

Report of the Evaluation of the Cook Islands Medical/Health Specialist Visits Schemes



**Commissioned by the
New Zealand Aid Programme, New Zealand Ministry of Foreign Affairs and Trade**

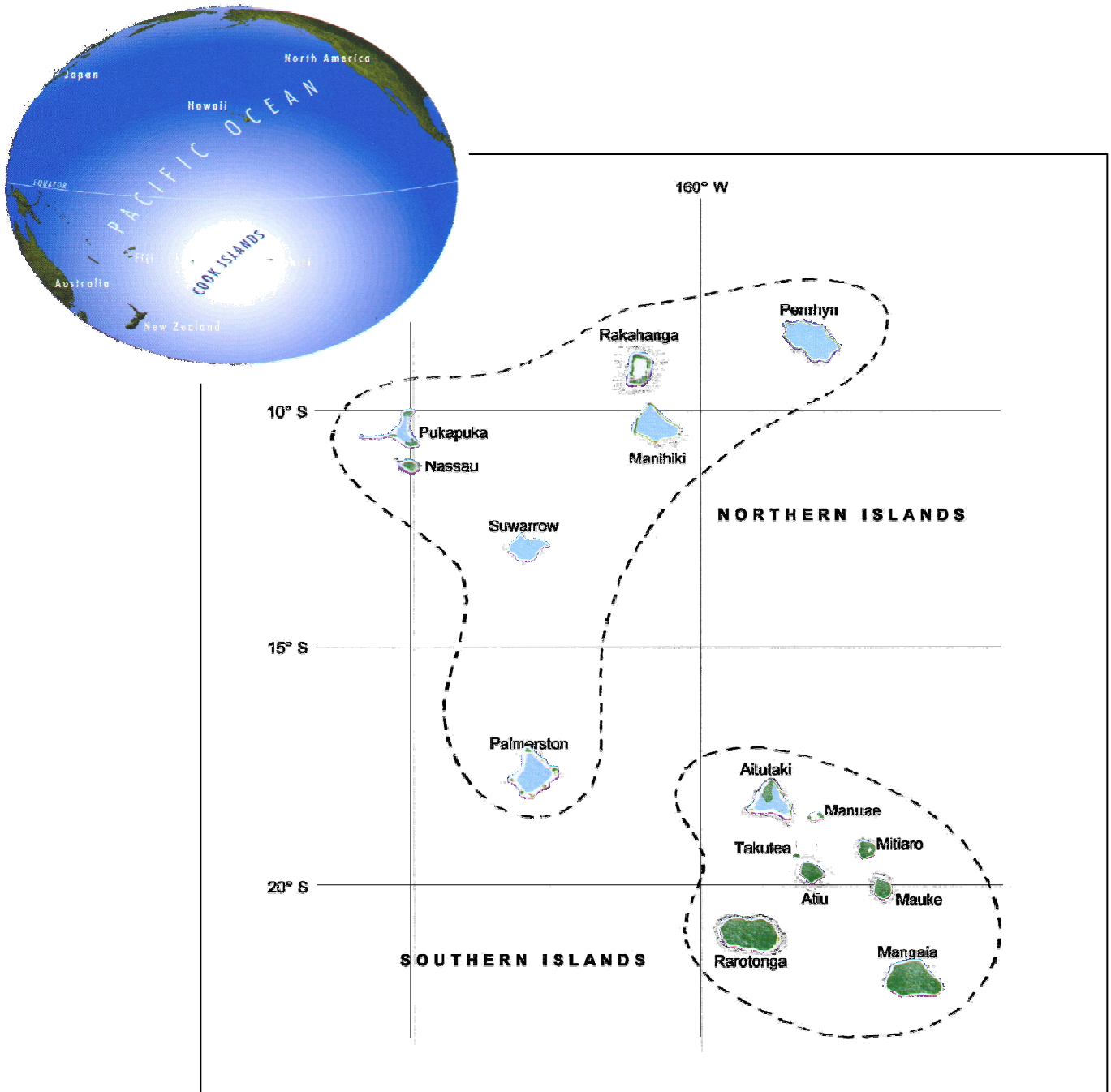
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**Wellington and Rarotonga
February 2011**

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Sonja Easterbrook-Smith and Vaine Wichman
would like to thank all those
who contributed to this evaluation.

Thank you maata.



Source: Ministry of Outer Islands and Physical Planning, Cook Islands Government

Evaluation of the Cook Islands Medical/Health Specialist Visits Schemes

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Summary

Background to the evaluation

To provide Cook Islanders with access to specialist services not available the Cook Islands, since 1994, the New Zealand Government has funded and initially managed medical specialist visits to the Cook Islands. Between 2004 and 2008, these visits took place under the Medical Specialists Visits (MSV) scheme and from 2008 to the present, under the Health Specialist Visits (HSV) scheme. Both schemes provided funding under tripartite arrangements between the New Zealand Agency for International Development (now the New Zealand Aid Programme), Ministry of Health Cook Islands (MOH CI) and the Cook Islands Ministry of Finance and Economic Management (MFEM), with management of the schemes now delegated to the MOH CI.

The schemes aim to improve the health status of Cook Islanders through access to visiting specialist health services and have objectives relating to: equitable access to specialists; emphasis on women's health; increasing local capacity; effective follow-up to screening programmes funded by MSV/HSV; and effective local management of scheme funds. New Zealand Government funds approved for the schemes were for \$160,000 per annum for the first four years, rising to \$175,000 for 2008/09 and to \$350,000 for 2009/10. The 2009/10 allocation to the HSV represented just over 3 percent of the total Cook Islands health budget.

An in-house review of the MSV undertaken in 2007 concluded that the MSV was working well, but recommended an evaluation to determine the outcomes of the scheme. This evaluation stems from that recommendation. Its purpose is to assess the relevance, effectiveness, efficiency and sustainability of the MSV and HSV schemes from July 2004 to June 2010 and to provide recommendations for the future of the HSV within a possible wider health sector programme.

Methodology for the evaluation

Sonja Easterbrook-Smith from New Zealand and Vaine Wichman from the Cook Islands undertook the evaluation. Their evaluation plan identified primary stakeholders as recipients of visiting specialist services and their families, visiting specialists, and MOH CI health workers who worked with and received training from visiting specialists. Secondary stakeholders included: MFEM as the recipient of schemes' funds; MOH CI as the implementing agency; the New Zealand Aid Programme of MFAT as funder; New Zealand Ministry of Health which has an MoU with MOH CI; Counties Manukau District Health Board (CMDHB) which receives most patients referred to New Zealand for treatment and relevant Cook Islands NGOs.

The New Zealand team member consulted with New Zealand-based stakeholders. For two weeks in November/December 2010, the team consulted with stakeholders in Rarotonga, Mitiaro and Mangaia then presented its preliminary findings in Rarotonga to representatives from the MOH CI, the New Zealand High Commission and NGO representatives. In the course of its consultations, the team interviewed a range of stakeholders, including Cook Islands health workers who had worked with visiting specialists, specialists who had visited under the schemes, and patients. The team promoted participation, for example, by meeting some health staff separate from their group or managers, securing a direct voice from children and young people who have received services, and inviting participants to discuss their interaction with the scheme in their own words. Patients were assured that personal information provided would remain confidential.

The team gathered information from a variety of sources. It used the quantitative information available, but drew largely on qualitative information. The team considered the material in terms of the evaluation's criteria concerning the relevance, effectiveness, efficiency and sustainability of the MSV/HSV schemes, relating these to the purpose and five objectives of the schemes.

Findings relating to the 'relevance' of the schemes

The team found that the schemes were relevant to both the Cook Islands and New Zealand Aid Programme's health sector policies and objectives. However, without a needs assessment at the outset to identify needs and priorities of different groups of people in the Cook Islands and a follow-up survey to assess results, it was not possible to determine whether the schemes had met needs and priorities of different groups. The team noted however that under the schemes, a range of specialists had provided services not otherwise available to various population groups and that patients were very satisfied with the services they had received.

Findings relating to the 'effectiveness' of the schemes

In terms of 'effectiveness', Cook Islands health workers and patients alike commented on the high quality of work and the dedication of the visiting specialists and their teams. The schemes have enabled large numbers of Cook Islanders to access these specialist health services. The MOH CI has worked increasingly to pre-screen patients to ensure that access to visiting specialists is based on need. Nevertheless, the team was told that people of influence sometimes apply pressure to be seen by specialists without meeting the pre-screening requirements, although the extent to which this denies access to others who need the services is not clear. The team identified two groups who may not be accessing services as readily as others. These are people with disabilities and people who reside in the outer islands of the Northern Group.

The focus on women's health had a slow start under the MSV but has increased in recent years, with regular uro-gynaecologist visits and the introduction of a mammography screening programme. There has been no input from scheme specialists into a cervical screening programme.

In terms of capacity building, through the strong relationships developed between the Cook Islands clinicians and visiting specialists, the HSV displays a collegial and collaborative approach whereby local clinicians are undertaking more specialist work themselves (within the constraints of available facilities and equipment) with supervision and support from the visiting specialists. This 'on-the-job' training approach has made a significant contribution to building the capacity of the local health workforce. While keeping this approach, the MOH CI has also begun to use scheme to provide dedicated training programmes for health staff.

Interviews with Cook Islands doctors and visiting specialists suggested that follow-up for those screened under the schemes was good. However, patients identified some issues of concern, for example, occasional shortages of drugs or, lack of prescribed equipment and the need to extend the coordination arrangements in New Zealand to help referred patients navigate the transition to New Zealand and attend their medical appointments.

Visiting specialists were clear that their visits had reduced the volume of patients referred to New Zealand for treatment. This was achieved either by direct provision of services in the Cook Islands such as cataract operations, by diagnosing conditions and developing treatment plans that could be

implemented in the Cook Islands, by up-skilling local clinicians to perform additional procedures, and by ensuring that only appropriate cases were referred for treatment in New Zealand.

The effectiveness of the schemes was enhanced by the strong sense of ownership by the MOH CI which is responsible for managing them, the commitment and reported low turnover of the Cook Islands health workforce, the high level of commitment displayed by visiting specialists, the supportive and collaborative relationships they build with the local health workforce, and the excellent support provided to visiting specialists by local health workers.

Findings relating to the ‘efficiency’ of the schemes

Given the many components to consider in mounting the programme of specialist visits, the MOH CI does well in planning and organising the annual schedules of visits. Arrangements and processes are well-established and generally work well (although specialists experienced some difficulties when the HSV Coordinator was absent on study leave). Six-monthly reporting on the schemes has improved significantly in recent years. The reports provide clear financial information with variances by HSV visit, indicate the AusAID-funded contributions, and include the cost of the local contribution. Although the schemes have never been audited, both MFEM and the New Zealand High Commission (NZHC) indicate that they are satisfied with the financial reporting prepared by the MOH CI and consider that scheme expenditure is well-managed.

Although there is inadequate hard data on which to assess the value-for-money of the MSV/HSV schemes, anecdotal reports suggest that New Zealand’s small investment provides considerable value. Some specialists receive no fees. Others accept low fees. Visits reduce referrals for treatment which carry high costs for the New Zealand health and income support services. Local health workers have skills developed from working alongside visiting specialists, and specialists donate to the Cook Islands a range of medical equipment and supplies from New Zealand.

Findings relating to the ‘sustainability’ of the schemes and the Cook Islands health service

The sustainability of the HSV is enhanced by the stability of the MOH CI health workforce. Local clinicians have developed strong relationships with visiting specialists who make long-term commitments to visit on a regular basis to provide services and to upskill their counterparts. HSV specialists also work to identify specialists to participate in the scheme in the future and report no shortage of people willing to join the scheme. The only identified threat to the sustainability of the HSV is the ongoing willingness of the New Zealand Government to fund it, or the ability of the MOH CI to absorb the cost in its small health budget if New Zealand funding were discontinued.

In terms of sustainability of the Cook Islands health service, visiting specialists provide support for their counterparts in ways that may assist in retaining their services in the Cook Islands. For example, visiting specialists assist with complex cases when they visit and are available by phone or email between visits to discuss cases. They provide learning opportunities not otherwise available to local clinicians, and often assist in securing locums for Cook Islands counterparts

Conclusions and lessons learned

Have the objectives of the schemes been achieved? Although there are improvements to be made, the objectives of the scheme have largely been met. Have the schemes been relevant, effective, and efficient and contributed to sustainability of the Cook Islands health system? Again, although improvements can be made, the answer to all these questions is ‘yes’.

While the focus of other visiting specialist schemes tends to be on ‘additionality’ i.e. providing partners with higher level clinical care than would otherwise be available or affordable (often provided by a changing cast of specialists), the HSV offers more. It models good development practice with local clinicians undertaking more of the work with the supervision and support of visiting specialists, many of whom make long-term commitments to the Cook Islands..

There are two key lessons to be learned from the schemes for broader development practice. The first relates to the significant benefits that the long-term, collaborative relationships between the Cook Islands health workers and the visiting specialists have yielded. The second relates to the effective results that flow from local ownership and management of a development project. The MSV/HSV schemes provide good models of both.

Under the present arrangement, the HSV scheme will run until November 2012. With its increasing focus on training, the scheme could usefully expand to support the professional development priorities of the MOH CI. Should the New Zealand Government decide in future to increase its assistance to the Cook Islands, the HSV scheme provides a sound centrepiece for support for a wider health sector programme. For effective ongoing monitoring of the scheme, it would be helpful if it’s monitoring and evaluation framework could be examined and possibly revised to ensure that it can provide the best possible data for maintaining the effectiveness of the scheme.

Recommendations

The evaluation team recommends that:

The New Zealand Ministry of Foreign Affairs and Trade and the Cook Islands Government:

1. *Examine* and possibly revise the monitoring and evaluation framework for the HSV scheme to confirm the outcomes sought and to ensure that indicators and measurement methods are realistic and include provision of baseline data where necessary.

The Cook Islands Government (through the Ministry of Health Cook Islands):

2. *Engages* a wider range of health workers in planning the annual schedule of specialist visits by including directors of all MOH departments and outer islands medical officers/practice nurses, and links its planning more clearly to identified needs and priorities as shown in Cook Islands morbidity and mortality data and the objectives of the Cook Islands Health Strategy.
3. *Develops* a policy or guideline on the fees that it will pay to HSV specialists and Cook Islands specialists-in-training.
4. *Advertises* specialist visits more widely, particularly engaging the assistance of local non-government organisations working in health-related areas, and *ensures* that visiting screening programmes to the outer islands are widely advertised to ensure maximum participation.
5. *Provides* staff with as much notice of HSV visits as possible, with two months’ notice the ideal.
6. *Develops* guidelines for staff on the pre-screening requirements for patients’ appointments with those visiting specialists not involved in population screening programmes (such as vision or hearing testing) which staff can cite when inappropriate access is sought.
7. *Works* to ensure that residents in the Northern Group have equitable access to specialist services provided under the HSV by organising periodic visits of groups of specialists to these islands.

8. *Works* to ensure that people with disabilities have equitable access to HSV services by working more closely with relevant NGOs that act as advocates for this group.
9. *Uses* HSV funding to bring outer-islands residents to Rarotonga to see HSV specialists, for example, for breast screening.
10. *Considers* seeking the services under the HSV of specialists in screening (to provide advice on developing an appropriate, cost-effective cervical screening programme), and in public health and primary health care.
11. *Retains* the successful on-the-job focus of visits for most specialists under the HSV, supplemented with dedicated training programmes that support the professional development priorities of the MOH CI and which include arrangements to formally monitor the effectiveness of the training in building staff capacity.
12. *Considers* introducing formal debriefing sessions at the end of the specialists' visits to extract more learning for local clinicians and their teams.
13. *Circulates* copies of specialists' reports more widely especially to those involved in the area where the specialist has worked.
14. *Considers* routinely submitting specialists' reports and recommendations to its executive group for discussion and decision, and to monitor implementation of recommendations, and *acknowledges* these reports, letting specialists know what recommendations have been accepted.
15. *Considers* how to ensure that adequate cover is provided when the HSV Coordinator is on leave, and *encourages* specialists to sign contracts before they arrive so that they can receive their per diems at the beginning of their visits.
16. *Considers* including in its six-monthly reports on the HSV summary data showing the specialist visits that took place during the period and setting out the numbers of people seen or treated, disaggregated by age group, gender, socio-economic status where possible and island visited, and *considers* adopting the UN Convention on the Rights of the Child definition of a child for data collection purposes as those under the age of 18.
17. *Explores* the possibility of New Zealand's health support for the Cook Islands providing funding for an extended coordination service for Cook Islands patients referred to New Zealand for treatment.

The New Zealand Ministry of Foreign Affairs and Trade

18. *Considers* delegating to the Ministry of Health Cook Islands responsibility for setting appropriate rates for per diems paid to visiting specialists.
19. *Considers* undertaking an audit, in terms of section 15 of the tripartite arrangement, of the expenditure by MFEM and the MOH CI of the funding provided for the HSV scheme.
20. *Notes* that the HSV scheme provides a sound centrepiece for a wider health sector programme, should the New Zealand Government decide to increase its assistance to this sector in the Cook Islands.

1 Background and development context

The 2006 census indicates that the population of the Cook Islands was 15,324. Compared with most developing countries, people in Cook Islands have a high standard of living. The Human Development Index for the Cook Islands was 0.789 for 2002 (the most recent recorded) which placed it first in the Pacific Islands region. The Cook Islands has high life expectancy, high levels adult literacy, and generally enjoys a good standard of service delivery throughout the country. Nevertheless, it remains vulnerable and faces a number of development challenges. These include, for example: depopulation through high rates of external migration and low birth rates; a narrow-based economy; vulnerability to natural disasters and long-term effects of climate change; skilled workforce shortages; the remoteness of some groups in the population particularly those living in the Northern Group, with high costs of energy and other supplies; and a widely-dispersed land mass (as shown in the map at the front of this report) with associated high costs of providing services.

As a self-governing country in free association with New Zealand, the Cook Islands has a special relationship with New Zealand which confers rights and obligations on both countries. Cook Islanders have New Zealand citizenship and unrestricted access to residence, work and publicly-funded health and education services in New Zealand. Under the special relationship, the Cook Islands determines its own economic, social and development aspirations, with New Zealand as its major development partner. The Aid Management Division (AMD) of the Ministry of Finance and Economic Management (MFEM) works with the Cook Islands Government to develop policies and priorities for development activities and to coordinate and manage the aid strategy.

In 2007, life expectancy at birth for Cook Islanders was estimated to average 68 years: 66 years for men and 70 years for women. Most common causes of death in 2009 were cardiovascular diseases, cancers, diabetes and injuries. The health service provides public hospitals in the main population centres of Rarotonga and Aitutaki and a network of dental clinics, health centres and community health clinics on the outer islands. With its small population, resource constraints and a shortage of health specialists, secondary and tertiary health services available in the Cook Islands are limited. Most specialist services are provided under the Health Specialist Visits (HSV) Scheme.

New Zealand's primary development assistance¹ to the Cook Islands in the health sector is its contribution to the schemes subject to this evaluation. New Zealand's 2009/10 contribution to the HSV scheme represented just over 3 percent of the Cook Islands health budget for that year.

2 Background to the MSV/HSV Schemes

Since 1994, the New Zealand Government has funded and managed medical specialist visits to Cook Islands. From 2004 to 2008, visits were funded under a tripartite arrangement between NZAID (now the New Zealand Aid Programme), MOH CI and MFEM for the Medical Specialist Visits (MSV) scheme. A similar arrangement for July 2008 to November 2012 underpins the now-named Health Specialists Visits (HSV) scheme. Under these arrangements, New Zealand provides funding to MFEM through AMD. AMD funds the MOH CI which now manages the schemes.

¹ AusAID and MFAT co-fund a joint programme of assistance to Cook Islands that MFAT manages on behalf of Australia.

The purpose of the tripartite arrangement for the MSV was to meet the costs of medical specialist visits to the Cook Islands so that all Cook Islanders could have access to medical specialists in order to improve their health status. Although the arrangement for the HSV is not explicit that the outcome sought is improved health status of Cook Islands people, the evaluation team has assumed that it is the same for both schemes. In 2008 with the change of name to the HSV, the scheme expanded to include allied health practitioners, biomedical engineers, technicians, and support staff.

The MSV/HSV schemes have the following five objectives:

- Objective 1: Equitable access to medical specialists
- Objective 2: Emphasis on women's health
- Objective 3: Increasing local capacity
- Objective 4: Effective follow-up to screening programmes funded by MSV/HSV
- Objective 5: Effective local management of the MSV/HSV fund

New Zealand Government funding approved for the schemes was for \$160,000 per annum for the first four years of the scheme, rising to \$175,000 for 2008/09, and to \$350,000 for 2009/10.

Under the MSV/HSV schemes, the New Zealand funding can pay for:

- visiting health specialists' fees based on MOH CI policy and guidelines;
- visit-related international and domestic travel and associated expenses for visiting specialists;
- internal travel from and to outer islands for patients requiring access to visiting health specialists, including accommodation and living expenses;
- reasonable expenses for family members when this is essential to travel with the patient;
- hire costs of medical equipment, including freight costs/insurance and associated supplies;
- purchase of consumables directly related to equipment used but not stocked by MOH CI; and
- devices or further diagnostic testing to implement the recommendations of health specialists during or after the visit, i.e. diagnostic tests, follow-up testing, prosthetic devices.

The MOH CI is responsible for: decisions on which specialist fields to include; dates and priority of visits; selection of specialists; organisation and itineraries of specialists and support staff during visits; expenditure of direct visit-related costs within the funding allocation; and visit promotion with appropriate acknowledgement of the New Zealand Aid Programme. In addition, the MOH CI contributes by funding costs of staff involved in planning, supporting implementing and reporting on the scheme; meals for specialists and teams; supplies and services e.g. pharmaceuticals, and through its fixed overhead costs. MOH CI is also responsible for coordinating the schemes with the AusAID-supported Pacific Islands Programme and Medical Equipment and Training Programme, and the Operation Tropic Twilight medical missions conducted by the New Zealand Defence Force.

In 2007, NZAID (now the New Zealand Aid Programme) in the Cook Islands undertook an in-house review of the MSV in consultation with the MOH CI and MFEM to assess the effectiveness and efficiency of the scheme's processes, financial management, monitoring and reporting. The review concluded that the scheme was relevant, well-managed and cost-effective, and recommended that an evaluation be conducted to determine the outcomes of the schemes. This evaluation results from that recommendation.

3 Purpose and scope of the evaluation

The purpose of the evaluation as set out in the evaluation terms of reference (see Appendix 1) is to:

- assess the relevance, effectiveness, efficiency and sustainability of the MSV and HSV since 2004, and
- provide recommendations for the future of the HSV within a possible wider health sector programme.

The evaluation team is asked to address a number of questions set out in the evaluation terms of reference and in the evaluation plan attached as Appendix 2. The evaluation is also asked to identify lessons learned from the operation of the schemes.

The evaluation covers the six-year period from July 2004 to June 2010. It assesses the achievement of the schemes' objectives and documents wider or unintended consequences of the schemes. The findings of the evaluation are addressed to both the New Zealand Ministry of Foreign Affairs and Trade (MFAT) and the Cook Islands Government (CIG). The report will go to MFAT, CIG, and also to AusAID as co-funder with MFAT of the joint programme of assistance to Cook Islands that MFAT manages on behalf of Australia.

4 Methodology/approach used

The evaluation team members were Sonja Easterbrook-Smith (team leader), a development consultant from New Zealand and Vaine Wichman, a development economist from the Cook Islands. The team's work was overseen by a steering group made up of representatives of MFAT's New Zealand Aid Programme, MOH CI and the AMD of MFEM. Before the evaluation started, the steering group briefed the team on the terms of reference for the evaluation. The team then prepared an evaluation plan (see Appendix 2) which the steering group approved. The plan identified the primary stakeholders of the schemes as:

- the recipients of visiting specialist services and their families;
- visiting health specialists who provided services under the schemes; and
- MOH CI health workers who provided support to visiting specialists, and /or who received training from visiting specialists.

Secondary stakeholders included: key staff of the AMD in MFEM as the recipient of funds for the schemes; in the MOH CI as the implementing agency; in the New Zealand Aid Programme of MFAT as funder of the scheme; in the New Zealand Ministry of Health which has an MoU with the MOH CI; and in Counties Manukau District Health Board (CMDHB) as recipient health board for most of the patients referred to New Zealand for treatment and as a party in the recently renewed memorandum of understanding with the MOH CI; and relevant Cook Islands NGOs as advocates for potential patients.

The team reviewed available documents and reports relating to the schemes and associated background material. In New Zealand, Sonja Easterbrook-Smith consulted with staff in the New Zealand Aid Programme and Special Relations Unit of MFAT, New Zealand Ministry of Health,

and the Pacific Programme of CMDHB. She also interviewed a range of specialists who had visited the Cook Islands under the MSV/HSV schemes and a representative of the New Zealand Defence Force about Operation Tropic Twilight, and sought comment from the Royal Society of Surgeons which is funded by AusAID to support specialist services in the Cook Islands.

In the Cook Islands, with the help of MOH CI, Vaine Wichman prepared the schedule of meetings with key stakeholders and organised the travel logistics and arrangements. Between 29 November and 10 December 2010, the team consulted in Rarotonga, Mitiaro and Mangaia. At the conclusion of its Cook Islands-based consultations, the team presented its preliminary findings to representatives from the MOH CI, the NZHC and some NGO representatives, summarising comments received from various stakeholders as set out in Appendix 3. (Note that the table now includes the summary comments of specialists that were not available at that time). The team leader provided progress reports on a weekly basis throughout the evaluation to the Development Programme Officer Cook Islands in the New Zealand Aid Programme.

The team completed its analysis of material gathered and submitted a draft report on 19 January 2011. The steering group reviewed the draft report and provided feedback on 4 February 2011. The team submitted its final report on 8 February 2011. In a separate document, the team commented on how it had responded to the feedback and on changes made to the report.

Privacy/confidentiality/ethics

The steering group provided a list of stakeholders and the team identified some additional contributors. A list of those consulted is set out in Appendix 4. Patients are not identified by name.

The team asked the MOH CI and its outer island health workers to identify some patients in Rarotonga, Mangaia and Mitiaro who had seen MSV/HSV specialists to ask whether they would participate in the evaluation. This approach was used in Mitiaro and Mangaia. In Rarotonga the MOH CI provided details of patients for the team to contact. In each case, the team checked that patients were happy to be interviewed, and assured them that personal information would be treated as confidential. All approached were happy to participate.

In the time available, the team was only able to interview 20 patients. Of those interviewed, six were aged under 18 (and were interviewed with a parent or parents present), nine were adult women and five were adult men. This small group represented engagement with a wide range of specialists: audiology, cardiology (adult and paediatric), gynaecology, mammography, ophthalmology, orthopaedics, neurology and general medicine. The team also interviewed 26 health workers who had worked with visiting specialists and 10 specialists who had visited in the schemes.

Approach

The evaluation team began interactions with stakeholders by explaining the purpose and objectives of the schemes and of the evaluation. The evaluation was not designed at the outset as a fully participatory one with, for example, input from patients and visiting specialists into the design of the evaluation, issues to be addressed or questions to be answered. However, the team promoted participation with, for example, arrangements made to meet as appropriate with health staff separate from their group or managers and to secure a direct voice from children and young people who had received services. Participants were invited to discuss their interaction with the scheme in their own

words. Questions developed for different groups (see the Evaluation Plan attached as Appendix 2) were used to assist the team rather than as formal formats for interviews.

Information gathering and analysis

The team sought information through a variety of means e.g. review of documents suggested by the steering group and additional material (identified at the end of this report), focus group discussions, observation, and face-to-face interviews with individuals, as well as through telephone interviews, email, and Skype. The team gathered qualitative and quantitative information. Qualitative information was cross-checked by asking the same question of different groups of stakeholders, and checking for documentary evidence to support their views.

The team analysed data relating to services provided by specialty, patient gender, age group, and home island, using the information provided by the MOH CI. There were a number of gaps in this data. Information on the socioeconomic status of patients, although requested in a performance indicator for the MSV (but not the HSV scheme) has never been collected and was not available.

Findings are based on analysis of information, largely qualitative, gathered from various sources. Assessment of the material is made in terms of the evaluation's criteria of relevance, effectiveness, efficiency and sustainability of the schemes, relating these to their purpose and five objectives.

Building evaluation capacity

Although the evaluation team did not include representatives of the funders, recipients, implementers or beneficiaries of the schemes, the evaluators sought to build the capacity of partners to undertake their own evaluations by modelling of good evaluation practice.

Addressing cross-cutting issues

Cross-cutting issues of human rights (equitable access to health specialists) and gender equality (emphasis on women's health) are central objectives of the schemes and were integral to the evaluation. In examining equitable access, the evaluation team looked at access by age as well as gender, but because information on the socio-economic status of patients had not been collected, was not able to identify whether poverty was a barrier to accessing services of visiting specialists.

Assessing value-for-money

Without baseline data, it was difficult to confirm the results achieved for the funding invested. Instead, the team focused its assessment on qualitative evidence of results achieved and commented on the cost/effectiveness of systems and processes used to manage the scheme. It also sought information on similar schemes for other countries in order to draw comparisons.

5 Limitations of the evaluation

Although the purpose and objectives of the schemes are results-focused, no baseline data had been collected at their inception. Performance indicators against which the MOH CI was asked to collect information related more to volume measures, process indicators and outputs than to results. As a consequence, the results of some of the schemes' objectives are not easily verifiable from the data collected. Summary data for one year is missing, as is one six-monthly report. Summary data does not always match information in the six-monthly reports. Nevertheless, data available gives some

indication of the direction of the schemes. Although the team used quantitative evidence where it could, it had to rely largely on qualitative information.

Given the short time allocated to the evaluation, getting to grips with activities and recommendations contained in reports of dozens of visiting specialists working in a range of specialities over six years and with the impacts of their work was a large task. Seeking information from stakeholders during December/January (when many were on leave) also had its challenges.

The evaluation was not designed from the outset by the parties to the tripartite agreement as fully participatory. This limited the ability of the evaluation to take account of questions or issues that primary stakeholders might have liked to see addressed.

Due to budget and evaluation timetable constraints, the team was unable to seek face-to-face input from patients, communities and health workers in the islands of the Northern Group. This was a concern given the focus of the schemes on providing equitable access to visiting specialists, with particular reference to the outer islands. The two islands visited (Mitiaro and Mangaia), although examples of small populations, have air access not available to many in the Northern Group. However, Mitiaro with its small population and health service headed by a nurse practitioner provided some similarities to the circumstances of islands in the Northern Group. Some limited input relating to the Northern Group was obtained by interviewing the Mayor of Rakahanga and the Medical Officer for Manihiki who were visiting Rarotonga while the evaluation team was there.

The Cook Islands team member was only contracted to be present for the Cook Islands portion of the implementation phase. This may have reduced her ability to evaluate the schemes in their totality. The two members of the team had never worked together before and had to develop their *modus operandi* as a team during the short time they worked together. This may have limited their ability to give the information gathering their full attention for the period.

6 Findings in relation to the MSV/HSV schemes

The terms of reference (ToR) ask the team to assess the relevance, effectiveness, efficiency and sustainability of the MSV and HSV schemes. To avoid confusion between the MSV/HSV objectives and the evaluation criteria, the MSV/HSV objectives are numbered as follows:

1. Equitable access to medical specialists
2. Emphasis on women's health
3. Increasing local capacity
4. Effective follow-up to screening programmes funded under the MSV allocation
5. Effective local management of the MSV/ HSV funds

And the criteria for the evaluation are identified as follows:

Objective A	Assessment of relevance
Objective B	Assessment of effectiveness
Objective C	Assessment of efficiency
Objective D	Assessment of sustainability

Objective A Assessment of relevance

The ToR ask the evaluation team to consider the five questions set out below.

(i) Have the schemes met the health needs and priorities of different groups of people in the Cook Islands?

Without a needs assessment at the outset of the schemes to identify needs and priorities of different groups (by geographic area, gender, socio-economic group and age) and a follow-up survey, it is not possible to assess the extent to which the schemes have met their needs and priorities. Nevertheless, under the schemes, different specialists have provided a range services for various population groups. For example, for children and young people, they have included visits by vision/hearing, paediatric and paediatric cardiology specialists; for women, they have included regular visits by a uro-gynaecologist and the introduction of a breast screening programme; for adult and older men and women, regular visits are provided by general medicine, cardiology, urology, orthopaedic, ophthalmology, ear, nose and throat/audiology, psychiatry, endoscopy and diabetes specialists. (A list of the type of visits by year and the islands visited is attached as Appendix 5). ‘Need’ has largely been determined by local clinicians based on the presenting conditions of patients. It is not formally linked to national morbidity and mortality data.

(ii) How relevant are the schemes to Cook Islands health sector objectives?

The Cook Islands National Development Plan 2007–2010 identified as a vision: for all Cook Islanders to have universal access to quality health services by 2020, and set a number of health targets. These included maintaining the medical specialist visits programme and strengthening the infrastructure of the health system with special attention to the outer islands. The Health Strategy 2006-2010 identified in its vision: ‘All Cook Islanders living healthier lives and achieving their aspirations’. The mission statement for the Ministry of Health is ‘to provide accessible and affordable health care of the highest quality by and for all in order to improve the health status of the people of the Cook Islands’. There is also a clear focus in the Ministry of Health’s 2009 Strategy and Business Plan on conducting outreach specialist visit programmes in at least five of the outer islands. The Ministry’s 2010-2020 Workforce Development Plan shows its concern for and commitment to developing a well-trained and competent health workforce.

The purpose and objectives of the MSV/HSV schemes, particularly those relating to improved health, equitable access to specialists and to increasing local capacity, are relevant to and consistent with the Cook Islands national and health sector objectives.

(iii) How relevant are the schemes to the New Zealand Aid Programme’s policies, priorities and regional health programmes?

The schemes are also relevant to the New Zealand Aid Programme policies and priorities which are set out in the: Pacific Strategy 2007-2015; the health policy Ending Poverty Begins with Health; and the NZAID (now the New Zealand Aid Programme) Health Strategy 2008-2013. The Pacific strategy identifies health improvement as an area of focus, noting that assistance to the Cook Islands reflects New Zealand’s constitutional commitments and close social relationships. Although its emphasis is on development of primary health care, it includes assistance for secondary and tertiary level care in selected Pacific countries where these are cost-effective and strategic.

For the first part of the evaluation period, the Cook Islands NZODA Country Strategy 2001/02 - 2006/07 underpinned the development cooperation relationship between New Zealand and Cook Islands. This was replaced by the Cook Islands Joint Country Strategy 2008 – 2017 (JCS), an agreement between the Government of the Cook Islands, the New Zealand Aid Programme and AusAID. The earlier strategy emphasised outer island health development and increased access to medical specialists. The JCS maintains these areas of focus, and notes that support for medical specialist visits will continue in the short term with the shape of medium-term support to the health sector to be considered during the life of the JCS.

(iv) How are specialist visits prioritised?

Between 2004 and 2008, MSV visits were planned by a project officer in the MOH CI's Finance and Planning Section with input from clinical staff in Rarotonga, particularly the Director of Clinical Services, and the doctors/nurse practitioners in the outer islands. In 2008, planning and management for the HSV scheme moved to the hospital setting. At the same time, HSV and patient referral coordinators were appointed creating full-time positions to support the HSV scheme and the referral programme. For the past two years, the Director of Clinical Services has planned the programme working with the HSV Coordinator. This process includes most but not all of the directors of departments in the MOH CI. It does not appear to include the Director of Nursing or the outer islands doctors /nurse practitioners. The MOH CI could usefully develop a broader planning approach, ideally engaging all the directors of departments (particularly the Director of Nursing) and outer island doctors/practice nurses to help identify specialist visit needs.

The priority for specialists sought under the scheme has largely been determined by local clinicians based on the presenting conditions of patients. Priority setting is not formally linked to national morbidity and mortality data or to health strategy documents beyond ensuring that there is an effective visiting specialists' programme. Because the schemes tend to have a secondary/tertiary clinical focus, there has been little focus on securing services of specialists in the primary or public health areas, although these areas feature strongly in the Cook Islands Health Strategy. It would be useful for the planning/priority setting process to demonstrate clearer linkages to Cook Islands' morbidity and mortality data and to the objectives of the Cook Islands Health Strategy.

(v) To what extent have visits been prioritised to meet specific needs as planned?

Although there have been occasional and unavoidable changes of plans, visits have generally been able to meet specific needs as planned.

Objective B Assessment of effectiveness

The ToR ask the team to assess the schemes' effectiveness in terms of eight questions set out below. With agreement from the steering group, the team added two, included below as (ii) and (vii).

(i) What has been the contribution of MSV and HSV in enabling Cook Islanders to have access to specialist health services?

To address this question, the team looked at the summary data available on the numbers seen or treated. This has some shortcomings. Data gathered for the 2007 review of the MSV covered the three-year period from July 2004 to June 2007 but included no information on 2005/2006 when several visits took place. No summary data was collected for 2006/2007. Good summary data was

available for the period from July 2008 to June 2010. The information collected on total numbers seen² by MSV/HSV specialists is shown below.

Numbers of people seen by visiting specialists by year

2004/05	2005/06	2006/2007	2007/2008	2008/2009	2009/2010
370	Not available	1792	Not available	2173	2471

Although the table is incomplete, it indicates that numbers being seen or treated by visiting specialists continue to grow and that the numbers are not insignificant. The growth in numbers seen correlates with the increased numbers of specialists visiting under the HSV and increased funding allocated to the scheme by the New Zealand Aid Programme.

Although the figures show the numbers of people who have accessed specialist services in these years, they do not indicate whether the use of services was appropriate, i.e. whether the people most in need were being seen. Where population screening services such as vision and hearing testing are provided, it is appropriate to see as many as possible to identify those who may need treatment, equipment or other follow-up. Where other specialist services are provided e.g. for orthopaedic or cardiac assessments, access should be directed to those most in need.

The MOH CI has increasingly worked to ensure that patients are pre-screened to assess their suitability for seeing visiting specialists. The introduction/development of the MedTech 32 patient information system and improved telecommunications links with the outer islands have assisted this approach. Rarotonga-based clinicians are now able to read on line the pre-screening notes prepared by outer islands staff and discuss cases with them before deciding which patients should come to Rarotonga to see visiting specialists. Nevertheless, the team was told by several health workers that people of influence sometimes apply pressure to be seen by specialists without meeting the pre-screening requirements - a not uncommon practice that places health workers in a difficult position and is viewed with irritation by some specialists who want to use their limited time to see those who most need their services. The extent to which this practice denies access to those who need the services is not clear. One commentator said that the practice may be diminishing as people see that specialists visit regularly. Meanwhile, it might be useful to develop guidelines for staff on pre-screening requirements for appointments with specialists (not engaged in population screening programmes) which staff can cite when inappropriate access is sought.

Because no particular information was collected relating to people with disabilities, their level of access specialist services is not clear. However, anecdotes suggested that this group was not able to access services as well as their non-disabled counterparts. The MOH CI may wish to take an active role in promoting equitable access to specialist services for this group.

Although there have been regular visits by some specialists to Rarotonga and the outer islands in the Southern Group (as shown in Appendix 5), visits to Northern Group islands have been limited. Travel to the Northern Group has its challenges with limited air services and lengthy-circuit shipping services which can result in long layovers on different islands. Chartered plane travel provides the best option, but it is expensive. (Although the team notes that the under spend on the

² Patients 'seen' by specialists include those seen for screening purposes and those who received treatment. Some patients may be counted more than once where they have seen specialists on repeat visits.

budget for 2009/2010 could have covered the costs of a specialist team visit to the north). In addition, planning and organising a joint visit by a range of specialists is no small task.

Visits to the Northern Group by MSV/HSV specialists over the evaluation period have included:

- November 2004, when a team of specialists (cardiology, paediatrics, ophthalmology, gynaecology and dermatology) visited Pukapuka, Manihiki, Rakahanga and Penryn³;
- April 2007, when the eye team visited Penryn and Manihiki⁴; and
- March 2008, when a team of specialists (ophthalmology, general medicine, surgery and gynaecology) visited Pukapuka, Penryn, Rakahanga, and Manihiki⁵.

As it is nearly three years since the last visit to the Northern Group, it may be timely to mount a visit in 2011. Given the workloads of previous visits, specialists consulted suggest that the team could usefully include an optometrist, two general physicians, a paediatrician and a gynaecologist. They suggest that, because of the difficulties associated with provision of surgery on the outer islands, patients needing surgery should be referred to Rarotonga.

(ii) To what extent and how are health workers and the wider community made aware of planned specialist visits?

The performance indicator for the HSV is that ‘Visits have been advertised broadly (newspaper, radio) and to special interest groups (e.g. disabilities groups, women’s groups etc)’. The tripartite arrangement suggested that advertising should acknowledge the contribution of the then NZAID.

Early in the year, the MOH CI sends a schedule of planned specialist visits to each department in the Ministry, the outer islands health offices, and to private doctors in Rarotonga. MOH CI confirms each visit about a month before it is due. For the wider community in Rarotonga, MSV visits were advertised in the newspaper, radio and TV about a month before each visit, and on occasion, newspaper articles were prepared about visiting specialists. NGOs with an interest in health issues were also advised. In the past two years, advertising for HSV visits in Rarotonga has been confined to the newspaper and does not appear to acknowledge the New Zealand Aid Programme. Although the six-monthly reports say that visits are advertised ‘to special interest groups (e.g. disabilities groups, women’s groups etc)’, NGOs indicated that they are not routinely notified of visits.

In the outer islands, the team was told that residents learn about specialist visits in a variety of ways, for example, from their local TV, announcements by health workers at maternal and child health clinics, notices posted in the village, through church and child welfare committees, or by direct follow up from the island doctor. Although outer islands health workers consulted were confident that local networks worked well, in the report of eye team visit in early 2009 to four outer islands in Southern Group, optometrists reported that few local people knew that they would be visiting⁶.

The experience of the eye team suggests that more attention is needed to ensure that populations on the outer islands are made aware of screening visits. In addition, in an effort to improve access by people who might not come forward without advocates, it would be useful to routinely alert those NGOs that provide health-related services. These include, for example, the Cook Islands Family Welfare Association which provides reproductive health services, the Cook Islands Breast Cancer

³ MOH CI, January – June 2005 Six-monthly Report p 3

⁴ MOH CI, January – June 2007 Six-monthly Report, p 2

⁵ Oral reports from specialists

⁶ MOH CI, January –June 2009, Six-monthly report, p 34

Foundation which promotes breast screening and assists outer islands women to travel to Rarotonga for mammography, Te Pa Taunga/ Te Vaerua Mental Health which provide services to people with mental illness and the Disability Council which assists people with disabilities.

(iii) To what extent and how are women and people from the outer islands accessing MSV/HSV?

This question relates to objectives 1 and 2 of the schemes concerning equitable access to specialists. Access by women is discussed under question (iv) below. As mentioned earlier, there are shortcomings in the data available. Summary data prepared for the MSV review for July 2004-June 2007 suggests that nearly 40 percent of those seen came from the outer islands of the Southern Group (where 20.6 percent of the population lived)⁷. Data for the period July 2008 to June 2010 indicates that around 24 percent of those seen by specialists during that period came from the Southern Group. Information on those seen by specialists between 2004 and 2008 in the Northern Group where 7.1 percent live is incomplete. There were no HSV visits to the Northern Group from July 2008 to June 2010, although some patients from the Northern Group will have been seen by specialists in Rarotonga.

(iv) Is there an effective emphasis on women's health (e.g. equal access, female health specialists, addressing women's needs)?

This question relates to objective 2 of the schemes which emphasises women's health. Performance indicators for the MSV included identifying women's health needs, services provided, data on access by women to services, and appropriate gender composition of specialist teams to encourage women to take advantage of visits. The indicator for the HSV focuses on access to services.

Summary data prepared for the review of MSV (July 2004-June 2007) said that 49 percent of those seen by visiting specialists were women, but noted that some 25 percent of the data collected was not gender disaggregated. There is no summary data available for 2007/08. Data for July 2008 to June 2010 indicates that just over 40 percent of adults seen were women. This drop is puzzling given that two breast screening rounds were carried out in this period, but without reliable data it is difficult to analyse this trend.

Summary data for the 2004-2007 review of the MSV indicated that ten specialist visits took place during that three-year period of which only one visit - that of a gynaecologist - focused directly on women-specific health needs. In the second three-year period from 2007 to 2010, however, there was an increased focus on women's health and the Ministry is to be commended for its efforts. The uro-gynaecologist made five visits to the Cook Islands between July 2007 and June 2010, and on one visit saw women on islands in the Northern Group. The focus of his visits to Rarotonga is on undertaking complex gynaecological surgery with the resident obstetrician/ gynaecologist. Regular visits (about every eight months) are now a well-established part of the HSV.

In September 2007, a medical physicist visited to test the mammography x-ray unit in Rarotonga against New Zealand quality standards. In October, around 300 women, mainly those living in Rarotonga, were screened marking the launch of an ongoing mammography programme for women aged 40 and over. The equipment was serviced again in early 2008 and later that year, over 300 more women were screened. Both times, the programme was timed to coincide with Te Maeva Nui

⁷ 2006 data from the Cook Islands Statistics Office

celebrations in Rarotonga to enable visiting outer islands women to take advantage of the screening. In 2009, the physicist tested the unit again ahead of screening conducted in August 2009. Although efforts to coincide with Te Maeva Nui celebrations were unsuccessful, the Cook Islands Breast Cancer Foundation funded return airfares to Rarotonga from their own fundraising and donations to enable 17 outer islands women identified as having symptoms or as coming from families with a history of breast cancer to be screened. A further 374 women were screened.

It appears that women in Rarotonga are now quite well covered by the programme. Unless they are in Rarotonga for other reasons at the time of screening, however, access for outer islands women is restricted. Given that the New Zealand contribution to the scheme can cover the costs of bringing outer islands people to Rarotonga to visit specialists (and given that the New Zealand allocation is often underspent), the team is unclear why scheme funding is not being used for this purpose, with the cost falling instead on the funds of the Cook Islands Breast Cancer Foundation.

So far, there has been no input from MSV/HSV specialists into cervical screening. At present, despite the best efforts of staff concerned, the service provided in Rarotonga can only be opportunistic given limited staff resources. Screening in the outer islands tends to be undertaken by a nurse attached to the Cook Islands Family Welfare Association on contract to the CI MOH. Overall, only an estimated 40 percent of eligible women receive regular cervical screening. This is the one area of women's health that still needs attention and could benefit from support to help develop an appropriate and cost-effective approach. A screening specialist from the New Zealand Ministry of Health which has a strong screening unit (and with whom the MOH CI has an MoU) may be able to assist here.

In relation to gender mix of specialists and their teams, data collected for July 2004 to June 2007 indicates that of the 26 people who visited under the MSV scheme, eight (or 30 percent) were women. Although no clear information is available for 2007/2008, during the two years from July 2008 to June 2010, 55 people visited of whom 20 (or 36 percent) were women. Of these, nearly 20 percent of the specialists were women. 100 percent of the nurses and radiographers were women.

Although more attention could be given to securing the services of women under the scheme both to provide role models and to increase the comfort of women patients, the team found no evidence that women had decided not to access services where services were provided by men. Patients reported that they were simply pleased to be seeing a specialist.

Out of interest, about four percent of all Cook Islands people seen by visiting specialists in the 2008-2010 period were aged under 16 years and around 20 percent were aged 60 years and over.

(v) To what extent has the capacity of local health professionals been increased?

This question relates to objective 3 of the schemes - increasing local capacity. Performance indicators for this component include engagement/observation by local staff in treatment of patients during MSV/HSV visits, and numbers of tasks and seminars delivered by specialists.

There can be no doubt that the schemes have contributed to building the capacity of the local health workforce through 'on-the-job training', with visiting specialists working alongside counterparts and their support staff. Although it is difficult to quantify the increase in capacity, all of the health workers interviewed who had worked with visiting specialists indicated that over a series of visits, they had benefited, citing improved clinical and diagnostic skills, increased confidence to take on a

higher level of responsibility or provide a wider range of services. For example, the paediatrician reported that he is now better able to identify heart murmurs; the gynaecologist can now manage more complex cases; and the anaesthetist has increased techniques and intensive care skills. Specialists confirmed that skills of counterparts and teams had increased in a variety of ways.

Specialists also have an indirect effect on capacity building where their recommendations have resulted in some formal training for Cook Island health workers. For example, a theatre nurse had a two-week attachment at Southland Hospital in 2005 and the obstetrician/gynaecologist went to Auckland City Hospital in 2009 for a two-week course on managing obstetric emergencies. On the recommendation of the eye team, a nurse undertook the eye training programme in 2009 and a doctor is undertaking the Diploma in Ophthalmology at present at the Fiji School of Medicine.

Visiting specialists reported that they had provided periodic seminars, workshops and lectures. Given that specialists' visits were short, busy and focused on services to patients, training sessions were generally short and informal and did not have measurable objectives. No summary data on the number and subjects of these sessions is available.

In recent times, the MOH CI has begun to use the HSV to provide dedicated training programmes to supplement on-the-job training⁸. Recent initiatives include high-dependency intensive-care training for nurses, ultrasound-use training for a radiographer and physiotherapist, training in the use of the MedTech 32 application for administration and management of patient care for outer islands health workers, and a visit by a clinical specialist to provide strategic advice to the MOH CI. This useful development could usefully expand to include professional development priorities identified by the MOH CI's professional development committee. These training programmes should include arrangements to formally monitor the effectiveness of the training in building staff capacity.

In relation to on-the-job training, more learning could be extracted from visits by holding formal debriefing sessions at their conclusion with specialists and staff who have worked with them. The approved MOH CI work plan for December 2009 to June 2010 indicated that such sessions would be held with visiting specialists, senior management and funding and planning directorate staff 'to ensure: key objectives for the visit were achieved; health and workforce performance indicators are reported; areas for improvement are identified with proposed solutions; and justification for future visits are considered and agreed'. This proposal has yet to become established practice.

(vi) Is there effective follow-up to MSV/HSV funded screening programmes?

Objective 4 of the schemes concerns effective follow-up for screening programmes. The performance indicator for the MSV was for data to be prepared on those identified as needing treatment following screening programmes, those referred for follow-up treatment and those who received the necessary treatment. The indicator for the HSV is that 100 percent of those with positive or unclear results have access to diagnosis and treatment.

For the first part of the evaluation period, data on follow-up for patients was kept on a paper-based system. The MedTech 32 patient information system is now in place in all but two of the outer islands. As a result, information on most patients and the follow-up treatment or management prescribed by specialists can be accessed by health workers in Rarotonga or the outer islands. The ready availability of this information assists health workers to provide appropriate follow-up.

⁸ As signalled in the 1 December 2009 Letter of Variation to the Tripartite Arrangement for the HSV

Interviews with Cook Islands doctors and visiting specialists suggest that follow-up for those screened is generally good, although Cook Islands health workers and specialists reported that they sometimes have difficulty obtaining discharge notes from the New Zealand health services to use in management of referred patients after their return to Cook Islands. Patients also identified some issues that could usefully be investigated. These included:

- occasional shortages of drugs e.g. penicillin for treatment of rheumatic heart disease;
- lack of equipment, e.g. a hearing aid for a child deemed to need one as a result of screening;
- conflicting experiences on the number of follow-visits that could be funded for children needing to go to New Zealand to see New Zealand-based specialists; and
- some confusion about the priority of different patients identified for referral to New Zealand on orthopaedic waiting lists.

Although in the past, a patient coordinator position was funded by the MOH CI in the Cook Islands Consulate Office in Auckland, it was discontinued. Patients who used the services of the coordinator spoke highly of the service, and local clinicians and visiting specialists indicated that the coordinator ensured that they received discharge notes relating to patients. The Pacific Regional Coordinator in the Pacific Regional Health at Counties Manukau DHB now appears to provide coordination services for about a third of patients referred from the Cook Islands but does not assist patients to access income support or take them to appointments as did the MOH CI funded coordinator. She provides services for patients referred to CMDHB but does not have an ‘agency’ role to provide services for those referred to other district health boards.

A number of patients referred to New Zealand by specialists commented on problems that arose in navigating the transition to New Zealand, attending their medical appointments, and where they expected a long stay, in accessing the New Zealand income support system. The report of a 2009 eye team visit⁹ indicated that ‘there have been many patients over the last year who did not attend their NZ appointments and it is difficult to work out where the breakdown is occurring – if there was the same contact person it would make it much easier’. Cook Islands clinicians and some visiting specialists now report difficulties in getting discharge notes for some patients returning to the Cook Islands after receiving treatment in New Zealand.

The MOH CI may wish to look at how it can ensure that all its patients are able to access an appropriate coordination service, perhaps by extending the role of the Pacific Unit at CMDHB to provide services for patients referred to any DHB, and to look at how best to provide ‘pastoral care’ such as helping patients to access income support and ensuring that they attend appointments. The New Zealand Aid Programme provides some funding through its health support for Niue to Counties Manukau District Health Board for coordination services for referred patients from Niue. The MOH CI and the New Zealand Government may wish to explore the possibility of establishing a similar service at CMDHB for referred Cook Islands patients.

(vii) To what extent are recommendations made in reports prepared by specialists followed up and acted on?

Specialists report that, as a result of their recommendations, there have been some changes. For example, departments now generally make appointments for individual patients rather than inviting

⁹ MOH CI, January to June 2009, Six-monthly Report, p35

all to arrive at the same time; theatre practice is more efficient; appropriate treatment protocols are used; appropriate drugs are purchased; some recommended consumables and equipment are purchased; and some health workers have received recommended training. However, specialists' reports are not acknowledged by the MOH CI, and specialists generally only become aware of whether their recommendations have been accepted when they next visit.

Given the value of observations and recommendations made by visiting specialists for improving health services in the Cook Islands, adopting a systematic approach to addressing their recommendations would be useful. One approach would be to submit all specialists' reports to the executive group meetings so that it could consider recommendations, and monitor the implementation of those that are accepted. It would also be a courtesy for the MOH CI to acknowledge reports, formally thank specialists and their teams for their services, and let them know which recommendations it has accepted and plans to implement.

(viii) Has the quality of visits (e.g. specialist skills, support teams, time allowed) been of an appropriate standard for meeting identified health needs?

The 2007 in-house evaluation considered the issue of good clinical practice. It recommended that reporting on the scheme include any adverse clinical events relating to visits or during post-operative care, and evidence of visiting health specialist team member's current practicing certificates and professional registration. At present, there are no formal procedures in Cook Islands for monitoring adverse events. During the evaluation period, the team was told that there had been no adverse events associated with specialists' visits. However, the HSV Coordinator now checks routinely to ensure that visiting specialists are registered practitioners.

Expectations for visiting specialists are now set out in contracts which they sign before they arrive. On arrival the Director of Clinical Services briefs specialists and their teams on the Ministry's expectations for their visits. Cook Islands health workers and patients alike commented on the high quality of work of specialists and their teams.

During the evaluation period, one long-serving visiting health worker was asked without warning to discontinue work and reported that the Ministry of Health gave no explanation for its decision. A letter from the worker's sponsor seeking an explanation from the MOH CI reportedly remains unanswered. As the MOH CI staff members involved are no longer employed by the Ministry, it was difficult for the team to gain an understanding of this event. Although this appears to have been a 'one-off' event, it highlights the need for the MOH CI to ensure that appropriate human resource processes are in place for all visiting specialists, and that where the services of particular specialists are no longer required, they are treated with respect and courtesy, mindful that their contribution has been made on a voluntary basis and often at some personal cost.

Given the regularity of many specialists' visits, the time allowed for visits appears adequate.

The only area where a few specialists were not complying with expected practice was in the completion of end-of-visit reports, as required in their contracts. In these cases, the HSV Coordinator has worked to prepare drafts which the specialists can amend and submit. Given that specialists come in their own time, often at personal cost, and work very hard during their visits, the CI MOH is reluctant to make an issue of this and has made arrangements to deal with it.

(ix) What factors have enhanced or constrained the effectiveness of the MSV/HSV?

Factors that have enhanced the effectiveness of the MSV/HSV schemes include the:

- strong sense of ownership that the MOH CI has as the manager of the scheme;
- commitment of the Cook Islands health workforce to provide effective health services to its community within available resources;
- commitment of visiting specialists to the Cook Islands people, and the high level of support and collaborative relationships they build with the Cook Islands health workforce;
- excellent support provided by local health workers to visiting specialists;
- effectiveness of the on-the-job training provided by visiting specialists;
- donations of equipment and supplies that visiting specialists often bring with them;
- effective coordination by the MOH CI with other externally supported programmes such as the Pacific Islands Programme and the Operation Twilight Medical Missions; and the
- high level of patient satisfaction with the work of the specialists.

Factors that have constrained the effectiveness of the schemes include the:

- MOH CI's reluctance to use scheme funds to bring people from outer islands to see specialists;
- limited opportunities for specialists to visit the outer islands of the Northern Group;
- pressure placed on health workers by people of influence to be seen by specialists without going through the pre-screening process;
- limited advertising of specialists visits and engagement with relevant NGOs; and
- the need for the MOH CI to ensure that appropriate consideration is given at a senior level to the recommendations contained in specialists' reports.

(x) To what extent has the MSV/HSV had an impact on the volume of patient referrals to New Zealand for health services?

MOH CI data (see Appendix 6) indicates that referrals of patients for treatment overseas have been trending down since 2007 while referrals from the outer islands to Rarotonga have been trending upwards. Although it is difficult to link these trends directly to MSV/HSV specialist visits without further information, increased referrals from the outer islands to Rarotonga appear to correlate with the increased number and frequency of specialists' visits, and visiting specialists consulted were clear that their visits reduced the volume of patients referred to New Zealand. This was achieved either by direct provision of services in Cook Islands e.g. on each visit the eye team carries out 50-60 cataract operations on people who would otherwise go to New Zealand for treatment, by diagnosing illness and developing treatment plans that could be implemented in the Cook Islands, by up-skilling local clinicians to perform additional procedures, and by ensuring that only appropriate cases were referred for treatment in New Zealand.

The number of cases referred to New Zealand over the evaluation period has averaged 155 per year. For 2008/09 and 2009/10, the number of referrals has been just under 140. The number of patient referrals requested by visiting specialists is reported to average around 30 per year¹⁰.

¹⁰ MOH CI , January –June 2009, Six-monthly Report, p 5

Objective C Assessment of efficiency

This section relates to objective 5 of the MSV/HSV - effective local management of the schemes. The ToR ask the team to assess the schemes' efficiency in terms of the four questions set out below.

(i) Were/are the schemes being managed and delivered effectively and efficiently?

Although there were no contracts during the first four years, specialists now complete contracts for each assignment which include visit dates, reporting lines, duties, budget, and a template for a written report. Duties generally include working closely with local counterparts (medical and nursing staff) to review and discuss management of selected patients or to perform appropriate procedures, together with a small teaching component. The budget identifies fees, per diems, travel, transport, and other costs. Fees range from \$0 to \$400 per day. Although the funding arrangement notes that visiting health specialists' fees will be 'based on MOH CI policy and guidelines', there is no MOH CI policy or guideline relating to fees paid to HSV specialists.

Assumptions about the level of fees to be paid to visiting specialists were set out in the Letter of Variation (LOV) to the HSV arrangement of December 2009¹¹. However, some specialists accept no fees, and fees paid to others exceed the \$250 per day indicated in the assumptions. Moreover, Cook Islands specialists-in-training receive a fee of \$150 per day rather than the MOH CI daily per diem indicated in the assumptions. Although there may be good reasons for these differences, for example, higher fees are paid to self-employed specialists who absorb considerable costs to employ locums during their visits under the scheme; these are not yet captured in a formal document.

Given that a policy on fees is an expectation noted in the funding arrangement, and in order to be transparent about fees, the MOH CI could usefully develop a policy or guidelines relating to the fee structure for HSV specialists. This could note that some specialists are happy to provide services without receiving any fee, and explain, for example, why Cook Islands specialists-in-training receive a fee rather than per diems, and why some specialists are paid at higher rates.

Arrangements and processes for HSV visits are now well-established and generally work well (although specialists experienced some difficulties when the HSV Coordinator was absent on study leave, and, where specialists have not signed their contracts before their visits begin, they sometimes receive their per diems only on the last day of their visits). Where possible, it would be useful to increase the length of notification of visits so that health workers have adequate time to order appropriate supplies, organise staff requirements, cancel scheduled appointments, re-screen patients, and arrange travel. CI health workers report receiving as little as two weeks notice on occasion, and although this is sometimes unavoidable, they suggest that an ideal lead time would be two months. NGOs would also welcome long notice of visits so that they can identify people who might benefit from seeing specialists and arrange travel, particularly for people with disabilities from the outer islands whose transport to Rarotonga and associated care requires more planning.

In terms of *meeting objectives and completing tasks of visits*, with the exception of the few mentioned earlier who do not complete end-of-assignment reports, visiting specialists easily meet the requirements of their contracts and health workers who work with them report a high level of satisfaction with the work that specialists undertake and complete during their visits.

¹¹ See 'Assumptions' set out on p 25 in the summary budget in the Letter of Variation 1 of 1 December 2009

In terms of *use made of completed reports*, in the past, specialists' reports went to the Director of Clinical Services and Project Officer responsible for the MSV, and if a specialist had visited an outer island, to the outer island doctor/nurse practitioner. Reports were also attached in full to six-monthly reports sent to the NZHC. In recent times, reports have gone to the Director of Clinical Services, HSV Coordinator, Director of Hospital Health Services and the lead clinician with whom the visiting specialist has worked, with summaries sent to the NZHC in the six-monthly reports.

Several clinicians (including outer islands doctors and nurse practitioners) involved in specialists' visits together with nursing and support staff who had worked with specialists commented that they would also like to receive copies of the specialists' reports. The evaluation team considers that it would be useful for all staff involved in specialist visits, together with the Director of Nursing, to routinely receive copies of specialists' reports.

The growing use and effectiveness of the MedTech 32 patient information system is assisting health workers to increasingly *monitor visit outcomes*. Systems or practice changes made as a result of visits are sometimes discussed in specialist reports and in the MOH CI's six-monthly reports to the New Zealand Aid Programme on the scheme.

In terms of *quality of reporting, including coverage and timeliness*, the tripartite arrangement for the MSV 2004-2008 required 'reporting against services provided', 'monitoring reporting' and '6-monthly formal monitoring of the ... programme for the first two years to ensure that devolution of responsibilities under the arrangement were working for the MOH CI and NZAID'. The MSV arrangement included objectives, outcomes and performance indicators, but did not ask specifically for reporting on these fields. The arrangement for the HSV is more explicit on reporting requirements. It also seeks 'reporting against services provided' and 'monitoring reporting' six-monthly against objectives and performance indicators set out in the schedule to the arrangement. It says that reports should contain information set out in a template¹² and include a brief narrative on training provided to local staff and any issues that have arisen. End-of-year reports must also include a list of medical specialist visits provided by other means (e.g. the AusAID funded PIP), and outline the major causes of morbidity and mortality in Cook Islands so that the parties can assess whether the right number and mix of health specialist visits is occurring.

Although the team was unable to locate one report for the MSV period (for January to June 2006), other reports provided some risk analysis and general comment, together with expenditure information on each visit, schedules of patients seen (identified by initials or patient code) and diagnoses made. There was no formal monitoring report after the first two years of operation. An AMD assessment¹³ of the 1 January to 30 June 2007 report commented on the lack of information on socio-economic status of patients, on transfer of skills to local counterparts, and on the absence of audits, noting that these were two years behind. The 2007 in-house evaluation of the scheme¹⁴ said the quality of reporting was improving, but noted a need for more evidence-based reporting.

Reporting since July 2008 has improved significantly (although the requested outline of major causes of morbidity and mortality in Cook Islands is not included). Reports are clear and provide information on each HSV visit under the headings: background; planning; results; and

¹² The template in Schedule 3 to the arrangement seeks information on the speciality, date, cost, islands visited, total seen/treated, total referred to Rarotonga, women, age group and home location.

¹³ AMD, July 2007, Assessment of the 6-monthly report -1 January – 30 June 2007

¹⁴ NZAID Manager in Cook Islands, 2007, Draft Review of Cook Islands Medical Specialists Visiting Scheme

recommendations. They also discuss each visit in terms of the scheme's objectives, outcome sought and performance indicators. The reports provide clear financial information with variances by HSV visits, and indicate the AusAID-funded PIP contribution. They also include discussion points for improving the scheme and recommendations for the New Zealand Aid Programme and MOH CI.

The team is unable to comment on the timeliness of reports as dates of submission were generally not included in the material provided. The team understands that there were delays due to work pressures at the height of the implementation of the health reforms in 2008, but otherwise, timeliness of reporting does not appear to have been an issue.

For monitoring and evaluation purposes, it would be useful for the MOH CI to routinely include in its six-monthly reports, summary data showing the specialist visits that took place during the period together with the numbers of people seen, disaggregated by age band, gender, socio-economic status where possible and island visited. It would also be useful for the MOH CI to adopt the UN Convention on the Rights of the Child definition of a child for data collection purposes as someone under the age of 18¹⁵. Overall, it would be useful to examine and possibly revise the monitoring and evaluation framework for the HSV to confirm the outcomes sought and to ensure that indicators and measurement methods are realistic, and to include provision of baseline data where necessary.

In terms of *financial management*, monthly acquittals are sent by the MOH CI to MFEM for checking and then on to the NZHC. Both MFEM and the NZHC are satisfied with the financial reporting prepared by the MOH CI. Although the scheme has still not been audited as required in the tripartite arrangement, MOH CI provides detailed acquittals and variance reporting which indicate that expenditure is generally well-managed. Reports now show the significant MOH CI contribution to support the HSV, giving a comprehensive picture of the overall costs of the scheme.

(ii) Is the funding arrangement being managed within financial budgets and fulfilling the terms of the contract?

In the tripartite arrangement for the MSV, NZAID (now the New Zealand Aid Programme) agreed to provide up to \$480,000 for the first three years. The arrangement stated that 'NZAID shall pay the amount based on the monthly forecast request, and taking into account any unspent funds from the previous period. NZAID retains the right to request that the Recipient refund to NZAID any unspent funds at any time'¹⁶. The arrangement was extended to June 2008 with the allocation of a further \$160,000. The HSV arrangement has a similar clause about refunding unspent funds. In practice, the AMD and CI MOH do not 'refund' under spending. Instead, it remains within the AMD Trust Account that receives and disperses funding for all activities under the Cook Islands harmonised aid programme.

NZAID, now the New Zealand Aid Programme, has funded MFEM on a monthly basis subject to satisfactory forecast and acquittal reports (taking account of any unspent funds from the previous period). MFEM makes the funding available to MOH CI for activities approved under the scheme. MFEM and the MOH CI keep separate accounts for the funding for the scheme. Both the NZHC and MFEM indicated that they are happy with the way the budgets are managed.

New Zealand funding allocated under the schemes during the evaluation period is set out below.

¹⁵ Summary data for the MSV for 2004 -2007 shows information on those aged 'under 15 years' while summary data for the HSV for 2008-10 shows information on those aged 'under 16 years'.

¹⁶ Tripartite Arrangement Cook Islands Medical Specialist Visit Scheme, 2004-2007, para 9

Budget and expenditure in the MSV/HSV for 2004-2010

Year	MSV/HSV budget allocation	Expenditure	Variance
2004/05	\$160,000	\$143,143	\$16,857
2005/06	\$160,000	\$189,101	(\$29,101)
2006/07	\$160,000	\$149,885	\$10,115
2007/08	\$160,000	\$152,098	\$ 7,902
2008/09	\$175,000	\$159,018	\$15,982
2009/10	\$350,000	\$295,593	\$54,407 ¹⁷

Source: New Zealand Aid Programme

The allocation is used to fund international and internal airfares, fees for specialists, per diems, car hire and other costs such as specialist equipment, purchase of supplies and air freight costs. As an example of how the allocation is spent, the January to July 2010 report shows expenditure across these components as: airfares (17 percent), fees (26 percent), per diems (48 percent), car hire (6 percent) and other costs (3 percent), a pattern of expenditure that appears appropriate for the HSV.

The MOH CI financial reports show that it carries the costs of: referrals of patients to Rarotonga; referrals requested by HSV specialists for patients to travel to New Zealand for treatment; support provided by clinical, nursing, administrative and management staff; laboratory tests and appropriate consumables. It is useful to note that, although permitted under the tripartite arrangement, scheme funds are not being used by the MOH CI to bring patients from the outer islands to see specialists in Rarotonga. Reports for the 2009/10 financial year show that the MOH CI spent \$35,320 on internal patient referrals associated with the HSV, an amount which could have been easily absorbed within the New Zealand Aid Programme's funding allocation for the scheme for that year.

The tripartite arrangement assumes that expenditure of the scheme's funding will be subject to regular MFEM audits. It also indicates that the New Zealand Aid Programme may audit HSV expenditure. In the absence of regular audits, the Aid Programme may wish to undertake an audit of the expenditure by MFEM and MOH CI of the funding provided for the HSV scheme.

(iii) Is the project providing value-for-money?

The New Zealand Aid Programme supports the longstanding New Zealand Medical Treatment Scheme (NZMTS) which provides secondary/tertiary health services to several Pacific states. Although its focus is on services for people referred to New Zealand for treatment, the NZMTS has a small visiting specialists' component. A 2010¹⁸ review of the NZMTS said that that data on access and results of interventions was poor, information on treatment costs ambiguous, and that there was insufficient information to verify the effectiveness of the capacity building component. The New Zealand Aid Programme's support to the health sector in Niue also includes a visiting specialists' component. A recent review of this programme concluded that the extent to which value-for-money of this arrangement could be measured was restricted by the lack of baseline information or an early

¹⁷ Note that MOH CI, MFAT and AMD agreed to roll over an under spend of approximately \$50,000 from 2009/10 to 2010/11

¹⁸ Diane Hendey, 2010, A Desk Review of the New Zealand Medical Treatment Scheme (Overseas Referrals Scheme and the Visiting Medical Specialists Scheme) 1 December 2005 – 31 December 2009

sector situational and needs analysis'¹⁹. As a consequence, neither programme provides a useful a comparison for the MSV/HSV schemes.

Given that the high level outcome sought from the MSV/HSV schemes is to improve the health status of people in Cook Islands, any improvements cannot be easily attributed to MSV/HSV alone. The extent to which the schemes contribute could only be assessed if they could be adequately measured against base-line data gathered at the beginning of the schemes. As with other schemes mounted in earlier times, these are not available, and most performance measures in place relate to processes rather than results. Nevertheless, specialists, local health workers and patients all suggest that New Zealand's small investment in the MSV/HSV provides considerable value-for-money.

Examples to support this conclusion are that:

- large numbers of Cook Islands people are able to access specialist services not otherwise available, and these services are likely to contribute improved health outcomes;
- as a result of specialist visits, referrals to New Zealand with associated high costs for the New Zealand health and income support services appear to be reduced or more appropriate;
- local health workers have their skills developed from working alongside visiting specialists and are able to take on a greater range of work;
- specialists visit the Cook Islands for what one described as 'non-commercial' reasons, using their annual leave or special leave without pay. Compared with the costs of specialist services in New Zealand, the fees paid to visiting specialists are minimal;
- some specialists use their fee to further contribute to the Cook Islands health sector, for example, to purchase equipment or supplies, to bring registrars from New Zealand to assist during visits, or to support distance learning for local health workers;
- other specialists donate equipment and supplies sourced from New Zealand companies e.g. hearing aids, spectacles, medical equipment and consumables, or surplus to their own employers' stocks e.g. ventilators and anaesthetic equipment; and
- the pattern of expenditure for the HSV funding seems appropriate for a scheme of this kind.

(iv) What are the key areas of success and the issues of concern?

In relation to the efficiency of the scheme, the key successes are the strong sense of ownership of the schemes by the MOH CI which manages them, the smooth-running financial arrangements developed for the schemes and the value-for-money that New Zealand derives from its assistance.

Issues of concern include:

- The reliance on the work of the HSV Coordinator. Specialists report that there was a gap in the smooth operation of the scheme when she was absent for several months on study leave, a problem that could have been addressed by ensuring appropriate back-up when she was away.
- The non use of scheme funds by CI MOH for travel by people from the outer islands to visit specialists in Rarotonga. Although under the MSV scheme, funds were reportedly used for this purpose, this has not occurred for at least the past two years, despite the fact that the scheme

¹⁹ Sheehan, N, Tamate, J and Briasco C, March 2010, Evaluation of the Halavaka ke he Monuina Development Partnership Arrangement, p22

budget has been routinely underspent. This funding could be usefully deployed, for example, to mount a visit to the outer islands of the Northern Group or to bring women in to Rarotonga for breast screening.

- The continuing requirement that visiting specialists be paid per diems at New Zealand Aid Programme rates. Given the devolution of all other aspects of the schemes by New Zealand to MOH CI, retaining this requirement seems unduly prescriptive.

Objective D Assessment of sustainability

The ToR ask the team to consider sustainability in terms of the two questions set out below.

(i) What factors are evident that may enhance or constrain sustainability of the HSV?

The sustainability of the HSV is enhanced by the stability of the MOH CI health workforce and the strong relationships that local clinicians have developed with visiting specialists. Many specialists make long-term commitments to visit on a regular basis to provide services and upskill their counterparts. These include, for example, annual visits from an eye team, breast screening team, a general physician, psychiatrist, urologist, uro-gynaecologist and an orthopaedic surgeon.

The HSV attracts altruistic specialists with a commitment to the people of the Cook Islands. Specialists are well-supported by local health workers and the wider community, and find their visits rewarding. HSV specialists work to identify specialists who may be able to work in the scheme in the future, and report that there is no shortage of people willing to participate.

The only potential constraint identified to the sustainability of the HSV is the willingness of the New Zealand Government to continue funding the scheme (or the capacity of the MOH CI to absorb the cost into its health budget if New Zealand discontinued its funding).

(ii) To what extent has HSV contributed to sustainability of the Cook Islands health system?

The Cook Islands health workforce is characterised by a high level of commitment to its people and a reportedly low rate of turnover. Many of its clinicians shoulder considerable responsibility, and as the sole resident specialists are constantly on call and have difficulty taking leave. Visiting specialists provide support for these workers in a number of ways that may assist in retaining their services in the Cook Islands. For example, they assist with complex cases when they visit and are generally available by phone or email between visits to discuss cases and provide support. With their on-the-job training focus, specialists provide learning opportunities not otherwise available to local clinicians. Specialists often assist in securing locums so that Cook Islands health workers can take leave (and indeed have served as locums themselves so that counterparts can take leave).

While the main focus of other visiting specialist schemes tends to be one of ‘additionality’, i.e. providing the partner with a trusted source of higher levels of clinical care in specialty areas than would otherwise be available or affordable (often provided by a changing cast of specialists), the HSV has another dimension. Through the on-going and often long-standing relationships developed by many visiting specialists, the HSV appears to have a more collegial and collaborative focus than other schemes. It demonstrates effective development practice, both with local clinicians learning to undertake more of the specialist work themselves with supervision and support from visiting specialists and through the strong sense of ownership that the MOH CI has of the schemes. The

'ownership' and 'on-the-job' training approach have contributed to building the capacity of the local health workforce and to the sustainability of the Cook Islands health system.

7 Wider or unintended consequences of the schemes

Although the team has no data on this issue, anecdotal reports suggests that referral of patients to New Zealand may be contributing to the depopulation of Cook Islands as patients and their families remain in New Zealand for ongoing treatment or for other reasons. By assisting the MOH CI to provide as much treatment as possible in Cook Islands and by reducing recourse to referrals, the schemes may assist in population retention.

As well as providing improved services for Cook Islanders, improved health services are also available to tourists visiting Cook Islands. Confidence in the quality of local health services may assist in promoting Cook Islands as a tourist destination, with associated benefits for its economy.

In terms of the health services in Cook Islands, there have been numerous donations of equipment and supplies associated with specialists' visits, together with additional funding sourced by specialists from trusts and other places. These contributions have assisted in providing improved services at no cost to the New Zealand or Cook Island Governments.

An interesting consequence of specialist visits relates to the way in which patients regard the local clinicians. The team was told that patients often consider the services of visiting specialists superior to those provided locally. In many circumstances, visiting specialists have endorsed diagnoses and treatments provided by local clinicians, persuading patients that they are getting excellent care locally. Local clinicians have found these endorsements helpful.

Supply of services may also be creating its own demand. As the population becomes aware to the availability of a service, they may come forward to be part of it. The rise in non-communicable diseases is a major issue. Specialists' visits have highlighted the issue and increased awareness that appropriate treatment and management is available.

8 Cross cutting issues of gender, poverty and human rights

Gender

The schemes have had a clear focus on women's health which has gained momentum in recent years. In addition to the services of a uro-gynaecologist and the introduction of the breast screening programme, gender disaggregated data collected shows that women have good access to the range of specialist services available, bearing in mind that women in two groups i.e. people with disabilities and people from the Northern Group may not be accessing services as well as others.

One issue that raises gender concerns relates to how women from the outer islands have been funded in recent times to have mammography in Rarotonga. Although the tripartite agreement is clear that it can be used for this purpose, HSV funding does not appear to have been used to bring any patients from the outer islands to see specialists in Rarotonga in recent years, with the costs falling instead on the MOH CI patient referral budget. While other symptomatic people come to Rarotonga to see visiting specialists under the MOH CI budget, an NGO - the Cook Island Breast Cancer Foundation has provided funding from its own fund-raised resources to pay for fares for

symptomatic women or women with family histories of breast cancer to travel to Rarotonga for mammography – a women-specific specialist service. The team is unclear why the Ministry does not pay in these cases and raises this for discussion and clarification.

An emerging issue being advocated by the Cook Islands National Council of Women includes the significance of men's health issues throughout the country. The MOH CI recently began a men's screening process in the community, and community groups are promoting the importance of men being checked up regularly. This may be an area where the HSV can contribute in the future.

Poverty

Because information on the socio-economic status of patients was not collected, the team was unable to identify whether poverty was a barrier to accessing services of visiting specialists. Data on the proportion of the population with weekly equivalent per capita expenditure less than the food and basic needs poverty line²⁰ indicates that while most are able to access foods, overall, 28 percent cannot meet basic needs for a decent living. Those in Rarotonga fare least well (30.5 percent) followed by the Southern Group (23.6 percent) and the Northern Group (7.6 percent). This distribution suggests that, in relation to patients living in poverty, the location of visits by visiting specialists may be appropriate.

Human rights

The New Zealand's Aid Programme's health policy 'Ending poverty begins with health' is based on the premise that health is a basic human right which includes access to and enjoyment of health services on the basis of non-discrimination and equality. This human rights concern is captured in the schemes' objective on equitable access to health specialists. Equitable access is discussed above under a number of headings, concluding that two groups may not be accessing services as well as others: people with disabilities and people from the Northern Group. The Northern Group remains the least serviced region of the scheme. The MOH CI is aware of this imbalance, and health planners have discussed the idea of mounting comprehensive health specialist visits to the Northern Group on a two-yearly basis. People with mental health issues can also be a vulnerable group. The rise in mental health cases has led to the MOH CI to support the efforts of various non-government agencies that provide drop-in and rehabilitation services to these clients. A number of visits by psychiatrists have been supported by the HSV and this has reportedly been influential in highlighting the importance of these services.

9 Conclusions and lessons learned

Have the objectives of the schemes been achieved?

In relation to objective 1, the quantitative data available suggests that the schemes have provided large numbers of Cook Islanders with access to a variety of specialist services and that, with two exceptions; the schemes have generally served groups well. The range of specialists providing services has been appropriate, but could usefully include specialists in the areas of public health, primary care, and cervical screening. In relation to objective 2, while the focus on women's health issues had a slow start, regular uro-gynaecology specialist visits are now well-established, as is the

²⁰ Source: Cook Islands Statistics Office 2008

breast screening programme. Future attention could usefully focus on expanding coverage for women of cervical screening, ideally within the context of an organised screening programme.

In relation to objective 3, through the relationships developed between the Cook Islands clinicians and the ongoing commitment of most visiting specialists, the HSV displays a particularly collegial and collaborative approach whereby many of the local clinicians are undertaking more of the specialty work themselves (within the constraints of the facilities and equipment available) with supervision and support from the visiting specialists. This 'on-the-job' training approach has been successful in building the capacity of the local health workforce. MOH CI has recently begun to include dedicated training programmes in the HSV scheme.

In relation to objective 4, data on follow-up for people screened could be more robust. However, it appears that those with needs identified in screening programmes generally receive appropriate follow-up services. A barrier to follow-up for some patients is the lack of an effective coordination service for patients referred to New Zealand. In relation to objective 5, although there are some improvements to be made, the scheme is running well. The limited investment by New Zealand in the MSV/HSV provides a considerable contribution to the small Cook Islands health budget and to the services that the MOH CI can provide. For New Zealand, the assistance provides value-for-money both in maintaining the health of Cook Islanders and in reducing recourse to expensive health and income support services accessed by people referred for treatment to New Zealand.

Have the schemes been relevant, effective, and efficient and contributed to sustainability of the Cook Islands health system? While there are some suggestions for improvements, the answer to all these questions is 'yes'.

The main lessons learned from the schemes for development practice are the significant benefits that long-term, collaborative relationships between the Cook Island health workers and the visiting specialists can yield, together with the positive results that flow from local ownership and management of development projects. The MSV/HSV schemes provide good examples of both.

Looking to the future, the team notes that the New Zealand Aid Programme emphasises fewer, deeper and longer engagements, suggesting that a small health-focused programme may be at risk in favour of commitments to other sectors. Although it is not Government policy, it is useful to highlight the recent report to the New Zealand Parliament of the Foreign Affairs, Defence and Trade Committee - the *Inquiry into New Zealand's Relationship with South Pacific Countries*. This report highlights the need to invest in improving the standard of health services in the 'realm' countries of Cook Islands, Niue and Tokelau with a view to providing services similar in standard to those received by citizens living in comparably-sized population centres in New Zealand.

In its present configuration, the HSV scheme is a sound investment for the New Zealand Development Programme. In the short to medium term, while continuing the work of the visiting health specialists, it provides a vehicle, without changing the nature of the tripartite arrangement, for providing more structured support for the health workforce development aspirations of the MOH CI, particularly in the professional development area. As an exemplar of good development practice in the areas of ownership and capacity building, it also provides a basis for expanded assistance to the health services in the Cook Islands should this become a priority for the New Zealand Development Programme.

Glossary of acronyms

AusAID	Australian Agency for International Development
AMD	Aid Management Division
CIG	Cook Islands Government
CMDHB	Counties Manukau District Health Board
GDP	Gross Domestic Product
HSV	Health Specialist Visits Scheme
JCS	Cook Islands Joint Country Strategy 2008 – 2017
MFAT	New Zealand Ministry of Foreign Affairs and Trade
MFEM	Cook Islands Ministry of Finance and Economic Management
MOH CI	Cook Islands Ministry of Health
MoU	Memorandum of Understanding
MSV	Medical Specialist Visits Scheme
NGO	Non-government organisation
NZAID	NZ Agency for International Development (now the New Zealand Aid Programme)
NZHC	New Zealand High Commission
NZMTS	New Zealand Medical Treatment Scheme
NZODA	New Zealand Official Development Assistance
NZDF	New Zealand Defence Force
NZDP	New Zealand Development Programme
PIP	Pacific Islands Programme
ToR	Terms of reference
WHO	World Health Organisation

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Appendix 1: MSV/HSV evaluation terms of reference

MSV / HSV Evaluation

Terms of Reference

1. Purpose of the Evaluation

- 1.1 The purpose of this Evaluation is two-fold:
- To assess the relevance, effectiveness, efficiency and sustainability of the Medical Specialist Visit Scheme (MSV) and Health Specialist Visit Scheme (HSV) since 2004, and
 - To provide recommendations for the future of the HSV within a possible wider health sector programme.
- 1.2 The findings of the Evaluation will be addressed to both MFAT and the Cook Islands Government. They will inform thinking around the nature and possible extension of future support to HSV, as well as the scope and modality of possible other support to the Cook Islands health sector. MFAT, Cook Islands Government, and the Australian Agency for International Development (AusAID), as co-funder of the joint programme of assistance to the Cook Islands, will receive a copy of the Final Report.

2. Scope of the Evaluation

- 2.1 The Evaluation will assess MSV and HSV over the period from July 2004 to June 2010 against their respective performance indicators. The Evaluation should include services to Cook Islanders (women, men, children), on the outer islands as well as Rarotonga. It should also document any wider or unintended consequences beyond those indicators that are learned by the evaluators.
- 2.2 The Evaluation is not a design for a revised HSV, although its findings and recommendations will feed into any extension to the HSV arrangement and design of any future broader assistance from the MFAT (through the New Zealand Aid Programme) and AusAID to the Cook Islands health sector.

Exclusions:

- 2.3 AusAID has two regional health sector programmes run by the Royal Australasian College of Surgeons that include the Cook Islands: 1) Pacific Islands Programme (PIP) that provides similar specialist visit services to HSV and 2) a Medical Equipment Maintenance and Training Programme. Cook Islands Ministry of Health (MOH) coordinates these programmes and integrates them with HSV. They are not part of the evaluation, but any aspects of these programmes that affect or impact on MSV or HSV can be included.

- 2.4 Two medical missions have been conducted by the New Zealand Defence Force: in June 2008 to Rarotonga and in June 2009 to Pukapuka. These missions are outside the scope of this evaluation but again, aspects of these programmes that affected HSV can be included.

3. Objectives of the Evaluation

- 3.1 The elements of the MSV and HSV are to be evaluated under the following headings. Each is accompanied with, but not limited to, a number of questions provided in order to add focus to the objective and assist the evaluators in developing their methodology.

- 3.1.1. Assess the **Relevance** of the MSV and HSV²¹ in terms of:

- (i) Meeting the health needs²² and priorities of different groups of people in the Cook Islands (disaggregated by geographic area, gender, socio-economic group and age)
- (ii) Cook Islands health sector objectives
- (iii) New Zealand Aid Programme's policies, priorities and regional health programmes
- (iv) How specialist visits are prioritised
- (v) Extent to which visits that have been prioritised meet specific needs as planned.

- 3.1.2. Assess the **Effectiveness** of MSV/HSV in terms of whether it is meeting its objectives and outcomes (as in Annexes 1 and 2). Questions may include but are not limited to:

- (i) What has been the contribution of MSV and HSV in enabling Cook Islanders, particularly those from the outer islands, to have access to specialist health services (development outcomes for HSV)?
- (ii) To what extent and how are women, and people from the outer islands, accessing MSV/HSV (**Objective 1**²³)?
- (iii) Is there an effective emphasis on women's health (e.g. equal access, female health specialists, addressing women's needs) (**Objective 2**)?
- (iv) To what extent has the capacity of local health professionals been increased²⁴ (**Objective 3**)?
- (v) Is there effective follow-up to screening programmes funded under the MSV/HSV allocation²⁵ (**Objective 4**)?
- (vi) Has the quality of visits (e.g. specialist skills, support teams, time allowed) been of an appropriate standard for meeting identified health needs?

²¹ The Schemes are more than the visits; they are likely to include MOH deciding what specialties, materials and equipment will be procured according to availability and the budget; planning to fit in with other activities; human resource aspects.

²² How "needs" will be defined and identified for the evaluation should be addressed in the Evaluation Plan. The New Zealand Aid Programme sees two aspects to "needs": 1) How MOH assesses and prioritises health "needs" and 2) How the MSV and HSV address those "needs".

²³ Objectives of MSV / HSV.

²⁴ This may include clinical, clinical support and general support personnel, as well as local capacity to analyse health statistics and information to guide future HSV planning, effective primary health care interventions and workforce development designed to meet population health needs.

²⁵ This may include community health services/interventions and integration of hospital/community services, including transfer/referral to NZ health system.

- (vii) What factors have enhanced or constrained the effectiveness of the MSV/HSV?²⁶
- (viii) To what extent has the MSV/HSV had an impact on the volume of patient referrals to New Zealand for health services?

3.1.3. Assess the **Efficiency** of MSV/HSV:

- (i) Were/are the Schemes being managed and delivered effectively and efficiently (**Objective 5**)? For example (but not limited to) what has gone well, and less well with respect to:
 - meeting objectives and completing tasks of visits
 - monitoring of visit outcomes
 - quality of reporting, including coverage and timeliness
 - financial management and reporting of each visit.
- (ii) Is the funding arrangement being managed within financial budgets and fulfilling the terms of the contract?
- (iii) Is the project providing value for money?²⁷
- (iv) What are the key areas of success and the issues of concern?

3.1.4. **Sustainability**

- (i) What factors are evident that may enhance or constrain sustainability of the HSV?
- (ii) To what extent has HSV contributed to sustainability of the Cook Islands health system?

3.1.5. **Lessons and Recommendations**

- (i) What are the lessons learned from the operation of the MSV and HSV to date?
- (ii) What recommendations can be drawn for any future assistance to the Cook Islands health sector?

4. **Methodology**

4.1 MFAT's (through the New Zealand Aid Programme) approach to evaluations is based on principles of partnership, transparency and participation but evaluations are independent from the views of any particular stakeholder. Evaluations should build the capacity of partners to undertake their own reviews and evaluations.

²⁶ This may include clinical leadership, strong health information systems to guide future policy and practice, strong financial management systems to strengthen accountability and cost effectiveness and workforce development indicators to measure a 'fit for purpose' workforce and to inform further training and development needs, including succession planning for key roles.

²⁷ This should be done by qualitatively comparing the money spent on the Schemes with the broad outcomes, impacts or changes brought about. The feasibility and scope for addressing the value for money question should be addressed in the evaluation plan. **If possible**, comparisons of value for money should be drawn with experience or norms in other medical treatment or visit schemes (in the Cook Islands or internationally), where similar outcomes or impacts have been aimed for and/or achieved. Comparisons could also be drawn between the health benefits achieved through the MSV/HSV and those that could be achieved for the same amount of funding from other interventions e.g. health promotion activities, improved primary health care services, etc. The review should also analyse the MSV/HSV's own cost structures to identify cost effectiveness issues, including whether savings could have been made (without disproportionately compromising outcomes) through different management methods, procurement, prioritisation, design, etc.

- 4.2 Cross-cutting issues of gender, poverty and human rights should be addressed in the evaluation.
- 4.3 A team of two, consisting of a local consultant and the Contractor will conduct the Evaluation. We anticipate the evaluation team will need to gather information from:
- The New Zealand Aid Programme, MFAT;
 - The Cook Islands, and possibly NZ, MOH;
 - Counties-Manukau District Health Board and any other providers of specialist health services to the Cook Islands;
 - (Possibly) some Cook Islanders in Rarotonga, one or more outer islands and NZ;
 - Health specialists involved in HSV;
 - The team is expected to submit an Evaluation Plan based on the objectives of the Evaluation for approval by the Steering Group before beginning work. See footnotes 2 and 3 and Annex 3 for guidance as to what could be in the Evaluation Plan. The team should also ensure that the intended outcomes of the Schemes are clear in the Evaluation Plan as a base to evaluate against.
 - The Evaluation Plan and any questionnaires and survey results should be appended to the written report.

5. Governance and Management of the Evaluation

- 5.1 A small Steering Group will be formed to oversee the evaluation, comprising representatives of the New Zealand Aid Programme at the High Commission in Rarotonga, Cook Islands MOH and Aid Management Division of the Cook Islands Ministry of Finance and Economic Management (AMD). The Steering Group will choose the team members, sign off the Evaluation Plan, seek feedback on the Draft Report from partners and stakeholders, and sign off the Final Report.
- 5.2 The international consultant will be managed by MFAT in Wellington and the local counterpart by the New Zealand High Commission (NZHC) in Rarotonga. NZHC Rarotonga will manage the team while in-country.

6. Key Documents

- 6.1 Key documents for this Evaluation include:
- MSV and HSV guidelines, monitoring reports, visit reports;
 - New Zealand Society of Anaesthetists' Report on Rarotonga Hospital;
 - New Zealand Aid Programme guidelines for:
 - Structure of Evaluation and Review Reports
 - Developing Terms of Reference (TOR) for Evaluations and Reviews (P14 Evaluation Plan)
 - Screening Guide for Mainstreamed and other Cross-cutting Issues
 - DAC Evaluation Quality Standards.

Deliverables

7. Key deliverables or outputs

- 7.1 Agreed **Evaluation Plan** approved by the Steering Group prior to the consultants arriving in-country.
- 7.2 **Draft Report** that complies with the New Zealand Aid Programme Guideline on the “Structure of Review and Evaluation Reports” and the “Development Assistance Committee (DAC) Quality Standards for Development Evaluation” – both available on the New Zealand Aid Programme’s website. The Draft Report will be peer reviewed by the Steering Group (and key stakeholders, e.g. New Zealand Aid Programme Staff in Wellington and Rarotonga, AMD, MOH). Revision / further work may be required if the Steering Group considers the Draft Report does not meet this Terms of Reference and / or Evaluation Plan, or the quality is not of an acceptable standard for a final report. The team will then prepare a **Final Report** reflecting comments received.
- 7.3 **Final Report** incorporating peer review feedback, not exceeding 30 pages, including the executive summary and excluding appendices.
- 7.4 The Evaluation Plan and Draft and Final Reports will be submitted to the Steering Group. The Final Report will be addressed to the Cook Islands Government and MFAT, who will share it with AusAID (who co-fund HSV through the delegated programme), other stakeholders and interested groups.
- 7.5 MFAT, through the New Zealand Aid Programme, publicly releases evaluation reports. Anything that would prevent the release of the report should be placed in a confidential annex.

8. Timing

- 8.1 Milestones are indicatively as follows:

	Milestone	Deliverables	Date (New Zealand / Cook Islands time)
1	<i>Evaluation Plan</i>	Agreed Evaluation Plan (approved by the Steering Group <u>prior</u> to consultant arrival in Cook Islands)	Midday 23 November / 22 November 2010
2	Presentation of preliminary findings	Completion of data collection and Presentation of preliminary findings to key Cook Islands stakeholders	10 December 2010 (Cook Islands time)
3	Draft Report	Final Draft Report submitted to the Steering Group for peer review feedback and comment. The submitted Draft Report should be of quality and standard noted in the Terms of Reference (see Note #2 below).	Midday 21 January / 20 January 2011
4	Final Report	Final Report, incorporating peer review feedback, submitted to the Steering Group	<i>Midday 10 February / 9 February 2011</i>
5	Approval of Final Report	Final Report approved by Steering Group	22 February / 21 February 2011

Background

The Cook Islands/MFAT (through the New Zealand Aid Programme)/AusAID Joint Country Strategy 2008 – 2017 has as one of its four objectives: *to improve the delivery of quality education, health and social services*. For health services, this is to be achieved by two means: 1) supporting visits by health specialists normally unavailable in the Cook Islands, that are accessible to people from all islands, and 2) possibly developing wider support to the health sector. This evaluation is directly related to only the first of these, but will also influence the other.

New Zealand has funded a MSV to the Cook Islands for many years (see Annex 1). MSV was informally assessed in early 2007 by MFAT and Cook Islands MOH personnel, who gathered stakeholder views about the management and implementation of the MSV and recommended an evaluation be undertaken to verify the anecdotal conclusions.

Following the 2007 assessment, the name of MSV was changed to the HSV to reflect the agreement to increase the range of specialists who participate in the scheme to include, as well as medical specialists, allied health practitioners, biomedical engineers and health management specialists (see Annex 2).

HSV is managed in-country by MOH, which sources specialists from New Zealand, Australia and the Pacific region according to an annual visiting programme. Funding is channelled through AMD, which also plays a role in six-monthly reporting on HSV to MFAT.

Actual expenditure on MSV was \$635,000 from 2004/5 to 2007/8. \$526,000 was available for HSV for the period 1 July 2008 to 30 June 2010. HSV will be continued with \$300,000 per year available for 2010/11 and 2011/12.

MEDICAL SPECIALIST VISIT (MSV) SCHEME (2004-2007)

From the Grant Funding Arrangement between NZAID²⁸, the Ministry of Finance and Economic Management (MFEM) and MOH (ref GRA/405/1)

PURPOSE OF THE MSV FUNDING ARRANGEMENT

The MSV Funding Arrangement was to meet the costs of MSVs to the Cook Islands so that all Cook Islanders have access to tertiary medical specialists to improve their health status.

A MSV is defined as a visit of an overseas-based medical practitioner working in a specialist tertiary field. The visit may include doctors and their specialist support staff (e.g. nurses, technicians, etc).

ACTIVITIES INCLUDED UNDER THE MSV FUNDING ARRANGEMENT

Medical specialists and support staff fees, based on normally accepted rates for the relevant specialist area.

Visit-related international and domestic travel and associated expenses including reasonable airfare (i.e. economy class), rental car costs, accommodation and per diems based on NZAID rates (available on the then NZAID website).

Domestic travel and reasonable travel expenses for outer islands patients to have access to the visiting medical specialists.

Hire costs (including transport costs) of specialist medical equipment.

The purchase of consumables related directly to the specialist medical equipment but normally stocked by the MOH.

Devices or further diagnostic testing to implement the recommendations of a medical specialists visit, e.g. prosthetic devices or follow-up tests.

ACTIVITIES EXCLUDED UNDER THE MSV FUNDING ARRANGEMENT

Development of infrastructure.

Purchase of other physical assets or supplies (including but not limited to buildings, furniture, computers, office equipment medical equipment and medical textbooks or manuals.

Consumables reasonably expected to be held by the hospital or Ministry of Health.

ROLES AND RESPONSIBILITIES

Under the MSV Funding Arrangement the MOH was responsible for:

- Decisions on which specialists field will be included in the programme in any year, the dates of the visit and its priority.

²⁸ NZAID (the New Zealand Agency for International Development) was previously the New Zealand government's agency to deliver the New Zealand government's international aid and development programme. This programme is now delivered through the New Zealand Aid Programme of MFAT.

- Selection of specialists.
- The organisation and itinerary of the specialist and their support staff during the visit.
- Expenditure of direct visit-related costs within the funding allocation, including follow-up costs such as the purchase of prosthetic devices, or further follow-up tests or diagnosis resulting from screening programmes.
- Visit promotion (with appropriate acknowledgement to NZAID/AusAID).

MONITORING AND REPORTING REQUIREMENTS

In the first two years under the MSV Funding Arrangement there was a 6-monthly formal monitoring of the MSVs programme to ensure that devolution of responsibilities under the MSV Funding Arrangement were working for the MOH and MFAT. Included in the monitoring discussions was an analysis of the data collected to ensure equitable access, the benefits of the visits provided and recommendations of the specialists. Programme objectives, outcomes and performance indicators were:

	Objective	Outcome	Performance Indicator
1	Equitable access to medical specialists	<p>Appropriate gender mix of patients benefiting from MSV.</p> <p>All socio-economic groups in the Cook Is benefit from each MSV.</p> <p>People from every island benefit from each MSV wherever possible.</p>	<p>Data collection forms are developed and used with patients' consent and assuring anonymity.</p> <p>Cross-correlated data on who has been treated for each visit by gender, island, socio-economic status (defined broadly), including copy of data collection forms.</p> <p>General population are aware that the programme exists and special interest groups are informed of visits (e.g. disabilities groups, women's groups etc).</p>
2	Emphasis on women's health	<p>Women have equal access to all visits.</p> <p>There is an appropriate gender composition of health specialist teams to encourage women to take advantage of the visit.</p> <p>Women' specialist health needs are included in the overall MSV programme.</p>	<p>Analysis of what issues exist for women's health needs, how these were confronted and what the outcome was (i.e. what was wrong, what action was taken, and what follow-up was there?).</p> <p>Data (anonymous) on the proportion of women (by island) were screened or treated for each visit.</p> <p>Report on what gender-specific activities were included in the MSV programme for the period being monitored (e.g. mammography, cervical screening, etc).</p> <p>Information on the gender composition of each MSV team.</p>
3	Increasing local capacity	<p>Where possible, the skills and experience of local health professionals involved in the delivery of specialist health care is increased.</p>	<p>Number of tasks and seminars delivered by the specialists.</p> <p>Access of students and other health care specialists allowed to observe.</p> <p>Engagement in training of local staff in the treatment of patients during MSV (i.e. including procedures and use of equipment).</p>

	Objective	Outcome	Performance Indicator
4	Effective follow-up to screening programmes funded under MSV allocation	Effective, timely and appropriate treatment of patients identified as requiring follow-up treatment following screening (e.g. audiology, breast screening, cervical screening).	Data on those identified as needing treatment following screening programmes included in the MSV programme, those referred for follow-up treatment, and those who received the necessary treatment.
5	Effective local management of MSV fund	The MSV Funding Arrangement is effective as a means of supporting the cost-effective, MOH management of the MSV programme and of meeting NZAID operating principles.	<p>Conditions of the MSV Funding Arrangement as adhered to (including what can and what cannot be funded).</p> <p>Appropriate data for reporting is recorded and reported.</p> <p>Brief summary of each visit, and the equitable access for patients, and expenses incurred (including fees, transport of patients from outer islands, etc).</p> <p>NZAID adheres to the funding schedule in the MSV Funding Arrangement.</p> <p>Issues arising from the MSV Funding Arrangement (e.g. level of funding to cover follow-up treatment to screening, difficulties of collecting data, etc) are raised and discussed in a manner that is satisfactory to both parties.</p>

HEALTH SPECIALIST VISIT SCHEME (2007-PRESENT)

From the current Grant Funding Arrangement between MFAT, MFEM and MOH (ref GRA/405/10)

CHANGE OF SCHEME NAME

The name of the MSV was changed to the HSV Scheme to reflect the broadening of the range of specialists that can be covered under the Scheme.

PURPOSE OF THIS ARRANGEMENT

The funding provided under the HSV Funding Arrangement is to meet the costs of HSVs to the Cook Islands, in order to improve access of all Cook Islanders to services that the Cook Islands' MOH is ordinarily unable to provide. This may include medical practitioners, allied health practitioners, biomedical engineers, technicians and support staff.

DEVELOPMENT OUTCOME

All people of the Cook Islands have improved access to specialist health services, not available through national health services

COSTS INCLUDED IN THE HSV FUNDING ARRANGEMENT

- Payment to visiting Health Specialists of fees based on MOH policy and guidelines.
- Payment to visiting Health Specialists of visit-related international and domestic economy class travel and associated expenses including departure taxes, rental car costs, accommodation and per diems based on New Zealand Aid Programme current rates (ref New Zealand Aid Programme web site).
- Internal travel from and to outer islands within the Cook Islands for patients requiring access to health specialists, including accommodation and living expenses.
- Reasonable expenses for family members when this is essential (e.g. parent of child 16 years and under) for travel of the patient.
- Hire costs of specialist medical equipment, including where necessary transport/freight costs/insurance and associated supplies.
- Purchase of consumables directly related to equipment utilised during visits but not normally stocked by the Ministry of Health, hospital or health centre.

Devices or further diagnostic testing to implement the recommendations of health specialists during or after the visit. i.e. diagnostic tests, follow up testing, prosthetic devices.

ACTIVITIES EXCLUDED UNDER THIS FUNDING ARRANGEMENT

- Development of infrastructure.
- Purchase of other physical assets or supplies, including but not limited to buildings, computers, furniture and office equipment.
- Consumables reasonably expected to be held by MOH, hospitals or health centres.

ROLES AND RESPONSIBILITIES

Under the HSV Funding Arrangement MOH is responsible for:

- Decisions on which specialist fields will be included in the programme in any year, the dates of the visit and its priority.
- Selection of specialists.
- The organisation and itinerary of the specialists and their support staff during the visit.
- Expenditure of direct visit-related costs within the funding allocation, as described above.
- Visit promotion (with appropriate acknowledgement to the New Zealand Aid Programme of MFAT/AusAID).

BUDGET

\$255,000 for 17 months from 1 July 2008 to 30 November 2009.
\$271,210 for 1 December 2009 to 30 June 2010.

MONITORING AND REPORTING REQUIREMENTS

Both the MFEM and the MOH agree to provide all reports required in terms of this Arrangement, including:

- Financial acquittal reporting.
- Financial forecast reporting.
- Reporting against services provided.
- Monitoring reporting.

The Objectives and Performance Indicators against which reporting should occur are in noted in the HSV Funding Arrangement (see Schedule Two of the HSV Funding Arrangement). A template is provided (see Schedule Three of the HSV Funding Arrangement) for the summary data requested.

SCHEDULE TWO OF HSV FUNDING ARRANGEMENT

Objective	Outcome	Performance Indicators
1. To enable all Cook Islands people to access specialist health services as needed, irrespective of sex, age or geographical location	People can benefit from each HSV according to their need	<ul style="list-style-type: none"> • Summary data on who has been treated/screened for each visit by sex, age and Home Island shows that a range of people have accessed the Scheme. • Visits have been advertised broadly (newspaper, radio) and to special interest groups (eg disabilities groups, women's groups etc). • MoH staff refer patients to specialist services as appropriate.
2. To enable women to access specialist visits for women's special health needs	Women can benefit from each HSV according to their need	<ul style="list-style-type: none"> • Summary data on who has been treated/screened for each visit by age and Home Island shows that a range of people have accessed the Scheme.
3. To enable MOH personnel to provide a higher level of service where possible	Improved technical skills and knowledge of local practitioners	<ul style="list-style-type: none"> • Number of tasks and seminars delivered by the specialists • Local staff observe or are engaged in the treatment of patients, including procedures and use of equipment
4. To provide effective follow-up to screening programmes	Patients identified as requiring follow-up receive effective, timely and appropriate diagnosis and, if necessary, treatment	<ul style="list-style-type: none"> • 100% of those with positive or unclear results have access to diagnosis and treatment.

**SCHEDULE TWO OF HSV FUNDING ARRANGEMENT
REPORTING TEMPLATE FOR SUMMARY DATA**

Specialty	Date	Cost	Islands visited	Total seen/ treated	Total referred to Rarotonga	Total referred to NZ	Women	Age Group			Home Location
								Under 16 years	17 - 59 years	60 years & over	

QUESTIONS TO BE ANSWERED IN AN EVALUATION PLAN

New Zealand Aid Programme encourages evaluators to answer the following types of questions in their 'Evaluation Plan':

- Who are the stakeholders in the review or evaluation, what is their interest or stake in the evaluation or review, what type of stakeholder are they (primary – directly benefit from the activity being evaluated or reviewed, secondary – indirectly involved with the activity etc), what issues or constraints are there in their involvement in the review or evaluation (e.g. power issues, access, confidentiality)?
- What information will be needed to answer each of the evaluation or review questions?
- What are the most appropriate methods for data/information collection to address each of the evaluation or review questions? e.g. Will qualitative or quantitative methods be used and why? How will evaluation or review participants be selected? What specific methods will be used – interviews (face-to-face or phone), email questionnaire, workshops, survey, focus groups etc? For quantitative surveys how will the appropriate sample size be decided, and what statistical analysis will be used to allow judgment on the reliability of results?
- From whom will information be collected to answer each of the evaluation or review questions, and how will the evaluation or review team ensure that the opinions of all appropriate stakeholders (eg women and men, young and old, powerful and less powerful) are included?
- What questions will be asked in questionnaires or interviews?
- How will information gathered be cross checked?
- What procedures will be used for data analysis – how will qualitative data such as interview notes be analysed, how will survey results be analysed?
- How will the way that crosscutting and mainstreamed issues (gender, environment and human rights, and if appropriate HIV/AIDS and conflict) have been addressed in the activity being evaluated or reviewed be assessed, and how will the evaluation/review be conducted in a way that takes crosscutting issues into account? [Reference: Screening Guide for Mainstreamed and Other Cross Cutting Issues]
- How will the findings be fed back and discussed with appropriate stakeholders during the evaluation process, and how will this be incorporated into the report?
- What risks, limitations or constraints are there likely to be to the review or evaluation and how can these be mitigated?
- How will ethical issues be addressed? For example how will participants of the review or evaluation be informed of the purpose and use of information they will provide? How will sensitivity to gender and culture be ensured during the review or evaluation? Is informed consent required from evaluation or review participants, if so how will this be obtained? How will confidentiality of participants be ensured and how will confidential material be stored? What potential harm to participants is there and how will potential harm be minimised?

Appendix 2: Evaluation plan for the Evaluation of the Cook Islands Medical/Health Specialist Visits Schemes

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**Prepared by the Evaluation Team:
Sonja Easterbrook-Smith and Vaine Wichman
November 2010**

1 Evaluation purpose and scope

In developing the evaluation plan, the evaluation team notes that the purpose of the tripartite arrangement for the medical specialist visits scheme (MSV) was to meet the costs of medical specialist visits to the Cook Islands so that all Cook Islanders could have access to tertiary medical specialists *to improve their health status*.

In 2007 with the change of name to the health specialist visits scheme (HSV), improved access remained as the scheme's purpose, but the means by which this could be addressed expanded to include allied health practitioners, biomedical engineers, technicians, and support staff. The development outcome specified for the HSV clarifies that improved access to specialist health services for Cook Islands people relates particularly to specialist services *not available through national health services*. Although the tripartite arrangement for the HSV is not explicit (as it is for the MSV) that the outcome sought is to improve the health status of Cook Islands people, the evaluation team considers that this is implied and will regard it as the outcome sought for both schemes.

The evaluation team notes that the MSV had five objectives relating to: (1) equitable access to medical specialists; (2) emphasis on women's health; (3) increasing local capacity; (4) effective follow-up to screening programmes funded under the MSV allocation; and (5) effective local management of the MSV fund. Although differently worded, objectives 1- 4 for the HSV reflect the same intent as those for the MSV. What is different is that the HSV does not include a fifth objective relating to the effective local management of the HSV fund. Whether this was intentional or was an omission is not clear at this stage. However, the evaluation team plans to consider the local management of both schemes for the full period under review as this appears to be the intention for the evaluation, as set out in the evaluation objectives contained in the terms of reference.

With these clarifications, the evaluation plan confirms the purpose and scope of the evaluation of the MSV and HSV as set out in the evaluation terms of reference.

2 Evaluation objectives and questions

The evaluation plan confirms the objectives for the evaluation set out in the terms of reference. In order to avoid confusion with the objectives for the MSV/HSV schemes which are numbered, the objectives for the evaluation are identified by letter as follows:

Objective A	Relevance
Objective B	Effectiveness
Objective C	Efficiency
Objective D	Sustainability

The evaluation plan also confirms the questions relating to each of these four objectives as set out in the evaluation terms of reference but with some changes. These changes, set out below, do not alter the intent of the questions as posed in the terms of reference, but rather seek to clarify, reduce repetition or explore other useful dimensions.

To this end, the evaluation team proposes in relation to the assessment of **Objective B: effectiveness** to:

- Remove from (i) the phrase *‘particularly those from the outer islands’* as this group is already specifically identified in (ii).
- Include as a question, *‘To what extent and how are health workers and the wider community made aware of planned specialist visits?’*
- Include as a question *‘To what extent are recommendations made in reports prepared by specialists followed up and acted on?’*

There is some reordering of the numbering of questions under this objective as a result of these inclusions. These are shown below in Table 1: Information required and sources.

3 Evaluators’ approach

Introducing the evaluation

The evaluation team will begin all interactions with stakeholders by explaining the purpose of the MSV/HSV schemes and the purpose/objectives of the evaluation. The team will also explain how information that participants provide will enable the team to evaluate the schemes and provide recommendations to New Zealand Ministry of Foreign Affairs and Trade (MFAT) and the Cook Island Government (CIG) with a copy to AusAID for the future of the HSV, in the context of a possible wider health sector programme. Participants will be informed that results of the evaluation can be accessed in time on the MFAT website.

Evaluation stages

The evaluation has three stages: preparation; implementation, and analysis/report writing. Implementation will involve information gathering in New Zealand and Cook Islands. The team will ask the Cook Islands Ministry of Health (MOH) to identify patients who were beneficiaries of the schemes, particularly those in Rarotonga, Mangaia and Mitiaro which the team will visit, and to approach them to see whether they are willing to participate in the evaluation.

Ethical issues

Evaluators will seek to apply DAC evaluation standards, and ensure the privacy and ensure privacy and confidentiality of participating patients and other contributors who request confidentiality. Care will be taken to ensure that contributors cannot be identified in the team's final report. The team will ask participants whether they agree to having their names included in the list of people who contributed to the evaluation. Confidential electronic information will be kept on password locked computers. Hard copy kept in locked storage. This material will be deleted from computers or disposed of as confidential waste six months after submitting the report.

No potential harm to participants is identified, although there may be potential benefits to participants if, for example, lack of follow-up action on patients is identified which can be addressed. These and any other ethical issues that may arise during the evaluation will be highlighted and appropriate action recommended.

Building evaluation capacity

The team is made up of independent evaluators for whom the evaluation presents no conflicts of interest. Members are experienced evaluators who demonstrate cultural safety in all their activities. Although the team does not include funders, recipients, implementers or beneficiaries of the schemes, the evaluators will seek to build the capacity of partners to undertake their own evaluations by modelling of good evaluation practice, and, where appropriate, by making recommendations that may assist in providing robust information or processes for future evaluations.

Participatory approach

As far as the team is aware, the evaluation has not been designed as a fully participatory evaluation, with, for example, design and questions developed with input from beneficiaries or visiting specialists. However, the team will work to ensure that consultations are undertaken in a participatory manner, with arrangements made to meet where appropriate (for example, for power, willingness to contribute or confidentiality reasons) with health staff separate from their managers, women separate from the wider community, or individuals separate from their families or communities. Effort will also be made to secure a direct voice from children and young people who have received services. Participants will be invited to discuss their interaction with the scheme in their own words. Interview questions developed for different groups will be used more as an *aide memoir* for the evaluation team rather than as formal formats for interviews.

Addressing cross-cutting issues

Cross-cutting issues of human rights (equitable access to medical specialists) and gender equality (emphasis on women's health) are central objectives of the schemes and will be

integral to the evaluation. In examining equitable access, the evaluation team will look at access by age as well as gender. Given the outcome sought that all socioeconomic groups in the Cook Islands should benefit from the scheme, the evaluation team will look for evidence that poorer people are accessing the scheme and that their socioeconomic status is not a barrier to this access. The team will also consider any relevant issues relating to HIV/AIDs or the environment that may arise in the course of the evaluation.

Assessing value-for-money

The question of evaluating the ‘value-for money’ of schemes that provide tertiary services presents some problems. It is well established that the greatest development gains in health are made through investment in public and primary rather than tertiary health services. (A review of the opportunity costs of investing the funding set aside for the HSV in other parts of the Cook Islands health service would be a project in its own right). However, the provision of MSV/HSV tertiary services must be seen in the wider context of human rights/access to health services and in the light of the special relationship between the Cook Islands and New Zealand, and the associated access of the Cook Islands population as New Zealand citizens to New Zealand health services. Given these considerations, the evaluation team proposes to focus its assessment of value-for-money to a qualitative evaluation of the money spent on the schemes in terms of the results achieved. If information is available about the costs and results of similar schemes for other countries, the team will seek to draw comparisons. The team will also comment on the cost/effectiveness of systems and processes used to manage the schemes.

Information gathering

The team will provide a systematic and objective assessment of the design, implementation and results of the scheme. It will seek information through a variety of means e.g. review of documents, focus group discussions, observation, and face-to-face interviews with individuals and groups, as well as through telephone interviews, and through the use of email/sat phone/skype. The team will gather qualitative and quantitative information. Qualitative information will be cross checked by asking the same question of different groups of stakeholders, and checking for documentary evidence to support their views. The evaluation team will critically assess the validity and reliability of information. Formal analysis will be undertaken of data relating to services provided by specialty, patient gender, island of domicile, and socioeconomic status, using the information provided by the Ministry of Health. It will also gather and assess information on the results of specialists’ visits. The team will review specialist reports to identify themes on processes used and support provided for their visits. The team will seek to draw lessons from the totality of the information gathered and analysed, and will identify any wider or unintended consequences of the schemes.

Provision of feedback

The team members will provide weekly feedback to the MFAT staff managing their contracts. If possible, at the conclusion of the visits to Mangaia and Mitiaro, the team will feed back preliminary findings to key stakeholders. At the end of the field work in Cook Islands, the team will meet with key stakeholders in Rarotonga to discuss its preliminary findings and receive feedback on these findings. At the conclusion of its analysis, it will present a draft report, in accordance with the MFAT Guideline on the Structure of Evaluation and Review Reports (September 2009) to the steering group which represents MFAT and the CIG. A final report will be submitted following consideration of feedback from the Steering Group and other New Zealand Aid Programme staff, as well as from Cook Island stakeholders.

4 Stakeholders (identification, involvement and constraints)

The MFAT Development Programme Officer for Cook Islands has provided the team with a list of key stakeholders who can contribute to the evaluation. Primary and secondary stakeholders and their interest in the schemes are shown below.

Primary stakeholders include:

- *The recipients of visiting specialist services and their families*

The evaluation team will meet with patients in groups or as individuals as appropriate to discuss their experiences with the schemes. The team will aim to meet with wider communities in Rarotonga, Mangaia and Mitiaro via focus groups to obtain their views on the effectiveness of the schemes for their communities. The draft programme developed for meetings in Cook Islands is attached as Appendix A.

Input from patients and their families is subject to two particular constraints. The first is the short time frame available for organising meetings with these stakeholders, given that they need to be identified and invited to participate. The second is that, the evaluation will only be able to have face-to-face contact with those living in Rarotonga, Mangaia and Mitiaro. The team will endeavour to contact patients in some of the more remote islands in the Northern Group by email and telephone.

- *International health specialists who provided services under the schemes*

The team will hold as many face-to-face meetings as possible in the time available with specialists who have visited under the scheme during the review period. The main constraint here will be work commitments of the specialists and difficulty in making time available for such interviews. The evaluation team will seek to interview by telephone or skype where face-to-face interviews are not possible.

- *Cook Islands health workers who provided support to visiting specialists, and /or who received training from visiting specialists.*

In relation to Rarotonga and outer-island based health staff who provide support to visiting specialists, as well as Cook Island health workers who have received training from visiting specialists, the evaluation team will aim to meet with these stakeholders in groups where possible, supplemented by individual meetings where key informants are not available for group meetings because of work commitments.

Secondary stakeholders include but are not restricted to:

- *Wider communities in Cook Islands, including Island Mayors of Mitiaro and Mangaia, in terms of their interest in the health of their communities.*

The team will hold focus group meetings with community members and if available, individual meetings with Island Mayors. These groups may include people who have sought services but have not been able to access them.

- *Key staff in the Aid Management Division of the Cook Islands Ministry of Finance and Economic Management (MFEM) as the recipient of funds.*
- *Key staff of the Cook Island MoH as the implementing agency.*
- *Key staff of the New Zealand Aid Programme of MFAT both in New Zealand and in Cook Islands, as funder of the scheme (noting that MFAT administers a delegated cooperation aid programme to Cook Islands on behalf of AusAID).*
- *Key staff in the New Zealand Ministry of Health with its interest in international health, in its MoU with the Cook Islands MoH, and in implications of patient referrals from Cook Island for specialist services in New Zealand.*
- *Key staff in Counties Manukau District Health Board in terms of its MoU with Cook Islands and as recipient of some referred patients.*
- *Relevant Cook Islands NGOs (Cook Islands Disability Council, Cook Islands National Council of Women, Te Pa Taunga and Te Vaerua (Mental Health Care Services), Creative Centre) as advocates for potential patients and as vehicles for publicising visits of specialists.*
- *The Royal Australasian College of Surgeons which manages the Pacific Islands Project under which some health specialists visit Cook Islands.*
- *AusAID which co-funds the HSV through the delegated programme.*

The team will aim to meet individually or, as appropriate, in groups, with key staff in the Cook Islands MFEM, the Cook Island MoH, the New Zealand Aid Programme of MFAT,

the New Zealand Ministry of Health, and Counties Manukau District Health Board. The key constraint here will be availability of key staff in the time available. The team will aim to contact the Royal Australasian College of Surgeons and AusAID by telephone, skype or email. Should it prove difficult to gather sufficient information during the implementation phase of the evaluation, the team will try to arrange interviews with key informants during the report writing phase.

5 Information collection

There are some differences between the performance indicators developed for the two schemes and these do not always contribute clearly to the outcomes sought. Some will be useful, for example, information on the sex, age, and the home island of patients will indicate who is accessing the scheme. Other indicators will assess processes rather than results. For example, performance indicators relating to capacity building such as recording the numbers of seminars provided will not enable the team to assess whether local health workers have improved their skills. Where these shortcomings exist, the team will have to gather information from documents and interviews to supplement the information provided by the indicators in order to make informed judgements about the outcomes. The team is likely to recommend that more effective performance indicators be developed for any future scheme.

Using the evaluation objectives of relevance, effectiveness, efficiency and sustainability, Table 1 below summarises for each evaluation question, the information source and the likely method that will be used to obtain the information from key groups of stakeholders. Questions prepared for interviews with the various stakeholders are attached as appendices B - E. Stakeholders not included in these groups will be asked questions relevant to their area of interest in the schemes.

6 Documents to be used

While there will inevitably some additional documents collected and reviewed, the main set of documents that will be used in the evaluation is that specified in the evaluation ToR and in the material provided to the team by the Development Programme Officer for Cook Islands.

7 Timeline

The timeline for the evaluation will be that set out in the evaluation terms of reference.

Appendix A outlines the timetable for information gathering in Cook Islands.

Table 1: Information required and sources (*New questions added are shown in italics*)

Questions	Information required	Information source	Method
<p>Objective A: Relevance</p> <p>Have the schemes met the:</p> <p>(i) Health needs and priorities of different groups of people in the Cook Islands (disaggregated by geographic area, gender, socio-economic group and age)</p>	<p>How has the MoH defined health needs?</p> <p>How have priorities been determined?</p> <p>What disaggregated data is available?</p>	<p>Cook Islands MoH</p> <p>Patients, families, NGOs and communities.</p>	<p>Document review.</p> <p>Perceptions of stakeholders</p>
<p>(ii) Cook Islands health sector objectives</p>	<p>Information on the health sector objectives during the evaluation period</p>	<p>Cook Islands MoH</p>	<p>Document review.</p> <p>Semi-structured interviews.</p>
<p>(iii) New Zealand Aid Programme's policies, priorities and regional health programmes</p>	<p>Information on NZ Aid Programme's policies, priorities and regional health programmes during the evaluation period</p>	<p>New Zealand Aid Programme, MFAT</p>	<p>Document review.</p> <p>Semi-structured interviews.</p>
<p>(iv) How have specialist visits been prioritised</p>	<p>Information on MoH processes</p>	<p>MoH</p>	<p>Document review.</p> <p>Semi-structured interviews.</p>
<p>(v) Extent to which visits that have been prioritised meet specific needs as planned.</p>	<p>Information on priorities, plans and actual visits organised.</p> <p>Difficulties encountered.</p>	<p>MoH Specialists.</p> <p>Australasian College of Surgeons</p>	<p>Document review.</p> <p>Semi-structured interviews.</p> <p>Interviews</p>

Question	Information required	Information source	Method
<p>Objective B: Effectiveness</p> <p>(i) What has been the contribution of MSV and HSV in enabling Cook Islanders to have access to specialist health services (development outcomes for HSV)?</p>	<p>Information on numbers of patients seen by specialists during the evaluation period compared with earlier times</p> <p>Information on criteria used for referral for specialist services</p>	<p>MoH reports</p>	<p>Analysis of 6 monthly reports and other data held by MoH.</p>
<p>(ii) <i>To what extent and how and are health workers and the wider community made aware of planned specialist visits?</i></p>	<p>Information on methods used to promulgate the scheme, target audiences, frequency.</p>	<p>MoH processes and reports. Health worker, patients, family members, NGO and community</p>	<p>Analysis of MoH reports. Semi-structured interviews. Perceptions of stakeholders</p>
<p>(iii) To what extent and how are women, and people from the outer islands, accessing MSV/HSV (Objective 1 of the schemes)?</p>	<p>Disaggregated data on patients seen by specialists during evaluation period</p>	<p>MoH reports. Island visits.</p> <p>MoH, health workers and specialists.</p>	<p>Analysis of reports. Island interviews and focus group discussions. Analysis of MoH data on visits and reports of specialists. Interviews.</p>
<p>(iv) Is there effective emphasis on women's health e.g. equal access, female health specialists, addressing women's needs (Objective 2 of schemes)?</p>	<p>Information of women's specialist services included in the scheme. Proportion of women accessing the scheme. Gender composition of visiting specialist teams</p>	<p>MoH and specialists' reports on specialties offered, patients seen and gender composition of teams.</p> <p>MOH staff and specialists</p>	<p>Analysis of data on visits</p> <p>Analysis of reports</p> <p>Interviews</p>

Question	Information required	Information source	Method
<p>Effectiveness (continued)</p> <p>(v) To what extent has the capacity of local health professionals been increased (Objective 3 of the schemes)?</p>	<p>Information on capacity development for clinical, clinical support and general support personnel, as well capacity to analyse health statistics and information to guide future HSV planning, effective primary health care interventions and workforce development.</p>	<p>MoH and specialists' reports on training provided. MoH and health worker perceptions. Visiting specialists' perceptions.</p>	<p>Analysis of reports. Semi-structured interviews.</p>
<p>(vi) Is there effective follow-up to screening programmes funded under the MSV/HSV allocation (Objective 4 of the schemes)?</p>	<p>Information on referral for treatment for people with abnormalities identified in screening. Appropriate recall for those with lower level abnormalities. Provision of appropriate primary care services where appropriate.</p>	<p>MoH reports. MoH, health worker and specialist perceptions. MoH records on patient referral, recall systems, and follow-up treatment provided.</p>	<p>Analysis of records and use of recall systems. Semi-structured interviews.</p>
<p>(vii) <i>To what extent are recommendations made in reports prepared by specialists followed up and acted on?</i></p>	<p>Information which seeks to improve the effectiveness of the scheme.</p>	<p>Specialists' reports. MoH, health workers, specialists and patients.</p>	<p>Analysis of specialist reports. Semi-structured interviews.</p>
<p>(viii) Has the quality of visits e.g. specialist skills, support teams, time allowed, been of appropriate standard for meeting identified health needs?</p>	<p>Given that there are no quality measures in place, information collected will involve perceptions of the parties</p>	<p>Specialists' reports. Discussions with specialists, MoH and health workers and patients</p>	<p>Analysis of specialist reports. Semi-structured interviews.</p>

Question	Information required	Information source	Method
(ix) What factors have enhanced or constrained the effectiveness of the MSV/HSV?	Stakeholder views with examples on what factors have enhanced or constrained the effectiveness of the MSV/HSV e.g. clinical leadership, health information systems, financial management systems workforce development indicators, succession planning for key roles.	MoH, specialists, health workers	Semi-structured interviews.
(x) To what extent has the MSV/HSV had an impact on the volume of patient referrals to New Zealand for health services?	Information on patient referral numbers by specialty during the evaluation period compared with the previous six years	MoH	Analysis of the data. Trends analysis.
Objective C: Efficiency (i) Were/are the schemes managed and delivered effectively and efficiently (Objective 5 of the schemes)?	Information on the operation of the schemes, including planning and financial reporting Information of data collected relating to performance indicators	MFAT MoH	Review of procedures, practices, reports etc.
(ii) Is the funding arrangement being managed within financial budgets and fulfilling the terms of the contract?	Funding arrangements and letters of variation for the schemes. MoH financial reports. Coordination with inputs from other donors.	MoH reports, Cook Islands national budgets for the relevant years. MoH, CI MFEM, and MFAT	Semi structured interviews.
(iii) Is the project providing value-for-money?	Information on broad results achieved against funding used. Information on costs of systems/ processes used to manage schemes	MoH reports and opinions. Information from other countries. MFAT, MoH, specialists.	Review of documents. Discussions with key staff

Question	Information required	Information source	Method
(iv) What are the key areas of success and the issues of concern?	Examples/evidence of successes and issues of concern	All stakeholders	Analysis of reports Discussions with key staff Input from other stakeholders
Objective D: Sustainability (i) What factors are evident that may enhance or constrain sustainability of the HSV?	Information on health workforce capacity development, systems and processes developed and new technology available	MoH, specialists and health workers	Semi-structured interviews
(ii) To what extent has HSV contributed to sustainability of Cook Islands health system?	Views of stakeholders with supporting evidence	MoH, specialists and health workers	Semi-structured interviews.

8 Evaluation limitations

The main limitation for this evaluation is the inability, due to budget and time constraints, to seek face-to-face input from beneficiaries, communities and health workers in the more remote Northern Group. This is a concern given the focus of the schemes on providing equitable access to the visiting specialists with a particular focus on the outer islands. The two islands that will be visited as part of the evaluation (Mitiaro and Mangaia), are not representative of all outer islands, particularly as these have air access not available to many in the Northern Group. A second limitation concerns the fact that the evaluation was not designed from the outset as participatory. As a result, it may not take account of questions or issues that primary stakeholders would have liked to see addressed.

The Cook Islands team member is only contracted to be present for the Cook Islands portion of the implementation phase. This may reduce her ability to evaluate the schemes in their totality. The two members of the evaluation team have never worked together before and will not have an opportunity to meet prior to embarking on their programme of work in Cook Islands. This may reduce their ability to work well as a team from the outset. Other limitations are the relative ‘new-ness’ of the New Zealand Aid Programme staff in Wellington and Rarotonga. The team plans to talk to former employees and employees who held key positions during the earlier in the evaluation period.

9 Risks and risk management

The main risks to the evaluation relate to:

- The tight time frame for the implementation phase which may have an impact on the extent to which the team can access key stakeholders.
- The timing of the consultations in Cook Islands when a new government is forming, which may affect the extent to which the team can access key stakeholders.
- Flight delays or cancellations.

To manage these risks, the team may need to follow up with some stakeholders during the report writing phase. The plan for consultations in Cook Islands provides some flexibility for appointments to be changed in the case of travel delays/cancellations.

Acronyms used

CIG	Cook Islands Government
HSV	Health Specialist Visits Scheme
MoU	Memorandum of Understanding
MSV	Medical Specialist Visits Scheme
MoH	Cook Islands Ministry of Health
MFAT	New Zealand Ministry of Foreign Affairs and Trade
MFEM	Ministry of Finance and Economic Management in Cook Islands

Appendix B (to the evaluation plan): Core questions for patients and families

Name:

Village:

Island of origin:

Sex:

Age:

HSV specialist used:

Year treatment started:

Brief description of condition treated and how the service was delivered:

Progress to date:

1. How did you first hear about the services provided by the scheme?
2. How long did you have to wait before being seen by the specialist?
3. Did you have to travel to receive the services? Where to?
4. Did you receive screening services e.g. mammography or cervical screening from a visiting specialist?
5. If so, how did you hear the results of the screening? From whom? How long did it take?
6. If there was an abnormality, did you have access to further diagnosis or treatment?
7. What arrangements were made to ensure anonymity of data collection about your participation in the scheme? (MSV performance indicator only)
8. What were the support services around the HSV like? E.g. follow up by health visits or meetings, monitoring visits and treatment, equipment, drug, care giving support?
9. What were your family/community support services like while you were undergoing treatment? Were there any hardships? If so, how did you and your family address these?
10. How do you feel about the treatment and services you received under the MSV or HSV?
11. What improvements, if any, would you like to see?

Appendix C (to the evaluation plan): Core questions for NGOs and communities

Name of NGO or location of community:

Your role (in NGO):

Key goals (NGO):

1. Are you familiar with the MSV/HSV? If so, how did you hear about it?
2. What are your key thoughts around the HSV treatment and service offered? To what extent do you think they meet the needs of the community?
3. To what extent do you consider that different groups, e.g. women, people with disabilities, poor people, people from the outer islands, have access to the services of the scheme?
4. What are the barriers, if any, to different groups accessing the services of the scheme?
5. What changes, if any, would you like to see to the scheme?
6. Looking forward, what do you see as the developing health issues for Cook Islands and how do you think the HSV scheme could assist?

Appendix D (to the evaluation plan): Core questions for visiting specialists

Name:

Specialty:

Number of visits undertaken and in which years:

1. How were you recruited for the scheme?
2. What processes were used to organise your visit to Cook Islands, e.g. timing, travel, accommodation, remuneration? How effective were these?
3. What arrangements were made by the Cook Islands MoH to plan for your specialist consultations, e.g. scheduling, equipment and supplies? How effective were these?
4. What fee did you receive for your services? How appropriate did you consider this to be?
5. What support did you receive from health workers in the Cook Island health service during your visit? How effective was this?
6. What emphasis was placed on gender equity in terms of e.g. the selection of your specialty, number of women patients seen, gender mix of the team you worked with, particularly seeking your services (if you are female)?
7. To what extent were you able to provide services to people from the outer islands? Did you travel to outer islands or did patients travel to you?
8. What follow-up services were provided for patients you saw? How adequate do you consider that these were?
9. Did you provide any training to Cook Island health workers e.g. on-the-job, seminars, workshops, etc. How effective do you think this was in terms of building local capacity?
10. Did you make recommendations in your report/s on your visit/s and if so, how were these addressed?
11. In your view, what assists and what constrains the sustainability of the scheme?
12. What impact do you think the scheme has on reducing the numbers of people referred to New Zealand for tertiary health services?

Appendix E (to the evaluation plan): Core questions for Cook Islands health workers

Name:

Position:

Location/village/island:

Brief description of your key responsibilities:

1. What do you know about the MSV/HSV services delivered in the country? Which ones? Why are you aware of these?
2. Have you done any work connected with the HSV? If so what has this been?
3. How effective do you think the specialist visits have been in addressing the health needs of people in your community?
4. How satisfactory were follow-up arrangements needed for patients seen by specialists?
5. In your view, how well are women, people from the outer islands, and poor people able to access the services of specialists visiting under the schemes?
6. Have you received any training from specialists visiting under the schemes? If so, what was the nature of the training?
7. How useful was this? What did you learn?
8. What impact have the schemes had on the regular health services provided by Cook Islands health workers?
9. What impact do you think the scheme has on reducing the numbers of people referred to New Zealand for tertiary health services?
10. What has assisted and what has constrained the effectiveness of the schemes?
11. Looking forward, what do you see as the developing health issues for Cook Islands and how do you think the HSV system could assist?

Appendix F (to the evaluation plan): Core questions for MoH CI officials

Name:

Position:

1. How well do the services of the MSV/HSV schemes fit with the Cook Islands priorities/objectives for its health services? How has the MoH defined health needs?
2. How has the MoH determined priorities for specialist services provided under the MSV/HSV? To what extent has the MoH been able to address the identified priorities by securing the services of appropriate specialists?
3. How and to what extent has the MoH incorporated gender equity in the schemes e.g. focus on women's health, encouraging women specialists to participate, and gender balance in teams?
4. How has the MoH coordinated the schemes with specialist visits supported by other donors?
5. How have the schemes been advertised?
6. What criteria are used for access to the scheme? How rigorously are these applied?
7. What disaggregated data on those accessing the scheme does the MoH collect? How is this information used?
8. In your view, has there been equitable access to visiting specialists by, for example, women, poor people and people from the outer islands to the services of the scheme? If not, what are the barriers to equitable access?
9. What has been the quality of the services provided by the visiting specialists?
10. What follow-up services are provided by local health services? How effective are these?
11. What training has been provided by visiting specialists? To what extent was local capacity built as a result of this training?
12. How are recommendations contained in specialists reports addressed?
13. What impact has support for the schemes had on the ongoing health services provided in Cook Islands e.g. diverting staff from usual duties; up skilling local staff?
14. How adequate was the level of funding provided for the schemes?
15. What impact do you think the scheme has on reducing the numbers of people referred to New Zealand for tertiary health services?
16. To what extent have the schemes provided value-for-money?
17. What have been the key successes and constraints to the effectiveness of the schemes?
18. Looking forward, what do you see as the developing health issues for Cook Islands and how do you think the HSV system could assist?

Appendix G (to the evaluation plan): Core questions for New Zealand Aid Programme officials

1. To what extent have the MSV and HSV schemes been consistent with the programme's policies, priorities and regional health programmes?
2. How does such a scheme sit with the programme's thinking on development assistance in the health sector in the future?
3. How is this influenced by New Zealand's special relationship with the Cook Islands?
4. How efficiently do you consider that the Cook Islands MFEM and CI MoH have carried out their responsibilities under the tripartite arrangement?
5. Do you consider that the scheme represents value-for-money?
6. What other visiting specialist schemes does the programme support? What information is available about the value-for-money of those schemes? How do the MSV/HSV compare?
7. What do you consider to be the key areas of success and/or issues of concern relating to the schemes?

Appendix 3

Summary of comments on the schemes by different groups of stakeholders

Objective 1:

Equitable access

Stakeholders

Comments

Patients/families	<ul style="list-style-type: none"> • Happy to have seen a specialist • Would like more and longer visits to outer islands • Some confusion about orthopaedic wait list priorities for NZ • May be less access for people with disabilities
NGOs	<ul style="list-style-type: none"> • Happy to have access for their client groups • Not always advised of visits of relevant specialists • People with disabilities may be less well served
Health workers	<ul style="list-style-type: none"> • As more specialists visit, able to increase access • Short visits limit numbers that can be seen • Would like more visits to outer islands esp. Northern Group • Pre-screening requirement improving service to most in need • BUT still get pressured by queue jumpers
Visiting specialists	<ul style="list-style-type: none"> • Access increasingly based on need • Concern by ophthalmologist that there may be unmet need among diabetics for treatment for diabetic retinopathy.

Objective 2:

Focus on women's health

Stakeholders

Comments

Patients/families	<ul style="list-style-type: none"> • Very happy to be part of mammography program • Happy to have services of gynecology specialist
NGOs/communities	<ul style="list-style-type: none"> • Would like better access by outer island women to mammography • Would like more cervical screening coverage
Health workers	<ul style="list-style-type: none"> • Would like to provide expanded cervical screening programme • Would like to introduce HPV vaccinations • Would like greater coverage of mammography • Ongoing need for services of a uro-gynaecologist
Visiting specialists	<ul style="list-style-type: none"> • Well served by local O&G specialist • Could improve cervical screening coverage

Objective 3: Increasing local capacity

Stakeholders

Comments

Patients/families	<ul style="list-style-type: none"> • No comments
NGOs	<ul style="list-style-type: none"> • Te Kainga getting good mental health training from visiting psychiatrist
Health workers	<ul style="list-style-type: none"> • High level of satisfaction with on-the-job training • Increased confidence to undertake procedures without supervision • Would like more dedicated training time • Some specialist recommendations for refresher training of local staff acted on • More health workers would like to be involved (however shift doctors sometimes can't be available) • Specialist reports could be used more widely for learning • Specialist endorsement increases respect for local workers
Visiting specialists	<ul style="list-style-type: none"> • Local capacity being developed • There to support local specialist with difficult cases

Objective 4: Follow-up of screened patients

Stakeholders

Comments

Patients/families	<ul style="list-style-type: none"> • Generally well satisfied but exceptions • On waiting lists for referral without being clear when to go • Prescribed medicines not always available • Prescribed aids not always available • Poor coordination assistance in NZ for those referred
NGOs/communities	<ul style="list-style-type: none"> • Nothing specific identified
Health workers	<ul style="list-style-type: none"> • Improved use of MedTech 32 enabling them to pick up management after specialist leaves • Can contact specialists in NZ to discuss cases • For patients referred to NZ, it can be difficult to get notes at end of treatment • Ongoing management can include drugs not available here • Referral policy to NZ has limitations for adequate follow up
Visiting specialists	<ul style="list-style-type: none"> • Local follow-up is good

Objective 5: Management of the schemes*Stakeholders**Comments*

Patients	<ul style="list-style-type: none">• Generally aware of specialist visits (sample included only those who had seen a specialist)• Unclear about priority for referral to NZ• Unclear about policy on follow-up visits to NZ• Not always well served for coordination in NZ
NGOs/communities	<ul style="list-style-type: none">• Would like input into which types of specialists should come• Would like early notification of specialist visits
Health workers	<ul style="list-style-type: none">• More would like to be involved in planning e.g. GPs, outer island doctors, private practitioners• Would like two months notification of visits where possible• Would like to receive specialists reports and to discuss
Visiting specialists	<ul style="list-style-type: none">• Visits well managed (less so when the HSV Coordinator was on leave)• Clinical and nurse/technical support well managed.• Reduces recourse to referral to NZ for treatment• Need a NZ-based coordinator
MFEM/ MOH	<ul style="list-style-type: none">• Happy with financial and activity reporting
NZ Development Programme	<ul style="list-style-type: none">• Happy with financial and activity reporting

Appendix 4: People who contributed to the evaluation³⁰

New Zealand

Ministry of Foreign Affairs and Trade

Tiffany Babington, Deputy Director, Special Relations Unit

Christine Biasco, Health Advisor, NZDP

Cherie Flintoff, Development Programme Officer, Special Relations Unit

Jonathan Kings, Director, Special Relations Unit

Stephanie Knight, former Aid Manager, Rarotonga (now in New York)

Guy Reading, Deputy Director, Polynesia, NZDP

Anna Reid, Policy Officer, Special Relations Unit

Monique Ward, Development Programme Officer – Cook Islands,

Geoff Woolford, Development Programme Manager Regional Human Devpt, NZDP

New Zealand Ministry of Health

Wendy Edgar, Manager, Global Health, Office of the Director of Public Health

Dr Mark Jacobs, Director of Public Health

Dr Hazel Lewis, Clinical Advisor, Cancer Screening, National Screening Unit

New Zealand Defence Force

Major Stuart Brown, Assistant Director, Strategic Commitments

Counties Manukau DHB

Director, Pacific Development and Regional Pacific Coordinator

Visiting health specialists

Dr Tim Cundy, Diabetes Specialist

Dr Bob Eason, General Physician

Diane Hamilton, Ear Nurse

Dr Ted Hughes, Anaesthetist

Dr Fran Jones, Breast Surgeon (visiting specialist from Australia)

Mr Andrew McDiarmid, Orthopaedic Surgeon

Alexandra Noble-Beasley, Podiatrist

Dr Paul Rosser, Ophthalmologist

Dr Martin Sowter, Gynaecologist and Obstetrician

Mr Jonathan Simcock, Neurologist

Australia

Project Manager, International Projects, Royal Australasian College of Surgeons

Cook Islands

20 patients who have been beneficiaries of the schemes

Rarotonga

New Zealand Development Programme, New Zealand High Commission

Julie Affleck, Aid Manager, Rarotonga

Christina Newport, former Development Programme Coordinator

Karen Nobes, Development Programme Coordinator

³⁰ Those listed have consented to having their names included in this appendix

Ministry of Finance and Economic Management
Jim Armistead, Aid Management Division

Ministry of Health

Tofinga Aisake, Manager, Information and Communication Technology
Dr Zaw Aung, Director of Clinical Services
Dr Yin Yin May Aung, Medical Officer – Obstetrics and Gynaecology
Tupou Faireka, Secretary of Health
Dr Rangiau Fariu, Director of Community Health Services
Josephine Henry, Registered Nurse
Dr George Hosking, Chief Dental Officer
Dr Karmen, Out-Patients Doctor
Ngati Matapo, Anaesthetist Technician
Dr Zizawur Aye Maung, Medical Officer
Dr Fran McGrath, Director of Funding and Planning
Stella Neale, Registered Nurse
Dr Tekaai Nelesone, Medical Officer, Atiu
Iokopeta Ngari, Director of Nursing
Dr Te Ariki Noovao, Surgeon
Dr Frank Obeda, Medical Officer, Manihiki
Mary-Ann Pukeiti, Registered Nurse
Helen Sinclair, Director of Outer Island Health Services
Dr Voi Solomone, Pediatrician
Doris Taripo, Registered Nurse
Pa Tauakume, HSV Coordinator
Peggy Teiotu, Patient Referrals Coordinator
Dr Henry Tikaka, Medical Officer – Outpatients (previous Director of Clinical Services)
Dr Mary Tuke, Anaesthetist
Maru Willie, MedTech 32 Operator, Information and Communication Technology
Heather Webber-Aitu, Director of Hospital Health Services

NGOs

Debbie Ave, National Coordinator, Cook Islands Disability Council
Dawn Baudinet, President, Cook Islands Breast Cancer Foundation
Kathy Koteka, Registered Nurse, Cook Islands Family Welfare Association
Mereana Taikoko, Centre Director, Te Pa Taunga/ Te Vaerua Mental Health
Polly Tongia, Project Officer, National Council of Women
Ake Utanga, Programme Officer, Cook Islands Family Welfare Association

Mangaia

Tere Akeake, Mayor of Mangaia
Helen Henry, Island Secretary
Dr Dawn Pasina, Medical Officer

Mitiaro

Teariki Boaza, Registered Nurse
Ngatokorima Patia, Nurse Practitioner

Others

Takai Munokoa, Mayor of Rakahanga
Dr T Uka, private medical practitioner, Rarotonga

Appendix 5: MSV/HSV specialist visits by year and by island: July 2004- June 2010 (incomplete)

Island	2004/2005	2005/2006	2006/2007	2007/2008	2008/2009	2009/2010
<i>Southern Group</i>						
Rarotonga	ENT/ Audiology General medicine	ENT Ophthalmology General Medicine	Dermatology ENT/ Audiology Endoscopy/laparoscopy General physician/echo- cardiology Gynaecologist Neurology Ophthalmology Orthopedics	Adult & paediatric cardiologist ENT/ Audiology General medicine ³¹ Gynaecology (twice) Mammography Ophthalmology/ medical retinopathy Orthopedics	General medicine Gynaecology (twice) Mammography Orthopedics (twice) Ophthalmology Otolaryngology/ ENT Paediatric cardiology Psychiatrist (3 times)	Adult cardiologist Diabetes specialist (twice) Endoscopist General medicine (twice) Gynaecology Mammography Ophthalmology Orthopedics (twice) Psychiatrist Podiatrist Urology (twice)
Aitutaki	ENT/ Audiology General medicine	General medicine	Dermatology ENT/ Audiology General physician/echo- cardiology Neurology Ophthalmology	ENT/ Audiology Adult & paediatric cardiologist General medicine Ophthalmology/ medical retinopathy (twice)	Ophthalmology Paediatric cardiology Psychiatrist	Ophthalmology Psychiatrist

³¹ The general medicine physician reportedly visited islands of the southern group, but those visited are not identified in the six-monthly report.

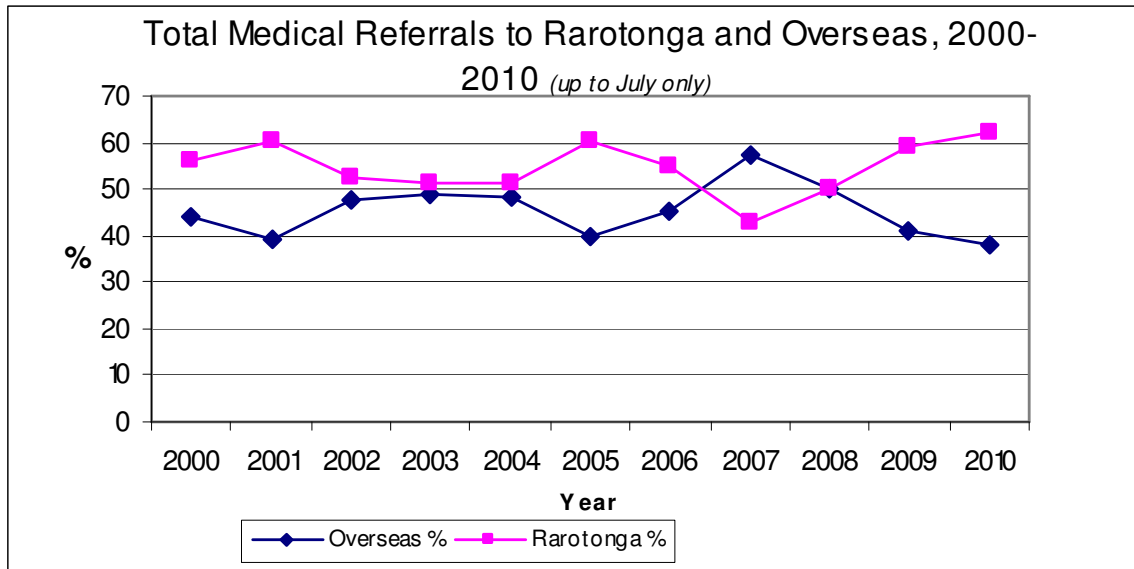
Island	2004/2005	2005/06	2006/2007	2007/2008	2008/2009	2009/2010
Mangaia	ENT/ Audiology General medicine	General medicine	ENT/ Audiology General medicine/echo- cardiology Ophthalmology	Adult & paediatric cardiologist ENT/ Audiology Ophthalmology/ Med. retinopathy (twice)	Ophthalmology Psychiatrist	General medicine Ophthalmology Podiatrist
Mitiaro	-	-	Ophthalmology	Adult & paediatric cardiologist ENT/ Audiology General medicine Ophthalmology/ medical retinopathy	General medicine Psychiatrist	Ophthalmology
Mauke	ENT/Audiolo gy	-	Dermatology Ophthalmology	Adult & paediatric cardiologist ENT/ Audiology General medicine Ophthalmology/ medical retinopathy	General medicine Ophthalmology Otolaryngology/ ENT	Ophthalmology
Atiu	-	-	Ophthalmology	Adult & paediatric cardiologist ENT/ Audiology Ophthalmology/ medical retinopathy	Psychiatrist Ophthalmology	General medicine Diabetes specialist Podiatrist Ophthalmology

Island	2004/2005	2005/06	2006/2007	2007/2008	2008/2009	2009/2010
<i>Northern Group</i> Manihiki	ENT/Audiology Cardiology Dermatology Gynaecology Ophthalmology Paediatrics	-	-	Eye screening	-	Ophthalmology
Rakahanga	Cardiology ³² Dermatology Gynaecology Ophthalmology Paediatrics	-	-	Eye screening	General medicine and Gynaecology Ophthalmology Surgery	-
Penryn	ENT/Audiology Cardiology Dermatology Gynaecology Ophthalmology Paediatrics	-	-	Eye screening	General medicine and Gynaecology Ophthalmology Surgery	-
Pukapuka	Cardiology Dermatology Gynaecology Ophthalmology Paediatrics	-	-	Eye screening	General medicine and Gynaecology Ophthalmology Surgery	-

Sources: July 2004 – June 2007: Summary table prepared for the 2007 Review of the MSV
July 2007 – June 2008: As no summary data was available, material was extracted from the 6- monthly reports for the period. This appeared to be incomplete and may not be accurate.
July 2008 – June 2010: Summary table prepared by the HSV Coordinator

³² Note that in the summary data prepared for the 2007 review does not include any of the visits undertaken in 2005/06 or data on the November 2004 visit of specialists (cardiology, paediatrics, ophthalmology, gynaecology and dermatology) to Pukapuka, Manihiki, Rakahanga and Penryn is not recorded. Also, the visit in March 2008 of specialists (ophthalmology, general medicine, surgery and gynaecology) to Pukapuka, Penryn, Rakahanga, and Manihiki not recorded in any summary data.

Appendix 6: Trends in medical referrals overseas from the Cook Islands



Source: Ministry of Health Cook Islands

Actual numbers of medical referrals from Cook Islands to overseas by year 2004/05 – 2009/10

2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
185	150	147	174	138	139

Source: Ministry of Health Cook Islands 2009