	Budget papers	5					10
Number of hospital admissions for diabetic sepsis and amputations (Total)	Health Information System (HIS) database	TBD					TBD
- Males							
- Females							

Hospital Length of Stay for diabetic sepsis and amputations	HIS	TBD					TBD
% of undiagnosed or uncontrolled hypertension (HT) and diabetes. (Total)	STEPS survey	TBD					TBD
- Males							
- Females							
Intermediate Indicators	Means of Verification	Baseline	Year 2	Year 3	Year 4	Year 5	Year 5 Target
% of shops surveyed complying with tobacco legislation	Compliance unit stats	TBD					
Revenue from legislation on tobacco and alcohol	Treasury budget papers	TBD					
Number of schools enrolled in coordinated schools program	School agreements	0					
Number of 15-19 y.o. in enrolled schools who are obese or overweight (Total)	Mini schools KAP survey	TBD					
- Males		TBD					
- Females							
% of 15-19 year olds in enrolled schools who do at least 4 hours exercise a week (Total)	Mini schools KAP survey	TBD					
- Males							
- Females							
% of 15-19 year olds in enrolled schools who eat 4 helpings of fruit and vegetable per day. (Total)	Mini schools KAP survey						

- Males							
- Females							
% (?number) of 15-19 year olds in enrolled schools who smoke one or more cigarette a day. (Total)	Mini schools KAP survey						
- Males							
- Females							
% of 15-19 year olds in enrolled schools who have taken up smoking in previous year. (Total)	Mini schools KAP survey						
- Males							
- Females							
Number (% of total) of villages in Tonga from which population has been screened for diabetes and hypertension	KAP survey	TBD		TBD			50%
Number of hospital admissions from demonstration communities for diabetic sepsis and amputations	KAP Survey	TBD		TBD			TBD
Hospital Length of Stay for diabetic sepsis and amputations from demonstration communities	HIS	TBD		TBD			TBD
% of undiagnosed or uncontrolled hypertension (HT) and diabetes in pilot communities	STEPS survey ? repeat screening	TBD		TBD			TBD
Decrease in number of diabetics controlled by diet or medication seen in diabetic centre	Diabetes database	TBD		TBD			TBD
% of ET+ meetings held in timely manner	Minutes of ET+						100%
% of reports submitted to ET+ within one month of timeline	ET+ and Annual Reports						100%

% milestones achieved in a timely manner	Et+ and Annual Reports						70%
% of monthly finance reports and acquittals presented to ET in timely manner	ET						90%

Annex 3: Terms of reference

Tonga Health Systems Support Program Terms of Reference – Independent Progress Report

1. BACKGROUND

The Government of Tonga (GoT) has developed national objectives and priorities for health that are reflected in Tonga's Strategic Development Framework 2011 – 2014, the Ministry of Health (MoH) Corporate Plan (2008/09 – 2011/12) and National Strategy to Prevent and Control Non-Communicable Diseases (2010 – 2015). These are also reflected in the Australia-Tonga Partnership for Development which was signed in August 2009. Priority Outcome Two of the Partnership articulates Australia's support to the national health priorities as follows:

- Halting the rise in prevalence of non-communicable diseases risk factors;
- Improving community health services; and
- Increasing the budget utilised for preventative health.

At the 2012 Partnership for Development Annual Talks, the Governments of Australia and Tonga signed on to a new health implementation schedule for the 2012-2013 financial year.

AusAID is supporting the GoT achieve these overarching objectives through the Tonga Health Systems Support Program (THSSP). While Australian support to the health sector in Tonga is based on a 10 year timeframe, the Subsidiary Agreement for THSSP covers the first four years (2009 – 2013) and provides AUD\$7.5 million.

THSSP utilises MoH systems for planning, implementation, procurement, accounting and reporting. The Program has four main areas for support:

- Funding to assist the MoH address components one (Preventive Health) and three (Community Services) of the corporate plan, and assist with the implementation of the national strategy to prevent and control NCDs.
- Funding, on a temporary basis, senior clinical and non-clinical staff to address critical staffing deficiencies while longer term solutions to the deficiencies are developed and implemented;
- An untied flexible fund of AUD 250,000 a year for unplanned small scale and/or urgent work; and
- Continued funding of AUD 60,000 a year for the St John of God Hospital, Ballarat and Vaiola Hospital twinning arrangement to support skills development and training.

The major NCD component (the first area of support outlined above) has five key strategies:

- Strategy One: Legislative and Fiscal Measures;
- Strategy Two: Behaviour Change Communication (Health Promotion);
- Strategy Three: NCD Primary/Community Care;
- Strategy Four: Diabetes Centre and Diabetes Outreach;
- Strategy Five: Program Management.

The program is in the process of a transition to a new approach, moving from project based support to program based support, as part of a deliberate strategy to improve Tonga's systems by using them.

An Executive Team Plus (ET+) comprising of the MOH Executive, AusAID, two Tonga Health NGO representatives, the Ministry of Finance & National Planning and the WHO country officer meet every six months to provide strategic oversight over the program. AusAID Tonga Post has engaged a Strategic Health Adviser (Dr Lynleigh Evans) who provides advice and guidance to both AusAID and the MoH on key programming issues.

1

The program is now in its final year. However, implementation of activities was delayed in the first year due to delays in recruiting a dedicated management team. The design framework recommended the recruitment of an Establishment Adviser to sit in the MoH and provide leadership and oversight of the program. Recruitment of this position was unsuccessful, and as such, it was agreed that two technical coordinators (Behaviour Change/Health Promotion and Community Health) and a program administrator be recruited to manage key aspects of the program. The team started in late January 2011 and report to the THSSP Program Manager (who is also the MoH Principal Planning Officer). AusAID's Strategic Health Adviser also commenced developing detailed annual work plans and budgets to help facilitate implementation and sequencing of key activities.

To assist both GoT and AusAID to monitor the operation and achievements of the Program and to make adjustments to its operation when needed, the design framework suggested six-monthly reviews throughout the duration of the program. Two reviews have since been carried out. Given the initial delay in program implementation, the first review was conducted in July-August 2011 and second review in March 2012. Recommendations from both reviews have been accepted by the MoH and AusAID and are being implemented. A stock take of Health Promotion Activities was also conducted in May 2012 and an Independent Audit Review was conducted in September/October 2012.

Given the program is in its final year, a review is timely as it will help inform AusAID decisions on the future of AusAID support to the program, and in particular, the needs for a 1 or 2 year program extension, and the design of a second phase thereafter.

2. Purpose

The purpose of this Independent Progress Report (IPR) is to provide the GoT and AusAID with information about the implementation of AusAID funded support to the health sector in order to improve Australia's support to the MoH, and subsequently, the operation and management of the health sector in Tonga. In addition to reviewing progress against THSSP objectives, the IPR will assess the strategic influence of the Program on broader health sector development in Tonga. The findings of this IPR will inform AusAID decisions on a Program extension of 1 -2 years, and a possible second phase thereafter.

3. Objectives

The overall objectives of the Independent Progress Report are:

- To review the progress of the THSSP against its original objectives;
- To assess the Program against AusAID's quality criteria (relevance, efficiency, effectiveness, impact, sustainability, gender equality and disability inclusive health measures, monitoring and evaluation framework, analysis and learning);
- To assess the strategic value of the program vis-à-vis broader sector development and the degree to which it adheres to aid effectiveness principles;
- Provide recommendations on how AusAID support for the health sector in Tonga should be delivered beyond June 2013, and particularly the possibility of a 1 – 2 year extension, and the design of a second phase thereafter.

4. Scope

The Independent Progress Report will have two components.

(1) Review of the Tonga Health Systems Support Program

The independent team is required to review the program to see if it is meeting its stated objectives, and to learn what is working well, and what is not (and why). It should include consideration and ratings of AusAID's quality criteria, with a strong focus on efficiency and effectiveness. Sample questions and rating scale for each criterion are provided at [Attachment A](#). Whilst ratings must be developed against the criteria (excluding impact), the team is not expected to structure the entire review explicitly around these

2

criteria and is encouraged to take the review approach that they feel is most appropriate to meet the stated objectives of this task.

In addition to the standard AusAID quality criteria, specific questions the review will assess include:

- The extent to which the current activities make a strategic contribution towards helping achieve the outcomes of the MoH Corporate Plan, NCD Strategy and the Australia-Tonga Partnership for Development;
- A rapid analysis of MoH budget, including (if data is available) trends in funding for preventative health care (an objective of the Australia-Tonga Partnership for Development), and an overview of quality of expenditure (e.g. ratio of staffing and operational costs, major expenditure items). The aim is to develop an understanding of the context in which the THSSP is being implemented and the quality of the broader plan to which it is aligning
- A review of the critical staffing positions recruited under the program (including number of positions, alignment with service delivery needs, and remuneration) . The review should also investigate the degree to which the programme is developing longer term solutions to address the challenge of recruiting and retaining staff for which there is international demand;
- The extent to which government systems for planning, implementation, procurement, accounting and reporting are being used, as envisaged.
- The effectiveness and sustainability of the organizational structure of the program team (number and type of positions) that has been created to effectively implement the program;
- The governance model and approval processes of the Program (e.g. adequacy of the program management and Executive Team Plus Strategic Committee) to effectively manage and provide oversight of the program;
- The usefulness of the flexible fund for the Ministry, and the appropriateness of its current parameters (for urgent, small scale and unplanned needs);
- How well the program is integrated and owned by the MOH;
- How well equity measures have been integrated into the program (gender, disability, geography) and provide recommendations on improvements that could be made to strengthen equity measures;
- The effectiveness of monitoring and evaluation approaches used for the program (including information collection), with particular attention to measuring impacts and outcomes of the program with respect to NCDs;
- The interaction of the program with other entities working with NCDs in Tonga (e.g. the Tonga Health Promotion Foundation and the NCD sub committees);
- Current issues which may be inhibiting the ability of the Program team to achieve its objectives; and
- What elements of the program components/activities should be continued in their current form (or be scaled up); what elements should be altered or discontinued, (provide commentary on alternatives where appropriate); and identify new program/activities for potential new investment on the second phase.

(2) Future AusAID support to the Ministry of Health

The second part of this review should include consideration of the following questions:

- Assess projected timeframes for completion of activities and the need for a program extension of 1 – 2 years;
- Given this program is based on a 10 year design, assess and recommend a way forward for AusAID's future support to the Health Sector in Tonga, beyond a program extension;
- What lessons from the review can be applied to the future AusAID support under the program? What future analytical work might be required;
- What "new" strategies/ approaches should AusAID consider to better support MoH in the key directions of the current program, either through a program extension, or beyond?
- What might be the key considerations around Aid Effectiveness and sustainability given the current and projected financing envelope for Tonga, and its comparative status in the region?
- How well the program fits with other bilateral and regional health programs supported by AusAID operating in Tonga (taking each in turn), and recommendations on how coordination or synergies between the two could be improved, if required.

5. Review Team

The review team consists of three members as follows:

- A team leader with background in health systems and programming, and monitoring and evaluation
- A team member with international expertise in public health, and knowledge of AusAID systems and processes; and
- AusAID Tonga Post's Strategic Health Adviser, providing knowledge and context of Australian support to the Tonga's health sector

6. Reporting roles and responsibilities of the team

The Team Leader will be responsible for and must:

- plan, guide and develop the overall approach and methodology for the review;
- be responsible for managing and directing the review's activities, representing the review team and leading consultations with government officials and donor agencies;
- 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, a draft Independent Progress Report and a Final Report; and
- represent the team in peer reviews, if required.

The other team members, under the direction of the Team Leader will:

- Assist the team leader during the review;
- Attend consultations with government, NGOs and donor agencies; and
- Contribute to the required dialogue, analysis and writing of the aid memoire, draft and final reports.

7. Review method

The review process will take up to 28 days for the Team Leader and up to 22 days for the team members and is expected to start 5th February 2013.

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

- Conduct a thorough desk review of relevant documentation, including but not limited to documents included in the reading list attached in Section 9;
- Develop a review plan, which will include methodology, indicate how the specific questions listed in the "Scope" section will be addressed (in the context of the AusAID quality criteria), and identification of key respondents and further documentation as required;
- Undertake a budget analysis to identify trends in MOH spending, especially on NCDs, and preventative health, to develop a broader understanding of the health sector context in which the program is operating;
- Undertake one in-country visit to meet with AusAID staff, key development partners and all relevant stakeholders;
- Submit an aid memoire, and draft report to AusAID Post that will coordinate comments and feedback from stakeholders. These comments should be addressed prior to submission of a final report.

8. Timeframes

This Independent Progress Review is expected to commence by 5 February 2013 (with fieldwork commencing on 11 February 2013) with the final report completed by 8 April 2013.

Dates	Activity	Location	Maximum number of days			
			Team Leader Catriona Waddington	HRF Senior Health Adviser Becky Dodd	Strategic Health Adviser Lynleigh Evans	
6-9 Feb	Background reading / desk review	At base	Up to 4 days	Up to 3 days	1 day	
09-12 Feb	Travel to Tonga	Base location / Tonga	Up to 2 days	Up to 1 day	Up to 1 day	
11-23 Feb	In-country mission (a mission schedule will be prepared for the team, including writing time)	Tonga	Up to 13 days (incl x2 Sat.)	Up to 13 days (incl x2 Sat.)	Up to 7 days (incl x1 Sat.)	
21 Feb	Aide Memoire presentation findings & preliminary recommendations	Tonga				
23 Feb	Travel to base location	Tonga / base location	Up to 2 days	Up to 1 day	Up to 1 day (21/2/2013)	

5

By 12 March	Finalise written inputs and submit draft Report to AusAID Post	Base location	Up to 5 days	Up to 3 days	Up to 3 days	
27 Mar	Receipt of feedback from AusAID / MoH on draft report (12 days)	Via email				
By 08 April	Respond to feedback, finalize inputs as required and submit final Report	Via email	Up to 2 days	Up to 1 day (as required)	Up to 1 day (as required)	
			Up to 28 days	Up to 22 days	Up to 14 days	

9. Reporting

The following reports are to be provided:

1. An aid memoire and presentation of key findings and recommendations presented to key stakeholders prior to completion of the time in country, 21 February 2013.
2. A draft report to AusAID taking into account comments from the presentation by 12 March 2013. The Report should follow the standard AusAID evaluation report template, and be no longer than 20 pages (excluding annexes).
3. AusAID will coordinate feedback from all stakeholders and forward these to the Team Leader by 27 March 2013. The team will then have up to 4 days (including Saturday) to incorporate comments and provide a Final Report to AusAID by 08 April 2013.

10. Reading documents

Background documents will be provided to the team prior to commencement of the review (please note this list is not exhaustive)

- Framework Design August 2009 Tonga Health Systems - Australian Support
- Subsidiary Arrangement between the Governments of Australia and Tonga for the Tonga Health Systems
- Australia-Tonga Partnership for Development 2009, & Health Implementation Schedule 2012-13
- P4D Outcome Statement October 2012 (following Annual High level Talks)
- Review of Public Expenditure on Health September 2010
- THSSP Six Month Review July 25 – August 8, 2011
- THSSP 2nd Six Month Review Report March 2012
- THSSP Stock take of health promotion activities May 2012
- MOH Corporate Plan (2008/09 – 2011/12)
- National Strategy to Prevent and Control Non-Communicable Diseases (2010 – 2015)
- National Strategy to Prevent and Control NCDs – Mid Term Review Report, December 2012
- THSSP Activity and Acquittal Quarterly Reports between 2010 - 2012
- MoH Health Promotion Unit 12 Month Work Plan
- Independent Audit Report October 2012
- AuAID Pacific Health Development Agenda

- AusAID concept paper for the Pacific Regional Health Programs
- AusAID Evaluation Report Template
- AusAID Aid Memoire Template

- **ATTACHMENT A**

Sample questions for an Independent Completion Report

Relevance

- Were the objectives relevant to Australian Government and partner government priorities?
- Were the objectives relevant to the context/needs of beneficiaries?
- If not, what changes should have been made to the activity or its objectives to ensure continued relevance?

Effectiveness

- To what extent were the objectives achieved? If not, why?
- To what extent were intermediary outcomes achieved?
- Did the activity contribute to the achievements?

Efficiency

- Did the implementation of the activity make effective use of time and resources to achieve the outcomes?

Sub-questions:

- Was the activity designed for optimal value for money?
- Have there been any financial variations to the activity? If so, was value for money considered in making these amendments?
- Has management of the activity been responsive to changing needs?
- Did the activity suffer from delays in implementation? If so, why and what was done about it?
- Did the activity have sufficient and appropriate staffing resources?
- Was a risk management approach applied to management of the activity (including anti-corruption)?
- What were the risks to achievement of objectives? Were the risks managed appropriately?

Impact (if feasible)

- Did the activity produce intended or unintended changes in the lives of beneficiaries and their environment, directly or indirectly?
- Were there positive or negative impacts from external factors?

Sustainability

- Do beneficiaries and/or partner country stakeholders have sufficient ownership, capacity and resources to maintain the activity outcomes after Australian Government funding has ceased?
- Are there any areas of the activity that are clearly not sustainable? What lessons can be learned from this?

Gender Equality

- What were the outcomes of the activity for women and men, boys and girls?
- Did the activity promote equal participation and benefits for women and men, boys and girls?

Sub-questions:

- Did the activity promote more equal access by women and men to the benefits of the activity, and more broadly to resources, services and skills?
- Did the activity promote equality of decision-making between women and men?
- Did the initiative help to promote women's rights?
- Did the initiative help to develop capacity (donors, partner government, civil society, etc) to understand and promote gender equality?

Monitoring and Evaluation

- Does evidence exist to show that objectives have been achieved?
- Were there features of the M&E system that represented good practice and improved the quality of the evidence available?
- Was data gender-disaggregated to measure the outcomes of the activity on men, women, boys and girls?
- Did the M&E system collect useful information on cross-cutting issues?

Analysis & Learning

- How well was the design based on previous learning and analysis?
- How well was learning from implementation and previous reviews (self-assessment and independent) integrated into the activity?

Lessons

- What lessons from the activity can be applied to (select as appropriate: further implementation/designing the next phase of the activity/applying thematic practices [i.e. working in partner systems/environment/fragile stages] to the rest of the program/designing future activities).

Annex 4: Documents reviewed

No.	Document Name	Date	Author
1	Tonga Health Systems – Australian Support - Framework Design	August 2009	AusAID
2	Partnership for development between the Government of Australia and the Government of Tonga	7 August 2009	GoA and GoT
3	Government of Tonga – Ministry of Health - Corporate plan 2008/09-2011/12	30 January 2009	GoT
4	Subsidiary arrangement between the Government of Australia and the Government of Tonga for the Tonga Health Systems Support Program 2009-2013	4 March 2010	Government of Australia (GoA) and Government of Tonga (GoT)
5	Review of Public Expenditure on Health - Final Report - Kingdom of Tonga - September 2010	September 2010	Tu'akoi Ahio, Dr Sunia Foliaki, Tevita Lavemaa and Mark Minford
6	Hala Fononga – Path to Good Health – Tonga National Strategy to Prevent and Control Non Communicable Diseases (2010-2015)		Tonga Ministry of Health, AusAID, NZAid, SPC, WHO
7	Hala Fononga – Path to Good Health - Mid Term Review of Tonga's National Strategy for the Prevention and Control of NCDs – 2010-2015	November 2012	Nossal Institute for Global Health
8	Tonga Health Systems Support Program – Quarterly Activity Report July-September 2010		
9	Tonga Health Systems Support Program – Quarterly Activity Report October-December 2010		
10	Tonga Health Systems Support Program – Six Month Review - July 25 – August 8, 2011 – AusAID, Tonga	August 2011	Lynleigh Evans, Ana Kavaefiaki, Kisione Tupou and Mia Urbano
11	Tonga Health Systems Support Program – Quarterly Activity Report – FY 10/11, Qtr4	21 September 2011	

12	Tonga Health Systems Support Program – Quarterly Activity Report – FY 11/12, Qtr1		
13	Tonga Health Systems Support Program – Quarterly Activity Report – FY 11/12, Qtr2		
14	Tonga Health Systems Support Program – Quarterly Activity Report – FY 11/12, Qtr3		
15	Tonga Health Systems Support Program – Quarterly Activity Report – FY 11/12, Qtr4 - April-June 2012		
16	Report for Tasking Note 9 – AusAID, Tonga - Strategic Health Advisor	March 2012	Lynleigh Evans, Kisione Tupou and Ana Fakaefiefa
17	Tonga health systems support program - Stock take of health promotion activities	May 2012	Glenn Laverack and Elsie Tupou
18	HPU 12-month workplan budget 2012-13		
19	Pacific health development agenda: AusAID priorities and strategies for health development across the Pacific	27 June 2012	AusAID
20	AusAID Pacific Health Regional Program - Delivery Strategy Concept Note - Consultation Draft		AusAID
21	Australia-Tonga Partnership for Development – Health Schedule 2012-2013	4 October 2012	AusAID and Tonga Ministry of Health
22	Australia-Tonga Partnership for Development – Annual Meetings Outcomes	4 October 2012	AusAID and Tonga Ministry for Finance and National Planning
23	The economic costs of non-communicable diseases in the Pacific islands – A rapid stocktake of the situation in Samoa, Tonga and Vanuatu – Consultation Report for Governments and development partners	9 October 2012	
24	Government of Tonga, Tonga Health Systems Support Program (THSSP), An Australian Agency for International Development (AusAID) Program - Audit Report for the period from 1 st July 2009 to 30 th June 2012	October 2012	'Uta'atu & Associates

25	Preventative health care budget definition		
26	Strategy Progress and Comments	November 2012	
27	Priority actions for the NCD crisis. The Lancet Vol 377, page 1438.	April 2011.	Beaglehole R et al

Annex 5: People interviewed

Schedule of Appointments for Independent Progress Report (IPR) team for the Tonga Health Systems Support Program (THSSP) - 11 to 22 February 2013

Team Members: Catriona Waddington, Health Advisor (team leader) and Rebecca Dodd, Senior Health Specialist (–AusAID Health Resource Facility).

#	Date	Time	Meetings	Y	N	Comments
	Mon. 11 Feb	10:00	Consultants arrive: Catriona Waddington (T/L) & Rebecca Dobb via Auckland NZ970	√		Little Italy Hotel will meet and transfer to accommodation
1	Mon. 11 Feb	11:30	AusAID Post : Scott McLennan 1st Secretary; Louise Scott 2 nd Secretary; Barbara Tu'ipulotu Program Manager-Health	√		Briefing at Australian High Commission (Salote Road), Conference Room
		12:30	LUNCH			
2		14:00	Minister for Health Honorable Minister Tu'i'afitu , Dr Siale 'Akau'ola, Director of Health, Mr Viliami Ika Principal Planning Officer and THSSP Program Manager	√		Courtesy and introduction of team at MoH – MoH Admin Bldg (<i>TEAM + HOM and AusAID SM/LS</i>)
3		15:30	Mr Viliami Ika, THSSP Program Manager, Mr Saula Ma'asi, THSSP Administrator, Miss Vaopina 'Ofa, THSSP Finance and Procurement officer	√		THSSP office, MoH (<i>Team</i>)
4	Tue. 12 Feb	09:00	Dr Toakase Fakakaetaukovi, THSSP NCD Community Health Technical Coordinator	√		Toa's office at THSSP offices, MoH (<i>Team</i>)
5		10:30	Mrs Sita Fotu, THSSP NCD Behaviour Change/Coms Technical Coordinator	√		Sita's office at THSSP offices, MoH (<i>Team</i>)
		12:30	LUNCH			
6		13:30	MoH Executive lead by the Director of Health Dr Siale 'Akau'ola, Tu'akoi 'Ahio - Principal Health Administrator, Viliami Ika - Principal Planning Officer, Dr Paula Vivili - Medical Superintendent, Sr. Sela Paasi - Chief Nursing Officer, Dr 'Amanaki Fakakaetaukovi- Chief Dental Officer and Dr Malakai 'Ake - Chief Med Officer, Public Health	√		At MoH Admin Bldg then onto TMA office with (<i>FULL TEAM + LS/BT</i>)
7		15:30	Sione Hufanga, MoH Information Officer	√		Sione's office, MoH Admin Bldg (<i>Team</i>) Saula to confirm

8	Wed. 13 Feb	08:30	Dr Lynleigh Evans, AusAID Strategic Health Advisor	√	Introduction and discussion at Little Italy Hotel (<i>Team + AusAID SM/LS/BT</i>)
		12:30	LUNCH		
9		14:00	Mr Tiofilusi Tiueti, Secretary for Finance & National Planning (MoFNP), Mrs Balwyn Fa'otusia, Deputy Secretary - Aid Management Division, MoFNP and Mrs Tufui Faletau, Deputy Secretary - Policy & Planning Division, Fakaola Lemani, Chief Accountant – Treasury	√	MoF – Back conference room, Treasury Bldg, (<i>TEAM</i>)
10		16:00	Available space - follow up with meetings as required		Meeting with AusAID Post – follow up on program documentation
11	Thu. 14 Feb	08:45	Tu'akoi 'Ahio, Principal Administrator	√	Tu'akoi's office, MoH Admin Bldg (<i>Team</i>)
12		09:45	Matron Amelia Afuha'amango (for Sr Sela Paasi, Chief Nursing Officer)	√	MoH Admin Bldg (<i>Team</i>) <i>NB: Sela is travelling</i>
13		10:45	Mrs Iemaima Havea, CEO TongaHealth Promotion Foundation	√	TongaHealth (next to MoH Admin Bldg) (<i>Team</i>)
14		12:00	Mrs Amelia Hoponoa, Executive Director, Tonga Family Health Association	√	TFHA offices, next to Tonga Water Board & Nuk Primary school field (<i>Team</i>)
		12:30	LUNCH		
15		13:30	Dr Paula Vivili, Medical Superintendent	√	Paula's office, Vaiola Hospital (<i>Team</i>)
16		14:30	Sr Fusi Kaho, Community Coordinator Nurse-Public health	√	MoH, Office next to THSSP office entrance (<i>Team</i>)
17		15:30	Dr Viliami Tangi - Senior Surgeon and Dr Eka Buadromo – Pathologist and Andy Lyon – Biomedical medical engineer	√	Vaiola Conf. room, next to Paula's office - specialists funded through THSSP Critical Deficiencies Vaiola Hospital conference room (<i>Team</i>)
18	Fri. 15 Feb	8:30	NCD Nurse Tutor, Sr Seini Fifita and NCD Nurse Supervisor Sr Seilini Soakai	√	Seini's office THSSP
19		9:30	Dr Tevita Vakasiuola, doctor in charge of Niu'ui Hospital, Ha'apai	√	Tele/conf. from THSSP offices (<i>Team</i>)
20		10:00	4 Chairs of NCD sub-committees; 1. Mrs Losaline Ma'asi, Deputy Director, MAFFF – Healthy eating; 2. Mrs 'Ana Kavaefiafi (retired nursing executive) Physical Activity; 3. Mr Sione Taumoevalau (CEO Red Cross	√	MoH Administration conf. room (<i>Team</i>) (<i>Savelio Lavelau will sit in for Drew Havea who will be overseas</i>)

21		11:30	– Tobacco); 4. Mr Drew Havea (Chair of the Civil Society Forum of Tonga – Alcohol) Dr Tevita Tu'ungfasi (recently returned doctor in charge of Ngu Hospital, Vava'ua	√	THSSP conf. room <i>Team</i>
		12:30	LUNCH		
22		13:30	Netina Latu, National Coordinator for ASOP, Ministry of Internal Affairs and Elizabeth Palu, HPU Sport for Health Communications Officer	√	MIA offices, (old MOTEYS building) across from Nuk Primary School and next to PTH (<i>Team</i>)
23		15:00	NCD Nurses (3) and Health Officers	√	Toa organizing at THSSP offices
24			Update with AusAID (<i>Team</i>))		
	Sat. 16 Feb		Writing day for team		
	Sun. 17 Feb		Sabbath – day off		Day off
25	Mon. 18 Feb	9:00	Dr Malakai 'Ake, Chief Medical Officer, Public Health, Dr 'Ofa Tukia and 'Eva Mafi – Health Promotion Unit, Public Health	√	Malakai's office, Public Health, MoH (<i>Team</i>)
26		10:00	Sesilili Kato, Legal Officer (MoH/THSSP)	√	THSSP offices
27		10:45	Pina 'Ofa, Finance&Procurement Officer, MoH/THSSP	√	THSSP offices
28		11:45	Ben Rolfe, AusAID Pacific Health Advisor	√	Ben arrives 10am Meet with Scott McLennan, Louise Scott and Barbara
29		13:00	LUNCH at Café Escape	√	Ben Rolfe, AusAID LS/BT (<i>Team</i>)
30		16:15	Dr 'Uhila moe Langi, CEO, Tonga National Qualifications Assessment Board	√	TNQAB offices , 1 st floor, Molisi Supermarket Bldg, Salote Rd (<i>Team + Lynleigh</i>)
31	Tue. 19 Feb	08:45 or 9am	Dr Siale 'Akau'ola (DOH) - discuss Aide Memoire and Concept Note on AusAID's Regional Programs	√	<i>Combined meeting</i> - MoH Admin Bldg brief prior to presentation (<i>Team, AusAID LS and Ben Rolfe</i>)
32		10:00	Paula Vivili, Medical Superintendent	√	
33		11:30	Milika Tuita, UNDP Representative + 2 Onetoto & Sione	√	<i>AusAID Conf. Room</i> – UNDP come here (<i>Team and BR</i>)
		12:30	LUNCH		

34		13:45	TEL/CON Sara Gloede, Aust Sports Com (ASOP)	√	AusAID small mtg (to be confirmed) ASC +61262141774 (Team)
		15:00	Mishka Tuifua, Chairperson Public Service Commission and Pelenatina Langa'oi, Chief Executive Officer	√	Prime Minister's Office – (TEAM + BT and BR) Tentative may change to Tuesday morning
			Available space		
35	Wed. 20 Feb	8:30 to Noon	Visit Health Clinics (1 st Kolovai HC – General Clinic and 2 nd Houma HC -Diabetic clinic) accompanied by Toa or appointed person/s	√	Pina and Ovava organized by Toa to arrange and be available (Team + Lynleigh, Ben)
		12:30	LUNCH		
36		14:00	AusAID Post	√	AusAID office (Team + AusAID SM/LS/BT))
37		15:00	TongaHealth, Iemaima Havea, CEO	√	Team
			Preparation for Presentation of Aide Memoire		
38	Thu. 21 Feb	10:00 – 12:00	Round table meeting at MoH to present Aid Memoire to include AusAID, MoH ET +other stakeholders	√	Vaiola Hospital main entrance (upstairs Conference Rm 1) (Team + AusAID Ben, SM, LS, BT) MOFNP Confirmed attendance
39		12:30	LUNCH		Lunch at T
40		14:30			
	Fri 22 Feb	11:30	Team departs NZ273		Ben Rolfe departs as well on same flight

Annex 6: Notes on the preventive health budget target

This technical note goes into some detail discussing issues around the preventive health spend indicator. It recommends that monitoring focuses on the simplest measure available, the percentage on prevention according to the government budget. Whilst imperfect, this measure can be used to raise the key policy issues – overall direction of spending and the salary/non-salary balance. Adopting a simple methodology enhances transparency and avoids distractions from the main policy issues.

Partnership for Development between Government of Australia and Government of Tonga

1. The 2009 Tonga/Australia Partnership for Development includes the following target: *“Budget for preventive health care reaches 10% of total public health operational budget by 2015.”*
2. The rationale for this target is that primary and secondary prevention activities are cost-effective, but under-funded in Tonga. Good primary/preventive care improves the efficiency of expenditure and (at least in the medium term) should lead to reduced pressures on hospital (secondary/tertiary) expenditure.
3. One potential strategy mentioned in the Partnership for increasing preventive health expenditure is a hypothecated tax on tobacco and/or alcohol.
4. The *Partnership* document describes the principal information sources to be used to measure progress with the indicator: “Allocations at the macro level will be provided via publicly available Budget Statements and in greater detail through Annual Management Plans linked to the MoH Corporate Plan. Tracking of actual expenditure throughout the year will be monitored through the Balanced Scorecard and Quarterly Reporting system and will include both donor and government expenditure.” In short, the aim is to use government budgets and expenditure records.
5. The *Partnership* document gives a baseline figure of 5 per cent (percentage of 2008/9 total public health budget allocated to preventive health). It is assumed that the 5 per cent baseline simply reflects the percentage of total budget assigned to the Preventative Health Care program, though this does not tally with the figures from the *Public Expenditure Review on Health*.¹⁸ The document notes that the budget for that year included a small level of donor funds (WHO only).

Government of Tonga targets

6. According to the 2010 *Public Expenditure Review on Health*, The GoT’s own target appears to be more ambitious than the one in the Partnership: “to increase recurrent preventive health care budget allocated to 15% by 2015”. This is a key performance indicator for Strategic Result Area 1 (Build capability & effectiveness

¹⁸ See Table 1, below. The figure for 2008/9 is 1.6 million Pa’anga for preventative care out of a total of 20.9 million for health (7.7%).

in preventive health services to fight the NCD epidemic & communicable diseases) related to the goal “Use effective preventative health measures, being good role models & developing public participation and commitment.” The source and status of this target is not known – it does not appear to be from the Strategic Development Framework or the MoH Corporate Plan.

Public Expenditure Review on Health

7. A public expenditure review (PER) of the health sector was conducted in 2010. This Review revealed an important point about measuring preventive health spend. The MoH budget has a category called “preventative health care”, but this does not include all the activities which might justifiably be included in a definition of preventive care. A more detailed review of preventive spending requires additional analysis. This point is illustrated in the next three paragraphs.
8. Table 1 shows that in 2006/7, using the broad categories of the government budget, **8.1 per cent** of spending was on “preventive care” (TOP 1.1 million out of TOP 13.5 million).

Table 1: Recurrent Health Expenditure, by sub-sector, 2006/07 - 2009/10 (in TOP million)

Recurrent Health Expenditure	2006/7¹⁹	2007/08	2008/09	2009/10
Curative, Dental & Nursing Care	8.6	12.3	13.7	12.0
Preventive Care	1.1	1.1	1.6	1.6
Other - Planning & Leadership	3.8	5.8	5.5	5.4
Recurrent Total Health Spending	13.5	19.2	20.9	19.0

Source: Health PER, which used estimates based on Treasury data, MoF Budget Statements & MoH Annual Reports.

9. The PER quotes a table from the National Health Accounts, which examined spending in more detail and allocated spending to narrow categories (Table 2). The following categories can reasonably be counted as “preventive”:

- Maternal and child health, FP and counseling
- Prevention of communicable diseases
- Prevention of non-communicable diseases
- Health promotion and other public health services
- Food, hygiene and drinking water control
- Environmental health.

The total for these categories is **9.7 per cent**.

¹⁹ In the report this is given as 2004/5, but it is assumed this is an error, given the title of the table and the subsequent columns.

Table 2: National Health Accounts – detailed “program budget” for health

Uses of health funds	Amount (TOP)	Percent	Per Capita (TOP)
Inpatient curative care	5,087,373	15.7%	49.9
Inpatient curative (overseas)	2,302,078	7.1%	22.6
Basic Outpatient Medical and Diagnostic Services	791,062	2.4%	7.8
Outpatient Dental Care	786,913	2.4%	7.7
Traditional Health Care	908,764	2.8%	8.9
Clinical laboratory	607,032	1.9%	6.0
Diagnostic Imaging	236,446	0.7%	2.3
Pharmaceuticals	3,143,266	9.7%	30.8
Maternal and Child health, FP and counseling	1,468,105	4.5%	14.4
Prevention of communicable diseases	211,462	0.7%	2.1
Prevention of non-communicable diseases	514,149	1.6%	5.0
Health Promotion & Other public health services	479,907	1.5%	4.7
General Government Administration of Health	2,855,282	8.8%	28.0
Health Administration & Health Insurance	129,060	0.4%	1.3
Capital Formation of health care providers	7,754,023	24.0%	76.0
Education and training of health personnel	1,925,693	6.0%	18.9
Research and development in health	2,701,300	8.3%	26.5
Food, Hygiene and drinking water control	74,754	0.2%	0.7
Environmental Health	384,447	1.2%	3.8
Other Health Related Functions	592	0.0%	0.0
Total	32,361,709	100%	317.3

10. So in 2006/7 the government budget shows an allocation of 8.1% to prevention. For 2005/6, the National Health Accounts showed 9.7% being spent on prevention. Although the figures are from different (albeit consecutive) years, it can reasonably be assumed that the NHA methodology includes more activities and will thus always yield a higher percentage.

Government budget categories

11. The government budget divides the health budget into six categories:

Leadership and policy advice (22%)
Preventative health care (6%)
Curative health care (40%)
Dental services (4%)
Nursing services (22%)
Health planning and information services (6%)

The percentages show the estimated figures for 2012/13, as given in the draft 2012/13 budget. A problem with the data is that it includes capital spending and is thus quite volatile. Total expenditure can be dramatically skewed by a few large building programs, as happened when the budget in 2012/3 appeared to be only 65% of the level the previous year. Table 3 illustrates this point. This problem can be avoided by taking the “assets” line off the budget total (see page 107 of 2013 budget).

Table 3: Health budgets by program (from 2013 draft budget statement)

Budget category	2011/12 revised estimate	2012/13 estimate
Leadership and policy advice	58%	22%
Curative	20%	40%
Preventative	5%	7%
Other	17%	31%
Total %	100%	100%
Total TOP	44,170,442	28,619,885
% of total MoH spend on assets (capital)	44%	2%

12. The preventative health care spending group includes three sub-programs – preventative health services, environmental health care and community health care. The breakdown is shown in Table 4.

Table 4: Sub-programs in government preventative health care program budget (TOP)

Sub-programs in government preventative health care program budget	2011/12 revised estimate (TOP)	2012/13 estimate (TOP)
Preventative health services	459,106 (19%)	451,314 (23%)
Environmental health care	1,463,784 (61%)	1,000,733 (52%)
Community health care	471,245 (20%)	483,230 (25%)
Total	2,394,135 (100%)	1,935,277 (100%)

The percentages spent on salaries according to the 2011/12 revised estimates are:

- preventative health services 98%
- environmental health care 64% (34% went to “maintenance and operations”)
- community health care 95%.

13. There has been some discussion about whether or not to include salaries in the target. Prevention is a labour-intensive activity and salaries should most definitely be included. The key issue is the salary/non-salary balance – how this has changed over time and whether the preventive health workers are constrained by shortages of the tools they need to work effectively.

14. The *Partnership* talks of total government + donor spend on prevention. At the moment it does not seem that the bulk of the THSSP budget is reflected in the MoH program budget. In practice this is not a problem, as including the THSSP budget would inflate “government spend” on prevention.

15. Even though the *Partnership* target refers to budget, it would technically be better to use after-the-event expenditure information if this is available reasonably easily. Otherwise it is best to use the published budget information if this is judged to be reasonably close to actual expenditure.

Conclusion

16. There are some areas of confusion around the preventive spend category. The origin of the 5% baseline is not clear (why is it not 8.1 %?); different ways of defining “preventive care” yield different percentages of total spend.
17. On the other hand, the government budget has a “preventive care” program budget, for which there is readily available information. The *Partnership* clearly states that government budgets and expenditure records should be the source of information for the target.
18. It is thus recommended that the government budget is used as the source for the information, with the focus on the preventive health care program and what this tells us about the priority given to prevention/promotion. A more complicated methodology would always be contentious and less transparent. The budget information as it stands raises a number of issues about quantity and quality for discussion:
- Why did the preventative care budget fall between the 2011/12 revised estimate and the 2012/13 estimate? (See Table 4)
 - Why do preventative health services and community health care have such low non-salary spends (Table 4)? For community health care presumably the drugs budget sits elsewhere, but even so.... If health promotion is a top priority, we would expect to see these budgets growing and having a health salary/non-salary balance.

Keeping the methodology straightforward will allow a focus on these types of strategic questions.

19. If there really is a feeling that the preventive care program budget misses some important areas of preventive spend, then the additions need to be kept as simple as possible and the methodology transparently recorded. The two main areas to consider including are:
- Reproductive health nurses and (in time) NCD nurses. Presumably they currently appear in the large nursing program budget.
 - Drugs and equipment for health centres and RH clinics? How easy is it to extract this data?
20. Relatively detailed work on items such as electricity bills is unlikely to be worth the effort, makes the indicator harder to understand, and distracts from the policy issues.
21. The denominator (i.e. total MoH budget) should exclude “assets” spending, as this makes the total annual budget figure very volatile.

Annex 7: Progress with NCD workplan (Draft as of 26/02/2013)

Dr Lynleigh Evans

The following is an update of progress with the NCD workplan together with recommendations of the review team.

1. STRATEGY ONE: LEGISLATIVE CHANGE

One has two components and progress in both these areas has been good. The legislation appears to be progressing satisfactorily. The MoH is keen to establish the Compliance unit although final decisions on this have not yet been made and long term sustainability of this unit must be understood before additional people are recruited. The question of hypothecated taxes remains unresolved.

- 1.1 Legislative oversight and new policy development:** New tobacco and alcohol legislation has been prepared and is in its final review process by the MoH before being sent to Government to undergo the processes required before it can be introduced to parliament and passed.

While progress with tobacco legislation has been excellent, the status of food legislation is less clear. A Food Act was originally presented to Parliament in 2006, and was revived in 2011. The team understands that his bill relates primarily to Food standards with respect to communicable diseases. The development of food legislation or regulations with relation to NCDs (food pricing, taxes etc) has been recommended in several reviews and should remain a priority for the MoH. If community consultation is required to strengthen this process, this should be supported.

During discussions it was realised that since the increase in the price of imported cigarettes several years ago, the domestic small scale production of tobacco for personal use and sale has increased significantly and home-made cigarettes are now commonly smoked. This is of concern as it will be very difficult to reduce this through policies or regulations. It emphasises the importance of a robust anti-smoking program to reduce demand for these products.

- 1.2 Ongoing compliance with health legislation relating to NCDs:** there has been good progress in this area as well. It is now well accepted that enforcing compliance within existing legislation is a major issue. The MoH is proposing the establishment of a three person compliance unit. One of these people is already in post and a second compliance officer would be recruited. The Ministry is also proposing a third person called a cessation officer. This person would support people who wanted to quit smoking and could establish and manage a quit line as well. Clinical intervention could be organised through the Section head, Dr 'Ofa, if required. These people would all reside within the HPU and Dr 'Ofa would be the Section Head.

The team believes this is a good initiative but is concerned about the long term viability if AusAID funding were withdrawn. If it is decided to go ahead, utilising additional AusAID resources, the team believes it should be introduced on a two year trial basis with clear goals and outcome measures developed at the beginning and the program reviewed after 18 months to assess whether it should be continued after this

period.

Key Recommendations:

- *Support the development of food legislation, regulations or policy to encourage healthy eating through differential pricing etc.*
- *Facilitate community consultation if this is required to progress this area;*
- *Endorse the establishment of the Compliance Unit for two years using AusAID funding but develop clear goals, robust baseline indicators and review progress after 18 months to assess whether the unit should be continued.*

2. STRATEGY TWO: BEHAVIOUR CHANGE

Overall, this strategy has struggled with several groups including THSSP, the HPU, TongaHealth and the NCD Sub-Committees continuing to engage in overlapping activities in a relatively uncoordinated fashion. It will therefore be discussed in more detail.

Currently, there are several plans that have been, or are being, developed, all of which are partially or fully funded by the THSSP. These are:

- The National NCD plan (Hala Fononga) and the Sub-committee workplans. This is a multisectoral approach and includes members from various ministries. The National NCD plan has been reviewed by the Nossal Twinning Partner (note that Nossal is also contracted to undertake capacity building activities within the HPU) and recommendations to improve governance and management of it have been made. The first of these was to establish a robust governance structure with clear roles and responsibilities of all parties. A local plan to implement these recommendations has been prepared and a workshop has been organized to start this process.
- In the meantime, the sub-committees are frustrated because they believe they have a mandate to develop plans and implement activities related to their specialty but have been hampered by difficulty obtaining funds.
- The HPU annual workplan. This resides within the MoH. This plan is focussed on target groups such as schools, workplaces and churches and the HPU has requested funds from THSSP to implement these activities.
- The Social Marketing Strategy (facilitated by Andrew Skuse). This also resides within the MoH in the HPU. This has been a strategy of the THSSP workplan and is also included in the HPU annual workplan. The team recruited to assist with the marketing strategy has only recently done their initial evaluation and their final report is not yet available. It appears, however, that they have taken on a wider mandate than just social marketing and have looked at a whole NCD Health Promotion Strategy with a three year implementation phase. This overlaps the Hala Fononga and the work completed by the Nossal Institute. It will be important to bring these groups all together in the near future to develop a clear governance structure and consistent direction for the future.
- In addition, TongaHealth (funded by AusAID regional program) also has a strategic plan. While TongaHealth was originally established as a funding body, over time its mandate has changed and it will be

important to ensure that there are clear roles and responsibilities for TongaHealth along with the other agencies involved in NCD Health Promotion.

While these overlapping activities have obviously been frustrating, the THSSP coordinator has actually been successful in accomplishing the activities in her workplan as shown below.

- 2.1 **Strategy and Governance:** This is discussed under Key Issues below and is one of the highest priority areas to address over the next two years.
- 2.2 **Knowledge Attitude Practices (KAP) and STEPS surveys:** This survey has been completed and the results sent to WHO for analysis. WHO has only just released the results of the 2004 survey, however, and there does not appear to be any expectation that the findings of the 2011 survey will be released soon. The MoH and AusAID should continue to lobby to get these important results as soon as possible. KAPS surveys should continue to be undertaken when required to assess the impact of activities and a more comprehensive but locally implemented KAPS/STEPS survey could be undertaken by the MoH in 2015 without WHO assistance and a full WHO survey redone in 2017.
- 2.3 **Twinning Program:** The twinning program appears to have successfully completed the activities in their contract. On the other hand, there is now an overlap with the TORs of the other external consultants. It will be important to ensure that the roles of all the external consultants are coordinated or that all the consultants be included as part of a “call down” facility.
- 2.4 **Social Marketing:** As mentioned above, while this activity has been undertaken, the team appears to have taken on a wider mandate than just social marketing. Nevertheless, the initial visit appears to have had an impact on, and acceptance by, the MoH. This could lead to significant progress but care must be taken to ensure that their activities are integrated with those of Nossal and with the national NCD strategy (Hala Fononga).
- 2.5 **Health Promotion Activities for Sub-committees:** As mentioned above, an overriding priority is to develop an acceptable and functional governance structure for the NCD national Committee and the sub-committees. At the moment, the sub-Committees do not feel they have had adequate access to funds for their activities. It is therefore difficult to assess their effectiveness.
- 2.6 **Health Promoting Schools Program.** THSSP is providing funding for this program through the HPU plan. The HPU plan covers Churches and Workplaces as target audiences for activities and support for the HPU plan could be expanded to include these areas with a name change to “supporting the HPU annual plan.”

Summary of Key Issues

Governance: A major impediment to progress is the lack of an effective overriding coordinating body and it is difficult to envisage real progress until this has been resolved. This must be given the highest priority. A workshop planned within the next few months to review the Governance of NCD Health Promotion activities will be integral to the success of the whole process. It should have wide representation, be carefully planned and be well facilitated.

Coordinated and Focussed Strategy: Currently there are many players doing many individual health promotion activities in Tonga. It is hoped that one outcome of the workshop will be the identification of a few key NCD Health Promotion priorities for which comprehensive national action plans can be developed. THSSP will then fund these comprehensive focused activities.

External Support: A confounding factor has been the contracting of several unrelated external groups to do different review activities for the THSSP. While each group appears to have done important work, in the long term, it would be beneficial to the Ministry to choose one trusted strategic partner and to channel external advice and assistance through this partner. In the interim, a “call down” facility where several groups are nominated as available to the MoH for the necessary inputs could be considered.

Key recommendations

- 1. Place the highest priority on resolving the governance and management issues relating to Health Promotion/Behaviour Change in the next few months through a multidisciplinary facilitated workshop.*
- 2. Ensure that one outcome of this workshop is the identification of a few key NCD Health Promotion priorities for which comprehensive national action plans can be developed.*
- 3. Consolidate the current external consultant groups into one trusted and effective strategic partner for external advice and assistance or a consortium who communicated regularly to ensure that activities were not overlapping. A “call down” facility could also be considered.*
- 4. Delay finalising the Behaviour Change/Health Promotion section of the THSSP budget until after the multidisciplinary workshop when the issues of Governance and coordination are resolved.*
- 5. If the Governance and management issues cannot be resolved continue to fund independent activities but only for a limited time.*

3. NCD PRIMARY CARE

Overall this program has made excellent progress in the last year and is now on target to achieve its original targets.

3.1 Infrastructure and Equipment: all Health Centres have now been audited to determine renovation needs and equipment gaps. Two Health Centres have completed renovation and two are in progress in the moment. Other Health Centres have had their equipment upgraded prior to renovations. The positive effect of this initiative was frequently raised and renovation of all centres should continue to be a key platform of the program. Progress with the renovations has slowed recently because of the work commitments of the Coordinator. AusAID has been recently approached to fund a person to assist in overseeing the renovations of other health centres through the program and this has been approved.

It is uncertain whether the lack of accommodation for the NCD nurse is a hindrance to the program but this should be considered and construction or renovation of accommodation included where it is believed that it will be difficult for the NCD nurse to get to the Health Centre without accommodation.

The scoping study for the Ha'apai boat has been completed with the recommendation that an ocean faring catamaran be purchased at a cost of approximately \$500,000 be purchased.

3.2 Program management and staffing: This component has been mostly

successfully completed. It remains unclear if the governance of the Health Centres has been fully discussed and clarified. In the pilot sites, it is evident that the team has generally sorted out the respective roles themselves but this has depended on ongoing cooperation and goodwill of the team members. The governance structure and roles and responsibilities should be clarified and formally endorsed and included as an early chapter in the Health Centre Operations Manual.

The other outstanding action is the review of the hospital to determine if the revitalisation of the Health Centres has led to areas where the hospital can save costs and to determine if there are new activities that could be devolved to the health centres.

3.3 Training and Curriculum Development: This component is well advanced. The curriculum has been developed with the assistance of an Australian nursing advisor, Professor Jan White, and has been endorsed in principle, by the qualifications Board. Both the MoH and the public Service Board have endorsed the inclusion of the NCD nurses into the Ministry Establishment and expressions of interest for the first group of 20 nurses to be trained are going out shortly. The course is scheduled to run from April to October 2011.

The Health Officers/Nurse Practitioners expressed a wish to be included in some of the NCD training and this should be considered wherever possible. It will be important not to forget the needs of this important group during this period when the NCD nurses are being established.

An evaluation of the program will need to be undertaken at some point after the nurses have been in their posts for a few months.

3.4 Development and endorsement of guidelines and check lists: This component has not progressed although a comprehensive Table of Contents for the Operations Manual has been developed. A consultant may be contracted to assist with the preparation of a manual. The HC Operations Manual will operational matters as well as clinical guidelines.

3.6 Information Systems and Reporting: The minimum data set for NCD nurse reporting has been developed but may need review and refinement over time. The NCD nurses are collecting this information on a monthly basis and reporting them by hand to the Supervising NCD Nursing Sister.

The computerization of the system is the next stage which needs to be developed and it is hoped that this can be completed within the extended program timeframe.

As this is a new and exciting initiative, it will be important that its progress is carefully monitored and that clear and validatable baselines and predictions are available. If this requires extra resources, these could be funded by the THSSP.

3.7 Roll-out of program: The program is ready to be rolled out as soon as the NCD nurses complete their training. It will be important that there is ongoing review and refinement once the initial roll-out is completed to ensure that gaps and needs are identified early and rectified. This will be the main activity of the next two years.

Recommendations

1. *That a construction supervisor be contracted to assist with the continued renovation of the Health Centres;*

2. *That consideration be given to constructing accommodation for NCD nurses at selected Health Centres;*
3. *That the budget for the Ha'apai boat be increased to \$500,000 and additional support be included to fund TA to oversee the tendering and eventual contracting for the boat;*
4. *That the governance structure of the Health Centres including relative roles and responsibilities of each member be developed and formally endorsed and included as a chapter of the Health Centre Operations Manual.*
5. *That the Hospital review be undertaken within the next 18 months;*
6. *That a comprehensive qualitative and quantitative evaluation of the NCD nursing program be undertaken approximately 6 months after the NCD nurses have taken up their posts.*
7. *That ongoing training needs and resources for Health Officers/Nurse Practitioners with respect to the NCD program are identified and included;*
8. *That funds be made available for support for a robust and validated research to be undertaken on the NCD program.*

4. DIABETES CENTRE, DIABETES OUTREACH AND OTHER CLINICAL PRIORITIES

4.1 Procurement of Drugs and Medical Supplies: Because of the increasing number of diabetics being diagnosed and their more comprehensive monitoring it is important to ensure that there are adequate drugs and supplies to continue to manage these patients effectively and delay the onset of complications.

4.2 NCD Outreach and training visits: NCD outreach visits from the Physician Dr Taniela Palu have been an overwhelming success. There was hardly one interview which did not mention how much difference they had made. Confidence in his skills definitely plays a significant part in making the health centres so much more attractive to the populations as places for treatment.

It will be important not only to continue and/or expand these visits but also to ensure that they can continue once Dr Palu retires.

4.3 NCD Disability Program: All Health Centre renovations include modifications allow disabled access. It will be important to ensure that this is not overlooked in any new renovations.

The purchase of wheelchairs has been very successful and is very visible as Tongans can often be seen undertaking exercise with the new chairs. It will be important to continue to support this program in the future.

4.4 RHD program, Clinical Outreach and Gestational Diabetes:

- The Oxygen Generator has been purchased and this activity has been closed;
- The RHD program continues well and should continue to be supported.
- Clinical Outreach has not progressed. Funds for travel expenses

have been made available through the THSSP but following the GOT guidelines. It is believed that one reason that the outreach has not occurred is because doctors feel this rate is insufficient to cover their expenses. AusAID is happy to increase funding for this activity but will not breach GOT guidelines and policies.

- The gestational diabetes trial has not commenced but is still a priority for the program. It is planned to introduce this as part of the nursing curriculum practical service.

Recommendations

1. *Continue, and possibly increase, the funding for drugs and supplies to the diabetes centre.*
2. *Continue and/or expand the service provided by Dr Palu.*
3. *If possible, identify and fund a suitable doctor for overseas training in management of diabetes and cardio-vascular disease to continue specialized diabetes outreach continues after Dr Palu's retirement.*
4. *Continue RHD funding, as required.*
5. *Find a way to ensure that MoH specialists undertake outreach visits to the islands on a consistent basis.*
6. *Trial the gestational diabetes proposal linked with the training of the NCD nurses.*

5. STRATEGY FIVE: PROJECT MANAGEMENT

Most of the activities in this section have been completed although the two financial teams still appear to be working independently with little integration or skills transfer from the THSSP to the MoH finance section.

- The main recommendation from the previous review was the purchase and use of the SUN systems so that program finances could be integrated with those of the Ministry. For various reasons this has not been successful. The THSSP has therefore recently purchased "Quickbooks" and will use this to manage their accounts in the short term.
- Ideally, the THSSP will move to SUN systems as soon as possible. On the other hand, if this is not possible, work should commence on gradually integrating THSSP activities into the MoH and eventually funding them through budget support.
- The other major issue of procurement is also being resolved with the establishment of a procurement unit within the MoH based under the Clinical superintendent. When this is fully operational, all procurement will be managed through this unit.
- The Program has a fixed asset register (FAR) of all THSSP assets and has undertaken the first of regular audits of the health centres. The Ministry also has FAR and the THSSP ensures that all items it purchases are put on the MoH FAR. These two processes should become integrated with time.
- Training in MoFNP procurement processes has occurred and procurement is now running more smoothly.
- The recent audit of the program finances was very thorough and has

been very well received.

- Finally, the team has requested funds for local professional development.

Recommendations

- *Continue to try to integrate THSSP financial management with that of the Ministry;*
- *Support in country training of program team staff;*
- *Include funds for local professional development for THSSP team members;*
- *Continue regular annual audits while the THSSP finances are independent of the MoH.*

Annex 8: Interview outline

This is a checklist of questions for review team members. Team members will in turn filter this list to establish which questions to ask during which interviews. Some of the questions can be addressed through background research (e.g. listing the objectives) and would not necessarily be asked of an interviewee.

NCDs

The questions below can be further broken down into the 4 technical strategies within the NCD component – legislative and fiscal measures; behaviour change communication; NCD primary/community care; and diabetes centre/ outreach.

What were the objectives of this component?

Given their priorities, are these objectives relevant to:

- Government of Tonga? Does it fit in well with the overall development of the health sector? The MOH Corporate Plan and NCD Strategy? (i.e. is the program *aligned*?)
- Government of Australia? (Including the Australia-Tonga Partnership for Development and the overall AusAID priorities of prevention and primary care)
- Tongans, and specific target groups such as at-risk groups for diabetes?

Were appropriate linkages made with other stakeholders, e.g. the NCD sub-committees and the TongaHealth Promotion Foundation)?

Was the component well-designed, incorporating relevant lessons?

Were the objectives achieved/are they likely to be achieved?

What were the main activities and intermediary outcomes?

Were the activities completed and intermediary outcomes achieved? (Obviously this is work-in-progress; the program is still being implemented.)

Did the activities and intermediary outcomes logically follow from the objectives?

Did the activities use time and resources effectively? (staffing, budget, delays, responses to changes in circumstances)

Were any changes to plans or budgets appropriately justified in terms of the use of time and resources?

To what extent was there active risk management?

What do we know so far about impact? (Changes in the lives of beneficiaries and their environment). How is this being monitored? Will it be possible to answer this question definitively by the end of the Program?

If there is a known impact, to what extent is this due to the THSSP? What other factors are at work?

Are the outcomes likely to be sustained when Australian funding ends? Why/ why not? (ownership, capacity, priority)

How can outcomes be disaggregated in terms of gender, disability and geography?
What does this tell us about (a) equity and (b) the relevance of the monitoring?

What are the most important equity considerations of this component of the THSSP?

Did activities promote the involvement of women/disabled people/people from remote areas?

How has the M&E system performed? Has it improved since THSSP began?

How does the component work in terms of aid effectiveness? To what extent is government in the lead? To what extent are there parallel systems or structures?

How has the component incorporated learning – from previous reviews, experience, other literature etc?

How long will it take to finish the activities in this component?

What lessons from this component are relevant for the program extension and/or next phase?

The broad pattern of these questions can easily be adapted to the other components, notably critical deficiency staffing and the flexible fund. In addition, there are the following specific questions for individual components.

Critical staffing

How many staff have been engaged and at what cost? Are they aligned with the Ministry's plans and needs? What are the longer term plans for such posts?

Is remuneration appropriate (i.e., in line with market rates)? How is remuneration determined and does it result in any issues with local staff?

Are the recruits used efficiently? How are they managed? Do they have training or supervisory functions?

Have they helped to build the capacity of their Tongan colleagues? How? What have been the challenges?

Flexible fund

Does the Ministry find it useful? How could it be more useful?

How appropriate are the parameters – small, urgent, unplanned? Is spending in line with these categories?

How does the “no objection” rule work?

Program management, governance etc.

There is a transition from project- to program-based support. How does this most affect the components? What are the risks and opportunities?

What does the Executive Team Plus discuss? Do they make, and follow up, recommendations?

How is the arrangement with the Strategic Health Advisor working?

How well does the management structure work?

Why has recruitment been so difficult and was everything possible done to overcome this?

How well do the staffing and reporting arrangements work? (Reporting to the MOH principal planning officer/THSSP program manager.) Is it sustainable? Were sensible adaptations made when it proved impossible to recruit the establishment advisor? How important is the physical location of offices?

Aid Effectiveness

How does the overall program perform in terms of aid effectiveness?

What is the state of the existing planning and financing architecture around which to align?

What is the overall donor landscape? Are donor coordination structures in place?

To what extent are government systems used? (planning, implementation, procurement, accounting, reporting).

What are the critical strengths and weaknesses of those systems from the perspective of the program? Is the program proactively helping to address these weaknesses?

How well harmonized is the program with the NCD and health systems support provided by other partners?

How well does the program fit with other AusAID funded health activities in Tonga? (regional and bilateral).

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