MINISTRY of HEALTH & MEDICAL SERVICES
Shaping Fiji's Health

Ministry of Health & Medical Services

National Strategic Plan

2016 - 2020

Executive Version

Contents

MESSAGE FROM THE MINISTER

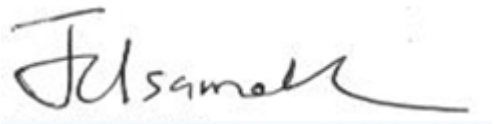
The National Strategic Plan (NSP) is the primary guiding document supporting our efforts to improve health and is an invaluable resource to keep us focused and on track over the next five years. The content of this NSP represents an extensive review of our documented progress to date and the current health situation in the country, as well as broad technical input from key health leaders, experts, clinicians, managers, and health workers. The many consultations during this process have required critical self-reflection, honest appraisal of our strengths and weaknesses, and strategic thinking about how we can make specific, tangible improvements over the next several years, not just as a Ministry, but as a network of health sector partners.

With that in mind, the National Strategic Plan 2016-2020 has been developed to align with the Government's priorities for the health sector, the global post 2015 development agenda, and the United Nations Sustainable Development Goals, which builds upon the Millennium Development Goals that preceded them. The "Healthy Islands" (HI) vision of the Pacific has also been considered as one of the key frameworks in developing this document. Based on the HI vision MoHMS has initiated the "Wellness Fiji" approach that forms the basis for reorientation of Fiji's Primary Health Care (PHC) delivery towards reaching people in the various "settings" in which they live, work and play and through expanded partnerships between peripheral health workers and local communities. Many of the themes that are highlighted in these development frameworks are cross-cutting and thus are integrated throughout the NSP.

The first Strategic Pillar focuses on strategic improvements to health service delivery and covers preventative, curative and rehabilitative care. The Ministry is committed to responding to all health needs of the population and based on evidence of health trends has selected three key Priority Areas to guide our efforts over the next five years.

The second Strategic Pillar, which focuses on health systems strengthening, includes five Priority Areas targeting key areas of improvement to ensure a well-functioning health system. This pillar is structured roughly in line with the World Health Organisation health system "building blocks", with some modifications to highlight current priorities within Fiji's health system.

Now that this document has been prepared, the next step is implementation. If we are to succeed, it will be together, as a network of partners who recognize that each sector of society has a role to play in influencing population health. On behalf of the entire MoHMS, I would like to express our enthusiasm and commitment to collaborate with all our partners to achieve the strategic objectives of the NSP 2016-2020.



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Mr Jone Usamate
Hon. Minister for Health & Medical Services

FOREWORD FROM THE PERMANENT SECRETARY

The Ministry of Health & Medical Services (MoHMS) National Strategic Plan 2016-2020 is a comprehensive document that outlines the overall direction and key objectives for the health sector over the coming five years. The detailed situation analysis, which covers a broad range of key health issues, has provided valuable insights about our current needs and has served as a platform for focused discussion and planning over the past several months.

The selected priority areas and objectives were developed based on extensive stakeholder consultation, both prior to developing the NSP and during the development process itself, to adequately reflect health sector perspectives from all relevant partners. The Fiji Government's plans and priorities for the health sector are also reinforced and reflected in this NSP, particularly under the health systems strengthening pillar (Strategic Pillar 2).

Over the next five years the MoHMS plans to substantially increase the health workforce and will continue to implement a strategic, needs-based approach to recruitment, deployment, training and retention with an emphasis on increasing both customer and employee satisfaction. One of the Ministry's responsibilities is to ensure that patients and health workers have access to safe and effective medicinal products.

Fiji's health care system is mainly publicly financed through general taxation, although private expenditures account for more than one third of total health expenditures. Given the growing population demand for health services, especially due to NCDs, the current financing system will be reviewed. Additionally over the next five years there is an urgent need for comprehensive health services and infrastructure planning in which facilities are built, equipped, and maintained according to a common set of standards and clearly defined population needs.

We can of course expect to encounter obstacles in achieving the targets we have set over the next five years. This should not discourage us but instead reinforce our commitment to multi-sectoral collaboration and our recognition of the fact that health and wellness are a collective responsibility of the country. New and emerging issues will also pose challenges and require us to adapt accordingly. However, one thing we can be certain of is that full implementation of this plan will produce major improvements in health service delivery that will provide significant and lasting benefits to the people of Fiji.

An expansive set of carefully selected indicators will help us collectively measure how we are progressing over time as well as whether or not our interventions are contributing to the intended outcomes. This in turn will allow us to critically reflect on our own performance and identify when and how we need to make changes and improvements over time so that we can achieve the best possible outcomes for the population.

All in all, an extraordinary level of effort from many different people and organizations has been put into developing this NSP, ranging from the initial review of evidence to identify key issues all the way to the final drafting, editing, and formatting of this document. Therefore I would like acknowledge the contribution of all stakeholders in developing this NSP and look forward to collaborating with relevant stakeholders in implementing the NSP 2016-2020.

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Dr Meciusela Tuicakau

Acting Permanent Secretary for Health and Medical Services

ACKNOWLEDGEMENTS

We wish to acknowledge the contribution of key partners including, other government ministries and departments, civil society organizations, development partners, faith-based organizations and private sector stakeholders. We acknowledge the contribution and support of the Hon. Minister for Health & Medical Services and the Assistant Minister for Health & Medical Services, Permanent Secretary, Deputy Secretaries, National Advisors, Directors, Clinical Service Network Chairs, and other MoHMS stakeholders.

We wish to further acknowledge the continuous guidance and facilitation of this process by the NSP Secretariat. The Secretariat's tireless efforts in leading the consultations and consolidating input from all of our key stakeholders have resulted in a clear, thorough, and insightful document.

We also express our sincere gratitude to the Fiji Health Sector Support Program for their financial and technical assistance, especially for Douglas Glandon, our Long-Term Advisor for Monitoring and Evaluation, who provided technical guidance, advice, and writing support throughout the NSP development process, as well as Dr. Jean-Jacques Frère, who facilitated valuable discussions during the development of our situation analysis.

Finally we would like to express our appreciation to the entire MoHMS staff and all health sector partners who have committed themselves to promoting health and wellness in the population and who will continue to work together to achieve the bold objectives outlined in this plan over the next five years.

Pre NSP 2016-2020 Stakeholder Workshop 13/11/14

SITUATION ANALYSIS

As with any strategic plan, an essential step in planning the way forward is to make sure we have a clear and comprehensive understanding of the current situation. In order to make the most of limited resources over the coming five years, strategic priorities and objectives should be determined based on a combination of need and expected impact. The situation analysis provides an overview of key health and health systems issues in the country, underlying contributing factors, consideration of future directions, and a summary of key needs to be addressed in the 2016-2020 period. High level discussion of several (although not all) cross-cutting health sector issues is included directly below, while more detailed analysis of particular health and health systems issues is included within each of the Priority Areas in the following section.

Overall, Fiji has achieved significant success over the past three decades in increasing life expectancy, improving health outcomes in mothers and children, and in reducing illness from communicable diseases. Some key health indicators are now reaching a plateau, which highlights the need for a more thorough analysis of the underlying determinants of morbidity and mortality in order to allocate health investments where they are likely to have the greatest impact in these areas.

Despite progress in some areas, the health system urgently needs to evolve to address the growing burden of non-communicable diseases (NCDs). As of 2011, NCDs already accounted for 40% of all healthcare costs for diseases, and this figure is expected to continue to rise in the near future, as the NCD epidemic will get worse before it gets better. The impact of NCDs on the economy is also high, not only in terms of the financial bottom line of the government and households, but also in terms of the labour supply, saving rates and capital accumulation.

Increasing national and international acceptance of the critical importance of social determinants of health (e.g., income, housing, food markets, education, transportation, public safety, social norms including gender equality, access to media, etc.) further emphasizes the need for a multi-sectoral, whole-of-society approach to health. This will require national recognition of population health not only as a positive social outcome but also as a vital asset for economic development and sustainability. The Ministry of Health and Medical Services (MoHMS) has a key role to play in leading this effort but cannot succeed without active collaboration from partners within and beyond the health sector.

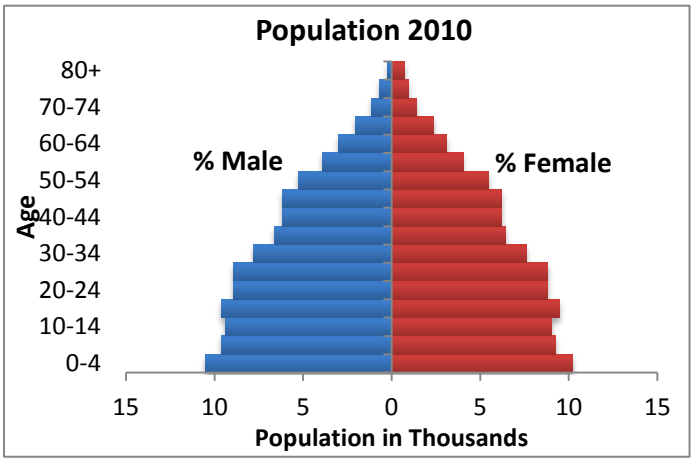
WHO further recommends to increase health professionals' awareness of the role of gender norms, values, and inequality in perpetuating disease, disability, and death, and to promote societal change with a view to eliminating gender as a barrier to good health. The National Gender Policy provides a framework for including gender perspectives in all activities of government and civil society, thereby promoting the full and equal participation of men and women in the development process. It includes 24 health-specific recommendations.

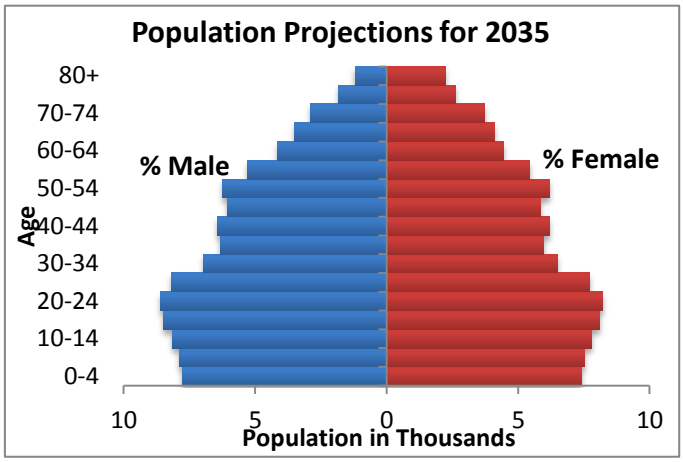
Persistent pockets of poverty also continue to be a major cause of ill health and a barrier to accessing health care when needed. Ill health, in turn, is a major cause of poverty, which creates a self-reinforcing cycle and contributes to a disproportionate concentration of health problems among the poor. While the overall national poverty headcount ratio declined from 39.8% in 2002/03 to 35.2% in 2008/09, this still leaves roughly a third of the Fijian population living in poverty, predominantly in rural areas, where agricultural output has been decreasing.

Demographics

The population projections suggest that the population will continue to increase slightly until 2030, will reach a plateau by then and probably decrease around 2025-2030.[1] Fiji still has a rather young population but the current burden of Non Communicable Diseases (NCDs) will persist and is going to be much heavier in the course of the next two decades when the age pyramid changes as shown on the following graphs.

[1] UN Population Division, World Population Prospects, the 2010 revision





Service Plans

There have been a number of service plans developed based on population projections, these are briefly discussed below. There are recommendations for building new facilities or upgrading current health facilities based on population projections.

Suva-Nausori Corridor Plan

Population data shows that the combined population of Suva and Rewa Sub-Divisions in 2013 was approximately around 300,953. Population growth was occurring at an average annual rate of 1.7% from 2007 till 2012. If these growth rates were to be sustained, the population would reach 350,000 within 10 years and would exceed 400,000 by 2031.

Health services in the Suva–Nausori corridor area has come under increasing pressure as a result of these population trends, with the National Referral Hospital, CWMH, absorbing much of the demand for sub-divisional hospital services, due to the lack of alternative facilities. The need to expand sub-divisional hospital capacity in the Suva-Nausori corridor with the development of a Sub-Divisional hospital at Nausori has been recommended.

The following options have already been selected and approved:

- Develop the Nausori Hospital as an upgraded SDH with 60 beds initially, expanding to 80 beds over the next ten years. It would provide A&E services to the Nausori-Tailevu area; maternity services to manage 2,500 deliveries per year and elective surgery provided on an outreach basis from CWMH, as well as routine medical and paediatric admissions.
- Maintain and develop the specialist referral role of CWMH, refurbishing and reconfiguring facilities as required.
- Develop a low risk birthing unit at Makoi to manage around 800 deliveries per annum. With adequate midwifery staffing and facilities, the unit could also provide antenatal/postnatal clinics.
- Redevelop the Valelevu HC site to include a Health Centre Level A and a Sub-Divisional hospital with around 50 beds, providing mainly medical/surgical admissions, low risk maternity services, day procedures, SOPD, allied health and clinical support services.

Western Corridor Plan

There has been a large increase in the overall population in the Western corridor since 2007 to 2013 i.e. a substantial increase of around 20,000 people. The Lautoka/Yasawa Sub-Division recorded the largest population increase of 15.7%. This is a very large increase by any international comparisons and puts significant pressure on health services.

Nadi Sub-Division also had a significant increase in population over the 7 years of 9.9% however there has been a large decrease in population in the Ba Sub-Division recorded for the six years. In contrast, the Nadroga/Navosa Sub-Division population has remained steady (with a slight increase recorded).

The majority of the population in the Western Corridor still resides in rural communities; therefore future health services investment generally in the Western division may need to focus on rural and peri-urban areas to take some pressure off the Sub-Divisional and Divisional hospitals. **The achievement of having all GOPD at Health Centers and Nursing Stations within a few years will be a significant outcome.**

The Future of Lautoka Hospital

The hospital had 224 beds devoted to its Divisional hospital role. Currently, the hospital supports a Divisional population of 308,930 people (2013 medical area population).

In 2040, the population of Fiji is forecasted to rise to 1,008,214, which is a rise of 0.60% per annum from 2015. It contrasts significantly to the Western Corridor medical area population growth rate of 1.09 % per annum between 2007 and 2013. A 0.60% growth rate per annum applied to the 241 beds actually being utilized, would result in 282 Divisional hospital beds and 110 non-specialist beds required by 2040 (total of 392 beds by 2040).

Even though there have been rapid increases in population in the Lautoka and Nadi Sub-Divisions in recent years, the population projections utilized, indicate a more moderate rate of growth over the next 25 years. This is one reason why only moderate increases in bed numbers are needed.

In the Lautoka Sub-Division the following urban health center development is recommended to relieve the GOPD numbers at the Lautoka Hospital:

- Kamikamica Health centre be significantly expanded to a level A health centre with a full range of services. Its GOPD capacity should rise from 6,611 visits in 2012 to 20,000 visits annually.
- Sai Viseisei Health Centre should also have some expansion in services, to allow for a growth of GOPD visits from 14,719 in 2012 to 20,000.
- The new Punjas funded Health Centre should have sufficient capacity to treat 14,714 GOPD visits annually.
- A new Health Centre in the west of the Lautoka urban area should be built with capacity to treat 14,715 visits annually. Either this Health Centre or the Punjas funded Centre should be a level A.

In the Nadi Sub-Division the following urban health center development is recommended to relieve the GOPD demand at the Sub-Divisional hospital:

- Namaka Health Centre to be expanded in capacity so as to allow its GOPD visits to increase from 19,044 in 2012 to 25,038 annually. It is already a level A centre.
- **A new Health Centre** to be built, as planned in Votualevu, with a capacity of 15,000 GOPD visits. This need only be a level B Centre, but with a permanent MO position.
- **A new Health Centre** to be built in the CBD of Nadi town, with a capacity of 20,000 GOPD visits. This should also be a level A Centre. The current services provided by the Nadi Health Centre could be absorbed into the services provided by this Centre.
- **A new Health Centre** to be built in the southern part of the Nadi urban area with a capacity of 15,000 GOPD visits. This need only be a level B Centre, but with a permanent MO position.

Future Developments:

I. Tavua to Korovou region has been declared tax-free zone, which may lead to growth in population in this region, however this may not be significant enough in the next 5 years to affect health service planning in terms of infrastructure development.

II. Road infrastructure development such as the Nabouwalu to Dereketi Road would require reviewing the services provided by the current health facilities in this area.

A comprehensive analysis will be conducted for the above and Northern Health Services in 2016.

Clinical Services Plan (CSP)

There is a need to link infrastructure and workforce planning to the CSP. The CSP is an operational level plan however it has major resource implications and needs to be considered together with the other Service Plans.

The following are some recommendations from the Review of CSP 2010-2013:

- Formalize a facility planning process and a briefing template designed to link future facility planning with service planning.
- Build Sub-Divisional hospital capacity and strengthen the clinical capability of Sub-Divisional hospital staff to enable greater devolution of clinical workloads from Divisional Hospitals.
- Formally link Workforce Planning and Clinical Service Planning to address the range of clinical workforce issues identified in the review, particularly the shortage of senior medical staff, by means of focused recruitment/retention strategies.

INTRODUCTION

The National Strategic Plan 2016-2020 is the overarching document that will provide overall strategic direction for health over the five year period. This NSP presents the reviewed Mission, Vision and Values of MoHMS, with the vision encompassing a 20 year outlook and the "wellness approach" to health.

The strategic framework has been developed after extensive situation analysis to gauge where Fiji is in terms of meeting global health indicators. This evaluation of "where we are" has facilitated the development of a document outlining "where we want to be" in 2020 and the objectives showing "how we will get there". Cross cutting issues such as gender, poverty and urbanization that also affect health status were considered in developing this document.

This NSP has been guided by the Roadmap to Democracy and Sustainable Socio-Economic Development (RDSSED) with due consideration to the post 2015 development agenda. Efforts have been made to align to Fiji Government priorities such as extension of opening hours and improving accessibility to services.

The plan is organized according to two Strategic Pillars, the first focusing on the delivery of health services to the population and the second focusing on systems strengthening to improve overall health sector performance. Under each of the pillars there are a series of Priority Areas, as illustrated in **Figure 1** below.

Figure 1: Strategic Pillars and Priority Areas

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

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

Diagram note: the canoe represents the MoHMS initiative to promote health and wellness in the Fiji population

Strategic Pillar 2: Health systems strengthening

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

Guiding Principles

Vision
A healthy population

Mission
To empower people to take ownership of their health
To assist people to achieve their full health potential by providing quality preventative, curative and rehabilitative services through a caring sustainable health care system.

Values
1. Equity
2. Integrity
3. Respect for human dignity
4. Responsiveness
5. Customer focus

General Principles

1. Health in all Policies approach
2. Healthy Islands concept
3. Sustainable Development Goals (SDG)
4. WHO Health Systems Building Blocks
    - Leadership/governance
    - Health care financing
    - Health Workforce
    - Medical products, technologies
    - Health information and research
    - Service delivery
5. Universal Health Coverage

Role and Function of the Ministry

Functions
The core function of the Ministry of Health and Medical Services is to provide high quality healthcare through capable governance and systems to the people of Fiji. We are committed to improve primary, secondary and tertiary healthcare.

The Ministry of Health and Medical Services commits to ensure accessible, equitable and affordable health services to all citizens of Fiji without discrimination.

a. Hospital Services
The office of the Deputy Secretary Hospital Services oversees the operational functions of the three Divisional Hospitals and the two specialist hospitals as well as the Fiji Pharmaceutical & Biomedical Services Centre (FPBSC). The three divisional hospitals are; Colonial War Memorial Hospital (CWMH), Lautoka Hospital and Labasa Hospital. The two specialist hospitals are; St. Giles Hospital and Tamavua/Twomey Hospital. FPBSC's core service is procurement and supply management (procuring, warehousing, distributing) of medical and health commodities.

The Divisional Hospitals serve as the main referral hospital in their respective divisions. CWMH, Lautoka and Labasa Hospitals provide a wide range of medical services which may not be available at Sub-Divisional Hospitals. Additionally the various Clinical Services Networks support the standardization and improvement in the provision of clinical services.

St. Giles Hospital provides medical and rehabilitation services for patients suffering from mental illness. Together with inpatient and outpatient care St. Giles Hospital provides other services such as occupational therapy, day care facilities, forensic assessments, counseling services, community psychiatric nursing, electro-convulsive therapy and pharmaceuticals.

Tamavua/Twomey Hospital blends three specialized hospital services i.e. Tuberculosis unit, Leprosy and Dermatology and Rehabilitation medicine under one management with the vision to be the best in specialized hospital care with "patient services at the heart of all" focus.

The National Rehabilitation Hospital at Tamavua continues to play an important part in the overall health service care delivery in Fiji. The hospital provides rehabilitation services to severely disabled persons namely spinal paralysis, stroke victims, prosthetic fitting for amputees and other cases of debility.

Hospital Services is the focal point for Ministry of Health and Medical Services to liaise with other NGO groups such as the Fiji Cancer Society, Kidney Foundation of Fiji and the St. John Ambulance. Hospital Services has become the coordinating link for the provision of specialized services offered by the aforementioned groups.
Services that have been outsourced for better results and provision of efficient services to the customers are the Ambulance Services, Hospital Cleaning and Security Services and Colonial War Memorial and Lautoka Hospital's Mortuary services.

b. Public Health Services

The Deputy Secretary Public Health is responsible for formulation of strategic public, primary health policies and oversees the implementation of public health programmes as legislated under the Public Health Act 2002. Effective primary health care services are delivered through Sub Divisional Hospitals, Health Centres and national programs outlined below:

Wellness Centre

The Wellness Unit was established in February 2012 by the merging of Non Communicable Diseases (NCD) control unit and the National Centre for Health Promotion (NCHP).

Family Health

The family health programs key aims are to manage, implement, monitor and evaluate programs pertaining to Child Health, Maternal Health, HIV/STI's, Reproductive Health and Gender.

Communicable Diseases (CD)

Some of the core functions of Communicable Disease program are:

- To set up an effective surveillance system for the controlling of communicable diseases in Fiji and where directed in the region.
- To promote and protect the health of the people of Fiji in regards to defined communicable diseases.
- Develop, support and sustain communication networks between other government departments and stakeholders on advice and training on communicable diseases.
- Support communicable disease quality assurance programs for Fiji and the region.

Environmental Health (EH)

The Environmental Health department is responsible for the promotion and protection of public health from environmental health risk factors such as pollution, unsanitary conditions, poor quality water supply, illegal developments, improper waste management practices, breeding of disease vectors and poor food quality.

Dietetics and Nutrition

The need for good and proper nutrition consultation and advice in our health facilities and community has never been higher. With the burden of NCDs and the high rate of premature deaths; our dieticians are focusing more than ever before on more local fresh foods, plenty of fruits and vegetables, physical activity and a reduction in salt, sugar and fat. With limited number of dieticians (62 dieticians to our population of approximately 900, 000) and resources we look to the support of the other health workers and stakeholders (local and overseas) to help us achieve our health vision of a nutritionally well Fiji.

Oral Health

The Oral Health Department is responsible for the delivery of sustainable oral health programs for all citizens of Fiji, through comprehensive legislative, promotional, preventative and curative activities that encourage the retention of natural teeth, resulting in better quality of life.

c. Regulatory Functions

Standards are set and maintained by various regulatory bodies and enforced by the relevant bodies such as the Central Board of Health (CBH), Fiji Medical Council (FMC), Fiji Dental Council (FDC), Fiji Pharmacy Profession Board (FPPB), Fiji Nursing Council (FNC), Private Hospital Board (PHB), Rural Local Authorities (RLAs), Hospital Board of Visitors (HBoV), Fiji Optometrists Board (FOB) and Fiji National Council of Disabled Persons (FNCDP).

Legislated Regulatory Bodies

Fiji Medical Council (FMC)
Fiji Dental Council (FDC)
Fiji Pharmacy Profession Board (FPPB)
Fiji Medicinal Products Board (FMPB)
Fiji Nursing Council (FNC)
Private Hospital Board (PHB)
Rural Local Authorities (RLAs)
Hospital Board of Visitors (HBoV)
Fiji Optometrists Board (FOB)
Fiji National Council of Disabled Persons (FNCDP)

The Fiji National University (FNU) following its incorporation with the Fiji School of Nursing (FSN) into FNU College of Medicine, Nursing and Health Sciences has accredited training programmes offered.

d. Policy Functions

The Planning and Policy Development Unit (PPDU), in consultation with the Public Service Commission and Ministry of Finance, coordinates the development, formulation and documentation of MoHMS Policies, the National Health Accounts, Donor Coordination, Department Plans and medium to long term strategies to align with the Ministry's long term mission and vision.

The Ministry has instituted an internal policy guidance document that operationalizes the regulatory, monitoring and service delivery guidelines laid down in the various legislations.

e. Support Services Functions

The support services functions are undertaken by the Division of Administration and Finance:

There are seven (7) units under the Division of Administration and Finance that implement, monitor and evaluate the support services of the Ministry.
The role of the Finance Accounts Unit is to monitor that goods and services are efficiently delivered on time as per the agreed budget.
The Asset Management Unit provides support for physical assets such as vehicle fleet, boats etc Board of Survey, Infrastructure maintenance, Capital projects and Capital Purchases.
The Human Resources (OHS/IR) role is to meet legislative requirements and provide advice and monitoring for a safe and healthy workplace for all staff, patients and visitors within any MoHMS facility. It is also to monitor and respond to issues relating to Industrial or workplace relations particularly in cases of disciplinary proceedings.

HR (Personnel) Unit is responsible for managing processes relating to leave entitlements, resignations, retirements, certificate of service, transfers and allowance, extension of relieving appointments, secondment, Annual Performance Assessment and reactivation of salary.
The role of HR (PPU) is to manage and ensure that a functional workforce is maintained within the Ministry. It manages all areas of engagement of new staff and tracking of current staff to fill vacancies.

The Training unit provides support and services in the continuous professional development to meet the needs of clinical and administrative staff.

The primary aim of the Workforce Planning process is for Ministry of Health & Medical Services to achieve best workforce outcome to train, recruit, retain and advance critical skills, roles and support the Ministry of Health & Medical Services staff to provide and deliver quality health services to the citizens of Fiji.

f. Health Information Research and Analysis Division

The Health Information, Research and Analysis Division is responsible for the overall development and management of health information; promoting appropriate research for the National Health Service; monitoring and evaluation of the Ministry's Corporate & Strategic Plans including Key Performance Indicators for ICO; and management of ICT services for the Ministry. It plays a vital role in the compilation and analysis of health statistics, epidemiological data, management of the information system (software) and also purchase and maintenance of computer hardware.

NSP 2016-2020 STRATEGIC DIRECTION

The National Strategic Plan is a platform for multi-sectoral collaboration to improve health in Fiji. This National Strategic Plan provides overall strategic direction for Fiji's health sector over the five year period from 2016-2020. This document was prepared by the MoHMS in consultation with key health sector stakeholders in order to serve as a platform for multi-sectoral collaboration, in alignment with key national, regional and international commitments and frameworks. These include the Fiji Government Manifesto, Fiji Green Growth Framework, Healthy Island's vision for the Pacific, United Nations Sustainable Development Goals, and others.

The first Strategic Pillar focuses on delivery of health services to the population and is divided into the following key priority areas:
1. NCDs, including nutrition, mental health, and injuries
2. Maternal, infant, child and adolescent health
3. Communicable diseases (CDs), environmental health, and health emergencies

The second Strategic Pillar focuses on health systems strengthening and is based on the WHO Health Systems Framework, "systems building blocks":
4. Primary health care, continuum of care, quality, and safety
5. Productive, motivated health workforce
6. Evidence-based policy, planning, implementation and assessment
7. Medicinal products, equipment & infrastructure
8. Sustainable financing

Each of the 8 priority areas has a set of General Objectives and Specific Objectives, as outlined in **Annex 1**.

Strategic Direction and Key Issues

Priority Area 1: Non-communicable diseases, including nutrition, mental health, and injuries

The need for a whole-of-society approach to reduce NCD risk factors in the population based on the "Wellness" approach to health has been identified as an important strategy.

The non-communicable disease (NCD) problem in Fiji and the region has been termed a crisis. Fiji continues to experience alarming increases in health risk factors (including obesity, raised blood pressure, raised blood glucose, and alcohol consumption) and in the overall health burden from NCDs. Healthy Islands Framework has significantly influenced the current approach to NCD's. It gave prominence to the "settings approach" that is adapted and used in the application of the "Wellness" concept. It supports the focus on environments where people live, work and play and the need for multi-sectorial collaboration to address the NCD burden.

Priority Area 2: Maternal, infant, child and adolescent health

Pregnant women need earlier antenatal care to address potential complications.

Maternal mortality in Fiji declined dramatically from the 1970s due to high quality service and increasing hospital deliveries but improvements have stagnated or "plateaued" in recent years, with the number of annual maternal deaths fluctuating in the range of 4 to 12 since 2000. Analysis of deaths in the last five years highlighted underlying causes from delayed presentation (which was often linked to poverty, low levels of education) and pre-existing cardio-vascular problems (including rheumatic heart disease) and other NCDs. While nearly 99% of women receive at least one antenatal visit, only 10.7% of pregnant women had an antenatal visit in their first trimester in 2013. These issues highlight the importance of promoting early antenatal care, especially among high risk and hard-to-reach communities.

Priority Area 3: Communicable disease, environmental health, and health emergency preparedness, response & resilience

Reducing communicable diseases requires improved surveillance and better partner coordination. There is a need for improved multi-sectoral approach to risk management and resilience for communicable diseases, health emergencies, climate change and natural disasters.

Addressing these issues will require restructuring the overall communicable disease program to strengthen and integrate key functions (surveillance and research; laboratory services; public health response; communications) as well as improved coordination with other government ministries, especially with the Ministry of Local Government, Housing and Environment, which is responsible for public health prevention and regulation activities in municipal areas.

From a strategic perspective, this calls for greater integration of planning and management in these areas, especially for climate-change and environment-related health issues both within the MoHMS as well as with other government ministries, especially with the Ministry of Local Government, Housing and Environment, which is responsible for all public health prevention and regulation activities in municipal areas.

Priority Area 4: Expanded primary health care, with an emphasis on providing a continuum of care and improved service quality and safety

Community-level Primary Health Care needs continued investment and expansion to be effective.

Fiji has placed a strong emphasis on increasing the coverage of Primary Health Care (PHC) for over 35 years, reinforced by the Healthy Islands concept for the Pacific Islands. This effort has been implemented primarily through community outreach visits by multidisciplinary health worker teams and collaboration with the nationwide network of volunteer Community Health Workers (CHWs). There is a need to further improve access and coverage of PHC.

Private sector collaboration is essential for providing a continuum of high quality care to patients.

Improving the access, coverage and quality of PHC requires integrated health systems approach. From a governance and service delivery perspective, the MoHMS has a broad array of policies, standards, and protocols to ensure safe, high quality services at all levels of the health system, from Nursing Stations to Divisional Hospitals. There is a need to establish a continuum in the provision of care in all areas, with a referral system based on well-defined networks of public and private providers.

Decentralization of services is an initiative to improve accessibility and respond to the health service needs of the population.

Decentralization of some services (out-patient services) from CWMH to major Health Centers in the Sub-Divisions has resulted in improving accessibility. This supports the initiative towards Universal Health Coverage which Fiji is working towards. There has also been an extension of opening hours at some facilities to further improve accessibility. MoHMS would be evaluating the decentralization process further with the intention of extending this to all Divisions with a focus on population centered health delivery system.

Priority Area 5: Productive, motivated health workforce with a focus on patient rights and customer satisfaction

Key gaps in the health workforce need to be filled across all cadres to manage current workload.

Based on a workforce needs assessment in 2013, the MoHMS has identified several key workforce issues to address, including staff retention and motivation, reducing staffing shortages in certain specialties, and ensuring that staff are deployed where they are needed most.

Priority Area 6: Evidence-based policy, planning, implementation and assessment

Raising the standards for evidence-based policy and planning will improve overall effectiveness.

The MoHMS plays a key governance and stewardship role in the health sector, including establishing legislative, regulatory, policy, and monitoring frameworks for health and leading inter-sectoral

coordination. In this area, there is a need for continued efforts to ensure that all MoHMS policies and plans are based on sound logic, sufficient data, and appropriate M&E mechanisms.

Priority Area 7: Medicinal products, equipment & infrastructure

Health infrastructure development needs to be based on population needs with a focus on maintaining and upgrading existing facilities.

While there have been significant expansions to Fiji's health facilities in recent years, there is also a pressing need to make sure those facilities are providing the right services in the right locations and that they are maintained over time. Over the next five years there is an urgent need for comprehensive health services and infrastructure planning in which facilities are built, equipped, and maintained according to a common set of standards and clearly defined population needs.

Priority Area 8: Sustainable financing of the health system

Need to consider long-term financing alternatives to reduce dependence on government funds and improve efficiency with due consideration of outsourcing of non-technical services.

Fiji's health care system is mainly publicly financed through general taxation, although private expenditures account for more than one third of total health expenditures. Donors play an important technical role but only account for an estimated 6% of total health spending. Policy, planning and budgeting are to be based on sound evidence and include considerations of efficiency and cost-effectiveness including outsourcing of some non-technical services.

"Healthy Islands Vision" in the NSP 2016-2020

The Healthy Islands (HI) concept is embedded in the National Strategic Plan 2016-2020. The HI vision has provided the strategic framework for the Health Service Delivery component (Pillar 1). The Health Systems Strengthening component (Pillar 2) further emphasizes critical aspects of Universal Health Coverage that will assist in achieving the HI Vision.

"Healthy Islands are where":

- *children are nurtured in body and mind;*
- *environments invite learning and leisure;*
- *people work and age with dignity;*
- *ecological balance is a source of pride; and*
- *the ocean which sustains us is protected*

The key Priority Areas (PA) covering the HI concepts are outlined below.

Priority Area 1: Non-communicable diseases, including nutrition, mental health, injuries

This PA focuses on strengthening the "settings" approach to Wellness and **multi-sectoral** engagement to slow the growth and eventually halt the NCD epidemic. This PA covers the need for multi-sectoral action and the need for appropriate **legislation** as detailed in the National Wellness Policy (NWP). The NWP is MoHMS overarching policy guiding the **"Health in All Policies"** approach.

The general objective is to promote population health and reduce premature morbidity and mortality due to NCDs as part of a whole-of-society approach to wellness and well-being. This objective is geared towards the vision that "**people work and age with dignity".** This PA has a total of 16 indicators, one of the indicators under this PA is:

- "# and % of Fiji government ministries that have officially adopted an institutional wellness program in alignment with the National Wellness Policy for Fiji". This promotes the inception of a conducive "**environments** (settings) **that invite learning and leisure."**

Priority Area 2: Maternal, infant, child and adolescent health

This PA focuses on earlier and expanded antenatal care; improved emergency obstetric services and **continuum** from birth through adolescence. This PA covers the whole continuum to ensure that **children are nurtured in body and mind** from birth till adolescence. This PA has a total of 28 indicators.

Priority Area 3: Communicable Disease, Environmental Health, and Health Emergency Preparedness, Response & Resilience

The key themes in this PA are better surveillance and outbreak prevention/control, **climate change adaptation** and health emergency resilience. One of the general objectives focuses on health emergencies, **climate change and natural disasters.** One of the specific objectives and some of the indicators for maintaining **ecological balance** and **protecting oceans** (pollution) are outlined below:

Specific Objective 3.1.1: Improve the coverage and effectiveness of environmental health and risk reduction interventions for communicable diseases

- # and % of rural Local Authority communities with Water Safety Management Plans
- % of rural Local Authorities adequately enforcing legislation related to pollution control

Priority Area 4: Expanded Primary Health Care (PHC), with an emphasis on providing a continuum of care and improved service quality and safety

This PA focuses on strengthening PHC with an emphasis on **community empowerment and engagement** as well as through building effective partnerships to foster this in order to improve **accessibility of Primary Health Care** services in urban, rural and remote areas. Some indicators are outline below:

- # and % of active community health workers trained in CHW Core Competencies
- # and % of health zones in which zone nurses have made least six community visits in the year

Priority Area 5: Productive, motivated health workforce with a focus on patient rights and customer satisfaction

This PA focuses on service provision through a caring and customer focused approach as well as the work satisfaction of staff. This focuses on creating a conducive **environment** for MoHMS employees to work in as well as the quality of services provided to customers. Some of the indicators are listed below:

- Average **customer satisfaction** rating, disaggregated by facility
- % of MoHMS **staff** reporting that they are **satisfied** with their job

The following PA's focus on "health systems strengthening" as steps towards achieving Universal Health Coverage (UHC) that will support progress towards achieving HI vision.

Priority Area 6: Evidence-based policy, planning, implementation and assessment

This PA focuses on establishing effective governance and accountability framework from an evidence based perspective and strengthening policy and planning. Some of the indicators under this PA are:

- Budgeting sub-score within Policy, Planning and Budgeting Index
- Policy and Planning sub-score within Policy, Planning and Budgeting Index
- Health Metrics Network (HMN) Health Information Systems self-assessment score

Priority Area 7: Medicinal products, equipment & infrastructure

Resource gaps are seen as a major deterrent to achieving HI vision. This PA focuses on expanding access to high quality essential medicines through effective supply chain management in order to meet population needs. A few indicators are mentioned below:

- Average availability of selected essential medicines in public and private health facilities
- Average % availability of tracer products in targeted facilities

Priority Area 8: Sustainable financing of the health system

This PA focuses on ways to improve health financing to support equitable access to quality services and provide financial risk protection. The general objective is to improve financial sustainability, equity and efficiency. Some of the indicators are mentioned below:

- General government expenditure on health(GGHE) as a proportion of general government expenditure(GGE)
- Ratio of household out-of-pocket payments for health relative to current health expenditure

ANNEX

Annex 1: Strategic Pillars, Priority Areas, General Objectives and Specific Objectives

Strategic Pillar 1: Provide quality preventive, curative and rehabilitative health services responding to the needs of the Fijian population including vulnerable groups such as children, adolescents, pregnant women, elderly, those with disabilities and the disadvantaged		
Priority Areas	**General Objectives**	**Specific Objectives**
1 NCDs, including nutrition, mental health, and injuries	1.1 To promote population health and reduce premature morbidity and mortality due to NCDs as part of a whole-of-society approach to wellness and well-being	1.1.1 Reduce key lifestyle risk factors among the population
		1.1.2 Early detection, risk assessment, behaviour change counselling, clinical management, and rehabilitation for targeted NCDs
		1.1.3 Integrate mental health services within primary health care in all facilities
		1.1.4 Improve national reporting on injuries due to violence, domestic abuse and traffic accidents
2 Maternal, infant, child and adolescent health	2.1 Timely, safe, appropriate and effective health services before, during, and after childbirth	2.1.1 Increase antenatal care coverage with an emphasis on early booking
		2.1.2 Improve obstetric care with a focus on adherence to key clinical practice standards
		2.1.3 Expand coverage of postnatal care services for mothers and newborns
	2.2 All infants and children have access to quality preventive and curative paediatric and nutritional services	2.2.1 Expand neonatal and infant healthcare, including community risk detection and referral
		2.2.2 Maintain high level of coverage for immunization services including new antigens
		2.2.3 Reduction of malnutrition through breastfeeding promotion and nutritional support
		2.2.4 Improve prevention and management of childhood illness, including emergency care
	2.3 Expand services to address the needs of adolescents and youth	2.3.1 Expand provision of preventive and clinical services to include 13-17 year olds
		2.3.2 Expand availability and coverage of Youth-Friendly Health Services targeting youth ages 15-24
3 Communicable diseases (CD), environmental health, and health emergencies	3.1 Multi-sectoral risk management and resilience for communicable diseases, health emergencies, and climate change	3.1.1 Improve effectiveness of environmental risk reduction for communicable diseases
		3.1.2 Enhance national health emergency and disaster preparedness, management and resilience
	3.2 Improved case detection and coordinated response for communicable diseases	3.2.1 Strengthen CD surveillance through integration of reporting processes and systems
		3.2.2 Improved prevention, case detection, and treatment of targeted communicable diseases

Strategic Pillar 2: Improve the performance of the health system in meeting the needs of the population, including effectiveness, efficiency, equitable access, accountability, and sustainability		
Priority Area	**General Objective**	**Specific Objective**
4 Primary health care, continuum of care, quality, and safety	4.1 Strengthen primary care and improve continuum of care for patients	4.1.1 Improve accessibility of primary health care services in urban, rural and remote areas
		4.1.2 Continuum of care and referral system in place between public & private provider networks
		4.1.3 Extend primary care service coverage through effective partnerships with communities
	4.2 Continuous monitoring and improvement of quality standards	4.2.1 Establish a systematic quality improvement process in all government health facilities
5 Productive, motivated health workforce	5.1 Motivated, qualified, customer-focused health workforce that is responsive to population health needs	5.1.1 Assess workforce needs for all MoHMS cadres and facilities on an annual basis
		5.1.2 Efficiently recruit and deploy qualified health workers based on service need
		5.1.3 Promote a healthy, safe, and supportive work environment to improve workforce satisfaction
		5.1.4 Collaborate with training institutions to ensure that graduates meet MoHMS requirements
6 Evidence-based policy, planning, implementation and assessment	6.1 Planning and budgeting are based on sound evidence and consider cost-effectiveness	6.1.1 Establish and apply standards for evidence-based policy and planning
		6.1.2 Rational budgeting and resource allocation to increase overall efficiency and cost-effectiveness
	6.2 Health information systems provide relevant, accurate information to the right people at the right time	6.2.1 Expand coverage of electronic patient management information systems in facilities
		6.2.2 Integrate systems for communicable disease surveillance, notification and reporting
		6.2.3 Establish interoperability between key info systems to facilitate integrated performance mgmt
		6.2.4 Improve consistency of key national health data and statistics with partner institutions
	6.3 Results-based monitoring & evaluation as a driver for organizational decision-making and behaviour change	6.3.1 Establish unit-level M&E standards to improve performance and accountability
		6.3.2 Integrate surveys and applied research into MoHMS annual planning cycle
7 Medicinal products, equipment & infrastructure	7.1 Quality medicinal products are rationally used and readily accessible to the public	7.1.1 Establish functional supply chain mgmt system to improve medicinal product availability
		7.1.2 Standardize the quality of imported and distributed medicinal products
		7.1.3 Regular evaluation of medicinal products use
	7.2 Ensure availability of essential biomedical equipment at facilities	7.2.1 Increased availability of essential biomedical equipment in government health facilities
		7.2.2 Maintenance plans to improve functionality and longevity of biomedical equipment
	7.3 Infrastructure planned based on service standards for operational and population needs	7.3.1 New and existing facilities based on updated role delineation and service engineering standards
		7.3.2 Infrastructure & equipment maintenance plans for all facilities to ensure operational safety
		7.3.3 Standardization and coordination of facility & equipment planning between key stakeholders
8 Sustainable Financing	8.1 Improve financial sustainability, equity and efficiency	8.1.1 Expand evidence base and analytical capacity for strategic health financing
		8.1.2 Develop an appropriate health financing strategy (model)

Annex 2: NSP Indicators

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

Obj. #	Ind. #	Indicators	Baseline	Target	Data Source	Frequency
1.1	g1	Premature mortality due to NCDs	40.7% (2014)	37% (2020)	Medical Cause of Death Certificates	Annual
	g2	Population prevalence of diabetes	21.6% (2014)	≤31% (2020)	National STEPS Survey	Periodic
1.1.1	s1	Prevalence of overweight/obesity in primary school children	15.7% (2013)	≤10% (2020)	School Health Records, CMRIS	Annual
	s2	Average number of decayed, missing and filled teeth (DMFT) among 12 year olds	~1.1% (2011)	≤0.9 (2020)	Oral Health Survey	Periodic
	s3	Prevalence of tobacco use amongst adults age 18+ years	17% (2011)	≤11% (2020)	National STEPS Survey	Periodic
	s4	# and % of Fiji government ministries that have officially adopted an institutional wellness program in alignment with the National Wellness Policy for Fiji	0/0% (2014)	3/20 (15%) (2020)	Wellness Policy Steering Committee records	Annual
1.1.2	s5	Amputation rate for diabetic foot sepsis	15.4% (2014)	≤10% (2020)	Hospital discharge data	Quarterly
	s6	Average % adherence to minimum standards for implementation of the Package of Essential NCD Services (PEN) among diabetes centres	0% (2014)	80% (2020)	Diabetes centre minimum standards audit	Six monthly
	s7	# and % of clients at diabetes centres that receive a cardiovascular risk assessment and behaviour change counselling intervention following the PEN model	0% (2014)	80% (2020)	Diabetes centre minimum standards audit	Six monthly
	s8	Cervical cancer screening coverage rate	15.8% (2013)	50% (2020)	Consolidated Monthly Return Info System	Annual
1.1.3	s9	Suicide rate per 100,000 population	9.8 (2013)	≤7.8 (2020)	Medical Cause of Death Certificates	Annual
	s10	# of cases of intentional self-harm, not including suicide	203 (2014)	≤150 (2020)	Hospital discharge data	Quarterly
	s11	Re-admission rate for mental illness within 28 days of discharge	TBC in 2015	TBC in 2015	Hospital discharge data	Quarterly
	s12	% of health facilities adhering to the mhGAP Intervention Guide	0% (2014)	60% (2020)	Mental Health team records, Wellness Unit	Six monthly
1.1.4	s13	Consistency of national reporting on all injuries, including violence, domestic abuse, and traffic accidents	Not establi-shed	Annual report circula-ted	Health Information Unit records	Annual
2.1	g3	Number of maternal deaths	9 (2014)	<8 annual-ly	Medical Cause of Death Certificates	
	g4	Perinatal mortality rate per 1,000 total births	12.7 (2014)	≤10.7 (2020)	Medical Cause of Death Certificates	Annual
	g5	Prevalence of anaemia in pregnancy at booking	31.8% (2014)	≤22% (2020)	Consolidated Monthly Return	Annual

Obj. #	Ind. #	Indicators	Baseline	Target	Data Source	Frequency
					Info System	
	g6	% of live births with low birth weight	6.3% (2014)	≤5% (2020)	Consolidated Monthly Return Info System	Annual
2.1.1	s14	% of pregnant women who receive ANC in their first trimester	29.6% (2014)	35% (2020)	Consolidated Monthly Return Info System	Quarterly
	s15	% of pregnant women with at least 4 ANC visits at term	43.5% (2014)	80% (2020)	Consolidated Monthly Return Info System	Quarterly
2.1.2	s16	Average % adherence to Mother Safe Hospital Initiative (MSHI) standards in divisional hospitals	30% (2014)	80% (2020)	MSHI quality improvement audit	Six monthly
	s17	Average % adherence to Mother Safe Hospital Initiative (MSHI) standards in subdivisional hospitals	38% (2014)	80% (2020)	MSHI quality improvement audit	Six monthly
	s18	Average % adherence to Obstetric Emergency Protocols in the six hospitals with the highest number of births	TBC in 2015	TBC in 2015	Obs. Emergency Protocols quality improvement audit	Annual
2.1.3	s19	% of women attending 1 week postnatal clinic	TBC in 2015	80% (2020)	To be developed in 2015	Quarterly
	s20	% of women attending 6 weeks postnatal clinic	56.6% (2014)	80% (2020)	Consolidated Monthly Return Info System	Quarterly
2.2	g7	Infant mortality rate per 1,000 live births	13.8 (2014)	≤8 (2020)	Medical Cause of Death Certificates	Annual
	g8	Under 5 mortality rate per 1,000 live births	18 (2014)	≤12 (2020)	Medical Cause of Death Certificates	Annual
2.2.1	s21	Neonatal mortality rate per 1,000 live births	7.7 (2014)	≤5 (2020)	Medical Cause of Death Certificates	Annual
	s22	% of infant deaths that occur outside of facilities	30% (2012)	≤15% (2020)	Medical Cause of Death Certificates	Annual
2.2.2	s23	Childhood vaccination coverage rate for all antigens	90% (2014)	≥95% (2020)	Natl Immunisation Survey/ CMRIS (proxy)	Annual
2.2.3	s24	# of admissions for Severe Acute Malnutrition	132 (2014)	≤50 (2020)	Hospital discharge data	Quarterly
	s25	# and % of children at well-baby clinics below standard growth rates	TBC in 2015	TBC in 2015	To be developed in 2015	Annual
	s26	% of children being exclusively breastfed at 6 months	Pop: 70.2% (2014)	Pop: 95% (2020)	Demographic and Health Survey/ CMRIS (proxy)	Periodic/ Quarterly
	s27	% of divisional and sub-divisional hospitals certified as meeting Baby Friendly Hospital Initiative (BFHI) standards	TBC in 2015	100% (2020)	BFHI certification assessment	Periodic
2.2.4	s28	% of primary school students screened for rheumatic heart disease	21% (2014)	≥47% (2020)	Consolidated Monthly Return Info System	Annual
	s29	Average % adherence to IMCI	TBC in 2015	≥95%	IMCI Adherence	Six

Obj. #	Ind. #	Indicators	Baseline	Target	Data Source	Frequency
		guidelines in health facilities		(2020)	Assessment	monthly
	s30	Average % adherence to WHO Pocket book of hospital care for children guidelines in subdivisional hospitals	47% (2014)	≥75% (2020)	WHO Pocket Book audit	Six monthly
2.3	g9	Adolescent birth rate per 1,000 girls aged 15 to 19	26.7 (2014)	≤30.2 (2020)	Hospital monthly returns/ PATIS/CMRIS	Annual
2.3.1	s31	Number of secondary schools classified as Health Promoting Schools	TBC in 2015	TBC in 2015	Ministry of Education	Annual
	s32	HPV vaccination coverage rate among Class 8 girls	HPV2: 92.2% (2014)	HPV2: 95% (2020)	Consolidated Monthly Return Info System	Annual
2.3.2	s33	# and % of Youth-Friendly centres meeting the minimum Youth-Friendly Health Services (YFHS) standards	TBC in 2015	TBC in 2015	YFHS minimum standards audit	Six monthly
	s34	Couple yrs protection rate (proxy for overall contraceptive use based on service utilization/distribution)	38.3% (2014)	>50%	Consolidated Monthly Return Info System	Annual
3.1	g10	# and % of sentinel sites with functioning vector surveillance and insecticide resistance monitoring	0/3 [0%] (2014)	3/3 [100%] (2020)	Environmental Health Unit records	Annual
	g11	# and % of health facilities meeting minimal standards for health emergency and disaster preparedness	TBC in 2015	≥75% (2020)	Health emergency and disaster min. standards assessment	Annual
3.1.1	s35	# and % of rural Local Authority communities with Water Safety Management Plans	35 of 5,300[0.6%] (2014)	122 of 5,300 [2.3%](2020)	Environmental Health Unit records	Annual
	s36	# and % of restaurants within rural Local Authorities graded A, B, or C for food safety standards	70% (2014)	≥60% (2020)	Environmental Health Unit records	Annual
	s37	% of high risk communities in rural Local Authority areas meeting vector surveillance standards	83% (2014)	≥95% (2020)	Environmental Health Unit records	Annual
	s38	% of rural Local Authorities adequately enforcing legislation related to pollution control	TBC in 2015	≥75% (2020)	Environmental Health Unit records	Annual
3.1.2	s39	# and % of health facilities meeting minimal standards for health emergency and disaster preparedness	TBC in 2015	≥75% (2020)	Health emergency and disaster minimum standards assessment	Annual
	s40	Avg. Capability Level (CL) for all International Health Regulation (IHR) core capacity requirements at Ports of Entry	TBC in 2016	≥CL2 (2020)	Environmental Health Unit records	Periodic
3.2	g12	Case fatality rate for leptospirosis	12.5% (2014)	4% (2020)	Medical Cause of Death Certificates	Annual
	g13	Case fatality rate for typhoid	3.5% (2014)	<1% (2020)	Medical Cause of Death Certificates	Annual

Obj. #	Ind. #	Indicators	Baseline	Target	Data Source	Frequency
	g14	Case fatality rate for dengue fever	0.8% (2014)	≤0.5% (2020)	Medical Cause of Death Certificates	Annual
	g15	Prevalence rate of tuberculosis per 100,000 population	110 (2014)	77 (2020)	National TB Program estimations	Annual
	g16	Total number of confirmed HIV cases	610 (2014)	≤1000 (2020)	Lab confirmations; mortality records	Quarterly
3.2.1	s41	Average % of routine reports received on time from the National Notifiable Disease Surveillance System	97% (2014)	≥99% (2020)	Health Information Unit records	Quarterly
	s42	Average % of routine syndromic surveillance reports received on time	80% (2014)	≥95% (2020)	Mataika House records	Quarterly
	s43	Average % of routine hospital-based active surveillance reports received on time	100% (2014)	100% (2020)	Mataika House records	Quarterly
	s44	Average % of routine laboratory confirmed surveillance reports received on time	39% (2014)	≥95% (2020)	Mataika House records	Quarterly
	s45	% completeness of IB-VPD surveillance reports, including zero-reports and sample collection	30% (2014)	≥95% (2020)	Mataika House records	Quarterly
	s46	% completeness of RV surveillance reports, including zero-reports and sample collection	50% (2014)	≥95% (2020)	Mataika House records	Quarterly
3.2.2	s47	Incidence of leptospirosis per 100,000 population	18.9 (2014)	TBC in 2016	Mataika House lab confirmations	Annual
	s48	Incidence of typhoid per 100,000 population	74.9 (2014)	TBC in 2016	Mataika House lab confirmations	Annual
	s49	Typhoid admission ratio (# admissions/# confirmed cases)	0.46 (2014)	≤0.40 (2020)	Hospital discharge/Mataika House	Quarterly
	s50	Incidence of dengue fever per 100,000 population	86 (2012-2013)	TBC in 2016	Mataika House estimations	Annual
	s51	Prevalence of lymphatic filariasis	>1% (2014)	<1% (2020)	Mataika House lab confirmations	Annual
	s52	Incidence of measles per 100,000 population	7.98 (2014)	Eradicate	Mataika House lab confirmations	Annual
	s53	Incidence of tuberculosis per 100,000 population	57 (2014)	≤53 (2020)	National TB Program records	Annual
	s54	Tuberculosis treatment success rate	85% (2014)	≥85% (2020)	National TB Program records	Annual
	s55	Tuberculosis mortality rate per 100,000 population	4.2 (2014)	≤3.4 (2020)	Medical Cause of Death Certificates	Annual
	s56	Number of new cases of HIV	64 (2014)	≤32 (2020)	Mataika House lab confirmations	Quarterly

Strategic Pillar 2: Health systems strengthening and performance

Obj. #	Ind. #	Indicators (Illustrative/draft)	Baseline	Target	Data Source	Frequency
4.1	g17	Number of outpatient department visits per 10,000 population per year	TBC in 2016	TBC in 2016	To be developed in 2016	Annual
4.1.1	s57	Avg. # of daily operating hours for government health facilities, disaggregated by type and division	TBC in 2015	TBC in 2015	To be confirmed in 2015	Annual
	s58	# of divisional hospitals with decentralized outpatient care	1 (2014)	3 (2020)	Hospital Services Division records	Annual
4.1.2	s59	% of hospital discharges with completed discharge summary	TBC in 2016	TBC in 2016	To be developed in 2016	Annual
4.1.3	s60	# and % of active community health workers trained in CHW Core Competencies	830 [53%] (2014)	1406 [90%] (2020)	Nat'l Community Health Worker Steering Comm. records	Quarterly
	s61	# and % of health zones in which zone nurses have made least six community visits in the year	TBC in 2015	TBC in 2015	To be developed in 2015	Annual
4.2	g18	Proportion of health centres and nursing stations that meet basic service capacity standards	TBC in 2016	TBC in 2016	To be developed in 2016	Six monthly
	g19	Intensive care unit hand hygiene rate (proxy indicator for infection control)	>90% (2014)	≥90% (2020)	Risk Manager reports	Quarterly
	g20	Surgical site infection rate for Caesarian section in divisional hospitals (proxy indicator for infection control)	10.8% (2014)	<5% (2020)	Risk Manager reports	Quarterly
	g21	Average length of stay for spontaneous vaginal delivery, singleton (proxy indicator for service delivery efficiency)	TBC in 2015	TBC in 2015	PATISplus	Quarterly
	g22	Acute myocardial infarction (AMI) in-hospital mortality rate (proxy indicator for service quality)	8.6% (2014)	≤8% (2020)	Hospital discharge data; Med Cause of Death Cert.	Quarterly
	g23	Unplanned readmission rate within 28 days of discharge (proxy indicator for service quality)	Labasa-2.3% Lautoka-1.4% (2014)	<10% (2020)	Hospital discharge data	Quarterly
4.2.1	s62	% of public hospitals and health centres audited at least annually against IMCI guidelines	0% (2014)	≥80% (2020)	Family Health Unit records	Six monthly
	s63	% of public hospitals audited at least annually against MSHI standards	100% (2014)	100% (2020)	Family Health Unit records	Six monthly
	s64	% of SOPDs audited at least annually against Diabetes Management Guidelines	0% (2014)	≥80% (2020)	Wellness Unit records	Six monthly
	s65	Implementation status of standardized national clinical quality and safety standards	TBC in 2017	TBC in 2017	To be developed in 2017	Annual
5.1	g24	Ratio of active skilled health care workers (doctors, nurses and midwives) per 10,000 population	37 (2014)	47 (2020)	Human Resource Dep't records	Annual
	g25	Avg. customer satisfaction rating,	TBC in 2016	TBC in	Patient Satisfaction	Annual

Obj. #	Ind. #	Indicators (Illustrative/draft)	Baseline	Target	Data Source	Frequency
		disaggregated by facility		2016	Survey	
	g26	% of MoHMS staff reporting they are satisfied with their job	TBC in 2016	TBC in 2016	Employee Satisfaction Survey	Annual
5.1.1	s66	Ratio of active doctors per 10,000 population	6.6 (2014)	10 (2020)	Human Resource Dep't records	Annual
	s67	Ratio of active nurses per 10,000 population	27 (2014)	55 (2020)	Human Resource Dep't records	Annual
	s68	Ratio of active midwives per 10,000 population	3.4 (2014)	16 (2020)	Human Resource Dep't records	Annual
	s69	Ratio of active allied health workers per 10,000 population	5.6 (2014)	TBC in 2015	Human Resource Dep't records	Annual
	s70	Ratio of active dentists and dental therapists per 10,000 population	1.7 (2014)	2.8 (2020)	Human Resource Dep't records	Annual
	s71	Workforce Indicator of Staffing Needs (WISN) assessment completed/updated annually	1st WISN done in 2014	WISN annual-ly	Human Resource Dep't records	Annual
5.1.2	s72	Average recruitment time	>16wks (2013)	≤6wks (2020)	Human Resource Dep't records	Annual
	s73	Ratio of vacancies to establishment for clinical cadres	30% (2014)	≤10% (2020)	Human Resource Dep't records	Quarterly
5.1.3	s74	# and % of divisional facilities in compliance with Occupational Health & Safety requirements for certification	4/6 [67%] (2015)	6/6 [100%] (2020)	Human Resource Dep't records	Annual
	s75	# and % of subdivisional facilities in compliance with Occupational Health & Safety requirements for certification	3/19 [16%] (2020)	19/19 [100%] (2020)	Human Resource Dep't records	Annual
	s76	% of regulated clinical workforce meeting Continuing Professional Development requirements	TBC in 2015	100% (2020)	Human Resource Dep't records	Annual
	s77	Workforce attrition rate, by cadre	1.9% nurses 2.6 % doctors (2014)	<2% nurses; <5% doctors (2020)	Human Resource Dep't records	Annual
5.1.4	s78	# and % health sciences training programs leading to a license to practice or professional certification that are accredited by a professional body	0% (2014)	100% (2020)	Human Resource Dep't records	Annual
6.1	g27	Policy, Planning, and Budgeting Index	TBC in 2016	TBC in 2016	National M&E Technical Team	Annual
6.1.1	S79	Policy and Planning sub-score within Policy, Planning and Budgeting Index	TBC in 2016	TBC in 2016	National M&E Technical Team	Annual
6.1.2	s80	Budgeting sub-score within Policy, Planning and Budgeting Index	TBC in 2016	TBC in 2016	National M&E Technical Team	Annual
6.2	g28	Health Metrics Network (HMN) Health Information Systems self-assessment score	TBC in 2015	≥450 (2020)	HMN Health Info Systems self-assessment	Periodic
	g29	Clinical Information System (CIS) maturity model score	TBC in 2015	TBC in 2015	CIS maturity model assessment	Periodic
6.2.1	s81	# and % of hospitals using a fully	3	24	Health Info Unit	Quarterly

Obj. #	Ind. #	Indicators (Illustrative/draft)	Baseline	Target	Data Source	Frequency
		functional PATISplus system	[13%](2015)	[100%] (2018)	records	
	s82	# and % of Level A health centres using a fully functional PATISplus system	0 [0%](2015)	20 [100%] (2018)	Health Info Unit records	Quarterly
	s83	Average % of admissions recorded in PATISplus system	30% (2014)	95% (2020)	Health Info Unit records	Quarterly
	s84	Average % of discharges recorded in PATISplus system	94% (2014)	99% (2020)	Health Info Unit records	Quarterly
	s85	Average % of births recorded in PATISplus system	6% (2014)	90% (2018)	Health Info Unit records	Quarterly
6.2.2	s86	Integrated surveillance system meets user-defined requirements for integration, completeness, timeliness, accuracy, and ease-of-use	TBC in 2016	System fully opera-tional by 2020	To be developed in 2016	Quarterly
6.2.3	s87	# and % of MoHMS information systems adhering to National eHealth data interoperability standards	TBC in 2017	TBC in 2017	To be developed in 2017	Annual
6.2.4	s88	% of MoHMS mortality records coded and submitted to the Fiji Bureau of Statistics	0% (2014)	100% (2017)	Health Info Unit records	Annual
	s89	# of major private sector health providers with basic service utilisation data	0 (2014)	102 (2020)	Health Info Unit records	Annual
6.3	g30	Quality score for MoHMS Annual Report, based on National M&E Technical Team standards for analytical reporting	TBC in 2015	TBC in 2015	National M&E Technical Team	Annual
6.3.1	s90	% of MoHMS national-level indicators that have complete, accurate metadata	69% (2014)	100% (2020)	National M&E Technical Team	Annual
	s91	Quality score for MoHMS unit Business Plan reports	TBC in 2015	TBC in 2015	National M&E Technical Team	Annual
6.3.2	s92	10-year costed survey plan covering all priority health topics, prepared and updated annually	Develop plan in 2015	Update annually	National Research Unit records	Annual
	s93	Targeted research plan to fill in key MoHMS knowledge gaps, prepared and updated annually	Develop plan in 2015	Update annually	National Research Unit records	Annual
	s94	% of key datasets from MoHMS health information systems available electronically through the National Data Repository with corresponding levels of access	0% (2014)	60% (2020)	National Research Unit records	Annual
	s95	% of MoHMS-approved research datasets available electronically through the National Data Repository with corresponding levels of access	0% (2014)	60% (2020)	National Research Unit records	Annual
7.1	g31	Average availability of selected essential medicines in public and private health facilities	TBC 2016	TBC 2016	National Medicines survey	Periodic

Obj. #	Ind. #	Indicators (Illustrative/draft)	Baseline	Target	Data Source	Frequency
7.1.1	s96	Avg. % availability of tracer products in targeted facilities	80% (2014)	≥90% (2020)	Fiji Pharm. Biomed. Services records	Six monthly
	s97	Stock wastage due to expiry as a % of the medicines budget	<3% (2014)	<3% (2020)	Fiji Pharm. Biomed. Services records	Six monthly
7.1.2	s98	% of imported medicinal products recorded in the Fiji Medicinal Products Register	0% (2014)	100% (2020)	Fiji Pharm. Biomed. Services records	Quarterly
7.1.3	s99	Assessment rating for rational use of medicines	TBC in 2016	TBC in 2016	Fiji Pharm. Biomed. Services records	Annual
7.2	g32	General Service Readiness score for health facilities – Equipment component	TBC in 2016	TBC in 2016	Health facility survey/assessment	Periodic
7.2.1	s100	% of facilities meeting General Service Readiness standards for equipment	TBC in 2016	TBC in 2016	Health facility survey/assessment	Periodic
7.2.2	s101	Average % of core medical equipment that is functional	TBC in 2016	≥85% (2020)	Health facility survey/assessment	Periodic
7.3	g33	Number of government health facilities per 10,000 population	TBC in 2017	TBC in 2017	Asset Management Unit records	Annual
7.3.1	s102	Develop comprehensive health services plan at the national level and for all four divisions	2 divisions (2014)	4 divisions + nat'l (2020)	Planning & Policy Dev't Unit records	Annual
	s103	% of new capital works and maintenance projects in adherence with MoHMS role delineation and service engineering standards, as articulated in the design brief	TBC in 2017	TBC in 2017	Asset Management Unit records	Six monthly
7.3.2	s104	% of facilities in compliance with Building Maintenance Plan and Equipment Maintenance & Replenishment Plan	TBC in 2017	≥60% (2020)	Asset Management Unit records	Annual
	s105	% of total capital works budget allocated to maintenance	14% (2014)	30% (2020)	Asset Management Unit records	Annual
7.3.3	s106	% of externally funded capital works projects in adherence with MoHMS role delineation and service engineering standards, as articulated in the design brief	TBC in 2017	TBC in 2017	Asset Management Unit records	Six monthly
8.1	g34	Current health expenditure (CHE) per capita, current FJD	299.3 (2012)	TBC in 2016	National Health Accts estimation	Periodic
	g35	General government expenditure on health as a proportion of general government expenditure	7.2% (2012)	10% (2020)	National Health Accts estimation	Periodic
	g36	Ratio of household out-of-pocket payments for health relative to current health expenditure	26.8% (2012)	TBC in 2016	National Health Accts estimation	Periodic
8.1.1	s107	National Health Accounts (NHA) estimation completed biennially to address strategic health financing policy questions	2011-2012 NHA (done in 2014)	NHA done annually (2020)	National Health Accounts estimation	Periodic

Obj. #	Ind. #	Indicators (Illustrative/draft)	Baseline	Target	Data Source	Frequency
	s108	Availability of data on government expenditure on priority health issues	Develop 2015 baseline	Update annually	Planning & Policy Dev't Unit records	Annual
8.1.2	s109	10-year costed plan of health financing assessments to address key policy issues and updated annually	Develop plan in 2015	Update annually	Planning & Policy Dev't Unit records	Annual

Annex 3: Consultation

Participants List

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