Solomon Islands National Health Strategic Plan 2022-2031 – Final Draft

Technical support for the Development of the Solomon Islands National Health Strategic Plan 2022-2031

Submitted by
Tetra Tech International Development Pty Ltd
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Acknowledgement

The National Health Strategic Plan 2022-2031 (NHSP 2022-2031) has emerged as a Ministry of Health-led process, mandated by the Ministry of Health and Medical Services (MHMS) Planning and Policy Division, as a successor to the National Health Strategic Plan 2016-2020 which was subsequently extended by a year to 2021.

The NHSP 2022-2031 was prepared using an inclusive and participatory process ensuring that the process involved all major strategic stakeholders, partner Ministries including the Ministry of National Development Planning, MHMS technical and public health experts, development partners including the WHO, UNICEF, UNFPA, DFAT, JICA, KOICA, PRC, USAID, the World Bank and ADB, civil society organizations, faith-based organizations and private sector organizations. The MHMS greatly appreciates the collaboration and support received from all our stakeholders. Their contribution and comments have helped shape and define the new NHSP 2022-2031.

Technical support for the development of the NHSP 2022-2031 was delivered by Tetra Tech International Development Pty Ltd and overall coordination of work by the Planning and Policy Division, with support from, the Senior Executive Management led by the Permanent Secretary of the MHMS. The production of this document was made possible through funding support from the World Health Organization (WHO). The MHMS conveys its sincerest acknowledgment to both Tetra Tech International Development and the World Health Organization (WHO) for the in-depth wealth of technical expertise that supported the MHMS to navigate the development of the NHSP 2022-2031.

Finally, the Planning and Policy Division of the MHMS is indebted to all the MHMS Programme Directors and Heads of Divisions, Provincial Health Directors and Senior Officers at both National and Provincial levels and extends its appreciation to the many individuals of the MHMS and the organizations who participated in the virtual consultations, provided comments via email and provided valuable inputs on the revised draft NHSP 2022-2031.

Message from the Minister for Health

The development of the National Health Strategic Plan 2022-2031 (NHSP 2022-2031) is guided by Objective 3 of the National Development Strategy 2016-2035 that “All Solomon Islanders have access to quality health and education” by which it stipulates that “access to quality health care is a universal aim of all Solomon Islanders”. It is upon this premise of the NDS 2016-2035 that the new NHSP 2022-2031 dwells on.

The NHSP 2022-2031 is further guided by the MHMS Role Delineation Policy and its Framework which targets to ensure improved quality health service delivery and towards the attainment of an improved standard of health.

The NHSP 2022-2031 has been developed using a consultative approach involving all key stakeholders both within and outside of the health sector, while taking cognizance of new actors in the health sector in helping to improve and strengthen health systems. It took into account some of the recommendations from the review of the NHSP 2016-2020, and further takes into account evidence from health trends from the MHMS, and other regional partners including the UN Agencies in the Pacific. All the evidence and recommendations have guided the prioritizations of key issues that trigger a high burden of disease and therefore are critically important to address these during this strategic plan.

The NHSP 2022-2031 provides the Health Sector focus, objectives and priorities to enable it to move towards attainment of the health outcomes. It provides a description of the health outcomes to be sought, priority health investments necessary to achieve the outcomes, resource implications and the workforce required to implement the strategic plan.

The Ministry of Health and Medical Services is most grateful to its staff both at National and Provincial levels, the World Health Organization Country Office in the Solomon Islands, our other UN Agency Partners, Bilateral and Multilateral Development Partners and other health stakeholders who contributed to various efforts in shaping the development of the NHSP 2022-2031. The Ministry is also committed to the full realization of this strategic plan. The NHSP 2022-2031 has developed a robust monitoring framework to track the achievement of critical milestones in a way that is responsive and accountable to the health needs of Solomon Islanders.

My Ministry looks forward to working collaboratively across the government and with key partner ministries, development partners and all other stakeholders to ensure the successful implementation of the NHSP 2022-2031.

Honourable Minister, Dr Culwick Togamana
Ministry for Health and Medical Services

Message from the Permanent Secretary for Health

The development of the National Health Strategic Plan 2022-2031 was developed at a time when so much was happening within the Ministry of Health and Medical Services (MHMS) on its preparedness and response efforts to the COVID-19 pandemic protecting the country by stretching its resources, and workforce while at the same time multitasking to attend to core responsibilities and expected health outcomes of the country. Amidst all that was going on and the substantive responsibilities that come with it, one thing was for certain and that was to ensure that the National Health Strategic Plan 2022-2031 (NHSP 2022-2031) was delivered in 2022.

The NHSP 2022-2031 is the guiding document outlining the national strategic directions to improve the health standards of Solomon Islanders over the next ten years. Its content reflects a comprehensive analysis of the Solomon Islands health sector progress and situation to date. It is also based on rigorous technical inputs from key health sector stakeholders, including programme managers in the health sector and in other public institutions, development partners as well as members of faith-based organizations and civil society organizations. Several consultations that were organized with all these stakeholders allowed us to design appropriate evidence-based strategic objectives and directions that will contribute to ensuring improved standards of living for our people. I thank you all sincerely for your substantial contributions.

The NHSP 2022-2031 builds on lessons learnt and important progress that was made from the implementation of the previous NHSP 2016-2020. The new plan is aligned to the global and regional agendas the Solomon Islands has committed to, including the Sustainable Development Goals (SDGs). The development of the NHSP 2022-2031 also considered the overall aspirations of the MHMS Role Delineation Policy (RDP) and lays out the priority strategic directions or objectives that will be key to ensuring universal access to equitable quality preventative, curative, rehabilitative and promotional health services regardless of where our people live.

All three strategic objectives highlighted in the NHSP 2022-2031 are guided by six guiding principles (*Equity, Integrity, Respect, Collaborative, Responsive, and Transformational Leadership and Ownership*) and three intertwining values that orient and underlie the provision of health services: *People-centred health services, integrated services and sustainable services*.

Unlike the previous NHSP, the new Plan is accompanied by a Monitoring and Evaluation Framework which shall facilitate our tracking of progress towards the targets and attainment of our goal to ensure healthy lives and promote the wellbeing of our people.

For the implementation of the NHSP 2022-2031 to be achievable and successful, combined efforts from all and different stakeholders will be needed. Therefore, I call on all our stakeholders including health professionals, civil society groups, development partners and others to work together with the National and Provincial Medical and Health Services for us to jointly achieve the NHSP goal and strategic objectives.

I have no doubt that with the unwavering political commitment of the Government, engagement and ownership of the pursuit of health by all our people, active community participation, coupled with the steadfast commitment of our health workers, the support of our development partners and other stakeholders, we will succeed in achieving the NHSP 2022-2031 goal and the strategic objectives.

Pauline Boseto McNeil
Permanent Secretary, Ministry of Health and Medical Services

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Abbreviations

AHC	Area Health Centre
API	Annual Parasite Incidence (malaria)
COVID-19	Coronavirus disease of 2019
DALY	Disability Adjusted Life Years
DFAT	Department of Foreign Affairs and Trade (Australia)
ELAM	Latin American School of Medicine
EoI	Expression of Interest
EPI	Expanded Program for Immunization
FNU	Fiji National University
FTE	Full Time Equivalent
GDP	Gross Domestic Product
GHS	Global Health Security
HI	Health Infrastructure
HDI	Human Development Index
HRH	Human Resources for Health
JICA	Japan International Cooperation Agency
KOICA	Korea International Cooperation Agency
KRA	Key Result Area
MCH	Maternal and Child Health
MHMS	Ministry of Health and Medical Services
NA	Nurse Aide
NAP	Nurse Aid Post
NHSP	National Health Strategic Plan
NCDs	Non-communicable diseases
NRH	National Referral Hospital
OPD	Outpatient Department
PFMA	Public Finance Management Act
PHC	Primary Health Care
PICTs	Pacific Island Countries and Territories
PPD	Planning and Policy Division
PPP	Purchasing Power Parity
PRC	People's Republic of China
RDP	Role Delineation Policy
RDT	Rapid Diagnostic Test
RHC	Rural Health Clinic
RN	Registered Nurse
RWSS	Rural Water Supply and Sanitation
SDG	Sustainable Development Goals
SEM	Senior Executive Management
SIG	Solomon Islands Government

SINAC	Solomon Islands National AIDS Council
SINU	Solomon Islands National University
SIITP	Solomon Islands Internship Training Program
SOPH	School of Public Health (Solomon Islands)
STI	Sexually Transmitted Infection
TB	Tuberculosis
Tetra Tech	Tetra Tech International Development
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPNG	University of Papua New Guinea
USAID	U.S. Agency for International Development
VBDCP	Vector-Borne Diseases Control Program
WATSAN	Water and Sanitation
WHO	World Health Organisation

Executive Summary

The Ministry of Health and Medical Services' vision for the people of the Solomon Islands is "a healthy future for all" by 2031, and our goal is to ensure that all Solomon Islanders have universal access to equitable quality, preventative, curative, rehabilitative and promotional health services irrespective of where they live.

This new National Health Strategic Plan (NHSP 2022-2031) has been developed to ensure that the Ministry's resources and efforts focus on achieving this vision and goal over the next decade.

This new NHSP builds on the successes and lessons learned during the implementation of the previous NHSP 2016-2020, as well as the experiences gained in preparing for and responding to the COVID-19 pandemic. The new plan also integrates the packages of service delivery as articulated in the Role Delineation Policy.

Several months of intense effort by Ministry leadership and staff has gone into developing this new NHSP, firstly by undertaking an analysis of the current situation in the health sector, identifying challenges that need to be addressed and then consulting with internal and external stakeholders to help the Ministry identify what it needs to do differently, and how it can achieve its vision of a "healthy future for all". The Ministry was supported throughout the development of this NHSP by a team of technical specialists funded by the World Health Organization.

To achieve its vision and goal, the Ministry has identified three strategic objectives (SO):

SO 1: Better governance of the health sector
Better governance is vital to achieving the Role Delineation Policy in driving Universal Health Coverage. National strategies and plans of the Government delivered through the Ministry address economic challenges and achievement of policies and development plans.

Further development of the Role Delineation Policy, modernizing health legislations and decentralization of authority as well as accountability and responsibility, strong clinical governance, and workforce and infrastructure strategies and plans are essential strategies to achieve better governance.

Our immediate priorities under this strategic objective include revising and updating the Health Legislation and Acts, strengthening Monitoring and Evaluation so that we can track progress and make evidence-based decisions, and developing a National Health Workforce Strategy to inform and guide our future health workforce requirements.

SO 2: Our systems and resources meet our needs and are responsibly managed
Health systems include the facilities, equipment, medicines, resources, workforce, and communities coming together to improve health outcomes.

Effective health systems require sufficiently skilled health workers, adequate health facilities and availability of equipment and medicines, including community participation to ensure the attainment of the highest standards of health.

Our immediate priorities under this Strategic Objective include improving the availability of medicines and equipment to better support the package of services to be delivered, addressing the shortfalls in basic health infrastructure needs such as power, water, sanitation, hygiene, waste and communications, and strengthening workforce performance management.

SO 3: All Solomon Islanders have equitable access to fully implemented, quality health care programs
Health service delivery is challenged by difficulties in accessibility, inequality of resource distribution and unfavourable social determinants of health. With a youthful population and more people now living longer or reaching old age, the Ministry, through the public health programs, will develop strategies to enhance the prevention and control of communicable and non-communicable diseases (NCDs).

Our most urgent priority under this Strategic Objective is to advance and enforce upstream population interventions and health legislation amendments that address NCD priority risk factors. Other immediate priorities include reversing the recent resurgence of malaria particularly in the 24 high incidence health zones, and to improve rehabilitation and prosthetics services so that patients recover quickly from disease, injury and surgery.

This new NHSP breaks with tradition in that it is a plan with a ten-year duration. We have done this deliberately because we recognize that sustainable change in the Solomon Islands takes time. This plan tackles areas that were previously neglected or not prioritized, particularly in infrastructure, policy and legislation. It will place us in a better position to decentralize some services and responsibilities and give communities more voice and say about the health services delivered in their area.

The NHSP provides us with a longer-term horizon that will allow us to come up with a comprehensive health financing strategy in acknowledgement of our changing income level and the need for some time in the not-too-distant future to start transitioning out of some financing mechanisms the country has previously relied on. The NHSP provides some guidance on resource allocation and informs decision making.

Our new NHSP also breaks with tradition in the way it is presented. For each of the three strategic objective areas, identified as being crucial to achieving our goal, we provide benchmarks to show where we are at right now, where we want to be in ten years, what our priorities are, and what strategies we will use to get there. We present this visually so that all staff, whether at headquarters, in the provinces or in rural health facilities, know what we want to achieve and understand how their efforts contribute to our shared goal.

The NHSP includes a Monitoring and Evaluation Framework to ensure that we are accountable for achieving the targets set.

Together, let’s embark on a journey towards a healthy future for all.

Introduction

Context and background of the NHSP 2022-2031

This new National Health Strategic Plan 2022-2031 (NHSP 2022-2031) represents the culmination of a Ministry of Health and Medical Services (MHMS) commissioned process that commenced in late 2020 with a review of progress against the previous NHSP 2016-2020. In late 2021, with technical support from an external team, our MHMS executive team conducted a situation analysis of the health sector, initially focusing on a desk study of all available documentation and data.

Purpose of the NHSP

The NHSP 2022-2031 establishes the Solomon Islands' vision, goal, objectives and strategies for ensuring the health of its population, and what services will be delivered where and by whom. It provides a framework for defining the resources that will be required to achieve its goal, and sets the priorities over a period of time.

Methodology for developing the NHSP

As an executive team, we validated the initial findings during two sensemaking workshops and identified gaps. We then consulted extensively over an eight-week period with internal stakeholder groups and individuals across the MHMS, including at the health facility level, to further validate and add context to the findings, fill in some of the missing gaps, and to hear of the challenges that health workers faced. These consultations were summarized in recurring themes, reported back, and reflected on by us.

From this, we were able to identify the broad strategic priorities that the new NHSP should focus on. From April to May 2022, with support of external consultants, members of our executive team undertook a series of small group consultations with external stakeholders, development partners and others with a focus being on early socialization of the potential strategic areas of focus that was under consideration by us and to obtain feedback.

Following the conclusion of the external consultations, we participated in three half-day facilitated sessions to develop the goal and broad strategic objectives and to reflect on the reasons for the 'unfinished business' from the previous NHSP and what needs to be done differently this time.

The draft NHSP 2022-2031 was introduced by our MHMS Senior Executive team to all stakeholder groups via information workshops and feedback was sought. The feedback was received, analyzed, and summarized by officers from the Planning and Policy Division (PPD) and presented to the Senior Executive for consideration, after which the external consultants were provided with instructions by us on finalizing the new NHSP.

The MHMS-led process outlined above has informed the direction committed to in this new ten-year NHSP and provides us with a strong sense of ownership of the NHSP.

Health Sector Overview

Health services across the Solomon Islands are delivered through approximately 353 facilities comprising of the National Referral Hospital, provincial hospitals, area and urban health centres, rural health clinics and nurse aid posts. Most provinces have access to at least two levels of health facilities, based on the population size and its distribution. Many of the facilities are in need of urgent upgrade, repair, renovation or replacement. The introduction of the Role Delineation Policy in 2018 provides a framework for service delivery planning.

The backbone of health service delivery in provinces and rural areas is provided by a well-trained nursing workforce. A lack of workforce planning has led to an oversupply of some cadres such as doctors and a scarcity in other cadres such as laboratory technicians, radiologists, physiotherapists and other allied health workers. There is an inequitable geographic distribution of the skilled health workforce, with provincial and rural areas struggling to attract and retain workers.

Approximately 51 per cent of funding for health services comes from the Solomon Islands Government, with the balance from development partners. Health as a proportion of total government spending is high and has generally increased year on year, although in absolute dollar terms it is below the average of Pacific Island Countries and Territories (PICTs) due to the low GDP of the country. There has been volatility and some unpredictability of funding from other sources. There is currently a high degree of financial risk protection to the people of the Solomon Islands with low out-of-pocket payments for health-related expenses.[1] There is some opportunity to introduce modest “user charges” over the next decade.

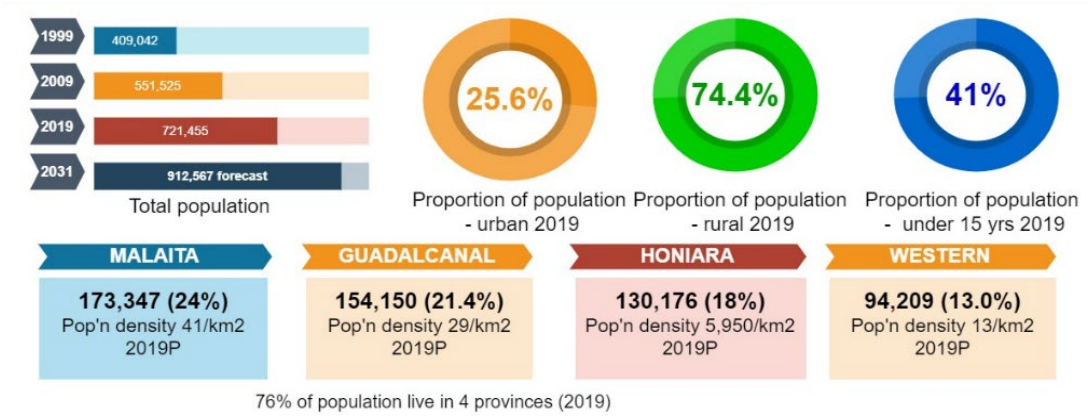
Despite these constraints, the Solomon Islands has been able to make good progress across a number of health indicators. There is improving coverage of effective, essential health services, a high satisfaction rate and until recently, steady progress on a number of health outcomes. There has been considerable progress made in advancing population health outcomes.

The country is at a crossroad and faces important health challenges that could undermine development gains made to date. In particular, the incidence of NCDs has reached crisis point, and threatens to overwhelm the health system if aggressive steps are not taken to halt and reverse this trend. A chronic under-investment in health facility maintenance could result in risks to patient and staff safety, and / or additional permanent closures due to the dilapidated state of facilities.

Although fertility rates are dropping, the total population is forecast to increase by an additional 190,000 by 2031, and the health system needs to plan now for this forecast increase.

Country Context

Figure 1: Country Context

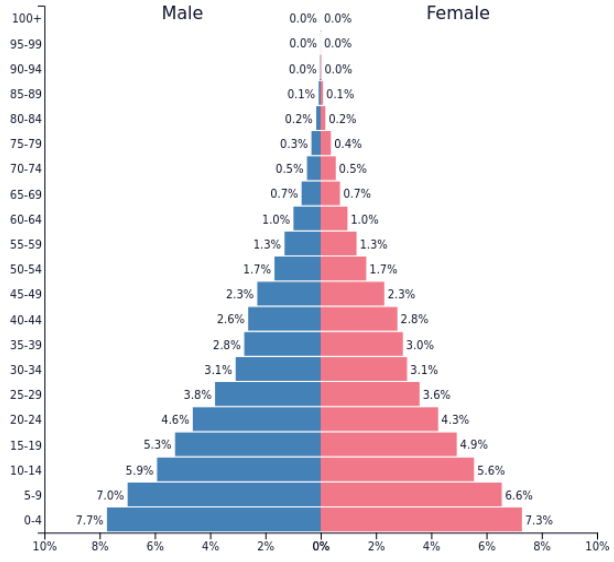


The Solomon Islands consists of six major islands, Choiseul, Guadalcanal, Malaita, Makira, New Georgia and Santa Isabel, and 992 smaller islands, atolls and reefs covering 28,466 sq. km.[2] The topography ranges from thickly forested volcanic uplifts with deep ravines to low-lying coral atolls. Honiara, the capital, is located on the island of Guadalcanal.[2] The island groups' rugged terrain and dispersal reduce community access to health services and increase the costs of delivering health care, health promotion, patient referrals and public health measures.

We are regularly impacted by natural disasters, which include cyclones, earthquakes, tsunamis, flooding, and landslides. Warm temperatures increase the risks of water and vector-borne diseases, such as diarrhoea and malaria, injuries and illnesses, and heat stress.[3] Tropical storms make sea crossings hazardous and impede emergency retrieval flights.

Around 35 per cent of our population live in low elevation coastal zones (0-10 metres above sea level,[4] making them vulnerable to rising sea levels and natural disasters such as tsunamis and sea surges associated with cyclones, which are made worse by the effects of climate change and sea level rises impacting coastal communities.[3]

Figure 2: Solomon Islands population



Source: Population.net

The Solomon Islands faces hazards that intersect with climate change, including poverty, inequality, and poorly planned development. Climate change may increase the number of people at risk of heat-related medical conditions, particularly the elderly, children, chronically ill, and at-risk occupational groups. Climate change also increases risks to food security through land degradation associated with salination of the soil in coastal areas impacting nutrition and health.

The National Statistics Office (NSO) estimates that we had a population of 721,455 at the time of the 2019 census.[5] Our population is relatively young, with around 41 per cent of the population aged less than 15 years (Figure 2). Our population grew at an average of 2.7 per cent per annum during 2009 to 2019, with wide variations between provinces, with the largest growth recorded in Honiara and the lowest being in Temotu (NSO). The population is forecast to increase to 912,567 by mid-year 2031 – an increase of around 191,000 from the 2019 provisional population count.[5]

Current Successes and Challenges

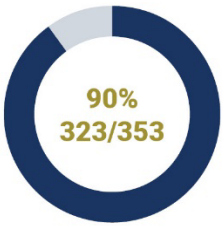
Figure 3: Current Successes and Challenges

Health Outcomes

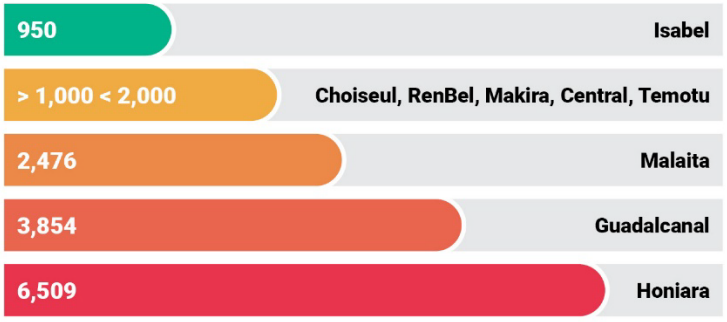
1. **TUBERCULOSIS** incidence decrease from 86/100,00 (2015) to 65/100,000 (2020)
2. **CHILD MORTALITY** modest decrease from 22.7/1,000 (2015) to 19.4/1,000 (2020)
3. **MALARIA** annual parasite incidence rate increase from 41.1/1,000 (2015) to 119/1,000 (2021)
4. **LIFE EXPECTANCY** increase from 57 years (1971) to 73.1 years
5. **DEATH CAUSED BY NCDs** estimated at 66.8% of all deaths (2019)
6. **DTP3** immunization coverage improved from 87% (2015) to 94% (2021)
7. **COVID-19** 21,237 confirmed cases and 149 deaths (2022)

Health Coverage

1. **UNIVERSAL HEALTH COVERAGE** service coverage from 48 (2015) to 50 (2019)
2. **HEALTH WORKFORCE DISTRIBUTION** 75% of doctors and 46% of nurses based in Honiara. 81% of population live in provinces
3. **WATER AND SANITATION** 22% of open health facilities without water and 49% without functioning toilet (2021)
4. **SKILLED BIRTH ATTENDANTS** 9 out of 10 women have a skilled birth attendant during birth
5. **HEALTH FACILITIES** Almost one out of ten health facilities closed due to condition of facility or no staff (2021)
6. **STOCK AVAILABILITY** of essential medicines at primary health facilities decreased significantly from 72% (2017) to 32% (2020)



Proportion of health facilities open 2021



Number of persons serviced per open health facility 2021 (DHIS2 & Census population)

Mixed Progress – Gains and Losses

We have made good gains in life expectancy and in reducing the under-5 and under-1-year-old deaths consistently over time.[6] The tuberculosis threat continues to steadily decrease. Most births are attended by a skilled birth attendant. We have seen improvements in the proportion of children receiving three doses of the combined diphtheria, tetanus toxoid and pertussis (DPT3) vaccine. The introduction of the Role Delineation Policy (RDP)[7] in 2018 has helped planning what services should be available at each level of health facility. Improvements have been made in processing of financial payments at national level with the introduction of a new D365 financial management system. Strong development partner support coupled with a whole-of-government response to the COVID-19 pandemic meant that we were able to quickly ring-fence and control outbreaks and to provide care and support to those most impacted by the virus.

Progress in other areas has become stagnant or reversed. After successfully reducing the threat of malaria year on year for much of the past 20 years, malaria is on the increase again with case numbers today back at 2008 levels, due to less effective control strategies, supply chain challenges, reduced funding, and the impact of COVID-19. The rapid rise in death and disability due to non-communicable diseases (NCDs) poses devastating health and economic consequences for everyone and can overwhelm our health system if nothing is done to reduce the rapidly increasing incidence of NCDs.[8,9] The COVID-19 outbreaks caused significant disruption across all health services. Challenging and burdensome recruitment processes and loss of staff has resulted in more than one out of every ten establishment positions being vacant.

While stocks of essential medicines were at 82 per cent at the National Medical Store (NMS) at the end of 2020, significant stock outs and shortages are experienced at primary health care facilities. Almost 10 per cent of health facilities are closed due to staff vacancies, being in a state of disrepair of there being no staff housing available. There has been community engagement in recent years compared to previously.

What Limited Our Progress During the Last Plan Period?

During the consultation process, MHMS staff and development partners identified challenges that contributed to the mixed progress achieved during the last six years. In particular, the COVID-19 pandemic public health emergency caused severe and prolonged disruption and stress on an already fragile system, forcing the postponement of many health services and a re-purposing of human and financial resources to prepare for and respond to the pandemic. We still do not know the full impact of COVID-19 given that 2021 data is not yet available for analysis.

Other challenges identified fall broadly under three categories: (i) governance and leadership; (ii) the operating environment; and (iii) human and financial resources. Many of the challenges were previously identified at the beginning of the NHSP 2016-2020 and remain unresolved until now. We better understand the reasons for this ‘unfinished business’ now and the impact it is having on overall progress. Specific strategies are incorporated into this new NHSP to resolve these challenges once and for all.

Some of the contributors to limited progress is some areas of focus in the previous NHSP include:

- The previous NHSP was not well known or understood – there was a disconnect between the strategies and what went into the Annual Operational Plan (AOP) of divisions, programs, and provinces
- The endorsement and broad socialization of the RDP in 2018 meant that to some degree it dominated and eclipsed the then current NHSP
- There was no overarching Monitoring and Evaluation (M&E) framework, or specific targets attached to the previous NHSP. That, plus the lack of timely data resulted in limited oversight, monitoring, and reporting of progress against the NHSP
- Resources were inadequate in some instances, and more frequently were available but not fully utilised
- Challenging budgeting processes particularly around delays in budget appropriation resulting in a reduced implementation window of only eight months
- Lack of clarity around the reform agenda and its impact on programs – Forecasting, supply, distribution, and stock management of essential medicines to peripheral health facilities is not working as it should be
- Human resource and system constraints in finance, procurement and infrastructure and a lack of understanding of the financial processes and procedures resulted in stalled or delayed work plan implementation at program level and inadequate project management capacity for infrastructure projects
- Poor work ethic of some staff, not showing up for work or carrying out their functions went without any disciplinary action being taken
- Outdated and ad-hoc legislation and policy gaps
- COVID-19 disrupted all aspects of service delivery – planned activities had to be 'thrown out of the window' and funding and resources were repurposed. Health system capacities were stretched
- Constraints were more visible as the same finance, procurement and infrastructure teams pre-COVID-19 also attended to the COVID-19 response
- Lack of focus on priorities and shifting of priorities - strategic leadership was not sufficiently focused on the MHMS-led activities, and then later became 100 per cent focused on pandemic and disaster response.

What Contributed to Progress this Last Plan Period?

There were elements that contributed to good progress being made with some aspects of the previous NHSP. These included periods:

- When strong leadership focused on overcoming barriers and bottlenecks to implementation. This was particularly evident during the COVID-19 response and lockdown. Basic business processes were able to continue due to flexibility and adaptability of leadership and staff
- When funding support was predictable and adequate, programs were able to build to scale and demonstrate measurable and consistent outcomes
- At the provincial level, when there were strong Provincial Government and community support, programs performed well. The Provincial Government Strengthening Programme of the Provincial Government helps this greatly.
- When technology was leveraged to improve the frequency of communication between national level and provincial leadership, it enhanced coordination and efficiency without the need to meet physically in face-to-face meetings
- Where strong (and sometimes new) partnerships were built between MHMS, other Ministries and development partners in a coordinated response around a common issue such as COVID-19
- Where management staff with strong technical and operational knowledge remained committed to the program / division over a long period of time.

What Needs to Be Done Differently in the Next Plan Period?

The recent experiences in tackling COVID-19 reinforces the need for us to strengthen ties with other government agencies to address challenges that cannot be solved purely through a 'health lens'. This applies not only during public health emergencies, but also when addressing the social determinants of health. Greater emphasis will be placed in this new NHSP on building collaboration and synergies with education, police, agriculture, trade, provincial governments, and faith-based and non-government organizations.

We acknowledge that COVID-19 is not the first, nor will it be the last pandemic to affect our country. In all probability, COVID-19 will still be around for some time to come. We cannot allow pandemics to completely disrupt and overwhelm our health system in the future as it did this time. Pandemic resilience will be built into our new NHSP so that basic public and clinical health services can continue to be delivered to the extent possible.

We have limited resources that needs to be managed effectively and efficiently. We did not do that as well as we could have, and these show up in the variability of our health outcomes. Barriers to implementation are often blamed on systems – our analysis suggests that poor work ethic, a lack of understanding the financial procedures and policies, and behavior is often the bigger problem. We will explore ways to change the internal culture to focus on performance and personal accountability, and to improve all aspects of relationship management and communication with staff and program.

The centralized management of services, resources and decision making has not contributed to improved health outcomes. To address this, a few years back, we embarked on a reform agenda with a view to decentralizing resources to the provinces. Some of the necessary prerequisites such as legislation, policies, procedures, clear delegations and the building of local capacity were not in place to support this reform, so it has not been as successful as we would have liked, and this has been to the detriment of previously well-performing programs. We will develop, document, socialize and implement a fit-for-purpose reform agenda during this new NHSP period.

Our previous NHSP was technically sound and appropriate, but it lacked a proper Monitoring and Evaluation Framework and targets against which progress could be measured, monitored, and reported against. Our new NHSP includes an overarching M&E Framework supported by enhanced M&E capacity within a repurposed Planning and Policy Division with additional human resource capacity.

Guiding Principles and Values of This NHSP

The National Health Strategic Plan 2022-2031 is based on the following guiding principles:

Equity - Striving for fairness and justice by eliminating differences that are unnecessary and avoidable.

Integrity - Ensuring transparent, ethical, and accountable performance at all levels and between staff and partners.

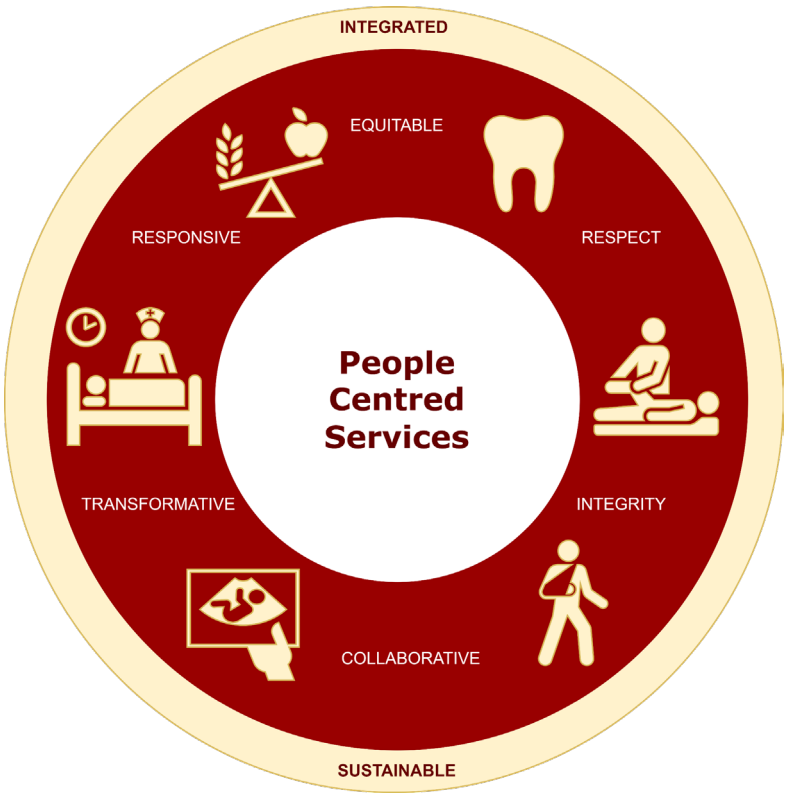
Respect - Embracing the dignity and diversity of individuals and groups.

Collaborative - The application of collective experience and knowledge of internal and external partners that responds to shared challenges and goals.

Responsive - Anticipating change and taking relevant actions that make a difference and achieve positive results.

Transformational Leadership-Ownership of, and championing the change required to achieve the vision for the health sector.

Figure 4: Guiding Principles and Values



With the above, the guiding principles will guide the improvement and development of the health system, its services and benefits in line with the mission statement of the NHSP. The NHSP is guided by three values that orient and underlie the provision of health services: People-centred health services, integrated services and sustainable services.

The Solomon Islands is a country that is ***people-centred*** and hence the provision of health services and care must also ensure health services and care that consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respects social preferences. People-centred care also requires that patients have the education and support they need to make decisions and participate in their own care and that carers are able to attain maximal function within a supportive working environment. People-centred care is broader than patient and person-centred care, encompassing not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policies and health services.

Integrated health services ensure that health services are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the course of life.

Sustainable health services ensure that knowledge management is built, improved and strengthened in the sector so as to improve performance. So often information is not shared between programmes and or amongst health professionals. However, in sharing information, building on existing knowledge, this increases collaboration and sharing of information to make health care organizations sustainable and able to provide optimal health care performance. There is a great reliance on knowledge and evidence-based information for decision-making and to inform policy.

Mission, Vision, Goal and Strategic Objectives

This NHSP builds on the strengths of the previous NHSP and establishes three objectives/areas of strategic focus that will guide health sector reform and performance over the next decade.

Our vision is “A healthy future for all”. Our goal over the next decade is to ensure that all Solomon Islanders have universal access to equitable quality preventative, curative, rehabilitative and promotional health services, irrespective of where they live.

We will achieve this through three strategic objectives which cut across all aspects of the health sector.

Figure 5: Mission, Vision, Goal and Strategic Objectives

Results Framework

Figure 6: Results Framework

SO 1: Better Governance of the Health Sector

WHO defines governance of the health sector as “a wide range of steering and rule-making related functions carried out by governments/decision-makers, as they seek to achieve national health policy objectives that are conducive to universal health coverage”. Leadership and governance will involve ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability. The main stakeholders who determine the structure of the health system and its governance are:[10]

1. The governments at all levels and across sectors
2. The health service providers and workforce
3. Development partners
4. Citizens (i.e. population representatives, patients’ associations, CSOs, NGOs and citizens associations).

We aim to achieve improved alignment between the laws of the country, international agreements and commitments, health policies and how we monitor, report and communicate performance. We will create a conducive and supportive internal environment to enable this new NHSP to achieve its strategic intention and objectives.

Where are we at now?

The Solomon Islands National Development Strategy 2016-2035 (NDS) sets out the broad development goals for the country to which all central and line Ministries contribute through their respective strategies. The NDS notes that poor governance and management at all levels have resulted in poor economic growth.

A Partnership Framework for Effective Development Cooperation describes actions that the SIG and development partners commit to undertake to ensure the achievement of the SIG’s development plans.

Health administration laws lay out the architecture of the health system and orient it towards achieving the country’s health priorities. There are gaps in the current laws, many are outdated and do not reflect how the health system is evolving and decentralizing.

We are guided by our NHSP, the most recent of which expired in 2021 after being extended by a year. Corporate, divisional, department and program level strategic plans are to align to the NHSP in their respective areas. The plans are operationalized through the Annual Operational Plan (AOP) budget process. Not all program / divisional strategic plans are current and they often lack a cohesive M&E framework or clear targets.

Overall, the MHMS has good financial governance oversight. There is a well-developed planning and budget cycle in place with several internal and external review and endorsement processes leading up to the final approval and appropriation of funds. Regular Ministerial budget committee meetings occur throughout the year to monitor budget expenditure and variances. An internal audit unit undertakes annual checks on the adequacy and effectiveness of the MHMS control environment and a report is submitted to the MHMS Audit & Risk Management Committee, and if required, submitted to the Ministry of Public Service (MPS).

Figure 7: SO 1 Current Metrics

Programs prepare annual narrative reports for inclusion in the MHMS Annual Report. Not all programs do this which delays the production of MHMS Annual Reports. Consequently, MHMS leadership rely heavily on financial monitoring as a measure of activity implementation and have less oversight on what is being achieved at the outcome level.

The governance and management of assets is an issue for the MHMS with asset registers not being kept or updated in many instances.

The Ministry has the Performance and Recognition Committee (PRC) which abides by the Performance Management Process, Policy and Procedure Manual. This Committee does not deal with disciplinary matters. It only awards confirmation, increments and promotion. Currently, there is no Disciplinary Committee of the MHMS. Staff are happy with confirmations, increments and promotions, despite the challenge in getting papers on time.

Relative to other countries, the MHMS has a low funding base due to the relatively low GDP of the country. Donor support is an essential requirement and a number of donors stand solidly as partners in the sector. Australia is the major source of development assistance to the health sector, with other significant contributors being the European Union, New Zealand, the Global Fund and Japan.

However, many donors are reducing funding support and we need to establish a funding transition plan to ensure all services can continue and be fully implemented.

What Would We Like to See Over the Next Decade?

Our aim over the next decade is to strengthen governance and leadership at all levels, supported by policies that improve the efficient and effective oversight, management, and accountability for our resources. We want to demonstrate that health is an investment rather than an expense, and we can best show this by improving our capacity to report on results, plan, and execute our budget at all levels. Through these measures, we will realize our vision of a healthy future for all and increase our government and development partners' confidence in the health sector. We will take the "driver's seat" and bring our community and development partners with us on 'our' health journey.

We will update current health-related Administrative Laws and Legislation to support the reform and ongoing decentralization of health services and empower our provinces to take control of health outcomes in their respective areas. Notably, we will work to establish a separate Public Health Act to provide an overarching legislative framework for public health and International Health Regulations (IHR) compliance in the country.

Some development assistance funds have been reduced or will be withdrawn. We will meet this challenge by finding other ways to strengthen the financing of health care services for our people.

We will help Provincial Governments and Provincial Health Leaders to take care of health services delivery and contribute to governance. 'Fit for purpose' provincial health governance models will be trialed and rolled out progressively in key provinces along similar lines to a Provincial Health Board. Partnerships with provincial governments and communities will be strengthened to promote community engagement in the governance of the health services delivered.

The National Referral Hospital (NRH) will develop entirely into a tertiary referral hospital, where primary and secondary services are provided elsewhere in the health system. It will be better empowered to manage its services and lead the development of good clinical governance in the Solomon Islands. We will strengthen the capacity to manage and maintain health infrastructure, and develop an integrated plan that considers the governance structures, workforce, supply and financial resources required to upgrade ageing health facilities and equipment over the next ten years.

We need to make M&E a priority to track progress and make evidence-based decisions. All program and divisional plans will align to our new NHSP as they come up for review/renewal. They will include an M&E framework with clear indicators and defined targets that will be regularly monitored and reported against annually. As a Ministry, our annual reports will, in the future, report on progress against the new NHSP and align to our M&E framework.

We will embed a high-performance culture throughout the Ministry where all staff feel valued, share the vision of a healthy future for all, are upskilled to meet current and future needs and feel inspired at their place of work. There will be a focus on training, strategic workshops and strengthening of disciplines. Regular supervisory tours will be promoted.

We need to think ahead about what our workforce needs to be over the next ten years, how we can better distribute staff equitably, and have a plan for this.

All Departments, our Provincial Governments, and our development partners can participate in improvement by using performance scorecards.

We will make some small but valuable changes in parts of the MHMS to improve the monitoring and management of our new NHSP. In line with the direction outlined in the new NHSP in consultation with the Ministry for Public Service (MPS), we will reorganize the structure of the leadership team and executive to better support the implementation and monitoring of the new plan and strengthen overall governance (see Figure 8). We will improve the visibility of medicine supply chain issues at the health facility level and acknowledge stock-outs as an issue of patient safety. Clinical governance will be a different portfolio of the DS-HC.

We will strengthen the Biomedical Unit, with oversight from a National Biomed Engineer, to meet the challenges of specifying, supporting and maintaining valuable medical equipment.

We will keep up the momentum and accelerate investment in addressing gender-based violence throughout the country.

The impacts of climate change are far-reaching, affecting communities in complex ways. We will respond to climate change demands when considering our facilities' design and placement and in our programs to better adapt to sea levels and epidemiological changes.

The leadership team will adopt a matrix taskforce project management approach for addressing projects that cut across multiple portfolios, such as the building, equipping, supplying, and staffing of a new health facility. Taskforces will be project specific and from inception. They will only disband once the facility is fully operational and able to deliver the full suite of services relative to its level.

Figure 8: Proposed Organisation Structure - National Level

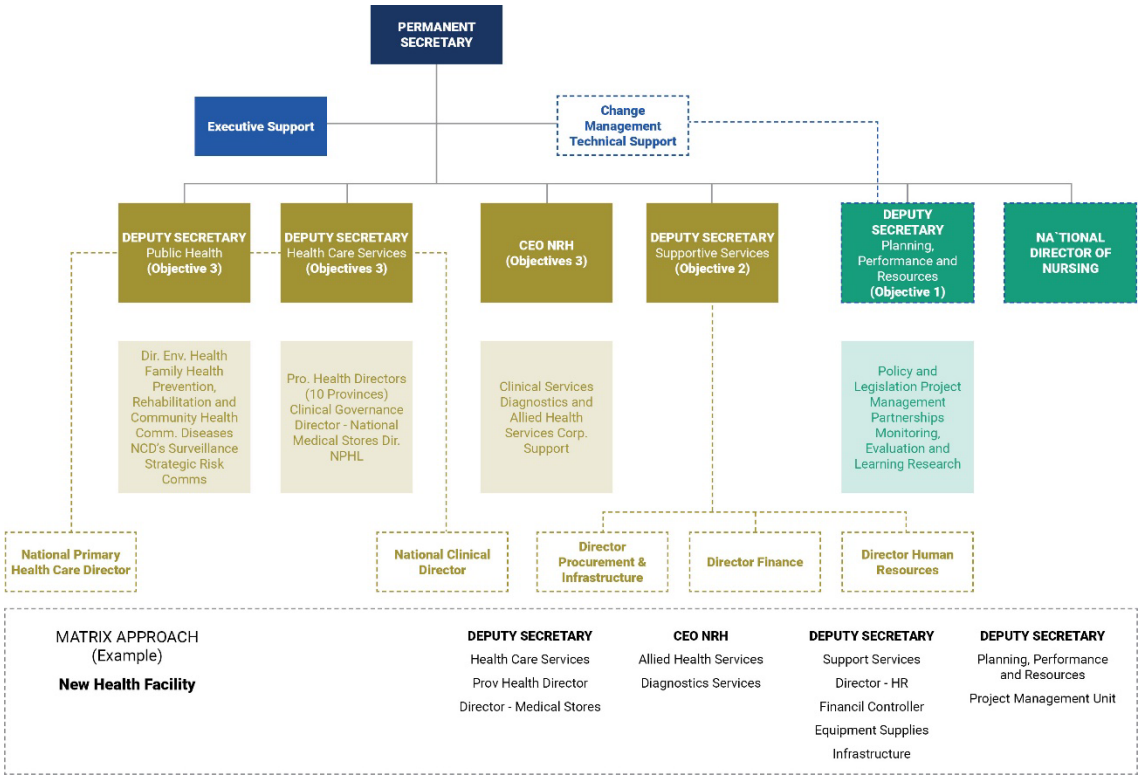
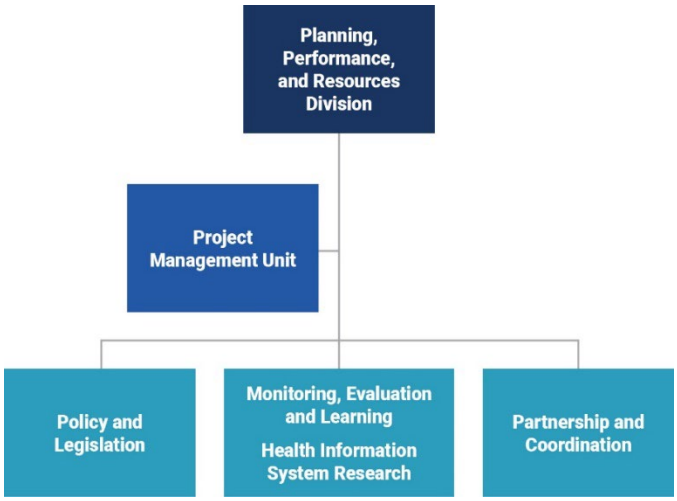


Figure 9: Repurposed Planning, Performance and Resources Division



The reform agenda and introducing a performance culture will be championed by the Permanent Secretary supported by a change management technical support and assistance.

The MHMS Planning and Policy Division will be repurposed and strengthened to take on additional roles and responsibilities, including monitoring the implementation of our new NHSP, NHSP-level project management, policy analysis and development, and legislative review.

Figure 10: Priorities for Better Governance

How do we get there?

Figure 11: Strategies for Better Governance

Strategy 1.1		Review and modernize health laws and regulations to better align to health sector strategies and policies
Strategy 1.2		Re-invigorate an MHMS-led Health Partners' Coordination Forum, building alliances with development partners, NGOs, CSOs, other Ministries and the private sector to coordinate the mechanisms of support to this NHSP
Strategy 1.3		Undertake a small reorganization of the MHMS to improve the monitoring and management of our new NHSP
Strategy 1.4		Decentralize some elements of health governance through the establishment of Provincial Health Boards, led by local government that includes broad community membership including FBOs, NGOs and CSOs
Strategy 1.5		Draft a National Health Workforce Strategy document as a companion to this NHSP
Strategy 1.6		Explore supplemental financing options including co-payments, fees, cost-sharing, revolving drug funds and private beds in hospitals
Strategy 1.7		Strengthen and resource activities to better address gender-based violence throughout the country
Strategy 1.8		Establish and apply a National Clinical Governance Framework for all Hospitals and Clinics that defines the structures, organization, and processes to regulate clinical services and assure patient safety
Strategy 1.9		Further develop the Role Delineation Policy and transform it into the National Standards for Health Services incorporating all services levels from the National Referral Hospital to Nurse Aid Posts
Strategy 1.10		Establish performance scorecards for development partners, provincial government, and Departments
Strategy 1.11		Establish a team within the MHMS dedicated to manage and undertake sector Monitoring and Evaluation (M&E)
Strategy 1.12		Draft a Strategic Health Infrastructure Development Plan as a companion to this NHSP
Strategy 1.13		Include climate change demands when considering facilities' design and placement, and in our resourcing of programs
Strategy 1.14		Focus on improving the equity of access to quality patient-centred services through policy directives, annual planning, funding models and monitoring and evaluation

SO 2: Our Systems and Resources Meet Our Needs and Are Responsibly Managed

Robust health systems provide access to essential, quality health services for all Solomon Islanders. Health systems include the facilities, equipment, medicines, resources, workforce, and communities coming together to improve health outcomes. These systems lead to better health care, increased resilience from infectious disease outbreaks, reduced prolonged economic hardship, and provide high-quality and affordable services to the individuals and communities with the least access to care, including women, children, and the rural poor. Resilient health systems promote health security by ensuring that emerging health threats are detected early, disease outbreaks are contained, and epidemics and pandemics are prevented.

Effective health systems require skilled health workers and responsible managers to attain the highest health standards and ensure availability, accessibility, acceptability and quality. The health workforce has a vital role in building the resilience of communities and health systems. Most of the health workforce are women, and investments in the health workforce provide employment opportunities and dignity. Low investment in education and training of health workers and the mismatch between education and employment strategies and population needs requires attention, as make the difficulties in deploying health workers to rural, remote and underserved areas.[4]

Where Are We at Now?

Health Information Systems

Our health information system centres around the District Health System2 (DHIS2), an open-source platform used by more than 70 countries worldwide for collecting and analyzing health data. The University of Oslo's HISP centre provides development and technical support for DHIS2 and new version releases. Since 2014, provincial officers have been able to enter data directly from the HIS monthly reporting form into DHIS2 and have access to view health information data through the DHIS2 dashboard except for Rennell and Bellona provinces.

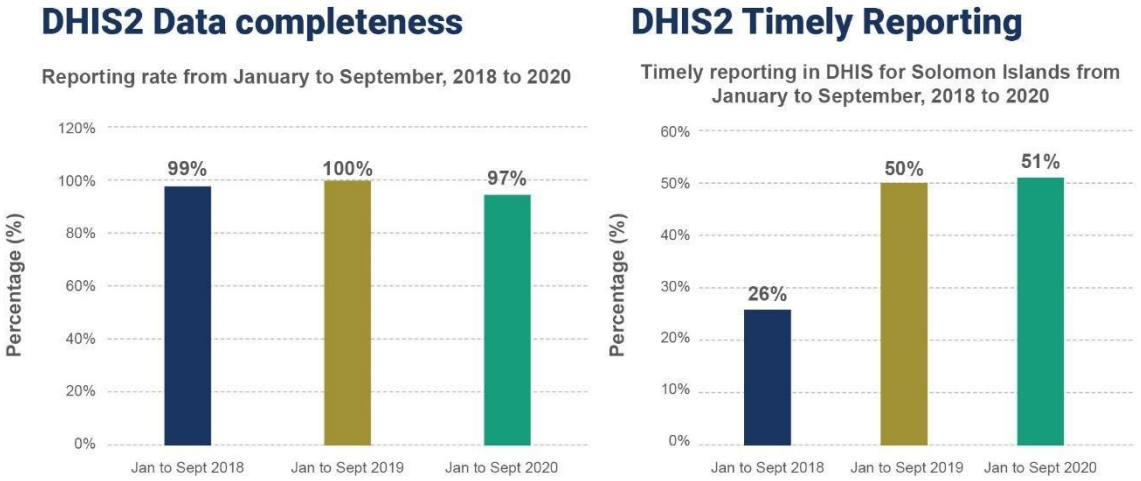
Several public health programs capture and analyse their routine program data. Some of this data is embedded into the DHIS2 HIS monthly reporting form, while other datasets such as malaria and tuberculosis are integrated separately into DHIS2. Other programs like the Solomon Islands Package of Essential Non-Communicable Diseases Programme (SOLPEN) and oral and dental health are yet to be integrated into DHIS2.

The National Referral Hospital collects information manually through the Daily Bed Statement and the Hospital admissions, discharge and transfer system (DATS). This provides data on daily bed census, patient admissions, discharges, transfers, deaths, immunization of newborn babies and outpatient attendance at OPD. These monthly statistics are entered into DHIS2 by medical records staff. A similar (excel-based) reporting system is used at Kilu'ufi and Gizo hospitals.

Medicines use are entered into a computerized inventory management system (M-Supply) at an aggregate data level and are not attributable to individual patients. M-Supply data is separate from DHIS2, although it can be integrated as in Tonga.

Overall, we have good data completeness, with it sitting at more than 90 per cent of all health facilities submitting reports. Timeliness of reporting remains an issue, with only 50 per cent of health facilities submitting on time.

Figure 12: DHIS2 Data Completeness and Timeliness



Source: HIS Unit Administrative records

Source: DHIS2

Our Health Information Systems team provides a range of routine and one-off reports, the most well-known of which is the core statistical health indicator report which is produced quarterly. This report collects, analyses and reports on 36 core indicators. The core indicators have remained the same for more than two decades now and need updating.

Financial Management Systems

We have had problems in spending allocated budgets. A range of factors have contributed to this including delays in the budget being appropriated, not enough staff to process funding requests, lack of communication when funding applications are not complete and lack of knowledge on different systems for requesting money and reconciling expenses. Failure to expend our allocated budget affects the full implementation of our health programs. It is a priority to solve the problems in this system.

Procurement and Supply Chain Systems

Approximately 30 per cent of our Ministry's annual budget relates to the procurement of goods and services and this is all handled by the procurement unit to ensure value for money and compliance with policies and Standing Orders. The procurement unit prepares the Annual Procurement Plan each year, checks compliance, and submits this to the Ministry of Finance and Treasury. The volume of procurement activity has increased over the past three years with the budget, yet the staffing levels remain the same.

The Procurement Unit has specialist skills in procurement processes but relies on other divisions for defining the specifications of items to be procured, which at times slows down the procurement process.

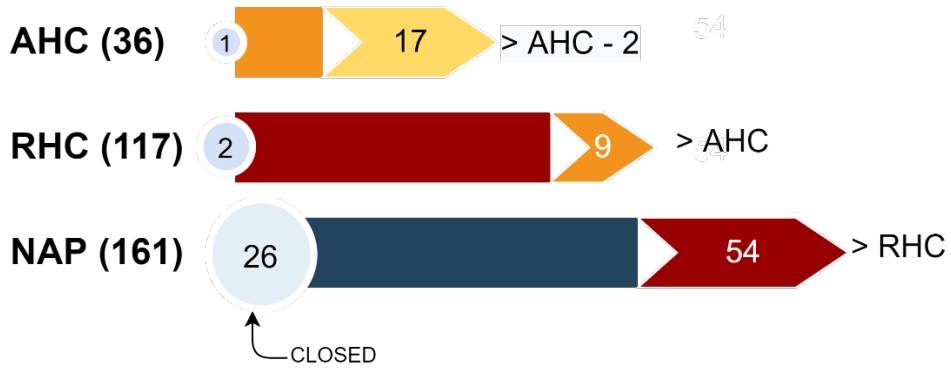
An annual procurement plan is extracted from the AOP (which is normally approved in April). The procurement modality used is dependent on the value of the procurement. The Procurement Unit undertakes a compliance check for anything less than SBD100,000, with divisions responsible for the actual procurement. Anything over this amount is handled centrally by the Unit.

COVID-19 has had a significant impact on procurement activities. It has been difficult to comply with procedures due to the urgency of the response. We have maintained a focus of not cutting corners and still ensuring value for money.

Infrastructure

The MHMS recognises the need for a coordinated approach between partners and all levels of government to improve *Health Infrastructure (HI)*. Many of our 353 health facilities are more than thirty years old, in poor condition, lack maintenance, basic water, sanitation, hygiene, building services, and the housing required to retain health workers outside Honiara. To achieve UHC and to respond to growth, and improve accessibility, up to 25 per cent of health facilities (see Figure 13) are estimated to require upgrades.

Figure 13: Summary of Recommended Clinic Upgrades from RDP Committee (2020)



An even greater investment is needed to bring each of our facilities' condition up to RDP standard for the existing level of service. Better planning, delivery and use of existing assets will be crucial. Identifying non-infrastructure solutions, alternative models of care, e-medicine, and building innovations will also be vital to offset the funding, resources, logistics and market capacity constraints.

While health infrastructure policy and planning at the MHMS has improved, providing adequate procurement and project management resources will remain key to removing bottlenecks and delivering better projects.

Nationwide utility infrastructure programs will increase rural electrification, telecommunications, and transport access. Emerging health issues, such as NCDs, pandemics, gender and sexual based violence (GSBV) will impact the type of infrastructure required at each level of facility. As will the strategies to improve accessibility for the disabled, elderly, youth, as well as remote communities and rapidly expanding urban populations, at an affordable cost.

There has been increased planning for, and investment in new projects at the NRH. This includes planning for recurrent maintenance to meet tertiary standards, and provide a level of specialty that enables the ministry to meet future clinical needs of the population. Donor support for this is essential.

The roll out of projects and business case propositions will focus on addressing overcrowding and infrastructure issues at the NRH, including eventual relocation of the NRH to a less disaster-prone site, that can accommodate future growth.

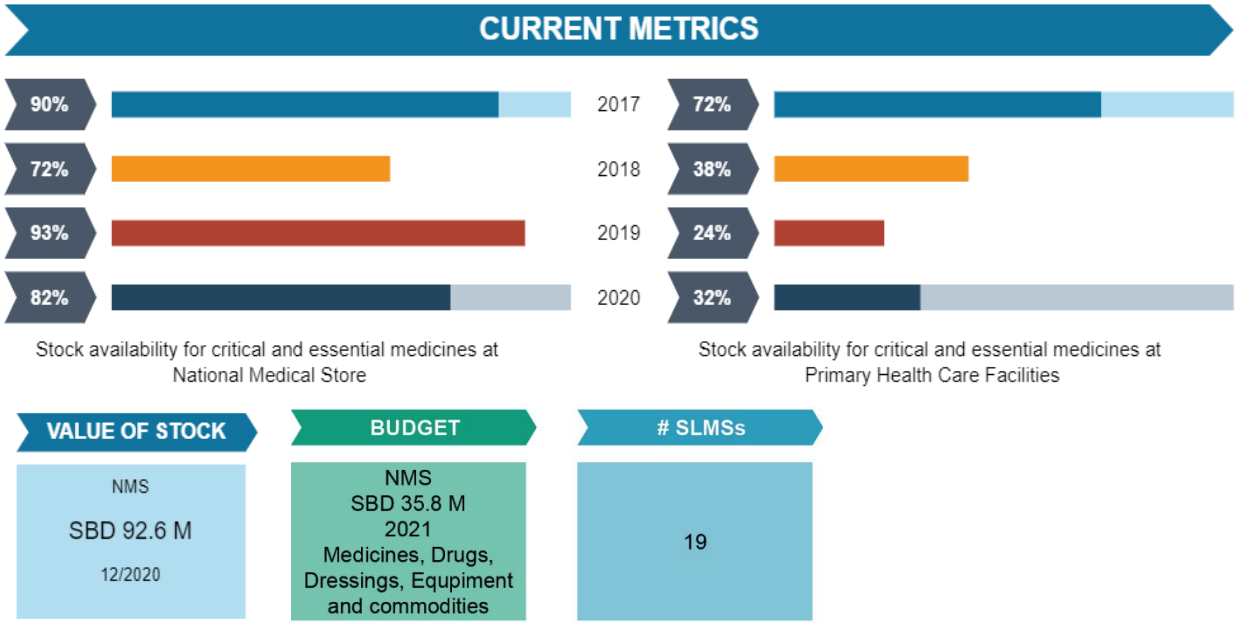
Similar activities are underway at provincial hospitals and Area Health Centres (AHCs) crucial to the decentralization of services, better health coverage and pandemic preparedness and to meet the RDP level of services and packages of care. Masterplans are complete or underway at Kilu-ufi, Kirra Kirra and Tulagi hospitals and Taro AHC, providing direction for future improvement.

With many Primary Health Care (PHC) clinics past their useful lifespan, we will re-evaluate whether their location is accessible or disaster prone and should be moved. Better planning coordination and commissioning is required, when establishing or upgrading new facilities. The RDP will be a key instrument to inform on infrastructure priorities.

There are also national and program infrastructure activities, including second level medical stores (SLMS), malaria storage shed, radiology, laboratory and National Dental programs, which will increasingly devolve services and management of assets to provincial and facility levels.

Medicines, Medical Supplies and Equipment

Figure 14: Medicines and Equipment



BASIC EQUIPMENT AVAILABILITY BY HEALTH FACILITY TYPE (2018 SARA SURVEY)

	CI	CH	GP	HO	IS	MK	MA	RB	TE	WE	AVERAGE
AHC	53%	66%	63%	57%	45%	57%	63%	58%	63%	62%	59%
RHC	60%	61%	55%	42%	52%	46%	52%	54%	68%	49%	54%
NAP	54%	44%	42%	41%	42%	45%	37%	n/a	41%	30%	42%

COST OF EQUIPPING NEW FACILITY TO RDP MINIMUM STANDARDS SBD (2018)

The National Pharmacy Services Division is responsible to ensure complete, equitable and safe access to essential medicines for the whole population of the Solomon Islands. It ensures the rational use of medicines and the transparent procurement of medicines and medical devices with appropriate quality control measures in place.

A 2021 budget of SBD35.8 million was allocated for the purchase of medicines, vaccines, oxygen, medical supplies, reagents, consumables and medical equipment. The value of stock held at the National Medical Stores (NMS) at the end of 2020 was estimated at SBD92.6 million. This volume of essential and hard to replace supplies in one location represents a significant national security risk in the event of a fire or other calamitous event destroying the stock.

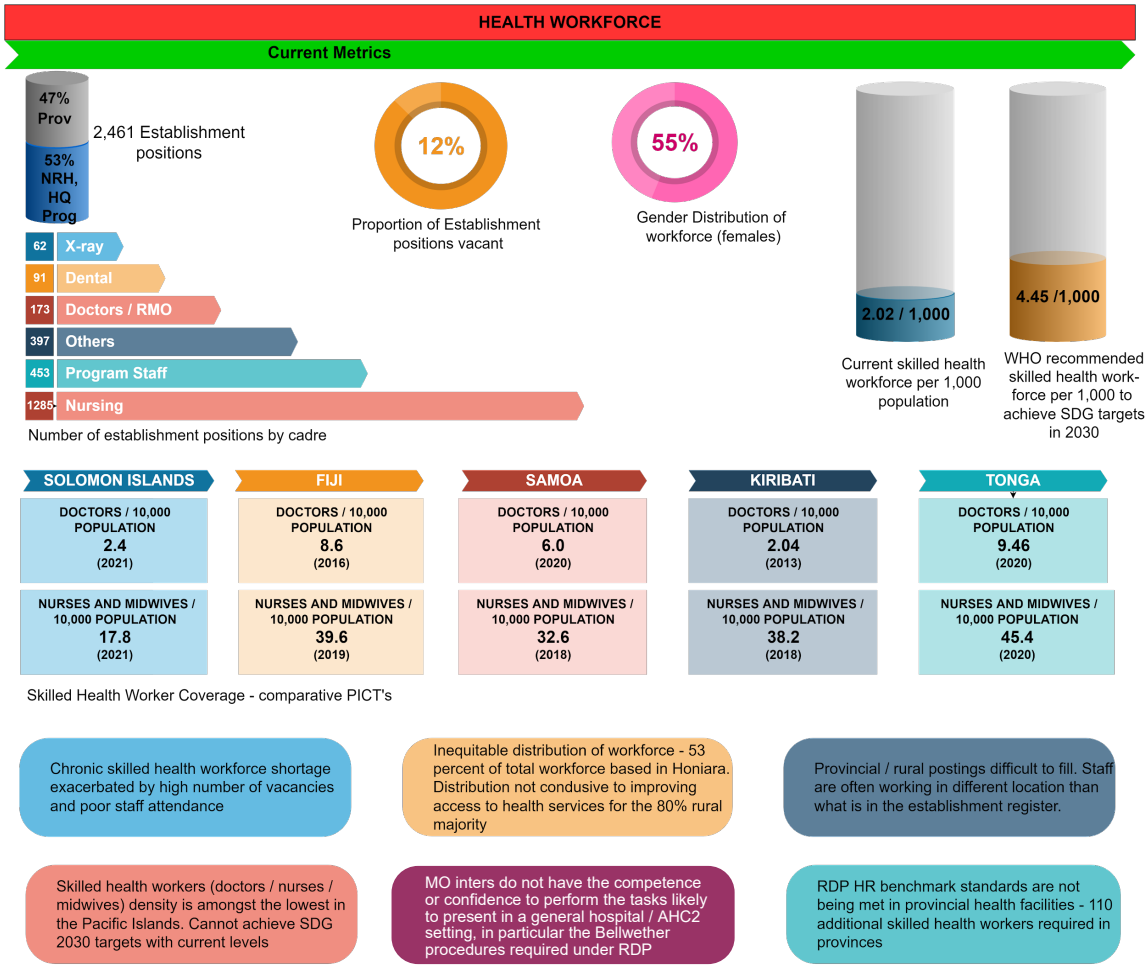
The medicines availability at NMS at the end of 2020 was estimated at 82 per cent and consumables at 89 per cent. Ensuring consistent availability of medicines and consumables at primary health care facilities remains a challenge, with supplies at the end of 2020 estimated at only 32 per cent. While we have good confidence in the medicines and consumables data coming from NMS, NRH, SLMS and some AHCs due to them using M-Supply, we have low confidence in stock availability data at all other health facilities.

The storage situation at NMS is deteriorating due to the inadequate storage relative to population growth and this has been compounded since the COVID-19 outbreak. Nineteen SLMSs in the provinces supplement storage at the NMS and support distribution at provincial level. There is a five-year plan for new strategically located SLMS storage facilities to be established (for example in the Shortland Islands) but this has not yet been realized. Buffer stores in Noro, Kilu'ufi and Guadalcanal province are planned as higher capacity SLMSs to address some of the national security risks associated with the NMS and also to reduce pressure on the NMS.

A National Medical Equipment Committee oversees the procurement, distribution and management of medical equipment for tertiary, secondary and primary health care services in line with RDP guidelines. Many health facilities lack items of basic medical equipment.

Health Workforce

Figure 15: Health Workforce



Our skilled health workforce density is amongst the lowest in the Pacific Islands. We face a triple burden of chronic skilled health workforce shortages, inequitable distribution of the workforce, and insufficient workforce to achieve the Sustainable Development Goals (SDG) health targets by 2030.

The shortage of skilled health workforce is exacerbated by a high number of vacancies, poor staff attendance and experienced staff leaving to take up more lucrative positions overseas.

We have an inequitable distribution of our health workforce with more than half of the total workforce based in Honiara. Provincial and rural postings are difficult to fill due to several factors, the most dominant of which is the lack of staff and family accommodation. Not being able to fill these postings represents a barrier to improving access to health services for the 80 per cent rural majority of the population, who are also arguably, the most vulnerable and in need.

We do not have good data on the physical work location of staff. Staff are often working in a different location to what is in the staff establishment register.

Newly trained skilled health workers often enter the workforce without all of the competencies required or expected of them, for example, where they are expected to provide emergency and essential surgical care in low resource settings. New sub-specialty areas of practice and technologies introduced at the NRH place demands and expectations to provide a level of nursing care and patient monitoring that nurses have not necessarily received training in.

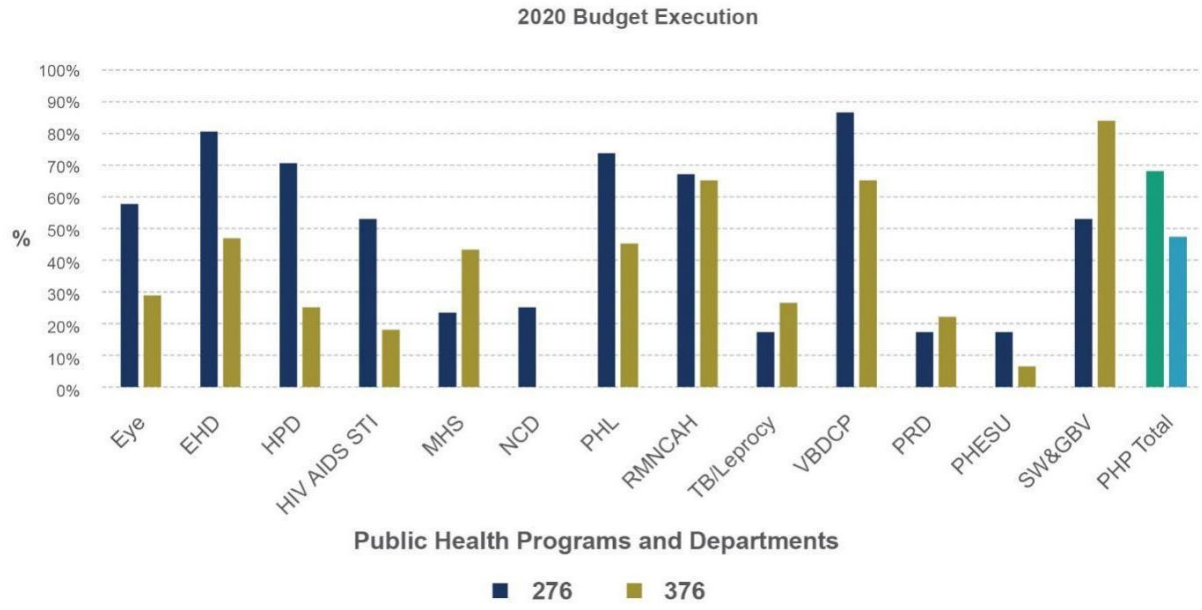
Program Management

In the MHMS, 13 public health programs and departments are responsible for the delivery of services covering primary health and prevention and control of disease, rehabilitation, health and risk communication and gender-based violence.

An internal review of Public Health programs was undertaken in July 2021. The review identified that a total of SBD67 million was allocated in the 2020 recurrent budget across the 13 programs - SBD4 million was from the Solomon Island Government (SIG) 276 budget and the remaining SBD63 million was funded from the 376 Development Partner (DP) budget,

The budget execution rate was 69 per cent for the SIG276 budget, and 48 per cent for the 376 DP budget.

Figure 16: Program Budget Execution



Despite low execution rates, several programs have been able to demonstrate notable achievements.

Challenges faced by the programs include insufficient human resources, deteriorating infrastructure, difficulties both with the amount of funding and accessing the funds, and logistics. Regular engagement with donor-driven activities sometimes compete with work plan activities.

As reported elsewhere, not all programs have a current Program Strategic Plan and M&E framework or policies to guide the implementation of strategies, and annual reporting is variable.

What Would We Like to See Over the Next Decade?

Health Information Systems

We want to better integrate the multiple health information data platforms we currently use and address data timeliness issues to provide analysis and data mapping at the sub-provincial level to ensure better targeted interventions at primary and community groups. We want to offer more 'heat maps' for the visual presentation of data instead of only bar graphs. The longer-term direction for health information will be guided by a Health Information & M&E development plan that will be developed during the early implementation of the new NHSP.

The data that we collect and report on, particularly the core indicators, will be aligned and expanded to enable better reporting against this NHSP and its M&E Framework. The HIS unit will, over time, be incorporated with the M&E unit based in the Planning, Performance and Resources Division.

We will utilise in-house expertise to develop DHIS2 further and to reduce reliance on technical support from the DHIS2 developers in Oslo.

Financial Management Systems

We would like to see that every request for funds disbursement is processed promptly and that there is good communication between the requester and the requestee. This will ensure that our health programs are implemented according to plan. We would also like to ensure that everyone involved in the process is thoroughly trained and confident in using the system.

Health Infrastructure

We have identified that significant investment in the 'hardware' components of the health system will be vital to meeting RDP standards and achieving UHC. A renewed focus on maintenance and better use of existing assets are fundamental, and we will continue with systems strengthening reforms to ensure the resources are there to plan, manage, deliver, and maintain health infrastructure.

An infrastructure audit, including condition assessments, will inform long-term investment plans. Providing policies, guidelines, resources, and improved governance will allow the staged development of health infrastructure that is more accessible for the disabled, elderly, youth, and at-risk groups.

The plan's first five years will focus on delivering current projects and designing an integrated service delivery plan that develops priority evidence-based projects in concert with the associated and necessary workforce, finance, operational, governance, equipment and supply plans.

We will work with provinces to increase their capacity to manage and maintain health infrastructure. When a facility is upgraded or established, we will ensure it is a priority project, accessible, staffed, funded, operated, supplied, equipped, maintained, and delivered to a good standard.

The ten-year health infrastructure outline options for NRH relocation to a less disaster-prone site while delivering additional smaller projects to improve secondary and tertiary care at the existing site. We will continue upgrading Urban Health clinics in Honiara City Council and surrounds to take the pressure off the NRH Outpatient Department, provide better Primary Health Care, and develop better models of care for NCDs, sexual and reproductive health, and GSBV.

We will strive to ensure all clinics have basic water and sanitation, hygiene, waste, power, communications and equipment and that critical health facilities are built or upgraded to improve UHC. It is possible that by 2030 with a well-resourced maintenance system, all clinics can be repaired, pandemic and disaster resilient, and compliant with RDP standards.

Strategies are also in place to improve program, administration, and medical store infrastructure. Projects to improve supply chain, diagnostics, dental, rehab, mental, eye health and social welfare are all working to decentralize services and move health care closer to people in rural communities and the urban fringe. The upgrade of AHC infrastructure will be front and centre of these plans. Health infrastructure will take precedence in supporting supervised births, population health, expanded program for immunization (EPI), vector-borne diseases control (VBDC), and essential programs.

Given that many health facilities are past their lifespan, a re-think is needed to determine whether clinic locations are accessible and climate change resilient. While clinics will remain important to local communities, the government and donors will not make significant investments in health infrastructure without the security of land tenure and compliance with minimum standards. Partnerships and improved ties with communities, provinces, and the private and faith-based sectors will be key to achieving these goals.

By building on success to date, Health Infrastructure in 2030 must be more resilient and accessible and accommodate growth and changes in health-seeking behavior. How we get there is summarised in "Annex 2: The Health Infrastructure Roadmap" in line with other planning processes such as the National Development Strategy, Rural Water and Sanitation Supply (RWSS) Strategic Plan and other program plans.

Procurement and supply chain

We want to ensure that we get the best value for money in procuring goods and services and that our procurement and supply chain become enablers rather than barriers to implementation. This will require us to build additional capacity in the Procurement Unit and outsource contract management for infrastructure projects. We will explore procuring directly from the manufacturers where practical to reduce costs.

Medicines, medical supplies and equipment

We want to achieve universal health care, reduce self-referrals and minimize risks to patient safety by ensuring the availability of quality-assured medicines and equipment appropriate to the services that are to be delivered by each facility level.

In the future, we would like better data to help understand prescription patterns and practices so that we can be assured that medicines are not being given out inappropriately. We also must invoke policies and procedures to prevent equipment from being removed from health facilities without authorization. We need to reduce wastage of medicines and supplies and unexplained loss of equipment, and we can only do this by having better systems, oversight, and supervision.

Ultimately, we would like all patients on long-term daily medication for chronic conditions such as hypertension or diabetes to have uninterrupted treatment by ensuring adequate drugs are available at all times.

New strategically placed storage facilities will be in place to help resolve storage and warehousing constraints and to address the risks to the national security of supplies posed by having the country's stockpile of medicines in one location.

With an increased emphasis on the procurement of specialist medical equipment, we will need to build additional capacity in biomedical services to ensure that we procure the right equipment with the correct specifications and that we can service and maintain this equipment at the national level in provinces.

Health Workforce

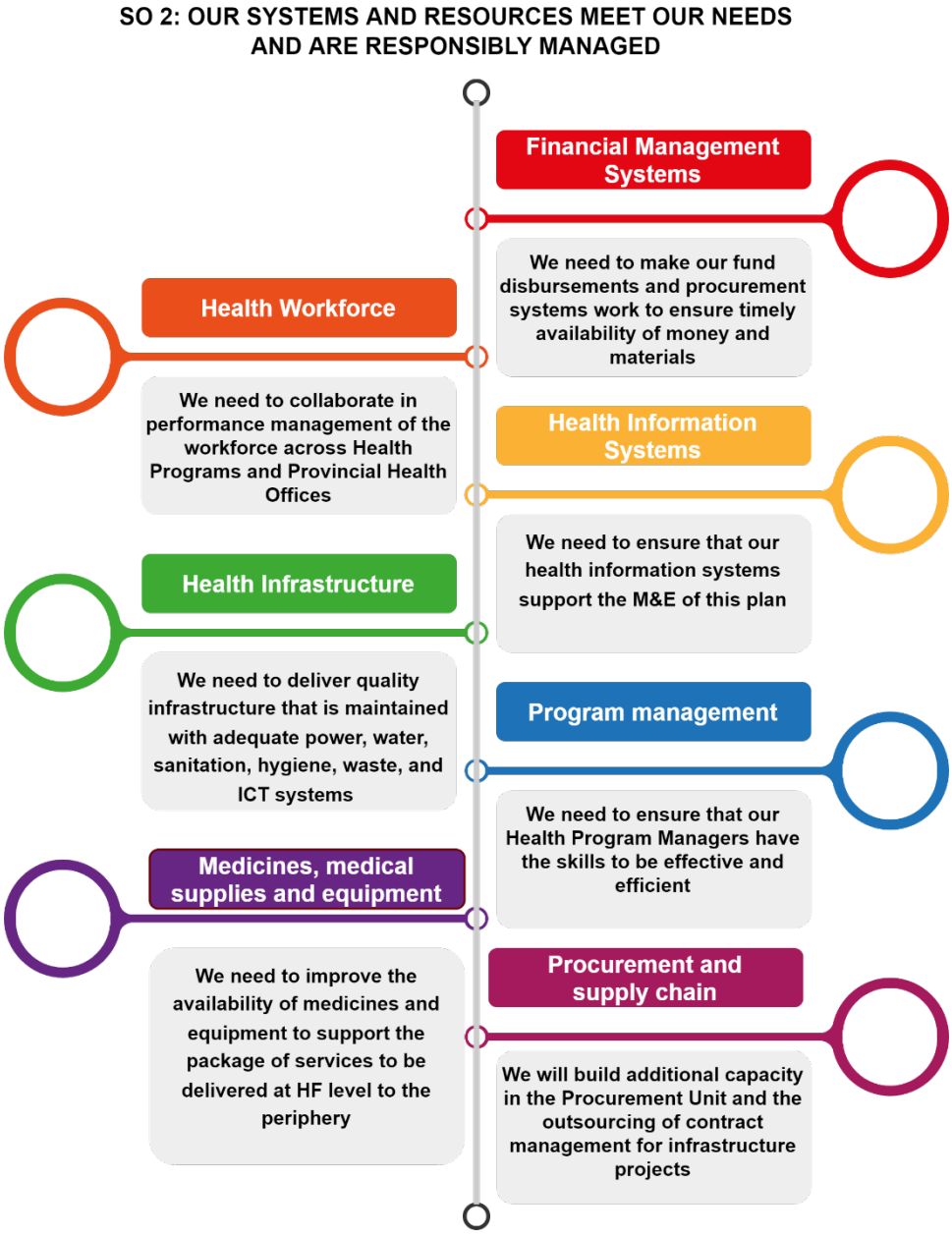
We need to plan for the future, given that our population will increase by an estimated 191,000 by the end of this decade. We know from benchmarking studies such as the 2018 Workforce Indicator Staffing Needs (WISN) study and the minimum HR requirements by facility type/cadre outlined in the RDP that our staffing numbers are low. This compromises patient safety and timely access to health services, mainly during Christmas when many facilities are closed due to the sole nurse taking time off and no replacement available. Even if we were to maintain our skilled health workforce ratios at the current low levels, we would require an additional 386 doctors, nurses and midwives over the next decade just to keep up with population growth.

We recognise that we are facing a potential future skilled health worker crisis with the population growth our country is experiencing, coupled with the loss of trained health workers due to retirement and migration. This new NHSP and the RDP provide us with a framework from which we will develop a comprehensive health workforce development plan to ensure that we have the correct number of health care workers with the proper knowledge, skills, attitudes and qualifications and that they are performing the correct tasks in the right place at the appropriate time to achieve the targets and outcomes agreed to in our new NHSP.

New partnerships will be established with training institutions to ensure that their capacities and curriculum better match our future health workforce needs. We want our development partners to align their support for short-course training and scholarships to our workforce development plan, which will be developed in the first year of this new NHSP.

We want to ensure in the future that health facilities in rural and remote settings are appropriately staffed at all times so that communities can access the health services that they need closer to where they live. We will need to incentivize rural and remote postings to attract and retain health workers in rural areas.

Figure 17: Priorities for Systems and Resources



How Do We Get There?

Figure 18: Strategies for Systems and Resources

Strategy 2.1		Continue with systems strengthening and provide an adequate resources plan, procure, manage and maintain HI, at the MHMS, NRH and each province
Strategy 2.2		Establish Clinical Governance Committees in all hospitals and Patient Safety Committees in all AHCs to set clinical policy, develop procedures and review Clinical Performance as matter of routine practice
Strategy 2.3		Establish Provincial Health Programs Collaboration Committees in each province, chaired by a member of the Provincial Government and with representation that includes National and Provincial health program leadership
Strategy 2.4		Improve funding disbursement and procurement systems applying business process analysis and establishing a performance framework
Strategy 2.5		Explore and establish mechanisms for inter-program and inter-province cost sharing
Strategy 2.6		Explore and establish mechanism for revenue generation in hospitals and clinics including co-payment or fees for selected services
Strategy 2.7		Modify establishment register and contracts so that positions are assigned to a specific facility as opposed to a division
Strategy 2.8		Develop a Health Information & M & E development plan that aligns to the information needs for the new NHSP
Strategy 2.9		Roll out M-Supply mobile to all AHCs / RHCs to strengthen all aspects of forecasting, supply and stock management across the country. Review and update SOPs in support of this
Strategy 2.10		Audit and reconcile Aurion database, payroll and physical staff lists to eliminate 'ghost' staff, confirm current location of work and to identify vacant positions
Strategy 2.11		Develop Three-year Rolling Capital Asset Plans. Update annually with AOP at National, Provincial and Program levels
Strategy 2.12		Conduct an Infrastructure Audit, to develop funded maintenance programs, and conduct Integrated Service planning for the Strategic Infrastructure Development Plan
Strategy 2.13		Establish Service/Facility plans for all remaining hospitals, and development plans for all hospitals starting with Kirra Kirra, Kilufi, Tulago and Taro GH
Strategy 2.14		Finetune the NRH Business Case to plan and roll-out: 1. Upgrade to current site > 2032 2. Upgrade to HCC/GCP clinics > 2032 3. New NRH at more stable site (2040)
Strategy 2.15		Update policies and minimum standards to include site, accessibility, pandemic, and disaster resilience, and WATSAN, hygiene, power, waste, ICT, transport & staff housing
Strategy 2.16		Establish a program of training and support that develops financial skills for non-financial health care managers
Strategy 2.17		Strategic placement of additional SLMS' to improve supply to the periphery and build buffer stores to reduce national security risk
Strategy 2.18		Increase capacity within the Procurement Unit to reduce procurement bottlenecks and improve fund utilization

SO 3: All Solomon Islanders Have Equitable Access to Fully Implemented, Quality Health Care Programs

More people are living longer and reaching old age, and this, combined with the high prevalence of risk factors, is causing growth in NCDs and related disabilities, as well as an increase in premature deaths. Vector-borne and communicable diseases continue to drive much of the country's mortality and morbidity. Infrastructure for sanitation and clean water fall well short of the needs of our communities, particularly in rural areas. Growing numbers of young women reaching reproductive age are increasing the demand for maternal, newborn and child health services.

Where Are We at Now?

Many health programs face bottlenecks in accessing funds, deploying staff to the field, and shortages of supplies resulting in less than full implementation and less than optimal quality of program activities. The situation similarly affects all levels of clinical care services in hospitals and clinics. The distribution of facilities, equipment, materials and staff is unequal, resulting in some communities not having access to the services they need.

The provisional population was 721,455 people in the 2019 census, representing an average annual population growth rate of 2.7 per cent[5]. At this growth rate, by 2031, the population will be 993,240. We need to plan for our health services and resources to meet a possible 27 per cent to 30 per cent increase in our people.

General Clinical Services and Essential Trauma Care

- Too much primary care is provided through provincial hospitals and the NRH. Primary health care should be delivered in primary care clinics
- We can expect 370,573 more people seeking Outpatient Department (OPD) services by 2031
- On average, 2.4 per cent of all outpatient consultations result in a referral
- Children are underrepresented in referrals, with 21 per cent of all referrals being less than 15 years of age, despite 40 per cent of the population being under 15[11]
- We can expect around 8,894 more referrals by 2031
- There are 1,757 beds throughout the country, only 2.53 beds per 1,000 people, less than the global average of 2.9-bed per 1,000 people
- The hospital bed occupancy rate (BOR) is only 32 per cent.[12] A BOR outside of 75 per cent to 85 per cent raises concerns about efficiency or admission and discharge criteria
- We need to understand hospital and health facility bed use better and ensure the correct number of staffed and equipped beds are in suitable locations
- There is limited clinical governance in the NRH with even less in other hospitals and clinics, impacting patient safety and the quality of services delivered.

National Reproductive, Maternal, Neonatal, Child and Adolescent Health Program

- The RMNCAH program has made good progress over the previous planning period, but work is still to be done
- Sexually Transmitted Infection (STI) rates are steadily increasing,[13] and chlamydia is prevalent among pregnant women - addressing high STIs is a priority
- Cervical cancer is the second most common cancer and cause of cancer-related death for women in the Solomon Islands[14] - we need to focus on the provision of HPV vaccination for young people, and we need to increase cervical screenings for women of reproductive age[15]
- The Solomon Islands has one of the highest domestic and sexual violence rates globally[16]
- Too many Solomon Islands women are married before age 18, with parents believing an early marriage will protect their daughters and provide them with economic opportunities
- The Contraceptive Prevalence Rates for married and all women have steadily improved since 2015[17]

- Prematurity and sepsis are the leading causes of morbidity and mortality for neonates[18]
- The stillbirth rate, perinatal mortality, infant mortality and under-five death are still too high
- Acute Respiratory Illnesses (ARIs) were experienced by 595 in every 1,000 children under five, and GI tract infections account for the death of one in 10 children. Reducing the number of child deaths is a foremost priority for the program
- The percentage of children immunized who have received one dose of the measles vaccine is 99.1 per cent[19]
- The combined diphtheria, tetanus toxoid and pertussis vaccine (DTP3} coverage is 94 per cent, with 40 percent of districts achieving more than 80 per cent coverage[19]
- 9.7 per cent of children are malnourished, with 29.30 per cent stunted[19]
- Overweight children under 5 are at 4 per cent.[19]

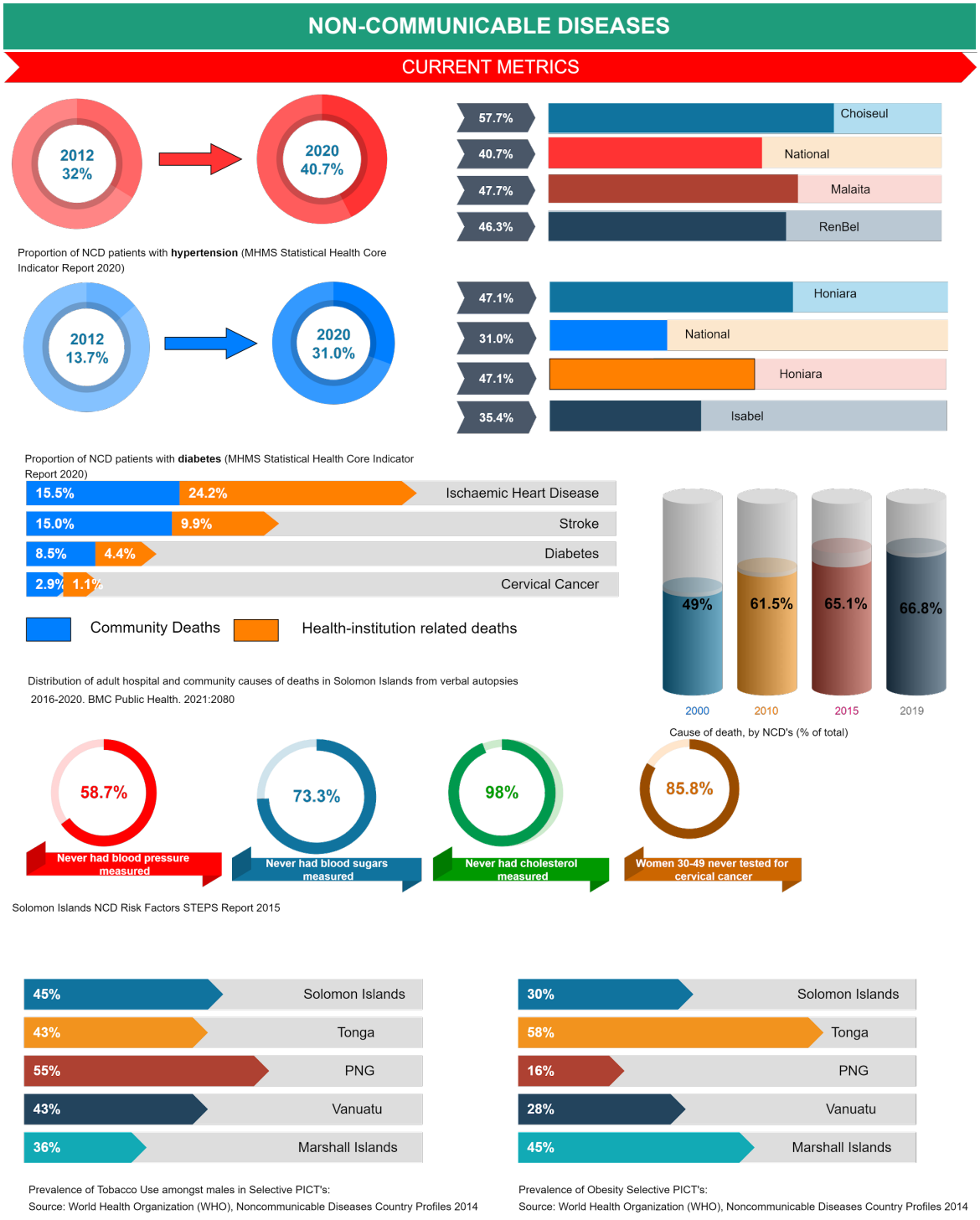
Population Health

- Health Promotion is required to ensure correct information, training, media communication activities, and establishing the healthy island setting models in villages, schools, workplaces, towns and markets
- Partnership with other stakeholders to meet the social welfare needs of disadvantaged groups in the provinces is vital, particularly with Disabled Persons Organisations (DPOs)
- Population Health needs resources to create awareness in communities of the new Child and Family Welfare Act 2017
- The Environmental Health Division will need to protect and promote a healthy environment to sustain a resilient and healthy population
- Access to essential clean drinking water and sanitation in rural areas needs to improve
- Too few of our disabled have access to services and support.

Communicable Diseases

- Malaria, which is endemic across the Solomon Islands, serves as a proxy indicator for the performance of our health sector, and when everything comes together right, you can quickly see positive results. Conversely, when things no longer go to plan, as has happened in recent years, a resurgence occurs, and the gains of the past two decades are quickly reversed
- We continue to maintain a downward trend in tuberculosis (TB), although this is at a slower pace than what we achieved previously
- Sadly, we are making no real headway with our efforts to reduce neonatal mortality, with children under one year dying at similar rates to a decade ago
- NCDs which include diabetes, heart and respiratory diseases, cancers and mental illnesses, have reached a crisis point, with 40 per cent of hospital beds being taken up by NCD patients. More than 6 out of 10 deaths are attributable to NCDs.

Figure 19: Non-Communicable Diseases



What Would We Like to See Over the Next Decade?

Our aim over the next decade is to achieve noticeable improvements in targeted health outcomes by improving the full implementation of “best value” public and population health interventions and working in collaboration with communities and partners to address some of the social determinants of health.

We cannot do everything, particularly in an environment where resources are scarce, and some of our programs are transitioning out of development partner funding. We will prioritize those diseases and interventions that are of benefit to the whole population. In particular, we will focus our sector on improving coverage in the following areas to maximize health outcomes for all:

- Full coverage and implementation of priority public and population health interventions
- Securing safe water and sanitation in all communities (in collaboration with RWASH)
- Expanded Program of Immunization, including HPV
- Malaria prevention, control and treatment
- Tuberculosis treatment and control
- Non-Communicable Diseases prevention and treatment
- Sexual and Reproductive health services, including Adolescent Health, Family Planning, Maternal and Child Health and Gender-Based violence prevention, treatment, and support services (in collaboration with the Ministry for Women, Youth and Children’s Affairs, Ministry of Justice and Legal Affairs)
- Build and maintain health security capacity to minimize the danger and impact of acute public health events that endanger people’s health
- Strengthen public health emergency response and resilience.

There is a wide variation in health outcomes between provinces and even in health zones within provinces. Some provinces have poorer health outcomes because of limited program coverage, while other poor health outcomes result from different factors, including the effectiveness of our interventions. We must identify where health outcomes are sub-optimal, understand the reasons behind them, and tailor our responses accordingly.

In this plan, the initial priority is given to those provinces that are far from health outcomes or have the highest burden of disease. Because data quality and coverage are variable, priorities may change as more data becomes available, and interventions result in positive change. Decentralizing services is a goal of the new NHSP, and it is hoped that this will result in improved health outcomes in rural communities.

NCDs require a whole-of-government and whole-of-society approach to be effective; our response cannot rely solely on one program. It will require all parts of the health sector to work together to address this health crisis. Preventive measures will address several risk factors, including betel nut, tobacco and alcohol use, poor nutrition, and lack of physical activity. Other measures will require us to collaborate with other sectors, including education, trade, agriculture, and key influencers such as churches. We will need different tools to modify behaviors, including legislation and taxation.

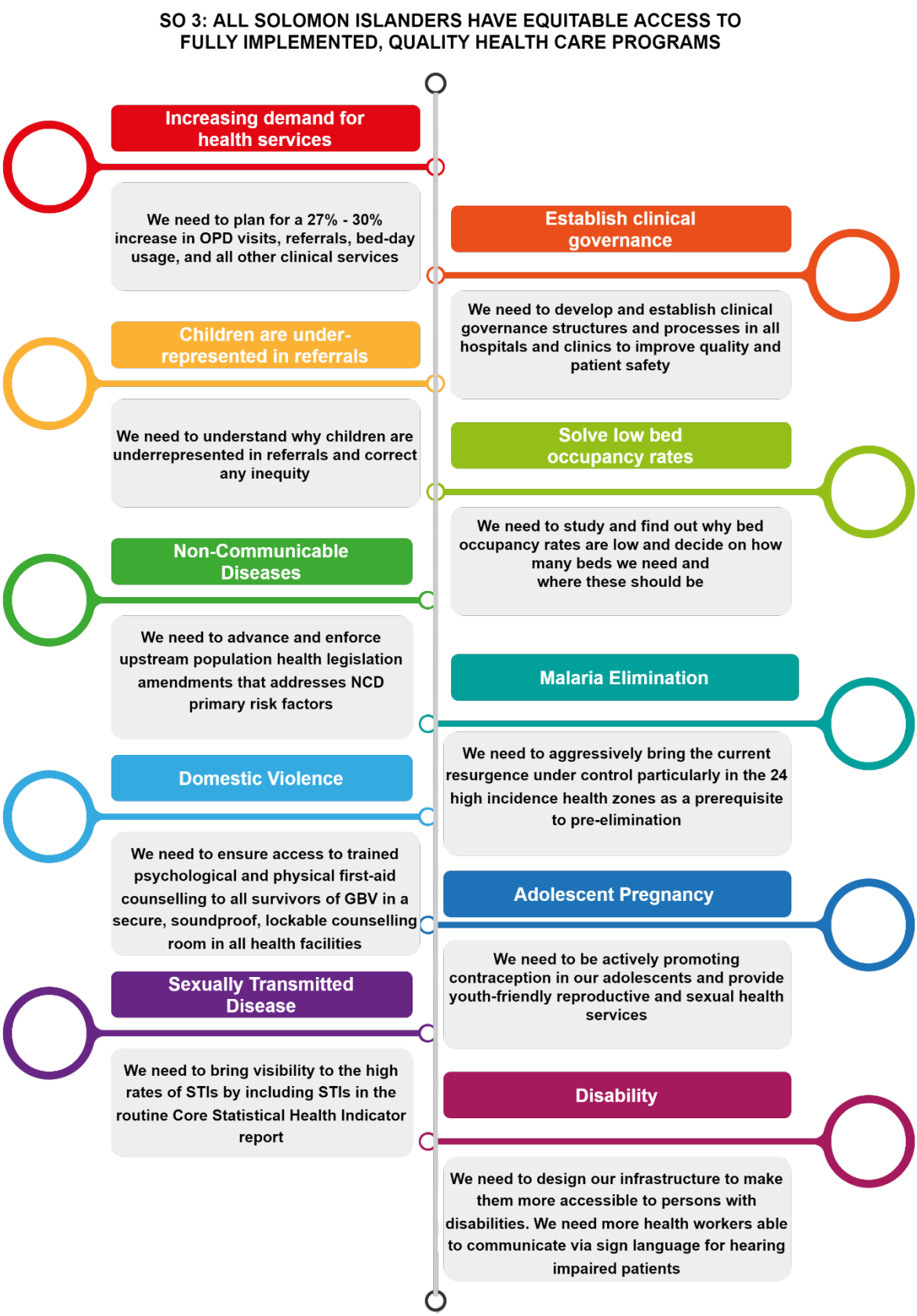
We must create a Public Health Act that aligns with the International Health Regulations (IHR). Through this Act, we can create a structure for mandatory reporting of all types of potentially notifiable diseases, including STIs, Malaria, TB and COVID-19, similar to other countries that have made achievements in this area.

Health promotion information and services must be provided to the target audience in the most appropriate language.

We need to review and overhaul services and support for Persons with Disabilities and investigate the potential to provide rehabilitative services for this group and those experiencing amputation resulting from diabetes complications.

We need increased attention to Sexual and Reproductive Health services in the provinces, including Adolescent Sexual Health.

Figure 20: Priorities for Quality Health Programs



How Do We Get There?

Figure 21: Strategies for Quality Health Care Programs

Strategy 3.1		Focus health programs on underserved communities and underrepresented populations to improve equity of access
Strategy 3.2		Improve health outcomes through community empowerment and engagement in planning, delivery and evaluation
Strategy 3.3		Strengthen and benchmark the provision of curative services to drive the improvement and attainment of high-quality care
Strategy 3.4		Establish clinical governance committees and processes in all Provincial Hospitals with oversight of all clinical services in the provinces
Strategy 3.5		Establish performance scorecards for health programs and clinical services - link these to the sector-level M&E
Strategy 3.6		Budget, build and maintain health security and International Health Regulations core capacity
Strategy 3.7		Explore why children are not well represented equitably in referrals and address any problems found
Strategy 3.8		Explore why bed occupancy rates are so low and address problems found
Strategy 3.9		Strengthen and enforce population upstream interventions addressing NCD primary risk factors
Strategy 3.10		Aggressively prevent, control, diagnosis and treat all malaria cases through building stronger collaboration and coordination with Provincial Health Offices
Strategy 3.11		Achieve universal access to TB prevention services as a prerequisite to ending TB in the Solomon Islands by 2035
Strategy 3.12		Fund actions to defeat domestic violence working with police and community
Strategy 3.13		Increase health promotion for safe sex to reduce STIs
Strategy 3.14		Strengthen disability services to ensure equitable access across the country

Implementation Arrangements

The NHSP 2022-2031 identifies key areas that need to be targeted and improved to achieve our vision and goal. It is intended to target priority service areas identified as significant challenges and critical to the achievement of the goal and vision of the health sector. The M&E Framework will be used to measure the sector's performance and the implementation of this NHSP.

This NHSP is aligned to the Sustainable Development Goals (SDGs) and other Global Health initiatives as well as to development partners and other stakeholder initiatives where possible. All stakeholders involved in the health sector are asked to align their strategies and plans to this NHSP that is consistent with global, regional and national strategies and frameworks. Each objective in this Plan has several strategies that describe how the objective will be achieved, and each strategy has several indicators to provide a roadmap toward achieving the objectives.

This NHSP will guide the development of our Annual Operating Plans. The annual planning process will be guided by the three health sector strategic objectives and their respective strategies. Beyond the strategies, each planning entity will develop activities that align with NHSP objectives and strategies. This strategy will guide programs that may be revising or developing specific strategic plans. The vision and goal will remain the same for all strategic plans of all health programs. All future strategic and operational planning in the health sector will be guided by the vision, goal and objectives of this NHSP. The starting point for the annual planning process is using the objectives and strategies in this document as the guide for their activities.

The table below shows the current status of program level strategic plans and their duration.

Figure 22: Current Status of Program Strategic Plans

Strategic Plan	Duration	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031
Solomon Islands Strategic Plan for Malaria	2021-2025										
Multi-Sectoral National NCD Strategic Plan	2019-2023										
Solomon Islands National TB Strategy	2021-2023										
HR Management Division Corporate Plan	2018-2020										
Draft Mental Health Strategy	2006-2010										
Solomon Islands RWASH Strategic Plan	2021-2025										

Monitoring and Evaluation

The M&E Framework (at Annex 1) outlines how the MHMS and its partners will measure progress against the goal and strategic objectives of the NHSP and the impact of these strategies on the health system and health outcomes. The M&E Framework will contribute to:

1. Developing local ownership and responsibility for implementing the NHSP and tracking our progress
2. Creating a shared understanding of what the MHMS wants to achieve and how we intend to go about this
3. Improving how we communicate our performance
4. Developing evidence for decision-making and accountability
5. Guiding the responsible use of our resources.

We apply a 'stepped' approach to implementing M&E over the 10 years of the NHSP. This will enable the MHMS to make strategic changes where necessary. Where possible, we will develop our own M&E tools and build local data management and analysis capacity.

We will ask our development partners to help us strengthen M&E, research capacity, and health information systems to track our path to achieving our strategic objectives.

Monitoring indicators are considered for tracking the progress of the NHSP at two key levels: the overall goal level and strategic objective level. Within the strategic objective level, indicators are mapped to the priorities of the three strategic objectives. Indicators presented are a combination of outcome and output indicators.

Much of the data and information required for reporting indicators are generated routinely in the annual reports. Measuring the outcome indicators will complement periodic surveys and studies such as the Demographic and Health Surveys (DHS)[20] and Maternal Mortality Survey.[21] These surveys help evaluate the population's health status and are conducted between three to five years intervals. The NHSP will be evaluated at mid-term and end-term.

The repurposed Planning, Performance and Resources Division will have a dedicated M&E Unit that will develop, monitor and revise an M&E Plan for the overall health sector containing clear indicators and defined targets that will be regularly monitored and reported against annually.

Annex 1: Monitoring and Evaluation Framework

GOAL: Ensure that all Solomon Islanders have universal access to equitable quality, preventative, curative, rehabilitative and promotional health services irrespective of where they leave			
IMPACT: Improved health status of the country's population			
Long term impact Indicators	**Baseline**	**Targets indicators**	**Means of Verification / Frequency of Data Collection**
Life Expectancy	73.1 (2019)	Increase life expectancy of all Solomon Islanders, from 73.1 in 2019 to 93.1 by end of 2031 for both male and female	SINSO / after 10 years
Population Growth rate	2.7%	By end of 2031, the population rate of all Solomon Islanders decreases from 2.7% to 2.4%	SINSO / 10 years
Maternal Mortality Ratio / 100,000 Live Births (LB)*	xx deaths per 100,000 live births in (20xx) Current rate of decrease is 8.1% (2020/2021)	By end of 2027, maternal Mortality rate per 100,000 live births decreases	World Bank, UNICEF, SDGs / Annually
Neonatal Mortality Rate/1,000 LB*	x deaths per 1,000 live births in (20xx) Current rate of increase is 27.6%	By end of 2027, neonatal Mortality Rate per 1,000 live Birth decreases	DHIS2 / Annually
Infant Mortality Rate / 1,000LB*	Infant mortality rate was xx deaths per 1,000 in (20xx) Current rate of increase is 19.6%	By end of 2027, infant Mortality Rate per 1000, Live Births decreases	DHIS2 / Annually
Under-five mortality rate / 1,000 LB*	xx deaths per 1,000 live births (20xx) Current rate of increase is 8.2%	By end of 2027, under–five mortality rates per 1,000 live births decreases	DHIS2 / Annually
Premature Mortality rate attributed to cancer, diabetes and hypertension (NCD)*	Estimated at 66.8% of all deaths in 2019	By end of 2027, all NCD-related deaths including cancer, diabetes and hypertension reduced from 66.8% of all deaths to 33.4%	DHIS2 / Annually

***All baselines and target indicators are to be inputted and/or verified by MHMS as they were received following final dates for feedback and have not been verified by Tetra Tech International Development.**

SO1: BETTER GOVERNANCE OF THE HEALTH SECTOR					
Key evaluation question: *Has the NHSP strengthened governance and leadership at all levels?* ***Headline indicator:*** *Proportion of divisional and program strategic plans aligned to the NHSP and containing relevant and measurable indicators*					
Domain / priorities	**Outcome indicators**	**Baseline**	**Targets***	**Means of Verification / Frequency of data collection (FDC)**	**Responsibility**
Priority 1.1: Health Policies and Strategic Plans Development of health policies and plans that support the effective management and monitoring of the new NHSP and the sector **National Health Workforce Strategy** **Support Decentralisation** **Improve MHMS Organisation**	1: Increase in number of key priority divisional, program and provincial policies or amendments to policies developed finalized and endorsed by SEM/Cabinet	(MHMS to complete upon establishing policies already approved)		1-6: Minutes of Senior Executive Meetings, Minutes of Provincial Executive Meetings and Cabinet endorsed papers [Collected] / Annually	M&E Unit within PPRD & HIS
	2: Number of divisional or programmes with drafted and approved corporate plans	3			
	3: Number of fully functional provincial executive committees with clear TORs	2			
	4: MHMS approved and endorsed for implementation the National health standards	MHMS to confirm			
	5: Development of a National Health Workforce Strategy with clear targets / metrics	MHMS to confirm			
	6: Establishment of a Monitoring, Evaluation and Learning team (within the repurposed Policy and Planning Division) and development of a clear M&E Plan for the sector	MHMS to confirm			
Priority 1.2: Health Capacity Performance management system that facilitates a culture of high performance. **Performance Scorecards**	1: MHMS officials, provincial health directors, zone managers and heads of divisions are well trained on results-based management, effective resource allocation, planning, and monitoring of work plans in alignment with operational plans and leadership and management	MHMS to confirm		Training Unit records [Need to be collected] / Annually	M&E Unit within PPRD & HIS
	2: Proportion of provincial governments and development partners participating in improvement through performance scorecards.	MHMS to confirm		Meeting minutes [Collected] / Annually	
	3: Establishment of performance scorecards for provincial governments, development partners and departments.	MHMS to confirm			
Priority 1.3: Health Systems **Clinical Governance** **Innovative Financing** **MHMS led Health Partners' Collaboration**	1: Internal Controls enacted in the Ministry of Health to improve systems and processes (Specifics to be confirmed by MHMS)	MHMS to confirm		Meeting minutes [Collected] / Annually	M&E Unit within PPRD
	2: Proportion of the budget executed on a quarterly base for recurrent budget, budget support and development budget improved annually.	Average % of budget executed in the last 3 years		2-5 Treasury/Ministry of Health budget report [Need to be collected] / Annually	
	3: Ministry of Health smoothly transition from donor partner funding gaps that are currently reducing to a sustainable health financing	MHMS to confirm			
	4: Value of funding secured or leveraged for health care services from non-traditional sources including development partners	MHMS to confirm			
	5: Number of supplemental financing options proposed / approved	MHMS to confirm			
	6: Total net official development assistance to medical research and basic health sectors (SDG indicator)	MHMS to confirm		6: SDG report 3.b.2 [Collected]	
Priority 1.4: Health Legislations and Regulations	1: Proportion of all MHMS outdated legislations that require legislative review or amendment	MHMS to confirm		1-2, 6-7: Minutes of Senior Executive Meetings Cabinet endorsed papers [Need to be collected] / Annually	Policy development function of the PPRD
	2: Number of new regulation or improvements to regulations	MHMS to confirm			

SO1: BETTER GOVERNANCE OF THE HEALTH SECTOR

Key evaluation question: *Has the NHSP strengthened governance and leadership at all levels?*
Headline indicator: *Proportion of divisional and program strategic plans aligned to the NHSP and containing relevant and measurable indicators*

Domain / priorities	Outcome indicators	Baseline	Targets*	Means of Verification / Frequency of data collection (FDC)	Responsibility
Health laws and regulations updated **National Health Services Standards**	3: Maintenance of health security capacities in the budget and growing core capacity for strengthening International Health Regulations	MHMS to confirm		3-5: Joint External Evaluation Report (JEE) [Collected] / Annually	M&E Unit within PPRD
	4: International regulations core-capacity index	MHMS to confirm			
	5: Metrices for ability to detect and respond to health threats demonstrate improvement	MHMS to confirm			
	6: Number of regulations, administrative procedures in development stages of analysis, drafting and consultation, legislative review, approval or implemented	MHMS to confirm			
	7: Some elements of health governance decentralized through establishment of provincial health boards	MHMS to confirm			

***All baselines and target indicators are to be inputted and/or verified by MHMS as they were received following final dates for feedback and have not been verified by Tetra Tech International Development.**

SO2: OUR SYSTEMS AND RESOURCES MEET OUR NEEDS AND ARE RESPONSIBLY MANAGED

Key evaluation question: *Has the NHSP optimised the management of systems and resources to improve health security and health outcomes?*
Headline indicator: *Number of Provincial Health Offices (including Boards and Program Committees) with increased capacity to undertake procurement, infrastructure, financing and workforce development activities (compared to baseline)*

Domain / priorities	Indicators	Baseline	Targets*	Means of Verification & Frequency of Data Collection	Proposed responsibility
Priority 2.1: Health Information Systems and Research Health information systems that support decision-making about health outcomes, program delivery and effective M&E across the sector **Health Information Systems**	1: Percentage of data completeness and timely reporting in DHIS2	MHMS to confirm		1 &2: DHIS2 Reports / HIS Unit Administrative [Need to be collected] 3 & 4: Meeting minutes [Need to be collected] Every six months	M&E Unit within PPRD & HIS
	2: Percentage of progress on integration of multiple health information data platforms				
	3: Number of officers providing HIS technical support for the HIS increased				
	4: Development of a Health Information M&E Development Plan				
	5: Proportion of Hospitals using the electronic medical record (EMR) system				
	6: Percentage of data completeness and timely reporting in DHIS2 (births, deaths, reportable diseases)				
Priority 2.2: Establish Quality Assurance and improvement Programme	1: Proportions of facilities that report high patient satisfaction with health services	MHMS to confirm			M&E Unit within PPRD & HIS
	2: Number of malpractice cases assessed and addressed				
	3: Number of hospitals clinically accredited based on WHO standards (Any level of hospital accreditation process that hospitals should aim to achieve)				
	4: Number of laboratories reaching 5-star (five star) accreditations (referring to the last assessment done in Hongkong) Is this referring to the Core Capacity standards				
	5: Proportion of Private Health Facilities (clinics/medical centres) achieving some level of accreditation process				
Priority 2.3: Health workforce – Establish effective performance management across the health programs and provincial health offices	1: Percentage of progress on updating the Aurion database and establishment register to ensure current staff are allocated to specific facilities	60% of workforce is in Province		1,2 &5: Meeting minutes [needs to be collected] 3&4: SDG report 3.c.6 [Collected] / Annually	Facility
	2: Development of performance scorecards for the health workforce	0			
	3: Proportion of HCW trained annually as % total as % of total workforce gap	MHMS to confirm			
	4: Health worker density increased to 2.3 Skilled Health workers per 1000 population	2.02 skilled health workers per 1000 population			

SO2: OUR SYSTEMS AND RESOURCES MEET OUR NEEDS AND ARE RESPONSIBLY MANAGED					
Key evaluation question: *Has the NHSP optimised the management of systems and resources to improve health security and health outcomes?* ***Headline indicator:*** *Number of Provincial Health Offices (including Boards and Program Committees) with increased capacity to undertake procurement, infrastructure, financing and workforce development activities (compared to baseline)*					
Domain / priorities	**Indicators**	**Baseline**	**Targets***	**Means of Verification & Frequency of Data Collection**	**Proposed responsibility**
Priority 2.4: Health Financing and Procurement -Funds disbursement and procurement systems that ensure timely availability of money, medicines, and equipment	1: Proportion of Provincial Health Office staff trained in using the procurement system to secure additional funding	MHMS to confirm		4: M-Supply data [Collected] 1, 2,3,5-: Meeting minutes [Needs to be collected] / Annually	MHMS
	2: Number of Procurement Unit officers available to process funding requests and support				
	3: Number of procurement processes automated increased				
	4: Number of infrastructure projects with outsourced contract management				
	5: Percentage of process of roll-out of M-Supply to all AHCs and RHCs to strengthen forecasting, supply, and stock management				
	6: Development process analysis and performance framework for funding disbursement and procurement systems				
	7: Number of additional SLMS and buffer stores increased to reduce national security risk				
	8: Percentage of SIG Recurrent Budget on Health as share of Total SIG recurrent budget				
	9: Percentage of SIG Development Budget on Health as a share of total SIG Development Budget				
	10: Percentage of Health facilities with < 5% of medical products/supplies/commodities stock outs				
	11: Percentage of medical supplies available at the National and Second Level Medical Stores				
	12: Percentage of SIG Recurrent Budget on Health as share of Total SIG recurrent budget				
	13: Percentage of SIG Development Budget on Health as a share of total SIG Development Budget				
Priority 2.5: Infrastructure and equipment	1: Number of health facilities functional and operational	MHMS to confirm			
	2: Number of Provincial Hospitals, AHC 1& 2, and UHC 1&2 constructed/rehabilitated				
	3: Number of “service ready” Health Facilities (they meet RDP requirements availability of services, appropriate guidelines, equipment, medicines, and trained staff)				
	5: Ratio ground ambulance/population (land and sea)				
	6: Percentage of health facilities without electricity/solar				
	7: Percentage of health facilities without water and sanitation				
Priority 2.6: Coordination and collaboration between health programs and Provincial Health Offices and Health Programs **Program management**	1: Proportion of provinces with a functioning Provincial Health Board and Provincial Health Programs Collaboration Committees	MHMS to confirm		1 &2: Meeting minutes [Needs to be collected] / Annually	Partnerships and coordination function of the PPRD
	2: Established mechanisms and SoPs for-inter program and inter-province cost sharing				
	3: Established program of training and support that develops financial skills for non-financial health care managers				
	4: Established Clinical Governance Committees in all hospitals and Patient Safety Committees in all AHCs				
	5: Proportion of provinces with a functioning Provincial Health Board and Provincial Health Programs Collaboration Committees				

***All baselines and target indicators are to be inputted and/or verified by MHMS as they were received following final dates for feedback and have not been verified by Tetra Tech International Development.**

SO3: ALL SOLOMON ISLANDERS HAVE EQUITABLE ACCESS TO FULLY IMPLEMENTED, QUALITY HEALTH CARE PROGRAMS					
Key evaluation question: *Has the NHSP facilitated the equitable delivery of quality health care programs and noticeable improvements in target health outcomes?* ***Headline indicator:*** *Coverage of essential health services (SDG indicator 3.8.1)*					
Domain / priorities	**Indicators**	**Baseline**	**Targets***	**Means of Verification & Frequency of Data Collection**	**Proposed responsibility**
Priority 3.1: Demand and Supply for Health Services - Supply of health services across National Referral hospitals, provincial hospitals, and clinics to adequately service health needs. **Increasing demand for health services**	1: Capacity to deliver a 27% to 30% increase in OPD visits, referrals, day bed usage and all other clinical services	MHMS to confirm		Facility Assessments / 1: DATS [Not yet collected] 2: Does it exist yet? 3: SDG report 3.c.6 [Collected] 4-6 National and Provincial Hospital, AHCs and RHCs reports [needs to be collected] 7: M-Supply inventory management system [Collected] / Annually	M&E Unit within PPRD
	2: National Health Workforce Strategy is aligned to the expected demand and supply across the sector and locations				
	3: Proportion of approved posts for clinicians, Proportions of health facilities with at least 80% of staff across all levels, health care worker density by region and professional cadre, Proportion of HCW trained annually, Proportion of HCW recruited annually.				
	4: Proportion of primary care services delivered by the National referral and provincial hospitals reduced				
	5: Proportion of health programs in under-served and under-represented populations increased				
	6: Proportion of rehabilitation and prosthetics services increased				
	7: Number of medicine use				
Priority 3.2: Health services utilization and Equity - Increased understanding underutilization to see equitable increases in referrals and day bed occupancy **Solve low bed occupancy rates** **Children are under represented in referrals**	1: Proportion of children represented in referrals are equitable	The proportion of children in the referrals was 21% in 2019		1: National and Provincial Hospital, AHCs and RHCs reports [Needs to be collected] 2-4: SDG reports 2.2 and 3.2 [Collected] Annually	M&E Unit within PPRD
	2: Proportion of beds per 1,000 people and bed occupancy rate increased	32.% published in 2015			
	3: Reduction in stillbirth rate, perinatal mortality, infant mortality and under five deaths				
	4: Reduce prevalence of stunting and wasting in children under five years of age	UCMR was 29.30% in 2020			
Priority 3.3. Clinical Governance - Effective clinical governance structures and processes in all hospitals and clinics that improves quality and patient safety **Clinical Governance**	1. Aggregate percentage increase in performance of health programs and clinical services	MHMS to confirm		1: SARA survey [Collected] 2-3: Meeting minutes [Need to be collected] 4: AHC and RHC reports [Needs to be collected] Annually	Clinical governance leadership reporting to province/national
	2: Establish performance scorecards for health programs and clinical services (that are aligned with the national M&E Framework)				
	3: Clinical governance committees and processes established in all Provincial Hospitals with oversight of all clinical services in the provinces				
	4: Proportion of primary health care services with full functional referral systems				
Priority 3.4: Sexual and Reproductive Health Services - Ensure universal access to sexual and reproductive healthcare services to reduce high rates of STIs and provide safe access **Adolescent Pregnancy**	1: There is routine analysis and reporting of data on STIs and utilization of family planning service	MHMS to confirm		1 and 3: SARA surveys [Needs to be collected] 2: Core Statistical Health Indicator Report [Collected] 3 & 4: Annual SDG reports 3.7.1 and 3.7.2 [Collected] Annually	Program managers
	2: Sexually transmitted infections (STIs) incidence rate	MHMS to confirm			
	3: Proportion in adolescent birth rate per 1,000 women aged 10 to 19 reduced	MHMS to confirm			
	4: Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods	Contraceptive Prevalence Rate was 19.0% in 2020			

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Domain / priorities	**Indicators**	**Baseline**	**Targets***	**Means of Verification & Frequency of Data Collection**	**Proposed responsibility**
Sexually Transmitted Disease	5: Percentage of Births attended by skilled health professionals	MHMS to confirm			
	6: Antenatal Care Coverage (4 – 8 standard visits)	MHMS to confirm			
Whole-of-government and partnerships approach to address NCDs and associated risk factors **Non-Communicable Diseases**	1: Premature noncommunicable disease (NCD) mortality reduced	NCDs accounted for 73% of deaths in 2019		1: World Bank [Collected] 3-4: SDG report 3.4.1. [Collected] 10: Meeting Minutes [Need to be collected] Annually	Program managers
	2: Mortality rate attributed to cardiovascular disease, cancer, diabetes, or chronic respiratory disease	66.83 % in 2019			
	3: Number of upstream population health interventions, policies and legislation enforced to address NCD primary risk factors	TBC by MHMS			
	4: Eye diseases problem morbidity rate at health facility level	TBC by MHMS			
	5: Teeth and gum diseases morbidity rate at health facility level	TBC by MHMS			
	6: Cataract Surgical rate	TBC by MHMS			
	7: Age-standardized prevalence of current tobacco use among persons 15 years and above	TBC by MHMS			
	8: Age-standardized prevalence of overweight and obesity in persons aged 18 years and above (defined as body mass index ≥ 25 kg/m^2 for overweight and body mass index ≥ 30 kg/m^2 for obesity)	TBC by MHMS			
	9: Cause of death by injury as a % of the	9.76% in 2019			
	10: Frequency of multi-sectoral national NCD committee / task force meetings per annum	TBC by MHMS			
Elimination of malaria and TB through aggressive prevention, control, diagnosis, and treatment **Malaria Elimination**	1: TB incidence per 100,000 population	TBC by MHMS		1-3: DHIS &SDG reports [Collected] 4-6: Asia Pacific Leaders Malaria Secretariat [Collected] 3: Meetings minutes [Needs to be collected] Annually	Program managers (leveraging resources / budget from the malaria and TB strategies)
	2: Proportion of TB cases that are detected and successfully treated.	TBC by MHMS			
	3: TB Treatment coverage rate	TBC by MHMS			
	3: Frequency of meetings / communiques with Provincial Health Offices in the 24 high incidence health zones to improve collaboration and coordination to eliminate malaria	TBC by MHMS			
	4: Malaria Incidence per 1,000 people at risk reduced	TBC by MHMS			
	5: Proportion of households with at least one LLIN	TBC by MHMS			
	6: Malaria proportional mortality rate	TBC by MHMS			
Strengthened disability services to ensure equitable access across the country	1: Proportion of hospital and clinic facilities with disability access 2: Number of health workers that can communicate via sign language for hearing impaired patients	1: Facility Assessments *[Needs to be collected]*		Annually	M&E Unit within PPRD

SO3: ALL SOLOMON ISLANDERS HAVE EQUITABLE ACCESS TO FULLY IMPLEMENTED, QUALITY HEALTH CARE PROGRAMS					
Key evaluation question: *Has the NHSP facilitated the equitable delivery of quality health care programs and noticeable improvements in target health outcomes?* ***Headline indicator:*** *Coverage of essential health services (SDG indicator 3.8.1)*					
Domain / priorities	**Indicators**	**Baseline**	**Targets***	**Means of Verification & Frequency of Data Collection**	**Proposed responsibility**
Disability	3: Proportion of action plans, policies and interventions that have targets and address barriers to access.	2: Health Workforce Strategy *[Needs to be collected]* 3: Meeting minutes *[Needs to be collected]*			
Working collaboratively across the health sector and with the community to reduce domestic and gender-based violence **Domestic Violence**	1: Proportion of psychosocial and physical health services for people experiencing domestic violence increased. 2: Proportion of health sector funding to address and reduce domestic violence across the country 3: Proportion of health workforce trained to identify and address domestic violence	TBC by MHMS		1: SARA survey [Collected] 2: Ministry of Health budget report [needs to be collected] 3: Health workforce strategy [needs to be collected] Annually	M&E Unit within PPRD

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Annex 2: The Health Infrastructure Roadmap

The Infrastructure Roadmap presents the strategic direction for the health sector over the next ten years and provides the framework for future activities to manage and improve Health Infrastructure (HI) in the Solomon Islands in support of the vision, goal and objectives of the NHSP 2022-2031.

The Roadmap sets out strategies to break the '*Build–Neglect–Rebuild*' model, and work within the systems reform, governance, monitoring and evaluation, and strategies embedded in the NHSP 2022-2031. The RDP will be a key instrument to inform on infrastructure priorities.

The roadmap is structured around strategies in three domain areas:

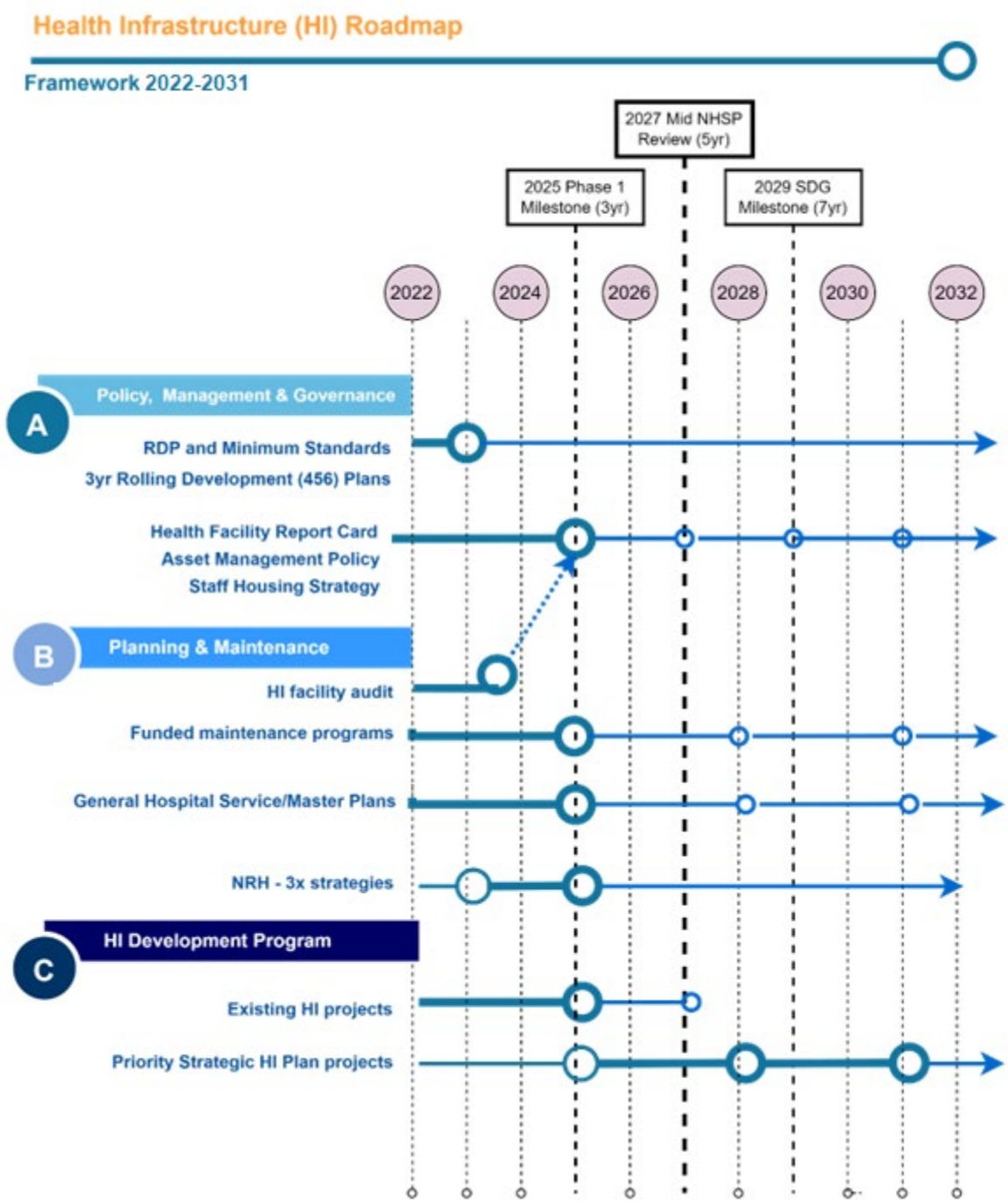
- Policy, Management, Governance and Systems Strengthening
- Planning, Asset Management and Maintenance
- HI Investment and Development Plan.

HI refers to health facilities such as hospitals, clinics, and support facilities like medical stores. It also includes components within each facility such as radiology, lab, and supply chain systems and storage appropriate to the package of services to be delivered by the facility level. HI includes the facility environment, and essential building services such as, water, sanitation, hygiene, waste, security, fire safety and communications. HI is managed by the MHMS, the NRH, Provincial Health Offices (PHOs), programs, and non-government partners. There is a role for all levels of government, private and faith-based health services and communities.

ROADMAP PRINCIPLES

Manage	To better manage assets at each stage of the lifecycle means providing the right policy, planning, governance, and partnerships with the resources to manage each project or activity.
Maintain	Maintaining the quality of existing HI will be as important as building new facilities. Starting with the basics of water, sanitation and hygiene, waste, power, ICT, supply chain and equipment.
Invest	The RDP and data will be used to provide evidence-based priority projects. Integrated planning, innovative design and building with proper commissioning will deliver adaptable fit-for-purpose HI.
Access	HI is within reach of people in remote areas, the urban fringe, the disabled and the vulnerable with specific needs for services like family planning, GSBV, rehabilitation and mental health care.
Target	Decentralization of services will continue, beginning with AHCs and medical stores. HI to support supervised births, population health, EPI, NCDs, VBDC and key programs will take precedence.
Resilient	Our HI needs to be pandemic and disaster ready. Durable, low maintenance and climate change resilient HI will improve health security, and lower whole of life costs.

The NHSP 2022-2031 envisions a "*Healthy Future for all*". The strategies, plans and actions are proposed as HI's contribution to achieving the goal of "Ensuring that all Solomon Islands have universal access to equitable quality preventative, curative and rehabilitative and promotional health services irrespective of where they live".



Each roadmap strategy outlines actions allowing flexibility in the method of delivery. The sequence of works allows the prioritization of projects based on data, evidence and standards outlined in the RDP, with adequate scoping, costing, planning and design. The strategies go beyond infrastructure for primary health care and extend to infrastructure for the broader MHMS and non-government programs, including eye care, VBDC and dental. This includes stand-alone facilities such as medical stores, and infrastructure and equipment embedded within health facilities.

Asset Management & Governance Update policies and minimum standards to include site, accessibility, pandemic, and disaster resilience, and WATSAN, hygiene, power, waste, ICT, transport and staff housing.		
Health Facility Registration & Report Card	Endorse the '*Health Facility Registration Policy*', monitor and report on the condition and compliance of HI every 2 or 3 years as per the RDP and standards.	Phase 1 > 2025 *MHMS*
RDP and Minimum Standards	Update Minimum Standard for Clinic Infrastructure to reflect standards, as a companion document to the RDP. • Site, land, accessibility, and resilience requirements • Building Code, and facility schedule/planning • Building Services, WATSAN, hygiene, waste, power, ICT • Standard Designs for each level of facility.	Year 1, 2023 *MHMS*
AMM Policy	Develop an ***Asset Management and Maintenance Policy*****,** that clearly outlines roles and responsibilities according to the PFMA, RDP and other key policies and governance frameworks.	2022-23 MHMS – All
Staff Housing Strategy	Develop a staff housing strategy. Identify where staff housing needs to be built to place workers outside Honiara, or where housing allowance are sufficient.	Phase 1 > 2025 *MHMS*
Multi-Year Rolling Capital Asset Plans Develop Three-year Rolling Capital Asset Plans. Update annually with AOP at National, Provincial and Program level		
3-year Development (456) Plans	Develop 3-year rolling capital assets plans and budgets in line with MoFT and DLGP policy.	Year 1, 2023 *MHMS*
Annual planning	Update annually as part for AOP process, for each province, program, the NRH and MHMS. Maintain a National Health Infrastructure Project Register	Year 1, 202 *MHMS*
HI AUDIT and Maintenance Plans Conduct HI audit for an Integrated Service Delivery Plan Develop Asset Management Policy with funded HI maintenance programs.		
Health Facility Audit	Conduct an RDP, site and building condition assessment of all HFs and hospitals, produce Asset Registers, and to inform integrated service planning for the *Strategic Infrastructure Development Plan*	2022-2024 MHMS - All
HI Maintenance	Cost, plan and implement Asset Maintenance programs for each level of facility, as part of the AMM Policy and Health Facility Audit.	2022-25 MHMS - All
General Hospitals (GH) – Service and Master Plans Establish service and facility plans for all remaining hospitals, and development plans for all hospitals starting with Kirakira, Kilufi, Tulagi and Taro GH.		
Kilufi, Kirakira, Taro & Tulagi GH	Create Hospital HI Development Plans, with priority projects identified from masterplans. Identify funding partners and develop a program of works, starting with WATSAN and the pandemic hygiene upgrades and surge measures being planned.	ALL 2023 – 2031 MHMS – Malaita, Makira & Central
Remaining GH	Develop service and facility plans, starting with WATSAN and hygiene/pandemic response projects underway.	Phase 1 > 2025, *MHMS, ISB, TEM*
	Create Hospital HI Development Plans, with priority projects identified from masterplans.	2025 > 2031

HI networks	Lab and radiology, supply chain, biomed, ICT and division/program HI networks linking the NRH/MHMS with GH and AHCs.	
NRH Finetune NRH Business Case and NRH Workplan to roll out HI strategy and plans.		
NRH Maintenance	Fund and roll out annual NRH Maintenance Program. Move large projects to 456 Development Plan to allow routine and corrective maintenance as recurrent AOP activity.	2022 > Recurrent NRH
Upgrade to current site	Organize all plans and business case into a strategy for redevelopment of existing site. Document 456 DP Projects and manage through NRH PMU.	2022 > 2030 NRH - MHMS
Upgrade HCC/GCP clinics	Upgrade HCC/GCP urban clinics to reduce the burden on NRH outpatients and deliver new models of care for NCDs and HIV/TB.	2025 > 2030 NRH – HCC - GCP
Naha Birthing	Complete and commission Naha Low-Risk Birthing Unit.	2022-23
New NRH at more stable site	Review NRH Business Case and develop workplan for relocation of NRH to an accessible, less disaster-prone site, that can accommodate growth.	2025 > 2040 NRH, MHMS, SIG
HI Systems Strengthening Continue with system strengthening and provide adequate resources to plan, procure, manage, and maintain HI, at the MHMS, NRH and each province.		
Project Management	For each program and project set a minimum requirement for service planning, design, engineering, quantity surveying, project management and site supervision. Look at SIG, Provincial and MHMS resources, as well as “off system “support from partners. Set up Project Management Units, and steering committees for large multi-year capital works and maintenance programs.	First 3 years > Ongoing MHMS - NRH
Appraisal and Quality Control	Strengthen the MHMS Infrastructure Offices ability to appraise and review project proposals, designs, and projects in construction.	
Provincial and Local	Work with all levels of government and non-government partners. Foster better co-ordination with Provincial Health Ministries, boards and committees to fund, maintain and deliver HI.	
HI Development Program We need to make large investments to restore our HF to support services		
Manage and Resource	Provide the financial and project management resources required to plan, procure, and deliver projects. Ensure policy, standards, governance, and partnership frameworks are in place.	2022 - 2025
Evaluate and maintain	Audit existing HI and use condition assessment to deliver re-current maintenance with upgrades to WATSAN, hygiene, power, waste, ICT, fire safety, accessibility, and housing. Review the location, land tenure, disaster resilience and accessibility need for each existing facility and proposed project.	Ongoing
Plan and refine	Develop a system wide plan for clinics, hospitals and program HI networks like supply chain, EPI, lab radiology and biomed. Create capital works programs for the NRH, Kilufi and, Kirakira hospitals. Complete service and facility masterplans for all remaining hospitals to inform program of works.	2022 - 2025
Program of Works	Continue with the delivery of existing projects. Identify better design, procurement, construction, and commissioning measures.	2022 - 2025
	Provide a fully scoped and costed program of priority projects. Develop individual project briefs, costed project management plans. For large projects, provide options, cost benefit analysis and delivery strategy accounting for local market capacity or external resources.	2024 - 2031

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