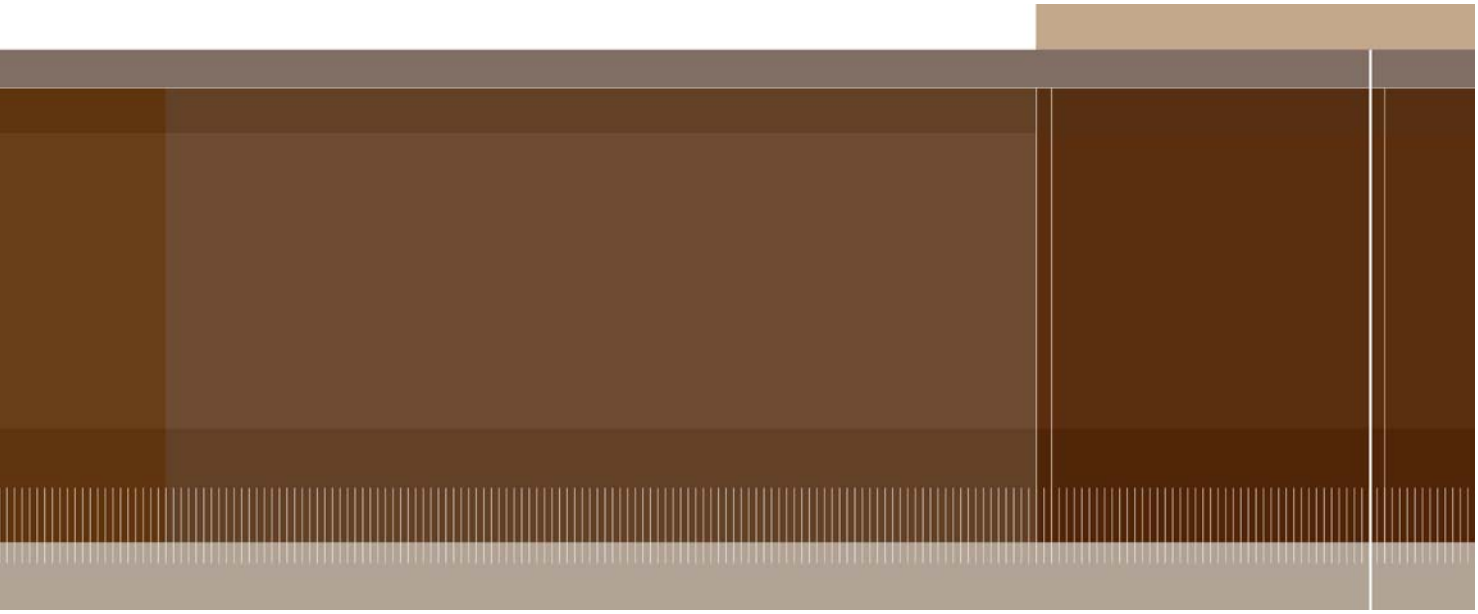
WORKING PAPER 3: VANUATU COUNTRY REPORT

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

JUNE 2009



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

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

ABBREVIATIONS

ADB	Asian Development Bank
AFD	Agence Française de Developpement
API	annual parasitic incidence
AusAID	Australian Agency for International Development
DTP3	Third Dose of Diphtheria-Tetanus-Pertussis Vaccine
HIS	Health Information System
HSPMDP	Health Sector Planning and Management Development Project
HSPPS	Health Sector Post Project Support
LLINs	long-lasting insecticide treated bed nets
MCP	Malaria Control Program
MDG	Millennium Development Goal
MEMP	Medical Equipment Maintenance Program
MFEM	Ministry of Public Finance and Economic Management
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
MOIA	Ministry of Internal Affairs
MOU	Memorandum of Understanding
NCDs	non-communicable diseases
NDH	Northern Districts Hospital
NGOs	Non-Government Organisations
OECD	Organisation for Economic Co-operation and Development
PacMI	Pacific Malaria Initiative
PacTAM	Pacific Technical Assistance in Medicine
PAHP	Pacific Action for Health Project
PNG	Papua New Guinea
PPP	Purchasing Power Parity
PRVBDP	Pacific Regional Vector-Borne Diseases Project
SCA	Save the Children Australia
SIA	Supplementary Immunisation Activity

STPES	The WHO STEPwise approach to Surveillance
STIs	sexually transmissible infections
SWAP	sector-wide approach
TA	technical assistance
U5MR	under-five mortality rate
UN	United Nations
UNICEF	United Nations Children's Fund
VCH	Vila Central Hospital
VPDs	Vaccine Preventable Diseases
WHO	World Health Organization

EXECUTIVE SUMMARY

Country context

Some 80 per cent of ni-Vanuatu lives in inclusive rural communities that can be mobilised to provide support to community services, or to individual members. Less positively, strong community identity can also result in pressure on politicians and officials to steer resources toward their place of origin. Although communities are inclusive, women can have limited participation in decision making, and gender violence is of concern.

Vanuatu has made good progress in reducing child mortality and is on track to achieve the Millennium Development Goal (MDG) for under-five mortality. However, most child deaths are still from preventable causes (such as pneumonia, diarrhoea and neonatal conditions) and many more could be averted with improved primary and preventive care, including by skilled birth attendants.

The availability of maternal health services varies greatly by province, with skilled birth attendance averaging 79 per cent nationwide, but reaching only 40 per cent in Torba. Malaria has come down sharply in recent years—though the resurgence in 2001–03 coincided with a gap between the end of Australian Agency for International Development (AusAID) support and the start of the Global Fund Program. This demonstrates the need to ensure continuity in development assistance if hard-won gains are to be sustained.

Health data in Vanuatu must be strengthened. Piecing together available data and impressions from field visits presents an overall picture of a health service that functions relatively well in most areas. The evaluation team was impressed by good practices in service planning and management and drugs seemed to be available with stock-outs of short duration, however there are serious gaps in coverage in parts of the country where access is difficult. Immunisation is a particular concern, with coverage dangerously low—especially in the most remote provinces—and not improving, due to a range of problems including poor cold-chain maintenance.

Issues to be addressed in the health sector include:

- financial allocation (more than half the budget is spent on hospitals and less than a quarter on community health) and financial management problems (too centralised, not transparent and some capacity issues in the provinces)
- workforce issues, including shortages of nurses due to insufficient training capacity; dependence on expensive expatriate specialists; and the longer-term issue of dependence on the services of volunteer village health workers in the community where the level of effort required of them may eventually require a more assured means of remuneration than the current varied and somewhat ad hoc arrangements
- the need to develop and support the increasingly important role of non-government organisations (NGOs) in health promotion, which have a comparative advantage in being able to address difficult issues (gender violence, sexual health, non-communicable diseases) and in working with hard-to-reach groups (youth, urban populations)
- the overly complex health information system, which has low coverage, lacks management data and gender disaggregation, and does not report to management on key performance indicators. At

the local level, however, the evaluation team found that facilities are collecting and using locally relevant information (such as community maps and population data).

Australian support to health in Vanuatu

Australia spends approximately $3 million to $4.5 million each year on health assistance to Vanuatu. In 2008, it will provide roughly one third of aid to the sector and about 12 per cent of public health expenditure. Major areas of intervention have included:

- support to health sector planning and management. The team observed evidence of sustained impact in the form of service delivery planning and other systems still in use at lower levels. The initial focus on technical assistance advisers and on reorganisation and planning at the centre attracted some criticism in interviews, and some planning documents produced by AusAID (for example, the human resources plan) lacked ownership and were never adopted. Other areas that might have achieved more had they had greater sustained support include information technology, the health information system (which does not generate useful reports for management at any level), and the procurement of high frequency radios, which were not given sufficient support to ensure they could be effectively used and maintained (unlike in Papua New Guinea (PNG) and to some extent Solomon Islands). The team agree with AusAID's decision to use the planning adviser to work with Ministry of Health (MOH) to develop a follow-on program with stronger ownership, abandoning the flawed 2005 proposal developed by consultants which featured a strong emphasis on capacity building
- long-running support to village health workers through Save the Children Australia (SCA), which appears to be having a positive impact at the community level. Bringing the program under MOH management is a positive step, despite initial teething problems
- long-running support to supplying Australian specialists, mainly at Port Vila hospital, clearly meets a need given the evident skill gaps, but may not be the most cost-effective approach
- support to small health grants, which has a good bottom-up approach, working with communities to achieve cost-effective construction and appears to have had a widespread impact on the quality of health facilities at all levels. There would be merit in raising the ceiling of this support to cover the full cost of a new dispensary, including necessary equipment and sanitation, and in developing a longer-term program to assist in systematic prioritisation.

Vanuatu has also received Australian development assistance by way of regional mechanisms, including direct support through bilateral projects addressing specific clinical or public health issues and indirect technical and financial assistance provided by United Nations (UN) agencies and funding instruments such as the Global Fund to Fight Aids, Tuberculosis and Malaria. Major issues with regional programs include:

- lack of attention to continuity which, in the case of the vector-borne diseases project, contributed to a doubling of malaria incidence due to a gap between the end of the AusAID-supported program and the start of Global Fund support
- lack of alignment with the country health strategy, with some examples of inappropriate interventions being inputs under the Pacific Islands Project, including discrete, short-term inputs that focused on individual patient management in a chronic disease context where a more sustained, public-health approach would have been more appropriate

> inability to respond promptly to country requests and timetables.

Options for the future

The main lessons in this country report—already recognised by AusAID and the MOH—are worth highlighting here:

> Ensure that the benefits of activities are not lost by too rapid a withdrawal at the end of a project or program.

> Continue the current approach to developing projects and programs that are closely aligned with MOH priorities.

> Develop a stronger orientation to provincial and community health service delivery, a direction that is consistent with the priorities of the draft health sector policy.

The health conference in November 2008 provides an initial opportunity to strengthen the dialogue on making progress toward establishing a sector-wide approach (SWAP). A good output from the conference might be to identify the steps required to develop a 2010 budget and work plan in which the Government of Vanuatu and donor contributions are identified, and allocated in line with agreed priorities.

Options for moving AusAID support to a program-based approach

Because of divergences between the approved MOH budget and the actual pattern of spending, AusAID will need to continue earmarking support to specific expenditures within the budget. There is, however, scope for improving alignment to and harmonisation with the Government of Vanuatu budget.

A path toward a program-based approach could work broadly as follows:

> AusAID indicates to the Government of Vanuatu the total financing envelope for health at the start of budget preparation (multi-year if possible).

> AusAID and the MOH agree on program areas and medium-term financial allocations for the proposed program areas.

> AusAID and the MOH negotiate the content of the programs, with all costs explicit, including technical assistance, and develop an agreed monitoring framework that meets AusAID and MOH needs.

> The understanding between the two governments would be set out in one or more Memorandum of Understanding (MOU) or joint financing agreements, which would specify the use of Government of Vanuatu procedures—possibly with some additional financial safeguards until accountability is more robust.

> The agreed expenditure programs to be supported by AusAID would be included in the MOH budget and annual work plans, with their own budget codes to ease financial reporting.

> If some AusAID activities are to end, they will be extended and phased out as necessary to ensure that what has been achieved can be sustained.

Although the exact pattern of support is open for discussion and development, Section 4.3 offers suggestions:

- a multi-year asset development plan, to include the existing small grants scheme, but integrated within an overall physical development plan
- a health workforce program
- community-based support, covering village health workers support and possibly other government partnerships with NGOs
- a technical assistance program, to be fully integrated with the overall Government of Vanuatu health strategy and included in the budget with explicit costs.

CHAPTER 1: BACKGROUND

1.1 Terms of Reference and methodology

The Office of Development Effectiveness 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 PNG, Solomon Islands and Vanuatu. This working paper summarises the findings from the Vanuatu country case study.

The team defines the health sector to include promotive, preventive and curative health services, whether provided or financed by Government or 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) leads 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).1

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 (Annex 1 lists references consulted and Annex 4 bilateral activities)
- interviews with key informants (Annex 2 lists those interviewed)
- field visits, to Sanma and Malampa provinces (Annex 3)
- debriefs with AusAID staff and Government.

1.2 Structure of the report

Section 1.3 provides brief background information on the country context. Section 2 discusses the health status and the structure and performance of the health system in Vanuatu. Section 3 contains the evaluation of Australian support to the health sector since 1998. It summarises Australian aid to the health sector in Vanuatu, and provides the team's analysis and judgments of the effectiveness of

1 World Health Organization (WHO), Organisation for Economic Co-operation and Development (OECD), World Bank (2008). Effective Aid, Better Health: Report prepared for the Accra High Level Forum on Aid Effectiveness, September 2008.

the overall program and of the main interventions. Section 4 draws some implications for the future of Australian support to the health sector.

1.3 Country context[2]

Vanuatu has a population of more than 220 000 living in more than 3000 localities with 69 inhabited islands. Most islands with significant populations are mountainous or steeply undulating. Vanuatu is prone to frequent earthquakes, cyclones and volcanic eruptions.

A prolonged period of declining per capita income came to an end in 2003, and in recent years Vanuatu has had the fastest rate of economic growth in the region, based on investment in land and tourism attracted by improved economic management. With 80 per cent of the population rural and mostly engaged in subsistence agriculture, it is arguable that the economic decline and the subsequent boom have had only limited impact on the majority of the population. Most islands have sufficient land to meet their food needs with minimal effort ('subsistence affluence.') Other aspects of poverty are present—for example 40 per cent of the population does not have continuous access to clean water, and communities have to devote increasing amounts of time to acquiring cash for paying school fees and acquiring other necessities. Communities with difficult physical access face greater difficulty in acquiring cash and make less use of health and other services. Vanuatu's first Household Income and Expenditure Survey in 2006 revealed that 90 per cent of the poor live in rural locations, though there are also pockets of severe poverty in Port Vila.

Local communities are inclusive, and capable of strong community action. Inclusiveness is associated with Vanuatu's hierarchical structure in which the chiefs and the churches play a leading role in reinforcing strong pressures to conform to traditional values. This means that women often have limited participation in decision making, and presents challenges for communities in dealing with gender-based violence. It also makes it difficult to address issues such as teenage sexual health. However, civil society organisations are becoming increasingly vocal in demanding greater accountability of Government and promoting legislation designed to protect vulnerable groups. For example, the Family Protection Order Bill, passed by Parliament but not approved by the President (at the time of the team's visit), was the subject of lively debate between stakeholders seeking change and stakeholders who are more conservative.

The downside of strong community identity is that politicians and officials at all levels face pressures to bring direct benefits to their own communities. Governments are weak coalitions that sustain the allegiance of their supporters by distributing patronage to the communities from which they come. The evaluation coincided with a change in government and a new MOH. There was an immediate call for a vote in the new administration.

The main planning and policy documents are the 1997 Comprehensive Reform Program and the Prioritised Action Agenda of 2003. Neither of these was effectively linked to resource allocation or

2 For a more comprehensive assessment of country context in Vanuatu, see AusAID's The Unfinished State: Drivers of Change in Vanuatu (2007).

successful in prioritising reforms—they are perceived as donor-driven with limited government ownership.3

The budget and financial management system has received strong technical assistance support from AusAID and has the potential to deliver a good standard of financial accountability. However, there is no effective process for detecting and addressing divergences from financial regulations (partly because audits have not been laid before Parliament and findings not followed up). This leaves accounting officers in a weak position to resist pressures from politicians and senior staff to spend money on purposes not included in the approved budget.

3 AusAID. The Unfinished State: Drivers of Change in Vanuatu (2007), pp. 34–42.

CHAPTER 2: VANUATU HEALTH SECTOR

2.1 Health financing

In 2005, Vanuatu spent 4.3 per cent of Gross Domestic Product on health, or about $88 per capita, compared to $65 per capita in Solomon Islands and $42 in PNG.4 Government accounted for 61 per cent of health spending, donors 16 per cent and households 18 per cent.5 The public sector share in Vanuatu is above the average for low-income countries and for the region, but is lower than PNG or Solomon Islands.

Allocation of health spending is heavily skewed toward Port Vila and toward hospitals, with more than half the total budget going to hospitals. Community health is allocated only 23 per cent of the budget, compared to 25 per cent for Vila Central Hospital (VCH). Some 47 per cent of MOH spending was on in-patient care and 13 per cent on general administration, compared to just 7 per cent on prevention and 22 per cent on outpatient, medical and diagnostic services.

All health facilities and aid posts charge fees. Additional non-fee-for-service fundraising is also actively pursued, usually with the support of chiefs, churches and other community leaders. Fee schedules are almost always visibly posted, indicating the price of different services as well as exemptions. Average out-of-pocket costs in 2005 were $14 per capita per year or $6 if payments to private providers are excluded.6 These costs do not appear to be a significant barrier to access for individuals from rural communities, but they may be in the growing informal urban areas where community support is less available and the depth of poverty is higher.

After a series of very large increases in the late 1990s, MOH spending declined slightly in real terms in 2000–05 as Government reduced its overall spending to stabilise the economy. MOH spending has since grown rapidly, although a large part of the increase has been absorbed in salaries, particularly a large adjustment in 2007. As a consequence, the non-salary operating budget of Government has shown little increase, and in real per capita terms in 2007 was lower than in 1999.

In practice, however, the situation is not as bad as these figures might imply. A substantial contribution from donors is not captured in the budget figures, and the pattern of actual spending differs substantially from the budget, not least because the salary budget includes provision for a large number of vacant positions. The Director-General of Health is free to recommend using underutilised salary expenditures for other spending, and requests are normally agreed by the Ministry of Public

4 WHO, World Health Statistics (2008). Adjusting for AusAID assistance not included would raise the figure for Vanuatu to $97 per capita. The alternative purchasing power parity (PPP) comparison shows PNG spending more, and a smaller difference with Solomon Islands, but there are reasons to believe the PPP comparison is misleading when applied to health.

5 MOH, Vanuatu National Health Accounts 2005 (July 2007). Including AusAID technical assistance would raise the donor share to 24 per cent of total health spending, and 30 per cent of public spending (defined as Government plus donor spending).

6 2005 National Health Accounts, op cit.

Finance and Economic Management (MFEM). In 2007, for example, the team was told that 15 vehicles were purchased by transfer of funds from the underutilised salary budget.

The draft health sector policy provided to the team contains a useful analysis of baseline spending in 2008 and future financing gaps to 2010. It makes the highly pessimistic assumption that government financing will remain unchanged while donor spending (based on existing pledges) will fall to just two thirds of existing levels by 2010 (Table 2.1, row 8). It envisages that total spending on investment in infrastructure and equipment will fall as the redevelopment of the Nursing School and the Northern District Hospital are completed (row 1). It also proposes a steep cut in spending on health sector development initiatives (row 2). These are characterised as '... an excessive involvement of MOH staff with policy making and strategy developments, which absorbs too much of the workforce ... in activities that do not necessarily generate effective actions at the level of service provision.'7 Salaries and other workforce costs remain unchanged, given that there are 20 per cent vacancies across the system (row 3). These cuts and the restraint on the salary budget help to create an increase in the under-funded budget for non-salary operating costs and the training budget, which are expected to increase by about 19 per cent over the next two years (rows 4 to 7). Operational costs increase by five per cent per year (about 2.6 per cent per capita), and drugs and supplies by 10 per cent per year. This analysis is at constant prices and would need adjustment for inflation.

On these assumptions, there would be a financing gap of 11 per cent in 2010 (row 9).

Table 2.1 Health expenditure and financing scenario 2008–10 (million Vatu)

	Baseline 2008			2009				2010			
Health system functions	Gov	DPs[8]	Total	Gov	DPs (pledges)	Gap	Total (needs)	Gov	DPs (pledges)	Gap	Total (needs)
1. Lower investment in infra structure and equipment	80	247	327	0	394	154	240	0	116	-110	226
2. Reduced spending on health sector development initiatives	0	285	285	0	175	62	113	0	215	101	114
3. No increase in salaries and health workforce costs	942	83	1,025	942	83	0	1,025	942	83	0	1,025
4. Increased operational costs (service	356	26	382	356	26	-19	401	356	26	-39	421

7 Draft Health Sector Policy (2008), p. 39.

8 Development Partners.

delivery) budget											
5. Increased drugs, chemicals and medical supplies	115	105	220	115	54	-73	242	115	54	-97	266
6. Increased workforce and community training	0	163	163	0	114	-126	240	0	114	-112	226
7. Increase in non-salary operating costs (%)							15.4				3.4
8. On these assumptions, total spending will be:	1,493	909	2,402	1,413	845	-3	2,261	1,413	608	-257	2,278
9. Percentage financing gap						-0.1%				-11.3%	

Source: Draft Health Sector Policy

However, the funding actually available is likely to be significantly higher than assumed in the draft health sector policy. For illustrative purposes, Table 2.2 shows the consequences of assuming that donors maintain 2008 spending levels, while government revenues grow by six per cent per annum, in line with recent economic growth. This would generate an additional Vatu 566 million in 2010, filling the 257 million financing gap shown in Table 2.1, and permitting 2010 spending to be eight per cent higher than the baseline and 14 per cent higher than that assumed in Table 2.1. If the increase were to be spent entirely on non-salary operating costs, it would enable them to increase by 60 per cent over 2008 levels.

Table 2.2 Illustrative 'high case' health expenditure and financing scenario 2008–10 (million Vatu)

	2008			2009			2010		
Health system functions	*Gov*	*DPs*	*Total*	*Gov*	*DPs*	*Total*	*Gov*	*DPs*	*Total*
If Government financing grows by 6% per annum and aid does not fall, then public-health spending could be higher:	1,493	909	2,402	1,583	909	2,492	1,678	909	2,587
Increase from aid policy estimate of resources				170	64	234	265	301	566
Enabling non-salary operating costs to grow rapidly									
Non-salary operating costs	471	294	765	641	258	899	736	495	1,231
% growth of non-salary operating costs, high scenario						17.5			36.9

Source: Evaluation team

2.2 Health service delivery: Outputs and outcomes

Service access and utilisation

Data on health service access and utilisation in Vanuatu are limited. The national Health Information System (HIS) provides reports on outpatient consultations at dispensaries, health centres, mobile outreach clinics and hospitals, but not at aid posts.9

Available data suggest quite high coverage and utilisation of health services. Around 80 per cent of women, for example, receive at least one episode of antenatal care and deliver with a skilled birth attendant and 62 per cent of children with an acute respiratory infection are taken to a health provider.10 The 2005 MOH annual report quotes a national average of 1.84 outpatient visits per person per year; adjusting to include aid post visits, it seems probable that the true national average is in excess of two visits per annum, relatively high by middle-income country standards.11 HIS data on the two provinces visited by the team (Sanma and Malampa) suggest that utilisation is not improving; there was no increase in outpatient contacts in 2005–07. It is possible, however, that effective work by the AusAID-supported Village Health Worker Project may be diverting demand from dispensaries to aid posts, in which case actual performance may be better than the reported figures imply.

There are significant differences in coverage between and within provinces, with per capita outpatient department visits ranging from 1.4 in Tafea to 2.1 in Penama in 2005. Access is inhibited by a lack of road access through mountainous terrain, or the need for boat transport to reach aid posts or health facilities from islands or remote coastal communities. In view of these constraints, there are likely to be significant pockets of under-utilisation of health services among more remote communities.

Health system outputs

Expanded Programme on Immunisation

Available data on immunisation coverage show much variation between sources; however, all indicate that coverage is low—and may be precarious—with wide fluctuations over recent years and also wide variations between provinces.

In 2003, the National Statistics Office estimated that 66 per cent of children in Vanuatu were fully vaccinated by 12 months of age. More recent data from UNICEF indicate that measles vaccine coverage fell below 50 per cent and DTP 312 coverage fell below 60 per cent in 2002–03. This was addressed by a national supplementary immunisation activity (SIA), which achieved coverage of 96 to 100 per cent in all provinces except Torba (76 per cent).

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9 An aid post reporting form has been in place for many years but data entry has only just commenced. To date, there has been no analysis of reporting compliance or service utilisation at this level.

10 The United Nations Children's Fund (UNICEF), Multiple Indicator Cluster Survey (MICS) (2007), provisional data.

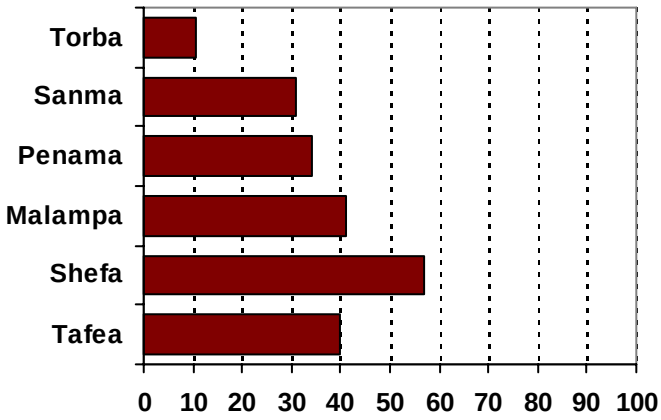
11 MOH 2005 annual report figures, quoted in MOH National Health Accounts 2005, July 2007.

12 Third dose of diphtheria-tetanus-pertussis vaccine.

Provisional data from the UNICEF 2007 MICS suggest that, nationally, only 40.1 per cent of children aged 12 to 23 months were fully vaccinated.13 Coverage was higher in urban (47.7 per cent) than in rural areas (36.4 per cent).

Relatively high birth rates and this low 'reach' of the routine Expanded Programme on Immunisation (EPI) (Figure 2.1) mean that coverage rates would be insufficient to maintain herd immunity against vaccine preventable diseases (VPDs). The most isolated maritime province, Torba, is regarded as extremely vulnerable to the emergence of epidemic transmission of measles and possibly outbreaks of other VPDs. A follow-up measles SIA and an assessment of the immunisation cold chain are planned for 2009.

Figure 2.1 Proportion (%) of infants 12–23 months of age fully immunised, by province, Vanuatu, 2007



Source: MICS, 2007 (provisional)

The team's observations in the field are consistent with the precarious situation described by coverage data. The team noted that, while stocks of vaccines at provincial distribution centres were adequate and EPI was provided during outreach visits from health centres, cold-chain monitoring was inconsistent and the cold-chain and vaccine logistics and hardware were precarious.

Health centres generally had one gas-powered vaccine refrigerator, no backup cylinder (meaning that, when the cylinder was empty, vaccines would have to be relocated to another facility and vaccination suspended while the cylinder was replaced) and limited access to repair services in the event of refrigerator breakdowns. Cylinder replacement might take days or even weeks, and might require funding from Health Committee resources.

Maternal and reproductive health care

UNICEF reports a decline in total fertility rate from 4.9 per woman in 1990 to 4.3 in 2003 and 3.9 in 2006, with a crude birth rate of 29 births per 1000 population. The provisional 2007 MICS estimates are that 37 per cent of women of reproductive age use 'any' modern form of contraception (ranging

13 'Fully vaccinated' means completed vaccination against the six priority EPI diseases: tuberculosis (bacillus calmette-guernin vaccine), DTP, poliomyelitis and measles.

from 23.1 per cent in Malampa to 51.9 per cent in Shefa); the most commonly used forms are oral and injectable contraceptives.

Nationally, 83.1 per cent of mothers report at least one episode of antenatal care from a skilled health professional—a doctor, midwife or nurse. Around 79 per cent of mothers had the assistance of a skilled birth attendant during delivery, and around 73 per cent delivered in a health facility. Again, there are distinct regional differences in obstetric care: delivery by a skilled birth attendant ranges from around 40 per cent in Torba province to more than 90 per cent in Shefa province—again, a function of the accessibility of health services.

In Sanma province, health centre managers have responded to this challenge by raising community funds to build waiting mothers' accommodation (to encourage women from more remote communities to stay close to the centre before the onset of labour) or by upgrading labour ward facilities, including antenatal care and risk screening in community outreach visits. They also conducted training for traditional birth attendants active in their catchment area.

Health outcomes

Childhood morbidity and mortality

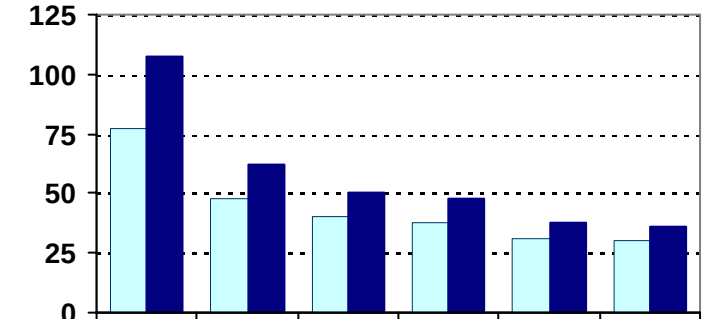
The most common causes of child mortality in Vanuatu—perinatal conditions, pneumonia and diarrhoea—are all readily preventable with better access to primary and preventive care and the availability of skilled birth attendants.

Figure 2.1 shows reported trends in the infant mortality rate and under-five mortality rate (U5MR) over the last 25 years; both indicators have decreased slowly during this period.14 UNICEF regards Vanuatu as 'on track' to achieve the MDG 4 U5MR target by 2015.15

Figure 2.2 Trends in reported infant and under-five mortality per 1000 live births, Vanuatu, from 1980 to 2006

14 Data are taken from UNICEF's ChildInfo data set and may be based on extrapolations of historical data or require government validation before being reported. Nevertheless, provisional data from a current study in Port Vila and Luganville (funded through AusAID's Australian Development Research Awards) provide comparable estimates for U5MR of 35 per 1000 in each centre.

15 'On track' means that the U5MR is less than 40 per 1000 live births, or that the U5MR is 40 or higher, but the average annual rate of reduction in U5MR for 1990–2006 is four per cent or better (UNICEF: The State of Asia-Pacific's Children, 2008).



	1980	1990	1995	2000	2005	2006
IMR	77	48	40	38	31	30
U5MR	107	62	50	48	38	36

Sources: UNICEF, UN Statistics Office MDG Indicators.

In the Asia-Pacific region, the U5MR in Vanuatu per thousand live births is above that in Samoa (28) and the Philippines (32), around the same as that most recently reported in Solomon Islands (37), below the Federated States of Micronesia (41), and much lower than PNG (64).

The most common conditions among children presenting to health facilities and aid posts visited by the team included upper respiratory infection, fever (generally treated as clinically suspected malaria), scabies and other skin infections, worm infestation, diarrhoea and malnutrition.

Maternal mortality

With a paucity of relevant data available, it is not possible to obtain a precise estimate of maternal mortality in Vanuatu. UNICEF reports a maternal mortality ratio for 2000–2006 of 68 per 100 000 live births,16 while the Asian Development Bank (ADB) cites the ratio as high as 130 per 100 000 in 2000.17

Many health workers questioned during our field visits could recall a maternal and/or neonatal death occurring in surrounding communities during the preceding two years. They cited haemorrhage as the most common reason for maternal deaths, but rarely had other information about the circumstances underlying any of the births. They surmised that remote geographic location and the onset of pregnancy complications at night (and the absence of suitable transportation) were likely contributing factors.

Malaria

The national malaria control program (MCP) in Vanuatu is strongly organised around a vertical approach. Its strategy is based on intensified vector control (principally through achieving a high coverage with long-lasting insecticide treated bed nets (LLINs), early case detection and prompt, effective treatment.

16 UNICEF. The State of Asia-Pacific's Children 2008: Child Survival.

17 ADB. Vanuatu—Millennium Development Goals. Available from: http://www.adb.org/Vanuatu/mdg.asp

About 10 per cent of health facilities have microscopy available, with the remainder diagnosing and treating on clinical grounds (by submitting a slide to a provincial microscopy laboratory for confirmation and surveillance purposes, the MCP is able to provide better, more accurate malaria data than the HIS).

In 2003, the national annual parasite incidence (API) was 73.9.18 Following the introduction of LLIN distribution in 2004 and subsequent intensification, there has been a significant decline in malaria incidence with the API falling to 23.3 per 1000. LLIN coverage is expected to reach ~80 per cent of the targeted coverage by population (one net per 1.7 people) by the end of 2008. (Figure 3.1 charts the national API since 2000, relative to the availability of externally funded support for malaria control).

All health facilities visited by the team had first and second line malaria treatments and at least some LLINs available. Health workers reported that deaths due to malaria were rare; nevertheless, in the provinces visited, the HIS reports five malaria deaths in Sanma and eight in Malampa over the last four years.

Non-communicable diseases

Vanuatu is on the verge of a rapid escalation in its burden of non-communicable diseases (NCDs). Among more than 600 subjects included in a STEPS survey in 2005 (WHO), 66 per cent were overweight or obese, 15 per cent had high blood pressure, 11.8 per cent were diabetic and 22.6 per cent had elevated serum cholesterol.

Diabetic peripheral vascular disease is now the most common reason for admission to surgical wards, representing about half of all patients admitted at the Northern Districts Hospital (NDH) and an estimated one-quarter at VCH.

Although the National Cancer Registry is no longer functional, preliminary data from the pilot phase of a Cervical Cancer Screening Project on Efate (see below) suggest a nine to 10 per cent incidence of pre-malignant and malignant cervical lesions among 500 women tested.

HIV infection and sexually transmitted infections

Vanuatu has reported a cumulative total of five cases of HIV infection, two of whom are on antiretroviral therapy and one on prophylaxis against opportunistic infections. Two have died.

Other sexually transmissible infections (STIs) represent an important risk factor for acquiring HIV infection. A survey among pregnant women in 1999–2000 found a 21.5 per cent prevalence of chlamydia and 27.5 per cent of trichomonas; a larger follow-up survey in 2005 found a chlamydia prevalence of 13.5 per cent.

18 Annual Parasite Incidence is defined as the number of microscopically confirmed cases of malaria registered in a year per 1000 individuals under surveillance. It is a much more precise measure of malaria incidence than simply recording clinically suspected malaria among patients presenting with fever.

2.3 Service delivery system

Apart from a few private practitioners operating in urban areas, and some private-sector pharmacies, the MOH has responsibility for overall management and oversight of the formal health system. Provincial health offices of the MOH in each province manage rural health services. Hospital managers also report directly to the MOH.

Box 2.1 summarises the four-tier structure of the health service delivery system. It indicates the standard staffing requirements for each type of facility, although actual staffing varies according to the catchment population and the availability of staff. The top three tiers—hospitals, health centres and dispensaries—constitute what is referred to as the formal health service, with all costs met from the MOH budget, whereas the fourth tier—aid posts—comprises the informal, or community-owned component of the health service.19 The community (in some cases with donor or NGO support) is responsible for the upkeep and maintenance of the aid post, and whatever support is required for the village health worker.

Health centres are the principal facility in an administrative zone. The team was unable to identify a precise formula, needs analysis or other objective basis for the location of dispensaries or aid posts.

Box 2.1 Health service delivery system

Hospitals

There are five main hospitals in Vanuatu, with one in each provincial centre (Torba is under development). The VCH in Port Vila and the NDH in Luganville are the two referral centres for Vanuatu's Southern and Northern Health Care directorates respectively. All hospitals provide obstetric, medical, paediatric, surgical, inpatient and outpatient services, and the VCH and the NDH also have specialist outpatient clinics.

Urban health facilities

The urban areas are served by dispensaries that fall under the municipal administrations of Port Vila (five) and Luganville (three). These are staffed by a nurse or a nurse practitioner.

Municipal dispensaries provide primary and preventive care and, in some cases, coordinate hospital management for patients in their catchment areas. They provide only limited preventive services (other than family planning) and no outreach services (other than occasional home visits).

Rural health care

The network comprises 32 health centres (staffed by a nurse practitioner, a midwife, a registered nurse and sometimes a nurse's aide), 89 dispensaries (staffed by a nurse and a nurse's aide) and 181 aid posts (staffed by a village health worker). Each health centre is functionally responsible for supervising dispensaries and aid posts in its catchment area, including receiving referrals and conducting supervisory, public health program and clinical outreach visits.

Community-based health facilities

Aid posts constitute the informal—or community owned—component of the health service. These are staffed by a

19 Vanuatu Health Sector Situational Analysis (2005).

single village health worker who receives up to three months of basic training in primary and preventive care. Other than in some very remote communities (where they may be paid a small provincial allowance or a proportion of user fees through the aid post committee), all village health workers operate as community-based volunteers.

Aid post links to the formal health system include receiving supplies and outreach supervision from the nearest health facility, and a requirement that they submit monthly HIS data sheets to the provincial HIS data manager.

2.4 Health sector issues

Provincial health services

Budget management

Funding shortfalls make it difficult for provincial health offices and provincial hospitals to implement their business plans. Although in recent years the MFEM has released the budget in full to the MOH, provincial health managers find that funds received are often far short of the amounts included in their monthly cash plans. In some cases, this reflects delays in the highly centralised process for approving even small amounts of money (e.g., the MOH requires prior authorisation for staff travel, signed off by the provincial health manager). In other cases, it reflects problems in acquitting funds leading to delayed releases, as in Malampa. There is also frequent internal reallocation within the MOH on the authority of the members of the Executive Committee who have to respond to a range of in-year spending pressures, including dealing with arrears payments from previous accounting periods (especially utility bills). This is symptomatic of a general problem of weak financial control across the sector.

Unexpected in-year spending pressures often arise, and the MOH will need to continue making adjustments to approved budgets. However, it would help provincial staff if the MOH could ensure that relevant managers are informed whenever such action is taken, and are preferably consulted in advance about the implications of any reassignment of their approved budget. The roll-out of the integrated financial management system in principle helps by providing online access to budgets, commitments made and remaining balances, but not all provinces have access yet, and provincial health managers may need technical advice on how to use the system.

Service planning and supervision

Provinces are divided into zones. Zonal health centres are responsible for overseeing services in their respective zones, including in the health centres themselves, at dispensaries, aid posts and any outreach services. In the provinces visited by the team, all health centres had maps displaying topographical features and the location of villages, dispensaries, aid posts, churches and in some instances households, together with population figures. They also exhibited up-to-date schedules providing a good overview of planned visits, both incoming and outgoing. Health workers agreed, however, that the planned schedules were not always kept and that monthly outreach activities frequently happened only bi-monthly or quarterly due to a lack of funds. In the same vein, there were no regular supervisory visits, although coordinators of programs with national or external funding, such as malaria, tended to visit more frequently than others.

There was some evidence of refresher training and workshops being organised covering both management subjects as well as technical topics, though experience across provinces varies. The same applies to meetings of the nurse practitioners in charge of zonal health centres to review progress and share lessons learned.

Community role

Health facilities usually have community health committees that exercise oversight of the facility and manage facility finances; aid posts generally have an aid post committee, which, if functional, fulfils the same purpose.20 Fees collected from outpatients can be retained and used for such purposes as service improvement, whereas inpatient fees are supposed to be returned to the MFEM. In principle, if revenues are used to pay for costs that should fall on the Government's budget (e.g., staff or patient travel), the committee should be reimbursed based on the submission of receipts and other documentation to 'acquit' the expenditure as if it were an accountable advance. In practice this rarely happens and a significant portion of what should be core operating costs are being met from user charges.

The functioning of facility and aid post committees is uneven, and some staff and village health workers report that their committee is defunct. In such cases, the provincial health manager may join efforts to encourage the community to revive the committee.

Health workforce: doctors and nurses

The Vanuatu MOH has struggled to attract, train and retain a skilled workforce of adequate size.

In 2006, the MOH reported that its health workforce included 312 nurses, 50 midwives, 51 allied health personnel and 29 doctors (of whom only 15 were ni-Vanuatu). Health care worker-to-population ratios—0.14 doctors and 1.45 nurses per 1000 population—place Vanuatu among the three Pacific countries with the lowest health workforce densities (the others being PNG and Solomon Islands).

The skilled health workforce is also distributed unevenly across the country. The VCH and the NDH absorb 42 per cent of the current health workforce; at the time of the team's visit, there was no medical officer stationed at Norsup (Malampa province) or Lolowae Hospitals (Penama province), or in Torba province.

These issues have been the subject of several situation analyses, a WHO-sponsored national consultation and planning meeting in October 2007, and subsequent mapping exercises to define actual staff numbers and their distribution. The current challenge is to operationalise this analysis and planning in a way that is feasibly and appropriately prioritised.

Doctors

The medical workforce currently depends on international doctors filling staff short-falls. These include Australian and New Zealand specialists sourced through Australian Volunteers International under the Pacific Technical Assistance in Medicine scheme (PacTAM) (Section 3.1); Chinese resident

20 The role and operation of health committees is defined by the Health Committee Act of 2003.

specialists (who practise without registration under a special dispensation from the MOH); and sometimes other short-term volunteer clinicians (including those who visit periodically on board 'medical mission yachts').

Clinical capacity is supplemented by four to six individual specialist or team visits through the Royal Australasian College of Surgeons Pacific Islands Project.

Under a recent agreement, 17 medical students have departed for undergraduate training in Cuba and more are expected to follow. One Cuban specialist is already at the VCH, and the placement of additional Cuban doctors in under-staffed provincial hospitals is imminent. Discussions about medical staff placements in Vanuatu have also been initiated with the Government of Israel. Appropriate strategies need to be developed to integrate these doctors.

The influences on quality of care of such a diverse range of clinical approaches needs to be managed and, if possible, standardised.

Nurses

Vanuatu is facing an impending crisis in the availability of nurses and nurse's aides, who represent the majority of health workers and constitute the backbone of the health service. An ageing nurse workforce, coupled with insufficient training outputs from the Vanuatu College of Nursing Education—the single Government nurse training school attached to the VCH—means a reduction in the number of health workers in the short- to medium-term is now inevitable.21 The cadre with the highest number and proportion of vacancies is nurse's aides.22 Given the shorter duration of pre-service training required, vacancies in this cadre may be more rapidly filled than for registered nurses or midwives.

In addition to the absolute number of nurses, the orientation of nurse training is mainly toward hospital-based practice (rather than community nursing). Greater emphasis is needed on public-health management in post-basic training, and the orientation of undergraduate training also needs to be reviewed.

Vanuatu is preparing to participate in regional efforts to increase and strengthen the health workforce in the Pacific, with a view to identifying opportunities to increase its own workforce and improve standards. Another priority in the ongoing health-sector reform process is to tackle human resources requirements,

Community-based health: Aid posts and village health workers

The network of aid posts staffed by village health workers plays an important role in providing community-based care to large numbers of rural villages, but also faces a number of challenges.

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21 The current intake of the nurse training school is around 25 every two to three years, while loss of staff due to retirement or ill health is estimated at up to 35 nurses per year. Although plans are underway to return to annual intakes, it will be years before there is any impact from this action.

22 According to the draft aid policy, there were 58 vacancies for nurse's aides compared with nine for registered nurses.

The location of aid posts and selection of candidates for village health worker training are determined according to agreed criteria and guidelines (although these are subject to political interests and community pressures). Many aid posts are closed, and there do not appear to be plans to significantly expand the aid post network or train significant numbers of new workers.

Village health workers are highly valued by their communities—principally for their curative role (mainly treatment of injuries and minor ailments), but also, to a lesser extent, for their role in improving health awareness and the environmental aspects of village health.

The MOH has recently taken over management of the contract with Save the Children Australia (SCA) from AusAID, and the impact of this will need to be monitored. In 2007, the ministers of health and internal affairs signed an MOU to the effect that the MOH would be responsible for training and supervising village health workers and supplying free drugs to aid posts, while Ministry of Internal Affairs (MOIA) would be responsible for providing financial support to the village health workers and helping communities to maintain and repair aid posts. Unfortunately, neither the MOIA nor provincial governments have the resources to provide the promised support.

For the moment, village health workers are volunteers—albeit with varying levels of support from their communities and, in more remote areas, from provincial governments. This model will come under pressure as many of the original workers (some of whom have been working for more than 20 years) retire and new, younger workers are trained. Young people (including young men) are keen to be trained, but more reliable payment systems need to be encouraged.

Non-state actors/Non-Government Organisations

NGOs play an important role in Vanuatu, particularly in supporting community activities and aspirations, and catering to youth and women. In relation to health, NGO activities may cover three distinct elements: (i) health service provision; (ii) health promotion; and (iii) support for civil society voice and social accountability. Of these, few NGOs in Vanuatu are engaged in the first, and those who are focus primarily on providing training and support supervision to village health workers. However, the team was told that churches are currently engaged in talks with Government with a view to a return to health service provision—abolished at the time of Independence—to increase health system capacity.

NGOs are very active in health promotion, particularly with HIV and STIs, but also in health lifestyle issues related to the rapidly increasing incidence of NCDs. Many are engaged in youth programs focusing on sex, substance abuse and unemployment. Violence against women and gender equality are also prominent advocacy topics, and have been widely acknowledged as issues needing attention and decisive action.

During the visit to Sanma province, the team found provincial health department and provincial administrations actively engaged with NGOs, and found their inputs helpful and complementary. The team also found exemplary coordination between several NGOs supporting service provision and health promotion. In Port Vila, apart from those working on HIV and STIs, there seems to be less effective communication and a need for more effective coordination in the health sector by the umbrella organisation, VANGO.

Drug management and supply

Basic management information on drug availability at the health facility level is weak, and non-existent at the aid-post level—this needs to be addressed.

Based on visual inspection and interviews with provincial health managers, clinical staff, village health workers and pharmacists, it appears that the drug supply system has been through phases of frequent stockouts, delays in delivery and a lack of a system for detecting expired drugs.

More recently, the work of the AusAID-financed Principal Pharmacist has led to improvements in the reliability of supplies and concerted efforts to remove expired drugs from the system. This now seems to be having an impact. Although some centres have experienced stockouts in the last year, this was typically infrequent and for relatively short periods. All health facilities visited, and all but one aid post, had essential drugs available;23 in the latter case, there were allegations the drugs were being resold for private gain.

Health information system and sector performance monitoring

The health information system is not at present generating useful reports for monitoring performance. Although aid posts fill in returns, they are not being analysed; coverage of reporting from other facilities is too low (e.g., less than 80 per cent in Malampa), and the MOH reports a high error rate in the returns that it does receive. Because of software problems, it is difficult to generate useful reports directly from the system, while provinces are unable to enter returns on the database, requiring raw returns to be forwarded to the MOH for physical data entry. The gaps in coverage and doubts about the accuracy of returns make the data difficult to interpret. Little, if any, use is made of the data collected to assess trends and plan services at any level of the system. In Malampa, the provincial health director had set up her own system for gathering basic data from facilities because the HIS was not providing the timely information she required.

In the facilities visited, record keeping and data entry appeared to be done correctly. Comments by health workers varied on the current health information forms. Some indicated they considered the forms overly complicated and time consuming to complete. The team's assessment is that the forms contain much data that might better be collected through surveys, organised either by the MOH or in collaboration with the National Statistics Office. Undertaking population-based surveys would also provide at least a partial check on the validity and reliability of HIS data.

On the other hand, some important data that could be obtained through the HIS are not being collected and analysed. The most important gap is the absence of any form of management data, such as drug stockouts, supervisory visits and regularity of reporting. A second important area for improvement would be to disaggregate the service utilisation data by gender. Gender disaggregated data are collected at the facility and aid post level, but they are not recorded in the summary reports passed on to the provincial and national levels.

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23 For the purposes of field visits, the team checked availability and expiry dates of these items which might be regarded as essential drugs: paracetamol, a broad spectrum antibiotic (e.g., procaine penicillin), first- and second-line malaria treatment, antibiotic eye ointment and intravenous fluids. The team also observed whether measles and other vaccines were in stock.

The most important problem with the HIS is that it is not used in any systematic way to inform management decisions. The team would suggest that the MOH would benefit from developing a broad-based performance monitoring framework, based on a set of judiciously selected core performance indicators that are regularly monitored in a 'dashboard' approach considering inputs and processes as well as outcomes and impacts. Such performance-monitoring frameworks, usually using no more than 20 to 25 key indicators, are a well-established feature in many countries where annual or bi-annual meetings of government, development partners and other stakeholders take place to jointly review progress and adjust plans and strategies accordingly.

Addressing the dearth of information in the health sector is clearly urgent: at present ministry and donors are 'flying blind'.

Health reforms 2008

A number of policies and reforms are being developed for review at the National Health Conference, due to meet in November 2008 (after a five-year gap). The first of these reforms is a restructuring of the MOH which aims to address some of the issues arising from an over-centralised system, including control over financial resources—despite the Government's decentralisation policy and stated intentions to delegate authority. Reportedly, in addition to the appointment of a new national director responsible for overseeing and guiding service delivery, it is envisaged that the Executive Committee will be expanded to include six provincial directors. This will be the third such restructuring in the last decade.

Another key feature of the current draft document is the establishment of a National Health Council. The Council is intended to be an independent body performing a watchdog function to monitor and review the work of the MOH and presumably to strengthen accountability and transparency. Its membership would include development partners and representatives of civil society. The political process of establishing the Council and agreeing on its functions is expected to take time. In the meantime, the development of a health sector performance monitoring framework needs to proceed at pace, along with urgent work on workforce issues and on financing and financial management.

In addition to the National Health Conference, a series of meetings with development partners is planned. These meetings are to take place semi-annually to review and discuss plans and progress in moving toward a sector program approach. To serve as a genuine forum for dialogue, the meetings will need to be well prepared and structured, identifying and documenting issues for discussion, providing clear information on budget implementation and on trends in health sector performance, and recording agreements reached.

The first of these 'partners in health' meetings took place in January 2008, with the MOH Director-General informing donors and NGOs of the forthcoming health reforms and the planned National Health Conference, and introducing a draft policy statement introducing the SWAP. In addition to setting out SWAP principles in fairly conventional terms, this document envisaged establishing monthly SWAP meetings, chaired by the Minister or Director-General, with all development partners invited. It proposed that these meetings would be the main decision making forum for the proposed SWAP. To the extent that the team understands the various proposals, it thus appears that the MOH is thinking in terms of twice-yearly major meetings to review progress and program future resources, plus a monthly working SWAP meeting for more routine monitoring. This is fairly standard in

SWAPs, although given the small population of Vanuatu and the limited capacity, it might be possible to streamline the number of meetings once the SWAP is established.

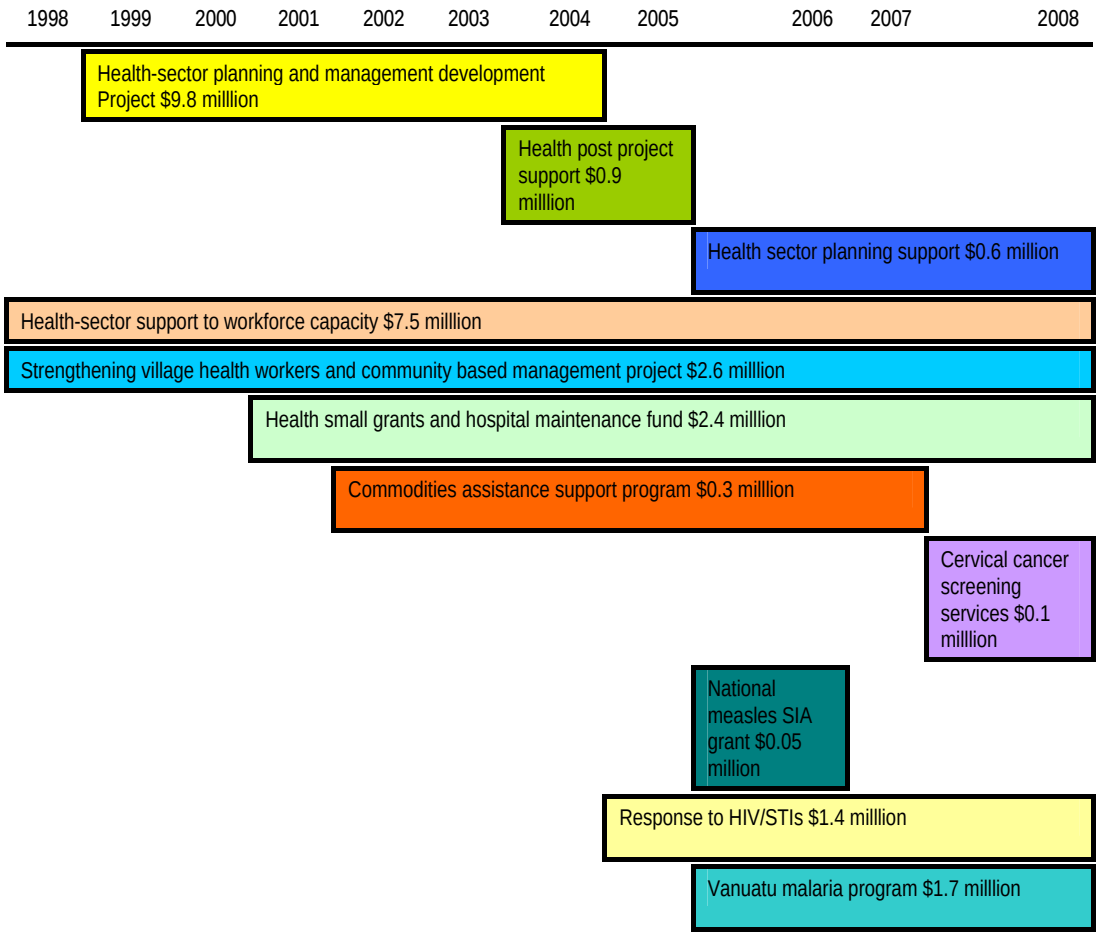
CHAPTER 3: AUSTRALIAN SUPPORT TO THE HEALTH SECTOR (BILATERAL)

3.1 Australian assistance to Vanuatu

Total Australian aid to Vanuatu in 2007–08 is estimated at $44 million, equivalent to 27 per cent of the Government of Vanuatu's 2008 budget. Of this, the bilateral aid program is estimated at $32 million, an increase of 40 per cent compared to 2006–07. Australia is by far the largest donor to Vanuatu, followed by the Millennium Challenge Corporation, New Zealand, the European Union, China and France.

Figure 3.1 outlines the major bilateral activities supported by AusAID in the health sector during the 1998–2008 period, when Australia provided more than $27 million through 11 different programs. Annex 4 provides further details.

Figure 3.1 AusAID support to the health sector in Vanuatu: bilateral activities



During the 1998–2008 period, the health sector also received Australian support from at least 10 regional programs. Figures on total annual AusAID expenditures in the health sector are not readily available. A 2005 assessment estimated that funding was in the range of $3 million to $4.5 million;24 this is broadly consistent with the annual spending levels implied by the projects listed in Annex 4. The draft health sector policy estimates AusAID spending in 2008 at about $3.15 million.25 This is about 12 per cent of public health expenditures. Over the period, Australian support has been significant, although highly fragmented.

This section summarises the assessment of the main interventions. Chapter 4 summarises the main lessons, and sets out options for the future.

Health Sector Planning and Management Development Project and Health Sector Post Project Support

The Health Sector Planning and Management Development Project (HSPMDP)—January 1999 to June 2004—and its successor the Health Sector Post Project Support (HSPPS)—July 2004 to June 2005—aimed to strengthen the capacity of the MOH to better plan, manage and deliver health services throughout Vanuatu.

Both programs focused on improving health service planning, integration and development while the HSPPS also had a specific emphasis on working at the provincial level. The HSPMDP deployed short- and long-term technical advisers and provided funding for workshops and other in-country training activities. It also undertook some small-scale procurement such as radios and all terrain vehicles for health facilities and computer equipment for MOH and provincial health managers.

The HSPMDP was successful in instituting a range of new processes and led to new initiatives such as the establishment of the provincial health grants fund in 2001 (which evolved into the small grants fund), and the rollout of the MFEM SmartStream budget software to the MOH. The benefit of these activities can still be seen. Other activities were important but less successful, such as the reshaping of the HIS, and the attempted introduction of a radio network. In contrast to PNG and Solomon Islands, it appears that the radios are not being used. Overall the team's assessment was that the project focused on the right things broadly, and in some areas had a positive and long-lasting impact, but the areas of least success perhaps indicate a lack of sufficient follow-up to ensure new systems were institutionalised.26

The HSPPS was designed to be more flexible and responsive to the priorities of MOH. It came about as a result of an MOH request for ongoing, short-term technical support pending the commencement of the new program being designed to replace the HSPMDP, and was purely a Technical Assistance (TA) mechanism—there was no procurement function. Advisers worked with small teams rather than one counterpart with the objective of consolidating the gains under the HSPMDP and helping the

24 Jim Tulloch, Notes on Australian support to the health sector in Vanuatu, March 2005.

25 Draft aid policy lists AusAID programs as expecting to spend Vatu 280 million in 2008. This excludes the cost of the regional NCD program, the support from the College of Surgeons and AusAID support to hospital maintenance.

26 Advisers also worked with counterparts on the 'Workforce Plan 2004–2013', 'Corporate Health Plan 2004–2006', and the 'Master Health Services Plan 2004–2009'.

MOH improve basic service delivery to rural areas. The Independent Completion Report found that the flexible arrangements were appropriate and supportive of greater development partner harmonisation, particularly with the WHO. It concluded that the VHPPS successfully continued the reform momentum built during the HSPMDP.

The impact of both projects can still be seen in some of the planning, budgeting and management systems at the provincial level and in the mechanisms for supervision and coordination of rural health service delivery. By and large the gains appear to have been sustained, although some plans developed by advisers have not yet been implemented (e.g., Master Health Services Plan and Human Resources Plan) and new planning processes have been developed instead. It is not clear why the advisers' work was not implemented, but the introduction of new planning processes by the MOH may be an indication that too little attention was paid to working jointly with the MOH to develop ownership, and perhaps that more could have been done to follow up and support implementation.

AusAID initially expected to follow the HSDMDP and the HSPPS with a new sector support program, which was designed in late 2005. Although the objective of 'supporting a Government of Vanuatu-led move toward ensuring all external and Government resources available to the health sector are used with maximum efficiency, to support a single health-sector strategy, plan and budget' was seen as desirable, there were concerns about the proposed implementation approach and lack of MOH ownership. In 2006 it was decided to proceed with only one element of the design—the recruitment of an AusAID-funded adviser to the MOH to work toward the same objective.

The intention was to support the move to a sector approach over a longer time frame with the health planning adviser working directly with the MOH and able to identify and bring in additional technical advice as required. It was also hoped the adviser would work with the MOH to establish a framework on which AusAID could begin to align its current projects with the priorities and future policy intentions of the MOH. The adviser has been actively involved in discussions and preparation of the draft health sector policy currently being developed by the MOH, but progress toward a more coherent approach to the AusAID projects has been slow.

Health small grants and hospital maintenance grants

Since 2000, AusAID has supported small grant programs for hospital maintenance and equipment and the construction and maintenance of rural health facilities. These programs are administered by the MOH using guidelines agreed to with AusAID. A committee within the MOH recommends funding based on a needs assessment, and construction and procurement are undertaken by the facilities, village committees or the MOH. The approach builds on strong community support to achieve relatively cost-effective construction. Most facilities in Vanuatu have received some sort of support from these programs over the period of their operation, which has been valued by both the MOH and the facilities.

Vanuatu Village Health Workers Project

Australian support to village health workers has been in place since 1994 through a number of phases.27 SCA was contracted to manage and implement the project in partnership with the MOH, through providing pre- and in-service training and supervision to village health workers and distributing essential equipment and educational materials.

More recent phases have focused on strengthening the provincial level management of the program, increasing nurses' supervision and support to village health workers in strengthening community management, and providing greater emphasis on the non-clinical roles of the workers.

AusAID, the MOH and SCA recognised the potential for loss of momentum and impact upon conclusion of the first phase of the project and negotiated a series of bridging phases (and funding). This effectively maintained continuity of inputs while the approach and details of the subsequent phase were being developed.

In 2003, more intensive support from AusAID was provided to pilot sites in Tanna (Tafea province) and Malekula (Malampa province) to support these change processes. Results indicate that support through pilot sites fostered accelerated outcomes, including more rapid establishment of provincial focal points, closer collaboration between village health workers and NGOs—such as World Vision (Tanna) and Rotary (Malekula)—and increased participation of nurses in conducting training programs with aid post committees and supervisory visits with the workers.28 Team visits to aid posts in Santo and Malekula islands also confirm that support to village health workers has had a good impact and services are well used.

Medical specialists at the Vila Central Hospital

The range of specialties supported by this long-term program includes general surgery, internal medicine, paediatrics, anaesthesia and obstetrics, and gynaecology. Their terms of reference include mentoring of ni-Vanuatu specialists, supervising interns and registrars (enabling VCH to be a recognised training institution by the Fiji School of Medicine), developing clinical systems and, where feasible, conducting specialist outreach visits to provincial centres. A combination of individual interests and external pressures (e.g., critical doctor shortages) means that, sooner or later, most default to in-line service provision.

Scholarships for health-related undergraduate studies

AusAID has also supported scholarships for health-related undergraduate studies (mainly at the Fiji School of Medicine and sometimes at the University of PNG). Among 13 scholarship recipients from 2006, around 20 per cent have discontinued their studies for various reasons, suggesting a need for improved mentoring and support while students are away from Vanuatu.

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27 Community Health Promotion Project (1994–1997), Vanuatu Village Health Worker Project (1997– 2002), and Vanuatu Strengthening Village Health Worker and Community-based Health Management Project (2003 to current).

28 Save the Children (2005). 'Vanuatu Strengthening Village Health Worker and Community-based Health Management Project: Completion Report', pp. 6–7.

AusAID also supports medical graduates to undertake their two-year internship in Vanuatu. This is contingent on an agreement between the Fiji School of Medicine and the MOH to maintain an agreed standard of specialist supervision at the VCH and the NDH.

Cervical cancer-screening project

The Brisbane Women's Health Centre is currently the key implementing partner of a five-year cervical cancer screening project. The project is currently in the pilot stage, targeting a second cohort of 500 self-selected female subjects living primarily on Efate. While the project broadly meets current technical criteria for screening programs29 it is not clear whether the ethical or recurrent cost implications to Government have been adequately considered.30 The project agreement with the MOH simply states that costs will be 'incorporated into existing structures and with new initiatives of Government', but there appear to be risks that it will lead (rather than inform or be led by) government policy in relation to cancer screening and management.

3.2 Australian support to the health sector (regional)

In addition to the above bilateral projects, Vanuatu has been supported by nine Australian-funded regional projects that have addressed clinical service provision, public health problems (e.g., vector-borne diseases, NCDs and preparedness for pandemic influenza), HIV and the maintenance of biomedical equipment. Because of the structure and management of these regional initiatives, it is impossible to quantify the exact value (in AUD$) of their contribution to the health sector in Vanuatu. Periodic and end-of-project evaluations have generally been positive about the overall impact of the regional projects, but have also identified issues and challenges.

Loss of momentum and benefits on conclusion of the project

Although not unique to the regional projects, the loss of momentum on cessation of project inputs and/or while waiting for a subsequent phase or project to begin has been a particular problem for Vanuatu. This also reflects a related issue: applying short-term solutions to longer-term problems.

The Pacific Regional Vector-Borne Diseases Project (PRVBDP) was implemented by the Secretariat of the Pacific Community in Vanuatu, Fiji and Solomon Islands. From 1998 to 2001, it provided technical and logistical support for malaria and other vector-borne disease control. In Vanuatu, one of the project's successes was achieving an early reduction in the incidence of malaria. Upon conclusion of the PRVBDP, the MOH was unprepared to maintain the level of inputs provided through the

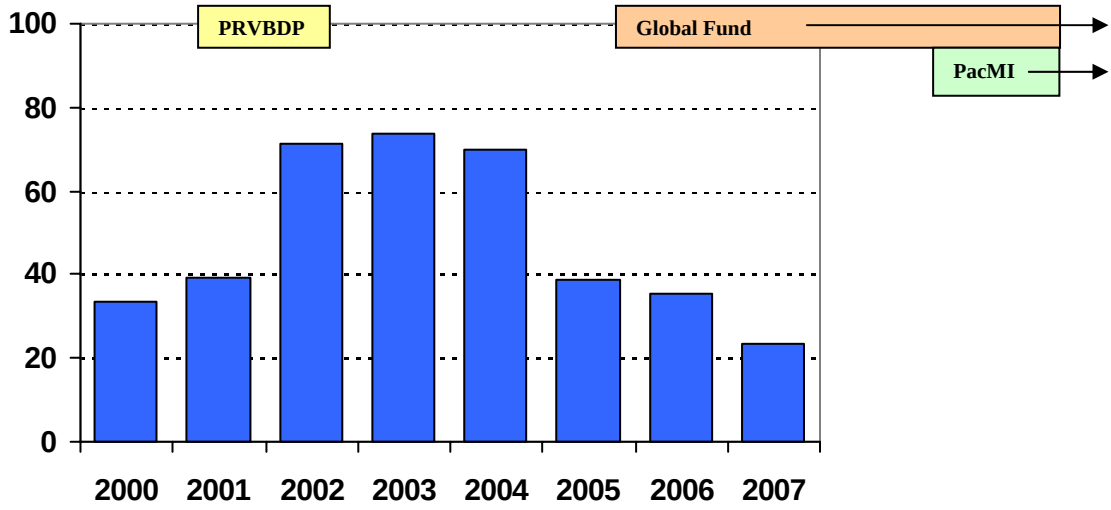
29 Andermann et al. Revisiting Wilson and Jungner in the genomic age: a review of screening criteria over the past 40 years. Bull WHO, 2008; 86: pp. 317–319.

30 Those women diagnosed with cervical lesions in need of surgical treatment are referred to the Australian gynaecologist at the VCH, while those requiring chemotherapy and/or radiotherapy are required to self-fund treatment in Australia or New Zealand (or are provided with palliative care in Vanuatu). The team also understands there is a view to extending the program nationally, and possibly introducing a human papilloma virus vaccination for pre-adolescent girls.

project. There followed a period without any major donor support for the national MCP, during which the incidence of malaria doubled (Figure 3.2).

Since 2004—with financial assistance from the Global Fund, ongoing technical input from WHO and, from 2008, the Pacific Malaria Initiative (PacMI)—there has been a reduction in malaria incidence again from the levels seen in the inter-project period.31

Figure 3.2 Annual malaria incidence per 1000 population, Vanuatu, 2000–07



Source: National Malaria Control Program.

The Pacific Action for Health Project (PAHP) provided support for NCD control in Vanuatu and two other Pacific countries from 2000 to 2005. External support for NCD control in Vanuatu virtually ceased from the conclusion of the PAHP until the commencement of a new regional AusAID-funded initiative the Pacific in 2008.32 The excellent results achieved in Vanuatu during PAHP have not been sustained by the MOH team working alone: legislation on alcohol control and regulations in support of the recently passed Tobacco Control Bill (April 2008) remain in draft form, and community-based healthy lifestyle initiatives have lost momentum.

The Medical Equipment Maintenance Project (MEMP) provided technical and logistic support for biomedical maintenance personnel in Vanuatu and six other Pacific countries. Project outcomes have not been sustained, largely because it did not ensure continuing access to mentoring, technical information and spare parts to maintain the skills that were developed. At the VCH, the maintenance

31 The introduction in 2009 of rapid diagnostic tests in rural facilities and artemesinin-containing combination therapy as first line-treatment will provide added impetus to the national MCP's goal of eliminating malaria within the next 10 to 12 years. The geographic focus for elimination will begin in Tafea province, where the islands of Aneityum and Futuna have already been declared free of Indigenous malaria transmission.

32 Bilateral AusAID funding supported the salary for the PAHP national coordinator for approximately six months between the conclusion of PAHP and the commencement of the regional NCD program; no funding was provided for operational NCD activities.

department was closed for the duration of the team's visit, wards and verandas were cluttered with disused equipment, and the team could see little evidence of scheduled preventive maintenance being undertaken.

Inputs may not be aligned to the individual country context

The Pacific Islands Project has provided funding to the Royal Australasian College of Surgeons to deliver tertiary surgical and other specialised services to Vanuatu and nine other Pacific island countries since 1998, and in Nauru since 2002. During the most recent phase of the Project (2001–06), Vanuatu received 25 procedural surgical visits and five visits by teams and individual specialists in diabetes medicine.

A 2006 review of the project found that its clinical service provision model was appropriate to the country context, and that those activities had been widely appreciated by the MOH. However, achievements in capacity development and skills transfer were modest, and mainly limited to opportunities for junior staff to assist visiting surgeons in the operating theatre (the training and skill-building conducted by the ear, nose and throat and audiology teams were a notable exception).

The diabetes component was found to be inappropriate to the country context. It provided discrete, short-term inputs that focused on individual patient management in a chronic disease context where a more sustained, public health approach would have been more appropriate. Inputs did not harmonise well with either the work of the PAHP or the surgical components of the project.

These lessons have been noted by AusAID, New Zealand Agency for International Development and Pacific countries as they begin to revise the way this type of assistance is provided so it is more country-led, flexible, and provides more structured support for skill building.

Other lessons from regional projects

A need to focus on multiple countries means that project teams spend much time travelling throughout the region, contributing to delays in responding to identified country needs and funding and instituting planned activities (e.g., the MEMP and, despite its other positive achievements, the Pacific Regional HIV/AIDS Project). Many regional initiatives have been developed in response to specific requests or resolutions arising from regional forums (e.g., the Pacific Health Ministers' Conference) rather than from individual country requests. All interventions within a country, whether responding to regional, country or sectoral initiatives, need to be structured and managed in such a way that they respond in a timely and predictable way to requests for assistance from the partner country, are consistent with national health policy and form part of the national strategy while, at the same time, making appropriate use of the intended regional synergies and economies of scale. The programs supported by Australia have not always been structured in a way that readily supports such a response. This may contribute to the problems of slow project or program design, inception and implementation, as well as to examples of inappropriate content.

CHAPTER 4: OPTIONS FOR THE FUTURE

The main lessons from this evaluation have already been recognised by both AusAID and the MOH, but are worth highlighting because they sometimes get lost sight of in practice. The team highlights the need to:

> Ensure that the benefits of activities are not lost by too rapid a withdrawal at the end of a project or program. It is recognised that projects cannot be allowed to meander on indefinitely, but there needs to be a consistent practice of planning the exit strategy from aid-supported activities, and granting extensions where the activities can improve the prospects for sustaining the benefits.

> Continue the current approach to developing a program closely aligned with MOH priorities. This implies taking longer to develop proposals in partnership with Government, but greater ownership should result in faster and more effective implementation. This was the thinking underlying the decision to abandon the 2005 proposal and the present approach of working on a new AusAID program in slower time in the context of the development of the MOH policy. It is nevertheless worth reiterating the point, as there is some frustration at the speed of progress over the last 18 months. It will be important to avoid unrealistic expectations regarding the speed at which a new program can be launched.

> Develop a stronger orientation to provincial and community health service delivery, a direction consistent with the draft health sector policy.

The rest of this report presents options for taking the principles forward which focus on:

> developing the partnership to support MOH priorities, in the context of the ministry's plan and budget

> moving bilateral support towards more of a program approach.

4.1 Moving toward sector wide planning and budgeting

The document on the SWAP that the MOH tabled at the January 2008 donors' meeting calls for all SWAP partners to support a single sector policy and expenditure program, under Government leadership, and adopting common approaches across the sector. It proposes to improve coordination with development partners through monthly meetings chaired by the MOH. The draft health sector policy produced by the MOH also reflects this vision—it refers to ensuring that all significant external funding is in line with the priorities and direction of the ministry. An annual business plan is expected to be prepared by way of a bottom-up process and reflected in the budget.

The AusAID-financed health planning adviser is supporting the MOH in moving toward developing the single strategy, plan and budget. The adviser's terms of reference envisage a joint planning process, organised around an annual sector review.33

The MOH vision of a single plan and expenditure program that captures both Government and donor funding fits well with the new budget process that will be introduced by the MFEM from 2010, and that has received substantial technical support from AusAID. Under the new approach, all donor

33 Health Sector Planning Adviser, Terms of Reference.

commitments will be included in the budget, with a process for donors to indicate their future funding at the start of budget preparations early in 2009. The MFEM will also require all financial support provided to Government to comply fully with government financial procedures and regulations. This means an end to financial arrangements whereby government ministries have access to funds through accounts and procedures that are outside or parallel to the Government's system. It does not exclude direct donor procurement of goods and services 'in kind' on behalf of Government, but the aid and associated expenditures should be captured in the budget.

If the MOH wished, they could build on the new budget process. The main benefit to the MOH would be to get more control over how donors spend their funds and to secure donor support for the new draft health sector policy and MOH expenditure priorities. This would involve talking to development partners at the start of the budget cycle, to discuss the preparation of the annual business plan and budget. Donors would be steered toward commitments that help to fill gaps in the MOH budget, and the budget submission would be prepared by the MOH and informed by good understanding of the resources available from donors and what the resources can be used for. The discussion with donors would take place each year before the start of budget preparation, but should adopt a medium-term approach rather than focusing only on the budget for the coming year. Looking at a longer time frame, say three years, gives more scope for shifting resources toward the MOH priorities that are underfunded. In the coming budget, both Government and donor resources will be largely committed to existing activities. In the outer years, as existing projects begin to wind down, there will be more uncommitted funds available and the MOH can steer future donor commitments to the new programs it wishes to see implemented.

One concern from the MOH side is to avoid having donors intrude into the role of Government in determining spending priorities. It will be important to keep the discussion relatively strategic, raising concerns about big issues such as adequate funding for provinces and for non-salary costs, without getting into excessive detail. The financial analysis included in the draft health sector policy is a modest first step in this direction, although it needs to be further developed to identify expenditure programs rather than just broad areas of spending. Discussion should focus primarily on programming future donor resources toward underfunded spending priorities.

The health conference planned for November 2008 provides an initial opportunity to start the dialogue, although time to prepare is short, and it should perhaps be seen as the start of a process of deeper engagement with development partners. A good output from the conference might be to identify the steps required to develop a 2010 budget and workplan in which Government and donor contributions are identified, and allocated in line with agreed priorities.

4.2 Options for moving AusAID support to a program approach

The most developed SWAPs in other countries have moved toward using donor funds alongside Government funds to finance any spending included within an agreed sector plan and budget, using Government procedures. This can have strong advantages in reducing transaction costs, improving sustainability and making it easier to prioritise. However, this approach requires a high degree of confidence in the budget process. At present, although sector spending is close to budgeted levels, the pattern of spending within the sector can diverge significantly from the approved budget due to in-

year spending pressures. It also inevitably involves close donor scrutiny and an expectation of involvement and significant influence on the sector budget.

A more realistic medium-term alternative that would achieve many of the same benefits would be for the MOH and AusAID to develop a smaller number of programs of support that are somewhat broader than current activities. The proposed movement to a program-based approach could work broadly as follows:

> AusAID indicates to Government the total financing envelope for health at the start of budget preparation—multi-year if possible.

> AusAID and the MOH agree on program areas and medium-term financial allocations for the proposed program areas.

> The MOH and AusAID negotiate the content of the programs, with all costs explicit (including TA), and develop, and agreed on, a monitoring framework that meets MOH and AusAID needs.

> The understanding between the two governments would be set out in one or more MOUs or joint financing agreements, which would specify the use of government procedures—possibly with some additional financial safeguards until accountability is more robust. Ideally, there would eventually be one MOU covering the entire support to the sector, but it may be more convenient to have separate agreements to avoid delays on one program holding up implementation of the others.

> The agreed expenditure programs to be supported by AusAID would be included in the MOH budget and annual workplans, with their own budget codes to ease financial reporting.

> AusAID activities that are to end, would be extended and phased out as necessary to ensure that what has been achieved will be sustained.

This program-based approach would be based on all costs being transparent with open discussion of alternatives—some of which may offer better value-for-money. The approach might eventually reduce the management costs currently being absorbed by the MOH and AusAID, although there would be an initial increase in management requirements while the new arrangements are developed.

4.3 Options for consolidating AusAID to health

The exact pattern of support for consolidating needs to be discussed in detail and developed. This section, however, touches on possible components. The suggested groupings of components excludes ongoing support available to Vanuatu through regional health initiatives (e.g., the NCD framework and clinical and workforce support) as these are initiated, funded and implemented in a different way to purely country-level development assistance.

Asset development program

Shifting the existing small grants scheme and hospital assets fund toward a multi-year assets development program is advisable, as the planning adviser has proposed. The aim would be to improve facilities in a more planned and prioritised way than is feasible with the existing approach. It could be based on an inventory of the existing distribution and condition of facilities relative to population and the identification of standard equipment needs and design parameters where these do not already exist. It will be important to retain the existing bottom-up community-driven aspects of the program, but prioritising community demands must be based on clear criteria. The team would

add that, although the impetus and demand needs to come from the MOH, it would be appropriate to provide TA to facilitate the process. The program could include necessary investments (and appropriate technical support) to develop the cold-chain.

Health workforce

The team has already noted that overall workforce planning and projection, undergraduate and post-graduate medical and nursing training, maintaining and developing a national specialist workforce, the imminent crisis in the nursing workforce, and other aspects of human resources are likely to be long-term needs (see Health Workforce: Doctors and Nurses, above). The focus must now shift to how Vanuatu's needs can be met most cost-effectively, and in a way that addresses the service-delivery priorities of the MOH's Master Health Services Plan.

Initially, to inform discussion about alternative ways of meeting the need for more doctors, the team proposes that AusAID shares with the MOH full details of the costs associated with existing support for the in-line specialist positions and other medical training inputs.

The team recognises that AusAID has historically recommended that the MOH consider alternatives to the provision of Australian specialists, that the costs are known to both parties, and that the Government has been offered the savings to spend on other health sector programs. However, as AusAID has not given explicit commitments on funding levels, and has retained tight control over decisions on the nature and use of aid to the health sector, it is difficult to convincingly show that cheaper alternatives will not result in less aid. Making costs transparent and providing alternatives within an agreed aid budget may not in itself result in different choices being made by the MOH, at least in the short term, but it will make such trade-offs explicit. Bringing such programs within an expenditure plan over which the Government has the power to exercise choice will expose them to the same pressures as other parts of the budget, and should make it more likely that value-for-money will eventually have greater influence on decision-making processes.

Within an expanded overall funding envelope, the team proposes that several alternatives for addressing workforce priorities be explored (as defined by an annual or medium-term health-sector workforce development plan).

For example, PacTAM specialists are usually aligned with the needs of hospital-based clinical care and are highly valued, but some of the specialties often command a high salary premium to attract the right candidate from Australia or New Zealand. Some available funds might therefore be used to provide incentives to attract qualified ni-Vanuatu or other Pacific Island clinicians to vacant positions, or to recruit staff from countries where medical salaries are lower than in Australia and New Zealand but that offer an accredited standard of qualifications and skills. (This latter point will be important for maintaining intern and registrar placements at the VCH and the NDH for ni-Vanuatu graduates from the Fiji School of Medicine).

It would also be valuable to continually review the mix of international specialists in relation to the available MOH workforce, trainee supervision needs and service-delivery development plans. Arguably, some of the intended mentoring and supervision functions of the PacTAM doctors could also be met by a stronger supervisory focus of the proposed new regional specialised services program.

In the context of how best to support the capacity of the VCH, the team notes that a proposal for an Institutional Twinning Project between the Westmead Hospital and VCH has been developed jointly between the Western Sydney Area Health Board, the MOH and VCH staff. The proposal has not yet undergone quality appraisal. The team encourages the MOH and AusAID to review the track record of a similar institutional linkage between the Middlemore Hospital (Counties Manukau District Health Board) in Auckland and the MOHs in Samoa and Tonga.

An area that has not yet been explored is placing specialists with a rural, public health, community medicine or community nursing focus. This is the level where much of the unmet service delivery and supervision needs lie, yet medical supervisory outreach visits to support public health managers and nurse practitioners at the provincial and sub-provincial level or to manage patients with chronic diseases in their community occur infrequently (if at all). Cuba and Israel both have a strong tradition of community medicine, while Australia can offer a high level of expertise in rural and remote area nursing and public-health medicine.

By mutual agreement, the savings accruing from adjustments to specialist medical and nursing staff support might be reprogrammed to alternative means of support for health workforce development. For example, within the expanded funding envelope, the team would recommend that opportunities for increasing undergraduate nurse training intakes be explored. Other areas include realigning nursing curricula with priorities for out-of-hospital care and public health management, and supporting specific post-basic training for specialist nurses. Such inputs would need to be well balanced with the assistance currently being provided by the Agence Français pour le Développement in redeveloping the nurse training school at the VCH, with appropriate dialogue between the MOH and both donors.

Additional undergraduate scholarships or post-graduate training placements could also be offered, or mechanisms put in place for improved mentoring and pastoral care for ni-Vanuatu students studying abroad.

Community-based support: Non-state actors

The VHW support through the SCA is programmed to run to 2011, and there will be a continuing need to help Government provide support to the VHWs beyond that. During the current contract, it will be important to review the future of the voluntary model, considering issues such as the desirability and feasibility of providing a more secure source of remuneration to the village health workers.

Technical assistance

There will be a continuing need for TA, but the draft aid policy suggests that TA for health sector development may have received excessive support in the past, to the detriment of service delivery. To make TA more demand-driven by the needs of the MOH policy and plan, one option would be to develop an annual TA plan that should be incorporated within the budget. Not all TA needs can be anticipated, and a small unallocated budget should be included. To avoid the TA becoming too supply-driven, however, the budget for this program should be built from identified needs rather than the TA being allocated a specific budget in advance. The planning adviser could help Government to identify the need for TA for supporting progress toward a SWAP. Areas that need to be addressed include:

- Streamlining the health information system to include both the data collected by MOH staff, and possible investment in surveys to collect data not obtainable from this source (and to provide a partial check on the reliability of the HIS).
- Supporting MOH capacity in financial management. This should be in close collaboration with the MFEM. The Ministry is proposing to establish bureaus in each province and to roll out the integrated financial management system to provinces. This should provide the basis for a far more effective financial management by provinces. Ensuring that it does so in practice will require:
  - MOH budget management to be made more transparent with more delegation of responsibility to provinces and zones to manage their own budgets. A starting point could be an analysis of the process by which budgets are currently prepared and managed, to identify where delays and other problems are occurring. This would help to facilitate a process for agreeing what could be changed to speed up and strengthen the system.
  - Training and support for provincial health staff to enable them to use the system to manage their budgets. This should be delivered by, or in close consultation with, MFEM staff.

4.4 AusAID capacity and the role of technical assistance advisers

In considering TA needs, it will be important to be clear about the role of TA advisers. Although the programs will be developed in a spirit of mutual respect and partnership, with the MOH in the lead, there will clearly be a need for:

- technical inputs to help develop the programs
- technical advice to both the MOH and AusAID to support negotiation of a program or programs that reflects the needs and policy positions of both.

With regard to the roles and responsibilities of TA advisers, an effective approach should involve specifying in a transparent and open manner that their primary responsibility is to work directly for the MOH, with infrequent meetings (for example, two per year) with AusAID to report on progress toward their objectives (with the MOH also participating in these meetings). With goodwill on all sides, in practice the MOH will likely find it convenient to share information and will sometimes use TA advisers as intermediaries, but it is nevertheless important that the formal position be respected.

If the role of the TA advisers is clarified in this way, there remains an issue of how AusAID ensures that health policy expertise is available to it at appropriate points in the development of the programs and with respect to the wider dialogue on the sector policy, plan and budget. Health policy specialists are available in Canberra, but not in Port Vila. Many of the substantive health-policy issues will be timetabled and can be appropriately handled by bringing in resource persons at the appropriate time (for example, during the annual review of the plan and budget) or by ensuring technical inputs and peer reviews at appropriate points in the development of programs that AusAID agrees to fund. Many of the other tasks will be aid administration issues requiring no particular health policy expertise. Nevertheless major issues will arise during the year, requiring decisions or advice from the donors, and for which health specific expertise will be needed. For example, TA work may produce policy recommendations with implications for the development partners that require a reaction to ensure that they do not get developed in a direction that donors may be unwilling to finance. If in-house health advisers are not available at appropriate times, AusAID may wish to consider the practice of donors such as the United Kingdom's Department for International Development and the World

Bank, which sometimes hire resource persons specifically to support their side of the policy dialogue, funded from the TA program.

ANNEX 1: REFERENCES

This Annex lists only those references specifically cited in the text. It does not list all of the documents consulted by the team in preparing this report.

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ANNEX 2: PEOPLE INTERVIEWED: VANUATU

Name	Designation	Organisation
Government of Vanuatu		
Myriam Abel	Director-General	MOH
Timothy Vocor	Director, Northern Health Care Group	MOH
Jonas Arugogona	Senior Health Planner	MOH
Rose Bahor	Donor Coordination	MOH
Jameson Mokoroe	Finance and Accounts Manager	MOH
Irene Titek	Manager, Human Resource Development	MOH
Morrison Bule	Assets Manager	MOH
Liency Ala	Acting Manager, Human Resources	MOH
Yvana Taga	Data Manager, Health Information System	MOH
Jerol Sakita	Nurse Coordinator, Cervical Cancer Prevention Program	MOH
Apisai Tokon	Project Manager, Cervical Cancer Prevention Program	MOH
Joe Kalo	Project Manager, Adolescent Health and Development Program	MOH and SPC
Graham Tabi	NCD Coordinator (Pacific Regional NCD Framework)	MOH and SPC
Theto Moses	Nutritionist, National NCD Program	MOH
Jennifer Timothy	NCD Project Officer	MOH
George Taleo	Manager, Malaria and other Vector-Borne Diseases	MOH
Markleen Tagaro	Acting Manager, TB and Leprosy Program	MOH
Willie Tokon	Senior Anaesthetist and Acting Medical Services Manager	VCH
Leipakoa Matariki	Acting CEO	VCH
Adelin Welin	Principal, Vanuatu College of Nursing Education	VCH
Jannet Ores	Nursing Services Manager	VCH
Robinson Toukoune	First-Year Intern	VCH
Andy Ilo	Junior Registrar Anaesthesia	VCH
Mawa Reuben	Acting Principal Radiographer	VCH
Terry Kalorib	Acting Laboratory Supervisor	VCH
Trelly Samuel	Internal Medicine Registrar	VCH
G.Tildena Manbavah	Registrar Anaesthesia	VCH
Crystal Garae	Second-Year Intern	VCH
Errollyn Tungu	Junior Registrar Obstetrics and Gynaecology	VCH
Gregoire Nimbtik	Director	Department of Strategic Policy and Coordination
Flora Kalsaria	Health-Sector Analyst	Department of Strategic Policy and Coordination
Betty Zinner Toa	Director of Finance	MFEM
Michael Busai	Chief Economist	MFEM

Fred Tanga	Budget Section	MFEM
Kunal Patel	Budget Section	MFEM
Joanne Asquith	Senior Expenditure Adviser	MFEM
Ben Tari	REDI Unit	Department of Provincial Affairs
Edward	Decentralisation Unit	Department of Provincial Affairs
AusAID		
Nick Cumpston	Counsellor	AusAID
Gordon Burns	First Secretary	AusAID
Lynnette Pirie	Senior Program Officer, Health	AusAID
Pamela Carlo	Program Manager	AusAID
Chris Bleakley	Governance for Growth Program	AusAID
Mark Harradine	Public Financial Management Coordinator, Governance for Growth Program	AusAID
Development partners		
Bernard Fabre-Teste	Country Liaison Officer	WHO
Dai Tran Cong	Malaria Scientist	WHO
Annick Traore	Health Training Projects Adviser	*Agence Française de Developpment*
Li Guangjun	First Secretary Development Cooperation	Embassy of the People's Republic of China in the Republic of Vanuatu
Chen Li	First Secretary, Economic & Commercial Counsellor's Office	Embassy of the People's Republic of China in the Republic of Vanuatu
TA personnel		
Joao Costa	Health-Sector Planning Adviser	MOH
Marcel Braun	Principal Pharmacist	Central Medical Stores
Non-state actors		
Jo Dorras	Founder/Director	Wan Smolbag Theatre
Helen Corrigan	Finance Manager	Wan Smolbag Theatre
Michael Taurakoto	Governance Program Manager	Wan Smolbag Theatre
Jean-Luc Bador	Coordinator	Rotary Against Malaria
Hilson Toaliu	Country Program Director	SCA
Jocelyn Loughman	Program Officer	World Vision
Joseph Lagoiala	Program Manager	Vanuatu Family Health Association
Peter Kaloris	Manager, Youth and Mental Health Project	Foundation for the Peoples of the South Pacific
Anthea Toka	Country Representative	OXFAM Australia Vanuatu Office
Elison Bovu	Executive Director	Vanuatu Society for Disabled People
Lesline Malsungai	President Port Vila Council of Women	Vanuatu National Council of Women
Anita Derouin	Vice President	Vanuatu National Council for Women
Lotty Kayai	Counsellor	Vanuatu Women's Centre
Ruth Yawai	Counsellor	Vanuatu Women's Centre
Pastor Shem Tema	Secretary General	Vanuatu Christian Council
Blandine Boulekone	Office Manager	Transparency International Vanuatu
Trisha Vogel	Paramedic Trainer—Australian Volunteers International Volunteer	Pro Medical
Jane Rosegrant	Country Program Manager	VSO
Whelma Villar-Kennedy	Program Manager, Gender and	VSO

	HIV/AIDS	
Moses Matovu	HIV Adviser	MOH and VSO
David Fegan	Specialist Physician	PACTAM – VCH
Jackie Glennon	Community Health Specialist (Community Paediatrician)	PACTAM – VCH
Jason Sly	Consultant Obstetrician and Gynaecologist	PACTAM – VCH
Samson Mesol	Senior Surgeon	PACTAM – VCH
Malekula		
Lambert Maltock	Secretary General	Malampa Provincial Government
Rosie Silas	Provincial Health Manager	MOH, Malampa
Antoine Telukluk	TB and Leprosy Officer	MOH, Malampa
Johny Joe	Environmental Health Officer	MOH, Malampa
Hellen Nabbanja	HIV/AIDS Volunteer	VSO
Genethy Tawunwo	Health Promotion Officer	MOH, Malampa
Jeanot Malcekan	Manager, Norsup Hospital	MOH, Malampa
Goretti Wersets	Nurse Practitioner, Norsup Hospital	MOH, Malampa
Gabriel Taisets	Registered Nurse, Norsup Hospital	MOH, Malampa
Noel Natan	Executive Officer, Norsup Hospital	MOH, Malampa
Henriette Nadive	Village Health Worker	Mae Aid Post
Talet	Aid Post Committee Member	Mae Aid Post
Rene Tamat	Nurse Practitioner	Atchin Tugunwet Health Centre
Solange Tamat	Registered Nurse	Atchin Tugunwet Health Centre
Philippe Misseve	Registered Nurse	Rensarie Dispensary
Dorah	Aid Post Committee Member	Limap Aid Post
Paulin Bahormal	Zone Nurse	Uri and Uripiv Islands
Willy	President, Council of Chiefs	Uri Island
Women and Youth Leaders		Uri Island
Regenvanu	President, Council of Chiefs	Uripiv Island
Bob Delwin	Nurse Aid	Dispensary, Uripiv Island
	President	Dispensary Committee, Uripiv Island
Joseph Taitsoegon	President, Council of Chiefs	Walla Island
Camille Malili	President	Akrie Malili Aid Post, Walla Island
Akrie Malili	Village Health Worker	Aid Post, Walla Island
Etienne Tiasinmal	President, Tourism Project	Walla Island
Mothy Vira	Women's representative	Walla Island
Marcellus Taisets	Youth representative	Walla Island
Ohleen Ruru	Village Health Worker student	Walla Island
Anna Turere	Member	Walarano Dispensary Committee, Walla mainland
Santo		
Jerolyn Tagaro	Acting Director	Northern Health Care Group
Joseph Mape	Provincial Health Manager	MOH, Sanma
Peter Malisa	Provincial Malaria Coordinator	MOH, Sanma
Valma Banga	EPI and MCH Coordinator	
Mikal Natnaur	HIS Officer	
Samuel Kemuel	Surgical Registrar	NDH

Tobie Tsiabon	Acting Allied Health Manager	NHCG
Regina Heheina	Health Pharmacist	NHCG
Rachel Kalmos	Matron	NDH
Pierre Bulevu	Acting Radiographer In-Charge	NDH
Casimir Liwuslili	Health Promotion Officer	MOH, Sanma
Keith Jacob Gasi	Environmental Health Officer	
Frank Katambula	Volunteer HIV Medical Mentor	VSO
Peninah Kose Katambula	Volunteer HIV Outreach Mentor	VSO
Anna Rory	Nurse-Midwife	Fanafo Health Centre
Thomas Palo	Village Health Worker	Jereviu Aid Post
Steve Vira	Nurse	Malau Health Centre
Collina Vira	Midwife	
Auguste Manwo	Nurse Practitioner	Port Olry Health Centre
Mercy Bebe	Nurse	Nabulvaravara (Chapuis) Urban Dispensary, Luganville
Vombani Mape	Nurse	Luganville Family Health Association
Marie-Michelle Liwuslili	Nurse Counsellor	Wan Smol Bag Youth Drop-in Centre, Luganville
Jeff	Administrator	WSB Youth Drop-in Centre, Luganville
Sakaria Daniel	Provincial Planner	Sanma Provincial Government

ANNEX 3: PROVINCIAL FIELD VISITS

Provinces visited and dates

Malekula Island, Malampa Province: 23–26 September 2008

Santo Island, Sanma Province: 22–26 September 2008

Purpose of visits

1. To review the organisation of the provincial health service, including annual activity planning and budgeting and the role of the provincial government in health service financing and management.
2. To identify the principal health problems affecting the population of the selected provinces, and how effectively provincial health services and communities are responding to those problems.
3. To identify the main challenges facing staff of provincial, district and 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 and appropriateness of direct and indirect Australian support for management and delivery of primary and preventive care health services in the selected provinces, seeking comparisons between better- and poorer-performing areas and approaches to support.
5. To examine the role of non-state providers in supporting and delivering health services, and how they interact with Government systems and Australian assistance.
6. In Malekula, to assess whether additional resource allocation through an Australian-funded piloting scheme for strengthening VHWs has achieved greater results.

Basis for selection of provinces for field visits*

Malekula

> One of two national pilot sites for the Australian-funded Vanuatu Strengthening Village Health Workers and Community-Based Health Management Project.

> Limited involvement of non-state providers.

Santo

> The largest island in Vanuatu, with many areas lacking direct road access.

> The base for the only other national referral hospital outside Port Vila, and for the Northern Health Care Group.

> Significant involvement of non-state providers (such as VSO and WSB).

> Not a pilot site for the *VHWs and Community-Based Health Management Project*.

*The evaluation team considered undertaking a field visit in Torba province, which is the most remote and least well-served province and where health service indicators like immunisation coverage are consistently much lower than elsewhere in Vanuatu. This was deemed not to be feasible for logistic reasons, given the short time available.

Consultations and sites visited

Malekula

- Provincial Government (Secretary-General)
- Norsup Hospital (Provincial Health Manager, Hospital Manager, Executive Officer, TB and Leprosy Officer, Environmental Health Officer, Nurse Practitioner, Health Promotion Officer, HIV/AIDS Officer)
- Provincial Health Centre
  - Atchin, Northeast Area
- Dispensaries
  - Rensarie, Central
  - Uripiv Island, Central
- Aid Posts
  - Mahe, Central
  - Limap, Central
  - Uri Island, Central
  - Walla Island, Northeast

Santo

- Provincial Government (Provincial Planner)
- Northern Health Care Group (Acting Director)
- Sanma Provincial Health Office
  - Provincial Health Manager
  - Individual public health program managers
- Northern Districts Hospital (including Pacific Eye Institute Clinic)
- Health Centres
  - Fanafo
  - Malau
  - Port Olry
- Urban Dispensaries
  - Nabulvaravara (Chapuis), Luganville
- Aid Posts
  - Jereviu

- Non-state providers
  - Vanuatu Family Health Association
  - Wan Smol Bag Youth Drop-in Centre

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

ANNEX 4: BILATERAL ACTIVITIES (A$ MILLIONS)

Health-Sector Planning and Management Development Project	1999–2004	$9.8
Health-Sector Post Project Support	2004–2005	$0.9
Health-Sector Planning Support	2006–2008	$0.6
Strengthening Village Health Workers and Community Based Management Project	1998–2008	$2.6
Health Small Grants Fund and Hospital Maintenance Fund	2001–2008	$2.4
Strengthening Response to HIV/STIs through VSO and Wan Smol Bag	2005–2008	$1.4
Health-Sector Support to Workforce Capacity	1998–2008	$7,5
Vanuatu Malaria Program	2006–2008	$1.7
Cervical Cancer-Screening Services	2008	$0.1
Commodities Assistance Support Program	2002–2007	$0.3
National Measles SIA Grant	2006	$0.1
Total	1998–2008	$27.4