WORKING PAPER 2: SOLOMON ISLANDS COUNTRY REPORT

EVALUATION OF AUSTRALIAN AID TO HEALTH SERVICE DELIVERY IN PAPUA NEW GUINEA, SOLOMON ISLANDS AND VANUATU

JUNE 2009

Australian Government
AusAID
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JUNE 2009

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As always, remaining errors of fact or judgement are the responsibility of the authors.

ABBREVIATIONS

AHC	Area Health Centre
AMC	Australian Managing Contractor
ARI	acute respiratory infection
AusAID	Australian Agency for International Development
DHS	Demographic Health Survey
EPI	Expanded Program on Immunisation
GDP	Gross Domestic Product
HF	high frequency
HIES	Household Income and Expenditure Survey
HIS	Health Information System
HISP	Health Institutional Strengthening Project
HSSP	Health Sector Support Program
HSTA	Health Sector Trust Account
ICR	Independent Completion Report
IMF	International Monetary Fund
IMR	infant mortality rate
ITN	insecticide-treated net
LLIN	long-lasting insecticide treated net
MCP	Malaria Control Progrmame
MEMP	Medical Equipment Maintenance Project
MHMS	Ministry of Health and Medical Services
MMR	maternal mortality ratio
MTEF	Medium Term Expenditure Framework
NCDs	non-communicable diseases
NMS	national medical stores
NRH	National Referral Hospital
NVPDCP	National Vector Born Diseases Control Programme
ODA	Official Development Assistance
ODE	Office of Development Effectiveness
PacMI	Pacific Malaria Initiative

PHC	primary health care
PIP	Program Implementation Plan
RAMSI	Regional Assistance Mission to the Solomon Islands
RHC	rural health centre
ROC	Republic of China
SBD	Solomon Islands dollars
SIG	Solomon Islands Government
SPC	South Pacific Community
STI	sexually transmitted infection
SWAP	sector-wide approach
TA	technical assistance
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCCT	voluntary confidential counselling and testing

EXECUTIVE SUMMARY

Background

This working paper summarises the findings of a review of Australian support to health services in Solomon Islands. It is one of three country case studies contributing to the Australian Agency for International Development's (AusAID) evaluation of Australian support for health service delivery in Melanesia, managed by AusAID's Office of Development Effectiveness (ODE).

Country context

Solomon Islands is still recovering from a sharp decline in Gross Domestic Product (GDP) that occurred during the ethnic tensions of 1999–2003, and remains dependent on external support through the Regional Assistance Mission to Solomon Islands (RAMSI) to maintain law and order. Aid is equivalent to more than 60 per cent of GDP, nearly half representing support for the police and criminal justice system. Australia is the source of 65 per cent of external aid.

Recovery of economic growth has depended on aid and unsustainable logging. The International Monetary Fund (IMF) forecasts slow economic growth, declining external aid, and a 30 per cent reduction in public expenditure per head between 2008 and 2012.

Health sector financing and financial management

Around 94 per cent of health spending is accounted for by the public sector (Government plus donors), with private out-of-pocket expenditure extremely low. Donors finance nearly all development spending and half of recurrent spending, with Australia accounting for 70 per cent of aid to health.

Public and donor spending on health has grown rapidly since the end of the tensions and the 2008 health budget, which captures most external aid, includes public health expenditure of more than eight per cent of GDP, a higher share than almost all low and middle income countries. Government health spending comfortably exceeds the 10 per cent share of total government expenditure agreed to with AusAID. The pattern of expenditure in recent years has included adequate provision for non-salary operating costs of running the health system.

The main budget allocation issue is the excessive share being spent on Honiara-based administration and on hospital services relative to provincial spending on primary and preventive services. However, the strategy for achieving reallocation is unclear. The Health Sector Support Program (HSSP) document envisages user fees as one way to manage the increasing demand for tertiary services and hence release resources for provinces. However, there is currently no government agreement to introduce fees. Nominal spending on the provinces has increased since 2004 but the withdrawal of AusAID support for provincial grants (support to church hospitals and training institutions continues) has meant that the substantial increase in Solomon Islands Government (SIG) provincial grants has been insufficient to maintain real per capita spending by the provinces. Allocation between the provinces also needs attention. Malaita, for example, receives less than its 30 per cent share in population despite having some of the most serious health challenges.

There is a strong case for AusAID to support provincial grants through the government system, but this would first require progress in financial management. Support to the provinces is necessary and should be an early priority for the work of the accounting firm being recruited to support financial management capacity in the health sector. Financial management risks can be managed by a combination of capacity building, formal auditing and strengthened management supervision, supplemented, if necessary, by sample tracking studies and a stronger community role. Risks to AusAID can be minimised by requiring repayment from future aid of any amounts found to have been incorrectly used. However, sanctions for non-compliance with accounting regulations should be proportional, with accounting risks balanced against the impact on the health services of disruptions to funds needed for service delivery.

Health system performance

Considering the recent challenges and constraints, the performance of the health system is positive, achieving high coverage (three quarters of the population use public health facilities and some 85 per cent of mothers give birth in a facility), high satisfaction levels and steady progress on health outcomes with relatively equitable access. These good results are confirmed by a range of independent surveys using different approaches.

Areas of concern include malaria (still the highest incidence outside Africa, but with an early sustained reduction to pre-conflict levels since the restoration of political stability), a five-fold higher maternal mortality ratio in out-of-facility births, recent sharp increases in sexually transmitted infection (STI) incidence and patients diagnosed with non-communicable diseases (NCDs), and family planning (where there is evidence of significant unmet demand). The health system is highly centralised, which concentrates relatively more resources (and hence demand) on the National Referral Hospital (NRH).

AusAID support to health

During 1999 to 2007, Australia provided some A$90 million in support for the health sector—63 per cent of this aid was spent through the health sector trust account, an off-budget fund managed by technical assistance (TA) advisers. It financed drugs and medical supplies, grants to provinces to meet operational expenditure, operational costs of the NRH, and (during the tensions) direct payment of salaries. It was largely successful in stabilising health spending during the tensions, when government revenue halved. The other major activity (25 per cent of Australian assistance to health) was the Health Institutional Strengthening Project (HISP), the main vehicle for providing TA. From 2007–08, in preparation for moving towards a sector-wide approach (SWAP), all support to the sector has been brought under a single instrument, the HSSP.

Performance of Australian aid

The positive performance of the health sector has only been possible because of sustained AusAID financial support, especially crucial in keeping services operating during the tensions and facilitating a speedy recovery of service coverage. The health system did not collapse as has happened elsewhere in the world during similar periods of instability and AusAID deserves a significant share of the credit for this. Installation of a radio system had a major impact on the management and effectiveness of the

system. The Health Information System (HIS) provides a range of useful information, the general accuracy of which is confirmed by a range of survey-based estimates. TA in planning and budgeting contributed to improved management and better integration of services.

There has been too little attention given to policy dialogue and agreement to ensure that aid interventions operate in a supportive policy framework, and too little attention to intervening at the right level and in the best way. AusAID might perhaps have done more to challenge the heavy emphasis on curative and facility-based care, and the under-emphasis on outreach, and called for more emphasis to be given to relatively neglected areas including family planning and non-communicable diseases (NCDs). Finding ways to make this practical politics in the face of long queues at the hospital gates is not easy.

The objective of reducing the share of the budget taken by the NRH requires a set of supportive policy measures that could include clarity on what services should be offered for free, freedom to refuse service or raise charges for other services, and commitment to a fixed budget to encourage savings. In the absence of a supportive policy environment there were obvious limits to what could be achieved by long-term AusAID technical support to the NRH, and it is not surprising that earlier evaluations of this support reached relatively negative assessments.

The approach has been fragmented, better at delivering specific inputs than at seeing the needs of the sector as a whole. For example, the support to the HIS focused on the needs of Honiara and did not make available data at local level in support of province planning, budgeting and management. It also failed to address the needs for data disaggregated by gender.[1]

There have been problems with lack of continuity. The most serious was the unplanned transition year before the start of the HSSP, which resulted in a 30 per cent drop in AusAID spending. There are other examples where greater attention could have been given to protecting the benefits of earlier work, including the substantial investment in radios and the work of individual TA advisers (e.g., manuals produced but never printed). This partly reflects the fact that long-term advisers stayed on average for just one year.

There are plans to carry out an equity analysis based on data from the Household Income and Expenditure Survey (HIES) and the Demographic and Health Survey (DHS). Preliminary data from the DHS suggests that the system at present is relatively equitable, with no evidence of lower utilisation by the poor. It is nevertheless a concern that poverty, gender and ethnicity issues do not feature at all in the HSSP results framework, and indicators are not disaggregated by gender. As the system expands towards universal coverage the task will be to identify who does not use the service, and what the constraints to doing so are. Disaggregated analysis and monitoring will be essential for this.

Opportunities and challenges for improving service delivery

To reach a durable agreement on future development of sustainable health services, the Ministry of Health and Medical Services (MHMS) should consider launching a broad consultative process to try to

1 This was noted in the design review for the HSSP in March 2008 and is to be addressed in subsequent revisions scheduled for the HIS data sheet.

define a future health sector strategy, including explicit agreement on the limits to government financing and provision. To be successful, this will need skilled facilitation informed by good understanding of alternative policy options and of the financial resources potentially available.

Provincial health services are the key to improving the coverage and quality of health services. Increased provincial budgets need to be supported by measures designed to help provincial health directors and their staff. To manage all aspects of services, provincial health directors need to be freed from many clinical duties they are performing. They and their management teams need support through training and continuing education. Budgets need to be linked to service delivery plans and an increased focus on performance needs to be encouraged at all levels—through supervision, regular performance reviews (supported by access to province level HIS data) and opportunities for provinces to exchange experiences. Incentives for staff need attention, particularly staff housing, and the implications of different employment terms depending on whether staff are financed centrally, by the province, or by the community. Reinforcing the role of health centre management committees would in turn reinforce these measures.

Physical facility plans and workforce plans are needed, which requires mapping the health workforce. The Infrastructure Plan, developed under HSSP, will hopefully commence implementation in early 2009.

Making progress towards a sector-wide approach

While the MHMS believes there is a clear strategy for the health sector in place, this needs further definition to clarify aspects of policies, resources, action plans and other implementation arrangements. Poverty and gender need more explicit attention, reflected in policy measures, resource allocation, explicit targets and the monitoring framework—which needs gender-disaggregation of indicators. For putting in place the policies and plan, it is important to seek broader national endorsement, beyond those currently holding office. To this end, many countries include a participatory consultation process at an early stage of policy or plan formulation, with a series of regional and national consultations involving diverse groups.[2]

Government cannot define health policies and plans without knowing what resources it can rely on. Donors, especially Australia, need to clarify what financial resources are potentially available for as far into the future as possible, and certainly for not less than five years. AusAID has moved forward in this direction through the five-year Subsidiary Arrangement. To be of real help to Government, however, funds need to be fully available for financing expenditures identified within the government health plan and budget, knowing the aggregate sum is of limited use if decisions on how funds are used are taken by the donor in a non-transparent manner. Government needs to ensure resources are not interrupted by gaps in timing between successive donor agreements. Any conditions require plenty of advanced warning (next budget not the current year), changes should be at a pace that the SIG can adjust to without severe disruption and dialogue on what is required to restore spending levels should continue.

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2 See the World Bank's Sourcebook for Poverty Reduction Strategies for examples.

The SWAP relies on two annual reviews as the main forum for dialogue with donors. Experience of other SWAPs suggests that one main review should be sufficient (preferably informed by province-level reviews), supplemented with an annual meeting to discuss and agree on the budget and operational plan. There is also likely to be a need for more regular contact to solve problems during the year, possibly by introducing donor representation for relevant parts of executive committee meetings.

AusAID provides one-third of total public expenditure on the health sector. Restrictions on what this can be used for risk distorting the budget (too little for provinces), while there are obvious dangers in the long-term dependence of the health sector on a parallel donor trust account for the supply of nearly all drugs. Good annual dialogue on the budget, plus measures to strengthen financial management and monitoring, should enable AusAID to provide support using government procedures without earmarking to specific purposes, and without incurring unacceptable risks of misappropriation.

Additional Australian resources for malaria control are being provided through the Pacific Malaria Initiative (PacMI) and it is envisaged that these will support and help maintain the good early reductions in malaria incidence while, at the same time, contributing to health systems strengthening. Efforts already undertaken to integrate PacMI and HSSP within a single sectoral plan are important in this regard and should be sustained.

Technical assistance and capacity building

Some individual advisers have achieved enduring results, for example the impact of the primary health adviser on provincial planning and budgeting. Nevertheless, the reliance on international advisers as almost the only mode of technical support has not served the sector well.

The team proposes an approach that identifies objectives, considers alternatives and plans and implements a sequence of interventions to achieve them. The TA, for example, might be designed following a joint review of whether existing functions need to be in Government, whether they should be handled differently and/or whether supporting policy changes are needed before success can be assured. The TA should be fully integrated in the sector strategy and defined around what is required to achieve the objectives, not by the contract of an individual. It could potentially include a range of coordinated inputs, possibly including training staff to fill line positions but with recruited officers having an explicit focus on developing the staff working to them, short- and long-term advisory inputs, introduction of systems improvements, contracting out of functions, and access to distance learning or mentoring. This is especially important in the context of a SWAP, which requires developing policies, systems, operational guidance, and providing follow-up training and support to national and provincial staff. This is likely to be best delivered by contracting organisations or firms to deliver a package of support.

Recommendations

The team's suggestions and recommendations are brought together in Section 6.

CHAPTER 1: INTRODUCTION

1.1 Terms of Reference and methodology

The ODE is evaluating the effectiveness of AusAID's contribution to improving the delivery of essential health services for the poor on a sustainable basis. The purpose of this evaluation is to draw lessons about what has worked and what has not, to inform the development of improved approaches for the future. The evaluation is based on three country case studies conducted in Papua New Guinea, Solomon Islands and Vanuatu. This working paper summarises the findings from the Solomon Islands country case study.

The team defines the health sector to include promotive, preventive and curative health services, whether provided or financed by Government or by non-government sources. Interventions in other sectors—such as water and sanitation, transport, or education—are not included, although it is recognised that they can have major impacts on health outcomes.

The path to achieving service delivery outcomes (increased utilisation and coverage, reduced gender and poverty related inequity) and impact (improved survival, reduced morbidity, improved equity and social and financial risk protection) passes through a number of stations. These include appropriate inputs in the form of funding, plans and harmonisation, as well as effective processes for national plan implementation, capacity building, performance monitoring and accountability. In turn, these inputs and processes are expected to produce a sound health system (governance, human resources, medicines and supplies, information) and improved services (access, safety, quality, efficiency).3

Evaluating AusAID's contribution to effective health service delivery in the study countries entails collecting and analysing essential information on each of these inputs, as well as on enabling and inhibiting contextual factors that help explain health sector performance.

The methodology of the study involved:

- a literature review and analysis of available data (references consulted are at Annex 1)
- interviews with key informants (Annex 2 lists those interviewed)
- field visits to sites in Guadalcanal and Malaita (Annex 3)
- debriefs with government partners and AusAID in Solomon Islands, and with AusAID staff in Canberra.

1.2 Structure of the report

The report starts with some brief background on the country (Section 1.3) and on AusAID support to the health sector (Section 2), followed by Section 3 on health sector development, which includes a discussion of how health services were financed (3.1) and what results have been achieved in health outputs and outcomes (3.2 and 3.3). Section 4 considers the performance of Australian aid in the sector over the period reviewed and Section 5 discusses opportunities and challenges for the future in

3 'Effective Aid, Better Health', report prepared for the Accra High Level Forum on aid effectiveness in September 2008. WHO, OECD, World Bank 2008

terms of the health system and services (5.1) and the conduct of the aid relationship (5.2). Section 6 offers some suggestions and recommendations.

1.3 Country context

Solomon Islands has a population of around 500 000 people spread over 992 islands covering 28 000 square kilometres. An outbreak of ethnic tensions in 1999 resulted in a decline in law and order and an associated steep decline in the economy, with a cumulative 24 per cent decline in GDP between 1999 and 2002, while real government tax revenues in 2001 and 2002 were only half the level of 1999.[4] Extortion and open corruption were widespread and prompted Government to request assistance. This resulted in the deployment in mid 2003 of the RAMSI which restored law and order, stabilised government finances, and has now turned attention to rebuilding the police, judiciary and other institutions of governance, and supporting improved economic management.[5] Fifteen countries contribute to RAMSI but Australia is by far the largest, providing more than 90 per cent of RAMSI's development assistance funding and around 80 per cent of RAMSI personnel. RAMSI is a long-term exercise.

Economic growth has averaged six per cent since 2003, but by 2007 real GDP per capita was still only 84 per cent of the pre-tension level. More worrying is the reliance of growth on unsustainable logging (10 per cent of GDP) and very high aid expenditures (35 per cent of GDP excluding military and police spending, but around two-thirds if included).[6] The IMF forecast a 30 per cent reduction in real government spending per head between 2008 and 2012. This is partly the result of negative growth in per capita income due to the impact of the decline in logging. Some 80 per cent of the reduction in per capita spending levels, however, is due to the IMF estimate that aid grants will fall from around US$122 million in 2008 to US$76 million in 2012, halving as a share of GDP. This may not happen, given AusAID commitment to increase aid spending, but the IMF analysis illustrates the necessity for clear information on future aid to permit the planning of public expenditure levels.

4 Calculated from IMF 'Solomon Islands: Selected issues and Statistical Appendix', August 2004 and Solomon Islands: Tax Summary and Statistical Appendix September 2007.

5 Australian National Audit Office, Audit Report No. 47 2006–07, Performance Audit, Coordination of Australian Government Assistance to Solomon Islands, 2007.

6 IMF, staff report for the 2007 Article 4 consultation, June 2007. RAMSI expenditure on the police exceeds total AusAID spending, the A$538 million allocation for 2005–06 to 2008–09 is equivalent to more than 30 per cent of period GDP.

CHAPTER 2: AUSTRALIAN AID TO THE HEALTH SECTOR

2.1 Australian aid to Solomon Islands and the health sector

Australia is by far the largest donor (Figure 2.1) in Solomon Islands. Current Australian assistance is equivalent to half of GDP, and exceeds Solomon Islands Government's own total expenditure (Table 2.1). The bulk of Australian Official Development Assistance (ODA) is provided through RAMSI. Law and justice accounts for 80 per cent of RAMSI expenditure, mainly for the police.

Figure 2.1 Official Development Assistance shares by donor

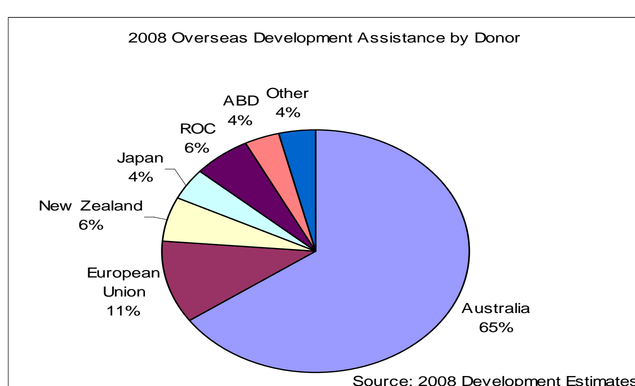


Table 2.1 Australian Official Development Assistance through RAMSI and the bilateral program

			A$ million	
	2004–05	2005–06	2006–07[1]	2007–08[2]
Total Australia ODA	179.1	224.7	219.8	223.9
Australia ODA to RAMSI	144.9	178.6	196.5	189.9
of which: AusAID	65.1	69.4	69.8	67.4
Other Australian government departments	79.8	109.2	126.7	122.5
AusAID bilateral ODA	27.4	28.6	27.7	28.0
Total Australia ODA as % of GDP	45%	50%	48%	50%

Source: AusAID 2007 estimates

Notes: 1 expected, 2 budgeted

Donors currently fund around half of the MHMS' recurrent expenditure and most of its capital expenditure. Again, Australia is the largest contributor, accounting for about 70 per cent of ODA to the sector.

Australian support has been provided primarily through the bilateral program, though Solomon Islands has also been included in a number of regional health initiatives funded by AusAID in the

Pacific. During 1999 to 2008, Australia provided more than $90 million to the health sector (Annex 4). During 1999 to 2007, there were two main initiatives. The HSTA spent 63 per cent of the total and was the major vehicle for financial support, including drugs and medical supplies, grants to provinces to meet operational expenditure and (during the tensions) direct payment of salaries. The HISP accounts for a further 25 per cent of the total, and was the main vehicle for providing TA. From 2007–08, in preparation for moving towards a SWAP, all support to the sector has been brought under a single instrument—the HSSP.

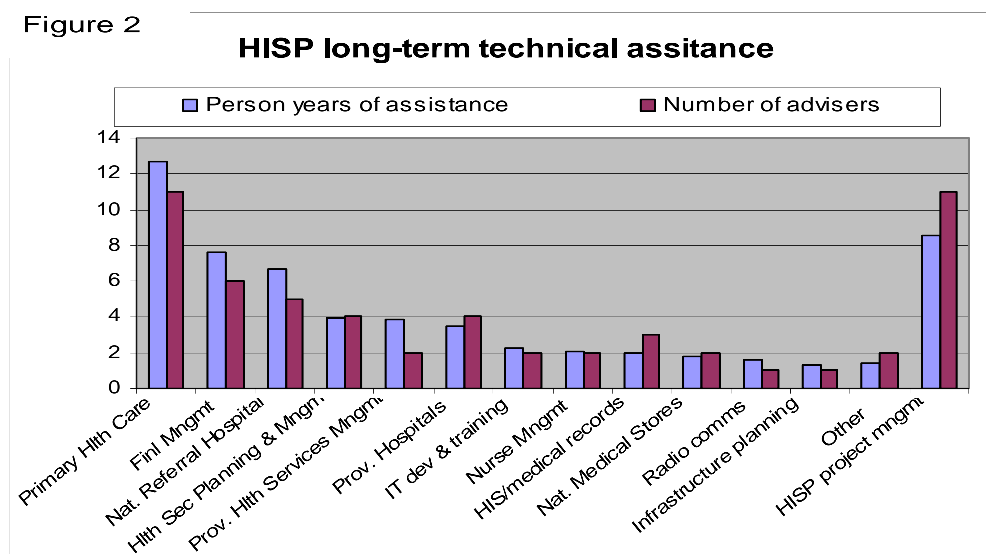
2.2 Summary of Australian aid activities in the health sector

The HISP was a conventional project implemented by an Australian Managing Contractor (AMC) on behalf of the Australian Government. Its objectives were to: (a) strengthen the management capacity of senior headquarters staff; (b) improve the efficiency and effectiveness of primary, preventive and promotive health services at the provincial level; and (c) develop the NRH's role and improve the efficiency and effectiveness of the hospital's service delivery.

Both HISP ($20 million) and its predecessor, the Interim Strengthening Project ($1.6 million, 1999–2001), were predominantly TA projects, with almost 80 per cent of expenditure accounted for by international personnel. Over the life of the project, the HISP provided a total of 64 person years of TA. Of this, 59 years were in the form of long-term TA though the average duration of an individual long-term technical adviser was just over 12 months. Figure 2.2 shows the distribution of long-term TA under the HISP.

The origins of the HISP lay in the immediate, pre-conflict period. This was characterised by efforts to introduce policy and structural reform within the SIG, and the establishment of a medium-term development strategy, the production of a five-year national health policy and development plan and the restructuring of the MHMS in preparation for a World Bank sector development project loan. The start was delayed by the conflict and the original design was re-examined by an AusAID health sector review mission in early 2001. The mission concluded that the design remained relevant in spite of the conflict and deteriorating economic situation. The HISP got underway in August 2001.

Figure 2.2 Health Institutional Strengthening Project long-term technical assistance



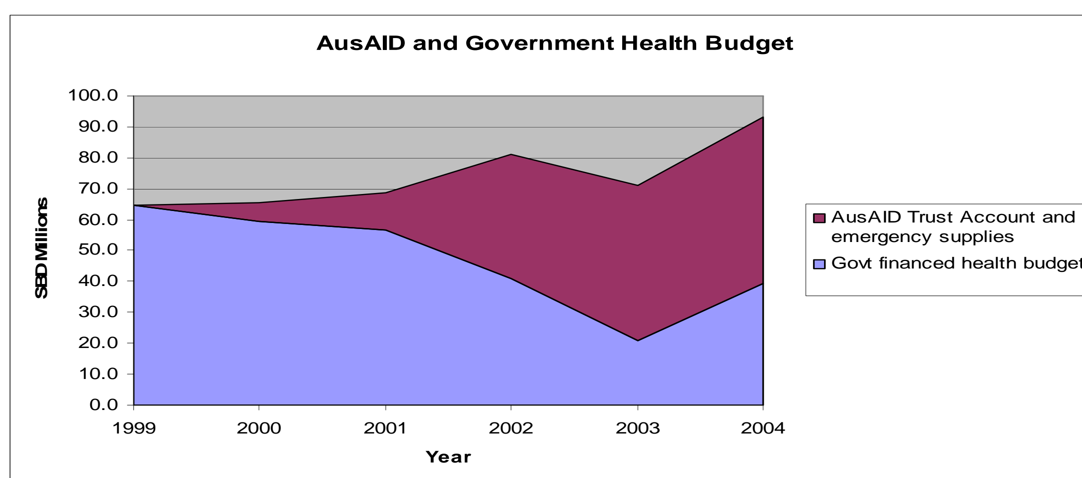
The HSTA was created in May 2001 in direct response to the adverse effects of the conflict, including withdrawal by all major donors except Australia, significant contraction of government revenue, loss of health care professionals, disrupted flow of essential drugs and other medical supplies, breakdown in communication between headquarters and rural and regional health services, and damage, destruction and theft of health care infrastructure.

It was set up as a mechanism to provide assistance in the almost total absence of provincial health grants from the SIG and initially met most recurrent costs (including some salaries). The HSTA channelled just over $50 million from 2001 to 2007 and during that time met the full costs of medical supplies and drugs, clinic radios, overseas pathology costs, overseas patient referrals, overseas locum doctors fees for the NRH, NRH operational costs, and, in addition to drug purchases, operational support for the National Medical Store (NMS). The HSTA operated outside of the SIG's recurrent budget and was managed originally by the Interim Strengthening Project technical advisers and then by the HISP advisers.

Data on government expenditure during the tensions is fragmented and definitions are not always given in the sources. The data in Figure 2.3 are subject to a significant margin of error, but they do serve to illustrate the impact that AusAID had in stabilising total health expenditure during a period when GDP fell by a quarter and government revenue halved in real terms. It did not prevent a dip in real spending, but the decline was moderate and growth quickly resumed from 2004.7

From 2007–08, AusAID has changed the nature of its engagement in the health sector in Solomon Islands by moving towards a SWAP. Australia will contribute A$60 million over five years to the SWAP through the new HSSP. The HISP was extended by one year to August 2007 to assist in the transition to the SWAP.

Figure 2.3 AusAID trust account and emergency supplies and government health budget8



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7 The figures on government financed health expenditure were estimated by multiplying WHO data on the share of GDP spent. by Government, net of external finance, by IMF GDP figures. The AusAID data on trust account spending were converted to Solomon Islands dollars using IMF average exchange rates with financial year expenditure distributed equally between the two calendar years.

8 Sources: WHO world health reports and world health statistics database; IMF for GDP and exchange rates; Table 2.2.

Although important progress is being made, the HSSP does not meet the conventional criteria for a SWAP, which includes Government and all significant development partners jointly supporting a single strategy and expenditure program for the sector, led by Government, with partners progressing towards using government procedures.

The HSSP was to have commenced in mid-2007 but was delayed, due in large part to challenges in the relationships between the key program partners and to a lesser degree the April 2007 tsunami. Unspent funds from the HSTA and tsunami relief[9] were used to bridge the gap in support (but did not prevent a 30 per cent dip in AusAID funding). The HSSP finally got underway in April 2008. At commencement, AusAID was the only contributing development partner. The HSSP program document, produced by an AusAID consultant, appears to lack government ownership. AusAID support is largely captured in the budget, but it is administered using parallel procedures and there is as yet no medium-term plan and expenditure program with clear service delivery and system reform objectives.

Under the HSSP, AusAID will continue to provide TA support to the MHMS. During the first couple of years, around 10 advisers will be provided, covering hospital management, community health, financial management, human resources, health information, procurement, medical supply and tendering, infrastructure, pharmaceutical procurement and supply chain management, and radio training. In addition, the World Bank will also provide TA to the MHMS to support expenditure management, performance monitoring, and training for senior central and provincial staff.

In addition to the HSSP, AusAID is currently contributing to a new regional PacMI, dedicated specifically to malaria control and, eventually, elimination. The budget allocated to the Solomon Islands National Vector Borne Diseases Control Programme (NVBDCP) from Australian funding is A$20 million from 2008–11, with possible extension to 2014. These funds will be used to address aspects of malaria control that lie outside the design of the other principal projects addressing malaria in the Solomon Islands.[10] PacMI will specifically address the need for additional high-level technical support to the NVBDCP, and will support the introduction of new treatment therapies and rapid diagnostic tests for communities and facilities without access to microscopy, overseas and in-country training for the program's technical staff and a malaria elimination pilot project in Temotu Province (Section 3.2).

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9 Tsunami relief funds were only borrowed temporarily.

10 The Global Fund to fight AIDS Tuberculosis and Malaria (Rounds 2 and 5) and Rotary Against Malaria, with technical support from WHO and the Secretariat of the Pacific Community (SPC).

CHAPTER 3: HEALTH SECTOR DEVELOPMENT 1998–2008

3.1 Health sector financing

Government and aid donors dominate health sector financing in the Solomon Islands. In 2004, they accounted for 94.5 per cent of health sector expenditure, the highest share in the world apart from some micro states, while private out-of-pocket spending was just three per cent.[11] Total health expenditure has been above five per cent of GDP, significantly higher than PNG and Vanuatu,[12] and above the average for low and lower middle income countries. The budget expenditure figures produced by the health ministry for 2008, which try to capture most development partner expenditure, give total spending of SBD$256 million, equivalent to a very high 8.7 per cent of GDP.[13] This is one of the highest percentages of expenditure on public health by any low or middle income country.

Budget allocations to the Ministry of Health

The HSSP agreement specifies a minimum 10 per cent share for the Ministry of Health, though the evaluation found some lack of clarity about how this is defined. Figures prepared by AusAID technical advisors to the Ministry of Finance imply that budget allocations to the Ministry of Health have been volatile, even before the sharp decline during the tensions (Figure 3.1). Some of the changes may be due to changes in definitions and coverage, though the sharp decline between 1999 and 2002 is due to the tensions. Indeed, even in recent years the budget document presents ministry and total budget information in different formats. There is a need for consistent definitions so that performance can be measured impartially against standards. For 2006 to 2008, on either a narrow or a broad definition, the health share in public expenditure was between 12 and 14 per cent of total government spending. Government expenditure equals 65 per cent of GDP in 2008, so a 10 per cent share based on the broad definition would imply government expenditure of 6.5 per cent of GDP, which is high by international standards.

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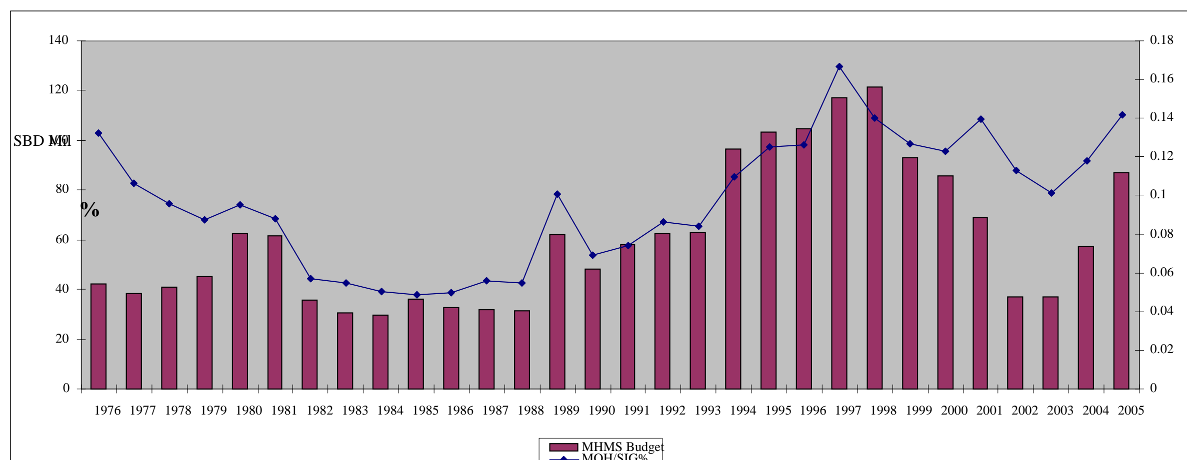
11 WHO health statistics database.

12 WHO give a figure of just 4.3 per cent in 2005, but this is down from 5.9 per cent in 2004, and seems to be a statistical anomaly, given that SIG and donor sources show both domestic and external spending increasing sharply.

13 Budget spreadsheet prepared by the Ministry of Health. Figures include water and sanitation, but the percentage would still be above eight per cent if water and sanitation is excluded.

Figure 3.1 Ministry of Health and Medical Services real budgets and % of Solomon Islands Government budget resources, (constant SBD$—date unknown)



Source: Chris Chamberlin, Solomon Islands Health Expenditure Review, 2006, based on data provided by the Ministry of Finance.

Allocation within the health sector

Public expenditure on health has a good balance between recurrent and capital spending, with adequate provision for drugs and non-salary operating costs. The main problems identified by the Health Expenditure Report and confirmed by the Project Implementation Plan (PIP)14 and the program document15 are a bias towards Honiara, with an excessive share of total expenditure on general administration (17 per cent) and on hospitals (32 per cent), dominated by the NRH.16 The program document envisages increasing the share of the 'frontline' (i.e., spending by or on behalf of provinces) from 32 to 40 per cent, by improving efficiency, and raising revenue equivalent to five per cent of recurrent spending, to defray hospital costs and divert inappropriate demand towards (free) primary services. The main problem with this strategy is that demand for hospital services continues to grow, and there is as yet no agreement to introduce user charges or define the limits to free, government financed and government provided services.

The team does not have data before 2004 on how much AusAID spent to support service delivery at province level and below, but the trust account was only active at that level from 2002 to 2004—spending in later years was centralised. Although there is likely to have been serious disruption between 2000 and 2001, aid funds continued to flow to the provinces during the latter years of the tensions, and was then phased out as SIG grants were increased. Figure 3.2 shows that there was a small decline in total support to provinces when trust account and Republic of China funding was withdrawn in 2005, but this was filled in by the SIG in the following years. AusAID and the SIG continued to support the church-run institutions and government training institutions to stabilise overall support to these special entities.

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14 Ministry of Health and medical services, Health Sector Support Program 2007–2012, Program Implementation Plan, version 8 July 2007.

15 Ministry of Health and medical services, Health Sector Support Program, Program Document, draft 7, 2 April 2008.

16 'Administration' may in practice include items that relate more to implementation of national programs.

Figure 3.2 Total resource flows to provincial and church health institutions, 2004–08

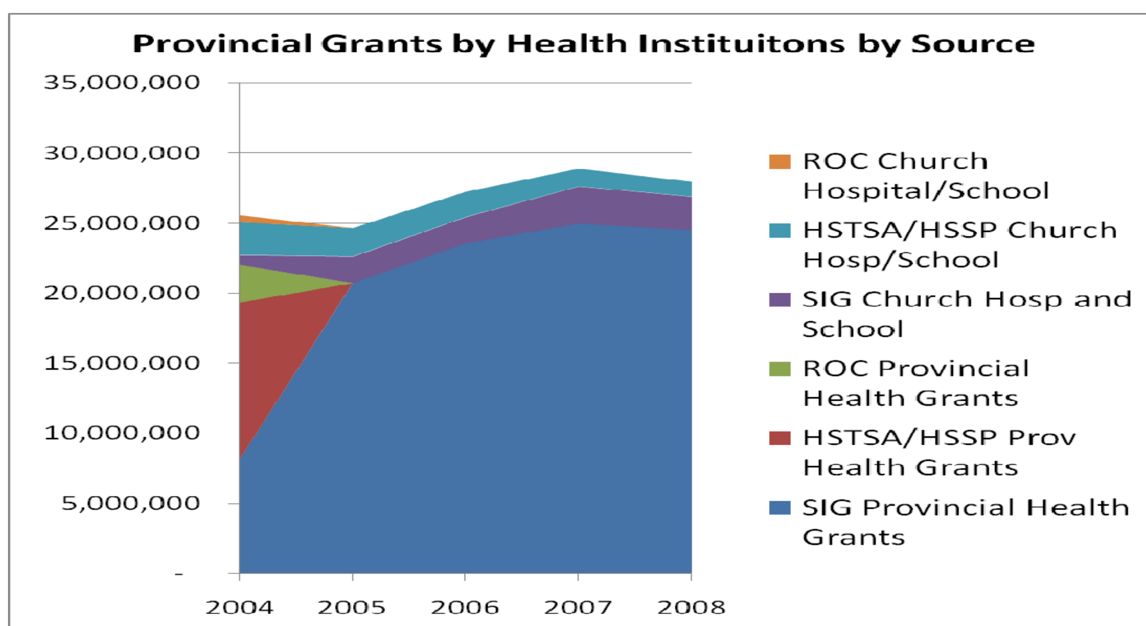


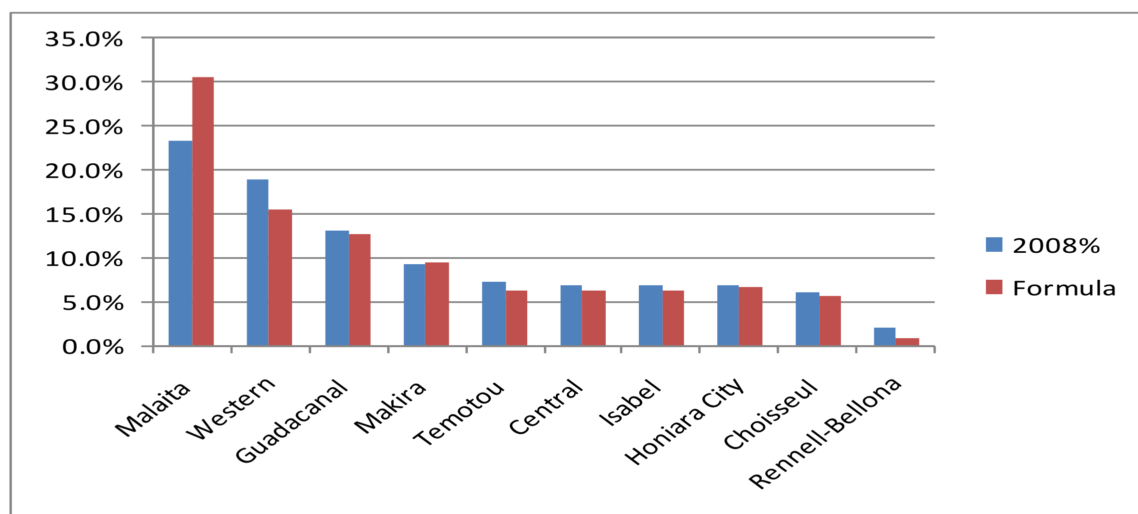
Figure 3.2 presents results for 2004 to 2008 in nominal terms. In real per capita terms, spending by provinces has fallen since 2004, increased spending from SIG resources being insufficient to offset the loss of donor support for provincial health grants.

Turning to the allocation between provinces, in 2003 AusAID consultants developed a resource allocation formula, which has since been abandoned. In 2007, a HSSP consultant revised the formula to better use available data and include a poverty variable.17 The team compared the actual percentage shares in the 2004 and 2008 budgets with those that would have been predicted by the formula. The main conclusion for both years was that Malaita (30 per cent of the total population18) receives a lower share than the formula would allocate. The shortfall has increased between the two years and in 2008 would imply increasing the allocation by one third (Figure 3.3). In terms of service delivery and some health outcomes, Malaita presents comparatively more serious health challenges than other provinces, as recent survey and HIS data demonstrate. This issue warrants attention from the MHMS executive.

17 Factors addressed in the revised formula include: population; an indicator of workload (primary health care (PHC) outpatient contacts); impact of hospitals etc. not funded by the Provincial Health Service; an indicator of disease burden (infant mortality rate); a poverty indicator (average annual per capita expenditure); a cost factor to account for differences in the cost of delivering health services in the provinces relative to Honiara due to remoteness, provincial logistics, and scale of operations. See HSSP Program Implementation Plan, pp. 44–46.

18 Solomon Islands National Statistics Office

Figure 3.3 Comparison of provincial grant allocations for 2008 and the allocation formula



Financial management and accountability and implications for AusAID

The default position in a SWAP is that the Government and development partners are jointly financing a single-sector strategy and expenditure program. As capacity develops, the donors make progress towards providing their financial support through the budget, using the same financial procedures as Government to disburse and account for the funds. This is especially important for financing the front-line services delivered by provinces. It is the provincial health departments with their limited financial management capacity that face the most severe difficulties and dangers of disruption when asked to juggle multiple sources of funding with different procedures.

AusAID has withdrawn from direct support to provincial grants, which (given that they represent 30 per cent of total spending and a bigger share of non-salary spending) limits the scope for increasing the province share in line with the targets of the HSSP. AusAID is reluctant to return to providing support to provinces because of ongoing problems in financial management at province level, including difficulties in acquitting provincial health grants. The financial management system SIG uses for province grants is based on an advance and acquit system. Provinces are in principle only able to draw new funds if they are up-to-date in accounting for previous advances. In theory, the accounting can be done at province level, with the province submitting statements of expenditure and bank reconciliations, but retaining original documents for subsequent audit. In practice, provincial accountants have received inadequate training on the computer software, and none of them are able to use the system. Instead, they are sending original documents to the accounts staff in the MHMS in Honiara, but the ministry lacks sufficient capacity to do the accounting on behalf of all provinces, and a substantial backlog has emerged. Government recognises that the problem is one of capacity rather than deliberate non compliance and has continued to disburse provincial grants despite the backlog in acquittals. The plan is to hire an accountancy firm to help clear the backlog and to provide technical support on the accounting software, but the current intention is to focus initially on central departments. This decision would be worth re-visiting, to give early priority to the provinces, which are, after all, the main priority identified for additional financial support.

If AusAID were to provide trust account funds again for provincial grants, the best way to do it would be by using the same procedures as Government. From a province point of view, government

and AusAID funds (together with those of other donors who might contribute to a pooled fund) would ideally be indistinguishable. Statements of expenditure related to the totality of the provincial grants could be prepared centrally, together with reconciled bank statements showing how the grants were financed from government and donor funds. Financial accountability at the province level would relate to the provincial grant as a whole.

Concerns about financial management in the health sector, the accounting backlog and the results of the 2005 audits of the NRH and the Ministry of Health (Annex 5) explain AusAID's cautiousness about providing financial support to provinces. Provincial health offices have yet to be audited (Western and Malaita provincial health offices will have been audited by late 2008) but the capacity issues discussed above make it likely that compliance problems will be revealed.

Given that Solomon Islands experienced a major breakdown in financial management during the 1999 to 2003 tensions, however, it is not surprising that the audits raise concerns. The Auditor General told the team that health is better than most government departments and that there has been significant progress in addressing concerns (Annex 5). The problems identified were mostly related to poor accounting and widespread, but low-level, petty theft, amounting in total to a relatively small percentage of total spending.

The main opportunities for fraud and misappropriation in health sectors usually relate to procurement and civil works (both centralised in Solomon Islands), selling or theft of drugs by falsifying prescriptions (not much in evidence given the small private sector and ready availability of drugs in the government system), illegal charges (evidently low given survey data on out-of-pocket health costs). In Solomon Islands, the main problem areas detected in audits have been stealing of catering supplies in the NRH, poor accountability for payments to patients to cover their transport costs, and a non-transparent practice of charging public patients for some services. The audit recommended a full review of fee practices for public and private patients, and issuance of a policy and fee schedule. Follow up to the NRH audit has been impressive in many respects (Annex 5), but in some areas there has been slow progress, including with policy on fee schedules and management, and strengthened monitoring of catering.

In terms of the risks related to provincial grants, the team can speculate (based on experience elsewhere) that there may be risks related to the misuse of official transport and fuel, falsification of staff expense claims, and similar problems to those detected at the NRH (catering abuses and payments by and to patients). Many of the problems will not be detected by audit—those intent on fraud are likely to ensure that receipts are provided, vehicle log books are signed, and other paper work is in order. Poor accounting is more likely to be the result of staff with inadequate financial management training failing to comply with complex procedures. Health staff who are busy looking after patients sometimes forget to manage pieces of paper. While missing receipts and disorderly accounts do not necessarily indicate fraud, they do need to be tackled. The HSSP is helping to address this by working with provincial health directors and accounting staff.

Controlling these financial risks depends on: building financial management capacity at province level; strengthening supportive supervision to ensure that managers are in a better position to judge whether claims are accurate; regularly examining in depth a sample of transactions to target areas of spending and individual departments or provinces where there is reason to suppose that risks are particularly high; and ensuring timely annual audit with a clear process for following up implementation of audit recommendations. These formal approaches can be strengthened by greater transparency and

community involvement in holding service providers accountable (e.g., posting the budget prominently on the walls of the facility, establishing facility management committees with community involvement), and by supplementing formal annual audits with financial tracking surveys to look in more depth at whether physical and financial resources arrive at their intended destination in full and on time and are appropriately used and accounted for.

When capacity has been built for provinces to report their expenditure using the Mind Your Own Business software, it will be reasonable for the MHMS to again insist on provinces being current with their financial reporting as a condition of drawing additional funds. The sanctions can be applied in a proportional way to minimise the disruption to services. For example, provinces can be encouraged to provide partial reporting (and receive a reduced replenishment) if all information is not to hand and they can be encouraged to seek technical support when problems are encountered.

The safeguards and additional measures described should be sufficient to minimise the fiduciary risks from provincial grants. If AusAID requires additional assurances as a condition of participation, it could follow World Bank practice by requiring re-payment from future aid of any amounts found to have been incorrectly used.

3.2 Health system performance: Outputs, outcomes and management performance

Demand for services: Access, utilisation, satisfaction and cost

Access and utilisation of health services compares very favourably with other low income countries. A Health Module within Solomon Islands HIES 2005–06 indicated that a high proportion of the population (87 per cent) seeks care if sick. Among those, 85 per cent sought care from a public facility, 4 per cent saw a private provider, and 3.5 per cent went to a traditional healer.

The RAMSI People's Survey 2007 (ANU Enterprises) asked about access to basic services (with an emphasis on health) and opinions on their availability and quality.

> Nineteen per cent of respondents said they had a health centre in their village or community; a further 42 per cent could reach a health centre in no more than an hour, and the rest took up to a half a day or longer to reach a facility.

> In the preceding year, 46 per cent of respondents had visited a health centre one to three times, 16 per cent had visited four to six times, and 14 per cent had visited more than six times. Twenty-four per cent had not visited a health centre. This implies average per capita outpatient contacts of at least 2.7 (consistent with the 2004 HIS estimate of 2.6). This is below the four per head recommended by the WHO, but actual achievement in many low income countries is less than one annual contact per head; the implied coverage is very high by low income country standards.[19]

> Access also appears to be equitable with no significant differences between income groups in immunisation coverage, and rural populations are no less likely to seek treatment from a health

19 http://www.who.int/hac/techguidance/tools/disrupted_sectors/module_07/en/index1.html. The figure is comparable with Indonesia (2.6) Portugal (3.4) and Macedonia (3), and is much higher than PNG (around 1.4) and most African and South Asian countries (1 or less).

facility. Poor and rural women and those with less education are slightly less likely to receive skilled assistance in delivery or to deliver in a facility, but the reported rates in the Demographic Health Survey are still very high, even for this group.

The national HIS indicates that annual acute care contacts decreased in all provinces except Isabel from 1999, reaching a trough of between 1.2 and 1.8 contacts per capita in 2002–03, when political instability and social unrest were at their peak. Service utilisation then recovered promptly, reaching two to 2.5 contacts per capita in all provinces except Malaita within two years. Community members and health workers consulted during the team's field visits ascribed the quick return to higher levels of service utilisation after 2003 to the traditionally high levels of trust and the strong relationship between the community and their service providers.

The results of the RAMSI People's Survey also reflect satisfaction with services:

- Of the 76 per cent of respondents who had visited a health centre at least once, 38 per cent said they were always satisfied with the services received and 40 per cent said they were sometimes satisfied.
- Twenty per cent gave reasons why they were not satisfied:
  - problems with a nurse or other staff such as an unacceptable attitude, slow service, absenteeism (3.1%)
  - medicines not available or not given (3.1%)
  - shortage of staff, medical supplies or other resources (5%)
  - treatment ineffective or expectations not met (3.3%)
  - inadequate facilities or no nurse (2.3%); and having to pay for services (2.5%).
- While 49 per cent of respondents said that health services had improved in the past two years, 39 per cent said they were the same, and 6per cent said they had deteriorated.

These data indicate a functioning system, where drugs and staff are available free-of-charge in more than 95 per cent of contacts. There may be some cultural bias towards answering questions positively but, even allowing for that, this is a very positive assessment compared to equivalent surveys of publicly funded primary care services in similar developing country and post-conflict environments.

Out-of-pocket expenditure on health

Average household expenditure on health is only 0.5 per cent of household spending in Honiara (~SBD 54) and Guadacanal (~SBD 26), and 0.2 per cent or less (generally <SBD 10) in all other provinces. The main cost to households is time and travel for those not close to a facility, and this was quoted by HIES respondents as the principal reason for not seeking care.20

Although there are some informal charges in health facilities (registration fees, private and community microscopy services), they are generally less than SBD 2 per occasion of service and do not appear to be a significant deterrent for most users; those unable to pay the prescribed fee at the time of service are able to pay later or, in some cases, in kind.

20 Solomon Islands Household Income and Expenditure Survey 2005–06.

Under Community Health Committee guidance, user charges are also being used creatively to maintain health facilities (e.g., purchase of cleaning materials) or services (e.g., to cover the cost of transportation). At Good Samaritan Hospital in Guadalcanal Province, microscopy fees were being used to cover a range of unfunded operating costs in the new facility.

Service delivery outputs

Table 3.1 presents selected health outputs and outcomes from a variety of recent data sources.

Table 3.1 Selected health service outputs and health outcomes, by source, 1986–2007

	Census 1986	Census 1999	National VBDCP data 2003	United Nations Children's Fund (UNICEF) Immunisation Survey 2004	HIES Health Module 2005–06	DHS 2007
		National NVPDCP data 1999				
IMR	96	66				24
Ante-Natal Care (any visit)					94%	95%
Delivery in health facility					86%	79%
Postnatal visit					94%	N/A
DTP3* vaccination				73-93%		88%
Measles vaccination				84-95%		87%
Bed net in house					85%	75%
Malaria Incidence		142.9 / 1,000	199.8/1,000	191.2 / 1,000		127.8 / 1,000

* Third Dose of Diphtheria-Tetanus-Pertussis Vaccine

Expanded Program on Immunisation (EPI)

The 2007 DHS suggests that, based on both inspection of parent-held immunisation cards and parental recall, immunisation coverage is consistently high across provinces and socioeconomic groups. Overall, among children aged 12 to 23 months, 83 per cent were fully vaccinated (i.e., had received bacillus calmette-guerin, measles and three doses each of DTP and oral polio vaccines).The DHS data reflect higher coverage rates than the national HIS (probably reflecting variable population estimates, birth cohorts and recording of immunisations administered). Nevertheless, the DHS and HIS results remain broadly consistent with an Immunisation Coverage Survey conducted by UNICEF and the MHMS in six more accessible provinces of Solomon Islands in 2004. However, that survey took a more rigorous approach to age-appropriate vaccination and found that a smaller proportion of children—in some cases less than 60 per cent of respondents—had received valid doses of vaccine. This probably reflected the difficulty reaching some communities with immunisation services during those years affected by ethnic tensions, as well as the broader target range of measles and other supplementary immunisation ('catch-up') activities (SIA) conducted in some provinces in 2001 and 2003.

Coverage rates consistently above 90 per cent are required to prevent break-through measles transmission and, although coverage is high compared with other countries included in the evaluation, Solomon Islands must still be regarded as at risk of outbreaks—irrespective of which data source is used.

Most facilities—including the paediatrics ward at the NRH—provided vaccinations on a one-day-per-week basis (except for children who had travelled long distances, in which case opportunistic vaccination was provided at the time of consultation. The team notes it would be extremely difficult to achieve the reported coverage rates by offering EPI services only one-day-per-week, even where SIA is also undertaken.

UNICEF and WHO have continued to support cold chain equipment and vaccine supply through the NMS. All facilities visited by the team had all EPI vaccines in stock and most had functional cold-chain equipment and a back-up plan in the event of a refrigerator failure. However, recording of refrigerator temperatures was extremely variable. Notably, the ageing domestic refrigerator in which vaccines were stored in the paediatrics ward at the NRH was unsuitable for the purpose and temperature recording was infrequent and irregular, yet vaccination was still being provided to in-patients. In Malaita, the team noted that vaccines still being stored and dispensed from a vaccine refrigerator that was unserviceable and not being monitored.

About four per cent of children had received no routine childhood vaccinations. From the 2004 Immunisation Coverage Survey, the most common reasons for non-vaccination include: non-availability of vaccines or an appropriately trained staff member at the facility, lack of parental awareness about immunisation, deferral on the basis of consultation on a 'non-immunisation' day at the facility, deferral on medical grounds, and residence in a remote location far from EPI services.

Antenatal care

In the 2007 DHS, 95.1 per cent of mothers reported at least one episode of antenatal care from a trained health professional—a doctor, midwife, nurse or nurse aide—for their most recent pregnancy during the five-year period immediately prior to the survey. Attendance for antenatal care is consistent across provinces and socioeconomic groups, but is slightly lower (88 per cent) among younger mothers (aged <20 years at the time of delivery).

Protection against neonatal tetanus is poor and inconsistent, with only 51.7 per cent of mothers adequately vaccinated in their last pregnancy. Unusually (given the challenges providing outreach visits—see below), tetanus coverage is higher among rural mothers (52.4 per cent) than those living in urban areas (47 per cent), and also higher among mothers who have at least some secondary education. Coverage is poorest in Malaita, where only 29 per cent of babies are born protected against tetanus. Nevertheless, although neonatal tetanus is not captured by the HIS, clinicians reported to the team that it is rarely seen.

Delivery by skilled birth attendant

The 2007 DHS reports that 85.5 per cent of mothers deliver with a skilled birth attendant, and 79.1 per cent deliver in a health facility. Skilled attendance at delivery is more common in urban than in rural areas (ranging from 69 per cent in rural Guadalcanal Province to almost 94 per cent in urban Honiara), and is least common among mothers with no education.

The HIS has undertaken independent validation of antenatal care and delivery data. The number of antenatal first visits exceeded the number of notified births in 2007 by 385, while individual clinic level validation suggests that more than 1000 births outside facilities were not notified.

Health outcomes

The National Health Strategic Plan 2006–10 places special emphasis on addressing malaria, common childhood diseases, non-communicable diseases and HIV and STIs.

Malaria

As a result of the ready availability of anti-malarial treatment, the susceptibility of the parasite to those drugs, and the widespread use of dichlorodiphenyltrichloroethane for vector control, malaria was nearly eradicated by 1975–76. A steady increase in incidence was noted between 1985 and 1988 and peaked at 440 cases per 1000 in 1992, leading to a reorientation of the program in 1991–92.

The national Malaria Control Program was devised, and continues to function (alongside the evolving health SWAP), as a vertical program.

Solomon Islands currently has the highest incidence of malaria outside of Africa.21 Figure 3.4 demonstrates the increase in malaria incidence during and after the ethnic tensions and the gradual return to pre-conflict levels.

Figure 3.4 Annual malaria incidence rate per 1000 by year 1999–2007

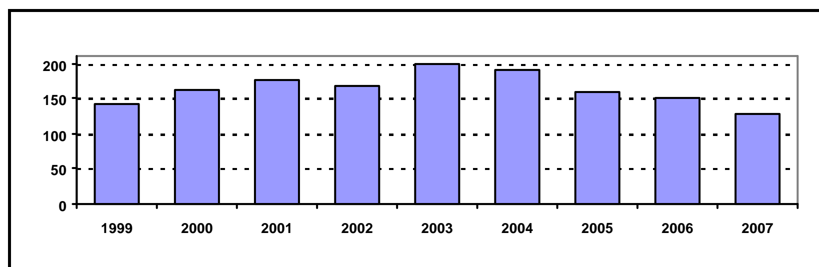
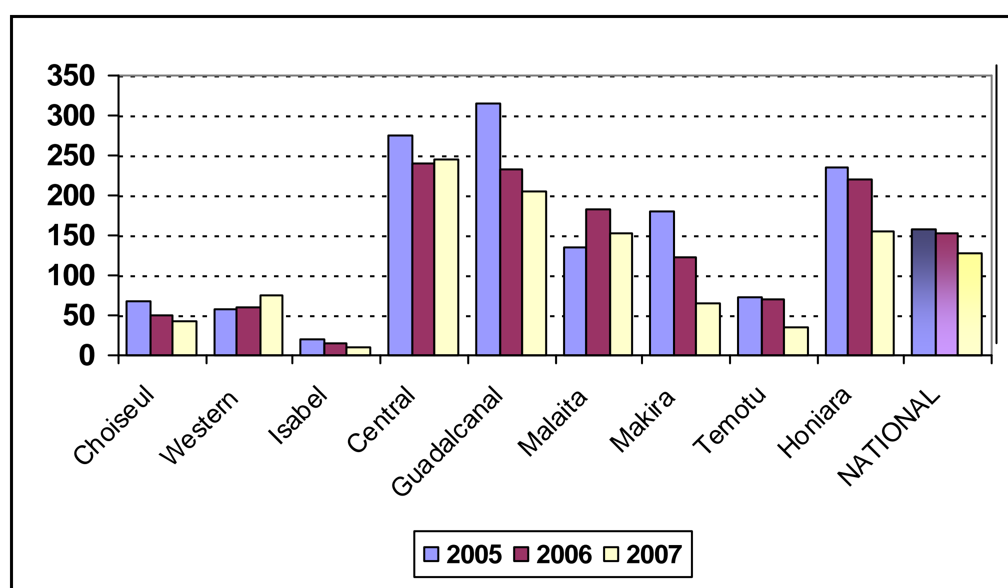


Figure 3.5 shows the annual trend over the last three years in each province (and nationally).The highest incidence is currently in the Central Islands, followed by rural Guadalcanal, Honiara and Malaita.

21 The countries with the highest reported malaria incidence rates per 1000 in Africa are Sao Tome and Principe (393.5), Liberia (381.5) and Tanzania (289.7)—World Malaria Report, WHO, 2005. The country with the highest incidence in Asia is Timor Leste (40.1)—Ministry of Health, 2007.

Figure 3.5 Annual malaria incidence rate per 1000 by province and year 2005–07



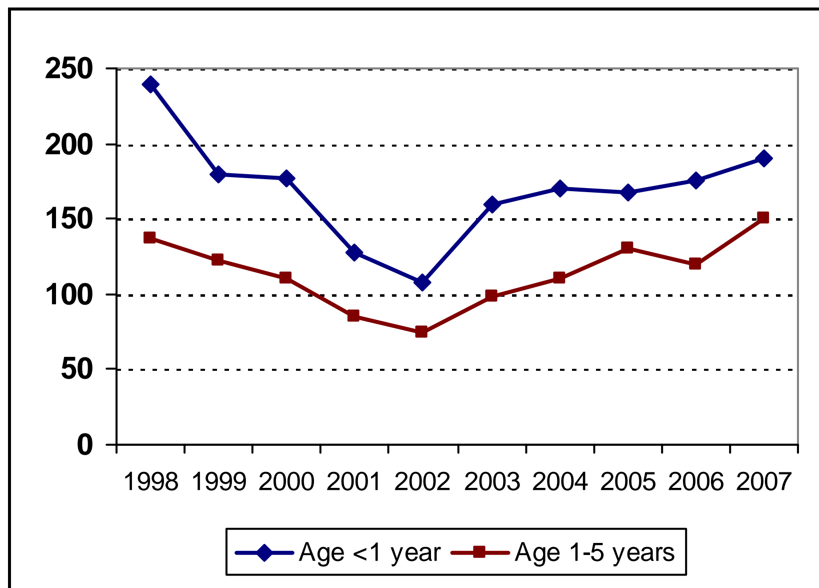
With financial support from AusAID and the Global Fund and operational support from WHO, the NVBDCP has intensified its re-impregnation of conventional beds with insecticide-treated mosquito nets (ITNs) and distribution of long-life insecticide-treated mosquito nets (LLINs), based on a target population coverage of two people per net. The 2007 DHS found that 75 per cent of both urban and rural households own at least one ITN or LLIN. Other NVBDCP strategies and activities include periodic mass blood surveys, indoor residual spraying in identified higher incidence communities and health promotion activities in partnership with provincial health offices.

The international Malaria Reference Group has recommended that Solomon Islands embark on a malaria elimination project in Temotu, a circumscribed, remote island setting with a relatively small population (~22,500) and limited population movement. A preliminary action plan has been developed, and a stakeholder meeting was held in Honiara at the time of the team's visit.22

Common childhood diseases: Acute respiratory infection (ARI) and diarrhoeal disease remain the most commonly reported illnesses—and the leading causes of death (after the neonatal period)—among children under five years of age. The HIS reports that, from 1998 to 2007, the incidence rates of ARI have been steady at around 2 to 2.5 episodes per year in infants and about one episode per year in children aged 1 to 5 years. Over the same period, the incidence of diarrhoea initially decreased in both infants and young children but has been increasing again since 2002 (Figure 3.6). While 84 per cent of households surveyed during the 2007 DHS had access to an improved water supply, only 17.6 per cent had an improved sanitation facility and 63.5 per cent of households had no access to any type of toilet.

22 Stakeholders include MRG, AusAID, the Global Fund, PacMI, WHO, the NVBDCP, Temotu NVBDCP, church organisations, Red Cross, Save the Children Fund, Rotarian Against Malaria, World Vision, Clinton Foundation and others.

Figure 3.6 Reported incidence rate of diarrhoeal illness per 1000 infants and young children

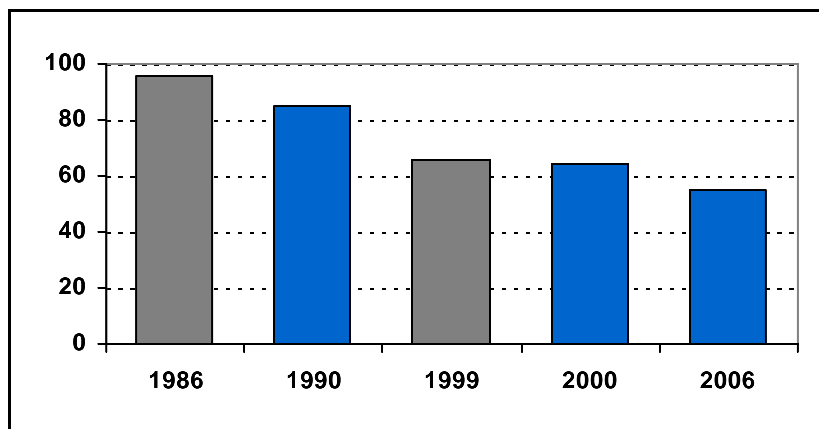


The DHS also captured information on illness among 535 children. Among these, about one in five had symptoms of ARI during the two weeks prior to the survey and around 40 per cent had diarrhoea. Around three quarters of children with these illnesses were managed appropriately (being taken to a health facility for those with symptoms of ARI, and administration of oral rehydration solution for those with diarrhoea).

Infant mortality

Figure 3.7 summarises trends in point estimates of infant mortality rate (IMR) based on national census data and published WHO estimates. These estimates suggest that IMR has been trending downwards, with some loss of momentum during the tensions.

Figure 3.7 Trend in estimated infant mortality rate per 1000 live births, 1986–2006



Legend: grey bars = national census data; blue bars = WHO estimates.

The 2007 DHS provides an estimate of IMR of 24 per 1000 live births during the five-year period preceding the survey, and 28 per 1000 during the previous five-year period. The team notes that these

estimates are lower than those from other recent sources, and that they are derived from birth history and subject to recall bias, sampling errors and large confidence intervals; they should therefore be viewed with some caution. WHO and UNICEF report that the under-five mortality rate fell from 121 per 1000 live births in 1990 to 88 per 1000 in 2000 and 72 per 1000 in 2006.

Non-communicable diseases (NCDs): NCDs are not subject to reporting through the HIS or addressed by the DHS. Health workers interviewed by the team noted a slow, but steady increasing prevalence of type II diabetes, and a dedicated diabetes clinic has recently been established at the NRH. Diabetic vascular disease accounts for less than 10 per cent of surgical ward admissions at the NRH (in contrast with other Pacific Island countries where peripheral vascular complications of diabetes may account for 75 per cent or more surgical ward admissions).

Among DHS respondents, 14.5 per cent of women and 5.8 per cent of men were obese (Body Mass Index >30).

HIV infection and STIs

To date, and despite routine screening in many antenatal clinics and the establishment of voluntary confidential counselling and testing (VCCT) clinics in many population centres, Solomon Islands has reported only 11 cases of HIV infection. Of these, four are alive and have commenced antiretroviral therapy, three are alive but not on treatment, three have died and one has been lost to follow-up.

This low incidence and prevalence is an interesting paradox, given the generalised epidemic in neighbouring Papua New Guinea (PNG), where prevalence rates are estimated at between 1.7 and 2 per cent, and the high and increasing incidence of other STIs in Solomon Islands.

STIs are subject to syndromic reporting (on the basis of genital ulcer and/or discharge) through the national HIS. The reported incidence of all STIs remained steady between four and eight notifications per 1000 until 2004, but since then has risen sharply to around 13 notifications per 1000. (The emphasis of the Pacific Regional Global Fund HIV Project on STI case detection and management may have contributed some case ascertainment bias).

More than 90 per cent of DHS respondents had heard of HIV or AIDS, and around 80 per cent understood that HIV could be transmitted sexually. About two-thirds of respondents knew that safer sexual practices (using a condom or limiting sexual contact to a single uninfected partner) could protect against infection.

Maternal and reproductive health

The median age of commencement of sexual activity is 18.2 years for women and 18.7 years for men. The 2007 DHS estimated the total fertility rate at 4.6 children per woman, a slight decrease from the 1999 census which reported a rate of 4.8). The total fertility rate in rural areas (4.8) is considerably higher than the rate in urban areas (3.4).

The DHS reports that 27.3 per cent of married women use a modern form of contraception; this is reported to be a slight increase in the contraceptive prevalence rate compared with 1999. The most common method is female sterilisation (reported by almost half of those practising family planning). Male sterilisation is uncommon and 7.3 per cent of women practise traditional methods of pregnancy spacing such as periodic abstinence (rhythm method), withdrawal and folk methods.

Due to the relatively small numbers and sometimes incomplete birth registration, there are wide variations in reported maternal mortality between years. UNICEF has estimated the maternal mortality ratio (MMR) for the period 2000–06 at 140 per 100 000 live births, with a lifetime risk of maternal death of 1 in100 (down from 1:130 reported by WHO and the United Nations Population Fund (UNFPA) in 2003. The HIS data for recent years is broadly consistent with this—the 33 deaths recorded in the two year period 2006–07 represented an average MMR of about 118. In 2007, there was a five-fold greater MMR for village births compared with health facility deliveries

A 2006 UNFPA Facility Assessment for Family Planning and Emergency Obstetric Care found that the most common causes of maternal death during the preceding 12 months were postpartum and antepartum haemorrhage, puerperal sepsis, complications from malaria in pregnancy, and pregnancy-induced hypertension. Principal contributing factors (consistent with findings during rural field visits by the team) included stockouts of essential antibiotics used to treat puerperal sepsis (see below), and distance and delays transferring women with haemorrhage, severe malaria or obstructed labour to a centre where blood transfusion and other aspects of comprehensive emergency obstetric care are available.

Health management and service delivery indicators

The HISP Independent Completion Report noted that '… there still remain serious shortages of essential drugs, clinical equipment and medical supplies at health facilities.' Other aspects of health management and service delivery that the team was interested to examine included HIS reporting compliance and the conduct of clinical and preventive outreach visits to rural communities.

Table 3.2 compares drug stockouts in provincial and sub-provincial hospitals during two different time periods. Although these data are based on order history and not on a specific stock-out survey of a package of essential drugs, they demonstrate deterioration in stock levels in all but two centres over an 18-month period.

Table 3.2 Percentage of stockouts by hospital, Jan–Feb 2005 and May–June 2006

Location	Jan–Feb 2005			May–June 2006		
	# of items ordered	# of items out of stock	% of items out of stock	# of items ordered	# of items out of stock	% of items out of stock
Kilu'ufi	245	48	19.5	310	106	34.1
NRH	198	51	25.7	273	95	34.7
Makira	95	31	32.6	127	44	34.6
Taro	100	21	21	122	42	34.4
Helena Goldie	160	21	13.1	189	61	32.2
Buala	312	18	5.7	322	41	0.3
Gizo	140	34	24.2	223	68	30.4
Atoifi	129	18	13.9	172	45	26.1
Tulagi	119	26	21.8	82	30	36.5
Lata	140	22	15.7	154	49	31.8
Total	**1,638**	**290**	**17.70**	**1,974**	**581**	**29.43**

Staff of the NMS argue that the situation worked better before the HISP and ethnic tensions.

During field visits to provincial hospitals and rural health centres, the team noted that essential antibiotics and antimalarial drugs (including paediatric formulations), vaccines and intravenous fluids were all available and in good supply; there was a shortage of one anaesthetic agent for spinal anaesthesia (e.g., used for caesarean section) in one facility. Artemesinin-containing antimalarial and pentavalent childhood vaccines were still being introduced at the time of the team's field visits.

All facilities had a back-up plan for managing short-falls in drug supply—usually 'borrowing' or requesting stocks from a neighbouring health centre or the nearest provincial or regional hospital. Health workers stated that most stockouts were of three to five days' duration, and that it was rare for an essential medication to be unavailable for more than 10 days.

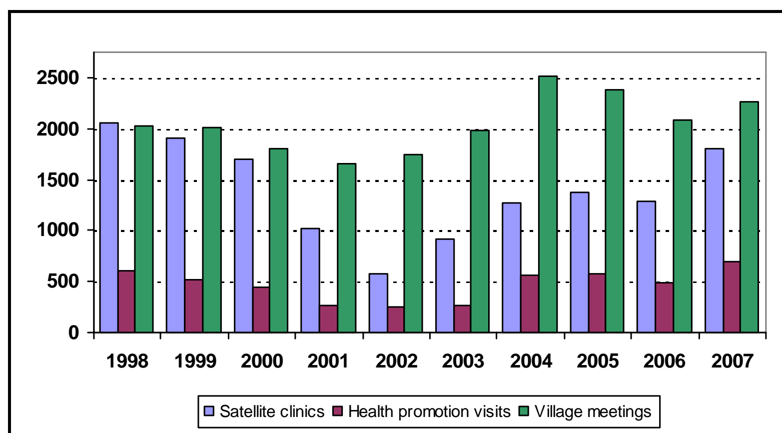
The HIS records outreach visits by medical officers and for the purpose of engaging in health promotion activities and community consultations. However, the team notes that the HIS reporting form is somewhat ambiguous on whether reported supervisory contact actually represents an outreach activity—in practice, this more often occurs when staff of peripheral health facilities come in to the central location (e.g., to collect their pay). As a result, annual HIS summaries are unable to report on supervisory outreach.

Figure 3.8 demonstrates trends in clinical, preventive and promotive outreach activities and community health liaison over the last 10 years.

Satellite clinics fell steeply during the ethnic tensions but their frequency has steadily recovered since the RAMSI intervention, reaching 1800 visits nationally in 2007. The number of patients reached during outreach visits (as opposed to fixed clinics) is not recorded. Some health workers interviewed by the team were conducting outreach visits to communities up to eight hours' walking distance from their health centre, generally on a two-monthly cycle.

Health education at schools has also shown a steady increase from 2003 to 2007. With some support from the HISP primary care adviser, Guadalcanal and Malaita provinces have introduced some structured content planning and quality assurance for health promotion outreach visits. Activities around environmental health and healthy lifestyles appear sound and are well harmonised across all public health programs except malaria (which is undertaken independently by national and provincial NVBDCCP staff at the time of LLIN/ITN distribution and other community level vector control activities).

Figure 3.8 Trends in outreach visits by year 1998–2007



The annual HIS summaries do not report on outreach visits by medical officers for the purpose of engaging in health promotion activities and community consultations. This may be because the HIS reporting form is somewhat ambiguous and includes not only supervision during medical officer visits (genuine outreach), but also supervision meetings when staff of peripheral health facilities come in to the central location (e.g., to collect their pay).

To emphasise the importance it places on health promotion and the provision of clinical care close to the home, Atoifi Hospital in Malaita has been including a doctor in its joint clinical and health promotion outreach teams for about 18 months. In that time, admissions to the children's ward for diarrhoeal illness and acute respiratory infection have fallen by an estimated 40 per cent, while admissions with severe, complicated malaria have fallen by between 15 and 20 per cent.

Conversely, village meetings have fallen slightly since 2004. During field visits, the evaluation team noted that there was some lack of clarity around the overlapping roles and functions of some village health committees and village government committees.

The overall HIS reporting completion rate has consistently stayed over 80 per cent over the last 10 years, including during the period of instability to 2003. In 2007, reporting compliance reached 100 per cent in all provinces except Western (95%) and Malaita (91%).

The team also notes that all data sources made available, except immunisation coverage, are reasonably consistent and indicate quite good service delivery and management performance at output and health outcome level despite the often difficult operating environment (political instability, geographic limitations). The team has already commented on the role of community trust in supporting the effectiveness of the health service.

Importantly, data presented in the annual HIS reports are not disaggregated by gender. The team should also comment on two possible additional limitations and contradictions in available performance data:

1. Health providers consulted during the team's field visits to Guadalcanal and Malaita commented on an escalation in the incidence of yaws over the last five to 10 years; this trend is supported by HIS data from Choiseul, Makira and Central Islands provinces (but is not so clear in other provinces). Yaws is a chronic skin infection that is a sensitive indicator of community hygiene and living conditions, and of any exposure to common medical treatment. Resurgence of yaws suggests that there are pockets of communities that continue to have poor—and possibly deteriorating—environmental hygiene and access to care.
2. EPI in most primary care facilities is generally available one day per week and there was limited evidence during the team's field visits of opportunistic vaccination at other times. The team has already noted above that it would be very difficult to achieve the reported coverage levels using a one-day-per-week approach to vaccination, even with the relatively high reported use of health services.

CHAPTER 4: PERFORMANCE OF AUSTRALIAN AID

4.1 Sustaining and strengthening the health system

The very substantial and positive achievements of the health system that have been documented in the previous section have only been possible because AusAID support sustained the system by supporting operating costs during the tensions. There are many examples around the world of health systems collapsing during similar periods of instability, with shortages of essential commodities, facilities falling into disrepair and disuse, patients deserting the system, staff leaving and discipline breaking down among those that remain- leading to absenteeism and large-scale misappropriation of resources. None of these things happened to a significant extent in Solomon Islands, and AusAID deserves a significant share of the credit for a system that—building on a significant background of positive community sentiment towards health services (Section 3.2)—continued to deliver a quality and coverage of services that would be the envy of most countries with equivalent per capita incomes. Timely support was also provided in the aftermath of the March 2007 tsunami.

With regard to TA, the HISP Independent Completion Report (ICR) concludes that AusAID contributed to the development of a 'culture of change' in several areas of the ministry, with senior managers now better understanding the importance of good management, planning and budgeting. At the national level, AusAID TA helped produce a series of plans and strategies for the sector.23 This helped install a more performance oriented culture at least in the MHMS executive, to match the long standing performance focus in the malaria program and in primary services. The SWAP preparations were facilitated by this work, even in the absence of a quantified performance framework.

AusAID support appears also to have had a positive impact on planning and budgeting at province level. In Guadalcanal, provincial staff were very positive about the contribution of the former AusAID-funded provincial planning adviser. The closer linkage from planning to budgeting introduced with AusAID TA, and the institution of regular review meetings (encouraged by the adviser, but still taking place) had encouraged more 'integration' of services within the provinces, resulting in more effective use of resources such as vehicles, boats and fuel. The team saw evidence of this process at work in Guadalcanal and Malaita, with the province stretching the budget by coordinating field visits. However, the sustainability of improvements in planning and budgeting has been patchy. In Malaita, the commitment to planning and review has not been sustained. The evaluation team also have some reservations about the specific approach to planning and budgeting that has been introduced. The plans the team was able to see indicate areas of activity, but these are not linked to service delivery plans. In Guadacanal, for example, the plan is simply a budget, with no explicit linkage to physical or performance targets or outputs.

The Malaria Control Programme (MCP) lies more outside these coordination arrangements than other public health programs. In Guadalcanal, for example, the coordination problems posed by vertical management (where the provincial MCP functionally reports first to the Director of the NVBDCP in the ministry and only secondarily to the Provincial Health Director) were exacerbated by the co-

23 See the background paper for this report which lists some of the planning documents. Chamberlin, C 'Recent Sources of Health Sector Information and Analysis for the Solomon Islands', AusAID, August 2008.

location of the provincial malaria staff with the national program (at the Solomon Islands Malaria Training and Research Institute) rather than with other provincial public health staff; this limited synergies with those other programs (e.g., for health promotion or other outreach activities). The NVBDCP and provincial malaria supervisors are also organised within different geographic boundaries (called regions) to those used by other public health programs (called zones).

AusAID financed and installed a functioning high-frequency (HF) radio network and in many cases solar lighting in health facilities. In particular the HF radios have been an overwhelming success, supporting both management and clinical tasks and resulting in improved security, better staff morale in rural areas and cost savings. Women have particularly benefited from the improved security.

AusAID helped put in place a significantly strengthened provincial HIS. As noted in Section 3, the figures reported appear to be of good quality and where comparisons are possible they are broadly consistent with the findings from a range of independent surveys using different methodologies (DHS, HIES, RAMSI survey, immunisation survey).

4.2 Areas where greater attention was needed

Neglected areas of health care

Family planning and reproductive health, although included in the National Health Strategic Plan 2006–10 (strategic area 7), appear to received limited attention in practice and within AusAID support. This is significant given the continuing pressures of high population growth, and needs to be remedied during the HSSP. There have been some inputs from AusAID (the HISP ICR, for example, refers to a sexual and reproductive health adviser), but the continuing relatively low emphasis on family planning and the low contraceptive prevalence rate suggests this needs more emphasis in discussions with Government.

NCDs (strategic area 5) have also been relatively neglected, but are an increasingly important part of the disease burden. They do appear to be receiving more priority within the HSSP. The approach aims to reduce avoidable death and morbidity from NCDs while limiting the pressures for expenditure on expensive curative care through a focus on behavioural change, early identification and low-cost interventions to manage conditions such as diabetes and high blood pressure before they require high-cost surgical intervention. AusAID has begun to address NCDs through a regional NCD initiative in partnership with SPC and WHO.

Over-emphasis on fixed facilities, under-emphasis on outreach

The health system has continued to develop on the basis of universal, free, facility-based services, without defining the limits to government action. Although good results have been achieved, these have been at relatively high cost, and may not prove sustainable in the light of the inevitable growth in demand for curative services. The static approach is also not suited to reaching the part of the population that does not currently use the services.

The Solomon Islands National Health Strategic Plan 2006–10 (developed with HISP support, 2005) seeks to promote PHC in the country through the National PHC Framework and Strategy (developed with HISP support in 2003) and establish health promotion centres in all communities. However, the

overall health system places a significant emphasis on the patient coming to the health facility (including for the delivery of primary care at secondary and even tertiary facilities), rather than taking primary and preventive services to the population. Australian support for the sector did not address this imbalance.

Part of the problem is that the plan is not explicit about the services that will be provided, nor how they will be delivered. Provincial plans are similarly unclear. A theoretical commitment to outreach or satellite clinics in some cases does not get implemented because staff are kept busy meeting the demand from static clinics, and are given little encouragement to ensure that satellite clinics take place. In one aid post the team visited, in Guadacanal, the nurse aid in charge mentioned security concerns and problems of physical exhaustion related to satellite clinics requiring her to walk long distances to satellite locations, carrying medical supplies, see large numbers of patients and then walk home. In another case, staff depended on the province to arrange transport for satellite clinics, but there was heavy demand on vehicles limiting the frequency and regularity of outreach. Alternative arrangements are possible (for example, some communities are able to make available community transport if arranged in advance), but the importance of outreach needs to be emphasised by management and supported with practical help in overcoming the logistical problems of providing services in remote locations.

In some respects, the HF radio network contributes to this imbalance, especially where they are not used as a management and efficiency tool but simply as a means of summoning transportation for patient referral to a higher level facility.

The problem of resources being increasingly sucked into curative services is exacerbated by the absence of national or provincial facility development plans or policies. This means that clinical facilities could be developed or constructed by donors (including other AusAID-funded activities such as the Community Support Program) outside of any strategic facility development plan. The team visited an example in Guadalcanal, where a hospital has been built by an Italian Non-Government Organisation. It has been adopted by the province as the health centre and has inherited the health centre budget, but the additional recurrent costs and staffing implications of this external aid fall on an already overstretched provincial health office. Without a clear physical development strategy it is difficult to refuse to adopt facilities provided by donors or built by communities. Preparation of a physical investment plan is envisaged as part of the ongoing preparation phase of the SWAP.

Greater policy dialogue: the case of the National Referral Hospital

The HISP ICR found no evidence of lasting impact from the support provided to or through the NRH. The team facility visit largely confirmed this negative view. There is some evidence of improved financial management following the audit, and the hospital management adviser has instituted for the first time a system for collecting and using basic performance data. It is, however, surprising that elementary performance data were not previously being produced by the NRH, which has had the services of successive AusAID financed international technical advisers over many years.

The main efficiency and financial management problems at the NRH are due to a government policy of free services, including food and lodging and return transport costs for both referred patients and

at least one accompanying carer.24 This results in high costs per bed night, and long average lengths of stay, exacerbated when patients have to wait for the next infrequent boat to their home island. Policy measures are needed to address these problems—they cannot be tackled adequately within the management authority of the hospital. Although introducing charges is emphasised in the program document (and the 2005 audit called for a review of fee schedules and of fee collection), the team found no evidence that it has been taken up at senior level in policy dialogue with the Ministry of Finance (which would make the decision) or even the Ministry of Health (which remains unconvinced).

It is unreasonable to expect a hospital adviser based at the NRH to address the policy issues around the redistribution of the budget. The NRH management will presumably expect the adviser to help them to make the best possible case for increased budget, whereas the strategic objective of the HSSP is to reduce the share of resources going to the hospital. The scope for the hospital adviser to successfully press the case for efficiency savings would be much stronger if Government had established a medium-term budget framework requiring the NRH to live within a fixed budget diminishing as a share of total spending, and had delegated more authority to the hospital to decide how to manage within that budget. At present, the NRH lacks the authority to tackle many of the problems it faces, narrowing the field of action within which the adviser can make a difference.

Fragmentation and lack of continuity

AusAID support has not been directed holistically towards the needs of the overall system, nor have distinct inputs been inter-linked or well coordinated with each other. An example is the failure to link support to local level planning with the support to develop the HIS. Provincial information systems and the collation and analysis of health data at the provincial level were not addressed by the HISP or other initiatives, limiting the availability of a timely evidence base for provincial level activity planning and resource deployment. The HIS serves the needs of the ministry and donors, but could make a much more significant contribution by paying attention to helping the provinces use the data to inform their planning and performance review. The HISP ICR commented: '… there was no capacity building in the key area of monitoring and evaluation, even though M&E are specifically identified for capacity building within Objective 1 of the Project.'

Loss of continuity in Australian support has often resulted in a loss of momentum, especially during the relatively unplanned transition year between the HISP and the HSSP. This included a lack of focus on protecting existing Australian-funded investments in the sector (e.g., the clinic radio network). Successive technical advisers have been in Post for relatively short periods, have had slightly different focus of interest, and have not always been succeeded by advisers able to or interested in following up on initiatives started by their predecessor. The team, for example, came across examples of manuals produced but never printed or disseminated.

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24 Return transport for the patient and their accompanying carer consumed a reported one-sixth of the NRH operating budget (SBD$1.2 million out of a total SBD$6 million) in 2007. The referring provincial facility covers only the cost of outward transport, and none of the costs of treatment, resulting in little incentive to restrain referral activity from the provinces. Overseas referral of pathology specimens from the NRH laboratory cost another SBD$800,000 in 2007.

Poverty, gender and ethnicity

Although the equity characteristics of the system in general appear to be positive, poverty gender and ethnicity have not been significant features in AusAID's engagement. The word 'poverty' appears only once in the PIP, in the context of a discussion of provincial budget allocation. The PIP does contain a good discussion of gender issues, but it is handicapped by the fact that the HIS (established with AusAID support) contains no gender-disaggregated indicators, even though there is a commitment to introduce some gender disaggregation from 2008 (Box 4.1). Only one key performance indicator in the results framework is gender disaggregated (condom use by men and women at last sexual contact). On the principle that 'what gets measured gets done', there is a risk that gender and poverty concerns will not receive much attention in implementation. The lack of emphasis is even more stark in AusAID documents—the word 'gender', for example, does not appear at all in the HSSP program document. This weakness was recognised in the recent HSSP design review and actions to address it have been identified.

The history of ethnic tension implies a risk that some groups may find themselves discriminated against when accessing health services, or that security concerns may affect access to services. It is mentioned briefly in the PIP, but the implications for the approach to local level planning of service delivery are not developed.

Box 4.1 Gender in the Health Sector Support Program

The mid-2007 PIP reports: 'To date, the absence of sex-disaggregated data within the Health Information System (HIS) does not allow any further investigation into who uses the health services and the gendered characteristics of ill health within the population. The focus of health research has been on biomedical determinants of health and illness at the level of individuals rather than the relationship between ill-health and population groups, i.e., gender or ethnicity ... Sex-disaggregated data would permit the identification of the differential impacts of ill-health on men and women, and would improve understandings of the social, economic and cultural factors shaping ill-health for improved health service delivery. The revised HIS currently being developed and programmed for implementation in 2008 includes a limited number of sex-disaggregated data fields.'

Technical assistance and capacity building

The approach taken by AusAID to TA has been a narrow one, focusing on individual technical advisers. There has been some commendable work (e.g., improved approaches to planning and budgeting introduced by the HISP primary care adviser), but the overall approach to TA was narrow and could have been better adapted to the range of needs for developing the health sector. The average tenure of long-term TA was less than a year, there was little direction as to the specific tasks they were responsible for, and little continuity between advisers—for example, hospital advisers shifted attention between infrastructure (no output) to financial management (some progress on audits and follow up) to management training (unclear how this will be integrated with other sources of such training).

CHAPTER 5: OPPORTUNITIES AND CHALLENGES

5.1 Health systems and services

National Health Plan: Costing what is affordable

Section 3.1 makes the point that current levels of spending on health as a share of GDP are very high by international standards, but that the future outlook for domestic revenues is grim, while the high dependence on donors to fund both recurrent and development spending makes the health services very vulnerable. The development partners provide such a large share of the funding that Government cannot decide what health services the public sector can afford to finance without knowing what resources the donors will provide, and what restrictions will be placed on how the resources can be used. The lack of ownership of the draft HSSP highlights the unmet need to discuss policy and try to reach an understanding on the limits to be placed on the government's role in the sector. The current government approach of providing comprehensive and nearly free public health services to all may become increasingly unsustainable as rising demand for expensive curative services collides with slower growth of resources. The risk is that the overall quality of services will suffer as Government tries to do more than the available resources can sustain.

Difficult choices have to be made. Improving access to services will require increased spending on provincial health services; but shifting resources towards those services in a sustainable way will require a credible policy for restraining spending on tertiary care. The share of expenditure on the NRH is already high, the demand for tertiary care will continue to increase, and the expectation of the population is that Government will continue to meet the full costs of virtually all services. In a political system in which clan interests dominate, and in a country with a fragile externally guaranteed peace, deciding what not to finance will be difficult. However, not deciding would mean the resources available for basic services would shrink to make room for increasingly expensive treatments mainly benefiting the population with access to Honiara.

The long-term opportunity and the challenge is to reach agreement on a costed health sector plan and policy framework that addresses these choices explicitly and clearly defines the package of services that will be provided at different types of facilities. However, the experience of other states with similar problems is that the best approach is to embark on a broadly consultative process to determine what the options and risk are, and to try to arrive at a sector plan that is financially sustainable and that commands wide support.25 This would need to be supported by good analytical work on costing various options and on alternatives to state financing for some services. There are already plans for undertaking technical work along these lines (for example, a Medium Term Expenditure Framework (MTEF) was attempted in 2007 and will be revisited).

Development partners have an important role to play both in providing TA to facilitate the process and—even more important—in providing greater clarity as to the likely level, time horizon and risks attached to future external support. The SIG is likely to remain dependent on donors to finance more

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25 Overseas Development Institute, 'Harmonisation and Alignment in Fragile States', draft report for Senior Level Forum On Development Effectiveness In Fragile States. Meeting in London, 13–14 January 2005.

than half of the aid budget for many years to come. If aid promises are not delivered, the SIG risks being left with a hollowed-out health service and stuck with unavoidable commitments to pay fixed costs like staff salaries, but without the necessary financial resources for the drugs and operational costs to enable staff to be productive. Government therefore needs to balance the benefits of more ambitious health plans against the risks of increased long-term dependence on donors. The more credible and long-term the donor commitments, the more ambitious the health plan can be in expanding services for the poor. AusAID has indicated an intention to scale up support to the health sector and to maintain it beyond the current five-year commitment, which is welcome. The stronger the financial assurances that can be attached to this intention and the further into the future they can be stretched, the safer it will be for the Government to plan for expanding health services. Ideally, AusAID would provide a rolling commitment for at least five years, rolled forward by one year at the start of each budget cycle, to always provide a five-year forecast.

The team does not minimise the difficulty of reaching agreement on the strategy. It may be that no financially sustainable agreement will be possible. However, a broad national process seems more likely to result in a degree of ownership for difficult reforms than simply trying to persuade the MHMS to adopt the reforms that are implicit in the SWAP document. It will be important to emphasise the alternative—trying to meet all growth in health demands without sufficient finance will severely damage the quality of existing services, as the experience of many countries in Africa during structural adjustment years can attest.

Strengthening provincial health systems

Provincial health systems are the key to improving coverage and quality of services in the Solomon Islands. Performance varies among provinces but the main challenges remain the same throughout the islands. A key output from the national planning process should be to clarify and cost what services provinces should provide. This is likely to be a balance between centrally determined targets, with some locally appropriate variation, and local flexibility on how targets will be met.

Organisation, management and planning

Provinces are divided into regions managed by Area Health Centres (AHCs). Each AHC has a consultant nurse aid in charge of PHC and outreach as well as a registered nurse aid responsible for looking after the facility-based services. With support from the HISP, some provincial health teams have been preparing operational plans, specifying activities and actions, responsibilities and some performance indicators—albeit focusing primarily on activity outputs. These plans also indicated financial requirements and source of funding. The provincial health officers receive most of their budget in kind (established staff, drugs and supplies are purchased centrally on their behalf). They have discretion to allocate their direct budgets, which cover the cost of provincial health employees and basic running costs such as fuel, utilities, travel and per diems.

The main constraint is that the small annual increment in the provincial budget gives little scope for planning significant service expansion and, in 2008, was insufficient to finance the increased cost of sharply higher fuel bills. Sustaining good planning practice requires reliable access to timely budgets and good management supervision, and can quickly collapse when these are absent. The planning system continues to be used and progress against the plan is regularly reviewed in Guadalcanal, where the main operational task is to allocate the inadequate budget between competing uses, stretching it as

far as possible by, for example, coordinating the visit program to ensure that transport is shared. Problems in financial management in Malaita have been accompanied by a decline in planning. Supporting the re-establishment of a sound planning process and extending it to regions and AHCs is a priority. To have real impact, it needs to be linked to resource allocation decisions that allocate meaningful additional funding to extend services to populations currently with low access to services.

A number of provinces conduct integrated PHC outreach programs from their headquarters. The plan is to spend one week each month on tour but in practice, integrated outreach visits take place on average only every other month. During these visits, the team comprising staff from each provincial health department/program (including, in some cases, a medical officer) provides a wide range of preventive and PHC services, referral and specialist clinics, and on-the-spot problem-solving in different parts of a province. It appears that the main reason for not implementing the schedule as planned is insufficient budget allocation to integrated outreach programs. As a result of a reduced program, not all designated sites can be visited within a year. Adequate allocation of resources to this activity is therefore essential.

Support and supervision

Notwithstanding capacity constraints, this is an area that requires greater attention. There is no regular program of supervisory tours from national level to provincial headquarters involving all major programs. There are also no regular supervision visits from a province to the AHCs, nor from the AHCs to other rural health facilities. Consultant nurse aides in charge of AHCs more often come to provincial capitals for quarterly meetings, but follow up appears to be insufficient to make a difference to the operational aspects of their work. Again, adequate financial resources need to be allocated and incentives put in place to establish a functional system of supervision that is coupled with on-the-job training and career development to both motivate and upgrade the performance of frontline workers.

Health information and performance reporting

The HIS is quite comprehensive (though gender blind) and reporting appears to be regular. However, all health information collected at provincial level is simply passed on to Honiara, and little or no use is made of the information collected to inform management and resource allocation decisions in a province or at the regional or facility level. Without adequate baseline information on current performance, it is difficult to set realistic local targets and develop agreed performance benchmarks.

Provincial Health Directors

There is currently no suitable forum for systematic exchange of experiences among the provinces—except for the Annual National Health Conference. Regular meetings of provincial health directors to exchange views and learn from one another can serve to review progress jointly and to motivate innovation. Such meetings should be part of a focused initiative to strengthen provincial health services.

Moreover, PHDs are mostly clinicians and lack training in public health planning and evaluation (although some are undertaking relevant postgraduate training—on their own initiative—through WHO's Pacific Open Learning Health Network). To ensure that public health and primary care

services are well planned and managed will require connecting PHDs and provincial health management teams with relevant available training and continuing education programs.

PHDs currently spend much time providing services at the hospital and are unable (or unwilling) to put sufficient effort into managing the health services of the entire province. Staff assignments will need to be revisited to ensure there are sufficient clinical staff to manage the work load.

Area Health Centres and Rural Health Facilities

A number of actions are required to make AHCs fully functional. Adequate staffing is a key issue which in turn is influenced by the availability or lack of staff housing. The need for supportive supervision and on-the-job training has already been mentioned, both to and from AHCs. To perform both facility-based and outreach functions, these health centres need to be adequately resourced. Earmarked budgets for AHCs, with clearly specified funds for outreach programs, would help ensure that these activities are not neglected in favour of clinical services at the facility. Adequate allowances for outreach and close monitoring of activities will help ensure that greater coverage is achieved.

A good indicator of outreach potential is the management of the family health card initiative, in which nurses from clinics, centres and posts visit their catchment villages to record for each family a basic set of health information. The family health cards have been widely implemented, and their regular updating and follow up would serve as a powerful outreach methodology.

Collaborating with Church Health Facilities

Most rural church health facilities are staffed by government employees. The contribution of the churches to rural health services consists primarily of making available premises, financing transport and, in some cases, employing additional staff. In some provinces, where area supervisory capacity is over-stretched, the possibility of delegating the management of health regions and AHCs to a church facility is being considered. Where provinces find it difficult to adequately support all their regional centres and AHCs, this may well be a model worth developing, whether informally or on a more formal contractual basis.

Although Memorandum of Understanding have been drafted between government and each of the four major church hospitals, it appears that none of these has been finalised. Moreover, as currently conceived, these memorandum do not include performance targets that can be readily monitored. The concept of performance-based contracts between government and church hospitals provides an opportunity for introducing a performance culture that could also be applied between different levels of the government health system, for example, between provincial health teams and regional health centre teams.

Employment conditions in the provinces

Salaries of provincial staff, particularly nurse aids, are financed from different sources, including the central public service, direct employment financed from the provincial health budget or in some cases, the community. A number of aid posts are also directly financed by Members of Parliament and local politicians. Each form of financing has implications for the salary level and employment conditions of the staff member concerned. The implications of having different employers offering different levels

of salary and benefits need to be explored as part of the country's broader public service reforms (see below).

Quality of care and access

Although overall utilisation is very high, questions have been raised about the quality of care provided. Reported problems include invalid vaccines due to broken cold-chains (though there is some evidence this is being tackled), as well as questionable validity of diagnosis and treatment, which is related to lack of supportive supervision and of opportunities for upgrading skills. Additionally, though overall utilisation is very high, some very remote communities may not be accessing services provided at facility level or through satellite clinics (the reported resurgence of Yaws is one indicator that some population groups are being missed). Unless a program of regular support and supervision, coupled with performance monitoring, is established, quality of care will continue to be a concern. Standard procedures and protocols also need to be established and disseminated through continuing education and training to ensure service quality.

Fostering community engagement

Community structures remain strong in Solomon Islands. The Government's People Focus further underscores the need and intention to encourage and support community action.

In the health sector, the community has an important role to play in supporting and overseeing health centre operations. Health centre committees are in place in many communities. However, their degree of functionality varies considerably depending on the traditional and church leadership in the area. There are opportunities for providing greater support to health centre management committees, and to connect the work of these committees with the broader-based village development committees that are active in creating 'healthy village' and health schools' initiatives.

Solomon Islands have a large number of international and local NGOs engaged in youth and women's programs, working through schools, women's groups and village development committees. There is increasing attention at the national level on the need to create and sustain umbrella organisations that effectively coordinate the efforts of different civil society and non-governmental organisations, support learning from experience and consider how to reconcile different dimensions of accountability—to communities, to Government and to funding agencies. However, it is at the local level where it will be most important to ensure that efforts by different stakeholders are mutually supportive, and that there is good communication between the provincial administration, Non-Government Organisations and community-based actors to ensure coherence. Particularly, community projects that involve infrastructure development need to be carefully coordinated to ensure that the operations of new facilities can be supported within existing budget limitations.

The health workforce

Current public service reforms now offer the opportunity to undertake a complete mapping of the existing health workforce in terms of size, distribution, functions and qualifications. At present, only incomplete information is available on human resources for health. This mapping exercise needs to be part of a larger review of health facilities in Solomon Islands, and on human resource requirements for improving coverage as well as quality.

The issue of differential employment conditions of service for health workers has already been mentioned, and also needs to be addressed as part of the public service review.

5.2 Making progress towards a sector-wide approach

Developing the strategy

The first requirement of an effective SWAP is agreement on a nationally owned sector policy and strategy, and a costed, multi-year program—ideally an MTEF—that reflects that strategy. The main elements of the program need to be costed, and priorities defined to fit the available resources. Many of the detailed policies to achieve the objectives referred to in the AusAID agreement are not yet in place, though the World Bank TA project envisages providing the necessary analytical support to help the SIG to develop them, and there are plans to produce an MTEF in 2008–09. At present, there is no clarity on the resources likely to be available and no clarity on the services that Government aims to provide. Although there is a loosely worded agreement with the wider donor group, the SWAP is at present in the preparation phase and limited to the agreement with AusAID plus a small TA support project from the International Development Association.

With good existing coverage, the priority now is to identify groups not reached by health services, which requires good, disaggregated understanding of who they are, where they are and what prevents them from accessing services. The gender and ethnic aspects of this need specific analysis. Specific gender-related issues include a substantial unmet demand for family planning as indicated by the DHS, a high incidence of teenage pregnancy, problems of gender-based violence, and constraints for women in remote areas accessing skilled birth attendance or emergency obstetric care when needed.

The program document for the HSSP proposed some policy directions (e.g., redirecting resources from tertiary care towards the provinces, with some use of cost recovery to do so), but ownership of the document is unclear, and the detail of the policies and of the action plan to implement the strategy remains largely undefined. Poverty and gender need more explicit attention and need to be reflected in policy measures, resource allocation, explicit targets and the monitoring framework—which also needs gender-disaggregation of indicators. The World Bank is planning to undertake an analysis of the equity of service coverage.26

Long-term aid commitments

On the resources side, aid dependence is so high that Government is unable to define health policies and plans without knowing what resources it can rely on from donors in general, and AusAID in particular. Public expenditure accounts for more than 90 per cent of health expenditure, aid accounts for more than half of public spending on health, and AusAID accounts for 70 per cent of aid, or one third of total health expenditure.

The team recognises the difficulty faced by any donor in making long-term commitments, but it is essential in a country as aid dependent as Solomon Islands. The partnership approach announced by the current Australian Government provides an opportunity to provide clearer and longer-term

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26 HSSP draft program document, Table 7

indications of likely aid levels. The Ministry will remain dependent on external aid far beyond the time period of the current commitment to the HSSP. AusAID and other donors will need to ensure resources keep flowing and are not interrupted by gaps in timing between successive donor agreements.

AusAID has not shown any inclination to impose policy conditionality on aid to the health sector, nor should it do so. However, the future level of support to the health sector should not be entirely unaffected by positive or negative developments in health policy. A strong commitment to front-line services and to rural outreach might merit increased support, while AusAID is likely to be unhappy to see increasing shares going to the tertiary hospital. With aid providing more than 30 per cent of the budget, any adjustments to spending levels requires advanced warning (next budget not the current year), changes should be at a pace that the SIG can adjust to without severe disruption, and discussion on what is required to restore spending levels should continue.

Broad national ownership

The problem in countries where politics is largely clan or wantok based, is that there may be no political or official structures at national level with the incentive or authority to conclude lasting agreements. This problem is reinforced where the political situation is as fragile as in Solomon Islands. Health ministers have not always engaged with the details of health policy, but it is unreasonable to expect officials to take responsibility for difficult and potentially unpopular reforms. For putting in place the policies and plan, the team has argued that it is important to seek broader national endorsement, beyond those currently holding office.

The team recognises that embarking on a major consultative process to clarify health sector policies and plans may seem like a distraction from the business of delivering services, especially as management capacity is fully stretched at all levels of the system. The team nevertheless believes it to be essential, and a high priority for TA support from World Bank or bilateral sources. The team's judgement is that the current approach to public sector financing and providing virtually all health services will become increasingly unsustainable in the face of demand rising faster than resources. Preserving the many excellent features of the existing system requires difficult decisions on future priorities. These decisions will be less difficult, and are more likely to be taken, if preceded by a major effort to promote public understanding and participation in the discussion of options.

Policy dialogue

A SWAP means a different way of conducting the relationship between Government and development partners. The key to it is policy dialogue, focused on establishing and maintaining an understanding between Government and development partners and covering what policy measures will be taken, what services will be delivered, how they will be funded and jointly monitored, and what revisions and adjustments are needed in light of monitoring. A workable understanding does not mean that partners agree on everything, but there needs to be an understanding on how areas of incomplete agreement will be handled, and a willingness to compromise.

The main mechanisms envisaged for conducting policy dialogue appears to be twice annual reviews, one of which will be a review of progress led by external experts, and the other of which will be led by one donor with the MHMS. These reviews will focus on the future budget and the MTEF. Currently,

there appears to be no committee structure for regular discussion between Government and development partners, though development partners will participate in the opening and wrap up sessions for each review.

The experience of other SWAPs suggests that two major reviews a year may prove to be over-kill. The major review should focus on progress (preferably preceded by province level reviews that feed in findings to the national review). Donors should be asked to indicate likely funding for the coming year shortly after the main review which therefore needs to be completed six to eight months before the start of the financial year, in time to inform the setting of budget ceilings. A smaller meeting to review the operational plans and budget/MTEF for the coming period should be scheduled as the budget is finalised, and needs to confirm Government and donor resources. In addition, experience of other SWAPs suggests there may be a need for a committee with some donor participation to meet at more regular intervals between reviews, to chase progress and address policy and management issues as they arise. At present, with only one donor participating, the need is being met informally, especially as two AusAID staff have offices within the MHMS, one of whom is a co-opted member of the Executive Committee. A more formal arrangement may be needed as participation extends to other donors.

The focus of policy dialogue on a comprehensive budget (including donor funding) is welcome, particularly in a highly aid dependent country like Solomon Islands. Dialogue on the budget will become more meaningful when there is greater clarity on what services Government will aim to provide, and what they are likely to cost, with costs adjusted to the different access conditions in different parts of the state. The budget needs to be structured to reflect the priorities of the strategy, and the Government and donor staff participating in the discussions need to be sufficiently informed with the outcome of various analysis and an understanding of the strategic shifts in budget allocation required to implement the plan.

5.3 Technical assistance and capacity building

TA has a range of different objectives requiring different approaches. The SWAP needs to be strengthened with policies, systems, operational guidance, and follow-up training and support to national and provincial staff. These requirements are time-limited interventions that require a range of skills to complete defined tasks over a finite period. They are likely to require more intensive inputs at some times of year (for example, budget preparation). They are likely to be most efficiently if carried out by letting a contract to one or more firms or organisations capable of putting together the teams and other resources required and to manage the tasks until objectives are achieved. They do not likely suit singleton technical advisers. They include the big-picture tasks required to support more effective delivery of services by staff at province level and below.

It is worth clarifying that this essentially requires a project approach; there appears to be a misunderstanding within AusAID that the SWAP means no more projects. Every government implements projects and every sector strategy is composed (on the development side) of projects. The difference with a SWAP is that donors finance the whole sector program. In some cases, this means donors providing sector budget support and letting Government manage the individual components. In other cases, donors earmark support to some sub-components of the overall strategy that have identifiable objectives and targets and resources allocated to them.

A second role involves managing the relationship with the donor partners. This is not necessarily a permanent role, and there is some merit in having it financed by aid donors, possibly staffed with people who are familiar with donor procedures. The administration of aid relationships can be a major burden on small ministries, and there can be a case for donors sharing some of this burden. The AusAID Office within the MHMs in part fulfils this role.

A third role is to provide TA advice to support Government in their side of the policy dialogue with donors and other stakeholders. The technical advisers provided by AusAID could in principle undertake this role, but their ability to do so is potentially compromised by dual loyalties, exacerbated by the recent decision to bring their management under AusAID. There is a case for revisiting that decision and for making it explicit that advisers work for the ministry and not for AusAID.

A fourth role for TA is in helping Government to carry out its core functions, either by filling jobs for which there is no qualified candidate or by advising government counterparts. In theory, AusAID financed technical staff have mostly been provided in advisory roles, though in practice they often end up handling operational tasks. Alternative approaches could be adopted—Government could recruit to line positions internationally, possibly using TA finance, but with recruited officers having an explicit focus on developing the staff working to them through supportive supervision or Solomon Islands staff could be supported by intermittent mentoring rather than a full-time adviser, supplemented by distance learning or training opportunities.

CHAPTER 6: RECOMMENDATIONS

The main purpose of this country case study is to inform the synthesis—and the team's Terms of Reference do not call for specific country recommendations. The team offers these suggestions, but acknowledges that they are based on a short time in-country, and that many others have trodden the same ground in greater depth.

6.1 The sector-wide approach

The team suggests reviewing several aspects of the SWAP:

3. The team believes that the strategy to be supported by the SWAP needs further definition, particularly to show how the share of funding allocated to primary and preventive services can be increased, with improved allocation between provinces.
4. The team also suggests reviewing the SWAP management arrangements, to consider adding provincial reviews, streamlining the proposal for two annual reviews, introducing explicit review of funding and expenditure priorities at the start of the budget process, and considering how to consult donors between formal reviews.
5. Consider re-visiting the monitoring framework to introduce more gender disaggregated targets and indicators.
6. Consider the advantages and disadvantages of a more explicit focus in policy formation and monitoring on other aspects of disadvantage and inequality.

6.2 Make long-term commitments

To enable the SIG to plan the future development of sustainable health services, it will be essential for Australia to provide a consistent and predictable level of support, preferably based on long-term (five plus years) rolling commitments, to avoid any dip in support between successive programs.

6.3 Move towards using government procedures for managing AusAID support.

AusAID provides one third of total public expenditure in the health sector. While funds are allocated, disbursed and accounted for by way of parallel routes, this potentially distorts the pattern of expenditure, undermines sustainability and weakens government systems for financial accountability. The current focus on financing only the central expenditures that can be readily accounted for makes key areas such as the drugs budget excessively aid dependent, while constraining the potential to re-allocate resources to the provinces.

If there is a good dialogue on the government budget in the context of financing an agreed strategy, the main risks are that the approved budget may not be implemented as planned, and that financial accountability weaknesses may expose AusAID to dangers of funds being misused or misappropriated. These fiduciary risks can be managed while using government systems and providing support to provinces and below:

> - Define expenditure programs eligible for support.

> - Use the government system but work with Government towards simplifying it and supporting those responsible for accounting. There is a need to accelerate support to provincial accountants in using the financing software.
> - Rely on statements of expenditure and bank reconciliation for acquittals, supplemented by selective checking of transactions weighted to those posing the greatest risk.
> - Continue to insist on timely formal audits of systems as well as transaction based audits, commissioning from outside where necessary.
> - Insist on follow up of audit recommendations.
> - Supplement formal accounting with independent sample based tracking studies, and support for transparency and for a community role in ensuring accountability.
> - Insist on repayment of funds found to have been misused (or reduce the next tranche of funding by the relevant amount).

6.4 Technical assistance

TA needs should be identified together with the Ministry as part of the process for developing the workplan for the SWAP, preferably with a process for coordination that involves other development partners supporting the SWAP.

When appraising TA needs, work with the MHMS to look at a broader range of alternatives beyond just providing international advisers (e.g., contracts with bodies that can provide a range of short- and long-term advisory inputs and training, contracting out the function or recruiting line staff regionally, distance learning and mentoring support, twinning arrangements).

ANNEX 1: REFERENCES

Australian National Audit Office, Audit Report No.47 2006–07, Performance Audit, Coordination of Australian Government Assistance to Solomon Islands, 2007.

AusAID, Office of Development Effectiveness, Independent Completion Report, HISP.

ANU Enterprises, People's Survey, 2007.

IMF Solomon Islands: Tax Summary and Statistical Appendix September 2007.

IMF Staff report for the 2007 Article 4 consultation, June 2007.

IMF Solomon Islands: Selected issues and Statistical Appendix, August 2004.

MHMS Health Sector Support Program 2007–2012, Programme Implementation Plan, version 8, July 2007.

MHMS Health Sector Support Program, Program Document, draft 7, 2 April 2008.

MHMS Chamberlin, C, Solomon Islands Health Expenditure Review, 2006.

MHMS 'Solomon Islands National Health Strategic Plan 2006–10', 2005.

MHMS 'National PHC Framework and Strategy', 2003.

Overseas Development Institute, Harmonisation and Alignment in Fragile States, draft report for Senior Level Forum On Development Effectiveness In Fragile States. Meeting in London, 13–14 January 2005.

Solomon Islands Statistics Office, Demographic and health Survey 2007, preliminary report.

Solomon Islands Statistical Office, Household Income and Expenditure Survey, 2005–06.

WHO, World Health Statistics Database.

WHO, World Health Report, various years.

ANNEX 2: PEOPLE INTERVIEWED: SOLOMON ISLANDS

Name	Designation/Organisation
Ministry of Health and Medical Services	
Dr George Manimu,	Secretary
Dr George Malefoasi	Secretary
Dr Divi Ogagoga	Undersecretary, Health Improvement
Dr Cedric Alepandava	Undersecretary, Healthcare
Allan Daonga, Daniel Rove Hugo Hebala	Aid Coordination / Planning
John Huniehu	Chief Planning Officer / Aid Coordination
Sarah Notere	Principal Planning Officer, Government Services
Lyn Legua	Acting Director, Planning
Alby Lovi,	Director, Health Promotion
Noel Itogo,	Tuberculosis/Leprosy Program
Junilyn Pikacha	Reproductive and Child Health
Bob Quiggin	Senior Budget Adviser
Michael Iarui	National Head of Nursing
William Same	Head of National Psychiatry
Ba'akai Iakoba	Chief Statistician
Joana Boso	Tsunami Project Coordinator
Ray Skinner/Wale	Director National Pharmacy
Alby Bobogare	Malaria Director
Issac Muliloa	HIV Coordinator
National Referral Hospital	
Douglas Ete,	Chief Executive Officer
Greg Chapman	Technical Assistance Adviser
Malaita Province:	
Dr Rex Maukera	Provincial Health Director
Mark Maukera	Director of Nursing
Helen Aotee	Clinical Nurse Consultant
Nelson Fifanty	Assistant Director of Nursing (Acting)
Helena Tolobulu	Nurse Manager
Ellen Matangani	Accountant
Billy Rulangi	Hospital secretary
Rockson Siliota	Program officer, EPI/HIS
Peter Babasi	Physiotherapist
Bendedict Alele	Registered Nurse—TB/Leprosy coordinator
Celement Wanefiolo	Health Promotion Officer
Marilyn Iro	Clinical Nurse, Reproductive Health Unit
Nevaline Talo	Nurse Educator, Training
Dr Junily Toata	Dental officer
Jockey Jatobatu	Pharmacy Officer
Nester Rara	Assistant Health Promotion Officer
Julie Hatai	Nurse instructor, Kiluufi hospital

Name	Designation/Organisation
Elias Houropo	Community health nurse consultant, central region
Martha Rafe	Finance and Administration Officer, Oxfam
Julia Fationo	HIV program officer, Oxfam
Rex Tara	Human Security Program Officer, Oxfam
Isaac...	Provincial Minister of Health
Harold …	Provincial Secretary
Eric Segoti	World Vision
Ethel…	SICA Federation of Women
Chris Cadone	Bishop of Malaita
Guadalcanal Province:	
Dr Bainivalu	Provincial Health Director
AusAID/Australian Government	
Peter Houghton	Australian High Commissioner
Paul Kelly	RAMSI Development Coordinator
Kamal Azmi	Counsellor, Honiara
Justin Baguley	Senior Development Program Specialist
John Izard	Health Adviser
David Green	Community Support Program
Kate Keane	Technical assistance—Financial management
Other	
Eric Muir	Deputy Auditor General
Nick Gagahe	Government Statistician, Ministry of Finance
Dr William Adu-Krow	Country Liaison Officer, World Health Organisation
Ramesh Puri	Director, Save the Children Australia
Dolores Devesi	Country Representative, Oxfam
Stephen Harries	Country Program Manager, World Vision
Stella Maebiru	Team Leader, Development Services Exchange
Brett	World Vision
Ashley Wickham	Independent consultant

ANNEX 3: PROVINCIAL FIELD VISITS

27–31 JULY 2008

Provinces visited and dates

Guadalcanal: 27–28 July 2008

Auki and North Malaita: 27–31 July 2008

East Malaita: 30–31 July 2008

Purpose of visits

1. To identify the principal health problems affecting the population of the selected provinces, and determine the appropriateness of Australian support to the health sector in Solomon Islands in helping to address those problems.
2. To identify how health services were affected during the ethnic tensions, how well they had recovered, and what residual problems existed.
3. To identify the main challenges affecting staff of rural health facilities in delivering primary and preventive health services to their catchment population, how they address those challenges, and the critical success factors where challenges are being met and/or performance is improving.
4. To gather data to help determine the effectiveness of direct and indirect Australian support for management and delivery of primary and preventive care health services in the selected provinces.
5. To examine the role of non-Ssate providers in delivery of health services, and how they interact with government systems and Australian support.

Basis for selection of provinces for field visits

Guadalcanal

> Good performance in terms of HIS reporting compliance.

> Parts of the Province severely affected by violence and population displacement during ethnic tensions of early 2000s.

> Rapid recovery of outreach services following ethnic tensions.

> Significant logistic constraints for service delivery and access to services for population living on the ‘weather’ (southern) Coast.

> Consistently ranks highly on National Malaria Control Program indicators for malaria incidence.

> Significant involvement of non-state providers:

> Catholic Church (Good Samaritan ‘Hospital’)—constructed by an Italian NGO outside of national or provincial facility development plans

> Seventh Day Adventist (SDA) Church (primary care facilities)

> Potential demand and health seeking behaviour management issues related to absence of provincial referral facility but easy access of North coast communities to NRH

Auki and North Malaita

> Location of Provincial Health Management Team in Auki.
> Location of Provincial Referral Hospital (Kilu'ufi) in Auki.
> Significant logistic constraints for service delivery—direct road access only along West coast.
> Parts of the Province severely affected by violence and population displacement during ethnic tensions of early 2000s.

East Malaita and Atoifi

> Significant logistic constraints for service delivery—no direct road access for most of the population served.
> Long-standing involvement of Atoifi SDA Hospital as non-state provider—providing secondary and primary care for almost 50 years and well established as a sub-provincial hospital facility.
> Long-standing involvement of Nafinua Area Health Centre (AHC) as non-state provider (South Seas Evangelical Church)—Government staff employed to work out of church-owned facility, with some church-funded health positions.
> Proposal for Atoifi Hospital to take over supervisory role of Nafinua AHC.
> Population of South and South East Malaita reported to sometimes travel to Honiara and NRH—even for primary care.

Consultations and sites visited

Guadalcanal

> Provincial Health Office (Provincial Health Director, Provincial Accountant, nurse managers, Public Health Program managers) in urban Honiara
> Provincial Malaria Control Program managers (co-located with national MCP at Solomon Islands Malaria Training and Research Institute)
> Area Health Centres
  – Good Samaritan ;Hospital' (former Grove AHC)
  – Marara AHC (site visit only)
> Nurse Aid Posts
  – Tamboko Clinic (site visit only)
  – Koleasi Clinic (site visit only—building empty as not yet registered or commissioned)
  – Tinagulu Clinic
> Nguvia 'health promoting school' project

Auki and North Malaita

> Provincial Health Office (Provincial Health Director, Provincial Accountant, nurse managers, Public Health Program managers)

> Kilu'ufi Hospital

> Dalanap Rural Health Clinic (Anglican church mission)

> Arao Rural Health Clinic

> Foondo Rural Health Clinic

> Mbta'ama Rural Health Clinic

> Mala Area Health Clinic

East Malaita and Atoifi

> Atoifi Hospital (Medical Officer, Nurse Manager and staff, Nursing College)

> Nafinua Area Health Centre (Area Supervisor and staff)

Relevant findings and observations from the field visits have been incorporated into the main body of the report.

ANNEX 4: AUSAID SUPPORT TO SOLOMON ISLANDS HEALTH SECTOR

AUD$000

Activity	1999–2000	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	Total
Health Sector Interim Sector Strengthening	531	1,082	18							1,631
Ministry of Health HISP		4,008	5,750	12,930	13,362	13,371	12,583	9,542	35	71,580
Of which: HISP project		7	1,736	2,536	3,385	3,898	5,006	3,442	35	20,045
Health Sector Trust Account		4,001	4,015	10,394	9,977	9,472	7,577	6,100		51,536
HSSP								2,700		2,700
Solomon Islands Health SWAP								676	107	784
Solomon Islands Health Sector Support									9,035	9,0352
Support for medical emergency supplies			2,217	(240)						1,978
Emergency medical recruitments/ placements			309							309
Vector Borne Diseases Control	497	339								836
Medical equipment maintenance project		103	105	89	103	82				481
Tertiary health services support		125	98	160	126	134				643
SP reproductive health and family planning training				140	131	102				373
Strengthening expanded program on immunisation				31	30	0				62
Malaria Reference Group meeting								94	(10)	84
TOTAL	1,028	5,656	8,498	13,111	13,751	13,689	12,583	13,012	9,166	90,495

Notes: 1—represents a supplementary payment to the Ministry of Health and Medical Supplies via the Health Sector Trust Account

2—includes A$3.4 million expended under the PacMI-Solomon Islands malaria program

ANNEX 5: AUDIT FINDINGS AND FOLLOW-UP

The audit of the NRH was conducted after MHMS management detected fraudulent practices in catering and patient travel. It was a full-scale performance audit, and it found abundant evidence of fraud and poor management in many hospital units. The NRH was at that time assisted by a long-term HISP advisor who helped the NRH executive to prepare a response and plan of action.

Here follows some of the major issues and follow-up actions as presented by the MHMS in its Management Response to the audit, in testimony to the relevant Parliament Committee:

> The Permanent Secretary will be required to authorise all services provided by the NRH (e.g., embalming).

> An annual review of the schedule of fees will be conducted with recommended revisions and submitted to Permanent Secretary.

> Only the formally appointed cashier will collect and receipt funds on behalf of the NRH.

> An invoice request form will be initiated that requires all supporting documentation to be attached.

> NRH expenditure statements, balance sheets, cash disbursements, cash receipts listings and bank reconciliation will be forwarded to the Ministry of Health headquarters monthly.

> A patient travel fee schedule will be developed and approved. Only approved and appropriately referred travel fares will be paid.

> Fraudulent activity by the Catering Manageress will be referred to the police.

> The catering section's accounting, tendering and work practices have been amended to be more transparent and effective.

Has the follow up to the audit been carried out as well as intended? A main focus of past and current control measures is the patient referral and travel payment system. Patient travel accounts for about 10 per cent of the NRH recurrent budget and is a highly sensitive issue, given that the payments are made to patients and one family member for expensive travel from other islands to Honiara and return. The NRH currently pays for return fares and in some case round trips, while the provincial health departments pay for the trip to the NRH on the basis of a clinical referral. While at hospital, the patient and one family member receive meals from catering.

The audit found evidence of fraud on the part of hospital staff and mismanagement of the payment system. The fraud case was referred to the police as the audit recommended. However, most of the issues identified in the audit were not addressed as of early 2007. In particular, the absence of patient referral guidelines had allowed for widespread uncertainty and abuse of the system. No new guidelines and protocol had been issued by early 2007, as promised in the follow up. None were presented to the mission in August 2008. Some tightening of practices seems to have taken place. In August, for example, the Chief Accountant reported that the hospital was relying on shipping company prices and passenger lists for payments to patients of travel costs. There are also new procedures to verify each patient payment through a community liaison officer, who examines the referral note and the NRH clinician report. The Audit said there should be only one payment point, the accounts payable cashier, but this has not yet been achieved. Management of the referral charter flights payments has also not yet been subjected to new control arrangements.

Despite efforts to gain control over this area of opportunity for fraud and abuse, it was not clear that this had been fully achieved, either from the reports of the last hospital adviser or from the Chief Accountant and the new hospital adviser. The Chief Accountant in fact said that spot audits of the patient referral and transport payment system should be conducted regularly.

Catering in the NRH was another area of reported abuse in the audit report, including staff theft of food and invoicing abuses. Here progress has been much more substantial. Catering has prepared estimates of food needs based on standard menus so that ordering is based on actual need. Proper supplier documentation is now retained for all payments to food suppliers. The fraud case has been referred to the police. Most importantly, tendering for fresh and manufactured food is now managed according to procurement regulations. Manufactured food is now supplied by three firms after a bill of quantities was supplied to potential firms and their price bids reviewed by the tender board. Theft of food from the kitchen or from patient trays is better controlled through secure storage of food and monitoring by the dietician. Food theft, however, is a continuing risk and needs close supervision and monitoring.

A third area of concern is the management of fee revenues by the NRH. The audit called for the appointment of a cashier by the Public Services Department, a review of fee collection practices and policies by the NRH, and issuance of new guidelines and a schedule of fees. So far, the cashier has been appointed, but the other steps have not been achieved.

A fourth area of follow up is NRH reporting to hospital and MHMS management. This has been partially successful. Financial reports are better organised and are prepared regularly. Hospital management reporting is getting underway, as evidenced in August 2008, with further improvements planned, with the help of the current Adviser.

The Auditor General met with the ODE team and commented on the follow up to the NRH Audit. He said that the NRH and MHMS were the two leading institutions within the SIG in terms of attention to follow-up actions. The cases of fraud and waste at the NRH were not centrally coordinated but opportunistic in nature by line staff. Provincial health management of national and local resources is the next focus for the Office of the Auditor General and there are plans for audits in two provinces (Malaita and Western) later this year.

The Office of the Auditor General's positive comments are supported by the many audit issues that have been fully addressed at the NRH, but it is apparent that some more difficult audit responses remain to be completed or launched. NRH management needs to undertake a further push to complete work in the more sensitive areas of patient referral, fee management and food theft.