



National Health Strategic Plan 2016 - 2020





Vision

“The People of the Solomon Islands will be
Healthy, Happy, and Productive!”

This is the strategic plan of the Ministry of Health and Medical Services (MHMS) for the period 2016 to 2020. In keeping with our national motto this plan provides leadership for the health system, in service to our government and the people.

In our quest for health we intend to reduce sickness, prevent the loss of young lives and relieve suffering. Our vision for health goes beyond fighting disease; we intend to contribute to the wellbeing of all our people. Happiness is more than a smile – it is people who are content, fulfilled, and have the freedom to live the life they choose. Productivity is more than making money – it is people who are not dependent but self-reliant, who live in a sustainable way, and are able to contribute to our society.

Message from the Minister of Health

Hon. Dr Tautai Agikimua Kaitu'u



On behalf of the government I endorse this strategic plan for the health sector. It lays out how we intend to improve the health of our people over the next five years. The government has identified a number of priorities in the area of programs, workforce, facility development, and legislation.

Our program priorities will ensure that our communities, especially remote areas, have access to safe water and basic sanitation.

We intend to improve access to trained health workers and ensuring that area health centres and provincial health systems are adequately resourced.

We also intend to improve the health facilities in Honiara and the provinces. We will progress the relocation and building of a new national referral hospital, provincial hospitals such as Kirakira and Kilu'ufi.

The government is also intending to bring health legislation up to date and make it more effective. This will include the Health Service Act, legislation for mental health, legislation on tobacco and alcohol to help control noncommunicable disease, and the legislation governing our key health professionals, the Medical Dental Board and the Nursing Council.

The government's underpinning values of accountability, transparency, equity and participation will also be given expression in the work that will be conducted under this plan. Together we will work to support our people to be Healthy, Happy and Productive.

Message from Permanent Secretary for Health

Dr Tenneth Dalipanda



This strategic plan is a sign post on our road to health. It is an opportunity, after considering what went well in the past and what did not, to refresh our vision and reset our direction for the next five years.

Reflecting on past performance, the MHMS faces a big challenge. We have shown improvement in areas such as malaria control and reducing neonatal deaths, but have plateaued in others. Overall we need to improve the quality of our service delivery.

The four Key Result Areas (KRAs) spell out the priorities that we must address; improved program coverage, partnerships, quality, and building a foundation for the future. These priorities apply to the whole organisation, not just one part or program.

Take immunisation coverage as an example. Getting full coverage of the population must come first. Never again should we allow our children to be exposed to a widespread measles epidemic.

The plan identifies other areas where we want to improve coverage, access and reach of services. This is what Universal Health Coverage (UHC) is really about.

To be effective at improving health we cannot continue to work in isolation, as health is generated by both our work and the impact we make with our partners. The plan will challenge us to work in a coordinated way with partners such as the churches, and with other line

ministries in our work across sectors.

Improving the quality of services is a key result area that also has relevance to every part of the MHMS. Not only in clinics, in hospitals and in public health programmes but also in internal financing and programming.

In preparing for the future, both the skills and the positioning of our workforce feature in the plan. Improving access is directly related to making sure a well trained and appropriately skilled workforce is available and accessible to meet the health needs of our rural and urban populations. The Sustainable Development Goals (SDG) are now on the global agenda and also feature in this plan. The SDGs cover the social determinants, so to achieve them working in partnership is essential, since we are serving the same populations.

To meet these strategic challenges, the MHMS is re-organising itself to become more streamlined, more effective and to make each dollar go further. Provinces will have greater sway at the executive table and we will be working to complete the role delineation policy, as it will help drive this strategic plan.

We face a challenging financial environment. Aid flows are fluctuating and hard to predict; whilst in some areas we have not fully spent the available resources. The government's commitment to financing the health sector has been steadily growing. Our challenge is to use it effectively and efficiently in the service of the people.

This plan outlines our approach on the road to health for our nation. I invite all our stakeholders to use it to guide their activities in the health sector through to 2020. This plan is the beginning of the journey. What we do, individually and collectively, over the next five years will make the difference to the health of our people.

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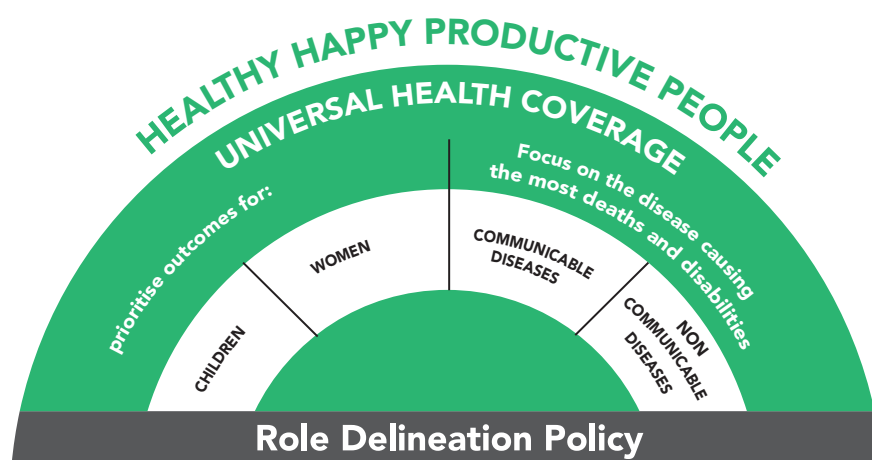
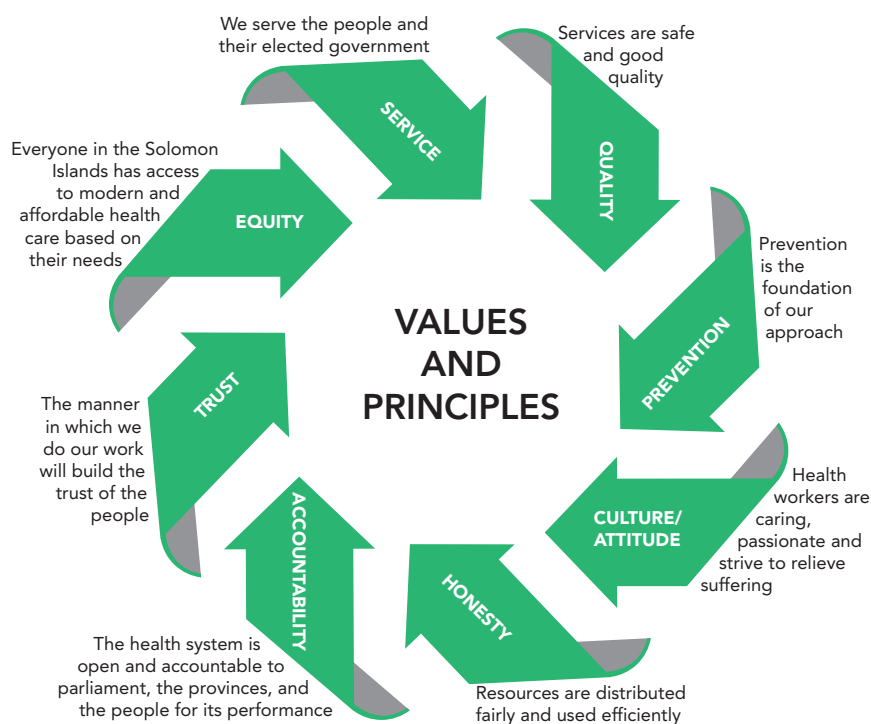
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Acronyms

AHC	Area Health Centre	NCD	Noncommunicable Diseases
AOP	Annual Operating Plan	NGO	Non-Governmental Organisations
CEO	Chief Executive Officer	NRH	National Referral Hospital
CHC	Community Health Centres (NAP)	NHSP	National Health Strategic Plan
DP	Development Partner	PEN	Package of Essential NCDs
FBO	Faith Based Organisation	RCDF	Rural Constituency Development Fund
GFATM	Global Fund Against Aids TB and Malaria	RDP	Role Delineation Policy
HR	Human Resources	RHC	Rural Health Clinic
KRA	Key Result Areas	SDG	Sustainable Development Goals
MDG	Millennium Development Goals	SIG	Solomon Islands Government
MHMS	Ministry of Health and Medical Services	SINU	Solomon Islands National University
MP	Member of Parliament	TB	Tuberculosis
MTEP	Mid Term Expenditure Prediction	WHO	World Health Organization
NAP	Nurse Aide Post (now called CHCs)	YLL	Years of Life Lost

The National Health Strategic Plan approach.

This plan focuses on implementation. Our priority objectives aim to improve child and maternal health outcomes, addressing communicable diseases and responding to noncommunicable diseases. This plan identifies the approach we will take to improve the health of the people. This involves identifying priority interventions and making sure they reach the whole population especially those most vulnerable and isolated.

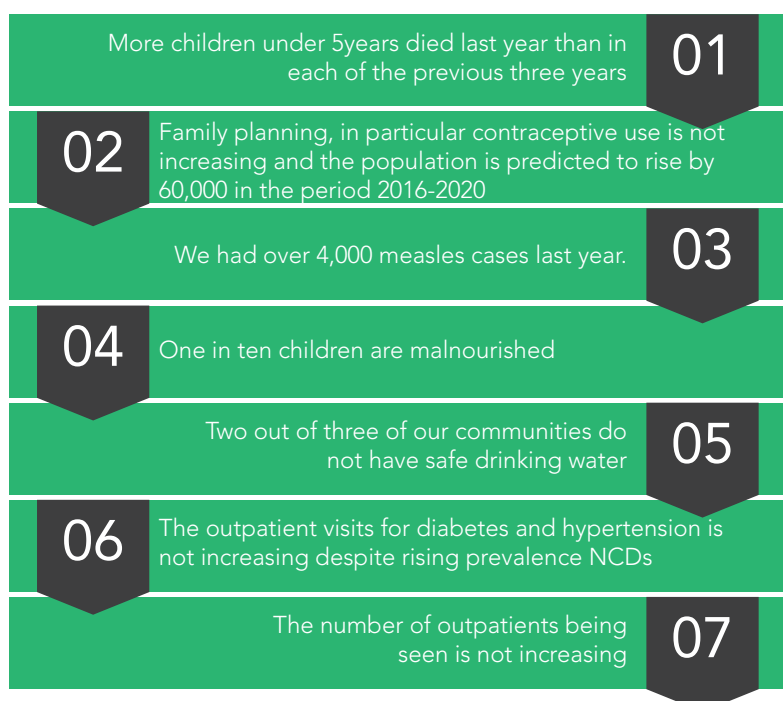
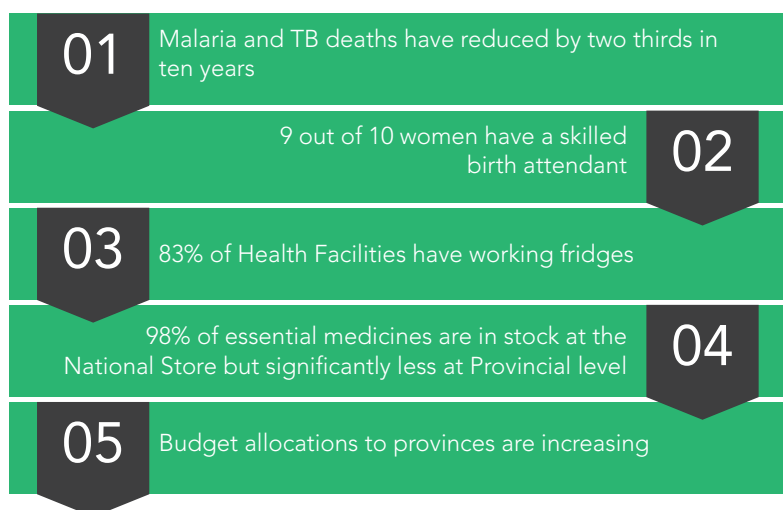


Improve Service Coverage	Build Strong Partnerships	Improve Service Quality	Lay the Foundations for the future
• Give priority to the most effective interventions • Give priority to the most underserved areas and populations • Give priority to the diseases causing the most deaths and illness	• With the People through healthy Islands/ Villages/ families/Schools/workplaces • With Provincial Government and MPs • With other government departments • With donors • With Churches, NGOs and Private sector • Within the MHMS	• Safety: First do no harm • Effective: Make sure what we do is effective • Efficient: Make best use of resources – money, people, equipment • Make best use of interventions: Prevention, primary care, secondary care, tertiary care • People Centred: Place the people at the centre of all activities • Timely: Deliver the right intervention at the right time. • Equity Ensure health is enjoyed by all	• Build health infrastructure: Train and recruit the health workforce • Develop a sustainable financing mechanism • Build the information system • Prepare for disasters and climate change • Learn from each other

Current Successes and Challenges

Parts of the health system are showing good progress; in other areas we are not progressing.

The malaria and tuberculosis (TB) threat are decreasing. Most women when giving birth are attended by a skilled birth attendant. Also, some support services show improvement. There has been improvement in supplies distribution, audit, financial control and health information systems. Over the last period we also succeeded in increasing the resources available at the provincial level.



Considerable challenges remain. We did not achieve the MDG child survival target, we experienced a major measles outbreak because immunisation coverage was too low, and too many children remain malnourished. The contraceptive needs of many women are not met. The number of visits to health facilities is static.

The performance differs between provinces.

Some provinces have good family planning and high contraceptive use in comparison to other provinces; nearly 100 per cent immunisation and nearly 100 per cent supervised births. This high performance shows what we are currently capable of achieving. This level of performance now needs to be reached in all the provinces, for all priority conditions, and across all Area Health Centres (AHCs) within provinces.

The health response needs to be tailored to the needs of specific locations. These range from geographically isolated islands such as Rennell and Bellona, to heavily populated areas of Malaita and urban Honiara. In Honiara, for instance, 100 per cent coverage has been attained for immunisation and skilled birth attendance, unlike any other province. Whilst this is good news, failure to provide these services nearer people's homes is inflating the figure for Honiara. The challenge in the capital is not only the availability of health services, but the need to move towards appropriate use of existing health services. The NRH redevelopment creates this opportunity. At present NRH is being used as a primary health care service, instead of specialising in referred services. Our most skilled clinicians could achieve much more if they were able to focus exclusively on the more difficult clinical problems. Part of the solution to the pressure on NRH is to improve service coverage in the provinces.

What hindered service improvement over the last five years?

A number of reasons for the slow progress have been put forward during this strategic planning process by the MHMS staff and development partners. Most groups identified aspects of leadership and delays in financial and human resource administrative systems as the main problem.

- Resources (especially pharmaceuticals and supplies) did not flow to the periphery of the system.
- Activities were fragmented, with poor coordination, particularly between the public health divisions.
- No clear prioritisation meant the agenda was crowded and there was a lack of priority.
- Resources were insufficient, or resources were available but not spent.
- Strategic leadership was primarily focused on donor-led, rather than MHMS led activities.
- Social conditions were deteriorating.
- Disasters and disease outbreaks interrupted service delivery.
- A fraud case crippled core functions such as procurement, and dented confidence within the sector and with donors.
- Some staff showed lack of discipline, including not showing up for work and not carrying out their functions, but were not disciplined.
- Decision-makers at provincial and national levels were unable to direct available resources to where needs were greatest.
- Operating budgets were tied up in specific programme funds, were not fully used, and could not be used to support core functions in the provinces

What helped service improvement over the last five years?

When resources, staff, information and service interventions were sufficient and worked in unison.

Where leadership at all levels was strong and accountable. Skilled leadership in provinces and programs is closely associated with improved performance.

When dedicated staff stayed focused on improving the work in their area of responsibility over a number of years.

Where strong partnerships were built both nationally and at the provincial level.

How will we expand on our achievements and address our weaknesses?

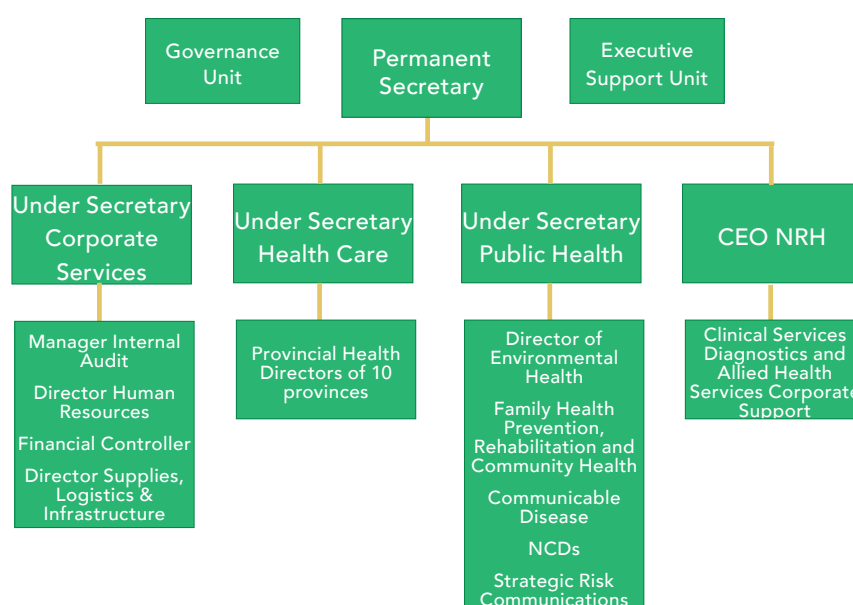
To start, the MHMS does not function in a vacuum. A number of important changes are being made by other parts of government to improve performance.

- The Ministry of Public Service, Solomon Island Government (SIG) has introduced performance requirements to measure investments in public servants against indicators relating to their positions. The indicators in this plan will support performance measurement.
- The Ministry of Finance and Treasury has instructed Public Financial Management that all expenditure must be related to the corporate or business plan of each Ministry.
- SIG is also moving toward the decentralisation of public service responsibilities making them closer to the community they are servicing.

Within the health system there is the realisation that centralised management of services has not resulted in better health outcomes or brought about greater access and broader coverage. The health system has not been utilising the available funds as efficiently as could have been expected. The weak health outcome results confirm this.

The MHMS has reformed its structure to accommodate several of the above points so there is clearer lines of responsibility and accountability between the various streams and functions.

It will give greater prominence to the issues being faced by the provinces, and support a greater focus across the MHMS on what is happening to front line services.



Apart from the organisational changes, there is a need to support a high performing culture throughout the MHMS. This involves clarity about everyone's contribution to the strategic priorities, supporting continuous learning, using performance data at each level, encouraging good communication across the MHMS and celebrating our successes and achievement as they occur.

Key Result Areas

This plan has been developed with four KRAs that apply across the health sector. These have a strong implementation focus. All stakeholders, both inside and outside of government, are encouraged to follow these KRAs. The KRAs are designed to encourage working across the organisational siloes. Most parts of the sector have responsibilities across more than one KRA.

The four key result areas are:



KRA 1: Improve Service Coverage



KRA 2: Build Strong Partnerships



KRA3: Improve Service Quality



KRA4: Lay the Foundation for the Future

KRA 1: Improve Service Coverage



Key Result Area 1: Improve Service Coverage

Our overall goal is to achieve Universal Health Coverage. This means that all people can access preventive, curative, rehabilitative and palliative health services they need and which the country can afford, and that they are of sufficient quality to be effective, while also ensuring that the use of these services does not expose the community to financial hardship.

What is happening now?

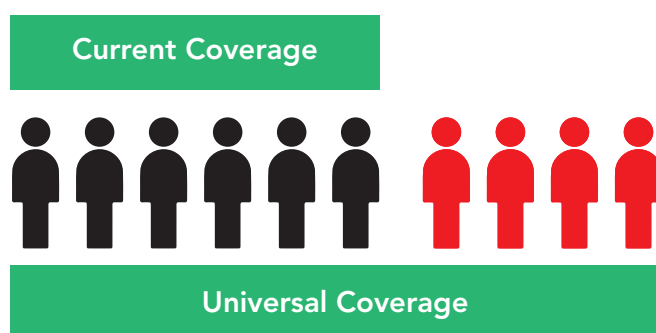


Figure 1 Coverage of basic services is incomplete.

We need to make sure all people of the Solomon Islands are getting access to basic health services. This is the highest priority.

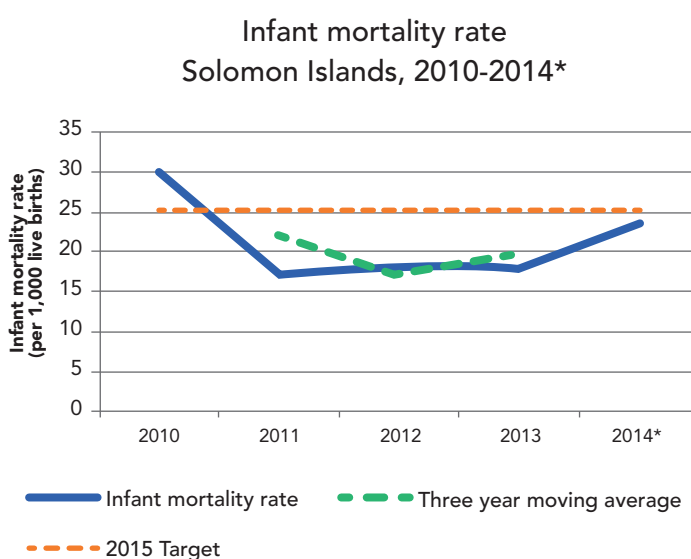


Figure 2 Slow progress on reducing infant mortality

Source: MHMS Core Indicator Report 2015

We are still battling to control communicable diseases and conditions impacting on mothers and children.

At the same time, noncommunicable diseases (NCD), consisting of diabetes, heart and respiratory diseases, cancers, mental health conditions and injuries are increasing.

Figure 3 shows 12 leading causes of early death in the Solomon Islands. Diabetes and stroke are now the leading cause of death and disability in the Solomon Islands.

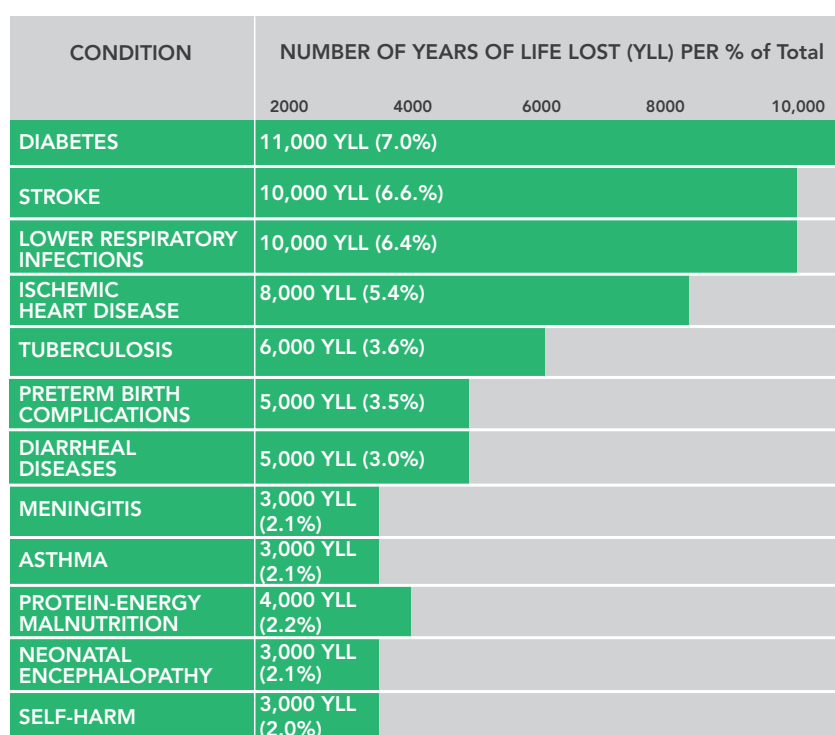


Figure 3: Leading Causes of Loss of Life in Solomon Islands showing the increasing NCD burden.

Source: Global Burden of Disease Study

What would we like to see?

Our aim over the next 5 years is to achieve better health outcomes by improving service coverage. Part of the reason for our lacklustre performance has been that we have tried to do too many things without making sure the basics are delivered to the whole population. We don't have the resources to do everything immediately, so we need to prioritise. Attaining high coverage in these interventions will save lives, save money and reduce future hospitalisations.

To improve coverage the sector will focus on:

- Strengthening the health response at the local level
- Full coverage of priority programs
- Improved service access for priority populations
- Focus on diseases responsible for most of the deaths and illness

Strengthening the health response at the local level:

This means ensuring health facilities are open, staffed and equipped.

Everyone in the community should be able to access a health facility and see a trained health worker with adequate supplies. The Role Delineation Policy describes this basic level of service. Currently, many provinces have health facilities that are closed. Supplies such as medicines are improving but still only reach 73% of primary care facilities, and often health workers are absent from their posts.

Full coverage of these priority interventions:

Listed below are the programs that will be given priority:

1. Immunisation
2. Family Planning
3. WASH
4. Supervised hospital or facility based deliveries and neonatal care
5. Malaria¹ Control
6. TB Control

Priority to the most underserved provinces and zones:

Current service coverage varies in different provinces and between different AHCs within provinces. Priority should be given to identifying the underperforming areas, understanding the reason for the underperformance, and taking appropriate action.

Provinces with low levels of service provision across several programs in 2014:

1. Malaita
2. Makira
3. Choiseul
4. Central

Due to the large variation in the size of provincial populations, areas of low service coverage at the zone or AHC level will reveal considerable under provision within provinces even when the provincial performance is strong. Hence the importance of focusing on zone coverage to identify weaker performing zones. Provinces will assess performance at the zone level in their annual planning process.

Within all populations, priority will be given to:

1. People with disabilities
2. Women exposed to violence and abuse

These priority populations are relevant to all programs and provinces. The MHMS has established a gender focal point to act as a resource to assist in the approaches required.

Focus on diseases responsible for most of the deaths and illness

The disease burden is rapidly shifting to NCDs, so we will build the NCD response in all parts of the health system. This requires much more than a specific program – all parts of the health system will be expected to turn their attention to addressing this increasing disease burden. Preventive measures will target the use of tobacco, alcohol, beetle nut, and other addictive drugs. A preventive approach is also required to address the poor diet and lack of physical activity underpinning obesity, diabetes, heart disease and stroke. Some of the most effective approaches involve working with other sectors and the use of legislation and taxation. Treatment for NCDs using the PEN package will be further developed for the Solomon Island context and rolled out to all health facilities. During this period the Healthy Lifestyle Committee and Fund will be established and will play an increasing role in supporting preventive activities.

¹ Malaria includes attention to Dengue and other Vector Borne diseases.

What needs to change?

Firstly, coverage needs to become the main focus for the sector. This will be reflected in prioritisation of resources, in reporting of indicators through the HIS and in assessing and rewarding performance at all levels of the system.

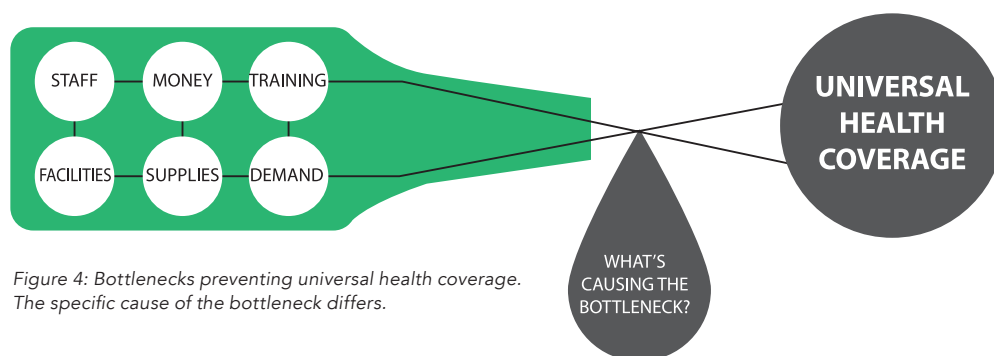


Figure 4: Bottlenecks preventing universal health coverage. The specific cause of the bottleneck differs.

The specific issues to be addressed to improve coverage differ for each province and each programme and zone within a province. Hence the importance of being able to make decisions on the allocation of resources from the provincial and zone levels. Currently, bottlenecks are preventing full coverage. We need to identify these bottlenecks at each level and overcome them.

Appendix one contains a description of how bottleneck analysis can be used to improve coverage, even when resources are lacking. It helps identify the specific cause of low coverage – which may differ in different zones and provinces.

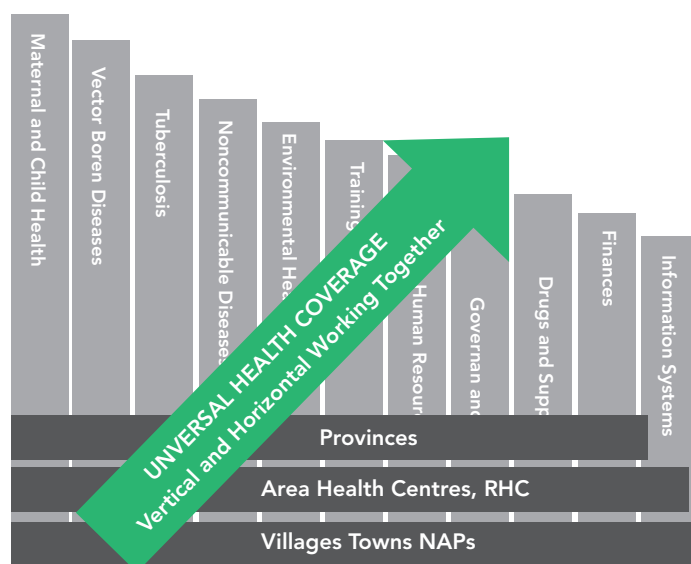


Figure 5: All parts of MHMS need to work cooperatively to achieve Universal Health Coverage.

To do this, programs, provinces, and corporate support services need to plan together, identify the bottlenecks, and take appropriate measures to address them. This needs to become part of a regular cycle of improvement. It relies on accurate, timely information and statistics.

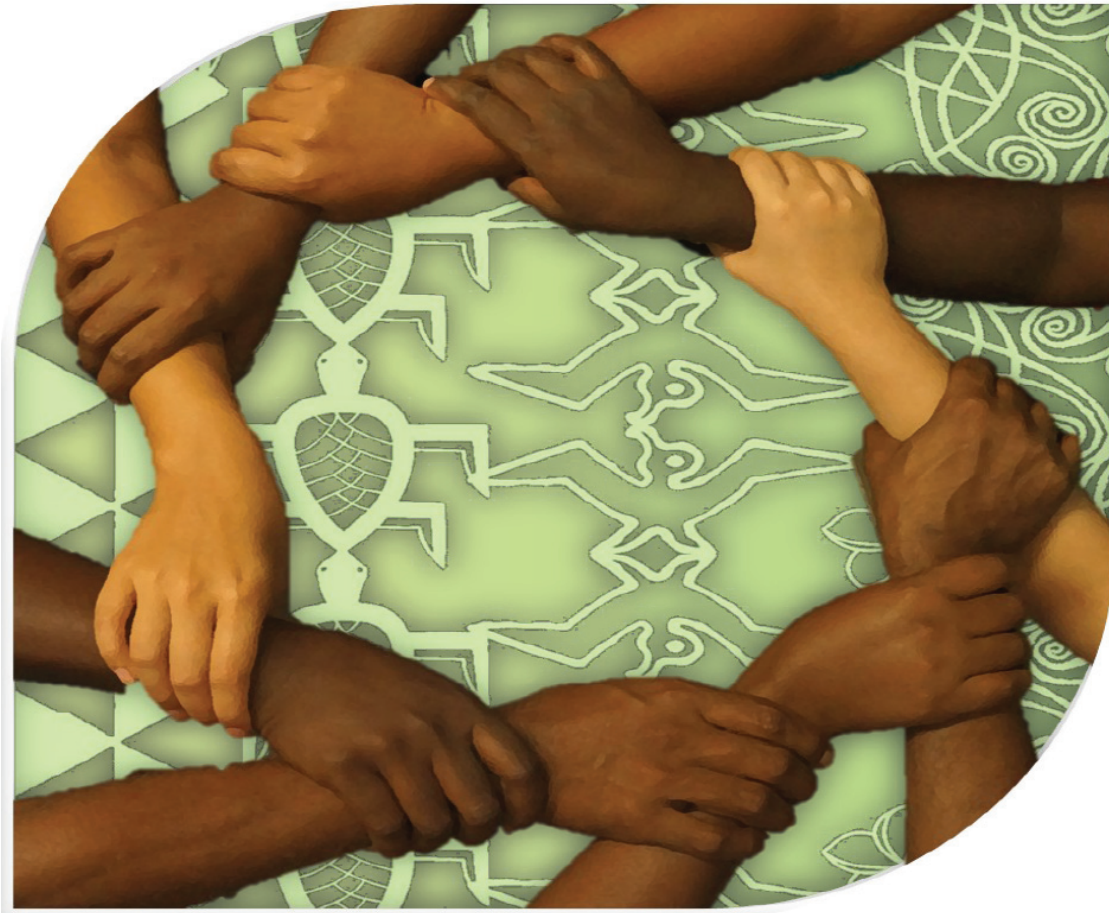
As a first step, improving the collection of vital information (such as births and deaths) is required.

What does this mean for Programs, Provinces, Hospitals and Support Services?

In this plan, programmes will strengthen the role of the Provincial Health Office and AHCs, so that they can focus on improving coverage for the province and the zones. We will also strengthen the oversight role of our national experts in specific programme areas and support them to take a more strategic approach to improving both the quality and coverage of their respective programmes. Corporate support services also need to incorporate the priorities into their plans and functions.

Hospitals also play a crucial role in coverage. For example, making sure every child who visits a hospital is fully immunised, and that lifesaving secondary care services such as a caesarean section or appendectomy is available when needed. Currently, hospital services are not available to many of the mothers when they give birth. Hospital services are concentrated in Honiara, with decreasing access to populations further away. Strengthening and in some cases establishing general hospitals, outreach secondary care services and transport for those with life threatening conditions plays an important part in improving coverage.

KRA 2: Build Strong Partnerships



Key Result Area 2: Build Strong Partnerships

Health is everybody's business. Health services make an important contribution to peoples' health, but so does family and village life, education, agriculture, fishing, clean water, sanitation and well distributed economic growth. The health services in this plan do not stop at the door of the aid post, rural clinic, AHC or hospital. Instead they are the springboard into the community – where much of health is generated. The health goals of our communities are also our goals. To achieve this, we (health, communities, other sectors and partners) all need to work together. Their success is our success.

What is happening now?

Two out of three of our communities do not have safe drinking water. Currently our activities and many of those of development partners working at the community level are fragmented.

Family planning levels are low, and declining, which has widespread consequences. Over this planning period, if population growth continues at the present rate, the population will increase by 60,000 by 2020, putting more pressure on food, water, education and health services.

Within the MHMS there is limited partnerships across programs, between programs and provinces, between NRH and the provincial hospitals. Currently, each service is planned in isolation, leading to gaps and overlaps, and missed opportunities to share and maximise resources.

What would we like to see?

Partnerships with the people through healthy Islands/ villages/ schools/workplaces

In this planning period we intend to make "Healthy Islands" the overarching framework for all health-related activities at the community level. The Pacific's Health Ministers poetically described this historic policy in 1995:

Children are nurtured in body and mind

Environments invite learning and leisure

People work and age with dignity

Ecological balance is a source of pride

The ocean which sustains us is protected

Within this framework there is a focus on healthy villages, healthy families, healthy schools, healthy markets, healthy workplaces, healthy towns and healthy cities. A healthy family is a precursor to a healthy village where there is safe water supply and sanitation, all children are immunised, women of reproductive age have access to information on family planning and appropriate options for contraception, children are sleeping under insecticide treated mosquito nets, and people with disabilities are able to fully participate in village life.

Healthy Islands is also the policy framework we will use for working closely with other sectors. This requires a partnership with provincial government, and MPs.

In addition, the multi sectoral approach to NCDs fits squarely in a healthy islands approach.

The MHMS will take a coordinated approach to this, with different public health programmes working together at the village level, and involving NAP and RHC staff. So too with donor programmes working at this level. They will all be encouraged to work within the healthy village policy.



Partnerships with Provincial Government, MPs, NGOs, Churches, and the Private sector.

The decentralisation of resources to the provincial level by the MHMS will require a stronger partnership at that level with other parts of government, churches, businesses, NGOs and local MPs. Provinces will develop a provincial health plan and this will be the opportunity to engage with all the health stakeholders in a province, and develop a coordinated approach to health.

The churches play an important role in our communities, and often already have programs and approaches consistent with a healthy settings approach. Where this is the case, building a strong partnerships with the existing church activities is likely to be more effective than starting a separate health program.

Mining operations are being established in some provinces, and this offers another opportunity for partnerships to address issues such as health infrastructure, as well as health issues arising secondary to the mining activity such as accidents, increased access to alcohol and tobacco.

Partnerships other government departments

Health improves through the actions of the health sector, but also when progress is made in other sectors. Tackling issues such as Water and Sanitation, Nutrition, and NCDs requires strong effective partnerships with the other relevant government departments.

Partnerships with donors and development partners

Development partners have made a major contribution to health in the Solomon Islands and in this period we intend to further strengthen this partnership. The number of donors and partners are increasing, and this calls for increased coordination. These partnerships will be guided by the government's policy on Aid Effectiveness. Donors and DP activity needs to be "on plan" in support of government priorities, "on budget", and also supportive of growth and sustainability.

In addition, through this partnership we will:

- Explore the implications of the current GFATM "results based" funding model, as well as the Joint Performance Assessment incentive programme to derive a consistent approach to performance incentives across the sector
- Work with development partners to build confidence in our delivery systems, and tackle the large infrastructure backlog
- Coordinate training and workshops into a structured, prioritised, in-service training

programme for all health staff

- Integrate service delivery across programmes by funding arrangements that incentivise cooperative activity at provincial and zone levels
- Work towards a predictable and sustainable funding path for achieving UHC and the SDGs

Partnerships with Education and Training Institutions

Training institutions play a foundation role in preparing the health workforce of the future. In order to build a strong health sector, there needs to be a close partnership between MHMS and training institutions, such as SINU, to ensure health workers are trained in sufficient numbers, with the right skills, and with a curriculum that is up to date and able to meet the changing health needs of the community.

Within the MHMS

Improved coordination is required across programs, provinces and across support services.

Corporate plans within the MHMS will describe the joint program of activity with other parts of the MHMS as well as what a specific program can do alone. The MHMS will develop and implement an internal communications strategy to facilitate this process.

What needs to change?

The shared agenda is guided by the National Development Strategy 2010 to 2020, where the government has stated its priorities for this period and identified the partnerships best positioned to action them. The MHMS has been asked to focus on rural infrastructure, water and sanitation, family planning, and support for people with disabilities. These are reflected in our priorities.

Current programmes and actors such as health promotion, RWASH, family planning, NCDs, MCH, local NAPs, and local MPs all need to coordinate their activities. MPs are included in this to acknowledge their role in supporting local development through the RCDP committees. NGOs, development partners, and churches also need to be included in local health partnerships. The change required is to work together under the Healthy Islands framework, to engage with villages and towns in an integrated approach to health improvement with the province taking the lead.

Provincial health strategies need strong partnerships with provincial government strategies, to address health infrastructure and coordination of local government development efforts.

Cooperative strategies need to be developed at the national level as well. For example: between Health and Education for healthy schools; between Health and Transport for injury reduction; between Health and Finance for sustainable health funding and for health positive, income generating taxation measures (such as tax on tobacco and alcohol); and between Health and Agriculture for improved nutrition.

Training programmes for all levels need to be integrated across programmes and prioritised. Underpinning this is the requirement to have and use quality information.

Increasing use of indicators to measure progress against agreed indicators will be an important part of this process. These indicators will be shared with the community itself, as well as the local MPs, donors and across the MHMS. Changing indicators for the better will become an important focus, and the yard stick by which the effectiveness of the partnerships are measured.

KRA 3: Improve Service Quality



A DAY IN THE LIFE OF OUR HEALTH SERVICES

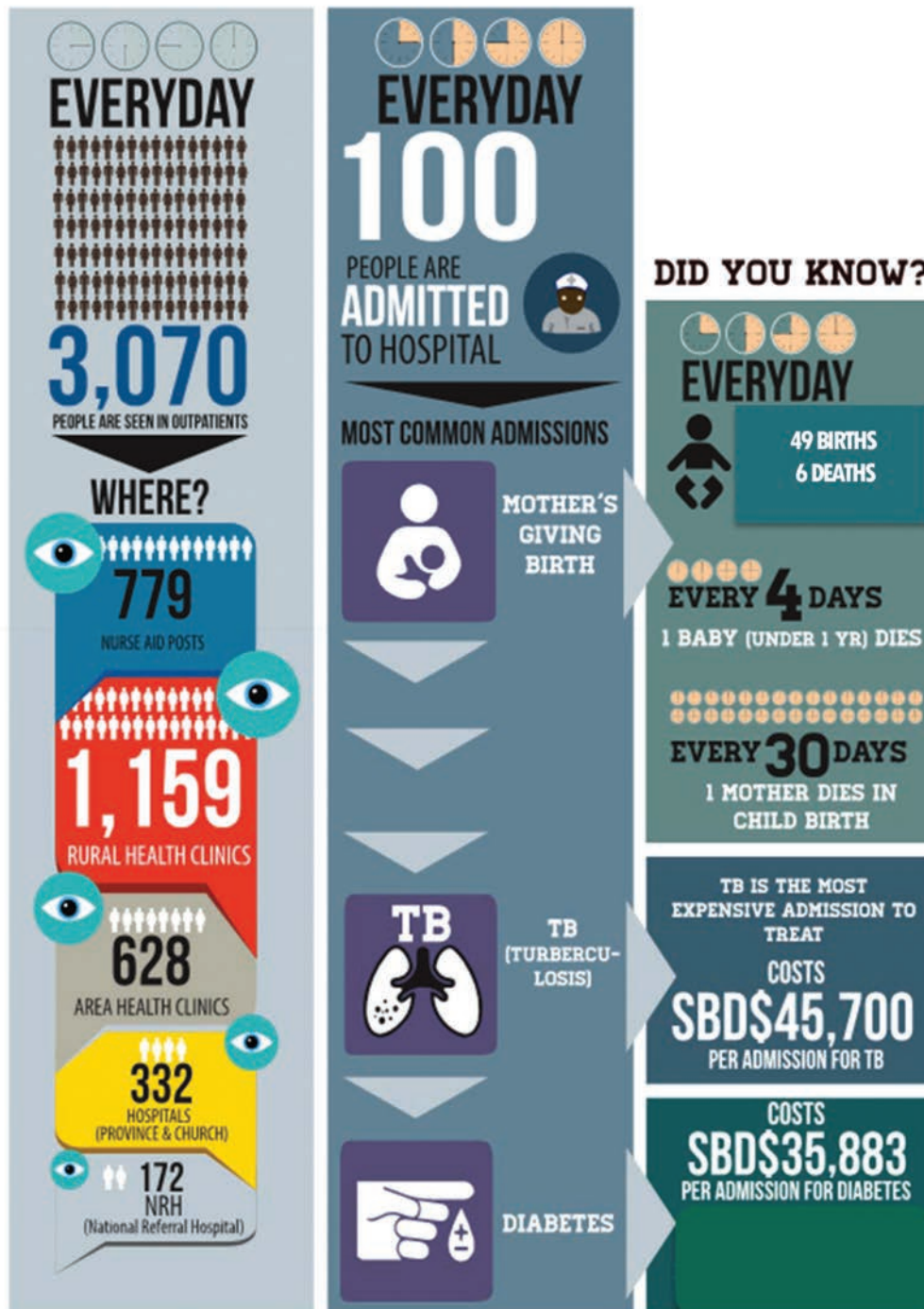


Diagram: Daily health service activities info-graph

Key Result Area 3: Improve the quality and support of Health Services

This planning period presents us with a unique opportunity to re-shape health service delivery to improve the quality of care. We can improve access for all of our people and develop, maintain and use our resources, particularly our skilled health personnel and infrastructure, more effectively and efficiently.

The re-shaping opportunities in this plan include the redevelopment of NRH, the provincial hospitals at Kilu'ufi and Kirakira, as well as the deployment of 130 newly trained medical officers. This KRA will assist in guiding these changes to improve the quality of the health system of the future.

Quality has a number of dimensions:

- Safety - do no harm
- Effective - make sure what we do works and is based on evidence
- Efficiency - make best use of resources; money, people, equipment-make best use of interventions; prevention, primary care, secondary care and tertiary care
- People centred - place the people at the centre of all activities
- Timeliness - deliver the right intervention at the right time
- Equity - ensure health is enjoyed by all

The quality includes how we nurture a professional workforce and ensure the safety of their practices. It covers the accreditation of each facility's ability to provide the services and what the community should expect it to be delivering.

Maintaining the quality includes ensuring there are adequate buildings, equipment and medical supplies to meet the needs of the communities.

The Role Delineation Policy describes what human and other resources are required for facilities to function effectively. There is a considerable gap to be closed between the current state of equipment and facilities and the level required under the RDP – We intend to partially close this gap by 2020 and complete the process over the next 10 years.

To strengthen services to achieve better health outcomes with limited public resources requires informed decisions. These decisions need to be based on relevant data that has been appropriately analysed.

What is happening now?

The info graphic (Day in the life of our health service) shows some of the activities occurring daily in our public health system.

Over 3000 people are seen daily, with over one third seen in Rural Health Clinics.

100 people are admitted daily to hospital, with most admissions in NRH. Childbirth is the commonest cause of admission, and we have 49 births a day.

Sadly, we lose a baby every four days, and a mother in childbirth every month.

Some conditions are expensive to treat: Each TB case costs \$45,700, each person admitted with diabetes cost \$35,883. A focus on more efficient and effective ways to treat these patients would save costs as well as patients' lives.

No data is available for the private sector activity and this is a gap we intend to fill.

We have considerable challenges ahead to make the health system safe, effective, efficient, people centred and equitable.

There is an expectation that by building more facilities health will improve. This is not always the case unless the longer term function, funding and staffing are carefully considered.

The growth of the national economy determines the size of the health budget, forcing difficult decisions about what can be funded. The need far outweighs the resources. New drugs and technologies are coming creating additional expenses, people's understanding and expectations of the health sector is increasing, and both the population and the NCD burden are predicted to grow.

What would we like to see?

In this period, we want to make progress on all the dimensions of quality. Increased coverage, as well as the scope of services that people have access to within the budgets that are available. We would also like to see a sustainable funding path, with a planned increase in expenditure and less year-to-year variation. This will enable better medium term and operational planning of services and interventions.

The challenge for hospital and health centre development is to ensure their services can be accessed by all who need them – not just those who live nearby. We would like to see better access to secondary and tertiary services and more emphasis on keeping people healthy, and treating people early, before they are so sick that they need to seek higher-level treatment.

To improve quality and performance requires sound governance and leadership based on appropriate frameworks of law, regulation, strategies and guidelines.

What has to change?

Planning and decisions around the important developments such as the NRH need to be based on the evidence for improving the health of the population and addressing the different dimensions of quality.

We intend to bring health legislation up to date and make it more effective and improve quality. This will include the Health Service Act, legislation for mental health, legislation on tobacco and alcohol to control noncommunicable disease, and the legislation governing our key health professionals, the Medical Dental Board and the Nursing Council.

KRA 4: Lay the Foundations for the Future



KRA 4 The Foundations for the Future.

The global focus on health development has been on the Millennium Development Goals, which conclude as this planning period starts. Replacing them is the Sustainable Development Goals, which sets more stringent targets than the MDGs, and these are to be achieved by 2030. This KRA outlines activities required in the coming five years, which will help build the foundations that will enable us to attain the SDGs.

What is Happening Now?

The health workforce

At present most skilled health workers and resources are in the main centres.

Facility	National Referral Hospital	Provincial and Church Hospitals	Area Health Centres	Rural Health Clinics	Community Health Centre
Number	1	11	27	115	190
Average no. of staff	621	58.5	8.3	3.5	1.5
Total number of Staff	621	643	216	402	135

Of the 86 practicing doctors, 73 are at NRH, and the other 13 at provincial hospitals.

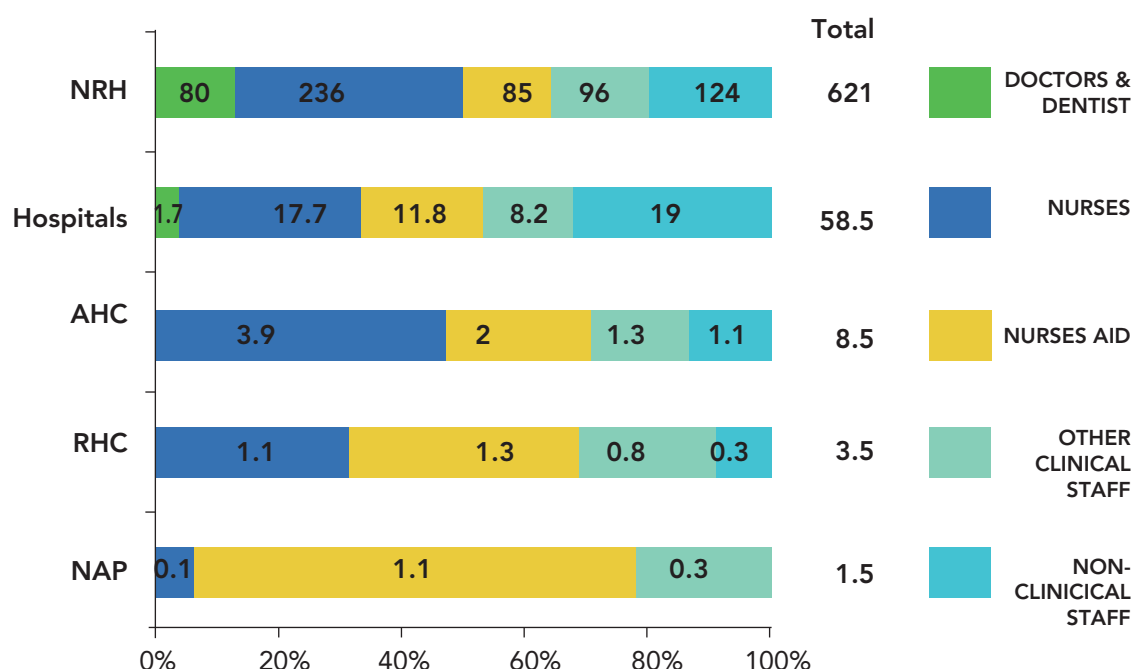


Figure 6 Health worker distribution across the health system shows the concentration of numbers and skills in NRH.

Source Health Facility Costing Study, Monash University 2014.

The Health Infrastructure

There is a pressing need to improve NRH's facilities. The situation in many Provincial Hospitals, AHCs, RHCs and NAPs is equally desperate. A survey in three provinces² in 2014 showed only 15 per cent had an adequate water supply, and 90 per cent did not have an adequate toilet. Of particular concern is the quality of the facilities available for women to give birth.

We have 344 health facilities, most of which were built at least 30 years ago. They have not been well maintained so there is now a big backlog of repairs and replacement needed to bring the facilities up to a suitable standard.

The total cost of these repairs and replacements has been estimated at SI\$2.3 billion, divided equally between NRH, provincial and church hospitals, and AHCs/RHCs/NAPs. Although the resources to fully address this backlog have not been identified, there are commitments by the government and potentially with donors which will see progress over this planning period.

Finances:

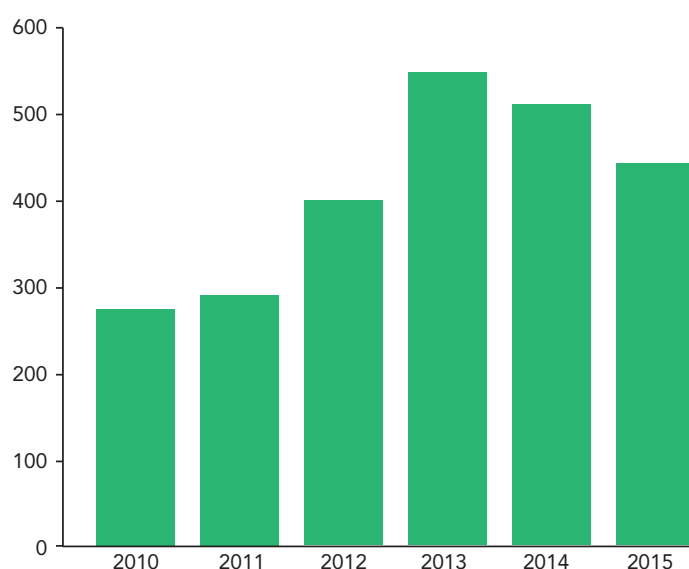


Figure 7: Total health allocation in \$(million) (Includes government and donor funds)

Source: World Bank presentation April 2015

The government is the main funder of health. It allocated approximately 14 per cent of its budget to health over the last five years, and has been increasing its contribution every year. In 2014 and 2015, there was a 4 per cent increase in government funds for health, but a reduction in donor funding from a peak in 2013. The amount of money available each year has to increase by about 7 per cent for the health sector to stay even unless efficiencies are made, because of the impact of population growth and inflation.

We are not spending all the available money. In 2014, MHMS was unable to spend 13 per cent of its recurrent budget and 94 per cent of its development budget. The provinces spent most of their budgets, as did NRH, pharmaceuticals and NCDs. The under-spending occurred in the budget that supports infrastructure and also in Public Health Divisions. The development budget was almost completely underspent because the purchasing and infrastructure unit was not functioning, a situation that has now been addressed.

What would we like to see?

Health workforce

The health system succeeds or fails on the strength of the health workers. The system is primarily nurse based, and continuing to build the capacity and capability of this workforce is essential. New technologies (such as drugs, vaccines, mobile phones, diagnostic tests) all have the potential to improve the effectiveness and reach of the workforce. For example, misoprostol, a drug that reduces bleeding after childbirth, can save many women's lives, provided the front line health workers have access to it. Technological advances are also increasing the need for allied health workers to operate specialised equipment.

We intend to plan and implement an approach to ensure the right health professionals working in the right places with the right skills, right equipment, right motivation and right supervision.

The number of doctors in the Solomon Island health system will more than double in the 2016–2020 period with one hundred and thirty-eight new medical graduates supplementing the 86 current medical graduates. This has the potential to have a profound impact on the health system of the future, if this workforce is trained and equipped to work outside of the main centres and to take both a population health as well as a clinical approach.

Health Infrastructure

NRH is being developed to improve tertiary service provision. The current approach is strategic, with the main focus in this planning period (2016–2020) on recovery and rehabilitation of the current facility while designing and strengthening primary and secondary healthcare services in Honiara, Guadalcanal and other Solomon Islands. NRH clinical leaders have called for a focus on quality through this reorganisation process.

Kilu'ufi and Kirakira are being developed to provide improved secondary care access for the people of Malaita and Makira provinces.

Strengthening primary care service provision in Honiara to take on at least 50 per cent of the NRHs current outpatient load, and providing a facility for maternity care for uncomplicated deliveries would substantially reduce both the outpatient and inpatient load at NRH, lower the cost of providing those services, and enable NRH to focus more on its specialities and referred inpatient services.

The NCD disease burden will have a big impact on this new development. The NCD burden will increase demand on inpatient facilities; however, it also requires a different response from both primary care and secondary care. It requires a chronic care management approach. The re-developments offer a unique opportunity to develop this different model of care in the urban centres not only for long-term conditions such as NCDs, but also for TB and HIV. This model would primarily be outpatient based, building on the function of existing AHCs, but also using the skills of hospital based specialists as part of the clinical team. Getting the right mix of inpatient, outpatient, and preventive care is an important focus of this development.

The developments of secondary and tertiary facilities require oversight by the MHMS executive, which is in the best position to guide the development so the wider system benefits are realised.

The Role Delineation Policy (RDP) has been developed to deliver on Universal Health Coverage. This policy defines the range and level of services – or packages of care – to be delivered to given populations across the Solomon Islands. It answers the question: who does what, where, and for whom? What staffing, equipment and drugs are required? What sort of buildings and transport? What will be needed in terms of drugs, energy, water, etc.? What will the cost be to build, and more importantly what will the cost be to run each year and how many health workers are required?

The current RDP policy focuses on RHCs and AHCs, and has already been applied to 18 facilities, to determine the cost of bringing facilities and equipment up to a standard consistent with the policy. This work has identified a considerable gap between current services and those required by the policy. Work is currently underway to apply the policy to the general hospital.

Role delineation is not an issue just for AHCs and RHCs. All parts of the system will be included in the policy, with their role and function specified. The role and function of NRH and Kilu'ufi will be defined in the master planning process being undertaken prior to the facility rebuilds. Decisions taken for these facilities will have a major impact on the cost and effectiveness of the rest of the health system for years to come. The impact of decisions for these facilities on resources and the workforce in the future is particularly important.

Finance:

The financial strategy is:

- Effectively, efficiently and accountably spend existing allocations, especially within Infrastructure and Public Health programmes.
- Improve information systems and accountability, and relate investments to improved results, so that both government and donors have increased confidence in the health sector.
- Build an evidence-based case for increased investment in health for the out years, and construct an out-year funding path.
- Utilise salary negotiations to incentivise universal coverage by developing attractive packages for retaining skilled professional working outside of the main centres.
- Work with government and donors to address the infrastructure deficit.
- Make the case for health as an "Investment" rather than a cost.

Often, health is seen as an "expense" rather than an investment. This is a limited view, as many health programmes have profound positive impacts on the wider economy and some health programmes can be income-generating for governments.

Take Family Planning as an example³. In this planning period if meeting unmet need for contraception meant contraceptive prevalence increased from 28 per cent to 38 per cent.

This would result in:

- 2,075 less births, slowing population growth from 2.5 per cent to 2.2 per cent
- A 50 per cent reduction in abortions.
- A reduction of maternal deaths by 12 per cent and infant deaths by 20 per cent
- A saving of \$180m in public education and health services
- A reduction of long-term staff and infrastructure costs for health services by 5 per cent and education by 10 per cent

A similar story is seen with other interventions. Each dollar spent on improved sanitation in the region returns \$3.60 in social and economic benefits⁴.

Health activities, such as tobacco and alcohol taxation, as well as having health benefits, generate government income.

³ Mackey-Buckley S, Kennedy E, Subramaniam S. The Case for Investing in Family Planning in Solomon Islands.; 2012.

⁴ World Health Organisation. Global Costs and Benefits of Drinking Water Supply and Sanitation Interventions to Reach MDG Target and Universal Coverage. Geneva; 2012.

What needs to change?

Workforce

The number of doctors in the Solomon Island health system will more than double in the 2016–2020 period. One hundred and thirty-eight new medical graduates will be available to health services during this planning period, supplementing the 86 current medical graduates. Up until now, most of the population have not had access to a doctor, unless admitted to hospital.

Training and orientation of these new graduates is being undertaken by NRH. The deployment of these graduates also has implications for other parts of the health system. Drugs and supply use will rise, particularly at AHC levels. Demand for housing, in service training, and development of career pathways will increase.

Ensuring this influx of expertise into the system flows through to the more peripheral areas and that it increases system performance overall will be a major management challenge. Resourcing will be a significant issue, as well as insuring that existing staff and systems are strengthened as the new expertise becomes available. Supporting a team approach in these facilities will be important. It will require adequate management, supervision, information, and support.

Due to the long lead time between when a health worker starts training and is ready for practice, during this planning period the MHMS needs to work with the Ministry of Education to ensure the health workers required for the 2020s are being trained in sufficient numbers and with appropriate skills to meet the future challenges.



Doctors and nurses from the Eye Care Department.

Finances

Firstly, we need to effectively spend the money we have been allocated.

The biggest part of expenditure is on staff costs and the decisions taken regarding staff costs have the biggest impact on the health budget. Universal coverage will require increasing the incentives for skilled health workers working in remote locations. These incentives can be negotiated when salary levels are set.

The Government's Medium Term Expenditure Pressures identifies spending pressures for the sector in the years ahead. It is updated annually. For the first part of this planning period, it has identified the additional costs related to the first two blocks of new medical graduates, and seeding costs related to NRH and Kilu'ufi developments.

This plan identifies additional areas of spending that are currently not part of the government's forward financial planning. The MTEP (Nov 2015) and forward expenditure estimates are in the appendix. The MTEP is updated regularly, and future updates need to include the following:

- the cost of rehabilitating the healthy system infrastructure, estimated at \$1.2 billion – spread between NRH (400m), General Hospitals (400m), and rural facilities (AHCs and RHCs) 400m. The current MTEP has identified \$684m for infrastructure which, if approved, should go halfway to addressing the infrastructure deficit in this planning period. At present, the NRH infrastructure planning and potential costs (as reflected in the MTEP) is in advance of the general hospital and rural facility infrastructure planning and costing. To meet the requirements of this plan, there needs to be a better balance between NRH and health infrastructure investment in provinces and zones. The current ratio of investment in the MTEP for 2015 and 2016 (NRH: General Hospitals: AHCs and RHCs) is 11:4:1. In other words, 11 dollars will be spent on NRH infrastructure for every four dollars spent on AHCs and every dollar on RHCs. There is an urgent need to progress the RDP's service delivery package costings so that out year financial forecasts present a better balance between central and peripheral expenditures on infrastructure.
- funding new graduate positions post-2018.
- increase in staff costs and new positions related to service delivery packages for RHC, AHC, General Hospitals and NRH. The operating costs of new facilities (especially staff costs) are the main expenditure, so these need to be modelled before final decisions around infrastructure are made.
- pharmaceuticals/supplies/ medical equipment growth consistent with increased coverage, COD arrangements with the global fund.
- contingency for disasters and disease outbreaks.

Infrastructure

We will change our approach to infrastructure. Facilities in the future will be built with regard to the population needs and how they will be resourced in the medium term. Decisions will be made based on full consideration of the long term impacts of the facility, and the opportunity costs – what else could be achieved for the same amount of money. The RDP service delivery package will provide the guidance. The future MTEP and resulting investments in infrastructure need a better balance of central and provincial expenditure as noted above. (see appendix)



Build the information system

The attainment of the goals in this strategy depends on the continued development of the information system. Vital registration, maternal death reporting and child death reporting are all required. Also the information needs to be analysed and produced in an easily accessible form. This applies to both the public and private sector.

Prepare for Disasters and Climate Change

For the Solomon Islands there is also the ever-present external and immediate threats of disasters leading to disease outbreaks plus the possibilities of emerging health threats and the need to be able to quickly and effectively detect these and respond. And all the while climate change is insidiously challenging the traditional lifestyles of Solomon Islanders. Preparation is required to respond appropriately to these threats.

Climate change effects the social and environmental determinants of health – clean air, safe drinking water, food supplies, secure shelter. Weak infrastructure makes the country more vulnerable.

The actions required to respond include:

- Increase the understanding of disaster risk
- Strengthen the disaster risk governance
- Invest in disaster risk reduction for resilience
- Enhance disaster preparedness for effective response and “Build Back Better” in recovery, rehabilitation and reconstruction

The new MHMS structure has established a section on disaster risk management as well as disease surveillance to progress this work.

Learn from the local and global success stories

There are high performing programs and provinces within the Solomon Island health sector and other parts of Melanesia. This provides an opportunity to learn from our own examples of best practice and finding solutions that work in our own settings.

The Planning Process

This strategic plan will frame the corporate plans of the MHMS. Currently there are a number of program strategic plans, with differing timeframes.

Over this period all planning will be synchronised to the 2016-2020 planning period, and subordinate plans will be referred to as corporate plans.

Corporate plans will be developed for each part of the MHMS, including each province, and these will cover the specific strategies and intended activities for the period 2016-2020.

Every year the Annual Operating Plan (AOP) will be developed on the basis of these corporate plans. See the appendix for an outline of the planning process. Further information and guidance will be described in a planning manual.

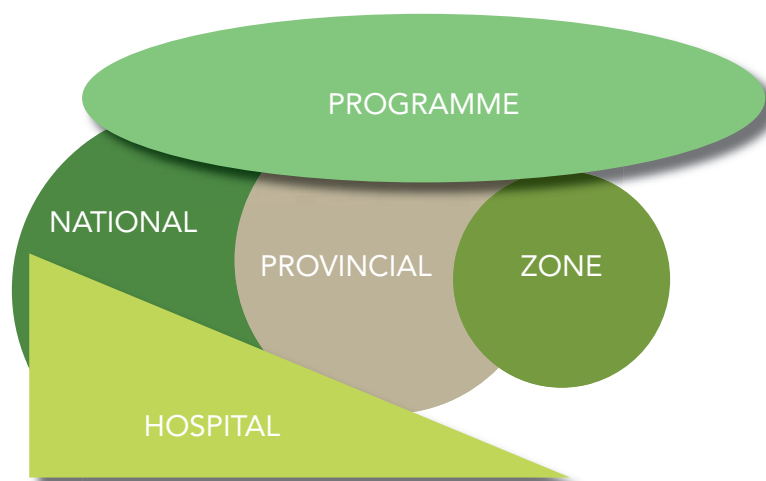
Indicators

Indicators show how we are progressing and will play a much more important role in the way health services in the Solomon Islands are run over the next five years.

Each domain will have different information needs to manage their area of responsibility. The indicators in this document are a subset of these wider information needs.

Indicators will monitor levels of activity in different parts of the health system. National, Provinces, Zones and Hospitals.

The Monitoring and Evaluation Indicators Framework diagrammatically shows the different levels of indicators that will be utilised. At each level, (i.e. Programme national, provincial, health zone and hospital) will be an agreed set of indicators that will be used by the MHMS to measure the achievements and progress of this plan.



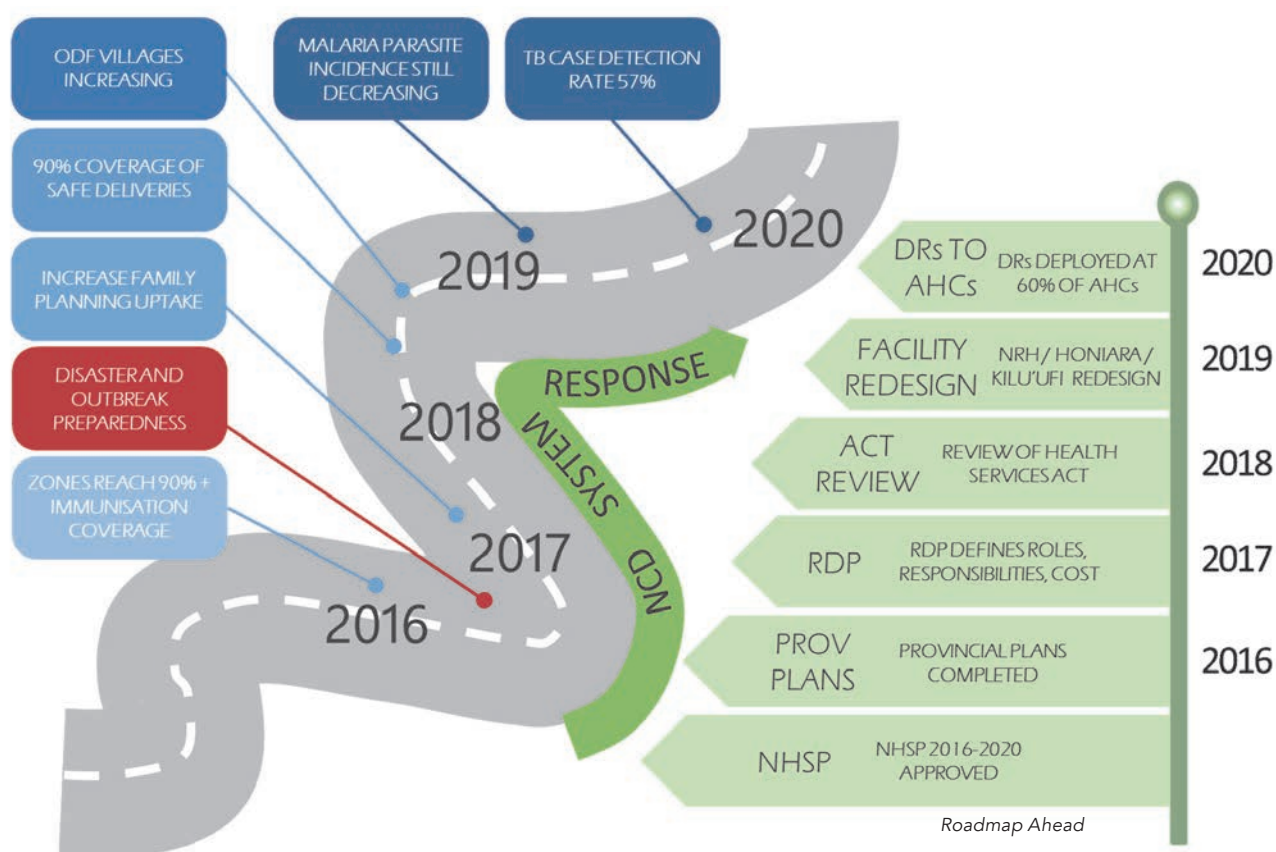
Monitoring and Evaluation Indicators Framework

Objectives

In this plan a number of objectives have been identified. These will be closely monitored by the executive team, using indicators to assess progress every quarter. To achieve the objectives, a number of different parts of the MHMS, and sometimes other parts of government, will need to develop a shared plan and work closely together.

The Road Ahead

The "road ahead" is summarised in the diagram below. Planning, policies, and indicators will support the KRAs outlined in this document.



Roadmap Ahead

Targets for some coverage priorities are set: immunisation (90% by end of 2016), safe deliveries (90% by 2018), deployment of doctors at AHCs (60% by 2019). Others will be developed for each of the priority programs in 2016.

National Health Strategic Plan Outcomes and Objectives 2016 - 2020

The national outcomes and objectives for 2016-2020 are shaped by the four key result areas and are outlined in the table below; it identifies the broader outcomes of the plan, the specific objectives and the lead department/ division responsible for the overall achievement of an objective(s). The table also lists the relevant corporate plans or sub-strategic documents that explicitly align and describes activities/actions toward achieving of objective; and indicators that help measure the achievements of those objectives against the plan.

Please note:

*The Lead Department/division ,leads the coordination of partners (divisions/departments/DPs/other stakeholders) to achieve the objective. The Lead is highlighted in blue. It does not imply they are solely responsible for this objective. Also listed are partners who play a significant role in delivering on the objective.

** As new corporate and provincial plans are developed, they will be shaped according to the four KRAs, and contain joint plans of the relevant lead departments/divisions. They will also identify key objectives for each area.

Outcome Statement	Objectives	Lead Department/ Division*	Relevant Corporate/ Sub-Strategic Documents**	Indicators
1. Improved child survival particularly for disadvantaged, remote, hard to reach	1.1 Reduce under 5 mortality to 15 per 1000 by 2020	Lead: Family Health Hospitals Provinces	RMNCAH corporate plan Family Planning 2020	1. Number of Health Stafftrained for RMNCAH competencies 2. Mortality rates for neonatal, infant, and child
	1.2 Immunisation coverage 90% for all children under 2 by 2020	Lead: Family Health Provinces		
	1.3 Number of communities with safe drinking water and sanitation	Lead: Environmental Health Provinces	WASH strategy	Number of ODF Communities
	1.4 All health facilities' open	Lead: Provinces, HR, Supplies logistics and infrastructure, FBOs, local health committees	RDP SOPs (to be developed)	Number of health facilities closed
	1.5 All health facility births and deaths are notified	Lead: MHMS HIS Ministry of Home Affair – Civil Registration	CRVS strategy.	1. Percentage of births and deaths notified by the health system
		Professional Health Boards Hospitals Provinces, FBOs		

Outcome Statement	Objectives	Lead Department/ Division*	Relevant Corporate/ Sub-Strategic Documents**	Indicators
2. Improved maternal health across all provinces, especially for high risk mothers and those in hard to reach communities	2.1 Reduce Maternal mortality to 7 per year by 2020	Lead: Family Health Hospitals Provinces	Reproductive and maternal neonatal child and adolescent health corporate plan	1. Number of maternal deaths per year 2. Percentage of maternal deaths audited 3. Average number of ANC Visits per Mother
	2.2 Improve family planning practices and knowledge	Lead: Family Health Provinces, FBO's Communities		1. Family Planning contact rate 2. Contraceptive prevalent rate 3. Number of adolescent births
	2.3 100% health facility based deliveries by skilled health workers by 2020	Lead: Family Health Provinces Infrastructure		% of births attended by a skilled birth attendant % of births in health facilities
3. Improved health and wellbeing of youth and adolescents	3.1 Develop youth and adolescents health strategy by 2018	Lead: Family Health (Adolescent) Provinces MWYAC		Availability of a youth and adolescents health strategy
4. Reduction in non communicable disease impacts	4.1 Reduction of NCD morbidity and mortality	Lead: Prevention Health promotion Hospitals Provinces		1. Number of new cases of lung cancer Lower limb amputation due to diabetes 2. Availability of essential of NCD medicines 3. Number of new diabetes presentations at outpatients
	4.2 Legislative Review and policy	Lead: Prevention/ NCD Program Public Health Police		Legislation reviewed and developed for: 1. Tobacco 2. Alcohol 3. Betelnut 4. Mental health
	4.3 Development of a legislation to address high calorie foods and beverages	Lead: Prevention/NCD Program Public Health Police		1. Legislation developed
	4.4 Reduce avoidable blindness in Solomon Islands by 25% by 2020	Lead: Eye Care Provinces	Eye Corporate Plan	Number of cataractsurgeries performed

Outcome Statement	Objectives	Lead Department/ Division*	Relevant Corporate/ Sub-Strategic Documents**	Indicators
CONTINUED 4. Reduction in non communicable disease impacts	4.5 Identify and assess dental health needs for Solomon Islands	Lead: Family Health Hospitals Provinces		Completion of an oral health strategic plan
	4.6 Hospitals provide mental health services	Lead: Mental Health Correctional Services, USPH Hospitals Provinces		1. Completed MH Act review 2. Number of health facilities delivering mental health services
5. Reduced burden of communicable diseases	5.1 Reduced malaria mortality	Lead: Malaria Program, Public Health Provinces Hospitals	Malaria Corporate Plan	1. Malaria mortality rate 2. Annual Parasite Index
	5.2 Reduce mortality and morbidity from TB	Lead: TB Program, Public health Provinces, Hospitals	TB Corporate Plan	1. TB treatment success rate 2. TB Case detection rate 3. Development of a DOT Policy 4. Number DOT compliance
	5.3 Develop community base DOT (direct observed treatment) policy	Lead: TB Program, Public health Provinces, Hospitals	TB Corporate Plan	1. TB treatment success rate 2. Case detection rate 3. DOT Policy developed 4. Number DOT compliance
	5.4 Reduce number and intensity of food and waterborne outbreaks	Lead: Environmental health Surveillance Unit Provinces, Hospitals		Reduction of diarrhoeal presentation
6. Reduce environmental health hazards	6.1 Develop environmental hazard exposure policy	Lead: Environmental health Public Health	Environmental health corporate plan National Strategic plans for Malaria, HIV, TB and Leprosy. National strategic plan for environmental health.	1. Policy developed 2. Act developed

Outcome Statement	Objectives	Lead Department/ Division*	Relevant Corporate/ Sub-Strategic Documents**	Indicators
7. Improved health sector responsiveness to gender based violence	7.1 Implementation relevant health related provision of Family Protection Act 2014	Lead: US Public Health NRH Hospitals Province, Police Social Welfare		1. Health compliancy with Act
	7.2 Nationalise 'Seif Ples' programme across identified health services by 2020			Number of facility with Seif Ples programme
8. All health services and facility are accessible to people with a disability.	8.1 Ratified Disability Convention by 2017	Lead: Planning Rehabilitation Facilities Provinces	Malaria Corporate Plan	Ratification of Disability Convention by 2017
	8.2 Develop Disability Act by 2018 TBdevelopment	Lead: Public Health NRH Hospitals Province, Police Social Welfare	TB Corporate Plan	Development of Disability Act by 2018
9. Strengthen Partnerships	9.1 Improve Partnership Coordination	Lead: Executive Support Unit -Planning DPs FBOs NGOs MDPAC Provinces	National Development Strategy	1. PCU fully established by mid 2016 2. Regularity of partnership meetings held 3. Number of MoU with stakeholders 4. DPs on plan on budget
	9.2 Increase multi-sector engagement			1. Policies developed outside health sector where health impact is considered
10. Strengthen Healthy Families and Villages	10.1 Healthy village policy reviewed and implemented in each Province	Lead: Health Promotion/ Prevention, Provinces NCD Program, MHMS Executives, Environmental Health Line Ministries Local Government DPs, FBOs, NGOs, CSOs	Healthy Village Policy	Number of healthy village initiatives per province

Outcome Statement	Objectives	Lead Department/ Division*	Relevant Corporate/ Sub-Strategic Documents**	Indicators
11. Achieve Universal Health Coverage	11.1 Role Delineation Policy implemented in all Provinces (AHC)	Lead: Planning /NRH/ Health Care MHMS Executives Public Health Provinces National Medical Store HR Province	All Corporate Plans Role Delineation Policy	1. Number of AHCs which are RDP compliant 2. Stock-outs at each health facilities 3. Number of outpatient visits per capita 4. NRH RDP/SDP developed
12. Establish a culture of quality improvement	12.1 Clinical governance established at each hospital	Lead: NRH Clinical Governance/ Governance Unit Provinces Hospitals Programmes Community Health		1. Clinical governance group formed 2. Clinical governance policy developed 3. Number of adverse events reporting developed
	12.2 Establish patient feedback mechanism at each hospital and health centre			1. Number of Patient satisfaction surveys conducted 2. Established mechanism for community engagement
13. Strengthen health system	13.1 Provincial Corporate plans developed by 2017	Lead: Planning / Corporate Service Provincial Health Directors Provinces, National Programmes Hospitals HIS	Provincial Plans (corporate and annual operational)	1. Provincial Corporate plans completed
	13.2 Health Information Systems :DHIS2 monthly reporting at 90% for each facility	Lead: HIS/ Provinces/ Hospitals National Programmes Hospitals Provinces		2. DHIS monthly reporting status by health facility (90%)
	13.3 Identify appropriate integrated hospital patient information system to build on ADT module		HIS Strategy	1. Identified integrated patient information management system 2. ADT implemented in Gizo, Kiluufi, NRH hospitals.

Outcome Statement	Objectives	Lead Department/ Division*	Relevant Corporate/ Sub-Strategic Documents**	Indicators
13.Strengthen health system <i>CONTINUED</i>	13.4 Implement information system to manage stock from secondary level medical store to health facilities	Lead: Supplies Logistics Infrastructure/ Provinces HIS	HIS Strategy	1. Number of facility
	13.5 HRH workforce and training plan developed by 2019 (US Corporate Services)	Lead: Corporate Services - HR		HRH plan by 2019
	13.6 Medical graduates deployed at Area Health Centres	Lead: Corporate services NRH Provinces		Number of AHCs with medical doctors (60% across all AHC)
	13.7 Provincial budgets are fully expended according to annual operational plans	Lead: Provinces/ Corporate Services-Finance Planning	Provincial Plans (corporate and annual operational)	Percentage of Provincial Budget Expended
	13.8 Develop and implement a health services management course for levels 1,2 and 3 to achieve recognised health service management qualification	Lead: Corporate Services - HR		Percentage of MHMS Management Staff who have completed Health Services Management Course
	13.9 Implement national health accounts by 2020	Lead: Corporate Services – Finance/Planning		NHA implemented

Outcome Statement	Objectives	Lead Department/ Division*	Relevant Corporate/ Sub-Strategic Documents**	Indicators
14. Relocation and devolvement of hospital and health services	14.1 To progress the reconfiguration of health services in Honiara including the relocation of NRH to ensure primary, secondary and tertiary needs of the population for safe effective, efficient, quality health services are met.	Lead: NRH MHMS Executives, Planning Corporate Services Provinces, Hospitals HIS HCC Development Partners	NRH Relocation Plan	
15. Solomon Island health is prepared for disasters, outbreaks and emerging population health issues	15.1 Improve preparedness and responsiveness for emergency and disaster outbreak	Lead: MEOC Environmental Health, Province HEOC NDMO	MHMS Emergency and Disaster Response Plans Provincial Corporate Plans	Number of outbreaks Number of outbreak deaths Post disaster/ emergency review show improve response
16. Strengthen and maintain health research	16.1 All health research approved via national ethics committee and processes, with abstracts reported to MHMS Executives each quarter and relevant forums	Lead: Research and Development/ USPH Planning Public Health		Number of research proposals
	16.2 Hold annual Health Research Symposium			Health symposium

Acknowledgements:

This strategy was developed with the planning division of MHMS under the guidance of the executive. WHO staff in the Honiara office provided excellent technical support. The informatics were designed by Millicent Barty of Honiara and WHO.

The statistical information came from the following sources:

MHMS Core Indicator report for 2014 (March 2015)

Health Facility Costing Study, Monash University 2014

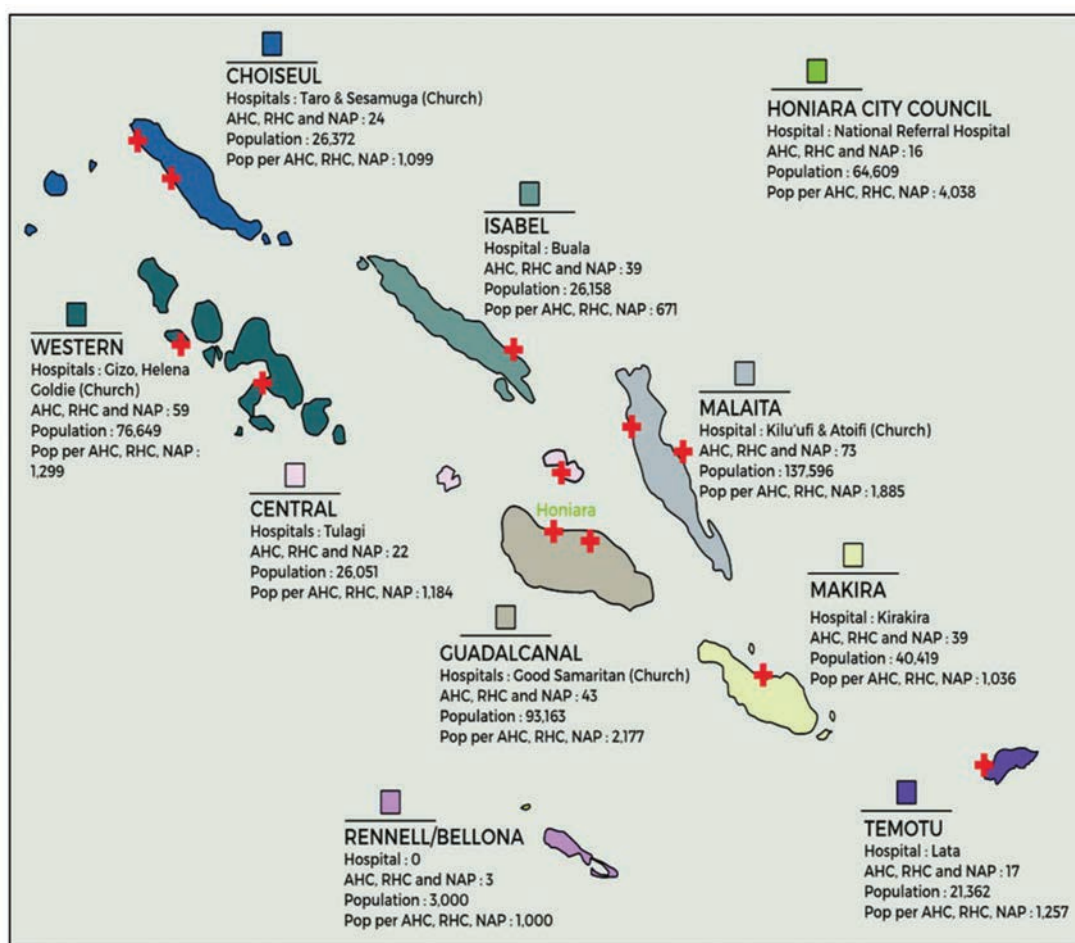
Presentations made by the World Bank at the JAPR meeting March 2015

The Global Burden of Disease Study

WHO Pacific Country Indicators

Appendix:

Health Infrastructure and Population in Provinces



Indicators:

General Description of Indicators

Many indicators are already being collected in the HIS. What will change is an increased emphasis on monitoring the performance of all health institutions, including AHCs and Hospitals. Where “new” indicators are required, these will be developed and trialled during 2016, before being used nationally from 2017.

The list of indicators below will be further developed during 2016, especially with the addition of program indicators.

Zone⁵/ Area Health Centre indicators:

- Patients seen
- Medicines availability
- Immunisation Coverage
- Contraceptive contacts
- Deliveries by Skilled Birth attendant
- Open defecation free communities
- Malaria reporting
- NCD risk profiles undertaken (new)
- Reporting of CRVS (new)

Provincial Indicators:

- Patients seen
- Medicines availability
- Staff FTE by cadre by zone (new)
- Immunisation coverage
- Contraceptive contacts
- Deliveries by SBA in a health facility
- ODF communities
- Presumptive cases of pulmonary TB who underwent bacteriological examination
- Malaria Incidence
- Tobacco legislation citations (new)
- Financial reporting (new)

Program Indicators:

The current situation is that programs have very large numbers of indicators, often established with the donor partners, and part of contract compliance for funding. In preparing their 2017 AOPs, (during 2016) programs will be required to identify 3-4 indicators that best represent the activity in their area.

⁵ This indicator covers all the health facilities in an Area Health Centre and their populations. Includes rural health clinics, community health centers.

NRH and General Hospital⁶ Indicators:

- Patients seen (OP and IP)
- Medicines and supplies availability (new)
- Diabetes and TB admissions and LOS (new)
- Clinical reviews, mortality and morbidity meetings, undertaken (new)
- Financial reporting (new)
- Bed occupancy
- Average length of stay
- Caesarean section operations (new)

Corporate services indicators:

- Medicines and supplies availability
- Health facilities with safe water and sanitation(new)
- Cold chain integrity (new)
- HIS reporting completeness
- Financial reporting (new)
- MTEP identified expenditures ratio on infrastructure (NRH: Gen Hospitals: AHCs and RHCs)
- Health trainees by cadre (new)
- Staff numbers, cadres, location.
- Donor contributions on plan and on budget (new)
- Donor funding forecast to 2020 (new)

National Indicators:

The national indicators to support this are the existing core indicator set. This contains 35 indicators. This has recently been reviewed, and 13 indicators were working well, 15 were working but required improvements, 7 were not working.

- Maternal deaths
- Infant mortality
- Under five mortality
- Unmet need for contraception (new)
- Access to antenatal care
- Acute respiratory infection in children
- Infants immunised
- Malnourished children
- Communities with access to safe drinking water

⁶ Currently the core indicator set only reports on NRH activity

- Communities with access to improved sanitation
- Basic hygiene practices
- Malaria Mortality rate
- Annual Parasite Incidence, Malaria
- Tuberculosis case notification rate
- Tuberculosis treatment success rate
- Presentation to a health facility with diabetes (includes IP new)
- Presentation to a health facility with hypertension
- Sin tax revenue (new)
- Access to rehabilitation services
- NRH patient discharges
- NRH bed occupancy
- NRH average length of stay
- Nurse to patient ratio
- Outpatient consultations per capita
- Registered nurses in rural health clinics
- Provision of mental health services (new)
- Unsupervised deliveries
- Stock availability at national medical store and primary health care facilities
- Water supply at health facilities
- Sanitation at health facilities
- Standard medical equipment at health facilities
- Recurrent budget allocation to provinces
- Financial reporting (new)

Universal Health Coverage

Our overall goal is to achieve Universal Health Coverage. This means that all people can use the preventive, curative, rehabilitative and palliative health services they need and the country can afford, and that they are of sufficient quality to be effective, while also ensuring that the use of these services does not expose the community to financial hardship.

UHC involves three main objectives:

- Equity in access to health services – those who need the services should get them, not only those who can pay for them or those in the main centers.
- Quality of health services is high so that it improves the health of those receiving services.
- Financial risk protection – ensure that the cost of using care does not put people at risk of financial hardship.

Role Delineation Policy

The policy we have developed to deliver Universal Health Coverage is called the Role Delineation Policy (RDP). This policy will operationalise this plan.

The policy defines the range and level of services – or packages of care – to be delivered to given populations across the Solomon Islands. It answers the question: who does what, where, and for whom? What staffing, equipment and drugs are required? What sort of building and transport?

The issues of role delineation apply to all parts of the MHMS, and this strategic plan outlines the main shifts in roles that need to be implemented over the planning period. The current RDP policy focuses on RHCs and AHCs, and has already been applied to 18 facilities. This work has identified a considerable gap between current services and those required by the policy. We intend to partially close this gap during this planning period.

Role delineation is not an issue just for AHC and RHCs. All parts of the system will need to examine their current role and adjust it to meet the requirements of this strategic plan. As well as describing the services that should be available, in this period we want to focus on the populations who are using the services. It is not enough just to have services available; they must also be used, and used by the whole population.

The problem faced by many health facilities is that the number of people requiring immediate attention takes all of the staff time, leaving limited time and resources to do preventive activities and outreach activities. Although this choice to focus on clinical care makes sense in the short term, it is not a good strategy, as the work in the community can in itself lessen the burden in the health facilities. The major health gains are made when services reach everyone in the community.

The health services in this plan do not stop at the door of the aid post, clinic, AHC or hospital. Instead they are the springboard into the community – where much of health is generated.

What this means is that knowledge of the community becomes important. Our job is to go beyond serving only those that knock on the clinic door, and make sure our services reach everyone in the community. “Universal” means “everyone”.

Nurse leaders at the RHC and AHC level have an important role to play in this. They have two roles. They need to run their health centres effectively, but they also need to know their communities well. This includes knowing who is living where, the numbers of people and their ages, and the major health issues they face. They need to know who are the most vulnerable in their communities, and make sure their services reach them. This is also called a population health approach, or, previously, the primary health care approach. Reaching universal health coverage rests on the shoulders of these frontline workers, and the rest of the health system’s role is to support them in their work.

The current RDP will require strengthening of its description of functions to encompass the population health approach. This includes identifying population coverage at the AHC level, and positioning public health officers at AHCs. The catchment population and subsequent service volumes should be the basis for facility staffing and funding.

The Master Plans for NRH and Kilu’ufi will help lay the foundation of the RDP for the National and Provincial level functions and facilities.

Bottle neck analysis⁷

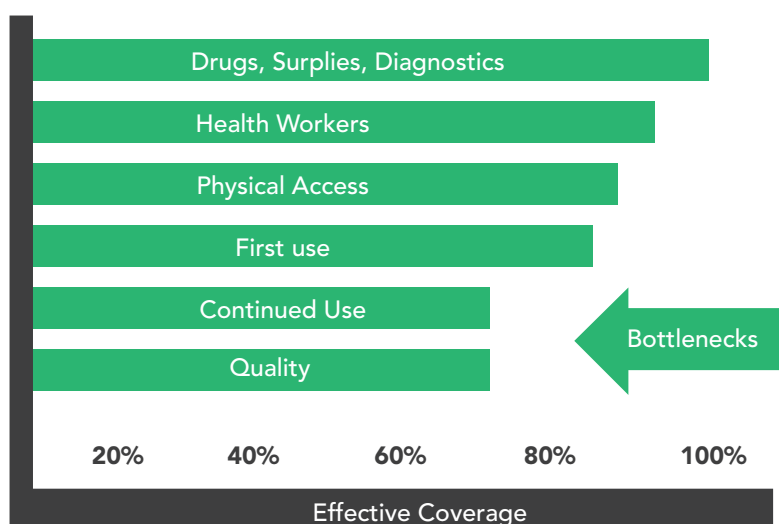
Bottleneck analysis is an evidence-based method for considering different aspects of delivering health services that may affect coverage and for developing strategies to address these problems. The bottleneck framework assumes six coverage determinants contribute to service delivery for effective health interventions: three on the supply side, two on the demand side and one on quality.

When resources are scarce, it is important to identify what particular aspect of the service is causing the bottle neck. For instance, in the example above, the quality of care and patients returning for repeat visits (continued use) and quality are the major bottleneck, and they need to be addressed to improve coverage. In this example, improving the supplies and the number of health workers will have little impact on coverage. If, in the example, quality and repeat visits improved, coverage would increase to 90% with existing resources. Increasing return visits would be addressed with a behavioural change program targeted at this aspect of the program.

This analysis can be done by single programmes, or groups of programmes. It can be done at each level. It should involve all the parts of the MHMS as they all contribute to improved coverage. It relies on good information on service coverage, supplies etc. It relies on local knowledge.

Some programs within MHMS already use other planning and coverage tools, such as microplanning and the RED (Reach Every District) strategy. Continued use of these approaches is encouraged.

⁷ Tanahashi T. Health service coverage and its evaluation. Bulletin of the World Health Organization. 1978;56(2):295-303



Out-year additional costs of the plan

	2016	2017	2018	2019	2020	Type of expense
New medical graduates	8.2m*	15.4m*	15.4m*	xx	xx	Rec
RDP service delivery package	xx	xx	xx	xx	xx	Rec
Increments in salaries and conditions	xx	xx	xx	xx	xx	Rec
Training Costs	xx	xx	xx	xx	xx	Rec
NRH and Honiara secondary care facilities	128m*	208m*	202m*	xx	xx	Dev
Kilu'ufi development	7.7m*	22m*	xx	xx	xx	Dev
General Facility upgrades	46m*	38m*	xx	xx	xx	Dev
RHC Upgrades	5.7m*	1.2m*	xx	xx	xx	Dev
AHC Upgrades	13.6m*	11.5m*	xx	xx	xx	Rec
Pharms/diagnostics and supplies increases	0.6m*	2.2m*	xx	xx	xx	Rec
Medical Equipment	xx	xx	xx	xx		Dev
Information / ICT	xx	xx	xx	xx	xx	Rec
Population growth	xx	xx	xx	xx	xx	Rec
Disasters and Climate Change	xx	xx	xx	xx	xx	Rec/Dev

*These are in the current (Nov 2015) MTEP

The government makes decisions every year on the actual amounts allocated to the health budgets. The MTEP shows potential future expenditure that will inform this annual government decision making. In order to adequately inform government decision making, accurate potential costing information is required for the items without amounts identified ("xx"). As noted earlier, the SI health system is unbalanced, with most resources and personnel deployed in Honiara, while the bulk of the population requiring services are in the provinces. The current MTEP will perpetrate this imbalance unless potential expenditure (both infrastructure and operating) for General Hospitals, AHCs and RHC are quantified and included in the next MTEP.

Outline of the Provincial and Program Planning Process

All parts of the MHMS in the development of their corporate plans will follow a similar process. The key steps:

1. Situation analysis: Form a planning group of key stakeholders to describe the current situation, and identify both good and poor past performance. Gather information on the population, disease patterns, health facilities, health workforce, equipment and supplies, performance information from HIS. Canvas local stakeholders, including patients, views of the health service.
2. Identify priorities based on the NHSP and the situation analysis above
 - a. KRA 1: Strategies and actions to improve coverage of priorities that are relevant for your area.
 - b. KRA 2: Partnerships required and seek their engagement in the planning and delivery process.
 - c. KRA 3: Strategies and actions to address the dimensions of quality.
 - d. KRA 4: Strategies and actions to build solid base for future service provision
3. Undertake a bottleneck analysis to identify what needs to be done to increase coverage in priority areas under KRA1. This includes identifying what behavioural change initiatives (demand side) are required to improve coverage.
4. Set Goals for the 5-year period.
5. Identify activities to achieve the goals under the 4 KRAs.
6. Select activities to be carried out, and identify and engage with the responsible part of MHMS and partners to agree on the course of action.
7. Determine resources available, what can be done with existing resources and the resource gaps.
8. Develop activity plans, costs and timelines annually in the AOP.
9. Incorporate indicators to monitor and evaluate with help from HIS.

Get Sign off of the Plan and promote it to relevant stakeholders (e.g. MPs, Provincial Officials, other parts of government)

How was this strategic plan developed?

This plan was developed over 2015. The following are the steps undertaken:

- A review of the 2011-15 plan was undertaken, and lessons learned identified.
- The MHMS executive met and agreed on the overall emphasis of the plan.
- Stakeholder consultation workshops were held, often involving a SWAT analysis, with the Executive, NRH senior staff, development partners, national program managers, PM's department.
- Discussions were held with each province on the priorities for the plan in preparation for the 2016 AOP.
- The draft plan was discussed in detail at the 2015 National Health Conference, with the conference agenda shaped according to the plan's KRAs, and café style discussion groups exploring the issues in depth from different perspectives.
- The plan was finalised after incorporating feedback from the NHC and approved by the MHMS executive in January 2016.



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