



Health Resource Facility

# **Fiji Health Sector Improvement Program (FHSIP)**

Aid Works Activity number INF 391

## **Independent Completion Report**

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## Acronyms

AusAID	Australian Agency for International Development
AUD	Australian Dollar
CWM	Colonial War Memorials (Hospital)
DAC	Development Assistance Committee
EPI	Expanded Program on Immunisation
FHSIP	Fiji Health Sector Improvement Program
FHSRP	Fiji Health Sector Reform Project
FSM	Fiji School of Medicine
FSN	Fiji School of Nursing
GOA	Government of Australia
H1N1	The so called swine flu virus
HIV	Human Immunodeficiency Virus
HPS	Health Promoting Settings
ICR	Independent Completion Review (Report)
IGOF	Interim Government of Fiji
LTA	Long Term Adviser
M and E	Monitoring and Evaluation
MOF	Ministry of Finance
MOH	Ministry of Health
NCD	Non Communicable Diseases
NCHP	National Centre for Health Promotion
PATIS	Patient Information system
PD	Program Director
PDD	Project Design Document
PIC	Pacific Island Country(s)
PO	Project Officer
PSC	Public Service Commission
QAC	Quality at Completion (Report)
RT	Radio Telephone
SDMTs	Sub Divisional Management Teams
STA	Short Term Adviser
UNICEF	United Nations Childrens Program
WHO	World Health Organisation

## Executive Summary

The Fiji Health Sector Improvement Program has been well implemented and has strengthened the capacity of the Ministry of Health Fiji under demanding circumstances. The program is funded by AusAID and, in its broadest sense, has supported the Ministry of Health Fiji (MOH) to pursue its own strategic and corporate plans. Initially a five year program it commenced in January 2004 and, following the granting of an extension, formally finished in December 2009. As part of the next phase of AusAID support, a 12 month transition phase was added (January – December 2010) to facilitate, as far as possible, a seamless transition from the current FHSIP to a future multi-year program of assistance. This transition phase has only just commenced and was not the subject of this review. FHSIP represents the first program within the health sector where AusAID used an “alliance partnering approach” to manage the program activities. According to AusAID guidelines all partners (AusAID, MOH and the Partner Contractor – JTA International) have equal rights and responsibilities that are exercised in a cooperative manner through the Governing Board” – the so called Charter Board. The program found itself working in a management environment which including the coup of 2006, major changes in the structure and personalities at the senior level of the MOH, the decision of the Interim Government of Fiji (IGOF) to cut the staffing levels of the public sector by 10% and more recently a decree that public servant had to retire at age 55. Due to these policies a very large number of senior and middle level staff, who had received skills development under the FHSIP were forced out of the sector.

The FHSIP Strategic Objective is to provide cost-effective financial and technical support to MOH Corporate and Divisional business plans. The program has 4 stated components. The component structure identified in 2004 was also modified to suit the MOH priorities. For the purposes of this ICR, the components in use at the current time are shown and are as follows: Rural and Public Health; Clinical services; Health Information and; Management.

A few of the multiple achievements of the program are mentioned here. The Fiji School of Nursing was strengthened with the establishment of a new basic nursing curriculum, Post Basic Certificate in Mental Health and Post Graduate Diploma in Midwifery along with training of 11 tutors. In the area of NCDs, with a focus on diabetes, the MOH was supported to develop a National NCD Strategic Plan, a National eye care strategic plan and some work in the area of dental services. “NCD tool kits” were supplied to all health centres and nursing stations enabling early detection of diabetes. Fixed facilities were upgraded to detect and manage diabetes complications. FHSIP also supported a “Fiji Save the Foot project” which sought to integrate the foot care clinic and home based care. Thanks to the Program there has been considerable improvement in the EPI program. Vaccine coverage has improved markedly, from levels of the order of 70% 5 years ago to coverage levels of 95% at the present time. Under the Secondary Services component, impacts were noted in several areas. Clinical Services plan was developed in 2005 and reviewed in 2009. Clinical Service Networks and Clinical quality improvement/risk management activities were established at hospitals. Through Advanced Paediatric Life Support training many young lives have been saved.

The early diagnosis and community management of mental illness was strengthened. Program activities (using dedicated Program Officers) enabled the MOH to develop an extensive in-service nurse training program in Mental Health and the deployment of trained nurses at the Division and subdivision level who do preliminary diagnosis and identification of patients with a potential mental illness. Divisions now operate outreach clinics, and work closely with psychiatrists who visit on a monthly basis from St Giles.

Other achievements of the program included the rollout of radio telephones and solar units to rural areas; the strengthening of the Fiji Pharmaceutical Services Store (FPSS) and many aspects of the MOH pharmaceutical supply chain such that drug “stockouts” are now uncommon at all levels and the success of small “performance enhancing projects”. These are

funded through the program and seek to address some key operational concerns within a short time frame for example projects targeted at needle stick injuries at Labasa hospital.

The key evaluation findings mirrored the positive achievements of the program in all the areas mentioned above. It is clear that the FHSIP has adhered to its “principle” that program activities should support the MOH to implement its own plans. Key to all these achievements was the use of Project Officers supported by the program working with the MOH. Many of these achievements are unlikely to be maintained in the middle term unless these Officers are maintained. Access to an independent and responsive Imprest (Trust) account has been an important feature of the program. It has supported timely implementation during difficult times. It has also given AusAID a secure financing mechanism that allows it to quickly address urgent needs such as support in response to natural disasters and epidemics. It should be retained in future programs. A lesson that can be learnt from this program is the very effective role that can be played by having senior and experienced Fijian nationals at the highest level such as the Program Director. It is recommended that they should be engaged at similar levels in future programs. While the program did have an extensive system that monitored many activities, lack of monitoring of such activities in the community as the number of new diabetics detected by the diabetic monitors, mental health and healthy setting activities were identified as areas that need strengthening. Basic maintenance of RTs also needs to be strengthened. Strategies to address staff motivation and retention and management approaches to build the capacity of staff to adapt and achieve under circumstances of constant change should be part of future programs. A major concern is the sustainability of the capacity building achieved through the program mainly due to the relatively low priority that the IGOF gives to the funding of the Ministry of Health and the low level of staffing predominantly due to IGOF policies.

***Evaluation Criteria Ratings***

Evaluation Criteria	Rating (1-6)
Relevance	5
Effectiveness	5
Efficiency	4-5
Sustainability	3
Gender Equality	4
Monitoring & Evaluation	4
Analysis & Learning	4-5

## 1. Introduction

### 1.1. Background and Context of the Fiji Health Sector Improvement Program (FHSIP)

The Fiji Health Sector Improvement Program is funded by AusAID and, in its broadest sense, it has supported the Ministry of Health Fiji (MOH) to pursue its own strategic and corporate plans. In this sense it is an example of Program aid rather than the more traditional project aid that has been the norm up to the time of commencement. Initially a five year program it commenced in January 2004 and, following the granting of an extension, formally finished in December 2009.

As part of the next phase of AusAID support, a 12 month transition phase was added (January – December 2010) to facilitate, as far as possible, a seamless transition from the current FHSIP to a future multi-year program of assistance. This transition phase has only just commenced and was not the subject of this review.

FHSIP represents the first program within the health sector where AusAID used an “alliance partnering approach” to manage the program activities. According to AusAID guidelines on its relatively new partnering approach.

“The Partnering approach is more than just a way to systematise and formalise the principles of good project management; it requires a new way of thinking about relationships. An important principle is that all partners (i.e. appropriate partner government agencies, AusAID and the partner contractor PC) have equal rights and responsibilities that are exercised in a cooperative manner through the Governing Board” – the so called Charter Board (Fowler J (2004) *Guidelines for Governing Boards under an AusAID Program Partnering Approach* )

A Charter Board (AusAID, MOH and the Partner Contractor – JTA International) was established to govern the strategic directions of FHSIP. It meets 4 times per year. The management of program operations is in the hands of a national Program Director and a Program Management Group chaired by the director and including 7 MOH divisional directors, AusAID and the PC.

The program was carried out in an evolving and challenging local environment. It followed on from the Fiji Health Sector Reform Project (FHSRP) which, among a range of outputs, had substantially put in place a new, decentralised organisation and management structure for the health sector, with greatly increased operational and management responsibility being given to Divisional Offices. This approach was championed by the then Permanent Secretary of the MOH and supported by the great majority of senior and middle level staff. However changes at the senior level a short time into the program resulted in these reforms being “rolled back”. The program found itself working within a different management environment. Further contextual changes including the coup of 2006, major changes in the structure and personalities at the senior level of the MOH, and the decision of the IGOF to cut the staffing levels of the public sector by 10% brought more challenges to the MOH and the Program. More recently a decree that public servant had to retire at age 55 had serious consequences, with a very large number of senior and middle level staff, who had been given training and skills development under both the FHSRP and FHSIP were forced out of the sector. Migration of experienced doctors and nurses overseas has also exacerbated health manpower shortages. A short description of the changes within the health sector since 2000 is given in Annex 1.

As noted in the *Tracking Development and Governance in the Pacific 2009* report Fiji’s progress towards achieving MDG goals, has stalled. Infant mortality rates were 16.8 in 1990 but worsened to 18.4 in 2007. Maternal mortality rates of 26.8 in 1990 had worsened to 31.1 in 2007. Both were well short of the MDG targets of 5.6 for infant mortality and 10.3 for maternal mortality. There has also been a marked increase in incidence of basic needs poverty

in Fiji over the past decade<sup>1</sup>. Total health expenditure in Fiji remains low, the MOH budget as a percentage of GDP was 2.57 in 2008, representing a continuing and steady decline from over 4 percent in 1993, and remains the lowest, in comparison to other Pacific Island countries<sup>2</sup>. The bulk of health resources are directed at curative care. Current Australian bilateral health support accounts for less than 3% of the total MOH budget (approximately \$140m in 2008), but 7% of its non-staff costs.

The wider context of a weak contracting economy, political uncertainty, limited transparency in the government and public sector, and an unpredictable government development agenda have also impacted health and health programs in Fiji. The Fijian economic situation, has been poor and is likely to remain so in the near future. Fiji's economy has been affected not only by the global recession but also by decreasing investment following coups. Fiji's economy was contracting even before the recent global recession and the floods in 2009. Following the 2006 coup, Fiji's economy contracted by 6.6 per cent in 2007. Falling foreign reserves forced the RBF to devalue the Fiji dollar by 20 per cent on 15 April 2009. The IGOF announced on 30 March 2009 a 50 per cent cut to the operational budgets of public service agencies.

## 1.2. Goals, Purpose and Objectives of the Program

In keeping with the original philosophy of the Alliance Partnering Approach, there was no PDD for the FHSIP, nor was there a program implementation plan (PIP) or logframe. Instead, the annual operating plans for FHSIP are prepared each year to support of the Ministry's own strategic and Corporate plans and are presented to the Charter Board for approval (including approval of the operating budget needed to achieve these plans).

FHSIP's stated strategy is as follows:

*Managed by a partnership, and based on MOH own plans, structures and processes, financial and technical support is provided to Head Office Divisions and Health Service Divisions via a program approach (a series of specific projects and whole-of-system initiatives) across four broad strategic areas: (1) Institutional Strengthening; (2) Public Health and Health Promotion; (3) Human Resource Development; and (4) Rural Health Service Delivery and Integration.*

The FHSIP Strategic Objective – as approved by the Charter Board - is to

*Provide cost-effective financial and technical support to MOH Corporate and Divisional business plans.*

The program has 4 stated components. The component structure identified in 2004 was also modified to suit the MOH priorities (i.e. the program was responsive). For the purposes of this ICR, the components in use at the current time are as follows.

- Rural and Public Health
- Clinical services
- Health Information
- Management

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<sup>1</sup> From 26 percent in 1996 to 24 percent in 2007

<sup>2</sup> Fiji Health Sector Situational Analysis Report, 2008



Within these components and as part of the ongoing objectives of the program to work with the MOH's own plans, a number of specific activities were developed, linked directly to the MOHs own plans. This is shown schematically in Annex 2.

### 1.3. Evaluation Objectives and Questions

This Independent Completion Review of the FHSIP Program is being undertaken as part of AusAID's quality reporting requirements. Findings from the Review will also feed into the design of Australia's next phase of assistance to the Fiji health sector.

Broadly the objectives of the review, as stated in the Terms of Reference are

- (i) To prepare an Independent Completion Review Report to independently assess relevance, efficiency, effectiveness, accountability, impact, and sustainability of the FHSIP activities.
- (ii) To provide a Quality at Completion ratings for these categories for the Program's Quality at Completion (QAC) Report; in accordance with the QAC guidelines; and
- (iii) Prepare a "phasing out" strategy to phase out current FHSIP activities by December 2010.

The full terms of reference for the Review, including the detailed objectives and scope of the mission are given in Annex 3.

### 1.4. Evaluation Scope and Methods

A detailed outline of the evaluation methodology for this ICR mission is given in a document entitled "*FHSIP/ICR – Evaluation Plan*" prepared by the ICR team leader for AusAID prior to the commencement of the review and given at Annex 4.

The methodology was grounded in a participatory approach and was transparent, at all times sharing views and findings with AusAID, MOH officials and the management team. It included:

- Review of relevant project documentation prior to, and during, consultations. The more important of these included the Strategic and Corporate Plans of the MOH; annual program reports and plans, the MTR Report; the M&E documentation, other review material and the draft Activity Completion Report.
- Visits to the MOH and health facilities and staff from the Central, Western and Northern Divisions. While in Suva it met with AusAID and with a range of officials from the MOH; CWM hospital, St Giles Hospital, Fiji Pharmaceutical Stores; Fiji School of Medicine; Fiji School of Nursing; WHO; and the FHSIP program staff. While in the Western and Northern Divisions the team visited a range of health facilities (nursing stations, health centres, subdivisional hospitals and divisional hospitals), met medical and nursing staff in each facility and saw at first hand many of the activities and initiatives of the program. Annex 5 lists all persons interviewed.
- In addition to these group discussions and one-on-one discussions; the review team listened to and discussed presentations at a Workshop organised by the review.
- Through questioning, discussion and analysis the ICR Team:
  - Addressed relevant specific issues
  - Explored more generic issues to assist assessment of the "bigger picture" such as key achievements of the project as judged by counterparts and other key stakeholders; disappointments and criticisms; the role that the project has played

in bringing about lasting changes within different areas of the health sector and its role in building capacity within the sector .

- To the extent possible within the limited time available for the review, key data and information presented in the various documents was tested through the consultation process. Ideas presented by one individual or group were examined in discussions with others in an attempt to minimise personal bias and provide some reality checks to the conclusions. However there may remain some measure of subjectivity in the conclusions.

## 1.5. Evaluation Team

The Review team consisted of two independent and experienced consultants, both drawn from slightly different backgrounds to add to the range of skills within the team. Between them they brought to the review a wide range of professional and development experience and skills.

*Dr Paul Freeman* – Team Leader. Dr Freeman is an experienced consultant with over 20 years experience in the international health development sector and qualifications in medicine, public health, health personnel education and management. He has consulted in 10 developing countries including 4 years living and another 5 years consulting in Papua New Guinea. He has previously consulted for AusAID, USAID, the World Bank, UNICEF, WHO and NGOs. He also worked at the community level in indigenous Australian communities for 7 years. He has current conjoint appointments with the University of New South Wales and the Global Health Department of the University Of Washington, Seattle.

*Dr Ross Sutton*. Dr Sutton is an experienced consultant with many years experience in the Pacific and especially Fiji. He also has many years of experience working with AusAID and is familiar with its policies and processes. He also has an understanding of good development practices, including the importance of the Paris Declaration on Aid Effectiveness and the Cairns Compact on Strengthening Development Coordination in the Pacific. Dr Sutton is familiar with the Fiji’s health sector and with key partner institutions within it such as the Fiji School of Medicine and Fiji School of Nursing. In 2008 Dr Sutton was the leader of a team that undertook a Situational Analysis of the Health Sector in Fiji.

Dr Sutton does have some limited prior contact with the FHSIP. As part of his terms of reference for the Situational Analysis referred to above, he was asked by AusAID to do a “check” on the progress of the FHSIP. This was neither a formal progress report, nor a mid term review. This potential “conflict of interest” was disclosed and deemed not to constitute a genuine conflict of interest that might disqualify him from this assignment.

## 2. Evaluating the Findings

The key findings of the review are discussed below under the headings of relevance; effectiveness; efficiency; impact, monitoring and evaluation, sustainability gender equality and analysis and learning as directed in AusAID’s ICR template.

### 2.1. Relevance

The review found that the program strategy, objective and activities were relevant to the plans and objectives of the MOH, and consistent with the then AusAID Fiji country strategy.

#### 2.1.1. Program Logic and Aid modality

This program commenced at a time when AusAID was in a transition phase in its approach to development. It was moving from a traditional project based approach (with predefined

objectives, outputs, activities and logframe) to a broader, less sharply defined, program approach which was more appropriate to thinking on development within AusAID at the time (and still is). Thus there was no specific PDD, nor was there a program logframe for the FHSIP. Instead the concept and logic for the program, and the agreed mission and objectives used throughout, sought to align the program activities with the plans and priorities of the MOH – consistent with good international development practice and with the principles of the Paris Declaration on Aid Effectiveness (it should be noted that this program commenced before Paris but anticipated most of the Paris Principles). Furthermore AusAID used an Alliance Partnering Approach to manage and direct the FHSIP. A definition of this is given in section 1.1 above.

While the program activities were directed towards supporting the priorities of the MOH, they were not funded through the MOH's internal budget mechanisms, but through an independent Imprest Account, administered by the Australian Partnering Contractor working closely with the MOH. This is discussed in more detail in Section 2.3. below. While effective and understandably justified due to local contextual factors this approach did not entirely follow Accra and Paris development principles. This will be discussed further in Section 7.

### ***2.1.2. Were the stated Objectives relevant to both the Fiji and AusAID requirements?***

As stated above, the objectives of the program were broad, namely *to provide cost-effective financial and technical support to MOH Corporate and Divisional business plans*. Despite their broad scope, there can be no doubt that the program's activities were relevant, to the needs of the MOH and to AusAID's then development philosophy and its higher level Fiji country strategy. More specifically

- Program plans supported the MOH's own corporate plans and addressed important areas of concern.
- Activities were planned, in association with the MOH, on a year by year basis and took account of lessons learned from the previous year.
- Activities were managed by the Program management Team, chaired by the national program director and on which there were 7 MOH directors, AusAID and the partnering.
- They were approved by the Charter Board which included the MOH. The Charter Board also included AusAID. The reviewer could find no objection by AusAID to the direction of the programs activities and it can only be assumed that it, too, felt that the program's activities were relevant to their own Fiji Country Strategy, as well as to the priorities of the MOH.

The activities of the program are also relevant because they conform to current capacity building practice in the health sector. Taken together with AusAID funded regional health programs in the Pacific they cover nearly all the major current activities included in capacity building in the health sector (see Annex 6).<sup>3</sup> One specific activity that is part of current international practice that was not included is the development and implementation of specific strategic planning to address staff motivation and retention.<sup>4</sup>

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<sup>3</sup> See the Global Health Workforce Alliance <http://www.who.int/workforcealliance> and <http://www.capacityproject.org>.

<sup>4</sup> For example Ministry of Health Government of Uganda. "Motivation and Retention Strategy for Human Resources for Health," Government of Uganda October 2008.

## 2.2. Effectiveness

The program has been effective. Throughout this review it was widely applauded at both the headquarters and divisional level and many of its achievements are having a positive effect on day to day operations of the Ministry – at the public health, clinical and administration levels.

### 2.2.1. Did the project achieve its specifically stated objective?

Quite clearly the program did achieve its broad objective. As stated above there is abundant evidence that the program worked closely with the MOH to ensure that it “*provided cost-effective financial and technical support to MOH Corporate and Divisional business plans*”. During discussions at the divisional level the review team was shown at first hand how the program worked with them in support of their individual plans. Furthermore there was strong praise for the way in which the program was able to provide financial support to the MOH and Divisional activities in a timely and responsive way. Not only did it do this for defined activities within the individual annual plans, but using the same cost effective pathways, it was able to channel additional AusAID support to enable the MOH to respond to the current typhoid pandemic and to floods and cyclones in the latter stages of the program.

### 2.2.2. Specific Achievements of the Program

Although the objective was broad, this approach did enable the program to address a wide range of priorities and there were some 32 sets of initiatives within the 4 component areas (see Annex 2. Diagram 1).

Against this background, the program can boast a number of very important achievements. A listing of achievements against key priorities that were set by the Program as part of its Annual Plans is given in Annex 7 and an even more detailed discussion (some 147 pages) on the initiatives of the program within each of the 4 components and by calendar year is given in Annex 1 of the programs Activity Completion Report. Because of its length, this document is not included here; however the document will be a valuable resource for further work in the sector.

A number of higher profile achievements - that are widely recognised within the sector - are discussed in more detail below (in no special order of priority):

1. Although a “generic” and not a technical achievement, the review team frequently heard of the positive benefits flowing from the responsiveness of the program’s financing mechanisms. Goods were procured quickly, funds were made available quickly to ensure that training courses were able to proceed and professional officers were contracted promptly. In the words of one director- “*things took days and not weeks, months or even years to happen – it really opened our eyes*” All partners - the MOH, AusAID and the FHSIP Management Office deserve credit for this.
2. The work with the Fiji School of Nursing – carried out in partnership with James Cook University is excellent. A new curriculum has been introduced, 11 staff have been trained to Masters Level; a research stream has been introduced into the curriculum; the library has been substantially upgraded and computers purchased to enable training in the use of computer (including in the use of PATIS) as part of the curriculum. Staff and students interviewed were very positive – students were interviewed as part of a progress review. This will have a long term benefit and the review team were told that the relationship with James Cook University established through the program is being maintained.

These activities at the FSN could well be seen as a very successful project in its own right – carried out within the broader framework of the program. In the words of the FSN director “*we really don’t know where we would be if it wasn’t for the FHSIP*” –

praise echoed by the new director of nursing within MOH. Also important in relation to nurse training was the upgrading of the Midwifery School at Lautoka hospital

3. There was a strong program of support in the area of NCDs, with a focus on diabetes. With FHSIP input, the MOH developed a National NCD Strategic Plan, a National eye care strategic plan and some work in the area of dental services. Of lasting impact has been the decision to supply “NCD tool kits” to all health centres and nursing stations. The team heard from nurses in remote nursing stations that they are able to screen for diabetes those patients visiting their facility and especially pregnant women during their first antenatal visit. This is particularly important as diabetes is an important risk factor during pregnancy and early detection and treatment is an important weapon in reducing maternal mortality and helping Fiji to achieve its MDG in this area. A cost benefit analysis undertaken with support of the program showed that it very cost effective (20% of the cost) to screen patients for diabetes and thus avoid patients beings seen at a later stage of their illness. Unfortunately there appears to have been little quantitative analysis to assess the impact of this initiative (see monitoring and evaluation section of this report).
4. Related to this has been a program to improve foot care for patients with diabetes. This is in recognition that “A reduction in the number of amputations resulting from diabetes” in one of the Ministry’s Key Performance Indicators. Fixed facilities were upgraded and a program of home-based foot care (based at CWM) was introduced. FHSIP also supported a “*Fiji Save the Foot project*” which sought to integrate the foot care clinic and home based care. At this stage there appears to be no apparent reduction in the number of amputations in diabetic patients, but hopefully this will follow.
5. Another set of initiatives targeted at NCDs successfully addressed Mental Health. Although this was not a major element of the program in financial terms, the results have been very encouraging. Whereas in earlier years Fiji’s mental health activities were largely confined to the St Giles hospital, program activities (using dedicated Program Officers) have enabled the MOH to now develop an extensive in-service nurse training program, and it now has a number of trained nurses at the Division and subdivision level. These trained nurses are doing preliminary diagnosis and identification of patients with a potential mental illness. Divisions now operate outreach clinics, and work closely with psychiatrists who visit on a monthly basis from St Giles. In addition the program supported a community education program and combined with the increased capacity at the Division level, a recent survey showed that 50% of first-visit outpatients (of which there are 6200 per year) came because they had been touched by the program.

The program has also commenced workshops for families and carers. It is good to see that these people have now set up a family support network to help families to support family members with a mental illness. The Medical Director of St Giles hospital and his staff were full of praise for the support given by the FHSIP and claimed that “mental health has now entered a new era in Fiji”. Unfortunately, despite the widespread recognition of the success of the program, sustainability is fragile without ongoing external support, unless the MOH gives it a high priority (and budget support) within its national budget.

6. FHSIP support of Health Promoting Settings (HPS) initiatives led to a substantial increase in the number of healthy settings, already established as an approach to health promotion in Fiji, from 170 in 2004 to 473 in 2008 an increase of 178.2%. Independent evaluations of the approach had found the approach to be successful in promoting behavioural change in relationship to personal hygiene and communities taking action for their own health. See Section 2.4 Impact. The annual number of



HPS decreased following withdrawal of small grants and other support recommended by the 2007 FHSIP Mid Term Review.

7. The roll out of 127 radio telephones and solar power to 90 rural health facilities has generally been a success and from the hospital level down to the nursing station there was strong praise. It was clear that the RTs were proving useful when nurses are seeking clinical advice from the hospital; in-service training, controlling stores and supplies and general communication with colleagues. In relation to its impact on referral of patients to larger facilities the team heard that in the western division the need for expensive helicopter evacuations has been significantly reduced but no hard data was available on this. RTs are also installed in a number of vehicles to give better flexibility to mobile health teams and ensure they remain in contact with their relevant hospital. The team also heard that the radio telephones proved particularly useful during the recent cyclone and in some cases they provided the only communication with the outside world.

**Despite this success of the RTs, the review team sounds a strong note of caution.**

This relates to the ongoing maintenance and servicing of the RTs. Data given to the team showed that in the Western Division some 39 out of 72 phones (54.2%) were “out of service” at the time of the visit. Similarly in the Northern Division, 8 out of 38 RTs, (21%) were reported as not working. This renders a very useful tool inoperable and ineffective. The cost of a Division wide maintenance contract is said to be very expensive (>\$FJD60,000 per year for the West) and unrealistic within the current MOH operating budgetary constraints. The Program needs to investigate this matter further, to identify the reasons for faulty performance (is it maintenance or genuine breakdowns) and the means of addressing it in a cost effective way. One solution may be for the FHSIP to provide further training to selected staff at the divisional level eg; hospital service engineers, equipment specialists etc who could support RT units in their division. Consideration might also be given to having available a few “back up” spare parts units in each division.

In relation to solar power the team were only able to visit one remote nursing station during this review (the remainder had direct access to the mains power supply). However it is understood that in the more rural areas of Fiji the installation of solar lighting has also improved the service available from these rural clinics – including the option for easier after-hours services in emergencies. The installation of both solar lighting and radio telephones has been particularly applauded by female staff. They have created a greatly enhanced sense of security among female staff - isolation is less and staff generally welcome the fact that they can contact supervisors and colleagues, not only for professional advice, ordering supplies and other tasks, but also for security purposes. Maintenance also appears to be a major issues for these units as 9 out of 15 units, (60%) were reported as not working in the Western Division. Similarly 8 out of 23 units (35%) were reported as not working in the Northern Division at the time of this evaluation.

8. The review team noted the widespread success of the Project Officer concept; both in achieving objectives but also in introducing many staff to the principles of performance management and the benefits to be gained by ‘focusing’ on set objectives as a management strategy. During the last 3 years the 34 project officers contracted through the program (approximately 50% seconded from the MOH but salaries paid by the FHSIP) have been a major vehicle for achieving program outcomes.

The review was very impressed with the project officer concept as a “learning by doing’ teaching tool. Furthermore it saw evidence that work of the POs demonstrated the need for this type of position within ongoing mainstream activities. As examples

the Fiji Pharmaceutical Services Store has recognised the importance of work done by two POs in the area of warehouse management and EPI cold chain management and these positions have been mainstreamed into normal staffing establishment. The mental health program is also continuing to use the skills of POs trained through the Program although funds have not been made available to mainstream these positions. The current training that staff are giving is threatened unless additional funding for these PO/trainers is made available.

However, despite its clear success as an implementation method, the Project Officer concept is an example of a parallel approach that does not make maximum use of existing local government systems and to that extent it is not consistent with the development principles of Accra and Paris. This aspect will be discussed further in Section 7.

9. Similarly there has been the success of small “performance enhancing projects”. These are funded through the program and seek to address some key operational concerns within a short time frame eg; projects targeted at needle stick injuries at Labasa hospital; standardisation of ward trolleys in Lautoka; quarantine procedures at Nadi airport and seaport have resolved immediate problems and put in place sustainable solutions. They have also demonstrated the importance of setting targets and focus on achieving them. Thus such mini-projects address specific problems but also are an important training strategy. The concept has been taken up by the MOH from its own budget resources, but to be successful it will be necessary to develop funding mechanisms that are very responsive. The review team heard that while there is praise for the MOH embracing this concept, the current funding mechanisms used are “very bureaucratic” and a disincentive; perhaps this needs to be reviewed.
10. The work to improve the Fiji Pharmaceutical Services Store (FPSS) is at last paying off and the team heard very positive comment that drug “stock outs” are now rare at all levels and in one case a doctor commented that “*the system is now better than I have ever known*” - albeit only 5 years. As part of the review of services the new Director of the FPSS, is re-examining the recommendations contained in early reports prepared with FHSIP support with a view to further strengthening the services. As stated above, the value of the work of Project Officers funded through the FHSIP has been recognised and the positions of warehouse and cold chain managers have been mainstreamed.
11. There has been considerable improvement in the EPI program. Vaccine coverage has improved markedly, from levels of the order of 79% 5 years ago to coverage levels of 95% at the present time. The HPV vaccine is also being successfully introduced with the support of the Program and improvements have been made in the cold chain – including at the Fiji Pharmaceutical Services store level. This reflects in part the input of the Project Officers, along with an active training program. By the end of 2009 FHSIP has successfully delivered a cumulative total of 40 Basic 3-Day EPI training courses since the development of the EPI Training Modules in 2006, reaching 620 vaccine providers and handlers nationally.
12. The risk management/clinical quality improvement initiative has proved very useful in Lautoka, Labasa and CWM Hospitals Senior staff indicated that although it did require the input of a dedicated risk management officer (not necessarily full time) the results made it worth the effort and commitment. It has forced senior managers and clinicians to focus on and improve systems and processes and not to blame individuals if things went wrong. “*It has forced us to look at what we are doing and why we do it*” as one senior clinician said. The review team was pleased to see that this concept has now flowed down to the sub-divisional hospital level eg; in Rakiraki a local committee has been appointed and the hospital doctor is a member of the broader divisional committee based in Lautoka.

13. Clinical Services plan was developed in 2005 and reviewed in 2009. A clinical services advisory committee is established at the national level to provide information quickly putting in place and advice to the Permanent Secretary for Health. Clinical service now has a voice at the highest level of decision making. This committee meets every quarter as does the national quality improvement committee.
14. Clinical Services Networks have been established to link clinical services throughout the country as another strategy in the quest for clinical quality improvement. The general view is that they have been very successful. Public health has now been added and this has strengthened the interface between divisional public health offices and clinical services so vital in improving services in areas such as MCH, mental health and NCDs.
15. Skills in Triage have been introduced at CWM and are reported to be effective by the Director of the Accident and Emergency Department. This report is supported by preliminary data from a study that is currently in progress.
16. Good work has been done in the area of management information systems, including the current roll out of the Public Health Information System (PHIS). The roll-out is completed but is paper based. A database at HQ level is being finalized, as is additional work with PATIS. While PATIS is used at the hospital level for patient care and internal management purposes, there is only limited evidence of the widespread use of these systems as a research tool and dynamic management tools. There are exceptions and in those locations where there are PATIS “champions”, there is evidence of its potential. The review team were told that the system is being transferred to one that is web based and this will help encourage wider use of the very valuable data being generated by the system. In this regard there would likely be benefit from close liaison with the FSM.

Unfortunately PATIS still does not include a module to capture data in health centres and nursing stations.

17. The program has developed an HIV/AIDS workplace policy and this has been used as the basis for a similar policy throughout the Ministry.

Most of the achievements of the MOH through the facilitation of the program listed above can clearly be attributed to the program. Either the initiatives or the resources made available through the program were not provided from elsewhere during the years of the program. For example, without the program’s input the Fiji School of Nursing would not have had its curriculum upgraded, teachers trained or new audiovisual resources. There is little evidence that the MOH would have been able to develop a National NCD Strategic plan or national eye care plan without program support. Similarly the widespread increase in the MOHs capacity to diagnose and manage NCDs would not have been possible without the “NCD tool kits” provided by the program. In the area of Mental Health, through program support the MOH was enabled to develop: an extensive in-service nurse training program that for the first time built nursing capacity to perform preliminary diagnosis and identification of patients with potential mental illness through outreach clinics; a community education program about mental illness; and facilitate the establishment of a family support network for patients with mental illness. Through training provided by the program the immunization coverage of 6 months to 5 year olds against Measles were raised from 79% to 98%. Sustainability of many of these achievements is questionable as will be discussed later under that heading.

In addition to building capacity not previously present, programs can help motivate personnel to use existing underutilized capacities in the short term but not longterm when they return to conditions that led to their previous underperformance. In other words workplace issues, motivation, management and general local contextual issues can temporarily be changed by a program’s facilitation and so reasonably be attributed to it but need also to be addressed in the



longer term for lasting change. We will discuss these issues further under Sustainability and Recommendations.

### ***2.2.3. Disappointments and Missed Opportunities.***

Given the complexity of the program, it is inevitable that there would be some disappointments and missed opportunities, despite the extensive list of achievements. They are few but important

1. An important disappointment relates to loss of staff from key positions. While it is clear that this is outside the control of the FHSIP, it is, nevertheless, important to put it on the record as it will have a bearing on sustainability of program activities. It will also impact the design of the next phase of AusAID support. The review team were constantly faced by the fact that many key frontline managers who have been trained through the Program have left the service because of the staff cuts or the imposition of the “over 55 decree”. While younger staff had filled their positions, often with a promise of a new vision for the MOH, the loss of experienced older staff will be felt for some time. The program quickly moved to address this by introducing a new series of training for 49 middle level managers but there are still many instances where loss of experience and “corporate memory” is likely to impact the sustainability of the FHSIP. A future program should endeavour to use these “retired” experienced staff usually on a voluntary basis especially as part of a Health Settings Program. The program also established a Senior Executive Leadership Training program that could be provided through local providers with the processes documented for the MOH. However, the viability of this Training Program is now uncertain. The program established an Executive Services Unit to support the Minister and CEO. However, these initiatives ceased after the coup in late 2006 as directed by AusAID.
2. Subject to the design of any new program, one step that the Program may take is to examine the skills of all the current PO’s, especially those who are on contract and in key areas such as EPI, NCDs mental health and develop a strategy, in conjunction with the MOH and AusAID to try to build them into any new program where their skills are relevant. To lose this experience, as well as the losses suffered through the public sector, would further undermine the sustainability of a range of important activities.
3. Despite the good work being done in the areas of early diabetes detection and foot care (in support of the MOHs own KPIs), the review team feels that not enough monitoring of outcomes has been done- in key areas. Nor have baseline studies been undertaken so that impact and outcomes assessment can be undertaken in future years. Key areas where this is most noticeable include NCD (eg the roll out of the NCD kits), the impact of foot care training on amputations and work in relation to the healthy settings initiatives.

This is discussed in more detail in the Monitoring and Evaluation Sections of this report.

4. As stated earlier, there are disappointments in the area of health information. While there has been some further roll out of PATIS (see above) progress has been slow. For example PATIS has still not been widely rolled out at the health centre level. A potentially powerful management tool is still not being used to its greatest effect. Much of the frustration lies with uncertainty as to whether the MOH is committed to supporting the sustainability of the system. Many of the computers in the hospitals are now relatively old and need upgrading; staffing positions to free up nurses from the tedium of data entry have not been created and importantly there are no qualified IT positions outside of those provided by the program.

5. Despite its obvious success there appears to be no funding allocated or positions created within the MOH to allow for the continuation of the Project Officer model. There are some obvious areas where this will give continuing benefit eg; in the areas of mental health, EPI and health promotion and community engagement eg in relation to NCDs, diet and nutrition etc. It is hoped that the MOH can find funds for these initiatives or alternatively the next phase of AusAID support will examine continuation of the PO model in core areas.
6. The fact that many RTs are “not working” is a disappointment. Their value to good health care has been well demonstrated and it is hoped that better maintenance and repair strategies can be implemented and that a monitoring system is implemented to detect at an early stage those units not functioning.

#### **2.2.4. Coverage**

It has already been stated that the program addressed a wide range of priority areas within the Ministry’s own corporate plans, as highlighted in 3.1. above and shown in Annex 2. However no discussion on the achievements of the Program is completed without reference to the wide coverage of the program in terms of the “clients” it touched. Although most specific activities were directed at MOH workers (43% of a study done in 2008-2009), the community (59%) constituted the greatest number of individuals touched by the program in the same period, followed by MOH/health workers (32%). Data from the program indicates that, up to the end of 2008, some 28,208 individuals have been registered or counted as having attended an event or received a service provided by the FHSIP initiatives. This of course will be magnified greatly when one considers the “multiplier” effect that those so-called clients generated when they went on to provide services to the public through their health centers, hospitals etc. A breakdown of these “clients” by type, by sex, age, by year of the program and geographic location is given in Annex 8.

#### **2.3. Efficiency and Management**

Good management appears to have contributed to a high level of achievement. The program was transparent; it was responsive to a very changing and challenging environment and many Fiji nationals were engaged in the management of the program – led by a national Program Director.

Although no cost benefit analysis or feasibility study was done in preparation for this program, and against which efficiency can be judged, evidence indicates that the program has been efficiently implemented – on budget and on time.

##### **2.3.1. General Management of the project**

The management structure of the program, composition of the governing Charter Board, the program Management Group and “Alliance” modality of equal partnership between AusAID, MOH and the Australian Partner Contractor were mentioned in the Introduction. A key feature of the above partnership approach was that all decisions were mutually agreed by all partners. MOH staff were represented on all selection committees for all program personnel.

The role of the Charter Board included: providing strategic direction to the program; providing financial oversight; approving annual plans and budgets; defining reporting and performance requirements, monitoring their fulfilment and ensuring the program maintained continuous quality improvement; reviewing any standards, guidelines or protocol developed by the Program; providing support to the Program Director and Management Group as necessary; and managing the Charter. The Management Group was responsible for the day-to-day management of the program, including reporting to the Charter Board and implementing any Charter Board resolutions; developing strategies and for achievement of program objectives and monitoring their fulfilment; developing Annual Plans and any necessary

variations for approval by the Charter Board; and receiving and reviewing financial reports. The Management Group was the primary body which considered requests for funds and made resource allocation recommendations to the Charter Board.

During the initial year of the program, there was also a Performance Management sub-committee (with representation from all Partners) which developed the Performance Monitoring and Evaluation Framework (PMEF). This formed the basis for the monitoring and evaluation of the Program. Following endorsement of the PMEF by the Charter Board, the committee was disbanded and the ongoing conduct of M&E delegated to the Program Management Office.

All key informants interviewed about the Charter Board and partnership approach stated that both generally worked well thanks to the generally cooperative productive climate that existed between all partners. The main facilitators of this climate were seen by MOH informants to be the PC which is not surprising given the recurrent changes of senior MOH personnel occupying their positions on a tentative basis, (For example there were three different Permanent Secretaries during the course of the Program). The Board members were generally able to come to agreement on key issues. Relationships were generally non adversarial. Generally there were no major problems with transparency, accountability and monitoring of achievements. The Imprest system for management of program funds operationally meant that program personnel contributed greatly to this transparency and accountability for funds rather than the MOH.

Review of minutes of Charter Board meetings, and other documents supplied to the Evaluation Team by the Project Management Office indicated that the Board was well organized and functioned well in relationship to all areas covered above. Achievement of outcomes was regularly reported and activities prioritized according to the local situation and resources available at that time. There was clear demarcation between what were the functions of the Board, the Program Management Group and the Project Management Office. Minutes demonstrated that independent professional advice was made available to the Board and Management group through external consultants. We could find no evidence of issues of conflict of interest in the documents reviewed.

While the evaluation team heard no criticisms of the contractor directly or indirectly from the MOH, AusAID Suva informed us that some MOH personnel had told them that at times the contractor functionally usurped the role of AusAID. The Director of JTAI was interviewed by phone. While she stated that the Charter Board generally functioned well, in practice the partnership between the three parties was not and could not be an equal one with AusAID and the MOH functionally making the final decisions while the PC's role was to implement them.

In more recent times, as changes have occurred in relations between Fiji and Australia at the Government level, concerns with this structure have emerged. At the Charter Board level all three partners were not really "equals" and there is a risk that the presence of an independent Australian Contracting Partner – despite their recognised competence, - may un-intentionally come between AusAID and MOH at the policy level; this at a time when policy dialogue between Australia and Fiji is "delicate". Furthermore at the Charter Board level there is a concern that changes in individual personnel representing AusAID (eg shift in representation from Canberra to Suva) and the MOH may have effected efficiency, although this is not evident when looking at the range of outcomes.

To ensure that future activities get full attention at the policy levels, it is suggested that AusAID ensure that their representation is at a senior level and remains constant as far as possible. A Coordinating Committee consisting of representatives only from AusAID and the IGOF will ensure that policy considerations of both parties are given priority. This group should work closely with the MOH's National Executive Committee although not be part of the NEC

At the management level it is important that the program actively embrace the Divisional offices and it is understood that arrangements being trialled during the current transition will include quarterly Management Group meetings, held in each of the Divisional Offices (i.e. 12 such meetings per year) This may prove to be onerous but should be assessed during this transition period.

### 2.3.2. Value for Money

In terms of program deliverables, the benefits and value for money to Fiji and to AusAID would appear to be good. This can only be a “subjective judgement” as no baseline cost benefit criteria were set neither were detailed cost benefit analysis carried out for individual program activities. Nevertheless this judgement is based on some key findings

- a) The program has come in on budget and on time each successive year – with some minor exceptions when funds were rolled over from one year to another. Financial data provided expenditure totalled \$AUD 22,582,644 against an approved budget of \$AUD 25,624,182 Annex 9 shows overall expenditure against budget by year. There is evidence that steps have been taken to obtain “value for money” in relation to program staff. For example there has been a plan to reduce the number of more expensive expatriate managers/advisers (from 6 in 2005 to 1 in 2008) and replace them over time with long term nationals as shown in Table 1 below. The timing of this strategy was subject to contract conditions for the expatriate managers

**Table 1: National/Expatriate Profile of FHSIP Management and Technical staffing Positions (excludes Project Officers)**

Year	Long Term nationals	Long Term expats
2004	1	3
2005	1	6
2006	1	2
2007	1	2
2008	3	1
2009	3	1

More strikingly, the concept of locally engaged Project Officers have been introduced to do much of the technical work that, in more traditional projects, would have been done by expatriate advisers. Table 2 below shows a steady increase from 37 person months of input by POs in 2004 to a peak of 388 person months in 2007. The use of expatriate advisers did not change significantly during this period even though it might have been expected to increase sharply as the coverage and level of activity increased.

**Table 2: Annual Total Person Months by category of project staff**

Project related Positions	Person Months					
	2004	2005	2006	2007	2008	2009
Project						

Officer	37	140	380	388	315	321
LTAAs (Int.)	63	63	21	21	10.5	10.5
LTAAs (Fijian)	10.5	10.5	10.5	10.5	31.5	31.5
STAs	8.8	23	21	20	19.1	12.1
Total	106	209.5	457.5	439.5	376.1	375.1

- b) Although, for commercial-in-confidence reasons it is not appropriate to give details, there is evidence that external technical assistance was secured at competitive rates and that there were no excessive contractor fees paid that might mitigate against “value for money” conclusions.
- c) Procurement of goods has been done through competitive tender following Australian Government Guidelines, with individual tenders being reviewed by representatives from the MOH and the program management team. The program appears to have been transparent at all times.
- d) The charter board - with both AusAID and MOH representation - has consistently reviewed results of the previous year’s activities and agree to the next year’s program of activities. This includes a detailed budget. Any concerns regarding excessive rates for consultants, excessive travel costs and procurement would have been seen by them.
- e) The FHSIP has been audited regularly by independent audit and the results have been satisfactory to the Charter Board.

## 2.4. Impact

This project has produced some positive impact in the areas of Measles immunization, Nursing, Clinical Services, Health Promotion, NCD control, Mental Health and Radio Telephones. However, in some areas we make this conclusion guardedly due to the paucity of good monitoring and evaluation data about outcomes and indeed outputs.

In the short term, the program clearly helped to prevent a further epidemic of Measles. In 2005 a cluster sample survey found that the national Measles Immunization coverage in Fiji was 79% and as expected in 2006, 125 laboratory confirmed cases of Measles occurred. Through FHSIP, thanks to widespread training of MOH staff and accompanying health promotion, 98% of 6 months to 5 year old were immunized against Measles. This coverage was confirmed to be 94% in 2008 by a high sensitivity cluster sample survey. Consequently in 2009 there were only 5 sporadic cases of Measles most likely introduced from tourists. However, as discussed below under Sustainability, POs remain central to maintaining this impact.

At the Fiji School of Nursing, the Director of the School informed the evaluation team that 48 students graduated with degrees this year. The establishment of the new basic nursing curriculum, Post Basic Certificate in Mental Health and Post Graduate Diploma in Midwifery along with training of 11 tutors and equipping of the institution with appropriate teaching, audiovisual and library equipment while technically an output, will surely have an impact on nursing and health services in Fiji. Within the basic nursing curriculum the students cover Surgery, Medicine, Mental Health and Public Health that gives them a broad base consistent with current MOH objectives. Within Public Health the students learn about community diagnosis, health promotion and monitoring and evaluation of primary health care programs- just the areas that we have found need further strengthening.



Under the Secondary Services component, impacts were noted in several areas. All clinicians interviewed spoke well of the Clinical Service Networks and Clinical quality improvement/risk management activities. The impact that clinicians spoke of is one of a change in outlook and thinking as previously noted. Their comments gave evidence of a change from passivity in the face of common problems, to one of positively working together to do something about them. At this stage, regular data collection needs to be strengthened to better monitor and share solutions to problems encountered. Paediatricians interviewed stated that the Advanced Paediatric Life Support training and equipment has saved many lives but could not produce any statistics as to how many.

Health promotion using the Healthy Promoting Settings (HPS) was supported by FHSIP in many areas of Fiji. After much early success, their current state is unclear. An evaluation at the end of 2006 comparing HPS areas with similar control areas found that:

- Practically all HPS had a positive impact
- Widespread improved personal hygiene and demand for sanitation
- Increased response to early symptoms of disease
- Increased dialogue on NCDs and active committees in HPS areas
- Widespread proactive attitude to problem solution<sup>5</sup>

Similarly reports showed positive health outcomes for leptospirosis, and typhoid prevention.<sup>6</sup> However, with the lack of systematic data collection and staff turnover within Districts and at the National Centre for Health Promotion (NCHP) data are not maintained about the number of current 'active' settings at national level. In several subdivisions the HPS Subdivisional Management Teams (SDMTs) are not seen as working well and are struggling to be established.<sup>7</sup> This is consistent with what we found when we visited one division and found that the interviewees had no detailed knowledge of the outcomes from the HPS activities in their division that they could share with us. At best we can say that HPS did have impact and could continue to do so but we currently do not know what is happening – due to a lack of monitoring and evaluation.

The establishment of outreach Mental Health clinics, along with a community education program and workshops for families and carers of Mental Health patients is another area of impact. The evidence of this impact is a recent survey that 50% of first-visit outpatients (some 6200 per year) came because they had been touched by the program and that a family support network has been established to help families to support family members with a mental illness. Even if lack of financial support means that these services are curtailed the momentum has now been established that health workers, family and community can intervene early to prevent further deterioration of mental illness and to provide support for family members. However, again this is an area where basic monitoring and evaluation needs to be established to provide definitive evidence to support funding of the program.

In the area of NCDs the Program should have had impact on the early diagnosis and management of NCDs, through making glucometers widely available at health facilities, especially nursing stations, better program planning and health promotion as part of HPS. However, no systematic monitoring of new cases and management in the community has been

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<sup>5</sup> Tebutt Research *Final Report: HPS Impact Evaluation Study* Tebbutt Research Pty Ltd December 2006.

<sup>6</sup> *Evaluation of the Fiji Health Sector Improvement Program Health Promotion Initiatives*. Report from the Health Promotion. Fiji Health Sector Improvement Program November 2009.

<sup>7</sup> *Evaluation of the Fiji Health Sector Improvement Program Health Promotion Initiatives*. Ibid November 2009.

established. However, monitoring of admissions, amputations and HITH exists and is important for management of diabetes complication rates.

Radio telephones may also have impact in rural areas but no systematic system of monitoring is established to measure this impact. Many of those experienced with their use in Western and Northern Districts said that they were invaluable, when working, for avoiding unnecessary helicopter evacuations and visits by doctors through consultation, ordering drugs and supplies, continuing education, and early notification of infectious diseases. A study by the Fiji School of Medicine supports the impact of radio telephones in all these area and also that they are cost effective.<sup>8</sup>

## 2.5. Sustainability

There is evidence of sustainability in several key areas, although the tight budget constraints and government policies in relation to staff will mean that in most areas of the Program sustainability is fragile and will remain a challenge.

Recent IGOF policies that have resulted in the loss of key senior staff members and the general loss of capacity and skills built up over many years with the support of the FHSIP, combined with the very tight budget constraints that are likely to remain or even worsen will no doubt threaten sustainability throughout the range of program activities.

Nevertheless there is evidence of sustainability in many areas and this can be built on.

### 2.5.1. Evidence of sustainability

As already stated there have been many positive achievements from this program, These are spread widely throughout the ministry's public health, clinical and administrative services areas. Many persons have been touched in a positive way by the program and they would wish to ensure some level of sustainability is attained. However at this stage the review team believes that sustainability is fragile and can best be described as being "mixed". Some activities would appear to be sustainable without any additional input from the program or from outside sources. However in the opinion of this review team some areas will require additional input from the program during the final year (2010). This is not a surprising finding considering that during its 6 years, the program has worked across 32 activity areas within the 4 broad areas of the entire Ministry. Unlike a traditional project, the FHSIP did not seek to achieve outputs and outcomes within a defined area of focus – rather it sought to address areas across a broad front. While this broad approach has meant that many areas of the ministry has received benefit, one potential price to pay for a lower level of focus is that many of the activities may be unsustainable – focus brings opportunities for reinforcement and sustainability which is often lost when one tries to do too many things across too broad an area.

Areas that appear to have a high measure of sustainability and will require little or no additional input in the medium term include:

- Strengthening of the Fiji School of Nursing.
- The strengthening of the Fiji Pharmaceutical Services Store
- NCD toolkits – apart from replacement of consumables. However their effectiveness needs to be evaluated as discussed above.

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<sup>8</sup> Roberts.G, Mudaliar.J, Prakash.B *Impact Evaluation Of The Northern Division Health Radio Network* Fiji School of Medicine 2006

- The Clinical Services Planning Framework. This is an excellent document that is already being used by MOH and which can be an even greater resource document if there is a full review of the current service delivery framework as recommended in the Fiji Health Sector Situational Analysis.

Areas that have proved to be of real value to the MOH and which, with some continued activity during 2010 should be sustainable in the longer term.

- Clinical quality improvement and risk management within the divisional and subdivisational hospitals.
- Other aspects of quality improvement including continued roll out of paediatric life support program (plus the advanced program), the clinical quality and risk management activities and the clinical services network.
- Steps taken to bring about improvements in immunisation coverage rates and immunisation skills training should, have the potential to be sustainable but evidence indicates that they need continued supervision - as used through the PO model. When POs at the Divisional level were ceased recently they had to be reintroduced due to falls in immunization coverage within 4 months.
- Radio Telephones and Solar Units are sustainable but training of users in basic maintenance needs to take place to keep them functional.

As will be discussed later under Conclusions and Recommendations, use of the Imprest Trust account for funding and the Project Officer model while demonstrated to be effective in the shorter term, and well justified as flexible responses to the local fragile context in Fiji, are not consistent with development principles for sustainable longterm capacity building of local institutions and systems.

### **2.5.2. Threats to Sustainability.**

Even for those areas where there is clear evidence of sustainability there are real threats. These include:

- Major threats to staffing and ongoing funding of MOH capacity building activities due to the low level of priority the IGOF gives to MOH funding in general and health sector staffing in particular. The Public Service Commission has imposed a 10% cut on staff numbers in all government agencies and decreed that staff must retire at age 55 (although front line clinical staff can be reengaged on contracts) . This has put enormous pressure on all areas of the Ministry that are already under severe pressures due to lack of staff. Many personnel trained by the program have been lost to the sector through these processes while others with expertise continue to emigrate.
- There are some uncertainties regarding the future of the project officers. Despite its success both as a means of implementing project activities, and as a “learning by doing” training tool (it has trained a pool of middle level managers who could now move on to give great benefit to the MOH), the project officer “model” certainly cannot be considered to be sustainable at this stage. Continued efforts need to be made during any new program to develop a “terms of engagement” set of rules for POs so that the best elements of the PO model can become a fixture within the MOH.

## **2.6. Gender Equity**

The program itself has taken steps to ensure gender equity in all program activities as can be seen from the following disaggregated data in Table 3 below for gender representation throughout the management positions associated with the program, its advisers and attendees at program training workshops and other activities.

**Table 3 Ratio of females to males in different elements of the Program**



	<b>Female:</b>	<b>Male:</b>
Charter Board	2 (33%)	4 (66%)
Management group	9 (60%)	6 (40%)
Program Management/LTAs	2 (50%)	2 (50%)
Program STAs (# person months)	9 (47%)	10 (53%)
Program admin staff	3 (75%)	1 (25%)
Project Officers	11 (44%)	14 (56%)
Training/workshop attendees 2008	803 (62%)	486 (38%)

Gender related activities with the MOH itself have been given impetus with the Dept of Women coming under the MOH umbrella; within the Department of Women, there has been a high level of awareness in gender mainstreaming. With this existing strong influence, FHSIP hasn't been asked to include any specific gender mainstreaming activities within its annual plans. Other areas of interest are:

- Dept of Women conducted a gender audit for MOH in 2003 (supported by ADB), with the following findings on the analysis of staff positions at MOH: 2003 Audit
  - Gendered division of labour, proportion of women at 77%
  - Men hold most senior positions:56%
  - Medical cadre: 39% women,
  - Nursing cadre: 95% women
- Following the presentation of this result to the MOH a number of awareness workshops were conducted by Ministry of Women

Currently the Minister of Health and the Permanent Secretary follow a guideline of including at least 2 women on all Hospital and other Boards and committees. Due to the high turnover of staff at MOH a new focal point for gender main-streaming has been nominated and is in the process of being briefed.

In the changing staffing environment brought about by IGOF policy changes the issue of gender equity within the MOH appears to have been well addressed and of those persons met, both male and females are well represented at the executive level within the Central Office and in the Divisions. The new Permanent Secretary is a woman.

Program activities were targeted towards female clients in particular. For example of all clients over the years 2006 to 2008, 10745 were female as opposed to 6600 males. HPV vaccinations, papsmear education and maternal health activities such as “baby-friendly training” obviously targeted women individually or through women’s groups. FHSIP mainstreamed HIV/AIDS responsibilities into its Project Officers. The Rural and Public Health team of POs included HIV as a development issue in the Health Promotion and Reproductive Training of Community Health Workers, secondary school students and staff nurses. Through the innovative ‘Stepping Stones” program the project addressed issues of improvement in community women’s confidence and assertiveness vis-à-vis males, male respect for women and reduction of risky behaviour to prevent transmission of Sexually Transmitted Infections. However, review reports read did not indicate whether the latter

program covered all of Fiji or only, as appeared, the Western Division. We could not find evidence of systematic activities designed to address domestic violence and gender violence issues more broadly other than that presented above.

### **Monitoring and Evaluation**

The Program has a Performance Monitoring and Evaluation Framework (PMEF) that was developed in 2004 and approved by the Charter Board. It seeks to ensure that the FHSIP is contributing to (a) the achievement of the MOH's own plans and that (b) the overall program strategy is being implemented as approved by the Charter Board. Monitoring and evaluation activities are apparent at all levels of the program as follows

- At the most senior level the Charter Board reviews reports from the program as part of its governance role. If necessary the Charter Board can propose major changes of direction that take account of the findings of this monitoring program.
- An independent MTR of the program was undertaken in May 2006. This review made 38 recommendations. The Program has responded appropriately to this review and its response to individual recommendation was discussed in detail during this current review.
- The program undertakes an annual program review which also goes to the Charter Board. Periodically more specific monitoring tasks are included in this Progress review eg in 2007 the program conducted a detailed review of the effectiveness of the work of the Project Officers.
- Use is made of a short term M and E specialist or, if a special technical area needs to be reviewed, a short term specialist in that area is engaged. For example the work of the Healthy Settings was reviewed in 2006. Each STA is set specific targets as part of their contracts and prepares a monitoring report – i.e. self-monitoring. These are reviewed as part of the overall annual program review.
- There was extensive review of the new curriculum and training programs at the Fiji School of Nursing.
- Each project plan developed by the PO contains its own monitoring plan - with stepping stone type indicators at different stages of the plan.
- Each Project Officer does a “self appraisal” of their personal performance against the objectives that they set with their own supervisor. In addition they receive an independent appraisal by their MOH supervisor – again using the objectives set in their “project” as one of the core criteria against which performance is measured. This is one of the few examples within the MOH where staff actually participate in a true “performance based appraisal”. It is a new concept for the MOH and one that should be expanded over time.
- Results of the all program review activities feed up to the Management Group and to the Charter Board. There is thus a high level of accountability.

However there are still important gaps. The need for more systematic monitoring and evaluation was expressed by the Permanent Secretary and her staff during the workshop during this evaluation. Some key initiatives such as the rollout of the NCD kits, the foot care program and to a lesser extent the mental health program need more detailed evaluation to assess benefit and impact. This takes on added significance as these programs have the potential to be of benefit to other countries in the region and to be incorporated in support programs of AusAID and other donors.

In relation to the HPS program, the comment in a 2009 review of the program needs to be

noted. Regular monitoring should take place in order to support implementation of local operational plans and can be done locally.<sup>9</sup> While impact evaluation should also take place but at a lower frequency, every two to three years because of the time that it takes to produce behavioural change, the skills necessary to conduct it correctly and the costs involved. The team was informed that staff became frustrated if they were asked to collect data but never saw the purpose and what happened to all of this information.

Despite the amount of evaluation undertaken it has often been relatively "passive". It is suggested that in future programs evaluation be more dynamic. In addition to the usual approach to evaluation, it is important in the Fiji context (where there is little culture of evaluation) that evaluation should be both dynamic and used as a "learning exercise" and that:

- Relevant staff are involved in developing the evaluation protocol and in evaluating the findings.
- Staff should understand why they are collecting data (which is often an onerous task)
- They must be given feedback of the results.
- The finding must be acted upon and if necessary changes made to the way things are being done.
- The complexity of evaluations be at a level that MOH staff can have a central role in them while a "culture" of evaluation is established. More complex methodologies will of course need to be used on some occasions that require external support-such as cluster surveys for immunization coverage but even these should include gradual building of local MOH capacity as an objective.

Another issue in relation to M and E is that the Ministry still does not have its own Performance Monitoring Unit that reports directly to the Permanent Secretary for the performance of the Ministry as a whole. There is a small unit within corporate services that does do some reviews of actual performance against corporate plans but there is no unit that monitors in an ongoing-way performance of the MOH against its KPIs or the MDGs. This low level focus on monitoring of achievement of the KPIs has been highlighted in the overall Fiji Health Sector Situational Analysis carried out in 2008. It is suggested that steps be made in any new AusAID programs to strengthen the capacity within MOH (including Divisions) to do high level evaluations and impact analysis so that the Ministry has available data on which it can base future programs and policies. However, as noted above this must be done gradually building first on problem solving and more basic evaluation skills towards establishing confidence in this area and a "culture of evaluation". Otherwise it is very unlikely that advanced skills in impact analysis will become established locally.

## 2.7. Analysis and Learning

There was no PDD or PIP and so there was no evidence of "analysis and learning" at the design stage. There was however clear evidence of analysis and learning from previous years monitoring results when planning the next years activities and in the application and analysis of the ongoing reporting of POs. Similarly FHSIP supported the ongoing evaluation, analysis and refining of program activities through the many research and evaluative studies carried out during the course of the project. Some of these studies are quoted in this document, while many more are to be found in the Annexes to the ACR.

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<sup>9</sup> *Evaluation of the Fiji Health Sector Improvement Program Health Promotion Initiatives*. Ibid November 2009.

The way FHSIP deal with the use and development of POs is one example of their approach to analysis and learning. POs were proposed and trailed by the program, the procedures and reporting that POs did during their work allowed constant feedback to be given on their activities and corrections made. A formal review of their performance was also carried out and the results applied in program activities.<sup>10</sup>

### 3. Overall Quality and Ratings

The ratings given below are against AusAID’s six point quality rating scale and are for delivery of the project.

**Table 4 Evaluation Criteria Ratings**

Evaluation Criteria	Rating (1-6)
Relevance	5
Effectiveness	5
Efficiency	4-5
Sustainability	3
Gender Equality	4
Monitoring & Evaluation	4
Analysis & Learning	4

#### Explanation of Rating

Relevance The work is relevant to the MOH's objectives and to the overall health strategy of AusAID

Effectiveness Achievements were appreciable

Efficiency All evidence would indicate that the Program has operated efficiently, but no baseline cost benefit analysis against which to assess.

Monitoring & Evaluation, when controllable by the program, was generally good at all levels.

Sustainability was mixed and still fragile in some areas. In no way detracting from the many excellent efforts of the program that would lead to more sustainable outcomes in a less fragile context, the major ongoing factor affecting the sustainability of program capacity building activities, and therefore the basis for the low sustainability rating, was fragility of staffing and management due to low and unpredictable funding and staff turnover as a result of IGOF actions beyond the control of the program. Many personnel trained were lost to the sector due to these policies. The fact that the program was very broad in nature which makes it difficult to provide the continuous level of “reinforcement” that is so often needed to ensure sustainability also contributed to a lesser extent.

Gender Equality Tables and narrative presented in this report demonstrated that this was well performed.

<sup>10</sup> Project Officer Review. Report from the Project Officer Review Adviser October FHSIP 2007

**Analysis & Learning** There was clear evidence of analysis and learning from previous years monitoring results and formal review studies when planning the next year's activities. However, it is a little surprising that the program continued to address such a wide area of the MOH's plans knowing that with such a relative small budget (\$F5-6 million of \$170 million national budget) the ability to make an impact and achieve real outcomes would be limited.

## 4. Conclusions, Lessons Learned and Recommendations

### 4.1. Overview

The findings of the review have been presented above against the specific criteria listed in the AusAID ICR Guidelines. Overall the findings have demonstrated:

- A program that is relevant to the Plans of the MOH and the Divisions and is well respected throughout the sector and beyond, for example within WHO.
- One which has made some significant achievements; some of which are likely to be sustainable but in other cases sustainability is fragile and require more inputs
- Its activities have reached out to all levels of the health sector, with the review team seeing examples of successful activities (and praise) at nursing stations, health centres, subdivisional hospitals, divisional public health offices, divisional hospitals, national referral hospitals (CWM and St Giles) and within the MOH.
- In some areas, such as its health promotion and mental health activities, the program also touched the community with positive results.
- A program with a governance and management framework that was new to AusAID at the time of commencement but, which nevertheless, appears to have operated effectively, although some changes are suggested for future programs.
- A responsive financing mechanism that not only served the program to support its normal planned activities but was also effective in supporting AusAID and the MOH to provide unplanned emergency assistance to address such situations as the H1N1 influenza pandemic and recent floods and cyclone.
- Despite the excellent program of capacity building done through FHSIP, recent IGOF policies have brought about changes outside the control of the program. These have depleted capacity within the sector, both in terms of the number of staff and loss of skills and experience. The program has responded quickly since these changes and have reinstated training to a new cadre of staff through the front-line managers course and specialist EPI training courses. Nevertheless this "capacity gap" needs to be taken into account in the design of the new AusAID support for the sector.
- In addition to addressing this "capacity gap" future programs need to address the ongoing conditions of the effect of high staff turnover, poor staff motivation and uncertainty that are now common—as mentioned by many interviewees—and are likely to continue to occur in the Fijian context. These conditions were appreciated as being common and addressable by the senior MOH personnel who attended the feedback and discussion meeting at the end of our evaluation. The solutions that the Fijian managers proffered at the workshop, combined with those that the Director of the Fiji School of Nursing offered at interview include: using participative management, developing common goals and teams and appreciating the contribution that both experienced and new staff can offer if given the chance. These solutions are well developed in basic modern participative management approaches that can be used successfully by trained local facilitators in the health field in developing countries to develop common vision nationally and locally, motivate staff, build successful teams, and organizations to cope with constant change. Examples of such approaches include

Appreciative Inquiry and practical application of building learning organizations and their combination.<sup>11</sup>

- While it is appreciated that Health Manpower planning is beyond the scope of the FHSIP and similar subsequent programs and should not be included in them so that the program does not lose focus, it is clear that systematic planning and monitoring of health personnel needs by site, institution and cadre need to be addressed in an ongoing manner through other appropriate programs. Similarly steps need to continue to address ongoing specialist medical and nursing needs if curative service in Fiji are to remain viable.

The FHSIP was consistent with the principles of the Accra Agenda for Action and the Paris Declaration in supporting the corporate plans and concerns of the MOH<sup>12</sup>. The program also was consistent with the principles in that it used local systems for its support of: the Fiji School of Nursing, development of MOH policies, health promotion settings, supply of equipment, management training, Clinical Service Networks and risk management/clinical quality improvement initiatives. However, it was not consistent with them in that it did not use local systems to the maximum extent possible (Accra Agenda) in key areas namely the use of the Imprest trust system for financing and the Project Officer model. The effectiveness of both these approaches has been documented above, are currently in use and well known to the MOH. Recent reviews of aid modalities seeking to strengthen Partner country systems contrast the importance of achieving results with building these systems, all emphasize the importance of good monitoring and evaluation systems.<sup>13, 14</sup> A recent DCA review contrasts achieving results with building longer term systems and notes that *“managing for development results is sometimes interpreted narrowly in terms of results-based management: it should perhaps better be understood as governments and their partners broadly building the capacities to monitor and evaluate, and using this information to inform the design and implementation of future plans and programmes...”*<sup>13</sup>

The Imprest Trust fund was setup to manage donor funds outside IGOF systems at the request of the MOH because there was no facility to allow separate management of donor funds with IGOF systems and concern from MOH that release of funds would be slow, impeding program progress. Similarly the MOH was very supportive of the Project Officer model because it allowed personnel to concentrate on specific priority tasks which was not the previous situation when MOH personnel commonly worked ineffectively as they were faced by a constant barrage of daily service demands. Consequently, given also the effectiveness of these approaches, MOH personnel may well oppose movement away from them.

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<sup>11</sup> CEDPA (1999) Strategic Planning An Inquiry Approach The CEDPA Training Manual Series Volume X downloaded from <http://www.cedpa.org>  
Senge PM (1990) *The Fifth Discipline: The Art and Practice of the Learning Organization* Doubleday New York.  
Mosley H, Lozare B. (2004) Bill and Melinda Gates Institute for Population and Reproductive Health. *Strategic Leadership And Management For Population And Reproductive Health.. Seminar Workbook For Participants* Bill And Melinda Gates Institute For Population And Reproductive Health, Bloomberg School Of Public Health, Johns Hopkins University, Baltimore, Maryland, USA.

<sup>12</sup> OECD The Paris Declaration on Aid Effectiveness (2005) Accra Agenda for Action 2008.

<sup>13</sup> Working Party on Aid Effectiveness Development Co-operation Directorate Development Assistance Committee. “Aid for Better Health- What Are We Learning About What Works and What We Still Have To Do? “An interim report from the Task Team on Health as a Tracer Sector DCD/DAC/EFF (2009) 14.

<sup>14</sup> Skolnik R, Jensen P, Johnson R. “Aid Without Impact. How the World Bank and Development Partners Are Failing to Improve Health Through SWAPs “ Advocacy to Control TB Internationally Results Education Fund Washington DC 2010.



Under the Imprest Trust system of financing in overview, where and how the money was spent was determined on the basis of joint decision-making within the Charter Board and Management group. The MOH was also involved in overseeing transparency and accountability for spending of these monies through FHSIP's systems reporting back to these groups, although, of course this process did not directly strengthen MOH systems in these areas. Financial details of this spending were also formally reported to the MOH and included in their annual budget. Given the unpredictable ad hoc decision making of the IGOF, and other contextual matters mentioned above the Imprest system can be seen as an effective interim flexible response necessitated by local circumstances that Programs should seek to move beyond for longer term aid effectiveness.<sup>15</sup>

FHSIP utilised two slightly different PO models (in approximately even numbers). One model seconded staff from the MOH (including the Divisional Offices) and, upon completion of their assignment, they returned to the Ministry although not always to their former position. They took with them into the MOH the new skills that they had learnt in their role as POs. Another model contracted outside persons for the period of their special tasks. They then left FHSIP when their contract was completed even though some have/may be taken into vacant positions within the MOH. The model that used seconded staff from the MOH caused staffing problems for the MOH in that in some cases it deprived the MOH of key staff even though FHSIP paid the salaries needed to “back-fill” these positions. POs were able to complete their activities not only because of the specific training and supervision that they received but also because of the structured working and organizational environment established for them through the program.

Given the learning that was achieved through the PO model, the best elements of the model should be able to be incorporated and further developed into MOH systems so that working equivalents are established within these systems. The reasons why MOH staff were not able to concentrate on specific tasks and achieve in their usual MOH workplaces what they were able to achieve when seconded as POs are multifactorial and so need to be addressed in MOH working environments. These many factors can be addressed by developing centers for learning and experimentation at a few selected locations. Through Program facilitation on a unit, health center or department by department basis, starting with a few units whose leaders are most open to change, working models of what operational training is needed by staff and management and how best to incorporate these changes into workplaces could be developed. Workplaces may also need to rearrange minimally. These units could then be visited by personnel from other units and change gradually taken to scale across MOH systems. They could also be used to develop implementation of the modern organizational and management practices mentioned above.

However, not only has the effectiveness of the PO model been established with the MOH but also the effect of abruptly stopping it. For example, through the program, thanks to widespread training of MOH staff and accompanying health promotion, immunization coverage of 6 months to 5 year olds against Measles were raised from 79% to 98%. However, recently when the work of the three POs, one based at the Divisional level in each Division, was ceased coverage rates for the current roll out of the HPV vaccination program dropped from 60% to 45% between rounds over a few months. When these POs were reinstated coverage rates were increased to 55% within a short period. Therefore in some key areas where the current use of the PO model has proven to be effective in producing the momentum needed for change, the model should be maintained while the systematized model within MOH systems mentioned above is developed and established.

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<sup>15</sup> Office of Development Effectiveness. AusAID Annual Review of Development Effectiveness 2008. Commonwealth of Australia 2009.

## 4.2. Conclusions and Recommendations

1. It is clear that the FHSIP has adhered to its “principle” that program activities should support the MOH to implement its own plans. Because of the broad nature of the objectives, there appears to have been no disadvantage in not having an old fashion PDD with a predetermined implementation plan and set of activities. The experience of the contracting partner no doubt helped in this regard. Indeed the aid modality used for the implementation of this program offered some advantages such as strong ownership of the program by all areas of the Ministry, and its ability to respond to the challenging environment in which it found itself.
2. The Project Officer model used in this program has proved to be successful and should be retained in future programs. It was universally applauded through the sector. It serves to give focus to achieving milestones in relation to key target areas- for example immunizations- but also serves as an excellent means of “on the job” capacity building, introducing the individual POs to such skills as planning., setting goals and outcomes and monitoring performance towards the achievement of those goals. However, as implemented it is not consistent with the longterm development of MOH systems. For reasons described above it should not be abruptly ceased but should be used in future programs until its key elements can be incorporated into MOH systems. One mechanism of how this could be done is described above.
3. That, consistent with solutions offered by MOH senior managers, training in modern participative management approaches to build successful teams and learning organizations to successfully deal with conditions of constant change and limited resources be included in future programs.
4. That, consistent with the previous recommendation and current international capacity building approaches, specific strategies to strengthen staff motivation and retention to cope with the constant conditions of change that occur in the health sector in Fiji be developed and implemented.
5. Access to an independent and responsive Imprest (Trust) account has been an important feature of the program. It has supported timely implementation during difficult times. It has also given AusAID a secure financing mechanism that allows it to quickly address urgent needs such as support in response to natural disasters and epidemics. In relation to future programs it is suggested that the Trust Account system should be maintained initially and:
  - Be operated by a company experienced in operating such accounts within a development context;
  - Program funds should be kept offshore in Australia and channelled to the program to fund agreed activities as required;
  - Must be audited independently;
  - All transactions must be transparent and a report of expenditure through the Imprest account must be given to the Governing Board/Coordinating Committee at least twice yearly.

However, the use of this Imprest system beyond an interim measure would not be consistent with good development practice. Subject to review of the unstable public sector and development climate in Fiji, consideration should be given to working towards strengthening IGOF systems and possible funding through them.

6. The program was transparent in all areas (staff and consultant selection, budgeting and reporting) and this created a ‘climate of trust’ between the parties and this was an important contributor to success. This should be a lesson for future activities.
7. A lesson that can be learnt from this program is the very effective role that can be played by having senior and experienced Fijian nationals at the highest level. In the



- FHSIP they served as the Program Director and in senior long term adviser roles. They were very familiar with the operation of Fiji health system, and its priorities at all levels. They had the respect and Trust of the MOH at the highest level.
8. An added benefit of this feature was that, because of their senior status, they were often appointed to important national technical committees and worked alongside representatives from other donors and international agencies such as WHO and UNICEF. They were thus a channel to enable a coming together of AusAID funded activities and those of other donors. This mechanism served to improve donor harmonisation and ensure that the work of other donors and agencies was taken into account when deciding on program activities.
  9. As stated in 7.1, the concept of a Governing Board (Charter Board), a Management Committee supported by a Management Office headed by a senior local person worked well and is relevant to future projects. However bearing in mind changing times in Fiji and the importance of ongoing high level policy dialogue between partners, it is suggested that in a future program:
    - a) The governing board consist only of representatives from the IGOF and AusAID – with no contracting partner involvement. Obviously IGOF would be represented by the MOH but provisions should be made to receive input from core central agencies such as MOF and the PSC. This should not be seen as a comment on the work done by the Contracting Partner in this program, which was excellent – but rather a reflection of the need for close and confidential policy engagement.
    - b) A formal management or coordinating group be established– a role that might best be served by the Executive Committee of the MOH. This Group will be able to give technical input in an ongoing manner and will ensure that program activities address the priorities of the MOH and are consistent with the Ministry’s annual plan.
    - c) A support team headed by a national Program Director with support from other senior national advisers and the capacity to call on external advisers as needed. The importance of this day to day “coordinating role by a Program Director, who sits outside the day to day work of the Executive of the MOH, but is respected enough to be seen as a “peer”, cannot be overstated.
  10. Health promotion is an essential part of any programs which address behavioural change as is the case in prevention of NCD, infectious diseases such as typhoid and maternal and child health. HPS has been evaluated to produce impact in this program. It should therefore be included in the next project. As suggested by three interviewees and supported by the Permanent Secretary of Health, making HPS more holistic through the inclusion of local community groups and institutions, such as churches, should be explored as means to strengthen HPS and make it more holistic.