MINISTRY of HEALTH & MEDICAL SERVICES

Shaping Fiji's Health

2025

EVALUATION REPORT

Strategic Plans & Performance

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Evaluation Report

Evaluation of the Ministry of Health & Medical Services **Strategic Plans and Performance**

Prepared for Ministry of Health and Medical Services	MINISTRY of HEALTH & MEDICAL SERVICES *Shaping Fiji's Health*
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- Team Leader and Evaluation Specialist – Dr. David Cownie
- Health Specialist – Mr. Peter Zinck
- Preventive and Primary Health Care Specialist – Dr. Temo Waqanivalu
- Institutional and Administration Specialist – Dr. Akapusi Ledua
- M&E Specialist – Mr. Mosese Qasenivalu
- Primary Data Collection and Quality Control Officer – Mr. Robin Weeks
- Research Assistant – Ms. Kelera Salusaludrau

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Mr. Ifereimi Coreregа
Director Monitoring and Evaluation
Head Secretariat
National Evaluation Steering Committee

PREFACE

Greetings and Bula vinaa, as the Minister for Health and Medical Services, I am delighted to share the Strategic Plan Evaluation Report 2025.

When the current Government entered office, one of its top priorities is to address and improve the deteriorating health status in the country. The neglected health infrastructure around the country has been an example. And as all of you know, this is easier said than done. As part of its commitment to improve Health Outcomes is to review and evaluate all its past Strategic Plans.

The evaluation of the Health Sector in Fiji was completed in 2024 by the World Bank and the report has been published. The report has clearly noted that despite the improvement in economic status for Fiji in the last decade, the health status indicators have either stagnated or deteriorated when compared with other countries of similar economic status as Fiji. This finding should be of concern to all of us, particularly, for us in the health service sector.

The recently completed Strategic Plan Evaluation project by the SIAPAC which we will read in the next chapters is an assessment of the effectiveness, efficiency, relevance, and cohesiveness of its Strategic Plan design, and implementation. I am particularly delighted to see completed, as I have been pushing for this evaluation to take place.

Monitoring and Evaluation (M&E) is often referred to as the compass that guides an organization towards impactful results. Without it, we are aking to sailors navigating a vast ocean in a dense fog –hopeful, certainly determined, but ultimately unsure of our true bearing and destination.

M&E, therefore, is not just a technical exercise; it is a culture we must embed, a way of seeing with clarity, learning with humility, adjusting with agility, and, above all, maintaining an unwavering honesty with ourselves about our progress and our shortcomings.

Today, I am immensely proud to acknowledge a significant milestone: the Ministry of Health and Medical Services is one of the first Govt ministry to complete a comprehensive and candid evaluation of its strategic plans, spanning from 2007 to 2025. The outcome of the evaluation has highlighted a number of important reflections for our collective consideration:

1. While the Ministry has recognized the indispensable value of foresight and planning, the evaluation revealed that, in many instances, we have grappled with prioritizing effectively, measuring our impact comprehensively, and adjusting our course in real-time. Possessing a plan and consistently achieving its intended results are two different undertakings. Coupled with this is the evolving nature of health challenges we face - the ever-present concern of sustainable health financing, the NCD crisis, the ongoing threat of communicable diseases pandemics, the critical shortages of health workforce, and the emerging global challenges like climate change.

2. M&E is a challenge and needs strengthening. The evaluation has noted that while monitoring data and understanding its immediate implications are important, we must build robust, routine evaluation into our health system. This will enable us to truly understand whether we are advancing the health sector in meaningful ways and genuinely making a difference in the lives of our people. M&E is evolving, and when embraced fully, can transforms the health service into a dynamic, powerful system for positive change.

3. True transformation is authentic, organic, and anchored in shared principles. The transformation must be deeply rooted in our shared vision based on the authentic context of Fiji, involves every dedicated staff at

all levels of the health service, and consulted widely amongst the people we serve, the partners we engage, and always honoring the invaluable wisdom and experience of our workforce.

4. We must build a health service that is fit for our purpose and our people. Our health system must be agile, responsive, and fundamentally data-driven, and centered on the voices of the population we serve. This includes embedding strong monitoring and evaluation functions at every level, adequately resourcing our learning systems, and ensuring that every plan, no matter how visionary, has a robust feedback loop that directly connects results to resources and critical decisions.

This Evaluation process will lead to a renewed, long-term commitment that will yield:

1. A clear Theory of Change for the health sector, where we articulate precisely what we want to accomplish, the pathways that will get us there.

2. A renewed, rights-centered Health Vision 2050 that reflects the aspirations of all Fijians and aligned to Fiji's National Development Plan and Vision 2050.

3. Careful consideration of whether we need to develop an overarching National Health Policy to provide a guiding framework.

4. And, flowing from all of this, a new, dynamic Health Strategic Plan for the period 2026 to 2030.

Let me conclude by saying that true learning is humble, acknowledging we don't have all the answers; true planning is honest, confronting realities even when uncomfortable; and true leadership is transformational, inspiring and enabling positive change.

May this Report help to lay the formidable foundation for a bold new chapter not just for health services by the Ministry of Health and Medical Services, but for the health, the well-being, and the dignity of every one in Fiji.

Thank You, Dhanyavaad, and Vinaka Vakalevu

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Honourable Dr. Atonio Lalabalavu
Minister for Health & Medical Services Fiji

ACRONYMS

Acronym	Meaning
ABR	Adolescent Birth Rate
AIDS	Acquired Immunodeficiency Syndrome
AMR	Antibiotic and Antimicrobial Resistance
ANC	Ante Natal Care
ART	Antiretroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
AYF	Adolescent and Youth-Friendly
BCG	Bacillus Calmette-Guerin Vaccine
CBD	Convention for Biological Diversity
CCA	Climate Change Adaptation
CCD	Climate Change Division
CCHEDRM	Climate Change, Health Emergency and Disaster Risk Management
CCHSAP	Climate Change and Health Strategic Action Plan
CD	Communicable Disease
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CHE	Current Health Expenditure
CHW	Community Health Worker
CMNHS	College of Medicine, Nursing and Health Sciences
Covid-19	Coronavirus Disease caused by the SARS-CoV-2 virus
CRC	Convention on the Rights of the Child
CRVS	Civil Registration and Vital Statistics
CSD	Climate Sensitive Diseases
CSN	Clinical Service Network
CSO	Civil Society Organisation
CWMH	Colonial War Memorial Hospital
DALY	Disability Adjusted Life Year
DBC	Disease Based Costing
DFAT	Department of Foreign Affairs and Trade, Government of Australia
DHS	Demographic and Health Survey
DMO	Divisional Medical Officer
DoE	Department of Environment
DPO	Disabled Persons Organisation
DPT	Diphtheria-Pertussis-Tetanus
DRF	Disaster Risk Finance
DRM	Disaster Risk Management
DRR	Disaster Risk Reduction
EH	Environmental Health
EHIA	Environmental Health Impact Assessment
EHO	Environmental Health Officer
ESU	Executive Support Unit

Acronym	Meaning
EU	European Union
F$	Fiji Dollar
FBO	Faith-Based Organisation
FBOS	Fiji Bureau of Statistics
FGD	Focus Group Discussion
FH	Family Health
FHA	Fiji Health Accounts
FLE	Family Life Education
FMIS	Financial Management Information System
FMS	Fiji Meteorology Service
FNDP	Fiji National Development Plan
FNU	Fiji National University
FPBS	Fiji Pharmaceutical and Biomedical Services
FWCC	Fiji Women's Crisis Centre
GBV	Gender-Based Violence
GCHE	Government Current Health Expenditure
GEWE	Gender Equality and Women's Empowerment
GHE	Government Health Expenditure
GoF	Government of Fiji
GP	General Practitioners
HDI	Human Development Index
HIA	Health Impact Assessment
HIES	Household Income and Expenditure Survey
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HR	Human Resources
HRBA	Human Rights-Based Approach
ICT	Information Communications Technology
ICU	Intensive Care Unit
IFC	International Finance Corporation
IHR	International Health Regulations
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illnesses
IR	Inception Report
IRC	International Red Cross
JICA	Japan International Cooperation Agency
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCTTT	Ministry of Commerce, Trade, Tourism and Transport
MDGs	Millennium Development Goals

Acronym	Meaning
MEL	Monitoring, Evaluation and Learning
MEPIR	Ministry of Employment, Production and Industrial Relations
MFAT	Ministry of Foreign Affairs and Trade (New Zealand)
MH	Mental Health
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate
MoF	Ministry of Finance, Strategic Planning, National Planning and Development
MoHMS	Ministry of Health and Medical Services
MoHMS SP	Ministry of Health and Medical Services Strategic Plan
MS	Medical Superintendents
MWCSP	Ministry of Women, Children and Social Protection
NCCCC	National Climate Change Coordinating Committee
NCD	Non-Communicable Disease
NDMC	National Disaster Management Council
NDMO	National Disaster Management Office
NDP	National Development Plan
NEC	National Employment Centre
NEOC	National Emergency Operations Centre
NEP	National Employment Policy
NGOs	Non-Governmental Organisations
NHA	National Health Accounts
NHEC	National Health Executive Committee
NHEDMO	National Health Emergency and Disaster Management Office
NNDSS	National Notifiable Diseases Surveillance System
NVCU	National Vector Control Unit
OECD	Organisation for Economic Cooperation and Development
OECD DAC	Organisation for Economic Cooperation and Development – Development Assistance Committee
OH	Oral Health
OHS	Occupational Health and Safety
OOP	Out-of-Pocket Expenditure
OP	Out Patient
PATIS	Patient Information System
PCV	Pneumococcal Conjugate Vaccine
PEN	Package of Essential NCD Interventions
PHC	Public Health Centre
PHIS	Public Health Information System
PICTs	Pacific Island Countries and Territories
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PNC	Post Natal Clinic
PSC	Public Service Commission
PWD	Persons With Disabilities
RHD	Rheumatic Hearth Diseases

Acronym	Meaning
RMNCH	Reproductive, Maternal, Newborn and Child Health
SC	Steering Committee
SDGs	Sustainable Development Goals
SDH	Sub-Divisional Hospital
SIAPAC	Social Impact Assessment and Policy Analysis Corporation International LLC
SIDS	Small Island Developing States
SOP	Standard Operating Procedures
SPC	Pacific Community
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TB	Tuberculosis
TC	Tropical Cyclone
ToC	Theory of Change
ToR	Terms of Reference
TWG	Technical Working Group
UN	United Nations
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV&AIDS
UNC	Universal Health Coverage
UNCRPD	United Nations Convention on the Rights of People with Disabilities
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNFCCC	United Nations Framework Convention on Climate Change
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USD	United States Dollar
VAC	Violence Against Children
VAT	Value Added Tax
VAWG	Violence Against Women and Girls
VfM	Value for Money
WASH	Water, Sanitation and Hygiene
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization
WHO PEN	World Health Organization Package of Essential Noncommunicable Disease Interventions
YLL	Years of Life Lost

SUMMARY SHEET

Introduction

This Evaluation Report presents updated findings from the evaluation of the Ministry of Health and Medical Services' (MoHMS) strategic plans and strategic planning process. It was conducted by the evaluation firm SIAPAC and included a team of 5 Fijian consultants and 2 international consultants. The evaluation was overseen by the Director of Monitoring and Evaluation, MoHMS, supported by an Evaluation Reference Group (ERG).

Methods

Three basic methods were employed: 1) a review of a considerable body of materials including planning documents by team members; 2) interviews with 71 officers and others in MoHMS at national and divisional levels, development partners, and civil society agencies; and 3) repeated engagement with high level Ministry officials and the oversight team, extensive discussions with experts on the team, and a dissemination workshop involving a wide range of actors in the health sector and in other sectors as appropriate.

Findings

The following is the summary rating of strategic planning performance:

Table 1: Summary Rating for Strategic Planning Performance

Overall Rating	Rating	Code	Description
	4		High rating
√	3		Moderate rating
	2		Somewhat low rating
	1		Very low rating

The overall rating for the performance of strategic planning in the health sector is 'moderate', tending slightly towards 'high' due to more positive findings in particular around Effectiveness, Cost-Effectiveness, and Relevance. Key constraints were associated with poorer performance around Adaptation, Coordination and the absence of tracking data to allow the measurement of Cost-Efficiency, and issues arising for Coherence. The main conclusion drawn from this overall rating is that investments in strengthening planning can yield a powerful return-on-investment, and that such investments are warranted.

Conclusions

Five overall conclusions were identified:

1. Strategic planning could play an enhanced role in transforming the sector if key actions are taken
2. There is a strong commitment to strategic planning within the Ministry, including among high-level actors
3. A more strategic approach is possible for the strategic planning process, based on recommended improvements in the strategic planning cycle
4. Strengthened strategic planning can support improved sectoral coherence
5. Strategic planning can advance effective wellness programming and a strengthened cross-sectoral approach

Recommendations

1. MoHMS should consider extending the validity of the current Strategic Plan (2020-2025) through to mid-2026, and then issue the Strategic Plan for the five-year period August 2026-July 2031 with a major review in 2029 to consider the direction of the next plan or changes to the current one, or both. The new National Development Plan is from 2025-2029, so the 2029 review would duly consider whether to prepare a new plan that would align with the NDP implementation timeline
2. Undertake actions aimed at informing the upcoming Health Summit, including: initial design of a high level Health Vision 2050 document; develop ToR for a Health Commission; develop theories of change for Vision 2050 and the upcoming strategic plan; develop a MEL framework for the upcoming strategic plan; put forward a strategy for institutional reform; assemble the body of evidence to inform the upcoming strategic plan and the Health Summit; and develop a concept note on whether the Ministry should lead development of a health policy
3. Establish a 'rolling plan' cycle that introduces evaluation into the process and allows plans to be updated at the end of year 3
4. Issue an official government response to recent studies of the health sector
5. Identify early wins to support trust in the health sector

EXECUTIVE SUMMARY

PURPOSE AND METHODS

To further strengthen accountability and improve delivery, MoHMS commissioned an evaluation of their Strategic Planning process and outcomes. The Purpose of the summative component of the evaluation is to "gain insights into the Strategic Plan's fit-for-purpose and "assess the extent to which [the Strategic Plan's] objectives have been achieved to date and are likely to be achieved by the end of the period". The Purpose of the formative component of the evaluation is to "draw lessons to inform the design of the next Strategic Plan 2026-2030". In addition to a review of documents and data to inform an understanding of progress against all four strategic plans, the evaluation covers insights and opinions from key informants on trends over time across the five-year plans in terms of focus, quality, and delivery.

The **Objectives** of the evaluation are as follows:

- Review the extent to which the current Strategic Plan (2020-2025) has set clear objectives that align with NDP and the SDGs, and the most pressing needs and priorities of communities. Review similar aspects of the previous plans 2007-2020.
- Analyse the extent to which the plans were implemented as planned and how it allowed for adjustments and adaptive management in the face of changing priorities and evolving evidence and contexts.
- Assess to what extent core elements and frameworks underpinning the plans have proven to be well developed, coherent and useful.
- Determine strengths and weaknesses in the design, operationalisation, and implementation of the plans, including prioritisation of actions, intended results, and resource management.
- Identify good practices and lessons learned that can be applied in future strategic planning processes.

The following Evaluation Criteria were employed: Relevance, Adaptability, Coherence, Effectiveness, Coordination, and Efficiency.

Two workstreams were employed: 1) primary data collection, including materials assembly and a number of interviews within the health sector, with other ministries, with civil society organisations and with development partners; and 2) track and report on progress against the results frameworks of the four plans, with a 'deeper dive' into the current strategic plan.

FINDINGS

Findings are presented by evaluation criteria. Findings from each are as follows:

Table 2: Overall Findings

Evaluation Criteria and Evaluation Question	Rating (high, moderate, somewhat low, very low)	Main Findings
Relevance - are the strategic plans aimed at doing the right thing	Moderate	1) The strategic planning process has secured the commitment of all key actors, and is respected if done correctly, underlining a belief that that plans are well intentioned and properly focused 2) The strategic plans mostly align with national priorities 3) The strategic plans are increasingly built on a solid understanding of the situation on the ground
Adaptability - has the intervention adapted well to emerging needs to maintain relevance over time	Somewhat Low	1) Adaptation was less based on innovation and forward thinking and more based on coping with unexpected situations as they arose 2) In those cases where this adaptation met the challenge (e.g., Covid-19), this was not connected to the strategic planning process nor was the effective of negative changes arising from Covid-19 strategic planning process considered 3) The strategic plans recognised the importance of adapting to the effects of climate change but did not elaborate a clear way forward

Evaluation Criteria and Evaluation Question	Rating (high, moderate, somewhat low, very low)	Main Findings
Coherence - how well do the strategic plans fit into the health sector and the health needs of the population	Moderate to Somewhat Low (the latter related to point 4 in the next column)	1) Coherence during planning was enabled through solid situation analyses informed by a wide range of stakeholders, followed by a clear statement of what the main challenges and opportunities were 2) It was reflected at operational level, but it was not feeding back into the strategic planning processes, therefore it created more incoherence. Learning is not built into the structural response 3) The strategic plans worked hard to clearly express how the Ministry and the health sector more broadly fit in terms of meeting priorities and overcoming challenges, albeit with limitations on how the private sector is supposed to be engaged 4) Despite this, coherence as implementation proceeded diminished in particular with regard to the coherence of health delivery including the private sector and civil society
Effectiveness - has the strategic planning process helped the health sector achieve objectives	Moderate	1) The strategic plans duly recognised the need for actions around policy, procedures, resource strengthening and allocation and similar 2) Progress towards health outcomes was not clearly connected to plan objectives, nor were outputs directly measured, but progress was made nonetheless 3) Without results reporting at operational level, it is difficult to say that what was delivered at activity level yielded results
Coordination - how well has implementation of the strategic plans been coordinated	Somewhat Low	1) Effective coordination in plan delivery is hampered by ineffective coordination mechanisms in the Ministry and especially in the sector more broadly 2) Coordination in plan development vertically (strategic, operational, business, divisional) is more solid, but lacks sufficient verification protocols to strengthen alignment 3) Coordination in plan implementation remains relatively weak, and is not well influenced by learning and innovation in the absence of timely information
Efficiency - how well are resources being used	High (in terms of strategic planning versus another approach)	1) Excluding cost-efficiency measurement, the value-for-money focus on cost-effectiveness yields a high rating 2) There is abundant evidence that investing in strategic planning has delivered considerable value associated with a common commitment to the process of plan development and implementation, identifying common objectives, and committing to responding to the problems clearly identified in situation analyses

Discussion: Findings from the evaluation identified both strengths and weaknesses in the strategic planning design and implementation processes. In some respects, weaknesses in strategic planning reflect broader weaknesses in the Ministry and in the sector, but there are specific weaknesses in the planning itself that warrant attention. Particular challenges arise in terms of poor adaptability, challenges to the coherence of plans vis-à-vis the health sectors and the needs of the population, and significant challenges undermining coordination and the efficacy of coordination. Particular strengths are associated with cost-effectiveness and commitment to strategic planning, progress evidence on a wide range of indicators, and the finding that the strategic plans are well focused and well aligned with development programming and public needs.

CONCLUSIONS

Five overall conclusions were drawn from the evaluation, followed by a main conclusion for each evaluation criteria. These are as follows:

Overall Conclusion 1: The Urgency to Transform the Health Sector and the Role of Strategic Planning: 'We better get it together, people are more and more unhappy, and we're seen as less and less accountable'. There are the words of one key informant in the Ministry who referred to the growing public discontent with public health sector delivery. The strategic planning process cannot solve the problems of trust and accountability, among other challenges, but the evidence gathered during the evaluation suggests that it can play an important role in helping to enable sector innovations and reforms that will help do so.

Overall Conclusion 2: Commitment to Strategic Planning: There are solid commitment to the strategic planning process, and equal commitment to strengthening the process. Lessons learned from problems emergent with the current 2020-2025 Strategic Plan reinforced the conclusion that effective planning supports effective performance.

Overall Conclusion 3: A More Strategic Approach to Strategic Planning: As the strategic planning process has strengthened over time, the need for innovations in the strategic planning process has become increasingly evident. The current strategic plans are meant to do too much at the same time that it doesn't have the tools to do so. This requires improvements at four points in the strategic planning cycle:

1) The strategic plans should not be burdened with expectations at ultimate outcome level, these outcomes are objectives that one aspires to achive in a 25-35 year timeline, not a five-year timeline. This is better left to an elaborated vision document for the health sector overall.
2) The strategic plans should not be expected to replace an overall policy for the health sector.
3) Engagement in strategic planning, and systems of accountability for strategic plan performance, can be enabled by the elaboration of a human rights-based approach to planning that includes engaging with rights-holders.
4) Accountability mechanisms can be strengthened in such a way that the connectivity between the strategic plans, the operational plans, and the business plans can be enhanced. This is not about creating a top-down infrastructure and more about helping to ensure that broader objectives as elaborated at strategic plan level are reflected throughout the plans, and that the learning, innovation, and adaptation that takes place as business plans are implemented are reflected upwards in the system.

Overall Conclusion 4: Improved Sectoral Coherence and the Role of Strategic Planning: Sector coherence is challenging within the Ministry itself but is particularly challenging across the public, private, and civil society health actors, including training institutions. The need for greater coherence is widely recognised and agreed, but strategic planning doesn't play a sufficient role in this regard because this coherence is not operationalised and tracked as progress towards plan implementation, but is rather presented as aspirational. Setting improved coherence as a long-term objective in a vision statement and identified in a health policy would then allow the strategic plans to take on 'implementable bites' of coherence as a stated interim outcome, and tracked accordingly. Given the distinct challenges facing coherence within the public sector and coherence across varied health actors, both streams will need attention.

Overall Conclusion 5: Wellness, Cross-Sectoral Approach and the Role of Strategic Planning: One notable aspect of endeavouring to achieve high level health-relevant outcomes is that these health outcomes are delivered through a range of sectors, and not just health. Wellness as one aspirational aim of development more broadly requires that MoHMS engage with non-health ministries in a coherent, meaningful manner and deliver an integrated set of non-health and health-outputs and outcomes. NCDs are the clearest example of a developmental challenge that has devastating health outcomes for Fiji, but the solutions to stemming the rise in NCDs fall largely outside of the direct remit of the Ministry. It requires collaboration with, and effective coordination with, education, agriculture, local government, enterprise development, and other ministries and sectors.

Given that the evaluation highlighted challenges to coordination even within the Ministry, and even more severe challenges facing coordination within the sector more broadly, coordination across sectors is even more challenging. Visioning, policy development, and planning can all play a role here, because much of what is required rises to the level of national planning, with MoHMS only one actor. Once the Ministry better 'finds it feet' in this broader remit, the strategic plans can take such coordination on board as things to deliver, and let this then cascade to the operational and business plans.

Conclusion Relevance: The Ministry needs to leverage broad-based support for strategic planning and use this to strengthen alignment with core national commitments, an emergent health vision and health policy, and at the same time strengthening alignment with the demands for a 'reset' coming from the stakeholders (both duty-bearers and rights-holders).

Conclusion Adaptation: The Ministry needs to shift adaptation from being a reaction to things that happen that require changes to a proactive means of anticipating these changes. Strategic plan content can support this, but it also means attention to strategic plan implementation within the context of cascaded plans including divisional, business, and operational plans, to institution plans. Warning signs often arrive on local and operational levels, and the strategic planning process needs to use this 'local knowledge' to anticipate changes required, and respond accordingly.

Further, adaptation within the strategic planning process at a higher level can be better on-boarded if the five-year plans include a mid-term review cycle coupled with a 'rolling plan' approach whereby at the end of year 3 the existing five year plan is updated.

Conclusion Coherence: Internal coherence within the Ministry and its planning process and the resultant plans was positive, but coherence declined over time as implementation proceeded as plans disconnected and coping rather than adaptation took place. External coherence associated with planning with the health sector more broadly was lower. Information and processes that would have enabled improved coherence as implementation proceeded were not in place, resulting in inadequate learning and innovation. This undermined the ability of the plans to help the Ministry and the Government more broadly to tackle the challenges facing the health sector.

Conclusion Effectiveness: Once the data were assembled, the findings showed that the Ministry and the sector had accomplished a great deal, despite problems and critical gaps in this regard. However, the extent to which these accomplishments were linked to the efficacy of planning was less evident. In many respects this related to outcome statements and expectations that were beyond the ability of any plans to deliver. What are therefore perceived as plan 'failures' or plan 'successes' are not necessarily connected to what the plans could deliver. Better matching what is possible, and why change may occur, would result in a stronger match between what is found as data are reviewed and plans evaluated and what they can actually deliver.

Conclusion Coordination: Coordination remained a particular challenge to the strategic planning process. Coordination across sections and within the health sector are especially challenging. Coordination in plan development vertically is mostly solid, but lacks sufficient verification protocols to strengthen alignment. Coordination in plan implementation remains relatively weak, and its improvement undermined by the lack of sufficient learning and innovation in the process.

Coordination can be improved within the planning process internal to the Ministry through a few key measures, but coordination within the sector and across sectors needs to be framed within the context of broader innovations and reform and systems strengthening activities. Coordination bodies established to enable coordination were not functioning well, highlighting the importance of transformation how Government approaches health, enabling a wide range of actors in the system, strengthening engagement across multiple sectors, delivering with these other actors against improved health outcomes (e.g., reduced levels of NCDs, lower levels of water-washed and water-borne diseases among children, greater reproductive health choice among women and men, young and old, and similar.

The dissemination workshop highlighted that there were a number of dormant or poorly functioning coordination entities in place that could well serve important roles within the context of health system transformation. Coordination bodies need clear purposes, short-term and long-term accomplishments, and strong political backing. If these are in place, the entitles could continue to serve important roles in the health sector for years to come.

As coordination will not work without these other improvements in place, the approach needs to be carefully considered and change can only be expected in the long-term. In terms of how this can be handled in the plans themselves, clear outputs and an interim outcome can be specified that focus on what can be achieved in the short-term, while longer-term changes are considered at higher levels.

Conclusion Efficiency: From a cost-effectiveness perspective, the strategic planning process has yielded high value-for-money compared to alternatives. It is highly valued and its contribution to the work of the Ministry is widely recognised. This suggests that there would be support throughout the Ministry for improvements to the strategic planning system. When implemented in the context of other innovations and reforms, this should be strengthened.

Having said this, it is clear from a number of interviews within and outside the Ministry that there are inefficiencies in the plan implementation process that warrant additional attention, including establishing measures to consider how efficiently plans are delivered and the return-on-investment in doing so.

LESSONS LEARNED

Five lessons learned were identified through the evaluation:

1. *Focus and 'Right-Size' the Strategic Plans:* The strategic plans cannot serve a range of functions that are beyond what they are able to deliver, and what they should deliver. This requires that the strategic plans focus on what can be achieved in each five-year period, and how this contributes to larger objectives that should be expressed at the level of a full vision document and, ideally, a health policy. Ideally, it would also contribute towards a multi-sectoral action plan, programme or similar aimed at tackling key constraints to wellness.
2. *The Right Time for Change:* Between this evaluation and the two Government-commissioned studies supported by the World Bank as well as proposed upcoming actions including the Health Summit, Fiji should be in a sound position to significantly strengthen both the role and the performance of strategic planning within the Ministry and, importantly, also within the health sector. And it should be in a position to leverage these improvements along with other innovations and reforms to improve health sector performance and health and wellness outcomes.
3. *MEL:* Significant improvements are needed in terms of the monitoring, evaluation and learning systems around the strategic plans and within the Ministry and the sector. Given that this finding has been repeated for years, it is important that these investments take place where the return-on-investment is assessed and shared. It also means the following:
    a. Investing in improved MEL will only yield sustainable results if the return-on-investment is calculated and understood and appreciated by those who are involved in MEL implementation, health sector decision-making, and supporting improved sectoral performance.
    b. Investing in this cannot over-burden operational entities and should rather enable them by supporting efficient information use at varied levels, including at facility and community levels.
4. *Wellness:* Intended improvements in health outcomes arise as much from non-medical determinants as well as health sector delivery under the remit of the Ministry.
4. *Trust:* Trust in the health system needs to be regained. There is a broader sense of 'loss' within the sector itself, a feeling that things can be done better and should be done better, and had been done better in the past. Strategic planning can play a critical role in supporting the range of actions required to regain this trust. Strategic planning can play a critical role in supporting the range of actions required to regain this trust.

RECOMMENDATIONS

Two priority recommendations and three additional recommendations were put forward, with one (priority recommendation 2) containing a series of sub-recommendations.

Priority Recommendation 1

MoHMS should consider **extending the validity of the current Strategic Plan** (2020-2025) through to mid-2026, and then **issue the Strategic Plan for the five-year period August 2026-July 2031** with a major **review in 2029** to consider the direction of the next plan or changes to the current one, or both. The new National Development Plan is from 2025-2029, so the 2029 review would duly consider whether to prepare a new plan that would align with the NDP implementation timeline.

This will give sufficient time for the Ministry to lead a consultative process involving both duty-bearers and rights-holders at national and sub-national levels through a number of methods of engagement. The process should be seen as an opportunity for health workers and the public to provide their inputs through multiple channels, ensuring that the Ministry hears their concerns and hopes and helping to strengthen the credibility of the planning process in the eyes of the public.

This timeline has the added benefit of allowing the strategic plan to coincide with the financial year. However, it would need to be issued sufficiently in advance of the financial year to allow operational and business planning to take place allowing costs to be specified.

Priority Recommendation 2

There is a sense that momentum is with regard to taking a more inclusive approach to planning that will support innovation and reform, with the need for a more transformational approach to planning and delivery reflected in the two recent World Bank supported assessments, Government's commitment to this evaluation, and the planned Health Summit. If this is indeed the case, then **core actions aimed at informing the Health Summit should proceed as a matter of urgency**. These include:

1) Beginning preparation of a **Vision 2050** document that sets forth aims and objectives and ultimate outcomes, grounded in a process of engagement with duty-bearers and rights-holders that would begin before the Health Summit, and thereafter continue with the full development of the Vision 2050 document and its issuance as a Government policy statement.

2) Develop clear **Terms of Reference for a Health Commission** that can affect action in the months following the Health Summit.

3) Develop **theories of change** at Vision 2050 and 2026-2031 Strategic Plan levels, clearly elaborating intended objectives, needed sets of actions, causal pathways, assumptions and hypotheses, and enabling and disabling factors.

4) Develop a **Monitoring, Evaluation and Learning Framework** with a Results Framework included within for the 2026-2031 Strategic Plan.

5) Pull together the information obtained on needed **institutional innovations** and package this in a manner that encourages the Health Summit to commission a process of innovation and reform.

6) Pull together the larger **body of evidence** available to inform the development of the 2026-2031 Strategic Plan.

7) Extending this 'body of evidence' approach, there are a **wide range of issues that arose during the evaluation that warrant due consideration** in two respects: a) high-level health sector findings that reference Ministry and sector performance can be put forward for discussion during the Health Summit; and b) more operational and additional strategic findings can be put forward for consideration by post-Summit committees, panels or similar.

8) Put forward a policy brief that informs a decision on whether the Ministry should lead development of a sector level **health policy**. The Ministry has protocols in place to do this.

Recommendation 3: Establish a **'rolling plan'** process that incorporates evaluation and learning and places them at the core of how planning proceeds.

The five-year timeline for the strategic plans is sound, but monitoring, reporting and review inputs that would inform adaptation and innovation is lacking. Strengthening each of these processes is important, and incorporating planning protocols that enable this is also important. For the latter, it is recommended that a mid-term review take place to be issued in the middle of Year 3, and an update of the strategic plan be prepared and issued at the end of Year 3 based on the mid-term review. This allows the plans to respond to improved systems of data management and learning processes and incorporate innovations and adaptations into the plans themselves.

Recommendation 4: Issue an **official government response**, perhaps in a white paper format, to the two World Bank supported studies, the upcoming NCD study, this evaluation, and other key studies underway that should be included and indicate areas of agreement and disagreement with recommendations, and a workplan associated with approved recommendations.

Recommendation 5: Identify **'early wins'** that can help regain trust in the health sector, which can also help duty-bearers in the sector see that change is possible. For strategic planning itself, some of the points under Recommendation 2 are intended to serve as early wins, but there are others. Further, early wins can be incorporated into the 2026-2031 Strategic Plan to show duty-bearers, rights-holders, development partners, and others involved in the delivery of health services that rapid progress is possible.

There are other possible actions as well. For example, post-Summit consultations led by senior Ministry personnel could engage key duty-bearers at sub-national and community levels, and rights-holders who are activists and volunteers in their communities, as well as rights-holders coming from a range of households, including vulnerable households and populations. Another example is to hold an initial cross-sectoral meeting to discuss how to move forward with wellness, and a potential 'early win' path established for one component (e.g., an existing donor financed initiative around improved nutrition among primary school students further supported by health and agriculture).

Another example is piloting an approach to communications that focuses on hearing from rights-holders. This can build on initiatives aimed at hearing from patients, but extends from 'patient-centred' to 'rights-holder-centred'. A final example is a public commitment to alignment with the new NDP, with the Ministry showing how its upcoming 2026-2031 Strategic Plan will enable the NDP.

SECTION 1. INTRODUCTION

1.1 INTRODUCTION

This Final Evaluation Report presents updated findings from the evaluation of the Ministry of Health and Medical Services' (MoHMS) strategic plans and the strategic planning process, following submission of the Preliminary Findings Report in April and a Draft Report on May, 2025.

1.2 OVERVIEW OF FIJI

Fiji is a Small Island Developing State located in the South Pacific at 17.7134 South Latitude and 178.0650 East Longitude. It is comprised of 333 islands, of which some 100 are inhabited spread across an area of 18,274km^2. The two main islands comprise Viti Levu, where the capital Suva is located, and Vanua Levu to the north. The country is divided into four administrative divisions covering Central, Eastern, Northern and Western divisions. The population in 2015 was estimated at around 870,000[1], of whom three-quarters live on Viti Levu, with over half the population living in urban areas. English is the official language, while iTaukei and Hindi are also commonly spoken.

Figure 1: Map of Fiji by Divisions

Fiji is classified as a 'High Human Development' nation, with significant improvements in development status in particular between 1990 and 2020[2] across the three dimensions of 'a long and healthy life, access to knowledge, and a decent standard of living', with particular gains in terms of per capita income. Gross Domestic Product (GDP) per capita was USD5,589 in 2017[3].

Some one-quarter (24.1%) of the population of Fiji lives in poverty (Fiji Household Income and Expenditure Survey (HIES) for 2019-2020[4]). Rural poverty is substantially higher than urban poverty, at 36.5% versus 14.0%, with two-thirds of those living in poverty residing in rural areas, despite only 45% of the population being rural. Poverty levels on remote islands are higher than the rates found on the main islands (Eastern Division, which includes a number of small islands, had the highest poverty rate in Fiji, at 39.2%). Poverty rates are highest among children (34.9% of children aged 0-10 live in poverty), with households in poverty more likely to have higher numbers of children. For peri-urban households, where livelihood strategies are quite narrow, are at particular risk of falling into poverty during economic decline, which proved to be a particular problem during Covid-19. The population of 'near poor' – those who are at risk of falling into poverty comprises another 15-30% of the population (with figures varied based on method used to estimate), or between 125,000-290,000 people.

[1] https://www.nationsonline.org/oneworld/fiji.htm
[2] https://hdr.undp.org/sites/default/files/Country-Profiles/FJI.pdf. It's rank in 2019 was 93 out of 189 countries and territories, with a value of 0.743 on a 0-1 scale.
[3] https://sustainabledevelopment.un.org/content/documents/25011Fiji_VNR_2019_final.pdf
[4] https://www.statsfiji.gov.fj/images/documents/HIES_2019-20/2019-20_HIES_Main_Report.pdf

The 2023 Country Gender Assessment[5] noted that Fiji's rating on the World Economic Forum's Gender Gap Index improved significantly from 0.638 in 2017 to 0.674 in 2021. Fiji was ranked 113th out of 156 countries in terms of gender parity in 2021. Only 66% of working aged women were working in the formal sector, compared to over 83% for men, but trends show that women outnumber men in professional occupations and are playing a pivotal role in emergent economic trends including the gig economy.

Fiji has made a number of commitments to gender equality, including being a signatory to the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, the ILO Equal Remuneration Convention (No. 100), the ILO Discrimination in Employment and Occupation Convention (No. 111)[6], the Pacific Platform for Action, the UNDAF for the Pacific (2018-2022) as well as the Commonwealth Plan of Action for Gender Equality, and has developed a National Gender Policy (2014)[7] as well as a National Women's Action Plan. The National Gender Policy commits the country to gender equality, links gender equality to the attainment of the sustainable development goals, advocates for gender mainstreaming, and commits to overcoming gender inequality and discrimination. Gender equality is also prevalent in a number of national strategic planning documents, including the 5 year/20 year development plan.

1.3 NATIONAL DEVELOPMENT PLANNING

Fiji's national development is guided by a National Development Plan and a series of sector development strategies. In 2017 Fiji issued a 5 and 20-year development plan (Government of Fiji, 2017)[8]. The Plan identifies two overall approaches to development in Fiji, one comprising 'inclusive socio-economic development' and the other 'transformational strategic thrusts. The former includes a commitment to a high-quality health care system and access to clean and safe water and proper sanitation. The overall health objective in the Plan states "In the next 20 years, medical services will be raised to international standards with a major focus on tertiary health care and overall medical service delivery"[9].

Priorities included investments that would reduce patient waiting time, more efficient inventory management, improve hospital services, expand hospital, health centre and nursing station infrastructure and the capacity of in-patient facilities, improve ambulance services and reduce health worker to patient ratios with particular emphasis on improving access to skilled doctors. Reference is also made to strengthening preventive health care focused on Non-Communicable Diseases (NCDs) in particular through the promotion of healthy eating habits, physical activity, and lifestyle changes. The Plan sets a target for 2026 for NCDs at half the rate of premature deaths before the age of 70 compared to the baseline in 2015 (from 68.2 to 34.9).

In 2024 Fiji issued an updated five-year plan[10] covering the timeline 2025-2029 with a vision to 2050. Built on three pillars of economic resilience, people empowerment, and good governance, the Plan recognises what it refers to as 'headwinds' that challenge progress, from post-Covid-19 recovery to geopolitical instability to climate change, low growth, and high debt.

Recognising years of instability and uncertainty in the political environment, the Plan places good governance, transparency and accountability at the centre of the Plan, with all members of the Coalition Government committing to these principles. Institutional strengthening, strengthening the rule of law, and strengthening the judiciary, state administration and Parliament along with building the capacity and efficiency of the civil service were all aimed at better and more accountable delivery of Government services.

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[5] MWCPA (2023). Fiji Country Gender Assessment. Deep Dive 2023, prepared by the Ministry of Women, Children and Poverty Alleviation, Government of Fiji, Suva, Fiji. No hyperlink available. Also see MWCPA (2023). Fiji Country Gender Assessment. Policy Briefs 2023, prepared by the Ministry of Women, Children and Poverty Alleviation, Government of Fiji, Suva, Fiji. No hyperlink available. Also see MWCPA (2023). Fiji Country Gender Assessment. Visual Report 2023, prepared by the Ministry of Women, Children and Poverty Alleviation, Government of Fiji, Suva, Fiji.

[6] Asian Development Bank (2016).

[7] Ministry for Social Welfare, Women & Poverty Alleviation (2014). Fiji National Gender Policy, Ministry of Social Welfare, Women and Poverty Alleviation, Suva, Fiji. Government intends to update the 2014 Policy based on the findings from the Gender Assessment issued in 2023.

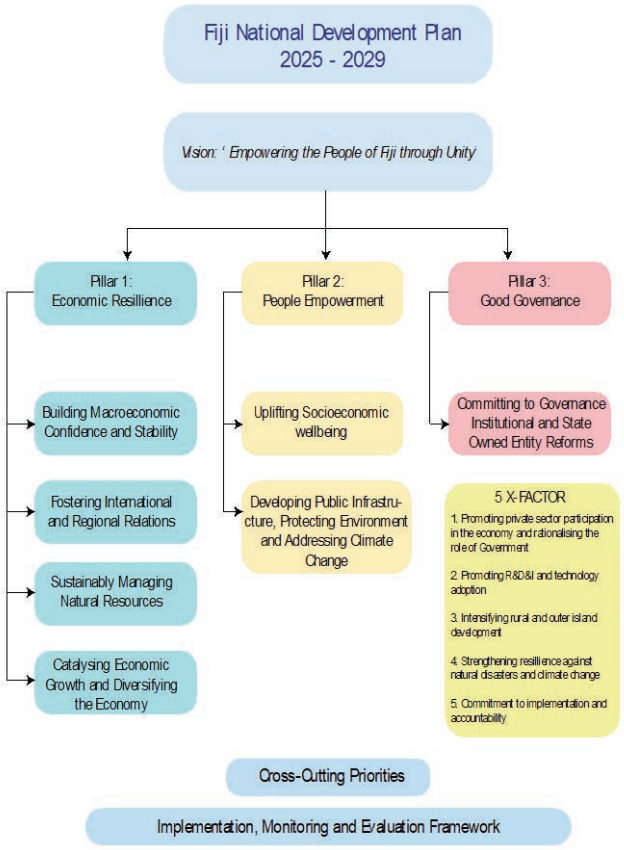
[8] https://www.fiji.gov.fj/getattachment/15b0ba03-825e-47f7-bf69-094ad33004dd/5-Year-20-Year-NATIONAL-DEVELOPMENT-PLAN.aspx

[9] https://www.fiji.gov.fj/getattachment/15b0ba03-825e-47f7-bf69-094ad33004dd/5-Year-20-Year-NATIONAL-DEVELOPMENT-PLAN.aspx, page 4.

[10] Government of Fiji (2024). Fiji National Development Plan 2025-2029 and Vision 2050, Ministry of Finance, Strategic Planning, National Development and Statistics, Suva, Fiji. https://www.finance.gov.fj/wp-content/uploads/2024/09/NPDF_final-9.pdf

The overall Vision was 'empowering the people of Fiji through unity', highlighting the importance of national harmony and shared goals, with the Mission stated as 'the Government prioritises the needs of all the people of Fiji at the centre of its national development policy and planning'. Six principles were identified as guiding the vision: inclusivity and participatory, sustainable economic recovery, good governance, mitigating the impacts of climate change and protecting the environment, evidence-based programming, and ensuring that no one is left behind. Cross-cutting priorities were identified as gender balance, community empowerment, addressing climate change, upholding moral and ethical values, good governance, and a commitment to political stability that ensured more balanced development. Internationally the Plan is aligned with the country's international obligations under the United Nations and other international and regional bodies and conventions, and aligned with the Sustainable Development Goals (SDGs).

Figure 2: National Development Plan 2025-2029 Vision 2050



The Plan includes key performance indicators with targets at 3 and 5 years, focused on priorities including providing clean drinking water, improving roads and drainage systems, upgrading health facilities, expanding affordable housing, and expanding school infrastructure, all with a focus on those locations identified as 'most in need', including those areas most at risk of natural disasters of the effects of climate change.

Health is discussed under Pillar 2: People Empowerment along with other social services, poverty alleviation, and other aspects of social well-being. The health care priority in the Plan was "to improve access to quality healthcare services", inclusive of expanding primary and secondary health care services, delivering through a multi-sectoral approach aimed at improving health outcomes in particular with reference to non-communicable diseases (NCDs), and in strengthening resilience to the effects of climate change and disasters. The Plan noted a renewed commitment to decentralisation and, through this, improved access to and quality of clinical health services. The Plan also noted the importance in improving how the Ministry collects and manages information, and the delivery of online health services. The Plan also recognised the increasing importance of primary sector health services delivery, and how public private partnerships could strengthen coordination and performance, and the importance of expanding health insurance coverage to the public and private sectors.

Sub-section 6.2 on health care specifies the goal of 'modernising Fiji's healthcare system to reduce disease incidence and enhance service quality'. Policies were identified as follows, with strategies specified for each:

- Establish Fiji-wide programmes to control the rate of premature deaths due to NCDs
- Provide high quality and comprehensive life cycle healthcare including maternal, infant, child and adolescent health family planning and sexual education, and parenting programmes (including an additional specification under women's empowerment to improve access to reproductive healthcare throughout the woman's lifecycle; also including an additional specification under youth to 'develop a youth friendly health service and promote physical wellness; also including safety, care and protection of children including 'frontline collaboration' of service providers involved in child health services, social protection, schools and early childhood education delivery)

- Strengthen mental health services (including an additional specification under women's empowerment to improve access to mental and stress care)
- Improve healthcare literacy and public healthcare awareness
- Foster research and development in healthcare
- Provide access to clinical healthcare services to all Fijians
- Expand primary healthcare, with an emphasis on providing a continuum of care and improved service quality and safety
- Enhance the effectiveness of healthcare management and delivery system
- Modernise and maintain health delivery systems and infrastructure to meet increased demands for quality health services

Key Performance Indicators (KPIs) at national planning level were specified:

Table 3: Key Performance Indicators

KPIs	Baseline (2025)	3 Years (2027)	5 Years (2029)
Maternal mortality rate per 100,000 live births	38	20	20
Infant mortality rate per 1,000 live births	18	10	10
Underfive mortality rate per 1,000 live births	28	15	15
Ratio of skilled health workers per 10,000 population	45	doctor – 10 nurse – 40	doctor – 12 nurse 45
Health expenditures per capita (FJD m)	548.3	358.4	448.0

In reviewing the policy statements and the priorities, and in particular considering the expectations around improvements across the KPIs, one is struck by the ambitious nature of the healthcare sector. Many of the strategies specified, for example, are not short-term actions (e.g., 'integrate mental health services into primary healthcare to ensure that mental health is a part of routine health checks', 'expand public healthcare and clinical services to appropriately address the needs of adolescents, youth and elderly'), and it is unclear how the strategies would yield such high level of improvements in the KPIs on maternal, infant and underfive mortality. In contrast, the healthcare worker ratios are less ambitious and likely consistent with current human resource and placement plans. The per capita savings shown from 2025-2027 are also quite ambitious, before levelling out for 2029, but appear to be related to strategies aimed at improving the situation in the next few years (e.g., supply chain management, improved information management, strengthened community and patient engagement in healthcare provision)

1.4 HEALTH CARE SYSTEM AND HEALTH STATUS IN FIJI

The health care system in Fiji is organised in four tiers: national, divisional, sub-divisional, and medical area. At the national level, the Ministry is organised by department and unit, each responsible for specific aspects of health care, public health, and medical services, including departments for Wellness, Family Health, Health Protection, Health Information and others, with a total of twelve 'cost centres' and six supportive departments. Health care is delivered through four administrative divisions, as per the national divisions of Central, Eastern, Northern and Western[11].

At the divisional and sub-divisional levels, health officers implement and coordinate health services under their remit. Each division oversees a number of sub-divisions and facilities including nursing stations (which provide basic care), health centres (which provide a range of care services), and sub-divisional and divisional hospitals, which provide in-patient and out-patient services. As access to quality services is currently concentrated at hospitals at sub-divisional and divisional levels, these hospitals are key providers for primary health care services, largely through out-patient and family planning services.

In 2023-2024 Fiji worked with the World Bank to conduct a review of the health sector[12]. The review covered health financing, service delivery, human resourcing, and engagement with private healthcare

[11] https://documents1.worldbank.org/curated/en/099121523194239123/pdf/P159865166e66800a1bde11b80f4c8a0a6d.pdf
[12] https://thedocs.worldbank.org/en/doc/39f4d9bf38e49370b49bf54e27ef6af3-0070012024/original/WB-Health-Sector-Review-Web-19-Dec-2024.pdf

providers. The review offers some key findings of central importance in understanding health status in Fiji. Key observations included the following:

- Despite being an upper middle-income country, Fiji has health outcomes more consistent with lower middle-income countries. Much of this is associated with what the report refers to as a 'catastrophic disease burden' from NCDs. Some 85% of all deaths are in 2019 were from NCDs, with two-thirds of these deaths among working-age Fijians.
- Life expectancy at birth is only 68 years, well below the average for upper middle-income countries of 77 years.
- Fiji's progress on lowering infant and under-five mortality have stagnated in recent decades (at 23/1000 live births and 28/1000 live births, respectively, in 2019), consistent with levels for lower middle-income countries.
- There are recurrent disease outbreaks, including zika and dengue fever in recent years, driven by climate change and rapid urbanisation, and rising challenges associated with tuberculosis and HIV.

The report notes that Fiji's health system is neither appropriately structured nor equipped to prevent and manage the nature and magnitude of its disease burden. Key conclusions in this regard include:

- There are gaps in reproductive, maternal, neonatal, child and adolescent health services, as well as in effective management of persons with NCDs.
- Many of those with NCDs are undiagnosed and are therefore not on effective treatment protocols. This means those with chronic conditions only seek health care when they require in-patient services.
- There are critical gaps in knowledge for staff in managing patients with chronic conditions, including lack of knowledge about adherence to clinical guidelines.
- Spending on primary health care has not kept pace with overall health spending, and has fallen to less than 20% of all health expenditures as of 2019. Most of this occurs at out-patient service points at hospital settings, rather than at primary health care facilities or community reach.
- Hospitals are operating at maximum capacity, in particular the national referral hospital Colonial War Memorial, while rural hospitals have low utilisation rates.
- Fiji's investments in primary health care are lower than the average rate for upper middle-income countries. These facilities do not provide adequate access to diagnostic services and medicines. Only 20% of primary health care facilities had all the standard safety precautions and equipment required.
- More than half of Fiji's primary health care facilities are in need of upgrading.
- Supply chain management challenges are intensifying.
- Fiji has made progress in terms of the minimum threshold of skills health workers when both public and private sectors are considered, but the high NCD burden and distribution of service challenges mean that the numbers are inadequate.
- There are particular problems in staffing in peri-urban areas around Fiji's largest cities.
- While Fiji has a new digital health strategy and recognises the importance of advances in this regard, there are a number of challenges that suggest that it will be some time before the objectives of the strategy can met.
- Budget underspending is a chronic problem, at 80% compared to 98% for other upper middle-income countries. This yields a public expenditure and financial accountability score of D.
- Progress has been made in policies relevant to advancements in the health sector, including the National Wellness Policy, the Reproductive Health Policy, the Healthy School Policy, and others.

The report focuses on four areas of reform within a vision framework Mo Bulabula ka Bula Balavu (wishing you a health life and a long life), comprising:

1. Redesign health service delivery to meet the health challenges of Fiji and the Pacific.
2. Spur the adoption of healthy behaviours in the population.
3. Build a modern workforce for the future.
4. Strengthen stewardship and data for a modern health system.

5. Cross-cutting issues cover: 1) enhance health resilience through health emergency prevention, preparedness, and response, using climate-smart solutions; and 2) improve health equities through pro-poor and gender-sensitive interventions.

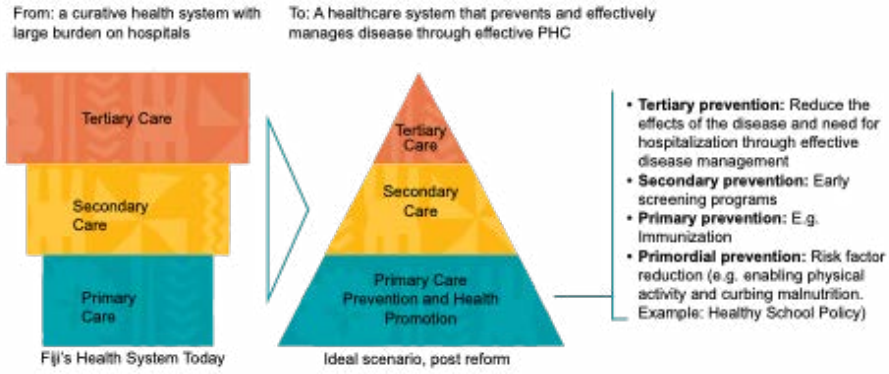
As per the first point, key to this movement away from a system focused on hospital-based, curative care to one that prioritises preventive care and disease management at the primary level, reflected in the figure to the right.

A second review was also conducted, also supported by the World Bank[13], focused on primary health care covering access, coverage and quality.

Service coverage was assessed for reproductive, maternal, neonatal, and child health, infectious diseases, and NCDs. The assessment found that reproductive, maternal, neonatal and child health service coverage has declined in the past decade, particularly in terms of access to antenatal care and family planning services. Gaps were also noted in terms of childhood diarrhoea, HIV, and tuberculosis, as well as low coverage of NCDs.

Quality was considered in terms of health care comprehensiveness, continuity of services, person centredness, provider competence, and safety practices. The assessment found gaps in delivery of comprehensive care for various health conditions, particularly NCDs, infectious diseases, and reproductive, maternal, neonatal and child health services.

Figure 3: From Curative to Preventive



There are disparities in terms of care provision across urban, peri-urban and rural, with particular access issues in peri-urban areas.

Five areas of reform were specified:

- Implement a people-centred model of care focused on delivering comprehensive PHC at the community level by updating the package of health services and redefining the next generation of PHC personnel.
- Enhance community-based services by bolstering proactive population outreach efforts and fortifying the Community Health Worker Programme.
- Strengthen governance and leadership for PHC for effective prioritisation and implementation of comprehensive PHC as part of a broader effort to enhance accountability for achieving collective health system results.
- Leverage the recently approved digital health strategy to enable regular analysis and application of information on PNC capacity, performance, and outcomes at facility, subnational and national levels.
- Strengthen and standardise systems for regular community engagement in PHC priority settings and accountability.

While numerous challenges were elaborated, the report noted that Fiji has a history of effective primary health care delivery through the provision of individual and community-based health care services, and public health preventive services focused on promoting and protecting the health of entire populations. In these respects, there was a basis for reform, and this was strengthened by widespread recognition of the need for reform.

[13] https://documents1.worldbank.org/curated/en/099121523194239123/pdf/P159865166e66800a1bde11b80f4c8a0a6d.pdf

1.5 EVALUATION TEAM

The evaluation is being conducted by SIAPAC International LLC, an evaluation consultancy firm with forty years of applied experience in this regard around the world, including in Fiji and elsewhere in the Pacific. The evaluation team is comprised of the following personnel:

- Team Leader and Evaluation Specialist – Dr. David Cownie
- Health Specialist – Mr. Peter Zinck
- Preventive and Primary Health Care Specialist – Dr. Temo Waqanivalu
- Institutional and Administration Specialist – Dr. Akapusi Ledua
- M&E Specialist – Mr. Mosese Qasenivalu
- Primary Data Collection and Quality Control Officer – Mr. Robin Weeks
- Research Assistant – Ms. Kelera Salusaludrau

1.6 EVALUATION MANAGEMENT

Institutional arrangements that supported and oversaw the evaluation were as follows:

Management of the Contract

- MoHMS Contact Person: Mr. Irefeimi Corerega, Director Monitoring and Evaluation [Projects], Head Secretariat NESC, MoHMS
- SIAPAC Contact Person: Dr. David Cownie, Director, SIAPAC International LLC

Operational Implementation of the Consultancy

- Ministry provision of a Focal Point
- Ministry provision of two members of a Working Group
- Ministry appointment and oversight of a Steering Committee
- SIAPAC onsite management through Mr. Peter Zinck
- SIAPAC offsite operational management through Mr. Robin Weeks
- SIAPAC onsite operational management through Mr. Robin Weeks

SECTION 2. METHODOLOGY

2.1 INTRODUCTION

This section overviews the evaluation, as well as the approach and methods employed to conduct the evaluation.

2.2 PURPOSE AND OBJECTIVES OF THE EVALUATION

To further strengthen accountability and improve delivery, MoHMS commissioned an evaluation of their Strategic Planning process and outcomes. The Purpose of the summative component of the evaluation is to "gain insights into the Strategic Plan's fit-for-purpose and "assess the extent to which [the Strategic Plan's] objectives have been achieved to date and are likely to be achieved by the end of the period". The Purpose of the formative component of the evaluation is to "draw lessons to inform the design of the next Strategic Plan 2026-2030". In addition to a review of documents and data to inform an understanding of progress against all four strategic plans, the evaluation covers insights and opinions from key informants on trends over time across the five-year plans in terms of focus, quality, and delivery.

The **Objectives** of the evaluation as per the ToR are as follows:

- Review the extent to which the current Strategic Plan (2020-2025) has set clear objectives that align with NDP and the SDGs, and the most pressing needs and priorities of communities. Review similar aspects of the previous plans.
- Analyse the extent to which the plans were implemented as planned and how it allowed for adjustments and adaptive management in the face of changing priorities and evolving evidence and contexts.
- Assess to what extent core elements and frameworks underpinning the plans have proven to be well developed, coherent and useful.
- Determine strengths and weaknesses in the design, operationalisation, and implementation of the plans, including prioritisation of actions, intended results, and resource management.
- Identify good practices and lessons learned that can be applied in future strategic planning processes.

Core Evaluation questions by **Evaluation Criteria** are as follows:

- To consider the Relevance of the Strategic Planning process and content to consider alignment with national development aims and, internationally, the Sustainable Development Goals (SDGs)
- To assess the Adaptability of Strategic Plans implementation as emerging needs are established.
- To consider the Effectiveness of the Strategic Plans in terms of its achieving its objectives and making a difference.
- To consider the Efficiency of resource use in the implementation of the Strategic Plans.
- To examine how well the Strategic Plans have been Coordinated.
- To consider Cross-Cutting Issues such as child rights, gender equality, disability inclusion, and sustainability. As part of this, consider how the Strategy Plan focuses relevant attention to the most vulnerable, disadvantaged, and marginalised groups, with gender equality and disability rights core to both the strategic planning process and the evaluation.

2.3 EVALUATION CRITERIA AND EVALUATION QUESTIONS

Evaluation criteria were specified in the ToR, with the approach to each adapted to the Ministry's particular approach to implementation and information needs for the specific TAP evaluation. The selected criteria for this evaluation are consistent with OECD DAC definitions[14], covering Relevance, Coherence, Effectiveness, Efficiency, and Sustainability. *Cross-cutting themes* were mainstreamed across the evaluation criteria as appropriate.

[14] https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

The following ToR-specified evaluation criteria definitions guided the evaluation:

Figure 4: Evaluation Criteria as Defined by the OECD[15]

- Relevance – **Relevance** asks whether the Plan is doing the right things, and includes whether other actors involved in the health sector are also doing the right things from the perspective of the Ministry.
- **Adaptability** considers the extent to which the Ministry has been able to understand and accommodate challenges and improve planning and delivery in the face of challenges and opportunities. Given that the 2020-2025 Strategic Plan included the Covid-19 pandemic, it will be especially important to understand how the Ministry responded to the extraordinary challenges of the pandemic.
- **Coherence** considers the 'fit' of the intervention and is divided into **Internal Coherence** (how well does the intervention fit internally to the Ministry?) and **External Coherence** (how well do other actors and programmes fit within the strategic plan objectives and intent? and how well does the Strategic Plan fit within the context of broader Government policies and priorities.
- **Effectiveness** asks whether the Plan is achieving its objectives, and is therefore a key focus of the evaluation.
- **Efficiency** asks the question 'how well have resources been used', with a focus on the cost-effectiveness of decisions made rather than cost efficiency, thereby considering the cost-effectiveness of decisions made in approach and focus.
- **Coordination** is broadly considered under Coherence, but also further considers the extent to which the strategic planning process strengthens health sector delivery through effective strategic plan coordination internally to the Ministry and externally to other health sector actors.
- **Cross-cutting issues** include gender and social inclusion, human rights, disability rights, the environment, climate change, and reaching those furthest behind.

These evaluation criteria were elaborated into an Evaluation Matrix that covered evaluation criteria, the main evaluation questions, the evaluation sub-questions, and associated issues to consider. Two additional columns identify stakeholders and methods:

[15] https://www.oecd-ilibrary.org/development/applying-evaluation-criteria-thoughtfully_543e84ed-en. The OECD report on 'applying evaluation criteria thoughtfully' aims to improve evaluation by updating the description of the 2002 defined criteria (and the addition in 2019 of coherence).

Table 4: Evaluation Matrix

Evaluation question and sub-question	Issues to consider	Stakeholders to be engaged	Sources, methods, tools
Relevance: Are the strategic plans aimed at doing the right thing? **Adaptability: Has the intervention adapted well to emerging needs to maintain relevance over time?**			
EQ1: How well aligned are the strategic plans with health requirements and trends as well as Fiji's developmental priorities, and how has this adapted over time?			
EQ1.1: To what extent are the strategic plans aligned with the needs of the health sector and health issues in Fiji?	Efficacy of process of aligning strategic plans with priorities, who is involved, who has a voice Extent to which strategic planning processes have facilitated alignment, or undermined it, compared to alternatives Ability of the strategic plans to meet the needs of varied populations, including those least likely to be reached by development interventions	Health sector workers Those involved in strategic plan delivery Development partners Implementing partners Climate change and DRR personnel	Workstream 1 KIIs with health workers, implementing partners, development actors (UN, donors), others Workstream 2 indicator tracking against relevant alignment issues
EQ1.2: To what extent are the strategic plans aligned with policies and development priorities?	Alignment with health sector policies Alignment with other sector policies relevant to health Alignment with the national development plan Alignment with national vision Alignment with supra-regional health sector priorities and approaches Ability of the strategic plans to meet the needs of varied populations as expressed in these policies and national plans Extent to which the strategic planning process has aligned with emergent climate change risks and strategies and disaster risk response		
EQ1.3: To what extent have the plans adapted over time to emergent needs?	Adaptation within the implementation timeline of a plan, processes and decision-making protocols Adaptation that arises from lessons learned on previous plans Adaptation that arises from crises (long-term secular changes and immediate risks)		
Coherence: How well do the strategic plans fit into the health sector and health needs of the population?			
EQ2: How has the strategic planning process fit in terms of how the health sector delivers, and how did it support health sector coherence in delivery over time?			
EQ2.1: How has the strategic planning process and content enabled more coherent approaches to health sector delivery across actors involved in the health sector?	Extent to which the strategic planning process and content has affected the position, credibility, and perceived reliability of the Ministry of Health vis-à-vis development partners, the UN system, implementing partners, regional bodies, national associations, and similar How has the strategic planning process and content promoted complementarity, harmonisation and coordination with other stakeholders and what has this meant for outcomes Has the MoHMS partnership strategy been appropriate and effective? How, when & why?	Those involved in strategic plan delivery Development partners Implementing partners	Workstream 1 KIIs those involved in guiding the strategic planning process, implementing partners, development actors (UN, donors), others Workstream 2 indicator tracking against relevant alignment issues
EQ2.2: How has the strategic planning process and content supported an improved understanding of health sector challenges and needs?	Has the strategic planning process and content strengthened dialogue within the health sector, and between actors in the health sector, Has evidence collection and learning strengthened an understanding of the needs and challenges of the health sector?		

EVALUATION QUESTION AND SUB-QUESTION	ISSUES TO CONSIDER	STAKEHOLDERS TO BE ENGAGED	SOURCES, METHODS, TOOLS
Effectiveness: Has the strategic planning process helped the health sector achieve objectives? **Coordination: How well has implementation of the strategic plans been coordinated?**			
EQ3: To what extent has the Project progressed towards achieving its objectives, how well was the strategic planning process coordinated to do this, and how effective was the result of this coordination?			
EQ3.1: How has the strategic planning process led to desired outcomes?	Measuring output status, how and why Measuring outcome status and reporting thereto Were outputs and outcomes perceived to be appropriate Progress towards higher order objectives Distribution of benefits across actors, including those populations left behind	Those involved in strategic plan delivery Development partners Implementing partners	Workstream 2 indicator tracking against relevant alignment issues Workstream 1 to fill gaps and secure insights on outcomes and objectives and targeted populations
EQ3.2: How has the strategic planning process added value to health sector planning and delivery?	Impacts on regulatory, strategy, policy innovation and quality Impacts on institutions, systems, processes Impacts on advancing human rights planning and programming Impacts on advancing gender and inclusion objectives		
EQ3.3: To what extent has the strategic planning process strengthened health sector coordination and results?	Efforts to strengthen coordination within the health sector across sections and results Efforts to strengthen coordination within decentralised systems and results Efforts to strengthen coordination across state and non-state actors, universities, professional bodies, and similar and results achieved		
Efficiency: How well are resources being used?			
EQ4: To what extent has the strategic planning process proceeded in a cost-effective manner?			
EQ4.1: To what extent has the strategic planning process been pursued in a cost effective manner?	Return on investment from strategic planning approach versus alternatives Integrated funding framework/lack thereof and impacts on cost-effectiveness Timely delivery/lack thereof	Those involved in strategic plan delivery Finance Procurement Development partners (funders) Implementing partners	Workstream 2 tracking of finances Workstream 2 tracking of return at output level against input costs Workstream 1 opinions and insights on efficiency (cost effectiveness and cost efficiency)
EQ4.2: To what extent has the strategic planning process been pursued in a cost efficient manner?	Cost efficiency results within the Ministry, with partners Cost efficiency of implementation protocols Cost efficiency of coordination mechanisms Cost efficiency of planning protocols and management of these plans		

2.4 APPROACH

The evaluation approach includes both summative and formative components.

The summative evaluation focus considers the extent to which the strategic plans are making progress against objectives, based on information sourced from secondary data and reporting as well as primary data from qualitative approaches (focused on the most recent plan, but where possible previous plans) and from a review of databases. The aim here is to establish the efficacy of the implementation of the strategic plans in terms of effectiveness, efficiency and coherence, with insights into impacts.

The formative evaluation focuses on taking these data and reports, considered opinions, and insights from stakeholders to draw conclusions, identify lessons learned and make recommendations on improving implementation of the current Strategic Plan (2020-2025). The formative evaluation is intended to inform the design of the 2026-2030 Strategic Plan. The focus here is on improving plan effectiveness, strengthening the relevance of the work of the Ministry and of other actors vis-à-vis the Ministry (ensuring that the

Ministry's priorities and approaches inform the actions of other actors to 'do the right thing'), and enhancing coordination of actions taken.

Information triangulation was ensured through the collection of information and insights from a wide range of key informants, including key informants in management and operational positions in MoHMS, key informants in other ministries, key informants in implementing partners, and key informants from other civil society agencies and donors. Triangulation is further supported by review processes that are included as part of evaluation management, and the conduct of the Dissemination Workshop.

Case Studies were carried out to cover three departments within the Ministry, one falling under primary/preventive, one falling under health service delivery and one falling under health systems improvements. For each, additional questions have been asked within the departments, with Ministry managers, and with informed civil society actors and donors. However, as the results of the case studies emerged, they proved less relevant to an understanding of the strategic plans and the planning process and more on needed reforms within the Ministry overall. They have therefore been handled over for use in preparations for the Health Summit.

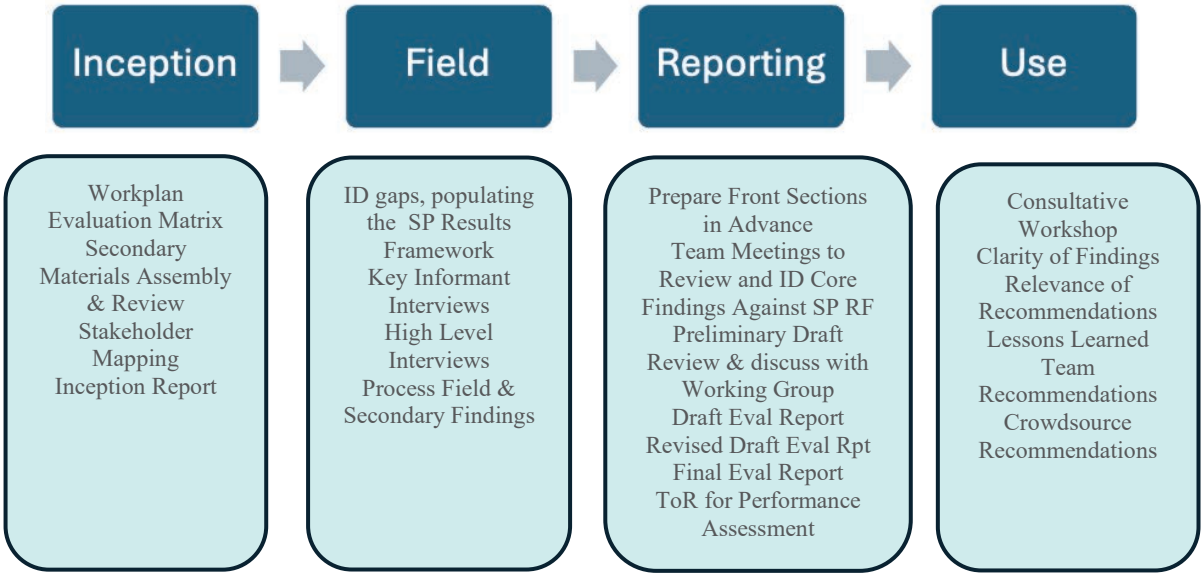
For the projections and future planning analysis component, the evaluation incorporated quantitative analysis based on the availability of data from the Ministry. The analysis focused on reporting against the strategic plans, including the identification of gaps.

2.5 EVALUATION TIMING AND METHODOLOGY

The phasing of the evaluation inclusive of the methodology applied during each phase is included herein. The evaluation was implemented in four phases:

1. Inception
2. Field
3. Reporting
4. Use

Key actions taken for each phase are reflected in the following figure:



2.5.1 INCEPTION PHASE

The Inception Phase began with the signing of the contract on 17 March 2025, with the Inception Phase completed with the submission of the Final Inception Report on 24 March 2025. It comprised onsite discussions between the Client and the Consultants, the preparation of the Inception Report, the updating of

the Workplan, secondary materials assembly and review, and the development of a means to assemble data for the evaluation which is processed against plan objectives, outcomes and main outputs.

The Inception Phase focused on the development of the Inception Report, inclusive of an updated Workplan, a Data Assembly template, and a working Stakeholder Analysis as part of a Stakeholder Engagement Strategy. The Inception Report was informed by a review of a wide range of secondary materials (a list of documents consulted to date is included in Annex A), the development of a Stakeholder Listing Matrix (see Annex C), and the elaboration of the Evaluation Matrix that was contained in the Terms of Reference (presented above); the final Key Informant Interview Instrument is included in Annex E.

The Inception Phase took place onsite for the two Fiji-based senior consultants and offsite for the remaining four senior team members.

As part of this offsite work, the off-site team engaged with the two Suva-based consultants Mr. Peter Zinck and Mr. Mosese Qasenivalu on the following as part of the Inception Phase, with Mr. Zinck and Mr. Qasenivalu meeting with the Working Group:

- Discussion of the Schedule and thereafter development of an operational Workplan for fieldwork and data/materials assembly (included in Annex F)
- Review of secondary materials, marking documents, and assembling summary information using agreed protocols. This included core documents used to implement the Strategic Plan, and the documents resulting from tracking Strategic Plan implementation
- Development of the Stakeholder Listing Matrix, inclusive of protocols identifying how to proceed with stakeholder engagement (included in Annex C)

The discussions with the Steering Committee covered both strategic and operational issues, including a review of the draft Schedule, discussion of Approach and Methods and Phasing, and Deliverables. The above actions, with the way forward elaborated in this Final Inception Report, provided the full 'framework' for the evaluation.

2.5.2 FIELDWORK PHASE

Following completion of the Inception Phase, attention shifted to implementation of primary data collection activities and further assembly of secondary information and associated data. The Primary Data Collection and Quality Control Officer, Mr. Weeks, led this Phase, working with the Research Assistant Ms. Kelera Salusaludrau as part of the first workstream, while the second workstream was led by Mr. Mosese Qasenivalu, the M&E Specialist. These two workstreams were as follows:

1. *Workstream 1: Primary Data Collection:* Collection of primary data from a wide range of key informants from the Ministry, from other key ministries and agencies, from civil society partners, from development partners, and from health private sector agencies. This workstream used a Key Informant Interview Instrument (see Annex E). In addition, the three content specialist conducted their own interviews using their own questions.
2. *Workstream 2: Results Framework:* Based on the Indicator Tracking System guiding the strategic planning process in the Ministry, the M&E Specialist assembled data and findings and tracked these systematically against objectives, outcomes and main outputs. This provided evidence for the evaluation in terms of available data, but it also allowed the evaluation to consider the efficacy of monitoring and reporting systems.

Workstream 1

This workstream was guided by a Master Stakeholder List which was extracted from the Stakeholder Listing Matrix. A dedicated MoHMS Focal Point was appointed by the Ministry to set up and manage all interview appointments in collaboration with the primary data collection team. At the end of the day, this mechanism proved extremely effective in security a considerable number of interviews. A total of 71 key informant interviews were conducted by the main team, followed by an additional dozen interviews conducted by the specialists on the team. The listing is included in Annex G, with the distribution of interviewees reflected in the following:

Table 5: Interviews Conducted

MoHMS	Donors/ Development Partners	NGOs	Academia	Total
53	8	6	4	71

MoHMS interviewees included officials from all sections of the Ministry as well as some divisional level interviews. Donor/development partner interviews included the main development actors supporting Fiji, as well as UN agencies. NGO interviews focused on implementing partners, while interviews with academics focused on those who work in the health arena.

To allow the fieldwork for the evaluation to proceed as efficiently as possible, the MoHMS Focal Point and the primary data collection team maintained continuous close contact and collaborated as a unit to keep track of all planned interview appointments and completed interviews with stakeholders. The team including the MoHMS Focal Point was authorised and endorsed by the Minister of MoHMS through an authorisation letter requesting support and cooperation from stakeholders. The Focal Point took the lead in setting up and monitoring the progress of **all** appointments for interviews with stakeholders as well as rescheduled any failed appointments to ensure comprehensive coverage and ensuring that all planned interviews were completed over a limited period of time for the duration of the primary data collection phase of the evaluation. It is important to note that cooperation among interviewees was extremely high, and included officials who approached the MoHMS Focal Point or the evaluation team asking to be interviewed.

Most of the interviews were recorded (with KII ethical approval) and notes compiled, with notes compared to audio recordings as necessary to fill any gaps. These transcripts were provided to the Team Leader for report preparation.

Workstream 2

Workstream 2 focused on the assembly of data from plan tracking systems, primary databases, and published materials, populating as fully as possible the strategic plan indicators. This was implemented by Mr. Mosese Qasenivalu, the team's M&E Specialist. He worked with the Working Group to determine how to assemble data to evidence indicators relevant for assessing progress in strategic plan implementation. The focus was at Strategic Objectives level which informed both Outputs and Outcomes.

The assessment drew on multiple data sources to ensure comprehensive coverage and triangulation:

1. **Performance Monitoring Data**: The primary quantitative data source was the MHMS Performance Tracking Matrix (2019-2023), which provided systematic tracking of indicators across all strategic priorities, outcomes, and outputs. This was supplemented by data from the MHMS Data Analysis Management Unit, which provided time-series data on health outcomes and service utilization.
2. **Financial and Resource Data**: Financial information was obtained from the National Health Accounts Unit and the Fiji Health Accounts: National Health Expenditure 2016-2021 reports, providing insights into health financing patterns, resource allocation, and expenditure efficiency.
3. **Regional Comparative Data**: The Pacific Data Hub SDG Dashboard (https://pacificdata.org/) supplied regional benchmarking data and contextual information on Fiji's progress toward health-related Sustainable Development Goals.
4. **Administrative Records**: Internal MHMS administrative documents, including annual reports, business plans, policy documents, and meeting minutes, provided additional context and qualitative information on implementation processes.
5. **Facility-Level Data**: Service statistics and quality indicators from health facilities across all four divisions (Central, Western, Northern, and Eastern) were analysed to assess variations in performance and identify geographic disparities.

These two workstreams proceeded in parallel, and the Working Group was regularly apprised of progress and problems arising (to help resolve).

2.5.3 REPORTING PHASE

The Reporting Phase began during the Field Primary Data Collection Phase, with all sections (including annexes) that did not require field findings prepared in advance. Once initial field findings were made available in early May, the Evaluation Report incorporated findings. Unfortunately some findings remained outstanding at the time of preparing the Draft Evaluation Report, but were included in the Final Evaluation Report.

2.5.4 USE PHASE

The Utilisation Phase covered the final stages of evaluation implementation to completion, and overlaps with the Reporting Phase. This Phase was completed by the end of May, with the Dissemination Workshop taking place from 28-29 May. The Dissemination Workshop used the Draft Final Consultant's Version of the Evaluation Report, following which the Consultant prepared and issued their final deliverable: the Final Evaluation Report (Consultant's Version). This was handed over to the Client in person by Dr. Cownie and other members of the evaluation team on 31 May 2025.

The Dissemination Workshop took place from 4-5 June 2025 at Novotel, Lami. The Dissemination Workshop comprised plenary sessions where overall findings and conclusions were presented and discussed, and working group sessions that focused on lessons learned and recommendations. Inputs provided during the Dissemination Workshop are reflected in the content of this evaluation report.

2.6 ETHICAL PROTOCOLS

In the design and conduct of the evaluation, the Consultants strictly adhered to the United Nations Evaluation Group (UNEG) Ethical Guidelines for Evaluation[16], the UNEG Code of Conduct for Evaluation in the UN System[17], the United Nations Protocol on Allegations of Sexual Exploitation and Abuse[18], the UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis[19], the WHO Ethical and Safety Recommendations for Research on Domestic Violence Against Women[20], and the United Nations Guidelines and Principles for the Development of Disability Statistics[21].

In addition, the following ethical considerations guided the evaluation, from design to data collection and analysis, reporting and dissemination:

- **Informed consent**. Ensuring informed consent is a fundamental requirement of the survey to comply with ethical standards and principles for research with human subjects. Participants were provided with clear information about the purpose, procedures, potential risks, and benefits of the study. They were invited to make an informed choice to participate in the survey, and their consent was obtained voluntarily, without any coercion or undue influence.
- **Voluntary participation and withdrawal**. Participation in the study was voluntary, and participants were informed that they had the right to withdraw from the study at any stage without facing any negative consequences. The data collectors informed participants of their right to withdraw when obtaining informed consent.
- **Confidentiality and privacy**. Respecting the confidentiality and privacy of participants is crucial. All data collected for the study have been treated with strict confidentiality and stored securely. Personally Identifiable Information were anonymised to protect participants' and respondent's identities. Only authorised individuals involved in the study had access to the data.
- **Do no harm**. The study prioritised the well-being and safety of participants. Measures were taken to minimise any potential harm or distress to participants. Sensitivity to gender equality, social

[16] http://www.unevaluation.org/document/detail/2866
[17] http://www.unevaluation.org/document/detail/100
[18] https://www.un.org/preventing-sexual-exploitation-and-abuse/sites/www.un.org.preventing-sexual- exploitation-and-abuse/files/un_protocol_on_sea_allegations_involving_implementing_partners_en.pdf
[19] https://www.unicef.org/evaluation/documents/unicef-procedure-ethical-standards-research-evaluation-data- collection-and-analysis
[20] https://apps.who.int/iris/bitstream/handle/10665/65893/WHO_FCH_GWH_01.1.pdf?sequence=1&isAllowed=y
[21] https://unstats.un.org/unsd/publication/seriesy/seriesy_10e.pdf

inclusion and the cultural contexts was strictly maintained throughout the study, and appropriate support mechanisms were put in place to address any potential adverse effects.

- **Non-discrimination**. The study upheld the principles of non-discrimination and treated all participants equally and fairly, regardless of gender, age, caste, ethnicity, sexual orientation, disability, and other characteristics.
- **Protection from sexual exploitation and abuse (PSEA)**. All members of the research team received awareness training and signed that they had read and are in agreement with the SIAPAC subcontractors handbook, which emphasises that no individuals including participants or respondents would be subjected to any form of exploitation or subjected to sexual abuse or harassment or any forms of abuse by individuals engaged in the study including enumerators, supervisors or other staff/personnel. In line with the United Nations Protocol on Allegations of Sexual Exploitation and Abuse, measures to prevent, investigate and respond to sexual exploitation and abuse (SEA) were put into place. All team members involved in the study were required to complete the online United Nations Sexual Exploitation and Abuse training[19] or similar equal quality training.
- **Transparency and accountability**. The study was conducted with the highest possible degree of transparency. The study methodology has been documented and reported transparently to allow the client and stakeholders to see the rigour and validity of the study.

For all primary data collection for the survey, it is important to note that for each interview or consultation, the introduction serves three fundamental and essential purposes:

- Ensures that the interviewee/respondent understands what the study is all about
- Ensures that the interviewee/respondent understands that the interview is confidential and
- Ensures that the interviewee/respondent gives her/his consent to participate in the interview.

It was also made clear to the interviewee/respondent that there was no direct material benefits linked to participation in the interview. The introduction and informed consent that appears in the data collection tools before any interview proceeded is as follows:

My name is _____, and I'm part of a team conducing an evaluation of Government's Ministry of Health and Medical Services 2020-2025 Strategic Plan. We are looking at how well the MOHMS current Strategic Plan has performed and invite stakeholders to provide their considered opinions and insights by means of consultations and interviews. This will help the evaluation to draw conclusions, identify lessons learned and make recommendations on improving implementation of the current Strategic Plan as well as to inform the design of the next five year Strategic Plan.

The evaluation is being conducted by SIAPAC a consultancy firm based in the USA, in collaboration with Fijian health experts and the MOHMS.

As part of the evaluation, we are consulting with stakeholders from government ministries and civil society involved with the national health programme in Fiji. We are interested in hearing your experiences and your opinion about programme performance, and what should be done to improve performance.

Consent

We are requesting your involvement in this evaluation. You are not being forced to take part, however we would really appreciate it if you do share your thoughts with us. If you choose not to take part in answering these questions, you will not be affected in any way whatsoever. If you agree to participate, you may stop participating in the discussion at any time and tell us that you do not want to continue.

Confidentiality

The information you provide us with will be treated confidentially. We will not be recording your names anywhere in the write up of the research. All responses will be anonymous and will not be shared with anyone else.

[Interviewer: If you are recording, please also add] *I would like to use a digital voice recorder to ensure that all of your responses are captured accurately. The recordings will remain*

confidential, will not be linked to your name or position, and will only be used for writing up the interview. Upon completion of the write up, the recording will be erased.

Risks/Discomforts

We do not see any risks in your participation. However, if you have any concerns regarding the way the interview was conducted, or any other concern regarding your participation in this study, please contact _____ at telephone _____.

Request to Proceed

May we proceed? ____ - 1 Yes ____ - 2 No

2.7 LIMITATIONS

The main limitation affecting the evaluation was an extraordinarily short timeline of 10 weeks, rather than the anticipated 16-20 weeks. This was necessitated by the delayed issuance of the contract and the financial year requiring that all funds for the evaluation be expended by the end of May 2025.

Fortunately, despite this extremely short schedule, the Client's facilitation of the interview appointments and the team's responsiveness to deadlines yielded the bulk of the data in advance of the Draft Evaluation Report being submitted. Additional materials arrived after the Draft was submitted and, as possible, incorporated into the Final Evaluation Report.

There were also practical limitations that affected data assembly:

2. **Data completeness**: While the MHMS Performance Tracking Matrix provided systematic monitoring for most indicators, some data points were missing or inconsistently reported, particularly for more recently established indicators.
3. **Timing variations**: Data collection timeframes varied across indicators, with some reflecting the fiscal year (August-July) and others the calendar year, creating challenges for precise temporal comparisons.
4. **Attribution challenges**: The COVID-19 pandemic and other external factors created significant disruptions that complicate the attribution of observed changes to specific Strategic Plan interventions.
5. **Qualitative depth**: While the assessment incorporated qualitative information from administrative records, more in-depth qualitative data from stakeholder interviews and field observations would have provided richer contextual understanding.

2.8 RATING SCALE

For each evaluation criteria, an overall rating is applied using the following scale:

Table 6: Rating System Used for Overall Evaluation Results

Rating	Code	Description
4		High rating on evaluation criteria
3		Moderate rating on evaluation criteria
2		Somewhat low rating on evaluation criteria
1		Very low rating on evaluation criteria

Where relevant this is further nuanced by lighter shading in an adjacent cell where a smaller number of aspects of performance against the evaluation criteria fall under that alternative rating.

SECTION 3. STRATEGIC PLANNING IN MOHMS

3.1 OVERVIEW

While the Ministry of Health in Fiji conducted strategic planning prior to 2007, the first full strategic plan approved to guide the Ministry and the sector was issued in 2007. Thereafter, the Ministry issued three follow-up 5 year plans covering the timeline 2011-2015, 2016-2020, and 2020-2025. The key elements of each of these plans is described below.

3.2 2007-2011 STRATEGIC PLAN[22]

The 2007-2011 Strategic Plan was designed and implemented with the Ministry of Health was overseen by two ministers, one for curative health services and another for primary and preventive health services. Linked to this Strategic Plan was the corporate plans which set targets and elaborated how these were to be achieved, themselves linked to annual business plans by sections and by divisions[23]. Six objectives were specified:

- Maintain adequate primary and preventive health care services and the promotion of health
- Maintain effective, efficient, and quality clinical health care and rehabilitation services
- Maintain an adequate, qualified and committed workforce for the health services
- Construction of new and continuous maintenance of all health infrastructure and facilities
- Maintain a management culture that promotes and supports continuous quality improvement
- Appropriate complimentary funding and resource allocation schemes identified for health services

Primary and preventive health were specified as the primary focus of the Ministry, while recognising that clinical health services were facing increased pressure and that services must be provided to the whole population.

Outcomes, while linked to the need for improvements in planning and delivery, are all health focused and include outcomes that follow a life-cycle focus:

- Reduce burden of NCDs
- Reverse the spread of HIV and prevent, control, or eliminate other communicable diseases
- Improve family health and reduce maternal morbidity and mortality
- Improve child health and reduce morbidity and mortality
- Improve adolescent health and reduce morbidity and mortality
- Improve mental health care
- Improve environmental health through safe water and sanitation

The description of indicators that would measure towards key health outcomes do in some cases focus on prevention. For NCDs for example they refer to active populations and healthy diets, while for environmental health they refer to access to safe water and improved sanitation. However, for all other indicators, they are entirely health focused, and are 'high level' indicators that focus on major changes (e.g., immunisation rates, under five mortality rate, malnutrition) rather than any interim measures.

The Mission was identified as follows: to provide health services through strengthened divisional health structures for the people of Fiji. The Vision was stated as: a well-financed health care delivery system that fosters good health and wellbeing for all citizens. Values were noted as follows: customer focus; equity; quality; integrity; responsiveness.

The Plan indicates alignment with the Millennium Development Goals (now replaced by the Sustainable Development Goals) and describes the nature of this alignment, and touches on alignment with national planning.

[22] https://www.health.gov.fj/wp-content/uploads/2018/03/Strategic-Plan-2007-2011.pdf
[23] During this planning period, there were three divisions, rather than the four that now exist, with the 2009 restructuring that divided Central from Eastern divisions.

Key constraints identified in the Plan included rising HIV and sexually transmitted infections, an increase in non-communicable diseases, the loss of skilled healthcare personnel due to emigration, insufficient training places in health schools in Fiji, increased demand for and rising costs of delivering services, the need for significant innovation in health sector financing (social insurance is specifically mentioned), and inadequate budgets. Even with this first plan, NCDs were noted as the most serious challenge to health in Fiji.

3.3 2011-2015 STRATEGIC PLAN[24]

The 2011-2015 Strategic Plan follows many of the priorities as stated in the 2007-2011 plan, including a commitment to primary and preventive health as key to the health and well-being of Fijians. The seven health outcomes from the 2007-2011 Strategic Plan were retained. These were considered across three strategic goals:

1. Communities are served by adequate primary and preventive health services thereby protecting, promoting and supporting their well-being (through localised community care)
2. Communities have access to effective, efficient and quality clinical health care and rehabilitation services
3. Health systems strengthening is undertaken at all levels in the Ministry of Health

Under each of these the relevant health outcomes had 'objectives' that gave specific targets. There were a very high number of targets under these objectives (81 under strategic goal 1, 43 under strategic goal 2, and 12 under strategic goal 3, giving a total of 136 total measures), many very ambitious.

Resourcing and the expansion of clinical services were again mentioned, while added to this was a renewed commitment to an evidence-based response informed by a strengthened Health Information Unit, and sustainable financing strengthened by the establishment of a Healthcare Financing Unit. The 2011-2015 Plan also elaborated a number of user fees aimed at generating new revenue.

Recognising that the previous outcome indicators were 'ultimate outcome' indicators, the 2011-2015 Strategic Plan noted that these are long-term aims, rather than targets expected to be achieved in the planning period. Instead, output level measures included in operational and business plans, as well as in divisional plans, would set viable targets for the planning period.

Unlike the 2007-2011 Plan, the 2011-2015 Plan explicitly noted that the implementation of the plan and progress towards outcomes could only be reached by the Ministry working with other Government departments, non-governmental organisations, and development partners. It did not, however, elaborate how this would take place.

The Mission was expanded from the one in the 2007 Plan and reflected other key determinants of success in delivery: to provide high quality health care delivery services by a caring and committed workforce with strategic partners, through good governance, appropriate technology and appropriate risk management, facilitating a focus on patient safety and best health status for all citizens of Fiji. The Vision was significantly revised as follows: a healthy population in Fiji that is driven by a caring health care delivery system. Values were expanded from the 2007-2011 focus (customer focus; equity; quality; integrity; responsiveness) to add in 'respect for human dignity', 'integrity', and 'faithfulness', all three reflecting the elaboration of a human rights-based approach to planning.

The 2011-2015 Plan offered additional elaboration of each focus area, and contextualised each in terms of health status and the health sector, including some problem statues as well as major new development. This included the significant expansion of training facilities that had taken place from 2008, and the continued expansion of these services during this planning phase.

The 2011-2015 Plan also specifically mentioned disaster preparedness and the need to strengthen the resilience of physical infrastructure.

[24] https://extranet.who.int/mindbank/item/5787

3.4 2016-2020 STRATEGIC PLAN[25]

The 2016-2020 Strategic Plan shifted to two 'strategic pillars', one focused in improvements to health service delivery covering preventative, curative and rehabilitative services, and the other focused on health systems strengthening. The former has three 'priority areas' and the latter five:

Strategic Pillar 1: preventive, curative, and rehabilitative health services

1. Non-communicable diseases, including nutrition, mental health and injuries
2. Maternal, infant, child and adolescent health
3. Communicable diseases, environmental health and health emergency preparedness, response and resilience

Strategic Pillar 2: health systems strengthening

4. Primary health care, with an emphasis on continuum of care and improved quality and safety
5. Productive, motivated health workforce with a focus on patient rights and customer satisfaction
6. Evidence-based policy, planning, implementation and assessment
7. Medicinal products, equipment and infrastructure
8. Sustainable financing of the health system

Priority areas 1 and 4 referenced the importance of prevention, community-based programming, and 'whole of government' approaches to delivery, the latter of which Priority 3 also mentioned, including Local Government which has the mandate for public health prevention in urban areas, where emergent health challenges were noted to be especially problematic.

The Vision was significantly shortened to 'a healthy population', while the Mission shifted more towards identifying people as rights holders that the Ministry had a duty to provide services and support to: 1) to empower people to take ownership of their health; and 2) to assist people to achieve their full health potential by providing quality preventative, curative and rehabilitative services through a caring sustainable health care system. Core values were more focused than in the previous plan, but retained a human rights focus: equity; integrity; respect for human dignity; responsiveness; and customer focus. The Plan again referenced the importance of multi-sectoral collaboration, without which objectives could not be met.

To this the 2016-2020 Strategic Plan added 'general principles', including a specific commitment to universal health coverage, the mainstreaming of health across policies throughout the country, commitment to the regional 'Healthy Islands Vision' which formed the basis for Pillar 1, and a commitment to relevant SDGs. The Plan also mentioned the 'WHO health systems building blocks' which elaborate on good practices around the following: leadership/governance; health care financing; health workforce; medical products and technologies; health information and research; and service delivery.

The Plan also offered a useful overview of the role and function of the Ministry, describing and elaborating on each of the following: hospital services, public health services; regulatory functions; policy functions; support services functions; and health information research and analysis services. The Plan referred to the Wellness Centre established under the previous 2011-2015 Strategic Plan, and expanded wellness to refer not just to health risk factors but also the environment within which people lived, and therefore the need for multi-sectoral collaboration to bring about changes in risk factors around NCDs.

For the first time, the Plan included tabular presentations of priority areas and objectives under each of the strategic pillars, offering additional clarity on intentions and focus and enabling operational and business planning. The objectives were then linked to key performance indicators in a separate annex, which included baseline values and targets, along with means of measurement. The majority of the indicators were ambitious, with a number of them indicating reductions in problems by almost (or over) 50% (e.g., tobacco use, amputation rates for diabetic food sepsis, reductions in intentional self-harm, prevalence of anaemia in pregnancy), but a number of the rest were more modest, albeit still often ambitious. Linkages between these targets and actions to be taken were not fully evident, but were expected to be made clear at operational level. In addition to rather ambitious targets, there were a total of 145 high level indicators (72 for Pillar 1 and 73 for Pillar 2).

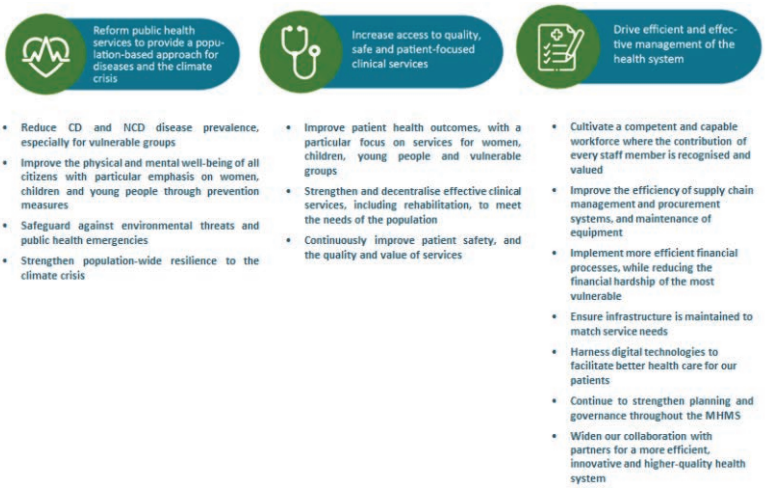
[25] https://www.health.gov.fj/wp-content/uploads/2018/03/Strategic-Plan-2016-2020-Executive-Version.pdf

3.5 2020-2025 STRATEGIC PLAN[26]

The 2020-2025 Strategic Plan shifted from two strategic pillars to three strategic priorities, and pulled this together under what the Plan refers to as a 'one-system approach'. This is specified as follows (page 18): "we aim to provide a one-system approach to the three core strategic priorities – we want to achieve [Universal Health Coverage] through the quality health care necessary for good health. Through an integrated approach to public health and strengthening patient services and the continuum of care, we will improve the health and well-being of all Fijians, and combat the social determinants affecting people's lives, especially the lives of those who are most vulnerable and marginalised". The three strategic priorities are as follows:

1. Reform public health services to provide a population-based approach for diseases and the climate crisis
2. Increase access to quality, safe and patient-focused clinical services
3. Drive efficient and effective management of the health system

Figure 5: Strategic Priorities



The main difference was the separation of prevention from curative and rehabilitation services through comprehensive approaches to NCDs, targeting those most in need, and safeguarding against environmental threats and public health emergencies. In addition, for this plan, climate change was front and centre (and forms an outcome area, Outcome 1.4), recognising the increasing negative health impacts of the crisis. And what was previously 'health systems strengthening' was now more focused on efficient and effective management, including supply chain management, efficient financial processes and means to protect the most vulnerable, strengthened infrastructure, digital technologies, and governance and accountability. The Plan specifically recognised the challenges facing informal settlements in peri-urban areas where some 15% of the population lives, and the risk of communicable diseases in this regard.

The use of the term 'population health' included an understanding that needs vary across age groups and that a life-cycle approach is required to meet health needs. It also further elaborated the target population in a manner reflecting this understanding. It notes that an integrated approach to public health will help shift away from a disease-focused approach that includes a broader commitment to wellness.

Figure 6: Health Customers

The Vision remained as 'a healthy population', with the Mission more closely matching the strategic pillars: 'empowering Fijians to achieve optimal health and well-being through the delivery of cost-effective, quality and inclusive health services'. Core values were similar to the two previous plans, but now included innovation in recognition of the need to be at the

[26] https://www.health.gov.fj/wp-content/uploads/2020/05/Strategic-Plan-2020-2025-1.pdf

cutting edge and be able to anticipate emergent problems. It again referenced the Healthy Islands Vision for the Pacific, and referred to signing the Yanuca Island Declaration on health in the Pacific and referenced the earlier Astana Declaration.

The Plan refers to yearly operational plans, annual business plans for each Ministry unit, and individual workplans; elsewhere divisional plans are referenced. The Plan includes a specific commitment to 'measure and monitor the outcomes we achieve based on key performance indicators'. Annual operational plans 'translate' the Strategic Plan into specific outputs and activities', while business plans outline activities by each unit, and this informs the budgeting.

Health-related indicators were noted as covering seven areas: reproductive, maternal, newborn and child health; infectious diseases; non-communicable diseases and mental health; injuries and violence; universal health coverage and health systems; environmental risks; and health risks and disease outbreaks. However, unlike previous plans (in particular the 2016-2020 Plan), the 2020-2025 Strategic Plan did not elaborate indicators and specify targets. Instead it noted that these would be covered in the Annual Operational Plans. The Strategic Plan itself instead added a number of outcomes compared to previous plans.

The Plan also outlines in some detail what it meant by 'efficient and effective management of the health system', describing innovations in health workforce development and management, elaboration of supply chain, procurement and equipment innovations, improvements to financial processes, the need for infrastructure improvements, and a commitment to digitalisation and a recognition of the dysfunctions of current systems. It also references the importance of partnerships and collaboration, specifically mentioning the role of civil society in providing specialised services and reaching hard-to-reach communities, and supporting health reach in disasters. It also referenced the rapid rise in private sector health providers, and the need to ensure that these providers are properly linked to the health sector overall. Reference is also made to 'cross-government partnerships' and working with other ministries to support 'wellness' that extends beyond what the health sector itself can deliver. And it references the strategic importance of support provided by development partners.

The Plan refers to the plan development process, which took a year under the guidance of a National Steering Committee guided by the Planning and Policy Development Division of the Ministry. This was informed by a situation analysis and risk assessment, along with consultations across all four divisions focused on health sector duty-bearers.

It is important to note that the adoption of the 2020-2025 Strategic Plan coincided with the Covid-19 pandemic which dramatically affected what the health sector delivered and how it did this. As the pandemic came after the Plan's publication, however, it does not feature in the Plan itself.

SECTION 4. INDICATOR STATUS BY STRATEGIC PLAN

4.1 INTRODUCTION

Workstream 2 involved the assembly of data by indicators as they appeared in the various strategic plans. These findings are presented first so that an overview of progress against stated intentions can be considered.

Findings are presented by plan by overall goal and outcome levels at this juncture. Where no data are available, these gaps are noted. At outcome level, narrative is offered to elaborate on findings.

Findings are presented for the most recent strategic plan and thereafter moves to each prior plan.

Note that the goals, strategic priorities, and outcomes are linked to the 2020-2025 plan, with data for previous plans provided where the outcome was previously included, even if different terminology has been used. This allows for better comparison. The extent of this alignment is included below the presentation.

4.2 STRATEGIC PLANS

Table 7: Strategic Plan 2020-2025

Goal/Outcome	Indicator	Definition	Baseline	Target	Actual
Goal: Universal Health Coverage by providing quality health care	Life expectancy at birth	Average number of years a newborn is expected to live	71.2 (2020)	73 (2025)	not available
Strategic Priority 1: Reform public health services to provide a population-based approach for diseases and the climate crisis					
Outcome 1.1: Reduce CD and NCD prevalence	Diabetes prevalence (%)	% of population aged 18+ with diabetes	16.8 (2020)	14.0 (2025)	not available
Outcome 1.2: Improve physical & mental wellbeing through prevention	Physical activity (%)	% of population meeting WHO recommendations for physical activity	36.0 (2020)	50.0 (2025)	not available
Outcome 1.3: Safeguard against environmental threats & public health emergencies	not specified	not specified	not available	not available	not available
Outcome 1.4: Strengthen population-wide resilience to the climate crisis	not specified	not specified	not available	not available	not available
Strategic Priority 2: Increase access to quality, safe and patient-focused clinical services					
Outcome 2.1: Improve patient health outcomes	Maternal mortality rate	# of maternal deaths per 100,000 live births	22.3 (2020)	15.0 (2025)	19.7 (2022)
Outcome 2.2: Strengthen and decentralise clinical services	Infant mortality rate	# of deaths 0-11 month olds per 1,000 live births	13.7 (2020)	10.0 (2025)	12.9 (2022)
Outcome 2.3: Continuously improve patient safety, & quality and value of services	not specified	not specified	not available	not available	not available
Strategic Priority 3: Drive efficient and effective management of the health system					
Outcome 3.1: Cultivate a competent and capable workforce	Doctor – population ratio	# of doctors per 10,000 population	6.7 (2020)	8.5 (2025)	7.1 (2022)
Outcome 3.2: Improve the efficiency of supply chain management, procurement, maint.	not specified	not specified	not available	not available	not available
Outcome 3.3: Implement more efficient financial processes, & reduce financial burden on poor	Government health expenditure (% of GDP)	% of GDP allocated to health sector	4.2 (2020)	5.5 (2025)	4.6 (2022)
Outcome 3.4: Ensure infrastructure is maintained	Population w/i 5km health facility	% of population living w/i 5kms health facility	85.0 (2020)	95.0 (2025)	87.0 (2022)

Goal/Outcome	Indicator	Definition	Baseline	Target	Actual
Outcome 3.5: Harness digital technologies to facilitate better health care	not specified	not specified	not available	not available	not available

Table 8: Strategic Plan 2016-2020

Goal/Outcome	Indicator	Definition	Baseline	Target	Actual
Goal: Universal Health Coverage by providing quality health care	Life expectancy at birth	Average number of years a newborn is expected to live	70.1 (2016)	72.0 (2020)	71.2 (2020)
Strategic Priority 1: Reform public health services to provide a population-based approach for diseases and the climate crisis					
Outcome 1.1: Reduce CD and NCD prevalence	Diabetes prevalence (%)	% of population aged 18+ with diabetes	16.0 (2016)	14.0 (2020)	16.8 (2020)
Outcome 1.2: Improve physical & mental wellbeing through prevention	Physical activity (%)	% of population meeting WHO recommendations for physical activity	34.0 (2016)	45.0 (2020)	36.0 (2020)
Outcome 1.3: Safeguard against environmental threats & public health emergencies	not specified	not specified	not available	not available	not available
Outcome 1.4: Strengthen population-wide resilience to the climate crisis	not specified	not specified	not available	not available	not available
Strategic Priority 2: Increase access to quality, safe and patient-focused clinical services					
Outcome 2.1: Improve patient health outcomes	Maternal mortality rate	# of maternal deaths per 100,000 live births	28.7 (2016)	20.0 (2020)	22.3 (2020)
Outcome 2.2: Strengthen and decentralise clinical services	Infant mortality rate	# of deaths 0-11 month olds per 1,000 live births	15.2 (2015)	12.0 (2020)	13.7 (2020)
Outcome 2.3: Continuously improve patient safety, & quality and value of services	not specified	not specified	not available	not available	not available
Strategic Priority 3: Drive efficient and effective management of the health system					
Outcome 3.1: Cultivate a competent and capable workforce	Doctor – population ratio	# of doctors per 10,000 population	5.8 (2015)	7.5 (2020)	6.7 (2020)
Outcome 3.2: Improve the efficiency of supply chain management, procurement, maintenance	not specified	not specified	not available	not available	not available
Outcome 3.3: Implement more efficient financial processes, & reduce financial burden on poor	Government health expenditure (% of GDP)	% of GDP allocated to health sector	3.8 (2016)	5.0 (2020)	4.2 (2020)
Outcome 3.4: Ensure infrastructure is maintained	Population w/i 5km health facility	% of population living w/i 5kms health facility	82.0 (2016)	90.0 (2020)	85.0 (2020)
Outcome 3.5: Harness digital technologies to facilitate better health care	not specified	not specified	not available	not available	not available

Table 9: Strategic Plan 2011-2015

Goal/Outcome	Indicator	Definition	Baseline	Target	Actual
Goal: Universal Health Coverage by providing quality health care	Life expectancy at birth	Average number of years a newborn is expected to live	69.2 (2011)	71 .0 (2015)	70.1 (2015)
Strategic Priority 1: Reform public health services to provide a population-based approach for diseases and the climate crisis					
Outcome 1.1: Reduce CD and NCD prevalence	Diabetes prevalence (%)	% of population aged 18+ with diabetes	15.6 (2011)	13.0 (2015)	16.0 (2015)
Outcome 1.2: Improve physical & mental wellbeing through prevention	Physical activity (%)	% of population meeting WHO recommendations for physical activity	31.0 (2011)	40.0 (2015)	34.0 (2015)
Outcome 1.3: Safeguard against environmental threats & public health emergencies	not specified	not specified	not available	not available	not available
Outcome 1.4: Strengthen population-wide resilience to the climate crisis	not specified	not specified	not available	not available	not available
Strategic Priority 2: Increase access to quality, safe and patient-focused clinical services					
Outcome 2.1: Improve patient health outcomes	Maternal mortality rate	# of maternal deaths per 100,000 live births	35.3 (2011)	25.0 (2015)	28.7 (2015)
	Infant mortality rate	# of deaths 0-11 month olds per 1,000 live births	16.8 (2011)	14.0 (2015)	15.2 (2015)
Outcome 2.2: Strengthen and decentralise clinical services	not specified	not specified	not available	not available	not available
Outcome 2.3: Continuously improve patient safety, & quality and value of services	not specified	not specified	not available	not available	not available
Strategic Priority 3: Drive efficient and effective management of the health system					
Outcome 3.1: Cultivate a competent and capable workforce	Doctor – population ratio	# of doctors per 10,000 population	5.0 (2011)	6.5 (2015)	5.8 (2015)
Outcome 3.2: Improve the efficiency of supply chain management, procurement, maintenance	not specified	not specified	not available	not available	not available
Outcome 3.3: Implement more efficient financial processes, & reduce financial burden on poor	Government health expenditure (% of GDP)	% of GDP allocated to health sector	3.5 (2011)	4.5 (2015)	3.8 (2015)
Outcome 3.4: Ensure infrastructure is maintained	Population w/i 5km health facility	% of population living w/i 5kms health facility	78.0 (2011)	85.0 (2015)	82.0 (2015)
Outcome 3.5: Harness digital technologies to facilitate better health care	not specified	not specified	not available	not available	not available

Table 10: Strategic Plan 2007-2011

Goal/Outcome	Indicator	Definition	Baseline	Target	Actual
Goal: Universal Health Coverage by providing quality health care	Life expectancy at birth	Average number of years a newborn is expected to live	67.5 (2007)	70.0 (2011)	69.2 (2011)
Strategic Priority 1: Reform public health services to provide a population-based approach for diseases and the climate crisis					
Outcome 1.1: Reduce CD and NCD prevalence	Diabetes prevalence (%)	% of population aged 18+ with diabetes	16.0 (2007)	14.0 (2011)	15.6 (2011)
Outcome 1.2: Improve physical & mental wellbeing through prevention	Physical activity (%)	% of population meeting WHO recommendations for physical activity	28.0 (2007)	35.0 (2011)	31.0 (2011)
Outcome 1.3: Safeguard against environmental threats & public health emergencies	not specified	not specified	not available	not available	not available
Outcome 1.4: Strengthen population-wide resilience to the climate crisis	not specified	not specified	not available	not available	not available
Strategic Priority 2: Increase access to quality, safe and patient-focused clinical services					
Outcome 2.1: Improve patient health outcomes	Maternal mortality rate	# of maternal deaths per 100,000 live births	35.3 (2011)	25.0 (2015)	28.7 (2015)
	Infant mortality rate	# of deaths 0-11 month olds per 1,000 live births	16.8 (2011)	14.0 (2015)	15.2 (2015)
Outcome 2.2: Strengthen and decentralise clinical services	not specified	not specified	not available	not available	not available
Outcome 2.3: Continuously improve patient safety, & quality and value of services	not specified	not specified	not available	not available	not available
Strategic Priority 3: Drive efficient and effective management of the health system					
Outcome 3.1: Cultivate a competent and capable workforce	Doctor – population ratio	# of doctors per 10,000 population	4.2 (2007)	5.5 (2011)	5.0 (2011)
Outcome 3.2: Improve the efficiency of supply chain management, procurement, maintenance	not specified	not specified	not available	not available	not available
Outcome 3.3: Implement more efficient financial processes, & reduce financial burden on poor	Government health expenditure (% of GDP)	% of GDP allocated to health sector	3.2 (2007)	4.0 (2011)	3.5 (2011)
Outcome 3.4: Ensure infrastructure is maintained	Population w/i 5km health facility	% of population living w/i 5kms health facility	75.0 (2007)	80.0 (2011)	78.0 (2011)
Outcome 3.5: Harness digital technologies to facilitate better health care	not specified	not specified	not available	not available	not available

Table 11: Measurements Across the Four Strategic Plans

Strategic Plan Period	Original Framework Level	Original Framework Description	Baseline	Target	Actual Achievement	Current SP Alignment
2007-2011	Goal	Improved health status of the people of Fiji	67.5 (2007)	70 (2011)	69.2 (2011)	Vision: A healthier Fiji
2007-2011	Outcome 1	Reduced burden of non-communicable diseases	16% (2007)	14% (2011)	15.6% (2011)	SP1, Outcome 1.1
2007-2011	Output 1.1	Increased awareness of NCD risk factors	45% (2007)	65% (2011)	58% (2011)	SP1, Output 1.1.2
2007-2011	Outcome 2	Improved maternal and child health	38.2 (2007)	30 (2011)	35.3 (2011)	SP2, Outcome 2.1
2007-2011	Output 2.3	Increased immunization coverage	84% (2007)	90% (2011)	88% (2011)	SP2, Output 2.2.1
2011-2015	Strategic Goal 1	Reduced burden of communicable diseases	28.4 (2011)	22 (2015)	24.2 (2015)	No direct equivalent
2011-2015	Strategic Goal 2	Reduced burden of non-communicable diseases	31% (2011)	25% (2015)	29.6% (2015)	SP1, Outcome 1.1
2011-2015	Health Outcome 3	Reduced maternal and child mortality	22.4 (2011)	18 (2015)	19.8 (2015)	SP2, Outcome 2.2
2011-2015	Objective 2.1	Improved health service delivery	65% (2011)	80% (2015)	72% (2015)	SP3, Outcome 3.4
2016-2020	Strategic Pillar 1	Universal Health Coverage	58% (2016)	70% (2020)	65% (2020)	SP3, Outcome 3.1
2016-2020	Priority Area 2	Reduce premature NCD mortality	28.2% (2016)	24% (2020)	26.1% (2020)	SP1, Outcome 1.1
2016-2020	General Objective 3	Strengthen health workforce	38.2 (2016)	45 (2020)	41.5 (2020)	SP3, Outcome 3.2
2016-2020	Specific Objective 4.2	Improve health information systems	85% (2016)	95% (2020)	91% (2020)	SP3, Outcome 3.5
2020-2025	Strategic Priority 1	Reduce burden of NCDs	762 (2020)	680 (2025)	[Data gap]	SP1
2020-2025	Outcome 1.1	Reduced NCD risk factors	32.1% (2020)	28% (2025)	[Data gap]	SP1, Outcome 1.1
2020-2025	Outcome 2.3	Improved child health	7.5% (2020)	5% (2025)	6.8% (2022)	SP2, Outcome 2.2
2020-2025	Outcome 3.4	Enhanced health service quality	3.6/5 (2020)	4.2/5 (2025)	3.8/5 (2022)	SP3, Outcome 3.4

4.3 DISCUSSION

While useful for tracking health delivery and health status over time, the ability to attribute improvements, or lack thereof, due to the strategic plans is not possible as this was not assessed in the reports that were issued. Given that this evaluation was not intended to measure impacts, this is not necessary, but it is nevertheless worthwhile describing the treats across the four strategic plans. These findings are summarised in the following table:

Table 12: Trends Across Strategic Plans

Goal/Outcome	Trend
Goal: Universal Health Coverage by providing quality health care	Steady improvement across all four strategic plans
Outcome 1.1: Reduce CD and NCD prevalence	Slight worsening of the problem
Outcome 1.2: Improve physical & mental wellbeing through prevention	Modest improvements, but targets not met
Outcome 1.3: Safeguard against environmental threats & public health emergencies	not available
Outcome 1.4: Strengthen population-wide resilience to the climate crisis	not available
Outcome 2.1: Improve patient health outcomes	MMR: steady improvement, but targets not met
	IMR: some improvement, but targets not met
Outcome 2.2: Strengthen and decentralise clinical services	not available
Outcome 2.3: Continuously improve patient safety, & quality and value of services	not available
Outcome 3.1: Cultivate a competent and capable workforce	Some improvement, but consistently below targets
Outcome 3.2: Improve the efficiency of supply chain management, procurement, maintenance	not available
Outcome 3.3: Implement more efficient financial processes, & reduce financial burden on poor	Gradual improvement, but consistently below targets
Outcome 3.4: Ensure infrastructure is maintained	Steady improvement, but below targets
Outcome 3.5: Harness digital technologies to facilitate better health care	not available

Overall findings indicated improvements across a number of health status and delivery measures, but not always on target. Chronic data unavailability affected six of the twelve outcome indicators.

SECTION 5. RELEVANCE AND ADAPTABILITY

5.1 INTRODUCTION

The evaluation criteria Relevance asks whether an intervention is doing the right thing. For this evaluation, it entails examining the extent to which the MoHMS strategic plans and the strategic planning process respond to the needs and priorities of the implementing agency and target groups. The evaluation criteria Adaptability has been grouped with Relevance as it covers how MoHMS adapted to continue to ensure relevance.

5.2 RELEVANCE

Table 13: Rating for Relevance

Rating for Criteria	Rating	Code	Description
	4		High rating on evaluation criteria
√	3		Moderate rating on evaluation criteria
	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

Overall Assessment[27]: The evaluation yielded a rating of 'moderate' in terms of the Relevance question 'is it doing the right thing?'. This is based on three core findings: 1) the strategic planning process has secured the commitment of all key actors, and is respected if done correctly, underlining a belief that the plans are well intentioned and properly focused; 2) the strategic plans mostly align with national priorities; and 3) the strategic plans are increasingly built on a solid understanding of the situation on the ground.

Discussion: The strategic planning process and content improved over time, and reflect concerted efforts in engaging with stakeholders in a meaningful manner (but largely limited to duty-bearers). There were of course limitations, but over time the planning process increasingly gave due consideration to challenges, opportunities and needed actions, and from the initial plans there was an effort hold the sector accountable for plan performance. The focus on NCDs was warranted, and intensified over planning cycles. The focus remained on prevention and the provision of primary health care services, while recognising that demand for clinical services was increasing. The shift from a focus on human resource development to a broader understanding of sector strengthening over time was a positive development as new plans emerged (in particular from 2016). Recognition of inequality in service provision and quality of service was guided by the situation analysis, and led to additional focus on how to strengthen service delivery where the need was greatest. Plans increasingly focused on reaching those most likely to be left behind, with specific reference to disability. Plans increasingly took on a life-cycle approach to programming.

While the operational plans were felt to be properly linked to the strategic plans, including when annual operational planning processes were put into place, a lack of attention to upward alignment meant that some business plans coming from the operational plan were not necessarily well aligned with the strategic plans, with the strategic plans providing little guidance. While a process of upwards alignment is stronger when a bottom-up process of planning takes place, the business plans focused more on the latter than the former, and there was little effort to link these priorities to the intentions of the strategic plans. This disconnect was most apparent for the 2020-2025 Strategic Plan where the disruptions of Covid-19 significantly undermined Plan implementation; . As accountability upwards to operational and strategic plans was weak, there was little incentive to align accordingly. This undermined alignment, but did allow sections to respond to felt needs more flexibly than might otherwise be the case.

[27] Relevance does not consider the effectiveness of actions taken but rather focuses on the efforts made in the planning process to align with national objectives, health needs, and trends in health status.

5.2.1 RELEVANCE AND ALIGNMENT

EQ1: How well aligned are the strategic plans with health requirements and trends as well as Fiji's developmental priorities, and has it adapted over time?

EQ1.1: To what extent are the strategic plans aligned with the needs of the health sector and health issues in Fiji?

EQ1.2: To what extent are the strategic plans aligned with policies and development priorities?

Overall Strengths: Key relevance attributes of the strategic plans, across the plans, were: 1) recognition of the key health challenges facing Fiji and reflecting this in the content of the plans; 2) recognition that the key health challenges required a focus on wellness and primary health care and prevention, in particular associated with NCDs, while also strengthening clinical health service delivery; and 3) attention to issues of alignment with Fiji's stated development priorities as reflected in the national development plan that governed the timeline for all these strategic plans, themselves aligned (initially) with the Millennium Development Goals and (thereafter) the Sustainable Development Goals.

The Planning Process: These attributes reflected the strength of the strategic planning **process** in terms of the situation analysis and linking this analysis to the stated priorities and outcomes. Those involved in strategic plan development engaged with a range of stakeholders to triangulate observations, conclusions, and plan content in an effective manner, overcoming evidence gaps as best as possible as plan development proceeded. Relevance was further illustrated by a growing recognition of the effects of climate change on health and well-being, and the importance of anticipating these impacts and planning accordingly. These issues were reflected in particular in the 2016-2020 and 2020-2025 strategic plans. This was also the case in the two most recent plans and their identification of particular health and well-being challenges facing poorer households, and recognition that different populations faced different vulnerabilities in this regard.

In addition, the rapid expansion of private health care services meant that the plans themselves needed to recognise the shifting nature of the health sector and what this meant for strategic planning. This is duly reflected in the last two strategic plans in particular. Partnerships with civil society is also noted, reflecting the delivery of some health services by non-state actors (e.g., mental health counselling services). Yet while the plans recognise the importance of the growing health private sector in particular, concrete means to strengthen the overall health sector is not elaborated in the plans, nor are these seen as desired outcomes but rather a statement of broader conditions that need to be considered.

Plan Innovation: As the strategic plans cascaded to operational plans and business plans the extent to which these aligned with the situation analysis weakened somewhat, and therefore the less relevant the strategic plans were to learning and innovation as implementation proceeded. For example, the strategic plans showed due recognition of demographic changes and factored this into their discussions in particular of clinical services and referral systems, while the rapid growth of peri-urban areas duly showed up in the more recent plans (from 2016 in particular). However, the situation analysis devoted less attention than warranted in terms of the links between rapid urbanisation and the expansion of informal settlements and the worsening of NCDs as well as communicable diseases, nor was it connected to increasing pressure at the higher end of referral network facilities in urban areas. This highlighted some weaknesses in connecting across the three strands of health care (systems strengthening, prevention and primary health care, and clinical services) within the strategic planning process, and reflected a deficiency in the strategic planning process.

More broadly, the ability to accurately state the problem was not always reflected in programming aimed at tackling these problems. For example, from the perspective of relevance and strategic planning, there was inadequate recognition of the challenges arising from referral systems that came from a growing distrust of the efficacy of the referral systems with the increasing public use of hospitals for out-patient services, and how to respond. This emergent problem, discussed as an efficiency issue below, challenged the relevance of the situation analysis in yielding strategic plan content reflecting the importance of tackling these issues, and disconnected the outcome associated with clinical services and referral systems from the actions that would be required to effect this.

Alignment: As the strategic planning process was routinised during the 2010s, the majority of key informants knowledgeable about the situation over time contended that alignment improved. The process of strategic planning proved to be of value to many of those involved at the various junctures, leading to the conclusion that the process of strategic plan development was specifically relevant to the needs of the health sector as reflected by the engagement of a wide range of stakeholders knowledgeable about the sector in the planning process. There was, nevertheless, a concern about the process employed for the development of the 2020-2025 Strategic Plan and the resultant content of this plan, and its relevance vis-à-vis the needs of the health sector. Key informants who were in the Ministry at the time contended that, while there were consultations, the rigorous approaches employed in particular for the 2016-2020 Strategic Plan were less robust for the 2020-2025 Strategic Plan. The result was a 2020-2025 Plan that was felt to be less 'grounded' in the perceptions and experience of those involved in the health sector. The problem was worsened by insufficient attention to the development of the indicators used to consider Plan progress which undermined Plan utility, whatever the strengths of the Plan content itself.

A more detailed discussion with key informants who observed both 2016 and 2020 processes noted that this was unfortunate, as the shift from two to three strategic objectives from the 2016-2020 Plan to the 2020-2025 Plan showed a better understanding of the health challenges facing the country and how the health sector could respond. For 2016-2020, the first strategic objective grouped all health care together, covering preventive, curative and rehabilitative services, while for 2020-2025 this was divided into two strategic priorities, one covering population-based approaches and another covering service provision. This was in part intended to show recognition of the varied skills and activities and problems that fell under each of these, but was also in part intended to highlight the worsening of resourcing of the population-based approaches as funds concentrated on clinical delivery. This shift was felt to be a primary example of the efficacy of the planning process in identifying the nature and magnitude of the problem.

Regarding alignment with the Healthy Islands Initiative, the Astana Declaration, and the WHO guidelines on Essential Public Health Functions, these were reflected in the previous plan and were covered in a useful fashion in the 2020-2025 Strategic Plan, connecting these with Plan objectives. The WHO guidelines, for example, are represented in how the Plan deals with public health intelligence, public health protection covering both emergencies and health threats, public health promotion, as well as governance. In these respects, plan alignment with relevant protocols and international agreements is positive.

Some health sector key informants highlighted challenges associated with internal Ministry policies and the policies and plans of other ministries and uncertain alignment with objectives as elaborated in the strategic plans. While the strategic plans themselves list out the various policies that affect the health sector, there is no critical analysis, nor an assessment of how they intersect with the strategic plans. This, and the lack of discussion of specific policy alignment in the plans, suggest that this concern is warranted. A few key informants that were aware of how theories of change are used in development programmes contended that a well-designed theory of change in the strategic plans would have aided due consideration of such internal and cross-sector alignment, and made these explicit.

Regarding alignment with the Healthy Islands Initiative, the Astana Declaration, and the WHO guidelines on Essential Public Health Functions, these were reflected in previous plans and were covered in a useful fashion in the 2020-2025 Strategic Plan, connecting these with Plan objectives. The WHO guidelines, for example, are represented in how the Plan deals with public health intelligence, public health protection covering both emergencies and health threats, public health promotion, as well as governance. Having said that, within each there are gaps that would warrant further elaboration including, for example, strengthening surveillance around communicable diseases, regulatory reform and accountability mechanisms, and how coordination is to be handled. Under primary health care, this is clearly presented and linked to key innovations such as the WHO PEN interventions and the Integrated Management of Childhood Illness are referenced and their principles are threaded through the Plan, but the central role of cross-sectoral coordination in effecting change (with particular reference to the role that this plays in preventing NCDs) is not clear. There are particular gaps in terms of how community-based care fits into primary health care, how the system functions and is incentivised, and what reforms are needed[28]. Similarly, there are critical gaps in

[28] This was thereafter covered in detail in a study supported by the World Bank and is discussed below.

elaborating how vulnerable populations will be reached, including for example people living in informal settlements which comprises some 15% of the population of Fiji.

Plan Content, Approach and Vulnerable Groups: One further relevance issue was the way in which the strategic plans considered gender, inclusion, vulnerability and similar, and how health needs and effective modalities to reach varied populations. The discussion of these issues improved across successive plans, and reflected a nuanced understanding of how the health sectors needs to meet the varied needs of different populations. By 2016, this was being framed in the context of human rights. However, what is not clear from the plans is how these issues are mainstreamed in terms of sector delivery, and how these extent to objectives beyond reference to women, men and persons with disabilities. Lessons on alignment were noted to be present in proposals for donor financing where these cross-cutting issues receive considered attention, but this has not influenced the strategic planning process overall. And further to alignment issues with other ministries, the discussions around gender and inclusion did not link to policies in place in other ministries that deal with just these issues, including cross sectoral policies around gender.

5.3 ADAPTABILITY

EQ1.3: To what extent are the strategic plans adapted over time to emergent needs?

Adaptation was included under the Relevance discussion, but warranted a separate overall assessment:

Table 14: Rating for Adaptation

Rating for Criteria	Rating	Code	Description
	4		High rating on evaluation criteria
	3		Moderate rating on evaluation criteria
√	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

Overall Assessment[29]: The evaluation yielded a rating of 'somewhat low' in terms of the Adaptation question 'did the intervention positively adapt over time?'. This is based on the following core findings: 1) adaptation was less based on innovation and forward thinking and more based on coping with unexpected situations as they arose; 2) in those cases where this adaptation met the challenge (e.g., Covid-19), this was not connected to the strategic planning process nor was the effect of negative changes arising from Covid-19 strategic planning process considered (e.g., flattened administration structures that undermined planning and the ability of planning to influence other sections of the Ministry) ; and 3) the strategic plans recognised the importance of adapting to the effects of climate change but did not elaborate a clear way forward.

Discussion: *Structurally* in terms of the strategic planning *process*, the cascade approach to planning did allow adaptation to emergent issues through annual operational plans, but the operational plans responded to emergent challenges more so than anticipating these challenges or, more accurately, responding effectively to those who had anticipated the challenges. Business plans coming from the operational plan were not necessarily well aligned, as noted above, and this stifled learning and innovation upwards to the operational plans and the strategic plans during plan implementation. These voices were largely heard in the design of the next strategic plan, albeit with constraints in particular for the 2020-2025 Plan.

Operationally in terms of strategic plan *implementation*, the results of the evaluation suggest that adaptation mostly occurs outside the rubric of strategic planning, and involved a mix of proactive and reactive actions taken at operational level that did not feed back into consideration of implications for strategic planning. In part this reflects an absence of evaluation activities, in this case the lack of mid-term reviews, that would

[29] Adaptation comprises two components: 1) adaptation as problems arose within an existing strategic plan; and 2) adaptation incorporated into the strategic planning process.

have systematically considered learning and adaptation and make recommendations for the remaining plan implementation period. It also reflects limitations in annual reporting against the strategic plan, where informed adaptation can be highlighted and reported. Fiji has a professional civil service and a number of highly trained and well experienced officers, and this holds true for MoHMS, despite staffing shortages and mis-placement of some of these officers (discussed further below under efficiency). There is, however, considerable volatility in political leadership that comes from a certain volatility in governance overall. Changes in structures, changes in tiering with management, this kind of restructuring affects the efficacy of planning as well as plan implementation. The effect of this volatility has meant that the ability of the Ministry to deliver against what it states it wants as indicated in the strategic plans is undermined. Adaptation, in this respect, can be both a positive and a negative attribute. It can yield instability in how operational plans are developed and implemented, and thereafter what this means for business plans, but at the same time it allows for new ideas and innovations to emerge. Given the nature of the current strategic planning process, these changes only emerge when the next five year plan is developed.

This means that adaptation is taking place, but is taking largely outside of the strategic plan implementation process. Field findings highlight adaptation occurring at operational levels, sometimes reflected positively in securing donor financing to enable warranted actions (e.g., programme strengthening, regulatory developments and reforms, policy development and implementation, etc.), and sometimes more focused on coping with emergent problems (e.g., solving immediate problems in specific circumstances such as resolving a problem at central stores).

In both situations this reflects a process of adaptation that is not reflected in broader learning at the strategic plan level, and as a result undermined lessons learned across cost centres and during strategic plan implementation at Ministry and sector levels. This has meant that adaptation is more reactive rather than proactive, trying to deal with problems after they emerge and not focusing on how the problems fit within a broader context of other challenges to sector deliver. Missed opportunities for evidence-informed adaptation are noted to have had real world consequences, for example not anticipating the rise in HIV infections due to intravenous drug use or not anticipating negative trends in terms of use of family planning methods to prevent unwanted pregnancies that can also play a role in preventing HIV infection (e.g., condoms).

Having noted these problems, there are examples of positive adaptation in terms of major challenges arising, but it is relatively unusual that these are linked to evidence generated through the planning process. As noted above, this linkage is undermined by the lack of systematic evaluation within the planning system, but at those unusual points where it does take place (e.g., the mid-term review of the 2011-2015 Strategic Plan), it can lead to change. In that particular case, it created momentum for the development of a Wellness Unit, and it led to strategies being put into place for enhanced staff retention. On the other hand, similar evaluation activities that did not take place could have played an important role in, for example, responding to the unintended consequences of restructuring under Covid-19 that has weakened the planning section and undermined plan implementation.

And while not strictly evaluative in nature, problem identification when preparing for the next strategic plan has led to some rapid innovations, such as the expansion of health sector training opportunities within Fiji, the development of new professional standards, attention to regulatory reform, and similar. These assessment processes are not as robust as they might be, a number of key informants noted, and as a result important opportunities are missed or undervalued. On the clinical side, particular problems with regard to over-burdened hospital services were the result.

With regard to disaster preparedness and response, the 2020-2025 Strategic Plan devoted more attention to these matters than previous plans, reflecting learning that occurred during the assessment and situation analysis processes put into place for development of the next strategic plan. Fiji learned from Tropical Cyclone Winston and established a much more robust disaster preparation and response system, inclusive of health. For the 2020-2025 Plan, the level of detail that would have reflected these lessons learned as they relate to the planning process represents a missed opportunity. Unfortunately, this information was not presented in a manner that yielded concrete, pro-active actions. The resultant lack of strategic direction from the 2020-2025 Plan undermined the clarity of planning and programming for climate change and for disaster preparation and response. As one high level key informant put it, ‘we had the pieces to the puzzle after we learned from TC Winston, we had the documents. We knew what we had to do to prepare for disaster and

respond to disaster, but we didn't following through'. The importance of the proposed climate hazard assessment system, for example, was recognised but lost momentum, and the lack of strategic plan evaluation meant that the planning process was not able to further such reform.

With Covid-19, it was similar. The Strategic Plan did not provide clear guidance on how to deal with pandemics such as Covid-19. Had the Strategic Plan helped strengthen disaster preparations, and had it helped Government learn from outbreaks such as dengue and Ebola, it would likely have been able to strengthen the Covid-19 response from the beginning. Instead, it was disconnected from the follow-up Covid-19 planning and implementation. One medical doctor in MoHMS lamented that this same lack of contribution appeared to be playing out in the emergent HIV crisis.

As one key informant in the development community noted, 'the strategic plans speak of the importance of adapting to problems as they emerge, but this is not fully reflected in decision-making on the ground. In part the problem is that while adaptation is seen as important in the strategic plan, it doesn't appear to be 'translated' into the plans developed based on the strategic plan. Adaptability should be a valued norm.'

SECTION 6. COHERENCE

6.1 INTRODUCTION

The evaluation criteria Coherence asks how well an intervention 'fits'. For the MoHMS Strategic Plans evaluation, this considers how well the plans 'fit' into how the Ministry views its role and executes its roles in health sector leadership and delivery, how this has or has not contributed to a more coherent health sector approach to delivery, and how these fits into the health needs of the population.

6.2 OVERALL FINDINGS

Table 15: Rating for Coherence

Rating for Criteria	Rating	Code	Description
	4		High rating on evaluation criteria
√	3		Moderate rating on evaluation criteria
	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

Overall Assessment: The evaluation yielded a rating of 'moderate' in terms of the Coherence question 'how well did the intervention fit?', with some aspects of Coherence rated as 'somewhat low' and therefore warranted light shading under that cell. This rating is based on the following core findings: 1) coherence during planning was enabled through solid situation analyses informed by a wide range of stakeholders, followed by a clear statement of what the main challenges and opportunities were; 2) it was reflected at operational level, but it was not feeding back into the strategic planning process, therefore it created additional incoherence. Learning is not built into the structural response; 3) the strategic plans worked hard to clearly express how the Ministry and the health sector more broadly fit in terms of meeting priorities and overcoming challenges, albeit with limitations on how the private sector is supposed to be engaged; and 4) despite this, coherence as implementation proceeded diminished in particular with regard to the coherence of health delivery including the private sector and civil society (thus the core reason for the light shading under 'somewhat low').

Discussion: The strategic plans endeavoured to place the plans and the process in terms of how the Ministry thinks and the sector delivers, building on what works and helping health actors to overcome deficiencies. This coherence was reflected both in the considered situation analyses that improved over time, and in priorities established and targets identified.

However, the coherence reflected in the plan development process faded as implementation proceeded, reflecting an inability of the plans to contribute over time to coherence in health sector delivery overall, and in influencing how delivery occurred in a manner that would help advance towards objectives.

There were particular challenges during implementation associated with the role of the private sector in health delivery, and in ensuring the coherence of health sector programming and delivery overall.

6.3 LEVEL OF 'FIT' AND COHERENCE IN DESIGN & DELIVERY

EQ2: How has the strategic planning process fit in terms of how the health sector delivers, and how did it support health sector coherence in delivery over time?

EQ2.1: How has the strategic planning process and content enabled more coherent approaches to health sector delivery across actors involved in the health sector?

EQ2.2: How has the strategic planning process and content supported an improved understanding of health sector challenges and needs

Commitment and Engagement: There is a clear commitment to planning within the Ministry, and this commitment remains strong, despite many criticisms associated with plan implementation, monitoring and adaptation over time. This held true even at the highest levels within the Ministry. With the exception of the process for developing the 2020-2025 Strategic Plan and inadequate follow-through connecting business plans back to the operational plan and the strategic plans, there were few criticisms of the planning process itself. Indeed, there was widespread agreement with the intentions and approaches as elaborated in the plans that strengthened up through the 2016-2020 Plan. While the content of the 2020-2025 Plan was also felt to have been consistent with the needs of the country and had offered an important overview of health sector challenges that it responded to, the process of 2020-2025 Plan development was felt to have been deficient. For the 2020-2025 Plan, the clarity offered by the separation of what they referred to as population-based approaches to the health sector from patient services

Having said this, a review of the consultative protocols for plan development suggests that, while considered attention has been devoted to widespread duty-bearer engagement (that is, those who deliver in the health sector at various levels, and those who are involved in governance of the health sector), but less so community level actors and households. The latter includes those who engage as duty-bearers but who are also rights holders such as local leaders and volunteers, while the latter are rights-holders who are the sector's customers.

Findings from discussions with various development partners suggest that they also take the Ministry's strategic planning process seriously, and that they do see a clear 'fit' of Government work in the health sector to the country's needs and development priorities. It is considered to be the Ministry's most clear expression of objectives and priorities. While development partners have their own objectives in providing assistance, they also endeavour to match these with the intentions of governments, and this is how it has been expressed during interviews. And while they recognise that Government takes the lead and must be seen to take the lead, there is a concern that their engagement in the planning process could have been stronger, both during design and during implementation.

Problem Statement: As discussed under Relevance, the planning process reflects solid situation assessments that have improved over time, even in the case of what was viewed as a weakened planning process for the 2020-2025 Strategic Plan. The problem relevant for Coherence is that the link between this solid analysis and clear solutions that can be affected in five years are less clear in the plans. While areas of particular concern are identified, such as the imbalance in expenditures between clinical services and preventive and primary health care, the plans do not sufficiently elaborate a way forward that would support coherence in delivery over time.

As one high level health officer put it, 'the strategic plans have a good sense of how health sector delivery occurs, and what is wrong, and what patterns there are to this dysfunction. But the plans don't take this understanding forward in a clear way to indicate what should be done. Better defining solutions, or rather solution processes, is critical and currently missing. As a result, the gap between what the plans understand and what is delivered under the plans increases over time'. Overall, the plans are increasingly focused on linking needed changes with an understanding of problems and priorities. As one key informant observed, 'this is a strategic way of looking at things. But this understanding of health requirements and trends is one thing, the actual commitments made under the plans need to be consistent with these priorities. At the end of the day, facility-based services at central point's see increasing pressure to perform, and this attracts

attention and funds. And below this, commitments to things like adolescent health don't appear to be linked to commitments, programmatic focus, human resourcing and training etc.'.

Institutional Structures and Coherence: The evaluation found some institutional structure issues within the Ministry that challenge the coherence of strategic planning and its ability to influence plan implementation over time. This, when coupled with the plans themselves not clearly elaborating the effects of the current and needed institutional structures and describing a process of reform weakens the ability of the plans to deliver, and furthers the disconnect between plan content and actions thereafter. One specific issue relates to restructuring that took place during Covid-19 that, while serving effectiveness in terms of the response to Covid-19, means that the Planning and Policy Development Division's oversight role is not enabled by a flattened structure within the Ministry. It's ability to influence the direction of plan implementation was noted to have weakened under this arrangement. Between this and the effects of Covid-19, and the Division has not been able to release the past few annual reports in a timely manner, undermining its role in influencing the direction of implementation with effective evidence backing decision-making.

Related to institutional structures was clarity of roles and responsibilities and systems of accountability that would further strengthen plan delivery. This would include achievement of plan objectives. Health system issues are considered in the plans, but the plans do not provide specifics in terms of how these improvements can be made, and described in terms of specific, achievable outcomes. Rather, they are just identified as issues needing attention. As a result, planning against these objectives remains largely undirected. Both 2016 and 2020 mentioned the critical issues around health system structure and function, for example, but did not use the planning process to describe how change could take place, nor outcomes specified in this regard.

Plan Focus: In the absence of a higher-level overarching health policy or a carefully constructed vision document, the strategic plans have become the focus of attention for high level 'aim' statements or high level 'ultimate outcome' statements under 'outcomes' that are far beyond what a five-year strategic plan can deliver. Two problems emerge in this regard: 1) progress towards these high-level outcomes is partially tracked, but there is no clear connection between the values found and the effects of plan delivery; and 2) when these high-level outcomes do not move in the desired direction (e.g., NCD prevalence declines by X%), there is frustration that progress is not being made.

The findings from Workstream 2 that focused on tracking progress against indicators illustrates both of these problems. The results show progress, but not necessary progress against these higher-level outcome statements. Significant progress is being made, but rather than seen to be what it is – solid progress – it is rather lamented that more should have been done.

One idea is to separate out the longer term aims from what can be achieved in a five-year strategic plan timeline. Interview findings within the Ministry suggest support for such an idea, allowing 'ultimate outcomes' or aims or impacts to be considered from a 25–30-year cycle and letting the five-year plans identify the equivalent of 'interim outcomes' that the Ministry and other actors feel are possible. This would have the added benefit of measuring the attainment of the interim outcomes, and progress towards them, in an 'operational' manner that would encourage real time monitoring and the utilisation of tools such as dashboards to reflect progress.

Policy: Some of the key informants raised a concern with regard to the absence of an overarching Health Policy and how this undermined the efficacy of strategic planning. While this is not the subject of this evaluation, the contention was that having such a policy would strengthen the health planning process because it could describe what can enable planning in a manner that strengthens the role of planning in sector delivery. The absence of a policy was felt to have left important points unsaid, including with regard to planning and the particular role of the strategic plans in the direction the Ministry takes. One specific issue mentioned was the need for policy clarity around the respective roles of Government, the private sector, and civil society in the sector, and how these actors can better work together. Another example was the critical role of health sector financing and the importance of health insurance schemes that reach uninsured populations. A third example was better clarity in terms of how the health sector can strengthen climate change response and disaster response and recovery.

Theory of Change: Related to the previous point, Coherence is undermined by a clear understanding of the causal chain behind plan outputs and outcomes and a clear understanding of enabling and disabling factors.

To ensure a better understanding of these factors, donor interventions in particular have (to varied levels of success) elaborated these causal chains in theories of change. In addition to the above elements, assumptions and hypotheses are specified, and this forms an important tool for tracking progress.

For the strategic plans, the *absence* of a clear theory of change has meant that these various factors, while often mentioned in various sections of the plans, are not brought together in a meaningful matter that can help improve coherence in delivery over time.

Learning: In the past few years, the Ministry has overseen assessments that offer powerful insights into health sector operations and delivery, including the two studies supported by the World Bank and the Ministry's commissioning of this evaluation, as well as the follow-on Health Summit which will engage a wide range of stakeholders and help 'crowdsource' a way forward for health sector innovation and change. Yet while learning is mentioned repeatedly in the plans, it is not presented in a manner where operational decisions can be made that would advance desired outcomes. Clarity in this regard would strengthen a process of critical thinking in terms of considering the coherence of plan delivery and inculcate critical thinking into the learning process.

Other: The evaluation raised a broader range of coherence issues with regard to legislative frameworks, the enforcement of laws, accountability and quality control that fall outside the remit of the evaluation itself. In a number of these cases the concerns related to an environment that undermined the coherent delivery of health services. Where the planning process does apply here is threefold: 1) the plans contain a listing of policies, regulations and laws that guide implementation in the sector, but none are described in an 'active' manner that would enable plan implementation; 2) the plans do not enable reform of this broader environment because such reform is not considered as plan-relevant outcomes; and 3) the absence of (1) and (2) means that the ability of the strategic planning process to effect changes in terms of accountability and governance more broadly is weakened.

SECTION 7. EFFECTIVENESS

7.1 INTRODUCTION

The evaluation criteria Effectiveness asks whether an intervention is achieving its objectives. Here this refers to how well the strategic plans and the planning process advanced the sector's objectives and delivered against objectives. This includes the effectiveness of Coordination arrangements and their use.

7.2 OVERALL FINDINGS

Table 16: Rating for Effectiveness

Rating for Criteria	Rating	Code	Description
	4		High rating on evaluation criteria
√	3		Moderate rating on evaluation criteria
	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

Overall Assessment: The evaluation yielded a rating of 'moderate' in terms of the Effectiveness question 'how well the intervention achieved its objectives?'. This is based on the following core findings: 1) the strategic plans duly recognised the need for actions around policy, procedures, resource strengthening and allocation and similar; 2) progress towards health outcomes was not clearly connected to plan objectives, but progress was made nonetheless; and 3) without results reporting at operational level, it is difficult to say that what was delivered at activity level yielded results

Discussion: While not necessarily fully or clearly elaborated, the strategic plans were able to help focus attention on needed improvements in terms of health care system functioning and strengthening (in particular around human resource development) that build on a common understanding among many actors about the importance of these needed improvements, and reinforced commitment. These were not, however, expressed as important outcomes or even results of plan implementation, reflecting a missed opportunity for the plans to add further credence to these actions. Nevertheless, as the following will show, progress was made against a range of objectives that suggest that the plans may have contributed to these successes, but the absence of systematic procedures for learning and reporting undermines this connection.

For the objectives themselves, they were too health status focused, disconnected with what could have been delivered given resources and the time needed for health status to change, and did not accurately reflect an understanding of the situation on the ground when setting targets (even though the magnitude of the problem was contained in the situation analysis presented in the later plans). The result was a series of missed opportunities around what could have been process objectives and means to effect possible change based on realistic targets and approaches. Nevertheless, while too health status-focused and therefore only partially relevant to the needs of the planning system and the health system overall, progress was made.

7.3 PROGRESS TOWARDS OBJECTIVES AND DESIRED OUTCOMES

EQ3: To what extent has the intervention progressed towards achieving its objectives, how well the strategic planning process coordinated to do this, and how effective the result was of this coordination?

EQ3.1: How has the strategic planning process and content led to desired outcomes?

Workstream 2 involved careful tracking of available data focused on the current strategic plan. As reports for the past three years were not readily available but some of the information was, this activity involved

extensive working sessions with the Planning Directorate and pulling together data from various sections of the Ministry. Broader data associated with private sector delivery was not, unfortunately, available, and is therefore not included in the following.

Progress Towards Strategic Priority 1: Reform Public Health Services to Provide a Population Approach for Diseases and the Climate Crisis

Fiji's implementation of Strategic Priority 1 reveals a complex landscape of achievements and challenges across its four sub outcomes 1.1 to 1.4 below. After analysing the comprehensive data from all outcomes and outputs, the overall status can be characterised as partially achieved, with significant variations in progress across different components of the public health reform agenda.

The Ministry has demonstrated notable success in establishing preventative infrastructure and community engagement systems, evidenced by the exceeding of targets for healthy settings (59 vs target of 52), high activation of Community Health Workers (99.6% vs target of 70%), and strong COVID-19 vaccination coverage (104% first dose, 95.2% second dose). These achievements reflect effective mobilization of resources and implementation capacity for specific high-priority initiatives.

However, these programmatic successes have not consistently translated into improved population health outcomes. Communicable disease indicators show alarming increases, with leptospirosis surging to 610.4 cases per 100,000, dengue reaching 681.1 cases per 100,000, and tuberculosis rising from 47 to 68 cases per 100,000. Similarly, premature NCD mortality remains stubbornly fixed at 64.6, despite extensive preventative programmes. This disconnects between programme implementation and health outcomes represents the most significant challenge in the Ministry's reform efforts.

Implementation across the strategic priority has been uneven, with some components showing strong progress while others lag significantly. Mental health integration has advanced impressively from 27.5% to 55.3% of facilities adhering to mhGAP guidelines, and typhoid case fatality has been eliminated from 4.8% to zero. In contrast, early antenatal care booking has declined from 38% to 28%, breastfeeding rates have fallen dramatically from 77% to 44-46%, and climate resilience assessments of healthcare facilities only began in Year 3 after two years of inaction.

The reform agenda has been particularly challenged in addressing environmental determinants of health and climate resilience. Access to improved drinking water sources has barely increased (95.42% to 95.45%), access to improved sanitation has slightly declined (49.24% to 48.79%), and only one healthcare facility (23% of targets) has been assessed for climate resilience despite Fiji's high vulnerability to climate-related disasters. These areas require urgent attention given their fundamental importance to population health in the face of increasing climate threats.

As the strategic plan approaches its conclusion in July 2025, the Ministry faces the critical challenge of addressing implementation gaps in surveillance, case management, and climate resilience while maintaining the momentum in areas showing positive progress. Strategic reallocation of resources toward underperforming components, strengthened monitoring systems to identify and respond to concerning trends, and greater emphasis on translating programmatic activities into measurable health outcomes will be essential to advance the public health reform agenda effectively in the remaining implementation period.

Progress Towards Outcome 1.1

The Ministry of Health and Medical Services has encountered profound challenges in achieving Outcome 1.1, with data revealing an alarming trajectory of worsening disease burden despite substantial investments in preventative infrastructure. Communicable diseases have shown troubling increases across multiple categories: leptospirosis has surged dramatically to 125.5 cases per 100,000 population (later reaching 610.4), dengue fever has escalated to 523.07 cases per 100,000 (ultimately reaching 681.1), and tuberculosis has risen from 47 to 68 cases per 100,000 population. Meanwhile, premature NCD mortality remains stubbornly fixed at 64.6, suggesting that the comprehensive preventative programmes established under Output 1.1.1—which successfully delivered 59 healthy settings (exceeding the target of 52), accredited 351 health-promoting schools, and achieved 105% of population screening targets—have not translated into tangible reductions in disease burden for Fiji's population.

This disconnects between strong programmatic foundations and poor health outcomes becomes particularly evident when examining the implementation gaps in surveillance and case management under Output 1.1.3. Despite achieving 100% reporting completeness in early warning systems and successfully mobilising 99.6% of Community Health Workers (far exceeding the 70% target under Output 1.1.2), the Ministry has experienced a troubling regression in field response capacity, with investigation rates for locally transmitted diseases falling to 51% from a previous 83%. Disease-specific management shows critical weaknesses, with tuberculosis treatment success stalled at 53% against an 80% target, HIV viral suppression reaching only 10% of patients, and geographic disparities revealing how national averages mask significant regional vulnerabilities, exemplified by the Northern Division's alarming 15% dengue fatality rate compared to the 0.35% national average.

The persistent and worsening disease indicators suggest that vulnerable populations remain disproportionately affected despite the Ministry's impressive achievements in establishing preventative infrastructure and community engagement systems. Environmental factors, including climate change impacts that create favourable conditions for vector breeding and pathogen transmission, may be outpacing current control measures, while implementation gaps between well-designed programmes and effective field-level execution continue to undermine disease control efforts. As the strategic plan period approaches its conclusion, these findings necessitate a fundamental reassessment of the Ministry's approach, with greater emphasis needed on strengthening the critical final steps of the disease control continuum—effective surveillance, case management, and treatment adherence—that ultimately determine whether strong preventative foundations translate into improved population health outcomes, particularly for Fiji's most vulnerable communities.

Progress towards Output 1.1.1: Preventative Programmes Targeting Risk Factors

The Ministry has demonstrated significant progress in implementing preventative programmes targeting risk factors under Output 1.1.1, with evidence of strong achievement across multiple indicators and consistent improvement over the strategic plan period. The data reveals a pattern of expanding preventative health infrastructure and growing reach of screening and awareness activities, though with some variation in implementation across different components.

The establishment of healthy settings shows impressive growth, increasing from a baseline of 21 to 59 healthy settings by Year 3, exceeding the target of 52. This 181% increase from baseline demonstrates substantial expansion of wellness-focused environments and suggests successful advocacy for the healthy settings approach across multiple sectors. The consistent upward trend indicates sustained momentum in this foundational preventative health strategy.

School-based health initiatives show mixed but generally positive results. While early data for health promoting school audits (10.7% of schools, covering 12 schools) and nutritional assessments (8.3% of schools, covering 31 schools) suggest limited initial coverage, by Year 3 the programme had achieved accreditation of 351 schools through the Health Promoting Schools programme. This represents significant scaling of school-based preventative health efforts. The dental fitness programme for 12-year-olds shows consistent improvement from 44.3% to 86% of the target age group made dentally fit, though actual achievement (56%) fell below the target, suggesting implementation challenges.

Population screening activities demonstrate substantial growth and over-achievement of targets. The percentage of targeted population screened for CD or NCD risk factors increased from an initial 24% (covering 940 SOPD cases) to 105% by Year 3, exceeding the target and indicating successful expansion of screening services. This over-achievement suggests either effective mobilization of resources or possibly conservative initial target-setting. The 501 awareness and screening campaigns conducted in Year 3 (with actual achievement of 969) further demonstrates the extensive reach of preventative health messaging and services.

Strategic planning and targeted interventions for vulnerable populations show completion of key deliverables. The development of the NCD strategic plan was initiated with a draft completed, though the data doesn't confirm final approval. The food and nutrition security programme implementation increased from 80% to 100% of targeted activities, indicating full implementation by Year 3. The chronic disease line

list and environmentally at-risk groups line list were both reported as 100% updated, suggesting effective tracking systems for vulnerable populations.

Overall, the data presents a picture of substantial progress towards Output 1.1.1, with most indicators showing positive trends and several exceeding targets. The Ministry has successfully expanded preventative infrastructure through healthy settings, significantly scaled up screening activities, and established systems for tracking vulnerable populations. School-based interventions show mixed results but with evidence of substantial expansion in coverage.

The consistent upward trends across multiple years suggest sustained commitment to preventative approaches and growing capacity for implementation. The over-achievement in several areas, particularly in screening campaigns and healthy settings establishment, indicates effective mobilization of resources and possibly conservative initial target-setting. The comprehensive approach addressing settings, schools, population screening, and vulnerable population tracking demonstrates a multi-faceted strategy to preventative health that aligns well with the output objective.

Progress towards Output 1.1.2: Strengthened Integrated Approach to Preventive Initiatives in Communities

The Ministry has demonstrated substantial progress towards Output 1.1.2, focusing on strengthening integrated preventive initiatives in communities through multidisciplinary teams. Based on the available data covering years 1-3 of the strategic plan, the implementation shows varying degrees of success across different components of community-based preventive health services.

The Community Health Worker (CHW) programme represents a notable achievement with 99.6% of CHWs reported as active, significantly exceeding the target of 70% and even surpassing the more ambitious benchmark of 96%. This high activation rate of community health workers provides a strong foundation for extending primary healthcare services into communities and supporting preventive health initiatives at the grassroots level. The successful maintenance of an active CHW workforce indicates effective systems for recruitment, support, and retention of these critical frontline health workers.

Outreach services demonstrate positive but incomplete progress, with 94% coverage of scheduled outreach visits against a target of 100%. The implementation of 11 outreach visits (with 97% accuracy) suggests a systematic approach to community-based service delivery. The adaptation of outreach activities to include COVID-19 screening during the pandemic period demonstrates flexibility in the outreach programme to respond to emerging health priorities. While falling slightly short of the target, the 94% coverage rate represents substantial achievement in extending preventive services beyond facility-based care.

The community engagement training component exceeded expectations significantly, with 150% of scheduled trainings conducted. This over-achievement suggests either an initial underestimation of training needs or an opportunistic approach to capacity building that capitalised on available resources and opportunities. The substantial over-delivery on training targets indicates strong institutional commitment to building community engagement capacity among CHWs and potentially reflects successful mobilization of resources for this activity.

Overall, the data suggests that the Ministry has made strong progress towards Output 1.1.2, with performance exceeding targets in two of three measured indicators and approaching the target in the third. The high percentage of active CHWs (99.6%) and over-achievement in training delivery (150%) are particularly noteworthy successes. The slightly lower performance in outreach coverage (94% vs 100% target) still represents substantial achievement while highlighting an area for continued attention.

The available data presents a picture of a well-functioning community-based preventive health system with strong human resource capacity through active CHWs, comprehensive training programmes, and extensive outreach services. These achievements provide a solid platform for continued strengthening of integrated preventive initiatives in communities through the remainder of the strategic plan period.

Progress towards Output 1.1.3: Strengthened Surveillance, Case Detection and Diagnosis for CDs and NCDs

The Ministry's journey toward strengthening surveillance, case detection, and diagnosis for communicable diseases reveals a landscape of mixed achievements through 2022-23. With the strategic plan period

concluding in July 2025, the available data paints a picture of moderate but inconsistent progress, with approximately 60-65% of targets achieved and notable variations across different disease control programmes.

Surveillance infrastructure development shows encouraging signs, with the Early Warning, Alert and Response System achieving 100% reporting completeness and 84-94% timeliness. This foundation proved valuable during the COVID-19 response, where the Ministry successfully implemented 94.7% of planned activities and developed comprehensive outbreak preparedness plans. The discarded non-measles rate of 2.30 per 100,000 population further indicates that active surveillance for vaccine-preventable diseases is functioning adequately.

However, the management of locally transmitted diseases reveals a troubling regression in field response capacity. Investigation of LTD cases with preventative measures has declined to 51%, down from a previous high of 83% and now falling below even the baseline of 54%. This deterioration in a fundamental surveillance function raises concerns about the sustainability of disease control efforts and suggests systemic weaknesses that require attention.

Disease-specific outcomes present a complex picture of both successes and persistent challenges. Typhoid management stands as a notable achievement, with case fatality rates eliminated from 4.8% to zero. Dengue control shows geographic disparities requiring targeted intervention, with the Northern Division's alarming 15% fatality rate contrasting sharply with the national average of 0.35%. Leptospirosis management remains problematic with fatality rates of 2.4%, only marginally improved from 2.9% and still above baseline targets.

Tuberculosis control emerges as perhaps the most significant programmatic weakness in the Ministry's communicable disease portfolio. Treatment success rates remain stalled at approximately 53% against an 80% target, while incidence has increased from 40 to 60 per 100,000 population. These figures suggest fundamental issues in the TB control programme that require comprehensive review, from case finding strategies to treatment adherence support.

HIV and STI management similarly demonstrate persistent gaps in achieving comprehensive care. Only 10% of HIV patients achieved viral suppression, while just 54% of adult patients receive antiretroviral therapy against the 80% target. The modest reduction in paediatric HIV cases from 23 to 14 represents one of the few positive trends in this area. The 42 congenital syphilis cases reported reflect preventable failures in antenatal screening and treatment that require urgent programmatic attention.

The absence of current data for years 4 and 5 of the strategic plan period creates a significant limitation in assessing recent progress. This reporting gap itself indicates challenges in the Ministry's monitoring and evaluation capacity and hampers comprehensive assessment of disease control trends in more recent periods.

Based on the available evidence, overall progress towards Output 1.1.3 can be characterised as having established the foundational surveillance infrastructure but struggling to translate this into consistent improvements in disease-specific outcomes. The Ministry has demonstrated capacity to respond to high-profile health emergencies like COVID-19 but faces ongoing challenges in addressing endemic diseases that require sustained, systematic approaches to surveillance, case detection, and diagnosis.

As the strategic plan period approaches its conclusion, the data suggests a need for renewed focus on strengthening field-level implementation of surveillance protocols, particularly for locally transmitted diseases where investigation rates have declined. The Ministry would benefit from examining the factors behind successful disease control initiatives like typhoid management to identify transferable approaches for other disease programmes, while addressing the persistent gaps in tuberculosis control and HIV treatment outcomes that continue to affect population health outcomes.

Progress Towards Outcome 1.2

Summary of Progress Towards Outcome 1.2: Improve the physical and mental well-being of all citizens, with particular focus on women, children and young people through prevention measures

Progress towards improving the physical and mental well-being of citizens through prevention measures shows mixed achievements across different components. While immunization services demonstrate positive trends with most vaccination indicators improving (particularly DPT-HepB-Hib, OPV, and MR coverage),

mental health integration has significantly advanced with facilities adhering to mhGAP increasing from 27.5% to 55.3%, and postnatal care attendance has strengthened from 75% to 84%. However, concerning declines are evident in early antenatal care booking (dropping from 38% to 28%), breastfeeding rates (falling from 77% to 44-46%), and high-risk maternal case referrals (decreasing from 91% to 84%).

A significant limitation in fully assessing progress towards Outcome 1.2 is the lack of disaggregated data by gender, age groups, and vulnerable populations. This data gap makes it difficult to determine whether interventions are effectively reaching the specifically targeted groups of women, children, and young people as emphasised in the outcome statement. The positive trend in reduced childhood obesity (from 3.4% to 2.7%) and improved cervical cancer screening coverage (exceeding targets at 39%) demonstrates some success in targeted prevention measures, but the dramatic decrease in absolute numbers screened for cervical cancer and declining NCD screening rates for mothers (from 67% to 37%) suggest uneven implementation across key population groups.

Overall, Outcome 1.2 is partially achieved, with implementation challenges related to resources, capacity, and possibly COVID-19 disruptions affecting consistent progress. To strengthen outcomes before the strategic plan concludes in July 2025, priority should be given to addressing declining preventive services through targeted awareness campaigns, investigating and correcting the causes behind breastfeeding rate decreases, revitalising the maternal high-risk referral system, and ensuring more balanced implementation with appropriate resource allocation across all components.

Progress Towards Output 1.2.1: Improved Maternal and Neonatal Health Services

The Ministry's efforts to improve maternal and neonatal health services with increased focus on health risk assessments show mixed results across the various indicators, with some areas demonstrating significant improvement while others reveal concerning declines.

Early antenatal care booking (Indicator i24) shows a worrying downward trend, declining from 38% of pregnant women receiving first-trimester care to just 28% (with accumulated figure of 47%). This regression falls below the target of >35% and the baseline performance, indicating that awareness and promotion activities for early booking (Activity 1.2.1.1) have not been effective. This decline in early antenatal care represents a critical gap in maternal health services, as first-trimester care is essential for early risk identification and intervention, potentially compromising maternal and neonatal outcomes.

In contrast, postnatal clinic attendance (Indicator i25) demonstrates substantial improvement, with 1-week postnatal attendance increasing from 75% to 84% (accumulated 87%), exceeding the baseline target of 70%. Similarly, the 6-week postnatal attendance (Indicator i40) remains strong at 76% (accumulated 73%), well above the baseline target of 50%. This positive trend suggests that efforts to strengthen postnatal clinic services (Activity 1.2.1.3) and implement postnatal checklists across all care levels (Activity 1.2.1.4) have been relatively successful, contributing to better continuity of care for mothers and newborns in the postpartum period.

High-risk maternal case referrals (Indicator i26) show a concerning decline from 91% to 84% (with 132 cases referred, accumulated 317 cases), falling below the target of >90%. This suggests that the early detection, diagnosis, and referral system for high-risk cases (Activity 1.2.1.5) has weakened, potentially leaving vulnerable mothers without appropriate specialised care. This downward trend requires immediate attention to ensure that high-risk pregnancies receive timely and appropriate interventions to prevent adverse outcomes.

The most significant improvement is observed in mental health integration, with health facilities adhering to the Mental Health Gap Action Plan (mhGAP) Intervention Guide (Indicator i27) increasing dramatically from 27.5% to 55.3% (accumulated 38%). This substantial progress, more than doubling the baseline of 22%, indicates that capacity building and supervisory visits for mhGAP implementation (Activity 1.2.1.6) have been highly effective, suggesting successful integration of mental health services into maternal care – a critical component often overlooked in traditional maternal health programmes.

Overall, while postnatal care and mental health integration show commendable progress, the concerning declines in early antenatal care booking and high-risk case referrals require urgent attention. The Ministry should prioritise strengthening awareness campaigns for early antenatal booking and revitalising the high-

risk referral system to ensure comprehensive improvement across all aspects of maternal and neonatal health services before the strategic plan concludes in July 2025.

Progress towards Output 1.2.2: Strengthened Immunization Services and NCDs Screening

Childhood immunization services demonstrate encouraging progress, with vaccination coverage increasing from a baseline of 49% to current rates of 78% and 67%, and further improving to 79% in the most recent reporting period. This positive trajectory, marked by a "green" status, indicates that the Ministry's implementation of EPI training and awareness activities for service providers and mothers is yielding results, though vaccination rates remain below optimal coverage needed for comprehensive community protection. As the strategic plan approaches its conclusion in July 2025, maintaining this momentum while addressing remaining coverage gaps will be essential for achieving population-level immunity benefits.

NCD screening for mothers presents a critical area of concern, with screening rates declining dramatically from a baseline of 67% to just 37% in the most recent period, earning a "red" status that signals substantial service deterioration. This regression is directly linked to resource constraints, particularly the minimal distribution of NCD screening kits, with only 3 kits placed against a target of 7. The significant gap between baseline performance and current achievement indicates serious implementation challenges in integrating NCD screening into maternal health services, requiring urgent intervention to reverse this negative trend before the strategic plan concludes next year.

The policy framework supporting both services shows limited progress, with no updates on the EPI policy and Cold Chain guidelines review, stagnation in MCH policy development for Fiji, and inadequate distribution of NCD screening kits to clinics. These systemic barriers create a critical gap in the enabling environment needed for comprehensive service delivery. Priority actions for the final year of the strategic plan should include accelerating NCD kit distribution, finalising the MCH policy, updating EPI guidelines, intensifying healthcare provider training, and addressing resource constraints to ensure the Ministry doesn't conclude the plan period with only partial achievement of this important output.

Progress towards Output 1.2.3: Improved Breastfeeding and Nutrition for Children

The initiatives aimed at improving breastfeeding and nutrition for children in Fiji show mixed results across the two main intervention areas. This assessment analyses the current status of implementation and identifies both achievements and challenges.

The Baby Friendly Hospital Initiative (BFHI) reaccreditation process has faced significant implementation challenges. Originally intended to involve external assessment and accreditation of health facilities, this activity was placed on hold due to COVID-19 restrictions. In lieu of external validation, internal audits were conducted, with 16 health facilities participating in this alternative assessment process. The Northern Division specifically achieved an internal compliance rate of 57%, suggesting moderate progress in maintaining BFHI standards despite the inability to complete formal external reaccreditation. The absence of external audit data for all facilities limits the comprehensive assessment of BFHI implementation quality and sustainability across the health system.

The strengthening of infant and young child feeding (IYCF) practices shows concerning trends in breastfeeding rates. From a baseline where 51% of children were being breastfed at 6 months, an intermediate measurement showed promising improvement to 77%. However, current data indicates a substantial decline, with breastfeeding rates dropping to 44% and 46% in the reporting period. The accumulated achievement figures of 61% and 104% appear inconsistent with the current percentages and require clarification. This significant decrease in breastfeeding rates is particularly troubling given the established benefits of continued breastfeeding for child nutrition, immunity, and development.

The data presents several critical gaps that hinder comprehensive assessment. The BFHI reaccreditation lacks information on plans to resume external assessments post-COVID, the criteria used for internal audits, and whether the 16 facilities represent the total target or just those assessed to date. For the IYCF component, the data does not clarify whether the two percentages (44% and 46%) represent different geographical areas or measurement periods, nor does it explain potential factors contributing to the substantial decline in breastfeeding rates from the intermediate 77% to current levels.

This assessment reveals concerning trends in Output 1.2.3 implementation. While adaptations were made to continue BFHI assessment during COVID-19 constraints, the dramatic decline in breastfeeding rates signals a potential regression in IYCF practices. This situation requires urgent attention to identify root causes and implement corrective measures. Potential factors may include reduced breastfeeding promotion during the pandemic, changes in health service delivery models, or socioeconomic pressures affecting maternal practices.

Moving forward, the programme should prioritise understanding the causes behind declining breastfeeding rates and develop targeted interventions to reverse this trend. Resumption of external BFHI assessments would provide more reliable data on facility compliance with breastfeeding support standards. Additionally, strengthening community-based IYCF promotion and support mechanisms could help address the apparent gap between facility accreditation efforts and actual breastfeeding practices. Comprehensive data collection and analysis will be essential to guide these interventions effectively and monitor their impact on improving breastfeeding and nutrition outcomes for children in Fiji.

Progress towards Output 1.2.4: Improved Prevention, Detection and Diagnosis of Childhood Illnesses

The implementation of initiatives to improve prevention, detection, and diagnosis of childhood illnesses in Fiji demonstrates variable progress across different intervention areas. This assessment examines achievements to date and identifies areas requiring further attention.

The management of Rheumatic Heart Disease represents a significant achievement within this output. From a baseline where only 48% of affected patients received adequate antibiotic prophylaxis, the programme has strengthened this critical preventive measure substantially. Currently, 76% of patients with acute rheumatic fever and rheumatic heart disease receive at least 80% of their required secondary antibiotic prophylaxis, with accumulated achievement reaching 86%. This positive trend indicates effective implementation of RHD case management protocols, potentially preventing recurrent episodes and limiting the progression of heart valve damage among affected children.

The nutritional component presents a more complex situation. Severe Acute Malnutrition admissions have decreased from 119 at the intermediate stage to 32 during the current reporting period. This reduction requires careful interpretation without additional context. The decrease could reflect either improved nutritional status in communities through effective preventive interventions or, alternatively, diminished case detection and referral mechanisms. This ambiguity highlights the importance of comprehensive monitoring systems that capture both facility-based treatment data and community-level screening coverage.

Implementation of the Integrated Management of Childhood Illness guidelines across health facilities shows meaningful improvement. From a baseline where 53% of facilities adhered to these evidence-based protocols, adherence has improved to 75%, maintaining the level achieved at the intermediate stage. This consistency suggests that the initial policy review has successfully translated into sustained changes in clinical practice, though the accumulated achievement of 67% indicates some fluctuation in implementation over time. The internal audit verification provides additional confidence in the reliability of this progress.

Despite these positive developments, significant gaps remain in the assessment. The provision of holistic care for RHD cases at subdivisional levels lacks documentation, raising questions about whether improved prophylaxis coverage is accompanied by comprehensive management addressing all aspects of patient care. Similarly, no information is available regarding the divisional training of trainers for Integrated Management of Acute Malnutrition, limiting understanding of capacity building efforts in this critical area. The implementation of the dietetics and nutrition programme also remains undocumented against its target of conducting over 80% of planned activities.

This assessment highlights the need for more balanced implementation and comprehensive reporting across all components of Output 1.2.4. While significant advances have been made in RHD management and IMCI guideline adherence, nutritional interventions require particular attention to ensure they receive comparable focus and monitoring. By addressing these gaps and building on existing successes, the programme can progress toward comprehensively improving the prevention, detection, and diagnosis of childhood illnesses across Fiji, ultimately contributing to better health outcomes for children throughout the country.

Progress Towards Output 1.2.5: Strengthened Adolescent Health Services

The assessment of Fiji's efforts to strengthen adolescent health services demonstrates partial progress, with successful development of a foundational care package but limited information on complementary training and implementation activities.

The Adolescent Health Services (AHS) care package development (activity 1.2.5.1) shows complete achievement, with 100% completion reported during the assessment period. This represents significant improvement from the baseline where "No report received" was indicated. The positive trend indicator (ä) confirms progress in establishing this essential framework for adolescent health service delivery. The successful development of the AHS care package provides a standardised approach to addressing the unique health needs of adolescents, which is a critical first step in strengthening comprehensive adolescent health services.

However, the assessment data reveals significant gaps in reporting on the other two key activities under this output. There is no information provided regarding activity 1.2.5.2 focused on reviewing the AHS training manual. Similarly, no data is available on activity 1.2.5.3 concerning the conducting of relevant AHS trainings. These omissions represent substantial gaps in the comprehensive evaluation of progress towards strengthening adolescent health services.

The absence of information on training manual review and training implementation raises concerns about the practical application of the developed care package. While having a well-designed care package is essential, its effectiveness ultimately depends on proper dissemination, training of healthcare providers, and consistent implementation across health facilities. Without data on these complementary activities, it is difficult to assess whether the care package development has translated into actual improvements in service delivery for adolescents.

The assessment suggests a potential sequencing issue in implementation, where the foundational document has been completed but subsequent steps to operationalise the care package through training and capacity building may be lagging. Alternatively, these activities may have been implemented but not properly documented or reported, highlighting potential gaps in the monitoring and evaluation framework.

Overall, while the development of the AHS care package represents a significant achievement, the comprehensive strengthening of adolescent health services appears to be at an early stage, with substantial work still needed in training, capacity building, and implementation. The absence of data on two of the three planned activities limits the ability to fully assess progress towards the complete output as defined.

To strengthen outcomes, the programme would benefit from ensuring comprehensive implementation and reporting on all components of the output, particularly focusing on the review of training materials and the delivery of training programmes to healthcare providers. Additionally, future assessments should include indicators that measure not just the development of frameworks but also their practical implementation and impact on service delivery for adolescents across health facilities.

Progress Towards Output 1.2.6: Strengthened Breast and Cervical Cancer Prevention, Screening and Diagnosis

The assessment of Fiji's efforts to strengthen breast and cervical cancer prevention, screening, and diagnosis demonstrates notable progress in cervical cancer screening coverage, exceeding the established targets while revealing potential gaps in comprehensive implementation.

Cervical cancer screening initiatives have shown substantial achievement, with 39% screening coverage reported during the assessment period. This significantly surpasses the target threshold of >10% coverage, indicating strong performance in this critical area of women's health. The accumulated achievement of 36% coverage with 277 women screened maintains this positive trend, though it represents a slight decrease from the baseline figure of 37% coverage with 4,578 women screened.

The positive trend indicator (ä) confirms consistent progress in expanding cervical cancer screening services, suggesting effective implementation of activity 1.2.6.1 focused on conducting cervical cancer screening at health facilities and in communities. This achievement is particularly significant given the importance of

early detection in improving cervical cancer outcomes and the typical challenges associated with screening programme implementation in resource-constrained settings.

However, the assessment data reveals an apparent discrepancy between the percentage coverage reported and the absolute number of women screened. While the coverage percentage increased slightly from 37% to 39%, the number of women screened decreased dramatically from 4,578 at baseline to only 277 during the reporting period. This substantial reduction in absolute numbers warrants further investigation, as it may indicate issues with data collection, reporting inconsistencies, or significant operational challenges in maintaining screening volumes.

Additionally, the assessment lacks specific information regarding activity 1.2.6.2 focused on capacity development for cervical cancer prevention in targeted medical subdivisions. The absence of data on training programmes, infrastructure development, or human resource capacity building represents a significant gap in the comprehensive evaluation of this output. Without this information, it is difficult to assess whether the screening achievements are supported by sustainable capacity development that would ensure long-term programme success.

The assessment also does not include information on breast cancer prevention, screening, and diagnosis activities, despite these being explicitly mentioned in the output title. This omission represents another significant gap in the evaluation of progress towards the complete output as defined.

Overall, while cervical cancer screening coverage has exceeded targets and shows a positive trend, the comprehensive strengthening of breast and cervical cancer prevention, screening, and diagnosis services appears to have gaps in implementation or reporting. The dramatic decrease in the absolute number of women screened requires explanation, and the absence of data on capacity development activities and breast cancer initiatives limits the ability to fully assess progress towards the complete output.

To strengthen outcomes, the programme would benefit from addressing these data gaps, investigating the discrepancy in screening numbers, ensuring comprehensive reporting on all components of the output, and maintaining focus on building sustainable capacity for cancer prevention and early detection services across all targeted medical subdivisions.

Progress Towards Outcome 1.3

Assessment of Progress Towards Outcome 1.3: Safeguard Against Environmental Threats and Public Health Emergencies

Progress towards Outcome 1.3 shows mixed achievements with significant variations across different components. The outcome-level indicators reveal minimal improvement in access to improved drinking water sources (95.42% to 95.45%) and a concerning slight decline in improved sanitation facilities (49.24% to 48.79%), suggesting stagnation in these fundamental environmental health determinants.

Under Output 1.3.1 (Environmental Health Service Delivery), implementation has been uneven. WASH interventions and vector management programmes have shown strong performance, with 85% achievement in WASH coverage and vector control activities improving from 42% to 79% in high-risk areas. However, critical gaps exist in Drinking Water Safety Plans implementation (only 32% achievement) and reduced water quality monitoring (197 samples tested versus baseline of 384). Food safety initiatives and tobacco-free settings show moderate progress but remain below targets, with only 50% of food establishments meeting hygiene requirements and 52% achievement in establishing tobacco-free communities.

Output 1.3.2 (Public Health Emergency Preparedness) demonstrates stronger operational capacity but incomplete coverage. While COVID-19 vaccination drives achieved 100% implementation with impressive primary dose coverage (104% first dose, 95.2% second dose), IHR compliance reached only 54% against a 100% target, and booster dose uptake remained low at 40% overall and just 25% among vulnerable groups. The absence of data on Border Health Protection Unit establishment represents a critical reporting gap for a key emergency preparedness component.

Overall, Outcome 1.3 is partially achieved, with stronger performance in response mechanisms than in preventive environmental health measures. Geographic disparities and implementation inconsistencies are evident across components. The data suggests that while Fiji has developed capacity to respond to specific

public health emergencies like COVID-19, more systematic efforts are needed to address underlying environmental health determinants and ensure comprehensive emergency preparedness systems. The minimal movement in outcome-level indicators despite various interventions raises questions about implementation effectiveness and the need for more targeted approaches to achieve meaningful impact before the strategic plan concludes.

Progress Towards Output 1.3.1: Improvement in the Effectiveness of Environmental Health Service Delivery

The assessment of Fiji's environmental health service delivery reveals mixed progress across six key intervention areas, with some initiatives showing promising advancement while others face significant implementation challenges.

Drinking Water Safety Plans (DWSP) implementation in rural communities has fallen considerably short of targets. Only 14 DWSPs were developed, achieving just 32% of the intended coverage against a target of 75% for rural sanitary district communities. The programme's initial momentum was severely impacted by COVID-19 restrictions, with only 0.5% of planned activities completed during that period. This underperformance highlights persistent challenges in expanding critical water safety planning to vulnerable rural populations.

More encouraging results are evident in the Water, Sanitation and Hygiene (WASH) interventions. The programme successfully reached 209 rural communities, schools, and healthcare facilities, achieving 85% of its period target. The accumulated achievement of 686 locations (85% of cumulative targets) demonstrates consistent progress in expanding essential water and sanitation services. The positive trend indicator confirms this as one of the more successful components of the environmental health portfolio.

Drinking water standards auditing presents a mixed picture. While 197 water samples were tested during the reporting period—exceeding the combined regional targets of 154 samples—this represents a significant decrease from the baseline of 384 samples. This reduction raises concerns about the comprehensiveness of water quality monitoring and potential gaps in the surveillance system designed to protect communities from waterborne diseases.

The Integrated Vector Management programme for controlling vector-borne diseases shows substantial progress, with 79% of high-risk areas undergoing source reduction programmes against an 80% target. This near-complete achievement represents significant improvement from the baseline of 42%, indicating effective scaling of vector control activities. However, the accumulated achievement of only 44% suggests inconsistent implementation across the full programme period.

Food safety initiatives demonstrate moderate advancement. By year three, 50% of food establishments met Good Hygiene Practices requirements (accumulated 46%), and 50% of high-risk foods received necessary health certificates (accumulated 43%). These figures indicate gradual improvement in food safety systems, though half of establishments and high-risk food products still fall below required standards.

The establishment of tobacco-free settings has made modest progress, with ten additional communities declared tobacco-free during the reporting period, bringing the total to 15 against a target of 29 communities (52% achievement). The positive trend indicator suggests momentum in this area, though the initial baseline noted implementation was limited to Western and Central divisions, indicating geographic disparities in tobacco control efforts.

Overall, the environmental health service delivery programme demonstrates variable effectiveness across its components. WASH interventions and vector control activities show the strongest performance, approaching their targets and demonstrating effective implementation strategies. Conversely, Drinking Water Safety Plans and comprehensive food safety coverage remain areas requiring significant attention, with substantial gaps between targets and achievements.

The assessment reveals both geographic and programmatic unevenness in service delivery that requires addressing to ensure equitable access to environmental health services across all regions of Fiji. While COVID-19 clearly disrupted initial implementation, particularly for water safety planning, the continued

underperformance in some areas suggests more systemic challenges that extend beyond the pandemic's immediate effects.

To improve outcomes, the programme would benefit from applying successful implementation approaches from the better-performing components to areas showing less progress, while ensuring consistent application of interventions across all geographic divisions. Strengthening monitoring systems, particularly for water quality testing, would also enhance the programme's ability to protect public health effectively.

Progress Towards Output 1.3.2: Strengthened Preparedness and Resilience to Public Health Emergencies

The implementation of measures to strengthen Fiji's preparedness and resilience to public health emergencies shows mixed results across different indicators during the first year of implementation.

In terms of International Health Regulations (IHR) self-assessment reporting, Fiji achieved a 54% compliance rate against a target of 100%. This represents a significant gap between the current status and the desired level of compliance with international health standards. The Health Protection component specifically reached 98% compliance, suggesting uneven progress across different aspects of the IHR core capacities. This partial achievement indicates that while some components of Fiji's health protection systems are well-developed, other areas require substantial strengthening to meet international standards for detecting, assessing, and responding to public health threats.

The COVID-19 vaccination drive demonstrates more positive outcomes. The nationwide vaccination campaign successfully conducted 100% of its scheduled vaccination drives, meeting the target completely. This reflects effective logistical planning and implementation capacity within the health system for large-scale vaccination efforts. The actual vaccination coverage shows impressive results with 104% coverage for the first dose and 95.2% for the second dose among the targeted population. The first dose exceeding 100% likely indicates that the actual number of people vaccinated surpassed the initial population estimates used for target setting.

However, the administration of booster doses presents a more challenging picture. Only 40% of eligible individuals aged 18 years and above received booster doses, with an even lower rate of 25% among vulnerable priority groups in communities. These figures suggest significant challenges in maintaining vaccination momentum beyond the initial doses, particularly for reaching vulnerable populations who may face greater barriers to accessing healthcare services.

The data for the Border Health Protection Unit (BHPU) establishment initiative lacks performance information, making it impossible to assess progress in this critical area of public health emergency preparedness. This gap in reporting represents a missed opportunity to understand how Fiji is strengthening its capacity to prevent the cross-border spread of diseases.

The overall pattern reveals stronger performance in executing planned activities (such as conducting vaccination drives) than in achieving comprehensive coverage across all population segments or meeting international compliance standards. This suggests that while operational capacity exists for implementing public health interventions, systemic challenges remain in achieving full coverage and compliance with international standards.

Moving forward, targeted strategies will be needed to address the gaps in IHR compliance, increase booster dose uptake among vulnerable populations, and ensure the Border Health Protection Unit is effectively established and operational. Additionally, improving data collection and reporting for all indicators would enhance the ability to track progress comprehensively and make evidence-based adjustments to implementation approaches.

Despite these challenges, the successful execution of the nationwide vaccination drive and the high coverage rates for primary vaccination series demonstrate that Fiji has developed substantial capacity for responding to public health emergencies, providing a foundation upon which further improvements in preparedness and resilience can be built.

Progress Towards Outcome 1.4: Strengthen Population-Wide Resilience to the Climate Crisis

Fiji's efforts to strengthen population-wide resilience to the climate crisis reveal a story of emerging capabilities amid significant implementation challenges. The Fiji Emergency Medical Assistance Team

(FEMAT) has demonstrated encouraging operational growth, evolving from no deployments initially to five community responses by the third year, suggesting an increasingly responsive emergency medical system taking shape. However, this field experience has not been complemented by the planned simulation exercises crucial for systematic capacity building, creating an imbalance in FEMAT's development that may limit its effectiveness during complex climate-related emergencies.

Progress in climate-proofing healthcare infrastructure has been notably delayed, with assessments of facility vulnerability only beginning in the third year and reaching just one healthcare facility (23% of targets). This slow pace raises concerns about the health system's preparedness for increasingly frequent and severe climate events, particularly given Fiji's heightened vulnerability to tropical cyclones, flooding, and rising sea levels that directly threaten healthcare delivery during times of greatest need.

The absence of outcome-level indicators for this strategic priority area creates a significant blind spot in understanding whether these operational activities are genuinely strengthening population-wide resilience. While FEMAT's increasing deployment frequency offers a promising foundation, the overall picture suggests a reactive rather than strategic approach to building climate resilience in Fiji's health system, with substantial work remaining to translate limited output-level achievements into meaningful protection for communities facing escalating climate threats.

Progress Towards Output 1.4.1: Strengthened Role of Fiji Emergency Medical Assistance Team (FEMAT) in Disaster Preparedness, Management and Resilience

The development of Fiji's Emergency Medical Assistance Team (FEMAT) over the past three years reveals both challenges and promising advances in the nation's progress toward enhanced disaster preparedness and medical response.

In the early stages of implementation, FEMAT faced significant hurdles in building its readiness capabilities. The team had planned to conduct regular simulation exercises—crucial practice sessions that would help medical personnel rehearse emergency scenarios and fine-tune their response protocols. Unfortunately, these exercises never materialised in the first year. Ministry officials noted "No report received" regarding these simulations, leaving a gap in the team's preparedness training that could have potentially compromised their effectiveness during actual emergencies.

Despite this rocky start, FEMAT's trajectory took a more positive turn when examining their actual deployment record. By the second year, the team had mobilised twice to communities in need, bringing essential medical services to areas facing healthcare challenges or recovering from disasters. These initial deployments established the groundwork for what would become a much more active operational presence in the following year.

The third year marked a significant expansion in FEMAT's reach and impact. The team more than doubled its deployment frequency, responding to five separate situations where communities required medical assistance. This remarkable increase demonstrated growing confidence in FEMAT's capabilities and suggested that health authorities were increasingly recognising the value of deploying these specialised medical teams to address healthcare gaps across the country.

This upward trajectory in deployments indicates growing operational maturity and expanding impact. With each mission, FEMAT teams gained valuable field experience, strengthened their coordination procedures, and developed deeper insights into the healthcare needs of vulnerable communities. The increasing deployment pattern suggests that FEMAT is evolving into a more responsive and effective component of Fiji's healthcare system, particularly for communities facing extraordinary challenges.

However, the contrast between FEMAT's operational growth and its training limitations creates an interesting tension in this progression. While the team has clearly demonstrated its ability to mobilise and deliver services in the field, the foundation of regular practice and simulation that typically underpins such emergency response capabilities remains underdeveloped. This situation is somewhat akin to a sports team that performs increasingly well in actual matches but rarely holds practice sessions—a situation that raises questions about long-term sustainability and optimal performance.

As FEMAT continues its evolution, the reintroduction of regular simulation exercises would complement its growing deployment experience, creating a more balanced approach to building emergency medical response capabilities. By combining the practical knowledge gained through field operations with structured training opportunities, FEMAT could further enhance its ability to serve as a critical lifeline for Fijian communities during times of greatest need.

The progress of FEMAT reflects broader challenges and opportunities in building resilient health systems in Pacific Island nations, where limited resources must be carefully balanced against growing threats from climate change and other emergencies. While progress has been uneven, the positive trend in FEMAT's operational footprint suggests that Fiji is moving in the right direction toward a more responsive and capable emergency medical system.

Progress Towards Output 1.4.2: Improvement in disaster preparedness and response to climate change effects

The Ministry of Health has been working to enhance the climate resilience of healthcare facilities across Fiji, recognising the increasing threats posed by climate change and natural disasters to the country's health infrastructure. Progress in this critical area has been slow but is now showing initial signs of advancement.

During the first two years of implementation (Y1 and Y2), there was no activity recorded for the assessment of healthcare facilities under the Climate Resilience and Environmental Sustainability for Health Care Facilities (CRESHCF) Guidelines. This lack of progress during the initial implementation period represents a significant delay in establishing baseline information about the vulnerability of healthcare facilities to climate-related hazards.

However, Year 3 has seen the first tangible progress in this area, with 23% of healthcare facilities now assessed under the CRESHCF Guidelines. This represents one healthcare facility that has undergone a comprehensive evaluation of its climate resilience and environmental sustainability. While this initial assessment is an important first step, the overall status of this activity is appropriately categorised as "Partially achieved," reflecting the substantial gap between current implementation and complete coverage of all facilities.

The assessment process is crucial as it provides detailed information about structural vulnerabilities, operational readiness, and adaptation needs for healthcare facilities facing climate-related threats such as cyclones, flooding, and rising sea levels. These assessments form the foundation for evidence-based planning and resource allocation to strengthen the resilience of Fiji's health system.

The second component of this output involves preparing concept proposals for prioritised vulnerable healthcare facilities. However, the provided information does not include specific data on the status of proposal development. This gap in reporting makes it difficult to assess whether the Ministry has begun translating the assessment findings into actionable project proposals that could attract funding for resilience-building interventions.

Progress Towards Outcome 1.4: Strengthen Population-Wide Resilience to the Climate Crisis

Fiji's efforts to strengthen population-wide resilience to the climate crisis reveal a story of emerging capabilities amid significant implementation challenges. The Fiji Emergency Medical Assistance Team (FEMAT) has demonstrated encouraging operational growth, evolving from no deployments initially to five community responses by the third year, suggesting an increasingly responsive emergency medical system taking shape. However, this field experience has not been complemented by the planned simulation exercises crucial for systematic capacity building, creating an imbalance in FEMAT's development that may limit its effectiveness during complex climate-related emergencies.

Progress in climate-proofing healthcare infrastructure has been notably delayed, with assessments of facility vulnerability only beginning in the third year and reaching just one healthcare facility (23% of targets). This slow pace raises concerns about the health system's preparedness for increasingly frequent and severe climate events, particularly given Fiji's heightened vulnerability to tropical cyclones, flooding, and rising sea levels that directly threaten healthcare delivery during times of greatest need.

The absence of outcome-level indicators for this strategic priority area creates a significant blind spot in understanding whether these operational activities are genuinely strengthening population-wide resilience. While FEMAT's increasing deployment frequency offers a promising foundation, the overall picture suggests a reactive rather than strategic approach to building climate resilience in Fiji's health system, with substantial work remaining to translate limited output-level achievements into meaningful protection for communities facing escalating climate threats.

Overall, progress toward improving disaster preparedness and response to climate change effects in healthcare facilities has been significantly delayed, with meaningful activity only beginning in the third year of implementation. While the completion of the first facility assessment represents a positive development, the pace of implementation will need to accelerate substantially to achieve comprehensive coverage of healthcare facilities across Fiji.

The slow progress in this area is concerning given Fiji's high vulnerability to climate-related disasters and the critical importance of maintaining functional healthcare services during emergencies. Moving forward, the Ministry would benefit from examining the factors that delayed implementation during the first two years and developing strategies to accelerate the assessment process. Additionally, ensuring that assessment findings promptly translate into concept proposals for vulnerable facilities will be essential to secure resources for necessary resilience-building interventions.

As climate change continues to intensify weather extremes and other environmental challenges in the Pacific region, strengthening the resilience of healthcare facilities remains an urgent priority that warrants increased attention and resources in the implementation periods ahead.

Progress Towards Strategic Priority 2: Quality Clinical Services

Overall Status of Strategic Priority 2: Increase Access to Quality, Safe and Patient-Focused Clinical Services

Fiji's health system has made progress toward increasing access to quality, safe and patient-focused clinical services, demonstrating a healthcare sector in meaningful transformation. The decentralization of specialist services has brought care closer to communities with specialist visit coverage rising from one-third to 88%, while the expansion of telehealth from 7 to 22 services has created new pathways for remote populations to access specialised care. These accessibility improvements are complemented by impressive gains in safety response systems, where resolution rates for incident reports have more than doubled to 89% and implementation of Root Cause Analysis recommendations has surged to 92%, reflecting a maturing safety culture with robust quality improvement mechanisms.

Child health outcomes reveal some of the most encouraging progress, with neonatal mortality improving dramatically from 16.2 to 6.5 per 1,000 live births and perinatal mortality decreasing by more than half. Patient-Centered care has similarly advanced, with feedback mechanisms capturing the voices of significantly more patients as survey response rates improved from 27% to between 75-99%, and complaint resolution reaching 96% within predetermined timeframes. These improvements demonstrate the Ministry's growing capacity to both listen to patients and systematically address their concerns through established governance processes.

Despite these achievements, persistent challenges threaten to undermine progress in specific areas. The concerning increase in maternal mortality from 29.7 to 44.3 per 100,000 live births despite near-universal skilled birth attendance suggests quality of care issues that require urgent attention. Similarly troubling is the decline in family planning coverage from 51.3% to 42.3% and the regression in basic infection control practices, with hand hygiene compliance in ICUs falling from 91% to 84% and surgical site infections for elective caesarean sections rising from 4.6% to 5.8%. These trends reveal a disconnect between system-level improvements and consistent implementation of standards at the point of care.

The Ministry has established strong foundations for continuous improvement while demonstrating resilience through adaptive implementation approaches when faced with challenges. The impressive systemic developments in service decentralization, safety mechanisms, and patient feedback systems provide powerful platforms for addressing the specific areas requiring attention. To fully realise Strategic Priority 2, the Ministry must now leverage these systemic strengths to ensure that quality improvements reach all

population groups equitably and translate effectively to consistent, high-quality care at every point of service delivery, particularly focusing on reversing concerning trends in maternal health, family planning, and infection control practices.

Progress Towards Outcome 2.1

Progress Towards Outcome 2.1: Improve Patient Health Outcomes with a particular focus on services for women, children, young people and vulnerable groups

Fiji's efforts to improve patient health outcomes for women, children, young people and vulnerable groups reveal a landscape of significant achievements alongside persistent challenges. The most notable successes are evident in child and adolescent health indicators, where neonatal mortality has dramatically improved from 16.2 to 6.5 per 1,000 live births, perinatal mortality has decreased by more than half to 11.3 per 1,000 births, and adolescent birth rates have fallen substantially to 6.5 per 1,000 women. These improvements, coupled with consistently high skilled birth attendance at 99.3%, demonstrate meaningful progress in several critical areas of maternal and child health service delivery.

However, these positive trends are counterbalanced by concerning developments in other key indicators. The maternal mortality ratio, while improved from its baseline of 95.8, has recently increased from 29.7 to 44.3 per 100,000 live births, suggesting quality of care issues despite near-universal skilled birth attendance. Even more troubling is the significant decline in family planning coverage, with the proportion of women having their contraceptive needs met through modern methods falling from 51.3% to 42.3%, indicating reduced access or utilization of essential reproductive health services.

Implementation of supporting initiatives shows similar variation, with Mother Safe Hospital Initiative standards improving from 26% to 49% adherence, while neonatal resuscitation training has reached only 17% of its scheduled delivery targets. The school health programme focused on reproductive health education appears aligned with declining adolescent birth rates, yet implementation data remains limited, making it difficult to fully assess its reach and effectiveness across secondary schools.

This mixed picture suggests that while Fiji has made substantial progress in several aspects of maternal and child health, significant gaps remain in ensuring comprehensive, high-quality care for all population groups. The disconnect between structural improvements and some worsening outcome indicators points to implementation challenges that require targeted attention as the strategic plan approaches its conclusion, particularly in addressing quality of maternal care and reversing the concerning decline in family planning coverage. The dismantling of the national coordination units removed an essential mechanism for cross-ministerial oversight and sector alignment. This significantly contributed to fragmentation by isolating planning, implementation, and monitoring functions. The absence of structural coordination mechanisms within the planning cycle meant that the hospitals and public health services operated independently, reducing the potential for integrated service delivery.

Progress Towards Output 2.1.1: Increased access to maternal and child health services based on population needs

The Ministry of Health has been working to strengthen maternal and child health services through several interconnected initiatives, with varying degrees of progress evident across different components of this important work.

The implementation of Mother Safe Hospital Initiative (MSHI) standards in divisional and sub-divisional health facilities has shown measurable improvement, though challenges remain. Initial internal audits revealed a concerning baseline of only 26% adherence to MSHI standards across facilities, with implementation particularly hampered by COVID-19 disruptions, especially in the Eastern Division where activities were placed on hold.

Despite these early challenges, subsequent internal audits demonstrated significant progress, with adherence rates rising to 63% in sub-divisional hospitals. The most recent data indicates an overall adherence rate of 49% across all facilities. This upward trend (as indicated by the "ä" symbol in the reporting) suggests that facilities are gradually improving their alignment with MSHI standards, though they remain below optimal levels of implementation.

The biannual internal audits of sub-divisional hospitals for MSHI compliance appear to be taking place as scheduled, providing important monitoring data that allows the Ministry to track progress and identify areas requiring additional support. Beyond data collection, the inability to use information systems in real time undermines patient care (e.g., hospitals are unable to track emergency room bed occupancy rates during dengue surges). These regular assessments represent a critical quality assurance mechanism for maintaining focus on maternal and overall health safety standards. The lack of real-time monitoring capacities, especially at facility level, limits the timeliness of decision-making. For example, delays in receiving patient data from rural nursing stations has impacted disease surveillance during outbreaks.

Progress in training on neonatal resuscitation and other newborn care services has been more limited. The data indicates that only 17% of scheduled training on neonatal resuscitation has been delivered, with 7 training sessions conducted. This relatively low completion rate suggests challenges in implementing the full training schedule, potentially limiting the capacity of healthcare workers to provide optimal care for newborns in distress. The status of this activity is reported as "ongoing," indicating continued efforts to deliver these essential training programmes.

The development of a monitoring tool for neonatal and infant deaths is mentioned as a planned activity, though the provided information does not specify the current status of this tool's development or implementation. Such a monitoring mechanism would be valuable for identifying patterns and contributing factors in neonatal and infant mortality, potentially informing targeted interventions to reduce these deaths.

Overall, the Ministry has made notable progress in improving adherence to Mother Safe Hospital Initiative standards, nearly doubling compliance rates from the initial assessment. However, significant work remains to achieve comprehensive implementation of MSHI standards across all facilities and to fully deliver the planned neonatal resuscitation training programme. The continued focus on regular internal audits provides a foundation for ongoing quality improvement, though accelerated efforts may be needed to address the gaps in training delivery and to complete the development of monitoring tools for neonatal and infant deaths.

As the Ministry continues its work to increase access to maternal and child health services, maintaining momentum in improving MSHI adherence while addressing the shortfall in training delivery will be important priorities to ensure that mothers and newborns throughout Fiji receive high-quality, evidence-based care that meets their needs.

Progress Towards Output 2.1.2: Strengthen sexual and reproductive health services

The Ministry of Health has been working to strengthen sexual and reproductive health services, with a particular focus on expanding education and awareness programmes in schools throughout Fiji. This initiative represents an important investment in the long-term health literacy and wellbeing of Fiji's youth.

The available data indicates that efforts to implement the school health programme in secondary schools have been ongoing, with a target of achieving coverage in more than 20% of secondary schools. While the information provided does not specify the current coverage percentage, it confirms that implementation activities are actively underway as part of the Ministry's Performance Tracking Matrix for 2019-2023.

The school health programme represents a strategic approach to addressing sexual and reproductive health needs by focusing on education and awareness at the secondary school level. By targeting adolescents during their formative years, the programme aims to equip young people with essential knowledge about sexual and reproductive health before they become sexually active, potentially reducing unplanned pregnancies, sexually transmitted infections, and other health challenges.

This ongoing initiative aligns with broader public health objectives to promote preventive approaches and health literacy. By strengthening sexual and reproductive health education in schools, the Ministry is working to build a foundation for healthier behaviours and informed decision-making among Fiji's youth. The programme likely encompasses age-appropriate information about reproductive health, relationships, consent, and accessing health services.

While implementation is confirmed to be in progress, the absence of specific coverage data in the provided information makes it difficult to assess exactly how far the Ministry has advanced toward the target of covering more than 20% of secondary schools. This highlights the importance of continued monitoring and

evaluation to track progress accurately and identify any implementation challenges that may require attention.

As the Ministry continues to work toward strengthening sexual and reproductive health services, maintaining focus on this school-based initiative will be important. Expanding coverage to reach and exceed the 20% target would represent meaningful progress in ensuring that young people across Fiji have access to essential sexual and reproductive health education, contributing to improved health outcomes in the years ahead.

Progress Towards Outcome 2.2

Progress Towards Outcome 2.2: Strengthening and Decentralising Clinical Services including rehabilitation, to meet the needs of the population

The Ministry of Health has made substantial progress in strengthening and decentralising clinical services, though implementation remains uneven across different components. The most significant achievements are evident in expanding access to specialist services, where decentralization efforts have increased specialist visit coverage from approximately one-third to 88%, while rehabilitation outreach has maintained 100% coverage of scheduled visits. Telehealth capabilities have also expanded impressively from 7 to 22 services, creating additional pathways for patients in remote areas to access specialised care. These improvements collectively represent meaningful advancement in bringing healthcare closer to communities throughout Fiji.

Clinical management of priority Non-Communicable Diseases shows encouraging momentum despite initial challenges. The adherence to Package of Essential Noncommunicable Disease (PEN) interventions has more than doubled from a baseline of 20% to 44%, while unplanned readmissions for NCD-related conditions have dramatically decreased from 6.6% to 1.18%. This substantial improvement suggests significantly enhanced effectiveness in both outpatient protocols and inpatient care for NCD patients, addressing a critical health priority for Fiji. However, the lack of data on PEN audit training represents a gap in understanding workforce development efforts that support these improvements.

The referral system remains the area with the least progress, functioning but falling short of transformation. Overseas medical referrals are being processed in 15-20 working days against a target of 2-3 weeks, while the review of the broader referral process stands at only 43% completion. This incomplete systemic reform limits the Ministry's ability to optimise patient transfers between facilities and levels of care, potentially affecting continuity of care for those requiring specialised services. The partial implementation suggests that while day-to-day operations continue, the fundamental work of system redesign has not advanced sufficiently.

When assessed against the single outcome indicator of average length of stay (which has decreased from 5.4 to 5 days), the overall progress toward Outcome 2.2 demonstrates positive movement, though with notable variation across components. The significant achievements in decentralising specialist services and improving NCD management are somewhat tempered by the limited advancement in referral system optimization. Nevertheless, the trend indicates that the Ministry is making meaningful strides toward a more accessible and effective clinical service system, with patients increasingly able to receive specialised care closer to home through a combination of decentralised services, telehealth, and targeted outreach initiatives.

Progress Towards Output 2.2.1: Increase access to effective treatment and specialist services

Over the past implementation period, the Ministry of Health has steadily worked to bring specialist healthcare services closer to communities throughout Fiji. The journey toward improved healthcare access has seen encouraging developments across several key initiatives, though challenges remain in some areas.

The Ministry's efforts to decentralise specialist curative services have yielded notable improvements. Where previously only about one-third of scheduled specialist visits were being covered, this figure has now risen to 88%. This means that many more patients can now receive specialised care without undertaking lengthy and costly journeys to major hospitals. While this represents significant progress, the Ministry continues to work toward achieving full coverage to ensure all scheduled visits can be fulfilled.

Rehabilitation services have been a particular area of consistency in service delivery. The rehabilitation programme has maintained complete coverage of all scheduled outreach visits throughout the measurement period. This reliability ensures that patients requiring physical therapy and other rehabilitation services

receive continuous care regardless of their location, supporting recovery and improved quality of life for those with injuries, disabilities, or chronic conditions.

Embracing technological solutions, the Ministry has expanded its telehealth capabilities from offering 7 services initially to 22 services in the most recent period. This growth reflects ongoing efforts to leverage digital platforms to connect patients with specialists remotely. While still evolving, these telehealth services provide an additional pathway for patients to access specialised care, particularly beneficial for those in remote areas or with mobility challenges. The Ministry continues to refine these services to ensure they effectively complement in-person care.

Clinical outreach activities have exceeded expectations, with six major outreach initiatives conducted compared to the target of two per division annually. These outreach efforts, including those utilising MV Veivueti for maritime communities, bring healthcare directly to isolated populations who might otherwise struggle to access services. Though surpassing targets is encouraging, the Ministry recognises the need to assess the sustainability of maintaining this higher level of outreach activity over time.

The decentralization of services from divisional hospitals has achieved a coverage of 94% of targeted specialised services, showing a slight decline from the previous 100%. This small regression suggests some emerging challenges in maintaining complete decentralization. The Ministry is currently examining the factors contributing to this decline to identify appropriate solutions and restore full implementation of this important initiative.

While progress is evident across most areas, the Ministry acknowledges that further work remains. The slight regression in decentralization from divisional hospitals highlights the ongoing challenges of sustaining comprehensive healthcare reforms. Additionally, newer initiatives like telehealth require continued refinement and integration into the broader healthcare system.

Looking ahead, the Ministry remains committed to building upon these foundations to further improve access to specialist services. By maintaining focus on these complementary approaches—decentralization, telehealth, rehabilitation outreach, and clinical outreach—the Ministry continues to work toward a healthcare system where geographical location presents less of a barrier to receiving quality specialist care. Through persistent effort and strategic resource allocation, the vision of more equitable healthcare access for all Fijians moves steadily closer to reality.

Progress Towards Output 2.2.2: Strengthen clinical management of priority NCDs

The Ministry's efforts to strengthen clinical management of priority Non-Communicable Diseases (NCDs) show mixed results, with significant improvement in some areas while others remain challenging. The data reveals both promising advancements and persistent gaps in NCD care delivery.

In implementing the Package of Essential Noncommunicable disease (PEN) interventions (Activity 2.2.2.1), the Ministry has achieved notable progress in adherence to minimum standards. From a baseline of 20% adherence among Special Outpatient Departments (SOPDs), the initial measurement showed concerning regression with only 7% adherence at Health Centres and 25% at Sub-Divisional Hospitals. However, the most recent data indicates a substantial improvement to 44%, more than doubling the baseline adherence rate. This positive trend is marked with an upward arrow (ä) in the tracking matrix, confirming the significant advancement in standardised NCD care delivery. The additional notation of "and 3" in the latest data point may indicate three facilities achieving particularly high compliance, though this interpretation would benefit from clarification.

The data is silent on Activity 2.2.2.2 regarding support training on PEN audit, with no specific metrics provided to assess progress in this area. This gap in reporting makes it impossible to evaluate whether healthcare providers have received adequate training on monitoring and improving PEN implementation, which is a critical enabler for sustained improvement in NCD care standards.

For the delivery of inpatient care services for NCD-related admissions (Activity 2.2.2.3), the Ministry shows impressive improvement in reducing unplanned readmissions. From a baseline of 6.6% unplanned readmissions within 28 days of discharge, there was an initial slight increase to 7% (though with incomplete reporting noted). However, the most recent data shows a dramatic reduction to 1.18%, representing an approximately 82% decrease from baseline. This substantial improvement suggests significantly enhanced

effectiveness of initial inpatient treatment and discharge planning for NCD patients. The additional notation of "and 49 (Acc-3.7% and 161)" may indicate cumulative figures or specific facility data, though the exact meaning requires clarification.

The overall picture reveals a healthcare system that has made substantial strides in both outpatient and inpatient NCD management. The more than doubling of PEN adherence rates indicates improved standardization of outpatient NCD care, while the dramatic reduction in readmission rates suggests enhanced effectiveness of inpatient interventions. These improvements likely reflect successful clinical protocol implementation, better continuity of care, and potentially improved patient education and follow-up systems.

Despite these positive trends, several challenges remain. The initial regression in PEN adherence before the subsequent improvement suggests potential implementation difficulties that required time to overcome. The lack of data on PEN audit training represents a gap in understanding workforce development for NCD management. Additionally, the incomplete hospital reporting noted during the interim measurement period raises questions about data quality and comprehensive monitoring across all facilities.

Moving forward, the Ministry would benefit from ensuring complete reporting across all facilities, clarifying the training and support provided for PEN implementation, and documenting the specific interventions that contributed to the dramatic reduction in readmission rates. These successful approaches could potentially be standardised and scaled across the healthcare system to further enhance NCD management.

The substantial improvements in both outpatient standardization and inpatient effectiveness demonstrate the Ministry's capacity to significantly strengthen clinical management of priority NCDs when focused interventions are successfully implemented.

Progress Towards Output 2.2.3: Efficient and effective referral system

The Ministry's efforts to develop an efficient and effective referral system show partial progress with notable areas requiring further attention. The data reveals both operational improvements and incomplete systemic reforms in the referral processes.

In the management of overseas medical referral applications (Activity 2.2.3.1), the Ministry has established a functional processing system but has not yet achieved optimal efficiency. The baseline target for processing overseas medical referrals was set at 2-3 weeks, while actual performance shows an average processing time of 15-20 working days. This represents a slight delay compared to the target timeframe, particularly when considering that working days exclude weekends, potentially extending the actual calendar time patients wait for referral decisions. The data also indicates a processing volume of "average 2 files/week," suggesting a relatively modest caseload that might have allowed for more streamlined processing. The overall assessment of "varying progress" in the tracking matrix accurately reflects this inconsistent performance in referral processing efficiency.

More concerning is the limited advancement in streamlining the broader referral processes (Activity 2.2.3.2). The review of the current referral process stands at only 43% completion, indicating that less than half of the planned systemic evaluation has been conducted. This incomplete review represents a significant gap in the Ministry's ability to comprehensively reform and standardise referral pathways. Without a complete assessment of existing processes, the development of improved protocols for patient transfers between facilities and levels of care remains constrained.

The partial completion of the referral process review may be impeding the Ministry's capacity to identify and address bottlenecks in patient transfers, potentially affecting continuity of care and appropriate access to specialised services. The limited progress on this review suggests that while day-to-day referrals are being processed, the more fundamental work of system redesign and optimization has not advanced sufficiently.

The overall picture reveals a referral system that is functional but suboptimal, with incremental progress in processing efficiency but insufficient advancement in systemic reform. The Ministry has maintained basic referral operations while falling short on the transformative improvements needed to ensure seamless patient transitions across the healthcare system. The incomplete review of referral processes represents a missed opportunity to identify and implement efficiency gains that could benefit both patients and providers.

Moving forward, the Ministry would benefit from accelerating the review of current referral processes, which would provide the insights needed to develop more streamlined protocols. Completing this foundational assessment would enable more targeted improvements in both domestic and international referral pathways, potentially reducing processing times and enhancing continuity of care for patients requiring specialised services.

Progress Towards Outcome 2.3: Continuously Improving Patient Safety and Service Quality

The Ministry of Health's efforts to enhance patient safety and service quality demonstrate a pattern of significant systemic improvements alongside persistent challenges in specific clinical practices. The most notable achievements are evident in the dramatic strengthening of safety response systems, where resolution rates for Unusual Occurrence Reports have more than doubled from 39% to 89%, and implementation of Root Cause Analysis recommendations has surged from 30% to 92%. These improvements reflect a maturing safety culture where incidents are not only reported but systematically addressed through established clinical governance processes, creating robust mechanisms for continuous quality improvement.

Customer service and feedback systems have similarly shown remarkable advancement, with patient experience survey response rates improving from 27% to between 75-99% across different hospitals, and complaint resolution through the #157 service reaching 96% within predetermined timeframes (up from 41%). This enhanced responsiveness to patient feedback provides crucial data for service improvement while demonstrating the Ministry's commitment to patient-Centered care. The successful development of clinical policies and guidelines (100% achievement) and full implementation of scheduled 5S-KAISEN awareness training further strengthen the structural foundations for standardised, efficient service delivery.

Despite these systemic improvements, concerning trends persist in specific clinical safety practices. Hand hygiene compliance in intensive care units has declined from 91% to 84%, while surgical site infections for elective caesarean sections have increased from 4.6% to 5.8%. These negative trends in fundamental infection prevention practices suggest a disconnect between policy development and consistent point-of-care implementation, potentially undermining the broader safety improvements. Additionally, the initial delays in developing National Patient Safety and Quality Framework and National Clinical Governance Framework, though later compensated by policy development, indicate challenges in establishing comprehensive structural foundations for quality improvement.

When assessed against the outcome indicators of unplanned readmission rates (CWM Hospital at 8.9%, Lautoka Hospital at 13.8%, and Labasa Hospital at 5.6%), the overall progress toward Outcome 2.3 reveals a healthcare system that has established strong improvement mechanisms but continues to face challenges in consistent clinical execution. These frameworks have not been institutionalised due to recurring leadership turnover, limited capacity at divisional level, and inadequate integration of performance systems into daily health operations. The impressive gains in safety response systems, quality improvement initiatives, and patient feedback mechanisms provide a solid foundation for addressing the specific clinical practice issues. Moving forward, the Ministry would benefit from leveraging these enhanced governance and feedback systems to specifically target improvements in infection control practices and standardised clinical care, ensuring that systemic advances translate more effectively to consistent, high-quality patient care at every point of service delivery.

Progress Towards Output 2.3.1: Provision of standardised clinical services

The Ministry's work toward standardising clinical services presents a mixed picture, with initial delays in framework development followed by substantial progress in policy implementation. The data reveals an evolution from planning to action in the Ministry's approach to clinical standardisation.

During the first year, the Ministry encountered challenges in establishing the foundational frameworks necessary for standardised clinical services. The planned development of a National Patient Safety and Quality Framework (Activity 2.3.1.1) did not materialise as expected, with reporting indicating "No report received" against indicator i55. Similarly, the development of a National Clinical Governance Framework (Activity 2.3.1.2) also showed no documented progress during this initial period, with the same "No report received" status for indicator i56. These early gaps in framework development represented missed opportunities to establish the structural foundations for standardised clinical care.

However, the subsequent years (Y2-Y3) demonstrate a significant shift in momentum and achievement. The Ministry successfully pivoted its focus to strengthening clinical governance and quality practices across all health facilities. This renewed effort resulted in the review and development of two policies and guidelines, with reporting indicating "100%" achievement against the relevant indicator. This perfect completion rate suggests the Ministry has fully addressed its targeted policy development goals for this period.

The contrast between the initial lack of progress on framework development and the subsequent full achievement in policy implementation highlights a potential strategic adjustment. While the foundational frameworks were delayed, the Ministry appears to have compensated by accelerating policy development and implementation, potentially using alternative approaches to advance clinical standardization.

The overall picture suggests that while the Ministry faced initial obstacles in establishing the overarching frameworks for standardised clinical services, it has since made substantial progress in developing the practical policies and guidelines needed to drive standardization at the facility level. This pragmatic pivot from conceptual frameworks to operational policies may represent an adaptive approach to achieving the ultimate goal of standardised clinical services.

Moving forward, the Ministry might benefit from revisiting the development of the originally planned national frameworks, which could provide stronger structural support for the policies and guidelines now in place. The successful policy development work creates a solid foundation, but integrating these policies within comprehensive national frameworks could enhance their sustainability and effectiveness across the healthcare system.

The transition from planning challenges to implementation success demonstrates the Ministry's resilience and commitment to improving standardization of clinical services, even when faced with initial setbacks in the development of formal frameworks.

Progress Towards Output 2.3.2: Improved patient safety and reduced variation of care

The Ministry has demonstrated both remarkable achievements and emerging challenges in its efforts to improve patient safety and reduce care variation. Over the reporting period, significant strides have been made in strengthening safety systems and responsiveness, while some infection control measures have faced setbacks requiring attention.

In intensive care units across paediatric and adult services, hand hygiene compliance has unfortunately declined from 91% to 84%, moving away from the target range of 92-98%. This downward trend in a critical safety practice raises concerns, particularly given the vulnerability of ICU patients and the essential role hand hygiene plays in preventing healthcare-associated infections in these high-risk environments.

Similarly concerning is the increase in surgical site infections for elective caesarean sections at divisional hospitals, which has risen from 4.6% to 5.8%. This upward trend suggests potential gaps in perioperative infection prevention protocols or their implementation, potentially exposing mothers to preventable complications during what should be a controlled surgical procedure.

In stark contrast to these challenges, the Ministry has demonstrated exceptional improvement in its safety response systems. The resolution rate for Unusual Occurrence Reports within established timeframes has more than doubled, climbing from 39% to an impressive 89%. This dramatic enhancement reflects a maturing safety culture where incidents are not only reported but systematically addressed through established clinical governance processes, ensuring that identified risks receive prompt attention and resolution.

Perhaps the most striking improvement has been in the implementation of Root Cause Analysis recommendations, which has surged from 30% to 92%. This remarkable progress indicates that the Ministry is not only identifying the systemic causes of safety incidents but actively implementing corrective measures to prevent their recurrence. The reported achievement of "100% RCA" suggests full adoption of this critical safety improvement methodology.

The Ministry has also established robust internal audit processes for Infection Prevention and Control, achieving 90% adherence to IPC standards. This high compliance rate indicates that despite challenges in

specific areas like hand hygiene, the broader infection control framework is being effectively implemented across facilities.

The overall picture reveals a healthcare system that has made substantial progress in establishing responsive safety systems and implementing improvement recommendations, while facing ongoing challenges in consistent application of infection control practices at the point of care. The impressive gains in safety response mechanisms provide a strong foundation for addressing the concerning trends in infection indicators. Moving forward, the Ministry would benefit from leveraging its enhanced governance processes to specifically target improvement in hand hygiene compliance and surgical infection prevention, ensuring that all aspects of patient safety advance in tandem toward the goal of safer, more consistent care for all patients.

Progress Towards Output 2.3.3 - Improved Quality and Value of Services by Improving Efficiency and Reducing Wastage

The Ministry has demonstrated substantial progress toward Output 2.3.3, particularly in enhancing customer service and complaint management systems. Patient experience survey response rates have improved dramatically across facilities, with impressive figures ranging from 75% to 99% across different hospitals, compared to the previous 27% rate that was hampered by COVID-19 disruptions. This significant improvement suggests enhanced patient engagement and a stronger focus on gathering feedback for service improvement. Similarly, the resolution of customer complaints has seen remarkable advancement, with 96% of complaints received through the #157 service now resolved within predetermined timeframes, up from 41% previously and approaching the 100% target.

Quality improvement initiatives continue to be implemented across health facilities, with 57 initiatives reported, though the relationship to the Year 3 target of 21 quality improvement initiatives (with an accumulated 92) requires clarification. The 5S-KAIZEN awareness training has achieved 100% of scheduled sessions, indicating full implementation of this efficiency methodology. However, the bed block management system in divisional hospitals remains a work in progress, with initiatives being implemented but the system not yet fully established. Overall, these results reflect significant strides in customer-focused service delivery and complaint resolution, while efficiency-focused structural changes like bed block management require continued attention to fully realise the output's goal of improved service value and reduced wastage.

Status of Strategic Priority 3: Health System Management

Overall Status of Strategic Priority 3: Drive Efficient and Effective Management of the Health System

The Ministry of Health has made notable but uneven progress toward achieving efficient and effective management of the health system. Significant successes in financial management, supply chain improvements, and technological infrastructure development stand in stark contrast to concerning challenges in workforce retention and equipment maintenance. The financial management systems demonstrate exemplary performance with near-perfect budget execution (89.2%), timely payment of community health workers (100%), and exceptional utilization of donor funds (97.3%) and CSO grants (100%), establishing a solid foundation for operational efficiency.

Despite these financial strengths, the Ministry faces a critical workforce crisis with an alarming 41% vacancy rate in the nursing cadre, threatening service delivery capacity despite impressive achievements in professional development and training programmes. This disconnect between strong training participation (95-100%) and high resignation rates suggests that while skill development is prioritised, underlying factors affecting workforce satisfaction and retention require urgent attention. Similarly concerning is the dramatic decline in equipment functionality from 95% to just 56%, representing a critical regression that directly undermines healthcare delivery capabilities despite good progress in supply chain management and maintaining above-target availability of tracer products (85-86%).

Digital transformation efforts show promising foundations with 97% of targeted health facilities now using Health Information Systems, but supporting elements of comprehensive training and research utilization lag behind. The Ministry has established key structural elements for improved governance through Divisional Command Centres (100% complete) and a comprehensive MEL plan with extensive capacity building (27 training sessions), though consistent implementation across all areas remains a challenge with only 72% of Business plan progress reports submitted on time.

The Ministry's journey toward efficient and effective management reveals an organization with strong systems for financial stewardship and partnership management, but facing significant challenges in human resource retention and equipment maintenance that threaten service delivery. To fully achieve Strategic Priority 3, the Ministry must urgently address the nursing workforce crisis, reverse the decline in equipment functionality, and ensure that established governance structures and frameworks translate into consistent implementation practices throughout the health system. The solid financial and partnership foundations provide a platform from which these critical challenges can be addressed if given appropriate priority and resources.

Progress towards Outcome 3.1: Cultivate a competent and capable workforce where the contribution of every staff member is recognised and valued

The Ministry has demonstrated variable progress toward Outcome 3.1 across its three outputs, with notable strengths in professional development and structural alignment but significant challenges in workforce retention and policy development.

Under Output 3.1.1, the Ministry has achieved 100% realignment of staffing needs to the new service delivery model, demonstrating strong operational restructuring to match evolving healthcare priorities. However, the supporting HR Manual remains in draft form pending finalization of permanent employment conditions, indicating that while practical staff realignment is complete, the formal policy framework is still developing.

Output 3.1.2 presents the most concerning challenges to achieving Outcome 3.1. Despite achieving 100% compliance with recruitment and selection processes and staff transfer guidelines, the Ministry faces a critical 41% vacancy rate in the nursing cadre (1,715 out of 4,162 positions unfilled) due to rapid resignations. This substantial gap directly undermines the goal of maintaining a competent workforce and suggests serious issues with staff recognition and valuation. The limited progress in analysing exit questionnaires (only one report produced against a target of four) further indicates gaps in understanding workforce attrition factors.

In contrast, Output 3.1.3 shows impressive progress in professional development, with 100% of NTPC levy-paying officers attending required courses, 95% of staff participating in needs-based training programmes, and 100% of nursing staff completing required professional development. The consistent 100% compliance with Occupational Health and Safety requirements across all 48 health facilities further demonstrates commitment to creating a supportive working environment.

Overall, the Ministry has made substantial progress toward the professional development and structural alignment aspects of Outcome 3.1, but the alarming nursing vacancy rate represents a critical challenge to achieving a "competent and capable workforce where every staff member is recognised and valued." The contrast between strong training participation and high resignation rates suggests that while skill development is being prioritised, other factors affecting workforce satisfaction and retention require urgent attention. To fully achieve Outcome 3.1, the Ministry needs to address the underlying causes of nursing resignations, complete the HR policy framework, and ensure that recognition and valuation of staff contributions extends beyond training opportunities to encompass retention strategies and workplace satisfaction.

Progress Towards Output 3.1.1 - Implement Plans and Policies to Manage the Workforce and Working Environment

The Ministry has made significant progress in aligning its human resources to support remodelled health service delivery, achieving 100% realignment of staffing needs to the new service delivery model. This complete realignment suggests a successful restructuring of personnel to match evolving healthcare priorities and service requirements, representing a major accomplishment in workforce management.

However, the development of supporting human resources policies and plans appears to be at an earlier stage. A draft HR Manual has been compiled, but it remains under review pending the finalization of permanent employment conditions. This indicates that while the practical realignment of staff has been completed, the formal policy framework to govern this new structure is still in development. The progress on policy realignment cannot be quantitatively assessed without specific percentage data, but the existence of a draft manual represents tangible progress.

The overall picture suggests a two-speed implementation approach: rapid and complete operational realignment of staffing, followed by a more deliberate development of the supporting policy framework. To fully achieve Output 3.1.1, the Ministry will need to complete the review and formalization of the HR Manual in accordance with Civil Service Guidelines and applicable employment legislation, ensuring that the already-realigned workforce operates within a clear and supportive policy environment.

Progress Towards Output 3.1.2 - Attract, Select, Recruit, Retain and Empower the Right People to Create a Diverse, Inclusive and Engaged Workforce

The Ministry has demonstrated mixed progress in workforce management efforts under Output 3.1.2. Significant improvements are evident in recruitment and selection processes, which have reached 100% compliance with OMRS policy and guidelines, up from 37% previously. Similarly, staff transfers and postings are consistently processed according to guidelines at a 100% rate, indicating strong adherence to established protocols for workforce mobility and distribution.

However, several challenges persist. The Annual Performance Assessment (APA) system appears to be in transition, with ESU staff completing their assessments while broader changes are underway in accordance with MCS Circulars 1 and 2/2023 regarding contract-based appointments. The quarterly analysis of exit questionnaires shows limited progress, with only one report produced against a target of four, suggesting gaps in understanding workforce attrition factors.

The most concerning area is the significant vacancy rate in the nursing cadre, where 41% of established positions remain unfilled (1,715 out of 4,162), despite 80% of vacant positions being filled through EOI or advertisement processes. This substantial gap reflects the impact of "rapid increase in recent resignation of Nurses" and represents a critical challenge to service delivery. More positively, allied health worker establishments have been fully updated (100%), with an 87% fill rate indicating better retention in these specialised roles.

Overall, while the Ministry has established strong administrative processes for workforce management (100% compliance with recruitment guidelines, transfer protocols, and P2P reporting), the substantial nursing vacancy rate suggests that the ultimate goal of creating a "diverse, inclusive and engaged workforce" faces significant retention challenges, particularly in this essential cadre. Addressing the underlying causes of nursing resignations appears to be a critical priority for achieving Output 3.1.2's objectives.

Progress Towards Output 3.1.3 - Provide Opportunities for Professional Development to Achieve a More Engaged, Skilled and Satisfied Workforce

The Ministry has made substantial progress in developing professional development opportunities for its workforce under Output 3.1.3, with particularly strong performance in recent implementation.

The induction process for new appointees and promotes was tracking positively at 97% compliance with agreed timelines, though it was temporarily affected by COVID-19 disruptions. Similarly, awareness sessions on key HR frameworks (My APA, OMRS, Disciplinary Guidelines, etc.) were conducted, albeit at a lower rate than targeted (23 sessions versus 38 planned).

Significant improvements are evident in training participation rates. While earlier data showed challenges with only 79% of officers attending funded training programmes and just 23% (326/1413) of NTPC levy-paying officers completing required courses due to COVID-19 restrictions, current reporting indicates 100% of NTPC levy-paying officers now attend required courses per the NTPC Act and the MHMS approved training plan. Additionally, 95% of staff are attending required training programmes based on needs analysis, and 100% of Registered Nurses/Midwives and Nurse Practitioners are participating in required trainings organised by the Fiji College of Nursing.

Occupational Health and Safety compliance has remained consistently strong at 100%, with all 48 health facilities registered and maintaining their respective OHS Committees. The Ministry has also achieved 100% compliance with timely payment of NTPC Levy and submission of Grant Claims to NTPC.

Overall, Output 3.1.3 shows impressive progress toward creating a more engaged, skilled, and satisfied workforce through professional development opportunities. The Ministry has successfully overcome earlier COVID-related disruptions to establish comprehensive training participation across all staff categories, with particularly strong performance in nursing professional development and OHS compliance. The high attendance rates for required training (95-100%) suggest an organizational culture that prioritises continuous learning and skills development, which should contribute positively to workforce engagement and satisfaction.

Progress towards Outcome 3.2: Improve the efficiency of supply chain management and procurement systems, and maintenance of equipment

The Ministry has demonstrated mixed progress toward Outcome 3.2, with notable achievements in supply chain management contrasted by concerning regression in equipment maintenance. Under Output 3.2.1, the Ministry has maintained consistently above-target availability of tracer products (85-86%), achieved 90% implementation of the supply chain management system following a comprehensive end-to-end review, and successfully implemented 96% of Free Medicines Programme reform recommendations. These achievements indicate substantial improvements in the efficiency of supply chain and procurement systems, directly supporting the first component of Outcome 3.2. However, the postponement of the Essential Medicines List review represents a gap in optimising the procurement framework.

For Output 3.2.2, quality assurance processes show varied progress, with the completion of the National Antimicrobial Resistance Action Plan review representing a significant achievement, while analytical testing capacity suffered a severe reduction (from 21 to only 3 samples) due to the temporary closure of the TGA laboratory, and the development of the Pharmaceutical Sector Strategic Plan faced delays. The most concerning area is Output 3.2.3, where equipment functionality has dramatically declined from 95% to 56%, representing a critical regression that directly undermines the maintenance component of Outcome 3.2. This substantial deterioration, coupled with gaps in reporting on maintenance activities and implementation of the replacement plan, suggests serious challenges in sustaining equipment functionality. Overall, while the Ministry has made commendable progress in improving supply chain efficiency through system reforms and maintaining good product availability, the alarming decline in equipment functionality represents a critical

area requiring immediate attention to achieve Outcome 3.2 fully. The contrasting performance across these outputs suggests that while procurement and supply chain systems have improved, equipment maintenance systems require urgent strengthening to prevent further deterioration in healthcare service delivery capabilities.

Progress Towards Output 3.2.1 - Improved Availability and Accessibility to Medical Products

The Ministry has demonstrated significant progress in improving the availability and accessibility of medical products under Output 3.2.1, though some activities remain incomplete. The availability of tracer products in targeted facilities has remained relatively stable, showing a slight decrease from 86% to 85% in the most recent reporting period. This represents a marginal decline but still maintains a reasonably high level of product availability, which is crucial for consistent healthcare delivery. The initial target of 82.8% has been consistently exceeded, indicating overall positive performance in this key metric.

Substantial progress has been made in implementing the supply chain management system, with 90% completion reported. This follows the earlier completion of an end-to-end review of the supply chain (100%) and subsequent implementation of recommendations. The high implementation rate suggests that the Ministry has prioritised modernising its supply chain infrastructure to improve efficiency and product availability.

The Free Medicines Programme has undergone significant reform, with 96% of review recommendations implemented. This high implementation rate indicates strong commitment to improving this essential service for the population and addressing previously identified issues.

However, some planned activities have faced delays or incomplete reporting. The review of the Essential Medicines List (EML) was postponed to the next financial year after the final meeting was cancelled. Additionally, there is no updated information provided on the quarterly subdivisional visits/stock takes (previously reported at 55 visits) or the reallocation of medicines based on service remodelling (previously at 100% completion).

Overall, Output 3.2.1 shows positive progress in improving medical product availability and accessibility, particularly through supply chain reforms and the Free Medicines Programme improvements. The consistently above-target availability of tracer products (85-86%) indicates that these efforts are translating into better product access at facility level. The incomplete EML review represents a gap that should be prioritised in the coming period to ensure the medicine selection remains appropriate and cost-effective for current health needs.

Progress Towards Output 3.2.2 - Quality Assurance Processes for All Medical Supplies Established

The Ministry has demonstrated varied progress in establishing quality assurance processes for medical supplies under Output 3.2.2, with notable achievements in certain areas alongside challenges in others.

The analytical testing of medicines with international quality control laboratories has faced significant challenges, with only 3 samples sent for laboratory testing at a WHO-accredited laboratory compared to the earlier 21 samples. This substantial reduction was attributed to the temporary closure of the TGA laboratory, with plans to resume testing in September. This temporary disruption represents a setback in the Ministry's quality assurance framework for medications.

Earlier reporting showed promising coverage of annual inspections of license holders, with 84% of private pharmacies and 79% of pharmaceutical wholesalers being inspected. These inspection rates demonstrate the Ministry's commitment to regulatory oversight, though updated information would be valuable to assess whether this momentum has been maintained.

A significant achievement has been the completion of the National Antimicrobial Resistance (AMR) Action Plan review, which reached 100% completion. This accomplishment positions the Ministry well to address the critical global health challenge of antimicrobial resistance and provides a framework for more appropriate use of these essential medications.

However, the development of the Pharmaceutical Sector Strategic Plan has encountered delays, with the consultant/reviewer unable to meet the established timeline. This important strategic document has

consequently been rescheduled for the next financial year, postponing the establishment of a comprehensive framework for pharmaceutical quality assurance.

Overall, Output 3.2.2 shows meaningful but uneven progress toward establishing robust quality assurance processes for medical supplies. The successful completion of the National AMR Action Plan review represents an important policy milestone, while the temporary reduction in analytical testing capacity and the delay in strategic planning highlight areas requiring attention in the coming period. Resuming full analytical testing capacity and expediting the development of the Pharmaceutical Sector Strategic Plan would significantly strengthen the Ministry's quality assurance framework for medical supplies.

Progress Towards Output 3.2.3 - Improved Functionality of Biomedical & Dental Equipment in Health Facilities

The Ministry's efforts to improve the functionality of biomedical and dental equipment in health facilities have shown concerning regression after initial progress. This output focuses on ensuring that healthcare facilities have properly functioning equipment, which is essential for effective service delivery.

The percentage of facilities having proper functional biomedical and dental equipment initially showed positive momentum, increasing from over 86% (achieved through COVID budget and donations) to an impressive 95%. However, the most recent reporting period indicates a dramatic decline to 56% (accumulated). This substantial drop of 39 percentage points represents a significant deterioration in equipment functionality across health facilities. This regression could have serious implications for healthcare service delivery, potentially limiting diagnostic and treatment capabilities at affected facilities.

The data does not provide specific information about the implementation of activity 3.2.3.2 regarding support for the maintenance of existing biomedical and dental equipment. This gap in reporting makes it difficult to assess whether maintenance activities have been consistently carried out, which might explain the sharp decline in functional equipment.

Regarding the development of a replacement and maintenance plan for biomedical equipment, earlier reporting indicated the completion of a replacement plan with ongoing priority purchases. However, no updated information is provided in the current reporting period, raising questions about whether the plan is being effectively implemented and whether it includes adequate provisions for regular maintenance.

The dramatic decline in equipment functionality suggests potential issues with the sustainability of initial improvements, possibly due to inadequate maintenance systems, budget constraints, or challenges in implementing the replacement plan. The lack of detailed information about maintenance activities and the current status of the replacement plan makes it difficult to pinpoint the exact causes of this regression.

To address this concerning trend, the Ministry would benefit from conducting a thorough assessment of the factors contributing to the decline in equipment functionality, reviewing and potentially strengthening the maintenance systems, and ensuring consistent implementation of the replacement plan with adequate budgetary support. Regular monitoring of equipment status across facilities would also help identify and address issues before they lead to equipment failure.

Progress towards Outcome 3.3: Implement more efficient financial processes whilst reducing the financial hardship of the most vulnerable

The Ministry has demonstrated exemplary progress toward Outcome 3.3 through consistently strong performance under Output 3.3.1 (Improved Budget Execution and Financial Performance). Budget execution has remained robust with a slight improvement from 88.5% to 89.2% ($338.9 million utilised from a revised budget of $379.8 million as of July 31, 2023), indicating effective financial management and resource utilization. The Ministry's strategic approach to budget management is further evidenced by the redeployment of $15.2 million from the original $395.1 million budget, demonstrating flexibility in addressing changing priorities. Financial monitoring practices have been exceptional, with 100% compliance in producing financial reports and the implementation of weekly compilations that exceed the required monthly reporting frequency, enabling more responsive financial management and contributing to the strong execution rate.

The Ministry has maintained perfect performance in the timely remuneration of Community Health Workers at 100%, which is crucial for supporting these essential frontline workers who often serve vulnerable populations in remote areas, directly addressing the outcome's focus on reducing financial hardship for the vulnerable. The successful completion of the mid-term budget review in the second quarter further strengthens the Ministry's financial oversight capabilities. The consistent excellence across all indicators suggests that the Ministry has established sustainable and efficient financial management systems that effectively support service delivery while ensuring timely payment to community-based workers who serve vulnerable populations, thus making substantial progress toward both aspects of Outcome 3.3 – implementing more efficient financial processes and reducing financial hardship for the vulnerable.

Progress Towards Output 3.3.1 - Improved Budget Execution and Financial Performance

The Ministry has demonstrated strong and consistent performance in improving budget execution and financial performance under Output 3.3.1, with all indicators showing positive results.

Budget execution has remained stable and robust, with the execution rate slightly improving from 88.5% to 89.2% ($338.9 million out of a revised budget of $379.8 million as of July 31, 2023). This high execution rate indicates effective financial management and utilization of allocated resources. It's worth noting that $15.2 million was redeployed from the original budget of $395.1 million, showing flexibility in budget management to address changing priorities or needs.

Regular budget monitoring has been exemplary, with 100% compliance in producing financial reports. The Ministry has gone beyond the required monthly reporting by implementing weekly compilations that are consolidated into monthly reports. This frequent monitoring allows for more timely identification of financial issues and opportunities for corrective action, contributing to the strong budget execution rate.

The Ministry has also achieved 100% timely remuneration of Community Health Workers, maintaining the perfect performance noted in earlier reporting periods. This consistent and timely payment is crucial for maintaining the motivation and retention of these essential frontline health workers who often serve in remote and underserved areas.

Additionally, the mid-term budget review was successfully completed in the second quarter as planned. This review provides an opportunity to assess financial performance halfway through the budget cycle and make any necessary adjustments to ensure optimal resource utilization for the remainder of the period.

Overall, Output 3.3.1 shows excellent progress across all indicators, demonstrating strong financial management practices within the Ministry. The combination of high budget execution, regular and frequent monitoring, timely payment of community health workers, and completion of the mid-term review reflects a well-functioning financial management system. These achievements contribute to the Ministry's ability to effectively implement its programmes and deliver health services to the population.

The consistent performance across multiple reporting periods suggests that the Ministry has established sustainable systems and processes for financial management, which should serve as a foundation for continued strong performance in this area.

Progress towards Outcome 3.4: Ensure infrastructure is maintained to match service needs

The Ministry's journey toward ensuring infrastructure matches service needs shows promising foundations but significant implementation challenges. While only 46% of health facilities have been upgraded against the ambitious 80% target, the Ministry has established crucial building blocks for future success, including a comprehensive infrastructure audit, an updated planning matrix for minor works, and exemplary financial management evidenced by 99% utilization of the allocated budget. The systematic approach to Board of Survey activities across divisions demonstrates methodical assessment practices, with Northern and Western divisions completed and Eastern division progressing according to schedule.

Asset management practices appear strong with a 95% vehicle returns submission rate, further indicating solid administrative processes. The disconnect between these well-established planning mechanisms and the actual facility upgrade rate suggests implementation bottlenecks that require attention, but the groundwork laid through comprehensive assessment and planning tools positions the Ministry to accelerate improvements if it can effectively translate these foundations into more aggressive implementation of facility upgrades to

better align infrastructure with service delivery needs. Notably, no progress was reported for Output 3.4.2 (Affordable aesthetic solutions implemented), representing a gap in the comprehensive approach to infrastructure improvement that should be addressed in future reporting periods.

Progress Towards Output 3.4.1 - Infrastructure Upgraded Based on Needs

The Ministry has made mixed progress in upgrading infrastructure based on needs under Output 3.4.1, with some notable achievements alongside areas requiring further attention.

The percentage of health facilities upgraded as per requirement shows significant room for improvement. While the target was set at 80%, only 46% of health facilities are being upgraded by respective Cost Centres to meet service delivery needs. This represents a substantial gap of 34 percentage points from the target. However, it's positive to note that a matrix has been updated for all minor works/upgrading works to be done, which suggests systematic planning for future improvements.

The Board of Survey (BOS) activities show encouraging progress, with completed surveys in the Northern and Western divisions, as well as in Kadavu. The Eastern division surveys were reported as in progress with a detailed schedule for various locations including Vunisea, Kavala, Lomaiviti (Levuka, Motoriki, Bureta, Gau, Nairai, and Batiki) between August and October. This structured approach to conducting BOS indicates good planning and implementation, though the report doesn't specify if all 23 targeted BOS were completed or if boarded items were successfully removed.

A significant achievement is the completion of a comprehensive infrastructure audit in the second quarter, which fulfils activity 3.4.1.3. This audit provides a crucial foundation for evidence-based decision-making regarding infrastructure investments and maintenance.

The utilisation of the minor works budget has been exemplary, with 99% of the allocated budget spent (achieving $634,520 from a revised budget of $1.4 million). This near-perfect budget execution demonstrates efficient financial management for infrastructure improvements, though it's worth noting that the budget was revised downward from its original allocation.

Regarding vehicle returns submission to the Asset Management Unit (AMU), the Ministry achieved a 95% submission rate, which is very good though slightly short of perfect compliance. This high rate suggests strong asset management practices for the Ministry's vehicle fleet.

No specific information is provided about activity 3.4.1.5 regarding the development of a prioritised action plan for minor works and its submission to AMU, making it difficult to assess progress in this area.

Overall, Output 3.4.1 shows a mixed picture with strong performance in budget utilization, infrastructure auditing, and vehicle returns, but significant room for improvement in the percentage of health facilities upgraded. The completion of the infrastructure audit and the updated matrix for minor works suggest that the Ministry has laid the groundwork for more systematic infrastructure improvements, which may accelerate the pace of facility upgrades in future reporting periods. To achieve the target of 80% of facilities upgraded, the Ministry would benefit from leveraging the completed infrastructure audit to develop a more aggressive implementation strategy, potentially with additional resource allocation.

Progress Towards Output 3.4.2 - Affordable Aesthetic Solutions Implemented

No Progress on implementation reported since the start of the Strategic Plan

Progress towards Outcome 3.5: Harness digital technologies to facilitate better health care for our patients

The Ministry has made moderate progress toward Outcome 3.5, with varying achievements across the three outputs. Output 3.5.1 (Improved Access to and Completeness of Patient Information) demonstrates the strongest performance, with 97% of targeted health facilities now using Health Information Systems and perfect compliance (100%) in timely submission of situation reports. However, gaps remain in measuring interoperability between systems and in the development of chronic disease registries. Output 3.5.2 (Training and Support) shows mixed results, with successful Data for Decision Making courses conducted across three divisions, but concerning gaps in supervisory visits, data verification audits, and Medical Cause of Death Certificate training.

Output 3.5.3 (Strengthen Research and Innovation) reveals the most limited progress, with functioning ethical review mechanisms and intern research training in place, but delays in conducting the annual research symposium and incomplete implementation of several planned activities. Overall, while the Ministry has made significant strides in deploying digital health information systems, the supporting elements of comprehensive training and research utilization lag behind. The technological infrastructure appears to be developing well, but ensuring staff capacity to effectively use these systems and leveraging research to drive innovation requires additional focus. To fully harness digital technologies for better patient care, the Ministry needs to address these implementation gaps and develop metrics that capture how these technological advancements are actually improving healthcare delivery and patient outcomes.

Progress towards Output 3.5.1: Improved Access to and Completeness of Patient Information

The Ministry has made substantial progress towards improving access to and completeness of patient information systems, with most indicators showing strong performance against targets. The implementation of health information systems appears to be a priority area with significant achievements.

Regarding PATIS Online Access to Targeted Health Facilities, while specific Year 1 performance data is not provided, the Year 2 data show excellent progress with 97% of targeted health centres now using Health Information Systems. This is very close to the target of 100%, indicating successful implementation of this activity and reflecting strong commitment to digitalising health information across the network of facilities.

The interoperability between current and new applications is more difficult to assess. Without specific performance data against the ambitious target of 98% of total discharges recorded in PATISplus system, it's unclear whether this integration is functioning as intended. This represents a gap in our understanding of how well the various systems are communicating with each other.

For the improvement of birth data capture at divisional hospitals, the reporting provides an absolute number of 7,519 births recorded in PATISplus system, but without knowing the total number of births, it's impossible to determine whether the 82% target has been achieved. This partial reporting limits our ability to fully assess progress in this critical area of vital statistics.

The Ministry has excelled in strengthening existing methods of reporting, achieving perfect compliance with 100% timely submission of situation reports by the command centre. This exemplary performance suggests strong operational discipline in information management and reliable communication channels within the health system.

The establishment of chronic disease registries appears to be in progress, with initial identification of chronic diseases such as diabetes mellitus and hypertension embedded in the HIS, and plans for further review with Nurses and Family Health. However, the report doesn't clearly indicate whether the full review of data sources and resource needs has been completed as targeted, leaving some ambiguity about the status of this important initiative for non-communicable disease management.

In Year 2, the implementation of 4 new health information systems represents significant progress in expanding digital health capabilities. This achievement demonstrates the Ministry's ongoing commitment to enhancing its technological infrastructure, though without a specific target, it's difficult to determine if this meets or exceeds expectations.

The Ministry shows particular strengths in the near-universal adoption of Health Information Systems across targeted health centres and perfect compliance with timely reporting requirements. These accomplishments reflect well-established processes and strong institutional capacity for health information management.

Areas requiring further attention include incomplete reporting on some indicators, lack of clear performance data for system interoperability, and the unclear status of chronic disease registries development. To strengthen future performance, the Ministry would benefit from ensuring complete data reporting with both targets and actual performance data in consistent formats, accelerating the chronic disease registry development process, developing clearer metrics for system interoperability, and considering indicators that measure the actual impact of improved information systems on healthcare delivery and patient outcomes.

Overall, Output 3.5.1 demonstrates strong progress in improving access to patient information systems, particularly in system deployment and reporting compliance, though some gaps in measurement and

reporting prevent a fully comprehensive assessment of all activities. The trajectory appears positive, with significant technological advancements enhancing the Ministry's capacity to manage patient information effectively.

Progress towards Output 3.5.2: Training and Support Provided for Using Information Systems

The Ministry has made moderate progress in providing training and support for using information systems, with varied levels of achievement across different activities. The capacity building efforts show some positive results, though there are notable gaps in implementation and reporting for certain components.

Regarding capacity building on data collection and analysis at all levels, the Ministry has conducted several trainings as planned. The Data for Decision Making (DDM) course was facilitated in collaboration with the Secretariat of the Pacific Community (SPC) for local participants, which represents an important step in building analytical capacity. Additionally, training was conducted in three divisions (Central, Western, and Northern) specifically targeting nurses. This geographic spread suggests a deliberate effort to extend capacity building beyond central facilities to divisional levels, which is commendable for ensuring wider system capabilities.

For the International Classification of Diseases (ICD) coding training, progress has been made with two trainings conducted. The involvement of SPC in planning the training and the specific scheduling of training in September (first quarter of 2023-24) demonstrates ongoing commitment to this specialised skill development. However, it appears there may have been some administrative delays, as the report mentions an ICD 10AM cabinet paper submitted to ESU awaiting response. This suggests that full implementation of the ICD training programme may be contingent on higher-level approvals, potentially slowing down the complete rollout of this important standardization initiative.

Notably, there is no reported progress on two activities: conducting supervisory visits and data verification audits (3.5.2.2) and regular training for Medical Cause of Death Certificate (3.5.2.4). The absence of information on these activities represents a significant gap in the comprehensive implementation of this output. Data verification audits are crucial for ensuring the quality and reliability of the information systems being deployed, while accurate certification of causes of death is fundamental for health statistics and planning. The lack of reported progress in these areas may indicate implementation challenges or reporting oversights that should be addressed.

The Ministry shows strengths in its partnership approach, collaborating with regional organizations like SPC to deliver specialised training. The geographic distribution of training across three divisions also demonstrates a commitment to decentralised capacity building, which is essential for system-wide improvement.

Areas requiring attention include the apparent gaps in implementation of supervisory visits, data verification audits, and Medical Cause of Death Certificate training. Additionally, the reporting lacks quantitative measures of training effectiveness or reach, such as the number of staff trained or improvements in data quality following training interventions. The dependency on external approval processes (as seen with the cabinet paper for ICD 10AM) may also be delaying full implementation of some training components.

To strengthen future performance, the Ministry would benefit from developing and reporting on clear metrics for training effectiveness, ensuring comprehensive implementation of all planned activities (particularly the currently unreported components), and potentially exploring ways to expedite administrative approval processes for training initiatives.

Overall, Output 3.5.2 shows partial progress in providing training and support for using information systems, with some successful training activities balanced against apparent gaps in implementation. The foundation for capacity building has been established, but a more comprehensive and systematic approach to training and support would enhance the effectiveness of the health information systems being deployed under Output 3.5.1.

Progress towards Output 3.5.3: Strengthen Research and Innovation to Support Health Systems Strengthening

The Ministry has made mixed progress in strengthening research and innovation to support health systems strengthening, with some activities showing clear advancement while others appear to have limited reported progress or implementation.

In Year 1, the planned annual research symposium (3.5.3.1) appears to be in the early stages of development, with only a proposal submitted. The absence of further information suggests that the actual symposium may not have been conducted as planned during this period. This represents a missed opportunity for knowledge sharing and dissemination of research findings that could inform health system improvements.

For the review and update of health research priorities (3.5.3.3) in Year 1, there is evidence of activity with 18 proposals reviewed and approved. This indicates functioning research governance mechanisms and suggests some level of alignment between research activities and health system priorities. However, it's unclear whether this represents a comprehensive review of health research priorities at the system level, or merely the processing of individual research proposals.

There is no reported progress on increasing awareness and training on operational research (3.5.3.2) in Year 1, suggesting this activity may have been delayed or not implemented during the initial period.

Moving to Year 2, there has been notable progress in research training (3.5.3.1), with intern presentations conducted across three divisions and continuous training and guidance provided to medical interns. This focus on building research capacity among new medical professionals is commendable and represents an investment in sustainable research capabilities within the health system.

The review of health research Standard Operating Procedures (SOPs) (3.5.3.2) has been initiated, with the SOP reviewed but further consultation required. This partial progress suggests an ongoing process that has not yet been completed, potentially delaying the standardization of research processes.

A significant achievement in Year 2 is the functioning of the Health Research Ethics Review Committee (3.5.3.4), with two committee meetings conducted. This represents important progress in establishing proper ethical oversight for health research, which is fundamental to responsible research governance.

For the Review of Health Research Portal (3.5.3.6), the submission of a Business Requirement Document indicates initial progress, though the actual review and any resulting improvements to the portal appear to be still pending.

There is no reported progress on reviewing and updating health research priorities (3.5.3.3) or updating the number of health research proposals (3.5.3.5) in Year 2, suggesting potential gaps in implementation or reporting for these activities.

The Ministry shows particular strengths in establishing ethical review mechanisms and providing research training for medical interns, both of which contribute to building sustainable research capacity within the health system. The review of SOPs and development of a research portal also demonstrate attention to creating the necessary infrastructure for effective research management.

Areas requiring further attention include the apparent delays in conducting the annual research symposium, the incomplete review of health research SOPs, and the lack of reported progress on several planned activities. Additionally, the reporting focuses primarily on process indicators (meetings held, documents submitted) rather than outcomes or impacts of research on health system strengthening.

To enhance future performance, the Ministry would benefit from ensuring implementation of all planned research activities, particularly the research symposium which provides an important platform for knowledge dissemination. Developing outcome-oriented indicators that capture how research is actually influencing health system improvements would also strengthen the assessment of progress. Completing the review of SOPs and fully operationalising the research portal would further enhance research governance and accessibility.

Overall, Output 3.5.3 shows partial progress in strengthening research and innovation, with some important foundational elements established (ethics committee, intern training) but several planned activities showing

limited implementation or reporting. The trajectory appears positive but would benefit from more comprehensive implementation and clearer demonstration of how research activities are contributing to health systems strengthening.

Progress towards Outcome 3.6: Continue to strengthen planning and governance throughout the MHMS

The Ministry has demonstrated mixed progress toward Outcome 3.6, with varying levels of achievement across the three outputs. In Output 3.6.1 (Plans and Policies Reviewed and Updated), moderate progress is evident with 75% of identified policies (9 out of 12) expected to be reviewed by fiscal year-end, though the Strategic Plan review lacks detailed reporting on substance and impact. Output 3.6.2 (Governance and Reporting Structures) shows uneven implementation, with excellent progress in establishing Divisional Command Centres (100% complete) but concerning gaps in developing supporting processes, frameworks, working groups, and evidence-based policy submissions.

Output 3.6.3 (Effective Monitoring, Evaluation and Learning System) demonstrates strong foundational work through the development of a comprehensive MEL plan and extensive capacity building (27 training sessions), but operational implementation remains a challenge with only 72% of Business plan progress reports submitted on time. Overall, while the Ministry has established key structural elements and frameworks to strengthen planning and governance, consistent implementation across all areas and more detailed qualitative reporting on impacts would significantly enhance progress toward this outcome. The trajectory appears positive but requires focused attention on closing implementation gaps and ensuring that established structures and frameworks translate into improved governance practices throughout the MHMS.

Progress towards Output 3.6.1: Plans and Policies Reviewed and Updated

The Ministry has made moderate progress in reviewing and updating plans and policies, with partial achievements against targets and some apparent gaps in implementation or reporting for key activities.

Regarding the review of identified existing policies (3.6.1.1), there appears to be a progressive implementation approach across multiple years. The target indicates that 12 policies were identified for development or review. In the reporting period, 6 policies have been addressed, with an additional 3 expected by the end of the financial year. This suggests that 9 out of the 12 identified policies (75%) will be reviewed or developed by the end of the current financial year.

While this represents substantial progress, it falls short of complete implementation of the identified policy review needs. The report doesn't specify which policies have been reviewed or developed, making it difficult to assess the strategic importance or impact of the completed work.

For the annual review of the Strategic Plan 2020-2025 (3.6.1.2), the reporting indicates that "SP review document was updated with the identified areas." This suggests that the review process has been initiated and some updates have been made to reflect identified areas requiring attention. However, the brief nature of this reporting provides limited insight into the comprehensiveness of the review, the specific areas identified for update, or whether the review has led to substantive changes in strategic direction or implementation approaches. The lack of detail makes it difficult to assess the quality and impact of this important governance activity.

The Ministry shows strength in making measurable progress on policy review, with a clear tracking of numbers against targets. The fact that 75% of identified policies will be reviewed or developed by the end of the financial year demonstrates a commitment to updating the policy framework that guides health system operations.

Areas requiring attention include the incomplete review of all identified policies and the limited reporting on the Strategic Plan review process. The reporting focuses on quantitative measures (number of policies reviewed) without providing qualitative information about the nature or significance of the policy updates. For the Strategic Plan review, the minimal information provided makes it impossible to assess whether this represents a thorough and meaningful review process or a more perfunctory exercise.

To strengthen future performance, the Ministry would benefit from ensuring completion of all identified policy reviews, providing more detailed reporting on both the process and outcomes of the Strategic Plan

review, and developing indicators that capture not just the completion of reviews but also their quality and impact on health system performance. Additionally, clarifying which specific policies have been reviewed and the nature of the updates would provide greater transparency and allow for better assessment of strategic alignment.

Overall, Output 3.6.1 shows progress in reviewing and updating plans and policies, particularly in terms of policy review numbers, but with some gaps in implementation completeness and reporting detail. The trajectory appears positive but would benefit from more comprehensive implementation and more detailed reporting on the substance and impact of the review processes.

Progress towards Output 3.6.2: Governance and Reporting Structures Aligned to Remodelled Health Service

The Ministry has demonstrated varied progress in its efforts to align governance and reporting structures with the remodelled health service. This critical area of work shows both notable achievements and concerning gaps that warrant attention.

The establishment of Divisional Command Centres represents a significant milestone, with reporting indicating full completion at 100%. This achievement cannot be understated, as these centres form the backbone of the new governance architecture supporting the remodelled service delivery approach. The successful operationalization of all planned DCCs demonstrates the Ministry's commitment to implementing structural reforms that enable more responsive and coordinated health services at the divisional level.

In the area of cabinet paper preparation, the Ministry has made moderate headway. Against a target of 10 cabinet papers, 2 have been submitted during the current reporting period, with an additional 3 expected by the financial year's end. While this progress is noteworthy, it appears the Ministry may fall short of its overall target, potentially limiting the policy and legislative advancements needed to fully support the remodelled health service. The ambiguous notation "3 (12)" in the reporting creates some uncertainty about the exact expectations and achievements in this area.

Several concerning gaps emerge when examining other planned activities. The establishment of refined processes and frameworks shows no reported progress, raising questions about whether the operational guidelines necessary for the new governance structures have been developed. Similarly, there is no indication that Divisional Working Groups have been established to address emerging issues, potentially leaving a gap in the problem-solving mechanisms needed at the divisional level.

The provision of evidence-based policy advice appears to be another area of limited implementation or reporting. Despite a target of 15 quality-standard submissions to senior leadership, no actual progress is reported. This gap is particularly concerning as evidence-based policy advice is fundamental to informed decision-making within the remodelled health system.

Regarding the timely submission of briefs, requests, and reports, the reporting indicates "26 of briefs, request and reports submitted as per deadline." However, without context on what percentage this represents of total required submissions, it is impossible to assess whether this reflects strong performance or significant shortfalls.

The Ministry's greatest strength lies in its implementation of structural changes through the Divisional Command Centres, demonstrating capacity to execute major organizational reforms. However, the apparent gaps in developing supporting processes, frameworks, and working groups suggest that while the structural elements are in place, the operational components may be lagging behind.

Moving forward, the Ministry would be well-served by ensuring implementation across all planned governance activities, not just the structural components. Particular attention should be paid to establishing the refined processes and frameworks that will guide operations within the new structures, as well as the working groups that will address emerging challenges. More consistent and comprehensive reporting would also enhance transparency and enable better assessment of progress against targets.

The journey toward fully aligned governance and reporting structures shows promise but remains incomplete. While the foundation has been laid through the establishment of Divisional Command Centres, the supporting elements needed to make these structures fully functional and effective appear to be still developing. With focused attention on the gaps identified, the Ministry has the opportunity to build upon its

structural achievements to create a truly integrated and responsive governance system for the remodelled health service.

Progress towards Output 3.6.3: Effective Monitoring, Evaluation and Learning System Established

The Ministry has made substantial progress in establishing an effective Monitoring, Evaluation and Learning (MEL) system, with significant achievements in the foundational elements but some ongoing challenges in operational implementation.

The development of a comprehensive MEL plan represents a critical first step in establishing a robust framework for tracking, assessing, and learning from the Ministry's activities. Reporting indicates that this foundational document has been successfully developed, marking the completion of a key Year 1 deliverable. This achievement provides the essential blueprint that will guide all subsequent monitoring and evaluation activities across the Ministry, ensuring a standardised and systematic approach to performance assessment.

Building upon this foundation, the Ministry has invested considerably in capacity building efforts related to the new MEL plan. The reporting indicates that 27 training and awareness sessions have been conducted, suggesting a substantial effort to ensure that relevant staff understand the new MEL framework and possess the skills necessary to implement it effectively. This widespread capacity building approach demonstrates the Ministry's recognition that effective monitoring and evaluation requires not just well-designed systems but also well-prepared personnel who can utilise these systems appropriately.

As the Ministry moved into Year 2 implementation, the focus shifted toward operational application of the MEL framework through performance reviews based on respective Business Plans. In this area, the Ministry has achieved a 72% submission rate for Business plan progress reports within the established timelines. While this represents a majority of the required reporting, it also indicates that more than a quarter of the expected progress reports were either not submitted or were submitted late. This suggests that while the MEL system has been established, its consistent application across all operational areas remains a work in progress.

The Ministry demonstrates particular strength in the development and dissemination phases of the MEL system. The successful creation of the MEL plan and the extensive training efforts reflect a thorough approach to establishing the foundation for effective monitoring and evaluation. The number of training sessions conducted (27) suggests a comprehensive effort to reach relevant stakeholders across the Ministry's operations.

The area requiring most attention is the consistent application of the MEL framework at the operational level. The 72% timely submission rate for Business plan progress reports, while representing a majority, indicates room for improvement in ensuring universal compliance with reporting requirements. This gap in timely reporting could potentially limit the Ministry's ability to identify and address performance issues promptly, thereby reducing the effectiveness of the MEL system in driving continuous improvement.

Looking ahead, the Ministry would benefit from investigating the reasons behind the delayed or missing Business plan progress reports and developing targeted interventions to address these challenges. This might include additional capacity building for units struggling with reporting requirements, streamlining of reporting processes to reduce administrative burden, or enhanced accountability mechanisms to ensure timely submissions. Additionally, the Ministry should consider assessing not just the timeliness but also the quality and utility of the submitted reports to ensure they are providing meaningful information for decision-making.

The journey toward an effective MEL system shows promising progress, with strong foundations laid through the development of the comprehensive plan and extensive capacity building efforts. The challenge now lies in ensuring consistent application of this framework across all operational areas. With continued focus on addressing the gaps in timely reporting and potentially expanding the assessment to include report quality and utilization, the Ministry is well-positioned to fully realise the benefits of its MEL system in driving performance improvement and organizational learning.

Progress towards Outcome 3.7

The Ministry has made exceptional progress towards Outcome 3.7 (widening collaboration for a more efficient, quality, innovative and productive health system), as evidenced by the remarkable achievements in Output 3.7.1. With 97.3% utilization of donor funds and 100% utilization of CSO grants, the Ministry has demonstrated outstanding capacity to establish and maintain effective external partnerships. These financial metrics indicate strong financial management practices, effective coordination mechanisms, and productive relationships with both donors and civil society organizations. While these achievements provide compelling evidence of successful collaboration, the Ministry could further enhance outcome assessment by developing indicators that directly measure how these partnerships contribute to efficiency, quality, innovation, and productivity in health service delivery.

Nevertheless, the current evidence strongly suggests that the Ministry has established a solid foundation of external partnerships that significantly strengthen the health system, with the consistent achievement of targets indicating that collaborative approaches have become a reliable and effective component of the Ministry's overall health service strategy.

Progress towards Output 3.7.1: Strengthened Partnerships with External Stakeholders

The Ministry has demonstrated remarkable success in strengthening partnerships with external stakeholders, achieving nearly perfect performance across the measured indicators. This achievement reflects a strong commitment to maximising collaborative relationships and effectively utilising external resources to support health service delivery.

In the area of donor fund utilization, the Ministry has performed exceptionally well, reporting a 97.3% utilization rate against a target of 100%. This near-complete utilization of allocated funds demonstrates the Ministry's capacity to effectively absorb and deploy donor resources for intended purposes. The specific notation "FAM-100%" suggests that certain funding streams, particularly those related to the Financial Assistance Management, achieved perfect utilization. This high level of fund utilization not only maximises the impact of donor contributions but also builds donor confidence in the Ministry's financial management capabilities, potentially paving the way for continued or expanded support in the future.

Even more impressive is the Ministry's performance in engaging Civil Society Organizations (CSOs) for service delivery. The reporting indicates 100% utilization of CSO grants, fully meeting the established target. This perfect utilization rate suggests that the Ministry has developed effective mechanisms for partnering with civil society actors, successfully channelling resources through these organizations to extend service reach and impact. The full utilization of these grants demonstrates the Ministry's recognition of the valuable role that CSOs play in complementing government health services and reaching communities that might otherwise be underserved.

The Ministry's strengths in external partnerships are clearly evident in these results. The near-perfect utilisation of donor funds and complete utilization of CSO grants reveal a well-functioning system for managing external relationships and resources. These achievements suggest strong financial management practices, clear communication with partners, and effective coordination mechanisms that enable smooth implementation of externally funded initiatives. The "Achieved" status noted for both indicators further confirms that these areas have met or exceeded expectations.

While the current performance is exemplary, maintaining this high level of partnership effectiveness will require continued attention to relationship management and administrative efficiency. The slight shortfall in donor fund utilization (97.3% versus the targeted 100%) might warrant some investigation to identify any systemic barriers that prevented complete utilization, though this small gap may simply reflect normal operational variations.

Looking forward, the Ministry might consider expanding its partnership metrics beyond financial utilization to include measures of partnership quality, sustainability, and impact. While efficient fund utilization is certainly important, the ultimate goal of these partnerships is to improve health outcomes. Additional indicators that capture the effectiveness of these partnerships in achieving health objectives would provide a more comprehensive picture of partnership strength.

The journey toward strengthened partnerships with external stakeholders shows remarkable progress, with near-perfect performance in the utilization of both donor funds and CSO grants. These achievements demonstrate the Ministry's capacity to effectively engage with and leverage external partners to support health service delivery. Building on this strong foundation, the Ministry is well-positioned to not only maintain these valuable partnerships but potentially expand them to address emerging health challenges. The consistent achievement of targets in this area suggests that external partnerships have become a reliable and effective component of the Ministry's overall approach to health service delivery.

Detailed Progress Against Indicators for the 2020-2025 Strategic Plan: As 2020-2025 is the current strategic plan, the team also did a more detailed assessment of progress towards output indicators. As these data had not been reported for some time, this involved extensive discussions with monitoring personnel at MoHMS and assembling data across a range of sources. Overall findings are presented in the following table, using the following 'status' coding system:

Key

Good progress, on track or exceeding targets

Moderate progress, some targets achieved but significant gaps remain

Limited progress, major implementation challenges or declining indicators

Table 17: Strategic Plan Progress

Strategic Plan Result Area	Status	Remarks
SP 2020-2025 Overall Goal - To achieve Universal Health Coverage (UHC) by providing quality health care necessary for good health through a one-system approach.		While significant foundations have been established, the slight decline in essential health service coverage (59.43 to 58.25) and increase in out-of-pocket expenses (21.80% to 23.10%) indicate stalled progress toward universal coverage.
Strategic Priority 1: Reform public health services to provide a population approach for diseases and the climate crisis		While there are notable successes in establishing preventative infrastructure and community engagement systems, these have not consistently translated into improved health outcomes, with concerning trends in communicable disease rates and stagnant NCD mortality.
Outcome 1.1: Reduce the burden of communicable and non-communicable diseases		Despite strong programmatic foundations, disease burden indicators show alarming increases (leptospirosis, dengue, tuberculosis) with premature NCD mortality remaining stubbornly fixed at 64.6.
Output 1.1.1: Preventative Programmes Targeting Risk Factors		Successful implementation of preventative programmes with strong community engagement and risk factor reduction initiatives.
Output 1.1.2: Strengthened Integrated Approach to Preventive Initiatives in Communities		Effective integration of preventive initiatives at community level with high participation rates and comprehensive coverage.
Output 1.1.3: Strengthened Surveillance, Case Detection and Diagnosis for CDs and NCDs		Improved surveillance systems established but gaps remain in comprehensive coverage and timely reporting.
Outcome 1.2: Improve the physical and mental well-being of all citizens, with particular focus on women, children and young people through prevention measures		Mixed achievements with improvements in immunization services and mental health integration, but concerning declines in early antenatal care booking and breastfeeding rates.
Output 1.2.1: Improved Maternal and Neonatal Health Services		Progress in service availability but declining early antenatal care booking rates affecting overall maternal health outcomes.
Output 1.2.2: Strengthened Immunization Services and NCDs Screening		Improvements in immunization coverage but inconsistent NCD screening implementation across regions.
Output 1.2.3: Improved Breastfeeding and Nutrition for Children		Concerning decline in breastfeeding rates with limited progress in nutrition programme implementation.
Output 1.2.4: Improved Prevention, Detection and Diagnosis of Childhood Illnesses		Strong systems established for childhood illness detection with comprehensive coverage and timely interventions.
Output 1.2.5: Strengthened Adolescent Health Services		Adolescent health services expanded but utilization rates and coverage remain below targets.
Output 1.2.6: Strengthened Breast and Cervical Cancer Prevention, Screening and Diagnosis		Screening programmes established but coverage rates remain below targets with geographic disparities.
Outcome 1.3: Safeguard Against Environmental Threats and Public Health Emergencies		Strong performance in emergency response mechanisms (COVID-19 vaccination) but minimal improvement in

Strategic Plan Result Area	Status	Remarks
		fundamental environmental health determinants like water and sanitation access.
Output 1.3.1: Improvement in the Effectiveness of Environmental Health Service Delivery		Environmental health services restructured but limited progress in improving water and sanitation access indicators.
Output 1.3.2: Strengthened Preparedness and Resilience to Public Health Emergencies		Robust emergency response systems demonstrated during COVID-19 with high vaccination rates and effective coordination.
Outcome 1.4: Strengthen Population-Wide Resilience to the Climate Crisis		Significant delays in climate-proofing healthcare infrastructure with assessments only beginning in Year 3 and reaching just one facility, despite Fiji's high vulnerability to climate-related disasters.
Output 1.4.1: Strengthened Role of Fiji Emergency Medical Assistance Team (FEMAT) in Disaster Preparedness, Management and Resilience		FEMAT capabilities enhanced but gaps remain in comprehensive coverage and resource allocation.
Output 1.4.2: Improvement in disaster preparedness and response to climate change effects		Critical delays in climate-proofing assessments with minimal progress in implementing adaptation measures.
Strategic Priority 2: Increase Access to Quality, Safe and Patient-Focused Clinical Services		Mixed progress with strong achievements in service decentralization and safety systems, but concerning trends in maternal mortality, family planning coverage, and infection control.
Outcome 2.1: Improve Patient Health Outcomes with a focus on women, children, young people and vulnerable groups		Significant improvements in child health indicators (neonatal mortality 16.2→6.5), but concerning increase in maternal mortality (29.7→44.3) and decline in family planning coverage (51.3%→42.3%).
Output 2.1.1: Increased access to maternal and child health services		MSHI standards improved from 26% to 49%, but only 17% of scheduled neonatal resuscitation training delivered.
Output 2.1.2: Strengthen sexual and reproductive health services		School health programme implementation ongoing but limited data on coverage against 20% target.
Outcome 2.2: Strengthening and Decentralising Clinical Services		Strong progress in specialist visit coverage (33%→88%), 100% rehabilitation outreach, expanded telehealth (7→22 services), and reduced NCD readmissions (6.6%→1.18%).
Output 2.2.1: Increase access to effective treatment and specialist services		Specialist visit coverage increased to 88%, 100% rehabilitation outreach coverage, telehealth services expanded from 7 to 22.
Output 2.2.2: Strengthen clinical management of priority NCDs		PEN adherence more than doubled (20%→44%), unplanned NCD readmissions dramatically decreased (6.6%→1.18%).
Output 2.2.3: Efficient and effective referral system		Overseas referrals processed in 15-20 days vs 2-3 week target, referral process review only 43% complete.
Outcome 2.3: Continuously Improving Patient Safety and Service Quality		Strong safety response systems (UOR resolution 39%→89%, RCA implementation 30%→92%) but declining infection control (ICU hand hygiene 91%→84%, caesarean SSIs 4.6%→5.8%).
Output 2.3.1: Provision of standardised clinical services		Initial delays in framework development, but 100% achievement in subsequent policy development.
Output 2.3.2: Improved patient safety and reduced variation of care		Exceptional improvement in safety systems (RCA implementation 30%→92%) but declining infection control metrics.
Output 2.3.3: Improved Quality and Value of Services		Patient survey response rates improved from 27% to 75-99%, complaint resolution reached 96%, 100% of scheduled 5S-KAIZEN training completed.
Strategic Priority 3: Drive Efficient and Effective Management of the Health System		Strong financial management and digital infrastructure, but critical challenges in workforce retention (41% nursing vacancy) and equipment functionality (declined from 95% to 56%).
Outcome 3.1: Cultivate a competent and capable workforce		100% staff realignment and strong professional development (95-100% training participation), but critical 41% nursing vacancy rate threatens service delivery.
Output 3.1.1: Implement Plans and Policies to Manage the Workforce		100% staffing realignment achieved, but HR Manual remains in draft form.
Output 3.1.2: Attract, Select, Recruit, Retain and Empower the Right People		41% nursing vacancy rate despite 100% compliance with recruitment processes; limited analysis of exit questionnaires (1 of 4 reports).
Output 3.1.3: Provide Opportunities for Professional Development		100% of NTPC levy-paying officers attending required courses, 95% staff participation in needs-based training,

Strategic Plan Result Area	Status	Remarks
		100% OHS compliance.
Outcome 3.2: Improve efficiency of supply chain and maintenance of equipment		Good product availability (85-86%) and supply chain reforms (90% implementation), but alarming decline in equipment functionality (95% to 56%).
Output 3.2.1: Improved Availability and Accessibility to Medical Products		Tracer products availability maintained at 85-86% (above target), 90% implementation of supply chain management system, 96% of Free Medicines Programme reforms implemented.
Output 3.2.2: Quality Assurance Processes for Medical Supplies		National AMR Action Plan review completed (100%), but analytical testing severely reduced (21 to 3 samples) and Pharmaceutical Sector Strategic Plan delayed.
Output 3.2.3: Improved Functionality of Biomedical & Dental Equipment		Dramatic decline in equipment functionality from 95% to 56%, limited reporting on maintenance activities.
Outcome 3.3: Implement efficient financial processes		Exemplary budget execution (89.2%), 100% timely payment of community health workers, perfect financial monitoring compliance.
Output 3.3.1: Improved Budget Execution and Financial Performance		Budget execution improved to 89.2%, 100% compliance with financial reporting and CHW payments, mid-term budget review completed.
Outcome 3.4: Ensure infrastructure is maintained to match service needs		Only 46% of facilities upgraded against 80% target, but strong planning foundations with comprehensive infrastructure audit and 99% budget utilization.
Output 3.4.1: Infrastructure Upgraded Based on Needs		46% of health facilities upgraded (against 80% target), but 99% budget utilization and completed infrastructure audit.
Output 3.4.2: Affordable Aesthetic Solutions Implemented		No progress reported since the start of the Strategic Plan.
Outcome 3.5: Harness digital technologies for better health care		97% of targeted facilities using Health Information Systems, but gaps in training, data verification, and research utilization.
Output 3.5.1: Improved Access to and Completeness of Patient Information		97% of targeted health facilities using Health Information Systems, 100% timely submission of situation reports.
Output 3.5.2: Training and Support Provided for Using Information Systems		Data for Decision Making courses conducted in three divisions, but gaps in supervisory visits and data verification audits.
Output 3.5.3: Strengthen Research and Innovation		Functioning ethics committee and intern research training, but delayed research symposium and incomplete implementation of several activities.
Outcome 3.6: Continue to strengthen planning and governance		Divisional Command Centres established (100%), comprehensive MEL plan developed, but only 72% of Business plan reports submitted on time.
Output 3.6.1: Plans and Policies Reviewed and Updated		75% of identified policies (9 of 12) expected to be reviewed by fiscal year-end, but limited reporting on Strategic Plan review impact.
Output 3.6.2: Governance and Reporting Structures Aligned		Divisional Command Centres 100% complete, but gaps in supporting processes, frameworks, and evidence-based policy submissions.
Output 3.6.3: Effective Monitoring, Evaluation and Learning System		Comprehensive MEL plan developed with extensive capacity building (27 training sessions), but only 72% of Business plan progress reports submitted on time.
Outcome 3.7: Widen collaboration for more efficient health system		Exceptional partnership management with 97.3% utilization of donor funds and 100% utilization of CSO grants.
Output 3.7.1: Strengthened Partnerships with External Stakeholders		Near-perfect donor fund utilization (97.3%) and complete CSO grant utilization (100%).

The Ministry's progress against strategic plan priorities, outcomes and outputs reveals a consistent pattern across all three Strategic Priorities, with each receiving an AMBER rating that reflects achievements in establishing systems and structures but critical challenges in translating these foundations into consistent health outcome improvements and operational effectiveness.

Strategic Priority 1 demonstrates progress in establishing preventative programmes and community engagement frameworks, with health promotion programmes exceeding targets for healthy settings and maintaining an extremely high 99.6% active rate for Community Health Workers. The Covid-19 vaccination campaign demonstrated the system's capacity for coordinated action, achieving 104% first-dose coverage.

However, these programmatic successes have not consistently translated into improved health outcomes, with increases in communicable diseases (leptospirosis, dengue, tuberculosis) and stagnant NCD mortality rates. Climate resilience efforts show particularly concerning delays, with climate-proofing assessments only beginning in Year 3 despite Fiji's high vulnerability to climate-related disasters.

Strategic Priority 2 shows notable achievements in decentralising clinical services (specialist visit coverage increased from 33% to 88%) and establishing robust safety response systems (UOR resolution improved from 39% to 89%), contributing to remarkable gains in child health with neonatal mortality dropping from 16.2 to 6.5 per 1,000 births. However, these improvements are undermined by worrisome trends in maternal mortality (increased from 29.7 to 44.3 per 100,000 births despite near-universal skilled birth attendance), declining family planning coverage (51.3% to 42.3%), and deteriorating infection control practices in critical areas like ICU hand hygiene (91% to 84%).

Strategic Priority 3 reveals good performance in financial management (89.2% budget execution) and partnership engagement (97.3-100% utilisation of external funding), with supply chains functioning well and maintaining good availability of essential medicines (85-86%). Yet these strengths are severely compromised by two critical red-flag areas: an alarming 41% vacancy rate in the nursing workforce—representing 1,715 unfilled positions—and a dramatic decline in equipment functionality from 95% to just 56%, both directly threatening service delivery capacity.

Health inequities persist across geographic and demographic lines, suggesting that the benefits of health system improvements aren't reaching all Fijians equally. The Northern Division faces a dengue fatality rate of 15% compared to the national average of 0.35%, highlighting dramatic regional disparities. Women encounter increasing challenges with rising maternal mortality and declining family planning services. Rural communities continue to have poorer access to sanitation facilities.

Chronological Analysis of Previous Strategic Plans (2007-2020)

The Ministry of Health and Medical Services (MOHMS) in Fiji has implemented three consecutive strategic plans prior to the current 2020-2025 plan. This analysis examines the evolution of strategic planning approaches, implementation effectiveness, and achievement of health outcomes across these planning cycles, providing important context for understanding the current plan's progress and challenges.

Strategic Plan 2007-2011

Basic Plan Framework: The 2007-2011 Strategic Plan was structured around six key strategic goals focused on primary and preventive health care, quality health services, workforce development, infrastructure maintenance, quality improvement, and funding mechanisms. The plan targeted seven specific health outcomes addressing NCDs, communicable diseases, family health, child health, adolescent health, mental health, and environmental health.

Implementation Effectiveness: The plan demonstrated moderate effectiveness in achieving its objectives. Significant progress was made in reducing infant mortality (from 19.5 to 10.2 per 1,000 live births), increasing immunization coverage (reaching 95% for measles), and expanding health infrastructure with completion of Navua, Nadi, and Sigatoka hospitals. However, the plan was less effective in addressing workforce challenges, ensuring consistent medicine supply, and controlling the rising burden of NCDs.

Key Contextual Factors: Implementation was significantly affected by the political environment following the 2006 coup, the global financial crisis limiting resource availability, natural disasters disrupting service delivery, and a 5% pay cut for civil servants affecting staff morale and retention.

Strategic Plan 2011-2015

Basic Plan Framework: The 2011-2015 Strategic Plan built upon the previous plan while introducing a more focused approach with three strategic pillars: Preventive Health, Curative Health, and Health System Strengthening. The plan aligned with the Millennium Development Goals and emphasized a more integrated approach to health service delivery.

*Implementation Effectiveness***:** This plan demonstrated improved effectiveness compared to the previous plan, particularly in strengthening health systems and expanding specialized services. The introduction of the Wellness Fiji approach represented a significant innovation in addressing NCDs through primary prevention.

However, the plan continued to face challenges in addressing workforce shortages, ensuring consistent medicine supply, and controlling the rising burden of NCDs.

Key Contextual Factors: The plan's implementation benefited from the return to democratic governance but was constrained by global economic challenges and the increasing impact of climate change on health.

Strategic Plan 2016-2020

Basic Plan Framework: The 2016-2020 Strategic Plan represented a more comprehensive approach with two strategic pillars: Health Service Delivery (preventative, curative, and rehabilitative care) and Health Systems Strengthening. The plan was organized around eight priority areas addressing NCDs, maternal and child health, communicable diseases, primary health care, workforce development, evidence-based policy, medicinal products and infrastructure, and sustainable financing.

*Implementation Effectiveness***:** The plan demonstrated significant effectiveness in responding to public health emergencies and establishing systems for quality improvement and patient safety. The plan showed remarkable adaptability in the face of multiple challenges including Tropical Cyclone Winston and the Covid-19 pandemic. However, the plan was less effective in addressing the persistent burden of NCDs and ensuring equitable access to services across all geographical areas.

*Key Contextual Factors***:** Implementation was significantly affected by natural disasters including Tropical Cyclone Winston affecting infrastructure, the Covid-19 pandemic disrupting normal health service delivery, technological advancements enabling digital health solutions, and the increasing impact of climate change on health.

Evolution of Strategic Planning Approach

1. *Increasing Comprehensiveness:* Each successive plan has demonstrated greater comprehensiveness and strategic coherence, evolving from the six somewhat disparate goals in 2007-2011 to the more integrated approach in 2020-2025 with clear strategic priorities.
2. *Shift from Disease-Specific to Systems Approach:* The strategic focus has evolved from primarily disease-specific interventions to a more balanced approach that emphasizes both service delivery and systems strengthening.
3. *Incorporation of Emerging Priorities:* Each plan has progressively incorporated emerging priorities, with the latest plan explicitly addressing climate crisis considerations and emphasizing a population-based approach.
4. *Inconsistent Development of Monitoring Frameworks:* While earlier plans showed progressive improvement in monitoring and evaluation frameworks with more comprehensive indicators and better alignment with international standards, the current 2020-2025 Strategic Plan was developed without an accompanying monitoring and evaluation framework. This significant omission represents a step backward in the Ministry's strategic planning approach, creating challenges for systematic tracking of implementation progress and achievement of objectives.

Persistent Challenges Across Planning Cycles

1. *Workforce Shortages and Migration:* All three completed strategic plans and the current plan continue to face challenges with health workforce shortages and migration, with the current plan showing an alarming 41% vacancy rate in the nursing cadre.
2. *Non-Communicable Disease Burden:* Despite consistent prioritisation across all plans, the burden of NCDs remains high, with premature mortality due to NCDs stagnant at around 68% in recent years.
3. *Geographical Disparities:* All plans have struggled to address the geographical challenges in service delivery to remote and maritime areas, with persistent disparities in health outcomes.
4. *Medicine and Supply Chain Issues:* While showing improvement over time, medicine stockouts and supply chain challenges have persisted across all planning cycles.

5. *Infrastructure Maintenance:* Maintaining health infrastructure to match service needs has been a consistent challenge, with the current plan showing only 46% of facilities upgraded against an 80% target.

Areas of Significant Progress

1. *Digital Health Systems:* From the first IT Strategic Plan in 2007 to the current 97% of targeted facilities using Health Information Systems, digital health capabilities have shown remarkable advancement.
2. *Emergency Response Capabilities:* The Ministry has demonstrated increasingly sophisticated emergency response capabilities, from managing disease outbreaks to the comprehensive COVID-19 response.
3. *Decentralization of Services:* Consistent progress has been made in bringing services closer to communities, with specialist visit coverage increasing from approximately one-third to 88% in the current plan.
4. *Child Health Outcomes:* Significant and consistent improvements have been achieved in child health indicators, with infant mortality reducing from 19.5 per 1,000 live births in 2006 to much lower rates in recent years.
5. *Financial Management:* The Ministry has demonstrated increasingly strong financial management practices, with current budget execution at 89.2% and perfect utilization of CSO grants.

Implications for Current Strategic Plan

The analysis of previous strategic plans provides important context for understanding the current plan's progress and challenges. The persistent challenges identified across planning cycles—workforce shortages, NCD burden, geographical disparities, supply chain issues, and infrastructure maintenance—continue to affect the current plan's implementation. However, the Ministry's demonstrated strengths in emergency response, digital health systems, and financial management provide a foundation for addressing these challenges.

The current 2020-2025 Strategic Plan represents the most comprehensive and integrated approach to date, building on lessons learned from previous plans while explicitly incorporating climate crisis considerations and emphasizing a population-based approach to public health services. The implementation to date reveals both significant achievements and critical challenges that reflect the Ministry's journey over the past fifteen years of strategic planning.

Conclusion: Strategic Planning Effectiveness and Progress Toward Objectives

The Ministry's fifteen-year strategic planning journey demonstrates a clear evolution toward greater comprehensiveness and systems thinking, with each successive plan building on lessons learned while incorporating emerging priorities. The current 2020-2025 plan represents the most sophisticated approach to date, establishing robust preventative infrastructure, safety response systems, and financial management practices that have contributed to significant achievements in child health outcomes, service decentralization, and digital health systems. However, persistent challenges across all planning cycles—particularly workforce shortages (now at 41% nursing vacancy), stagnant NCD burden, geographical disparities, and implementation gaps between well-designed programs and field-level execution—continue to impede the full realization of desired health outcomes.

Despite establishing strong foundations and demonstrating remarkable adaptability to contextual challenges like political instability, natural disasters, and the COVID-19 pandemic, the Ministry faces critical operational challenges that require urgent attention, including the alarming decline in equipment functionality (from 95% to 56%), concerning trends in maternal mortality and family planning coverage, and delayed climate resilience measures. The disconnect between systemic improvements and concerning outcome indicators suggests implementation gaps that must be addressed to translate strategic aspirations into equitable, quality health services for all Fijians. Moving forward, prioritizing the nursing workforce crisis, strengthening disease control implementation, reversing concerning maternal health trends, establishing robust equipment maintenance systems, and accelerating climate resilience measures will be essential to enhance the effectiveness of strategic plan implementation.

7.4 ADDED VALUE

EQ3.2: To what extent has the strategic planning process strengthened health sector coordination and results?

Effectiveness is also considered in terms of the added value that strategic planning offered in terms of health sector results (including both health outcomes as well as systems improvements and similar) and the coordination of the health sector overall.

Because the ToR separated out Coordination as an evaluation criteria of interest, it is rated separately from Effectiveness as well as included in Effectiveness overall.

Table 18: Rating for Coordination

Rating for Criteria	Rating	Code	Description
	4		High rating on evaluation criteria
	3		Moderate rating on evaluation criteria
√	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

Overall Assessment: 1) Effective coordination in plan delivery is hampered by ineffective coordination mechanisms in the Ministry and especially in the sector more broadly; 2) coordination in plan development vertically (strategic, operational, business, divisional) is mostly solid, but lacks sufficient verification protocols to strengthen alignment; and 3) coordination in plan implementation remains relatively weak, and is not well influenced by learning and innovation in the absence of timely information

Discussion: Limitations in coordination within the Ministry, and especially between the Ministry and other actors in the health sector (most notably the private sector), undermine coordination for planning as well. Institutional reforms in recent years have undermined the authority of the Planning Division and therefore its ability to initiate coordination and hold all accountable. In part the problem is driven by a lack of clarity in terms of 'coordination for what?'. During plan development, the purposes of coordination are specific and clear with a defined timeline and deliverables. During plan implementation, the purposes of coordination begin to blur, worsened by the absence of defined, achievable outcomes that coordination can support.

Plan Development: During plan development, considered attention is devoted to coordinating inputs into the strategic plan, and those involved in the process highlight the effectiveness of actions taken by the Planning Division to lead these activities. Consultative processes include all sections of the Ministry as well as the divisions, and broader consultations also take place. Deliverables are agreed among the varied actors, and those key informants specifically knowledgeable about the process note that an efficient process is put into place in this regard. There are nevertheless limitations in the engagement of non-governmental actors, including the private sector and civil society and development partners.

Within the Ministry, with the exception of some concerns about the limitations of the 2020-2025 Strategic Plan development process, key informants tended to believe that the plan development process was sound, well organised, and well managed. It was rather at the point where the operational plan and the business plans were developed where some problems emerged, and there were largely associated with a lack of mentoring with regard to content, targets, outputs and outcome clarity and similar where the Planning Division could shore up coordination mechanisms to strengthen outcomes at business plan level.

They are included in the planning processes, but the role of the private sector is so poorly defined that the purpose of their involvement in strategic planning is not fully clear.

Civil society actors reported being involved (except for the 2020-2025 Strategic Plan where involvement was minimal or non-existent), but often felt that their opinions were not fully heard. Earlier engagement in pre-planning was mentioned, giving civil society actors an opportunity to position themselves for more effective involvement, and allowing them sufficient time to work together for the development of things like position papers on critical issues (e.g., mental health counselling, pandemic planning).

Development partners recognised that their position was different from national actors, and that their role was more to help facilitate and strengthen planning processes rather than engage in direct planning itself. But as a few commented, the planning process could play a valuable role in the consideration of 'entry points' for support so that they would plan ahead. There were also known deficiencies in the plan implementation process where development partners could play an important role.

Plan Implementation: Ministry personnel interviewed about coordination in this regard noted that without clear purpose and achievable aims, the return on investment of coordination declines. Clear objectives, specific deliverables, and stronger information and reporting were all noted as important to effective coordination. Coordination with donors is highly valued by donors, who are anxious to take the lead from the Ministry, but engagement is sporadic and the purposes of such engagement not always clear. Coordination with the private sector is nascent, but is recognised as critical to overcoming the considerable deficiencies in Government – private sector health services relations.

Limitations on engagement in planning also extended to civil society, including with implementation partners that may strengthen coherence. These agencies recognise that Government leads the sector, sets policy, determines the legal and regulatory environment, and has overall responsibility to serving the people of Fiji. But civil society can offer important insights from their perspectives, not just as rights organisations or advocacy entities but also as implementing partners. In many respects, they feel that they could be a more critical resource to support Government's planning efforts in the health sector. As one civil society partner noted, 'we are key partners of the Ministry, but we're not always properly involved in the strategic planning process, nor in working with the Ministry to translate these into the operational plan. But we deliver, and we could deliver better if we were central to planning. It was better in the past, and the problem was much worse for the 2020-2025 Plan, we were not even consulted at all. We need to be brought back on board for the next Plan'.

Donor coordination has weakened over time, and in the post-Covid era has not recovered to where it was before. Consistent, structured mechanisms for donor engagement is critical to the 'onboarding' of partners and strengthening the linkages between Government-expressed needs and support from development partners. As they gap widens, misunderstandings multiply. As one development partner put it, 'we rarely meet with the Ministry together, we should be doing this multiple times during the year, we want to be on the same page. We also need to hear regularly from the Ministry, what's going on, where are emergent problems, what are the concerns.' Another key informant added 'we appreciate the politics around engaging with development partners, we respect that. We also realise the time it takes to work with each partner. If we get together under Ministry invitation, this will improve these dynamics. Another argued that 'engaging in development, being consulted, this is important. Understanding how Government is expressing its priorities is also important. Helping Government to reflect on implementation is also an area where we can assist, and this means supporting the planning process'. Another noted 'I've been here for almost XX years, working in the health sector, but I can't recall a single time when we've had a meeting to discuss implementation of the Strategic Plan'. This might be an issue for the current plan, designed at a time when the situation changed radically with the Covid-19 pandemic. The Ministry engages with us all the time, but not on this, even in detailed meetings.

Cross-Sectoral Coordination: One limitation of the health sector planning process and its implementation identified by key informants during discussions related to the health plans concerned the fact that many health-related outcomes required the active, sustained engagement of non-health actors. NCDs is perhaps the best example, but there are many others (e.g., early childhood education and the development of positive hygiene practices at an early age). While at business plan level examples of cross-sectoral engagement is described, these have failed to attain a 'critical mass' that would have strengthened such programming overall. The result has been persistent challenges facing these desired health outcomes because critical programming components that fall outside the health sector were not given sufficient attention. The plans

showed recognition of this, but no clear way forward, and such delivery was not identified as a desired outcome, but rather mentioned as a problem.

Having said this, when asked, many of the key informants within the Ministry noted that there were relatively few successes in sustained cross-sectoral programming despite the obvious need, and that caution was warranted. Reforming how the planning process focuses attention on achievable outcomes is one way forward to support improved cross-sectoral programming (see Plan Focus below), but some of the development partners noted that this was a key area of interest for donor funding.

Health Sector Results

A number of questions were asked related to health sector results, and how strategic planning contributes in this regard. A wide range of issues were mentioned, and are therefore presented as bullet points followed by an overall discussion. This involves a mix of responses from Ministry key informants, civil society, other ministries and development partners. Where there are critical differences across actors, this is mentioned.

- √ Plan implementation does not sufficiently encourage innovation. In many respects those working in the sector are overwhelmed by the challenges faced, and often this means reacting to problems rather than anticipating them. Within such an implementation environment, new ideas don't have enough room to 'take hold', and innovation is stifled. Strategic plan implementation has the potential to significantly change the situation in this regard.
- √ As noted above under Coherence, health outcomes are at a very high level, and are not specified in terms of what can be delivered in the five-year planning period.
- √ Health outcomes are largely diseases-focused results, and do not include critical process measures that need attention. This ranges from outcomes associated with, for example, health sector financing, health insurance and health coverage for the poor, or outcomes associated with institutional reform and adaptation to needs, systems strengthening, and human resource planning, or outcomes associated with policy, regulatory and legal reforms, etc.
- √ As the plans cascade down to business plans, there is considerable confusion about what outcomes and outputs are, what can be achieved, and what resources would be required. The Planning Directorate can play an important role in this regard, but given the magnitude of the challenges, appointing a consultant to assist may also be required. One non-health specialist in the Ministry highlighted the challenges: 'We've had a number of strategic plans, and they speak about outputs and outcomes. And we've had operational plans and business plans that do the same. But if you asked the majority of people in the ministry to discuss the difference between outputs and outcomes, what one is versus the other, and how this can affect their implementation, odds are that many will not be able to do so. Not only that, but many would not consider the way in which the strategic plans have handled these issues to be very good. But this can be solved, if we do better in the formulation process, but also in engaging these very people in the process, and train them as we do so. Once people are clear, they often are quite happy to engage.'
- √ The focus on health sector delivery tends to under value the importance of customer satisfaction, which is underpinned by faith and trust in the system, a feeling that people are being heard and opinions valued, and that people feel that they are treated with due respect. Customer satisfaction with delivery builds on these things, and is not a replacement. Prevention and health promotion, for example, is built on respect for cultural norms and relies on the effective functioning of social capital networks where community volunteers (among them the Community Health Workers) and local activists are respected and listened to and, with active listening, so are local health workers. As one key informant put it, 'humans have two ears and one month, there is a reason for that'. Trust is built at this level, faith in the system comes from this level. In peri-urban and urban areas, of course, these systems are often weaker, and effective communication is done differently.
- √ The strategic plans have done little to help us better reach the public, they talk about the importance of public engagement, the importance of people having voice, and telling us that people are customers and deserve respect. But we need guidance to better define what this means, so that we can push this in the business plans and the overall operational plan. If we had something around communications – two way – as an outcome, that would certainly help. And even then, we cannot let this be an exercise where we collect information but we don't use it effectively.

- √ Communications are focused on outreach, rather than setting up two-way challenges of communication (e.g., social media, events, etc.). In a situation where trust has been undermined, setting up systems that listen rather than just inform are critical. The strategic plans do not view communications in this manner, and as a result a critical channel for effective engagement is under-valued. This doesn't mean, of course, that the Ministry and the decentralised authorities have to deliver all such communications, outreach and active listening, as there are civil society organisations and private sector actors that have the requisite skills, and there are likely development partners that would be interested in supporting these innovations.
- √ Governance in the health sector is not receiving sufficient attention, and the situation has worsened in the past decade or so. Accountability mechanisms are weakening and accountability itself is declining, highlighting the need for institutional reform and innovation, policy and regulatory reform, strengthened training, and similar.
- √ There is a dearth of health *administrators* in the Ministry that would be better placed to deliver against the requirements of an increasingly complex and diverse health sector. Training programmes focus heavily on health professionals, but do not generate sufficient health administrations. This tends to yield a focus on health-focused solutions when the challenges are often much broader. This holds for the Ministry overall but also hospital administration, divisional leadership, and more.
- √ The Ministry is meant to be an oversight agency, not an implementing agency, and a commitment to decentralisation underlines the desire of the Ministry to move in this direction. The strategic plans do not devote sufficient attention to the demarcation issues around the role of the Ministry and the roles of other actors.
- √ Wellness is considered in terms of how the health sector can directly deliver, rather than wellness from the point of view of the rights-holders. It focuses specifically on NCDs and health promotion, but needs to be elevated to a level where it is central to how the Ministry thinks. Wellness is mental health; it isn't just the absence of disease. It isn't just healthier foods. Wellness is less abuse of women. Put it at the top, put it front and centre in the next plan. But even if we do, how do we get leadership to take this seriously.
- √ The Digital Health Strategy needs to be resourced, but delays in implementation aren't just coming from a lack of resources. The deficiencies in information systems have been known for some time, and technical solutions to governance problems are not solutions. The way in which information can strengthen governance and accountability in a progressive fashion, recognising what is possible and what is not, should inform technical solutions that would follow.
- √ Gender, inclusion and equity are all stated objectives of the planning process, and feature in the strategic plans. However, their present at output level and the nature of programming aimed at delivering against these objectives are not clear. The strategic plans can offer a means to strengthen this planning and delivery, and do so in a manner that is defined by Fijians relevant to social and cultural norms for effective change.
- √ Lessons can be learned and applied from performance monitoring systems.
- √ Almost all key informants asked contended that more attention needed to be focused on strong monitoring system with measurable indicators, but that the number of indicators cannot overwhelm the system. The 2016-2020 Strategic Plan was regarded as a solid document, but there were concerns about the very high number of indicators that required a great deal of data collection and assembly, often by health workers who had little time to do so, and who were not the ones who were uses these data. (Data use at each level is a separate challenge.) One Ministry official lamented that 'we keep saying that information is critical, we keep saying we will invest in this, but here we are, little better off than a decade ago. It seems that we really don't mean it'.
- √ Fiji has proven that it can coordinate complex actions cross-sectorally when disaster strikes. Lessons can be learned from what Fiji did to make this work.
- √ The life-cycle approach adopted for the strategic plans from 2016 was supported by key informants who were aware of the efficacy of the approach. Most however raised concerns that the lack of a patient-centred system undermined this approach. As one civil society actor noted, 'when we look at the plan we see the reference to life cycle approach, but we don't see this translated into clear implementation strategies for delivering for women, for children, for the vulnerable. Why can't we be clearer? Why can't we have specific objectives?'

- √ Achievement of outcomes as identified in the strategic plans, of course, are significantly affected by the strengths and weaknesses of the Ministry overall. Organisational restructuring that removed deputy secretaries and weakened operational leadership was felt to have weakened the ability of the Ministry to proceed with implementation of strategic planning priorities as expressed in operational plans, or at least slowed progress. The weakening of the planning infrastructure in the Ministry was also noted as detrimental to the efficacy of planning in the Ministry. The dated Public Health Act is another example, where updating the legislation would enable important actions that are noted as necessary to advance in the strategic plans. In part this reflects how the plans tackle non-health outcomes, or rather largely don't tackle them. Similarly, inefficient financial processes undermined implementation across multiple strategic plans. Many of these and associated constraints are noted in the strategic plans, what is missing is linking these to solutions that the strategic plans could help to advance.
- √ Training of health workers has come a long way. Three universities in Fiji are now involved in human resource development in the health sector.

SECTION 8. EFFICIENCY

8.1 INTRODUCTION

The evaluation criteria Efficiency asks how well resources are being used. This considers cost effectiveness – were resources used in the most effective manner – and cost efficiency – were resources used in as cost efficient a manner as possible.

8.2 OVERALL FINDINGS

There are two basic means to measure Efficiency. The first measure is cost-efficiency, that is, the unit costs of delivery and the return-on-investment of this expenditure. These second measure is cost-effectiveness, that is considering the investments in light of the next most likely alternative, and assessing the return-on-investment in this regard. The first table refers to cost-efficiency, the second cost effectiveness.

Table 19: Rating for Cost-Efficiency

Rating for Criteria	Rating	Code	Description
	4		High rating on evaluation criteria
	3		Moderate rating on evaluation criteria
	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

Overall Assessment: The absence of available data makes it impossible to provide an overall rating covering cost-efficiency measurement focused on unit costs of delivery. However, when cost-efficiency is compared to achievement of outcomes and return-on-investment is measured, then the cost-efficiency of the plans is very low. For the purpose of this evaluation, the latter approach to cost-efficiency measurement.

Discussion: One problem with the current orientation of the strategic plans is that they identify extremely ambitious outcomes that do not clearly connect with what is possible, nor a clear path to indicate how the strategic plans contribute towards these higher order outcomes. Normally these types of targets would be set at impact level and then outcomes are set that have an opportunity to succeed, inclusive of interim outcomes that reflect progress towards ultimate outcomes. With these outcomes, it is then possible to consider expenditures on planning and plan delivery against targets and achievements, and estimate an overall cost-efficiency value. Based on currently specified outcomes cost-efficiency cannot be rated fairly.

8.3 FINDINGS FOR COST-EFFECTIVENESS

Table 20: Rating for Cost-Effectiveness

Rating for Criteria	Rating	Code	Description
√	4		High rating on evaluation criteria
	3		Moderate rating on evaluation criteria
	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

Overall Assessment: Excluding cost-efficiency measurement, the value-for-money focus of cost-effectiveness measurement yields a 'high' rating. There is abundant evidence that investing in strategic planning has delivered considerable value associated with a common commitment to the process of plan development and implementation, identifying common objectives, and committing to responding to the problems clearly identified in situation analyses. Having said this, it is clear from a number of interviews within and outside the Ministry that there are inefficiencies in the plan implementation process that warrant additional attention, including establishing measures to consider how efficiently plans are delivered and the return-on-investment in doing so

Discussion: In situations where cost efficiency cannot be measured, measures of Efficiency rely more on cost-effectiveness, referring to the value-for-money of delivering in one manner rather than another. It is less focused on achievement of X outcomes, and rather focused on whether an alternative means would have yielded greater value-for-money.

For cost-effectiveness of the plans and the planning process, the comparison is with the 'no strategic planning' option, with planning only at operational level and connected to national development planning rather than sector-specific planning. In this case, there is abundant evidence that the strategic planning process added considerable value, providing both higher-level objectives that the Ministry intended to strive for, and providing guidance to the development of the operational plan and business plans. This would not have been possible with an alignment focus only on the national development plan or similar. The situation would have potentially been improved with the existence of a health policy and associated plan of action, and a vision statement of higher order anticipated impacts, desired goals, and similar, but even this would have been insufficient for the purposes of effective planning.

8.4 COST-EFFECTIVENESS IN STRATEGIC PLAN DEVELOPMENT AND IMPLEMENTATION

EQ4: To what extent has the strategic planning process proceeded in a cost-effective manner?

EQ4.1: To what extent has the strategic planning process been pursued in a cost-effective manner?

Overall Attributes of Cost-Effectiveness in the Planning Process: The results of the discussions with a wide range of key informants highlights a secular trend with the cost effectiveness of planning improving over time with each new plan. Plan quality improved, situation analyses improved, clarity of objectives improved, and intentions improved in particular with the 2016-2020 Strategic Plan. There were concerns about the efficacy of the 2020-2025 Strategic Plan that undermined plan utility, and its ability to guide the sector, but it retained strong content despite flaws in design processes and weaknesses in monitoring and reporting. The Covid-19 pandemic further weakened the 2020-2025 Strategic Plan's cost effectiveness in terms of implementation, severely undermining programming and reporting.

These improvements coincided with the development and strengthening of the planning operations within the Ministry. The most important innovation aimed at strengthening the efficiency of planning operations was the establishment of the Policy, Planning and Budget Unit during the 2007-2011 Strategic Plan. Leadership at the time was broadly supportive of the role that this Unit could play in strengthening planning and, through this, improved clarity in terms of expressing goals and objectives and elaborating means to achieve these. This is now the Planning and Policy Development Division, and has expanded in both staffing and in terms of responsibilities.

The evaluation found solid commitment to effective planning throughout the Ministry for the duration of the planning period under review. None of the interviewees questioned the value of planning, and none suggested that the strategic planning process be abandoned. The extent to which engagement in such planning added value compared to the costs associated with this planning (direct costs, time spent on planning versus other actions, etc.) was also not identified as a problem by any of the respondents. This would appear to also reflect a perception that the cost-effectiveness of planning warranted such an investment of time and resources.

Commitment to Efficiency: A review of the plans back to 2007 found efficiency as a stated intention with examples of areas of needed efficiency of delivery in the sector (efficiency of budget spend, efficiency of delivery of stock, inefficiencies associated with limited use of diverse health financing options, etc.). However, none of the plans included plan-related objectives associated with improved efficiency in the planning design and implementation processes, and how these improvements could yield improved value-for-money invested in planning. This reflects broader constraints in how the strategic plans focused on disease-related outcomes and the relative absence of outcomes associated with improved processes. This undermined both the potential for improvements in the cost-effectiveness of plan implementation and the cost-effectiveness of health sector delivery.

Inefficiencies in Sector Delivery: Chronic inefficiencies in aspects of health sector delivery mentioned in successive strategic plans reflects two points relevant to the strategic plan evaluation: 1) the strategic planning process included a sound assessment of these inefficiencies for the public health sector overall; but 2) the strategic planning process of identification of these inefficiencies did not clearly improve delivery. The lack of process outcomes in the plans is one problem, as noted above, while the lack of realistic outcomes is a second (discussed under Relevance above). But a third is associated with the absence of a strategic framework that would clearly identify causal pathways that could be monitored and reported over time, a problem that would be overcome by a well-constructed theory of change and a monitoring and reporting system against this theory of change. Each of these undermined the ability of the strategic plans to contribute to improved efficiency in operations.

Cost-Effectiveness and Strategic Planning: While the evaluation found that strategic plan cost-effectiveness was robust, and was felt to be so by a wide range of key informants, this did not negate the need to continue to improve the cost-effectiveness of the planning process, with particular attention to plan implementation.

One key aspect relates to data collection and use. Monitoring and reporting on the strategic plans has worsened in recent years, and the value-for-money of data collection against indicators in the plans is uncertain but was a concern raised by interviewees in the Ministry. The burden of collecting data was reported to fall heavily on personnel delivering health services, who don't benefit from data use, and also on under-staffed units within the Ministry. The 2016-2020 Strategic Plan carefully and clearly elaborated indicators to be measured and, while there were a number of problems associated with indicators mis-set at different levels or inappropriate to track progress (e.g., outputs that were rather interim outcomes, activities described as outputs), and while the reporting burden was noted to be excessive, it nevertheless showed what could be done, and what was lost with the 2020-2025 Strategic Plan. Improvements are therefore possible, and the Ministry has already shown how.

Monitoring and Reporting: Related to this, monitoring and reporting on health sector delivery by the private sector is nascent, with major gaps that challenge the cost-effectiveness of health sector delivery overall. This reflects a deficiency in the strategic planning process, where specific outputs and outcomes could have been better specified with tangible and reasonable expectations in a five-year timeline, resulting in strengthened oversight and supporting the expansion of private sector delivery at the same time. Further, done well, and robust monitoring and reporting procedures can build positive working relationships, especially when done in the context of enhanced engagement of the private sector in setting health sector goals and objectives, and by reporting on positive developments in public documents.

Programme reports by a range of development partners across sectors consistently highlight deficiencies in monitoring, evaluation, and reporting. The same could apply for strengthening planning in the health sector overall. The broadening of strategic plan expectations with regard to private sector delivery, as well as civil society engagement, present an opportunity for a development partner to assist innovative efforts through a strengthened strategic planning process, in particular around monitoring and reporting. Interviews conducted for this evaluation highlight a concern that the sector doesn't function as a sector, but rather as public and private sector delivery at best, and with civil society occupying a relatively undefined position. A few of the higher-level key informants in the Ministry argued that, properly supported with finance and technical support from development partners, significant gains could be made with focused attention on sector coherence while strengthening planning processes overall. While development partners did not present specific areas of support, they did note that under the Ministry's statement of priorities assistance could be

offered in priority areas, including strategic planning. This links well with widespread recognition of the problems facing sector coherence.

Other: Other ways in which the strategic planning process has not enabled more efficient operations in the sector overall include the following:

- It is not easy to establish how the priorities as elaborated in the strategic plans dovetail with actual financial allocations and priorities. A great deal of financial decision making takes place outside MoHMS, and the extent to which these allocations are checked against priorities as expressed in the strategic plans is unclear. What is evident is that there is a sensitivity to criticisms associated with poor service delivery in health settings, and this tends to reinforce expenditures in terms of facility-based curative services despite the intentions of the strategic plans.
- The integrity of procurement processes is critical; the Ministry needs to demonstrate that things are done right. This needs to be done in a transparent manner, so that everyone knows that it is being done right. But procurement processes are very cumbersome and inefficient, and this undermine in particular responsiveness to required infrastructure investments and improvements. The strategic plans do not contain a commitment and stated desired set of outputs or outcome to improving these processes.
- Health financing remains a serious concern, out-of-pocket expenses continue to rise, and affordability for poorer households is felt to be worsening. There are a wide range of health financing options available, but while the strategic plans state the problems, they do not support actions that would strengthen solutions.
- Referral systems are felt to not be functioning well, with the stated pyramid now look more and more like an inverted pyramid, with services being sought from the top. This reflects performance problems in the referral system that has led health system users to see care at sub-division and division and national referral hospital levels.
- There is a high level of agreement with the efficacy of decentralisation of health services. However, the cost-effectiveness of delivery of these services is not tracked, and the strategic planning process does not enable such tracking.
- Communications is an under-financed area within the Ministry, and is heavily focused on a narrow set of activities associated with higher-level decision-making. The strategic plans refer to the importance of communications, but do not offer a clear assessment of the performance of communications let along alternative models of delivery. In addition, communications are still understood as informing the public, rather than serving as a means to hear from rights-holders. Properly done, communications can add significant value to the plan development and implementation processes, and can serve the sector more broadly.
- Select key informants mentioned the Executive Support Unit, and it was noted as a positive development aimed at improving accountability and performance. Yet its role in strengthening strategic planning has not been fully considered, which is critical in linking the planning sector to high-level objectives and accountability at the political level, not just operationally. Given the importance of challenging the more serious emergent problems facing the health sector (e.g., strengthening sector wide programming and accountability, the ability to respond quickly to emergent challenges (e.g., HIV, dengue), etc.), and given the importance of anticipating emergent challenges and respond in an efficient manner, key informants contended that identifying how the Unit can play a role in strategic planning was critical to any new plan development and implementation.
- The strategic plans themselves and most key informants interviewed lamented severe constraints on learning and evidence-based programming due to inadequate monitoring, evaluation and reporting mechanisms. At the same time, those who were involved in assembling data to report up to the strategic plans noted how burdensome data collection and reporting could be, especially during implementation of the 2016-2020 Strategic Plan, no matter how warranted such data collection and review was. When asked how strategic planning could help resolve both problems, few clear recommendations were offered. This yielded considered discussions within the evaluation team, yielding specific recommendations found in the final section of this evaluation report, as well as in the executive summary.

SECTION 9. CONCLUSIONS, LESSONS LEARNED AND RECOMMENDATIONS

9.1 INTRODUCTION

This section offers conclusions drawn from the findings presented above, followed by overall lessons learned and recommendations.

9.1.1 OVERALL

The overall ratings are first provided to give context to the conclusions, lessons learned and recommendations presented thereafter. This includes a conclusion drawn about the performance of the strategic plans across the varied evaluation criteria. It should be highlighted that the overall finding doesn't reflect adding the results across evaluation criteria together, as they are not equal in important. It rather represents an overall assessment following completion of the evaluation:

Table 21: Summary Rating for Strategic Planning Performance

Overall Rating	Rating	Code	Description
	4		High rating
√	3		Moderate rating
	2		Somewhat low rating
	1		Very low rating

9.1.2 RELEVANCE

Table 22: Summary Rating for Relevance

Rating for Criteria	Rating	Code	Description
	4		High rating on evaluation criteria
√	3		Moderate rating on evaluation criteria
	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

9.1.3 ADAPTATION

Table 23: Summary Rating for Adaptation

Rating for Criteria	Rating	Code	Description
	4		High rating on evaluation criteria
	3		Moderate rating on evaluation criteria
√	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

9.1.4 COHERENCE

Table 24: Summary Rating for Coherence

Rating for Criteria	Rating	Code	Description
	4		High rating on evaluation criteria
√	3		Moderate rating on evaluation criteria
	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

9.1.5 EFFECTIVENESS

Table 25: Summary Rating for Effectiveness

Rating for Criteria	Rating	Code	Description
	4		High rating on evaluation criteria
√	3		Moderate rating on evaluation criteria
	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

9.1.6 COORDINATION

Table 26: Summary Rating for Coordination

Rating for Criteria	Rating	Code	Description
	4		High rating on evaluation criteria
	3		Moderate rating on evaluation criteria
√	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

9.1.7 EFFICIENCY

Table 27: Summary Rating for Cost-Effectiveness

Rating for Criteria	Rating	Code	Description
√	4		High rating on evaluation criteria
	3		Moderate rating on evaluation criteria
	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

9.2 OVERALL CONCLUSIONS

9.2.1 OVERALL SUMMARY RATING

Table 28: Summary Rating for Strategic Planning Performance

Overall Rating	Rating	Code	Description
	4		High rating
√	3		Moderate rating
	2		Somewhat low rating
	1		Very low rating

The overall rating for the performance of strategic planning in the health sector is 'moderate', with the situation better in terms of Effectiveness, Cost-Effectiveness, and Relevance. Key constraints were associated with poorer performance around Adaptation, Coordination and the absence of tracking data to allow the measurement of Cost-Efficiency, and issues arising for Coherence. The main conclusion drawn from this overall rating is that investments in strengthening planning can yield a powerful return-on-investment, and that such investments are warranted.

9.2.2 OVERALL CONCLUSIONS

Five overall conclusions have been identified:

Overall Conclusion 1: The Urgency to Transform the Health Sector and the Role of Strategic Planning: 'We better get it together, people are more and more unhappy, and we're seen as less and less accountable'. There are the words of one key informant in the Ministry who referred to the growing public discontent with public health sector delivery. The strategic planning process cannot solve the problems of trust and accountability, among other challenges, but the evidence gathered during the evaluation suggests that it can play an important role in helping to enable sector innovations and reforms that will help do so.

Overall Conclusion 2: Commitment to Strategic Planning: There are solid commitment to the strategic planning process, and equal commitment to strengthening the process. Lessons learned from problems emergent with the current 2020-2025 Strategic Plan reinforced the conclusion that effective planning supports effective performance.

Overall Conclusion 3: A More Strategic Approach to Strategic Planning: As the strategic planning process has strengthened over time, the need for reforms in the strategic planning process has become increasingly evident. The current strategic plans are meant to do too much at the same time that it doesn't have the tools to do so. This requires improvements at four points in the strategic planning cycle:

1) The strategic plans should not be burdened with expectations at ultimate outcome level, these outcomes are objectives that one aspires to in a 25-35 year timeline, not a five year timeline. This is better left to an elaborated vision document for the health sector overall.
2) The strategic plans should not be expected to replace an overall policy for the health sector.
3) Engagement in strategic planning, and systems of accountability for strategic plan performance, can be enabled by the elaboration of a human rights-based approach to planning that includes engaging with rights-holders.
4) Accountability mechanisms can be strengthened in such a way that the connectivity between the strategic plans, the operational plans, and the business plans can be enhanced. This is not about creating a top-down infrastructure and more about helping to ensure that broader objectives as elaborated at strategic plan level are reflected throughout the plans, and that the learning, innovation, and adaptation that takes place as business plans are implemented are reflected upwards in the system.

Overall Conclusion 4: Improved Sectoral Coherence and the Role of Strategic Planning: Sector coherence is challenging within the Ministry itself but is particularly challenging across the public, private, and civil society health actors, including training institutions. The need for greater coherence is widely recognised and agreed, but strategic planning doesn't play a sufficient role in this regard because this coherence is not operationalised and tracked as progress towards plan implementation, but is rather presented as aspirational. Setting improved coherence as a long-term objective in a vision statement and identified in a health policy would then allow the strategic plans to take on 'implementable bites' of coherence as a stated interim outcome, and tracked accordingly. Given the distinct challenges facing coherence within the public sector and coherence across varied health actors, both streams will need attention.

Overall Conclusion 5: Wellness, Cross-Sectoral Approach and the Role of Strategic Planning: One notable aspect of endeavouring to achieve high level health-relevant outcomes is that these health outcomes are delivered through a range of sectors, and not just health. Wellness as one aspirational aim of development more broadly requires that MoHMS engage with non-health ministries in a coherent, meaningful manner and deliver an integrated set of non-health and health-outputs and outcomes. NCDs are the clearest example of a developmental challenge that has devastating health outcomes for Fiji, but the solutions to stemming the rise in NCDs fall largely outside of the direct remit of the Ministry. It requires collaboration with, and effective coordination with, education, agriculture, local government, enterprise development, and other ministries and sectors.

Given that the evaluation highlighted challenges to coordination even within the Ministry, and even more severe challenges facing coordination within the sector more broadly, coordination across sectors is even more challenging. Visioning, policy development, and planning can all play a role here, because much of what is required rises to the level of national planning, with MoHMS only one actor. Once the Ministry better 'finds it feet' in this broader remit, the strategic plans can take such coordination on board as things to deliver, and let this then cascade to the operational and business plans.

9.3 CONCLUSIONS BY EVALUATION CRITERIA

9.3.1 RELEVANCE AND ADAPTABILITY

Two conclusions have been drawn here, one focused on improving relevance and the other aimed at improving adaptation.

Relevance

The summary rating for Relevance is repeated below:

Table 29: Summary Rating for Relevance

Rating for Criteria	Rating	Code	Description
	4		High rating on evaluation criteria
√	3		Moderate rating on evaluation criteria
	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

Conclusion Relevance: The Ministry needs to leverage broad-based support for strategic planning and use this to strengthen alignment with core national commitments, an emergent health vision and health policy, and at the same time strengthening alignment with the demands for reform, and in fact, transformation, coming from the stakeholders (both duty-bearers and rights-holders).

Adaptation

The summary rating for Adaptation is repeated below:

Table 30: Summary Rating for Adaptation

Rating for Criteria	Rating	Code	Description
	4		High rating on evaluation criteria
	3		Moderate rating on evaluation criteria
√	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

Conclusion Adaptation: The Ministry needs to shift adaptation from being a reaction to things that happen that require changes to a proactive means of anticipating these changes. Strategic plan content can support this, but it also means attention to strategic plan implementation within the context of cascaded plans including divisional, business, and operational plans, to institution plans. Warning signs often arrive on local and operational levels, and the strategic planning process needs to use this 'local knowledge' to anticipate changes required, and respond accordingly.

Further, adaptation within the strategic planning process at a higher level can be better on-boarded if the five year plans include a mid-term review cycle coupled with a 'rolling plan' approach whereby at the end of year 3 the existing five year plan is updated.

9.3.2 COHERENCE

The summary rating for Coherence is repeated below:

Table 31: Summary Rating for Coherence

Rating for Criteria	Rating	Code	Description
	4		High rating on evaluation criteria
√	3		Moderate rating on evaluation criteria
	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

Conclusion Coherence: Internal coherence within the Ministry and its planning process and the resultant plans was positive, but coherence declined over time as implementation proceeded as plans disconnected and coping rather than adaptation took place. External coherence associated with planning with the health sector more broadly was lower. Information and processes that would have enabled improved coherence as implementation proceeded were not in place, resulting in inadequate learning and innovation. This undermined the ability of the plans to help the Ministry and the Government more broadly to tackle the challenges facing the health sector.

9.3.3 EFFECTIVENESS AND COORDINATION

Effectiveness

The summary rating for Effectiveness is repeated below:

Table 32: Summary Rating for Effectiveness

Rating for Criteria	Rating	Code	Description
	4		High rating on evaluation criteria
√	3		Moderate rating on evaluation criteria
	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

Conclusion Effectiveness: Once the data were assembled, the findings showed that the Ministry and the sector had accomplished a great deal, despite problems and critical gaps in this regard. However, the extent to which these accomplishments were linked to the efficacy of planning was less evident. In many respects this related to outcome statements and expectations that were beyond the ability of any plans to deliver. What are therefore perceived as plan 'failures' or plan 'successes' are not necessarily connected to what the plans could deliver. Better matching what is possible, and why change may occur, would result in a stronger match between what is found as data are reviewed and plans evaluated and what they can actually deliver. Having said this, it is clear from a number of interviews within and outside the Ministry that there are inefficiencies in the plan implementation process that warrant additional attention, including establishing measures to consider how efficiently plans are delivered and the return-on-investment in doing so.

Coordination

The summary rating for coordination is as follows:

Table 33: Summary Rating for Coordination

Rating for Criteria	Rating	Code	Description
	4		High rating on evaluation criteria
	3		Moderate rating on evaluation criteria
√	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

Conclusion Coordination: Coordination remained a particular challenge to the strategic planning process. Coordination across sections and within the health sector are especially challenging. Coordination in plan development vertically is mostly solid, but lacks sufficient verification protocols to strengthen alignment. Coordination in plan implementation remains relatively weak, and its improvement undermined by the lack of sufficient learning and innovation in the process.

Coordination can be improved within the planning process internal to the Ministry through a few key measures, but coordination within the sector and across sectors needs to be framed within the context of broader transformative and systems strengthening activities. Coordination bodies established to enable coordination were not functioning well, highlighting the importance of transformation how Government approaches health, enabling a wide range of actors in the system, strengthening engagement across multiple sectors, delivering with these other actors against improved health outcomes (e.g., reduced levels of NCDs, lower levels of water-washed and water-borne diseases among children, greater reproductive health choice among women and men, young and old, and similar.

The dissemination workshop highlighted that there were a number of dormant or poorly functioning coordination entities in place that could well serve important roles within the context of health system transformation. Coordination bodies need clear purposes, short-term and long-term accomplishments, and strong political backing. If these are in place, the entitles could continue to serve important roles in the health sector for years to come.

As coordination will not work without these other improvements in place, the approach needs to be carefully considered and change can only be expected in the long-term. In terms of how this can be handled in the plans themselves, clear outputs and an interim outcome can be specified that focus on what can be achieved in the short-term, while longer-term changes are considered at higher levels.

9.3.4 EFFICIENCY

The summary rating for Efficiency is repeated below:

Table 34: Summary Rating for Cost-Effectiveness

Rating for Criteria	Rating	Code	Description
√	4		High rating on evaluation criteria
	3		Moderate rating on evaluation criteria
	2		Somewhat low rating on evaluation criteria
	1		Very low rating on evaluation criteria

Conclusion Efficiency: From a cost-effectiveness perspective, the strategic planning process has yielded high value-for-money compared to alternatives. It is highly valued and its contribution to the work of the Ministry is widely recognised. This suggests that there would be support throughout the Ministry for improvements to the strategic planning system. When implemented in the context of other reforms, this should be strengthened. Having said this, it is clear from a number of interviews within and outside the Ministry that there are inefficiencies in the plan implementation process that warrant additional attention, including establishing measures to consider how efficiently plans are delivered and the return-on-investment in doing so.

9.4 LESSONS LEARNED

There are five overall lessons learned from this evaluation:

1. *Focus and 'Right-Size' the Strategic Plans:* The strategic plans cannot serve a range of functions that are beyond what they are able to deliver, and what they should deliver. This requires that the strategic plans focus on what can be achieved in each five-year period, and how this contributes to larger objectives that should be expressed at the level of a full vision document and, ideally, a health policy. Ideally, it would also contribute towards a multi-sectoral action plan, programme or similar aimed at tackling key constraints to wellness.
2. *The Right Time for Change:* Between this evaluation and the two Government-commissioned studies supported by the World Bank as well as proposed upcoming actions including the Health Summit, Fiji should be in a sound position to significantly strengthen both the role and the performance of strategic planning within the Ministry and, importantly, also within the health sector. And it should be in a position to leverage these improvements along with other reform actions to improve health sector performance and health and wellness outcomes.
3. *MEL:* Significant improvements are needed in terms of the monitoring, evaluation and learning systems around the strategic plans and within the Ministry and the sector. Given that this finding has been repeated for years, it is important that these investments take place where the return-on-investment is assessed and shared. It also means the following:
    a. Investing in improved MEL will only yield sustainable results if the return-on-investment is calculated and understood and appreciated by those who are involved in MEL implementation, health sector decision-making, and supporting improved sectoral performance.
    b. Investing in this cannot over-burden operational entities and should rather enable them by supporting efficient information use at varied levels, including at facility and community levels.

5. *Wellness:* Intended improvements in health outcomes arise as much from non-medical determinants as well as health sector delivery under the remit of the Ministry.
6. *Trust:* Trust in the health system needs to be regained. There is a broader sense of 'loss' within the sector itself, a feeling that things can be done better and should be done better, and had been done better in the past. Strategic planning can play a critical role in supporting the range of actions required to regain this trust.

9.5 RECOMMENDATIONS

The following core recommendations are offered, aimed at strengthening the strategic plans, the strategic planning process, implementation, monitoring, evaluation and learning. Priority Recommendation 2 is a **process** recommendation that contains within it a series of sub-recommendations that would emerge from the processes being put into place. This should be considered as part of the review of recommendations.

Priority Recommendation 1

MoHMS should consider **extending the validity of the current Strategic Plan** (2020-2025) through to mid-2026, and then **issue the Strategic Plan for the five-year period August 2026-July 2031** with a major **review in 2029** to consider the direction of the next plan or changes to the current one, or both. The new National Development Plan is from 2025-2029, so the 2029 review would duly consider whether to prepare a new plan that would align with the NDP implementation timeline.

This will give sufficient time for the Ministry to lead a consultative process involving both duty-bearers and rights-holders at national and sub-national levels through a number of methods of engagement. The process should be seen as an opportunity for health workers and the public to provide their inputs through multiple channels, ensuring that the Ministry hears their concerns and hopes and helping to strengthen the credibility of the planning process in the eyes of the public.

This timeline has the added benefit of allowing the strategic plan to coincide with the financial year. However, it would need to be issued sufficiently in advance of the financial year to allow operational and business planning to take place allowing costs to be specified.

Priority Recommendation 2

There is a sense that momentum is with regard to taking a more inclusive approach to planning that will support innovation and reform, with the need for a more transformational approach to planning and delivery reflected in the two recent World Bank supported assessments, Government's commitment to this evaluation, and the planned Health Summit. If this is indeed the case, then **core actions aimed at informing the Health Summit should proceed as a matter of urgency**. These include:

1) Beginning preparation of a **Vision 2050** document that sets forth aims and objectives and ultimate outcomes, grounded in a process of engagement with duty-bearers and rights-holders that would begin before the Health Summit, and thereafter continue with the full development of the Vision 2050 document and its issuance as a government policy statement.

2) Develop clear **Terms of Reference for a Health Commission** that can affect action in the months following the Health Summit.

3) Develop **theories of change** at Vision 2050 and 2026-2031 Strategic Plan levels, clearly elaborating intended objectives, needed sets of actions, causal pathways, assumptions and hypotheses, and enabling and disabling factors.

4) Develop a **Monitoring, Evaluation and Learning Framework** with a Results Framework included within for the 2026-2031 Strategic Plan.

5) Pull together the information obtained on needed **institutional reforms** and packaging this in a manner that encourages the Health Summit to commission such reform.

6) Pull together the larger **body of evidence** available to inform the development of the 2026-2031 Strategic Plan.

7) Extending this 'body of evidence' approach, there are a **wide range of issues that arose during the evaluation that warrant due consideration** in two respects: a) high-level health sector findings that reference Ministry and sector performance can be put forward for discussion during the Health Summit; and b) more operational and additional strategic findings can be put forward for consideration by post-Summit committees, panels or similar.

8) Put forward a policy brief that informs a decision on whether the Ministry should lead development of a sector level **health policy**. The Ministry has protocols in place to do this.

Recommendation 3: Establish a **'rolling plan'** process that incorporates evaluation and learning and places them at the core of how planning proceeds.

The five-year timeline for the strategic plans is sound, but monitoring, reporting and review inputs that would inform adaptation and innovation is lacking. Strengthening each of these processes is important, and incorporating planning protocols that enable this is also important. For the latter, it is recommended that a mid-term review take place to be issued in the middle of Year 3, and an update of the strategic plan be prepared and issued at the end of Year 3 based on the mid-term review. This allows the plans to respond to improved systems of data management and learning processes and incorporate innovations and adaptations into the plans themselves.

Recommendation 4: Issue an **official government response**, perhaps in a white paper format, to the two World Bank supported studies, the upcoming NCD study, this evaluation, and other key studies underway that should be included and indicate areas of agreement and disagreement with recommendations, and a workplan associated with approved recommendations.

Recommendation 5: Identify **'early wins'** that can help regain trust in the health sector, which can also help duty-bearers in the sector see that change is possible. For strategic planning itself, some of the points under Recommendation 2 are intended to serve as early wins, but there are others. Further, early wins can be incorporated into the 2026-2031 Strategic Plan to show duty-bearers, rights-holders, development partners, and others involved in the delivery of health services that rapid progress is possible.

There are other possible actions as well. For example, post-Summit consultations led by senior Ministry personnel could engage key duty-bearers at sub-national and community levels, and rights-holders who are activists and volunteers in their communities, as well as rights-holders coming from a range of households, including vulnerable households and populations. Another example is to hold an initial cross-sectoral meeting to discuss how to move forward with wellness, and a potential 'early win' path established for one component (e.g., an existing donor financed initiative around improved nutrition among primary school students further supported by health and agriculture).

Another example is piloting an approach to communications that focuses on hearing from rights-holders. This can build on initiatives aimed at hearing from patients, but extends from 'patient-centred' to 'rights-holder-centred'. A final example is a public commitment to alignment with the new NDP, with the Ministry showing how its upcoming 2026-2031 Strategic Plan will enable the NDP.

ANNEX A: DOCUMENTS CONSULTED

The following is the current listing of documents assembled and reviewed to date. Additional documents will be added as the evaluation proceeds.

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ANNEX B: TERMS OF REFERENCE

TERM OF REFERENCE

Consultancy Services on the Evaluation of the Ministry of Health and Medical Services Strategic Plans and Performance

MINISTRY OF HEALTH AND MEDICAL SERVICES

THE TERM OF REFERENCE REQUIREMENT

1 Background

The Ministry of Health and Medical Services MOHMS is undertaking a comprehensive evaluation of the effectiveness and efficiency of health care provision, accessibility of services and overall quality of health care provided for the duration of the past four 5-year Health Strategic Plans from 2007 to 2023. The National Evaluation Steering Committee will play an active role in the evaluation and management of the project-Evaluation of MOHMS Service Performance. Unique to this evaluation, a steering committee of key personnel and stakeholders representing a diverse field of experience in health systems management, operations and planning will be engaged to co-manage the exercise with the Director Monitoring and Evaluation Project Office

1.2 Introduction

The MOHMS is working to improve access to quality preventive, curative, rehabilitative and palliative services that help individuals, and the population overall, underpinned by a strong health system.

Fiji's health system is based on a three-tier model that provides an integrated health service at primary, secondary and tertiary levels. This system was inherited from the British colonial administration and has undergone several modifications over time. The health system is basically divided into two health programmes: primary and preventive health care services and curative health care services. These two programmes and their respective disciplinary areas largely determine the organizational structure and the modus operandi in the MOHMS.[30] In response to the changing pattern of disease and emerging issues the Ministry have adopted the Health Protection programme to address policy and regulatory compliance.

Clinical services across the primary and secondary health care sectors absorb the majority of the health budget.31 Decentralization has been a major focus, shifting general outpatient services to sub-divisional health centres and bringing services closer to densely populated areas. More services are also being decentralised and operated through special outpatient departments (SOPDs) and general outpatient department functions.[32]

Public provision of health care is free or at very low cost for all persons in the country. Fiji's health services have been predominantly financed by the government. As stated previously, financing of health care is still largely reliant on public funding from general taxation. Health facilities provide a range of services according to their role and function in the system. Pharmaceuticals on the essential drugs list are provided free-of-charge at government health facilities.

1.2.1 Ministry of Health Strategic Plan Direction

The MOHMS Strategic Plan framework sets out the MOH organizational vision to deliver results for achieving National Development Plan Goals and contribute to the attainment of the Sustainable Development Goals (SDGs) The MOHMS Strategic Planning process, (hereafter also referred to as 'the Plan'), were developed using a consultative approach involving a wide range of stakeholders, including Government, Non-Government, private sector and Civil Society. The strategic direction of the MOHMS plan is dictated by the overarching Sustainable Development Goals, National Plans, Declarations, Ratifications and legislative functions.

Over the years the development of the MOHMS Strategic Plans considers the Global and Local contexts which impacts the health of all Fijians. At the Global level, consideration is given to key factors which

[30] WHO, 2011, The Fiji Islands' health system review. (Health Systems in Transition, Vol. 1 No. 1 2011) Accessed 13 Sept 2024. https://iris.who.int/bitstream/handle/10665/207503/9789290615439_eng.pdf

[31] MOH Strategic Plan 2020-2025

[32] MHMS (2018) *Annual Operating Plan 2018-19*

influence population health such as the shift in population demography placing high demands for services on certain age groups, triple burden of NCD, re- emerging of Communicable Diseases and epidemics, ensuring Universal Health Coverage, renewed emphasis on empowering health workforce, responding to need to climate crisis which have bearing on health, improving health outcomes through health systems strengthening and being responsive to gender and disability inclusive society.

The Strategies being developed over the last 20 years can be categorised into the three thematic areas which address issues that affects population health, the delivery of services and the improvement of health systems.

Programme that addresses Population health	Health Services Delivery	Health Systems Improvements
Preventative Programmes • Non-communicable diseases • Communicable diseases • Climate crisis • Family Health • Primary Health Care • Other **Health Protection** • Environmental health • FCDPC	• Integrated health services • Patient care, safety and customer service	• Health workforce • Supply chain, procurement and equipment • Financial processes • Infrastructure • Digitalization • Planning and governance • Partnerships and collaboration

Over the course of 20 years of developing the Strategic Plans, the Strategic Priority Areas have been streamlined to focus on the three [3] thematic core Strategic areas above:

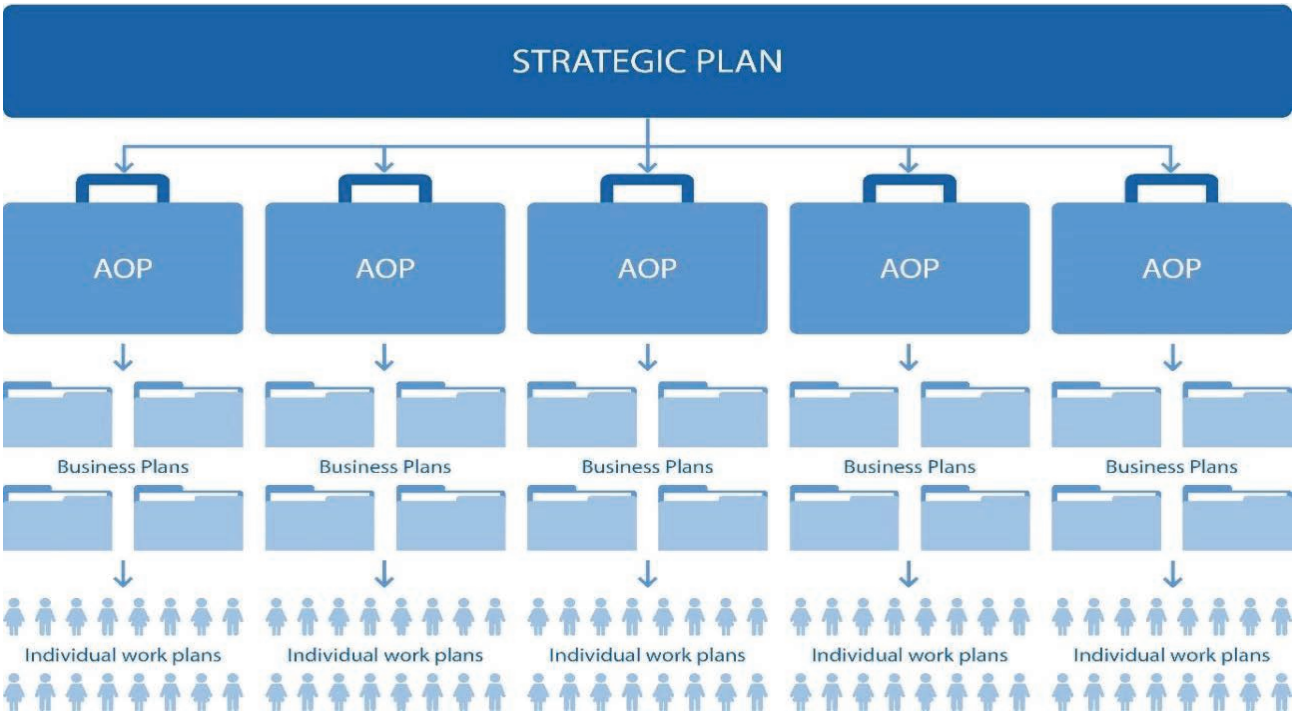
1. Programmes addressing Population Health
2. Health Service Delivery
3. Health Systems Improvement.

The evaluation will look at these 3 Strategic Thematic Areas and the components which were formulated to address this Strategic Areas. Some of the Strategic Plans cover all three areas some do not but focus only on certain strategies.

Each Strategic Plan Strategic Priority Area vary over the years and are inconsistent in its design and lacks Monitoring and Evaluation Framework. However, the Monitoring data which reflects the results of the implementation of the Business Plan is well articulated and conducive for Monitoring purposes. The MOHMS Health Information Unit plays a huge role in the periodic collation of reports and Annual reports and information related to various thematic sectors of the Ministry operations. The Health Planning Policy Development Division is tasked with setting the strategic direction on all plans developed and actively involved I the monitoring of Business Plans and AOP achievements.

1.2.2 MOHMS Strategic Planning and Governance

The Strategic Plan provides the reference framework for operational planning and implementation across the Ministry. MOHS Strategic Plan is a rolling five-year plan and implemented through Annual Operational Plans (AOP). The AOP translates the Strategic Plan into results-based outputs and activities. Business plans outline activities of the AOP for each functional unit, including the 12 cost centres, budgeting the expenditure commitments for the fiscal year. The Ministry publish a National Health Accounts (NHA) report for each fiscal year in collaboration with WHO. The NHA report assists in evidence-based planning and is a reference document for understanding expenditure flows in Fiji's health system. It details information on out-of-pocket spending, providing critical information for financial protection and UHC.



Over the past 20 years planning cycle, the Strategic Plans being developed reflects multiple shifts in Strategic Priorities that the organization has been undertaking in its programming and operations to achieve sustainable, outcome-level changes and respond to ever changing global and local level health needs. Apart from the three [3] thematic priority areas the strategic plans is responsive of the gender and disability mandate.

- **Gender equality and disability rights are highlighted as major priorities and cross-cutting programmers.**

The Plan prioritises structural changes to address gender inequities, focusing on integrating gender equality into all programming. In also underscores efforts on disability rights, aiming to promote and protect the rights of persons with disabilities in different settings.

The planning process for the MoHMS is based on the government's national strategic planning process.

1.3 The Proposed Evaluation

This year the MOHMS has made a key commitment to conduct Evaluations, of its past four [4] of the 5 years Strategic Plans implemented from:

1. Strategic Plan 2007-2011
2. Strategic Plan 2011-2015
3. Strategic Plan 2016-2020
4. Strategic Plan 2020-2025

The MOHMS Planning and Evaluation Office is commissioning an independent evaluation of the MOHMS 5-year Strategic Plans, from 2007-2025. The evaluation aims to assess the fitness for purpose of the Strategic Plan, the progress made to date, and to inform the development of the next Strategic Plan.

These terms of reference present the background to the evaluation, its purpose and objectives, the proposed evaluation questions and methodology, management and governance arrangements, and the required

qualifications and experience of the evaluation team. The evaluation is expected to be carried out between October and November 2024. A summary of the preliminary evaluation findings, conclusions and recommendations will need to be prepared by the end of November for presentation to the MOHMS Senior Executives in November 2024, along with its management response.

1.3.1 Purpose, Objectives, Scope and Use

This evaluation is a key priority in the MOHMS Plan for Evaluations in 2024.

1.3.1.1 Purpose

The overall purpose is to gain insights into the Strategic Plan's fitness for purpose, the extent to which its intended objectives have been achieved to date and are likely to be achieved by the end of the period, and to draw lessons to inform the design of the next Strategic Plan, 2026-2030.

The evaluation will focus on the Outcome level in order to guide the improvement of performance within the organization by identifying areas of strength, weaknesses and gaps, and obstacles to achievement of outcomes.

1.3.1.2 Objective

The specific **objectives** of the evaluation are as follows:

1. ***Review*** the extent to which the Strategic Plans has set clear objectives that align with NDP and the SDGs, and the most pressing needs and priorities of communities; and
2. ***Analyse*** the extent to which the Plan was implemented as planned and how it allowed for adjustments and adaptive management in the face of changing priorities and evolving evidence and contexts; and
3. **Assess** to what extent core elements and frameworks underpinning the Plan have proven to be well developed, coherent and useful.
4. ***Determine*** strengths and weaknesses in the design, operationalization, and implementation of the Plan, including its prioritization of actions, intended results, and resource management; and
5. ***Identify*** good practices and lessons learned that can be applied in future strategic planning processes.

The findings, conclusions and recommendations of the evaluation will be used to inform MOHMS strategic direction and support the development of the next strategic plan.

1.3.1.3 Scope

The **thematic scope** of the evaluation will cover the three (3) Thematic Areas- ***Population Health Programmes Strategies***, ***Health Services Delivery*** and ***Health Systems Improvement***. The **temporal scope** will be the timeframe of the previous Strategic Plan from 2007-onwards and the current Strategic Plan, 2020-2025. The focus will be on the years 2007 to mid-2024, as data on results achieved are available for this period at the time of this evaluation.

The Consultancy Service is divided into 4 and interested applicants are invited to apply to offer service for all four [4] Consultancy services.

Consultancy Services 1

1) Evaluation of Strategic Plan 2007- 2011

- **Key Thematic Area to be evaluated**

THEMATIC AREA 1 **Population Health Programme Strategies**	**STRATEGIC OBJECTIVE**
Strategic Goal 1 Maintain an adequate primary and preventative health care services and promotion of health	**By the end of 2011 we want to have achieved the following**
Health Outcome 1- Reduce burden of Non-communicable Diseases (NCD)	• Reduce amputation rate for diabetic sepsis from 13% to 9% • Prevalence of diabetes reduced from 15% to 12%
Health Outcome 2 Begin to reverse the spread of HIV/AIDS and preventing, controlling and eliminating other Communicable Diseases (CD)	• HIV/ AIDS prevalence among 15–24-year-old pregnant women reduced from 0.04 to 0.03 by 2011 (MDG) • Prevalence of Tuberculosis reduces from 10% to 5%.
Health Outcome 3 Improved family Health and reduce morbidity and mortality	
Health Outcome 4 Improved child Health and reduce child morbidity and mortality	• Infant mortality rate reduced from 23 to 17/1000 live births by 2011 (MDG)
Health Outcome 5 Improved adolescent Health and reduce adolescent morbidity and mortality	• Contraceptive prevalence rate amongst population of childbearing age increased from 46% to 56% • Reduction in teenage pregnancy rates from 15% to 8% in 2011 • Reduction in STI cases amongst 15–24-year-olds reduced from 15% to 10% 2011
Health Outcome 6 Improved mental Health care	
Health Outcome 7 Improved Environmental Health through safe water and sanitation	
THEMATIC AREA 2 **Health Service Delivery**	
Strategic Goal 2 Maintain an effective, efficient and quality health care and rehabilitative services	• Participation of private health care provider increased from 2 to 10 • Doctors per 100000 population increased from 36 to 42 • Elimination of stock outs of drugs from present 100 items per month • Bed occupancy rate reduced from 80% to 60%
Strategic Goal 4 Construction of new and continues maintenance of all health infrastructure and facilities	
THEMATIC AREA 3 **Health Systems Improvement Strategies**	
Strategic Goal 3 Maintain an adequate, qualified and committed workforce for the Ministry	

Strategic Goal 5 Maintain a management culture that promotes and supports continuous quality improvements	
Strategic Goal 6 Appropriate complimentary funding and resource allocation schemes identified for the health services.	

Consultancy Services 2

2) Evaluation of Strategic Plan 2011-2015

THEMATIC AREA 1 **Population Health Programme Strategies**	**STRATEGIC OBJECTIVE**
STRATEGIC PRIORITY/ GOAL	
Strategic Goal 1 Communities are served by adequate primary and preventative health services thereby protecting promoting and supporting their well being through localised community care	**By the end of 2015 we want to have achieved the following**
OUTCOMES	
Health Outcome 1 Reduce burden of Non-communicable Diseases (NCD)	• Objective 1.1 General NCD indicator • Objective 1.2 Tobacco Control indicator • Objective 1.3 Nutrition indicator • Objective 1.4 Physical Activity indicator • Objective 1.5 Oral Health indicator • Objective 1.6 Alcohol Reduction • Objective 1.7 Cancer indicator
Health Outcome 2 Begin to reverse the spread of HIV/AIDS and preventing, controlling and eliminating other Communicable Diseases (CD)	• Objective 2.1 HIV/ AIDS indicator • Objective 2.2 STI indicator • Objective 2.3 Typhoid control indicator • Objective 2.4 LF indicator • Objective 2.5 GF TB Control indicator • Objective 2.6 DF SP Indicator • Objective 2.7 Leptospirosis indicator • Objective 2.8 Pandemic preparedness
Health Outcome 3 Improved family Health and reduce morbidity and mortality	• Objective 3.1 Maternal Mortality Indicator • Objective 3.2 Maternal health Indicator for safe motherhood • Objective 3.3 CPR Indicator • Objective 3.4 Maternal Mortality Indicator • Objective 3.5 Nutrition Indicator
Health Outcome 4 Improved child Health and reduce child morbidity and mortality	• Objective 4.1 Child and Infant Mortality Indicator • Objective 4.2 EPI Indicator • Objective 4.3 Nutrition Indicator • Objective 4.4 Well Child Indicator
Health Outcome 5 Improved adolescent Health and reduce adolescent morbidity and mortality	Objective 5.1 [STI Indicator] Objective 5.2 Nutrition Indicator
Health Outcome 6 Improved mental Health care	Objective 6.1 Suicide prevention Indicator
Health Outcome 7 Improved Environmental Health through safe water and sanitation	Objective 7.1 Access to Safe water Objective 7.2 Access to Sanitation Indicator
THEMATIC AREA 2 **Health Service Delivery**	

Strategic Goal 2 Communities have access to effective, efficient and quality health care and rehabilitative services	
Health Outcome 1- Reduce burden of Non-communicable Diseases (NCD)	Objective 1.1 NCD Indicator Objective 1.2 Risk Management Indicator Objective 1.3 Laboratory services indicator Objective 1.4 Radiology services Indicator Objective 1.5 NCD Control indicator Objective 1.6 Prostheses availability indicator
Health Outcome 2 Begin to reverse the spread of HIV/AIDS and preventing, controlling and eliminating other Communicable Diseases (CD)	Objective 2.1 HIV Indicator Objective 2.2 STI indicator Objective 2.3 Risk Management Indicators Objective 2.4 Laboratory services indicator Objective 2.5 Partner notification Objective 2.6 Infection Control Indicator Objective 2.7 Typhoid indicator Objective 2.8 T. B indicator
Health Outcome 3 Improved family Health and reduce morbidity and mortality	Objective 3.1 Maternal mortality Indicator Objective 3.2 Maternal morbidity indicator
Health Outcome 4 Improved child Health and reduce child morbidity and mortality	Objective 4.1 General Child Health Indicator Objective 4.2 Child Mortality indicator Objective 4.3 Child morbidity indicator Objective 4.4 EPI indicator Objective 4.5 Nutrition indicator Objective 4.6 Child Health or nutrition indicator Objective 4.7 RHD Indicator Objective 4.8 ICU indicator
Health Outcome 5 Improved adolescent Health and reduce adolescent morbidity and mortality	Objective 5.1 STI indicator
Health Outcome 6 Improved mental Health care	Objective 6.1 Increase no. of staff trained in mental health and provision of psychiatric services in divisional hosp
THEMATIC AREA 3 **Health Systems Improvement** **Strategies**	
Strategic Goal 3 Health systems strengthening is undertaken at all levels of the Ministry of Health	
Health Care Financing	• Objectives 8.1 to Objectives 8.9
Health Facility utilisation and Assessment Indicator	
Human Resource Management	
Medicine and Consumable Management	
Private Public Partnership	
Auxiliary Services	
Health Planning and Infrastructure	
Monitoring and Evaluation	

Consultancy Services 3

3) Strategic Plan 2016-2020

Strategic Pillars, Priority Areas, General Objectives and Specific Objectives

THEMATIC AREA 1 **Population Health Programme Strategies**	**STRATEGIC OBJECTIVE** **By the end of 2020 we want to have achieved the following**
Strategic Pillar 1: Provide quality preventive, curative and rehabilitative health services responding to the needs of the Fijian population including vulnerable groups such as children, adolescents, pregnant women, elderly, those with disabilities and the disadvantaged	
STRATEGIC PRIORITY	
Strategic Priority Area 1: NCDs, including nutrition, mental health, and injuries	
GENERAL OBJECTIVES/ OUTCOMES	
1.1 To promote population health and reduce premature morbidity and mortality due to NCDs as part of a whole-of-society approach to wellness and well-being	1.1.1 Reduce key lifestyle risk factors among the population
	1.1.2 Early detection, risk assessment, behaviour change counselling, clinical management, and rehabilitation for targeted NCDs
	1.1.3 Integrate mental health services within primary health care in all facilities
	1.1.4 Improve national reporting on injuries due to violence, domestic abuse and traffic accidents
Strategic Priority Area 2: 1. Maternal, infant, child and adolescent health	
GENERAL OBJECTIVES/ OUTCOMES	
2.1 Timely, safe, appropriate and effective health services before, during, and after childbirth	2.1.1 Increase antenatal care coverage with an emphasis on early booking
	2.1.2 Improve obstetric care with a focus on adherence to key clinical practice standards
	2.1.3 Expand coverage of postnatal care services for mothers and new-borns
2.2 All infants and children have access to quality preventive and curative paediatric and nutritional services	2.2.1 Expand neonatal and infant healthcare, including community risk detection and referral
	2.2.2 Maintain high level of coverage for immunization services including new antigens
	2.2.3 Reduction of malnutrition through breastfeeding promotion and nutritional support
	2.2.4 Improve prevention and management of childhood illness, including emergency care
2.3 Expand services to address the needs of adolescents and youth	2.3.1 Expand provision of preventive and clinical services to include 13–17-year-olds
	2.3.2 Expand availability and coverage of Youth-Friendly Health Services targeting youth ages 15-24
Strategic Priority Area 3: 3 Communicable diseases (CD), environmental health, and health emergencies	
GENERAL OBJECTIVES/ OUTCOMES	
3.1 multi-sectoral risk management and resilience for communicable diseases, health emergencies, and climate change	3.1.1 Improve effectiveness of environmental risk reduction for communicable diseases
	3.1.2 Enhance national health emergency and disaster preparedness, management and resilience
3.2 Improved case detection and coordinated response for communicable diseases	3.2.1 Strengthen CD surveillance through integration of reporting processes and systems
	3.2.2 Improved prevention, case detection, and treatment of targeted communicable diseases
Strategic Pillar 2: Improve the performance of the health system in meeting the needs of the population, including effectiveness, efficiency, equitable access, accountability, and sustainability	

Strategic Priority Area 4: Primary health care, continuum of care, quality, and safety	
4.1 Strengthen primary care and improve continuum of care for patients	4.1.1 Improve accessibility of primary health care services in urban, rural and remote areas
	4.1.2 Continuum of care and referral system in place between public & private provider networks
	4.1.3 Extend primary care service coverage through effective partnerships with communities
4.2 Continuous monitoring and improvement of quality standards	4.2.1 Establish a systematic quality improvement process in all government health facilities
Strategic Priority Area 5: Productive, motivated health workforce	
GENERAL OBJECTIVES/ OUTCOMES	
5.1 Motivated, qualified, customer-focused health workforce that is responsive to population health needs	5.1.1 Assess workforce needs for all MoHMS cadres and facilities on an annual basis
	5.1.2 Efficiently recruit and deploy qualified health workers based on service need
	5.1.3 Promote a healthy, safe, and supportive work environment to improve workforce satisfaction
	i. Collaborate with training institutions to ensure that graduates meet MoHMS requirements
Strategic Priority Area 6: Evidence-based policy, planning, implementation and assessment	
GENERAL OBJECTIVES/ OUTCOMES	
6.1 Planning and budgeting are based on sound evidence and consider cost-effectiveness	6.1.1 Establish and apply standards for evidence-based policy and planning
	6 s.1.2 Rational budgeting and resource allocation to increase overall efficiency and cost-effectiveness
6.2 Health information systems provide relevant, accurate information to the right people at the right time	6.2.1 Expand coverage of electronic patient management information systems in facilities
	6.2.2 Integrate systems for communicable disease surveillance, notification and reporting
	6.2.3 Establish interoperability between key info systems to facilitate integrated performance management
	6.2.4 Improve consistency of key national health data and statistics with partner institutions
6.3 Results-based monitoring & evaluation as a driver for organizational decision-making and behaviour change	6.3.1 Establish unit-level M&E standards to improve performance and accountability
	6.3.2 Integrate surveys and applied research into MoHMS annual planning cycle
Strategic Priority Area 7: Medicinal products, equipment & infrastructure	
GENERAL OBJECTIVES/ OUTCOMES	
7.1 Quality medicinal products are rationally used and readily accessible to the public	7.1.1 Establish functional supply chain management system to improve medicinal product availability
	7.1.2 Standardise the quality of imported and distributed medicinal products
	7.1.3 Regular evaluation of medicinal products use
7.2 Ensure availability of essential biomedical equipment at facilities	7.2.1 Increased availability of essential biomedical equipment in government health facilities
	7.2.2 Maintenance plans to improve functionality and

	longevity of biomedical equipment
7.3 Infrastructure planned based on service standards for operational and population needs	7.3.1 New and existing facilities based on updated role delineation and service engineering standards
	7.3.2 Infrastructure & equipment maintenance plans for all facilities to ensure operational safety
	7.3.3 Standardization and coordination of facility & equipment planning between key stakeholders
Strategic Priority Area 8: Sustainable Financing	
GENERAL OBJECTIVES/ OUTCOMES	
8.1 Improve financial sustainability, equity and efficiency	8.1.1 Expand evidence base and analytical capacity for strategic health financing
	8.1.2 Develop an appropriate health financing strategy (model)

Consultancy Services 4

4) Strategic Plan 2020-2025

THEMATIC AREA 1 **Population Health Programme Strategies**	**STRATEGIC OBJECTIVE**
STRATEGIC PRIORITY	
Strategic Priority 1: Reform public health services to provide a population-based approach for diseases and the climate crisis	**By the end of 2025 we want to have achieved the following**
OUTCOMES	
Outcome 1.1 – Reduce CD and NCD prevalence, especially for vulnerable groups	**1.** Shown evidence that Fiji has reduced CD and NCD burdens, and is working towards eliminating leptospirosis, typhoid and dengue
Outcome 1.2 – Improve the physical and mental wellbeing of all citizens with particular emphasis on women, children and young people through prevention measures	2. Reduced the number of inpatients presenting symptoms of CDs and NCDs, especially women, children and young people
	3. Reduced the obesity rate in school children monitored during school visits.
Outcome 1.3 – Safeguard against environmental threats and public health emergencies	**4.** Strengthened the IHR capacity of the health system (human resources, surveillance, laboratory and response).
	5. Upgraded the Centre for Disease Control from a Level 2 to a Level 3 facility, as part of strengthening the IHR response
Outcome 1.4 – Strengthen population-wide resilience to the climate crisis	6. Increased the number of health facilities that meet minimum standards for health emergency and disaster preparedness.
	7. FEMAT's role strengthened as part of the overall response to outbreaks and disasters as well as deployment for outreach services, including a range of medical and emergency services
THEMATIC AREA 2 Health Service Delivery	
Strategic Priority 2: **Increase access** to quality, safe and patient-focused clinical services	**STRATEGIC OBJECTIVE**

Outcome 2.1 – Improve patient health outcomes, with a particular focus on services for women, children, young people and vulnerable groups	8. Improved access to services for women, children, young people and vulnerable groups.
	9. Found solutions that reduce the risk of maternal, neonatal, perinatal, infant and child deaths, leading to improved quality of service and reduced mortality rates.
Outcome 2.2 – Strengthen and decentralise effective clinical services, including rehabilitation, to meet the needs of the population	10. Reduced the length of stays for inpatient treatment, especially for women and children, by providing a more integrated service from the community level upwards, which will also reduce the risk of complications.
Outcome 2.3 – Continuously improve patient safety, and the quality and value of services	12. Improved access to standardised treatment services including timely diagnosis, treatment, and efficient referral. This will reduce readmission rates and improve the use of operating theatres.
THEMATIC AREA 3- Health Systems Improvements Strategies	**STRATEGIC OBJECTIVE**
Strategic Priority 3: Drive efficient and effective management of the health system	13. Increased where required, the number of skilled doctors, nurses, midwives, allied health workers and psychiatrist providing health care services either directly or indirectly through the MHMS.
Outcome 3.1 – Cultivate a competent and capable workforce, where the contribution of every staff member is recognised and valued	14. Improved overall performance ratings of all staff employed by us, measured through individual staff work plans.
Outcome 3.2 – Improve the efficiency of supply chain management and procurement systems, and maintenance of equipment	15. Reduced stock-outs of essential medicines and commodities across nursing stations, health centres, and sub-divisional and divisional hospitals, and established a system to measure stock-outs
Outcome 3.3 – Implement more efficient financial processes, while reducing the financial hardship of the most vulnerable	16. Improved budget execution, financial performance, management and greater efficiency
Outcome 3.4 – Ensure infrastructure is maintained to match service needs	17. Maintained a level of infrastructure at health facilities at all levels based on standards or endorsed plans.
Outcome 3.5 – Harness digital technologies to facilitate better health care for our patients	18. Increased access to detailed electronic patient information for staff and patients across the country

1.3.2 Timeline for Consultancy Work

The evaluation will take place over approximately 40 days, from January to April 2025. The timeline is structured as follows:

- 8 days Desktop Review
- 11 days Data Collection and Analysis
- 1-day Validation Workshop
- 20 days Report Compilation

The timeline is subject to change upon the discretion of both contracting parties to allow for variation and flexibility in the Data Collection and reporting phase but maintaining exact number of days for consultancy services [40 days].

2.0 EVALUATION QUESTIONS

2.1 Evaluation Questions

The evaluation will assess the Strategic Plan's performance, effectiveness, and impact using the following criteria:

1 Relevance and Adaptability: Assessing if the Strategic Plan (SP) is doing the right things and adapting well to emerging needs.
2 Coherence: Evaluating how well the SP fits with other initiatives and partners.
3 Effectiveness: Determining if the SP is achieving its objectives and making a difference.
4 Efficiency: Analysing how well resources have been used in implementing the SP.
5 Coordination: Examining how well the implementation of the SP has been coordinated.

The evaluation will also consider cross-cutting issues such as child rights, gender equality, disability inclusion, and sustainability. It will pay particular attention to the most vulnerable, disadvantaged, and marginalised groups.

2..1.1 Key Evaluation Questions and Sub-Questions

The evaluation will focus on the following 5 key evaluation questions (KEQs):

Relevance and Adaptability: Is the SP doing the right things and adapted well to emerging needs?

Coherence: How well does the SP fit with other initiatives?

Effectiveness: To what extent has the SP achieved its objectives? Is the SP doing it right?

Efficiency: How well have resources been used?

Coordination: How well has the implementation of the SP been coordinated?

These KEQs is further broken down into specific sub-questions in the table below to ensure a comprehensive evaluation.

EVALUATION CRITERIA	KEY EVALUATION QUESTIONS	SUB QUESTIONS
RELEVANCE AND ADAPTABILITY	IS THE SP DOING THE RIGHT THINGS AND ADAPTED WELL TO EMERGING NEEDS?	• To what extent are the objectives aligned and been consistent with the needs, priorities, and policies of the government (including alignment to National Development Priorities and targets, national plans, strategies and frameworks). • How dynamic and responsive has the SP been to emergent and unforeseen needs, especially those of the most vulnerable, disadvantaged and marginalised groups? • how well did the SP were able to promote stakeholder ownership • To what extent have MOHMS outputs and assistance contributed to outcomes?
COHERENCE	**HOW WELL DOES THE STRATEGIES FIT?**	• To what extent has the SP strengthened the position, credibility and reliability of the health system as a partner for the other actors, and has served as an effective partnership vehicle? • To what extent has the SP promoted complementarity, harmonization and co- ordination with other key stakeholders to maximise the achievement of results? • Has the MOHMS partnership strategy been appropriate and effective? What factors contributed to effectiveness?

EFFECTIVENESS	HAS THE SP ACHIEVED ITS OBJECTIVES? IS THE SP DOING IT, RIGHT?	• Were the stated outcomes or outputs achieved? • What progress has been made towards the outcomes? • Which factors have contributed to achieving (or not) the intended outcomes? • What extent has the SP contributed effectively to provide greater clarity and transparency of results achieved and resources used? • To what extent did the SP adopt and promote resilience-building approaches in support of governments' sustainable development objectives? • How effective has the SP been in achieving the objectives outlined in the Strategies? • What have been the benefits for the people and communities targeted by the interventions, including the most vulnerable, disadvantaged, and marginalised population? • To what extent has the implementation of the SP contributed to key institutional, behavioural and legislative changes that are critical for catalysing progress towards the SP desired impact? • To what extent has the SP contributed to the promotion of gender equality and women's in governance? • To what extent did the SP support promotion of patient rights, including disability inclusion?
EFFICIENCY	HOW WELL HAVE RESOURCES BEEN USED?	• Was the SP supported by an integrated funding framework and by adequate funding instruments? What were the gaps, if any? Have resources been allocated efficiently? • Has the SP been implemented in a timely way? • Has the SP reduced transaction costs for partners through greater coherence and discipline? • Did MOHMS coordination reduce transaction costs and increase the efficiency of SP implementation? • To what extent has the SP collectively prioritised activities based on the needs (demand side) rather than on the availability of resources (supply side), and reallocated resources according to the collective priorities and changing needs if/where necessary? • How adequate has the SP been in facilitating the effective reallocation of resources to emerging needs and priorities?
COORDINATION	HOW WELL HAS IMPLEMENTATION OF THE STRATEGIC PLAN BEEN COORDINATED?	• To what extent has the Strategic Plan fostered internal coordination, through the promotion of synergies and interlinkages between its interventions? • To what extent the MOHMS and donor agencies successfully coordinated the implementation of SP, AOP's and specific programmes to maximise efficiency, coverage, reaching the most vulnerable (disabled, women, youth, etc) while reducing overlaps • To what extent the planning and coordination of the SP efficiently contributed to a coherent implementation and to the achievement of indicators' targets (outputs and outcomes)?

3.0 METHODOLOGY AND APPROACH

The evaluation will follow a robust methodological framework that provides a structured plan for the conduct of the evaluation, including the overall approach, data collection methods and analysis techniques, and principles related to evaluation ethics and quality standards. The methodological framework serves as a roadmap to ensure that the evaluation is conducted in a systematic, rigorous, and transparent manner that promotes the independence, utility, and ethical integrity of its findings. The evaluation methodology will be confirmed as part of the inception phase but is anticipated to be based on the elements outlined below.

a) ***Approach***

'Evaluation approaches are conceptual, analytical models that encompass specific ways of structuring and conducting data collection and analysis. This evaluation will rely on a combination of approaches, including the following:

b) **Utilization-focused**

The evaluation will be planned and conducted to enhance the likely use of both the findings and the process itself to inform decisions and improve performance. This includes ensuring the practical utility of evaluation findings and generating them promptly, prioritising active stakeholder involvement, and being responsive to user needs.

c) **Criteria-guided**

The high-level evaluation questions cover the key evaluation criteria of relevance, coherence, efficiency, effectiveness, impact1 and sustainability. These criteria provide a normative framework to support consistent, high-quality evaluation by offering a range of lenses and complementary perspectives that together provide a holistic picture of the evaluation subject. Annex 2 provides a mapping of how the evaluation questions relate to these criteria.

d) **Modelling and foresight**

To inform its forward-looking component, the evaluation will seek to use predictive modelling and foresight techniques to forecast the likelihood of achieving intended outcomes by the end of the strategic plan period.

e) **In-depth case studies**

A selection of in-depth case studies will provide a deeper understanding of an issue or situation in a specific context and how various elements have led to observed results. This evaluation may use case studies to examine critical issues and innovations in implementing the Strategic Plan, such as enablers and change strategies.

f) **Triangulation**

Triangulation will enhance the reliability and validity of findings by cross-validating them from multiple data sources, methods, or perspectives. By integrating different sources of data, triangulation helps mitigate biases, corroborate evidence, and provide a more comprehensive understanding of the evaluation topic. If triangulation is not possible, this shall be stated, and any findings based solely on a particular source or group of respondents are to be indicated as such.

During the evaluation's inception phase, other approaches may be considered to complement or refine those listed above. The evaluation should include the following steps, or propose alternatives that will achieve the desired outcome.

Given the budget constraints and streamlined timeline, the evaluation will focus on efficient data collection methods and targeted stakeholder engagement. The methodology will include:

1. Comprehensive desktop review of existing MOHMS Strategic Plans, health data reports, policies, and past evaluations.
2. Targeted data collection through interviews, surveys, and site visits to health facilities and stakeholders.
3. A one-day validation workshop with the MOHMS Steering Committee to validate preliminary findings and discuss recommendations.
4. Preparation of a detailed report, including recommendations for the future 2026-2030 Strategic Plan.

PHASE 2: INCEPTION

During this phase, the Independent Evaluation Consultant team is expected to gain a deep understanding of the evaluation topic, review available documentation and datasets, assess possible information gaps, and refine the evaluation questions and methodology. Deliverables for this phase include:

- *A PowerPoint presentation* outlining the refined evaluation questions and methodology for presentation to the National Evaluation Steering Committee (NESC) and
- *An inception summary* of a maximum of 30 pages or 20,000 words without annexes, confirming a refined and shared understanding of what is to be evaluated and how for review by the Director Monitoring and Evaluation and the National Evaluation Steering Committee (NESC).

The inception summary will include;

i. an initial over-view and analysis based on data collection and review, (ii) the refined scope and set of evaluation questions,
ii. the evaluation methodology,
iii. an engagement strategy for key stakeholders, including an approach of how the evaluation can best feed into the development of the next Strategic Plan, and
iv. the evaluation work plan. The evaluation framework, draft data collection tools, a list of suggested key informants and other key tools and resources will be presented in the annexes.

3.5.1 Step 1. *Desktop Review*

I. **Document review**, including the following types:

- ***Strategic Plan Documents,*** related to the design, operationalization and implementation of the plan, including related official publications, frameworks, planning documents, and implementation guidelines.
- ***Annual Reports,*** which provide comprehensive overviews of the organization's activities, achievements, challenges, and financial performance over a specific reporting period.
- *Programmatic Reports,* which provide insights on interventions implemented under the Strategic Plan and information on activities undertaken, outputs delivered, and outcomes achieved.
- ***Budget and Financial Documents,*** including budget allocations, National Health Expenditure reports, and financial statements to provide insights into the allocation of resources, funding trends, and financial sustainability.
- ***Evaluation Reports,*** providing insights on performance, lessons learned, and areas for improvement.
- ***Research and Studies*** that provide evidence-based insights into key health issues and challenges affecting population health or that are relevant to strategic planning in general.
- ***Policy Documents,*** including position papers and advocacy materials which can provide insights into the organization's policy priorities.
- ***Partnership Agreements***, which provide insights into MOHMSs partnership strategies and its role within broader development networks.

II. Desktop Document Analysis

Based on these types of documents, the review is expected to enable three distinct types of analysis:

a. *A **desk review of background documents***, with the main aim to provide a deeper understanding of the Plan's development, key elements, and use;

III. **Data review**, comprising:

- ***Monitoring Data*** that show progress toward intended results, including indicators related to programmatic areas or other priority areas and initiatives. This data may include baseline or end-line surveys, ongoing monitoring data and surveys such as NCD Step Survey or Health Surveys or data from studies, assessments and evaluations.
- ***Financial Data*** providing information on budget allocations, expenditures, funding sources, and resource mobilization efforts.
- ***Administrative Data*** containing information on service delivery, resource allocation, and personnel.

Emphasis will be placed on making **extensive use of existing secondary data**, such as documents and datasets, to limit the need to collect primary data through interviews and surveys.

3.5.2 Step 2. Data Collection

Data collection and analysis will be based on mixed methods, harnessing the best available quantitative and qualitative data and building on the strengths of each to gain a comprehensive understanding of the relevant issues to be assessed. The following data collection methods are foreseen:

Key informant interviews or **focus group discussions** will be conducted semi-structured, either face-to-face or online. These conversations are mainly foreseen with the following groups:

- ***MOHMS Staff*** directly involved in programme implementation, monitoring or evaluation of the Strategic Plan. This may include senior management, managers, and technical experts in these areas.
- *Government Officials* involved in the design and implementation of the Strategic Plan or overseeing relevant policy areas.
- *Donor Representatives* from agencies, foundations, and international development organizations that provide funding or support to MOHMS programmes and initiatives.
- *Civil Society Representatives* from organizations collaborating with MOHMS on programme implementation or advocacy activities.
- *Academics and Researchers* with expertise in areas relevant to the Strategic Plan that can offer insights into emerging trends, good practices, and evidence-based approaches.
- *Implementing Partners and other Key Stakeholders,* which may include children and young people, as well as representatives from private sector partners, UN agencies, or international organizations.

The MOHMS Evaluation project team will coordinate logistics and arrangements for the data collection phases.

3.5.3 Step 3. *Data analysis techniques*

Data analysis involves the use of various techniques to organise, interpret and synthesise information collected and is critical to gaining meaningful insights. The following key data analysis techniques are expected to be used:

- **Transcribing and Coding Data:** Qualitative data collected through interviews or focus group discussions is transcribed into written text to ensure accuracy and facilitate subsequent analysis. Following transcription, data is coded by systematically categorising and labelling text segments based on themes, concepts, or patterns to identify recurring themes and extract relevant information.

- **Statistical Analysis:** Quantitative data collected through surveys or as part of the data review (e.g., monitoring and financial data, other secondary data sources) will be analysed to determine distributions, relationships and trends using statistical techniques such as descriptive statistics, inferential statistics, regression analysis, and hypothesis tests.

3.5.4 Step 4. validation workshop

The Consultant will present preliminary data findings in a validation workshop. The Ministry will be responsible for the organising of the workshop and logistics.

4.0 REPORTING

The work undertaken will be presented as a report. The report is the key deliverable and will include the components identified above for analysis. The report will be presented as an initial draft. MOHMS will

provide comments, and these will be incorporated to produce the final report. The final version of the report should be provided as a suitable electronic version and should be print-ready.

The Consultant and Director Monitoring and Evaluation will discuss on the reporting format.

5.0 DELIVERABLES AND TIMELINES- Schedule of Payments

Payment for this consultancy will be based on milestone/deliverables.

ANNEX C: OPERATIONAL STAKEHOLDER LISTING

This is an initial mapping of stakeholders for the Strategic Plan review, and will be refined during the Inception Phase. The total number of stakeholders to be consulted has been estimated at 100 across 70 interviews, with a number of interviews involving multiple persons.

Donors	Implementing Division/ Unit/ Agency							Other Partners						Rights holders
	Gov (MOH)	Gov (Other)	Local NGO	Int NGO	WRO[33]	Other UN	Academia	Gov	Local NGO	Int NGO	WRO	Other UN	Academia	
Strategic Priority 1: Reform public health services to provide a population-based approach for diseases and the climate crisis **(PUBLIC HEALTH REFORM) – Lead: Deputy Secretary Public Health (DSPH)[34]**														
Outcome 1.1. Reduce communicable disease and non-communicable disease prevalence, especially for vulnerable groups **(DISEASE CONTROL)**														
DFAT UNICEF WHO UNFPA NZMFAT	DSPH CDU WC NCHP HIRAD[35] FHU[36]							MAFF[37]	MSP FCS DF RFHAF		FWRM	WHO UNICEF UNAIDS[38]	USP FNU UoF	Patients and Health Service Users Vulnerable Groups (e.g., Indigenous Communities, Elderly Population)

[33] WRO= Women's Rights Organization
[34] Lead for strategic priority 1
[35] For Surveillance
[36] For Vulnerable groups
[37] Oversees food security and agricultural health. Relevant for public health through nutrition and food safety initiatives
[38] A global initiative aimed at coordinating and supporting international efforts to combat HIV and AIDS

Donors	Implementing Division/ Unit/ Agency							Other Partners						Rights holders
	Gov (MOH)	Gov (Other)	Local NGO	Int NGO	WRO[33]	Other UN	Academia	Gov	Local NGO	Int NGO	WRO	Other UN	Academia	
Outcome 1.2. Improve the physical and mental well-being of all citizens, with particular emphasis on women, children and young people through prevention measures (PREVENTIVE WELL BEING)														
DFAT UNICEF WHO UNFPA NZMFAT	DSPH NCHP SGH FHU DNU WC HC							MWCPA MOE[39] MYS[40]	MSP FCS YC4MH DF EP RFHAF	IPPF	FWRM	WHO UNICEF UNFPA	USP FNU UoF	Women and Children Youth and Adolescents Healthcare Professionals (advocating for mental health)
Outcome 1.3. Safeguard against environmental threats and public health emergencies (ENVIRONMENTAL HEALTH PROTECTION)														
DFAT UNICEF WHO NZMFAT	DSPH EHD CDU HIRAD							MoEnv[41]	FRCS		FWRM	WHO UNEP	USP FNU UoF	Community-Based Organizations (CBOs) Indigenous Communities (especially those impacted by environmental

[39] Responsible for education policy and programmes. Can support mental health initiatives and health education among young people -check FLE subject taught at schools
[40] Focuses on youth development programmes. May support mental and physical well-being initiatives for young people - TBC
[41] Manages environmental policies and climate change initiatives.

Donors	Implementing Division/ Unit/ Agency							Other Partners						Rights holders
	Gov (MOH)	Gov (Other)	Local NGO	Int NGO	WRO[33]	Other UN	Academia	Gov	Local NGO	Int NGO	WRO	Other UN	Academia	
	PPDU													changes)
Outcome 1.4. Strengthen population-wide resilience to the climate crisis **(CLIMATE RESILIENCE)**														
DFAT UNICEF WHO UNFPA NZMFAT	DSPH EHD PPDU HIRAD CDU								FRCS		FWRM	UNEP	USP FNU UoF	Elderly Population People with Disabilities
Strategic Priority 2: Increase access to quality, safe and patient-focused clinical services **(QUALITY CLINICAL SERVICES) – Lead: Office of the Deputy Secretary Hospital Services (DSHS)**														
Outcome 2.1. Improve patient health outcomes, with a particular focus on services for women, children, young people and vulnerable groups **(PATIENT CENTRED CARE)**														
DFAT UNICEF WHO UNFPA NZMFA	DSHS CWMH, LH,							MWCPA[42]	MSP[43] FCS[44] YC4M			UNICEF UNFPA UNAID	USP FNU UoF	Women and Children Youth and Adolescents

[42] Focuses on gender equality and women's empowerment.
[43] Medical Services Pacific provide clinical services, health education, and focus on women and youth health
[44] Fiji Cancer Society conducts cancer awareness, prevention, and patient support services

Donors	Implementing Division/ Unit/ Agency							Other Partners						Rights holders
	Gov (MOH)	Gov (Other)	Local NGO	Int NGO	WRO[33]	Other UN	Academia	Gov	Local NGO	Int NGO	WRO	Other UN	Academia	
T	LAH SDH FHU CSN HC								H[45] DF[46] EP[47] RFHAF FRCS[48]			S		Vulnerable Groups (including Indigenous Communities)
Outcome 2.2. Strengthen and decentralise effective clinical services, including rehabilitation, to meet the needs of the population (DECENTRALISED SERVICES)														
DFAT UNICEF WHO UNFPA NZMFAT	DSHS SDH HC TTH[49] CSN PPDU	FNCDP									FWRM	WHO UNFPA	USP FNU UoF	Patients and Health Service Users Healthcare Professionals

[45] Youth Champs for Mental Health (YC4MH) provides mental health advocacy and support for young people
[46] Diabetes Fiji promotes diabetes prevention, awareness, and patient support
[47] Empower Pacific provides counseling services and mental health support
[48] Fiji Red Cross Society promotes emergency response, disaster preparedness, and community health
[49] Rehabilitation

Donors	Implementing Division/ Unit/ Agency							Other Partners						Rights holders
	Gov (MOH)	Gov (Other)	Local NGO	Int NGO	WRO[33]	Other UN	Academia	Gov	Local NGO	Int NGO	WRO	Other UN	Academia	
Outcome 2.3. Continuously improve patient safety, and the quality and value of services **(SERVICE QUALITY AND SAFETY)**														
DFAT UNICEF WHO UNFPA NZMFAT	DSHS FMC FNC PHB HIRAD PPDU										FWRM	WHO	USP FNU UoF	Advocacy Groups Patients and Health Service Users
Strategic Priority 3: Drive efficient and effective management of the health system **(HEALTH SYSTEM MANAGEMENT) Lead: Department of Administration and Finance (DAF)**														
Outcome 3.1. Cultivate a competent and capable workforce, where the contribution of every staff member is recognised and valued **(WORKFORCE DEVELOPMENT)**														
DFAT UNICEF WHO UNFPA NZMFAT	DAF HRP HRIR											WHO UNFPA	USP FNU UoF	Healthcare Professionals Advocacy Groups (for workforce

Donors	Implementing Division/ Unit/ Agency							Other Partners						Rights holders
	Gov (MOH)	Gov (Other)	Local NGO	Int NGO	WRO[33]	Other UN	Academia	Gov	Local NGO	Int NGO	WRO	Other UN	Academia	
	HRPPU TU WPU													rights)
Outcome 3.2. Improve the efficiency of supply chain management and procurement systems, and maintenance of equipment (SUPPLY CHAIN EFFICIENCY)														
DFAT UNICEF WHO UNFPA NZMFAT	DAF FPBSC AMU FMPB FAU											UNICEF	USP FNU UoF	Patients and Health Service Users (ensuring availability of services)
Outcome 3.3. Implement more efficient financial processes, while reducing the financial hardship of the most vulnerable (FINANCIAL MANAGEMENT)														
DFAT UNICEF WHO UNFPA NZMFAT	DAF FAU PPDU HIRAD							MOF[50]			FWRM		USP FNU UoF	Vulnerable Groups (including low-income families) Elderly Population

[50] Manages national financial policies and budget allocations. Important for ensuring sustainable funding for health initiatives

Donors	Implementing Division/ Unit/ Agency							Other Partners						Rights holders
	Gov (MOH)	Gov (Other)	Local NGO	Int NGO	WRO[33]	Other UN	Academia	Gov	Local NGO	Int NGO	WRO	Other UN	Academia	
	AMU													
Outcome 3.4. Ensure infrastructure is maintained to match service needs **(INFRASTRUCUTRE MANAGEMENT)**														
DFAT UNICEF WHO UNFPA NZMFAT	DAF AMU PPDU FAU										FWRM		USP FNU UoF	Patients and Health Service Users Community-Based Organizations (advocating for infrastructure needs)
Outcome 3.5. Harness digital technologies to facilitate better health care for our patients **(DIGITAL HEALTH)**														
DFAT UNICEF WHO UNFPA NZMFAT	DAF ICT HIRAD PPDU										FWRM	UNICEF	USP FNU UoF	Youth and Adolescents (increased tech-savvy) Patients and Health Service Users
Outcome 3.6. Continue to strengthen planning and governance throughout the MHMS **(GOVERNANCE AND PLANNING)**														

Donors	Implementing Division/ Unit/ Agency							Other Partners						Rights holders
	Gov (MOH)	Gov (Other)	Local NGO	Int NGO	WRO[33]	Other UN	Academia	Gov	Local NGO	Int NGO	WRO	Other UN	Academia	
DFAT UNICEF WHO UNFPA NZMFAT	PPDU HIRAD CBH All Regulatory Bodies											WHO	USP FNU UoF	Advocacy Groups Community-Based Organizations
Outcome 3.7. Widen our collaboration with partners for a more efficient, innovative and higher-quality health system **(PARTNERSHIP ENHANCEMENT)**														
DFAT UNICEF WHO UNFPA NZMFAT	PPDU DAF All Divisions RLA HBoV	FNCDP						MTCSME[51]			FWRM		USP FNU UoF	Local Governments and Municipalities Advocacy Groups

[51] Focuses on economic development and tourism. Can support health tourism initiatives and public health messaging

1. DONORS

DFAT – Australian Government Department of Foreign Affairs and Trade
NZMFAT – New Zealand Ministry of Foreign Affairs and Trade
WHO – World Health Organization
UNICEF - Pacific- United Nations International Children's Emergency Fund (Pacific)
UNFPA - United Nations Population Fund

2. IMPLEMENTING DIVISION/ UNIT/ AGENCY (ACCOUNTABLE TO SP IMPLEMENTATION)

Government – Ministry of Health and Medical Services

ADMINISTRATIVE & MANAGEMENT

PPDU - Planning and Policy Development Unit
HIRAD - Health Information Research and Analysis Division
DAF - Division of Administration and Finance
ICT - Information and Communication Technology Services

EXECUTIVE OFFICES

DSPH - Deputy Secretary Public Health
DSHS - Deputy Secretary Hospital Services

CLINICAL & HOSPITAL SERVICES

CWMH - Colonial War Memorial Hospital
LH - Lautoka Hospital
LAH - Labasa Hospital
SGH - St. Giles Hospital
TTH - Tamavua/Twomey Hospital
SDH - Sub-Divisional Hospitals
HC - Health Centres
CSN - Clinical Services Networks

PUBLIC HEALTH UNITS

WC - Wellness Centre

NCHP - National Centre for Health Promotion
FHU - Family Health Unit
CDU - Communicable Diseases Unit
EHD - Environmental Health Department
DNU - Dietetics and Nutrition Unit
OHD - Oral Health Department

SUPPORT SERVICES
FPBSC - Fiji Pharmaceutical & Biomedical Services Centre
AMU - Asset Management Unit
FAU - Finance Accounts Unit
HRP - HR Personnel Unit
HRIR - HR OHS/Industrial Relations Unit
HRPPU - HR Policy and Planning Unit
TU - Training Unit
WPU - Workforce Planning Unit

REGULATORY BODIES
FMC - Fiji Medical Council
FDC - Fiji Dental Council
FPPB - Fiji Pharmacy Profession Board
FMPB - Fiji Medicinal Products Board
FNC - Fiji Nursing Council
PHB - Private Hospital Board
RLA - Rural Local Authorities
HBoV - Hospital Board of Visitors
FOB - Fiji Optometrists Board
CBH - Central Board of Health

Government – Other
FNCDP – Fiji National Council of Disabled Persons
IC to confirm other Government min/depts which are implementing agencies of the MHMS SP

Local NGO
IC to confirm whether there is any local NGO implementing activities under the MHMS SP?

International NGO
IC to confirm

Women's Rights Organisations
Is FWRM an implementing agency of the Fiji MHMS SP? IC to confirm.

Other UN – IC to confirm which of the Un agencies are donors, which are implementing agencies of MHMS SP of OR both
WHO – World Health Organization
UNICEF - Pacific- United Nations International Children's Emergency Fund (Pacific)
UNFPA - United Nations Population Fund
UNAIDS - Joint United Nations Programme on HIV/AIDS
UNEP – United Nations Environment Programme

Academia
Are USP, FNU or UOF contracted implementing agencies of activities under the SP? IC to confirm.

Other
IC to confirm

3. OTHER PARTNERS[52]

Government – Other

MWCPA - Ministry of Women, Children and Poverty Alleviation
MOE - Ministry of Education
MOEnv - Ministry of Environment
MYS - Ministry of Youth and Sports
MAFF - Ministry of Agriculture, Fisheries, and Forestry
MOF - Ministry of Finance, Strategic Planning, National Development and Statistics
MTCSME - Ministry of Trade, Cooperatives, Small and Medium Enterprises

Local NGO

MSP - Medical Services Pacific
FCS - Fiji Cancer Society
YC4MH - Youth Champs for Mental Health (YC4MH)
DF - Diabetes Fiji
EP - Empower Pacific
RFHAF - Reproductive & Family Health Association of Fiji
FRCS - Fiji Red Cross Society

International NGO

IPPF – International Planned Parenthood Federation

Women's Rights Organizations

FWRM - Fiji Women's Rights Movement

Other UN

WHO – World Health Organization
UNICEF - Pacific- United Nations International Children's Emergency Fund (Pacific)

[52] Other Partners - They are not directly accountable for SP outcomes. They 0perate independently with their own strategic plans and priorities. Their funding may or may not be tied to MHMS strategic plan implementation. They complement MHMS services rather than being directly responsible for delivering specific SDP outcomes. Their relationship with MHMS is collaborative rather than contractual for SP implementation.

UNFPA - United Nations Population Fund
UNAIDS - Joint United Nations Programme on HIV/AIDS
UNEP – United Nations Environment Programme

Academia
USP – University of the South Pacific
FNU - Fiji National University - College of Medicine, Nursing & Health Sciences
UoF – University of Fiji

Other
IC to confirm

4. RIGHTS HOLDERS

Patients and Health Service Users
Healthcare Professionals
Advocacy Groups
Patients and Health Service Users
Vulnerable Groups (including low-income families)
Elderly Population
Community-Based Organizations
Youth and Adolescents
Local Governments and Municipalities

ANNEX D: KII CONTROL SYSTEM

A tracking system has been created that will ensure that the key informant interview process proceeds as efficiently as possible. The following is a draft, with the tools themselves being discussed with the Client.

The first sheet is for MoHMS:

Interview #	Appointment Day	Appointment Date	Appointment Time	Name	MINISTRY	ADMIN & MANAGEMENT Unit/Div	EXECOFFICES	HOSPITAL/CLINIC/HC Services	PUBLIC HEALTH UNIT	SUPPORT SERVICES	REGULATORY BODIES	Position	Email	Mobile #	Notes
1					Government MOHMS										

Key:

	Confirmed
	Completed

No response/not available

IMPLEMENTING DIVISION/ UNIT/ AGENCY (ACCOUNTABLE TO SP IMPLEMENTATION)
Government – Ministry of Health and Medical Services (MOHMS)

ADMINISTRATIVE & MANAGEMENT

PPDU - Planning and Policy Development Unit

HIRAD - Health Information Research and Analysis Division

DAF - Division of Administration and Finance

ICT - Information and Communication Technology Services

EXECUTIVE OFFICES

DSPH - Deputy Secretary Public Health

DSHS - Deputy Secretary Hospital Services

CLINICAL & HOSPITAL SERVICES

CWMH - Colonial War Memorial Hospital

LH - Lautoka Hospital

LAH - Labasa Hospital

SGH - St. Giles Hospital

TTH - Tamavua/Twomey Hospital

SDH - Sub-Divisional Hospitals

HC - Health Centres

CSN - Clinical Services Networks

PUBLIC HEALTH UNITS

WC - Wellness Centre

NCHP - National Centre for Health Promotion

FHU - Family Health Unit

CDU - Communicable Diseases Unit
EHD - Environmental Health Department
DNU - Dietetics and Nutrition Unit
OHD - Oral Health Department

SUPPORT SERVICES

FPBSC - Fiji Pharmaceutical & Biomedical Services Centre
AMU - Asset Management Unit
FAU - Finance Accounts Unit
HRP - HR Personnel Unit
HRIR - HR OHS/Industrial Relations Unit
HRPPU - HR Policy and Planning Unit
TU - Training Unit
WPU - Workforce Planning Unit

REGULATORY BODIES

FMC - Fiji Medical Council
FDC - Fiji Dental Council
FPPB - Fiji Pharmacy Profession Board
FMPB - Fiji Medicinal Products Board
FNC - Fiji Nursing Council
PHB - Private Hospital Board
RLA - Rural Local Authorities
HBoV - Hospital Board of Visitors

This sheet is for other Government actors:

Interview #	Appointment Day	Appointment Date	Appointment Time	Name	MINISTRY	DEPARTMENT	UNIT	Position	Email	Mobile #	Notes

Key:

	Confirmed
	Completed
	No response/not available

GOVERNMENT: OTHER

MWCPA - Ministry of Women, Children and Poverty Alleviation
MOE - Ministry of Education
MOEnv - Ministry of Environment
MYS - Ministry of Youth and Sports
MAFF - Ministry of Agriculture, Fisheries, and Forestry
MOF - Ministry of Finance, Strategic Planning, National Development and Statistics
MTCSME - Ministry of Trade, Cooperatives, Small and Medium Enterprises

This sheet is for development partners (donors):

Interview #	Appointment Day	Appointment Date	Appointment Time	Name	DONOR	PARTNER	UNIT	Email	Mobile #	Notes

Key:

	Confirmed
	Completed
	No response/not available

DONORS

DFAT – Australian Government Department of Foreign Affairs and Trade
NZMFAT – New Zealand Ministry of Foreign Affairs and Trade
WHO – World Health Organization
UNICEF - Pacific- United Nations International Children's Emergency Fund (Pacific)
UNFPA - United Nations Population Fund

PARTNERS

WHO – World Health Organization
UNICEF - Pacific- United Nations International Children's Emergency Fund (Pacific)
UNFPA - United Nations Population Fund
UNAIDS - Joint United Nations Programme on HIV/AIDS
UNEP – United Nations Environment Programme

This sheet is for non-governmental organisations:

Interview #	Appointment Day	Appointment Date	Appointment Time	Name	International NGO	Local CSO	Position	Email	Mobile #	Notes

Key:

	Confirmed
	Completed
	No response/not available

INTERNATIONAL NGO

IPPF – International Planned Parenthood Federation

LOCAL NGO

MSP - Medical Services Pacific

FCS - Fiji Cancer Society

YC4MH - Youth Champs for Mental Health (YC4MH)

DF - Diabetes Fiji

EP - Empower Pacific

RFHAF - Reproductive & Family Health Association of Fiji

FRCS - Fiji Red Cross Society

This sheet is for academia:

Interview #	Appointment Day	Appointment Date	Appointment Time	Name	University	Faculty	Position	Email	Mobile #	Notes

Key:

	Confirmed
	Completed
	No response/not available

ACADEMIA

USP – University of the South Pacific

FNU - Fiji National University - College of Medicine, Nursing & Health Sciences

UoF – University of Fiji

ANNEX E: KEY INFORMANT INTERVIEW INSTRUMENT

Key Informant Interview Instrument
Evaluation of MoHMS Strategic Plans and Performance

Prepared by SIAPAC for the
Ministry of Health and Medical Services

	Information	Details
1	Level	____ - 1 national level ____ - 2 divisional level - 3 local level/area-based organisation (below division)
2	Type of Organisation [Int: Tick only one. Do not mix types of interviewees in a single set of KIIs] [Int: Ensure no hierarchy in a single department or similar] [Int: Some of these organisations will not have been involved with the Strategic Plan design or implementation but work in areas affected by the plans. If they have zero knowledge of the Plans or the planning process, terminate interview]	____ - 1 MoHMS internal ____ - 2 other government ministry ____ - 3 implementing partner ____ - 4 civil society organisation (Fijian) ____ - 5 non-governmental organisation (locally incorporated int'l) ____ - 6 non-governmental organisation (international) ____ - 7 UN agency ____ - 8 development partner (donor) ____ - # other (specify): _____
3	Location (for divisional) [Int: tick as many as appropriate]	____ - 1 Eastern Division ____ - 2 Western Division ____ - 3 Central Division ____ - 4 Northern Division
4	Location (province, district, or community) [Int: indicate level e.g., XXX district]	_____
5	Online/In-Person	____ - 1 online ____ - 2 in person - 3 mix
Interviewee 1		
	First Name	
	Surname	
5	Title (Mr., Mrs., Ms., Dr., Rev., etc.)	
6	Gender	
7	Position	
8	Name of Organisation/Institution	
9	Role in the Health Sector [Int: short description of responsibilities]	
Interviewee 2		
	First Name	
	Surname	
10	Title (Mr., Mrs., Ms., Dr., Rev., etc.)	
11	Gender	
12	Position	

	Information	Details
13	Name of Organisation/Institution	
14	Role in the Health Sector `[Int: short description of responsibilities]`	
Interviewee 3		
	First Name	
	Surname	
15	Title (Mr., Mrs., Ms., Dr., Rev., etc.)	
16	Gender	
17	Position	
18	Name of Organisation/Institution	
19	Role in the Health Sector `[Int: short description of responsibilities]`	
Interviewee 4		
	First Name	
	Surname	
20	Title (Mr., Mrs., Ms., Dr., Rev., etc.)	
21	Gender	
22	Position	
23	Name of Organisation/Institution	
24	Role in the Health Sector `[Int: short description of responsibilities]`	
Interviewee 5		
	First Name	
	Surname	
25	Title (Mr., Mrs., Ms., Dr., Rev., etc.)	
26	Gender	
27	Position	
28	Name of Organisation/Institution	
29	Role in the Health Sector `[Int: short description of responsibilities]`	
30	Date	Date:
31	Length of Interview (minutes)	
32	Co-operation	- 1 high - 2 medium - 3 low
33	Interviewer Name	
34	Other Interviewer Name	

Introduction

My name is _____, and I'm part of a team conducting an evaluation of the Ministry of Health and Medical Services' strategic plans and the planning process. We are trying to understand whether and how the strategic planning process has added value to the planning and delivery of health services in Fiji, the extent to which objectives are being achieved, and what this means for the next strategic plan covering the period 2026-2030.

The evaluation is being conducted by SIAPAC, an international consultancy firm with extensive experience in Fiji.

We are interested in hearing your experiences and your attitudes about plan utility and performance, and what should be done to improve performance.

Consent

We are requesting your involvement in this evaluation. You are not being forced to take part; however, we would really appreciate it if you do share your thoughts with us. If you choose not to take part in answering these questions, you will not be affected in any way whatsoever. If you agree to participate, you may stop participating in the discussion at any time and tell us that you do not want to continue.

Confidentiality

The information you provide us with will be treated confidentially. We will not be recording your names anywhere in the write up of the research. All responses will be anonymous and will not be shared with anyone outside the research team.

[If you are recording, please also add] *I would like to use a digital voice recorder to ensure that all of your responses are captured accurately. The recordings will remain confidential, will not be linked to your name or position, and will only be used for writing up the interview. Upon completion of the write up, the recording will be erased.*

Risks/Discomforts

We do not see any risks in your participation. However, if you have any concerns regarding the way the interview was conducted, or any other concern regarding your participation in this study, please contact Mr. Peter Zinck at mobile number 926-9370.

Request to Proceed

May we proceed? ____ - 1 Yes ____ - 2 No

Section 1: EFFECTIVENESS (awareness)
Awareness of the MoHMS Strategic Planning Process

101) As a first question, what can you tell us about the MoHMS strategic planning process, both design and implementation? [Int: The aim is to just get a basic sense of awareness, how far back this extends, and similar. Most key informants should be able to give quite a bit of detail in this regard, but those farther away from health or health project implementation may have less information. This is not a problem, but rather helps us understand their responses to the questions below. And it considers the effectiveness of outreach, implementation, and communications]

Section 2: EFFECTIVENESS (involvement)
Involvement in the MoHMS Strategic Planning Process and Actions

201) How, if at all, have you been involved in the design of the strategic plans? [Int: We need to understand their involvement in the 5-year planning process by plan, followed by their involvement in the annual planning process. For the 2020-25 plan, get additional details on written inputs, committees, workshops, consultations, etc.]

201a) How effective would you say this design *process* has been? [Int: ask about over time, if they have been involved across more than one, then ask about the annual planning process.]

201b) How effective would you say this design process has been in terms of considering inclusion of the various needs of different Fijian population groups, including women and men, younger persons, the elderly, sexual minorities, non-majority ethnic groups, persons with disabilities, institutionalised populations, and others? [Int: Get information on if and how different groups were consulted, who was involved, and how this influenced the plans] [Int: For those involved in implementation, within Government and with implementing partners, how do they track inclusion information when they report]

202) [For MoHMS and implementing partner/programme implementer of development project] How are you/how is your agency involved in the implementation of the strategic plans?

202a) How effective would you say plan *implementation* has been in terms of how the Plan added clarity and focus to your institution, or agency's work, gave clear direction, supported effective implementation of your work or objectives? Where has it specifically been ineffective or irrelevant? [Int: ask about over time, if they have been involved across more than one, then ask about the annual planning process.]

202b) How effective would you say this implementation process has been in terms of meeting the various needs of different Fijian population groups, including women and men, younger persons, the elderly, sexual minorities, non-majority ethnic groups, persons with disabilities, institutionalised populations, and others? [Int: Get information on if and how different groups were consulted, who was involved, and how this influenced the plans]

203) [For civil society/activist organisation] How, if at all, is your organisation or agency involved in the strategic planning process, or in supporting the objectives and activities of the strategic plans? [Int: They are not implementing partners, so this question is more focused on their engagement as interest groups. It can be their attempts at, or efforts to be involved in engagement, it can be the Ministry's attempts at, or efforts made to engage them, or it can be a mix of both]

203a) How effective would you say this design process, and in the implementation of strategic plans has this been in terms of meeting the various needs of different Fijian population groups, including women and men, younger persons, the elderly, sexual minorities, non-majority ethnic groups, persons with disabilities, institutionalised populations, and others?

203b) [If their involvement or engagement is minor] Given your agency's rather minor involvement in the strategic planning process and implementation, do you see weaknesses in the planning process and implementation because of this? [Int: the aim is to find out how their objectives as an organisation are being advanced, or not being advanced, in a manner that they feel affects or influences the development of Fiji's health services sector]

204) [For development partners] How is your organisation or agency involved in the strategic planning process, or in supporting the objectives and activities of the strategic plans? [Int: after description, if they do not mention financing, ask if they are providing financial support to the strategic planning process or activities supporting the current and/or earlier plans. If financed, get details on trends over time]

204a) From your perspective, what have been the strengths and weaknesses of the strategic planning *process*? [Int: Ask about over time, if their agency has been involved across more than one, including both the five-year planning process and annual plans. We want to establish trends as possible. [If they are only familiar with 2020-2025, ask them about the strengths and weaknesses of this particular planning process, both for the overall plan and annual planning]

204b) How effective would you say this strategic planning process has been in terms of meeting the various needs of different Fijian population groups, including women and men, younger persons, the elderly, sexual minorities, non-majority ethnic groups, persons with disabilities, institutionalised populations, and others?

204c) From your perspective, what have been the strengths and weaknesses of the strategic plan *implementation*? [Int: Ask about over time, if their agency has been involved across more than one, including both the five-year planning process and annual plans. We want to establish trends as possible] [If they are only familiar with 2020-2025, ask them about the strengths and weaknesses of this particular plan's implementation, both for the overall plan and annual planning]

204d) How effective would you say strategic plan implementation has been in terms of meeting the various needs of different Fijian population groups, including women and men, younger persons, the elderly, sexual minorities, non-majority ethnic groups, persons with disabilities, institutionalised populations, and others? [Int: Get information on if and how different groups were consulted, who was involved, and how this influenced the plans]

Section 3: EFFECTIVENESS (focus and approach)
Consideration of Focus of MoHMS and Partners in Implementing the Plans

301) [Ask those involved in the details of plan design and implementation. If only implementation, also include here] The 2016-2020 Strategic Plan had two pillars: 1) provide quality preventive, curative and rehabilitative health services responding to the needs of the Fijian population including vulnerable groups such as children, adolescents, pregnant women, elderly, those with disabilities and the disadvantaged; and 2) improve the performance of the health system in meeting the needs of the population, including effectiveness, efficiency, equitable access, accountability, and sustainability.

Alternatively, the 2020-2025 Strategic Plan indicated three strategic priorities: 1) reform public health services to provide a population-based approach for diseases and the climate crisis; 2) increase access to quality, safe and patient-focused clinical services; and 3) drive efficient and effective management of the health system.

The change reflected a greater emphasis on reform and health systems management in 2020-25, and *within reform* a population-based approach that included prevention, a lifetime of good health, and building healthy communities and healthy environments that yield improved health outcomes. Delivery of clinical services was then focused on patient-focused health services at health facilities.

As a first question, we would like to hear from you whether you agree with these changes in how the current Strategic Plan 'thinks' about health. [Int: Get details as possible, including all three strategic priorities] [Int: Ask them whether they felt that the changes made the plan's intentions more or less realistic]

301a) Has this change been reflected in how the Ministry approaches health sector planning and implementation? If so, how? For now, please try and put aside the impacts of the Covid-19 pandemic in responding to this question.

302) [Ask those involved in the details of plan design and implementation. If only implementation, also include here] Considering Strategic Priority 1 in the 2020-2025 Strategic Plan 'reform public health services to provide a population-based approach for diseases and the climate crisis', and please try and ignore for now the impacts of the Covid-19 pandemic, was this a good way to approach population health? Consider this also from the perspective of international good practices, how well aligned is this? [Int: Ask them whether the plan's intentions were realistic or not]

303) [Ask those involved in the details of plan design and implementation. If only implementation, also include here] Considering Strategic Priority 2 in the 2020-2025 Strategic Plan 'increase access to quality, safe and patient-focused clinical services', and please try and ignore for now the impacts of the Covid-19 pandemic, was this a good way to approach service access and quality? Consider this also from the perspective of international good practices, how well aligned is this? [Int: Ask them whether the plan's intentions were realistic or not]

304) [Ask those involved in the details of plan design and implementation. If only implementation, also include here] Considering Strategic Priority 3 in the 2020-2025 Strategic Plan 'drive efficient and effective management of the health system', and please try and ignore for now the impacts of the Covid-19 pandemic, was this a good way to approach strengthening management and systems? Consider this also from the perspective of international good practices, how well aligned is this? [Int: Ask them whether the plan's intentions were realistic or not]

Section 4: EFFECTIVENESS (performance)
Assessment of Effective Performance of MoHMS and Partners in Implementing the Plans

401) Overall, and again putting aside the effects of the Covid-19 pandemic (we'll discuss this in a few minutes), how well did the Ministry do in responding to the new strategic approach to health as outlined in the 2020-2025 Strategic Plan?

401a) How well did implementing partners do in responding to the new strategic approach?

401b) Did development partners respond positively to this new strategic approach? Did they enable this plan?

402) Each health plan considers the needs of vulnerable population groups in Fiji, and the 2020-2025 Strategic Plan makes specific reference to these groups and the need to deliver in a way and with programmes that meet their specific needs, with a particular focus on reaching most vulnerable groups. How did the 2020-2025 Strategic Plan do in this regard? How does this compare to earlier plans?

403) [Ask those involved in the details of plan design and implementation. If only implementation, also include here] Considering Strategic Priority 1 in the 2020-2025 Strategic Plan 'reform public health services to provide a population-based approach for diseases and the climate crisis', and ignoring for now the impacts of the Covid-19 pandemic, how did the Ministry deliver in this respect?

403a) How well did implementing partners perform?

403b) How well did development partners perform in terms of supporting this Strategic Priority?

404) [Ask those involved in the details of plan design and implementation. If only implementation, also include here] Considering Strategic Priority 2 in the 2020-2025 Strategic Plan 'increase access to quality, safe and patient-focused clinical services', and ignoring for now the impacts of the Covid-19 pandemic, how did the Ministry deliver in this respect?

404a) How well did implementing partners perform?

404b) How well did development partners perform in terms of supporting this Strategic Priority?

405) [Ask those involved in the details of plan design and implementation. If only implementation, also include here] Considering Strategic Priority 3 in the 2020-2025 Strategic Plan 'drive efficient and effective management of the health system', and ignoring for now the impacts of the Covid-19 pandemic, how did the Ministry deliver in this respect?

405a) How well did implementing partners perform?

405b) How well did development partners perform in terms of supporting this Strategic Priority?

Section 5: ADAPTABILITY
Strategic Plan Adaptability in Response to Circumstances/Trends/Changing Priorities

501) [Ask within MoHMS and with implementing partners] Again ignoring Covid-19 for the moment, how have you modified your implementation strategies to adapt to emergent needs, new challenges, opportunities, etc. [Int: After they describe, ask them what information they had and how they got it that led to these changes, how they proceeded to make changes, and how they tracked what happened because of what they changed]

502) [Ask development partners] Again ignoring Covid-19 for the moment, how well as the Ministry and its implementing partners been able to respond to challenge and opportunities not initially anticipated? That is, have they adapted their implementation strategies to respond to emergent needs, new challenges, opportunities, etc.

502a) Was your organisation or agency involved in supporting these adaptations and adaptive processes?

502b) Were these adaptations based on solid, evidence-based information, or did they proceed without proper information?

502c) Were these adaptations clearly tracked and reported?

503) Now, Covid-19. The pandemic hit soon after the 2020-25 Strategic Plan was released. Were you involved in the health sector's response to Covid-19? If so, please describe what happened in terms of the health sector responding to the pandemic.

504) How did the pandemic affect implementation of the 2020-25 Strategic Plan? [Int: After they explain the overall effects, ask about how they went about coping with Covid-19 but still proceeding as possible with Strategic Plan implementation]

504a) Considering Strategic Priority 1 'reform public health services to provide a population-based approach for diseases and the climate crisis', how well did the Ministry cope with Covid-19 when advancing this priority? What worked and what did not?

504b) Considering Strategic Priority 2 ‘increase access to quality, safe and patient-focused clinical services’, how well did the Ministry cope with Covid-19 when advancing this priority? What worked and what did not?

504c) Considering Strategic Priority 3 ‘drive efficient and effective management of the health system’, how well did the Ministry cope with Covid-19 when advancing this priority? What worked and what did not?

505) How well have the strategic plans adapted to responding to changing needs in terms of current health requirements and trends?

Section 6: COORDINATION
Assessment of Coordination Arrangements in Plan Design and Implementation

601) [Ask within MoHMS and with implementing partners] We’ve discussed various aspects of design and implementation above, and how successful or not the Ministry has been in terms of effectiveness. One last issue that is linked to effectiveness is the efficacy of coordination systems and actions, as they have been adapted over time. We want to understand the efficacy of coordination arrangements for plan *design* and plan *implementation*, and consider strengths, weaknesses, and changes over time. Please consider these factors as follows:

601a) For your specific unit/department/section/division (design and implementation)

601b) For the Ministry overall at national level (design and implementation)

601c) For the Ministry at divisional level (design and implementation)

601d) For the Ministry at provincial, district and local levels (design and implementation)

601e) For the Ministry in terms of coordinating with other ministries (design and implementation) [Int: if the discussion is general to ‘government’, ask about specific ministries, including both sectoral ministries and planning and financing ministries, as well as disaster response cluster involvement and climate change programming, and those ministries and sections that focus on vulnerable groups]

601f) For implementing partners at strategic and operational levels (design and implementation)

601g) For the Ministry in terms of its liaison with civil society organisations and NGOs, including disaster response cluster and those who work with vulnerable populations (design and implementation)

Section 7: RELEVANCE
Alignment of the Strategic Plans with National and International Protocols

701) Based on you understanding of the strategic planning process and objectives, how well aligned do you feel the current plan (2020-2025) is with the Fijian National Development Plan? Where is it well aligned, and where is it deficient?

702) What about alignment with various health policies, how well aligned do feel the current plan (2020-2025) is with these policies? Where is it well aligned, and where is it deficient?

703) What about alignment with Pacific regional health priorities, including health priorities aimed at avoiding the spread of diseases or dealing with common health challenges facing other countries in the region?

704) What about alignment with the relevant Sustainable Development Goals, including Rights, Health, Gender, Urban Development, Environment and others you would like to mention?

705) What about alignment with national policies on gender, disability, child protection, social protection, education, community development, disaster response, climate change, and any others that you would like to mention?

706) [For development partners] How well aligned are the *objectives* of the health strategic plans with the objectives of your organisation?

706a) What about your organisation's specific priorities in terms of your support for Fiji? Where is it well aligned with your priorities, and where is it deficient?

707) [For development partners] How well aligned has the strategic planning *process* been in terms of your organisation's commitment to inclusive development processes? Where is it well aligned in terms of process and commitments to rights-based programming, and where is it deficient?

708) [For implementing partner/programme implementer of development project] How well aligned are the *objectives* of the health strategic plans with the objectives of your organisation?

708a) What about your organisation's specific priorities in terms of your priorities in Fiji? Where is it well aligned with your priorities, and where is it deficient?

709) [For implementing partner/programme implementer of development project] How well aligned has the strategic planning *process* been in terms of your organisation's approach to inclusive development processes? Where is it well aligned in terms of process and commitments to rights-based programming, and where is it deficient? [Int: How did they identify what to include that would track inclusion when implementation proceeds]

710) [For civil society/activist organisation] How well aligned are the *objectives* of the health strategic plans with the objectives of your organisation?

710a) What about your organisation's specific priorities in terms of your priorities in Fiji? Where is it well aligned with your priorities, and where is it deficient?

711) [For civil society/activist organisation] How well aligned has the strategic planning *process* been in terms of your organisation's approach to inclusive development processes? Where is it well aligned in terms of process and commitments to rights-based programming, and where is it deficient?

712) [For civil society/activist organisation] Overall, how well aligned are the strategic plans with current health requirements and trends as well as Fiji's developmental priorities?

Section 8: COHERENCE
'Fit' Within the Health Sector and the Needs of the Population

801) How has the strategic planning process and content enabled improved coherence (or logic) in health sector planning and delivery? Where has it been deficient?

802) How has the strategic planning process supported an improved understanding of health sector challenges and opportunities?

803) How has the strategic planning process and content improved the ability of the Ministry to better respond to the unfolding needs of the populations they serve? [Int: After the general discussion, raise the issue of vulnerable groups and marginalised populations]

Section 9: EFFICIENCY
Assessment of Efficiency of Performance of MoHMS and Partners in Implementing the Plans

901) Regarding the cost *effectiveness* of the strategic plan design and implementation, was there a better way that the Ministry could have proceeded in terms of its development planning and plan implementation rather than the strategic planning process they employed? Or was the approach they actually used the most cost effective?

902) Where was the strategic planning process deficient in terms of poor "value-for-money" on the time and resources used to design and implement the strategic plans?

903) Where did the strategic planning process excel in terms of the "value-for-money" of their actions?

904) Regarding the cost *efficiency* of the strategic planning process, that is the return-on-investment for every dollar invested from actions taken through the strategic planning process, where was the strategic planning design and implementation process deficient in terms of poor return-on-investment?

904a) Consider this in terms of the cost efficiency of how the Ministry works internally, including implementation protocols.

904b) Consider this in terms of the cost efficiency of how the Ministry works with implementing partners.

904c) Consider this in terms of the cost efficiency of how the Ministry works with donor agencies, including programmes in the health sector.

904d) Consider this in terms of the cost efficiency of coordination mechanisms across various actors in the health sector.

905) Where did the strategic planning process excel in terms of the return-on-investment for every dollar invested of their actions?

906) Consider the ways in which the strategic plans have changed over time, what changes have improved cost effectiveness? What changes have undermined cost effectiveness?

Section 10: ATTITUDES

[MoHMS Personnel ONLY]

We'd like to present some attitudinal scale statements to you, and ask you to agree or disagree, and how intensely, and then explain your response.

#	Statement	Agreement	Discussion
1001	Staff turnover and staff shortages undermine plan implementation [Int: Get insights on change over time after the initial response, if not mentioned]	strongly agree agree disagree strongly disagree	
1002	Inadequate financing undermines plan implementation [Int: Get insights on change over time after the initial response, if not mentioned]	strongly agree agree disagree strongly disagree	
1003	The fact that the planning process listens to many voices strengthens the strategic plans	strongly agree agree disagree strongly disagree	
1004	Too much time is invested in high level strategic planning, this can be done in policies, let the plans be clearly operational	strongly agree agree disagree strongly disagree	
1005	The Ministry has proven to be very adaptable in implementing the strategic plans, and this has strengthened the outcomes of the plans	strongly agree agree disagree strongly disagree	
1006	While the needs of especially vulnerable groups are mentioned, in practice it doesn't receive sufficient attention in implementation	strongly agree agree disagree strongly disagree	
1007	We know how we are progressing along activities and outputs, but really, we don't have a very good understanding of how we are progressing in terms of outcomes	strongly agree agree disagree strongly disagree	
1008	There is a clear connection between what we are doing and what the people of Fiji need	strongly agree agree disagree strongly disagree	
1009	The way in which strategic planning is done in the health sector here, is not up to the task of reform needed to improve health here in Fiji	strongly agree agree disagree strongly disagree	

#	Statement	Agreement	Discussion
1010	The changes in the strategic plans, including both process and content, from 2006 until now show greater attention to a human rights-based approach to the health sector	strongly agree agree disagree strongly disagree	
1011	The top-down hierarchy structure in government ministries prevents effective implementation	strongly agree agree disagree strongly disagree	
1012	Improving communication channels and data sharing at all levels of the ministry would improve health services delivery to all Fijians	strongly agree agree disagree strongly disagree	
1013	Improving data collection and HMIS at all levels of the ministry would improve health services delivery to all Fijians	strongly agree agree disagree strongly disagree	

Section 11: Closing

1101) As a final question, do you have any recommendations for the design and implementation of the 2026-2030 Strategic Plan? `[Int: After their initial recommendations, ask the following if not already raised]`

1101a) What you feel are neglected or not prioritised issues that need attention.

1101b) How the process of plan development could be improved, and why.

1101c) How marginalised and excluded populations can be better involved in the planning process and how they can receive proper attention in the plan.

1101d) How the plan can better anticipate emergent challenges.

1102) Do you have any other comments?

ANNEX F: WORKPLAN

Activity	Timeline	Deliverables
Phase 1: Inception	**March**	
Contract Signature	17 March	
Document assembly and review	March – April	
Prepare Draft Inception Report incl. updated workplan and Stakeholder Engagement Strategy	March	
• Initial materials reviewed early in inception	March	
• Additional materials were provided following the first ESC	18 March	
• Materials continue to be reviewed and marked	March – April	
Draft Inception Report submission for review by Client	18 March	Deliverable: Draft Inception Report 18 March
Deliverable 1: Draft Inception Report including Workplan and Stakeholder Engagement Strategy	18 March	Inv. #1: 25% upon submission of Draft Inception Report
Client review of the Draft Inception Report and submit comments	18-19 March	Comments provided on 19 March
Stakeholder Listing for Key Informant Interviews	March	
• Initial listing took place	March	
• Listing updated in discussion with the Client	19-22 March	
• Sorted into a KII scheduling sheet	23-24 March	
Development of field instrument	March	
• Tool divided into sections to be able to be used at different levels	21-25 March	
• Tool adapted by team subject specialists for use for specialist interviews	26-28 March	
• KII tool submitted separately	25 March	
Consultant revises Draft Inception Report and submits final	20 March	
• Full review and updating as required	20-24 March	
• Prepared evaluation matrix	23-24 March	
• Added KII control sheets	23 March	
Final Inception Report preparation and submission (electronic submission)	24 March	Deliverable: Final Inception Report 24 March
Phase 2: Fieldwork & Preliminary Findings	**March - May**	
Detailed Timeline for Stakeholder Interviews and set up appointments (Lead: MoHMS Focal Point)	20 March – 11 April	
M&E Specialist interviews and document review to populate Strategic Plan indicators	19 March – 17 April	

Activity	Timeline	Deliverables
• Detailed planning meetings with Working Group and securing data	From 18 March	
• Liaison with Focal Point to assemble data	From 18 March	
• Categorising data as it comes in by plan and indicator	From 18 March	
D. Cownie in Suva	16-27 April	
• Team meetings	17-27 April	
• Meetings with Mosese to review data against indicators and consider implications of output data against outcomes, including reviewing reporting documents from the Ministry and assess relevance for both plan tracking and evaluation criteria assessment	17-27 April	
• Conduct joint interviews with senior personnel in MoHMS with Peter		
• Conduct interviews with development partners in Suva		
• Team roundtable to consider preliminary evaluation findings	24-25 April	
• Meet with Working Group to discussion preliminary evaluation findings, adjust as per discussion	25 April	
Draft Preliminary Evaluation Findings Report preparation and submission, including findings from M&E Specialist work, KIIs, and document review	5-27 April	Deliverable: Preliminary Evaluation Findings Report 27 April
R. Weeks in Suva	29 March – 6 April 22 April - 2 May	
Stakeholder interviews (NLKII) in Suva by R. Weeks and K. Salusaludrau	31 March – 9 May	
Transcribe and compile NLKIIs	31 March – 10 May	
Deliverable 2: Draft Preliminary Evaluation Findings Report (only 1 version)	27 April	Inv. #2: 20% upon submission of Draft Preliminary Evaluation Findings Report
Phase 3: Reporting	**May**	
Draft Evaluation Report preparation and submission (inc. feedback on Preliminary Evaluation Findings Report from the Client	1 – 25 May	Deliverable: Draft Evaluation Report 25 May
D. Cownie in Suva	25 May – 1 June	
Anticipated sections up front: acknowledgements, table of contents, list of acronyms, executive summary (findings, conclusions, lessons learned, recommendations)	Initially prepared in March-April	
Section 1: Introduction (short overview of Fiji, health status in Fiji, background on the strategic planning process, purpose focus and objectives of the evaluation)	Initially prepared in March-April	
Section 2: Methodology (workstreams 1 and 2) and Evaluation Management (role of Focal Point, role of Working Group, role of Evaluation Steering Committee, operations, issues arising)	Initially prepared in March-April	

Activity	Timeline	Deliverables
Section 3: Indicator Status by Strategic Plan (information from Mosese on each indicator in the plans)	Initially prepared in April	
Section 4: Evaluation Findings – Relevance and Adaptability	Outline prepared in March/April, findings in May	
Section 5: Evaluation Findings – Effectiveness and Coordination		
Section 6: Evaluation Findings – Efficiency		
Section 7: Summary Findings		
Section 8: Conclusions and Lessons Learned		
Section 9: Recommendations		
PowerPoint Presentation to Steering Committee (draft report)	26 May	Deliverable: PowerPoint Presentation 26 May
Deliverable 3: Draft Evaluation Report	26 May	Inv. #3: 25% upon submission of Draft Evaluation Report 26 May
Client review of the Draft Evaluation Report and submit comments	26-28 May	
Development of detailed Terms of Reference for a full institutional assessment	May	Deliverable: Draft and Final versions of ToR for full institutional assess in mid-and end May
Phase 4: Use		
D. Cownie in Suva	26 May – 2 June	
T. Waqanivalu in Suva	27 – 28 May	
A. Ledua in Suva	27 - 28 May	
PowerPoint Presentation to the Dissemination Workshop (and associated materials)	28 May	
Dissemination Workshop (inc. groupwork)	28-29 May (1.5 days)	
Final changes and submission of Final Evaluation Report	29 - 31 May	
Hand over report to the Ministry	31 May	
Deliverable 4: Final Evaluation Report	31 May	Inv. #4: 20% upon submission of Final Evaluation Report 30 May
Completion of Consultancy	31 May	

ANNEX G: INTERVIEWEES

Ministry of Health and Medical Services

#	Date	Name	MINISTRY	Position	Email
1	2.4.2025	Dr. Luisa Cikamatana	Government MOHMS	Acting Chief Medical Advisor	lcikamatana@health.gov.fj
2	2.4.2025	Melaia Katonivualiku	Government MOHMS	Media Liaison Officer	-
3	2.4.2025	Dr. Vineet Chand	Government MOHMS	Head of Research, Health Information, Data Management and IT	vineet.chand@health.gov.fj
4	2.4.2025	Mr Eliki Waqavakatoga	Government MOHMS	Head of Planning & Policy Development Division	eliki.waqavakatoga@health.gov.fj
5	3.4.2025	Temo Ravula	Government MOHMS	Senior Admin Officer – Assets Management Unit	travula@health.gov.fj
6	3.4.2025	Mrs. Joana Lesuma	Government MOHMS	Statistician	joana.lesuma@health.gov.fj
7	3.4.2025	Dr. Jone Turagaluvu	Government MOHMS	NAOH	jone.turagaluvu@health.gov.fj
8	3.4.2025	Sr Colleen Wilson	Government MOHMS	Chief Nursing and Midwifery Officer	colleen.wilson@health.gov.fj
9	4.4.2025	Shaneel Prakash	Government MOHMS	Director Digital Health	shaneel.prakash@health.gov.fj
10	4.4.2025	Rajneel Krishan	Government MOHMS	National Health Accounts Coordinator	rajneel.krishan@health.gov.fj
11	7.4.2025	Lavenia Mataitoga	Government MOHMS	Pharmacovigilence Officer	lavenia.mataitoga@health.gov.fj
12	7.4.2025	Dr. Akesh Narayan	Government MOHMS	Sub Divisional Medical Officer - Central Division	akesh.narayan@health.gov.fj
13	8.4.2025	Peni Lebaivalu	Government MOHMS	Divisional Surveilance Officer - Western Division	peni.lebaivalu@health.gov.fj
14	8.4.2025	Sr Amelia Nasetava	Government MOHMS	Director Of Nursing - Western Division	amelia.nasetava@health.gov.fj
15	8.4.2025	Rakesh Kumar	Government MOHMS	Divisional Health Inspector - Western Division	rakesh.kumar@govnet.gov.fj
16	8.4.2025	Dr Abdul Shah	Government MOHMS	Divisional Medical Officer - Western Division	abdul.shah@health.gov.fj
17	9.4.2025	Dr Devina Nand	Government MOHMS	Head of Wellness	devina.nand@health.gov.fj
18	9.4.2025	Sr Miliakere Nasorovakawalu	Government MOHMS	Director Of Nursing - St Giles Hospital	mnasorovakawalu@health.gov.fj
19	9.4.2025	Ateca Kama	Government MOHMS	Chief Dietician & Nutritionist	ateca.kama@health.gov.fj
20	9.4.2025	Dr Nanise Sikiti	ASPEN	Consultant O&G (Oncologist)	nsikiti@aspenmedical.com.fj
21	9.4.2025	Dr Talei Vasuitaukei	Government MOHMS	Sub Divisional Medical Officer - Northern Division, Savusavu	tjioji89@gmail.com

#	Date	Name	MINISTRY	Position	Email
22	9.4.2025	Dr. Kiean Gaikwad	Government MOHMS	Medical Superintendent - St. Giles Hospital	
23	10.4.2025	Dr Tiko Saumalu	Government MOHMS	Divisional Medical Officer - Northern Division	tiko.saumalua@health.gov.fj
24	10.4.2025	Sr Naomi Ligaiviu	Government MOHMS	Director Of Nursing - Northern Division	naomi.ligaiviu@health.gov.fj
25	10.4.2025	Dr Jaoji Vulibeci	Government MOHMS	Medical Superintendent - Labasa Hospital	jaoji.vulibeci@health.gov.fj
26	10.4.2025	Sr Suman Raman	Government MOHMS	Director Of Nursing - Labasa Hospital	suman.raman@health.gov.fj
27	10.4.2025	Krishna Kumari	Government MOHMS	Hospital Administrator - Labasa Hospital	
28	10.4.2025	Vakaruru Cavuilati	Government MOHMS	Divisional Health Inspector - Northern Division	
29	10.4.2025	Rapeka Vuniwawa	Government MOHMS	Divisional Health Information Officer - Northern Division	
30	11.4.2025	Reapi Wadali	Government MOHMS	Manager Performance Management Discipline	rtragigia@health.gov.fj
31	11.4.2025	Mr Vamarasi Fasala	Government MOHMS	Head of Ambulance & Blood Services	vamarasi.fasala@health.gov.fj
32	14.4.2025	Dr Mike Kama	Government MOHMS	Medical Superintendent - Tamavua Twomey Hospital	mnkama02@gmail.com
33	14.4.2025	Dr Sravaniya Dasi	Government MOHMS	Divisional Medical Officer - Eastern Division	sravaniya@gmail.com
34	14.4.2025	Dr Tevita Qoriniasi	Government MOHMS	Divisional Medical Officer - Central Division	tevita.qoriniasi@health.gov.fj
35	14.4.2025	Dr Daniel Faktaufon	Government MOHMS	Chief Medical Officer - Fiji Centre for Communicable Disease Control	dbfaktaufon@gmail.com
36	15.4.2025	Sr Sereani Kafoa	Government MOHMS	Director Of Nursing - Central Division	sereani.kafoa@health.gov.fj
37	15.5.2025	Sr Akosita Sukanaivalu	Government MOHMS	Director Of Nursing Eastern Division	akosita.sukanaivalu@health.gov.fj
38	15.4.2025	Mosese Koroitunidau	Government MOHMS	Divisional Health Inspector - Central Division	mosese.koroi@health.gov.fj
39	15.4.2025	Koto Sovita	Government MOHMS	Divisional Health Information Officer - Central Division	koto.sovita@health.gov.fj
40	15.4.2025	Jiosefa Draunidalo	Government MOHMS	Director Recruitment	jiosefa.draunidalo@health.gov.fj
41	15.4.2025	George Kasami	Government MOHMS	Manager Training	george.kasami@health.gov.fj
42	16.4.2025	Dr. Luke Nasedra	Government MOHMS	Medical Superintendent - CWM Hospital	
43	16.4.2025	Asena Raiwalui	Government MOHMS	Hospital Administrator - CWM Hospital	
44	16.4.2025	Sr. Luisa Wauca	Government MOHMS	Director Of Nursing - CWM Hospital	

#	Date	Name	MINISTRY	Position	Email
45	16.4.2025	Mereoni Gaunavinaka	Government MOHMS	Superintendent Medical Imaging Technology - CWM Hospital	
46	16.4.2025	Neelamba Devi	Government MOHMS	Lab Supervisor - CWM Hospital	
47	16.4.2025	Josifini Tuiloma	Government MOHMS	Physiotherapy Superintendent - CWM Hospital	
48	17.4.2025	Virisila Livicala	Government MOHMS	National Biomedical Coordinator	
49	23.4.2025	Dr. Rachel Devi	Government MOHMS	Head of Family Health	rachel.devi@health.gov.fj
50	25.4.2025	A. Kaure	Government MOHMS	Assistant Head of Executive Support Unit	akaure@health.gov.fj
51	30.4.2025	Lydia Andrews	Government MOHMS	Manager Clinical Governance	lydia.andrews@health.gov.fj
52	30.4.2025	Sheenal Singh	Government MOHMS	National Health Information Officer (M&E)	
53	2.5.2025	Luke Vonotabua	Government MOHMS	Chief Health Inspector	luke.vonotabua@health.gov.fj
Total		**53**			

Donors/Development Partners

#	Date	Name	DONOR/PARTNER	Position	Email
1	29.4.2025	Dr. Frances Bingwor	DFAT	Programme Officer Health	qinzhenginfiji@gmail.com
2		Tui Sikivou	DFAT	Health Programme Manager	
3	30.4.2025	Jane Anderson	MFAT	First Secretary	Jane.Anderson@mfat.govt.nz
4		Josefa Tabua	MFAT	Health Advisor	Josefa.Tabua@mfat.net
5	1.5.2025	Dr. Ammar Aftab	ADB	Health Specialist	aaftab@adb.org
6	5.5.2025	Dr. Mark Jacobs	WHO	Pacific Representative	jacobsma@who.int
7	6.5.2025	Dr. Titilola Duro-Aina	UNFPA	Chief of Health & Technical Advisor, SRHR	duro-aino@unfpa.org
8	7.5.2025	Yuki Suehiro	UNICEF	Chief of Health and Nutrition	ysuehiro@unicef.org
Total		**8**			

Non-Governmental Organisations

#	Date	Name	NGO	Position	Email
1	22.4.2025	Nilesh Reddy	Project Heaven Trust	MD	projectheavenfiji@gmail.com
2		Ms. Viniana	Project Heaven Trust	M&E Officer	
3	22.4.2025	Railala Nakabea	Medical Services Pacific	Country Director	country.director@msp.org.fj
4	23.4.2025	Patrick Morgan	Empower Pacific	CEO	patrick.morgam@empowerpacific.com
5		Mereisi Tavaiqia	Empower Pacific	Operations Programmes Manager	
6	23.4.2025	Dr. Pariksha Naidu	Fiji Dental Association & Commonwealth Dental Association	President	drpcnaidu@yahoo.com
Total		**6**			

Academia

#	Date	Name	University	Position	Email
1	25.4.2025	Dr. Akisi Ravono	University of Fiji	Nursing Coordinator	akisik@unifiji.ac.fj
2	25.4.2025	Dr. Dhirendra Lal Dr. Neil Sharma	College of General Practitioners	President	
3	25.4.2025	Sr. Eleni Kata	Sangam Nursing	Director of Nursing	eleni.kata@sit.ac.fj
4	30.4.2025	Dr. Samuela Korovou	University of Fiji	Deputy Dean Head of Public Health	samuelak@unifiji.ac.fj
Total		**4**			

ANNEX H: DISSEMINIATION WORKSHOP

MINISTRY OF HEALTH EVALUATION OF STRATEGIC PLAN DISSEMINATION WORKSHOP PROGRAM
WEDNESDAY 4th-5th June 2025

Day 1: Wednesday 4th June 2025

TIME	PROGRAMME	SPEAKER
8.30am-9am	REGISTRATION	Secretariat
9.am	Devotion	
9.05am	Official Welcome	Chairperson NESC
9.10am	Opening Remarks by Hon. Minister for Health	Hon. Ratu Atonio Lalabalavu
9.30am	MOHMS Strategic Plan Evaluation Project Overview	DM&E
10.00am	MORNING TEA	
10:30am	Evaluation Process and Findings	Dr. David Cownie Mr. Peter Zinck
11:30am	Core Findings by Indicators	Mr. Mosese Qasenivalu
11:50am	Gaps by Indicators for Strategic Plans	
12:30pm	Efficacy of Strategic Planning Process and Implementation • Health Services • Clinical • Primary/Public Health • Health Systems	Mr. Peter Zinck Dr. Temo Waqanivalu Dr. Akapusi Ledua
12:45pm-1:15pm	DISCUSSION	Facilitator
1:15-2pm	LUNCH	
2pm	Conclusion and Lesson Learned	Dr. David Cownie
2.30pm	Main Recommendations	Mr. Peter Zinck
2.30pm-3:30pm	DISCUSSIONS	Facilitator
3.45pm	End of Day 1	
	AFTERNOON TEA	

Day 2: Thursday 5th June

TIME	PROGRAMME	SPEAKER
8.00am- 8:30am	REGISTRATION	Secretariat
	Devotion	
8.30am	RECAP DAY 1	SIAPAC
8:45am	Group Discussions Overall Strategic Planning Process Preventive and Primary Health Care Clinical Services Health Systems	
11:00am	**MORNING TEA**	
11:00am- 1:30pm	Areas To Be Considered for New Strategic Priority	SIAPAC
	Discussion	
	WAY FORWARD **on recommendations**	
	CLOSING	
1:30pm- 2:30pm	**LUNCH**	

EVALUATION REPORT

Strategic Plans & Performance

2025

SIAPAC
Social Impact Assessment and policy Analysis Corporation
Your Partner in Development

MINISTRY of HEALTH & MEDICAL SERVICES
Shaping Fiji's Health