

# Vanuatu Health Program Investment Design Document

Final

January 2019

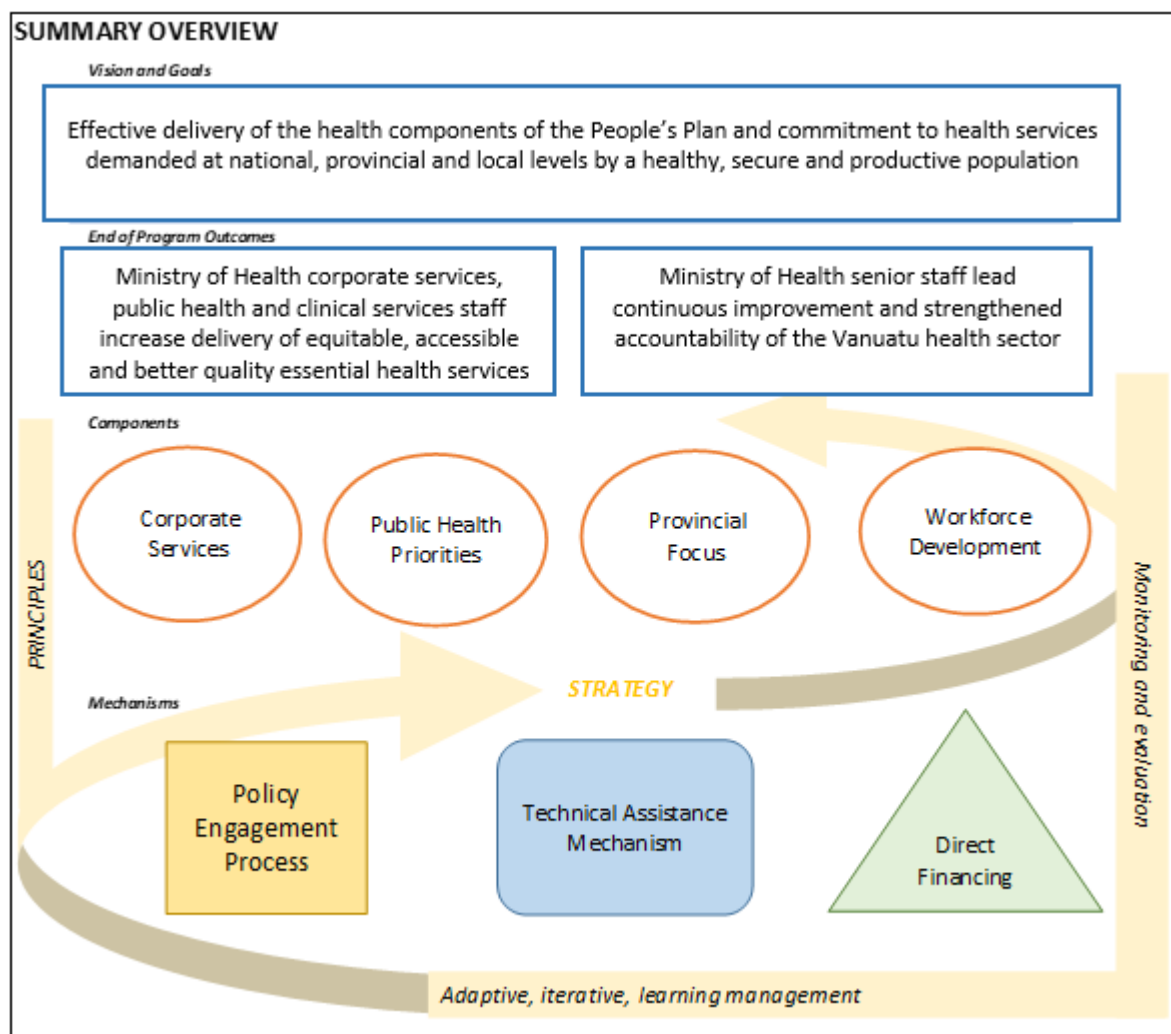
## Table of Contents

Executive Summary .....	iii
1. Introduction .....	1
2. Policy context .....	1
3. Analysis .....	3
4. Approach .....	4
5. Program Design .....	5
5.1 Overview and key features.....	5
5.2 Outcomes .....	8
5.3 Strategy and program logic .....	8
5.4 Monitoring and Evaluation .....	11
5.5 Components .....	12
<b>Component 1: Corporate Services</b> .....	12
<b>Component 2: Public Health Priorities</b> .....	13
<b>Component 3: Provincial Focus</b> .....	15
<b>Component 4: Workforce Development</b> .....	16
5.6 Mechanisms and Delivery Approach.....	18
<b>Direct Financing</b> .....	18
<b>Technical Assistance</b> .....	19
<b>Policy engagement</b> .....	20
<b>Funding for Development Partners</b> .....	21
5.7 Governance and management arrangements.....	22
<b>Governance arrangements</b> .....	22
<b>Management Arrangements</b> .....	24
6 Implementation.....	25
<b>Inception Period</b> .....	25
7 Feasibility Analysis .....	26
<b>7.1 Risk</b> .....	26
<b>7.2 Gender Equality and Social Inclusion</b> .....	26
<b>7.3 Climate Change</b> .....	28
<b>7.4 Safeguards</b> .....	28
Annex 1 - Monitoring and Evaluation and Program Logic .....	30
Monitoring and Evaluation Framework.....	30
Program Logic.....	35
Annex 2 – Terms of Reference .....	38

## Executive Summary

A long term investment in the health sector supports Australia's bilateral relationship in Vanuatu in supporting economic prosperity, security and stability. Health is recognised as an important priority to both Vanuatu and Australia in the recently adopted People's Plan (The National Sustainable Development Plan) and the Australia-Vanuatu Aid Partnership Arrangement 2016-19.

The investment is designed as a long term 15 year program, in three phases of five years. This investment design document (IDD) covers the first five year phase. The design structure is represented by the following summary diagram:



The key principles of the program include:

- Build on successes and past investment
- Support government-led reform
- Be problem driven, iterative and adaptive
- Focus on capacity development rather than substitution
- Integrate gender equality and social inclusion

The program has two equally important and mutually reinforcing end of program outcomes (EOPOs):

- Ministry of Health senior staff lead continuous improvement and strengthened accountability of the Vanuatu health sector
- Ministry of Health corporate services, public health and clinic services staff increase delivery of equitable, accessible and better quality essential health services

The components and objectives include:

1. **Corporate services:** Committed Ministry of Health (MOH) leadership provides effective oversight and stewardship of the health sector.
2. **Public health priorities:** Highest evidence based public health priorities addressed by MOH to meet community needs.
3. **Provincial Focus:** Improved planning and delivery of primary health care services in selected Provinces
4. **Workforce development:** Strengthened clinical competency of the Vanuatu medical workforce (doctors and nurses)

The program will be delivered through three delivery modalities: **direct financing, technical assistance and policy engagement.**

Distinctive features of the program which differentiate the program from previous support are reflected in these design elements include:

- The Direct Financing Agreement (DFA) is retained from the past program, and different funding streams that directly support the MOH are now consolidated through this one instrument. Flexibility to respond to natural disasters will be incorporated into the DFA, so that additional emergency funds can be contributed when required through an available mechanism.
- Previously multiple management arrangements are consolidated under one contractor which provides more space for DFATs policy engagement role
- There is now a strong provincial focus within the program
- The arrangements for technical assistance are more responsive to MOH priorities and innovative in approach
- There is a conscious focus on integration of gender and social inclusion throughout implementation
- The design engages with the support from DFAT regional and global programs to more effectively coordinate and leverage existing investments
- Australia steps up its role in development partner coordination and policy engagement to reduce demands on government and ensure external assistance supports a government-led agenda
- Additional support to strengthen disaster response and coordination mechanisms, including the health cluster system

The two outcomes reflect the importance of sustainability in the strategy behind the design: support for short term immediate needs which have direct health benefit, while working on the longer term systemic changes required for sustainability. The analysis showed that while financing and resources in themselves are not the binding constraint to improvements in the sector, and a renewed focus needs to be on stimulating demand to address systemic and structural constraints, resources are required to maintain equilibrium of services and system functioning and to get 'buy in' to processes of prioritisation and agenda setting.

This **program logic** is reflected in detail in the **monitoring and evaluation framework** (Annex 1) in the intermediate and immediate outcomes, outputs and indicators. The key feature of the MEF is the methodology for analysis and reporting on change against each level of outcomes and indicators, including a participatory monitoring and review process each six months by the Health Sector Steering Committee with MOH, DFAT and delivery partners involved.

Approximately AUD25 million is available for the program over five years. The budget allocation will be negotiated with the Ministry of Health on an annual basis within the mechanisms of the Direct Financing Agreement and MOH TA pool allocations (through a managing contractor).

The **Joint Partnership Arrangement** (JPA) established in 2011 provides the architecture for Government of Vanuatu to oversee and engage in policy and sector-wide dialogue with development partners. No new mechanisms will be established for this program, although existing arrangements will need to be refreshed. It includes a small Health Sector Steering Committee comprising government and development partners funding the sector through the health system and a broader Joint Partner Working Group (JPWG) for coordination of implementation and information sharing.

A **managing contractor** will support MoH (through a team leader/national facilitator) in problem definition, prioritisation, planning and allocation resources throughout implementation.

This highest level **risks** relate to the broader context which require ongoing monitoring and management through implementation:

- **Political instability**, which may affect key leadership positions and policy directions within the GoV
- **Sudden economic shocks to Vanuatu economy**, which could impact upon the health budget.
- **Natural disasters and emergencies**, particularly related to climate change, which may divert financial and human resources from ongoing service delivery.
- **Gender inequality and social exclusion**, which may impact upon the ability of women and girls, and vulnerable populations including people with disability, to access services, participate in health planning, and take up leadership positions being improved.

Other design and implementation risks are moderate, and more able to be ameliorated within the resources and management capacity of the program.

## Acronyms

ANS	Assessment of National Systems
APCCAP	Australia Pacific Climate Change Action Program
BIP	Business Improvement Plan
DFA	Direct Funding Agreement
DP	Development Partner
DFAT	Department of Foreign Affairs and Trade (Australian Government)
DSPPAC	Department of Strategic Policy, Planning and Aid Coordination
GDP	Gross Domestic Product
GESI	Gender Equality and Social Inclusion
GOA	Government of Australia
GOV	Government of Vanuatu
HIS	Health Information System
HSS	Health Sector Strategy
HSSC	Health Sector Steering Committee
ICN	Investment Concept Note
IPPF	International Planned Parenthood Foundation
JPA	Joint Partnership Agreement
JPWG	Joint Partners Working Group
M&E	Monitoring and Evaluation
MEF	Monitoring and Evaluation Framework
MFEM	Ministry of Finance and Economic Management
MOH	Ministry of Health
MP	Member of Parliament
MWSP	Medical Workforce Support Program
NCD	Non communicable disease
NGO	Non-government organisation
NPP	New Policy Proposal
PEA	Political Economy Analysis
PER	Public Expenditure Review
PF	Provincial Facilitator
PFM	Public Financial management
PMO	Prime Minister's Office
PSC	Public Service Commission
RFQ	Request for Quotation
SDGs	Sustainable Development Goals
SIP	Sector Investment Plan
SRH	Sexual and Reproductive Health
SWAP	Sector Wide Approach
TA	Technical Assistance
TAG	Technical Assistance Group
TOR	Terms of Reference
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
VCH	Vila Central Hospital
VCNE	Vanuatu College of Nursing Education
WASH	Water and Sanitation, Health
WB	World Bank
WHO	World Health Organisation

## 1. Introduction

This investment design document outlines the features and operational arrangements for the first five year phase of a 15 year program of assistance to the health sector in Vanuatu.

The investment concept note (approved February 2018) outlines the policy and strategic rationale for an investment in the health sector. It proposed that the future program reflect a focus on protecting past achievements, consolidate and improve efficiency of management arrangements, better integrate gender and social inclusion, improve governance and monitoring and evaluation arrangements, and strengthen the partnership with the Government of Vanuatu.

A design strategy and options paper<sup>1</sup> was prepared in February 2018 subsequent to an in-country mission<sup>2</sup>. An internal DFAT Reference Group recommended that the future design adopt the ‘step up and better’ option of supporting internal government-led reform efforts, and incorporate support at the provincial level into the program. A design mission was conducted in June 2018 to further develop the design strategy and develop operational arrangements with the Government of Vanuatu and implementing partners.

## 2. Policy context

**Improving health services is a shared objective of Vanuatu and Australia, and is important to the bilateral relationship.** An objective of the Australia-Vanuatu Aid Partnership 2016-2019 is to improve early education and essential health facilities, with the key outcome (H) “Vanuatu Government leadership and management deliver effective and equitable health services”.<sup>3</sup> The high level political commitment of Government of Vanuatu to health as a priority is demonstrated in the People’s Plan 2016-2030 which applies the Sustainable Development Goals at the country level and references a healthy population as one of its national priorities, and includes targets for gender equality and reduction of gender based violence.<sup>4</sup> The government has increased the health budget over recent years (by 25%) and launched a new Health Sector Strategy (2017-2020) which outlines a comprehensive and ambitious plan towards equitable access, particularly for primary health care and improvements in services for women and girls.

**Australia’s primary bilateral interests in Vanuatu in promoting prosperity, security and stability depend upon a functioning and effective health system.** The 2017 Foreign Policy White Paper<sup>5</sup> outlines a framework for “opportunity, security and strength”. An improving health system in Vanuatu supports these key objectives through its linkages to economic development, global cooperation, and stability and security in the region.

*Economic development:* The economic development of Vanuatu is reliant on a healthy population. Tourism is a key economic sector in Vanuatu, contributing 17.2% of GDP<sup>6</sup> from approx. 100,000 annual visitors to Vanuatu, of whom two-thirds are Australian, and there are around 3000 long term Australian residents living and working in Vanuatu. Confidence in the tourism sector is critical to Vanuatu’s economic resilience. A key white paper objective

---

<sup>1</sup> Available separately as an internal confidential DFAT document. This included a detailed Political Economy Analysis.

<sup>2</sup> A three person design team comprised of Paul Nichols (Team Leader), Deborah Thomas (GESI Adviser) and Jack Eldon (Health Systems Strengthening and Design Adviser) worked with the Post (1<sup>st</sup> Sec, Senior PM and Program Manager), and was accompanied by the Principal Health Specialist DFAT Canberra, and Senior Program Manager Regional Health Program Suva Fiji.

<sup>3</sup> This priority is also included in the DFAT Aid Investment Plan for Vanuatu.

<sup>4</sup> Government Vanuatu, National Sustainable Development Plan, 2016, Society goals 3 and 4; <https://www.gov.vu/en/publications/vanuatu-2030/26-national-sustainable-development-plan-2016-to-2030>

<sup>5</sup> Department of Foreign Affairs, 2017, “2017 Foreign Policy White Paper”, <https://www.fpwhitepaper.gov.au/>

<sup>6</sup> TRAVEL & TOURISM ECONOMIC IMPACT 2017 VANUATU, World Travel and Tourism Council, <https://www.wttc.org/-/media/files/reports/economic-impact-research/countries-2018/vanuatu2018.pdf>

is “ensuring that Australians remain safe, secure and free”. Functioning basic and tertiary health services ensure that Australians are protected from disease and can access emergency services when required. A healthy and productive population is also fundamental to a growing economy, particularly for prevention and early response to infectious diseases (such as TB, malaria and HIV) which impact on the working population. Vanuatu has signed up to the new Pacific Labour Scheme which enables citizens of Pacific island countries to take up low and semi-skilled work opportunities in Australia.

Relatively high rates of population growth<sup>7</sup> can also undermine any benefits of growth<sup>8</sup> and so ensuring basic primary health care services is a fundamental economic investment. The World Bank reports that 50% of the economic growth differentials between developing and developed country nationals are attributed to poor health and low life expectancy. “The healthier the citizens of a country, the more effective the workforce, the better the health of their children, the fewer births, and hence the fewer dependents”.<sup>9</sup>

*Global Cooperation:* working in the health sector presents strategic opportunities “to promote and protect the international rules that support stability and prosperity and enable cooperation to tackle global challenges”<sup>10</sup>. The health sector in Vanuatu presents opportunities to work with traditional partners (such as New Zealand and the UK, and international organisations such as the World Bank, WHO and UN agencies) but also to engage with non-traditional actors such as China (becoming more active in the health sector) to build bilateral relationships and use soft-power influence to contribute to the international rules based order.

*Security and Stability:* Health security and threats resulting from climate change are recognised in the White Paper as an emerging challenge for global security and Australia’s interests. There is a strong relationship between strong health systems in country and the ability to prevent pandemics, respond to disease outbreaks, building resilience and strengthening response to natural disasters and crisis when they arise. Cyclone Pam and the Ambae Volcano are estimated to have cost 2% of GDP across 2016 and 2017, thus undermining economic growth and opportunities for Australian trade and investment. “Stepping up engagement in the Pacific” involves “more integrated and innovative policy and making further, substantial long-term investments in the region’s development”. Long term investment in health, which is a stated Vanuatu government and Pacific regional priority is consistent with this commitment.

Australia’s aid commitments to the health sector are outlined in the “Health for Development Strategy 2015-2020” which focuses on building “country-level systems that are responsive to people’s health needs”, and strengthening “preparedness and capacity to respond to emerging health threats”<sup>11</sup>. There is a strong constituency in Australia that supports endeavours to improve health services in Vanuatu, including volunteers and supporters of professional bodies (the Royal Australian College of Surgeons), NGOs (CARE, Save the Children) and community groups (such as disability rights groups and allied health professionals who regularly visit and work in Vanuatu).

---

<sup>7</sup> Population growth est 2.2% p.a , [http://countrymeters.info/en/Vanuatu/#population\\_2018](http://countrymeters.info/en/Vanuatu/#population_2018)

<sup>8</sup> Economic Growth est. 3.2% p.a., 2017 <https://www.adb.org/countries/vanuatu/economy>

<sup>9</sup> Collins, Francis S “Growing importance of health in the economy”, <http://widgets.weforum.org/outlook15/10.html>

<sup>10</sup> Department of Foreign Affairs, 2017, “2017 Foreign Policy White Paper” , <https://www.fpwhitepaper.gov.au/>

<sup>11</sup> DFAT, Health for Development Strategy 2015-2020, Canberra, 2015. <https://dfat.gov.au/aid/topics/investment-priorities/education-health/health/Pages/health.aspx>



### 3. Analysis<sup>12</sup>

**While there have been significant improvements in recent years, there remain considerable challenges to achieving government stated health status targets.** Despite increases to health expenditure making Vanuatu relative to other lower middle income countries (\$158 per capita), Vanuatu has not achieved recognised targets for child mortality and maternal health<sup>13</sup>, and faces the double burden of communicable and non-communicable diseases. Stunting and immunization coverage remain a problem. NCDs now account for 70% of all deaths and impose large economic costs on society and family and drain the resources of the health system. The youth bulge is an increasing priority for health services, particularly adolescent sexual and reproductive health. Financing itself is not the constraint to further improvement, but institutional and policy reforms and leadership and management capacity to deliver better services. Vanuatu continues to rely on Australian and international clinical expertise for the national referral hospital (Vila Central Hospital) which is unaffordable and unsustainable for Vanuatu in the longer term.

**Gender inequality pervades the life cycle and is perpetuated through the structural fabric of society including the delivery of health services.** Marriage and childbearing start early impacting women's health, education opportunities and economic development<sup>14</sup>. Women have limited control over their lives and limited access to reproductive and sexual health services. Rates of intimate partner violence are high and violence is severe<sup>15</sup>. Sixty percent of women who have ever been in an intimate relationship have been subjected to physical or sexual violence of which 20% has a permanent physical disability as a result; refusing sex is reported to be a trigger for partner violence<sup>16</sup>. There is a significant gap in the national response to violence against women and children.

**Gender equality and equitable and inclusive development are at the heart of the National Sustainable Development Plan but this has not yet been institutionalised in the health sector or sufficiently addressed by development partner programs.** Senior and middle-management in the MOH is male dominated though women make up over 56% of the total workforce<sup>17</sup>. The increased politicisation of sector leadership further disadvantages women who have weaker political capital. The MOH does not yet have a specific harassment policy or confidential procedures for reporting and dealing with cases of harassment. Awareness of the special needs of people with disability and the responsibility of health staff to enable people with disability to have equal access to essential health care is limited. People with disability are not entitled to free health care though they are highly vulnerable and at great risk of extreme poverty<sup>18</sup>.

**The gains made from previous investments are vulnerable to shocks.** Achievements have been made in corporate services and public financial management, workforce development (particularly nurses and midwives), upgrading the health information system, and systems for medical supplies and asset management. Quality clinical services have been supported by supervision and training of

---

<sup>12</sup> Refer to Volume 2 - Annex 6, Discussion Paper on Country and Sector Analysis for more detailed analysis.

<sup>13</sup> The Millennium Development Goal – MDG - targets agreed to by the Government of Vanuatu and supported by the international donor community

<sup>14</sup> DHS 2013 found 22% of women aged 15-49 had been married before they were 18 years of age.

<sup>15</sup> Vanuatu Women's Centre and the Vanuatu National Statistics Office. May 2011. Vanuatu National Survey on Women's Lives and Family Relationships.

<sup>16</sup> Vanuatu Women's Centre and the Vanuatu National Statistics Office. May 2011. Vanuatu National Survey on Women's Lives and Family Relationships.

<sup>17</sup> Out of the past 13 Director Generals only one has been a female. In 2016 the total health workforce included 369 men and 478 women with more women than men in the nursing service and more male doctors and male administrators than female (MoH, Annual Report 2016).

<sup>18</sup> UNICEF Pacific and Vanuatu National Statistics Office, Children, Women and Men with Disabilities in Vanuatu: What do the data say?, UNICEF, Suva, 2014.

specialists at Vila Central Hospital and training of interns (recently qualified doctors completing formal training). These gains need to be protected by a stronger emphasis on leadership and management capability at the MOH with affordable workforce plans, stronger business planning processes and financial management systems (and staff skills to implement them) to ensure that services are funded in a timely manner and supervised. A longer term strategy for the medical workforce, linked to regional efforts in training and professional development for specialists and referral systems is required. Longer-term planning needs to also incorporate the impacts of disasters and climate change to ensure the sector is prepared for a future that is more disaster-prone and where the impacts of climate change exacerbate nearly all existing health challenges (like reduced access to adequate nutrition, changing patterns of vector-borne diseases, increased flooding and longer, hotter heatwaves). Unaddressed, these challenges have the capacity to overload the health system and undermine its structural integrity.

**The platform has been laid by the MOH for more effective management and systems for service delivery.** A new Health Sector Strategy (2017-2020) has been completed, and senior staffing appointments made (for example the Director of Corporate Services and Finance Manager). Key priorities for health systems strengthening has been laid out in the Strategy providing a strong road map to improving service delivery. There are signs at provincial level that managers and clinicians are motivated and committed to improve services within the resources available. Central agencies are taking a stronger interest in engaging with the performance of the health sector<sup>19</sup>, and other sources of finance (such as a new ADB grant/loan for vaccines) and new entrants (such as China) are engaging in the sector.

**In supporting this momentum for reform, Australia needs to learn the lessons from the past.** Previous programs have been fragmented and costly to manage<sup>20</sup>; technical assistance has often been substituting capacity rather than working with government-led plans and has focused at central level; development partners have supported vertical programs and high transaction costs on the MOH; and projects have been ‘externally problem driven solutions’ rather than working at a pace of change and on priorities led from within the government system. For example, the gains made to eliminate malaria from two provinces (at high cost to donors) are recognised at serious risk as funding has been withdrawn and the MOH does not have the systems or capacity to maintain services at the same standard.

## 4. Approach

The underlying strategy for the program is to support government-led efforts for reform, in line with the commitments of the Australia-Vanuatu Aid Partnership agreement 2016-19, and consistent with the strong signs of progress and commitment from the GOV through the People’s Plan and Australia’s Health Sector Strategy. In pursuing this strategy, the future program will incorporate the following critical features:

- A more direct effort to support service delivery and reform efforts at provincial level. This will both demonstrate what can be done to improve services, and highlight the key systems and policy reforms needed from central level to support those services.
- Consolidation of Australia’s funding streams to the GOV into one key mechanism, the DFA. This will enable a higher level policy discussion with the MOH on funding priorities across primary and tertiary, corporate and clinical support, in line with their own strategic planning.

---

<sup>19</sup> such as through the monitoring framework of the People’s Plan, and reporting requirements for New Policy Proposals

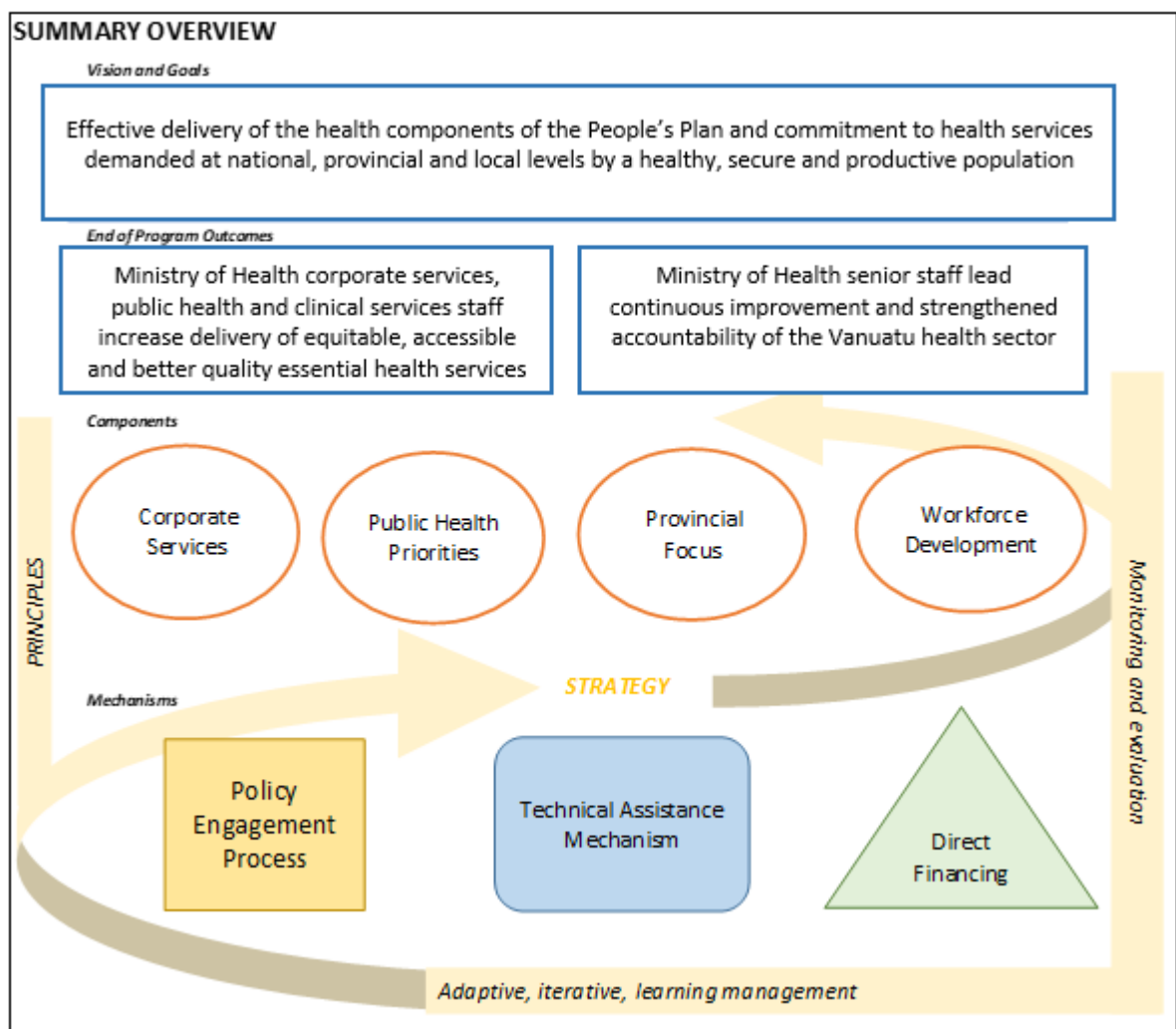
<sup>20</sup> With little coordination between bilateral, regional and global DFAT investments

- Being more innovative in the way technical assistance is planned and managed. This will reduce the simple capacity substitution default of past assistance and work more at a pace that the MOH can absorb.
- Consolidation of the management arrangements for the program under one managing contractor. This will reduce DFAT’s internal transaction costs.
- Simplifying funding and reporting relationships with key in-country development partners (WHO and UNICEF). This will bring these partners into a more strategic planning arrangement with DFAT and the MOH for both technical assistance planning and activity planning.
- Building in clear linkages and mechanisms for working with DFAT regional and global programs to maximise opportunities to leverage from this existing support in country
- Strengthening DFATs role in policy engagement with the GOV and stakeholders.

## 5. Program Design

### 5.1 Overview and key features

The program is designed as a long term 15 year strategy, in three phases of five years. This IDD covers the first five year phase. The design structure is represented by the following summary diagram:



- There are clear **principles** which underpin the approach to the program. These are derived from the analysis and lessons learnt, and provide guidance for ongoing strategic oversight, governance and management of the program.
- There are four key **components**, which represent the key areas of investment of the program, each with discrete outputs and intermediate outcomes. The outputs define the scope of work which may be implemented, with specific indicators and targets developed on an annual rolling plan.
- Three main types of input, defined as '**mechanisms**' which have separate management, financing and implementation responsibilities, and which provide the basic operational and implementation arrangements for the program. The mechanisms are designed as key processes with specific methodologies, and are included in the M&E framework with immediate outcomes for ongoing monitoring.
- There is a program logic model, which is described as the '**strategy**' of the program. The logic model serves as the basis of the monitoring and evaluation framework. It articulates the development thinking and pathway to sustainable changes expected from the design. The **adaptive, iterative and learning approach to management** represented in the summary diagram ties the **monitoring and evaluation** arrangements to the strategy and principles and is a critical design feature which is required to bring about the changes expected from the program.

Each of these features is outlined in detail in sections 4, 5 and 6 of this IDD.

Distinctive features of the program which differentiate the program from previous support are reflected in these design elements include:

- The DFA is retained from the past program, and different funding streams that directly support the MOH are now consolidated through this one instrument. Flexibility to respond to natural disasters will be incorporated into the DFA and managing contractor, so that additional emergency funds can be contributed when required through an available mechanism.
- Previously multiple management arrangements are consolidated under one Contractor which provides more space for DFATs policy engagement role.
- There is now a strong provincial focus within the program.
- The arrangements for technical assistance are more responsive to MOH priorities and innovative in approach.
- There is a conscious focus on integration of gender and social inclusion throughout implementation.
- The design engages with the support from DFAT regional and global programs to more effectively coordinate and leverage existing investments.
- Australia steps up its role in development partner coordination and policy engagement to reduce demands on government and ensure external assistance supports a government-led agenda.

## Principles

### Principles

- Build on successes and past investment
- Government-led internally driven reform
- Problem driven, iterative and adaptive
- Capacity development rather than substitution
- Integrated gender equality and social inclusion

These principles emerge from the country and sector analysis and sound development experience. They are not meant to be generic statements of good practice, but have a specific rationale and intent in the context of this program.

- An approach that **builds on successes and past investment** rather than stopping and starting again is required because gains have been hard won despite the many challenges and shortcomings of previous work, and the operational and management arrangements have taken time to develop. The program will have **flexibility** to respond to natural disasters and scale up if new funding partners emerge.
- The strategy of the program is to step up this past engagement to support government-led internally **driven reform** towards a more effective suite of investments over time, particularly through provincial engagement and internally driven demand for systems reform. The program is structured to support current government priorities (based on past program investments and successes) and ways of working (financing and TA) that matches their own internal management structures (corporate, public health, and clinical directorates of the MOH).
- A **problem driven, iterative and adaptive** approach will be adopted. The management capacity and space for driving change within the MOH is likely to vary considerably over time (dependent on personnel, political climate and resources available) and the immediate needs and challenges of the Vanuatu health system changes dramatically in the context of natural disasters and emerging health problems. The design is structured to enable TA and grant financing to be provided in a manner which works at the pace and priorities of MOH leadership and management, and be able to respond to critical challenges as they arise. This means that not all problems will be solved at once, but rather smaller elements of reform and system changes will be tackled when the MOH identifies them with a plan to resolve them and when there is demand and capacity to sustain change. **An effective M&E system** will be critical to identify the right times to change course and respond, and to be able to measure that support was provided in the right manner at the right time (at the pace and priority of internal demand as articulated in the program logic).
- Innovative and empowering methodologies specifically for more responsive TA planning and management will be deployed to ensure **capacity development rather than substitution**, particularly to work with the MOH on analysis and problem definition, as well as potential solutions, so that the MOH can take the leadership role in the issues being addressed. This may mean that the program delivery (particularly in systems strengthening) slows down in order for the government to be in the lead, and to promote sustainability by ensuring that TA respond to real demand from within, not imposing external solutions.
- The program design **integrates gender equality and social inclusion (GESI)** throughout its structures and implementation. A separate GESI strategy is articulated to demonstrate how this

was achieved in the analysis and design. However in implementation, ongoing consideration of these issues are enabled in the design by using the feedback from the M&E system on the gender and inclusive impacts of the program.

### **Budget Allocation**

A total of approximately AUD25 million is available for the program over five years. The budget allocation will be negotiated with the Ministry of Health within the mechanisms of the DFA and MOH TA Pool allocations.

Within those annual allocations the allocation to components (corporate, public health and clinical workforce) may vary from year to year, although will total the summaries included in the following table over five years. This allows for continuation of current levels of assistance under the DFA and TA for calendar year 2019, and progressive introduction of funding for provincial level activities and TA in line with the design. See following sections on mechanisms for planning and budgeting arrangements.

## 5.2 Outcomes

The program has two equally important and mutually reinforcing end of program outcomes (EOPOs):

<p><b>End of Program Outcomes</b></p> <p>Ministry of Health senior staff lead continuous improvement and strengthened accountability of the Vanuatu health sector</p> <p>Ministry of Health corporate services, public health and clinic services staff increase delivery of equitable, accessible and better quality essential health services</p>
---

These describe who will be doing what differently on the last day of the five year period covered by this design. The program will contribute to changes in each of these areas. Indicators are included in the monitoring and evaluation framework with methods for analysing and reporting on these changes.

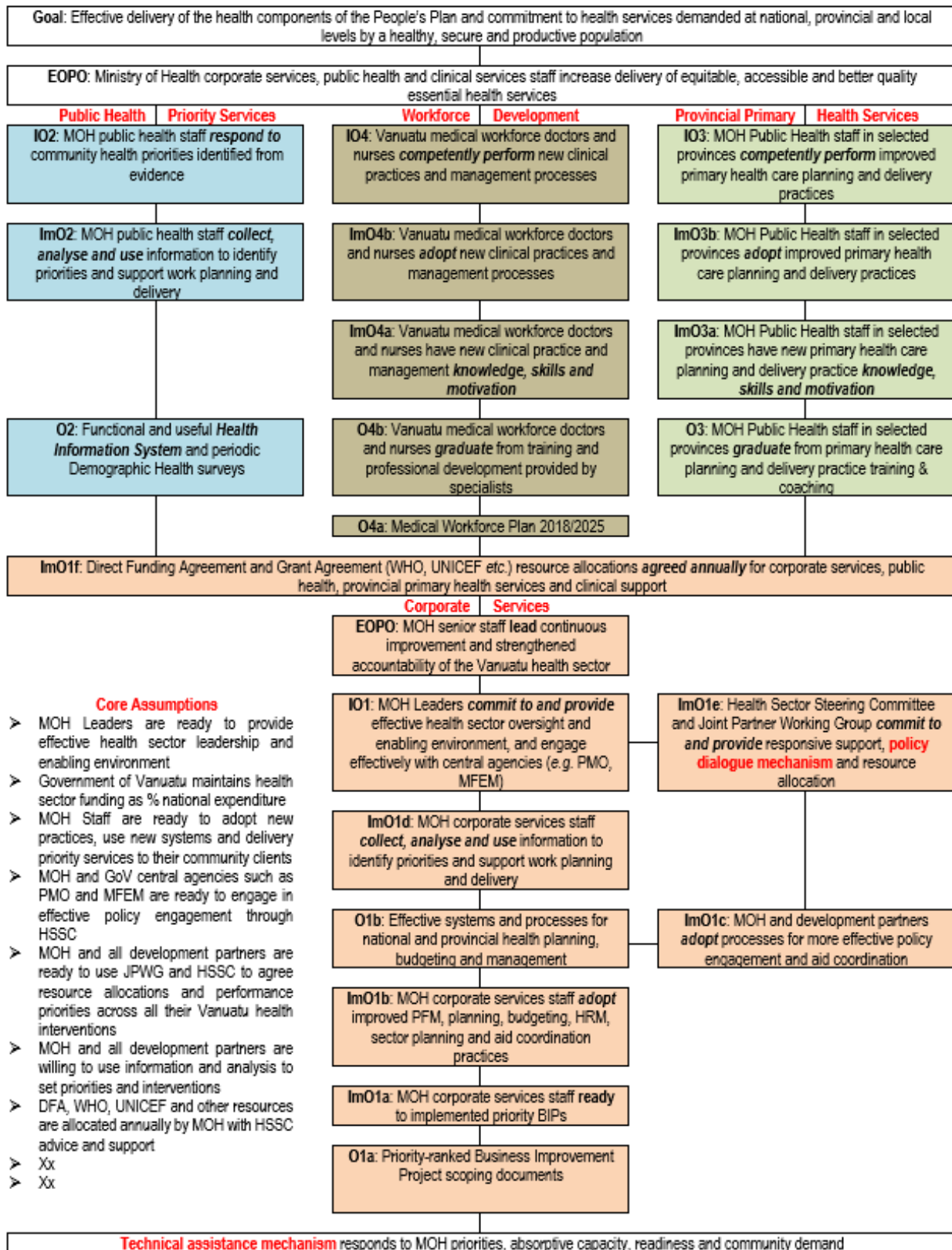
## 5.3 Strategy and program logic

These two outcomes reflect the importance of sustainability in the strategy behind the design: support for short term immediate needs which have direct health benefit, while working on the longer term systemic changes required for sustainability. The analysis showed that while financing and resources in themselves are not the binding constraint to improvements in the sector, and a renewed focus needs to be on stimulating demand to address systemic and structural constraints, resources are required to maintain equilibrium of services and system functioning and to get 'buy in' to processes of prioritisation and agenda setting. The strategy (or program logic<sup>21</sup>) is provided on the next page and described in the narrative that follows.

---

<sup>21</sup> The program logic is explained in more detail in Annex 2: Program Logic and Monitoring and Evaluation Framework. For communication and public diplomacy purposes, the Summary Diagram explains the key features of Components and Mechanisms.

## Logic model – Vanuatu Health Program



- The corporate services component is the foundation for sustainable change over the long-term as well as effective delivery of services and meaningful policy dialogue during the first phase of implementation. This is placed first in the logic (that is at the bottom of the schematic model), although interventions in all four components may be conducted concurrently as partners and counterparts are **ready** for change and able to **adopt** new practices.
- The first EOPO comes early in the logic, recognising that in the long term the goal and second EOPO will be delivered only if corporate services (including aid coordination) exist and are used as a foundation.
- The design adopts a **government-led approach**, so the logic reflects this. Development partner engagement, technical assistance and resource allocation are all linked to MOH leadership and systems. A number of assumptions are required for this to work, and the core ones are listed on the left hand side of the logic model (Annex 1).
- For service delivery changes, counterparts are assumed to be ready to change and have an environment that motivates them. That allows immediate outcomes (ImO) relating to **adoption** of new practices, before intermediate outcomes (IO) relating to **commitment** or **competent performance** are delivered.

The program will focus on high quality systems and processes that support performance by:

- Getting high level political and leadership support for a transparent and open prioritisation of human and financial resources, and the policy reform agenda, through providing financial support through government systems.
- Facilitating government led planning and implementation in a conscious and careful manner, responding to their priorities at a pace they can absorb.
- While working at a provincial level to build capacity for, and stimulate internal demand for reform, and by demonstrating good practice of improving services using locally available resources.
- And maintaining the integrity of clinical standards and workforce capability to maintain trust in the health system from communities and sustaining the gains from past investments.

This strategy has both short and long term benefits. It is a pragmatic and practical approach to address both GOV and GOA interests and needs. There are trade-offs and tension between the approaches of short term financial assistance and capacity substitution versus system strengthening tied to policy reform goals that build longer term sustainability. This requires an adaptive and learning approach to the monitoring and evaluation of the program, and active engagement from Australia and Vanuatu in governance and management oversight, to ensure the program maintains the balance between competing interests and respond to current political and policy priorities.

The focus on process and flexibility also means that the design does not nail down activity level planning, but rather provides a framework for the outer boundaries of what may be funded and implemented under the program. These boundaries are articulated in the mechanisms (direct financing, technical assistance, and policy engagement) and under each of the components.



## 5.4 Monitoring and Evaluation

The process driven, government-led, adaptive approach to the design requires a similar response to monitoring and evaluation. The program logic is reflected in detail in the monitoring and evaluation framework (MEF) (Annex 1) in the intermediate and immediate outcomes, outputs and indicators. The indicators are structured around two approaches: the qualitative indicators that reflect the program logic of how change will happen; matched with the indicators on health services and status that come from the MOH HIS. A key feature of the MEF is the *methodology* for analysis and reporting on change against each level of outcomes and indicators.

The structure for analysis and reporting on the program has three key elements:

- A baseline, mid-term and end of period evaluation mixed method analysis. This will draw on the MOH data from the health information system, and other published information, as well as a political economy analysis of the context. This will be implemented by the contractor as part of its responsibilities across the program, beyond the specific activities it is responsible for implementing. Some simple methods for making qualitative judgements against qualitative indicators are introduced, using rubrics against pre-set scales to outline the expectations for what changes from poor, fair, good, very good and excellent would look like for that indicator.<sup>22</sup>
- Six monthly internal participatory review processes will be conducted by the Health Sector Steering Committee. This process will be managed by the contractor, and facilitated by an Adviser reporting directly to the Australian High Commission (AHC). The same indicators will be assessed in a more ongoing and participatory manner using basic reports on inputs and outputs from Implementing Partners, and participatory judgements, rather than the more formal methods for data collection and analysis.
- Regular concise quarterly reporting from the contractor (and other development partners). These reports will provide information on inputs and activities delivered, as well as an analysis of achievements of progress towards the Outputs and their indicators in the design.

It is the use of this information and analysis by the governance structures of the program that is critical to keeping the program on track. The outputs, outcomes and indicators are structured around key qualitative changes that impact upon sustainability and momentum for change, as well as the more basic quantifiable targets for health services and health status. Active management by stakeholders (MOH, AHC, development partners, contractors) with a focus on the outcomes is needed to ensure that change happens.

Resources for M&E include an M&E short term adviser in the managing contractor team; continuing support for strengthening the MOH Health Information System (HIS) and the associated TA; and an Adviser working directly to AHC to assist in the analysis and evaluative judgements required across the program.

---

<sup>22</sup> An example is included in Annex 2

## 5.5 Components

### *Component 1: Corporate Services*

Intermediate Outcome 1:

***MOH Leaders commit to and provide effective health sector oversight and enabling environment, and engage effectively with central agencies (e.g. PMO, MFEM)***

Phase 1 indicators (*targets identified in MEF*):

- Effective systems and processes for national and provincial health planning, budgeting and management
- More transparent and effective public financial management at all levels
- More efficient use of limited human resources at all levels
- Better use of evidence for policy and decision making
- Better collaboration and engagement between MOH and Central Agencies

Indicative Outputs:

***Priority-ranked business improvement project scoping documents (in planning and budgeting, PFM, HR, HIS).  
Effective systems and processes for national and provincial health planning, budgeting and management***

The program will build upon DFAT contributions to strengthened health systems. The planning and implementation process relies on bringing together the combination of grant finance and technical assistance to support the implementation of government-led and managed plans and priorities.

The scope of business improvement plans (BIPs) to be initially endorsed include in the areas of:

- Public Financial Management (including internal audit)
- Planning and budgeting
- Human resource management and workforce development (see also component 4)
- Health Information System
- Sector planning and coordination, including with development partners and Central Agencies
- Other areas as agreed jointly by MOH/DFAT and the Health Sector Working Group.

The implementation strategy includes:

- A national level facilitator (who also acts as the managing contractor's team leader)<sup>23</sup> who will respond to the priorities of the MOH Director Corporate Services and other MOH staff, and support them to scope and plan approaches to addressing these key priorities. Approaches will include a mix of grant finance and TA, both long and short term. Capacity development will be integral to each workplan. The national facilitator acts as TA to the MOH for strategic planning, analysis, research, organisational development, leadership and management capacity development, implementation support and monitoring and evaluation.
- An MOH manager will be identified as the lead for each BIP and they will be responsible for implementation and reporting within the MOH accountability system
- BIPs will be approved within the MOH planning process, and endorsed by the Health Sector Steering Committee (HSSC) after consideration by the Joint Partners Working Group (JPWG).
- The facilitator will support the MOH (Director Corporate Services) to compile and update annual plan for the BIP pipeline each six months, where newly identified activities can be proposed and endorsed by the HSSC. (*The TA elements of this annual plan will also be included in the TA Plan, see following sections*).

---

<sup>23</sup> Note that the two functions are combined into one position due to resource constraints – further consideration should be given to the workload demands on the National Facilitator/Team leader, and the introduction of a Deputy TL, or Operations Manager, to support the role if needed after the Inception Phase one the Provincial Component starts up.

- Ongoing monitoring by the MOH and review by the Steering Committee (see M&E section later) is critical to implementation of the approach.

Further discussion of the approach to corporate services is included in the related discussion paper (Volume 2).

The Health Sector Steering Committee will review reports against the BIP pipeline (presented by the Director Corporate Services) each three months.

### *Component 2: Public Health Priorities*<sup>24</sup>

Intermediate Outcome 2:

***MOH public health staff respond to community health priorities identified from evidence***

Phase 1 indicators (*targets identified in MEF*):

- Immediate community priorities addressed by MOH public health programs
- Well coordinated development partner funding and TA to address public health priorities.
- Better collaboration between MoH directors and central agencies to resolve institutional issues undermining public health services.

Indicative Outputs:

***Functional and useful health information system and periodic Demographic Health surveys***

Vanuatu has identified a range of public health priorities in the Health Sector Strategy, including in the areas of malaria, TB, immunisation (EPI), reproductive, maternal, neo-natal and child health (RMNCH), diabetes/hypertension, nutrition and emergency response. A wide range of programs is currently implemented mostly with development partner assistance (WHO, UNICEF, UNDP, NGOs- World Vision, CARE, DFAT). There are also new programs in the pipeline for health security (DFAT regional and global), new vaccines (ADB) and family planning (UNFPA). However, the scope of public health priorities currently supported by DFAT and other development partners operates at a pace and scale that the MOH cannot easily manage and absorb, creating duplication, inefficiencies and failure to build long term capacity.

The program will strengthen the internal MOH planning and support process for public health activities to enable the MOH prioritise amongst competing interests and demand; manage effectively from within MOH resources and capacity; address evidence based needs and “best buys”; and better coordinate assistance offered from the donor community. DFAT will provide grant financing and TA to support the MOH to implement their (realistic and manageable) plans, and work with other development partners (in-country, regionally and globally) to coordinate assistance and implementation through the MOH planning process.

The implementation strategy for this component involves:

- The national level facilitator supporting the Director Public Health to prioritise public health activities in the MOH budget and planning process to bring international assistance on-budget and on-plan. (Note that the planning mechanism and tools for this process have already begun to be established).

<sup>24</sup> This IDD uses the term ‘public health’ to align with the internal corporate structures of the GOV MOH – these structures separate Corporate Services, Public Health and Clinic Services. Public health in this context includes the systems of health service delivery that is the responsibility of the Provincial Health Office, which includes all primary health care services, and primary care facilities, but excludes the hospital system which operates under the Curative Services Directorate.

- The national level facilitator will support MOH managers to scope, plan and budget for their planned activities, and to establish coordination mechanisms for planning and implementation of DP externally managed activities. The internal MOH planning formats (some in place some to be established for different levels and work units) will be utilised for this process.
- DFAT grant finance and TA assistance will be allocated to the agreed MOH priorities, against well-developed work plans and clear scope of work, to be managed by a MOH manager.
- The overall allocation of DFA finance and TA to the public health priorities will be reflected in the DFA funding allocation (budget) and the TA Plan which is submitted to the Joint Partner Working Group for endorsement. (See TA mechanism in following section).
- The MOH Manager will be responsible for implementing the plans, and reporting through the MOH system. The national level facilitator will support MOH managers to prepare their reports where required (alongside any associated TA involved in the activity).

The Health Sector Steering Committee will review reports against the MOH public health plans (presented by the Director Public Health) each three months.

### *Component 3: Provincial Focus*

Intermediate outcome 3:

***MOH public health staff in selected provinces competently perform improved primary health care planning and delivery practices<sup>25</sup>***

Phase 1 indicators (*targets identified in MEF*):

- More confident and motivated provincial health management
- Local solutions to problems implemented
- Higher spend of recurrent budget allocations
- Increased quality and quantity of outreach and supportive supervision
- Increased funding to deliver services to remote and neglected populations
- Increased demand from provinces to central MOH to address constraints
- (*relative improvement in National MOH HIS service delivery and health status indicators compared to other Provinces*)

Indicative Outputs:

***MOH public health staff in selected provinces graduate from primary health care planning and delivery practice training & coaching***

This component of the program will support provincial level health managers and health workers to unblock constraints and develop local solutions to improve local services, while creating ‘bottom up’ demand for reform from centralised systems and structures affecting them.

The process for implementation includes:

- A provincial facilitator will be based at the provincial health office. The provincial facilitator will work closely with health managers and providers to understand the conditions and constraints of frontline service delivery and build working relationships and political understanding of how key actors in the province - including elected representatives, local government, other sectoral programs (education, WASH, infrastructure), civil society organisations and community structures, contribute to health. They will support provincial health management to develop local solutions to prioritised service delivery gaps. The inherently problem-driven, iterative and adaptive nature of the process complements the traditional management style of the MoH where plans and resources are set by the Ministry centrally.
- A provincial grant from the DFA will be channelled to the province via the Ministry’s business plan and financial management system. The grant will be used to fill funding gaps and support local solutions not available through current GOV budget allocations, and provide scope to target neglected and underserved populations and issues which are often overlooked due to funding constraints.
- Oversight of the grant will be undertaken by a small focused provincial steering group that meets annually to evaluate proposals, ensuring agreed conditions are met, and then periodically to review spending and physical progress.

---

<sup>25</sup> Primary health care (PHC) is the key focus on this component, although it operates at Provincial level under the Public Health Directorate of the MOH. The more general public health services and priorities remain the focus of Component 2.

- An operations manual for use of the grant will be prepared during the program's inception period (three month period immediately after managing contractor commences). Flexibility will be provided in deciding how to spend the grant based on costed plans that fully consider the recurrent cost implications of any expenditure.

Over the 15-year horizon, DFAT will aim to cover all six provinces beginning with two provinces in the first five-year phase.

Drawing on DFAT's previous experience with provincial level support in Vanuatu, province selection will be through a transparent competitive bidding process led by the MOH. The criteria for selection will be agreed with DFAT during inception and include measures on gender equality, social inclusion and increasing equitable access to health services.

A minimum of three annual funding cycles will be invested in each selected province to provide time for tangible improvements in service delivery and to build the confidence of provincial managers to make demands on the MOH and their capacity to manage.

The contractor will work closely with the MOH to monitor and evaluate the effectiveness of this component. The provincial facilitators will prepare regular reports on outputs and outcomes, and a regular reflection and analysis process introduced to engage with the provincial and national health managers involved. The contractor will prepare a report to the Health Sector Steering Committee each three months on progress. Evidence and lessons from phase one of the program will decide the pace and direction of scale up.

#### *Component 4: Workforce Development*

Intermediate Outcome 4:

***Vanuatu medical workforce doctors and nurses competently perform new clinical practices and management processes***

Phase 1 indicators (targets where appropriate):

- Number of specialist locums supplied to Vila Central Hospital (VCH) and Northern Provincial Hospital (NPH) enable continued provision of referral services
- Medical workforce retention rates [disaggregated by sex, province and type of staff]
- Number of qualified nurses and trained midwives graduating from Vanuatu College of Nursing Education (VCNE)
- Collaboration between MOH, VCH, VCNE and other Vanuatu and regional education institutions to maintain ongoing clinical training and standards

Indicative outputs:

***Vanuatu medical workforce doctors and nurses have new clinical practice and management knowledge, skills and motivation***

***Vanuatu medical workforce doctors and nurses adopt new clinical practices and management processes***

The program will continue past investments in medical and nursing workforce development and continue to provide locums to fill critical medical specialist positions to maintain functioning hospital referral services at VCH and NPH. Vanuatu has made good progress in training and deploying its medical workforce but will require inputs from visiting core specialists (in the areas of general medicine, general surgery, obstetrics, paediatrics, emergency and anaesthetics) until 2025/26 when it is expected to become self-sufficient.

The scope of support to be provided under the program includes:

- Ongoing funding for the VCNE to train nurses and midwives
- Clinical professional development, training and mentoring for interns (ni-Vanuatu doctors completing training at VCH, particularly for those trained in Cuba and China as well as Fiji School of Health Sciences and other medical schools)
- Provision of international locums to fill essential gaps at Vanuatu's main referral hospitals.
- Visiting medical specialists, for clinical practice and professional development of ni-Vanuatu consultants at VCH.

The process for implementation includes:

- Completion by the MOH of the (currently interim) Medical Workforce Plan 2018-2025 (which may involve some program TA as requested) to finalise a plan for longer term withdrawal of Australian direct assistance to VCH medical specialists by December 2019 as condition of ongoing support to VCH
- Development of the integrated workforce plan (as a business improvement project of component 1), supported by grant finance and TA.
- Annual allocation of grant finance (through the DFA) for the VCNE in the MOH budget and planning process, to be endorsed by the Joint Partners Working Group. Plans and scope of work for VCNE to be in line with the internal MOH planning process and formats. DFAT will continue its technical support to VCNE to build the leadership and training capacity of the college, including support to curriculum development, international trainers to mentor ni-Vanuatu staff and support delivery of the new degree program.
- Annual allocation of clinical TA for professional development and locums in line with MOH priorities and needs; supported by annual allocation of grant finance for specific activities not requiring TA (such as professional development and leadership training costs)
- AHC (supported by the contractor) will facilitate strengthened coordination and linkages with regional and global programs (in particular the Fiji School of Health Sciences) for ongoing professional development of the medical workforce (trainee interns, interns, registered doctors and specialists) including leadership development.

Responsibilities for this component lies with the Director Corporate Services (for Workforce/HR planning), the Director Clinical Services (professional development, leadership training and clinical TA); and the Director VCNE. These MOH managers will report progress quarterly to the Health Sector Steering Committee, with support of the contractor.

## 5.6 Mechanisms and Delivery Approach

The program will be delivered through three key mechanisms, each with a specific delivery approach and implementation partner.

### *Direct Financing*

Immediate outcome:

***Direct Funding Agreement and Grant Agreement (WHO, UNICEF etc.) resource allocations agreed annually for corporate services, public health, provincial primary health services and clinical support***

Indicator:

- Financing provided by Australia contributes to overall MOH coordination and prioritisation of funding and delivery of services

The Direct Financing Agreement (DFA) with the MOH will be the core financing mechanism for this program. Funding will be provided on-budget and on-system, with the mitigation measures to ensure a zero tolerance for fraud as outlined in DFAT's Assessment of National Systems (ANS) report (outlined below). The following arrangements will be implemented for the DFA:

- All streams of funding to the MOH from DFAT will flow through the one DFA instrument.
- There will be three sub-allocations of funding, and parameters established each FY. For the overall five year phase these include:
  - Corporate and public health support
  - Clinical workforce support (including VCH, interns and specialists, and nurses and midwives education and VCNE)
  - Provincial level financing
- Funding will be able to procure any inputs and activities, apart from the following specified exclusions: capital expenditure for vehicles and new infrastructure unless agreed with DFAT in writing through a formal exchange of letters.<sup>26</sup>
- Funding allocations of the available funds against MOH health sector strategy and business plans will be led by the MOH in their planning and budgeting processes, with final approval subject to 'no objection' received from the funding partner (in this case DFAT) at the Health Sector Working Group meeting. The national level facilitator will play a lead role with the MOH in establishing the mechanism and processes for this allocation within the MOH and with development partners. (Funding for 2019 will be allocated by activity at cost centre level as for 2018, in order to ensure certainty for the MOH).
- Provincial level grants, once allocated, will be managed at the provincial level by the relevant line managers within their area of responsibility within the government system. The allocation of funds will be subject to an internal MOH approval process of the proposed plans and budget, subsequent to a local level stakeholder committee process. The Provincial Level Facilitators will work with provincial managers to develop these proposals and plans for the MOH consideration prior to funding allocation. Allocation of provincial funds may initially occur out of sequence to standard MOH annual budgeting processes in order to be responsible to local planning timeframes and priorities, although over time would be consistent with standard processes.

<sup>26</sup> TA for asset maintenance, and expenses for travel (such as vehicle lease) may be included in DFA expenses. This exclusion list is subject to negotiation and final agreement in the DFA.



- DFAT funded finance and audit staff based in the MOH will sign off of expenditure against the DFA as current practice (in line with ANS recommendations). Challenges of perception between the requirements of DFAT audit staff and MOH finance procedures will be reconciled in the inception period through standard operating guidelines distributed by the MOH to reinforce the understanding DFAT is enforcing the internal MOH requirements. Ongoing assistance will be available to the MOH through the TA mechanism (and DFA) to continue to build and implement PFM systems and procedures so that all MOH expenditure receives the same level of transparency and accountability.
- Financial reporting against the DFA will be on-system and the responsibility of the MOH. TA support is available to the MOH to fulfil these obligations as required.
- The DFA will be structured with flexibility in mind to enable additional emergency funds to be contributed for natural disasters or other unforeseen events as required.

Provinces will be introduced to the program over the fifteen year time horizon, likely to be two provinces in phase one; followed by three in phase two and a final province in phase three. In the first phase, provinces will be invited to ‘bid’ for participation, against a set of criteria established by the MOH (with agreement by DFAT). Draft criteria for consideration by MOH include balancing:

- Greatest need and health challenges
- Commitment of leadership to quality improvement
- Capacity to implement within the operating environment and risk profile
- Commitment to gender equality and social inclusion

These criteria and selection of provinces will occur in the inception period.

A new DFA will be developed and negotiated between DFAT and the GOV prior to program commencement.

### *Technical Assistance*

Immediate outcome:

***Technical assistance mechanism responds to MOH priorities, absorptive capacity, readiness and community demand***

Indicator:

- TA planning and support is facilitated so that the reform agenda works at a pace that the GOV/MOH can absorb and lead

The TA mechanism will be demand driven and government-led. This means that short and long term TA will only be deployed against MOH plans and priorities to address critical challenges identified with sustainable and local solutions. Not all issues and problems will be addressed at once or in concert, but in an adaptive and responsive manner. The operating features of the TA mechanism include:

- There will be one single TA mechanism, managed by a contractor responsible for delivery of the overall health program on behalf of DFAT (see following section on management arrangements)
- TA will pursue a more robust government-led strategy, supporting MOH to take up its legitimate leadership and oversight roles through a GoV-led TA steering group,

- There will be a key TA Facilitator at national level, and facilitators at provincial level, who have distinctive terms of reference to work within the government system to create demand and facilitate local level planning using a facilitated learning process methodology (sometimes called process consultation). These facilitator roles will ensure that a capacity development (not substitution) approach is adopted. (Refer to TORs in Annex 2)
- An annual TA workplan will be developed by the contractor with the MOH and approved by the Health Sector Steering Committee through a 'no objection' process.
  - The TA plans will include bilateral funding from all partners, including global and regional partners, in the development of one TA plan, to be approved by GoV,
  - Individual tasks or workplans for specific issues can be developed throughout the year and added to the Workplan as approved by the MOH and HSSC.
- There will be a shift towards TA using a wider range of methodologies, including facilitation rather than 'doing'. This will involve long-term provincial and facilitators. There are several strategies and tactics in the 'facilitator's toolbox', all of which are geared towards supporting government to take responsibility, even if this slows down the pace of progress.
- More conventional TA inputs will be brought in (usually short-term or on a call down basis) to address specific technical issues constraining institutional development. Ideally there should be no TA in long-term, in-line positions.
- Responsibility for TA workplans will be the relevant line manager of the MOH (who proposed and owns the workplan), and they will report through the MOH to the HSSC on progress. The contractor will also have a quality assurance role, supervising the work and performance of the individual advisers and ensuring that the line manager is supported to perform their management role. The contractor will consolidate an overall annual report on TA effectiveness for the HSSC.
- The contractor may also be required to facilitate rapid deployment of assistance (funding or personnel) immediately following a natural disaster.

### *Policy engagement*

Immediate outcomes:

***MOH corporate services staff ready to implemented priority BIPs***

***MOH corporate services staff adopt improved PFM, planning, budgeting, HRM, sector planning and aid coordination practices***

***MOH and development partners adopt processes for more effective policy engagement and aid coordination***

***Health Sector Steering Committee and Joint Partner Working Group commit to and provide responsive support, policy dialogue mechanism and resource allocation***

***Effective processes for policy engagement between GOV and development partners***

Indicator:

- Number of reforms identified, agreed and implemented by GOV and development partners

The program will step up Australia's role in engaging in policy dialogue between development partners and the Government of Vanuatu on health issues. The consolidation of management arrangements and streamlining of the program operations creates opportunities for AHC to deepen

its analytic and engagement role. Additional expertise and advice will be sought when required. Key operational arrangements for policy engagement will include:

- Reinvigorating the JPA established by the MOH with development partners to provide opportunities for exchange on health priorities and development issues. AHC will negotiate a smaller, higher level of representation to the most senior Joint Partner Working Group and establish a new TOR and agenda to facilitate exchange of views and dialogue on priority policy concerns.
  - AHC will identify each year a set of key policy concerns and priorities for dialogue with the MOH and development partners, and undertake analysis and develop policy positions for dialogue. Each year only two to three high level key issues should be identified. Resources to engage health specialists or advisers to prepare analysis and policy papers has been set aside.
- AHC will maintain effective working relationships with key leaders in the sector, within the MOH, development partners and central agencies, and seek to use personal influence to advocate for policy positions identified.
- AHC will maintain effective working relationships and information sharing with regional and global program officers to identify opportunities for collaboration, joint planning, and exchange between those programs and bilateral efforts. Funds will be set aside to resource consultation meetings (two per year between bilateral and regional program managers, in Fiji and Port Vila)
- DFAT will continue to support WHO and UNICEF in country through country level funding partnerships that support the core work programs of each agency. Country level core funding agreements will be negotiated that 'buy in' these development partners to the overall strategy and approach of the program (e.g. participating in JPA arrangements, HSSC, TA mechanisms and reporting flows), without the need for activity and input level planning, budgeting and management. Draft agreements will be developed and negotiated for 2019 prior to program inception.
- AHC will engage with the World Bank (funded through global and regional programs) on PFM assistance to the health sector, and ensure coordination with the program.
- AHC will maintain linkages with civil society organisations and external stakeholders to ensure the program remains relevant and demand driven.
- AHC will be able to use the operational arrangements of this design to focus on managing towards end of program outcomes, particularly through participation in the 6 monthly Health Sector Steering Committee participatory reviews, and the joint governance mechanisms, to influence MOH policy and decision making and prioritisation.

### *Funding for Development Partners*

The bilateral program will continue to support WHO and UNICEF to ensure they maintain a meaningful in-country presence that supports MOH priorities, and can maintain active membership of sector coordination and contribute to policy dialogue with the government. Their technical and policy engagement is designed to contribute to all components of the program as described in the relevant sections above and as demonstrated in the logic model (Annex 1).

The nature of DFAT's bilateral support will shift from funding specific activities and personnel to an annual contribution to each agency's respective country program. The new program will strengthen in-country partnerships with WHO and UNICEF and continue to provide annual contributions to each agency's country program. These programs are already well aligned with DFAT's Pacific health strategy and the proposed provincial focus of the new bilateral program (WHO is strongly focused on strengthening Vanuatu's health security systems, and UNICEF is refocusing to work at the provincial

level). Core funding will be provided in a way that provides flexibility while ensuring agencies respond to the evolving sector wide approach proposed by the new program. This will provide the opportunity for AHC to move away from concerns over the details of WHO and UNICEF activities, towards a more strategic partnership focused on health outcomes, and an opportunity for the two UN agencies to work strategically alongside DFAT to influence GOV policy.

A revised JPA is being developed which will provide the framework for development partners to engage with government on policy and sector wide development issues, for the alignment of spending plans against the HSS and provincial priorities, and to ensure a more robust framework for coordinated policy dialogue. TA will help MOH to lead policy and sector review meetings with key development partners and keep the JPA on track. DFAT will be freed from oversight of WHO and UNICEF activities, and focus instead on engaging both agencies to maintain active involvement in policy dialogue, advocacy and support.

Decision making around the allocation of resources will be undertaken by the Health Sector Steering Committee, chaired by the Director General and involving key funding partners. This will move planning and budgeting processes closer to a sector wide approach, with TA helping MOH to lead prioritisation processes, ensure development partner contributions are coordinated, and that investments align with MOH priorities.

DFAT has several policy interests it may wish to pursue in the new program. For example, whilst the guiding framework for DP allocations will be the existing HSS and new/updated provincial plans, DFAT will seek to include a clear policy focus on priorities such as equitable access to affordable public and primary health care, gender and social inclusion, and health security - to ensure that DFAT priorities (as well as those of GoV) are being addressed. The proposed health sector coordination arrangements provide space for DFAT to articulate and promote these critical areas, and for development partners to agree the dimensions of wider sector reform.

Monitoring progress against development partner expenditure, results and policy reform will be the responsibility of the Health Sector Steering Group, supported by TA.

## 5.7 Governance and management arrangements

### *Governance arrangements*

The JPA established in 2011 provides the architecture for Government of Vanuatu to oversee and engage in policy and sector-wide dialogue with development partners. No new mechanisms will be established for this program, although existing arrangements will need to be refreshed. It includes a small Health Sector Steering Committee comprising government and development partners funding the sector through the health system and a broader Joint Partner Working Group (JPWG) for coordination of implementation and information sharing.

The revision and updating of the JPA which is underway provides AHC the opportunity to negotiate a JPA that meets the governance requirements of the new program and avoids the need to establish a separate governance mechanism. As intended under the JPA (2011), the new arrangement will need to include a reinvigorated high-level Steering Committee through which MOH maintains oversight and monitors the progress of development partner programs delivered through the health system (UN, DFAT, World Bank, Asian Development Bank, etc) and their coherence with national policy, the emerging reform agenda and business plans.

The managing contractor will provide support (through the team leader/national facilitator) to MOH to assist them with managing the revised JPA, establishment of TOR for the JPWG and HSSC and holding regular steering committee and coordination meetings.

The Health Sector Steering Committee (HSSC) will function as the primary operational management mechanism for the program. It will be chaired by the MOH and including representatives of major development partners contributing to the sector (DFAT, UNICEF, WHO, World Bank; and representatives from relevant central agencies (PMO, MFEM, PSC). The team leader provided by the managing contractor will support the committee to function effectively and the program management office will provide secretariat functions.

The HSSC will meet four times a year, set the overall strategic direction of the program and agree quarterly TA workplans. It will consider regular reports on implementation provided by the Team leader, and meet quarterly to agree program priorities, consider progress and challenges, and agree on actions to address persistent constraints and bottlenecks. The HSSC will report formally to the GOV and GOA. Issues which are not resolved by consensus or agreement at the HSSC will be elevated to the principals responsible within the GOA and GOV (MOH) as appropriate and resolved through direct partnership talks and negotiation.

HSSC meetings will also play an important role in influencing the program's overall agenda. The program's 'process methodology' is built around a continuous action-learning cycle, and regular analytical reflection and review is central to the approach. Therefore regular review meetings will provide opportunities for open discussion and agreement around what is working well, why, and how success can be multiplied; and where persistent bottlenecks remain, why, and what can be done to remove them. This in turn provides a basis for accountability at subsequent reviews.

In addition to the HSSC meetings, bilateral meetings with AHC and MOH will be held on a quarterly basis.

The contractor will report operationally to the HSSC. The formal contract and accountability remains a direct report between the contractor and AHC.

## *Management Arrangements*

The Vanuatu Health Program sits within the responsibility of the Deputy Australian High Commissioner at the Australian High Commission in Port Vila. The health program team in AHC will oversee implementation. It will ensure close and active operational engagement by DFAT, and robust policy and strategic engagement in program oversight committees.

DFAT will procure the services of a single managing contractor, selected through a competitive DFAT-managed open tender process, to consolidate the management of TA and manage overall program implementation. The selected contractor will be accountable to DFAT for the management and delivery of technical components of the bilateral program, as specified by the Contract and Terms of Reference (refer to Annex 2). The managing contractor will establish a program management office in Port Vila, led by a full time, in-country team leader accountable to a home based program director. The program director (also known as the contractor representative) will act as the single point of contact for DFAT for the purposes of contract delivery.

The contractor will establish a technical team comprising the following personnel:

- a full-time, in-country team leader, based in the project management office, responsible for management, coordination, coherence and oversight of all technical elements of the bilateral program, including clinical workforce support, and liaising with WHO, UNICEF and other recipients of DFAT funding who are outside the bilateral program but whose activities and outputs need to be aligned with program objectives;
- The team leader will also perform the role of in-country national level facilitator, responsible for supporting the MOH and key stakeholders in central agencies and guiding/mentoring provincial facilitators;
- full-time provincial facilitators to support provincial health managers and other relevant provincial stakeholders (*provincial facilitators may be nationally engaged personnel*);
- short-term TA and specialist expertise as nominated in the Contractor's tender (particularly to address M&E and gender and social inclusion and humanitarian support for the program as part of the team's specialist skills);
- necessary project management, financial management and procurement support staff.

The managing contractor, through the technical team, will:

- Prepare and implement a strategic framework that outlines program principles, approaches and activities;
- Prepare annual workplans in collaboration with MOH departmental directors, for approval by the Health Sector Steering Committee;
- Lead the delivery of agreed workplans, adopting a supporting, facilitative approach with program stakeholders;
- Work collaboratively with the MOH executive team to strengthen organisational capacity in identified technical areas at national and provincial levels;
- Integrate attention to gender equality and social inclusion into all areas of technical assistance and program management;
- Facilitate and support the active engagement of relevant central agencies to help remove obstacles and improve MOH performance;
- Work collaboratively with provincial health managers and other relevant stakeholders to develop and deliver a provincial-wide vision for improved service delivery;

- Ensure the challenges and lessons of experience from provincial health service provision are communicated effectively to central level policy makers and directors, and acted upon;
- Support the MOH to implement the revised JPA and establish / strengthen necessary mechanisms for program oversight, including the Health Sector Steering Committee. Support oversight mechanisms to function effectively;
- Provide strategic analysis and policy advice to the health management team in AHC to assist DFAT strengthen its policy engagement roles and maximise its impact;
- Develop and support implementation of an M&E Framework to help steer program direction;
- Provide quarterly reports to the HSSC and DFAT on activities and outputs in all aspects of program delivery, including achievements, challenges, recommendations, expenditure, risk management and next-quarter activities;
- Develop effective communication tools to demonstrate progress, facilitate cross-learning opportunities, and that contribute to overall M&E.

DFAT will retain separate funding agreements with WHO and UNICEF. These agreements will stipulate that management and oversight of these agreements will be through the mechanisms of the overall MOH-led governance arrangements of the HSSC. Reporting, workplans and funding allocations will be subject to the internal MOH and DP led processes, which will focus on outcomes and strategy of the overall program design. Direct AHC management of these agreements will be 'light touch' exception and risk based engagement.

## 6 Implementation

### *Inception Period*

The inception period (first three months after the managing contractor commences) will include mobilization of the team leader (who also plays the role of the national level facilitator) and establishment of the program office. This period will include building relationships with key actors in the Ministry of Health, central GoV agencies, DFAT (AHC and regional managers) and other development partners; socializing the shift in DFAT's investment to the health sector; and work planning. During inception the program team will support MOH to assess, prioritize and agree TA needs for subsequent years, subject to an annual planning process. The funding allocations and key activity planning for calendar year 2019 will have been undertaken by MOH and DFAT with technical support, prior to managing contractor commencing. From commencement, the contractor will support MOH develop the methodology for selecting phase one provinces and undertake the provincial selection process; this will include the participation of central agencies such as DSSPAC and MFEM. A key output of inception will be the design of the provincial health funding, how it will operate, be managed and overseen, and development of an Operational Manual. In preparation for launching the provincial focus in year two, the contractor will mobilise provincial facilitators during the Inception period. The program team will support MOH prepare its DFA proposal for 2020 which will be negotiated with AHC. The program team will support MOH to operationalize the newly revised JPA and governance mechanisms which are integral to the new program.

With completion of the Medical Workforce Support Program (MWSP) in October 2019, responsibility for negotiating and securing specialist locums for Vila Central and Northern hospitals will transfer to the new contractor. The contractor will also work with AHC and regional managers to identify how continuing professional development achievements under MWSP can be sustained and augmented via DFAT regional assistance and networks.

## 7 Feasibility Analysis

### 7.1 Risk

The overall risk assessment for the program is Moderate Risk.

The key risks to the program which have been considered in the design, but require ongoing monitoring and management through implementation include:

#### Context Risks

- **Political instability**, which may affect key leadership positions and policy directions within the GoV
- **Sudden economic shocks to Vanuatu economy**, which could impact upon the health budget.
- **Natural disasters and emergencies**, particularly related to climate change, which may divert financial and human resources from ongoing service delivery. Longer-term climate change impacts (within the lifetime of this program) have the potential to overwhelm Vanuatu's health system.
- **Gender inequality and social exclusion**, which may impact upon the ability of women and girls, and vulnerable populations, to access services, participate in health planning, and take up leadership positions being improved.

#### Modality Risks

- **Lack of engagement in governance arrangements** from MOH, DFAT and/or development partners, which would undermine the leadership and capacity of the MOH.
- **Lack of leadership and management capacity** in MOH to lead planning and reform agenda in medium-long term, which may lead development partners and the program to implement vertical and separate programs and undermine sustainability.
- **Shifting AHC resources and/or approach** undermines the program strategy, which would send mixed signals to the MOH, development partners and Contractor on maintaining a focus on working at a pace that the MOH can lead and absorb, and undermine sustainability.

#### Implementation risks

- **Allocations for financing MOH under the Direct Funding Agreement are not directed to agreed priorities** or distort the MOH health budget, which would reduce the impact of Australian assistance in influencing the overall budgeting and planning processes.
- **TA not facilitated**, managed and provided in a manner that works within MOH capacity and pace that is sustainable; and/or the MOH has key workforce gaps so that TA have no counterparts; which may mean that TA operate independently and while implementing short term activities, would not achieve long term change;
- **Poor Contractor technical and leadership capacity** and poor program management, which would undermine the approach; and
- **Poor quality monitoring and evaluation**, which may impact the ability of the HSSC and DFAT to effectively manage the program and ensure outcomes are achieved.

These risks are to be monitored and managed through the mechanisms of the HSSC six monthly review and reflection process, and through DFAT internal Aid Quality Check. Recommendations for management responses to emergent risk are included in the Risk Matrix (Annex 4).

### 7.2 Gender Equality and Social Inclusion

The new health program integrates the principle of gender equality, social inclusion and equity (GESI). This will be achieved by integrating GESI into the program logic and results framework and making the objective of GESI explicit in each program area of work. The problem-driven, iterative and adaptive nature of the program and the enabling policy environment provides the space for GESI to emerge as a priority within each of the four program areas. This will however require



considered and persistent attention by the management contractor to present, promote and provoke government attention to gender and equity issues through analytical and TA facilitation processes, and evidence generation. Ensuring that the management contractor has the expertise and commitment to integrate and advocate for GESI through the respective delivery mechanisms will be essential. This will include requiring GESI capacity as a core area of expertise in the program team, ensuring gender balance and gender equal pay in staffing and consultants, and provision of modular and continuing GESI training and evaluation of all program staff and consultants.

While remaining committed to the government-led and responsive nature of the program, it is foreseen that support to the four program areas will have the potential to progress priority GESI gaps and concerns.

- Corporate services: TA will ensure that government considers critical gender issues related to staff security and retention, women leadership development and career progression, harassment policies and procedures, and the equity implications of human resource distribution and development. Where there is appetite within the Ministry, technical assistance will drill down into agreed GESI related problem areas to support MOH develop systems-based solutions, which may include policy, institutional, evidence and capacity building responses.
- Public health priorities: TA to support the integration agenda will ensure that GESI is integrated into the dialogue and decision-making process. GESI awareness raising and capacity building of key stakeholders will help create the conditions to foster commitment to solve problems that hinder the most vulnerable from accessing services. The Department of Women Affairs, the Ministry of Justice and Community Services and the Vanuatu Women's Centre will be leveraged to assist and work with the MOH to create sustainable responses to issues of social exclusion and barriers to access in line with national policy. Technical assistance will play a linking and facilitating role potentially coupled with DFA, to assist the government develop strategies to address priority gaps in services and service delivery approaches for underserved populations (e.g. outreach and home-based care) and related capacity building of health staff (e.g. training to provide compassionate and dignified care to survivors of family violence, early identification of children with disability).
- Provincial focus: TA facilitation to be provided to focal provinces will have a strong focus on GESI and provincial health grants will provide top up funding which could be used to reach underserved populations. GESI criteria will be included in the methodology for selecting provinces and GESI concerns will be included as indicators to be monitored by the provincial steering group overseeing the provincial health grant. Provincial and national facilitators will be expected to ensure that GESI issues are raised, evidenced, understood and considered in the facilitation process. In line with the theory of change, the provincial focus will be a vehicle for progressing local responses to GESI gaps and raising demand for GESI solutions to the national level.
- Workforce development: The traditional gendered nature of nursing and the predominantly female nursing workforce means that nursing development in the Vanuatu context has strong gender equality and women's empowerment potential. VCNE's demand for GESI training to be included in the nursing curriculum is an entry point for nurturing more compassionate and gender sensitive attitudes and caring practices. Further scoping of entry points for GESI in regional programs focused on health sector workforce development and how this can be leveraged for Vanuatu will be undertaken.
- Policy engagement: Policy commitments to gender equality, disability inclusive development and equity underpin the potential for the program to more strongly address GESI in policy

dialogue than has been the case in the past. With GESI integrated into the program logic and results framework and each of the four program areas it is expected that GESI related issues will be an integral part of policy dialogue and will be monitored by the program. To complement formal policy dialogue mechanisms and TA approaches, GESI issues will be included in the program communications strategy and materials to nurture, amplify and generate government and public demand for inclusive reform. Innovative tools such as equity dashboards and digital stories will help intersect program communications, monitoring and policy influencing.

### *7.3 Climate Change*

The WHO has called climate change the “greatest health challenge of the 21st Century.”<sup>27</sup> Climate change has implications for Vanuatu’s entire health sector and will exacerbate the full range of existing health challenges in the country. MOH highlighted the need to better understand and manage the risks of climate change in the Health Sector Strategy 2017-2020’s Goal 3.1.2: “The potential impacts of climate change and the actions required to deal with these are known and incorporated in program development.”

In order to ensure climate change is integrated into Australia’s assistance, the program will draw on the services of the Climate Change Support Unit under the new Australia Pacific Climate Change Action Program (APCCAP). The APCCAP Support Unit has commissioned an analysis of the implications of climate change for the health sector in the Pacific. This analysis will help inform advisory support provided through the program. The APCCAP Support Unit can also provide a range of more specific services to the program, including: supporting national level analysis of climate change and the health sector and help to link health service providers to up-to-date sources of climate information to inform planning and strategies. Other forms of support to be provided through the program include training of health workers, working with the World Bank on GIS mapping for policy and planning, contributing to health security threat analysis and preparedness, and supporting policy engagement with the GOV on emerging priorities.

### *7.4 Safeguards*

The program will address the requirements to ensure environment and social safeguards in the following manner:

- **Environmental protection:** The program has no activities or outcomes which impact upon the natural environment. This assumes that no new infrastructure is supported. This will be revisited should infrastructure be funded through the program.
- **Children, vulnerable and disadvantaged groups:** All personnel (Contractor, TA and DP funded) will be required to have a Working with Children Check. The program seeks to improve the lives of vulnerable and disadvantaged groups, particularly through the focus on improving service delivery through support at Provincial level. No groups will be adversely affected by any program activities.
- **Indigenous people:** Vanuatu is a culturally diverse society, with the indigenous populations having full political, economic and social rights. The program aims to improve services nation-wide, and is not directed towards any particular ethnic group or segment of society.
- **Health and safety:** The program works within the policies and procedures of the MOH concerning health and safety. All TA and personnel will comply with MOH policies and

---

<sup>27</sup> WHO. December 2018. Health and Climate Change: COP24 Special Report  
<<https://apps.who.int/iris/bitstream/handle/10665/276405/9789241514972-eng.pdf?sequence=1&isAllowed=y>>

procedures. The Contractor will ensure that a workforce health and safety policy for the program is complied with.

## Annex 1 - Monitoring and Evaluation and Program Logic

The Design Strategy and Options Paper, prepared as part of the analysis for this design, outlined a range of strategies that Australia could pursue in response to the political economy of Vanuatu's health sector. The strategy selected was to 'step up' Australia's engagement, moving away from previous focus on service delivery support and technical assistance, towards a more sustainable approach of addressing underlying constraining factors, such as leadership and accountability in the sector. However, the strategy selected emphasised the importance of stimulating and supporting an endogenous approach, stimulating demand for change from within, and building on local momentum and priorities. The choice was made not to make a sudden change in the approach and support which may have negative impacts on service delivery, and potential political and bilateral relationship implications, but to transition the program over time. In a sense this can be described as a 'two track' approach, reflected in the two end of program outcomes:

- **Ministry of Health senior staff lead continuous improvement and strengthened accountability of the Vanuatu health sector**
  - This reflects the move towards a more sustainable developmental approach in the **way the program is delivered**, and emphasises the process approach of the program.
  - The underlying strategy for this process is deliberately not directly overt in the summary diagram of components and outcomes, because it critical that the change process is generated from within government and within the context, not driven from a 'planned' and 'directed' program design or external advisers.
- **Ministry of Health corporate services, public health and clinic services staff increase delivery of equitable, accessible and better quality essential health services**
  - This reflects the ongoing support of previous assistance in many respects: support for clinical services at Vila Central Hospital, technical assistance, training, and sector budget support (direct financing agreement) for government priorities. Many of the funding priorities and activities will look much the same as previously.

An ongoing tension for the design is the potential conflict between these two outcome areas. The adaptive approach to monitoring and evaluation, and the role of DFAT in policy engagement, are two key strategies to 'keep the program on track' so that the balance between these priorities can be maintained in light of current health needs and demand, local political economy issues, policy interests and the bi-lateral relationship.

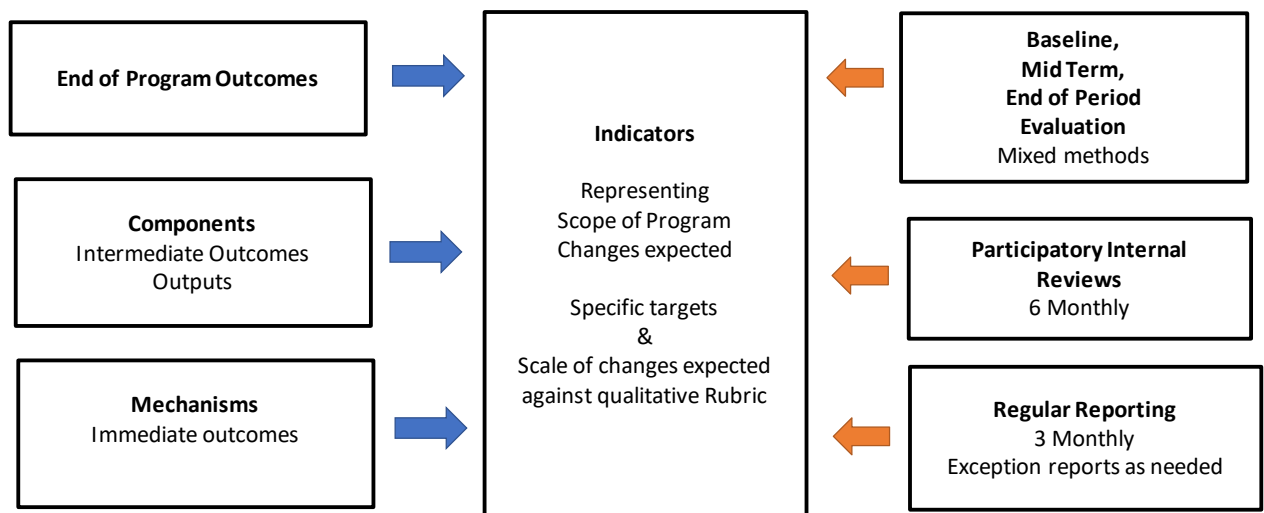
The M&E Framework reflect the pathways to both of these end of program outcomes. It includes a mix of indicators that come directly from the GOV's own Health Information System, and stated national goals, plans and baselines (all related to the quantifiable, objective, health service delivery and status data, for which the GOV is primarily responsible). The process oriented qualitative indicators require reflection from implementers (with the MOH and DFAT) to form judgements about whether the program is 'on track' towards a more sustainable approach that addresses the underlying political economy factors of leadership and accountability in the sector.

### Monitoring and Evaluation Framework

The Monitoring and Evaluation Framework reflects the key features of the theory of change (or program logic) behind the program strategy. This is outlined in detail through the indicators column of the framework (attached) which is aligned to the end of program outcomes; the intermediate outcomes and outputs of the components; and the immediate outcomes of the mechanisms. The

selection of indicators is of two kinds: those related to the internal program logic of how change happens (qualitative indicators), matched with relevant indicators on health services and health status coming from the MOH HIS. No additional information gathering on health information will be undertaken outside the MOH health information system. The approach adopted is that the program logic of influencing the leadership, governance and accountability of the sector will improve the performance of the MOH in delivery and outcomes, and both these features are reflected through the outputs and outcomes. However it is recognised that Australian funding cannot be held directly accountable for the quality and extent of services delivered and changes in health status reflected in the design. The MEF utilises two key mechanism for monitoring and evaluation: a regular 6 monthly reflection and review of progress (against both outputs and outcomes) which uses qualitative participative judgements and process; and more formal methods for evaluation annually, mid-term, and end of program. The same set of indicators is used for these two different methods for outcome monitoring.

### Monitoring and Evaluation Framework



Key features of the implementation of the M&E Framework include the following:

1. **Methodologies for data collection analysis (against indicators):** are of two types:
  - **Health status and services indicators** drawn from the MOH Health Strategy and the Peoples Plan MEF. The data for these indicators will be available from the MOH Health Information System. These are included in Red in the table below. Some specific data collection for the baseline is required to complete the data set prior to Inception.
  - **Qualitative judgements for progress against pre-determined scales** (from poor or weak, fair, good, very good and excellent) with rubrics developed prior to Inception to be used for making the qualitative judgements for change as it occurs. These can then be made in robust and valid ways by using self-assessment and participatory methods on an annual (MT and EOP) basis against the baseline in a standardised manner. The PEA and analysis done for the design provides a basis for the baseline and for the content of qualitative assessment in the rubrics to be developed. An example would be:

**Indicator: Well coordinated development partner funding and TA to address public health priorities.**

Poor	Fair	Good	Very Good	Excellent
------	------	------	-----------	-----------

Development partners and MOH plan and manage TA inputs with little coordination, poor engagement from counterparts, lack of supervision from MOH, infrequent and inconsistent reporting, and lack of overall oversight across the portfolio of TA	Development partners and MOH seek input from others in developing TOR and recruitment; provide some level of reporting to MOH, but TA work independently against own workplans and accountable primary to the donor.	Development partners and MOH develop TOR jointly and participate in selection of TA; MOH has counterparts to supervise and engage with TA; TA provide regular reporting to MOH, and share information with other development partners	Development partners and MOH develop a joint overall TA workplan; MOH leads on developing TOR and recruitment and contracting of TA; TA is primarily accountable to MOH line supervisor and provides internal reports through the MOH	MOH develops an overall workplan for TA against priority projects; led by MOH managers, TA provides regular reporting and MOH provides regular supervision and feedback to TA and to the donors on performance.
---	--	---	---	---

**Target: Significant improvement from baseline**

2. **Baseline:** for the program is mostly completed, with some additional information to be gathered and analysed prior to Inception. This data collection and analysis can be commissioned from existing partners (contractor, World Bank and WHO/UNICEF) prior to program commencement.
3. **Additional methods for evaluation** will be developed in the inception period, including staff satisfaction and engagement surveys, as indicated in the EOP targets. These may be used to develop a more sophisticated baseline at the start of the program as indicated in the MEF.
4. **Regular Review and Reporting:** program implementers (the MOH, managing contractor, WHO and UNICEF) will provide regular reports against the Mechanism Immediate outcomes and the component outputs to the Steering Committee. A 6 monthly review and analysis at this meeting will provide ongoing qualitative judgements about the progress of the program in following the strategy (theory of change) and achieving outcomes. The regular review and reflection process will draw upon the facilitation of an Adviser working with AHC to conduct the meeting and prepare a review report. The more formal Annual and MT and EOP analysis will use more formal evaluation methods.
5. **Resources for M&E:** will include a STA M&E specialist included in the contractor core management team; a Technical Specialist working directly to AHC; an investment in the HIS through the DFA and the TA Mechanism. Terms of Reference for the M&E role and inputs of the contractor will be proposed by bidders as part of the tender process, depending on the expertise and roles allocated by contractors to the TL/National Level Facilitator and other support personnel nominated.

The detailed Monitoring and Evaluation Framework follows.

Category	Component	Statement (JF)	Indicators	Out com	HSS	NSDP	Process/Output	Output (HIS indicators) (annual)	Outcome (HIS indicators) (EOP 2023)
Governance	Corporate services	ImO1f Direct Funding Agreement and Grant Agreement (WHO, UNICEF etc.) resource allocations agreed annually for corporate services, public health, provincial primary health services and clinical support	% split between recurrent / DP funding (by cost centre / program - operations)	IO1	Effective systems and processes for national and provincial health planning, budgeting and management	1	1	% change <u>annually</u> between recurrent / DP funding (by cost centre / program - operations)  % of budget allocation towards corporate, public health & curative by province	VI 057 Proportion of aid-posts, open, staffed and functioning. VI027 Proportion of healthcentres and dispensaries open with full services. VI024 Proportion of unfilled clinical position (by cadre). VI 025 Average recruitment time to fill a VI 041 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease.
Governance	Corporate services	ImO1e Health Sector Steering Committee and Joint Partner Working Group <b>commit</b> to and provide responsive support, policy dialogue mechanism and resource allocation  ImO1c MOH and development partners <b>adopt</b> processes for more effective policy engagement and aid coordination  O1b Effective systems and processes for national and provincial health planning, budgeting and management	% of completed actions arising from JPWG and HSC meetings  % HSC attended by representatives of central agencies	IO1  IO2	Effective collaboration and engagement between MOH and Central Agencies  Better collaboration between MoH directors and central agencies to resolve institutional issues undermining public health services			% change <u>annually</u> of completed actions arising from JPWG and HSC meetings	
Governance	Corporate Services	ImO1b MOH corporate services staff <b>adopt</b> improved PFM, planning, budgeting, HRM, sector planning and aid coordination practices.  O1b Effective systems and processes for national and provincial health planning, budgeting and management	# valid/approved strategic and operational plans in place (based on required/standardised planning framework and aligned to HSS) (PF IO 1 indicator modified)	IO1	Business improvements projects scoped, planned and managed by MOH (in planning and budgeting, PFM, HR, HIS).			% of <u>annual</u> operational activities completed (MOH Corporate services)	VI 021 Proportion of deliveries with skilled health personnel in facility (Supervised delivery). VI 154 Percentage of babies born in facility given BCG within 24hrs. VI 137 Drop out rate, 1st to 3rd dose DTP. VI 019 Measles (MCV1) immunisation coverage. VI 004 Penta 3 (DTP3) immunisation
Governance /Budget		ImO1d MOH corporate services staff <b>collect, analyse and use</b> information to identify priorities and support work planning and delivery	Budget: variance of budget vs actual spend - disaggregated by cost centres/program and by province	IO1 IO3	Better use of evidence for policy and decision making  Higher spend on recurrent budget allocations			<u>annual</u> changes in budget variance (proportion unspent) by cost centres/program and by province  % of budget allocation towards corporate, public health & curative by province	
Governance	Corporate	ImO1d MOH corporate services staff <b>collect, analyse and use</b> information to identify priorities and support work planning and delivery	Implementation: Operational plan periodic reporting - % activities completed (qly/annual) HIS periodic reporting (process/output indicators)	IO1	Better use of evidence for policy and decision making			% of <u>annual</u> operational activities completed (National)  changes in selected health system output indicators at national level	

Governance	Public Hlth Provincial	IO2 IO3	MOH public health staff respond to community health priorities identified from evidence MOH Public Health staff in selected provinces competently perform improved primary health care planning and delivery practices	Implementation: Operational plan periodic reporting - % activities completed (qly/annual) HIS periodic reporting (process/output indicators)	IO1	Better use of evidence for policy and decision making			% of <b>annual</b> operational activities completed (Provincial Health Services) changes in selected health system output indicators at provincial level		
HR	Corporate Services	ImO1a	MOH corporate services staff <b>ready</b> to implement priority BIPs	% of MOH corporate positions filled on permanent basis disaggregated by sex (PF IO1 indicator)	O 1 IO1	Business improvements projects scoped, planned and managed by MOH (in planning and budgeting, PFM, HR, HIS). Efficient use of limited human resources at all levels; Gender equality and women leadership development integrated into human resource policies and procedures	1	1	% change <b>annually</b> of MOH corporate positions filled on permanent basis disaggregated by sex (PF IO1 indicator)	VI 147 Case Notification rate of all forms of TB – Bacteriologically confirmed & clinically diagnosed New and Relapse cases (per 100,000 population)	
HR	Public Hlth	IO2	MOH public health staff <b>respond to</b> community health priorities identified from evidence	% of MOH public health management and program positions filled on permanent basis disaggregated by sex	IO2	Well coordinated development partner funding and TA to address public health priorities. Better collaboration between MoH directors and central agencies to resolve institutional issues undermining public health services			% change <b>annually</b> of MOH public health management and program positions filled on permanent basis disaggregated by sex (PF IO1 indicator)		
HR	Province	IO3	MOH Primary Health Care managers and staff in selected provinces <b>competently perform</b> improved primary health care planning and delivery practices	% of MOH primary health care management positions filled on permanent basis disaggregated by sex	IO3	More confident, motivated and capable provincial health management			% change <b>annually</b> of MOH primary health management positions filled on permanent basis disaggregated by gender		
HR	Workforce	IO4	Vanuatu medical workforce doctors and nurses <b>competently perform</b> new clinical practices and management processes	Proportion of unfilled clinical position (by cadre) (VI024 - HIS indicators)	IO4	Number of skilled health workers to 10,000 population	1		% change <b>annually</b> clinical positions (by cadre) filled on permanent basis		
HR/ Training	Workforce	IO4, O4a, O4b, ImO4a, ImO4b. IO3, O3, ImO3a, ImO3b	see logic model	# of personnel trained (by type of training, province, gender)	IO1 IO4	Efficient use of limited human resources at all levels; Gender equality and women leadership development integrated into human resource policies and procedures. # of qualified nurses and trained midwives graduating from VCNE Collaboration between MOH, VCH, VCNE and other Vanuatu and regional education institutions to maintain ongoing clinical training and standards			% of health facilities fully functional according to Role Delineation by province (by year) % budget allocation towards clinical workforce development		
Budget	Corporate Services	IO1	MOH Leaders commit to and provide effective health sector oversight and enabling environment, and engage effectively with central agencies (e.g. PMO, MFEM)	% government spend of GDP towards health	IO1	Committed MOH leadership provides effective oversight and stewardship of the health sector			% ratio of DP / MOH budget allocation towards programs over time		
Health Inform'n	Public Hlth Provincial	O2	Functional and useful Health Information System and periodic Demographic Health surveys	Reporting rate for routine monthly HIS Statistiks Ripot (VI058 - HIS indicators)	IO3	Relative improvement in National MOH HIS service delivery and health status indicators compared to other Provinces			% reporting rates (by level of health facility)		



## Program Logic

A summary of the process orientation of how change will happen is included in the main document.

### Summary of theory of change/program logic

*The program will focus on high quality processes that support reform from within by:*

- *Getting high level political and leadership support for a transparent and open prioritisation of human and financial resources, and the policy reform agenda, through providing financial support through government systems,*
- *Facilitating government led planning and implementation in a conscious and careful manner, responding to their priorities at a pace they can absorb;*
- *While working at a provincial level to build capacity for, and stimulate internal demand for reform, and by demonstrating good practice of improving services using locally available resources;*
- *And maintaining the integrity of clinical standards and workforce capability to maintain trust in the health system from communities and sustaining the gains from past investments.*

These key features of the change process are reflected in the Monitoring and Evaluation Framework through selection of critical indicators at the outputs, immediate outcomes, intermediate outcomes, and end of program outcomes. They alone, however, do not reflect the whole nature and scope of the program, nor do they resonate sufficiently and clearly enough for key stakeholders to see their key interests and priorities reflected. Consequently, a summary diagram is used for communications purposes with the four key components and three mechanisms rather than the detailed causal logic of the larger number of sophisticated indicators.

The causal logic of the program can be described as follows:

1. The corporate services component is the foundation for sustainable change over the long-term as well as effective delivery of services and meaningful policy dialogue during the first phase of implementation. This is placed first in the logic (that is at the bottom of the schematic model), although interventions in all four components may be conducted concurrently as partners and counterparts are **ready** for change and able to **adopt** new practices.
2. The first EOPO comes early in the logic, recognising that in the long term the goal and second EOPO will be delivered only if corporate services (including aid coordination) exist and are used as a foundation.
3. The design adopts a **government-led approach**, so the logic reflects this. Development partner engagement, technical assistance and resource allocation are all linked to MOH leadership and systems. A number of assumptions are required for this to work, and the core ones are listed on the left hand side of the model.
4. For service delivery changes, counterparts are assumed to be ready to change and have an environment that motivates them. That allows immediate outcomes (ImO) relating to **adoption** of new practices, before intermediate outcomes (IO) relating to **commitment** or **competent performance** are delivered.

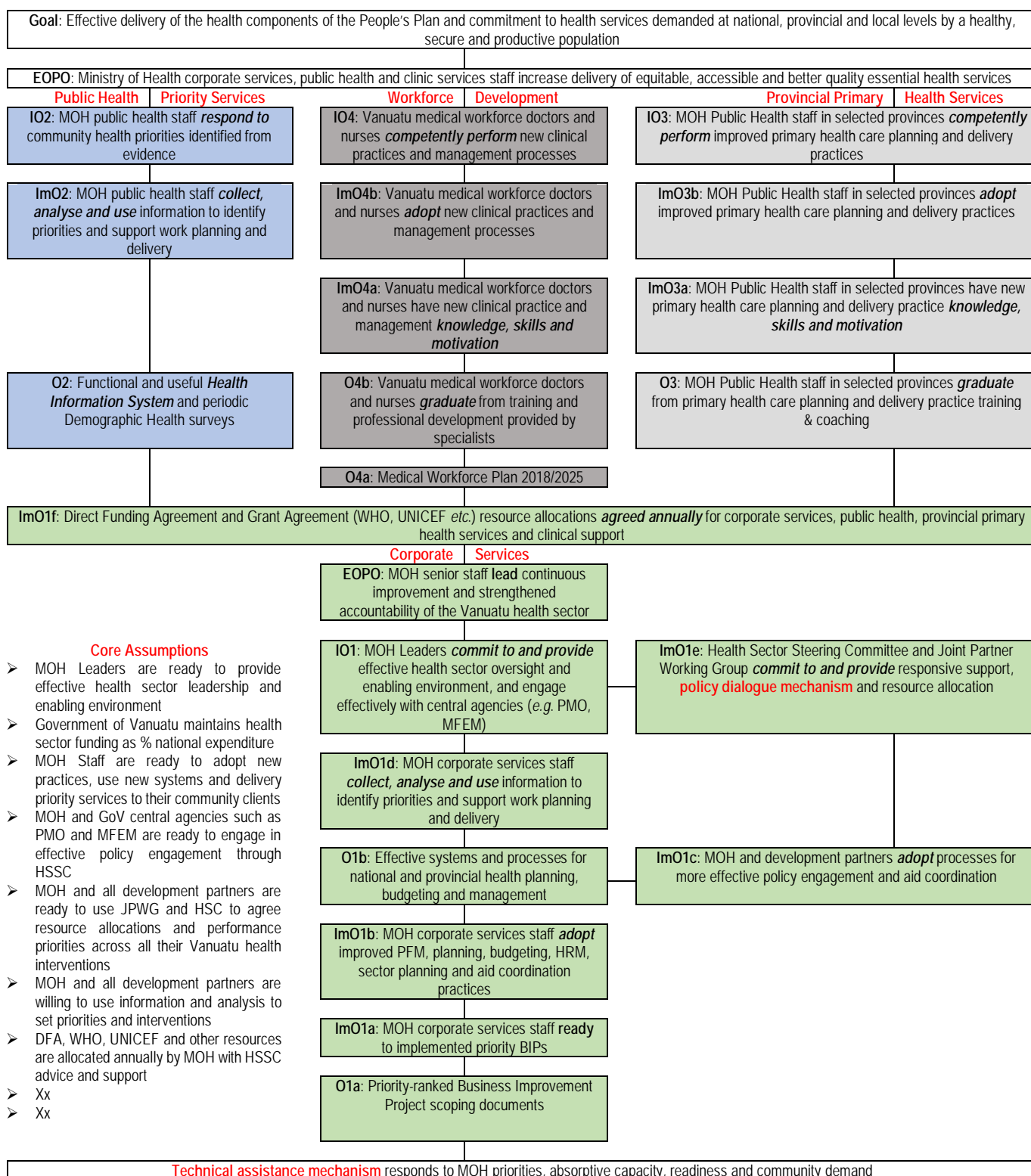
The outputs, immediate outcomes, intermediate outcomes, end-of-program-outcomes and assumptions identified in the logic model provide the foundation for a useful performance assessment framework. This would typically include:

- **Management monitoring** – indicators of resource allocation (money, TA, time)
- **Progress monitoring** – indicators to assess adequacy of progress against budget (from management monitoring); against annual work plans (aligned to HSSC annual resource allocation)

agreements but including outputs and any variance in the delivery against plan); and towards EOPO (aligned to the logic model)

- **Performance monitoring** – indicators to assess delivery of immediate and intermediate outcomes and identify any variance in their delivery against plan
- **Evaluative studies** – periodic health sector contextual update, and testing of those core assumptions that are impacting the program (*e.g.* reasons for lack of progress as expected) or that the program is impacting (*e.g.* policy engagement affecting resource allocation to provinces or an enabling environment for health sector workforce).

## Logic model – Vanuatu Health Program



## Team Leader/National Level Facilitator

<b>Position:</b>	Team Leader/National Level Facilitator
<b>Duration of Engagement:</b>	
<b>ARF Discipline and Job Level:</b>	
<b>Reports to:</b>	DFAT
<b>Location:</b>	

### Position Objective

To provide senior leadership and facilitation support for the implementation of the Vanuatu Health Program, working collaboratively with the Ministry of Health, DFAT and other Delivery Partners.

### Responsibilities

1. Engage strategically with the MOH, other GoV Agencies, DFAT, and Delivery Organisations to develop collaborative relationships and promote sector coordination for effective policy dialogue.
2. Facilitate strategic planning, technical advice and planning support to the Ministry of Health at national level, and lead the work of Provincial Facilitators working with Provincial MOH staff.
3. Oversee the development, quality and implementation of Technical Assistance Plans, and facilitate support for effective monitoring and review of the program in line with the M&E Framework.
4. Lead the Core Team in program planning, resource management and technical support for the program, including support to the Delivery Organisations and Implementing Partners as required.
5. Monitor the changing policy and operational environment, manage risk, and provide pro-active advice and management to respond appropriately.
6. Ensure that the program and its activities, deliver services on budget, and demonstrate value for money through the effective and efficient use of program resources.

### Selection Criteria

**Communication and political acumen:** High-level interpersonal skills, including verbal and written communication, and an excellent ability to develop and maintain results-focused stakeholder relationships while demonstrating high levels of political acumen.

**Team work:** Demonstrated ability to lead and work effectively with others and facilitation and negotiation of effective solutions in complex settings.

**Capacity development:** Demonstrated extensive experience in capacity development approaches and the ability to utilise a range of techniques to increase the confidence, skills and service delivery standards of peers, counterparts and partner agencies.

**Cultural sensitivity:** Demonstrated ability to work sensitively in a complex cross cultural operating environment, particularly in the Pacific.

**Operational Management:** Demonstrated experience in team leadership and management, including planning, budgeting, financial management and risk management.

**Technical skills:** High level relevant strategic management skills and extensive practical experience in working successfully in a public sector international development context, preferably within the health.

**Performance Management:** Experience in the oversight of monitoring and evaluation, research and learning processes to ensure quality and improve performance of programs and projects.

**Qualifications and Experience:** Post-graduate tertiary qualifications in public health, public sector management, health economics or management; plus 10+ years of relevant professional experience.

## Provincial Facilitators

<b>Position:</b>	Provincial Facilitator
<b>Duration of Engagement:</b>	
<b>ARF Discipline and Job Level:</b>	
<b>Reports to:</b>	DFAT
<b>Location:</b>	

### Position Objective

To provide facilitation support for planning, management and implementation of local solutions and advocacy to address critical constraints to service delivery, working collaboratively with the Provincial and National Ministry of Health other health service delivery partners at the local level.

### Responsibilities

1. Engage strategically with the Provincial MOH managers, other GoV Agencies, local NGOs and CBOs to develop collaborative relationships and promote coordination for local prioritisation, planning and implementation.
2. Develop approaches and plans for technical assistance and grant financing that address local priorities, and supports local Provincial MOH leadership capacity, to address critical health constraints.
3. Support ongoing monitoring and review of planning and implementation.
4. Assist local GOV staff to advocate for policy reforms and priorities that meet local needs and address constraints.
5. Monitor the changing policy and operational environment, manage risk, and provide pro-active advice and management to respond appropriately.

### Selection Criteria

**Communication and political acumen:** High-level interpersonal skills, including verbal and written communication, and an excellent ability to develop and maintain government and community relationships for joint effort.

**Team work:** Demonstrated ability to lead and work effectively with others and facilitation and negotiation of effective solutions in complex settings.

**Capacity development:** Demonstrated extensive experience in capacity development approaches and the ability to utilise a range of techniques to increase the confidence, skills and service delivery standards of peers, counterparts and partner agencies.

**Cultural sensitivity:** Demonstrated ability to work sensitively in a complex cross cultural operating environment, particularly in the Pacific.

**Operational Management:** Demonstrated experience in planning, budgeting, financial management and risk management for health or related community programs.

**Technical skills:** Relevant experience in public health or related community programs.

**Performance Management:** Experience in the monitoring and review of community based and capacity building programs, particularly in participatory analysis processes.

**Qualifications and Experience:** Graduate tertiary qualifications in public health, public sector management, health economics or management; and 5+ years of relevant professional experience.