



Evaluation of Samoa Health Sector Management Programme (Health SWAp)

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Contents

1. Introduction	1
1.1. Background	1
1.2. Purpose	1
1.3. Terms of reference.....	1
1.4. Work programme	2
1.5. Disclaimer re availability of materials	2
1.6. Acknowledgments.....	2
2. Development of the Samoa health SWAp	3
3. Implementation of the Samoa health SWAp	6
3.1. Health Sector Plan 2001 – 2018.....	6
3.2. SWAp Programme of Work	7
3.3. Medium term expenditure framework.....	10
3.3.1. The SWAp resource envelope	10
3.3.2. Development of the MTEF	11
3.4. Monitoring & evaluation framework	13
3.5. Governance and management	14
4. What has the Samoa health SWAp achieved?	17
4.1. Program outcome indicators.....	17
4.2. SWAp process monitoring indicators.....	19
4.3. Expenditure	19
4.4. Efficiency	20
5. Observations on the Samoa health SWAp	22
5.1. Establishment of the SWAp	22
5.2. SWAp program of work.....	23
5.3. Governance and management of the SWAp.....	25
5.4. Monitoring & Evaluation	27
5.5. Medium term expenditure framework.....	28
6. Summary assessment of the Samoa health SWAp	29
7. Recommendations for the future	34
7.1. Issues to be addressed by the current SWAp.....	34
7.1.1. Confirm final PoW	34
7.7.2. Prioritise key projects	34
7.7.3. Strengthen project management.....	35
7.2. Options for future support to health in Samoa	35

7.2.1. Return to project-based support	35
7.2.2. Move to sector budget support	35
7.7.3. Establish a second SWAp.....	36
Annex 1 Terms of Reference	38
Annex 2 Interviews conducted.....	45
Annex 3 Documents reviewed.....	46
Annex 4 Programme of work as detailed in SWAp Inception Report.....	48
Annex 5 SWAp monitoring and evaluation framework (April – July 2008)'	49
Annex 6 Health SWAp Process Monitoring Indicators	51
Annex 7 Analysis of Review Missions	53

Tables

Table 1: SWAp Initial Draft Programme of Work (2009-10).....	8
Table 2: SWAp Programme of Work (2010-11).....	9
Table 3: Details of SWAp review and support missions (2008 – 2012).....	16
Table 4: SWAp expenditure versus budget as at 31 December 2012.....	20

Figures

Figure 1: Health sector resourcing (2009/10 – 2013/14).....	12
Figure 2: Use of funds (2009/10 – 2013/14)26.....	13
Figure 3: GoS and DPs' contributions to health spending (2009/10 – 2013/14) 28	

Acronyms

DHS	Demographic and health survey
DP	Development partner
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS TB and Malaria
GoS	Government of Samoa
HAC	Health Advisory Committee
HIS	Health Information System
HPSC	Health Program Steering Committee
HRF	Health Resource Facility
HSCRM	Health Sector Coordination, Resourcing and Monitoring
HSP	Health Sector Plan 2008-2018
IFR	Interim Financial Report
JPA	Joint Partnership Agreement
M&E	Monitoring and evaluation
MFAT	Ministry of Foreign Affairs and Trade's Aid Programme
MoF	Ministry of Finance
MoH	Ministry of Health
MTEF	Medium term expenditure framework
MTR	Mid-term review
NCD	Non-communicable Diseases
NHS	National Health Service
PAD	Program Appraisal Document
POM	Program Operational Manual
PoW	Program of Work
SCU	SWAp Coordination Unit
SPPR	Strategic Planning, Policy and Research Division
SWAp	Sector Wide Approach
TTI	Maietoa Tanumafili II Hospital
TTM	Tupua Tamesese Meaole II Hospital

1. Introduction

1.1. Background

In July 2008 the Government of Samoa entered into an agreement with key development partners to establish the architecture and relationships for a sector-wide approach (SWAp) in the health sector.

The SWAp aims to bring development partners' funds together with Government of Samoa's own health sector budget to support the implementation of elements of the Health Sector Plan 2008-2018.

The initial phase of the SWAp is scheduled to come to an end in 2013. In order to guide deliberations on future support to Samoa's health sector the SWAp development partners have commissioned a Mid-Term Review of the Health Sector Plan 2008-2018 and a Review of the Health SWAp.

This report presents the findings and recommendations stemming from the Review of the Health SWAp.

1.2. Purpose

The purpose of the Review of the Health SWAp is to assess the effectiveness of the program in supporting the implementation of the Health Sector Plan 2008-2018; the extent to which it has delivered value for money; whether the program design was appropriate to the political, policy and fiscal context; and whether it has laid a foundation for future donor engagement.

In addition, the Review is expected to identify lessons for the design of any future program of support to Samoa's health sector.

1.3. Terms of reference

The review was required to be:-

- rigorous in the evaluation methods used and justification of findings;
- independent in presenting views and recommendations that are informed, but not constrained, by a extensive consultations;
- grounded to ensure the review is located in its Samoan context and considers the contextual factors within which all health activities operate; and
- constructive in taking a learning oriented approach proposing how positive findings may be sustained and built on and how weak areas may be addressed.

Methods to be employed included review of relevant literature and analytical work, policy and performance frameworks from donors, key informant interviews, document review, and analysis of budgets and other data.

The results of the evaluation will be disseminated to the Government of Samoa and all development partners in the health sector and discussed at the Health Advisory Committee which has oversight of the health sector in Samoa. A summary of some of the key findings will also be made available publically.

A full copy of the Terms of Reference can be found at Annex 1.

1.4. Work programme

The Review involved a series of interviews coupled with extensive analysis of relevant documentation. Fieldwork was undertaken in Apia, Samoa from 4 – 13 March 2013.

Details of key informants who were interviewed as part of the Review are set out in Annex 2.

A list of documents reviewed is also attached at Annex 3.

1.5. Disclaimer re availability of materials

During the course of the Review it became apparent that the standards of record keeping among development partners was poor. There also appear to have been a number of weaknesses in version control of key documents which, in turn, have resulted in multiple, inconsistent and sometimes contradictory data being recorded.

The limited time available for fieldwork, coupled with the volumes of data collected over a period of more than five years and the diversity of storage arrangements, meant that it was not always possible to investigate and reconcile conflicting data sources, or to locate some key items of missing information.

Suggestions to correct any errors of fact that appear in this report, and that can be attributed to non-availability of definitive data or other information, are welcome.

1.6. Acknowledgments

Staff of the Samoa Ministry of Health, National Health Service and other Government Departments were generous with their time, open in sharing their views and experiences, and helpful in providing access to relevant materials. Their support is greatly appreciated.

In addition development partner staff in Apia and Canberra provided many valuable insights which have been central to the analysis presented in this report.

2. Development of the Samoa health SWAp

Sector-wide approaches (SWAp) have been adopted in the Pacific and elsewhere as a means to improve development effectiveness. Details of the SWAp concept, including its application in the Pacific, have been outlined extensively in the literature and are not repeated here.^{1,2}

Analysis of development assistance options in the Pacific indicated that Samoa was well placed to adopt greater harmonisation of donor policies and procedures.³ Accordingly, an education SWAp was established in Samoa in 2006 and a SWAp-like Water Sector Support Program ran from 2005–2010.

An aide mémoire produced following a World Bank mission in June 2006 reports that ‘the Government expressed its clear commitment to develop a sector-wide approach (SWAp) to health sector development’.⁴

In 2007 the Government of Samoa (GoS) published a Health Sector Plan 2008-2018 (HSP).⁵ At that time both the AusAID/NZAID-funded Samoa Health Project and the World Bank’s Health Sector Management Project were approaching completion. GoS, AusAID and New Zealand identified the potential to design a new Health Program which would apply a SWAp to support the implementation of the HSP.

The World Bank produced a Program Appraisal Document (PAD) for the SWAp in April 2008.⁶ Subsequently a Joint Partnership Agreement (JPA) underpinning the adoption of a SWAp to deliver a new five-year Health Program was signed in July 2008.⁷ The parties to the JPA are the Government of Samoa (GoS), AusAID, NZ Ministry of Foreign Affairs and Trade’s Aid Programme (NZ MFAT), International Development Association (World Bank), UNFPA, UNICEF and WHO.

The JPA signals a commitment on the part of the four ‘pool partners’ (GoS, AusAID, NZ MFAT & World Bank) to provide pooled funding for the SWAp. The remaining signatories are identified as development partners who, while being signatories to the JPA, did not intend at the time of signing to pool any of the funds they provide to the health sector in Samoa. The pool partners and other signatories are collectively referred to in the JPA, and throughout this report, as Development Partners (DP).

As described in the JPA the SWAp has two main objectives. They are:

- from an institutional perspective ‘to improve the effectiveness of the Government of Samoa in managing and implementing the HSP using results from sector performance monitoring’;

¹ Cassels, A. 1997. *A guide to Sector-Wide Approaches for Health development: Concepts, Issues and Working Arrangements – Jointly involving governments and development agencies in healthcare provision through SWAps*. Geneva: WHO

² Negin, J. 2010. *Sector-Wide Approaches for health: an introduction to SWAps and their implementation in the Pacific region. Health Policy and Finance Knowledge Hub Working Paper No. 1*. Melbourne: Nossal Institute for Global Health.

³ AusAID & NZAID. 2001. *Harmonising donor policies and practices in the Pacific*. Canberra: Commonwealth of Australia.

⁴ World Bank. 2006. *Samoa, Draft Aide Memoire, Health Sector Consultation and Implementation Support Mission, June 19-26 2006*.

⁵ Government of Samoa. 2007. *Health Sector Plan 2008-2018*.

⁶ World Bank. 2008. *Program Appraisal Document ... in support of Health Sector Management Program*

⁷ Independent State of Samoa, AusAID, NZAID, IDA, UNFPA, UNICEF & WHO. 2008. *Joint Partnership Agreement – Samoa Health Sector Program FY 2009-2013*.

- in terms of development 'to improve access to, and utilisation of effective, efficient and quality health services to improve the health of the Samoan population'.

In pursuit of those objectives, the JPA proposes that activities under the SWAp will be undertaken in three broad areas:

- health promotion and prevention
- quality health care service delivery
- strengthening policy and regulatory oversight of the health system.

The JPA states that, in implementing the SWAp, DPs will be guided by the following principles:

- Samoan leadership and ownership of the Program is maximised
- the support provided and its implementation is well aligned to GoS needs and priorities
- fairness, transparency, openness, accountability and mutual trust in all dealings
- a focus on sustainable and equitable development that meets the needs of the beneficiary communities
- the strategic orientation of policies and strategies
- quality, relevance, professionalism and excellence in the implementation of the Program
- the effective and efficient use of funding and resources
- a commitment to coordinated monitoring and evaluation within a results-based model focusing on improved decision making
- the pace of implementation is appropriate and responds to the absorptive capacity of the GoS
- where possible harmonisation of DPs' commitments and collaboration on implementation to simplify procedures and provide for a complementary division of labour.

The DPs also commit in the JPA, to 'applying the partnership commitments espoused in the Paris declaration on Aid Effectiveness'.⁸

In respect of governance and management of the SWAp, the JPA indicates the following:

- The Ministry of Health (MoH) has 'overall responsibility for program administration, financial management and procurement' as well as an 'overall coordinating role for implementation of the Program'. Other health sector agencies, including NGOs and private sector bodies, will also be involved in delivering aspects of the Program.

⁸The principles are:

1. Ownership: Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.
2. Alignment: Donor countries align behind these objectives and use local systems.
3. Harmonisation: Donor countries coordinate, simplify procedures and share information to avoid duplication.
4. Results: Developing countries and donors shift focus to development results and results get measured.
5. Mutual accountability: Donors and partners are accountable for development results.

Source: _

<http://www.oecd.org/dac/effectiveness/parisdeclarationandaccraagendaforaction.htm>

- The Ministry of Finance (MoF) is the 'executing agency' and has joint responsibility with MoH for management of the financial contributions of the DPs.
- A Health Program Steering Committee (HSPC) brings together high-level GoS officials from various Ministries and representatives of DPs and other health sector bodies to 'provide coordination among local stakeholders and external dialogue and coordination with DPs'.⁹
- A SWAp Coordination Unit (SCU) within the MoH to 'be responsible for day-to-day Program administration, procurement and financial management'.

Activities under the SWAp were to be defined in an annual Program of Work (PoW) prepared under the supervision of the SCU.

A 'Health Summit' involving GoS, pool partners, other DPs, health sector agencies and civil society organisations, would be held in March each year to assess the previous year's performance, address any issues arising, review a draft PoW for the following year, and confirm an agreed version.

In addition to the annual Health Summit a further Joint Review Meeting in September each year provides an opportunity for DPs to monitor performance and review draft financial statements.

⁹ HSPC members 'comprise high level GoS officials (MoH, MoF, NHS, Ministry of Women, Community & Social development and Ministry of Education, Sports & Culture), coordinating representatives from the DPs, a representative of other health institutions, a representative of the private sector and a representative of NGOs'.

3. Implementation of the Samoa health SWAp

Prior to the signing of the JPA an 'inception mission' involving representatives of GoS, AusAID, NZ MFAT and World Bank took place in April 2007 to 'reach a shared understanding of the requirements to establish a SWAp'.¹⁰ That mission identified, *inter alia*, the need to develop a medium term expenditure framework (MTEF) for the sector covering the period 2008-2012, a monitoring and evaluation (M&E) framework and 'detailed implementation and operational plans (at least for the first 12-18 months)'.

Those documents, together with the overarching HSP, are central to the operation of the SWAp.

3.1. Health Sector Plan 2001 – 2018¹¹

The HSP is the guiding document for the SWAp. It was launched in February 2008 and was informed by a number of pre-existing documents including:-

- GoS's Strategy for the Development of Samoa 2005-2007
- two previous planning documents (Health Sector Strategic Plan 1998-2003 & Health Sector Plan 2004-2008)
- a Health Sector Situational Analysis conducted in 2006.

The HSP seeks to address four significant challenges, as identified by the earlier Situational Analysis. They are:

- rapidly increasing levels of non-communicable diseases
- maternal and child health
- emerging and re-emerging infectious diseases
- injury as a significant cause of death and disability.

Although it was prepared and published before the JPA was signed, the HSP clearly anticipates the establishment of the SWAp. It suggests that 'the shift towards a sector wide approach (SWAp) in health was inevitable', highlights a number of areas that a SWAp should focus on and also identifies, as a key risk to the delivery of the HSP, that 'the SWAp approach may be too technocratic and centrally driven'.

The HSP identified six strategies and related objectives for the sector as follows:

¹⁰ GoS, AusAID, NZAID & World Bank. *Samoa Combined SWAp Inception Mission. April 16-24 2007, Draft Aide Memoire.*

¹¹ GoS MoH. 2008. *Health Sector Plan 2008-2018,*

Strategy	Objective
1. Health promotion and primordial prevention	To strengthen health promotion and primordial prevention
2. Quality health care service delivery	To improve access to and strengthen quality health care delivery in Samoa
3. Governance, human resource for health and health systems	To strengthen regulatory governance, human resources for health and the leadership role of the Ministry of Health
4. Partnership commitment	To strengthen health systems through processes between the Ministry and health sector partners
5. Financing health	To improve health sector financial management and long term planning of health financing
6. Donor assistance	To ensure greater development of partner participation in the health sector

A number of 'outputs' and related indicators, together with details of the 'means of delivery' (the agency(ies) responsible) are specified for each objective. In total the HSP identifies 31 outputs and 142 indicators.

A separate, but related, structure was created for the purposes of the SWAp. Under that structure each SWAp-related activity is assigned to one of three components, each of which addresses a number of the HSP strategies and objectives. The components are:

- Component 1: Health promotion and prevention
- Component 2: Enhance quality health service delivery
- Component 3: Strengthen policy and regulatory oversight of the health system

Those three components were adopted as the basis for developing the PoW and managing its implementation. While Components 1 – 3 appear to reflect, in broad terms, the HPS's first three Strategies there does not appear to be any explicit linkage between the HSP objectives and strategies on the one hand and the three Components and their constituent activities on the other.

In 2011, as part of a 'redevelopment' of the SWAp (discussed in detail below) a further long-term outcome area was added to the program, namely 'Improved risk management and response to disasters, emergencies and climate change'.¹² While no formal amendments were made to the HSP itself, that additional outcome is reflected in subsequent plans and programs of work.

3.2. SWAp Programme of Work

An appraisal mission in April 2008 (a few months before the JPA was signed) noted that a draft program of work for the first year of the SWAp (2009-2010) had been prepared.¹³ That program identified a total of 45 proposed initiatives to be undertaken as part of the SWAp at a total estimated cost of SAT\$25.0 million (equivalent to

¹² GoS MoH. (2011) *Redevelopment of the Health SWAp Program*.

¹³ GoS, AusAID, NZAID & World Bank. *Samoa, Draft Aide Memoire, Health Sector Management Program, Appraisal Mission, April 9-15 2008*.

approximately US\$10.2 million at April 2008 rates)¹⁴. Initiatives were assigned to Components as shown in Table 1 below.

Table 1: SWAp Initial Draft Programme of Work (2009-10)

Component	Number of initiatives	SWAp funding		Proportion of total cost
		(SAT\$ million)	(US\$ million)	
1. Health promotion and prevention	15	6.12	2.50	24%
2. Enhance quality health service delivery	15	10.73	4.38	43%
3. Strengthen policy and regulatory oversight of the health system	15	8.15	3.33	33%
Total	45	25.00	10.21	100%

A further annex to the April 2008 aide mémoire is headed 'Revised Program Proposals' and identifies 47 proposals of which 40 (with a total cost of SAT\$21.3 million) are described as 'go ahead', six are 'not included' and one is 'to be considered further'.

The relationship between the Draft PoW outlined in Table 1 above and the 'Revised Program Proposals' is unclear. Some proposals listed in the former are omitted from the latter (and vice versa) while a number of proposals are included in both documents but with different indicative costs.

An aide mémoire prepared following a further implementation support mission in September 2009 reports that 'The draft PoW for the period January 2009 to June 2010 was sent [*presumably to DPs*] in August 2009'. Thus the PoW for the initial 18 months of the SWAp appears still to have been in draft form more than a year after the JPA was signed.

The September 2009 mission also agreed that a second PoW, to cover the period July 2010 to June 2011 should be prepared by mid-February 2010.

Less than two weeks after members of the September 2009 mission left Samoa, however, the island of Upola was struck by a major tsunami. Recognising the need to address a number of major health issues in the post-tsunami period the pool partners agreed to allocate up to US\$3 million of SWAp resources to fund the immediate response. Several new activities were thus added to the initial PoW and, it appears, work towards preparing a second, formal PoW was effectively put on hold.

A 'redevelopment' of the SWAp took place during 2010/11 and resulted in the adoption of a revised format for presentation of future PoW. The revised format sought to simplify monitoring and reporting while also clarifying the alignment between the PoW and HSP. It grouped activities into a number of 'key sector areas' which, in turn, could then be mapped onto the three SWAp components.

The SWAp inception report published in January 2011 includes, as an annex, the PoW for 2010-2011.¹⁵ That version of the PoW, which is summarised in Table 2

¹⁴ A separate document, which appears to have been prepared concurrently, consolidates a number of initiatives to propose a total of 39 at a total cost of SAT\$26.6 million.

below, details 101 activities (including a number rolled over from the previous PoW together with several post-tsunami activities) and identifies total SWAp funding of SAT\$24.2 million or approximately US\$10.5 million at January 2011 rates (see Annex 4). Five activities are listed as being funded by DPs outside the SWAp. The increase in the proportion of costs allocated to Component 2 reflects, in part at least, additional funding for post-tsunami activities.

Table 2: SWAp Programme of Work (2010-11)

Component	Number of initiatives	SWAp funding		Proportion of total cost
		(SAT\$ million)	(US\$ million)	
1. Health promotion and prevention	30	4.22	1.82	17%
2. Enhance quality health service delivery	51	16.15	6.97	67%
3. Strengthen policy and regulatory oversight of the health system	20	3.88	1.67	16%
Total	101	24.25	10.46	100%

A further 'health redevelopment and program implementation review mission' in December 2011 'recognised the challenges faced to date with the development of annual PoW and observed that the various PoW prepared up to that point had failed fully to reflect 'all the work being done to address the priorities in the HSP' including activities funded using recurrent GoS budgets.¹⁶ That mission also proposed the use of a new template for future PoW which, it was suggested, would facilitate inclusion of all sources of financing available to the sector and better support further monitoring and evaluation (M&E).

At the time the Review was carried out the most recent version of the PoW that had been formally recognised by development partners was set out in a document marked as 'Reprioritised Sept 14 2012 end of June balances'. That version adopts the new template proposed by the December 2011 mission.

Subsequent to the Review, a new version of the PoW was developed in a document marked 'Program of Works 2011-2012 (Reprioritised March 14 2013)'. That version, which had not been submitted to development partners at the time of the Review, details 153 activities, grouped under 44 'strategies'. Total SWAp funding amounts to SAT\$46.9 million in 2011-12 and SAT\$29.2 million in 2012-2013¹⁷. Activities include a number that are marked as 'Completed' (presumably prior to the 2011-12 year) together with several that are funded by SPC and GFATM.

¹⁵ Crawley, UB. (2011) *Health Sector-Wide Approach (SWAp) Program: Inception Report. Annex 5*

¹⁶ GoS, AusAID, NZAID & World Bank. *Aide Memoire, Samoa Health SWAP Program, Health Redevelopment and Program Implementation Review Mission, December 8-16 2011.*

¹⁷ Equivalent to US\$20.3 million at 30 December 2011 and US\$12.9 million at 31 December 2012 respectively.

3.3. Medium term expenditure framework

According to the World Bank, a MTEF should comprise ‘a top-down resource envelope [and] a bottom-up estimation of the current and medium-term costs of existing policy’.¹⁸ Successive PoW, as described above, have provided estimates of the costs of the SWAp and, more recently, elements of health sector spending funded from other sources. This section discusses the SWAp resource envelope and examines how it has been incorporated into the MTEF.

3.3.1. The SWAp resource envelope

An appraisal mission in April 2008 established an ‘indicative financing plan’ which estimated costs of US\$8 million for the first 18 months of the SWAp.¹⁹

The PAD (April 2008) reported that the ‘indicative resource envelope’ for the SWAp program over its five-year life was estimated to be US\$24.5 million made up as follows:

- World Bank funding of US\$3 million
- GoS funding of US\$1.5 million
- AusAID and NZ MFAT funding of US\$5 million and US\$3 million respectively over the initial two years of the program
- additional potential funding from AusAID and NZ MFAT of AUS\$3 million/year and NZ\$2 million/year respectively in each of the third, fourth and fifth years of the program.

Immediately following the September 2009 tsunami DPs agreed urgently to reallocate US\$3 million of SWAp funds to support the health sector response. Following further negotiations an additional US\$3 million of World Bank funding was added to the overall SWAp budget to allow re-programming of activities displaced by the post-tsunami response. The total potential funding envelope for the SWAp thus increased to US\$27.5 million.

According to the most recent aide mémoire total funding commitments as at 31 October 2012 were some US\$25.0 million made up as follows²⁰:

World Bank	US\$6.0 million
AusAID	US\$12.6 million
NZ MFAT	NZ\$6.0 million
GoS	US\$1.5 million
Total*	US\$25.0 million

* NZ\$6.0 million ≈ US\$4.9 million as at 31/10/12

Later in 2012 New Zealand confirmed it would meet its additional funding commitments of NZ\$2 million per year in respect of the third, fourth and fifth years of the program, bringing the total contributed to NZ\$12 million and the overall program funding to approximately US\$30 million.

¹⁸World Bank. (1998). *Public Expenditure Management Handbook*.

¹⁹The figure of US\$8 million appears to be based on the costs of the 40 proposals described as ‘go ahead’ in the list of ‘Revised Program Proposals’ appended to the April 2008 aide mémoire as opposed to the costs summarised in Table 1.

²⁰GoS, AusAID, NZAID & World Bank. *Aide Memoire, Samoa Health SWAP Program Joint Review Mission, 21 October – 1 November 2012*.

In addition to the funding detailed above AusAID has recently committed to providing a further US\$3 million funding for medical equipment and NZ MFAT plans to contribute a further NZ\$4.3 million for capital works projects (pharmaceutical and medical supplies warehouse, orthotics & prosthetics facility and primary care centre).

3.3.2. Development of the MTEF

The inception mission that took place in April 2007 proposed the appointment of a consultant to facilitate the development of a MTEF however the next combined mission in October 2007 found that work on the MTEF was still at a preparatory stage.²¹

A further review mission in October 2008 'acknowledged the importance of the MTEF and its key findings, and agreed that it was critical to continue this work on an annual basis'.²²

The 'implementation support mission' in September 2009 recommended the development of a 'rolling' MTEF which would include both pooled and non-pooled partner contributions. It also suggested that the health sector MTEF might be more closely integrated with the GoS budget process and proposed the recruitment of an MTEF advisor to provide support.²³

No copies of the initial Medium Term Expenditure Framework were available for review but an updated document (known as MTEF2) covers the period 2011-2015.²⁴ It identifies total resources (GoS and development partners combined) for the sector of SAT\$622.3 million (approximately US\$264.3 million at mid-March 2013 rates) over the five-year period from 2009/10 to 2013/14.

Development expenditure (i.e. donor funding) over the same period is estimated to be SAT\$259.4 million (US\$114.3 million) of which SAT\$55.0 million (US\$24.2 million) is expected to be provided by the SWAp, \$159.1 million (US\$70.1 million) by the People's Republic of China (principally capital expenditure for the new MoH headquarters and hospital buildings) and the balance by other donors operating outside the SWAp (see Figure 1).²⁵

²¹ GoS, AusAID, NZAID & World Bank. *Samoa Health Sector Program (SWAp) Preparation Mission. 22-26 October 2007, Draft Aide Memoire.*

²² GoS, AusAID, NZAID & World Bank. *Samoa, Aide Memoire, Health Sector-Wide Approach Programme, Implementation Support Mission, October 27-30 2008.*

²³ GoS, AusAID, NZAID & World Bank. *Samoa. Aide Memoire, Health Sector-Wide Approach Program, Implementation Support Mission, September 14-18 2009.*

²⁴ GoS MoH. (Undated) *Update of the Medium Term Expenditure Framework for the Samoa Health Sector 2011-2015 (2nd edition)*

²⁵ The difference between the figure of US\$24.2 million quoted in MTEF2 and US\$25 million in the November/December 2012 aide memoire may be due, in part at least, to exchange rate fluctuations.

Figure 1: Health sector resourcing (2009/10 – 2013/14)²⁶

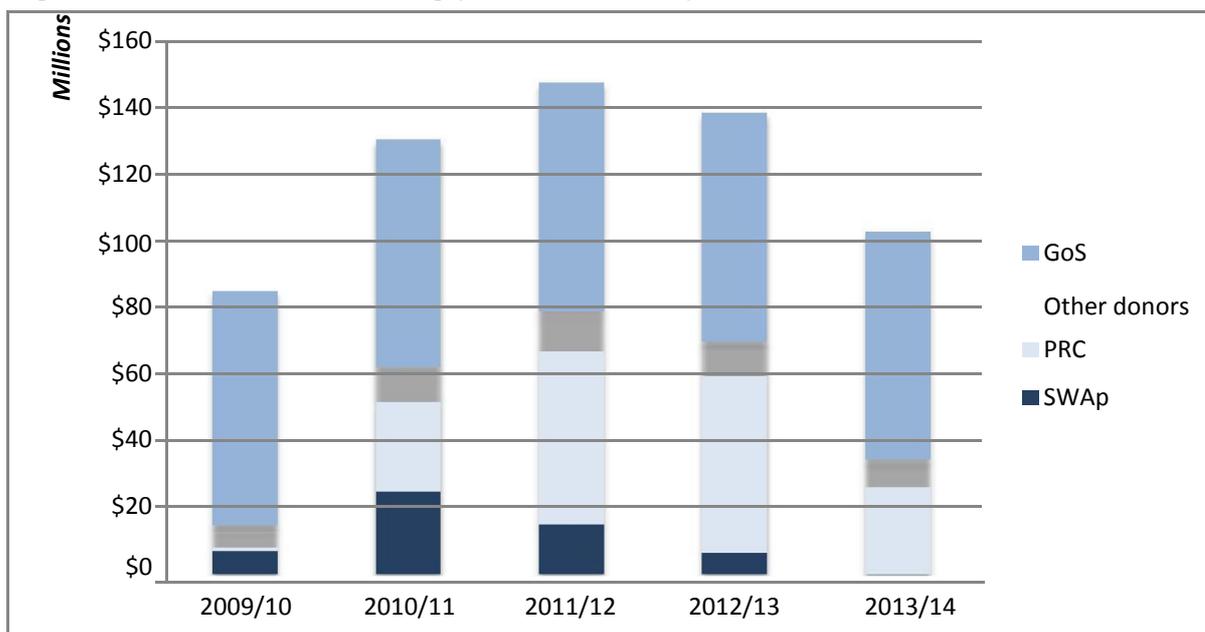


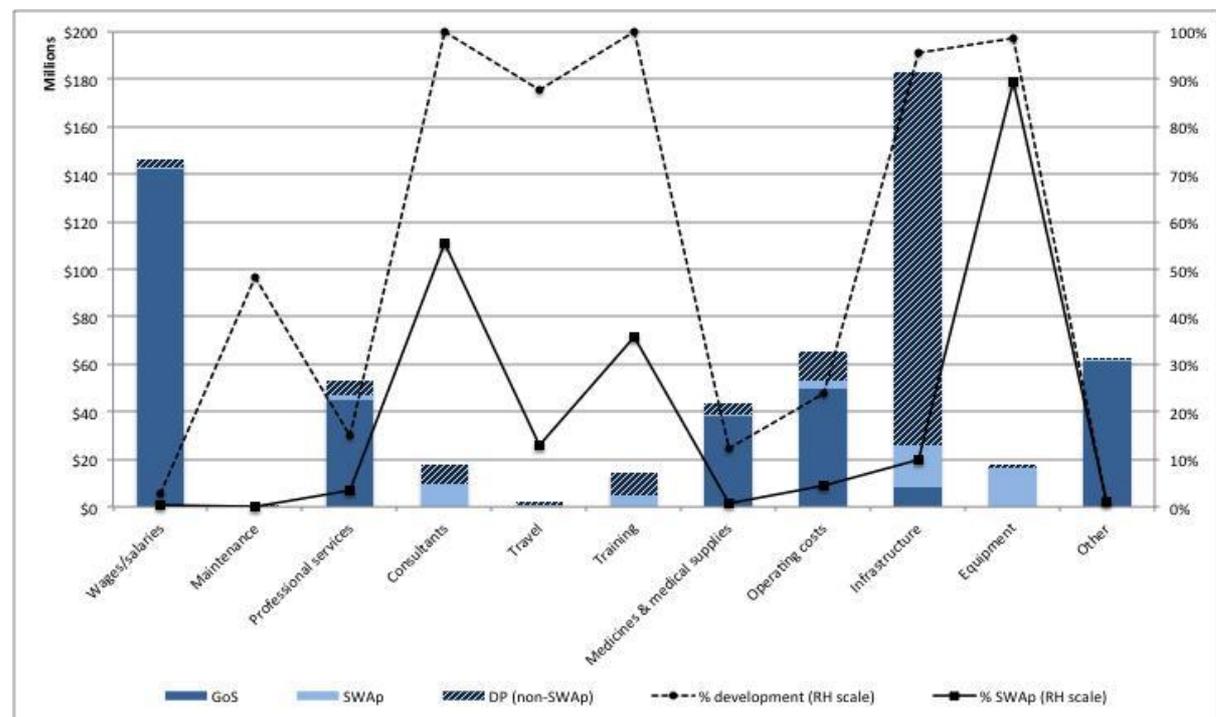
Figure 2 (below) presents data from MTEF2 on how funds are expected to be spent. The most significant items are wages/salaries and infrastructure (principally the new MoH headquarters and hospital buildings) which together are expected to account for more than half (54 per cent) of all spending. Total spending on maintenance over the five year period is just under SAT\$500,000 (split roughly 50/50 between GoS and development partners) which amounts to just 0.24% of total spending on infrastructure and equipment over the same period. In contrast, more than four times that amount (SAT\$2.04 million with 12 per cent funded by GoS) is expected to be spent on travel.

Figure 2 also highlights the fact that there are significant variations in the extent to which SWAp funding is used to support different budget elements. Almost 90 per cent of equipment costs and more than 50 per cent of consultancy costs will be funded by the SWAp; whereas SWAp funding plays only a minor part in funding maintenance, professional services, medicines and medical supplies.

Over the five-year period covered by MTEF2 the main areas to be funded by development partners are consultants, travel, training, infrastructure and equipment. The SWAp's impact is expected to be greatest in respect of consultants and equipment. GoS itself will meet some 97 per cent of salary costs.

²⁶ GoS MoH. (Undated) *Update of the Medium Term Expenditure Framework for the Samoa Health Sector 2011-2015 (2nd edition)*

Figure 2: Use of funds (2009/10 – 2013/14) ²⁶



3.4. Monitoring & evaluation framework

As noted above, M&E was seen from the outset as an essential component of the SWAp.

Consistent with the overall SWAp objectives defined by the JPA, the PAD suggested that the M&E framework for the SWAp should have two specific foci:

- program outcome indicators – to monitor health sector performance
- SWAp process monitoring indicators – to assess institutional development outcomes.

Accordingly, Annex 3 of the PAD presents a proposed collection of 61 indicators made up as follows:

- eighteen outcome indicators for the overall medium-term (2009-2013) ‘program development objective’ of ‘improved access to, and utilisation of effective efficient and quality health services to improve the health status of the Samoan population’;
- a number (28 in total) of ‘results indicators’ for the SWAp’s three components;
- fifteen ‘program indicators’ for monitoring the health SWAp process.

The aide mémoire prepared following the April 2008 appraisal mission, the Program Operational Manual (POM), published in June 2008, and the JPA, signed in July 2008 all included an identical M&E framework comprising 25 indicators as detailed in Annex 5. Although those indicators were a subset of the 61 in the PAD there were a number of differences in terminology adopted. It appears that the smaller indicator set was adopted as the initial basis for M&E.

By the time of the September 2009 review mission baseline data were reported to be available for just three of the 25 proposed indicators:

- prevalence of diabetes – based on the 2003 STEPS survey

- adolescent birth rate – from the 2006 census
- percentage of children under 1 year receiving at least one dose of measles vaccine – also from the 2006 census.

The next references to the M&E framework in the context of the SWAp appears to occur in the aides mémoires produced following the March and November 2012 implementation support and review missions both of which provide updated data and commentary on a wider range of indicators.^{27,28}

In parallel with the development of the SWAp M&E framework MoH also published two editions of a 'Monitoring & Evaluation Operational Manual' which 'specifies a comprehensive set of core indicators (financial & non-financial) that will form the basis for performance measurement in the context of the health sector'.^{29,30} The Manual details a further set of performance indicators, some of which are also included in the SWAp M&E framework. It is apparent, however, that two sets of indicators are intended to serve different, albeit complementary, purposes.

3.5. Governance and management

In addition to specifying governance and management roles for the Ministries of Health and Finance, the Health Program Steering Committee and the SCU the JPA also specifies three key governance mechanisms as follows³¹:

- Health Summit – to take place in March each year in order to review and agree the PoW for the following year informed by:
 - an annual audit report and accompanying management letter
 - an annual programme management report for the preceding year
 - a report from a Technical Review Mission
 - inputs from the M&E system
- Joint Review (referred to in the PAD as 'Joint Supervision') – in September each year to 'assess the previous year's performance and discuss important topics identified in the course of implementation' and establish the basis for stakeholders' actions in the following year informed by:
 - draft PoW and budget forecast for the following financial year
 - draft annual procurement plan for the following financial year
 - quarterly program management reports for the preceding quarters
 - a Mid-Term Review of the program by GoS to be conducted by December 2010 to be followed, some three months later, by a Mid-Term Evaluation conducted by the pool partners

Neither the GoS Mid-Term Review nor the pool partners' Mid-term Evaluation identified in the JPA took place.

In 2010 GoS requested that the Mid-Term Review process be 'recast' as a program redevelopment. As a result of that redevelopment the HSPC was renamed the

²⁷ GoS, AusAID, NZAID & World Bank. *Aide Memoire, Samoa Health SWAp Program, Implementation Support Mission, March 19-23 2012. Annex 1.*

²⁸ GoS, AusAID, NZAID & World Bank. *Aide Memoire, Samoa Health SWAp Program, Joint Review Mission, 21 October – 1 November 2012. Annex 1.*

²⁹ GoS MoH. 2009. *Monitoring & Evaluation Operational Manual (Health Sector Performance).*

³⁰ GoS MoH. 2011. *Monitoring & Evaluation Operational Manual (Health Sector/System Performance).*

³¹ Independent State of Samoa, AusAID, NZAID, IDA, UNFPA, UNICEF & WHO. 2008. *Joint Partnership Agreement – Samoa Health Sector Program FY 2009-2013.*

Health Advisory Committee (HAC) and assigned responsibility for oversight of the health sector more generally as well as implementation of the SWAp. Its membership was also expanded to include representatives of the National Council of Churches and other civil society organisations.

Health Summits were held in 2009 and 2010 but the event has since been replaced by an annual Health Sector Forum, convened by MoH.

In place of the more formal Joint Review process described in the JPA, a series of missions, typically involving GoS and DP representatives has taken place. Details of such missions since the launch of the SWAp in July 2008 are summarised in Table 3 overleaf.

Table 3: Details of SWAp review and support missions (2008 – 2012)

Dates	Title	Participating agencies						
		GoS	AusAID	NZ MFAT	WB	UNFPA	UNICEF	WHO
27-30 Oct 2008	Implementation Support Mission							
14-18 Sep 2009	Implementation Support Mission							
15-26 Feb 2010	Technical Support Mission & Pre-appraisal for Additional Financing		*					
22-26 Nov 2010	Health Redevelopment & Implementation Mission							
18-21 Apr 2011	Health Redevelopment Mission							
8-16 Dec 2011	Health Redevelopment & Program Implementation Review Mission							
19-23 Mar 2012	Implementation Support Mission							
21 Oct – 1 Nov 2012	Joint Review Mission							

* AusAID was represented by NZ MFAT during the February 2010 mission

4. What has the Samoa health SWAp achieved?

The M&E framework is intended to be the principal mechanism for assessing the impacts of the SWAp but weaknesses in the M&E framework and its application, the absence of valid 'baseline' measures and incomplete documentation in some areas, make formal, rigorous evaluation of SWAp achievements problematic.

The Mid-Term Review of HSP, which is currently under way, may provide a more comprehensive assessment of achievements. Details of relevant findings from this review are summarised below.

As described previously, the M&E framework encompasses both program outcome indicators and SWAp process monitoring indicators. Those, together with the issue of efficiency with which resources have been used, provide some limited insights into the achievements of the SWAp.

4.1. Program outcome indicators

In respect of programme outcomes, it is apparent that the SWAp has delivered benefits in a number of important areas. Examples noted in aides mémoires and/or reported during the course of this review include (in no particular order):

- completion of a demographic and health survey (DHS) in December 2009 - which has also provided baseline data for subsequent M&E
- acquisition of medical supplies and equipment
- development of a new 'credentialing centre' and simulation facilities for continuing professional development of nursing staff
- provision of grants for health promotion activities such as nutrition advice and support for growing fruit and vegetables at community level - 171 such grants were reportedly provided during the first 12 months of the SWAp
- social marketing for health promotion via media campaigns
- extensive training and staff development - 45% of spending during the first year of the SWAp was directed towards such activities
- preparation of national policies on tobacco control, health promotion and non-communicable diseases
- planning and legislative development work to underpin the establishment of a new National Health Promotion Foundation
- establishment and operation of a Samoan Parliamentarian Advocacy Group for Healthy Living
- implementation of a registration regime for health professionals, overseen by a Registrar
- assessments of nutrition and sanitation in more than 60 schools
- delivery of injury prevention programmes involving media messaging and first aid training for teachers
- improved systems and processes for hospital waste management.

Despite the obvious potential for initiatives such as the above to impact positively on health system performance and, ultimately, on health outcomes there are few data that can be called upon to substantiate such assumptions. Indeed it was noted in an early aide mémoire that 'the evidence base for making assumptions about the impact of project activities on outcomes remains underdeveloped'.³²

³² GoS, AusAID, NZAID & World Bank. *Samoa, Draft Aide Memoire, Health Sector Program (SWAp), Pre-appraisal Mission, 10-14 March 2008.*

There are, however, some health outcome data which relate in broad terms both to the objectives of the SWAp and to the period in which it has operated. Those data, though few in number, point to mixed results as follows:

- the infant mortality rate fell from 20.4 per 1,000 live births in 2006 to 15.6 per 1,000 live births in 2011³³
- the birth rate among women aged 15-19 increased from 28.6 per 1,000 in 2006 to 38.1 per 1,000 in 2011³³
- the numbers of under 5's presenting to TTM and MTII Hospitals with diarrhoea and gastroenteritis rose from 1,962 in 2008 to 2,157 in 2009 and 2,280 in 2010
- reported coverage of DTP3 immunisation almost doubled between 2008 (46 per cent) and 2010 (87 per cent)

It is notable that, despite the obvious and recognised importance of NCDs in Samoa, there appear to be no reliable, national data on changes in NCD prevalence over the life of the SWAp.

The SWAp appears to have fallen short of expectations in a number of programme outcome areas. Some of the more significant examples are:

- slow progress with three key capital works projects - pharmaceutical and medical supplies warehouse; orthotics & prosthetics facility; and primary care centre
- failure to develop and implement a comprehensive health information system due to non-performance of a TA – which has had 'knock-on' adverse impacts on the ability to acquire and analyse health sector activity data for M&E purposes
- delays in establishing improved cervical and breast cancer screening programmes - both in terms of policy/protocol development and procurement of equipment.

It is intuitively obvious that better-trained staff, new equipment, stronger policy settings, enhanced health promotion efforts etc will lead to better health outcomes. What is less clear, however, is the extent to which the specific mix of initiatives delivered by the SWAp was the most appropriate in terms of its ability to deliver improvements in terms of both the overall level and the equity of health outcomes among the Samoan population.

There are also problems of attribution: positive (or negative) changes in health outcomes may have stemmed from factors unrelated to the SWAp. As noted in an early aide mémoire, 'given weaknesses in baseline data ... making assumptions about the counterfactual (what would happen in the absence of the project) may lead to inaccurate conclusions about the net benefit of the project'.³⁴

As discussed below the absence of a clear 'theory of change' underpinning the SWAp creates uncertainties in any assessment of its overall effectiveness. In particular, evaluation is clouded by the failure adequately to specify the anticipated links between the high level objectives set out in the HSP, the initiatives in the SWAp PoW and their outputs in terms of improved health outcomes.

In assessing programme outcomes it is important also to acknowledge that, during the life of the SWAp to date, Samoa has faced the challenges of an H1N1 ('swine flu') outbreak, a tsunami and, more recently, a major cyclone. While building

³³ Source: National Census reports 2006 & 2011

³⁴ GoS, AusAID, NZAID & World Bank. *Samoa, Draft Aide Memoire, Health Sector Program (SWAp), Pre-appraisal Mission, 10-14 March 2008.*

resilience to such events is itself one of the objectives of the SWAp, their impact on communities and the services they require cannot be overlooked.

4.2. SWAp process monitoring indicators

In terms of SWAp process monitoring indicators there are few relevant data. Details, where available, are summarised at Annex 6. Those data point to some achievements in terms of SWAp processes but are of limited value as a basis for assessing the success or otherwise of the SWAp as an aid modality.

More subjectively, MoH staff and other GoS officials engaged in managing the SWAp perceive a number of benefits from a process perspective, particularly when contrasted with the alternative of dealing with a suite of individual, stand-alone projects of equivalent size and complexity. Specifically:-

- adoption of the SWAp modality has led to improvements in GoS capacity to plan and manage complex health sector projects
- use of a single system to record and report SWAp-related finances, while initially demanding, has been more efficient than complying with varying individual project requirements
- use of a single SCU to oversee all aspects of the program has reduced transaction costs for GoS
- the ability to consolidate interactions with DPs into a single process as opposed to a series of discrete bilateral engagements has supported more efficient and consistent dialogue
- the SWAp modality has supported a move away from opportunistic and potentially competitive bidding among (or within) health sector agencies to secure project-based funding in response to (actual or perceived) priorities among DPs.

4.3. Expenditure³⁵

There have been delays in disbursing SWAp funds throughout the life of the program. Also, while DPs have been flexible in their financial responses to unforeseen demands (e.g. post-tsunami) planning has undoubtedly been complicated by a number of unplanned adjustments to funding levels over the life of the SWAp.

At the end of September 2011 (effectively three years into the program) it was estimated that only 40.6 per cent of planned funding had been expended.³⁶

The most up-to-date financial figures, sourced from the Interim Financial Reports (IFR) for the quarter ending 31 December 2012, suggest that 48 per cent of planned funding had been spent with a further 12 per cent committed but not yet spent. Details are set out in Table 4.

³⁵ The figures presented here, in common with many used by GoS and development partners in the context of the SWAp, are complicated by variations in exchange rates and inconsistencies among development partners in their reliance on different currencies to record and report SWAp-related budgets and spending.

³⁶ GoS, AusAID, NZAID & World Bank. *Aide Memoire, Samoa Health SWAP Program, Health Redevelopment and Program Implementation Review Mission, December 8-16 2011.*

Table 4: SWAp expenditure versus budget as at 31 December 2012

	SAT\$ million	US\$ million*	Proportion of budget
Total budgeted expenditure (based on PoW)	74.2	32.6	100%
Expenditure to date	35.5	15.6	48%
Committed but not yet spent	8.9	3.9	12%
Unallocated	29.8	13.1	40%
* SAT\$1 ≈ US\$0.44 as at 31/12/12			

The above figures reflect an assumed budget of US\$32.6 million over the life of the SWAp which exceeds the actual sum allocated by DPs. Based on the original budget of US\$27.5 million the proportion of funds unallocated reduces somewhat to US\$8 million or 29 per cent of the lower budget figure.

Both MoH and DP representatives highlighted the complexity of procurement as a significant weakness within the SWAp process. The requirement that purchasing decisions be subject both the GoS Tender Board processes and to World Bank processes was frequently cited as a source of delays to overall SWAp implementation.

Concerns regarding procurement were first noted by a review mission in February 2010 while the aide mémoire from the April 2011 Mission highlights 'procurement capacity gaps'.

The report of the SWAp redevelopment in 2011 states that 'Procurement has been the major issue and presented challenges in the implementation of the program'.³⁷ It is apparent, however, that problems were attributable not only to the process itself but also to capacity constraints within the SCU. Thus, specific concerns identified in the redevelopment report were:

- low thresholds for the application of procurement methods and approvals
- eligibility of national firms and contactors to participate
- delays in receiving approval and clearances
- limited capacity and understanding of the processes by managers and staff.

Adjustments made subsequent to the redevelopment including increased thresholds to permit greater local discretion, provision of procurement TA and other capacity building measures have reportedly resulted in noticeable improvements.

4.4. Efficiency

An assessment of the SWAp also needs to consider the efficiency with which the program was delivered.

Again, the absence of benchmarks, comparators and reliable performance data make it difficult to determine efficiency.

Rigorous procurement processes, combining those of the GoS Tender Board and the World Bank, have been applied throughout the life of the SWAp. While those processes have created challenges and brought about delays in implementation (as noted above) it is reasonable to assume that value for money ought to have been achieved in all significant purchases of goods and services. Indeed some MoH staff

³⁷ GoS MoH. (2011) *Redevelopment of the Health SWAp Program*.

acknowledged that the burden of rigorous procurement, while often irksome, was justified as a means to ensure good outcomes.

The Interim Financial Reports (IFR) for the quarter ending 31 December 2012 show total 'SWAp Unit Operational Costs' of SAT\$3.46 million over the life of the program. That equates to some 4.7 per cent of total SWAp expenditure. Some 'overhead' costs (notable DPs' costs and the costs of senior GoS management time) are clearly excluded from that figure. Nevertheless the data do suggest that the costs of managing the program as a whole have not been excessive.

As noted above, key players involved in implementing the SWAp also suggest that the administrative burden has been substantially less than might have been experienced if a program of similar scale and scope had been delivered via more traditional project-based approaches.

5. Observations on the Samoa health SWAp

This section presents observations on key aspects of the Samoa health SWAp, based on key informant interviews and review of relevant documents. Observations are grouped under similar headings to those used in Section 3 above to describe implementation of the SWAp as follows:-

- Establishment of the SWAp
- SWAp program of work
- Governance and management of the SWAp
- Monitoring and evaluation
- Medium term expenditure framework

5.1. Establishment of the SWAp

The decision to adopt a SWAp appears not to be clearly documented and there are varying accounts of how, when and by whom the proposal was first mooted.³⁸

The previous Samoa Health Project and Health Sector Management Project reportedly identified a number of implementation issues which a SWAp would need to take into account. They included:

- the need to pace implementation in line with the absorptive capacity of the health sector
- constraints associated with sustainable capacity building
- the need to develop effective monitoring and evaluation systems
- the need for sustained partner engagement and donor coordination
- the importance of aligning development partner processes with GoS systems
- the issues associated with procurement and managing civil works in the Samoan context.

It is not clear to what extent those factors were addressed during the establishment of the SWAp and there is little evidence to suggest that a considered approach was taken to assess and build upon learnings from previous experiences: either from health sector projects in Samoa or SWAps in Samoa and elsewhere.

A major realignment of the Samoan health sector which took effect from 1 July 2006 saw a formal separation of the MoH and the newly established National Health Service (NHS). The intent was to establish a clear distinction between the Ministry's key roles in strategic direction setting, policy formulation, regulation and monitoring for the sector as a whole and the NHS responsibility for delivery of services via publicly owned health facilities.

At the time the SWAp was under development the revised institutional arrangements were still relatively new and both MoH and NHS appear still to have been struggling fully to come to terms with their revised roles. A review of the realignment found that, initially, 'there was general confusion and misconceptions among staff about the exact roles, responsibilities and linkages between the two new entities' and 'there was seen to be a power struggle between NHS and MoH management over which entity was in control'.³⁹ Although the situation has clearly improved significantly since

³⁸ Negin, J. 2010. *Sector-Wide Approaches for health: a comparative study of experiences in Samoa and the Solomon Islands*. Health Policy and Finance Knowledge Hub Working Paper No. 3. Melbourne: Nossal Institute for Global Health.

³⁹ GoS (2011) *Review of the Ministry of Health Realignment. Report of the Review Committee*.

then, it is apparent that tensions between MoH and NHS did not create the ideal environment for establishing a major, multi-year program such as the SWAp.

The SWAp, as a development modality, requires a robust and prioritised sector strategy against which partners' can align their support. Samoa's HSP, as is common in developing countries, is aspirational. It defines 31 outputs and 142 indicators with each of the latter representing a specific action, goal or target to be met. In fact, however, the scale of the tasks defined, coupled with the lack of any rigorous prioritisation or phasing over the five years of the Plan, has limited its utility as the guiding document for the SWAp. As in other countries, the adoption of a SWAp has shined a light on weaknesses in the sector planning process.

Overall it appears that the process of establishing the SWAp may have been unduly hasty. There was clearly a commitment and enthusiasm on the part of DPs to maintain support for Samoa's health sector and to build upon the momentum that had been established by previous health sector projects. GoS for its part was also keen to sustain the rate of progress that had been achieved and to continue work to implement the HSP. As a result, however, some shortcomings in terms of the sector's readiness may have been overlooked. It has even been suggested that the establishment of the SWAp 'faced an artificial deadline of June 2008' based on the timing of a World Bank board meeting.⁴⁰

The redevelopment of the SWAp that took place in 2010 appears to have simplified a number of processes and clarified roles and responsibilities. The rationale for undertaking the redevelopment, and its timing, cannot be discerned from available documentation. It has been suggested anecdotally that it was a response to perceived delays in program implementation. Ironically, however, the redevelopment process itself appears to have led to further implementation delays.

The fact that the redevelopment replaced the Mid-Term Review (by GoS) and Mid-Term Evaluation (by pool partners) that were originally specified in the JPA could, with hindsight, have been unfortunate since those initiatives may well have highlighted weaknesses and identified possible remedies earlier in the life of the SWAp. The redevelopment could then have been undertaken, more legitimately and logically, in response to issues identified by the Mid-Term Review and Evaluation.

5.2. SWAp program of work

The PoW is the key document that underpins the SWAp. For each initiative under the program the PoW should record *inter alia* details of its aims and objectives, the specific activities to be carried out, the implementing body, deadlines and budget. According to the SWAp Program Operational Manual the PoW should be updated annually to reflect priorities agreed among the DPs.⁴¹

In practice, the process of establishing and subsequently updating an agreed PoW appears to have been somewhat haphazard.

An initial list of 91 'preliminary proposals' for inclusion in the SWAp was drawn up early in 2008. A Pre-Appraisal Mission in March 2008 'acknowledged and endorsed the broadly inclusive and participatory process' that had been adopted.⁴² Details of that process, including how proposals were solicited, and their relationship to the

⁴⁰ Negin, J. 2010. *Sector-Wide Approaches for health: a comparative study of experiences in Samoa and the Solomon Islands*. Health Policy and Finance Knowledge Hub Working Paper No. 3. Melbourne: Nossal Institute for Global Health.

⁴¹ GoS MoH. 2008. *Program Operational Manual for Samoa Health SWAp Program*

⁴² GoS, AusAID, NZAID & World Bank. *Samoa, Draft Aide Memoire, Health Sector Program (SWAp), Pre-appraisal Mission, 10-14 March 2008*.

strategies and objectives set out in the HSP are, however, unclear. The fact that the same Mission also suggested that the list should be reviewed and reprioritised within a week could be seen to indicate a lack of rigour in arriving at the 45 activities included in the agreed PoW for the first year of the SWAp.

More generally, the aides mémoires analysed as part of this review suggest that the various PoW underpinning the SWAp were not based on extensive or sophisticated policy dialogue between DPs and GoS.

Over the life of the SWAp, AusAID, NZ MFAT and the World Bank have had only limited and often intermittent in-country access to health sector expertise. Their ability to contribute to meaningful policy dialogue with Samoan counterparts has thus been limited. In addition, the role of review missions appears to have been largely one of reacting to proposals developed by MoH and other sector bodies rather than working interactively to identify, develop and prioritise initiatives that might help to achieve the HSP objectives.

In fact, prioritisation itself appears to have been a weak point throughout the life of the SWAp to date. The initial PoW and subsequent revisions thereof contain a wide variety of activities which vary greatly in terms of their nature, their scale, their cost and their likely impact on the priority areas identified in the HSP. Those activities clearly all have the potential to contribute to improvements in health system performance and, ultimately, to health outcomes. The basis on which they were selected for inclusion in preference to other potential activities is, however, rarely made explicit.

The criteria used to determine whether or not to include specific activities in the PoW would be made clearer by the development of an explicit 'theory of change' which explained how individual program initiatives were expected to contribute towards achieving the overarching priorities of the health sector. The approach adopted to date has failed adequately to address the 'missing middle' between high-level objectives and detailed program activities.

From the outset DPs have encouraged the development of a PoW that includes activities and investments funded from other sources (including GoS revenues) in order to have a comprehensive overview of progress towards the HSP objectives. In its Country Cooperation Strategy for Samoa 2102-2018 WHO also identifies 'Full participation of all health development partners in the SWAp programme and integration of activities' as one of four key development cooperation challenges.⁴³

However, successive PoW have failed fully to adopt a whole-of-sector view, and have tended to focus more or less exclusively on SWAp-funded initiatives. The impression created is thus one of a health sector strategy that is driven by the SWAp as opposed to vice versa.

According to MTEF2 the SWAp is expected to fund just 22 per cent of development expenditure over the period 2009/10 to 2013/14. PRC-funded capital works account for a further 64 per cent but there are clearly a number of other activities that ought to be reflected in a comprehensive PoW.

Following the SWAp redevelopment that took place in 2011 the PoW has expanded to include at least some non-SWAp activities, although it still does not appear to reconcile fully with the data in MTEF2.

There have also been some significant shortcomings in respect of PoW documentation. Difficulties in reconciling numerous different versions and

⁴³ WHO (2012) *Samoa. Country Cooperation Strategy. 2012-2018*. WHO (WPRO)

presentation formats make it hard to establish a clear 'audit trail' of changes to the PoW over time, and hence to track the evolution of the SWAp as a whole.

A contemporary example of poor documentation standards is provided by the two most recent versions of the PoW. The version designated 'Reprioritised September 14 2012' lists a series of earlier revisions in March, April and May 2012. Those revisions are also noted in the subsequent version of the PoW, which is designated 'Reprioritised March 14 2013', but that later version makes no reference to the September 2012 amendments.

There is clearly a good level of 'institutional knowledge' within the SCU which can help to overcome weaknesses in formal record keeping, albeit with considerable risks if key individuals leave. From the DPs' perspective, however, staff turnover is inevitable and incomplete and/or inconsistent documentation can create problems for accountability.

It is appropriate the PoW be amended from time to time, both in order to accommodate changing needs and circumstances and also to reflect new knowledge, information and capabilities gained from investments in training and capacity building. In practice, however, the evolution of the PoW, and the basis on which initiatives have been added, removed, re-scheduled or re-costed may have been rather more ad hoc than was intended. Various versions of the PoW appear to have existed at any point in time with no single 'source of truth' being available for reference by all parties engaged in the SWAp.

The task of tracking changes to the PoW and monitoring deliverables is also complicated by the fact that the format used to present the PoW has altered several times during the life of the SWAp. The most recent change of format was made in response to a request by DPs following a Review Mission in December 2011, more than three years after the launch of the SWAp.

5.3. Governance and management of the SWAp

There appear to have been a number of weaknesses in the governance of the SWAp, many of which are attributable to shortcomings on the part of DPs.

For its part, MoH appears to have approached the task of managing the SWAp with energy and enthusiasm. While there are indications of some weaknesses in administrative processes, record keeping and supervision they appear to be less significant, and hence create less risk, than in many similar public sector bureaucracies. Of greater concern, however, is a perception that the Ministry has not always been fully open and transparent in its dealings with development partners. If valid, those views could be seen as indicative of poor policy dialogue leading to potential loss of trust.

Staff in the SCU report having encountered some significant challenges in the early stages of the program but they believe they have subsequently learned a great deal from the experience.

Concerns were expressed regarding possible conflicts of interest faced by MoH as a result of its dual responsibilities both for coordinating the SWAp within GoS and for delivering certain elements of the program. Some staff suggested that resource allocation under the SWAp had favoured MoH interests at the expense of NHS, private sector and NGO health care providers. In support of that view the Realignment Review Committee found that 'There was some concern about transparency in relation to training opportunities funded through the SWAp' and, as a

result, 'many people felt they missed out on much-needed training'.⁴⁴ Use of more explicit and transparent prioritisation processes to shape the PoW could help to alleviate such concerns.

A Financial Management Capacity Assessment conducted by the World Bank in November 2007 (almost one year prior to the launch of the SWAp) found that the program would be delivered in a 'moderate risk environment' and identified internal control weaknesses in the systems of the Ministry of Health and Ministry of Finance.⁴⁵ Subsequent financial management reviews carried out in June 2010 and June 2011 both rated overall financial management of the program as 'moderately satisfactory'. Successive review missions have also been generally positive in their comments on financial management and weaknesses, where they have been identified, appear in the main to stem from poor record keeping and/or data entry on the part of SCU staff.

As noted above, the process of establishing the SWAp was poorly co-ordinated and possibly rushed. It has also been suggested that there was a lack of clarity surrounding the respective roles of the three key pool partners (AusAID, NZ MFAT and World Bank) during the design phase. The decision to identify NZ MFAT as the 'Coordinating Development Partner' (and not subsequently to rotate the role among DPs as originally intended) was also questioned by some who viewed AusAID as having greater health sector expertise and a more significant financial exposure to the programme.

Adherence to the formal governance processes set out in the original JPA has been poor. Although DPs have conducted Review Missions broadly in line with expectations they appear to have been less than fully effective as a means to exercise oversight of the program. Aides mémoires do not follow a consistent format and 'action points' from one mission are not routinely reported on by the next.

While a degree of turnover among DP staff is to be expected, the variability in representation on review missions is a matter of some concern. Analysis of aides mémoires relating to nine missions that took place between September 2009 and November/December 2012 (see Annex 7 for details) reveals that:-

- a total of 32 different DP representatives took part
- the most consistent participation was by GoS, whose representative participated in eight of the nine missions
- three other representatives (two from NZ MFAT and a World Bank consultant) participated in five or six missions
- 15 representatives participated in just one or two missions.

More generally, DPs' project management (of the SWAp as a whole, rather than individual components) has been weak. Fundamental disciplines such as records management, change control (e.g. processes to agree, approve and record alterations to the PoW), version control for key documents, and risk management have not been afforded sufficient attention.

Increased effort during the initial stages of the SWAp to establish robust reporting formats and protocols, templates etc., would likely have yielded significant longer-term benefits.

⁴⁴ GoS (2011) *Review of the Ministry of Health Realignment. Report of the Review Committee.*

⁴⁵ Mphande, D. (2007) *Samoa Health Sector Wide Approach. Financial Management Capacity Assessment. Draft Report for Discussion.* World Bank.

DPs also appear at times to have been too willing to tolerate slippage in implementation and to accommodate missed deadlines. The frequency with which projects appear to have been 'rolled over' from one PoW to the next with little formal justification coupled with the apparent acceptance of GoS wish to redevelop the SWAp and forego the planned Mid-Term Review and Evaluation also suggest a degree of passivity that might have been unhelpful.

At a more fundamental level, DPs also appear to have allowed seemingly arbitrary changes to both the format and content of important documents which has, in turn, made obscured accountability arrangements.

The Paris Declaration's principle of alignment, which states that 'donor countries ... use local systems' ought not be used as a basis for neglecting basic disciplines of accountability and good project management.

Governance of a SWAp clearly presented a number of new challenges to all involved and revealed some significant weaknesses in DPs' systems and processes. It is difficult to attribute specific shortcomings in SWAp performance as a whole to those weaknesses. Nevertheless it is likely that better governance could have improved overall efficiency and effectiveness of the SWAp.

As noted by Negin in his review of the health SWAp in Samoa and Solomon Islands 'Systems that ensure greater harmonisation and coordination are new for development partners as well, and partner mechanisms are not necessarily ideally suited to make this transition seamlessly. The challenges that SWAp establishment brings to the fore represent a number of significant alterations to the manner of working of development agencies.'⁴⁶

5.4. Monitoring & Evaluation

As noted above, weaknesses in the SWAp's M&E framework have inhibited assessment of both program outcomes and SWAp processes.

Despite the emphasis placed on the need to establish a sound M&E framework during the design stages of the SWAp successive aides mémoires indicate that progress was slow. Specification of performance measures was inconsistent and availability of baseline data was, at best, patchy. The apparent mismatch between the SWAp M&E framework and that set out in the MoH Monitoring & Evaluation Operational Manual is also confusing.

Some of the indicators used for M&E are poorly defined, lack targets or benchmarks and/or are likely to be difficult to collect and interpret. Examples (drawn from the Program Operational Manual) include⁴⁷ :-

- 'improved medical waste management' – with no detail of how improvement is to be assessed
- 'demonstrated outcomes of training plan by component' – fails to specify types of training or outcomes to be measured
- 'disaggregation of data by sex, age and domicile enhances planning for services' – is a statement as opposed to a measure however if disaggregation is a desired output (as it should be) then failure to define which data (service

⁴⁶ Negin, J. 2010. *Sector-Wide Approaches for health: a comparative study of experiences in Samoa and the Solomon Islands*. Health Policy and Finance Knowledge Hub Working Paper No. 3. Melbourne: Nossal Institute for Global Health.

⁴⁷ GoS MoH. 2008. *Program Operational Manual for Samoa Health SWAp Program* (Tables 7.1 & 7.2)

utilisation, health status, participation in specific programmes etc) limits the value of this measure.

Completion of the DHS in 2009 has provided more data to support improved M&E but delays in implementing reliable health information systems that encompass both hospital- and community-based services have meant that ongoing performance assessment has been difficult.

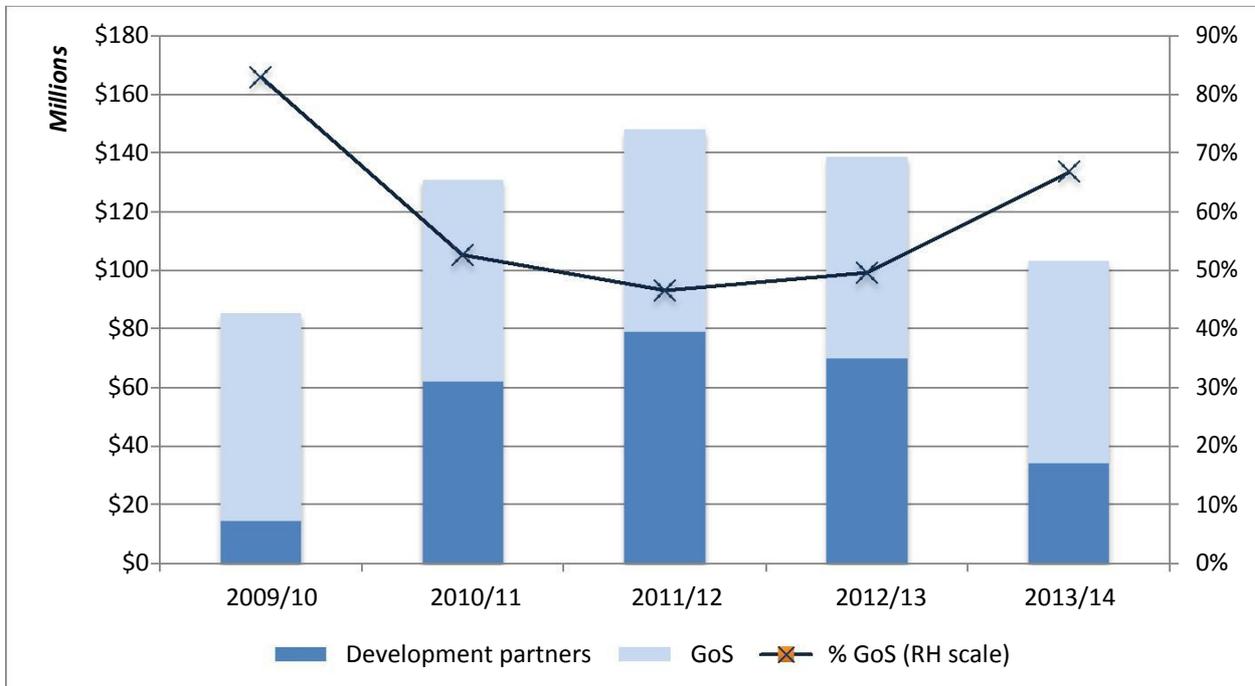
5.5. Medium term expenditure framework

The updated MTEF (MTEF2) provides a comprehensive overview of planned health sector funding over the period 2009/10 to 2013/14.⁴⁸ No copies of the previous MTEF (MTEF1) were available from either MoH staff or DPs consulted during the course of the review.

Review of MTEF2 and discussions with MoH and DP staff suggest that SWAp-related data in the MTEF were derived using a ‘bottom-up’ process of consolidating cost estimates for individual activities, as opposed to a more strategic, ‘top-down’ approach whereby an overall funding envelope would first be identified and used as the basis for deriving a prioritised PoW.

MTEF2 provides an overview of the respective roles played by GoS and development partners in funding Samoa’s health sector. In 2009/10 GoS funding for health was SAT\$70.6 million (US\$28.1 million) and accounted for about 83 per cent of total spending. In each of the next four years, however, GoS funding is shown to be steady at SAT\$68.8 million per year and to comprise between 47 per cent and 67 per cent of total spending (see Figure 3).

Figure 3: GoS and DPs’ contributions to health spending (2009/10 – 2013/14)



⁴⁸ GoS MoH. (Undated) *Update of the Medium Term Expenditure Framework for the Samoa Health Sector 2011-2015 (2nd edition)*

6. Summary assessment of the Samoa health SWAp

The terms of reference for the SWAp review list a number of specific questions to be addressed. They are summarised below, together with responses based on the analysis presented in earlier sections of this report.

Question/issue	Response
To what extent has the modality and delivery architecture been effective in reducing transaction costs and fragmentation, facilitating policy engagement and leveraging donor investments?	<ul style="list-style-type: none">• SCU staff report reduced transaction costs compared with previous project-based approaches – especially in the later years of the program• SCU costs account for approximately 4.7 per cent of total SWAp expenditure to 31 December 2012• MoH and DPs view reduced fragmentation as a positive aspect of the SWAp – multiple dialogues and reporting relationships have been successfully consolidated into a single communication channel• Meaningful policy engagement has been limited – successive PoW appear largely to have been derived by soliciting ad hoc proposals that are subsequently retro-fitted to HSP strategies and objectives and there is little evidence of collaborative efforts among DPs to operationalise strategic intent• The SWAp has not itself succeeded in attracting investments from additional DPs although it has coincided with significant investment in capital works on the part of PR China – SWAp is estimated to account for 22 per cent of health development expenditure, PR China 54 per cent

<p>Has the SWAP delivered the anticipated benefits in terms of more harmonized and aligned donor support, with increased health sector coordination, stronger national leadership and ownership, and strengthened countrywide management and delivery systems?</p>	<ul style="list-style-type: none">• The SWAp has reinforced the sector-wide leadership role of MoH although ambiguities remain with regard to some aspects of the health sector realignment• The SWAp may have served to highlight the over-ambitious nature of the HSP and its lack of clear prioritisation and/or sequencing of initiatives• SCU staff appear to have gained confidence and competence over the life of the SWAp• NHS has played a limited role in developing PoW and overseeing implementation of some elements• SCU's location within MoH is perceived as having driven a 'MoH-centric' view of the sector which has inhibited effective coordination between MoH and NHS• Involvement of other health sector players in planning and priority-setting has been limited although there has been investment in village-level prevention and health promotion initiatives• Strengthening of delivery systems has occurred, notably through staff training and capacity building but delays in some key capital works projects have been unhelpful (notably primary care centre and orthotics/prosthetics facility)• Significant funding for hospital development by PR China which was not foreseen in HSP has distorted spending priorities and weakened focus on primary/preventive services as envisaged by SWAp
<p>Comment on the results framework and monitoring processes, including the utility of the Aides Memoires, review missions and processes.</p>	<ul style="list-style-type: none">• Weak M&E has been a significant obstacle to assessing progress and measuring achievements throughout the life of the SWAp• Some M&E measures are poorly defined and/or meaningless• Early completion of DHS (reportedly to a high standard) was a worthwhile investment to establish baseline indicators• Failure to progress HIS development has constrained ability to collect and consolidate health service activity data• DPs' monitoring processes have been poor – characterized by inadequate record keeping, poor documentation, weak project management, inconsistent reporting and 'revolving door' staffing

<p>To what extent has the Program supported the implementation of the government's HSP?</p>	<ul style="list-style-type: none">• Overall Program structure comprises three components that directly reflect HSP objectives• SWAp activities have largely been consistent with HSP but its underlying program logic was not always clear• Progress towards some HSP priorities (e.g. immunisation rates) has been poor
<p>To what extent has the program filled a financing gap?</p>	<ul style="list-style-type: none">• SWAp has contributed significantly to health sector financing over the period 2008/09 to 2013/14 – health has accounted for 12 – 18 per cent of government expenditure, and some 7 per cent of GDP over that period• GoS funding for health is projected to remain static over the same period• US\$3 million additional funding was provided to support post-tsunami activities• If SWAp and PR China construction projects were excluded there would have been little change in development budget over the periods covered by MTEF1 and MTEF2.
<p>To what extent has the Program supported systems strengthening via a relevant, efficient, harmonised and aligned program of technical cooperation?</p>	<ul style="list-style-type: none">• Relevance is suggested by PoWs' conformance with HSP strategies and objectives which, in turn, reflect Samoa's health situation - although it is difficult to assess whether other, more relevant investments might have been possible within the framework of the SWAp• Robust procurement processes and seemingly modest overhead costs suggest a reasonable level of efficiency - although procurement delays have undoubtedly impeded progress and hence reduced efficiency in some areas• Harmonisation has been achieved through donors' adherence to common arrangements for planning, funding, monitoring, reporting etc; division of labour between donors and GoS appears to have been appropriate; and transparency of reporting etc has been good• Alignment of technical cooperation has been limited – donors appear only to have come together to address issues via six-monthly review missions and there has been little or no joint analytical or capacity building work• The SWAp has been reasonably well-aligned with GoS strategies, institutions and procedures – although donors may have been rather too reticent to propose more robust systems and processes when they might have been helpful

<p>To what extent has the program held actors mutually accountable and focused on managing for results?</p>	<ul style="list-style-type: none"> • Weaknesses in M&E coupled with poor governance have inhibited a focus on results and limited capacity to enforce accountability • Inconsistent format and content of key documents is not conducive to effective accountability over time
<p>To what extent has the program leveraged financial investments through effective dialogue around any critical health systems challenges?</p>	<ul style="list-style-type: none"> • Donors' response to tsunami was quick and seemingly effective • PR China capital works programme may have diverted resources and managerial attention from key challenges in NCD, prevention and primary care as identified in HSP – suggests SWAp has had limited impact in leveraging investments to reflect priorities
<p>How far is the SWAp aligned with the priority needs of the sector, the GoS sector strategy, the MoH and NHS multi-year planning processes, and with the strategic priorities of the funding partners?</p>	<ul style="list-style-type: none"> • Links between HSP and detailed analysis of health needs is not apparent • The SWAp is aligned with HSP but strength of alignment and underlying logic are not clear • Suggestion that SWAp has driven MTEF rather than vice-versa – similarly PoW based on bottom-up aggregation of individual projects as opposed to top-down approach to operationalise HSP
<p>To what extent has the program provided value for money and returns on donor investments in terms of systems strengthening and service delivery?</p>	<ul style="list-style-type: none"> • Program has undoubtedly delivered results in terms of systems strengthening and service delivery but absence of reliable metrics and/or counterfactual means formal assessment and analysis of opportunity costs is impossible
<p>To what extent has the program been a sound investment by increasing equity?</p>	<ul style="list-style-type: none"> • SWAp has funded a number of outreach services aimed at rural communities • Programme outcome indicators address 'disaggregation of data by domicile' and 'share of annual outpatient visits by poorest quintile of population' – DHS, STEPS and proposed HIS will provide the former but no data on the latter are yet available • Investment in hospital facilities (and any subsequent 'knock-on' impacts on SWAp priorities) may unduly favour urban communities

<p>To what extent was the program design appropriate to the political, policy and fiscal context?</p>	<ul style="list-style-type: none">• GoS has had previous experience with SWAp (in water and sanitation and education sectors) and Ministry of Finance appears to have good capacity to serve as executive agency• Establishment of SWAp soon after health sector realignment created additional tensions and some confusion• Suggestions that policy/operational split between MoH and NHS is still evolving and lack of clarity in some aspects may have complicated aspects of SWAp implementation
<p>To what extent has the SWAp laid a foundation for future donor engagement?</p>	<ul style="list-style-type: none">• SWAp has required close collaboration between donor partners and GoS• Progress to date in capacity building, training and improving management processes within MoH and NHS should establish a stronger foundation for future investments
<p>How well have gender equity and disability inclusiveness been integrated into the program and how could they be improved?</p>	<ul style="list-style-type: none">• Few explicit references to gender equity or disability inclusiveness in SWAp-related documentation (HSP, PoW, M&E etc) or in aides mémoires prepared by DPs• NGOs play a lead role in many disability support services and may have had insufficient opportunity to participate in SWAp• PoW includes a strategy to 'Improve maternal and child health' but progress appears to be slow – IFR for December 2012 indicates only 0.3 per cent of budget for planned cervical screening programme had been disbursed

7. Recommendations for the future

The current SWAp is scheduled to conclude at the end of 2013 although there is the potential for donors to agree to a six-month 'no-cost extension' to allow implementation of SWAp-related initiatives to continue until mid-2014.

Among existing DPs, AusAID and NZ MFAT have indicated their willingness to maintain support for Samoa's health sector. The World Bank's position is less clear. GoS is keen to see a continuation of development assistance for health.

Recommendations stemming from the current review can be divided into:-

- issues to be addressed by the current SWAp; and
- options for future support to health in Samoa.

7.1. Issues to be addressed by the current SWAp

In light of the limited time still available to the current SWAp and the scale of sunk costs (in terms of systems and processes) the immediate focus should be on ensuring activities over the next year maximise returns on investment to date.

Based on the findings of this review, suggested priorities to enhance the current SWAp during the remainder of its life are as follows:-

- confirm final PoW
- prioritise key projects
- strengthen project management

7.1.1. Confirm final PoW

Frequent changes to the PoW, coupled with uncertainty regarding the status of different versions, have been a source of confusion and possible delay in project implementation.

According to its original timetable the SWAp now has less than one year left to run and a significant proportion of total funding has yet to be committed. It should be possible for all parties to be able to establish a comprehensive project plan (in the form of an agreed final PoW) to cover a 12-15 month period and, once established, to collaborate and ensure its delivery.

Such a plan/PoW should be realistic in terms of what it sets out to achieve and should have sufficient detail to permit close monitoring. It is likely to include significantly fewer projects than the current PoW, with those that are excluded possibly being considered for inclusion in any future programme.

7.1.2. Prioritise key projects

In preparing the final PoW particular attention should be paid to a number of projects which either address key challenges identified by GoS, reflect funding partners' strategic priorities or have the potential to establish a firmer foundation for future support to the health sector.

Specific priority projects might include:

- outstanding/incomplete post-tsunami projects
 - development and implementation of HIS
 - orthotics & prosthetics facility and primary care centre (possibly 'packaged' with the pharmaceutical and medical supplies warehouse)
 - cervical screening programme
 - establishment of Health Promotion Foundation.
-

7.7.3. Strengthen project management

The SCU should be tasked with managing implementation of the final PoW, possibly with additional short-term TA to put in place rigorous project management processes (which could prove to be of value to any post-SWAp program).

For their part, DPs should also implement more intensive monitoring arrangements for the remainder of the SWAp. Six-monthly review missions will need to be supplemented by more regular, albeit less formal, meetings to review progress and provide additional support as required. Apia-based staff are well placed to conduct such meetings.

7.2. Options for future support to health in Samoa

Three options for any future support to health in Samoa have been identified. They are:-

- return to project-based support (possibly via a managing contractor)
- move to sector budget support
- establish a second SWAp.

7.2.1. Return to project-based support

Prior to the current SWAp AusAID, NZ MFAT and the World Bank all partnered with GoS in health sector projects. Those projects were generally seen to be successful but there was a clear desire, on the part both of GoS and of DPs, to move towards a more harmonised and collaborative approach.

The SWAp is viewed as having delivered benefits for Samoa as well as reducing transaction costs and supporting MoH efforts to adopt a whole-of-sector view. Staff within the SCU, and elsewhere in the sector, have invested significant time and effort in acquiring new skills required to operate within the SWAp environment. Having experienced successful SWAps in other sectors, GoS is a strong supporter of the modality.

As this report explains, the SWAp has had significant shortcomings. GoS and DPs have all, at times, failed fully to meet the ambitious expectations expressed at the time the program was launched.

It is not possible to assess whether the SWAp was more or less successful than continuation of the previous project-based approach might have been. It was not a controlled trial. What is clear, however, is that GoS would most likely view a return to a project-based approach unfavourably. It would be viewed as unjust and disproportionate 'punishment' for the weaknesses of the SWAp, not all of which can be attributed to GoS.

Adoption of a project-based approach might be viewed by DPs as a means to ensure that the failures of the SWAp were not repeated; but there can be no guarantee they would not be replaced by other failures within the project context. A return to project-based support could also constrain DPs' ability to engage meaningfully with GoS on broader dialogue on sector-wide reform.

A more constructive and developmentally appropriate approach would be to seek to 'lock-in' the gains achieved through the SWAp while also working to ensure that its weaknesses are eliminated.

7.2.2. Move to sector budget support

Moving to sector budget support may be viewed as representing a further step towards the vision of country-led development assistance as exemplified by the Paris

Declaration. As such it can also be seen as the logical progression from a SWAp-type approach.

In the case of Samoa, the water and sanitation sector has made the transition from a SWAp to sector budget support.

Many in the Samoan health sector are eager to see any post-SWAp assistance using a sector budget support approach. Their views are tempered by others who consider that national systems and capabilities are not yet sufficiently well developed to ensure the effectiveness of sector budget support.

Discussions with MoH and other GoS representatives highlighted the following pre-requisites for sector budget support to function effectively:

- robust arrangements for sector-wide stewardship
- strong financial management
- effective sector-wide planning and priority setting mechanisms
- sound sector-wide M&E with performance measures aligned to sector plans and priorities
- clearly-defined institutional arrangements, and well delineated roles, within and between the public and private sectors

While Samoa has achieved a great deal in respect of such issues over the past four years it is clear from this review that more needs to be done. In particular, the role of MoH as an impartial and independent steward of the sector as a whole is still evolving, and there is both a need and an opportunity to strengthen planning, priority setting and M&E approaches.

Moving to sector budget support for health at the present time could result in misalignment between priorities and actual allocation of resources, while the lack of effective, sector-wide M&E mechanisms and poorly developed HIS would inhibit monitoring of sector performance by GoS and DPs alike.

Sector budget support, if implemented, would also need to be underpinned by an effective framework of incentives and sanctions in order to ensure meaningful commitment to on-going policy dialogue and enable DPs' to continue to drive reform.

Adoption of sector budget support for health is rightly viewed as a medium term goal for Samoa. Based on the evidence available, however, it could be premature to pursue that goal immediately on completion of the current SWAp.

7.7.3. Establish a second SWAp

Establishing a second five-year SWAp (to run from 2014 – 2018) would allow GoS and DPs to build on the achievements to date while also taking steps, from the outset, to eliminate some of the weaknesses encountered in the current program. It represents a sensible mid-course between the other options outlined above and would also allow all parties more time to prepare for an eventual move to sector budget support.

The timing for development of a second SWAp (referred to here for convenience as SWAp2) is opportune:

- the DHS and STEPS surveys prepared under the current SWAp provide a sound basis for identifying future priorities and defining baseline performance measures
 - the plan to develop an improved HIS should allow better monitoring of health service utilisation
 - the current mid-term review of the HSP provides an opportunity to 'refresh' the HSP for the coming five years – and thus to identify priorities for SWAp2
-

- AusAID's recently-published Pacific Health Development Agenda provides guidance on the Agency's priorities for health in the region
- AusAID has recently increased its Apia-based specialist health sector expertise while NZ MFAT will shortly be appointing a new Samoa-based Manager for its aid programme

Factors that need to be addressed in developing a possible SWAp2 include the following:

- stronger planning and priority setting – the period leading up to the launch of a possible SWAp2 provides an ideal opportunity for DPs to engage with the health sector in Samoa (under the leadership of MoH) to support the preparation of a revised HSP and to facilitate the development of a revised PoW which is more closely linked to sector strategies, objectives and priorities;
- better M&E – the development of a realistic and relevant M&E framework, and compilation of comprehensive baseline data should be a pre-condition for establishment of SWAp2;
- improved governance on the part of DPs - there is a need for DPs to adopt more rigorous project management disciplines for the programme as a whole; to improve the focus, consistency of approach and follow-up on action points by Review Missions; to strengthen record keeping; and to be more assertive in seeking reports etc from country counterparts;
- consideration of a more meaningful incentive framework – a second SWAp might include provision for a proportion of DPs' funding to be made contingent on achievement of specific intermediate goals, both in respect of program outcomes and SWAp processes (akin to the monitoring and evaluation framework adopted for the current SWAp);
- development of pro-formas and templates for reporting – there is scope for DPs to work with SCU staff to reflect on experience to date and develop a comprehensive set of spreadsheet-based reporting formats which all parties can agree to use consistently throughout the life of the SWAp, thus alleviating many of the problems attributable to poor version control and inconsistent reporting formats during the current program.

While by no means universally endorsed, it was also suggested there might be merit in reconsidering the role of MoH as Implementing Agency for SWAp2. In other sectors the Ministry of Finance has acted as Implementing Agency and appears to have been successful in adopting an impartial, sector-wide view. Adopting a similar approach for a future health SWAp could be useful as a means to clarify and reinforce the institutional arrangements established under the health sector realignment.

If the period of time before the launch of a second SWAp can be put to good and productive use in addressing the issues outlined above (together with the outstanding issues to be addressed by the current SWAp as discussed on page 34) establishment of SWAp2 is clearly a feasible and attractive option.

Annex 1 Terms of Reference

Monitoring and Evaluation Specialist

Evaluation of Samoa Health Sector Management Programme (Health SWAp)

Terms of Reference (January 2013)

Background

Health Sector:

In Samoa, the structure of the health system is a somewhat complex arrangement which has a number of implications for Development Partners. In 2006, following calls for changes to the organization and management of the sector a reform process (coined 'The Realignment') was undertaken. It resulted with the Ministry of Health and National Health Services being split and provided with separate legislative mandates⁴⁹. The management system was also revamped and strengthened to bring about shifts in authority. Resources were reallocated to support the new role of the MOH as health sector regulator and NHS as a service provider. The reform agenda was also designed to reorient the sector towards a population-health approach, aiming to strengthen primary health care services for the most vulnerable groups. Greater emphasis was placed on health promotion, protection and prevention services as opposed to curative services.

The reform saw the MOH reorient their focus to be one of governance, which included strategic planning, regulation, monitoring and evaluation, standards setting, and performance management⁵⁰. They also became responsible for managing the budgets of state health entities, human resources and providing policy direction over primordial health promotion and prevention services.

As the Government agency responsible for the provision of health care services, the National Health Services account for 80% of the public health sector budget⁵¹. Their network of health services comprises of national referral hospitals *Tupua Tamesese Meaole II* (TTM) Hospital and *Maliotoa Tanumafili II* (MTII) in Savaii, as well as six district hospitals and 13 community health centres. All primary health care facilities are staffed by nurses, with limited scheduled visits by physicians. Specialised care not available in Samoa is provided to some patients via overseas treatment programs, funded by the Samoan and NZ Governments, or at great personal expense.

There is an expanding private health sector, including private medical clinics, private pharmacies, dental practices, an estimated 900 traditional healers (including Traditional Birth Attendants)⁵², alternative therapists (acupressure clinic, chiropractic, myotherapy) and private physiotherapists. The only private hospital, Medcen, was recently acquired by the GOS when it ran into financial issues after reportedly being poorly run.

In 2009 the Euro Health Group was commissioned to review Clinical Services in Samoa and produced the *TTM Hospital Clinical Services Plan*. This concluded that while the overall health care services model in Samoa provided good value, the system would require upgrades to the general hospital services to comply with accepted clinical standards. A recommendation was made to replace existing

⁴⁹ MOH annual report 2006-07

⁵⁰ Ibid

⁵¹ National Health Accounts; 2004-05, MOH

⁵² Ibid

structures with a new tightly integrated teaching hospital. The Government of Samoa sought a loan from the People's Republic of China and construction is now nearing completion.

Sector Wide Approach (Health SWAp):

Two years after the realignment in July 2008, the Government of Samoa signed a Joint Partnership Arrangement with key development partners (AusAID, World Bank, NZ Ministry of Foreign Affairs and Trade's Aid Programme (MFAT), WHO, UNFPA, UNICEF, SPC) with leadership provided by GOS establishing the architecture and relationships for a sector-wide approach in the Health Sector.

The Health Sector Management Program Support Project (known as the Health SWAp) was designed to help the Government of Samoa (GoS) implement the first five-year period of its Health Sector Plan (FY 2009-2018). Under the Health SWAp it is intended that the development partners' funds are used together with the Government's own sector budget. MFAT is responsible for donor coordination and arrangements in their role as lead development partner (DP). The World Bank provides all procurement and fiduciary management oversight of the Health SWAp.

The Health SWAp has three components

- (i) Health Promotion and Prevention;
- (ii) Enhancement of Quality Health Care Service Delivery; and
- (iii) Strengthening Policy, Monitoring and Regulatory Oversight of the Health System.

It is the first time this mechanism has been undertaken in Samoa. The development objective was to *improve the effectiveness of the Government of Samoa in managing and implementing the Health Sector Plan using results from Sector Performance Monitoring.*

The medium term aim (2009-2013) is to *improve access to and utilisation of effective, efficient and quality health services to improve the health status of the Samoan population.*

Implementation is based on an annually revised and agreed programme of work and budget, a framework to monitor results (known as the PAD indicator table), and a rolling procurement plan and procurement supervision process, and coordinated by a Health SWAp coordination structure and a unit based in the Ministry of Health (MoH).

During 2010/11, shared concerns on slow progress, an inputs-focussed programme of work, procurement difficulties, and a lack of results reporting and whole of sector perspective, led to a redevelopment process which amended some of the structural elements of the design. Since then, a new programme of work has been developed providing a stronger overview of work within the sector against the sector plan. A restructured Health Advisory Committee (HAC) has been established with a Terms of Reference that require an overview of the sector; more intensive procurement and management support to assist the rate of implementation, procurement and expenditure; reporting frequency has been reduced but with stronger expectations on the sector coverage, timeliness and quality.

Timing

This evaluation comes as the Health SWAp has completed four years of implementation, has fully programmed a revised envelope of around USD \$29.3m, and expended USD \$12.3m as at 31 September 2012.

While the Health SWAp clearly has a considerable portion of the programme yet to implement, it has been agreed that it is preferable to evaluate the Health SWAp as a

management tool for improving the harmonisation and alignment of aid to the health sector and its achievements at this point so as to allow the findings to usefully feed into planning for subsequent engagement in the Health Sector.

In January 2013 the MoH will undertake a mid-term review (MTR) of the Health Sector Plan (HSP).⁵³ While separate terms of reference and plan of work have been developed for the mid-term review of the HSP there are some expected synergies between the two reviews and given the relatively small size of the sector it was agreed, during the Joint Donor Mission in October 2012, that a single review process (where possible and suitable) with separate outputs was appropriate.

HRF will provide a consultant for the review of the Health SWAp and the broader review will be led by the MoH. Liaison and arrangements in-country will be provided by the SWAp coordination unit (ACEO Strategic Planning, Policy and Research Division (SPPR) and ACEO Health Sector Coordination, Resourcing and Monitoring (HSCRM)) and AusAID's health specialist.

Purpose

The purpose of this evaluation will be for the consultant to independently assess the program. The assessment will cover:

- The evaluator/consultant should determine the modality and established delivery architecture and comment on its effectiveness to date in reducing transaction costs and fragmentation, facilitating policy engagement and leveraging donor investments.
 - Consultant to assess and compile findings to determine if the SWAP delivering the anticipated benefits in terms of more harmonized and aligned donor support, with increased health sector coordination, stronger national leadership and ownership, and strengthened countrywide management and delivery systems?
 - Consultant to assess and provide substantial comments on the results framework and monitoring processes, including the utility of the Aid Memoirs, review missions and processes.
- The consultant should determine the extent to which the program has supported the implementation of the governments HSP; the consultant to compile substantial findings;
 - in terms of filling a financing gap;
 - in supporting systems strengthening via a relevant, efficient, harmonised and aligned program of technical cooperation;
 - in supporting delivery of the HSP and improving service delivery by holding actors mutually accountable and managing for results;
 - in terms of leveraging financial investments through effective dialogue around any critical health systems challenges.
 - How far is the SWAp aligned with the priority needs of the sector, the GoS sector strategy, the MoH and NHS multi-year planning processes, and with the strategic priorities of the funding partners?

⁵³ The objectives of the MTR are to measure progress toward achieving the goals, objectives and key strategies of the plan, derive lessons learnt from its implementation over the four (4) year period and develop policy options and strategies for the updating of the HSP.

- The consultant's evaluation will determine the extent to which the program has provided Value for Money; returns on donor investments in terms of systems strengthening and service delivery. To what extent has the program been a sound investment?
 - Including: to what extent has it added value (TA, policy, governance, architecture of the health system, managing for results) and reduced duplication, lowered transaction costs, increased equity and sustainability, and improved aid effectiveness and health sector efficiency?
- Given the above and progress to date; the consultant will determine to what extent was the program design appropriate to the political, policy and fiscal context? To what extent has it laid a foundation for future donor engagement and what are the critical lessons for the design of any future program.
- Consultant to provide findings on how well have gender equity and disability inclusiveness been integrated into the program and provide recommendation on improvements that could be made to strengthen gender and disability

The results of the evaluation will be disseminated to the Government of Samoa and all Development Partners in the Health Sector and discussed at the HAC. A summary of some of the key findings will also be made available publically.

Scope

The time period covered under the evaluation is **June 2008 to date**.

The target groups include health professionals (both public and private), health education agencies, the relevant sectoral and central agencies of the Government of Samoa, the relevant political leadership of Samoa, and the development partners (in-country and HQ). Annex 1 contains a suggested list of stakeholders.

1. Principles/approach

The principles that will underpin this evaluation will be:

- Rigour in the evaluation method and justification of findings;
- Independence in that while the team will consult widely and openly and gather many views, the final report will be the view of the evaluation team;
- Groundedness in that the team will carefully locate the evaluation in its Samoan context and consider the contextual factors within which all health activities operate;
- Constructive in that the team will take a learning oriented approach proposing how in future, positive findings may be sustained and built on and how weak areas may be addressed;

Methods

The methods should encompass review of relevant literature, including analytical work from World Bank PF3, relevant policy and performance frameworks from donors⁵⁴, key informant interviews (operating at different levels within the sector and sector organisations), document review, budget analysis, data sources etc.

While an independent report is sought, it is expected that a consultative approach and careful validation of the findings will be undertaken.

⁵⁴ Including the AusAID Pacific Health Development Agenda

Monitoring and evaluation specialist

The evaluation is commissioned by AusAID and the evaluator will be accountable to AusAID. However, oversight of the evaluation process will be the responsibility of the Health Advisory Committee who will also facilitate access to key stakeholders within the Ministry of Health, Ministry of Finance and NHS. This evaluation will be undertaken by a contractor engaged from AusAID's Health Resource Facility (HRF). HRF's Specialist Pool, is group of high-level consultants who offer advice on support to AusAID on strategic issues, through a call-down arrangement.

The successful candidate should possess necessary attributes (knowledge, skills, experience) required to execute the SWAp evaluation. The Monitoring and Evaluation Specialist:

- Must be an experienced evaluator with health systems expertise;
- Must have direct experience of a sector programme, preferably in health, working through partner government systems including in mature and larger programmes using SBS;
- Must have knowledge and substantial experience of implementing effective responses to Non-Communicable Diseases in a developing country, preferably Pacific context;
- Must have excellent written and presentation skills.

Milestone and Timeframe

The contractor will ideally begin in week of 4 February 2013 so the evaluation may be endorsed by Health Advisory Committee by 31 March 2013. The following table outlines the output/ milestone and timeframe for the specialist:

No.	Output/milestone	Description	Inputs	Due date
1	Evaluation plan	Literature review, briefing and finalised evaluation plan	3	26 February
2	Field work complete	Field work complete and draft findings provided to stakeholders during a stakeholder workshop	10 days in-country field work	4-14 March
3	Draft report	Preparation of the draft report and submission to Health Advisory Committee	6 days	5 April
4	Final analytical report (30 pages not including annexes)	Acceptance/approval by Health Advisory Committee after any revisions of the draft are completed, and debriefing	3 days	1 week after receipt of comments (est. 26 April)

Reporting

The Government of Australia provides general guidelines and formats for documentation. Draft reports will be clearly marked as drafts and will have the revision date noted on the cover. All reports must be provided in the format and on the media approved or requested by AusAID/HRF.

Relevant documents including but not limited to the programme of work, Aide Memoires from the six monthly joint review missions, Joint Partnership Agreement as well as analytical work conducted under the auspices of the SWAp, previous situational analyses and key donor strategic documents, including the AusAID CAPF and Pacific Health Development Agenda, will be provided to the consultant prior to the evaluation.

Annex 1

MINISTRY OF FINANCE (MOF)	
Peseta Noumea Simi	Assistant Chief Executive Officer, Ministry of Finance Health Advisory Committee Chairperson
Oscar Malielegaoi	Assistant Chief Executive Officer Budget Division
MINISTRY OF HEALTH (MOH)	
Palanitina Tupuimatagi Toelupe	Director General, Chief Executive Officer
Pelenatete Stowers	Assistant Chief Executive Officer, Nursing and Midwifery
Frances Brebner	Registrar
Ualesi Falefa Silva	Assistant Chief Executive Officer, HPPS & CFP 1
Gaulofa Matalavea Saaga	Assistant Chief Executive Officer, HSCRM
Sarah Faletoese Su'a	Assistant Chief Executive Officer, SDPD
Sosefina Talauta Tualaualelei	Assistant Chief Executive Officer, CSD
Darryl Anesi	Program Accountant
Richard Tafua	Accountant
Violet Aita	Procurement Specialist
Victoria Ieremia Faasili	Principal Component Assistant
NATIONAL HEALTH SERVICE (NHS) OF THE MINISTRY OF HEALTH	
Tupuola Koki Tuala	NHS Board Chairman
Leota Laki Sio	General Manager
Kassandra Betham	SWAp Manager / CFP2
Dr Tia Vaai	Head of Clinical Services
NEW ZEALAND AID PROGRAM	
Pete Zwart	Manager New Zealand Aid Program (Samoa)
Marion Clark	Development Manager Health New Zealand Aid Program (Wellington)
AUSTRALIAN AGENCY FOR INTERNATIONAL DEVELOPMENT - AusAID	
Megan Counahan	Health Specialist (Samoa)
Ben Rolfe	Senior Health Specialist (Canberra)
UNITED NATIONAL FUND FOR – UNFPA	
Virisila Raitamata	UNFPA Representative (Fiji)
WORLD HEALTH ORGANIZATION – WHO	
Dr. Yang Baoping	WHO Representative (Samoa)
Brooke Conway	WHO
WORLD BANK	
Eva Jarawan	Lead Health Specialist (Washington)
Eileen Brainne Sullivan	Health Specialist (Washington)
Stephen Hartung	Financial Management Specialist (Sydney)
Miriam Witana	Procurement Specialist (Sydney)
Maeva Natacha Betham Vaai	Liaison Officer (Samoa)

Annex 2 Interviews conducted

Name	Position
Ms Violet Aita	Procurement Specialist, MoH
Mr Darryl Anesi	Program Accountant, SCU, MoH
Ms Cassandra Betham	SWAp Manager, NHS
Ms Frances Brebner	Registrar, MoH
Ms Frances Brown-Reupena	Water & Sanitation Sector Coordinator, Ministry of Natural Resources & Environment
Dr Megan Counahan	Health Specialist, AusAID Samoa
Dr Joan Macfarlane	Consultant HPS MTR (MoH)
Ms Gaulofa Matalavea	Manager, SCU, MoH
Ms Karen Viliamu Punivalu	Senior Development Programme Coordinator, International Development Group, New Zealand Ministry of Foreign Affairs and Trade
Mr Ben Rolfe	Senior Health Specialist, AusAID Canberra
Ms Uelesi Falefa Silva	ACEO, HPPS, MoH
Ms Peseta Noumea Simi	ACEO, MoF & Health Advisory Committee Chairperson
Mr Anthony Stannard	Counsellor Development Cooperation, AusAID Samoa
Ms Pelenatete Stowers	ACEO, Nursing & Midwifery, MoH
Ms Sarah Faletoese Su'a	ACEO, SDPD, MoH
Ms Palanitina Tupuimatagi Toelupe	Director-General & CEO, MoH
Dr Baoping Yang	WHO Representative, Samoa
Mr Pete Zwart	Manager, NZ Aid Program, Samoa

Annex 3 Documents reviewed

- *Health Sector Plan 2008-2018*, GoS MoH (2008)
 - *Samoa Country Profile*, SPC (2008)
 - *Program Operational Manual for Samoa Health SWAp Program*, GoS MoH (2008)
 - *Program Appraisal Document ... in support of Health Sector Management Program*, World Bank (2008)
 - *Samoa: Review of the Tupua Tamasese Meaole Hospital Masterplan* Euro Health Group (2009)
 - *Redevelopment of the Health SWAp Program*, GoS MoH (2011)
 - *Health SWAp: Inception Report*, GoS MoH (2011)
 - *Review of the Ministry of Health Realignment*, GoS Review Committee (2011)
 - *Update of the Medium Term Expenditure Framework for the Samoa Health Sector 2011-2015 (2nd edition)*, GoS MoH (Undated)
 - *SWAp Workplan: FY2010-2011:-*
 - Component 1 – Health promotion and prevention
 - Component 2 – Enhancement of quality health care service delivery
 - Component 3 – Strengthening policy, monitoring and regulatory oversight of the health system
 - *Monitoring & Evaluation Operational Manual*, GoS MoH (2011)
 - *Whole of Country 'One-Health' Integrated Programme for Healthy Living: Village Health Fair Report (Sep 2010 – Aug 2011)*, GoS MoH (2011)
 - *Health Financing Options for Samoa*, World Bank & GoS (2012)
 - *In Sweet Harmony? A Review of Health and Education Sectorwide Approaches (SWAps) in the South Pacific: Phase 1 of a Joint Learning Initiative*, AusAID, NZ MFAT & World Bank (2012)
 - *A Literature review of the Health Situation in Samoa*, AusAID (2012)
 - *Country Cooperation Strategy, Samoa, 2012 – 2018*, WHO Western Pacific Region (2012)
 - *Health Sector Program: Progress report (July – Dec 2012)*, GoS MoH (2013)
 - *Quality at Implementation Report for Samoa Health Sector Support*, AusAID (February 2013)
 - *Health Sector Program Progress Update (July – Dec 2012)*, GoS MoH (2013)
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- *Aides Memoires: Samoa Health SWAp Program:-*
 - June 2006
 - November/December 2006
 - April 2007
 - October 2007
 - April 2008
 - October 2008
 - September 2009
 - February 2010
 - November 2010
 - April 2011
 - December 2011
 - March 2012
 - October/November 2012

Annex 4 Programme of work as detailed in SWAp Inception Report⁵⁵

Component	Key sector areas	Activities	
		Number	SWAp funding (SAT\$)
1. Health promotion and prevention	• Health promotion strategies	15	\$1,674,448
	• Non communicable diseases	7	\$1,024,720
	• Infectious diseases and vector control	5	\$878,300
	• Injury prevention	1	\$258,900
	• Health care waste development	2	\$380,300
2. Enhance quality health service delivery	• Upgrading the skills of the health workers	19	\$625,148
	• Reproductive, maternal & child health services	2	\$260,000
	• Improved primary health care and community health outreach	7	\$4,408,300
	• Improved forecasting & management of pharmaceutical requirements	2*	\$200,000
	• Physical disability services improvement	3*	\$0
	• Oral health and dentistry	6*	\$944,539
	• Blood safety collection and storage	0	\$0
	• Mental health services	1*	\$0
	• Infrastructural improvements and medical equipment	11	\$9,713,000
3. Strengthen policy and regulatory oversight of the health system	• Human resources development strategy	10	\$2,795,411
	• Monitoring & evaluation	6	\$500,913
	• Public-private partnership	1	\$496,600
	• Strengthening quality assurance	3	\$83,200

* Note: Includes activities funded outside the SWAp

⁵⁵ Crawley, UB. (2011) *Health Sector-Wide Approach (SWAp) Program: Inception Report. Annex 5*

Annex 5 SWAp monitoring and evaluation framework (April – July 2008)^{56,57}

Program development objective	Impact indicators
<p>The proposed health sector program's objective in the medium-term (2009-2013) would be to improve access to, and utilization of effective, efficient and quality health services to improve the health status of the Samoan population.</p>	<p>Control of non-communicable diseases</p> <ul style="list-style-type: none"> • Prevalence of diabetes <p>Improved maternal and child health</p> <ul style="list-style-type: none"> • Perinatal mortality rate <p>Universal access to reproductive health services</p> <ul style="list-style-type: none"> • Adolescent birth rate <p>Control of communicable diseases</p> <ul style="list-style-type: none"> • Incidence of water- and foodborne infections (To include S. Typhi) <p>Injury prevention and management</p> <ul style="list-style-type: none"> • Injuries in children (under 15 years)
Intermediate results	Results indicators for each component
<p>Component 1: Health Promotion and Primordial Prevention</p> <p>Supporting the transformation of the health sector from a medical model towards wellness orientation and health promotion</p>	<ul style="list-style-type: none"> • People aged 18 yrs and over overweight or obese • Percentage of children under 1 year received at least one dose of measles vaccine • Improved medical waste management
<p>Component 2: Quality Health Services</p> <p>Improving the quality of health services through strengthened human resources, standards, supplies, equipment and infrastructure</p>	<ul style="list-style-type: none"> • Primary care utilization by gender, age, domicile • Antenatal care coverage for at least one visit • Proportion of Rheumatic Heart Disease patients complying with treatment
<p>Component 3: Improving Policy, Monitoring and Regulatory Oversight of the Health Sector</p> <p>Support the MOH in its policy development, coordination and regulation of the sector</p>	<ul style="list-style-type: none"> • Staff mix and distribution according to national standards • Evidence of performance monitoring leading to policy and regulatory action to improve health services • Demonstrated outcomes of training plan by component

⁵⁶ GoS MoH. 2008. *Program Operational Manual for Samoa Health SWAp Program* (Tables 7.1 & 7.2)

⁵⁷ Independent State of Samoa, AusAID, NZAID, IDA, UNFPA, UNICEF & WHO. 2008. *Joint Partnership Agreement – Samoa Health Sector Program FY 2009-2013*.

Objective	Health SWAp Process Monitoring Indicators
<p>Health SWAp institutional development objective: To improve the effectiveness of the Government of Samoa in managing and implementing the HSP based on the use of results from sector performance monitoring</p>	<ul style="list-style-type: none"> • Per cent health sector budgets and disbursements conform to policy objectives and HSP priority areas • Share of annual outpatient visits by poorest quintile of population (indicator of equity of access – HIES)
<p>Policies and plans implemented according to agreed priorities</p>	<ul style="list-style-type: none"> • MTEF and related Procurement Plan updated and adjusted based on recommendations from sector reviews • Key Sector Partners' corporate Plans and Government investments aligned with HSP priorities.
<p>Greater efficiency in use of resources</p>	<ul style="list-style-type: none"> • Percentage of SWAp Program funds released according to agreed schedule • Number of reported drug stock-outs by facility
<p>National ownership and commitment to health sector program</p>	<ul style="list-style-type: none"> • Health expenditure as percentage of govt. expenditure • Stakeholders participation in program planning and implementation reviews
<p>Results of performance monitoring used in shaping the program implementation</p>	<ul style="list-style-type: none"> • Disaggregation of data by sex, age and domicile enhances planning for services
<p>Improved health sector governance</p>	<ul style="list-style-type: none"> • MOH Financial Audits submitted on time and action plan agreed for resolving outstanding issues. • DHS and other statistical reports completed within stated timeframe and made public

Annex 6 Health SWAp Process Monitoring Indicators⁵⁸

Health SWAp Process Monitoring Indicator	Impact
<p>Per cent health sector budgets and disbursements conform to policy objectives and HSP priority areas</p>	<ul style="list-style-type: none"> • SWAp accounts for approx. 9% of total health spending (GoS plus DPs) over period 2009/10 – 2013/14 • Unclear what proportion of non-SWAp spending reflects HSP priorities
<p>Share of annual out patient visits by poorest quintile of population (indicator of equity of access – HIES)</p>	<ul style="list-style-type: none"> • No data available
<p>MTEF and related procurement plan updated and adjusted based on recommendations from sector reviews</p>	<ul style="list-style-type: none"> • MTEF2 published in 2011 • Procurement plan updated 3-monthly
<p>Key Sector Partners' corporate Plans and Government investments aligned with HSP priorities.</p>	<ul style="list-style-type: none"> • MoH, NHS and National Kidney Foundation have Corporate Plans in place which reflect HSP priorities
<p>Percentage of SWAp Program funds released according to agreed schedule</p>	<ul style="list-style-type: none"> • IFR indicates total disbursement as at 31 December 2012 equal to 71% of overall SWAp budget
<p>Number of reported drug stock-outs by facility</p>	<ul style="list-style-type: none"> • 2 per cent stock outs in rural public health facilities in March 2012 • 95% availability of essential medicines at all public health facilities as at March 2012
<p>Health expenditure as percentage of govt. expenditure</p>	<ul style="list-style-type: none"> • 2008/09 = 17.4 per cent • 2009/10 = 12.6 per cent • 2010/11 = 12.4 per cent • 2011/12 = 16.0 per cent
<p>Stakeholders participation in program planning and implementation reviews</p>	<ul style="list-style-type: none"> • Stakeholders participated in annual Health Summits (2009 & 2010) and subsequently in Annual Health Forums

⁵⁸ Data in this table are drawn from various sources including MTEF2, Nov/Dec 2012 Joint Review Mission aide memoire, IFR and key informant interviews.

Disaggregation of data by sex, age and domicile enhances planning for services	<ul style="list-style-type: none">• Survey data (e.g. DHS & STEPS) are disaggregated• HIS data (where available) are also disaggregated
MOH Financial Audits submitted on time and action plan agreed for resolving outstanding issues.	<ul style="list-style-type: none">• Unqualified reports have been received annually 'with few minor management and administrative outstanding issues'
DHS and other statistical reports completed within stated timeframe and made public	<ul style="list-style-type: none">• DHS completed in 2009 and report published in February 2010• STEPS survey will be in the field March/April 2013

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