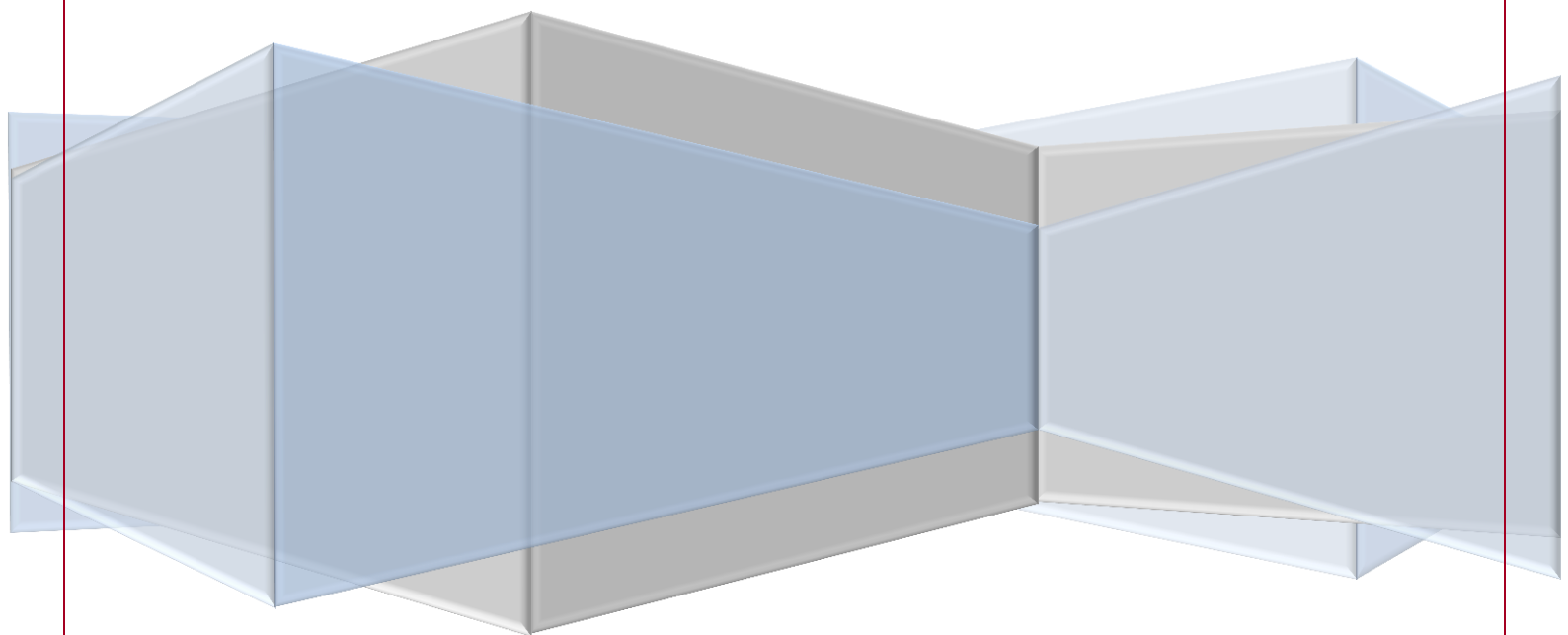


Integrated People-Centred Health Services Case Study

**Role Delineation Policy, Solomon
Islands**



Contents

Executive summary	i
1. Introduction	1
2. Problems to be addressed by Role Delineation	1
3. Health service delivery transformation	4
4. Health system enabling factors and barriers	10
5. Change management	13

Executive summary

Problems to be addressed by Role Delineation Policy

The Solomon Islands' 670,000 people are mostly well served with a nurse-run provincial primary care system, which addresses communicable and non-communicable diseases.

However, while 80% live in rural areas, resources and health staff are too heavily focused in the capital city of Honiara. Of only 86 doctors, 73 are at the National Referral Hospital. Over 50% of the national health workforce are nurses or nurse aides, and two thirds are in the provinces. Many Health Centres are run down, with up to 70% requiring upgrade, repair or renovation. There are no consistent standards for quality of health facilities, and some new facilities are being built without reference to national priorities.

While around 100 doctors have been trained in Cuba and will return in the coming years, they will require top-up training on return. Their placement in rural areas will require additional resources for equipment, laboratory staff and medical supplies.

Health service delivery transformation

Senior policy makers have prepared draft Role Delineation Policy and Packages of Services. Their successful advocacy has now resulted in alignment of the National Development Plan, the National Health Strategic Plan and the Role Delineation Policy.

The RDP defines the range and level of services to be delivered to given populations across the Solomon Islands, to ensure better access to primary health care in all locations.

A revised set of Service Delivery Packages was developed in 2016. They outline what will be provided at Rural Health Centres, Area Health Centres, Urban Health Centres, and General Hospitals. Services to be provided at the National Referral Hospital will be defined later.

The Service Delivery Packages include staffing requirements at each level, infrastructure required, equipment, essential registers, manuals, guidelines and forms, and essential medicines to be provided at each level.

These will be used by government to guide resource allocation, by national and provincial health planners to guide changes, by local communities to identify what range and quality of services they can expect, and by local staff to assess what services their clinics should be delivering.

Health system enablers and barriers

Enablers include a well-developed Health Information System which can inform progress, and realistic timeframes set by MHMS. There are now increasing numbers of doctors graduating and returning from Cuba, good policy and planning support, and increasing funding to support their placement in provinces. The Government has allocated 14% of its budget to health over the last five years, and in the last two years there was an increase of 4% in funds for health. Donor and development partner funding is also increasing. Rural health service delivery costs are lower than national hospital costs, which should make changes viable.

Barriers include that some vertical programs are not consistent with the RDP, poorly developed governance systems for provincial health services, and a predicted need for

increased drugs and supplies for Area Health Centres. It will be important to gain the support of politicians to implement the RDP in all provinces. Community engagement is sometimes difficult in remote areas. Outreach and promotion of new services available in rural areas will therefore be important.

Change management

There is strong Government commitment to the RDP. There has been good development of Service Delivery Packages, with extensive consultation throughout the country. The current strong leadership within the MHMS will advocate to politicians and encourage their involvement and support for the RDP.

Senior policy makers are now planning the next steps to roll out the RDP from 2017-2020. The MHMS will finalise the RDP, then undertake costing. The National Health Strategic Plan predicts that health system transformation will cost SBD\$1.2 billion, to be spread between the National Referral Hospital (\$400m), General Hospitals (\$400m), and rural facilities (AHCs and RHCs: \$400m). It says there is an urgent need to progress the RDP's service delivery package costings so that out year financial forecasts present a better balance between central and peripheral expenditures on infrastructure.

After costing, a Human Resources for Health Plan will be developed. Each province will be supported to develop leadership and managerial capacity to oversee the change to improved Role Delineation. Annual Monitoring and Review of the rollout of the RDP and the Service Delivery Packages will also be important.

The National Health Strategic Plan fully supports the implementation of the RDP, noting that, "Reaching universal health coverage rests on the shoulders of these frontline workers, and the rest of the health system's role is to support them in their work."

1. Introduction

The Solomon Islands is developing a Role Delineation Policy to help the country move towards Universal Health Coverage, using processes consistent with the WHO global strategy on people-centred and integrated health services.

This Case Study documents the design, development and effectiveness of the health service delivery reform process. It will promote learning and interaction on integrated people-centred health services, by contributing to the web platform IntegratedCare4People: www.integratedcare4people.org/practices/

2. Problems to be addressed by Role Delineation

A health system review in 2015 summarised the current strengths and weaknesses of the health system:

The Solomon Islands is a small, low-middle income Pacific island country. With a population of some 670 000 and per capita health spend of SB\$600 a year, its health system can be characterized as conceptually “fit for purpose” but needing ongoing maintenance and development in some key areas such as management and service administration. The system has significant weaknesses but also considerable strengths. With limited resources, the country achieves comparatively high rates of equitable access to basic services. It achieves this through a nurse-run provincial primary care system, with a relatively functional referral system and subsidized patient transport. ⁱ

Another description of primary health care has noted serious shortages of health workers, essential drugs, clinical equipment and medical supplies. The country is dealing with the “... double disease burden of both communicable and non-communicable diseases”.ⁱⁱ WHO has noted that there is steady progress in combating malaria and tuberculosis. NCDs are increasing, and 30.8% of men and 44.4% of women are overweight or obese, while early detection of diabetes remains a challenge.ⁱⁱⁱ

80% of the population live in rural areas. But Rural Health Centres are often run down and have no staff. ^{iv} The health system review of 2015 noted:

Surveys of area health centres and rural health clinics in 2005 in 2012 highlighted the urgent need for upgrade, repair or renovation; many facilities were operating without proper water and sanitation, electricity and basic medical equipment. Up to 70% of health clinics required significant upgrade, repair or renovation. The degradation of health facilities has happened over many decades, and while not properly and regularly maintained due to funding constraints and poor budgeting.

There are serious shortages of clinical equipment and medical supplies at most health facilities, with hospitals often relying on old and poorly maintained medical, diagnostic and surgical equipment. However, the availability of medicines in rural areas is improving.

About three quarters of the population lives within one hour's travel time from the nearest health facility, which for most is either an AHC or RHC. However, referral times from health facility to hospital vary widely within Solomon Islands and depend on the type of transportation available (by foot, vehicle, canoe, boat or plane), the weather, and how long it takes to organize transportation, which in turn depends on whether boats, ships or aeroplanes are ready. ⁱ

Of the 86 practising doctors, 73 are at the National Referral Hospital, and the other 13 at provincial hospitals. The National Health Strategic Plan notes that, "At present the National Referral Hospital is being used as a primary health care service, instead of specialising in referred services."^{iv} The case study key informants noted that people travel to health services in central locations, but then often can't afford accommodation, food or transport home. 6,000 babies, around 40% of all births, are born the national at the National Referral Hospital. ^v

However, as noted by Whiting *et al*, "Until primary and secondary provincial health facilities are strengthened, people will continue to travel to the National Referral Hospital to access a perceived higher quality of health care which, consequently, necessitates the concentration of resources in Honiara."ⁱⁱ Staff are concentrated in the main centres. There are 621 staff at the National Referral Hospital, and 643 in Provincial and Church Hospitals. There are only 216 staff at Area Health Centres, 402 at Rural Health Clinics and 135 in Community Health Centres.^{iv} Over 50% of the health workforce is nurses or nurse aides, and two thirds of these are based in the provinces. There are shortages of doctors and medical specialists, but also medical laboratory staff, radiologists and other allied health professionals.ⁱ

Eight of the nine provinces have public hospitals. There are also four faith-based hospitals owned and operated through various church organizations.ⁱ

The Healthy Settings approach, including outreach for basic services and public health, is being explored as a more efficient way to provide services to remote areas rather than building new physical facilities. But the case study was informed that this is not happening much, and "Health ends at health facilities". Informants noted that this sometimes costly strategy requires all programs in a province to work together as a system, not just the health department. However, the health promotion teams and WASH teams have been organised vertically, with limited integration into broader health systems. The Provincial Health Directors have not been directly involved in facilitating the Health Settings approach.

While some new health facilities are being built, these are not fully integrated into the existing networks. Senior health policy makers informed this case study that every week a new person comes into the head office to say they want to build a health facility. They have, "the urge, and the money". A recent proposal has already allocated \$1.3 million SBD for a facility, before talking with the Ministry of Health and Medical Services (MHMS). In some instances, new health facilities are planned as an outcome of political motives or private donations, and are not guided by national consideration of service needs. While this may be well intentioned, it is uncoordinated, and often not accompanied by the material and non-material resources required for fully functional and sustainable facilities. In some instances, the national standards for the different types of facilities are compromised. Overall, the expectation is that the MHMS will provide the ongoing resources to cover gaps.

Provincial Health Directors also provide clinical services. Indeed, the Provincial Health Director is often the only doctor in the province, and has to be available to respond to individuals' health needs and outbreaks of diseases, such as dengue which was present in Guadalcanal Province during the case study. There is currently no law to define what health services should be provided by Provincial Governments.

Most doctors in the past have been trained in Fiji or Papua New Guinea, but in small numbers. To complement this, an agreement was made with Cuba in 2001 which has led to 96 Solomon Islanders studying medicine in Cuba. 22 have now returned, with another 74 expected to return over the next five years.ⁱ While this increases the number of doctors who might work in rural areas, the case study was informed that it also presents challenges. The graduates are trained mostly in public health, and require top-up clinical training that is being provided by the National Reference Hospital. Once placed in rural areas, funding will have to be provided for salaries, and the demand for medical supplies and technologies will increase.

The respective roles of these new doctors and the existing nurses, who currently manage the Area Health Centres, are yet to be determined. There will need to be decisions taken about governance and management. Will nurses become managers and the new doctors act as clinical directors? Should there be newly created positions of Administration Directors, so that doctors can run clinics and nurses engage in more outreach services? Can nurse aides be trained cost effectively to be upgraded to general nurses?

While there are many challenges, the health system review did reinforce that the system is effective overall. For example, 87% of women sought antenatal care from a trained provider, and 85% had a skilled birth attendant present at birth. Another indicator of success is that 68% of children under five received treatment for fever from a health facility or a trained provider.ⁱ

The Solomon Islands, with its rural population, is thus well placed to consider the potential benefits of Role Delineation, with the creation of different levels of appropriate health facilities, and substantial decentralisation of the health workforce, to better meet the needs of its mostly rural populations.

Summary of findings about problems:

The Solomon Islands' 670,000 people are mostly well served with a nurse-run provincial primary care system, which addresses communicable and non-communicable diseases.

However, while 80% live in rural areas, resources and health staff are too heavily focused in the capital city of Honiara. Of only 86 doctors, 73 are at the National Referral Hospital. Over 50% of the national health workforce is nurses or nurse aides, and two thirds are in the provinces. Many Health Centres are run down, with up to 70% requiring upgrade, repair or renovation. There are no consistent standards for quality of health facilities, and some new facilities are being built without reference to national priorities.

While around 100 doctors have been trained in Cuba and will return in the coming years, they will require top-up training on return. Their placement in rural areas will require additional resources for equipment, laboratory staff and medical supplies.

3. Health service delivery transformation

Current health service levels

The current health system includes five levels of care:

- Nurse Aide Post (NAP), staffed by nurse aides
- Rural Health Clinic (RHC), staffed by nurses
- Area Health Centre (AHC), staffed by nurses
- Provincial Hospital, mostly staffed by nurses, with small numbers of doctors
- National Referral Hospital, staffed by doctors, nurses and other health professionals.

The first draft of the Role Delineation Policy, in February 2012, replaced the previous five levels with six newly defined levels:

- Rural Health Centres level 1 and level 2
- Area Health Centres level 1 and level 2
- General Hospitals
- Specialist National Referral Hospital.^{vi}

For reasons explained below, these levels were revised in 2016. The current Service Delivery Package defines what will occur in these six levels:

- Rural Health Centre, just one level
- Urban Health Centre, for Honiara and provincial capitals as required
- Area Health Centres levels 1 and 2
- General Hospital
- While the National Referral Hospital will remain, it will be moved to a new location, and has not yet been included in the new Service Delivery Package.^{vii}

Moving towards people-centred and integrated health services

Health service delivery transformation is not finalised, but is well underway. It is consistent with the WHO global strategy on people-centred and integrated health services, 2015. This global strategy notes that there is no “one model” of people-centred and integrated health services, but that there are service design principles to enhance access. These principles will

ensure that people receive a continuum of health promotion, disease prevention, diagnosis, disease management, rehabilitation and palliative care services, at different levels of sites and care, and according to their needs throughout the life cycle. The principles explain that services should be: Comprehensive, Equitable, Sustainable, Coordinated and Led by whole-systems thinking. They should enable a shift in the balance of care so that resources are allocated closer to needs. Care should provide, “the right care at the right time in the right place.”^{viii}

Initial development of the Role Delineation Strategy

The Solomon Islands Role Delineation Strategy was first discussed in 2004, but many external factors, including conflict, meant that it was not further developed until 2011. The previous National Health Strategic Plan, 2011-2015, noted a proposed move towards a “package of services”.^{ix} After consultation, a comprehensive draft Service Delivery Package was then developed and published in 2012. This defined levels of health services, staffing, equipment and infrastructure needs. Policy makers now agree that, in retrospect, it was too detailed and too prescriptive of what should happen in every health facility in the country.

In 2014 the Service Delivery Packages were developed further through an iterative, consultative process with national program directors and staff. Individual packages were then peer reviewed by local and international experts with feedback helping to refine the packages. Consultations with provincial health directors, program officers, clinical staff, as well as visits to facilities around the Solomon Islands also informed the final packages.

The intention was to pilot these in 18 districts. However, this proved more difficult than envisioned. The piloting commenced in just three districts: Seghe, Malu and Marau. However, it was realised that piloting the reform had implications for financing, human resources and governance. These had not been considered adequately, and the districts found it difficult to implement the Service Delivery Packages without further assistance. Simply providing Service Delivery Packages did not enable staff to make necessary changes on their own. District reports on implementation of the Role Delineation Policy were inconsistent and did not explain enough about what changes were occurring, or why some changes were not being implemented.

One clinic did try to re-design outreach, and introduced improved services aligned with the Service Delivery Package. At least one of the three districts, Malau, involved communities and church health committees in discussions. However, without direct support, training and involvement of the MHMS, clinics were struggling to implement the RDP. Thus, the pilots were put on hold until the policy was developed more carefully.

New National Development Strategy includes Universal Health Coverage

In 2015 and 2016, policy makers turned their attention to ensuring that Universal Health Coverage became embedded in the new National Development Strategy, and later was placed as a central concept in the new National Health Strategic Plan. There is now alignment of the National Development Plan, the National Health Strategic Plan and the Role Delineation Policy. This took considerable effort, including advocacy and articulation of why the RDP was important and what it would involve.

The new National Development Strategy 2016-2035 was launched in April 2016. The vision is “Improving the Social and Economic Livelihoods of all Solomon Islanders”. The strategy

includes five long term Objectives, one of which is consistent with Universal Health Coverage: All Solomon Islanders have access to quality health and education. This is even more clearly defined in the text of the strategy, which notes that, “Access to quality health care is a universal aim of all Solomon Islanders”, “The vision for health is to contribute to the well-being of all Solomon Islands people”, and, “The overall goal is to achieve universal health coverage”.^x

National Health Strategic Plan emphasises Role Delineation Policy

The new National Strategic Plan on Health 2016-2020 was developed immediately following the launch of the National Development Strategy. It is written clearly, and places the Role Delineation Policy as central to achieving Universal Health Coverage, which is the highest level Goal of the plan. This contributes to the National Development Goal of “Healthy, happy productive people”. Thus, health is clearly a high level priority of the Solomon Islands Government. The Permanent Secretary for Health, Dr Tenneth Dalipanda, says in the introduction to the strategic plan that the role delineation policy will help drive the National Health Strategic Plan.^{iv}

The plan describes the approach illustrated in **Figure 1**:

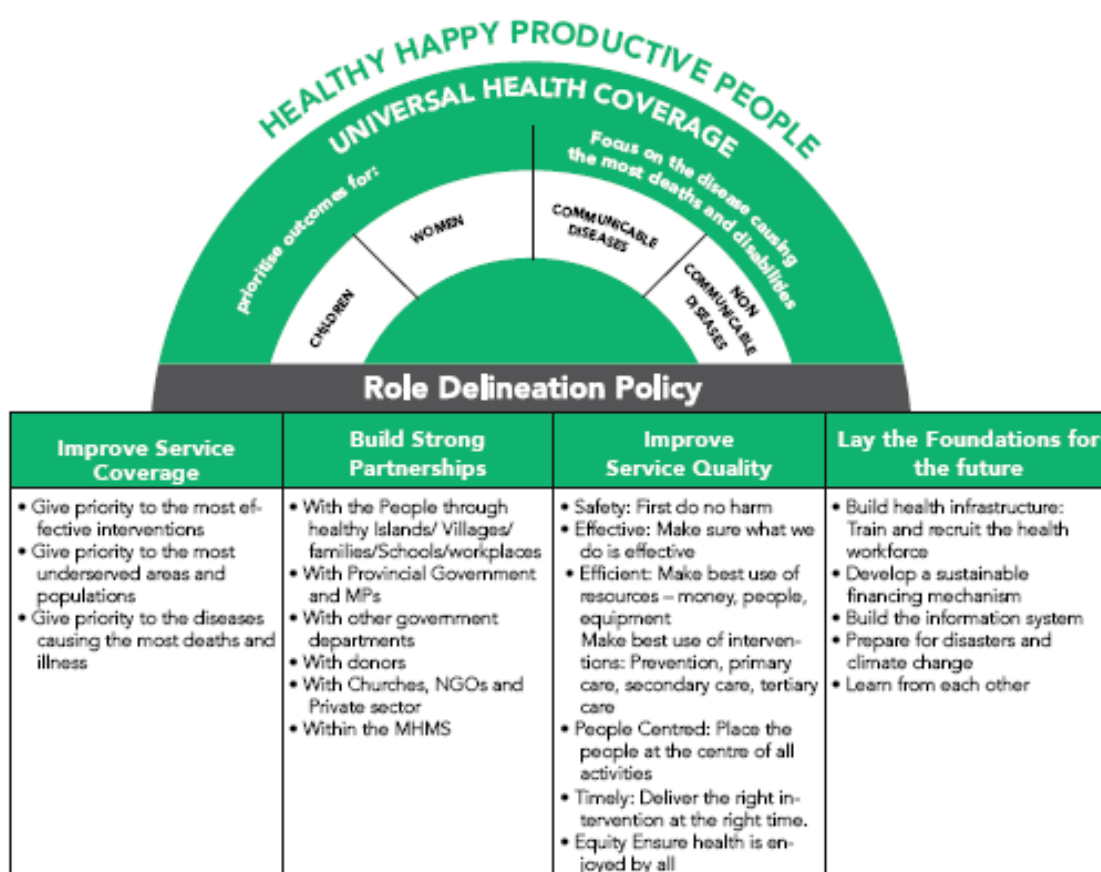


Figure 1: Pictorial summary of the National Strategic Health Plan

Source: National Strategic Health Plan 2016-2020, page 8 ^{iv}

Role Delineation Policy and Service Delivery Packages

The National Health Strategic Plan explains the purpose of the RDP:

The Role Delineation Policy defines the range and level of services – or packages of care – to be delivered to given populations across the Solomon Islands. It answers the question: who does what, where, and for whom? What staffing and drugs are required? What sort of buildings and transport? What will be needed in terms of drugs, energy, water, etc? What will be the cost to build, and more importantly what will be the cost to run each year and how many health workers are required? ^{iv}

The introduction to the current Role Delineation Policy states that, “The Role Delineation policy (RDP) reflects the principle of Universal Health Coverage ... The policy is a tool for better defining the range and level of services – or packages of care – to be delivered to given populations across the Solomon Islands. The Role Delineation Policy aims to set the standard requirements for health facilities across the country.” ^{vii}

At the national level, the task was to define *what* services are required to best meet the health needs of the nation. It is for provincial health authorities to decide, in light of local contexts and needs, *how* the services can be provided.

System architecture defines service levels

The Service Delivery Packages finalised in November 2016 specify a limited list of public health and clinical services that should be delivered at each level of the health system. The packages outline what should be available at Community Centres, Rural Health Centres, Urban Health Centres, Area Health Centres levels 1 and 2, and General Hospitals. Service packages for the National Referral Hospital will follow.

The system architecture outlined in the Service Delivery Packages is based on the levels of health services noted here, presented from most remote to most central.

Community Centres

Existing health facilities that do not meet the minimum requirements for classification as a Rural Health Centre will be reclassified as Community Centres. Community Centres will not be staffed on a full time basis. Rather, health services will be provided on an outreach basis from Area Health Centres and Rural Health Centres. The importance of this outreach is highlighted in the National Health Strategic Plan: “The health services in this plan do not stop at the door of the aid post, clinic, Area Health Centre or hospital. Instead, they are the springboard into the community.” ^{iv}

Rural Health Centres

In most cases a Rural Health Centre will service small rural populations of 1000-2500 people, and would be accessible by all people within one hour, using the local available means of transport (walking, paddline, truck, etc). It would have at least 70 contacts per week. A focus on outreach will ensure that all communities in the catchment area are visited regularly by staff based at the RHC with support from staff based at supervising Area Health Centres.

Urban Health Centres

An Urban Health Centre will provide services in the urban areas of Honiara, and in provincial capitals as required. It will service more than 4,000 people, and will have at least 200 contacts per week. Urban Health Centres will generally provide primary health care services to the urban population. The services provided and staffing will differ due to the proximity of a General Hospital in the provinces and due to the higher population density in Honiara.

Area Health Centres

AHCs will be upgraded so that they are able to adequately manage the health zone for which they are responsible while acting as an important link in the referral pathway from the community level to the hospitals. The Area Health Supervisor will be responsible for leadership in the zone and will report to the provincial health office.

An Area Health Centre Level 1 will service larger zones or more densely populated areas with large and often growing populations. It will serve more than 2,500 people, within 3 hours travel, and will have at least 150 contacts per week, with at least 150 inpatient admissions per year. It will supervise at least 3 Rural Health Centres.

An Area Health Centre Level 2 will serve more than 4,000 people plus be a referral catchment, within 4-5 hours travel, and will have at least 200 contacts per week, with at least 250 inpatient admissions per year. It will supervise at least 4 Rural Health Centres.

General Hospitals

General Hospitals provide general acute curative inpatient and outpatient services to the population of a province. General Hospitals accept patient referrals from lower level facilities based on higher level clinical care requirements. General Hospitals include provincial hospitals and church hospitals. All facilities in the zone will be accountable to the provincial health office. The General Hospital will serve more than 20,000 people, with at least 400 contacts per week and at least 1,000 inpatient admissions per year.

National Referral Hospital

The National Referral Hospital provides tertiary and general hospital services to the population of Honiara and to referred patients from the General Hospitals and other health facilities throughout Solomon Islands.

Services will be consistent with priorities of the National Health Strategic Plan

The Service Delivery Packages are designed to achieve services within four health fields, with specific services to be provided at each facility level. The four health fields, matched to the NHSP, are:

1. RMNCAH (reproductive health, MCH, child welfare, EPI, adolescent health, nutrition and HIV/STI)
2. Communicable diseases (TB/leprosy and malaria)
3. Non-communicable diseases (NCDs, eye health, mental health and dental health)
4. Community health (health promotion, social welfare, community-based rehabilitation, environmental health and rural WASH, Disaster Risk Reduction and climate change)^{vii}

Each service level will address all four of these health fields. The Service Delivery Packages define comprehensively what will be required in services at each level:

- Staffing requirements at each level: roles and required numbers
- Essential infrastructure. Facility requirements are defined, and there are now proposals to develop specific floor plan requirements for each level of service
- Equipment requirements
- Essential registers, manuals, guidelines and forms for each level
- Essential medicines.

The Service Delivery Packages will now be used by government to guide resource allocation, by national and provincial health planners to guide changes, by local communities to identify what range and quality of services they can expect, and by local staff to assess what services their clinics should be delivering.

The Service Delivery Packages are intended as guidelines, not specifications:

“Actual implementation and roll-out requires consideration of resource availability; particularly staffing, financing and availability of physical infrastructure, as well as the development of support systems such as supervision, administration, monitoring and communication. Provincial health authorities will be responsible for implementing the packages and will prioritise certain aspects over others depending on local need. National policies and best practice recommendations will change and these service delivery packages will be enhanced as more resources are made available. These service delivery packages are intended to be dynamic and will be continuously refined in line with emerging evidence and information.”^{vii}

Summary of findings about health service delivery transformation:

Senior policy makers have prepared draft Role Delineation Policy and Packages of Services. Their successful advocacy has now resulted in alignment of the National Development Plan, the National Health Strategic Plan and the Role Delineation Policy.

The RDP defines the range and level of services to be delivered to given populations across the Solomon Islands, to ensure better access to primary health care in all locations.

A revised set of Service Delivery Packages was developed in 2016. They outline what will be provided at Rural Health Centres, Area Health Centres, Urban Health Centres, and General Hospitals. Services to be provided at the National Referral Hospital will be defined later.

The Service Delivery Packages include staffing requirements at each level, infrastructure required, equipment, essential registers, manuals, guidelines and forms, and essential medicines to be provided at each level.

These will be used by government to guide resource allocation, by national and provincial health planners to guide changes, by local communities to identify what range and quality of services they can expect, and by local staff to assess what services their clinics should be delivering.

4. Health system enabling factors and barriers

This section describes enablers and barriers, based on the experience from the rolling out of the pilot of the Role Delineation Policy and the evolving clarification of Service Delivery Packages. It builds on input from discussions with senior policy makers, who themselves have extensive experience working in provinces as well as at central level.

Enabling factors

Information systems and knowledge management is strong

The Ministry's Monitoring and Evaluation Framework is being developed, and is now advanced. The RDP will be able to draw on the Health Information System indicator set to inform progress. The Health Information System is working, and will inform about people's use of services and their health outcomes.

Quality improvement and safety

The National Health Strategic Plan notes that, "There is a considerable gap to be closed between the current state of equipment and facilities and the level required under the RDP. We intend to partially close this gap by 2020." This is a realistic timeframe. It should enable gradual improvement of health services as the different levels of facilities are introduced over a five year period.

Some aspects of quality improvement and safety will depend on the ability of provinces to support the gradual transition of services to a more decentralised level, while maintaining enthusiasm and active involvement of existing staff whose roles will be changing.

Health workforce

With new medical graduates returning from Cuba in the next few years, the numbers of doctors will more than double in the 2016-2020 period. 138 new medical graduates will supplement the existing 86 medical graduates (doctors and dentists). Training and orientation of these new graduates is being undertaken by the National Referral Hospital.

The health system review in 2015 noted that the distribution of personnel among the provinces is relatively even. This means that there is equity between provinces, apart from the recognition that there is too much centralization in Honiara.

Regulatory frameworks

There is good MHMS policy and planning support for Public Health, and some health programmes already have good corporate plans. This will be improved once the RDP is finalised.

The RDP reinforces a clear distinction between the roles of the MHMS national program and provinces. At the national level, there is a direct line of accountability from Provincial Health Directors of 10 provinces, to the Under Secretary Health Care, to the Permanent Secretary. The positioning of the provincial directors so close to the top of the ministry indicates a strong focus on issues being faced by the provinces. The NHSP includes an organogram of the national MHMS, and an organogram for the provinces is now under development.

Provinces will soon develop provincial health plans. It will be important to finalise the RDP before this occurs. The community has good awareness of how health systems function. There is an existing network of village health communities and churches, and the churches support the RDP.

Funding and payment systems

The NHSP notes that the government is the main funder of health. It allocated 14 per cent of its budget to health over the last five years, and in the last two years there was a 4 per cent increase in funds for health. The Government has already identified the additional costs relating to the first two blocks of new medical graduates, and seeding costs related to NRH and Kilu'ufi developments. The NHSP includes a summary of the costs in the Medium Term Expenditure Plan as an annex. However, this is presented as a guide to Government, not a commitment to exactly what resources will be available. The number of donors and development partners is increasing.

Rural service delivery costs are low. There is facility based planning and budgeting, with project allocation and project management. Funds are provided reliably to the provinces. Annual Operating Plans and Budgets include Area Health Centres and Rural Health Centres.

Barriers

Information systems

There are some conflicting demands for indicators and many are collected nationally, not locally. While the emphasis will be on Universal Health Coverage, there are inevitably national vertical programs which will overlap with this, and have their own reporting requirements.

Quality improvement and safety

There is a need for improved governance mechanisms for provincial and health centre decision making. This can be alleviated if the national policy makers explain carefully the intended outcomes of the RDP. They can then plan ahead for clear transition mechanisms for development of physical infrastructure, medical supplies and technologies and human resources.

Health workforce

The new medical graduates trained in Cuba will require extra training in aspects of the Solomon Islands public health and medical systems. Existing nurses will need support and capacity building in some cases to move into management roles.

The main barrier will be the level of financing for new staffing positions, and for upskilling of nurse aides, through training, and then ongoing support of their higher level roles.

The NHSP recognises that once more doctors are placed in the provinces, drugs and supplies will need to increase, particularly in Area Health Facilities. The inflow of people who have been trained in Public Health in Cuba will enable some task shifting at Area Health Centre and Rural Health Centre levels. However, this will need to be carefully negotiated, and implemented first in new pilot projects. A pre-determined prescriptive outline of roles for nurses, doctors and managers will not on its own lead to successful outcomes in all contexts. The MHMS will need to provide options for job descriptions and scope of practices at different service levels.

Regulatory frameworks

It will be important to gain the support of politicians for careful application of the Role Delineation Policy in all provinces. It will be important to make the RDP very clear, and to have a good explanation of why the policy is required, even though this may mean some short term proposals for new health facilities may have to be reviewed.

Sometimes vertical program priorities make it hard to specify role delineation. For the foreseeable future, some externally funded programs will continue to have a vertical approach. In the longer term, engagement with donors should ensure that vertical programs take account of the Role Delineation Policy.

Community engagement is sometimes difficult, due to remoteness of some communities, low health literacy and low awareness of the benefits of smaller, localised services. Some people will, in the short term, continue to visit the National Referral Hospital. Once services in their own locations are improved, it will be important to host community meetings, and to conduct outreach, to ensure widespread awareness of locally available services and to build trust in them.

Funding and payment systems

The RDP has cost implications for staffing, equipment and infrastructure (whether refurbishment or building new facilities). Provinces will need support to develop new types of Annual Operational Plans and Budgeting Plans. The MHMS has already increased

provincial budgets, but has not yet provided direct guidelines about how to allocate the increased funding. As a result, most of the extra funding has gone to Provincial Hospitals. Future funding will need to reach Area Health Centres and Rural Health Centres.

The case study was informed that the MHMS Infrastructure Unit was not staffed in the last year, so only 1.5% of infrastructure funding was spent. In contrast, the Ministry of Education

Summary of findings about health system enablers and barriers:

Enablers include a well-developed Health Information System which can inform progress, and realistic timeframes set by MHMS. There are now increasing numbers of doctors graduating and returning from Cuba, good policy and planning support, and increasing funding to support their placement in provinces. The Government has allocated 14% of its budget to health over the last five years, and in the last two years there was an increase of 4% in funds for health. Donor and development partner funding is also increasing. Rural health service delivery costs are lower than national hospital costs, which should make changes viable.

Barriers include that some vertical programs are not consistent with the RDP, poorly developed governance systems for provincial health services, and a predicted need for increased drugs and supplies for Area Health Centres. It will be important to gain the support of politicians to implement the RDP in all provinces. Community engagement is sometimes difficult in remote areas. Outreach and promotion of new services available in rural areas will therefore be important.

spent 60% of its infrastructure funding. Provinces are also reluctant to build new infrastructure when ongoing maintenance is uncertain.

5. Change management

Staged development of the Role Delineation Policy and advocacy for its approval

Senior policy makers informed this case study that the RDP is an initiative of the Ministry of Health and Medical Services, not just an imposition by donors. There is strong government commitment to the RDP. The current Health Executive will, in the next year, take steps to ensure it is explained within and outside the health sector, receives adequate support from the government and development partners, and is implemented in stages that allow for review and ongoing revision.

The RDP has evolved over many years now. Whiting *et al* have explained that, “By first agreeing on the services that should be available to rural populations and then working out how that could be achieved, it was possible to identify and look for ways to overcome the barriers to providing those services.”ⁱⁱ

Early stages included defining why it is important to undertake Role Delineation, and extensive consultation to inform the development of Service Delivery Packages. Important advances in advocacy have now been made, ensuring the RDP is central to the National Health Strategic Plan, 2016-2020.

The NHSP includes a timeline for different aspects of health service transformation. This notes that the RDP will be completed in 2017. This will define roles, responsibilities and costs. It also notes that Provincial Plans are to be completed in 2016. However, it may be useful to finalise the RDP before these Provincial Plans are completed.^{iv}

This gradual approach, and use of advocacy to politicians, provinces and other sectors is consistent with WHO's approach to people centred and integrated health services. This states that, "The reorientation of care delivery will require transformational change sustained over many years", and that "There is a need to create an enabling environment that brings together the different stakeholders to undertake transformational change."^{viii}

Key informants recognised that there has been good development of the Service Delivery Packages, but that these now require further advocacy and explanation of why they are important. A simple version of Role Delineation will now be prepared to use in advocacy and to build commitment to the required changes across the country at all levels. This will be similar to the diagram produced for the National Health Strategic Plan, which visually showed how the Role Delineation Policy is central to the whole strategy. It will be useful if these two visual summary diagrams can be printed on each side of a single sheet.

The current strong leadership within the MHMS will then need to sensitise politicians to the importance of the RDP and gain their support for its rollout in their own provinces. To assist with this, the MHMS will need to prepare costing estimates, based on the Service Delivery packages. The costing estimates might define minimum and maximum funding levels to support implementation of health services at different levels. Area Health Centres and Rural Health Centres should be costed as the first priorities.

Human Resources for Health Plan

The MHMS will soon develop the first Human Resources for Health Plan. The Role Delineation Policy will be used to inform what is required in that plan.

Revision of job descriptions for health workers is ongoing. Options being explored include having just one Coordinator for up to five Area Health Services, upgrading existing malaria microscopists to run small laboratories, and defining where nurses should be deployed within the RDP.

The Human Resources for Health Plan will outline what is required for capacity development, training, scholarships, recruitment, retention of staff, and how to upgrade the skills of nurse aides (because these existing positions will be abolished). There is already a Medical and Dental Doctors Posting Committee, and it has developed a Human Resources Plan for dentists and dental officers. Its members will be involved in developing the Human Resources for Health Plan.

The MHMS will work with the Ministry of Education to ensure the health workers required for the 2020s are being trained in sufficient numbers and with appropriate skills to meet the future challenges. Universal coverage will require increasing the incentives for skilled health workers working in remote locations.

Staged rollout strategy for Role Delineation Policy

The National Health Strategic Plan predicts that the cost of rehabilitating the health system infrastructure, estimated at SBD\$1.2 billion, will be spread between the National Referral

Hospital (\$400m), General Hospitals (\$400m), and rural facilities (AHCs and RHCs: \$400m). It says there is an urgent need to progress the RDP's service delivery package costings so that out year financial forecasts present a better balance between central and peripheral expenditures on infrastructure.

While there will be some additional costs, it is important to keep in mind the advice of Whiting *et al*: "With effective management and leadership, a decentralised health system that is more flexible and responsive to local population health needs should be more effective at targeting limited resources where they are needed."ⁱⁱ

Next steps

Each province will be supported to develop leadership and managerial capacity to oversee the change to improved Role Delineation. This will include direct support for capacity building of Provincial Health Office staff, including Provincial Health Officers and others, who may include Administrative Officers for Area Health Centres. The provincial health leaders should be supported to define requirements for numbers of facilities they will need to have at each level in three years from now. Working groups in each province, with support from the MHMS, can then decide which of their existing facilities should be closed, upgraded or redeveloped. Priority health facilities would be identified as the first to refer to the Service Delivery Packages to define what they will do, what staff they have and what staff they need, and what it will cost to make changes.

Annual Monitoring and Review of the rollout of the RDP and the Service Delivery Packages will also be important. This will consider:

- Performance assessment, conducted in a supportive way in the first years, recognising the importance of management of change
- Continuous quality assurance, including documentation of lessons learned during early pilot stages of the RDP
- Review of the Service Delivery Packages in light of implementation experience.

Further assistance may be sought from donors, specifically to support Role Delineation and changes in facilities. Some donors may be encouraged to support facility development, in accord with new planning guidelines for different levels of facilities. Others may be asked to focus on staff training.

In the next year, 2017, the national policy makers will focus on explaining the RDP to others, developing new pilot initiatives, costing of proposed changes, and considering what is required for improved governance of health services at the provincial level. Guidance will be required to ensure effective implementation.

Taking health to communities

The final page of the National Health Strategic Plan sums up the current challenges with an optimistic conclusion: “Our job is to go beyond serving only those that knock on the clinic door, and make sure our services reach everyone in the community ... Nurse leaders at the

Summary of findings about change management:

There is strong Government commitment to the RDP. There has been good development of Service Delivery Packages, with extensive consultation throughout the country. The current strong leadership within the MHMS will advocate to politicians and encourage their involvement and support for the RDP.

Senior policy makers are now planning the next steps to roll out the RDP from 2017-2020. The MHMS will finalise the RDP, then undertake costing. The National Health Strategic Plan predicts that health system transformation will cost SBD\$1.2 billion, to be spread between the National Referral Hospital (\$400m), General Hospitals (\$400m), and rural facilities (AHCs and RHCs: \$400m). It says there is an urgent need to progress the RDP’s service delivery package costings so that out year financial forecasts present a better balance between central and peripheral expenditures on infrastructure.

After costing, a Human Resources for Health Plan will be developed. Each province will be supported to develop leadership and managerial capacity to oversee the change to improved Role Delineation. Annual Monitoring and Review of the rollout of the RDP and the Service Delivery Packages will also be important.

The National Health Strategic Plan fully supports the implementation of the RDP, noting that, “Reaching universal health coverage rests on the shoulders of these frontline workers, and the rest of the health system’s role is to support them in their work.”

RHC and AHC level have an important role to play in this ... Reaching universal health coverage rests on the shoulders of these frontline workers, and the rest of the health system’s role is to support them in their work.”

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- ⁱ Hodge N, Slatyer B, Skiller L. Solomon Islands Health System Review. *Health Systems in Transition*. 2015;5(1)
- ⁱⁱ Whiting S DT, Dalipanda T, *et al.* Moving towards Universal Health Coverage through the Development of Integrated Service Delivery Packages for Primary Health Care in the Solomon Islands. *International Journal of Integrated Care*. 2016;16(1)
- ⁱⁱⁱ World Health Organization. Solomon Islands Country Cooperation Strategy at a glance. Honiara: WHO; 2014
- ^{iv} Ministry of Health and Medical Services. Solomon Islands National Health Strategic Plan 2016-2020. Honiara: Ministry of Health and Medical Services; 2015.
- ^v Australian High Commission website: National Referral Hospital's post-natal ward officially opened. 19 February 2015. <http://solomonislands.highcommission.gov.au/honi/200215.html> accessed 30 November 2016
- ^{vi} Ministry of Health and Medical Services. Policy on Role Delineation of Health Services (draft). Honiara: MHMS; February 2012
- ^{vii} Ministry of Health and Medical Services. Service Delivery Packages for Solomon Islands Health Facilities. Honiara: MHMS; November 2016
- ^{viii} World Health Organization. WHO global strategy on people-centred and integrated health services. Geneva: WHO; 2015
- ^{ix} Solomon Islands Government. National Health Strategic Plan 2011-2015. Honiara: Ministry of Health and Medical Services; 2010
- ^x Solomon Islands Government. National Development Strategy 2016 to 2035. Honiara: Ministry of Development Planning and Aid Coordination; 2016