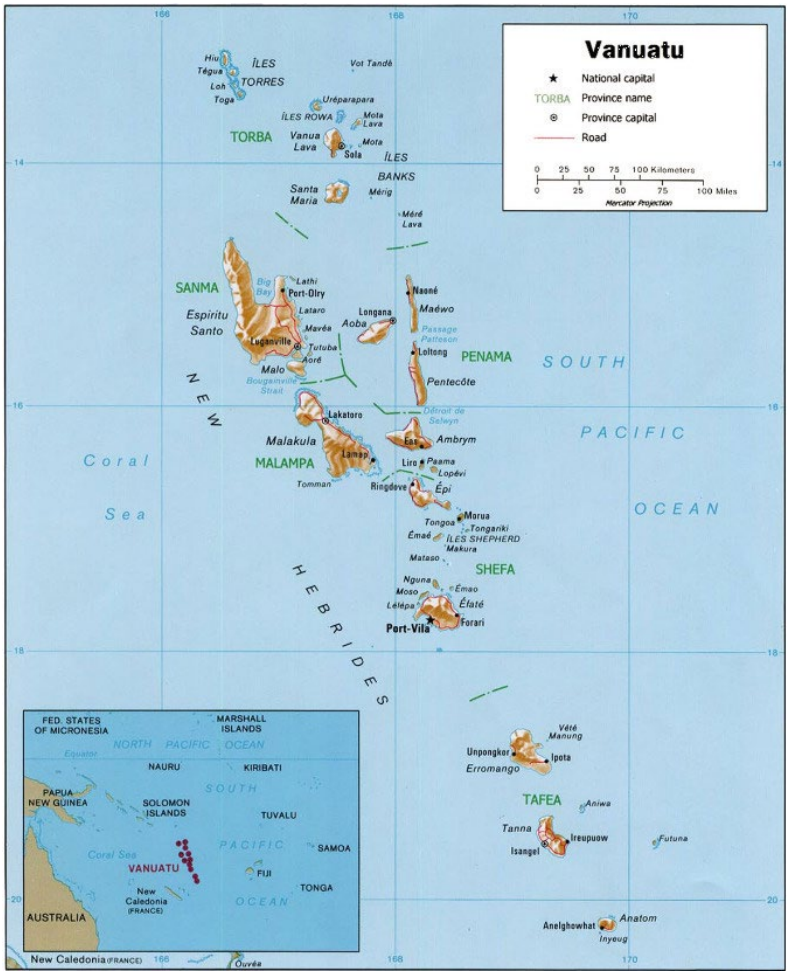
Mid Term Review Report
Vanuatu Australia Health Partnership (VAHP)
(formerly Vanuatu Health Program)

July 2023

Strategic input on health to the Australian Government

Specialist Health Service



[1]

Vanuatu is an island nation in the South Pacific Ocean, northeast of New Caledonia, east of Australia and west of Fiji.

The archipelago has a population of 319,137 (in 2021). The capital and largest city is Port Vila.

Vanuatu is divided into the six provinces: Malampa (capital: Lakatoro); Penama (capital: Saratamata); Sanma (capital: Luganville); Shefa (capital: Port Vila); Tafea (capital: Isangel); and Torba (capital: Sola).

Acknowledgements

The Review Team would like to acknowledge all stakeholders who have contributed to the Mid-term review process including representatives from across different parts and levels of Government. The Team was fortunate to have the opportunity to meet with a range of individuals across health and non-health sectors from high level decision-makers to personnel and partners, government and non-government, who are working at the front line of service delivery, planning and advocacy efforts.

The Review Team would like to sincerely thank the AHC Health Team who worked tirelessly to schedule and support consultations over a two-week period in April and ensure that a cross section of views would be captured and reflected in the final report and recommendations.

[1] https://www.nationsonline.org/oneworld/map/vanuatu-map.htm. Accessed on 12/05/23

Executive Summary

Introduction

The subject of this Mid-term review is the investment that was originally called the Vanuatu Health Program, a AUD25 million, five-year initial phase (2019-2024) of a 15 year investment, implemented by Managing Contractor, DT Global. The Vanuatu Health Program has significantly expanded in scale and scope since its original design and was rebranded and relaunched as the Vanuatu Australia Health Partnership (VAHP) just before the Mid-term review. The terms of reference for this Mid-term review were, however, specifically focused on the original AUD 25m investment that aims to support the leadership capacity of MoH staff and the delivery of essential health services.

VAHP was designed to have a problem-driven iterative adaptation (PDIA) approach to supporting Vanuatu's Ministry of Health (MoH) to effectively deliver the health components of the National Sustainable Development Plan (NSDP 2016-2030). It focuses on supporting MoH senior staff to lead continuous improvement processes and strengthen accountability across the health sector and on supporting key departments of the MoH to deliver more equitable, accessible and better-quality essential health services. The design of the original VAHP investment remains relevant and appropriate given health sector performance challenges and resultant inequitable and low levels of access to essential health care. Needs are pressing given the increasing burden of non-communicable diseases, continuing challenges with communicable diseases and sexual and reproductive health and the implications of climate change for the health sector.

The **purpose** of this Review is to assess the extent to which VAHP is on track to meet its objectives, as outlined in the 2019 Investment Design Document, and how the Program is contributing to the Vanuatu health sector. It also seeks to identify lessons and generate recommendations to strengthen investment design, logic, outcomes, implementation and management during the final two years of this first phase of VAHP as well as to inform future phases.

Implementation of VAHP started in September 2019 but, from early 2020, VAHP's planned activities were significantly impacted by needing to prioritise the dual crises of the global COVID-19 pandemic and Tropical Cyclone Harold. VAHP itself was a crucial asset to Australia during COVID-19 preparation and response and, thanks to relationships forged during the inception phase of VAHP and previous phases of DFAT support to the health sector, the VAHP team were a trusted partner of choice for the Government of Vanuatu (GoV). This was then echoed in the contribution that VAHP was able to make to Tropical Cyclone Harold recovery. There is no doubt that the goodwill and trust that VAHP generated during these periods has been, and will continue to be, foundational for its future work.

Findings

A significant early finding of the Review was the **absence of a results framework** for VAHP. The practical implications of this are that, beyond the broad foundations laid in the initial design document, the scope and level of ambition for the End Of Program Outcomes and for the Intermediate Outcomes were not subsequently defined and indicators for tracking and assessing progress against these Outcomes were also not agreed and used. The Review found that this lack of definition during early implementation, and resultant ambiguity regarding objectives, strategies and expected outcomes for VAHP has resulted in **limited understanding of VAHP's original 'intent' regarding supporting MoH leadership and strengthened delivery of essential health services**. A lack of understanding regarding what VAHP is trying to achieve, and the strategies it is pursuing, was found across all groups of stakeholders. There is additional confusion regarding the status of VAHP, as originally designed, relative to the significant additional investments subsequently funded by VAHP in response to COVID-19 and Tropical Cyclones Harold, Kevin and Judy.

The future effectiveness and efficiency of VAHP would, therefore, be enhanced by greater internal and external clarity on the above issues and clear communications to stakeholders on the same. Other benefits would then flow from this, including a clearer focus for GoV-VAHP policy dialogue and technical assistance and a subset of Direct Finance Agreement (DFA) resources more directly tailored to what it is aiming to achieve. Strategic annual work planning, that is logical and coherent programming of activities to meet clear and mutually understood and agreed development outcomes, would also benefit from greater clarity on VAHP's strategic intent.

Given, first, VAHP's role in responding to the dual crises and, second, ambitious design assumptions, the Review's assessment is that overall, relatively little progress has been made against VAHP's original EOPOs and IOs. Within the now much broader VAHP it is assumed that there is still, however, an intention to support MoH leadership and strengthened health systems for essential health service delivery. For this to succeed, this specific stream of work under the Partnership will need to maintain a profile, have a name/strapline (such as Provincial Essential Health Services) and be given explicit operational space and resourcing to ensure effective progress. The risk otherwise is VAHP not being able to demonstrate any meaningful contribution to sustainable health sector development for *essential health services* come the end of the fifteen year investment.

Despite challenges there are several positive findings from VAHP's implementation to date. One notable achievement has been **VAHP's effective engagement in the development of the MoH's Health Sector Strategy (HSS) 2021 - 2030**. VAHP, as a member of the HSS Steering Committee, provided high level support to MoH leadership, including advice that led to the establishment of an Inclusive Working Group and Inclusive Pillar in the Strategy itself. Unlike the previous health strategy, HSS is intentional in its focus on inclusion, equity and accessibility for all. As a member of the recently established Inclusive Health Committee, VAHP will have ongoing opportunities to support health inclusion. It is also planning to support the related forthcoming MoH Gender Policy and action plan.

VAHP has made progress incorporating **GEDSI considerations** and investment into the Partnership. In addition to specific small-scale activities aimed at survivors of Gender Based Violence and SOGIE (sexual orientation, gender identity, and gender expression) community inclusion, VAHP's Women In Leadership (WIL) training program is a relatively new, and potentially flagship, initiative. Its profile, sense of achievement and potential to both expand in scale and advance the inclusive leadership objectives of the HSS were highlighted by a range of stakeholders, including the MoH Executive and the Public Service Commission (PSC).

The Review found that VAHP has made a good start implementing its **Provincial Focus Strategy** and modelling provincial level working. A renewed and expanded focus on the Provincial level is strategic, given challenges at central MoH level, including the continuous turnover of MoH staff and the related difficulty progressing and sustaining systems strengthening and reform. VAHP has a strong Provincial team based in Santo that is supporting all Provinces. In Sanma Province specifically, they are supporting leadership on the ground and helping drive collaboration between the MoH, the Secretary General of Sanma and Provincial Government. This collaboration has led to local political commitment to, and leadership of, a pilot project in Tasmalum Area Council to tackle gaps in Primary Health Care (PHC). VAHP will provide support to tackle bottlenecks through local, provincial and national systems as an explicit bottom-up strategy to 'nudge' reform. The Review does, however, highlight the need for VAHP to clarify understanding regarding what the Pilot is actually trying to demonstrate, what success would look like and how progress will be monitored and measured. Without strategic planning and monitoring tools in place, there is a real risk of the Tasmalum pilot simply demonstrating that donor funds can improve service delivery but in ways that are neither sustainable nor replicable.

A significant strength of VAHP is that it is a **flexible and responsive** Partnership that is thinking and working politically and **supporting ni-Vanuatu leadership**. This is very much in keeping with VAHP design principles. Nonetheless, it is important to distinguish between VAHP responsively supporting MoH on a wide range of articulated requests across the sector, as and when they arise, and VAHP and MoH agreeing clear objectives for VAHP and the Partnership then supporting MoH adaptively and flexibly to achieve them. This requires both clarity on the objectives of VAHP and a refreshed understanding of the use of Adaptive Management.

The Review team understands that coordination of external support for the sector generally worked well during recent crises and that, for COVID-19 in particular, DFAT played a key role both in facilitating that coordination and supporting the World Health Organization (WHO) and UNICEF. However, the current **lack of coordination** of external support to the sector is apparent, resulting in duplication, funding gaps and inefficient use of significant levels of external resources that are often underspent as a result. This is then echoed in a lack of active governance arrangements for the sector, with, MoH governance arrangements for VAHP limited to a somewhat administrative, rather than strategic, Governance Advisory Committee (GAC). Lack of GoV coordination is compounded by limited informal coordination between health sector partners themselves. DFAT, ideally in conjunction with, or in support of, WHO could consider proactively progressing informal donor coordination.

Climate change considerations are not currently mainstreamed in VAHP[2]. Whilst there is evidence of local and traditional knowledge being utilised for climate change adaptation and resilience, especially at Provincial level, the review found a reactive, rather than proactive approach to climate change and disaster on the part of the health sector. There is lack of coordination around climate policy and an apparent lack of knowledge and experience at national and Provincial level regarding climate change health resilience, including forthcoming opportunities to access climate finance.

Recommendations

This report makes the following 21 recommendations in relation to the above findings.

Program Intent and Strategy
1. DFAT and VAHP to better articulate and communicate the intent of, and strategy for, VAHP's ongoing investment to support MoH leadership and strengthen the delivery of essential health services (i.e. the area of focus of this Mid-term review).
2. To facilitate engagement with GoV on strengthening essential health services (an area strongly related to, but also distinct within other streams of VAHP support – see Figure 3), this area of VAHP effort be given a recognised strapline/name and be given explicit operational space and resourcing to ensure effective progress.
VAHP Modalities
3. The results framework and the updated theory of change (recommendation 2) lead prioritisation of strategic VAHP technical assistance inputs and policy dialogue inputs, with a stronger Provincial focus for the technical assistance.
4. VAHP consider a greater physical presence in MoH to enhance policy influence (see also recommendation 10). The Direct Finance Agreement modality is addressed at recommendation 11.
PDIA approach
5. VAHP draw on relevant expertise to review their perceived and actual ways of working with adaptive management and PDIA, with a view to using the approaches more effectively.

[2] Potential frameworks for increased mainstreaming are DFAT's Climate Change Action Strategy and the Pacific Healthy Islands framework *Health Promotion International*, Volume 32, Issue 3, June 2017, Pages 549–557, https://doi.org/10.1093/heapro/dav094

Provincial Focus
6. A new Provincial Health Adviser/Facilitator position be recruited and based in MoH Corporate for greater presence in MoH and with specific responsibility to advise and support partner coordination, Provincial planning and budgeting and support the 'bottom-up' Provincial Focus Strategy (working in close liaison with VAHP's Provincial facilitators).
7. The Tasmalum Working Group urgently focus on the strategic intent of the Pilot - what it is trying to achieve and demonstrate, in particular in relation to decentralisation, health systems strengthening and GEDSI; how success is being defined; over what time period the Pilot will run; and how it will be monitored and reported.
Workforce Development
8. In close collaboration with the Public Service Commission (PSC) and the Vanuatu Qualifications Authority (VQA), VAHP build on current support to VCNE to scale up and prioritise broader support to Nursing as the Partnership moves into Phase 2.
9. In close collaboration with PSC and the VQA, VAHP increasingly support development of pre-training, and introduction of in-service training, for nursing cadres. This to include exploring the potential for virtual training and taking the opportunity to integrate GEDSI/Inclusive Health and climate considerations into relevant modules.
Health Sector Coordination
10. DFAT, ideally in conjunction with or in support of WHO, consider proactively progressing informal donor coordination. A first step might be to co-host with WHO a health partners catch-up with a view to institutionalising such catch-ups on a regular basis. As a minimum, DFAT to consider informally coordinating on a regular basis with the agencies to which it provides funding (WHO, UNICEF, UNFPA etc).
Direct Finance Agreement
11. Ways of working with DFA be reviewed with a view to making it more efficient. Several specific recommendations are proposed at the end of section 3.4.2 of the report.
GEDSI
12. Working closely with central agencies, VAHP expand Women in Leadership opportunities for nurses, including those at Provincial level, to support and model inclusive leadership.
13. VAHP to build on current program of work in GBV to support the establishment of a register of on-call health professionals that are equipped and trained to respond to GBV service demands during times of emergency which are a more frequent occurrence due to climate change.
14. If continuing GBV focus into next phase VAHP work collaboratively to expand current activities to pilot and monitor a comprehensive GBV service package including testing referral pathways and other MoH approved 'service ready' elements at Provincial level, with a view to scaling in the next phase.
15. As part of the Tasmalum pilot and together with the Tasmalum Working Group, explore opportunities for piloting disaggregated data collection and reporting as part of the overall demonstration activity.
Climate
16. DFAT and VAHP ensure VAHP- funded infrastructure, as well as building contractors, comply with DFAT safeguards and standards.
17. At relevant opportunities, VAHP include climate resilience in various health training programs**.**
18. VAHP broker its Provincial relationships to facilitate potential Global Environment Facility funding opportunities for health.
Monitoring and Evaluation
19. M&E and Adaptive Management expertise be urgently drawn into broader discussions of the future intent and strategies for VAHP. Outputs of that process should include an updated theory of change (complete with working assumptions) and a results framework that makes clear the level of ambition regarding what VAHP is trying to achieve and the indicators for monitoring progress against outcomes. Results frameworks also to be developed and agreed for the Women in Leadership and Tasamlum Pilot initiatives.
20. GEDSI considerations to be mainstreamed into the theory of change and results framework.
21. DT Global increase M&E TA support for the Program.

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Abbreviations

Abbreviation	Description
AHC	Australian High Commission
CSO	Civil Society Organisations
DFAT	Department of Foreign Affairs and Trade
DFA[3]	Direct Finance Agreement
DLA	Department of Local Authorities
DWA	Department of Women's Affairs
DG	Director General
EOPO	End of Program Outcome
GAC	Governance Advisory Committee
GBV	Gender based violence
GEDSI	Gender Equality, Disability and Social Inclusion
GEF	Global Environment Facility
GoV	Government of Vanuatu
HCW	Health Care Worker
HIS	Health Information Systems
HSS	Health Sector Strategy
HSSC	Health Sector Steering Committee
IHC	Inclusive Health Committee
IO	Intermediate Outcome
JPWG	Joint Partners Working Group
KEQ	Key Evaluation Question
MEL	Monitoring Evaluation and Learning
MFEM	Ministry of Finance and Economic Management
MTR	Mid-term Review
MoF	Ministry of Finance
MoH	Ministry of Health
NCDs	Non-Communicable Diseases
NDC	Nationally Determined Contribution
NPH	Northern Provincial Hospital
NSDP	National Sustainable Development Plan
NGO	Non-government organization
PDIA	Problem Driven Iterative Adaptation
PFM	Public Financial Management
PG	Provincial Government
PH	Public Health
PHC	Primary Health Care

[3] Variably referred to in VHP and MoH documentation as Direct Finance/Financing/Funding Agreement/Arrangement

Abbreviation	Description
PMO	Prime Minister's Office
PSC	Public Service Commission
PWD	People living with a Disability
RMNCAH	Reproductive maternal, newborn, child and adolescent health
SG	Secretary General
SOP	Standard Operating Procedures
SPC	The Pacific Community (formerly South Pacific Commission)
SRH	Sexual and reproductive health
STA	Short Term Adviser
TA	Technical Assistance
TWG	Technical Working Group
UHC	Universal Health Coverage
UNDP	United Nations Development Program
VAHP	Vanuatu Australia Health Partnership
VCA	Vulnerability, Capacity and Adaptation Assessments
VCH	Vanuatu Central Hospital
VCNE	Vanuatu College of Nursing Education
VCTP	Vanuatu Clinical Training Program
VHP	Vanuatu Health Program
VSP	Vanuatu Skills Partnership
VQA	Vanuatu Qualifications Authority
WHO	World Health Organization

1. Background and context

1.1. Introduction and objectives

The subject of this Mid-term review is the investment that was originally called the Vanuatu Health Program, a AUD25 million initial five-year phase (2019-2024) of a 15 year investment implemented by Managing Contractor, DT Global. The Vanuatu Health Program has significantly expanded in scale and scope since its original design and was rebranded and relaunched as the Vanuatu Australia Health Partnership (VAHP) just before the Mid-term review. The terms of reference for this Mid-term review were, however, specifically focused on the original AUD 25m investment that aims to strengthen the capacity of MoH staff and the delivery of essential health services. VAHP is designed to have a problem-driven iterative adaptation (PDIA) approach to supporting Vanuatu's Ministry of Health (MoH) effectively deliver the health components of the National Sustainable Development Plan (NSDP) 2016-2030. It focuses on supporting MoH senior staff to lead continuous improvement processes and strengthen accountability across the health sector and support key departments of the MoH to deliver more equitable, accessible and better-quality essential health services. VAHP's design is intended to shift DFAT's health sector support away from direct service delivery towards helping address systemic constraints such as leadership and accountability.

1.2. Health in Vanuatu

The NDSP aims to achieve a 'healthy population that enjoys a high quality of physical, mental, spiritual and social well-being'. This objective is pursued in the Health Sector Strategy (HSS) 2022 - 2030 which commits to progressing Universal Health Coverage (UHC) by ensuring more equitable distribution of Primary Health Care (PHC) services across the country.

1.2.1. Health challenges

Like other Pacific Island Countries, Vanuatu faces ongoing challenges with communicable/infectious diseases such as tuberculosis and leptospirosis[4] and with sexual and reproductive health, as well as increasing rates of noncommunicable diseases (NCDs), now the leading causes of adult morbidity and mortality. For example, over the period 2016 to 2018, the number of new cases of diabetes increased 200% in females and 536% in males[5] and in 2019 alone there were 61 associated, preventable, lower limb amputations[6]. While improvements have been seen in childhood immunisation and number of births supported by skills birth attendants, maternal mortality and under five mortality rates are considered unacceptably high. Around 45% of preventable deaths in newborns are associated with malnutrition[7] and one in five children experience stunted growth. Access to sexual and reproductive health services (SRH) and information is low[8] and there are high rates of teenage pregnancy and sexually transmitted infections. High rates of physical, sexual and gender-based violence (GBV) against women and children incur high personal, public health and social costs and there is a lack of appropriate services for survivors. The MoH aims to progress reproductive, maternal, newborn, child and adolescent health (RMNCAH) targets through strategic

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[4] https://apps.who.int/iris/rest/bitstreams/609639/retrieve#:~:text=HEALTH%20SITUATION,conditions%20affecting%20mothers%20and%20children. Accessed on 02/05/23

[5] https://documents1.worldbank.org/curated/en/289451643709153886/pdf/Dealing-with-Disasters-Analyzing-Vanuatu-s-Economy-and-Public-Finances-Through-the-Lens-of-Disaster-Resilience.pdf

[6] https://www.who.int/news-room/feature-stories/detail/vanuatu-caring-for-people-with-diabetes#:~:text=Sitting%20under%20the%20shelter%20of,are%20living%20with%20the%20condition. Accessed on 02/05/23

[7] Health Sector Strategy (2022 -2030), Vanuatu Ministry of Health.

[8] Spotlight Initiative, 201: Country Program Document: Vanuatu; Spotlight Initiative to Eliminate Violence Against Women and Girls; Suva

partnerships with key development agencies to deliver on the HSS and the RMNCAH Policy.[9] There are low levels of awareness of the special needs of people with disability among health service providers and, as a result, people with disability continue to experience challenges when accessing services and are not entitled to free health care despite unique vulnerabilities and risk of extreme poverty.[10] [11]

Vanuatu also faces climate change related challenges such as increases in infectious and mosquito borne diseases like dengue and malaria[12]. To highlight the significance of climate-related impacts, Table 1 shows the number of health facilities damaged by Tropical Cyclone Harold, the estimated monetary value of the damage of which was US$16 million[19]. Building a resilient and sustainable health system that can respond to future pandemics and natural disasters remains a key challenge for the Government of Vanuatu (GoV).

Table 1: Damage to health facilities caused by TC Harold[13]

Facility Type	Sanma	Penama	Malampa	Total
Aid Post	19	8	11	38
Dispensary	15	11	2	28
Health Center	6	4	3	12
Hospital	1	0	0	1
Sub-Total MoH Facilities	41	23	16	80
Administration	1	0	0	1
Total	**42**	**23**	**16**	**81**

1.2.2. Health sector management, planning and budgeting challenges

In addition to the Minister of Health, senior leadership at the MoH consists of the Director General and three Directors responsible for a) policy, planning and corporate services; b) public health; and c) hospitals and curative services. The MoH has experienced a number of leadership changes in recent years which impacts momentum progressing policy, programming and potential reforms.

At the time of VAHP design the three Directorates oversaw six hospitals, 35 health centres, 91 dispensaries and approximately 200 aid posts[14]. According to the Role Delineation Policy, 85% of facilities are in rural locations serving highly dispersed villages and local communities.

Ability to deliver quality, accessible and affordable health care to the people of Vanuatu is limited by factors that include inadequate operational budgets, lack of outreach services and health workforce issues. The latter includes shortages of skilled health workforce such as nurses and medical officers; challenges filling health posts in rural areas; lack of in-service training, supervision and support for health personnel; and absence of career pathways. There is limited formal government demand for

[9] Vanuatu RMNCAH Policy and Strategy (2021-2025), Ministry of Health
[10] UNICEF Pacific and Vanuatu National Statistics Office, Children, Women and Men with Disabilities in Vanuatu: What do the data say?, UNICEF, Suva, 2014.
[11] Vanuatu Health Program Investment Design (2018)
[12] https://climateknowledgeportal.worldbank.org/sites/default/files/country-profiles/15825-WB_Vanuatu%20Country%20Profile-WEB.pdf. Accessed on 05/05/23
[13] Analysing Vanuatu's economy and public finances through the lens of disaster resilience Republic of Vanuatu: Country Economic Memorandum and Public Expenditure Review. World Bank. 2021
[14] Workforce Development Plan (2019-2025), Vanuatu Ministry of Health

accountability and performance of the health sector, resulting in limited use of evidence for planning and budgeting

The health worker density in Vanuatu is low, resulting in closed or understaffed facilities and inequitable and inefficient health services. Further constraints include insufficient basic medical equipment and the poor state of health facilities. There is evidence of a relative under-provision of services in rural areas where the majority of the population lives[15]. Decentralising essential health services closer to people and scaling up integrated outreach for socially and geographically isolated groups are contingent on working with the Public Service Commission (PSC) to address key but intractable health workforce bottlenecks. MoH recruitment and retention targets, especially for registered nurses and midwives[14], are inadequate to serve even current population needs, let alone the changing needs of a growing population. Health workforce challenges are expected to increase, given projections for the increase in frequency and intensity of climate related events, such as floods, cyclones, storms etc. and their corresponding impacts on healthcare services.

Gender equality and equitable and inclusive development are central to the NSDP and the HSS. Whilst historically few women have occupied decision making or leadership roles, this situation is gradually improving within MoH. This trend will hopefully be sustained and lead to an increase in women's ability to influence sectoral policy and reform, for example, development of a harassment policy and confidential procedures for reporting and handling harassment[15]

Inefficient and inequitable budget allocations are further compounded by constraints on the overall health budget resulting from the economic impacts of the pandemic, ongoing supply chain challenges, high inflation rates and economic shocks linked to climate change[16]. In 2020, only 19% of domestic health expenditure was allocated to Community Health Services while hospital spending accounted for 50 percent of total health expenditure in 2020 (Table 2). Vila Central Hospital (VCH) consumed more than half of that total hospital expenditure and Northern Provincial Hospital 27 percent. Domestic expenditure on VCH was, therefore, greater than expenditure on all Community Health Centres. The paucity of the latter leads to limited funding reaching front line facilities, service delivery or outreach.

Table 2: Domestic health expenditure by administrative level (VT million)[18]

Administrative Level	2016	2017	2018	2019	May 2020
Hospital	835.5 (51%)	1030.9 (51%)	1345.9 (49%)	1329.3 (46%)	656.0 (50%)
Community Health Services (CHS)	288.7 (17%)	324.1 (16%)	498.8 (18%)	560.9 (19%)	232.2 (19%)
Central Support Services	218.7 (13%)	292.8 (15%)	458.3 (17%)	496.4 (17%)	161.3 (12%)
Central Medical Store	219.3 (13%)	224.7 (11%)	230.1 (8%)	260.1 (9%)	148.8 (11%)
Cabinet	64.4 (4%)	94.3 (5%)	99.8 (4%)	107.1 (4%)	37.1 (3%)
Public Health Programs (National)	25.9 (2%)	41.6 (2%)	102.79 (4%)	132.31 (5%)	43.9 (3%)
Total	**1,654.9**	**2,008.3**	**2,735.5**	**2,886.1**	**1,300.3**

Note: Represents health centers, health dispensaries, and administration/management of provincial health services.

Source: Financial Management Information System reports (2016 – May 2020)

In 2018, the average Bed Occupancy Rate for hospitals in Vanuatu was only 28 percent, indicating considerable inefficiencies in the hospital sector (occupancy rates in the vicinity of 70-90 percent are expected for hospitals). Hospital payroll, at around 81 percent of total budget in 2019, continues to crowd out operational expenses and payroll also dominates Community Health Service (CHS)

[15] Vanuatu Health Program Investment Design Document, 2019

[16] World Bank. Advancing UHC Annual report to DFAT 2022.

expenditure. In 2019, 84 percent of CHS expenditure was directed at wages, allowances and other personnel costs[17].

1.3. Overview of Australian health investments in Vanuatu

1.3.1. Bilateral, regional and global health programs

As illustrated in Annex 1, DFAT's overall contribution to the health sector is comprised of bilateral, regional and global investments. In FY 20/21 the DFAT bilateral health investment was AUD 11.09m but the overall DFAT health sector investment was approximately double that at AUD 21.08m[18]. DFAT also have a number of bilateral programs in other sectors with actual or potential linkages to health, including for example the Vanuatu Skills Partnership (VSP).

1.3.2. Lessons from previous DFAT health investments in Vanuatu

There have been various reviews of Australia's health sector support to Vanuatu. Main observations of a 2015 review included the following points, many of which remain relevant:

- DFAT's health sector support is fragmented and would benefit from clearer focus and sense of direction
- The balance of funding is too skewed towards hospital care when primary care offers more potential for cost-effectiveness and equity
- There is no overall focus on results
- Development partners should be more harmonised
- Program management concentrates by necessity on numerous administrative tasks, making it difficult to focus on important issues related to strategy and performance

Key lessons from a 2018 review leading into the design of VAHP included:

- Key determinants of health sector reform and improvement are factors outside the health sector itself related to the broader political, economic and social context
- In the absence of MoH coordination, Australia needs to be more proactive in its engagement across MoH to ensure internal linkages and coordination is undertaken
- The bilateral program includes a complex mix of investments with a recognised need for consolidated management, improved focus on results, strengthened gender and equity considerations and more coordinated ways of working. The results of Australia's broad-ranging support are 'sub-optimal, not value for money, and inefficient to manage'
- Australian support through regional and global programs has multiple MoH entry points and is not actively coordinated or directed by Post due to lack of time and lack of mechanisms
- Bilateral funding to WHO and UNICEF does not sufficiently draw on their comparative advantage or recognise global and regional core funding already being provided by Australia
- Technical Assistance (TA) is not structured towards capacity building outcomes, often substituting capacity and focused at central level
- Direct Finance Agreement (DFA) resourcing is operating in transaction mode rather than in a manner that creates opportunities for policy dialogue
- Supporting clinicians at VCH represents a 'free good' without consideration of the opportunity cost of that budget for the whole health system

[17] Analysing Vanuatu's economy and public finances through the lens of disaster resilience Republic of Vanuatu: Country Economic Memorandum and Public Expenditure Review. World Bank. 2021

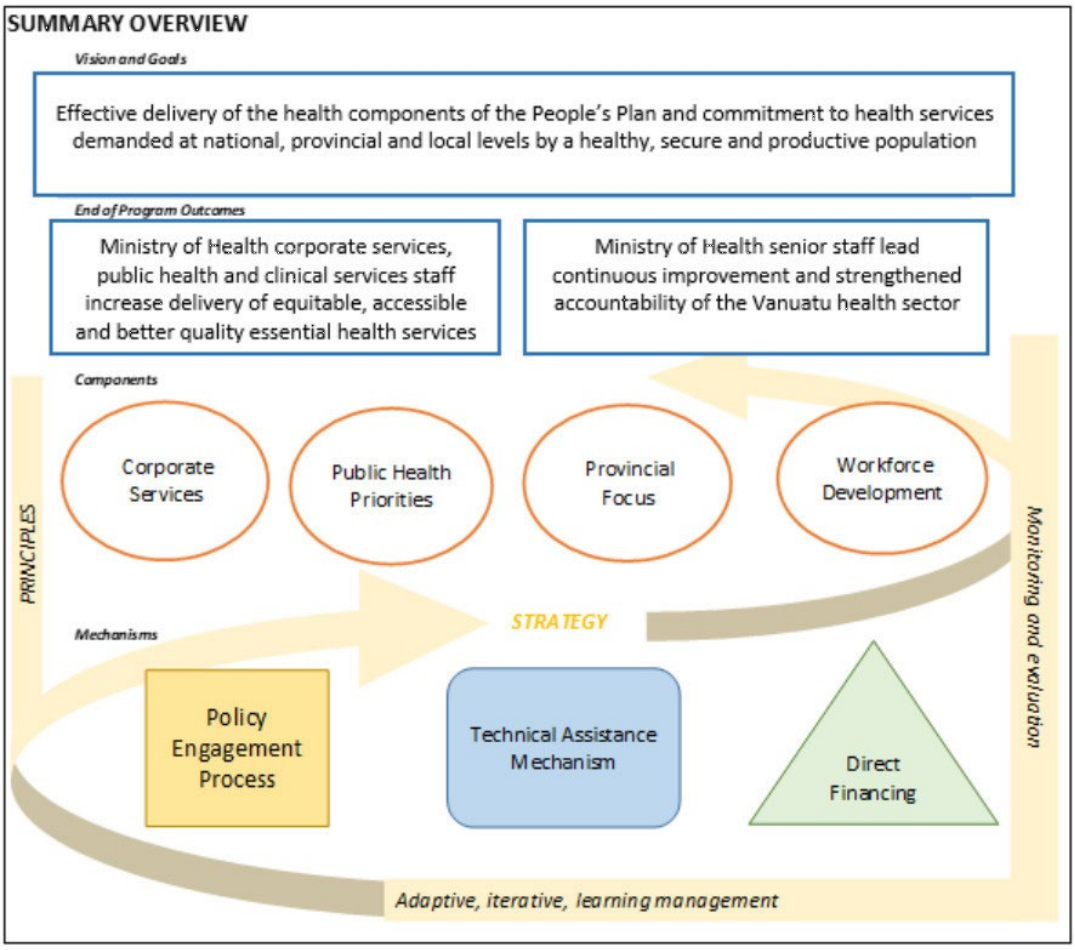
[18] Health in Vanuatu: Australia's Support. DFAT. July 2022

The VAHP design document states that support to the health sector over 25 years had yielded limited reform and that projects had provided external solutions rather than working at a pace of change and on priorities led by government. The example was given of the expensive gains made by donors to eliminate malaria from two provinces being at serious risk with the end of donor funding and the lack of systems or capacity to maintain services.

1.4. Overview of the Vanuatu Australia Health Partnership

The vision of the investment being reviewed, was to support MoH to deliver on the health components of the NSDP by responding to the needs of the population at all levels. The design structure from the VAHP Design Document is reproduced in Figure 1. The logic model from the same document is at Annex 2.

Figure 1: Overview of the original VAHP Design Structure



1.4.1 Intermediate Outcomes and core components

In addition to the agreed end of program outcomes (EOPOs) presented in Figure 1 above, the investment has four intermediate outcomes which correspond with core program components. These are described in Table 3.

Table 3: Intermediate outcomes and corresponding components

No	Intermediate Outcomes	Component
1	MoH leaders commit to and provide effective **health sector oversight** and enabling environment and engage effectively with central agencies e.g. PMO, MFEM).	Corporate services
2	MoH **public health** staff respond to community health priorities identified from evidence.	Public health priorities
3	MoH public health staff in selected **provinces** competently perform improved primary health care planning and delivery practices.	Provincial component
4	Vanuatu **medical workforce doctors and nurses** competently perform new clinical practices and management processes.	Workforce development

The **Corporate services** component focuses on provision of support to MoH to improve planning, asset and financial management. This component aims to support better use of evidence for policy and decision making and more efficient use of limited human resources at all levels.

The **Public health** component supports partner coordination, evidence informed planning and collaboration between MoH directors and central agencies to resolve institutional issues that weaken public health service delivery.

The **Provincial** component entails implementation of VAHP's Provincial Focus Strategy, which includes the health services delivery strengthening pilot project in Tasmalum Area Council, Sanma Province. The pilot aims to provide support to tackle bottlenecks up through local, provincial and national systems as an explicit bottom-up strategy to 'nudge' reform. The provincial component supports provinces to access and administer funding through the Direct Finance Agreement (DFA) which also provided significant support to the COVID 19 and TC Harold responses.

The **Workforce development** component aims to influence improved collaboration between MoH, the Vanuatu College of Nursing Education (VCNE) and VCH and support continuity of referral services through specialist locums at VCH and Northern Provincial Hospital (NPH). This component supports the delivery of improved health services through adoption of new clinical practices and management processes and support to VCNE (nurses and midwives).

1.4.2 Management and governance

The investment delivers support through (a) Direct Finance Agreement funding into GoV systems for all four components (56%), (b) Technical Assistance (TA) and facilitators working with MoH on program deliverables (10%) and (c) program support costs through DT Global (34%)[19]. Flexibility in the VAHP design has enabled the program to pivot as required to the operating context and emerging priorities. A Governance Advisory Committee (GAC) jointly chaired by MOH and DFAT decides on program activities and the strategic direction of VAHP.

From 2020 – 2022, VAHP's key activities included supporting MoH to maintain essential health services while also rolling out Vanuatu's National Deployment and Vaccination Plan for COVID-19 vaccines and preparing for and responding to COVID-19. VAHP's advice was apparently instrumental in GoV's timely decision to close international borders as the COVID-19 delta variant was spreading

[19] DFAT VHP MTR TORs

globally. Significant additional financial and human resources have been provided to MoH to combat the dual crises of COVID-19 and Tropical Cyclone Harold. VAHP's activities take place in all six provinces. A health check and strategic review of VAHP conducted in 2021 by DT Global informed a DFAT decision to extend the program for another two years. Phase 1 of VAHP will end in September 2024. DT Global undertook a follow up health check in 2022.

1.4.3 Timeline of key events

A timeline at Annex 3 highlights key activities and events from January 2019 to March 2023. The timeline demonstrates that VAHP established early engagement with MoH on the HSS through their involvement in the HSS Steering Committee. The timeline also shows momentum on GEDSI from the early stages of the Program to the involvement of the GEDSI coordinator in the Inclusive (technical) Working Group for the drafting of the HSS.

2. Approach and methodology

2.1. Purpose and scope

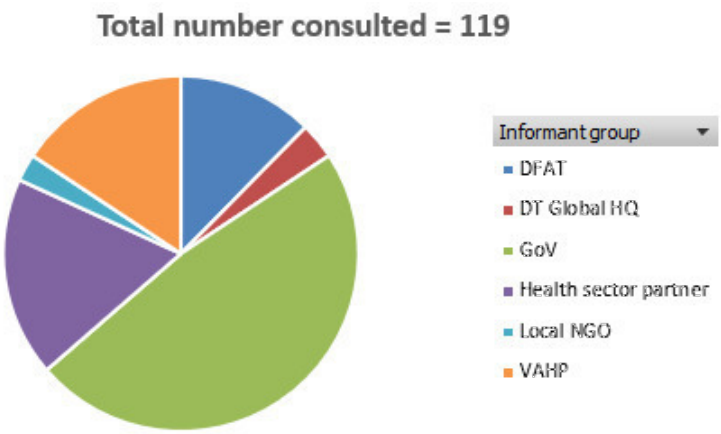
The purpose of this Review is to assess the extent to which VAHP is on track to meet its outcomes and how it is contributing to the Vanuatu health sector. The MTR team composition and Terms of Reference (TORs) are included at Annex 4 and Annex 5. The scope of the MTR TORs was the investment as defined in the original Vanuatu Health Program Investment Design Document. More recent VAHP investments (COVID-19 and disaster response activities, including infrastructure) were agreed as out of scope for the MTR.

2.2. Methodology and data collection

2.2.1. Document review and Review Plan

For the desk review, grey literature was sourced primarily through SHS and DFAT Post and publicly available literature. Documents reviewed are listed at Annex 6. The desk review assisted in mapping the policy environment, GoV and development partner investments and activities in health.

Figure 2. Numbers consulted by informant group



2.2.2. Consultations

The MTR team conducted key informant interviews and focus group discussions with 119 individuals including over 50 GoV representatives (Figure 2). A full consultation list is in Annex 7. The Review team were impressed with the cooperation and engagement of in-country GoV and other stakeholders consulted as part of the Review, including highly committed staff working in a range of organisations in Sanma, Penama and Shefa Provinces. Key informant interviews were semi-structured and guided by the KEQs.

2.2.3. Data analysis

Data validation session and Aide Memoire. At the end of the in-country mission, a wrap up session was held with DFAT Post to discuss initial findings of the Review. These findings were subsequently submitted in a written Aide Memoire that was further discussed and approved by DFAT.

Analysis and synthesis of evidence. A data analysis matrix was used as a framework to guide this stage of the MTR and to support identification of emerging themes and data gaps which informed further consultations and additional informant interviews. The national consultant on the Review team played an important role in helping to interpret data through their in-depth knowledge of the health system and political economy.

2.2.4. Limitations and changes to methodology

- As VAHP did not routinely report progress on the IOs and towards the EOPOs, the MTR Team did not have access to a clear set of key performance indicators, baseline data or trend data
- The depth of analysis undertaken by the MTR team was limited by the availability of data collected and reported by the MoH Health Information System and VAHP
- To the extent possible, information was triangulated to strengthen reliability but the MTR was not tasked with verifying the accuracy of quantitative and qualitative program-related data.
- Economic analysis of efficiency and value for money was beyond the scope of the MTR

2.2.5. Ethical Considerations and Safeguarding

As the MTR is not a research exercise the MoH authorised it to proceed without ethics applications and approval. Key informants were informed of the purpose, methods and intended use of the MTR at the commencement of interviews or focus group discussions. The national development adviser briefed the Review team on relevant cultural, safeguarding and access considerations.

3. Findings and analysis

3.1. Key achievements

VAHP has demonstrated a strong commitment to supporting MoH deliver on its priorities and vision for quality, equitable, accessible health services. This is evidenced in the program's engagement at both the national level, for example HSS engagement, and provincial level, for example partnership with Provincial Government. VAHP's contributions and ways of working with MoH were widely acknowledged during consultations.

Following a series of targeted GEDSI consultations and a desk-based review in year 1, VAHP developed its Inclusive Health Strategy early in implementation (see Annex 3). The VAHP GEDSI team have continued to demonstrate their commitment to work both adaptively and politically in an often challenging operating context. The COVID-19 response, for example, included use of available data to ensure vaccines were available to people with disabilities (PWD). Work has subsequently extended to GBV awareness training, targeted support to the SOGIE (sexual orientation, gender identity, and gender expression) community and advisory support that led to an inclusive health pillar in the HSS. A Women in Leadership (WIL) initiative is supporting MoH commitment to a more

inclusive leadership approach and is an example of the gains that can be made through collaboration.

VAHP has established a strong provincial team tasked with implementation of its Provincial Focus Strategy and modelling provincial level working. In Sanma the team is working with the DFAT-funded VSP to support leadership and drive collaboration between Provincial Government and Provincial MoH staff. The formal Tripartite Agreement and partnership between VAHP, VSP and the Provincial Government demonstrates VAHP's willingness to work strategically and learn from the experiences of another locally-driven and politically-responsive program. There is local political commitment to the Tasmalum Pilot and local governance structures, which together are leading to preliminary problem identification and solution analysis for PHC bottlenecks at the pilot site. With continued commitment to multi-sectoral collaboration, clarity on what the pilot is trying to achieve and clear M&E, the pilot has potential to demonstrate learnings that could inform service delivery models at PHC level.

On **health workforce**, VAHP continue to fund VCH locums through the Direct Finance Agreement, DFA, but have transitioned them from Australian contracts to MoH contracts and Ministry of Finance systems. Meanwhile, with support from a VAHP funded Quality Audit Officer, VCNE is advancing efforts for its own re-accreditation.

Whilst opportunity for greater efficiency and effectiveness are evident and discussed throughout the report, the VAHP team is commended for being as adaptive and responsive as they have been and the next 18 months will be an opportunity to further develop the potential of the Partnership.

3.2. Effectiveness

3.2.1 Program Intent and Strategy

The Vanuatu health sector is crowded with fragmented and uncoordinated development partner inputs. The Review found many stakeholders (including MoH, WHO and other UN agencies, and even some VAHP staff) had limited understanding of what the original VAHP AUD 25m investment is trying to achieve and the strategies it is pursuing with respect to supporting MoH leadership and strengthened essential health services. This is in large part because, beyond the broad foundations laid in the initial design document, the scope and level of ambition for the End Of Program Outcomes and for the Intermediate Outcomes were not subsequently defined, plus indicators for tracking and assessing progress against these Outcomes were not agreed and used. There is additional confusion regarding the status of VAHP, as originally designed, relative to the significant additional investments subsequently funded by VAHP in response to COVID-19 and Tropical Cyclones Harold, Kevin and Judy. Much of the latter investment is in infrastructure and it has clearly shifted the focus of VAHP engagement away from the original VAHP agenda of supporting MoH leadership and strengthened delivery of essential health services through Adaptive Management approaches. During many Review consultations it proved difficult to engage stakeholders in discussion on the intended strategic content of VAHP, flagging missed opportunities to progress the intended development agendas of the original (and ongoing) investment.

Nonetheless, within the now much broader VAHP, is it assumed that there is still an intention to support MoH leadership and strengthened health systems for essential health service delivery. For this to succeed, this specific component of the Partnership will need to maintain a profile, have a name/strapline (such as Provincial Essential Health Services) and be given explicit operational space and resourcing to ensure effective progress. The risk otherwise is VAHP not being able to demonstrate any meaningful contribution to sustainable health sector development for *essential health services* come the end of the fifteen year investment.

The effectiveness and efficiency of VAHP would be significantly enhanced by greater internal and external clarity on its intent. Other benefits would then flow from this including clearer strategies for supporting GoV to deliver VAHP outcomes; a clear focus for policy dialogue between GoV and VAHP; technical assistance and Direct Finance Agreement (DFA) resources more directly tailored to agreed VAHP outcomes; and more coherent annual work planning to ensure logical and coherent programming of activities that support the achievement of VAHP outcomes.

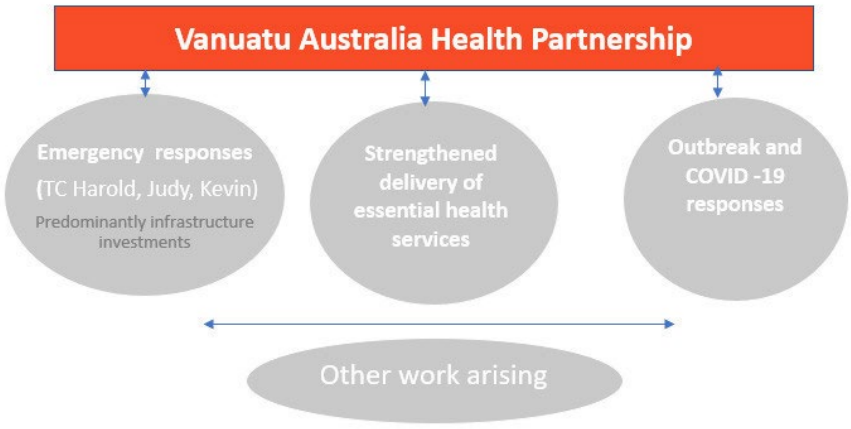
This finding and related recommendations would benefit from further consideration before the significant TC Harold infrastructure response begins implementation.

Recommendations: Intent and Strategy

1. DFAT and VAHP to better articulate and communicate the intent of, and strategy for, VAHP's ongoing investment to support MoH leadership and strengthen the delivery of essential health services (i.e. the area of focus of this Mid-term review).

2. To facilitate engagement with GoV on strengthening essential health services (an area strongly related to, but also distinct within other streams of VAHP support – see Figure 3), this area of VAHP effort be given a recognised strapline/name and be given explicit operational space and resourcing to ensure effective progress.

Figure 3: VAHP areas of support, noting strong linkages amongst them.



2.2 Overview of progress towards Outcomes

A program's theory of change and results framework should provide a line of sight to the EOPOs and IOs and support reporting to DFAT on progress towards outcomes. A significant early finding of the Review, however, was the absence of a results framework for VAHP. As a result, the scope and level of ambition for the EOPOs and the Intermediate Outcomes have never been defined. Similarly, indicators for tracking and assessing progress towards the outcomes have not been defined and agreed and the proposed theory of change in the 2019 design document has not been updated.

The Review was not, therefore, able to draw on any routine data or reporting on progress towards outcomes. The Review was also not in a position to collect primary data and there is limited routine MoH reporting. Ambitious yet ill-defined intentions for VAHP, together with contextual challenges, have inevitably limited determination of its effectiveness but Annex 8 provides a summary of the

Review team's sense of progress towards the EOPOs and IOs. Further findings on M&E and recommendations for the future M&E are provided in section 3.7 below.

3.2.3 VAHP and COVID-19

The absence of an agreed results framework for monitoring progress towards outcomes in the first three years of VAHP implementation is in part due to the dual crises of COVID-19 and Cyclone Harold that unfolded within a few months of VAHP becoming operational. These events interrupted inception processes, shifted priorities and proved to be both an opportunity cost and an opportunity for VAHP.

Due to relationships established under VAHP and under previous phases of DFAT support to health, the VAHP team were a trusted partner of choice for GoV during COVID-19 and VAHP was a crucial asset in Australia's support to COVID-19 preparation and response. While assessment of VAHP support for MoH on COVID-19 is outside the scope of this Review, feedback on this from consultations was extremely positive. Similarly, stakeholders were equally positive about VAHP's contribution to the immediate recovery phase of TC Harold. Key lessons from the dual crises were the importance of having a presence on the ground and a willingness to be flexible and responsive, including having flexible modalities such as the DFA (Direct Finance Agreement). There is no doubt that the goodwill VAHP generated during these periods has been, and will continue to be, foundational for its future work as it focuses back on the intent of the Partnership as originally designed.

The demands of COVID-19 drove GoV coordination of development partners and improved coordination among partners themselves. Efforts to maintain momentum on coordination in current 'COVID normal' times are proving unsuccessful. Similarly, improvements seen in surveillance in the context of COVID-19 appear to be waning with respect to leptospirosis, malaria and other identifiable diseases. Such examples highlight the challenge of sustaining systems strengthening in the Vanuatu health sector.

3.2.4 Assumptions underpinning VAHP design

The VAHP design included a set of assumptions that would need to hold true for the Program to achieve its outcomes. Ideally, assumptions should be reviewed and refreshed annually to inform strategic planning. If this has been happening for VAHP, it does not appear to have been formally captured. The VAHP MEL Strategy (June 2021) acknowledges the importance of reviewing assumptions but makes no reference to VAHP's own assumptions. The MEL Strategy presented a new theory of change with no assumptions cited (it should be noted that the Review team were briefed by VAHP that that theory of change did not in fact supersede the theory of change in the Design). There is a fleeting reference in the 2021 annual report to some key assumptions not holding but the 2022 annual report does not make explicit reference to program assumptions.

The Review identified the following findings related to the assumptions:

Assumption 1. MoH leaders are ready to provide effective health sector leadership and enabling environment. The need for greater leadership was part of the rationale for the Program design. At any given time there will always be effective leaders in the overall constellation of MoH Executive and management and VAHP is ready to support such leadership. The constant turnover of MoH staff at management level is a significant constraint to supporting leadership. This appears to be less of an issue at Provincial level which points to greater prospects of VAHP success (see section 3.3.9).

Assumption 2. Government of Vanuatu maintains health sector funding as % national expenditure. This assumption has held. While the proportion of total government budget allocated for health has stagnated (10% in 2010, 8% in 2018, 7% in 2020, 9% in 2021), real per capita expenditure on health (in 2020 US$) has risen from $106 in 2010 to $114 in 2022[20].

Assumption 3. MoH staff are ready to adopt new practices, using new sytems and deliver priority services to their community clients. There has been limited adoption of new practices and systems at the national level. Potential readiness at the Provinical level meanwhile is largely untested because it is somewhat stymied by the inadequacy of operational budgets to actually deliver services. The Tasmalum Pilot is a relevant response in this context, aiming to demonstrate what can be achieved through a combination of financial resources and committed local government and MoH staff.

Assumption 4. MoH and GoV central agencies such as the Prime Minister's Office and Ministry of Finance and Economic Management are ready to engage in effective policy engagement through the Health Sector Steering Committee (HSSC). This assumption has not held. There is an absence of coordination of external inputs and the HSSC is non functional.

Assumption 5. MoH and all development partners are ready to use Joint Partners Working Group (JPWG) and HSSC to agree resource allocations and performance priorities across all their Vanuatu health interventions. This assumption has not held. Neither the JPWG nor the HSSC are functional. The Review found that development partners express a desire for coordination and yet coordination amongst themselves is in practice also lacking.

Assumption 6. MoH and all development partners are willing to use information and analysis to set priorities and interventions. The HSS has not led to altered government plans and budgets. There is limited MoH reporting and MoH plans and budgets are not evidence based. It is not possible to assess the extent to which other partners would use information and analysis were it available. VAHP is programming its own support to align with the NDSP and HSS.

Assumption 7. DFA, WHO, UNICEF and other resources are allocated annually by MoH with HSSC advice and support. Given HSSC is non-functional, DFA resourcing is agreed by the Governance Advisory Committee. It is understood that WHO and UNICEF funding decisions are made by DFAT[21].

In conclusion, the some of the underlying assumptions that informed the design were optimistic about leadership, coordination, analysis and evidence-based planning and budgeting. In section 3.7.3 it is recommended to downgrade the level of ambition regarding EOPO 2.

3.2.5 Principles underpinning VAHP

The design highlighted five working principles for VAHP which are:

- Build on successes and past investment
- Government-led internally driven reform
- Problem driven, iterative and adaptive approach
- Capacity development rather than substitution
- Integrated gender equality and social inclusion

[20] World Bank. Advancing UHC Annual report to DFAT 2022. Unpublished.

[21] Noting that the WHO reform agenda favours core funding of country offices through Geneva.

A comprehensive 2018 Design Strategy and Options Paper ensured that VAHP built on the **lessons and successes of previous investments** and it is important that these previous lessons are not overlooked (see section 1.3.2 for summary of lessons). The Review found that during regular implementation VAHP has worked hard to adhere to **government-led internally driven reform** and a **PDIA approach**. Whilst the demands of COVID-19 brought back a substitution imperative, with only a few exceptions (for example TA to the Asset Management Unit in MoH), there has been a **shift away from substitution into capacity development**. Finally, VAHP has made good strides in increasing **integration of GEDSI** considerations in its work. In summary, apart from pragmatic adaptations in times of crisis, the principles have been upheld and continue to be reflected in VAHP's ways of working. Some specific recommendations on the PDIA approach are made in section 3.3.8.

3.2.6 Effectiveness of VAHP modalities

During the Review consultations, MoH indicated significant appreciation for VAHP's approach to working with them. VAHP staff are considered accessible, with Provincial Health Managers relaying how easy it is to call VAHP staff and address any problems. MoH also welcome the flexibility of VAHP workplans and consider VAHP a trusted partner. The three main VAHP modalities are technical assistance, policy dialogue and DFA. This section outlines Review findings on each of these modalities:

Technical assistance

The Review found technical assistance (TA) inputs to be ad hoc and lacking in coherence. This finding is apparent in the 2023 Workplan and result from the above-mentioned lack of strategic planning and programming. Some of the challenges with respect to TA include:

- TA inputs should align with the outcomes of the Program and its agreed strategies. However, in the absence of a working version of a theory of change there is a disconnect between the inputs and the expected outcomes of VAHP. This allows for the apparent ad hoc advisory inputs currently seen.
- Several Short Term Advisers (STA) with a demonstrated track record of making strategic inputs to VAHP appear to be being underutilised relative to VAHP's needs
- Advisers across the Program seem to be operating in silos rather than operating as one team with joint objectives. The Review found several examples of advisers being unaware of work happening beyond their own responsibilities and of lack of familiarity with the overall 2023 VAHP Annual Workplan
- Some interviewees felt that TA is overly focused at the central MoH level
- The current Public Health LTA is about to leave. This, however, provides an opportunity to revise priority TA in line with VAHP

Policy dialogue

Policy dialogue is engagement that supports the government consider and address complex problems and it requires strong relationships plus subject matter expertise. For VAHP, policy engagement and dialogue need to align with the overarching program strategy. There would also be benefit in greater clarity regarding DFAT and VAHP's respective roles in policy engagement. Across development partners there is currently a lack of technical policy engagement with MoH Corporate, including with the Policy and Planning Unit which should be the engine room of policy, planning and budgeting. With the departure of the World Bank from the health sector, it is not clear who will continue budget analyses and advocacy, for example for more equitable and efficient budget allocations between hospitals and community health services and between payroll and operational budgets. Using health financing policy as an example, the Minister of Health (recently departed and since replaced) told the Review team he would like to increase user fees at health centres to reduce

GoV subsidies for healthcare. Other stakeholders indicated a desire to introduce social health insurance. Both are key policy issues which, if enacted, could further undermine equitable access to PHC.

There is also need for strategic and coordinated engagement on NCDs, including reframing NCDs as a development issue, economic issue and climate issue (rather than just as a health promotion issue). Unless there is resistance for such engagement from MoH, there is opportunity for VAHP to scale up its engagement on such issues with 'just-in-time' strategic discussions, analyses, think pieces etc. VAHP purposefully moved out of MoH into its own office to facilitate the transition away from substitution. However, several stakeholders indicated VAHP needs a greater physical presence in MoH to be influential, even if that entails a split model working between MoH and its own office (as is the case with VESP, the Vanuatu Education Support Program).

Direct Finance Agreement[22]

DFAT has been using Direct Finance to support the health sector for many years. This mechanism has proved a durable and effective way of maintaining funding flows. DFA provides flexible funding and supports capacity building by being channeled through MoH/Ministry of Finance (MoF) plans, budgets and Public Financial Management systems. Although MoH is accountable for management of the DFA and delivery of its activities, DFA is not Sector Budget Support (despite being described as such in some documents), given it is ringfenced for very specific activities and GoV does not have full discretion over its use.

The various streams of DFA resources under VAHP are highly valued by GoV at National and Provincial level. The DFA enables access to much needed supplementary budget. However, the high transaction costs of accessing DFA resources is a source of considerable frustration for GoV. Further findings on DFA plus recommendations for its use are included under the Efficiency section at 3.4.

Recommendations: VAHP Modalities

3. The results framework and the updated theory of change lead prioritisation of strategic VAHP technical assistance inputs and policy dialogue inputs, with a stronger Provincial focus for the technical assistance.

4. VAHP consider a greater physical presence in MoH to enhance policy influence (see also recommendation 10).

The Direct Finance Agreement modality is addressed under Efficiency at recommendation 11.

3.2.7 Effectiveness of governance arrangements

As mentioned at 3.3.4 above, as the Vanuatu health sector normalises after the acute phase of the pandemic, there are proving to be a lack of effective sector governance processes, particularly at the **national level**. Governance arrangements anticipated at design, including the annual Joint Partner Arrangement, the Joint Partners Working Group and the six-monthly Health Sector Steering Committee (comprising MoH, DFAT and development partners) are not functioning. Their absence represents missed opportunities for coordination and policy dialogue with GoV and other relevant stakeholders. Governance arrangements for VAHP with the central MoH are currently limited to the Governance Advisory Committee (GAC) between MoH, DFAT and VAHP (TORs attached at Annex 9). Minutes of GAC meetings suggest a largely transactional focus on administrative and management

[22] Variably referred to in VAHP and MoH documentation as Direct Finance/Financing/Funding Agreement/Arrangement.

issues, including decisions on DFA allocations. It is not apparent that the GAC requires DFAT engagement and consideration could be given to VAHP alone holding these routine quarterly governance meetings with MoH. DFAT could join a supplementary 'GAC Strategic Meeting' with more focus on policy and VAHP outcomes (rather than activities) at six monthly intervals.

Governance arrangements at the **Provincial level** are still being finalised (see section 3.3.9 below). At the national level, there is proposed to be a (Provincial) policy reference group for VAHP Provincial work, comprising MoH Director General (DG), DG of Internal Affairs, Secretary General (SG) Sanma, VAHP and VSP. This reference group will be crucial for bringing Provincial and Tasmalum agendas back to the national level to 'nudge' progress on bottlenecks. Any updates from SG Sanma/MS NPH to the GAC could be extended to a broader stakeholder audience of those also operating at the Provincial level.

In terms of governance for the Tasmalum pilot, there is an existing Tasmalum Health Committee although it is understood that Sanma health committees met only once last year (2022). Consideration is being given to whether Area Council Committees should replace health committees and WHO is engaging on the regulatory changes that would entail. Quarterly meetings between the 11 Sanma Area Councils, including Tasmalum, have apparently not occurred. There is a Tasmalum Working Group (TWG) whose membership is VAHP, VSP, Provincial Health Manager, and Secretary General (SG) Sanma (chair). All TWG members are members of the Provincial Technical Advisory Group (PTAG), also chaired by the SG. PTAG has a broad membership across various government sectors and departments but there is a need to broaden membership to include relevant development partners and non-government organisation representatives operating at the provincial level.

3.2.8 Effectiveness of the PDIA approach

A significant strength of VAHP is that it is a flexible and responsive Program that is thinking and working politically and supporting ni-Vanuatu leadership, both in government and within its own management. The flexibility of VAHP plans, and of DFA resourcing in particular, was repeatedly acknowledged during consultations, including by the MoH Executive. A current example of flexibility, with a clear line of sight to overall intent, is VAHP's efforts to support VCNE's unanticipated needs for reaccreditation.

However, the Review found there is a need to distinguish between VAHP being responsive to MoH on a wide range of requests across the sector, as and when they emerge, and VAHP and MoH agreeing clear overall outcomes and annual outputs for the Program and then VAHP supporting MoH adaptively and flexibly to achieve those outcomes using an Adaptive Management approach.

> *Adaptive approaches 'need to set out a **clear end goal**, hypotheses for how to achieve that goal(s) and a strong approach to evidence-building and decision-making to test whether those hypotheses are valid or not.'*[23]
>
> *Adaptiveness, or what is now called Adaptive Management, is about more than just flexibility, however: it involves intentionally setting up processes to test approaches, generate learning and then adapt based upon this information.*[24]

Extensive literature on adaptive programs states that because greater flexibility is a design objective, it is important to guard against the program being asked to do everything and losing strategic

[23] ODI. Top Tips: How to design and manage adaptive programs. 2016

[24] Opportunities and challenges for DAC members in 'adapting to context'. ODI. Samuel Sharp, Leni Wild. 20 March 2021

focus[25]. One technique to do this is to have specific and precise investment criteria for all new activities and strong, inclusive internal contestation of what will and will not be funded.

Within various Adaptive Management approaches, the PDIA approach is distinguished by its relentless focus on a specific problem and an approach that makes many small 'bets' on tackling that problem, learning and adapting as it goes.[26] A PDIA approach is most relevant, therefore, in contexts where there is a strong appetite for change and a range of ideas to be backed and tested regarding how to achieve that change. The DFAT Governance for Growth program in Vanuatu is using Adaptive Management, working with government leaders with a desire for reform. PDIA may, however, be less appropriate in the Vanuatu health sector context, particularly at national level. Even at the Provincial level it is not clear that PDIA is being used experimentally to simultaneously back multiple 'bets' (funding one Pilot with uncertain prospect of success cannot be equated with PDIA). The PDIA approach being understood as 'peoples' story' and a 'local problem – local solution' approach are locally appropriate interpretations but may at the same time be insufficient interpretations of the potential of a PDIA approach. VAHP's pursuit of a PDIA approach is driving the program M&E focus in a way that is heavily focused on activities and process rather than on outcomes and impact. It has also resulted in a misunderstanding that intent and outcomes do not need to be defined when in fact the experimentation and adaptation under a PDIA approach means clarity of overall intent is particularly important.

Adaptive Management is only likely to work where there is a high degree of trust between donor and managing contractor. The nature of the contract between the donor and managing contractor has been found to be one of the most significant constraints on effective Adaptive Management[27]. In an Adaptive Management environment, good practice is for the donor to hold the contractor accountable for output and outcome level achievements and not to have a micro-focus on inputs and activities. Success also entails:

- High levels of budgetary delegation
- High levels of delegation to teams regarding activity-level decisions
- High levels of delegations to teams to manage local relationships/networks
- Budgets allocated to high level outcomes with internal management authorised to quickly shift funds based on the political context and performance of initiatives (against a clear set of criteria)[28]

[25] Teskey, G., & Tyrrel, L. (2021). Implementing Adaptive Management: A front-line effort — Is there an emerging practice? (Working Paper). Abt Associates.

[26] Teskey, G., & Tyrrel, L. Implementing Adaptive Management: A front-line effort — Is there an emerging practice? (Working Paper). Abt Associates. 2021.

[27] Ibid

[28] Ibid

Recommendation: PDIA

5. VAHP draw on relevant expertise to review their perceived and actual ways of working with Adaptive Management and PDIA with a view to using the approaches more effectively.

3.2.9 Provincial Focus and Workforce Development Components

This section assesses two of four VAHP Program components: Provincial Focus and Workforce Development, as per the original design. The other two Components, Corporate Services and Public Health, are addressed more generally throughout this report. Further discussion and reflection on the Provincial Focus and Workforce Development is warranted given the findings from the Review.

Provincial Focus Strategy

The Provincial Focus Strategy (PFS) aims to support Provincial Governments and Provincial Health to deliver on UHC commitments in line with the Decentralisation Plan 2017-2027 and the HSS. Through a facilitation plus funding model, VAHP support provincial partners to better understand and resolve service delivery bottlenecks and facilitate communication and cross sectoral collaboration. This is in the context of a changing landscape of responsibility and management, for example, DLA appointments of area administrators. Recent DLA changes provide an opportunity for interrogating new ways of working at, and between, provincial and national level. The PFS is complemented by infrastructure that is managed under the broader VAHP. Currently a stand-alone component of the Partnership, the Provincial Component, it is inextricably linked to all aspects of the design including public health and corporate planning.

VAHP made a highly valued contribution to the GoV COVID-19 response by mobilising 'just in time' technical support and DFA at provincial level. In addition, to support to the vaccine roll out VAHP supported infection prevention and Control and Personal Protective Equipment trainings, surveillance data collection and reporting and development of risk communications materials. During TC Harold, VAHP supported reconstruction efforts on Mala Island, Tasmalum and NPH and provided DFA resources, all of which were acknowledged as timely and beneficial. The VAHP now provides financial management support by building capacity to manage DFA using local systems. Infrastructure projects, whilst outside the scope of the PFS, also continue to provide important linkages and entry points for collaboration. Ongoing and sustained support to provinces, for both reconstruction and building resilience, is important considering the expected increase in extreme weather events due to climate change, such as cyclones and floods.

The health service delivery strengthening Pilot in Tasmalum, whilst in its inception phase, is a significant component of the Provincial focus. The Pilot, inspired by the learnings and successes of VSP's journey as a locally led, politically aware, GoV and DFAT funded Program, has a high level of support from local stakeholders who appeared confident that it can deliver locally driven change overtime. This change was varyingly articulated to the MTR as: increased access to services through integrated outreach; more efficient use of resources through enhanced cross sectoral coordination; strengthened supply chain and workforce; and improved data. Improvements that will be particularly important given the increasing pressure that the health sector continues to feel under a changing climate with resultant health impacts.

Challenges and opportunities

VAHP is working with stakeholders, for example, through the Tripartite Partnership Agreement (Provincial, national and VSP) and has progressed well in building trust and growing their influence and relationships. However, given the number of development partners, including DFAT funded partners, operating in the Provinces it is recommended that VAHP further prioritise establishing formal and informal linkages with organisations working at Provincial level and also supporting

partner coordination efforts more broadly. This will help considerably in advancing shared strategic interests such as disability inclusive training for health workers and improving clinical responses for survivors of GBV.

Discussions with stakeholders point to an urgent need for VAHP to further clarify a strategic understanding of what the Pilot is trying to demonstrate, what success looks like and how progress will be monitored and measured. This needs to be clarified with full VAHP team engagement from Director down to ensure coherent and strategic inputs. In the absence of these processes, there is a real risk the Tasmalum pilot will only demonstrate that donor funds can improve service delivery but in ways that are neither sustainable nor replicable.

The PFS highlights the importance of bottom-up pressure to support sustainable improvements in service delivery and the role of VAHP to facilitate and fund locally driven initiatives, such as Tasmalum, to influence reform at national level. Whilst key stakeholders are identified (MoH, PSC, DLA, Ministry of Finance and Economic Management) it is less clear how the 'bottom up' pressure will be applied and if the GAC approved (Policy) reference group will be activated. VAHP could therefore be working more intentionally to identify what policy dialogue and policy products are needed and how VAHP will facilitate formal and informal dialogue to progress these. With the VAHP focused on facilitation and support at provincial level (PG, PH, Area Councils) there appears to be a potentially critical and strategic risk to the Provincial component if the bottom-up strategy is not further articulated, resourced and monitored.

Based at Corporate Planning Unit, the Review team recommends the recruitment of a **Provincial Health Adviser/Facilitator** to support VAHP's Provincial work, including supporting GoV with partner coordination from a central MoH platform. Thinking and working politically, the locally engaged Adviser would facilitate the bottom-up strategy, working with stakeholders at all levels to develop a shared understanding and ownership of health system issues and solutions. The position would support strengthened partner coordination, evidence informed planning and budgeting toward resolution of system challenges, such as workforce capacity and Health Information Systems, that represent significant roadblocks to progressing UHC within Provinces. The Adviser would support Provincial leaders, where there is interest, to engage with MoH Executive in progressing solutions to bottlenecks. Located in Port Vila the Adviser would be part of the Provincial team. Targeted international Short Term Advisory (STA) inputs may be determined as required by the (Policy) reference group, once established. Additional technical support may include development of 'just in time' Policy briefs.

Recommendations: Provincial Focus Strategy

6. A new Provincial Health Adviser/Facilitator position be recruited and based in MoH Corporate for greater presence in MoH and with specific responsibility to advise and support Provincial planning and budgeting, partner coordination and support the 'bottom-up' Provincial Focus Strategy (working in close liaison with VAHP's Provincial facilitators).

7. The Tasmalum Working Group urgently focus on the strategic intent of the Pilot - what it is trying to achieve and demonstrate, in particular in relation to decentralisation, health systems strengthening and GEDSI; how success is being defined; over what time period the Pilot will run; and how it will be monitored and reported .

Workforce development

Approximately 85% of health facilities are in rural and remote areas that serve a highly dispersed population[29]. The workforce, comprising nearly 1000 personnel, includes over 500 nurses, midwives and nurse aides. At the time of VHP design, 30 students were graduating from VCNE annually - well below the estimated number needed to meet workforce requirements and population demands. Despite workforce development being recognised as a long standing and significant challenge for MoH, changes to workforce in recent years have been more reactive than part of an integrated and well planned workstream guided by Policy[9].

Gendered aspects of the workforce development

Women make up a majority of the health workforce with highest representation in the lowest paid roles including nursing. This makes women particularly vulnerable to the effects of a poorly equipped, understaffed, unsupported and low paid workforce. Any support to strengthen policy and practices for the female dominated nursing cadre is therefore an opportunity to progress GEDSI outcomes and an inclusive service delivery model.

VAHP progress to date – Workforce Development

Workforce development under VAHP has been focussed on human resource management and development planning; support to nurse training and to bio-medical organisation and technician training. During COVID-19, VAHP supported MoH to plan staffing requirements for quarantine and isolation facilities.

VAHP has supported the Vanuatu Clinical Training Program (VCTP) with post-graduate intern training with a focus on foreign trained doctors, training for locum doctors and the transition of international locum (medical specialists) contracts from the managing contractor to MoH/MoF. The VCTP has made some progress on medical workforce planning and addressing some of the 'capacity to practice' concerns surrounding the foreign trained doctors – linked to a broader plan to reduce dependence on international locums. Champions such as the Director of Clinical and Hospital Services, for example, have engaged directly with GAC to present plans to resolve workforce gaps. DFA funds were also utilised to conduct a rapid review of the VCTP training program. For the nursing component a Quality and Audit Officer supports VCNE to address recommendations from an audit conducted by the Vanuatu Qualifications Authority. VAHP is supporting VCNE to systematically resolve issues including Quality Management Systems.

Challenges and opportunities

Implementation of planned activities under the Workforce Development Component has been slow to date. This is particularly evident in areas that require sustained engagement and input from MoH, for example, challenges with the Human Resource information and performance management systems. These are a shared responsibility with PSC and are limiting MoH capacity to monitor staff performance. Workforce issues such as the current personnel shortages are rooted within systemic level challenges including MoH capacity to focus on problem identification and resolution. These challenges are barriers to progressing UHC and are undermining MoH, and therefore VAHP, efforts to progress a decentralised health system and inclusive and climate resilient aspects of the HSS.

Building momentum around key issues such as nurse shortages, training and workforce policy requires VAHP to support MoH to work strategically with partners at national and provincial level including central agencies. As with all aspects of VAHP, the solutions need to be problem-driven and adaptive. Meaningful progress toward the achievement of more equitable, socially inclusive, disaster and climate change resilient services is contingent on achieving sustainable improvements in quality and access to services. This in turn depends on having enough, adequately trained, supported and

[29] Workforce Development Plan, Vanuatu Ministry of Health. 2019-2025

equipped health personnel, particularly nurses. To deliver on HSS aims the MoH will require scaled-up outcomes in health workforce development with an emphasis on nursing as a contribution to strengthened essential health services. The Review team is aware of ongoing policy discussions at national level concerning potential consolidation of all technical institutions, likely to include VCNE, under Ministry of Education. The VAHP should remain on standby to support and advise MoH if and when this policy decision is made.

As well as a continued focus on current activities, an approach to increase the number and capacity of nurses would simultaneously work to address more substantive blockages around long term workforce planning and budgeting at national and provincial level where there is interest. A proposed expanded workforce development component with an increased focus on provincial level planning, would also help position MoH to cope with current and future impacts of climate change by building a workforce, including surge capability, that is better placed to deliver essential health services during periods of emergency. Acknowledging the complex nature of this proposed scale-up and the need for senior multi-government stakeholder engagement over time, DFAT has (subsequent to the MTR) flagged an interest in exploring embedding an advisor within PSC to support GoV-MoH on workforce development and WIL (refer GEDSI recommendation 12).

Recommendations: Workforce Development

8. In close collaboration with the Public Service Commission (PSC) and the Vanuatu Qualifications Authority (VQA), VAHP build on current support to VCNE to scale up and prioritise broader support to Nursing as the Partnership moves into Phase 2.

9. In close collaboration with PSC and the VQA, VAHP increasingly support development of pre-training, and introduction of in-service training, for nursing cadres. This to include exploring the potential for virtual training and taking the opportunity to integrate GEDSI/Inclusive Health and climate considerations into relevant modules.

3.2.10 Health Sector Coordination

Government of Vanuatu Coordination

The Review team understands that coordination of external support for the health sector generally worked well during recent crises and that DFAT played a key role both in facilitating that coordination and supporting WHO and UNICEF. However, now that the sector has entered a 'COVID normal' era, the Review found a current lack of health sector partner coordination despite an expressed desire on the part of development partners for GoV to take a lead role in coordinating. Such government coordination of donors seems to be challenged by a mixture of capacity, incentives and turnover of GoV officials.

Lack of coordination results in duplication, funding gaps and highly inefficient use of the significant levels of external resources flowing into the health sector. Around 20% of total health sector expenditure comes from development partners, with DFAT, ADB, and UN organisations the main contributors. However, while budget implementation for domestic funds is high, for on-system development partner funds it is low at 53% in 2021[18]. Lack of coordination also leads to misunderstanding and friction between stakeholders rather than cohesion around supporting Government objectives. From the GoV perspective it can represent a burden for stretched staff to be dealing with multiple partners with different but overlapping priorities.

At the time of the Review, establishment of a MoH Project Management Unit (PMU) to manage development assistance for health was under discussion, with the Minister of Health (now departed)

relaying that he was considering a submission. Several stakeholders deemed this a good development and VAHP would be well placed to support such a move should it gain traction. There may prove to be some momentum given that establishment of a PMU would help catalyse the hoped-for transfer of Global Fund Principal Recipient from UNDP to MoH.

Partner coordination
The Review team found that in the 'COVID normal' era, the lack of formal coordination by GoV is compounded by ongoing limited informal coordination between health sector partners. WHO is broadly considered the most appropriate agency to facilitate informal health donor coordination. However, while this is in practice not happening, DFAT (rather than VAHP) faces a choice to continue with the present vacuum of coordination or take a more proactive role given the size of its contribution to the sector and given that it funds several other agencies from a combination of bilateral, regional and global platforms.

Coordination at the Provincial level
There is a need to plan for donor coordination at the Provincial level given the increasing engagement of donors at this level. In Sanma, for example, not only is VAHP supporting the Tasmalum Pilot but WHO also has a PHC pilot comprising three pillars of high relevance to VAHP: governance and leadership; integrated outreach; and community engagement and participation. There is a specific need to coordinate Provincial Public Health investments which are predominantly donor funded. In Penama it was highlighted that the Public Health managers must engage with 15 different projects through which they receive support. Amongst others, these include UNICEF (with ADB cofinancing) support for immunization, Global Fund for malaria (with support from DFAT and WHO) and TB, UNFPA for RAMNCH and Save the Children Australia for school health. VAHP Provincial staff will contribute to coordination through supporting Provincial planning and budgeting and consideration could be given to whether the pace of scaling up such support across all six provinces is adequate. The proposed Provincial Health Adviser/Facilitator position based in central MoH (Section 3.3.9) could also play a role in supporting GoV coordinate external support for Provincial health sectors.

Coordination amongst DFAT's own health sector investments
For greater effectiveness, DFAT needs to strengthen coherence and coordination across the breadth of the Australian Government's Vanuatu health sector support (see Annex 1), an issue that has been flagged in previous reviews. From consultations it is apparent that relationships with several DFAT-funded health partners, especially the UN, could be strengthened and that this in part relates to the lack of informal coordination. A strengthening of these relationships would obviously provide a more promising foundation for collaboration and coherence across the full spectrum of DFAT health sector investment.

The scale of DFAT investment in Sexual and Reproductive Health (SRH) is notable in Annex 1. This includes global and regional support to the International Planned Parenthood Federation, global and regional support to UNFPA (with the regional support focused on family planning) and regional support to UNFPA Supplies. SRH is an important agenda in Vanuatu where the Total Fertility Rate in 2020 is 3.78 (approximating to the average number of children per woman) and around 19% of women have an unmet need for family planning (that is they want to delay or avoid pregnancy but are not using any contraception). In Sanma, as an example, the population growth rate is 2.7% which will result in a doubling of the current 61,458 population in 25 years. This is an agenda that cuts across health, women's self-determination and the economy (economic growth figures being directly impacted by population growth). It is noteworthy that population growth is not being built into health workforce projections. While DFAT global and regional initiatives are investing in and advocating for SRH in Vanuatu, the VAHP design itself is largely silent on the issue. In terms of

making strategic connections across investments and noting that VAHP's 2020 Inclusive Strategy itself highlights SRH as a priority, DFAT Post may want to consider increased engagement on SRH and opportunities to amplify the agenda through VAHP future programming.

Recommendation: Health Sector Coordination

10. DFAT, ideally in conjunction with or in support of WHO, consider proactively progressing informal donor coordination. A first step might be to co-host with WHO a health partners catch-up with a view to institutionalising such catch-ups on a regular basis. As a minimum, DFAT might consider informally coordinating on a regular basis with the agencies to which it provides funding (WHO, UNICEF, UNFPA etc).

3.3 Efficiency

3.4.1 General considerations

To represent an efficient use of resources, VAHP would need to be delivering results in an economic and timely way, as well as in the flexible and adaptive way in which it was designed. Based on the findings of this Review, VAHP's efficiency is compromised by its lack of clearly demonstrated impact to date (for the variety of reasons, internal and external to VAHP, section 3.3.2 outlined above). The COVID-19 imperative of the last couple of years, however, means VAHP's value for money relative to expected impact cannot be meaningfully assessed.

Efficiency considerations within VAHP include:

- The lack of clear program intent resulting in somewhat ad hoc rather than strategic investments, technical assistance and policy engagement across the health sector
- The transaction costs of the DFA modality that appear to represent inefficient use of VAHP and MoH time (addressed in more detail below)
- M&E systems that over-invest in tracking activities at the expense of outputs and outcomes, meaning VAHP is currently unable to demonstrate tangible success and achievements or fully learn from failure
- The potential to link more effectively with other partners. As an example, VAHP is delivering awareness training to MoH health staff on GBV Standard Operating Procedures (SOPs), with limited to no collaboration with Vanuatu Women's Centre or UNFPA GBV colleagues (funded by DFAT Canberra through the regional Transformative Agenda and co-developers of the SOPs with MoH)

Efficiency considerations external to VAHP include:

- Lack of coordination of development partners' health sector efforts and lack of coordination amongst development partners
- The need for GoV to reallocate resources away from inefficient, inequitable and underutilised (in patient) hospital services towards other levels of health care, for example currently closed clinics and NCD prevention. This is one of three headline health sector recommendations of the World Bank's recent Public Expenditure Review[30]. An increased VAHP focus on essential health services at Provincial level, manifested through Provincially focused policy dialogue, technical assistance inputs and DFA resourcing, has the potential to facilitate this shift. Some support for hospitals is of course appropriate, as a necessary part of a functional health system, and to be responsive to

[30] Analysing Vanuatu's economy and public finances through the lens of disaster resilience Republic of Vanuatu: Country Economic Memorandum and Public Expenditure Review. World Bank. 2021

explicit GoV demands. However, this has to be proportionate as access to hospital is limited for many ni-Vanuatu

- The need for VAHP policy engagement at both National and Provincial level to flag sectoral inefficiencies. Examples include the insufficiency of operational budgets to deliver Community Health Services and inefficient health workforce distribution. Despite GoV's commitments to UHC, PHC and the Role Delineation Policy, actual commitments are demonstrated through budget allocations which, in practice, leave Provinces unable to deliver even minimum service delivery standards with respect to those commitments, especially in rural areas[31]. More discussion is also needed on *integrated* primary health care and *integrated* outreach as more efficient service delivery models than the current siloed services for example, separate oral, eye and mental health outreach

3.4.2 Direct Finance Agreement (DFA)[32].

Scale of DFA

The VAHP Design document was envisaging approximately AUD1m of DFA support each year. It also planned for various health sector funding streams, including support for natural disasters, to be consolidated into the one DFA stream for the first time. As can be seen in Table 4, with the advent of DFA support for COVID-19, TC Harold and Ambae recovery, the volume of DFA being processed by VAHP in 2022 was more than five times greater than envisaged for VAHP itself at design (and this is before significant funding flows for the main response to TC Harold). VAHP processed 1,059 DFA Local Purchase Order payments in 2021 and 999 in 2022. Whilst some of the original intent of DFA was to build Public Financial Management (PFM) capacity for government's own systems, it seems likely that this scale of DFA would undermine that intent.

Table 4: Relative shares of DFA Budget Current across Components, 2022[33]

Component Name	Component Budget Current (Vt)	%
Corporate Services	19,490,574	4.1
Public Health	18,429,995	3.9
Provinical Focus	33,138,000	7.0
Workforce Development	17,995,000	3.8
COVID-19 Quarantine Support	12,477,484	2.6
COVID-19 Preparedness Support	200,150,636	42.1
TC Harold Initial Response	3,668,672	0.8
Ambae Recovery Program	27,207,248	5.7
COVID-19 Vaccination Support	142,350,273	30.0
Total	474,907,882	100.0

Views on VAHP-related DFA

Across all GoV consultations, VAHP Direct Finance was warmly welcomed and described as a helpful and responsive arrangement in support of business plans. Many interviewees mentioned that DFA flowed for COVID-19 and after TC Harold long before government support ramped up. DFA was credited with helping funds flow from National to Provincial level in Sanma.

> '*Money is always available, it just takes time.'*
> *'Money is there for us to use'.*
> *'We can ask for money anytime, once the money is in the MoH'.*

[31] Vanuatu Health Sector Strategy. 2021-2030.

[32] Variably referred to in VHP and MoH documentation as Direct Finance/Financing/Funding Agreement/Arrangement

[33] VHP DFA Finance Report 2022

'We are dependent on VAHP money for lots of programs.'

Almost all interviewees mention that DFA comes with high transaction costs and onerous paperwork and that decisions are often slow. These frustrations were often perceived to result from VAHP rather than MoH processes. There was some frustration expressed that time can be spent applying for DFA only to find that the request is ineligible because the relevant DFA allocation is fully committed. Multiple requests were made for lighter processes now that there is, from interviewees' perspective, greater capacity and improved trust. Whilst DFA is supposed to work with and through GoV planning, budgeting and PFM systems, some interviewees mentioned DFA working around them instead.

Allocation of DFA

Proposals for the use of DFA are agreed jointly by DFAT, VAHP and MoH at the quarterly GAC meetings. From GAC papers it appears that there is a nominal 60% National - 40% Provincial DFA allocation formula. The Provincial allocation amounts to approximately VT 5.5m per year for each of the six Provinces with around 90% of Provincial DFA spent on Public Health activities and around 10% on Corporate related training. The National DFA is allocated to each of the MoH Directorates, Corporate – Public Health – Hospital and Curative, with decisions on overall allocations amongst them made annually.

The thinking behind pooling all DFA from the start of VAHP was to strengthen policy dialogue on, and scrutiny of, overall health budget priorities[34] but it is not apparent that this influence has materialised. In the absence of DFA funding amounts being contingent on GoV's own budget allocations or agreements on GoV 'floors and ceilings' for priority budget lines (e.g. Community Health Services), DFA may be popular but may also be entirely fungible (i.e. displacing MoH allocations and/or MoF allocations to MoH and thereby not represent additionality for the sector).

The eligibility parameters for DFA are not entirely clear. In papers prepared for the GAC it is stated that DFA resources need to align with the objectives of the NSDP, the HSS and the two VAHP End-of-Program Outcomes. However, each of these have different parameters and the narrowest of them (VAHP EOPOs) are not well defined (see section 3.3.2). Elsewhere, in the DFA application form it is stated that the 'Proposal must clearly state how the proposed activities will achieve the Inclusive Health Strategic Objectives of the HSS' which is yet another framing. DFA Project Proposal Guidelines also have a set of 10 criteria, of which one or more must be met. The overall sense from consultations on DFA is that anything and everything might be supported so long as it is either in a MoH business plan or is subsequently agreed by the GAC. Dissatisfaction with exclusion clauses for DFA (namely catering and Daily Subsistence Allowance) were raised in a few consultations. These clauses actually stem from VAHP applying the requirements of the PFM Act and the Financial Regulations of Vanuatu but these GoV requirements are not well understood.

Provincial DFA

Table 5: DFA Allocations and Expenditure by Province. 2022.

Province	Population[35]	DFA Budget current 2022 (Vt)[36]	% Current budget spent
Shefa	103,987	5,500,000	99.42

[34]Vanuatu Health Program. Design Strategy and Options Paper. May 2018.

[35] Vanuatu 2020 National Population and Housing Census

[36] VHP DFA Finance Report 2022

Province	Population[35]	DFA Budget current 2022 (Vt)[36]	% Current budget spent
Sanma	60,884	5,500,000	53.91
Tafea	45,714	5,500,000	50.73
Malampa	42,499	5,638,000	85.80
Penama	35,607	5,500,000	55.92
Torba	11,330	5,500,000	4.87
Total	300,019	33,138,000	58.55

Provincial DFA grants are channelled to the Provinces via the MoH's business plan and financial management system. In Sanma the GoV health recurrent budget is around VT 8 million and VAHP DFA contributes a further VT 5.5 million. In Penama in 2022, the health recurrent budget was around VT 7 million and the Province ended up using VT 3.0 million of its VT 5.5 million DFA allocation. In practice, absorptive capacity for the DFA can be an issue (see Table 5 above) with funds ending up being returned unspent. An example was shared of DFA training budgets going unspent because of lack of Provincial capacity to recruit trainers. For Penama Health officials, delays in agreeing DFA are felt to be compounded by proposals having to go from Penama to Santo to Vila. In contrast, Shefa has strong capabilities and a large population and spent VT 5.3 million of its VT 5.5 million last year with the slight underspend attributed to delays with the GAC process. Rather than allocating equal DFA allocations to each Province, irrespective of population size, absorptive capacity or established partnerships, it is recommended that VAHP consider more nuanced DFA allocation formula. Such formulae can represent good practice for resource allocation from national to subnational levels.

VAHP is using DFA as an instrument across all Provinces. As a result, for it to fulfil its potential, VAHP will need to address relationship and capacity building across all Provinces. Proposed scaling up of the Provincial Focus Strategy demands an increased VAHP presence in every Province, including a Provincial Facilitator. Where there are established relationships and processes at Provincial level, for example in Sanma and Shefa currently, consideration might be given to decentralising DFA decisions to Provincial committees rather than passing decisions back to central MoH level where GAC delays impact the timely flow of funds.

Assessment of the way DFA is working

The DFA appears an unsatisfactory and inefficient instrument. Instead of being budgeted into plans up front, it is used to fill funding gaps after GoV have allocated their own budget, potentially incentivising MoH to systematically not fund priority activities known to be attractive to VAHP. Using DFA to fill funding gaps for items not covered by current GoV budget allocations is not a sustainable way to 'support local solutions'.

DFA appears to be managed as something akin to a small grants scheme with heavy transaction costs for both GoV and VAHP. What are essentially unfunded activities within GoV business plans are being 'projectised' by the DFA guidelines. Applications for DFA are framed by those guidelines as competitive 'effective, innovative and creative project proposals' to be assessed and selected by MoH and DFAT through the GAC, with successful projects being funded by VAHP. The guidelines demand a proposal that includes outputs, outcomes, alignment with VAHP, alignment with GESI, time plan, M&E, risk assessment, beneficiaries, social and environmental impact assessment. This appears a disproprotionate, inappropriate and inefficient process for what are generally not projects but rather financial inputs for unfunded activities. For example Public Health supervisory visits at a modest cost of AUD 3,500. DFA appears a complicated way of providing small amounts of money in a resource-constrained environment. The Review team's assessment is that these complicated

processes mean VAHP are focussing efforts 'down in the weeds' at the expense of engaging more strategically. Changes need to be made to extricate GoV, VAHP and DFAT from this level of transaction.

Subject to stronger PFM and accountability, DFA should ideally be working as something more akin to sector budget support. In such a scenario, VAHP's DFA allocations would be confirmed at the start of the annual GoV planning and budgeting cycle (June/July of the year prior). Using Provincial DFA as an example, the Provinces would then know their *combined* GoV/DFA budget envelope and plan and budget accordingly. VAHP would then focus its efforts and capacity building in support of the annual planning and budgeting processes (rather than on multiple micro in-year processes) and the DFA would be genuinely reflected 'on plan' and 'on budget' rather than mopping up unfunded budget lines.

Once annual plans and budgets are agreed, in principle VAHP should not be part of day-to-day MoH decision-making on course corrections or changed priorities during the year. Inserting VAHP in such management issues appears to set up inappropriate lines of accountability. Even less so can a case be made for DFAT engaging in that level of decision making.

Performance accountability for the use of the combined GoV/DFA funds could also be an annual conversation, focused on agreed annual plans and targets. Monitoring and performance management should not be a conversation that happens budget input by budget input, especially given 88 such inputs in 2021. Meanwhile, **financial accountability** for the funds having been used in the manner intended should of course be tracked through PFM systems. Moving away from proposal-based drip-feeding of DFA into unfunded budget lines towards a more developmental sector budget support-like instrument would entail enhanced PFM advisory support and a higher appetite for fiduciary risk on DFAT's part. That said, annual DFA allocations for each Province are around AUD70,000. As a result, using the modality more progressively at Provincial level might be considered a higher, but low value, risk for a budget that is not currently representing value for money because of the high administering cost.

Consideration could be given to greater clarity on what DFA is trying to achieve and therefore greater clarity on its **parameters**. It is currently a flexible fund that buys considerable goodwill and can be used for almost anything in the MoH's business plan. This leaves a disconnect between the flexible way in which DFA is deployed and the more specific outcomes of the Program through which it is funded. Once VAHP's intent and theory of change are clear, consideration could be given to more explicitly allocating DFA in support of Intermediate Outcomes, rather than simply aligning allocations to the MoH organogram. However, the HSS is broad and it is therefore important for the DFA to focus on public and primary health care, in particular operational budgets and outreach; equitable access to affordable health care; and GEDSI to ensure that it is being used to address DFAT and GoV's mutual priorities.

Recommendation: Direct Finance Agreement

11. Ways of working with DFA be reviewed with a view to making it more efficient. Such a review to consider:

- Shifting the modality further towards sector budget support practices
- Focusing VAHP's engagement on annual planning and budgeting processes for *combined* GoV and DFA funding, with early declaration of DFA allocations
- Increasingly using DFA to leverage more efficient GoV budget allocations
- Focusing VAHP's engagement on performance of overall plans rather than performance of individual budget contributions
- Lightening processes for in-year funding requests and moving away from requirements for project proposals
- DFA allocations more clearly aligning to the joint GoV-DFAT objectives for VAHP (with guidelines updated accordingly)
- Introducing DFA allocation formulae across Provinces to improve allocation and utilization of funds

Decentralising DFA decision making to Provinces with sufficient capacity.

3.5 Gender, disability and social inclusion

Analysis of how gender equality, disability and social inclusion (GEDSI) are being addressed by the VAHP considered the impact of both targeted and mainstreamed activities and the extent to which these align with the changing policy and strategic context. The Review considered GEDSI against the backdrop of the inclusive aims and UHC principles of the NDSP and HSS. Gender constraints, disability and geographical isolation, and the intersectionality amongst them, are key barriers to progressing UHC in Vanuatu[37]. Taking the example of geographical isolation, demand side barriers to UHC include the high indirect costs of transport to access services while supply side barriers include insufficient health workers posted to remote areas. VAHP should support the full breadth of the Inclusive Health dimension of the HSS as well as specific gender and disability agendas.

3.5.1 Guiding Policy Framework and Strategic approach to GEDSI

The HSS is underpinned by commitments made by GoV to address gender equality and ensure human rights for all including:

- National Strategic Development Plan 2016 -2030
- National Gender Policy (2015 -2019)/(2020-2030)
- National Disability Inclusive Development Policy 2018–2025
- Reproductive, Maternal, Child, New-born, Child and Adolescent Health (RMNCAH) Policy (2021-2025)

VAHP, as a member of the HSS Steering Committee, provided high level support to MoH leadership including advice that informed the strategic direction of the HSS and led to the establishment of an Inclusive Working Group and Inclusive Pillar. These contributions were acknowledged by MoH during the Review. Despite established policy, challenges translating this policy into practice were evident including the lack of coherence across the different ministries on Policy implementation; operating budgets; and ownership of Policy commitments among MoH leadership.

[37] Discussion-paper-Universal-health-coverage-gender-equality-and-social-protection. A Health Systems Approach. UN Women. 2020

Support to MoH for gender budgeting and business planning is aligned with the National Gender Policy and HSS priorities. However, progress in this area has been slow with the inclusive elements of the HSS only partially reflected in the Corporate Plan (2022-2025). Whilst a key focus of the VAHP design was the integration of GESI with business planning, such as analysis of finance, administration and logistic processes, VAHP were unable to progress this component of the plan. The lack of traction around planning also likely impacted VAHP ability to support MoH to progress in key areas such as disability inclusive development priorities. With the establishment of the Inclusive Health Committee (IHC) in April 2023 (chaired by Director Policy and Planning) and plans to develop a Gender Strategy, it is recommended that VAHP pursue these potential entry points to increase business planning/gender budgeting as well as other workstreams that have been slow or unable to move forward. The composition of the committee including Department of Women's Affairs and CSOs may also help position VAHP to further support MoH to work collaboratively with partners to advance some key GEDSI priorities including at the provincial level where the program is now focussed.

3.5.2 Women In Leadership program

WIL is a relatively new, potentially flagship, program for VAHP and MoH. The profile, sense of achievement, and potential WIL program represents to advance HSS inclusive leadership objectives were evident during the Review. VAHP have worked politically to secure buy-in across ministries and utilised communications strategically. This has contributed to an understanding of Program intent. Involving participants such as Director PSC and Acting DG Health was strategic as they may be able to champion an expanded program. The team facilitated local and regional expert inputs and leveraged DFAT funded investments, for example, the Balance of Power Initiative, which adds to the depth of analysis and planning. WIL has potential to be a 'green shoot' and an exemplar of 'small-scale sustainable reform improvement' that can be further leveraged to support policy reform and complement the Provincial program[38]. With a female ni-Vanuatu Director, VAHP also has an opportunity to demonstrate a 'women in leadership' model.

3.5.3 Understanding and responding to the needs of the LGBTQ+ community

The VAHP GEDSI Team worked politically and strategically over a period in late 2022 to secure a public expression of support from the MoH for the LGBTQ+ community in Vanuatu. Working alongside a local NGO, Vpride, VAHP and MoH endorsed the annual Vpride Fashion Show. Post-campaign feedback highlighted further opportunities for MoH to support the LGBTQ+ community for example, provision of mental health support and sexual health services. When considering scaled up support, VAHP should consider the priority of expanded LGBTQ+ targeted activities relative to other VAHP priorities.

3.5.4 Strengthening health service delivery for survivors of GBV

VAHP is supporting MoH to deliver GBV training sessions to health personnel with plans to extend this work to the provinces[39]. This training, which to date has reached 34 health workers, has potential to improve knowledge of clinical responses to GBV using the recently developed SOPs. Without a more comprehensive plan in place, however, VAHP risks being unable to demonstrate impact from this activity, for example, increased use of the SOPs. If VAHP continue to deliver the current GBV awareness activities, it could consider expanding the scope through a pilot activity that

[38] VHP APEA Report, 2020

[39] The purpose is to promote awareness among health personnel of the Standard Operating Procedures (SOP) for the clinical management of SGBV launched in late 2021 by MoH and UNFPA.

includes a broader, more ambitious, systems strengthening focus that involves formal/informal partnerships with key partners such as Vanuatu Women's Centre and UNFPA who co-developed the SOPs[40]. A Pilot could include activities that aim to address recognised, and associated, system challenges, for example, essential commodities supply, testing, reviewing referral pathways and budget gaps. A longer-term plan would logically consider leveraging current entry points with VCNE to integrate GBV training in the core nursing curriculum (section 3.3.9 Workforce Development).

With increased frequency of climate change related disasters and the associated increases in the incidence of GBV and demand for GBV services, VAHP should consider how best to support MoH to establish a register of emergency on-call GBV trained and equipped health workers. A potential entry point would be the GBV in Emergencies Sub-cluster noting Ministry of Justice and Community Services is a member and also a member of the newly formed MoH Inclusive Health Committee[41].

3.5.5 Inclusive health service delivery

VAHP supported MoH to integrate GEDSI considerations into Vanuatu's National Deployment and Vaccination Plan on COVID-19 vaccines. VAHP is planning to support MoH to progress Policy commitments through the multi partner Inclusive Health Committee (IHC) and activities under discussion with the Tasmalum WG[42]. With VAHP support the Acting DG has approved Provincial disability officers as part of the MoH re-structure. Alongside the ADB funded Gender Coordinator role, these dedicated positions represent an opportunity for MoH/VAHP as they step up their GEDSI work in the Provinces in line with the HSS.

Whilst no disability or gender disaggregated data were made available, the Review team were advised that COVID-19 vaccination data for PWD were entered in the MoH Health Information System. In the absence of routine data collection, VAHP have been unable to meaningfully progress collection and reporting of inclusive data. Support to improve data collection, analysis and planning is needed in order to track progress against commitments made in the NSDP and the HSS. VAHP are planning to utilise evidence-based data collection tools and integrate these into baseline activities at Provincial level. An opportunity may, therefore, exist for demonstrating improved disaggregated data collection practices and reporting during the Tasmalum pilot. In a positive step forward the Secretariat of the Pacific Community with the Ministry of Justice and Community Services, have developed software for GoV to collect and report disability 'census type' data utilising provincial 'compliance officers'. Baseline provincial data combined with SPC work, should result in some disaggregated data being available for use by the MoH. Further consideration is needed to help progress routine collection of disaggregated data by MoH – the IHC may open up avenues for this.

3.5.6 Improved access to health services for people with disability

VAHP uses a standard 'inclusive building' model when constructing health centres including in the Tasmalum Area Council visited by the Review team. Since 2019 three health facilities have been completed with two more due in 2023. These facilities include access ramps and accessible toilets. In addition, the building model includes private consultation rooms suitable, and required, for clinical service delivery (screening/counselling) for survivors of GBV and as such complements the GBV work currently underway in the Provinces. During the Review process, design issues were noted that may have access implications for PWD, including door width and other interior flaws. Processes and planning appear to be led by MoH with VAHP support but opportunities to strengthen Provincial

[40] As of 2016, the Vanuatu Women's Centre was the only organisation providing counselling support to women and children who had experienced violence from an intimate partner, family and non-family members[41]
[41] https://asiapacific.unwomen.org/sites/default/files/2022-12/UN_WOMEN_VANUATU.pdf Accessed on May 31, 2023
[42] National Disability Inclusive Development Policy (2018–2025)

Government and Provincial Health involvement in infrastructure development were raised as an opportunity to ensure future infrastructure projects are more inclusive. Other inclusive activities supported by VAHP include[43]: Physiotherapy Inclusive Integrated Outreach; and supporting MOH to endorse Provincial Disability Officer roles (confirmed by ADG in 2023). VAHP, as members of the IHC, plan to support ongoing access improvements as reflected in the Corporate Plan (2022-2025).

3.5.7 Progressing UHC agenda through inclusively focussed workforce development and partnerships

Despite being a priority for MoH and VAHP, apart from GBV trainings, the Review team is not aware of any GEDSI focused Health Care Worker (HCW) training being supported to date. A key challenge is the significant nurse shortage which has resulted in health facilities being understaffed or non-operational, undermining MoH ability to progress inclusive training. The Review recommends a potential re-focus on inclusive pre-service and in-service nurse training. The aim would be to help MoH to address, amongst other systems issues, nurse shortages and training and support, which hamper efforts to progress GEDSI. The re-focus would represent a more sustainable way of supporting MoH to improve inclusive access and health outcome aspects of the GEDSI Strategy. The VAHP recruited Quality and Audit Officer based at VCNE and the Principal Nurse Officer being on the IHC may represent new entry point for re-opening this inclusive nurse training discussion. Any future trainings should be considered in close collaboration with PSC and Vanuatu Qualifications Authority in partnership with local NGOs such as disability advocacy organisations that are well positioned and willing to support, as was reiterated during consultations. Whilst facilitation, or brokering, of relationships between MoH and NGOs is an expressed intention of VAHP, and evidenced in the Vpride Fashion Show/campaign and WIL, the Review considers this an area that could be further strengthened in the context of GBV, disability and the Provincial Focus Strategy. The proposed new nationally-based Provincial Health Advisor/Facilitator role, encompassing a partner coordination focus, may be well placed to support coordination including with central agencies to advance this component of work.

3.5.8 Lessons on GEDSI

Despite challenges gaining traction, VAHP should continue to pursue opportunities and new entry points, such as the newly formed MoH IHC, to strengthen integration of GEDSI into business planning processes at MoH. In addition to the recommendations below, VAHP could consider introducing a system to systematically track progress against agreed entry points on GEDSI and review on a regular basis with the whole VAHP team. Whilst out of scope, the Review highlights an opportunity to review procurement and planning processes for infrastructure projects to ensure that capital works are fit for purpose and provincial health are engaged in the process including Provincial Health and Provincial Government Disability Officers.

VAHP should be cautious about investing in new areas, apart from inclusive training opportunities at provincial level, to specifically address GEDSI. The focus should be on being more strategic, including identifying and pursuing new partnerships, and generally strengthening GEDSI in existing investments. With appropriate partner engagement, including PSC and DWAs, recommendations 12 and 13 may represent the most strategic and relatively low risk opportunities to progress impactful gender responsive programming within VAHP. Recommendation 14 whilst strategic would require a significant and well defined workplan and results framework to guide programming toward integration within MoH systems. Recommendation 15 is part of the demonstration activities and aims to model good practice around disability disaggregated data collection. As such it would

[43] Other GEDSI activities may have been conducted but these were the ones highlighted by VHP

represent low risk and low impact in the short term but may support broader strategic efforts overtime to strengthen data practices. The more substantive disability responsive recommendation is detailed under workforce development.

Recommendations: GEDSI (refer also to recommendations 8 and 9)

12. Working closely with central agencies, VAHP expand Women in Leadership opportunities for nurses, including those at Provincial level, to support and model inclusive leadership

13. VAHP to build on current program of work in GBV to support the establishment a register of on-call health professionals that are equipped and trained to respond to GBV service demands during times of emergency which are a more frequent occurrence due to climate change.

14. If continuing GBV focus into next phase, VAHP work collaboratively to expand current activities to pilot and monitor a comprehensive GBV service package including testing referral pathways and other MoH approved 'service ready' elements at Provincial level, with a view to scaling in the next phase.

15. As part of the Tasmalum pilot and together with the Tasmalum Working Group, explore opportunities for piloting disaggregated data collection and reporting as part of the overall demonstration activity.

3.6 Climate and environment

3.6.1 Vanuatu Context

Countries in the Pacific region are particularly vulnerable to the effects of climate change. Vanuatu has been identified as the country most at risk of potential natural disasters, including cyclones, flash floods, volcanic eruptions, earthquakes and tsunamis. Changes in climate can cause health impacts, including increased water and foodborne diseases, increased vector-borne diseases, malnutrition, and fish poisoning. Vanuatu is identified as the nation most in need of technical assistance and resourcing to establish systems and processes to prepare and respond to disasters[44]. A Nationally Determined Contribution (NDC) is a non-binding national plan highlighting climate change mitigation, including climate-related targets for greenhouse gas emission reductions. The GoV NDC acknowledges the country's vulnerability to climate change, emphasises the detrimental impact of that climate change on human health[45], and highlights the importance of enhancing access to essential healthcare services as a funding priority.

A regional example of working on the intersection of climate change and health is presented in the box below.

[44] Kathryn J. Bowen, Kristie L. Ebi, Alistair Woodward, Lachlan McIver, Collin Tukuitonga & Patricia Nayna Schwerdtle (2023): Human health and climate change in the Pacific: a review of current knowledge, Climate and Development, DOI: 10.1080/17565529.2023.2185479

[45] https://unfccc.int/documents/578782

Box 1. Intersection of Climate Change and Health

Fiji has actively engaged in addressing the intersection of climate change and health through its participation in the WHO/UNDP Global Pilot Project on Health Adaptation to Climate Change (2010–2015). This initiative has guided Fiji's efforts in several key areas. Firstly, they have prioritised the enhancement of surveillance systems for diseases sensitive to climate change, ensuring timely detection and response. Additionally, Fiji has developed climate-informed health Early Warning Systems to anticipate and prepare for climate-related health risks. They have also conducted Vulnerability and Adaptation assessments to identify specific challenges and opportunities in relation to climate change impacts on health.

Fiji's commitment to climate-resilient health planning is evident through the development of their Health National Adaptation Plan. This strategic framework aligns health sector priorities with climate change considerations, enabling the integration of climate adaptation measures into healthcare policies and programs. Furthermore, Fiji has been at the forefront of piloting climate-informed health interventions, exploring innovative approaches that address climate-related health challenges.

3.6.2 Review Findings Related to Climate Change

- The review found a reactive approach to climate change and disaster within the health sector. Constant refurbishment and rebuilding of health facilities following repeated natural disasters is evidence of this
- There is a lack of coordination at GoV policy level and a lack of institutional capacity and individual capability at national and provincial level in relation to climate change health resilience
- VAHP, understandably, also has limited awareness and capabilities regarding climate change health resilience
- At Provincial level there is evidence of local and traditional knowledge being used for resilience. VSP, for example, is supporting agriculture projects with strong climate change and health resilience linkages. There may, therefore, be potential climate-relevant partnerships to be built between VSP and VAHP
- The Vanuatu health sector has yet to perform a Vulnerability, Capacity and Adaptation Assessment (VCA) for the sector and its health facilities
- The Health Sector Strategy 2021-2030 highlights the creation of a multi-year, budgeted Capital Plan for the sector, focused on developing disaster and climate change resilient infrastructure. If enacted, this would greatly enhance the ability of health facilities to withstand challenges and maintain operations
- There is a need for relevant training and capacity-building on climate-resilient health systems for public health and healthcare professionals. This should cover climate risks faced by individuals, communities, and healthcare facilities, as well as approaches to safeguarding and enhanced public health in the face of current and future climate change impacts
- Both the GEF, Global Environment Facility, (WHO implemented**)** and VAHP align with the Health Sector Strategy. VHAP might use its Provincial relationships to broker relationships with WHO, MoH and others around accessing GEF when it makes calls for proposals
- Although the original investment that is the focus of the MTR did not itself does not fund infrastructure, refurbishment and rebuilding of health facilities is occurring under the broader VAHP. VAHP does provide 'in-line' technical assistance to the Asset Management Unit (AMU) in MoH to ensure the quality of infrastructure project management and capital works associated with recovery from the Ambae eruption, TC Harold, and the COVID-19 response. While review of infrastructure was out of scope for the Review, site visits during the consultations raised some

concerns that this work may not be adhering to DFAT safeguards and standards and, in addition, may not comply with relevant Category 5 cyclone standards. Structural compliance certifications by external engineers should be a priority prior to occupation of the health facility buildings. When built to the correct standards, health centres can also double as evacuation centres.

Recommendations: Climate Change

16. DFAT and VAHP ensure VAHP- funded infrastructure, as well as building contractors, comply with DFAT safeguards and standards.

17. At relevant opportunities, VAHP include climate resilience in various health training programs**.**

18. VAHP broker its Provincial relationships to facilitate potential GEF funding opportunities for health.

3.7 Monitoring and evaluation

3.7.1 VAHP M&E: Challenges

An MTR is an opportunity to consider an investment's performance against DFAT M&E standards. This MTR found that there was no current working version of the theory of change or results framework, no agreed level of ambition for VAHP and no agreed indicators to track progress against EOPOs or IOs. This can probably be attributed to a number of factors. A first is likely misunderstandings about M&E standards for a Program taking an Adaptive Management approach (see section 3.3.8 above) and a second the impact of the Program pivot on early consolidation of M&E processes. VAHP has had inadequate M&E advice and resultant M&E weaknesses need to be urgently addressed.

Below provides a summary of key challenges related to M&E:

- The results framework in the design document was not a fully developed draft and no further work has been done to develop it during inception or implementation
- The design document included an initial theory of change in the form of a Logic Model (see Annex 2). A theory of change was presented in the 2021 MEL Strategy (with an excessive eleven intermediate outcomes rather than the original four). However, the Review team were advised by VAHP that the new version had no status and were directed to consider the original one in the design document as current
- The 2021 MEL Strategy is a complex and at times theoretical paper yet, at the same time, fails to provide basic course corrections on the above shortcomings. It makes no mention of the need for a results framework and, instead established a focus on monitoring activities, process and problem areas which then duly became the focus of annual reporting to DFAT. Although DFAT did initially question DT Global on whether the MEL Strategy was fit for purpose, three consecutive annual reports that do not report on progress against Outcomes were accepted
- Monitoring of impact is essential for Adaptive Management approaches. There is an urgent need for an agreed M&E approach for the Tasmalum pilot and the WIL initiative
- Trying to monitor individual DFA allocations in M&E appears to be misplaced effort (see section 3.4.2).

3.7.2 VAHP M&E: Strengths

- M&E advice can be hard to source and VAHP has had a couple of false starts. At the time of the Review, relatively new arrangements had been put in place for both the Program Quality

Coordinator (responsible for M&E) and the M&E STA. It is hoped that these developments will now lead to the required course corrections
- VAHP's Program Quality Coordinator is a localised position, in keeping with VAHP principles
- VAHP have made efforts to systematically capture information on process in an online reporting system that informs annual reporting. The system captures categories of challenges and captures activities, including comprehensive information on meetings and records of discussions. This system was suspended during COVID 19 and re-introduced in May 2022
- Recently produced and disseminated case studies have provided qualitative information on VAHP activities and achievements and VAHP newsletters profile the same

3.7.3 Ministry of Health M&E

Given the challenges outlined above, VAHP has not been well placed to contribute to strengthened MoH M&E capabilities and systems. Although the sole MoH counterpart on M&E has requested support, she is currently not in her position while Acting as Director of the Policy and Planning Unit. There are inherent difficulties progressing this agenda within MoH and VAHP would need to source significantly more technical assistance to be able to attempt a twin track approach of strengthening both its own and MoH's M&E.

MoH production and dissemination of routine health information remains a challenge and there is little or no routine reporting against key health indicators. The last MoH annual report is dated 2021 although health outcome and service delivery indicators were not available for 2020 or 2021. The new HSS requires data to be disaggregated by sex, age, location, and disability at a minimum but currently, in most cases, data collected as sex disaggregated are not reported as such. There is still progress to be made integrating data from vertical programs such as TB and HIV into the health information system[46]. The M&E framework for the new HSS should in theory be a platform to support and progress sectoral M&E but, in practice, it has provided limited traction. In this context, aside from modest engagement at the Provincial level related to other relevant efforts there, the review team would be reluctant to recommend VAHP focus on trying to strengthen MoH's health sector M&E in the short to medium term.

Recommendations: M&E

19. M&E and Adaptive Management expertise be urgently drawn into broader discussions of the future intent and strategies for VAHP. Outputs of that process should include an updated theory of change (complete with working assumptions) and a results framework that makes clear the level of ambition regarding what VAHP is trying to achieve and the indicators for monitoring progress against outcomes. Results frameworks also to be developed and agreed for the Women in Leadership and Tasmalum Pilot initiatives

20. GEDSI considerations to be mainstreamed into the theory of change and results framework

21. DT Global increase M&E TA support for the Program.

Work on the first recommendation above should be undertaken collaboratively by DFAT and VAHP, working through appropriate processes. The Review team recommends consideration of the following in addressing this recommendation:

[46] Analysis from World Bank 2022 Advance UHC Annual Report. Unpublished.

- In the design document the current EOPOs have EOPO1 (improved essential health services) explicitly contingent on EOPO2 (strengthened leadership) which is conceptually problematic. If EOPO2 is a means to an end (i.e. EOPO1) it could be recast as an Intermediate Outcome (logically nested as the IO of 'corporate' efforts)

- Removing EOPO2, strengthened leadership, from being an EOPO resonates with the challenges of working in the MoH Corporate space and acknowledges the over ambition of the design's original assumptions

- The above changes would make the overall intent of the workstream of the original investment akin to EOPO1, strengthened delivery of essential health services, which resonates well with VAHP's aspirations to scale up the Provincial Focus Strategy

- Whatever is cited in the EOPO needs to then be defined and monitored. If the EOPO were to remain focussed on 'increased delivery of equitable, accessible and better-quality essential health services', VAHP would be accountable for supporting demonstrated impact on the *volume*, *equity*, *accessibility* and *quality* of essential services, with concomitant strategies and M&E in place for each of those dimensions. Rigour in defining each of these dimensions and adaptively managed strategies for improving them are not currently in place

- Putting aside the Provincial component, the current components are somewhat artificially siloed to reflect the structure of the MoH Directorates (Corporate – Public Health – Hospital and Curative Services). This obviously aligns with MoH Directors' interests in DFA allocations for their areas of responsibility. It might, however, benefit from a conceptual rethink when the theory of change is developed (to capture for example the importance of *integrated* essential health services)

- As a principle, drawing on specific MoH indicators that align with VAHP Outcomes and tracking those for monitoring is encouraged. This is not, however, a valid approach if it is clear at the time the results framework is developed that no such data are or likely will be available. VAHP should avoid going into the next review with a narrative that its M&E was premised on MoH monitoring, of which there was none

- There is a growing body of literature on M&E for Adaptive Management approaches. Table 6 outlines different types of indicators to consider for Adaptive Management investments[47]. DFAT's Design & Program Advice Section (DPA) is also available to provide advice and support. Suffice to say, Adaptive Management requires more M&E flexibilities than traditional investments. For example, outputs and intermediate outcomes, and how to achieve them within overall outcomes, are not defined for the duration of the program but are revised and developed, on the basis of documented data and justification, as the program proceeds. Nonetheless, Adaptive Management does not absolve responsibility for defining the overall outcomes to be delivered and how progress with be monitored and measured

[47] Overseas Development Institute. Opportunities and challenges for DAC members in 'adapting to context'. Samuel Sharp and Leni Wild. March 2021

Table 6 Typology of Results Indicators[48]

Bedrock indicators. A core set of benchmark indicators that remain fixed through the lifetime of the programme (e.g. at the outcome and impact level), with greater flexibility at lower levels of the results chain (outputs, activities).

Open-ended indicators. A 'basket' or menu of indicators, of which the programme is expected to achieve some, for instance aiming to achieve some tangible reform in a given area but not specifying exactly what this will look like.

Learning/adaptive practice indicators. Indicators that attempt to measure processes of learning and adaptation.

Measuring risks and assumptions. Measurement of assumptions of the programme and level of risk associated with programme activities. For example… 'context indicators' measure political, social and economic conditions in relation to the programme.

4. Summary of recommendations

The Mid-term Review team recommend that:

Program Intent and Strategy
1. DFAT and VAHP better articulate and communicate the intent of, and strategy for, VAHP's ongoing investment to support MoH leadership and strengthen the delivery of essential health services (i.e. the area of focus of this Mid-term review).
2. To facilitate engagement with GoV on strengthening essential health services (an area strongly related to, but also distinct within other streams of VAHP support – see Figure 3), this area of VAHP effort be given a recognised strapline/name and be given explicit operational space and resourcing to ensure effective progress.
VAHP Modalities
3. The results framework and the updated theory of change lead prioritisation of strategic VAHP technical assistance inputs and policy dialogue inputs, with a stronger Provincial focus for the technical assistance.
4. VAHP consider a greater physical presence in MoH to enhance policy influence (see also recommendation 10).
PDIA approach
5. VAHP draw on relevant expertise to review their perceived and actual ways of working with Adaptive Management and PDIA, with a view to using the approaches more effectively.
Provincial Focus
6. A new Provincial Health Adviser/Facilitator position be recruited and based in MoH Corporate for greater presence in MoH and with specific responsibility to advise and support partner coordination, Provincial planning and budgeting and support the 'bottom-up' Provincial Focus Strategy (working in close liaison with VAHP's Provincial Facilitators).
7. The Tasmalum Working Group urgently focus on the strategic intent of the Pilot - what it is trying to achieve and demonstrate, in particular in relation to decentralisation, health systems strengthening and

[48] Ibid.

GEDSI; how success is being defined; over what time period the Pilot will run; and how it will be monitored and reported.

Workforce Development
8. In close collaboration with the Public Service Commission (PSC) and the Vanuatu Qualifications Authority (VQA), VAHP build on current support to VCNE to scale up and prioritise broader support to Nursing as the Partnership moves into Phase 2.
9. In close collaboration with PSC and the VQA, VAHP increasingly support development of pre-training, and introduction of in-service training, for nursing cadres. This to include exploring the potential for virtual training and taking the opportunity to integrate GEDSI/Inclusive Health and climate considerations into relevant modules.
Health Sector Coordination
10. DFAT, ideally in conjunction with or in support of WHO, consider proactively progressing informal donor coordination. A first step might be to co-host with WHO a health partners catch-up with a view to institutionalising such catch-ups on a regular basis. As a minimum, DFAT to consider informally coordinating on a regular basis with the agencies to which it provides funding (WHO, UNICEF, UNFPA etc).
Direct Finance Agreement
11. Ways of working with DFA be reviewed with a view to making it more efficient. Several specific recommendations are proposed at the end of section 3.4.2 of the report.
GEDSI
12. Working closely with central agencies, VAHP expand Women in Leadership opportunities for nurses, including those at Provincial level, to support and model inclusive leadership
13. VAHP to build on current program of work in GBV to support the establishment a register of on-call health professionals that are equipped and trained to respond to GBV service demands during times of emergency which are a more frequent occurrence due to climate change.
14. If continuing GBV focus into next phase, VAHP work collaboratively to expand current activities to pilot and monitor a comprehensive GBV service package including testing referral pathways and other MoH approved 'service ready' elements at Provincial level, with a view to scaling in the next phase.
15. As part of the Tasmalum pilot and together with the Tasmalum Working Group, explore opportunities for piloting disaggregated data collection and reporting as part of the overall demonstration activity.
Climate
16. DFAT and VAHP ensure VAHP- funded infrastructure, as well as building contractors, comply with DFAT safeguards and standards.
17. At relevant opportunities, VAHP include climate resilience in various health training programs**.**
18. VAHP broker its Provincial relationships to facilitate potential Global Environment Facility (GEF) funding opportunities for health.
Monitoring and Evaluation
19. M&E and Adaptive Management expertise be urgently drawn into broader discussions of the future intent and strategies for VAHP. Outputs of that process should include an updated theory of change (complete with working assumptions) and a results framework that makes clear the level of ambition regarding what VAHP is trying to achieve and the indicators for monitoring progress against outcomes. Results frameworks also to be developed and agreed for the Women in Leadership and Tasamlum Pilot initiatives.

20. GEDSI considerations to be mainstreamed into the theory of change and results framework.
21. DT Global increase M&E TA support for the Program.

5. Annexes

Annex 1. Global And Regional DFAT Health Investments In Vanuatu[49,50]

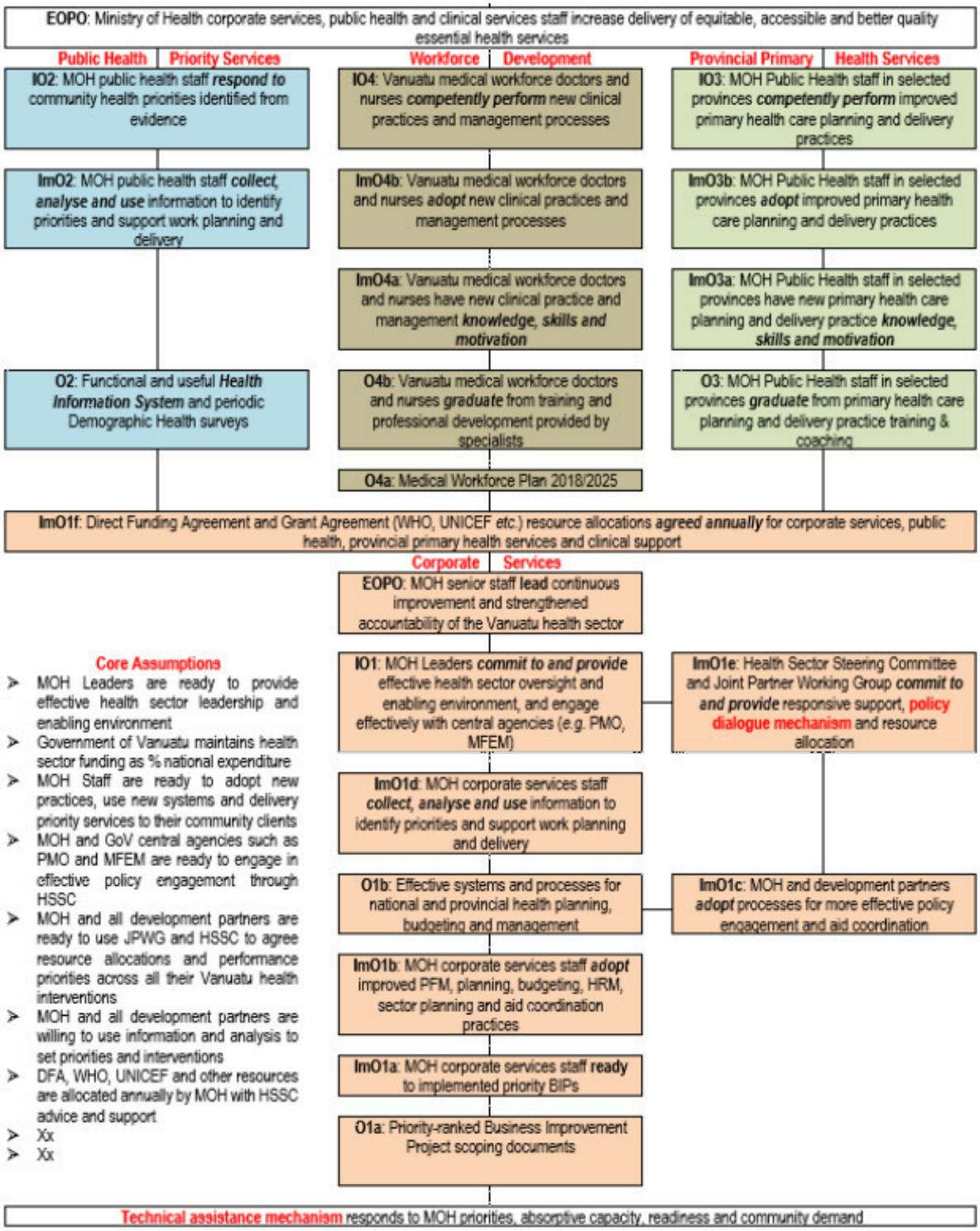
GLOBAL DFAT INVESTMENTS	Description
WHO Core Voluntary Contribution	Annual core voluntary contributions agreed through the DFAT-WHO Strategic Partnership Framework
Global Fund to Fight AIDS, TB and Malaria	Core funding to the Global Fund to accelerate the end of AIDS, tuberculosis and malaria as epidemics.
UNAIDS Core Contribution	Annual contribution as agreed through the DFAT-UNAIDS Strategic Partnership Framework an objective of which is the integration of the AIDS response into the wider context of health and sustainable development in Asia and the Pacific.
IPPF Core Funding	Addressing sexual and reproductive health and rights by working with governments, faith-based organisations and civil society
UNFPA Core Funding	The United Nations Population Fund assists countries in collecting, analysing and disseminating population data, and supports developing policies and programs on gender and maternal health, particularly reproductive health, including family planning, safe motherhood, HIV/AIDS prevention, gender-based violence and promoting gender equality.
Global Polio Eradication Initiative	To support global polio eradication efforts and protect Australian interests by managing the risk of polio re-emerging in this region. AUD105 million. 2015-2025.
REGIONAL DFAT INVESTMENTS	**Description**
UNFPA Transformative Agenda for SRH in the Pacific	Supports UNFPA's Pacific Subregional Office's Transformative Agenda for Women, Adolescents and Youth in the Pacific, to reduce unmet need for family planning towards zero.
UNFPA Supplies	UNFPA Supplies Program in the Pacific, including support for supplies to transition to national plans and budgets.

[49] Drawing on 'Health in Vanuatu: Australia's Support. DFAT. July 2022

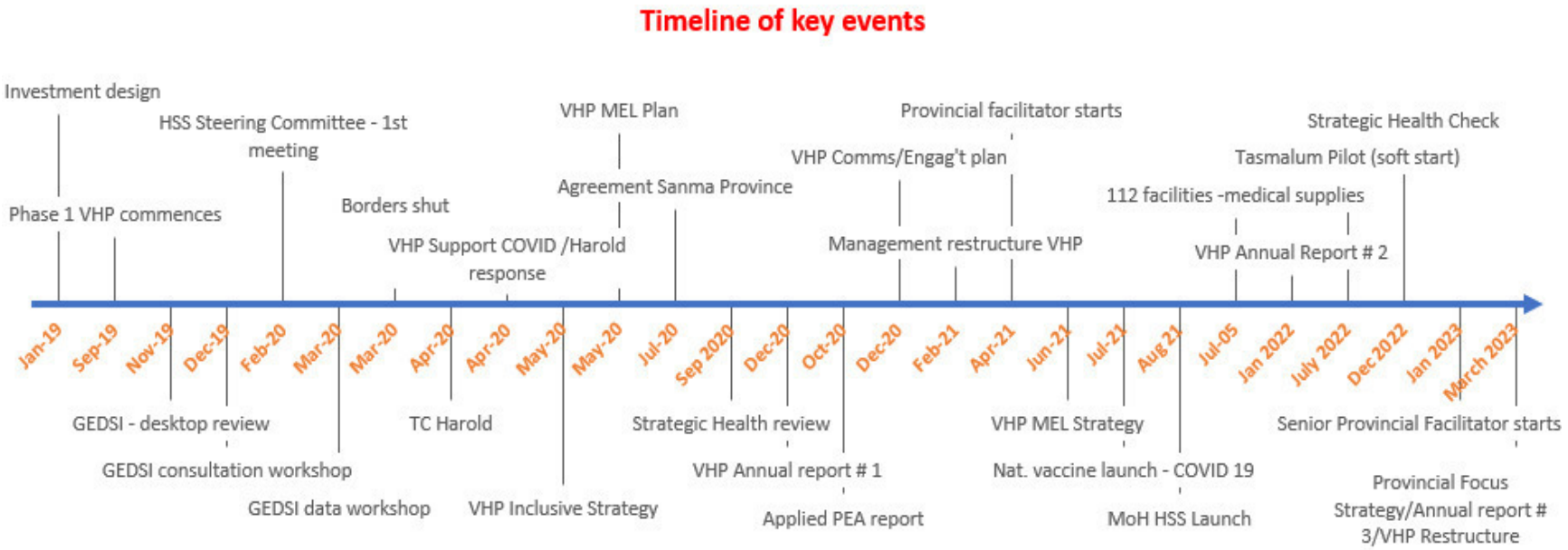
[50] These figures do not include the Australian NGO Cooperation Program (ANCP) and Australia Awards which also contribute to the Vanuatu health sector

Indo-Pacific Sexual and Reproductive Health and Rights COVID-19 Response (SRHR C-Surge)	Regional/multi-country. UNFPA, UNICEF, IPPF and MSI. AUD46 million. 2021-2024. To accelerate the capacity of service providers and technical specialists to help address urgent unmet need for SRH services and information. Vanuatu has been allocated $100k for IPPF to provide high-quality SRH services through established service delivery channels.
Regional Specialised clinical services and health workforce	Pacific Clinical Services and Health Workforce Improvement Program: Fiji National University, College of Medicine, Nursing and Health Science (FNU CMNHS) plus Visiting Medical Teams from Royal Australasian College of Surgeons (RACS) (11 Pacific Island Countries and Territories: Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, Nauru, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu)
Support to SPC Public Health Division	Core funding to the Pacific Community (SPC) Public Health Division to implement their business plan, which focuses on: NCDs, surveillance, health governance; and clinical services. 2021-2025.
Tupaia – Partnership for health information for health security and disaster preparedness	Regional support to Beyond Essential Systems to develop health information and surveillance systems across the Indo-Pacific. AUD13.57 million. 2019-2024.
Pacific Pharmaceutical Laboratory Testing Program Phase 2	Through the Pacific Medical Testing Program (PMPT) Phase 2, the Therapeutic Goods Administration (TGA) tests samples of medicines and therapeutic goods for quality assurance. 2021-2025. AUD2.0 million. Regional/multi-country: FSM, Fiji, Nauru, Kiribati, Palau, PNG, RMI, Samoa, Solomon Islands, Timor Leste, Tonga, Tuvalu, Vanuatu
Health Security Initiative for the Indo-Pacific region	Various investments to strengthen health security, COVID-19 response and pandemic preparedness. Successor is the Regional Health Partnerships for the Pacific and Southeast Asia.

Annex 2. Logic Model – Vanuatu Health Program



Annex 3. Timeline of Key Events



Annex 4. Review Team Composition and Responsibilities

Liz Kennedy, Joint Team Leader and GEDSI Adviser, is a Public Health Specialist with 20 years of experience managing and advising public health programmes in developing countries and extensive international field experience in development and advocacy, research and evaluation. Liz's experience includes nine years working in the disability sector and experience in GESI/disability mainstreaming. In addition to her role as Joint Team Leader, Liz will provide technical inputs on GESI and disability inclusion across the MTR process.

Jane Pepperall, Joint Team Leader and International Health Specialist, has over 30 years of experience in global health policy development and in supporting national health sector development in the Pacific, Asia, and Africa, with particular interests in health systems and health financing. In addition to her role as Joint Team Leader, Jane will contribute technical and contextual knowledge of Australian support to health programming in the Pacific across the MTR process.

As Joint Team leaders, Liz and Jane will be responsible for leading on all aspects of the evaluation including document review; an agreed review plan, in-country and remote consultations; an agreed Aide Memoire and final MTR report; and managing the inputs of other team members at all stages of the review.

Gregoire Nimbtik, **Ni-Vanuatu Health Adviser**, has over 20 years of experience in senior government positions in Vanuatu, most recently as Director General in the Ministry of Prime Minister, Republic of Vanuatu and previously as Director in the Department of Strategic Policy Planning and Aid Coordination. Greg will be a primary resource person for the team, supporting the Team Leaders with technical and contextual knowledge of Australian support to Vanuatu's health sector, the Vanuatu health system and the Vanuatu operating context more broadly. Greg's responsibilities will include document review; participation in stakeholder consultations; and technical inputs on the Review Plan, Aide Memoire and MTR report.

Rakesh Chandra, Climate and Disaster specialist, has 18 years of experience in the field of environmental health management and administration in both the Fiji Ministry of Health and local government. He is now working as a national consultant providing inputs, support and advice on climate change and climate finance with a focus on information knowledge management. Rakesh's responsibilities will include document review; participation in stakeholder consultations; and technical inputs to the MTR Plan and final MTR Report with a focus on ensuring that climate and disaster resilience are fully considered and addressed. Arrangements are in place for Rakesh to draw on additional inputs as required from Kathryn Bowen, Professor and Deputy Director of Melbourne Climate Futures and Professor of Climate, Environment and Global Health at the University of Melbourne.

Annex 5. Terms of Reference Mid Term Review

1. Position Title	Vanuatu Health Program Evaluation
2. Team Members	Joint Team Leader & GEDSI Adviser Joint Team Leader & International Health Specialist National Development Specialist Climate and disaster resilience and health specialist
3. Program	Vanuatu Health Program
4. Term	Work to be conducted between 13 February 2023 – 31 July 2023
5. Background	The Vanuatu Health Program (VHP) is a five-year AUD25 million investment (2019-2024). VHP is implemented by Managing Contractor DT Global and through a partnership with the World Health Organisation (WHO) in-country office. VHP is the first phase of a 15-year program, designed as a problem-driven iterative approach program (PDIA) to support Vanuatu's Ministry of Health (MoH) to "effectively deliver the health components of the National Sustainable Development Plan 2016-2030 and commitment to health services demanded at national, provincial and local levels by a healthy, secure and productive population". The agreed end of program outcomes (EOPO) for the investment are: **EOPO1** – MOH corporate services, public health and clinic services staff increase delivery of equitable, accessible and better-quality essential health services; and **EOPO2** – MOH senior staff lead continuous improvement and strengthened accountability of the Vanuatu health sector. VHP is delivered under four components and with four key Intermediate Outcomes (IOs): • **Corporate Component 1** seeks to strengthen MOH leadership **IO1**. MoH leaders commit to and provide effective health sector oversight and enabling environment and engage effectively with central agencies. • **Public Health Component 2** seeks to strengthen public health **IO2**. MoH public health staff respond to community health priorities identified from evidence. • **Provincial Focus Component 3** seeks to improve provincial level management and systems **IO3**. MoH public health staff in selected provinces competently perform improved primary health care planning and delivery practices. • **Workforce Development Component 4** ensures a competent workforce that delivers quality health services **IO4.** Vanuatu medical workforce doctors and nurses competently perform new clinical practices and management processes. VHP delivers support through (i) funding into Government of Vanuatu (GoV) systems for all four components under a Direct Funding Arrangement (DFA) (56%); (ii) technical assistance (TA) and facilitators embedded or working with MoH on program deliverables supplied through DT Global and the WHO (10%); and (iii) program support costs through Cardno (34%).

	From 2020 – 2022, VHP's key activities included supporting MoH to maintain essential health services while also rolling out Vanuatu's National Deployment and Vaccination Plan (NDVP) on COVID-19 vaccines, as well as preparing for and responding to the COVID outbreak in March 2022. Significant additional financial and human resources have been provided to MOH to combat the dual crises of COVID-19 and Tropical Cyclone Harold. This change in context impacted the program and the focus of VHP significantly. Program implementation is governed in partnership with MoH, which has endorsed this operating model and is gradually taking stronger ownership of the program. Allowing flexibility in the VHP design has enabled the program to pivot as required to the operating context and emerging priorities. A governance advisory committee jointly chaired by MOH and DFAT decides on program activities and the strategic direction of VHP. VHP's activities take place in all six provinces of Vanuatu. A health check and strategic reviews of VHP conducted in 2021 by DT Global informed a DFAT decision to extend the program for another two years. Phase 1 of VHP will end in September 2024. DT Global undertook a follow up health check in 2022.
6. Purpose and objectives	The team will conduct a mid-term evaluation of the VHP that provides key findings on program progress and achievements and recommendations to inform any updates or modifications to the design for the next phase of Australian investment in the Vanuatu Health Program.
7. Duty Statement	The evaluation will: • Evaluate VHP's **effectiveness** in terms of progress toward achieving the EOPOS and IOs. • Assess VHP's performance in terms of: i) **efficiency**; ii) **gender quality, disability and social inclusion** and iv) **monitoring and evaluation**. • Evaluate the suitability of the VHP modality and governance arrangements and make recommendations which are sensitive to the current political context and economy. • Evaluate the impact of the pivot to COVID-19 on achievements of VHP's own objectives and identify resultant lessons • Provide recommendations for improving performance of Australia's future health sector investment in Vanuatu including options for enhanced climate and disaster resilience integration. Evidence and analysis of lessons learned from previous health investments should be included. Recommendations are to include suggested revisions to the VHP design, VHP program logic and outcomes, and/or governance arrangement, modality or contract arrangements and partnerships. The evaluation should respond to the following key evaluation questions with a credible evidence base. Sub-questions will be prioritised and refined further with the DFAT team through the evaluation plan:

	1. Effectiveness – Is VHP making progress towards its expected outcomes? a. To what extent is VHP on track to achieve its EOPOs? b. To what extent is VHP achieving its IO targets? c. What assumptions have held true? What have not? Why? d. To what extent has VHP worked in keeping with its principles? e. Has VHP contributed to results outside of its EOPOs and IOs, and how? f. How is VHP's effectiveness hindered and/or enhanced by the VHP modalities, governance arrangements and level of resources? g. How is the political economy of the health sector (including frequent health leadership changes) hampering sustainability of VHP's efforts? h. How did the pivot to COVID-19 impact achievement of VHP's own objectives and are there resultant lessons? i. How is VHP supporting coherence and coordination across the breadth of the Australian government's health sector support? j. How effective has the interaction of VHP been with other Australian Government investments including through multilateral and regional organisations? k. In what ways could effectiveness be improved, particularly given the impact of COVID-19 on MoH and Vanuatu? **2. Efficiency – How well are VHP resources being used?** a. Is VHP delivering, or likely to deliver, results in an economic and timely way? b. How is VHP's efficiency impacted by the current modalities and level of resources with the dual emergencies of COVID-19 and regular disasters such as TC Harold and slow onset climate impacts like sea level rise? c. How could efficiency be increased, particularly considering the impact of COVID-19 on MoH and Vanuatu and considering future disasters and pandemics? **3. Gender equality and social inclusion (GESI) and disability inclusion – Is VHP contributing to greater equity and social inclusion?** a. To what extent is VHP's inclusive strategy meeting DFAT'**s** gender, disability and social and environmental safeguards policies, standards and requirements? b. To what extent is VHP aligned with the new Health Sector Strategy and GOV's gender policy, disability, RMNCH policies and how might this be strengthened? c. To what extent are VHP-supported improvements benefiting women and children, and people with disabilities? d. What are the main barriers/risks to progressing impactful GESI and disability inclusive health sector responses and why? e. What evidence is there of VHP contributing to closing health equity and gender equality gaps? f. Were adequate financial and human resources set aside for VHP's GESI and disability agenda? g. Has VHP been able to progress gender budgeting? h. What are the main lessons learned from VHP in relation to a) GESI and disability inclusion and b) safeguards; and what might be the priority opportunities and recommendations going forward?

4. Climate and environment – How can VHP increasingly address health sector related climate and environment considerations?

a. To what extent is VHP meeting DFAT's environmental safeguards policies, standards and requirements

b. How is VHP aligning to the National Health Plan for Disaster Risk Management and Climate Change Adaptation?

c. How can climate change and disaster resilience considerations be integrated into future programming to ensure more resilient health systems?

5. Monitoring and evaluation

a. To what extent is VHP's M&E system: producing the right information at the right time to inform learning and adaptation; supporting 'local solutions'; facilitating risk management; enhancing strategic decision-making by VHP and MOH; and demonstrating VHP impacts?
b. To what extent is VHP strengthening M&E capability within MOH?
c. How and to what extent did VHP adapt MEL activities, including planned capacity development work with MOH, during the dual emergency period?
d. What qualitative examples are there of the generation of data/information influencing GoV policy and priorities?
e. To what extent is VHP strengthening information systems to better monitor and plan for GESI and disability inclusion?
f. How could the M&E system be improved to effectively measure implementation progress, and progress towards meeting expected outcomes?

In consultation with MoH, this evaluation will inform the **key decision** by DFAT whether to continue VHP under the current managing contractor arrangements via contract extension, or re-tender the program.

The evaluation will also inform **secondary decisions** by DFAT management, in consultation with MoH, regarding any amendment to the design of VHP and what lessons from VHP should be shared.

Annex 6. Document Review List

Vanuatu Health Program Documents
Vanuatu Health Program Investment Design (2018)
Vanuatu Health Program. Design Strategy and Options Paper (May 2018)
VHP Annual Report (Jan - Dec 2020)
VHP Annual Report (Jan - Dec 2021)
VHP Annual Report (Jan - Dec 2022)
VHP Inclusive Health (GESI) Strategy and plan of action (2020)
VHP Inclusive Health Strategy - Revised GEDSI Strategy (2022)
VHP MEL Strategy (2021)
VHP Monitoring, Evaluation and Learning Plan (2020)
VHP MEL Strategy Summary (2021)
VHP Annual Workplan (2023)
VHP Provincial Focus Strategy (2023)
VHP Strategic Health Check December (2022)
VHP Strategic Health Review – Findings
VHP Case study series (2022)
VHP Stakeholder Engagement and Communications Plan (2020)
Government of Vanuatu Documents
Vanuatu 2030 The Peoples Plan - National Sustainable Development Plan 2016 to 2030
Health Sector Strategy (2021 - 2030)
Monitoring and Evaluating the HSS
Vanuatu MoH Corporate Plan (2022-2025)
MOH Annual Business Plan (2022)
Reproductive, Maternal, Child, New-born, Child and Adolescent Health (RMNCAH) Policy (2021-2025)
MoH Workforce development plan (2019 -2025)
National Gender Equality Policy (2020-2030)
Vanuatu National Youth Policy (2019-2024)

NCD Policy and Strategic Plan
Health Sector Strategy (2017-2020)
Vanuatu Mental Health Policy and Strategic Plan (2016 -2020)
Vanuatu National Child Protection Policy (2016-2026)
National Disability Inclusive Development and Policy (2018 - 2025)
DFAT Documents
Strengthen the resilience of Pacific Health Systems Climate Smart Recovery
Consultations on Future Priorities for Regional Health Programming in the Indo Pacific Region (2022)
Development for All 2015–2020: Strategy for strengthening disability-inclusive development in Australia's aid program
Development for All 2015–2020: Strategy
DFAT Child Protection Policy (2018)
Gender Equality and Women's Empowerment Strategy (2016)
Environmental and Social Safeguards Policy (2019)
Vanuatu Skills Partnership - Better Balance Strategy - *has an explicit commitment to mainstream efforts in gender equality, disability inclusion and climate change management throughout all its activity.*
Effective Support for Women's Leadership in the Pacific: Lessons from the Evidence (2019)
Vanuatu COVID-19 Development Response plan (2020)
Design and Monitoring and Evaluation Standards (2022)
Health in Vanuatu: Australia's Support. DFAT (2022)
Other Documents
Implementing Adaptive Management: A front-line effort.
Rapid Gender Analysis - Post Harold
Gender Equality Brief for Vanuatu. UNWOMEN (2020)
Strategy and Implementation Plan to accompany the RMNCAH Policy plus standard operating procedures for the clinical management for the rape, sexual violence and gender-based violence
Health Facility Readiness & Service Availability (HFRSA) assessment report
Needs Assessment: Women and young people with disabilities – Vanuatu (2022)
Vanuatu Health Financing Systems Assessment: Spend Better. World Bank (2018)
Analysing Vanuatu's economy and public finances through the lens of disaster resilience Republic of Vanuatu: Country Economic Memorandum and Public Expenditure Review. World Bank. 2021

Opportunities and challenges for DAC members in 'adapting to context'. ODI. Samuel Sharp, Leni Wild. 20 March 2021
Teskey, G., & Tyrrel, L. Implementing Adaptive Management: A front-line effort — Is there an emerging practice? (Working Paper). Abt Associates. 2021.
Making adaptive rigour work: principles and practices for strengthening MEL for Adaptive Management. ODI. 2019
Towards evidence-informed Adaptive Management. ODI. 2019
ODI. Top Tips: How to design and manage adaptive programs. 2016
Rogers, P. and Macfarlan, A. An overview of monitoring and evaluation for Adaptive Management. Monitoring and Evaluation for Adaptive Management Working Paper Series, Number 1, September 2020
Supporting Adaptive Management: monitoring and evaluation tools and approaches. ODI. 2019
Australian Health Portfolio Review, Vanuatu. Catriona Waddington and Jack Eldon. Health Resource Facility 2015

Annex 7. MTR Consultation List

Organisation	Title
Department of Foreign Affairs and Trade	
Heidi Bootle	Head of Mission AHC
Clemency Oliphant	Deputy High Commissioner
Olive Taurakoto	Senior Program Manager Health
Paul Regnault	First Secretary Infrastructure and Health
Belinda Karae-Lewa	Program Manager Health
Patricia Fred	Program Manager Health
Shannon Ryan	Governance for Growth
Alice Kalontaw	Senior Program Manager Humanitarian
Yvette Andrews	Program Manager Education
Josiana Jackson	Senior Program Manager Infrastructure
Gina Dehinavanna	Program Manager VSP and scholarships
Hannah Gregory	Political Team Rep
Jodie Kapula	Program Manager Gender
Renie Anderson	Senior Program Manager, Police and Justice
Dr Frances Bingwor	Senior Program Manager Health, Suva Post
Vanuatu Australia Health Partnership	
Shirley Tokon	Partnership Director
Rebekah Svilicic	Deputy Director
Chatu Yapa	Health Security Support - Adviser
Jackie Mundy	Strategic Health Support- STA
Chris Hagerty	Health Planning Support -STA
Emele Duituturaga	GEDSI Support - STA
BerlinRose Nimbtik	GEDSI Coordinator
Dick Hopkins	Strategic Provincial Facilitator - FTE
Ricky Lee	Provincial facilitator, Santo
Kenslyne Lele	Provincial finance officer, Santo
Leisongi Oscar	DFA Manager
Jack Obed	Finance Officer
Fred Philemon	Infrastructure Support Officer
Nelly Willie	Program Quality Coordinator
Kate Morioka	MEL support - STA
Yohann Lemonnier	Communications Coordinator
Sereana Marum	Finance and Operations Manager
Nish Vivekananthan	Former PFM Adviser now Director, Pacific Consulting Limited
DT Global	
Anna Gibert	Strategic programming support (PEA) - STA
Cynthia Ojiambo	Contractor Representative
Ben Fraser	Former Contractor Representative
Angela Lenn	Pacific Region Program Lead
Joanne Choe	Head of Program Quality and Gender, DT-Global Asia Pacific
MOH	
Rick Tchamako Mahe	Hon. Minister for Health
Judith Melsul	Acting Director General
Posikiai Sam Tapo	Director Corporate Services
Dr Sereana Natuman	Director Curative and Hospital Services
Dr Jenny Willie	Director Public Health
Nellie Muru	Manager Environmental Health
Marie Nirua	HIS Unit representative

Organisation	Title
Wesley Donald	National Coordinator, Malaria and OVBDCP
Terina Mele	Admin Support Officer, TB/HIV)
Gibson Ala	National Coordinator, NCD Unit
Jaques Rory	Health Promotion
John Taiva	Principal Compliance Officer
Sandy Sawan	Disaster and Emergency Officer
John Jovi	Projects and AID officer
Stevenson	Acting Manager Finance
Jasen Diopa	Principal Pharmacist
Edmund Tavale	Assets Manager
Wendy Williams	Surveillance Unit Acting Manager
Mennie Nakoma	Acting Planning Unit Manager
Simo Simoen	EPI Manager
Len Tarivonda	Former Public Health Director (now with Peace Corps)
Harriet Sam	Principal Nursing Officer
Rebecca Iaken	M&E Officer
Jean-Jacques Rory	Health Promotions Manager
Morris Amos	Shefa Health Administrator
Obed Manwo	Public Health Manager
Dr Vincent Atua	Medical Superintendent, VCH
John Ailir	Sanma Health Administrator
Vanua Sikon	Sanma Public Health Manager
Beverlyn Tosiro	Nursing services manager
Dr Andy Ilo	NPH Medical Superintendent
Dr Orelly Thyna	Head of Paediatrics, VCH
Markson Tabi	Penama Public Health Manager
Macklyn Tagaro	Penama Health Administrator
Senior Clinical Instructor	Vanuatu College of Nursing Education
Public Health - instructor	Vanuatu College of Nursing Education
Midwifery instructor	Vanuatu College of Nursing Education
Government of Vanuatu – Non-Health	
Hon. Matai Jeremaiah	Minister for Trade and Tourism
Hon. Ralph Regenvanu	Minister for Climate Change
Stephen Nako	Provincial health administrator, Torba province
Henry Wetul	Public health manager, Torba
Albert Ruddley	Secretary General Sanma Province
Nancy Swua	Disability officer community service Penama
Dickinson Leli	Physical Planner (CRIM), Penama
Hensly Roy	Registration Officer, Penama
Manson Tavi	Provincial NDMO officer, Penama
Moses B	Penama Provincial Government Council
Kelly Tabi	Assistant Secretary General, Penama
Gloria Hinge	Child Protection Officer, Penama
Salome Kenneth	Public health manager, Malampa province
Lolyne Jeremiah	Public health manager, Tafea Province
Evelyne Emile	VCNE Principal Educator
Viran Tovu	DSPPAC- Senior Policy Analyst- Health Sector
Michelle Trief	Department of Local Authorities
Nigel Taribete Malosu	Deputy Director Ministry of Finance and Economic Management
Health Sector Partners	
UN Agencies	

Organisation	Title
Dr Eunyoung Ko	Country Liaison Officer, WHO
Dr Philippe Guyant	Communicable Diseases Medical Officer, WHO
Eric Durpaire	Chief of UNICEF Field Office
Emily Deed	Vanuatu Office Lead- SRH Specialist, UNDP
Roselyn David	National Consultant Spotlight Initiative
SPC	
Cecille Depuille	Program Coordinator, SPC
Mia Rimon	Director, Melanesia, SPC
Embassy of France	
Gwennan Delannee	Representative, French Embassy
Embassy of Japan/JICA	
Hiroko Watahashi	First Secretary, Embassy of Japan
Akihito Motegi	Representative (Project Formulation), JICA
CARE	
Bridgette Thorold	Country Director, CARE
Frida Sam	Policy Advisor, CARE
Save the Children	
Louise Nasak	GCF, Save the Children
Sherold Manna	Early Childhood, Save the Children
Jack French	Acting Country Director, Save the Children
NGOs	
Julius Moffat	Program Manager, Vanuatu Family Health Association
Nelly Caleb	National Coordinator, Vanuatu Disability Promotion and Advocacy Association
Gillio Baxter	Executive Director, VPride
BoP	
Wilson Toa	Country Director, Balance of Power
VSP	
Fremden Yanhambath	Director, Vanuatu Skills Partnership (VSP)
Janiengco Vusilai	Project officer, VSP
Amos Tolu	Project manager VSP
Simeon Bage	Skills Centre Manager, VSP (Sanma)
Steven Tavnalsit	Skills for Health Officer, VSP (Sanma)
Health Security Initiative	
Andrew Lyons	Biomedical Engineer, Health Security Initiative
GIZ	
Peter Wallace	Public Financial Management Adviser, GIZ

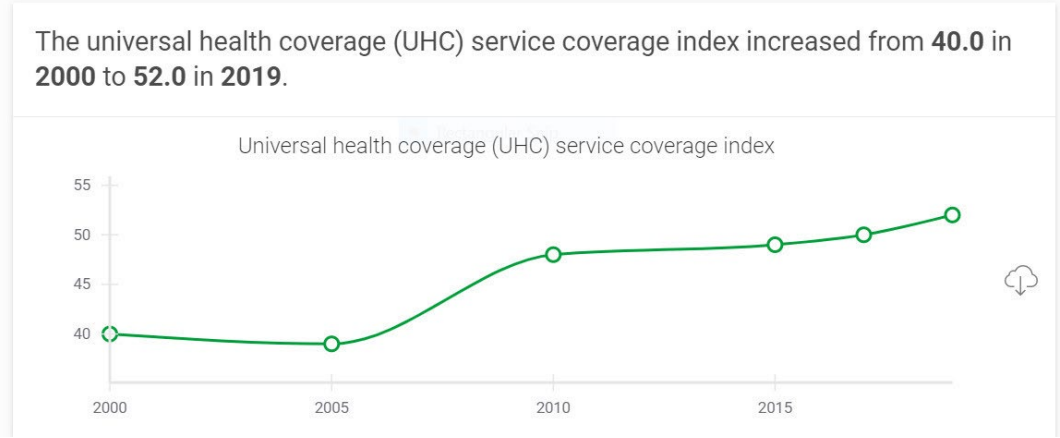
Annex 8. Summary Views on Progress Against Outcomes of Original VHP Investment

VHP OUTCOMES	SUMMARY VIEWS ON PROGRESS
End of Project Outcomes	
1. MOH corporate services, public health and clinic services staff increase delivery of equitable, accessible and better-quality essential health services. *[No VHP indicators]*	The scope and level of VHP's ambition were never defined (and subsequently monitored) with respect to increased delivery; equity; access; and quality of essential health services. VHP is not yet on a path to be able to demonstrate progress as it has not yet defined what changes it is trying to support and so is not tracking that progress. The **volume of essential health services** delivered by MoH is inadequate and there is evidence of a relative under provision of services in the rural areas where the majority of the population lives.[51] Outpatient visits have increased from 1.4 visits per person in 2016 to 1.9 visits per person in 2019 but regional inequities exist. There is a lack of relevant MoH health sector reporting (for example, the MoH annual health report for 2022 did not issue). **Equitable essential health services**. In the absence of routinely disaggregated data, neither GoV nor VHP can demonstrate if they are contributing to closing gender/disability/disadvantage gaps in access to essential health services. VHP shows intent to do so by prioritising gender, disability and support to Provincial health services. **Accessible essential health services.** Health workforce shortages, especially of nurses, is one of the main constraints to accessible essential health services. Vanuatu has 1.4 nurses and midwives per 1000 population (2019), compared to 2.2 in Solomon Islands and 3.8 in Vanuatu[52]. The resulting staff shortages caused the temporary closure of certain health care facilities. Furthermore, an uneven distribution in the supply and deployment of health workers led to inequities in the effective provision of health services. Outpatient visits to health facilities, including aid posts, averaged 1.8 per person in 2016 (compared to 2.1 in Solomon Islands and 4.9 in Kiribati).[53] **Better quality essential health services**. Neither GoV nor VHP are quality assuring service delivery through, for example, introduction of standards and accreditation systems. In one specific area of quality, complementary VAHP inputs are improving the quality of buildings and equipment. Other relevant VHP contributions to enhanced quality include training and the injection of DFA resources. UN data on **delivery of essential health services:** Coverage of essential health services is UN SDG indicator 3.8.1. This Service Coverage Index (SCI) is reported on a unitless scale of 0 to 100, which is computed as the geometric mean of 14 tracer indicators of health

[51] Analysing Vanuatu's economy and public finances through the lens of disaster resilience Republic of Vanuatu: Country Economic Memorandum and Public Expenditure Review. World Bank. 2021

[52] Nurses and midwives (per 1,000 people) | Data (worldbank.org)

[53] Vanuatu Health Financing Systems Assessment: Spend Better. World Bank (2018)

	service coverage interventions. These include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access. The next Global Monitoring Report of SCI data is due later in 2023. From Vanuatu trend data (below) in the years up to the pandemic, it can be anticipated that the SCI will have remained stagnant at best given the negative impact of COVID-19.  Source: Vanuatu SDG Country Profiles
2. MOH senior staff lead continuous improvement and strengthened accountability of the Vanuatu health sector. *[No VHP indicators]*	Momentum on this agenda during the lifetime of VHP has been undermined by regular turnover of staff, including Ministers, at the central MoH, resulting in progress being patchy rather than sustained. The development of the Health Sector Strategy by senior MoH staff is a positive example of leadership. Again, however, subsequent staff turnover resulted in some loss of continuity and momentum between the HSS and the subsequent Corporate Plan, notably with respect to Inclusive Health. The design was premised on what proved to be optimistic assumptions about capacity and appetite for enhanced leadership, coordination, analysis and evidence-based planning and budgeting.

	Intermediate Outcomes
1. MoH leaders commit to and provide effective health sector oversight and enabling environment and engage effectively with central agencies.	Indicators proposed at design (not used by VHP): • Effective systems and processes for national and provincial health planning, budgeting and management • More transparent and effective public financial management at all levels • More efficient use of limited human resources at all levels • Better use of evidence for policy and decision making • Better collaboration and engagement between MOH and Central Agencies
	Summary views on progress: ➢ The dual crises saw enhanced leadership within MoH and enhanced collaboration and engagement between MoH and central agencies. More recently there has been positive collaboration between MoH and PSC on the Women In Leadership Initiative. ➢ Despite VHP working with a range of able MoH officials, the general sense from the review was of little progress relative to the mutually agreed aspirations of the design. ➢ A disconnect between budgets and plans continues, with little sign of budget decisions being informed by evidence and analysis but, rather, budgets and plans simply being rolled over from year to year. This came through in provincial consultations and was also apparent in the way that HSS has not been followed through into revised budget allocations. ➢ Similarly, long standing health workforce constraints do not appear to have improved.
2. MoH public health staff respond to community health priorities identified from evidence.	Indicators proposed at design (not used by VHP): • Immediate community priorities addressed by MOH public health programs • Well coordinated development partner funding and TA to address public health priorities. • Better collaboration between MoH directors and central agencies to resolve institutional issues undermining public health services
	Summary views on progress: ➢ This would have benefitted from further definition at inception. 'Community health priorities' and 'health priorities identified from evidence' may not align. Ideally HSS would be the framing of priorities. VHP did not find ready entry point to support the Corporate Plan that should have flowed from HSS. ➢ MoH public health staff clearly responded well to the threat of COVID-19, evidence by strengthened surveillance, more effective donor coordination and good COVID-19 immunization coverage.

	Public Health is heavily reliant on external funding and external TA, both of which remain poorly coordinated, leading to inefficiencies and failure to build long term capacity. VHP's own TA inputs on Public Health were felt by the Review to be somewhat ad hoc. There is no evidence of strategies and plans for strengthening of coordination on the part of GoV or partners.
3. MoH public health staff in selected provinces competently perform improved primary health care planning and delivery practices.	Indicators proposed at design (not used by VHP): • More confident and motivated provincial health management • Local solutions to problems implemented • Higher spend of recurrent budget allocations • Increased quality and quantity of outreach and supportive supervision • Increased funding to deliver services to remote and neglected populations • Increased demand from provinces to central MOH to address constraints • Relative improvement in National MOH HIS service delivery and health status indicators compared to other Provinces
	Summary views on progress: ➢ The Review was impressed by Provincial Public Health staff in Sanma and Shefa Provinces. ➢ PHC service delivery is undermined by significant constraints that include inadequate operational budget and too few health workers, which, combined, result in insufficient PHC services being delivered through health centres, dispensaries and outreach. ➢ PHC services benefit from DFA funding and the planning and budgeting of those DFA resources has, per se, an element of capacity building. ➢ In Tasmalum some initial problem identification has begun although strategic planning and programming to address those problems, with alignment of relevant TA, has yet to happen. No routine Health Information System reports were being submitted by Tasmalum health centre at the time of the visit. ➢ No demonstrated evidence of VHP influencing GoV's own recurrent budget allocations to the Provinces. ➢ The domestic recurrent budget allocation has always been close to being fully or over expended (99% in 2018, 96% in 2019, 105% in 2020). The over-expenditure in 2020 was a result of the additional financing received for COVID throughout the year. No demonstrated evidence of increased quality and quantity of outreach and supportive supervision through MoH's own resourcing.
4. Vanuatu medical workforce doctors and nurses competently perform new clinical practices and management processes.	Indicators proposed at design (not used by VHP): • Number of specialist locums supplied to Vila Central Hospital and Northern Provincial Hospital enable continued provision of referral services • Medical workforce retention rates [disaggregated by sex, province and type of staff] • Number of qualified nurses and trained midwives graduating from Vanuatu College of Nursing Education (VCNE) • Collaboration between MOH, VCH, VCNE and other Vanuatu and regional education institutions to maintain ongoing clinical training and standards.

	➢ Locum(s) are being funding by VHP and progress has been made getting these positions supported and managed through government systems. ➢ No apparent progress on broader Medical and Health Workforce planning issues (retention, allocation of staff across Provinces, absenteeism etc). ➢ Planned VHP supported training through the Vanuatu College of Nursing Education (VCNE) had a setback when VCNE accreditation was withdrawn but valuable VHP support provided to VCNE in their efforts to secure reaccreditation and to support their collaboration with MOH, VCH and other Vanuatu and regional education institutions. No evidence that training and capacity building gets followed up with impact assessment e.g. use of clinical competence vignette tools.

Annex 9. Terms of Reference GAC

TERMS OF REFERENCE

Ministry of Health – DFAT Governance Advisory Committee
Terms of Reference

Mandate
To provide advice and make recommendations with regards to:

- the strategic oversight and governance of the Vanuatu Health Program (VHP);
- the direct funding arrangement between the Government of Australia and the Government of Vanuatu; and
- Support and assist the Ministry of Health in the delivery of Business Plans and the Health Sector Strategy.

Scope

1. All issues pertaining to the strategic oversight and governance of the Ministry of Health-DFAT Governance Advisory Committee
2. Consideration of Business Plans for forthcoming calendar years including revenue and expenditure priorities.
3. Oversight of the VHP annual work plan and technical assistance plan.
4. Oversight of the progress of execution of the Business Plan and Direct Funding Agreement budget execution for the current calendar year.
5. Assessment and review of performance of the health sector based on the indicators described in the Performance Assessment Framework (PAF).
6. Review and update of program risk management plan/strategy.

Membership

- Director-General of Health
- Director - Policy, Planning and Corporate Services
- Director – Hospitals and Curative
- Director – Public Health
- First Political Advisor, Minister for Health
- Private Secretary, Minister for Health
- First Secretary, Health & Infrastructure, DFAT
- Senior Program Manager, DFAT
- Program Manager, DFAT
- Team Leader, VHP
- Deputy Team Leader, VHP
- Other attendees as required.

The Ministry of Health-DFAT Governance Advisory Committee is not a legal entity, will not be deemed to constitute or create any legally binding, enforceable obligation (express or implied) or international treaty on the part of the Government of Vanuatu or any other Partner and is not intended to give rise to legal process.

Chairs

The Committee shall be co-chaired by the Director-General of the Ministry of Health and the First Secretary, Health and Infrastructure, DFAT, Port Vila.

Recommendations and Decision-making

- Recommendations will be made by consensus.
- Where a consensus in the Governance Advisory Committee cannot be reached on an issue the issue will be held over to a later date, determined out of session or not proceeded with.
- Important recommendations must be approved by the MoH Executive Committee.

Meetings

Meetings will be held as required, but not less than once per quarter. Meetings will take place in person. VHP will be responsible for the logistic arrangements for each meeting and for providing secretariat support.

Amending the Terms of Reference

The Terms of Reference may be revised upon a recommendation of the Governance Advisory Committee.