PACIFIC CHOICE

A New Vision for the Health Sector in Tonga

Asian Development Bank
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Change and Capacity Development Strategies

By Kaveinga Tu’itahi, Tonga

Asian Development Bank
Capacity Development Series

This sub-series is published by the Asian Development Bank to provide the governments of its Pacific developing member countries (PDMCs) with analyses and insights on key issues and lessons learned with respect to capacity development. Cases studied highlight a range of experiences throughout the region by sector, theme and source of external support, revealing approaches to capacity development that work best and the conditions that have been conducive to their success. They also explore the unique challenges faced by PDMCs in addressing capacity constraints as well as some of the opportunities facing governments and the people in the Pacific islands. Among other things, the case studies underline the importance of PDMC leadership, engagement of local partners, strategic attention to long-term capacity issues and effective use of external resources. It is our hope that the findings in these reports will help to guide future capacity building efforts in the Pacific.

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Despite 50 years of aid in the Pacific region, including some S$17 billion invested over the past 25 years, overall results in terms of sustainable improvements in capacity have been mixed, at best. This raises questions, not only in the Pacific but also throughout the developing world, about approaches to capacity development—what works, what doesn’t, and why? The Asian Development Bank (ADB) recognizes the importance of capacity development, having officially embraced it as a thematic priority in 2004. ADB’s commitment is consistent with the Paris Declaration on Aid Effectiveness and the Pacific Principles on Aid Effectiveness. The programs of a number of other funding agencies, including the Australian Agency for International Development (AusAID), New Zealand Agency for International Development (NZAID), United Nations Development Programme (UNDP), and the World Bank also embrace the importance of more effective capacity development.

Increased interest in capacity development in recent years reflects an acknowledgment of the shortcomings in development assistance over the past 50 years. This has led to calls for approaches that are more systematic and integrated, and which focus more on developing country ownership and achievement of sustainable results. Capacity amounts to the policy, procedures, personnel, organizations, institutions, and supporting environment required to effectively deliver development outcomes. In particular, ADB has focused on the ability of public sector capacity to deliver essential services, thereby strengthening the compact between government, civil society, and the private sector. Capacity development is much more than just training or skills transfer. It is really about effective organizations and institutions, a sound unpoliticized policy environment, accountability systems, effective relationships, and appropriate incentives. And as noted in this study, capacity development should be firmly rooted in a country's political economy.

To gain a better understanding of what works in terms of approaches to capacity development, ADB’s Pacific Department (PARD) commissioned a regional study in 2007. The study was rooted in 20 case studies from 11 countries across the region, prepared mainly by Pacific islands consultants. The case studies covered a range of programming experiences—from economic planning, to infrastructure development, health and legal sector reform, and civil society enhancement, as well as different modalities for supporting capacity development. ADB’s intent in commissioning the overall study was to draw upon the individual findings and recommendations to help guide future capacity building efforts in the Pacific, including institutionalizing a more focused and effective approach to capacity development in ADB’s country programs and operations.
The case studies in this series and the overall study report are the result of collaboration among a number of consultants working with ADB under the direction of Steve Pollard, Principal Economist, PARD. The team leader for the overall study was Joe Bolger, and the authors of the studies were Helio Augusto, Kevin Balm, Brian Bell, Ron Duncan, Ben Graham, Ueantabo Mackenzie, James McMaster, Samson Rihuoha, Cedric Saldanha, Tom Seta, Paulina Siop, Esekia Solofa, Kaveinga Tu’itahi, Henry Vira, and Vaine Wickman. The study also benefited from the input of a number of resource persons, including Tony Hughes (Solomon Islands), Lynn Pieper (Timor-Leste), Tim O’Meara (Samoa), and Patricia Lyon, Senior Capacity Development Specialist, AusAID. The case studies represent the situation at the time of writing in 2007.

In conclusion, this report seeks to enhance understanding and dialogue on capacity development and its potential for contributing to poverty reduction and improvements in the quality of life of all Pacific islanders. I trust that you will find it both thought-provoking and practically helpful in advancing our collective commitment to development in the Pacific.

Philip Erquiaga
Director General
Pacific Department
The Pacific Choice
Kingdom of Tonga Facts

Population: 116,921 (July 2007)
Political status: constitutional monarchy
Capital: Nuku’alofa
Location: Oceania, archipelago in the South Pacific Ocean, about two-thirds of the way from Hawaii to New Zealand
GDP - per capita: $2,200 (2005 est.) (PPP)
Literacy: 98.9%
Independence: 4 June 1970 (from UK protectorate)
Head of State: King George TUPOU V
BACKGROUND

Declining Health Services and Demands for Change

TONGA was approaching the closing years of the 20th century with serious challenges to its health services. Thus, in January 1997, the Government of Tonga requested the Australian Agency for International Development (AusAID) and the Tongan Ministry of Health to develop plans for an extensive program of support for the sector. A project identification team visited Tonga the following month. The team recommended AusAID support for a project aimed at improving planning, management, and resource utilization in the Ministry of Health. By February 1999, the Project Manager had taken up his new post and work commenced on the project.

A number of critical concerns had compelled the Tongan Government to contemplate serious changes in the health sector. Over the preceding few decades, the Ministry of Health’s capacity to cope with the demand for its services had declined noticeably. High staff turnover and attrition rates led to staff shortages and deprived the health sector of essential specialized skills. Many of the qualified and experienced doctors, nurses, and other staff had migrated abroad.

In the 1980s and early 1990s, the country’s regressing economy aggravated the brain drain. The ministry could hardly cover ongoing staff costs let alone higher remuneration or other incentives to retain staff. Money for training and development of replacement staff; procurement of essential equipment, drugs, maintenance, and repair of existing facilities; or even to provide for much-needed additional facilities was scarce.

1 The Vaiola’ Hospital, for example, which is located in the capital, had opened in the early 1970s with the support of the British. The Ministry of Health had its headquarters there until 2005, despite the fact that the facility had deteriorated badly due to inadequate maintenance and repair. A request for separate offices for the ministry was approved in 2000 and construction began in 2003, with funding allocated from the project that is the subject of this case study. The new building, which shares a compound with the main hospital, opened in 2005, and for the first time the ministry was physically separate from the hospital.
Service delivery on the main island as well as in rural areas and the outer islands suffered. Calls for upgraded and new health centers staffed by qualified health workers in these localities became more and more persistent. The ministry’s already heavy dependence on donor\(^2\) and other external funding sources for sponsorship of overseas training and for equipment and facilities escalated further.

At the main hospital in the capital, Nuku’alofa, the situation was severe as critical staff shortages led to long queues and prolonged waiting times. Patients from rural areas also flocked to the main hospitals, swelling the numbers as public complaints mounted.

The loss of Tonga’s medical skills was compounded by a shortage of management capacity. There was also significant dissatisfaction with the leadership, decision making, processes, procedures, and practices of the ministry and of hospital services in particular. Staff complaints became more vocal and widespread. Project documents and other sources highlighted specific concerns, including an “autocratic management style,” which was affecting staff morale. Similarly, it was noted that “the hierarchical management system (had) not encouraged input from staff in areas outside their immediate responsibilities.”\(^3\)

**Keeping the Ship of Health Afloat**

Notwithstanding these difficulties, some notable achievements were still being realized in the sector. For example, the Ministry was still able to optimise investment of the substantial assistance from Tonga’s development partners to secure training opportunities, which helped rebuild staff levels, assist the development of facilities, and support procurement of necessary drugs and equipment.

A reasonable level of health services was thus maintained. Indeed, the progress achieved and the results produced had allowed Tongans to enjoy a standard of health comparable to countries of similar per capita income.

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2 The main development partners have been Australia, New Zealand, Japan, and the World Health Organization.

To combat the brain drain problem, a retention strategy was implemented with some success. Early on though in the drive to resolve the staffing crisis, it was recognized that there was no strategy for developing management, leadership, and other capabilities among the ministry’s staff, especially medical personnel. On entry into the service, doctors were slotted into departments where it was assumed that tending to the needs of patients would be sufficient incentive for them to perform and to stay engaged. However, frustration or thirst for further knowledge or experience often drove them to leave the service either through retirement, resignation, or migration.

A rostering system was established, rotating younger doctors into different practice areas, including the outer islands hospitals. Refresher courses were established and mounted more frequently, both locally and overseas when financial resources were available. Doctors were thus exposed to a wider variety of practice situations, having opportunities to deal with people at the grassroots. Most significantly, they were empowered to “find themselves” professionally and to assert and affirm their special areas of interest. Importantly, they acquired valuable management experience, which ensured that they were better equipped for higher postings with greater responsibilities. This strategy enhanced the Ministry’s ability to manage the ongoing risk of human resource capacity depletion.

It is important to underline that the “achievements” of the period just described had to do mainly with improvements in facilities and some stemming of the outflow of Tongan staff. However, serious problems remained in the areas of management systems, policies, procedures, and practices, including the need for proper strategic planning, plan implementation skills, coordination, and monitoring in the ministry’s corporate operations, as well as in its health delivery services. These problems highlighted critical management capacities and systems that the ministry needed to strengthen. In addition, challenges posed by the rising incidence of non-communicable diseases began to aggravate the situation in the sector. Beyond these specific concerns, restoration of public confidence in the ministry remained an overarching but unrealized goal. All in all, although the efforts made during this period did help to resolve some of the outstanding challenges in the sector, many problems persisted.
The Storms Intensify: Changing, More Urgent Challenges

Thus, as the ministry moved toward the end of the 1990s, the nature of the challenges facing the health sector had changed and there was a real concern that if these were not confronted urgently and vigorously, the ability to sustain access to an adequate level of service would be severely compromised.

Significant advances in the control of communicable diseases had brought real improvements to the health of Tonga’s people. However, lifestyle diseases were now on the rise. Non-communicable diseases had become ‘Public Enemy Number One’ almost everywhere, and Tonga, for its part experienced significant increases in diabetes, obesity, cardiovascular diseases and neoplasm (cancer). These diseases imposed severe strains on the country’s health system and became the most critical strategic and management challenge facing the ministry, compounded by ongoing financial and human resource issues.

The analyses in the first phase of the AusAID-funded project confirmed though that the ministry’s “core problem” was a need for proper “planning, management and coordination.”

The analyses also suggested that a properly functioning management system would contribute to, among other things, improvements in planning, human resource management, training, and communications. Moreover, it would help resolve problems relating to work practices and performance monitoring while providing improved means of identifying solutions to difficulties faced in areas such as medical records, procedures for patient admission, transfer, and discharge.

Overall, this was the situation at the time of the conception and design of the AusAID-funded Tonga Health Sector Management and Planning Project.

The ministry was ripe for reform.
WITHOUT CAPACITY DEVELOPMENT
All Hands on Deck: Rallying Behind the Reform Process

The current top leadership and executive management of the ministry came into their present positions during the early to mid-1990s, culminating in the March 1999 appointment of the new Minister of Health, Hon. Viliami Ta’u Tangi, FRACS.

What is most remarkable about the ministry’s current management team is their vigilance in addressing the various challenges confronting the sector and taking a visionary and strategic approach - building on what their predecessors had been able to start - within the limited resources available.

The current minister of health assumed his duties early in the project cycle. Being relatively young and open to meaningful change, he quickly made his intentions clear and placed the full weight of his office behind the project. The minister has remained the foremost champion of change and a key driver of project initiatives for the ministry.

Engaging the Enemy: A Call to Arms

In his opening address at the 7 June 1999 “Visioning Workshop,” the Honorable Viliami T. Tangi left the participants in no doubt whatsoever as to the magnitude of the task that lay before them and what was expected of everyone. Sharing a key paragraph from his 25 February 1999 Letter of Appointment, he rallied the gathering of senior and middle management personnel of the ministry, saying

> The Ministry of Health is now being reviewed with the objective of restructuring and reorganizing it to achieve a quality service and to be more efficient, effective and productive. There is a need to create a more positive image through practical examples and results to improve the confidence of the public in the Ministry of Health, its staff and services provided.⁴

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These words left the staff of the ministry with some tall orders indeed. To call for review, restructuring, and reorganizing to achieve quality service; to increase levels of efficiency, effectiveness, and productivity; and to create a more positive image for the Ministry of Health was a truly momentous challenge.

The director of health is of the same generation as the minister and was equally receptive to the changes being brought forward. He too was a very able and dedicated supporter of the transformations being made in the sector under the project. Together they represented “new blood” and a new generation of management and leadership for the ministry.

The minister and the director both enjoyed the respect and support of the senior executives in the ministry and they worked very closely together, as well as with project staff and other key stakeholders, to move the programs forward. They all clearly took ownership of the reform process.

Amongst the most pressing needs were three critical areas identified in broad ranging dialogue between ministry and project staff during the first phase of the project. These were management development, financial management, and human resource management. It was anticipated that initiatives dealing with these key issues would help resolve many of the problems highlighted earlier. The top leadership and senior executives remained focused on these key areas, steering a safe course for the ministry through the turbulent waters they were navigating.
WITH CAPACITY DEVELOPMENT
THE REFORMS: RETHINKING TONGA’S HEALTH

The Tonga Health Sector Management and Planning Project

Goals and Objectives

The Tonga Health Sector Management and Planning Project was initiated with the signing of a Memorandum of Understanding on 2 July 1998 between the Government of Tonga and the Government of Australia, with the overall goal being “to significantly improve the planning, management and delivery of health services of the Government of Tonga.”

The project had three phases. Phase I, February 1999 to February 2001, focused on an intensive diagnosis of capacity issues in the ministry as well as assessing Phase II viability taking into account the magnitude of proposed changes and MOH’s absorptive capacity. Phase II, June 2001 to June 2003, concentrated on consolidating the achievements of the first phase and extending the programs at division and section levels. Phase III, September 2003 to August 2004, was extended to December 2005. The focus of this phase was sustainability and consolidation of achievements from the earlier phases as well as developing a model and guidelines that other government agencies could use.

The extension of Phase III also led to the addition of a completion phase to the end of 2007. This phase concentrated on ensuring overall project sustainability.

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A key feature of this project was the highly participatory and consultative approach taken throughout its various phases. The processes and procedures followed in the formulation, development, and articulation of project goals and objectives are testimony to this.

**Project Implementation Arrangements and Activities**

The project was officially launched on 30 March 1999 with an initial call for a “Review of Health Services Vision and Goals.” In October of the same year, a report developed by the executive and staff of the ministry entitled “Health Services Visions and Goals” was finalized. Almost immediately thereafter, the team leader submitted the document to the first secretary, development assistance at the Australian High Commission in Nuku’alofa. This submission was supported by a letter from the ministry’s senior health planning officer stating that the Project Steering Committee had discussed and endorsed the report—as well as confirming that the “Ministry is happy that the Team has satisfied Milestone 1.2.1.”

The statement of the ministry’s vision for the future, its purpose (mission), and core values, developed and articulated in the October 1999 report, was incorporated into and formed the basis of the National Health Plan, subsequently issued as “Tonga’s Health 2000.”

Tonga’s Health 2000 set out a comprehensive statement of goals, performance indicators, and objectives for the ministry. These were adopted as the goals and objectives for the project. The goals and objectives statement is rather lengthy and covers a wide range of areas right across the ministry’s operations.

The main thrust was to forge a program of change and improvement throughout the ministry, touching all aspects of its human, financial, physical, informational, policy, legislative, and institutional resource bases. It also included clear provisions for capacity building at the organizational, institutional, and policy levels, as well as plans to strengthen individual skills.
Conceptualizing Capacity Development in the Project Plan

Based on available documentary and oral evidence, the definition and framing of capacity and capacity building issues under the project and proposed reforms was clear. A few examples from ministry and project sources highlight this.

At the level of individual capacity development, the need for staff training and development was clearly weighed and articulated to ensure that staff received training “to meet the needs of the Ministry of Health and provide quality health care services.” Changes in human resource policies and systems were also introduced to “improve the retention of trained national personnel.”

Further, at the systems level, the project sought to ensure that the “Tonga Health System had an efficient and effective financial management system.” There was emphasis on the need to “identify and establish a computerized financial information system” with a stipulation to “implement (an) appropriate training program” to ensure that the Ministry of Health had the skills to run it properly.

These changes also included measures “to improve and strengthen workforce management in the Ministry of Health” with the first objective being “to improve the management of the Tongan health services workforce.” The two core activities to drive this were proposals to “revive (the) Human Resource Development Committee” and to “introduce an appropriate Human Resource Information System (HRIS).”

Additionally, the plan called for establishment of a training committee and a training needs analysis of the Ministry of Health.

In reviewing the approach to capacity development in the project, two significant and related issues became apparent. First, the key capacity building interventions in the project were designed to be ministry-led. The interventions clearly targeted

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6 According to Senior Health Administrator, Human Resources, Ms ‘Olivia Tu’ihalamaka, AusAID project staff were keen to ensure that ministry staff were fully informed, agreeable to and would be fully engaged in all follow-through activities in the project.
capacity needs at various levels identified by ministry staff. Project records indicate that the implementation was consistent with the project plan.

The second issue was a recognition by project stakeholders that some of the capacity development measures planned would necessarily be long term in nature. This effectively meant that the exercise would, at least in some instances, be more of an evolving process, allowing time for the fruits of the capacity building efforts to mature and to become established as part of government practice. In fact, a human resource specialist continued to work closely with the senior health administrator under the extension and completion phase to further develop the ministry’s human resource systems, policies, and practices.

**Implementing the Reforms**

The participatory approach taken in the project meant that there was close collaboration between the project team and ministry staff, with parameters for cooperation and roles of country stakeholders clearly defined. This enabled ministry staff to propose, negotiate, and ultimately define the key directions and focus of the project themselves. The process ensured that Tongan stakeholders had the space to contribute views and ensure an appropriate agenda that reflected the ministry’s needs. ‘Olivia recalls “I can say that effectively all they (AusAID) did was ask us what we needed, then they just coached us along and facilitated our journey in this project” 

The project harnessed the energy of the ministry’s capacity through workshops, on-site discussions, and meetings, as well as through capitalizing on the active involvement and leadership of the minister of health, director of health, senior executives, and other staff. Highly interactive meetings, consultations, and discussions were a regular feature of the project. Indeed, throughout the implementation of the various components, project advisors always engaged and worked with committees or working groups of staff drawn from relevant areas, analyzing problems and developing solutions. Appropriate recommendations were then submitted to the Project Coordination Committee,

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7 Ms ‘Olivia Tu’ihalamaka has been and continues to be the key person in the implementation and ongoing support of the various capacity development initiatives associated with the Project.
The capacity development initiatives undertaken throughout the project addressed needs at the individual, organizational, and multi-organizational levels. Interventions were also promoted at the institutional level, such as the establishment of policy and executive committees. Linking actors across the broader governmental system helped to ensure more effective use of existing capacity. The collaborative approach was also evident in the arrangements for overall project management and coordination. The Project Coordination Committee was an example; it included representatives from the Ministry of Health (Chair), Ministry of Finance, Prime Minister’s Office (Chief, Establishment Office\[9\]), Ministry of Foreign Affairs, Central Planning Department, Australian High Commission, and the Australian managing contractor.

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9 This is now the Public Service Commission office.
The key issues and lessons emerging from this review of the Tonga Health Sector Management and Planning Project with respect to capacity development are many and varied. A few significant ones are considered below.

Timing and Readiness

As noted previously, at the time this project began, Tonga’s Ministry of Health was ready for change. Cumulative problems that had built up over the preceding decades were calling out for resolution. The change in sector leadership also contributed to a more enabling environment for change, which included an openness to act on the demands of the health service’s key stakeholders, the citizens of Tonga.

At the national level, the Government was also gearing up its overall Economic and Public Sector Reform Programme, which was launched in 2001. Change and reform were the hot topics in public sector dialogue at the time. The momentum generated by these broader reforms helped create a more enabling environment for the health reforms and gave added impetus to them.

Beginning with the End in Mind: A Clear Vision and Direction

Folk wisdom has it that if we do not know where we’re going, we will never get there. The evidence from the project shows that the Ministry of Health had a clear sense of where it wanted to be as it embarked on its journey in 1999, as evidenced by the minister’s clarion call in opening the Visioning Workshop. In that opening address, he clearly articulated not only the ministry’s circumstances at that time but also the strategic directions for
getting out of it, as well as the picture of what was waiting for the ministry—and indeed the country—at the destination of that journey. The lesson arising from this experience is the need for a vision that is clearly conceived, well articulated, broadly understood, and open to strategic adjustment as lessons are learned.

**Local Champions and Leadership**

To a very significant degree, the Ministry of Health and the project benefitted from the exemplary leadership of senior ministry officers and their optimum use of project personnel. This included the involvement of the minister of health, director of health, other senior management, doctors, nursing staff, and others which served to remind us of the importance of top management buy-in, support, leadership, and active engagement.

**Participatory Approaches and Local Ownership**

A recurring feature of this project was the opportunities afforded key ministry staff throughout all phases to work closely with ministry colleagues, other government agencies, and AusAID project staff to articulate ministry needs and to define directions as well as the focus of the project. This opened up space for staff to actively pursue the reforms and gave broader legitimacy to the project based on the notion, referred to earlier, of “developing Tongan solutions to Tongan problems.”

High levels of participation in project activities contributed to the strong sense of ownership demonstrated by key Tongan stakeholders. Indeed, the ministry is now considered a role model among organizations in the Kingdom by virtue of its performance in the implementation of this project and the successes achieved.

At the national level, a strategic network of forward/backward links and alliances was established and developed, tapping into capacity and sources of support from other government bodies, ministries, and agencies. The collaboration with the Ministry of Finance on the Ministry of Health financial management system is one example. The wider relationships forged through
the composition of the Project Coordination Committee also highlight this point.

**Intensive Diagnosis of CD Issues**

Another significant characteristic of the project was the intensive diagnosis and identification of the ministry’s capacity issues in the first phase. This involved the minister, director, and all senior officers of the ministry coming together, initially in a “Visioning Workshop” and then in other intensive and interactive sessions—sitting down with AusAID personnel and working through the problems and needs of the ministry—then developing and producing a checklist of key capacity development priorities to be addressed through the project. There are clear lessons here, particularly relating to the approach to the diagnosis, the clarity of focus on what was needed (including capacity requirements), and what could be done to address the needs identified. Moreover, the diagnostic process itself demonstrated important themes associated with other lessons, e.g., regarding participation, local leadership/ownership, and donor facilitation.

**Facilitative Donor Role**

The facilitative and supportive role played by AusAID, and project advisors, was a major success factor in the implementation of the project. From inception, the basic operational philosophy was that the ministry would not only own the project but also drive it. In this context, the project advisors would serve primarily as facilitators, offering the benefit of their experience from other contexts but mainly supporting the efforts of MOH colleagues to fulfill their tasks effectively. And this is how the project did, in fact, unfold.

**An Integrated Approach: Factoring in the Broader Capacity System**

The collaborative links with other agencies and stakeholders outside the ministry during project implementation have been referred to already. By taking a broader, “non-siloed” approach, the ministry was able to not only tap into the government’s broader capacity system, but gain support for project implementation from a wider constituency while strengthening
relationships for the future. This is likely to benefit the ministry over the longer term and will also help to facilitate transfer of this reform experience across other departments and agencies.

**Effective Communication**

Another key success factor in this project was that the overall vision, mission, goals, and objectives were widely communicated throughout the ministry, and to other stakeholders. In talking with ministry personnel and in observing them at work and in discussions, it was clear that a “spirit of change” was in the air. Staff knew what was coming and what was expected of them. There was a positive and pervasive sense of anticipation and willingness to embrace a much brighter future in the “new” ministry.

**Real Benefits?**

The full effects of the project on the wider public and nongovernment sectors may well take some time to become fully evident. Opinions gathered from observation and informal exchanges with and among clients waiting for services around consulting rooms and other public areas at the main hospital were mixed. One group expressed gratitude and spoke of being pleased with the obvious tangible progress in development and improvement of physical facilities. A few preferred to “wait and see” whether or not these “changes for the better” would trickle through to other less obvious qualitative aspects, including changes in professional attitudes and performance standards. And one often heard expression of a somewhat philosophical “only time will tell” sentiment, echoing a general skepticism born of past experience.
Looking Forward

The Tonga Health Sector Management and Planning Project has received predominantly favourable reviews. As such, the moral of its story may well be that “Prospects for developing or effectively utilizing domestic capacity are enhanced when a) capacity issues (individual, organizational, and institutional) are addressed systematically, and b) the approach to capacity development is rooted in host country vision and leadership.”

The story that this case study has attempted to tell is, to a large extent, only a preliminary narration based on promising success signals. The project has sought to address a comprehensive range of issues across the ministry, focusing on the short, medium, and long term. Monitoring of progress is ongoing and the full impact, and associated benefits, may take a little time yet to show.

On balance though, the project’s progress to date is acknowledged. And indeed it should be an inspiration leading to greater vigilance in support of ongoing improvements, particularly those focusing clearly on long-term, sustainable improvements in capacity which can yield real and enduring benefits for the citizens of Tonga.

For now, however, and given the positive and encouraging indicators already being experienced, the Ministry of Health would be well advised not to rest on its laurels. The key question should always be “If it works – how can we make it work better?”

Draft terms of reference issued January 2007 for the Pacific consultants on this ADB capacity development study.
A New Vision for the Health Sector in Tonga

Problems facing Tonga’s health care system intensified in the 1990s leading eventually to a decision by the government to address the “core problem” - the Ministry of Health’s planning, management, and coordination capacity. This case explores how attempts to enhance MoH’s organizational capacity, and improve its organizational culture, were aided by: consistent and strategic leadership and political support, participatory approaches, a clear sense of the capacity challenges, and the facilitative role played by AusAID. The paper describes it as a process of “developing Tongan solutions to Tongan problems”.

This sub-series is published by the Asian Development Bank to provide the governments of its Pacific developing member countries (PDMCs) with analyses and insights on key issues and lessons learned with respect to capacity development. Cases studied highlight a range of experiences throughout the region by sector, theme and source of external support, revealing approaches to capacity development that work best and the conditions that have been conducive to their success. They also explore the unique challenges faced by PDMCs in addressing capacity constraints as well as some of the opportunities facing governments and the people in the Pacific islands. Among other things, the case studies underline the importance of PDMC leadership, engagement of local partners, strategic attention to long-term capacity issues and effective use of external resources. It is our hope that the findings in these reports will help to guide future capacity building efforts in the Pacific.

About the Asian Development Bank

ADB’s vision is an Asia and Pacific region free of poverty. Its mission is to help its developing member countries substantially reduce poverty and improve the quality of life of their people. Despite the region’s many successes, it remains home to two thirds of the world’s poor. Nearly 1.7 billion people in the region live on $2 or less a day. ADB is committed to reducing poverty through inclusive economic growth, environmentally sustainable growth, and regional integration.

Based in Manila, ADB is owned by 67 members, including 48 from the region. Its main instruments for helping its developing member countries are policy dialogue, loans, equity investments, guarantees, grants, and technical assistance. In 2007, it approved $10.1 billion of loans, $673 million of grant projects, and technical assistance amounting to $243 million.