



Keeping countries at the centre

Assessment of WHO's performance
of its roles and functions in the Pacific



World Health
Organization

Western Pacific Region

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ACRONYMS

CLO	Country Liaison Officer
CRGA	Committee of representatives of governments and administrations
CSU	Country Support Unit
DPS	Division of Pacific Technical Support
EPI	Expanded Programme on Immunization
FNU	Fiji National University
ICD	International Classification of Diseases
IHR	International Health Regulations
MCCS	Multicountry Cooperation Strategy
MCH	Maternal and Child Health
NCD	Noncommunicable disease
PEN	Package of Essential Noncommunicable Disease Interventions for Primary Health Care in Low-resource Settings
POLHN	Pacific Open Learning Health Network
PPHSN	Pacific Public Health Surveillance Network
PSSS	Pacific Syndromic Surveillance System
SPC	Secretariat of the Pacific Community
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WR	WHO Representative

EXECUTIVE SUMMARY

The Division of Pacific Technical Support (DPS) represents an innovative approach WHO has taken to assist Pacific island countries and areas achieve improved health outcomes.

This assessment has found that DPS has very quickly made progress in bringing a Pacific island focus to the work of WHO.

There is strong support from countries, which have reported increased levels of service and responsiveness since the establishment of DPS. There has been a measurable increase in resources, activity and personnel at the country level in the subregion. Countries highly value WHO's support, although many were unaware of the new organizational structure.

While applauding WHO's support to countries working towards regional and global priorities, many countries expressed a desire for WHO to be more responsive to their needs, to take less of a "silo" approach, and to pay greater attention to the countries' own processes and priorities.

Development partners gave DPS a mixed review. Progress was noted in improved coordination and increased availability of technical expertise in the subregion. However, many felt WHO was missing opportunities at the country level to better leverage the efforts of other development partners. In general, partners felt that the rationale or business model for DPS was not well articulated within the Division, and consequently not communicated or understood by other development partners.

The assessment concludes that DPS is a "work in progress". The magnitude of the transformational change required to move from a "mini Manila", where DPS replicates the roles and functions of the WHO Regional Office for the Western Pacific, to a fit-for-purpose subregional organization playing a central role in country-focused health development is considerable. Substantial changes have been achieved in a short period, and the high level of confidence WHO enjoys from Member States creates a strong platform to meet future challenges.

To meet these challenges it is recommended that DPS more clearly articulate its role and function in discussions with countries and agencies whose focus is health in the Pacific. The increased emphasis on country-led agendas should be further supported by strengthening country-led review and planning cycles, and better aligning WHO activities to country systems and processes. WHO is uniquely placed to facilitate the work of other donor partners in health; this potential is not currently being realized.

BACKGROUND

The effective delivery of WHO's work in the Pacific requires a unique response as the subregion's 21 island countries and areas are scattered over the world's largest ocean.

Regional support for health development at the country level in these small, isolated island states can involve three overlapping approaches. First, due to the small size of the population and its local health administration, it is necessary in the long term to directly support the health sector with a range of technical support functions. These technical support functions are those that would normally be found in a national ministry of health, and are considered essential public health functions. The support in these cases should be directly answerable to the island government, while the personnel involved may be serving several island states. Examples include provision of health economics and epidemiology expertise. This has been referred to as "capacity substitution".

The second approach is to actively build capacity where the explicit objective is to grow local capacity and capability such that national self-sufficiency is attained at some future point. In this case, regional support is time limited and has a specifiable endpoint.

The third approach relates to support for regional public goods, where countries of the Pacific that share common challenges and opportunities for development, address these more effectively and efficiently at a regional level through collective action and cooperation. In this case there is a shared agenda among the countries concerned, and governance and accountability are regional rather than specific to an individual country. Examples could include regional purchasing functions or approaches to trade and health.

WHO's mandate comes from Member States through either regional (WHO Regional Committee for the Western Pacific) or global (World Health Assembly) governance mechanisms. Its funding mechanism is predominantly from bilateral arrangements with donor governments (Australia is the dominant donor in the Region). The expectation is that WHO supports implementation of regional and global priorities, and it responds to specific needs of countries when they fall outside these priorities. An effective mechanism for responding to locally identified needs is a major challenge given the low capacity and remoteness of many island states.

Enhancing WHO's performance and effective leadership at country level is one of the top priorities of WHO reform. The efforts are geared towards supporting a country "needs-led" approach by more effectively supporting Member States and partners to identify, articulate and prioritize health needs in countries, helping the countries access evidence-based and cost-effective technical assistance, and demonstrating value for money and the impacts of WHO's work.

The approach WHO has taken in the Pacific is anchored on the recent establishment of the Division of Pacific Technical Support (DPS). The Division, established in late 2010, aims to provide the mechanism to coordinate and consolidate WHO inputs from the various levels and to create synergies among offices, as well as between regional and country levels. Three strategies were identified by the newly formed office: to strengthen WHO's leadership role in the Pacific; to identify joint priorities and strengthen collaboration;

and to build country and nongovernmental organization capacity and systems with an emphasis on primary health care.¹

WHO normally depends on the capacity of its country offices to perform core functions. However, because of their relatively small size, the 21 island countries and areas are served by four WHO country offices, and in four countries by the presence of Country Liaison Officers. The remaining countries and areas do not have resident personnel.

The Multicountry Cooperation Strategy for the Pacific, signed in 2012 by the Member States in the Pacific sets the strategic direction for WHO in the subregion, excluding Papua New Guinea. The strategy aims to support countries to reduce risk factors and vulnerabilities, to increase access to/coverage of high-quality services, and to ensure health services and systems are cost effective.

In 2012, the WHO Regional Office for the Western Pacific completed an external assessment of WHO's performance of its roles and functions at the country level in the two largest Pacific islands: Papua New Guinea and Solomon Islands. These reviews noted that the link between the other Pacific WHO country offices and DPS has the potential to enhance WHO effectiveness, and also noted the importance of clearly delineating the respective roles of the two offices to ensure that benefits and synergies are maximized. In 2013, coinciding with this assessment, a review was also conducted of the roles and functions of the Regional Office. The Papua New Guinea, Solomon Islands and Regional Office reviews should be read in conjunction with this report.

¹ Adapting Pacific medical internships to changing contexts [Policy brief]. Human Resources for Health Knowledge Hub, University of New South Wales, Sydney. Condon R, et al. 2013

METHODS

The objectives of the assessment were threefold:

- to evaluate the performance of WHO's roles and functions in the Pacific;
- to review the role of DPS, its ways of working, and its relations with other WHO offices and other stakeholders; and
- to assess the added value of DPS for achieving better results at the country level.

The assessment undertook a formative rather than a summative approach, reflecting the short time that the DPS has been in existence. The initial findings were shared with WHO staff in the Pacific and discussed in a workshop with DPS staff before completion of the final report.

Assessment design

For each of the objectives, a series of questions was generated, and for each series of questions, possible data and information sources were identified. The questions formed the basis of the discussion with WHO staff and stakeholders, acting as a guide rather than a rigid questionnaire.

The questions were based on WHO's roles and functions as defined in the Eleventh General Programme of Work:

- Providing leadership on matters critical to health and engaging in partnerships where joint action is required;
- Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
- Setting norms and standards and promoting and monitoring their implementation;
- Articulating ethical and evidence-based policy options;
- Providing technical support, catalysing change and building sustainable institutional capacity; and
- Monitoring the health situation and assessing health trends.

Desk review

The assessment team undertook a review of existing published and informally published literature from the countries and at the Pacific regional level. Documentation from WHO's administration system on budgets, staffing and travel were prepared by DPS and Country Support Unit (CSU) staff and reviewed by the assessment team.

Qualitative interviews of WHO Pacific staff and relevant stakeholders

Due to the complexities of the subregion and the resource constraints of the evaluation, four countries out of the 21 were selected as sites for in-depth, face-to-face interviews:

Fiji, Kiribati, Samoa and Tuvalu. Telephone interviews were conducted with stakeholders from three additional countries: Federated States of Micronesia, Nauru and Solomon Islands. These seven countries were selected to give consideration to the range of political/administrative arrangements, different ethnic groupings, various population sizes and different locations in the Pacific.

Relevant stakeholders

Interviews were conducted with senior health officials in the respective countries, including the Health Minister if available. United Nations and other donor and technical partners were interviewed about their interactions with WHO at both the country level and the regional level. A list of relevant WHO technical and donor partners interviewed appears in Annex 1.

FINDINGS

The assessment's findings have been grouped under three headings: the extent to which WHO/DPS has developed a truly country-centred approach; the effectiveness of the role of leading, convening and coordinating development efforts; and the approach to capacity development.

A country-centred approach

The assessment looked at the extent to which WHO had adopted a country-centred approach. It is assumed that a country-centred approach would see WHO meeting the needs of countries' health leaders and its resources being directed more to the country level and less at the regional level.

The following information were considered:

- the extent to which WHO was meeting country needs
- deployment of staff to Pacific island countries
- travel of Regional Office staff to countries
- financial resources available to countries.

WHO meeting country needs

WHO is held in very high regard by the ministers and senior officials of the countries interviewed in this assessment. In some instances, WHO's country responsiveness was linked in the minds of government officials to the creation of DPS, but most countries had limited awareness of the new organizational arrangement. Several countries identified areas where the responsiveness to country needs could be improved.

In Fiji, a country where most health programmes are modeled on WHO guidelines, the Health Minister felt the Organization's performance had improved since the introduction of DPS:

"In a nutshell, WHO is now more proactive, more transparent, and able to mount timely responses to specific technical requests."

Similar high regard was expressed by Tuvalu officials, who also felt responsiveness had improved since the creation of DPS:

"WHO is better at really discussing issues and understanding them from our perspective. WHO people are well versed in our issues."

Similar high regard was expressed by Nauru officials, but in this case based on a longer-term perspective:

"WHO is the most faithful over many years ahead of any other organization."

The criticism countries had of WHO related to the resources and focus WHO activities gave to global and regional priorities, when these did not always include the country's own priorities. There was also concern in some instances that WHO did not listen effectively to country concerns. This is discussed below.

“Countries at the Centre” and “Regional and Global Priorities”

The work of WHO encompasses global and regional priorities as well as responses to country-identified issues. Although Member States play a role in the governance of WHO at regional and global levels, there may not always be synergy between the country's priorities and those of WHO.

The role WHO plays in this regard is complex. It is an advocate and fundraiser as well as an implementer. Current examples of regional and global agendas are the work on noncommunicable diseases (NCDs) including tobacco control, and the International Health Regulations (IHR). In these programmes, WHO plays an advocacy role with governments and donors to garner the necessary support to build the required systems response. Despite global agreements that governments have made, WHO staff often find little awareness and support within governments for progressing the issue and no prior capacity or resources to do so. Regional and global policy decisions are not always backed with the resources for implementing these decisions. Thus the role of WHO officials also includes advocacy to attract donor and government funding, and advocacy at the government level to see regionally and globally agreed approaches adopted. In these instances, WHO is not responding specifically to an expressed local need, but trying to roll out a policy, programme or approach that has a regional or global mandate.

The local context and priorities often differ from those derived from regional and global multi-country negotiations. Countries appreciated the assistance WHO was providing in addressing these regionally and globally agreed priorities. However, some countries expressed concern that when issues were raised outside of these regional and global areas, WHO was less responsive. One development partner drew attention to the mismatch between the disease burden and the global response when NCDs are compared with HIV/AIDs. NCDs are responsible for the subregion's major disease burden but receive relatively few donor resources.

Some development partner interviewees expressed a view that WHO did not effectively adapt these regional and global approaches to the context of the particular country and the country's own plans and priorities. What was missing was the ability to lead policy discussions at the local level, and suitably adapt global and regional policies to the unique national and subregional contexts. Countries appreciated the assistance WHO was providing in addressing these regionally and globally agreed priorities. At the same time, some countries expressed concern that when issues were raised outside of these areas, WHO was less responsive. One country reflected on past strong support from WHO in providing primary health care to outer islands, but despite the need remaining, the focus had now moved to other areas.

This dilemma was illustrated in relation to WHO's response to a diarrhoeal outbreak in Kiribati that resulted in the death of a number of children in 2013. There was criticism from some development partners that WHO was focused on NCDs and paid less attention to preventable conditions like diarrhoea through a safe, adequate water supply, and that the communicable disease response from WHO focused on surveillance but was less active in addressing upstream causes, such as a safe water supply.

This illustrates well the complexity involved in both responding to local needs and pursuing global and regional agendas. The focus on NCDs is appropriate due to the disease burden in Kiribati. However, the country experiences the double burden of both NCDs and communicable diseases to a greater extent than many other countries in the

region, hence it requires a continued strong response to both. The strong surveillance response by WHO was also appropriate as it helped local authorities identify the causative organism of the diarrhoeal outbreak, but a sustained upstream approach is required.

The assessment team's view of this is that WHO responded well considering its resources, but more could have been achieved with a greater focus on leveraging and enabling the actions of other development partners. An improved response would require greater capacity and capability of the country office – as noted later, the Kiribati country office appears to be underresourced in relation to the disease burden.

There was criticism from some country officials that WHO local officials did not listen to their concerns. There was also comment that WHO (and the countries themselves) were not responding adequately to the needs that global and regional strategies had identified. Examples given included NCDs and health systems, where there was a considerable gap between the regional or global strategies and the resources both WHO staff and countries had to carry them out.

To summarize this section, this assessment found high levels of trust and confidence from countries and, in some instances, recognition of improved responsiveness since the establishment of DPS. Development partners had a more mixed reaction to WHO's efforts. Issues for future focus include increased responsiveness to local context and more emphasis on the convening and coordinating role of WHO in support of these small island states.

Deployment of staff to Pacific island countries

The number of staff deployed outside of the DPS Suva office has increased from 2010 to 2013. In 2010, 23 staff were deployed outside of the DPS office, rising significantly to 33 in 2011 and then falling to 32 in 2013. As a percentage of staff deployed in the subregion, this is an increase over the period from 37% to 48%. This information confirms an increased country focus.

The staff mix in terms of percentage of Professional (P) staff has increased slightly. In the Suva office, it has increased from 42% to 44%, excluding unfilled vacancies.

The increase in numbers deployed is most marked for Solomon Islands. The higher numbers of staff in Samoa (8) and Tonga (4) compared to Kiribati (3) suggest further consideration should be given to how staff are deployed in relation to population size and need.

Table 1. WHO staff in Pacific island countries

Office	2010	2011	2012	2013
CLO/FSM	2	1	1	2
CLO/KIR	2	3	3	3
CLO/TON	2	4	4	4
CLO/VUT	6	7	6	6
WR/WSM	9	10	9	8
WR/SLB	3	8	9	9
Total Outside of SP	23	33	32	32
WR/SP	38	42	40	33
Grand Total	62	75	72	65

FSM: Federated States of Micronesia

KIR: Kiribati

TON: Tonga

VAN: Vanuatu

SMA: Samoa

SOL: Solomon Islands

SP: Suva (South Pacific DPS office).

Table 2. Percentage of staff outside Suva office

	2010	2011	2012	2013
Staff outside DPS/Suva office	37%	44%	44%	49%

Table 3. Percentage of Professional staff

	2010	2011	2012	2013
P staff in DPS/Suva	42%	43%	45%	44%
P staff in COs outside of DPS/Suva	33%	39%	40%	33%

Expenditure in the subregion and the countries

Figure 1 tracks the funding available for implementation in the subregion from 2004–2005 to 2012–2013. Before 2010, the subregional Pacific budget was allocated to the technical divisions in the Regional Office. In 2010, a new budget centre, Pacific Island Countries, was created. The figure shows significant growth in both subregional budget and in country expenditure since 2006–2007, supporting a strong subregional and country focus.

The expenditure through WHO reached US\$ 35.6 million by 2012–2013. The expenditure is dominated by staff costs, which were US\$ 13.9 million in the last year. Staff costs in 2012–2013 as a percentage of total expenditure were less in 2012–2013 than in 2010–2011. The largest percentage increase occurred in contractual services. Direct financial cooperation with countries doubled, reflecting a greater country focus.

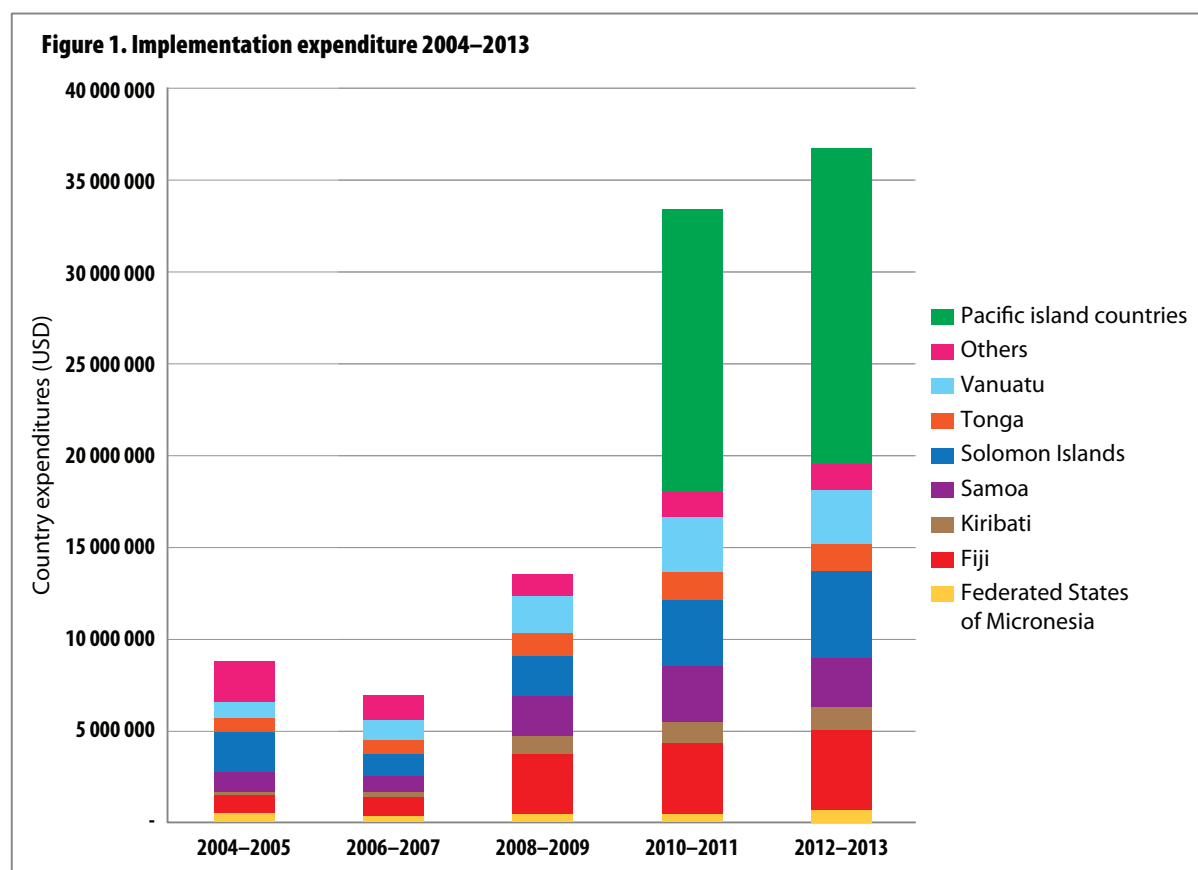


Table 4. Expenditure categories 2010–2013

Expenditure types	2010–11	2012–13	Percent change (of total budget)
Staff costs	15 427 334	13 937 657	-7%
Contractual services	2 569 583	4 310 418	5%
Direct financial cooperation	4 945 948	5 714 899	1%
Travel	3 148 149	4 095 386	2%
Medical supplies & literature	654 045	932 881	0.6%
General operating costs	1 944 260	2 327 246	0.7%
Others	4 830 651	4 349 813	-2%
Grand total	33 519 970	35 668 300	

Travel of Regional Office staff to countries

There had been an increase in travel, with a marked increase at the country level. From an analysis of travel documentation at DPS between 2010 and 2013, the number of trips increased by 50%, with a doubling of the number of trips to Pacific countries and Fiji provinces. As a percentage of total trips, Pacific country visits increased from 33% to 45% in the period. There was also a fivefold increase in trips to more central WHO offices (Manila/Geneva) and developed countries in the Region.

Table 5. DPS personnel work-related travel destinations 2010–2013

	2010	2011	2012	2013
Geneva or other regions	2	2	3	8
Manila & other non-Pacific countries (including Australia & New Zealand)	6	10	27	35
Suva and Nadi	80	108	112	70
Pacific countries and provinces in Fiji (excluding Suva & Nadi)	44	40	36	91
Total	132	160	178	204

Source: Count of Arrival Country/City DPS, December 2013.

This pattern suggests an increase in activity focused on Pacific countries at the same time as regional and global travel activity has also increased. This increased regional travel reflects a greater level of participation of DPS staff at regional meetings.

To summarize this section, this assessment found high levels of trust and confidence from countries and, in some instances, recognition of improved responsiveness since the establishment of DPS. Development partners had a more mixed reaction to WHO's efforts. There has been a measurable increase in resources, activity and personnel at the country level in the subregion. Countries and development partners generally expressed a desire for WHO to be more responsive to their respective needs, to take less of a silo approach, and to pay greater attention to the countries' own processes and priorities while supporting regional and global priorities.

Leading, convening and coordinating development efforts

DPS: Configuration

DPS reflects the structure of the WHO Regional Office for the Western Pacific with its four programmes (combating communicable diseases; building healthy communities and populations including health security and emergencies; health sector development; and management, administration and finance). Interviews with both divisional personnel and countries described the organization as “siloed”, with significant opportunities being missed to work more effectively across divisions. Progress was being made in cross-divisional work on health systems and NCDs.

Most countries reported dealing separately with the individual divisions. The exception was Tuvalu, where officials were very appreciative that a country focal point had been established at a senior level in DPS. This had led to improved coordination (see Tuvalu DPS assessment) and responsiveness.

Reaction from other development partners concerning DPS' coordinating and convening role was mixed, ranging from strongly supportive to raising concerns that the increased activity of DPS had not led to tangible benefits for health efforts in the Region.

In 2013 DPS convened a partners meeting in Suva, with WHO country office staff in attendance. This initiative was generally supported by the development partners involved.

Coordination and convening of health development partners in some Pacific island countries was a significant source of criticism. WHO was seen as the organization with the main in-country presence (compared with other health-related development partners) but most felt it used its resources to pursue its own agenda and failed to take opportunities to leverage the work of other partners to the best advantage. This is a missed opportunity and is discussed further below.

The relationships between development partners

Secretariat of the Pacific Community (SPC) and DPS

There has been longstanding tension between the Secretariat of the Pacific Community (SPC) and WHO concerning WHO's subregional role in health. The majority of development partners, and the two organizations themselves, expressed a desire for a clearer separation of roles and less duplication of effort. To this end, an agreement² had been reached between the leaders of DPS and SPC's health section to divide responsibility for health support for Pacific island countries and areas in the following way: WHO is to focus on health systems; SPC is to focus on the wider determinants of health through working across sectors.

The current reality is that there is considerable overlap, with both organizations delivering both health systems and intersectoral policy support for Pacific island countries and areas. This is further complicated by SPC's focus on regional public goods, while WHO is the organization that is more likely to have a country presence providing on-the-ground technical expertise to provide this support. The review team noted a strong and effective working relationship between the two organizations at the operational level in some areas of work, while for other areas of work there was considerable tension and distrust among the staff involved. One informant noted that relationships were better where the personnel were operating from the same city (Suva).

Most informants noted improvement in the SPC/WHO relationship as a consequence of the joint statement issued in August 2013 by the two leaders. However, for this agreement to be effective it will need to be supported by the enabling environment, including the approach of donors, and be operationalized within each of the organizations.

The current division of activities is largely driven by short-term funding streams. When SPC or WHO attract funding from a particular donor for a particular activity, they recruit trained personnel in that area. However, this is only sustained for the period that the particular funding stream allows (examples at 2-1-22³, Global Fund). The 2-1-22 review noted that a consequence of this approach was an intense focus of both organizations on themselves as they focused on attracting funding and recruiting the necessary expertise, rather than on the NCD challenge in countries.

How donor funding support occurs has a major influence on the division of roles between these organizations. A way forward is for donor funds to progressively align their funding with the agreed division of responsibility. In addition, such an approach will need to be discussed and supported by the respective governance groups of DPS and SPC, Pacific Health Ministers for WHO and the Committee of Representatives of Governments and Administrations (CRGA) for SPC.

² Presentation: Enhancing Collaboration between SPC & WHO. SPC/WHO Health Development Partners meeting, 16 August 2013.

³ Independent Completion Review of Pacific Regional 2-1-22 Non Communicable Diseases Programme Final Report. Sancho J, Moodie R, Gilchrist A, Foliaki S. October 2011, AusAID HRF.

Both organizations also need to pay more attention to the way their relationship is managed below the senior. To operationalize the leaders' intentions would require a change in management processes over three to five years, where duplication of roles and gaps are progressively addressed by both organizations. In areas of obvious overlap (NCD, Surveillance) virtual teams could be formed, with responsible managers moving towards complementarity across the range of skills required over time.

The recommendation in this assessment of greater focus on country level review, planning and budgeting processes presents an opportunity for the two organizations to work together at the operational level and resolve areas of overlap, and reposition resources to fill the many gaps.

One UN

Three United Nations agencies (UNICEF, UNFPA, and WHO) are in the process of developing a joint approach in Kiribati, Solomon Islands and Vanuatu. It is still in its formative stages, and is focused on a specific programme (Reproductive, Maternal, Newborn, Child and Adolescent Health). One United Nations partner expressed anxiety that this arrangement does not play to the organizations' current strengths, and may not be beneficial in the long run. The issue discussed above about the tension between regional and global agendas versus local agendas will become increasingly relevant to the shared approach by the United Nations partners. There will be real gains from effective coordination, provided the capacity to respond to country needs outside of United Nations mandates is maintained.

South–South in the Pacific

The assessment team observed dynamic South–South activity in the Region, especially in human resources for health.

Fiji is supplying trained health personnel across the Pacific and has the potential to do much more, especially regarding the supply of trained nurses. The Health Minister noted that Fiji is also keen to build its capacity as a biotech hub for the subregion. Fiji National University is developing centres of excellence of regional health significance in NCDs and health finance.

Dramatic changes in the workforce are predicted for the Region with almost 800 Pacific medical students currently enrolled in undergraduate programmes within or outside the Region (including at the Latin American Medical School in Cuba). Kiribati is anticipating the return of 31 new medical graduates from Cuba over the next four years, plus 12 others from elsewhere. Solomon Islands will see 90 new graduates over the next six years. The impact of this wave of medically qualified personnel will be profound, and will substantially challenge most aspects of health systems in the countries (especially financing, drug supplies, role definitions and facility staffing).

In Kiribati, postgraduate nursing training has been established that is also accessible to nursing graduates from other countries.

WHO is actively engaged in helping countries manage these initiatives, especially the challenges presented by the influx of Cuban-trained medical personnel. The Cuban doctor training programme is a government-to-government initiative through the respective countries' ministries of foreign affairs. In some countries, the Ministry of Health was not consulted at an early stage, and this also delayed WHO's involvement. An early assessment in December 2013 of the qualification and readiness of graduates

from Kiribati revealed that the graduates were not fit to provide the required clinical services. An intensive internship programme is being developed in consultation with the Fiji School of Medicine to prepare the Kiribati graduates for clinical service.

Cuba has been training doctors for developing countries since 1963 and for the Pacific since 2000. The assessment team's view is that WHO globally missed (or was unable to access) an opportunity at the start of this process, and now that the newly trained doctors are arriving there is a necessary but late attempt to look at how this valuable resource can be optimized.

DPS roles and responsibilities

The 21 countries and areas of the Pacific have unique relationships with other countries for historical and current geopolitical reasons. These range from strong oversight (France and the French Pacific, the United Kingdom and the Pitcairn Islands), through to looser arrangements such as New Zealand's "realm" countries (Cook Islands, Niue, Tokelau), Australia's special relationships (Nauru, Tuvalu) and the Northern Pacific islands' relationship with the United States. The development of DPS with its focus on support for Pacific island countries and areas raises issues of where responsibility in specific countries lies. It is clear from this review that there is no explicit agreement as to where responsibility for health and health systems support for these countries falls in relation to the expected role of WHO through DPS. Options include WHO playing a very minor role or, with agreement from the countries concerned, WHO taking responsibility as the major health and health sector technical support for these small states. Either way, greater clarity is required.

A related issue is the reality of the Region's geography. DPS is well situated to support South Pacific states; however, the Northern Pacific Micronesian states are much more physically accessible to the Manila office than the Suva office. A typical flight schedule from Suva to the Northern Pacific is likely to take several days each way. For Northern Pacific states there is an issue between physical inaccessibility on the one hand, and the enthusiasm they have for working with their South Pacific peers (who face similar problems) through DPS on the other. This assessment does not have a solution to this problem, other than suggesting the assistance for Northern Pacific states will need a different mix of contributions from Suva and Manila from the support for South Pacific states.

DPS capacity and capability

As noted earlier, DPS is structured according to the structure at the WHO Regional Office for the Western Pacific. Understandably, it does not have the breadth of expertise that is available at the WHO Regional Office for the Western Pacific in particular areas. A number of interviewees reported a piecemeal approach taken by WHO – vertical approaches going in depth into a specific issue, but neglecting a more comprehensive approach. Examples include a strong focus on Expanded Programme on Immunization (EPI) but relative disinterest in wider maternal and child health (MCH) issues. Other interviewees noted the emphasis on surveillance, but weak responses to the issues that the surveillance system was identifying. Capacity support depends on the skills of the individual personnel employed, so core functions understandably will at times be missing from the support DPS is offering to countries. An example is in health systems, where some areas are strong (such as human resources, laboratory and pharmacy support) while in other areas there are gaps – such as the absence of anyone with

health financing expertise in the health systems division despite the prime importance of this building block, especially if the focus is on universal health coverage. DPS covers these gaps through use of consultant contracts, but inconsistent coverage remains at times when these core competencies are required to support countries.

The approach being taken to capacity development

Much of the work of DPS with countries falls under “capacity development” rather than direct service provision. Changes had been made to improve the delivery of capacity development activities, such as a move from regional meetings to a greater focus on country activities. During this assessment, the NCD team described its experiences in the roll-out of PEN (Package of Essential Noncommunicable Disease Interventions for Primary Health Care in Low-resource Settings – see Annex 7).

During the conduct of this assessment it became apparent that the approach to capacity development was not consistent across DPS. It was clearly a focus of all the divisions, but it did not appear to be guided by an overall framework or routine evaluation. Although any intervention is inevitably a mixture of capacity development and service provision, setting out exactly what capacity is being developed, how it is being developed, and the endpoints of those developments (i.e. when local capacity is built to the point that WHO assistance is no longer required) would be very useful for WHO, donors and the countries concerned.

The country capacity strategy and workplans

The current WHO Multi-country Cooperation Strategy for the Pacific is a high-level strategic document, more focused on WHO programmes and priorities that have been developed in consultation with the countries concerned. It has low visibility outside of WHO.

THE CHALLENGES AHEAD

The degree of organizational structure and cultural change required to implement the innovative vision of DPS is considerable. The findings of this report demonstrate that significant progress has been made by DPS in developing a stronger country focus for WHO activities in the subregion. This early progress will need to be consolidated and the areas of weakness addressed if the expected transformational changes are to be achieved.

A country-centred approach

Small island countries and areas (for example, those with populations less than 50 000) will not have the capacity to undertake all the essential public health functions in the foreseeable future, and the support of DPS (and other agencies) could be viewed as a permanent part of the countries' health systems. For example, most small countries and areas do not have, and are unlikely to have in the future, sufficient local expertise in public health law, health information systems, surveillance monitoring and evaluation, or health care financing.

This situation is unique to small island countries and areas, so this type of support is an exception to the way WHO normally operates. It will require a strong country focus in DPS, as well as the appropriate skills to support countries in practical ways. Countries themselves are politically independent and do not want a subservient relationship for the provision of core public services, so the way in which these services are delivered needs to respect national autonomy.

This assessment recommends an approach that would reinforce the centrality of the governments' own review and planning processes. At DPS, a country focal point has been established for some (for example, Tuvalu) but not all countries. We recommend that for countries where DPS has significant programmes, a focal point at a senior level in the Division be established.

At the country level, WHO/DPS staff could provide stronger support for each country's annual review, planning and budgeting process. This process would help frame all health donor activities within the context of the countries' own plans and processes. Issues such as the need for capacity substitution, regional public goods and capacity development activities would then be identified as part of the country's annual plans. Activities for, or on behalf of, countries by health development partners would be reported directly to the country's health authorities as part of the review process. Such an approach would be wholly consistent with furthering the aid effectiveness agenda, resulting in closer alignment and harmonization of donor activities with country processes.

To be effective, this approach requires a skill set from those providing technical support that is commensurate with the country-led approach. It also requires WHO/DPS to have available (directly or through other development partners) expertise to cover the core functions of a national health system.

Such an approach would also need to be explicitly recognized by funders in their funding agreements with countries and donor partners.

Leading, convening and coordinating development efforts

This assessment has found that the strong support for DPS from countries is not mirrored in the views of all development partners. In addition, significant South–South developments are occurring, in which opportunities for WHO involvement would be beneficial, particularly at the early stages of the process.

The challenge ahead is to build a more collective view of the health development task for small Pacific island countries and areas with the different stakeholders, and within that develop a clearer articulation of DPS. The current initiative, of inviting development partners to a regional meeting with country staff; is a suitable platform for taking these next steps. The next steps will require a clearer expression of the “theory of change” – in other words, how and why health in the Pacific will be different because of what DPS does. Part of this thinking needs to include a discussion with interested countries and areas (such as Australia, France, New Zealand and the United States of America) regarding where responsibility for health and health sector technical support for these small countries and areas lies. In addition, it would be very helpful at this stage to get better clarity on issues such as the tension between regional and local health priorities, and the scope of WHO’s coordinating and convening roles. Of equal importance is that both the theory of change and the subsequent business model of DPS operations are communicated clearly to all stakeholders in the region. Currently there is limited understanding outside of DPS itself of its roles and functions and their rationale.

The emergence of increased South–South health development activity is a very significant development in the subregion, and one which is likely to become increasingly important. WHO’s approach needs to change so that it positions itself to become involved early in helping both donors and recipients of South–South initiatives, in much the same way it is involved in North–South initiatives. The experience WHO has had with the Cuban medical training should be reviewed, and the lessons learnt applied to other South–South initiatives planned or underway in the Region.

DPS capacity and capability

As DPS develops a more collective view of health development in the Pacific and strengthens its convening and coordinating role, these approaches will need to be reflected in its own capacity and capability development. Currently gaps are addressed through backstopping from the WHO Regional Office for the Western Pacific and WHO headquarters. This assessment recommends WHO/DPS take a more proactive role in making sure Pacific island countries and areas are always able to call on support for their core public health functions. This could be helped by the development of a Pacific health knowledge technical roster, which would identify available expertise both within WHO and in other development partners in the Region. It could also be used to improve the quality of the technical support as discussed below.

Sustainability

There are many excellent developments in the Region but their long-term support is unstable, and the efforts are fragmented across multiple agencies. Consider information systems as an example: irrespective of the exact nature of the post-

2015 development agenda, we know that it will need to be underpinned by effective information systems. Vital registration, communicable disease and NCD surveillance and monitoring are indispensable components, yet these are not fully developed across the Pacific. Considerable progress is being made, with WHO supporting development and standard setting, for example, International Classification of Diseases (ICD) coding, at the country level. Technical support and tools development has occurred through the Australian Government Department of Foreign Affairs and Trade Health Information System Knowledge Hub (whose funding has been discontinued) as well as WHO's technical development on NCD surveillance (STEPS). Regional coordination mechanisms through the Pacific Health Information Network (PHIN), supported by the Health Information Knowledge Hub operating from the University of Queensland and Pacific Public Health Surveillance Network (PPHSN) are run by SPC, while the Pacific Syndromic Surveillance System (PSSS) is run by WHO. Country visits revealed further complexity, with a variety of computerized clinical record systems being established, such as the patient record system being introduced in Tuvalu.

The picture above is of multiple initiatives, with different agencies playing leading and supporting roles. Nearly all are limited by fixed-term funding arrangements, when a comprehensive health information system should be the sustainable core of any health system.

There is a need for more sustainable development across the health systems agenda, not just in health information systems. There is insufficient clarity on how current initiatives will progress through to completion, or how to sustain country support where local capacity will always be stretched. The current strategies and guidelines on WHO's work are not written from a small island state's perspective.

Evaluation, monitoring and quality improvement

DPS is uniquely placed to test and evaluate different approaches, and develop the evidence base for what works in health capacity development in the context of Pacific island countries and areas. A greater emphasis on evaluating the outcomes of capacity development efforts, as well as the approach being taken to reach these outcomes is recommended.

One country requested a greater focus on evaluation and monitoring as part of WHO's support. This is a cross-cutting theme, not specific to any one division. Some development partners raised concerns about the inconsistent quality of some of WHO's efforts, such as using consultants with little understanding of the local context, and operating at too high a level to impact on the practical needs of countries. Our view is that this is an exception, with most activities by DPS being conducted by experts with local Pacific experience and expertise. However, it does raise the issue of how the quality of the inputs is measured and improved.

Part of the response to these issues could be the adoption of a consistent quality improvement framework, both in relation to WHO/DPS support for country processes and in its own domain. This assessment has already suggested how WHO/DPS could focus support for the review, planning and operating cycle of island governments. Previously in this assessment, the need to be more systematic in the way capacity development is approached has been highlighted.

LIMITATIONS

Established in late 2010, DPS is now in its third year. As such, DPS is a “young” organization. Inevitably, the initial focus has been on management issues such as staff recruitment and appointment. This assessment occurred during this early phase in the Division’s development, when the full impact of its establishment may not yet be apparent. Differing views were frequently offered from various stakeholders regarding WHO/DPS quality and effectiveness. This assessment has highlighted areas where there was consistent commentary from multiple stakeholders.

CONCLUSIONS

WHO has a long-standing global and regional structure, and DPS is an innovative attempt to develop a subregional focus to increase responsiveness to countries’ needs. In its second year of full operation, DPS has clearly made progress in bringing a closer country focus to the Pacific subregion. This is seen in stakeholder responses, financial investment, personnel deployment, and travel as a reflection of staff activity.

However, the “point of difference” of this subregional structure is not yet fully developed. Clearer articulation is required of how DPS will make a difference in the region. While the ability of the existing organizational structure to deliver vertical programmes is acknowledged and appreciated, there is a demand from countries for WHO to listen more carefully to their needs and support their priorities. Development partners express a need for a strengthening of WHO’s convening role in the subregion, and for better utilization of its country presence by more actively leveraging the work of all health development partners in support of the countries’ priorities.

RECOMMENDATIONS

1. Increase the country focus

- WHO/DPS to focus more on supporting national health policy review, strategy, and operational planning processes:
 - WHO staff member/s to contribute to each country's annual review and planning process. This process could identify capacity development activities, including capacity substitution, as part of the country's annual plans.
 - Collaborate with development partners in country-focused review and planning support, as needed.
- Strengthen WHO country office health leadership with capability to provide this support:
 - Strengthen the competitive recruitment process for Country Liaison Officers (CLOs), with an emphasis on country-relevant skills, in particular health systems performance/improvement, convening skills and management skills.
 - Strengthen the performance assessment of country office and DPS staff.
 - Increase the delegation of selected administrative responsibilities from the WHO Regional Office for the Western Pacific to DPS (e.g. travel⁴).
- Take a more proactive role in coordinating and convening donors in the health sector at the country level:
 - Hold regular health partner meetings and consultations; share information.
 - DPS staff visits to countries to include mission briefing with other development partners.
 - Assist countries and donors to align inputs with national planning processes.
- WHO/DPS to provide more flexible support arrangements for countries without a WHO presence, such as missions of sufficient length in countries and fewer short-term visits.
- WHO/DPS to assist countries to adapt global and regional priorities to the health needs of their populations.
- Establish a senior DPS focal person for each Pacific island country without a WHO presence.
- Strengthen a team approach to countries across divisional silos within WHO/DPS.

2. Strengthen the convening function of WHO/DPS

- WHO/DPS to articulate its business model for Pacific country support and communicate this with countries and development partners
 - Define/clarify WHO/DPS roles and responsibilities with Pacific Islands that have special relationships with Australia, France, New Zealand and the United States of America.

⁴ For example, DPS has been delegated authority to authorize travel of Suva-based staff within the Pacific. It would be useful if that delegation of authority were extended to all DPS staff based in the Pacific (i.e. those in other country offices).

- Ensure technical support is consistently and sustainably supplied to countries.
 - One option could be to develop a Pacific Island Health Knowledge Technical Roster as a basis for stable capacity assistance to small Pacific island countries and areas (modeled on the technical roster called “the TB Team”) covering disease states, health systems, populations, public health competencies and specific country specialists.
 - Other options can be explored.
- Continue to convene health partners meetings between WHO and development partners to:
 - develop a quality assurance mechanism for development partners advice for health in Pacific island countries and areas;
 - information sharing;
 - review policy/strategy; and
 - discuss resource needs (human, financial).
- Build on the SPC/WHO agreement through the following implementation actions:
 - seek governance (SPC Director-General and WHO Regional Director for the Western Pacific) agreement and donor support;
 - partner with SPC in country-focused planning, review and budgeting processes;
 - develop a joint operational change management plan over five years to improve SPC/WHO alignment; and
 - conduct joint annual or biannual collaboration meetings.
- Strengthen harmonization among United Nations agencies including, but not restricted to, United Nations joint programming. In particular, partner more effectively with UNICEF and UNFPA to support Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) in the subregion.
- More actively communicate with key partners and stakeholders:
 - strategic communications with countries and development partners; and
 - share knowledge and understanding about country situations within DPS and among partners. Some options for information sharing include Internet-based updates (and newsletters) about DPS and partners’ activities in specific countries.
- Include South–South health development activities as an integral part of convening partner activities:
 - review the lessons learnt from the influx of Cuban-trained medical graduates for their applicability to other South–South activities.
- Develop a consistent approach to capacity development at DPS level:
 - Document and evaluate existing capacity development approaches being undertaken by DPS and other development partners.
 - Lead discussion on a capacity development framework for the Pacific and agree with partners and countries on an appropriate approach for each country.
 - Conduct regular reviews of progress in capacity development in relation to human resources for health, and of the standard and appropriateness of training programmes.

ANNEXES

ANNEX 1: PERSONS INTERVIEWED AS PART OF THIS ASSESSMENT

Government officials

Fiji

Mrs Unaisi Bera, Acting Deputy Secretary, Public Health, Ministry of Health, Fiji

Dr Wayne Irava, Fiji National University, Fiji

Dr Berlin Kafoa, Dean's Project Team Leader, Fiji National University, Fiji

Dr Neil Sharma, Minister of Health, Fiji

Dr Wendy Snowden, Fiji National University, Fiji

Kiribati

Dr Leita Atanrerei, NCD/PEN Program, Kiribati

Dr Bwabwa Oten, Director, Curative Services, Kiribati

Ms Mamao Robate, Director, Nursing, Kiribati

Mr Beia Tabaia, Deputy Director, Nursing, Kiribati

Dr Kautu Tenaua, Minister of Health, Kiribati

Dr Teatao Tira, Director, Public Health, Kiribati

Federated States of Micronesia

Mr Marcus Samo, Assistant Secretary of Health, Department of Health and Social Affairs, Federated States of Micronesia

Nauru

Dr Samu Korovou, Assistant Director Public Health, Ministry of Health, Nauru

Mr Vincent Scotty, Environmental Health Officer, Nauru

Dr Seta Vatuwaqa, Director Public Health and Acting Secretary for Health, Ministry of Health, Nauru

Mr Isireli Vuanivono, Senior Health Inspector, Nauru

Samoa

Mrs Eseta Hope, Dean, Faculty of Nursing, Samoa

Mr Leota Laki Sio, General Manager, National Health Services, Samoa

Professor Pelenatete Stowers, ACEO Nursery and Midwifery Quality Assurance, Samoa

Dr Robert Thomsen, ACEO Medical and Allied Health Services Quality Assurance, Samoa

Mrs Palanitina Toelupe, Director General, Ministry of Health, Samoa

Solomon Islands

Dr Lester Ross, Permanent Secretary for Health, Solomon Islands

Tokelau

Dr Silvia Tavite, Tokelau Department of Health

Tuvalu

Mr Fauoa Maani, Minister of Health, Tuvalu

Dr Stephen Homasi, Director for Health, Tuvalu

Dr Nese Conway, Public health department and primary health care, Tuvalu

Development partners

Dr Karen Allen, UNICEF Representative, Fiji

Ms Puonita Atabi, Climate change, Tuvalu Association of Nongovernmental Organizations, Tuvalu

Mrs Tupepepa Aumua, Child Protection for UNICEF and Gender Based Violence for UNFPA, Samoa

Dr Iobi Batio, Australian Government Department of Foreign Affairs and Trade, Kiribati

Dr Tai-Ho Chen, Quarantine Medical Officer, USCDC, Hawaii

Ms Megan Counahan, Australian Government Department of Foreign Affairs and Trade Health Specialist, Samoa

Mr Toomu Hauma, Coordinator, Tuvalu Association of Nongovernmental Organizations, Tuvalu

Ms Annie Homasi, Outgoing Coordinator, Tuvalu Association of Nongovernmental Organizations, Tuvalu

Mr Mike Hunt, Counsellor, Australian Government Department of Foreign Affairs and Trade, Kiribati

Dr Dennie Iniakwala, Team Leader, HIV & STI Programme, Secretariat of the Pacific Community, Fiji

Ms Susan Ivatts, Senior Health Specialist, Human Development Pacific, World Bank

Ms Patricia Kehoe, Senior Fund Portfolio Manager South and East Asia, Global Fund to Fight AIDS, Tuberculosis and Malaria, Geneva, Switzerland

Mrs Donna Lene, Director, Senese (Inclusive Education), Samoa

Mr Lono Leneuoti, Programme Officer, Tuvalu Family Health Association, Tuvalu

Ms Helen Leslie, First Secretary, New Zealand High Commission, Fiji

Mr Shinya Matsuura, Project Formulation Adviser, JICA, Fiji

Ms Solstice Middleby, Regional Counsellor, Australian Government Department of Foreign Affairs and Trade, Fiji

Dr Jason Mitchell, Chief Executive Officer, Oceania Society for Sexual Health and HIV Medicine, Fiji

Ms Karen Punivalu, Senior Development Programme Coordinator, The New Zealand Aid Programme, Samoa

Dr Robert Reid, Country Director, U.S Peace Corps, Federated States of Micronesia and Palau

Dr Tim Rwabuhemba, UNAIDS Coordinator for the Pacific, Fiji

Dr Josia Samuela, Manager, Health Advancement Unit, Secretariat of the Pacific Community, Fiji

Ms Paulini Sesevu, Senior Program Manager, Australian Government Department of Foreign Affairs and Trade, Fiji

Dr Naawa Sipilanyambe, Chief of Health, UNICEF, Fiji

Ms Beth Slatyer, Health Adviser, Australian Government, Department of Foreign Affairs and Trade, Australia

Ms Sumi Subramaniam, Principal Development Manager Health, The New Zealand Aid Programme, New Zealand

Ms Tinaailuta, UNICEF Health/EPI, Kiribati

Mrs Susana Tuisawau, Pacific Foundation for the Advancement of Women (PacFAW), Fiji

Dr Colin Tukuitonga, Director, Public Health, SPC, New Caledonia

Mrs Maeva Betham-Vaai, Joint Liaison Officer, World Bank/Asian Development Bank, Samoa

Mr Peter Zinck, UNFPA Health System & Reproductive Health Commodities Security Specialist, Fiji

WHO officials

Dr Dong-il Ahn, WHO Representative and Director, Division of Pacific Technical Support, Fiji

Ms Audrey Aumua, Technical Officer, Health Information Systems, Fiji

Dr Yang Baoping, WHO Representative Samoa, Samoa

Ms Teiti Bwenawa, PacELF Programme Manager, Kiribati

Dr Juliet Fleischl, WHO Representative, Solomon Islands

Dr Sevil Huseynova, Country Liaison Officer, Federated States of Micronesia

Mr Javier Arina-Iraeta, Programme and Administrative Officer, Fiji

Dr Eric Nilles, Acting Team Leader, Division of Combating Communicable Diseases, Fiji

Dr Ezekiel Nukuro, Team Leader, Division of Health Sector Development, Fiji

Ms Gaik Gui Ong, Senior Programme Management Officer, Fiji

Dr Andre Reiffer, Country Liaison Officer, Kiribati

Mr Kireata Ruteru, Noncommunicable Diseases Programme, Kiribati

Dr Madeline Salva, Medical Officer, HIV/STI, Fiji

Ms Jane Wallace, Senior Health Adviser, Fiji

Dr Temo Waqanivalu, Team Leader, Building Health Communities and Populations, Fiji

ANNEX 2: SAMOA REPORT

Sunia Foliaki, Pieter van Maaren

Background

Enhancing WHO's performance and effective leadership at country level is one of the top priorities of WHO reform, both regionally and globally. Improving WHO's performance ensures that WHO is delivering results at the country level.

The effective delivery of WHO's work in the Pacific has required a unique response. Because of the small size of many of the island countries and areas, the 21 island countries and areas (excluding Papua New Guinea) are served by three WHO country offices South Pacific (Fiji), Samoa and Solomon Islands and by four Country Liaison Officers—Federated States of Micronesia, Kiribati, Tonga and Vanuatu.

The approach to further strengthening WHO's capacity to support countries in the Pacific is anchored in the establishment in 2010 of the Division of Pacific Technical Support (DPS). DPS provides the mechanism to coordinate and consolidate WHO inputs from the different levels and to create synergies among offices, and between regional and country levels.

The assessment will explore the way DPS helps individual countries and areas to carry out these core functions by evaluating the performance of WHO's roles and functions in the Pacific. In addition, selected country visits aim to gain a better understanding of WHO's functioning at country level and the extent to which DPS has contributed to an increased country focus.

This report provides feedback on the visit to Samoa, a desk review of relevant documents, and interviews with WHO country office staff and senior government health officials, as well as representatives of the main development partners involved in Samoa's health sector (see Annex 1: Persons interviewed as part of this assessment). The report looks at three critical areas: country focus; convening and coordination; and capacity development.

Findings

The WHO country office in Samoa is led by the WHO Representative (WR), who heads a team of nine staff consisting of three Professional staff (two International and one National Programme Officer), five administrative staff and one driver. The office also hosts one staff member from UNICEF and UNFPA, respectively.

Although there has been regular professional staff turnover, the size of the country office has remained more or less the same over the past decade. In line with the increasing focus on NCDs in the Pacific, recently a Technical Officer for NCD/Health Systems joined the country office. WHO Samoa has its own Country Cooperation Strategy (2012–2018), which is aligned with the National Health Sector Plan 2008–2018 and is incorporated in the WHO Multi-Country Cooperation Strategy for the Pacific (2013–2017). WHO provides support in Samoa for a wide range of priority areas, and roughly half of its 2012–2013 budget of US\$ 2.7 million is direct funding to the Ministry of Health for implementation of activities.

Country focus

Wide recognition and appreciation exists among the various levels and departments of the Ministry of Health for WHO's continuous technical, policy and strategy support, particularly in the areas of nurse/midwife training, communicable diseases, MCH and NCDs. This appreciation is shared by the development partners and nongovernmental organization staff met during the visit.

At the same time, the Ministry of Health has been critical of the lack of WHO support in the areas of health systems and NCDs through both resident staff and external technical support. The Ministry therefore welcomed the recent appointment of the Technical Officer for NCD/Health Systems.

Development partners, in particular those involved in the Sector-Wide Approach (SWAp) for Health, have also been critical and urged WHO to play a more active role in the SWAp, including the pooling of WHO resources and technical inputs in the SWAp coordination unit. Although not all partners agree with WHO's leadership in health sector coordination, they do agree that WHO should exert its technical leadership in health and argue that WHO must do a better job in this area.

Over the years, WHO's support has been spread over too many priority areas, thereby somewhat failing to focus on the areas where support is needed most: NCDs and health systems (including health financing and human resources). With the newly appointed Technical Officer for NCD/Health Systems, WHO has the opportunity to reprioritize its technical support.

WR Samoa notes that the establishment of DPS has facilitated access to direct technical support, which is also confirmed by Ministry staff, with the exception of the Nursing Section, where support is still largely provided through the WHO Regional Office for the Western Pacific in Manila. Although most of the development partners are aware of the establishment of DPS, they have not noticed much difference in WHO's support.

The representative of the only nongovernmental organization the authors met (SENESE) had low awareness of DPS. Most of the nongovernmental organization's communications with WHO are with the country office and the WHO Regional Office for the Western Pacific, particularly concerning work on disability, its focus in Samoa.

Convening and coordination

In Samoa, the Ministry of Health and development partners acknowledge WHO's technical leadership in health matters. The Ministry also wants WHO to take a prominent role convening and coordinating in the health sector, under its leadership. There is a clear desire among the senior staff in the Ministry and National Health Services for WHO to capitalize on its privileged position as a trusted partner of the Ministry.

However, some of the development partners consider the role of convening and coordinating more appropriate for the main funding partners in the SWAp mechanism, in particular Australia and New Zealand. In this context, WHO has played a reactive rather than a proactive role.

As the SWAp is nearing its final stage (there will be a no-cost extension in 2014), with no indication of a renewal of the pooled funding arrangements, WHO has an opportunity to position itself as the technical leader in the health sector with a clear convening and coordination role. For this to materialize, the dialogue between WHO and other development partners has to become stronger and more effective.

Capacity development

The Ministry of Health has articulated a clear wish for WHO to strengthen its country office in support of developing technical capacity in the most important priority areas of Samoa's National Health Sector Plan, including NCDs and health systems development.

Traditionally, WHO has provided strong support in the area of communicable diseases, for example, TB and HIV. A technical officer for NCDs has recently been appointed in the country office, which is likely to have a positive impact on Samoa's ability to better address this area of work.

Although WHO has contributed significantly to capacity development of the nurses and midwives cadre, it has been largely on an ad hoc basis. Samoa has a current health workforce plan but the difficulties with implementation are reflected in the looming crisis of shortages in midwives (short term) and nurses (medium term).

Apart from the need for support in the area of human resources for health, a more general health systems focus in Samoa is necessary. Following the split between policy and planning at the Ministry of Health and the delivery of health services through the National Health Service (NHS), both policy and operational issues have emerged – for example, health financing; maintaining a primary health care focus in Samoa; and the increase of private health services. The increasing cost of health services delivery (recently a new national hospital, funded by China through a concessional loan, has become operational) poses a problem for the Ministry and various solutions are being considered, including the introduction of user fees.

The Pacific Open Health Learning Network (POHLN) has played an important role in capacity development in the health sector in Samoa. It is appreciated by the Ministry of Health and over the years has provided opportunities for many health staff to update their knowledge and skills in a range of areas. This was explicitly expressed by senior nursing staff in the Ministry.

Conclusion and recommendations

WHO is acknowledged for its technical leadership in health by both the Ministry of Health and health development partners. This leadership is particularly clear in the areas of communicable diseases and maternal and child health. However, with the epidemiological transition that affects Samoa, the demand by the Ministry for technical inputs from WHO is shifting towards NCDs and broader health system areas, including health financing and human resource development. With support from DPS in Suva, a technical officer for NCDs has joined the country office. But WHO's capacity to support health systems development is limited, which hampers its role in supporting the Ministry with policy development and planning.

In terms of convening and coordination, WHO has been somewhat reactive, something that is explicitly mentioned by the development partners. Although WHO's financial input in the SWAp in Samoa is limited, WHO is expected to play a more important role in determining the technical direction of support by development partners.

Finally, with the opportunities provided through DPS, WHO Samoa is in a position to provide targeted support in developing capacity in the Ministry of Health to deal with a changing environment in health. Rather than assisting ministry staff to attend regional meetings, longer-term technical support could be provided on the ground in areas such as health financing, public-private partnerships and human resource development.

These conclusions lead to the following recommendations:

- WHO (DPS and country office) should play an active role and provide strong support to the Ministry in its annual health sector review and planning and strategy development process, and provide appropriate technical assistance for its implementation.
 - Specific attention should be given to supporting work on NCDs.
 - With support from DPS, more attention should be given to health financing issues, including the provision of guidance in managing the National Health Service.
- WHO should take a more proactive role in convening and coordinating development partners in health (including UN partners).
 - WHO needs to support the Ministry of Health in health sector coordination.
 - Information should be shared among development partners.
 - Agreement is needed with SPC on the division of labour in delivery of technical assistance.
- In consultation with both the Ministry and development partners, WHO is to support a capacity development exercise.
- A health workforce development plan is to be established to identify gaps in technical knowledge and skills in health systems development, for example, quality assurance of health service delivery, and support efforts to address these gaps.

ANNEX 3: KIRIBATI REPORT

Sunia Foliaki, Pieter van Maaren

Background

Kiribati, located in the Pacific, consists of 32 low-lying atolls spread over 3.5 million kilometres of ocean, but with a total land area of only 811 square kilometres.

The 2010 census counted a population of 103 466. Just over half of the population are now living on the capital island, putting extreme stress on its environment and infrastructure. The Gross National Income per capita is US\$ 3300 (PPP international) and life expectancy is 65 for males and 71 for females. Other health profiles of Kiribati are well documented by WHO.

A WHO country office was established in Kiribati in 1982 with a clear mandate to support public health services. Activities initially focused on health promotion and establishment of and collaboration with village welfare groups and churches. Outreach to outer islands is said to have been a major success in the past, but this has not always been continued because of budget constraints. Kiribati is party to the WHO Multicountry Cooperation Strategy for the Pacific. Dr Sunia Foliaki and Dr Pieter van Maaren visited Kiribati from 6 to 8 December 2013 as part of a team tasked with an external assessment of WHO in the Pacific.

Findings

WHO relationship with government

The Minister of Health and Public Health personnel expressed strong appreciation for WHO's leadership in health and its support as a trusted development partner. Officials were positive about the role WHO had played in helping address NCDs, and noted the impact of the PEN clinics, which were provided with protocols, guidelines and relevant technical assistance. The Director of PEN had regular and satisfactory meetings with the CLO and provided DPS with regular progress reports, but noted he received very little feedback from these reports.

The lymphatic filariasis programme is working well, communicating and reporting regularly to the WHO Regional Office for the Western Pacific and DPS.

The support and awareness of WHO's efforts in public health was less apparent in hospital services. The Director of Hospital Services stated that there had been limited involvement with both the CLO and DPS.

The Minister of Health was not familiar with the specifics of the DPS concept and structure, and the Director of Public Health similarly was only somewhat aware of the new DPS set-up, so they were unable to comment specifically on this new organizational arrangement. However, from the information provided by DPS, it seems Kiribati has benefited from more regular and substantial country visits since DPS has been in existence (Table 1), resident staff numbers have remained the same, and programme budget allocation (Table 2) is at the 2008–2009 level in the 2012–2013 biennium.

Table 1. DPS staff activity in Kiribati 2010 to 2013 (excluding consultants)

	2010	2011	2012	2013
DPS personnel visits	1	0	4	4
WHO resident staff CLO	2	3	3	3

Table 2. Programme budget allocation Kiribati 2008 to 2013 biennia

	2008–2009	2010–2011	2012–2013
Kiribati	1 271 000	1 105 000	1 247 000

Concern was expressed about long bureaucratic processes in WHO to access and release funds. The Director of Hospital Services, for example, has not been informed of the funding available from WHO for 2014. Problems were raised, especially concerning travel arrangements (for example, often short notice; per diem paid late; inconvenient flight arrangements). A concern was the six-month delay for cholesterol strips for the PEN programme; the stocks that were received are mostly nearing their expiry dates.

The nursing division was satisfied with the regularity of WHO-arranged meetings outside Kiribati.

Leading, convening and coordinating

Health partners active in Kiribati include Australia, Global Fund, Japan International Cooperation Agency (JICA), New Zealand, SPC, UNFPA and UNICEF.

Appreciation was strong for the support from WHO in developing the National Health Strategic Plan 2012–2015. However, there had been a problem with its launch, delayed until late 2013 due to problems with the contractor. Health authorities also suggested that WHO and other partners were not well versed in or aligned with the current Health Strategic Plan.

WHO has been asked by Kiribati Ministry of Health and Medical Services (MHMS) to conduct high-level mediation with the GAVI Alliance on behalf of Kiribati. Kiribati no longer qualifies for GAVI support as its gross domestic product is above the GAVI threshold, largely because of the income from fishery licences. The GAVI decision does not take into account the high health costs, the high poverty level and the abundance of health problems in Kiribati.

A number of doubts were raised about the accuracy of the health information system. For example, conflicting figures were reported for immunization rates according to a recent review by UNICEF. Issues were also raised relating to the attendance by mothers with their under-5 children at the child and maternal health clinics and the follow-up by clinic staff in the villages.

This assessment has identified a clear role for WHO to be more proactive in both its communication with the MHMS and its convening role with development partners. As the agency with the most senior representation, there is untapped potential for WHO to facilitate more actively the engagement of other donor agencies, and thus earn its leadership role in coordinating the efforts of donor partners.

There is clearly an unmet need to facilitate coordination with donor partners on a multi-agency, multi-donor approach to addressing health and social issues related to health.

Capacity development

Ministry of Health and Medical Services staff capacity remains a major issue: although there are some highly qualified personnel, the workload exceeds individual capacities. For example, public health practitioners are also required to do clinical work; even the Minister is still active in providing obstetric services.

Recently, 14 Cuban-trained medical graduates arrived in Kiribati. A review by the Fiji School of Medicine of these Cuban-trained medical graduates stated they have insufficient capacity to work as doctors in Kiribati. An internship programme is being actively discussed by the Government, the Australian Government Department of Foreign Affairs and Trade and the Fiji School of Medicine to enable the Cuban graduates to perform adequately and safely in Kiribati as doctors. WHO has provided policy and technical guidance to Kiribati and other Pacific island countries and areas as part of the initiative on the integration of foreign-trained medical graduates.

The POLHN programme received very positive comments as it was providing an opportunity for career development. Its value was further enhanced as the qualifications were linked to promotion within the health service. Suggestions were made to improve its accessibility by adjusting opening hours according to student needs (including after-office hours).

WHO's support to nursing services is strongly appreciated in terms of training activities, supervision and support for outer islands, nursing competencies/skills/capacity upgrade and textbooks for the nursing school from WHO in both Suva and Manila.

Other partners supporting the nursing profession are UNFPA and UNICEF (curriculum development); JICA (volunteers in nursing school); Australia and New Zealand (training materials); and in the past the European Union has provided support for curriculum development.

Ministry officials commented that capacity development is better served by technical assistance provided through prolonged missions, rather than the fly-in/fly-out scenario. Short-term visits resulted in recommendations being made, but with little feedback to locally based officials and insufficient assistance with implementation and hands-on support.

WHO has the opportunity to take more of a leading role in assisting the Government to coordinate human resources development. This could also include assistance with the Kiribati health/medical internship programme and possible regional (Nauru, Solomon Islands and Tuvalu) internship programmes, and assistance to better define the role and function of these health workers following completion of the internship programme.

Other areas for future capacity support include development of the capacity to analyse and present data in Kiribati from various ongoing health programmes (PEN, EPI coverage, cancer registry), assistance with the second STEPS Survey which is scheduled for 2014, and support for legislation on tobacco taxation.

According to the Public Health Division, major support is available for MCH, HIV and TB, but more financial support is still needed for NCDs, family planning and mental health.

Country-centred approach

The NCD epidemic has appropriately been a focus in all Pacific island countries in recent years. However, in Kiribati it is clear that the "double burden" of disease is still present. The number of deaths under 5 years old due to diarrhea in 2012 was reported by UNICEF personnel interviewed to be more than 30 (the figures at the time of writing were not officially confirmed) and in the months of June/July in 2013 six child deaths were reported over a very short time. The Pacific Syndrome Surveillance System (PSSS) reported the increase in diarrhoea cases, and the regional laboratory system effectively identified the cause as rotavirus. According to the Director of Public Health, the cause of the deaths was strongly associated with poor nutrition. UNICEF, and other partners, felt overall that the Government (health and other sectors) response was not sufficient to address the underlying causes, such as malnutrition and inadequate water and sanitation. All acknowledge that addressing these underlying causes is difficult, with shortages of potable water, increasing salination of soils and seawater incursion.

WHO potentially can play a role in helping the Government address the health situation. While the Regional focus and country response to the NCD problem is appropriate, an equally enthusiastic response is needed to continue to address areas such as MCH.

The determinants of health need a multi-agency and multisectoral approach in a country where a recent assessment suggests 66% of the population is below or just above the poverty line.

WHO could also support the Government in more accurately determining health status and identifying priority and emerging health issues, for example helping to address accuracy concerns around EPI coverage data, levels of malnutrition, and child health and maternal mortality.

The country-centred approach could also be better reflected in DPS. Its vertical nature limits the response effectiveness when it needs to address issues that cross disease areas (such as nutrition, which is both an NCD and a communicable disease issue).

ANNEX 4: FIJI DPS ASSESSMENT

Sunia Foliaki, Pieter van Maaren, Don Matheson

Fiji recently increased its government-sourced health budget to F\$ 222 million, bringing health from 4% to 5% of gross domestic product.

Relationship with Fiji Government

The Fiji government health sector (Minister of Health, public health leaders) were very positive in their views of WHO support, and of the improvements they had noticed in that support since the establishment of DPS. The Minister felt the Organization's performance had improved since the introduction of DPS – whereas before, WHO was something of a black hole – now when the Government asks for something, it happens:

“... in a nutshell, WHO are now more proactive, more transparent, and able to mount timely responses to specific technical requests.”

Most health programmes in Fiji are modeled on WHO guidelines. The Government perceives no loss of focus on Fiji as a consequence of the Suva office moving from a country to a subregional focus.

The Government had recently established a budget and policy planning group, and felt there was considerable value in the active connections with knowledge hubs and with Fiji National University. There was growing interest in economic evaluation. The Minister declared a strong interest in monitoring and evaluation of programmes, as well as innovative approaches to problems such as nutrition.

The Programme Budget from WHO for Fiji had remained stable over the last three biennia.

Table 1. Programme budget allocation Fiji

	2008–2009	2010–2011	2012–2013
Fiji	US\$ 3 722 000	US\$ 3 534 500	US\$ 3 982 000

Leading, convening and coordinating

The Government of Fiji hosts a Health Partners meeting every six months, where development partners share information and align with the Government's programmes and strategies. The agenda is driven by the Government, with a focus on government priorities such as the Millennium Development Goals, NCDs, climate change, ageing and the post-2015 agenda. The Government tries to avoid silos driven by partners.

The Minister looks to WHO for support in his efforts to shift investment from medical care to primary health care and to strengthen the role of community health workers.

Fiji also plays a significant role in producing health workers for the wider region, a role which, according to the Minister, it is keen to expand. He cited the example of Fijian-trained health professionals taking up positions in Papua New Guinea when they had reached Fiji's retirement age of 55 years. In addition, he expressed a wish to strengthen Fiji's role as a hub for the Region in areas such as biotechnology.

The leadership role WHO plays in Fiji and regionally was emphasized in discussion with a regional women's nongovernmental organization. WHO plays an important role in raising policy issues that would be very difficult for nongovernmental organizations to raise. An example was given related to sexual and reproductive health. The nongovernmental organization also highly commended WHO on inviting the nongovernmental organization sector as full participants to a regional food security summit, recognizing the vital role women

play in the nation's nutrition. This was then followed up by WHO supporting the women in organizing activities in their communities. The same informant also complimented the Organization for holding its events in more modest settings – as opposed to five-star hotels favored by some United Nations agencies, making their events inaccessible to ordinary people. The nongovernmental organization's view was that WHO could play a much bigger role in encouraging governments to have greater engagement with civil society in pursuit of health goals.

Country-centred

Donor contributions are playing a smaller role in the country's health financing system as a result of increasing government investment, and, as noted above, there is a donor coordination mechanism run by the Government. According to senior officials, WHO has responded in a timely fashion to seven specific requests for technical advice from the Government. Quarterly round-table meetings with WHO identify gaps and discuss implementation plans, and WHO activities follow the Ministry of Health's plan, whereas with other agencies it is difficult to get the whole picture of their support.

“WHO's assistance empowers us, upskills our knowledge, and listens to MOH's plan”

Conclusions from Fiji

The Fijian Government had clearly seen additional value in the work of DPS, and the improved responsiveness to requests for technical assistance was particularly noted. It holds WHO's work in high regard and looks to its technical leadership in addressing health issues.

Donor coordination is a government-led activity in Fiji and consists primarily of information sharing with the Government on a six-monthly basis.

Of particular interest was the growth of, and enthusiasm for, South–South activities in health. Fiji is a major supplier of health personnel for the subregion, and has the intention of developing its capacity as a support hub beyond human resources to medical technologies.

ANNEX 5: TUVALU DPS ASSESSMENT

Don Matheson, Kunhee Park

DPS office relationship with Tuvalu

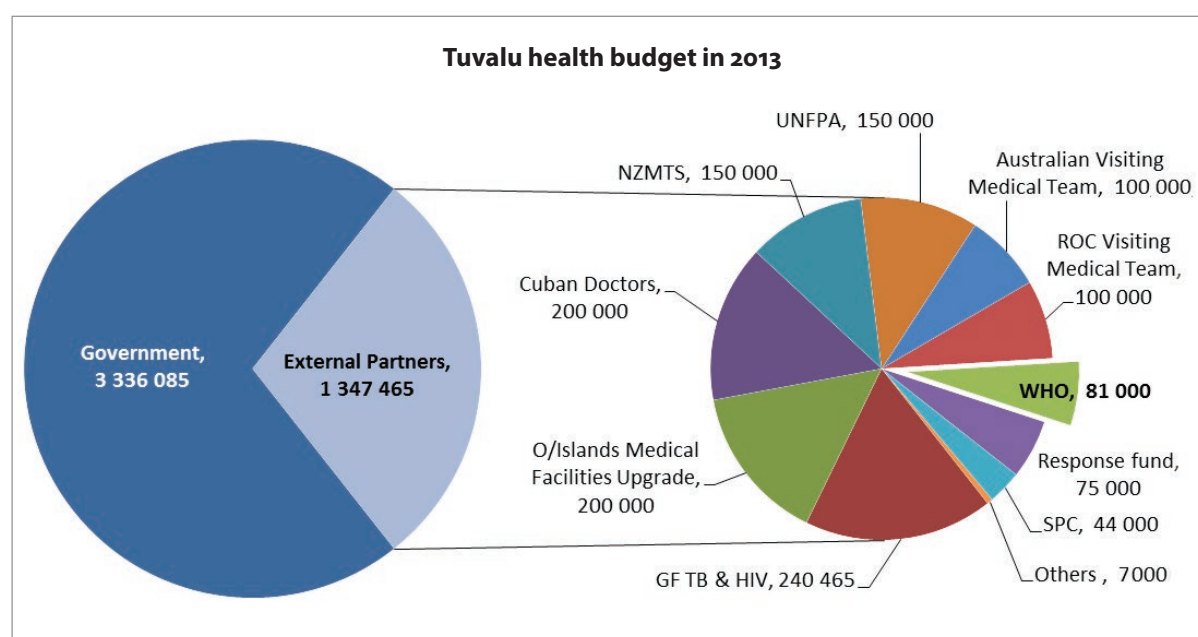
The WHO/DPS office in Suva has provided strong support for the health sector in Tuvalu. A particular highlight (on both sides of the relationship) was the visit to Tuvalu by Dr Dong Il Ahn and Ms Gaik Gui Ong in June 2012. This visit and the way it was conducted communicated a significant change in the way WHO was operating to the Tuvalu health leadership – the sense that WHO was taking their issues seriously, and at a senior level prepared to gain an understanding of the situation on the ground. This has been followed up by an agreed programme of work, involving most of the DPS divisions. Close relationships between DPS and Tuvalu have also been strengthened by the active role of a Suva-based Country Liaison Officer, Ms Ong, and the advantage both Tuvalu and DPS officers have taken of visits by senior Tuvalu staff to the Suva office when they have been in Fiji on other business.

“Compared with other development partners, WHO are better at really discussing issues and understanding them from our perspective. WHO people are well versed in our issues and there is good handover when new staff come on board, while with other agencies, people change very frequently and the new people don’t understand our situation.”

Aid effectiveness

At the government level, an annual “Donor Round Table” has been introduced in Tuvalu. This has made a big difference to coordinating the aid effort, which was previously “all over the place”. It connects the aid to the development plan, and has reduced the overlap between different donor programmes. In the Round Table, it is possible for government officials to discuss what donors will and will not support, and to plan accordingly. It is also assisted by the donors meeting together in Fiji before their arrival in Tuvalu, so that issues between donors are resolved in advance of the Round Table meeting.

The current arrangement, in which WHO and the Government of Tuvalu produce a biennial plan that specifies the assistance that WHO will provide to the Ministry of Health over the period, is a major step forward in aligning WHO’s activities with the country’s needs.



Other development partners significantly involved in the health sector (UNFPA, UNICEF) develop similar agreements for their work.

However, these agreements are not synchronized with the Government's planning and budget cycle. The Ministry of Health undertakes an annual review process, where the heads of each department in the Ministry review the performance in their area of responsibility and prepare a budget for the Government to consider in the coming year. This process has not been consistently conducted in the last two years because of leadership changes in the Government. The 2013 review went ahead as usual, following a change in Government.

This review process is a very valuable element in the Ministry's planning system, where performance information is considered and training needs assessed. Consideration could be given to extending this mechanism, through the engagement of the nongovernmental organization sector in both assessing performance (from a patient perspective) and local nongovernmental organizations' role in supporting health promotion efforts in the annual plan. It would also be the optimal time for providing technical assistance, both in the analysis of system performance and in advising the Government on the options for taking the issues forward.

For consideration would be a process where WHO convenes (in Suva) a meeting of the development partners involved in health in Tuvalu (this could be an adjunct to the Donor Round Table). WHO would then help Tuvalu undertake its annual health review and planning process for the coming year, including in this process the potential commitments from the development partners. The resulting plan would be the Tuvalu Government's, with development partner activity reporting to the Ministry for its activities as part of the plan, as well as reporting within the specific development partner. This would truly be a country-centred process.

Capacity development and capacity substitution

The issue of the long-term capacity substitution needs of Tuvalu were discussed. With the senior personnel sharing large clinical commitments, it is clear ongoing support is needed for the foreseeable future for technical support from a public health (see essential public health functions) and a health systems perspective (expertise covering all six building blocks).

Recommendation:

- Align the WHO planning process with that of the Ministry of Health.
- WHO to more actively coordinate health donor inputs (especially SPC, UNICEF, UNFPA, GF).
- WHO to offer technical assistance to the MOH team in conducting the annual review and budget setting process.
- DPS to reduce the administrative complexity of its contracting process, with one grant and quarterly tranches.
- WHO to identify capacity development activities, including the capacity substitution component of its assistance to the Tuvalu Health Ministry.

Government annual health expenditure and budget and WHO's financial support

In 2008, total government health expenditure was AU\$ 4.1 million. Thirty-five per cent of the budget was for salaries and allowances and 50% for the Medical Treatment Scheme. According to the 2014 health budget, the total government health budget is AU\$ 4.6 million. Of this, AU\$ 1.3 million will come from external partners.

WHO's direct fund support (Direct Financial Cooperation) to Tuvalu in 2012–2013 was AU\$ 129 888 with 13 transactions (ranging from AU\$ 580 to 65 824). There were nine country missions in 2012–2013 which cost US\$ 12 897 (travels of short-term consultants are not included here. The table below does not include opportunity cost of staff time).

Table 1. Travel costs to Tuvalu of DPS staff

Year	2012	2013
Total number of visits	5	4
Total travel cost (US\$)	6719	6178

There were 16 participants from Tuvalu to WHO-organized out-of-country meetings, workshops and trainings, which cost US\$ 68 954 in 2012–2013. (The table below does not include the opportunity cost of participants' time.)

Table 2. Participants' travel costs

Year	2012	2013
Total participants from Tuvalu*	10	6
Total travel cost (US\$)	46 051	22 903

*Meetings organized by the WHO Regional Office for the Western Pacific

Finally, according to a quick survey of senior technical officers based in Suva (seven respondents), 2.8% of staff time was allocated to provide technical support to Tuvalu, at an approximate cost of US\$ 167 000. (The total staff cost of the DPS workplan was US\$ 5 965 000 for 2012–2013.)

In summary, WHO's overall financial support to Tuvalu in 2012–2013 would be US\$ 363 763.

Table 3. Summary of WHO financial support to Tuvalu 2012–2013

Direct financial cooperation (DFC)	114 912
Country missions	12 897
Out of country meetings	68 954
Suva based officers' staff time (estimation)	167 000
Total (US\$)	363 763

ANNEX 6: RESPONSES TO SPECIFIC QUESTIONS

Objective	Questions	Evaluation findings	Comments
Performance of WHO's roles and functions	Does WHO/DPS provide leadership on matters critical to health for Pacific?	Yes, DPS does provide leadership on matters critical to health in the Pacific. However, this is mainly restricted to areas of global and regional priority that are on WHO's agenda. It is not taking the opportunities to leverage development partners inputs more generally in its coordinating and communication role.	Press releases show modest output on specific conditions or WHO-specific matters. They do not provide commentary or overview of subregional specific issues or system performance. The main leadership influence is through the strong relationships with Ministers and Ministry of Health personnel. There is scope to more actively lead communication on specific subregional health issues and report on system progress (not just WHO priorities). There is also considerable scope to take a more strategic role in relation to emerging issues that are unique to the subregion – such as increasing numbers of foreign-trained health workers.
	Does DPS shape the research agenda and stimulate the generation, translation and dissemination of valuable knowledge on health for the Pacific?	Shaping the research agenda was not strongly evident in the work of DPS or its communications. DPS leaders were keen to develop more subregional specific research. Together with SPC, DPS had developed a funding/supporting role in NCD research with Fiji National University. There is considerable scope to more actively foster research activity based on the contextual issues facing small island countries and areas.	Press releases did not have a research focus. In particular, WR expressed interest in research into multiple aspects of primary health care as it is applied to small island countries and areas.
	Has WHO/DPS set norms and standards and promoted monitoring of their implementation?	WHO/DPS was widely acclaimed for the role it was playing in promoting norms, standards and guidelines. It was the issue interviewees identified as the most positive contribution that WHO makes. Criticism made of this activity is that it is not always backed by adequate funding (by both donors and countries), and there was also concern raised by a number of interviewees that monitoring of implementation needed to be strengthened.	Some interviewees suggested implementation was not WHO's strong point because of the cumbersome nature of its administrative processes.

Objective	Questions	Evaluation findings	Comments
	Has WHO/DPS articulated ethical and evidence-based policy options?	The regional nongovernmental organization interviewed commented positively on WHO's role in taking ethical positions even when they are not particularly popular with politicians.	
	Has WHO/DPS provided technical support?	Strong provision of technical support in all countries was found in the evaluation. Responsiveness to requests from government for technical assistance was very positively noted by Fiji's Health Minister.	See full report for details.
	Has WHO/DPS catalysed change?	Strong evidence that WHO was catalysing change processes in NCDs and implementation of the International Health Regulations and POLHN. Less evidence in health systems, where although DPS was reacting to specific issues, such as new medical graduates, there was less evidence of strategic leadership.	
	Has WHO/DPS built sustainable institutional capacity?	DPS is building its own capacity at the country level, as well as taking some action (e.g. POLHN, workshops) to build local capacity. The need for a consistent approach to capacity development is discussed in the report.	WHO/DPS has considerable experience in capacity development. However, the assessment noted multiple different approaches in different divisions. There was no systematic way in which the experiences across the Organization were being understood or evaluated, and being used to inform best practice across the Organization. This is a missed opportunity.
	Has WHO/DPS monitored the health situation in the Pacific and assessed health trends?	Strong evidence of monitoring of NCD status (STEPS) and emerging communicable diseases (Syndromic surveillance system). Less evidence of system-wide monitoring, and weaknesses yet to be addressed in basic health information systems such as birth/death registration.	Although good progress is being made, there were questions arising related to the integration of these activities into local health and statistical information-gathering activities. Informants felt these WHO efforts often stood outside local health information-gathering activities and could be better integrated.

Objective	Questions	Evaluation findings	Comments
	Has WHO differentiated its approach according to the various complexities of the various Pacific island countries and areas? for example capacity building, or capacity substitution	The deployment of resources generally reflected the different contexts. However, the report questions the relative level of support for some high-needs settings such as Kiribati. It also recommends more clarity on the roles and responsibilities of WHO vis-a-vis the role partner governments are taking in specific countries.	
	How has DPS dealt with its twin roles – DPS for Pacific as well as CO for Fiji?	Very well. Fiji officials reported increased service support and responsiveness.	
	Is DPS a full partner of the Regional Director's Cabinet?	Yes. However, its geographical position and its generalist focus (other Cabinet members cover a specific issue) are potential barriers.	
	What is the vision of DPS for its future? How are different funding scenarios being considered?	DPS is in its establishment phase. It is interested in these evaluation findings in considering its future direction. Different funding scenarios were not discussed.	
	What does it see as the pros and cons of centralization to Manila, of decentralization to country offices?	Countries (especially Federated States of Micronesia, Samoa) argued for increased WHO capacity in their countries. Country officials strongly supported the subregional focus DPS brought, and in some cases, felt DPS had increased responsiveness. This was strongly expressed in most of the small island countries and areas. COs in larger countries (such as Solomon Islands) saw DPS support and Manila support as more interchangeable.	
	How is it seeing the impact of the outcomes of the "regional public good" discussions?	"Regional public good" did not feature strongly in the interview discussions. Countries asked for a greater focus on their priorities rather than regional priorities.	The report suggests a distinction be drawn between capacity substitution (direct service provision of core public health competencies), capacity development and regional public health goods. It also suggests that these activities are defined in and led from the annual review/planning and budgeting process. This would allow a clearer articulation of what services are provided by which agency and their intent. It would also assist in monitoring and evaluating progress.

Objective	Questions	Evaluation findings	Comments
	Does DPS have a role in mentoring, fostering peer learning between countries?	WHO's main focus is on delivering programmes according to its regional and global priorities. Mechanisms for country-to-country learning were less evident. The issues raised for health systems by the influx of foreign-trained personnel is an area WHO is now engaging, and supporting country peer learning. Fiji expressed a clear desire to increase its subregional role.	
Ways of working, roles and functions of DPS	What role is DPS undertaking?	Delivery of its regional and global programmes and priorities.	
	How is the "country needs" focus maintained and balanced with "WHO needs"?	WHO priorities clearly dominated its work in countries (see text for discussion of this). The assessment recommends there be a better balance with country needs-led developments.	
	Are the workshops and activities in countries motivated by articulated country needs or WHO's agenda?	As above.	
	How do the various planning instruments come together – Country Plans, CCS, MCCS, UNDAF, Pacific Plan?	These are discussed in detail in the text. In summary, country plans are not synchronized with donor activity. CCS and MCCS are high level. DPS has developed more operational action plans that better align with the country's actual work programme. The joint UN programming initiative in Kiribati, Solomon Islands and Vanuatu is in its formative stages, and few references were made by interviewees to the Pacific Plan.	
	How is the aid effectiveness and the One UN agenda reflected in DPS' approach?	The joint UN programming initiative in Kiribati, Solomon Islands and Vanuatu is in its formative stages. Aid effectiveness issues did not feature highly in discussions with either countries or DPs; however, the issues are clearly understood and being acted on in Fiji and Samoa. The report makes a key recommendation in relation to improving alignment of planning and budgeting processes to improve aid effectiveness.	

Objective	Questions	Evaluation findings	Comments
Relationship of DPS with other entities		The relationship with DPS is discussed in detail in the report. It was an area the assessment identified as needing greater attention by DPS. Development partners felt coordination and leadership opportunities were being missed, and there was limited understanding by other development partners of DPS' role in the Region. This was partially because DPS' subregional role and function had not been effectively communicated, and partly because DPS had not yet fully developed its own thinking on the role it is undertaking.	
	What is its relationship with country offices, CLOs, countries?	See report	
	How has DPS impacted on the fragmentation of WHO services to Pacific islands?	Most countries felt DPS had increased local responsiveness, and in some cases (Tuvalu) reduced fragmentation with the establishment of a country focal point. However, this was the exception, with the majority of countries calling for better integration of WHO/DPS activities, and the removal of siloed approaches.	
	How important/critical is WHO support for the country's health system, as provider of technical advice, and as provider of funding?	All countries identified WHO as the most "trusted adviser" in relation to health. The technical advice, norms, standards and guidelines were most highly valued. WHO's role as a direct funder of services was limited.	
	How does DPS deploy its resources?	See report for details. There has been an increase in deployment of resources at the country level.	
	How does DPS tailor its support in relation to other technical advisory agencies in the region?	See report for details. Some progress has been made in relation to the SPC relationship, but there is still much to be done to get better synchronization. The report recommends greater clarity regarding roles and responsibilities of DPS in countries with special relationships with Australia, France, New Zealand, USA.	

Objective	Questions	Evaluation findings	Comments
	How has DPS addressed the impact of multiple donor demands for senior health personnel to be out of the country?	It has made progress in moving its focus from regional workshops to work in specific countries. It has not impacted on other donors in this regard.	
Added value of DPS in the Pacific	How has the situation changed since DPS was established?	DPS has positively impacted on WHO support for countries' health agendas in the subregion. It is still in its early days and closer alignment to country agendas is required in future. There is considerable untapped potential in WHO strengthening its convening role so that the effectiveness and efficiency of all health development assistance is optimized.	

ANNEX 7: DPS CAPACITY DEVELOPMENT AND NCDs

New approach to capacity development

These are the lessons learnt from the experience with the Package of Essential Noncommunicable Disease Interventions for Primary Health Care in Low-resource Settings (PEN) implementation.

Direction

- Avoid Pacific–regional level trainings and workshops that don't necessarily guarantee capacity building of countries and follow-up actions in countries.
- Instead, focus on hands-on support to build capacity of the country's focal points by organizing national meetings and training at country level with the strong participation of DPS technical staff as well as through programme implementation.
- As a result, the number of regional meetings was reduced but the number of country visits was increased. This has led to more country-specific support, enabling more people to be trained at the country level and reducing the absence of key country staff attending regional meetings outside their countries.

Example: Capacity development for PEN Pacific

PEN is a package of interventions that uses the primary health care facility as a setting for healthy living and people-oriented and integrated NCD services focused on reducing or delaying major NCD outcomes. It builds on existing skills of primary health care workers with the introduction of new tools with some degree of sophistication, especially for nursing personnel.

To build capacity the following were carried out:

- DPS introduced the PEN programme in the Pacific NCD Forum 2011.
- DPS did not organize regional-level training but established project officers (SSA) in each of its country offices (Federated States of Micronesia, Fiji, Kiribati, Samoa, Solomon Islands, Tonga, Vanuatu) in 2012 and then brought the project officers and country NCD focal points (usually non-medical) to an introductory training in Suva.
- Following the initial training, project officers mobilized their own Ministry of Health team back home and organized national training, including staff from the six to eight health facilities to implement the feasibility phase of PEN: the Suva-based team visited the country and conducted training with them on initiation of services in the health facilities earmarked. In addition, two Pacific island countries (Cook Islands and the Marshall Islands) specifically requested in-country training, which was supported. One of the key activities during in-country training is identification of a medical officer in public health to be the PEN Coordinator, which has now been established in most countries.
- Approximately six to eight months after initiation, a follow-up visit is carried out by the Suva-based team or consultants. This visit provides assessment and hands-on training and mentorship to the staff of the health facilities, together with the NCD focal person and the national PEN Coordinator. One of the key activities in this assessment and follow-up visit is assessment of the pharmaceutical situation, and this has resulted in discussion with management and costing exercises being carried out – all with the leadership of the PEN Medical Coordinator.

Through these initiatives, the PEN programme has been initiated, mainly by local staff with supervisory and assessment visits by WHO; the Medical PEN Coordinator has been identified, trained and established; and programme implementation in-country continues with considerable ownership. Also because of the in-country focus, the capability of primary health care workers for the programme was identified as weak and remedial solutions were discussed. Another benefit is that it has brought public health and clinical teams together in countries.

ANNEX 8: PRESS RELEASES FROM DPS

DPS press releases as seen on the website

- DPS does not have a specific DPS communications strategy, but rather fits into the regional strategy.
- Overall, Ms Jane Wallace, Senior Health Advisor, is the focal point, and she and Mr Saula Volavola work on this together. Mr Volavola focuses in particular on strategic health communications, audio visual and media relations. Ms Wallace focuses more on the web, writing and the external relations side of communications.

For press releases, DPS has a section on its website, <http://www.wpro.who.int/southpacific/mediacentre/en/>

- The number of press releases in 2012–2013 is higher than that in 2010–2011

Table 1. Number of press releases per year

Year	Number of press releases	Contents
2010	3	Technical programmes related: 2 WHO governance related: 1
2011	4	Technical programmes related: 3 WHO governance related: 1
2012	7	Technical programmes related: 5 WHO governance related: 2
2013	5	Technical programmes related: 4 WHO governance related: 1

Press releases are an indicator of the media profile of DPS. Their significance needs to be considered alongside the personal interactions (for example, DPS staff visits to countries) at both the regional and country level.

