CBSC

THE CAPACITY BUILDING SERVICE CENTRE IN PAPUA NEW GUINEA

INDEPENDENT EVALUATION REPORT

FINAL VERSION

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Thought for the Report

Too many decisions about changes are made by people untouched by the change process

Peter Block, Business Philosopher

LIST OF ACRONYMS

AAP	Annual Activity Plan
AusAID	Australian Agency for International Development
CBIP	Capacity Building Implementation Plan
CBSC	Capacity Building Service Centre
DNPM	Department of National Planning & Monitoring
DP	Development Partner
DPLGA	Department of Provincial & Local Government Authority
EPI	Expanded Program on Immunization
GOPNG	Government of Papua New Guinea
HSSP	Health Sector Strengthening Project
HSIP	Health Sector Improvement Program
HSIPMB	HSIP Management Branch
IMRG	Independent Monitoring Review Group
JTAI	Jane Thomason & Associates International
M&E	Monitoring & Evaluation
MTEF	Medium Term Expenditure Framework
NDOH	National Department of Health
NZAID	New Zealand Agency for International Development
PHA	Provincial Health Adviser
PHAA	Provincial Health Authorities Act
PPII	Provincial Performance Improvement Initiative
RCBT	Regional Capacity Building Team
SEM	Senior Executive Management
SIT	Service Improvement Team
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
TA	Technical Assistance (or Technical Advisor)
TOR	Terms of Reference
WHO	World Health Organisation

EXECUTIVE SUMMARY

The purpose of CBSC was to *develop the competencies and capabilities of individuals, groups and agencies in the PNG health sector* with the goal of improving the health of all Papua New Guineans. It perpetuated TA as the main modality and assumed that sufficient additional funds for service delivery would flow through pooled funds from the Health Sector Improvement Program (SWAp). CBSC commenced in 2005, has a value of $70m over five years, and is scheduled to complete in mid 2010. It comprises one third of AusAID's assistance to the health sector, with a further third being through the SWAp and the remainder through projects.

There were several design weaknesses which have limited achievement of purpose: the pathway from inputs of TA to the outcomes of improved service delivery and health status were not specified and have remained a 'black box', paving the way for confusion about exactly what CBSC was aiming to achieve. Others were the assumption that sufficient funds would flow through government systems and the SWAp to address service delivery shortfalls, and the absence of a clear focus on public health. These could, and should, have been addressed during implementation.

The governance arrangements of CBSC were based on the now discredited Partnership Agreement. This resulted in CBSC becoming a parallel system when the intention had been that it would ultimately be incorporated under SWAp governance. It also marginalised DPs from decision making.

Findings at National Level A wide range of support has been provided to NDOH at central level to improve capacity in: decision making; planning and managing resources; delivery of priority programs; and coordination and integration of service delivery. Much of the work is now strategic, addressing capacity constraints within NDOH to take forward a major change agenda in policy development, planning, restructuring, and addressing service delivery to the provinces through the creation of a provincial health authority. These are necessary core functions but not sufficient to effect changes at service delivery level which will impact on health status.

Findings at Subnational level Support at provincial level is less focused and more thinly spread. A reflection of attempts to be effective over twenty widely differing provinces, in the context of semi-functional decentralisation, has been too much change during a short time frame. From mid 2008 the impetus for change has come from AusAID with the intention of bringing coherence between CBSC and SNS. This occurred outside the formal governance structure and has reduced the Charter Board to a rubber stamping process. The changes have also resulted in emphasis on planning and management at the expense of public health.

Support to the SWAp has occurred significantly in new Strategic and Corporate Plans, Annual Activity Plans, and developing shared processes and approaches. There has been considerable support to HSIP to directly manage core systems although this is parallel to core NDOH systems. Less has been achieved in overall coordination of support to capacity building and the majority of TA continues to be supplied by AusAID with minimal DP involvement. The SWAp in PNG is still seen more in terms of an arrangement for harnessing and releasing resources into the health sector and is therefore still relatively immature. However, CBSC has played a part in supporting a number of the key building blocks.

Learning about capacity building CBSC has succeeded in improving the relationship between TA and counterparts to the extent that TA are owned by both NDOH and the provinces. The picture is no longer, as many stakeholders continue to believe, polarised between advisory/in-line, clinical/administrative, and international/national support but represents a complex palate. In line with international applied research supported by AusAID on capacity development, CBSC has proved that capacity building does not occur through planned approaches but rather emerges in an often 'messy' way. CBSC struggled, and failed, to develop an overarching strategy for capacity development in NDOH but support has *become* strategic. This is more tangible at national level, where support is more intensive, than provincial level. It has also become clear that 'pure' capacity building, in the absence of resources for infrastructure and human resource development has minimal impact on service delivery.

CONCLUSIONS

Relevance Support at national level is relevant, more so advisory than in-line, but is weakened by reliance on TA and on the government sector. At provincial level support is relevant but limited by thin spread and focus on 'back office' planning and management rather than 'front office' service delivery.

Effectiveness Much of the support is highly valued and the immediate effect is significant and identifiable. Longer term effect is less identifiable. At provincial level effectiveness has been reduced by frequent change except where the same adviser has remained throughout.
Efficiency It was beyond the scope of this evaluation to assess allocative efficiency. In terms of technical efficiency the absence of other capacity enablers to influence events has reduced TA potential.
Impact could not be assessed owing to the short duration of CBSC, the lack of a theory of change in design, and the absence of any baseline against which to compare progress.
Sustainability is the crunch issue. It could, and should, have been addressed earlier through a formal and independent MTR. At the national level sustainability, other than the in-line positions, is a qualified 'yes'. At provincial level it is insufficient to make a sustainable difference and many of the factors determining health status are beyond the control of CBSC in geography, politics and culture.
Gender Equality In the absence of a gender focus in design, and with little demand from NDOH or the provinces, CBSC has found small but meaningful ways of working with a gender lens.
Monitoring and Evaluation has proved a continuing challenge, complicated by competing views and unrealistic expectations about what CBSC should achieve, and also by notorious difficulty in monitoring the nebulous concept of capacity building. However, sincere attempts have been made.
Analysis and Learning CBSC has sought to learn and improve and there is evidence of reflection on wider issues of ownership, culture and values which are just as important as technical aspects. There are missed opportunities to utilise learning within AusAID.

Evaluation Criteria	Rating (1-6)	Comments
Relevance	4 *adequate*	Relevance has been constrained mainly by design weaknesses
Effectiveness	4 *adequate*	Short term effectiveness is limited by longer-term sustainability,
Efficiency	4 *adequate*	Efficiency is limited by the dominance of TA in design
Impact	Not rated	
Sustainability	3 *less than adequate*	Specific gains might be sustainable but longer term is less optimistic
Gender Equality	5 *good quality*	Strong commitment and increasing evidence of improvement time
Monitoring and Evaluation	4 *adequate*	Limited by competing expectations and frequent change
Analysis and Learning	5 *good quality*	Reflects serious commitment to learning and continuous improvement

OPTIONS FOR THE FUTURE

Consideration of the future must be seen in the light of deteriorating health indicators in PNG and the lack of impact of Australian aid both under project mode and the last four years of CBSC and the SWAp. Discontinuation at this stage would place existing achievements at risk, reduce sustainability of ongoing work, and damage a potentially strong partnership with NDOH.

Option 1: close CBSC is not recommended.

Option 2: extend CBSC for 2 years is recommended. Extension acknowledges that TA has limitations as the major modality, and that it is desirable to design of a new program of support which takes a broader view of capacity building, but allows time for a proper transition which maintains the gains. Over two years CBSC can phase out in-line positions, broaden the menu of options as identified in the 2009/10 Improvement Plan, and change the governance arrangement in favour of alignment with government structures and to include DPs. Appropriate support under extension might include: national policy and strategic direction; development of the SWAp; restructuring in NDOH; and unifying public health under the provincial health authority framework. Two years also allows time for the important debate between NDOH and all development partners about the future of TA, and its quantum and management as a pooled resource.

Options for the longer term: AusAID will need to review, with GoPNG, all its aid modalities in the health sector. TA has an important role but other capacity enabling strategies should be addressed through, for example, financial support to existing institutions and to physical infrastructure and human resource development. Additional support can be provided to DPs to give them a greater voice at the table and address the imbalance of AusAID as the dominant partner.

THE MAIN REPORT

INTRODUCTION

BACKGROUND

The Capacity Building Service Centre (CBSC) is an AusAID funded program which commenced in June 2005 and is due to finish in mid 2010. The *goal* of CBSC is to support the health sector of PNG in order to improve the health of all Papua New Guineans and its *purpose* is to develop competencies and capabilities at the individual, organisational and system levels in the health sector.

The design of CBSC was influenced by a range of factors including dissatisfaction with poor health sector performance, the weak impact of project-based assistance, NDoH rejection of previous approaches and contractor management of resources, and by slow progress towards the Health Sector Improvement Program (HSIP), which was the PNG version of a sector wide approach (SWAp). Being unwilling to invest directly through government systems, AusAID opted to embrace the SWAp but to minimise risk by maintaining externally managed capacity for the provision of TA. At the time of design, TA was a favoured modality within AusAID and viewed as a key value added investment.

With a value of up to $70 million AUD over five years, in 2008, CBSC was AusAID's largest program in the health sector. It has operated both at a central level in NDOH and in the provinces. At its height, in 2007, it employed 156 people, including advisers, people employed in in-line positions and CBSC management and operational staff.

In 2008 AusAID's total contribution to the health sector amounted to $48.7 million.[1] Approximately a third went to HSIP ($13.3 million), a third to CBSC ($17 million), while the remainder was divided between a number of projects. The largest of these was the HIV/AIDS program ($11.5 million) with smaller amounts of funding to WHO, the Institute of Medical Research and Tertiary Health Services. AusAID provides support to other stakeholders in the health sector through the Church Partnerships Program and the Sub-National Strategy Program.

CBSC's design was shaped by dissatisfaction with the preceding project-based approaches and a renewed commitment to the Health Sector Improvement Program (HSIP) which was PNG's version of a sector wide approach (SWAp). In recognition of the time required for capacity building it was designed as a ten year program, contracted for five years with the possibility of extension.

Papua New Guinea ranks 138th out of 178 countries in terms of human development.[2] It is one of the most diverse countries in the world – geographically, biologically, linguistically and culturally – with many tribes, sub tribes, clans and sub clans spread over 20 provinces. Although it has abundant natural resources, this has not led to economic prosperity for the majority of its people.

A World Bank analysis in 2007 observed that there was an emerging consensus in PNG – both at government level and among civil society – that service provision in many parts of the country was collapsing and that human development outcomes had seen little improvement in 30 years.[3] In spite of a 35% real increase in

[1] AusAID (2009) PNG Health Sector Performance Report for 2008
[2] *Human Development Report* UNDP, 2006
[3] *Strategic Directions for Human Development in PNG* World Bank 2007

funding of the health sector between 1996 and 2004 the coverage and quality of health services had decreased, around 300 aid posts were closed, and antenatal coverage had declined from 80% to 58%. Among the factors identified were flaws in the decentralisation arrangements which resulted in: unclear allocation of responsibilities and inadequate implementation of key system functions; inadequate oversight by the National Department of Health (NDOH); and a decline in the integrity of budget institutions and systems. The result of this was that neither politicians not public servants, especially at provincial and district levels, accepted responsibility for delivering primary health services and essential public health functions.

A 2005 analysis of capacity, change and performance issues in the health sector contended that, while PNG had a fundamentally sound national health policy, implementation had fallen far short of the mark.[4] Weaknesses identified, using a capacity development lens, included factors internal to the health sector, such as management issues, relationships, financing arrangements and the skills of health workers; and external factors including the macro-economic environment, the political context, law and order and deteriorating infrastructure. In spite of this, the study also identified many successes which were due to positive attitudes and skills of senior managers to deal with contextual variables, and the ability of particular units to isolate themselves from dysfunctions in the broader system.

During the period in which CBSC has operated, there has been significant political instability and a lack of consensus on strategic development issues. Between the government and development partners (DPs) there have been growing uncertainties about how best to assist and work together in an environment of fragile development outcomes.

EVALUATION OBJECTIVES & METHODOLOGY

The TOR for the evaluation state that it aims to fulfil several purposes:

a) evaluate the effectiveness of the CBSC
b) enable AusAID and GoPNG to reflect and act on the lessons from the CBSC
c) inform the design of future assistance to the health sector, and improve AusAID's ability to help GoPNG meet its development challenges in the context of a sector wide approach with development partners
d) inform AusAID's Annual Review of Development Effectiveness report, Annual Thematic Performance Reports, Annual Program Performance Reports and Country/regional strategy reviews.

The evaluation takes place almost one year before scheduled completion of CBSC in July 2010, and after only four years of implementation, in order to provide information to inform decision making about the future. The context is one in which GoPNG is developing a New National Health Plan and AusAID is developing a new strategy for assistance in the health sector.

The evaluation took place in two phases. The first was a Scoping Mission in August 2009 during which an Evaluation Plan was developed in a participatory way with the National Department of Health (NDOH), National Department Planning and Monitoring (NDPM) and Development Partners (DPs). This was an unintended consequence of being unable to schedule the full evaluation as early as intended but proved to be important in terms of generating ownership for the evaluation. The second phase, in September/October 2009 comprised fieldwork at both national and provincial levels.

The team consisted of three independent international consultants (including a staff member from WHO) and representatives from DNPM and AusAID.

Full details of the evaluation methodology including the original Evaluation Plan, its elaboration during fieldwork, and reflections on the limitations are attached as Annex 2. The main limitation was the absence of a program logic against which to determine whether what had been intended had been achieved, and of a

[4] Bolger, J et al *PNG's Health Sector: a review of capacity, change and performance issues*. Discussion Paper 57F, ECDPM

baseline. This determined the choice of evaluation form being 'interactive' rather than 'impact'. The aim of the team was to encourage maximum participation of stakeholders and to focus the evaluation on learning for the purpose of improvements in capacity building in the future.

EVALUATION FINDINGS

Q1: TO WHAT EXTENT DID CBSC ACHIEVE ITS PURPOSE?

THE DESIGN OF CBSC

Changing ways of working

The design, which had been a long process undertaken by AusAID staff with strong participation from NDOH, reflected the intention of both partners to mark 'a qualitative shift in the way advisers and partners work together' and to signal that 'change is in the air'.[5] At goal level the aim was to support the health system of PNG in order to improve the health of all Papua New Guineans. The purpose statement reflected a 'persistent and uncompromising emphasis' to *develop the competencies and capabilities of individuals, groups and agencies in the PNG health sector*. The means by which this would be achieved was through sourcing, managing and supporting national and international advisers who had credible technical qualifications, excellent interpersonal skills, a strong commitment to and skills in capacity building, and an interest in the development of PNG. This history is important because many of the criticisms levelled at CBSC have been about the over-use of TA. Where the design was seen as ground-breaking at the time, only four years later it is criticised including within AusAID.

Although the design contained a logframe there was no explicit theory of change articulating how the TA would result in an outcome of improved service delivery and an ultimate impact on health status. Objectives were the development of a TA framework within NDOH, appropriate recruitment and management processes for advisers, and effective management of CBSC. At purpose level the assumption was that factors beyond the health sector would not undermine its improved capacity to function. In fact this assumption did not hold true as broader issues across the whole public service, such as accommodation for staff and fund flows were already identified as key barriers to progress, along with exceptionally challenging issues of access resulting from the physical geography of PNG. If such an institutional analysis was either done by, or available to the design team, it is not reflected in the design itself.

The Linkage with the SWAp

It was initially envisaged that about 50% of the total CBSC budget of A$70m would be devoted to national level 'needs'. That budget was for TA and immediate office costs only. No separate budget was created for goods and services. The decision that had been reached was that any such requirement would be met by securing resources allocated through the government's own recurrent and development budgets, and /or by accessing AusAID allocations and those of other DPs made through the HSIP. This arrangement was in marked contrast to the method of funding its predecessor (HSSP), reflecting an intention for CBSC to have to work through existing government channels (and HSIP). In consequence, this has meant that CBSC has often been dependent on other sources of funding for many of its deliverables, especially in relation to service delivery. It follows also that it will be extremely difficult to attribute any change in the performance of the health sector to be the sole consequence of CBSC support.

[5] Discussion with senior AusAID staff involved in the design and stated in the design document itself

In retrospect, it was an unrealistic assumption that the already struggling HSIP could make a significant enough improvement within a short time frame to ensure that CBSC TA could build capacity by working alongside their counterparts in the same conditions that already constrained service delivery. An AusAID evaluation in 2008 observed that, as a parallel system HSIP had diverted attention away from management of the much larger resources of NDOH, incurred high management costs to account for relatively low expenditure, focused government staff time on financial management rather than service delivery, and instituted procedures which prevent funds reaching service delivery levels on time and in the amounts required.[6] However, by May 2009, the Independent Monitoring and Reporting Group (IMRG) was painting a more positive picture as a result of development both within the health sector (the Provincial Health Authorities Act, development of a new National Health Plan) and also in the wider government (the Reform of Intra-Government Fiscal Arrangements (RIGFA), the NEC approved trial of a Service Delivery Mechanism Model in five provinces) that are all likely to have an effect on how the health sector operates.[7]

Public health aspects of design

The other important design weakness was the absence of a public health focus. In focusing predominantly on the *how* of capacity building, which is elaborated clearly and convincingly, the *why* and *what* questions were largely unanswered. Faced with an overwhelming challenge, and pressure to be responsive to widely differing requests, the failure of the design to specify what sort of capacity needed to be built, and for what public health purpose, paved the way for what has emerged as a strongly policy and planning rather than a service delivery orientation.

In short, the CBSC design was to focus predominantly on a single dimension of capacity building (TA), a single beneficiary (the government sector) with a single management contractor – a One-One-One approach.

A further consequence of the design framework, which is beyond the scope of this evaluation, is the allocative efficiency of AusAID's overall support to the health sector. Over the last four years, AusAID's support to PNG has been either through CBSC; by means of sector budget support channelled through the HSIP; or through support to a specific number of health-related projects. The team's review of only one of the key modalities of AusAID support necessarily runs the risk of ignoring other modalities in the total picture; but, is a consequence of the 'silo' approach adopted to financial support.

THE PROCESS OF CBSC

The Design Document envisaged that the guiding principles and criteria under which CBSC should operate would require: a 'needs analysis' of real problems affecting the efficient and effective use of public resources and/or the delivery of services; an assessment that GoPNG does not have the necessary internal resource capacity to tackle the problems; and, a shared understanding that the problems are amenable to, and most appropriately addressed by, the use of TA.

Not surprisingly perhaps, the identification and measurement of 'need' and the provision of appropriate and responsive technical assistance to it, is challenging both methodologically and practically. The evaluation team identified four parallel approaches that had been taken during the last four years:

1. A 'self-perceived need' approach whereby individuals and groups were encouraged to articulate their own needs for capacity building. Significant efforts were made to systematise this approach through the annual activity plans (AAPs), whereby those plans incorporated an extra section to be completed on the need for additional support. This 'bottom-up' approach is commendable, both for its attempt to be

[6] *Evaluation of Australian Aid to Health Service Delivery*. *Working Paper 1: Papua New Guinea Country Report* AusAID Office of Development Effectiveness, June 2009

[7] IMRG Report No 6, May 2009

inclusive and for seeking to tie requirements into the implementation plans. As an approach, however, it was not well understood and has been discontinued for the current planning cycle.

2. A 'professionally defined' approach A stock-take was initially completed in early 2005, to determine what was known about capacity at the national and provincial level, within the hospitals and at the individual level. It was an admittedly brief review, yet concluded that, while much was already known, in other cases more work would need to be done to establish the actions required and their priority. The report included proposals for a capacity mapping exercise, to guide interventions and the associated resource allocations. This was prepared in March 2007, following the use of self assessment tools. Once again, however, it was considered to be but one aspect of a suite of tools that could be utilised to assess various aspects of organisational capacity. It was seen to be particularly strong on providing a list of 'symptoms and signs', but weak in terms of a 'diagnosis' on types and stages of capacity building assistance required.

3. A 'supplier induced' provision of TA To what extent was there evidence that CBSC advisers (singly or collectively), or the managing contractor itself, were instrumental in deriving a need for the services/TA that they themselves wished to provide? A prior commitment existed at the outset of the CBSC to absorb former HSSP staff, and twenty-one staff were transferred across either into similar if not identical roles and functions, or into newly created positions. Inevitably, advisers are used for the skills, knowledge and attributes they possess. At the same time, it would be difficult to conclude that advisers are simply inducing a demand in areas where they feel more comfortable or which are more satisfying. Equally, while the managing contractor may have an in-built incentive to 'spend' the budget, the approval process for the identification and recruitment of staff is through the agreement of the Charter Board. The Final Audit report concluded that the contractor was not unduly influenced by 'profit' in the management of CBSC or in the selection of TA as the preferred modality, a position with which the team concurs.[8]

4. An 'expressed need' i.e. demand approach, especially at the national level. In the early stages of CBSC this need may have been expressed more through a series of ad hoc requests for TA by government than through a systematic annual process of identifying and prioritising TA requirements, this has become more of a considered process over time, as will be noted below. Decisions on what skills would be most valuable to the organisation were government led, and in which the sourcing of appropriate TA was also seen to be a robust and professionally driven activity. Longer term, and with government leading, this opens up the prospect of including TA as an integral part of the MTEF and annual planning processes.

One further observation the team wishes to make is on both the size of the CBSC budget and its distribution. On scale, it would be difficult to escape the conclusion that the number of TA staff employed through this AusAID initiative at the outset approached the size of a number of Ministries of Health in countries at similar levels of development. This situation is still much evident at the NDOH and begs questions on the 'absorptive capacity' of that Department. Part of the explanation is that significant numbers (maybe a third) of all TA are still currently occupying in-line positions. Whether this is an appropriate use of DP support is discussed later; as is the matter of identifying 'counterpart' capacity, and potential 'displacement' consequences.

Finally, on issues of balance, two considerations reflect the team's continuing concerns. The first is whether or not the balance of funding between TA and other capacity building modalities is the most appropriate (the allocative efficiency argument between CBSC and HSIP, for instance). The other is the balance between TA and non-TA support in the context of CBSC, given the limited menu made available for the latter in the original Design.

[8] *Contractor Performance Audit of the PNG CBSC: Final Audit Report* Stantons International, 2009

Within CBSC neither the need for TA, nor the responses required in terms of roles and functions to be discharged, is uni-dimensional. Responses range from recruiting advisors primarily for their analytical skills (e.g. in epidemiology, health economics, gynaecology); those whose skills are essentially ones of facilitating and co-ordinating (e.g. in public administration); those whose skills are largely in program management (e.g. formulating proposals, liaising with other agencies, purchasing); and, those who are employed in posts established by government but are the subject of long-term vacancies (e.g. in technical divisions of EPI, STI, MCH, or in management support positions in HSIP). Accordingly, CBSC can be viewed more as a multi-purpose people carrier; and, less that of a single vehicle responding to a single dimension of need by working closely with a single beneficiary (counterpart) to develop his or her knowledge, skills and attitudes.

GOVERNANCE ARRANGEMENTS

The original design intention was that CBSC would, over time, build the capacity of the new HSIP Management Branch (HSIPMB) such that it could ultimately report to it. However, slow progress in its establishment and functioning has resulted in CBSC continuing to operate as a parallel structure. It has also become clear that NDOH has not wanted to take on the role of recruiting and managing TA, especially international TA. In consequence, de facto, the parallel governance of CBSC has posed challenges of harmonisation and complementarity with other DP intentions and support.

The original governance intention was complicated by the introduction, after the design was complete and without consultation with NDOH, of a new type of contracting mechanism within AusAID known as the 'Partnering Approach' which was governed through a Charter. The Charter Board brought together NDoH, AusAID and the Contractor as equal partners in the decision making process in a process intended to be a flexible and responsive way of jointly establishing objectives, management, co-ordination, reporting arrangements, and performance measurement of all parties at all levels. However, the unintended effect was to establish parallel governance and management arrangements and, in operating outside HSIPMB, to exclude DPs from the decision making process. This then served to compound perceptions among DPs that AusAID, as the largest and strongest donor, was not a consultative partner.

Concerns about the inappropriateness of the Charter Board, in the context of the SWAp, were first raised by the contractor, JTAI, at the very earliest stages in 2005. In June 2007 the GoPNG/Donor Partner Summit stressed the importance of donors aligning their processes with HSIP and the IMRG[9] Report of November 2007 subsequently recommended that CBSC should be realigned with HSIP and NDOH. The Charter Board then resolved to disband itself as soon as satisfactory alternative governance arrangements, consistent with the SWAp, were in place and to bring the functions of the Management Advisory Group under NDOH committee structures. In April 2008 the Charter Board reviewed progress on the issue and agreed to postpone a decision on its future because a Mid Term Review of CBSC was planned for July 2008 and Executive Restructuring was going on in NDOH. Although it is a normal requirement of AusAID, and is usually an independent process, the MTR never took place[10]. It was replaced by internal processes of Rapid Review and Desk Review, the findings of which were not presented to or discussed by the Charter Board. No discussions about the future of the Charter Board took place subsequently.

[9] The HSIP (SWAp) is monitored by an Independent Monitoring Review Group

[10] One of the reasons for this was that the ODE Evaluation was taking place around the same

Within AusAID few such Partnership Approach contracts were issued and a review in 2006 already identified a range of risks and unintended consequences.[11] Among those were three factors which have been experienced by CBSC and help to explain why governance has proved so challenging:

- difficulty in developing a shared vision between partners, creating confusion and tension and negatively affecting both relationships and progress
- declining willingness to participate in the Charter Board meetings because of the excessive demands on time generated by them
- lack of capacity of AusAID staff who are not technical specialists and feel ill equipped to participate meaningfully in a technical Charter Board, and reluctant to make decisions where the implications are not fully understood
- difficulty in viewing the contractor as an equal partner

The experience of CBSC, in terms of making a governance arrangement work, was therefore not unusual.

FINDINGS AT NATIONAL LEVEL

Support to the national level has essentially been support to the NDOH. Little or no support has been provided to other central departments of government, nor to the non-governmental sector represented at national level, for example the Churches Medical Council (CMC). The wide range and levels of government support can be analysed under four main clusters: improved decision making; improved capacity to plan and manage resources; improved capacity of NDOH's priority programs; and, increased co-ordination/integration of services at the sub-national level. The team's findings are as follows:

IMPROVED CAPACITY FOR DECISION MAKING

A key objective of public sector reform is that of improving the effectiveness of the decision-making process within government. CBSC support recently has been employed in what has increasingly become an extensive exercise to restructure and re-profile the NDOH itself. To date, the restructuring has yielded an approved Senior Executive Management (SEM), with some progress made to the finalisation of an organogram covering all levels. That process was conducted to redefine the vision, mission, and core functions of the Department, in order to determine an organisational structure that was deemed 'fit for purpose'. It has also meant re-clarifying those roles and functions deemed vital to be performed centrally, from those now judged more appropriately discharged at a local level (provincial, district facility).

The next steps taken have been to look at an appropriate staffing of the Department, through a 'peopling exercise' to determine overall numbers, positions and grades. Re-profiling of a Ministry or Department is never an easy exercise, and that process is not yet complete. Also factored into the exercise has been the issue of outsourcing i.e. identifying those functions that could be out-sourced to yield economies and efficiency gains.

CBSC has also supported the reconstituted SEM, appointed in January 2009, to strengthen the executive function. These TA are identified specifically as Policy Officers, performing an in-line rather than advisory function, with the expectation that their key contribution will be to improve effectiveness of the 'top of the office' functions. Viewed as support over one to two years, their purpose is to help senior managers to better operate at the strategic level by facilitating processes that will build the capacity of the executive office (e.g. through the preparation of briefs, facilitating group meetings and documentation, building capacity in national staff and logistics). This type of TA, meeting a need that is not currently identified as a core public service function, is currently highly valued by the Executive and, while the exercise of some real technical skills is also

[11] *Review of Risk in AusAID's use of Partnering and Managing Contractor Approaches*, August 2006

evident by the POs, it is the ability of the Executive to be effective in the new structure that is the critical factor.

Another key support to the Department has been in developing and disseminating policy and in the translation of those policy intentions into a Departmental Strategy and Corporate Plan. This is core business of the Department in the new structure, and support from CBSC has been seen in the development of the Corporate Plan 2009-2013, and in the development of policy documents across the health sector and on specific sub-sectors. Again, the real value-added may be in facilitating a decision-making process. These activities should be sustainable without further support in due course. Once national policies are nested within overall government policy, and once sector policies are translated into their various entities (e.g. human resources, finance) and technical requirements (e.g. MCH, HIV/AIDS/STI), then periodic review is the only remaining in-house requirement. Otherwise, diminishing returns would set in for a longer-term TA presence. Work to date on establishing policy frameworks and in developing planning capacity should be sufficient for the work to be carried forward by the new staffing establishment, except perhaps in specific areas where a case by case justification by Government for further TA support is made e.g. HR policy, gender policy in health.

Improved Capacity to Plan and Manage Resources

CBSC assistance has been significant over the last four years in this area, in both supporting the national health planning efforts, and in ensuring functionality of key management entities within the Department. Thus, CBSC efforts (alongside others), have helped to develop planning capacity within the Department to fulfil its core function of 'shaping the future'. Plans now exist with ten year, five year and one year time horizons, a product in part of the analytic and logistical support provided through CBSC technical assistance. Major challenges still remain, however, to deliver fully costed and resourced plans, and to integrate capital planning into the service planning function. Annual Activity Plans (AAPs) have been developed and several years experience have made these plans more effective mechanisms. Resourcing the plans still remains an ongoing challenge, not least in terms of finance and workforce requirements.

On the management strengthening side, an early decision was made that in-line positions should continue to be supported from CBSC where these could not be filled by existing government procedures, or where a moratorium on filling positions had been introduced. Even so, the implicit principle was that CBSC support could only be considered when leaving the post vacant would otherwise result in wider system failure. Thus, for example, support has been forthcoming to fill positions in the field of management support systems e.g. capital works, financial management, procurement, though a number of these positions have been filled subsequently by the transfer of the same staff to established in-line positions, Yet other positions have also been created to meet Development Partner (DP) requirements, a consequence of the concern felt on the efficiency and probity of existing government systems.

Longer term, many if not all in-line positions could be expected to be filled through the restructuring exercise, and by the removal of parallel management systems to handle DP support to the health sector. The TA advisory role in planning and management might then be expected to be focused, in a variety of ways, on specific skill deficits e.g. development of a long-term work force plan for the health sector; development of a sector-wide MTEF, but could be sourced from among the DPs in a variety of ways.

Improved Capacity of Priority Programs to Deliver

The four national key priority health programs in recent years reflect the key concerns over the lack of progress made in respect of the millennium goals. These are: HIV/AIDS/STI/Sexual Health; Safe Motherhood; Malaria; Child Health, including EPI. A number of CBSC advisers and program managers have been appointed to work within each of these programs with a range of responsibilities, including:

- mobilising resources into the health sector in general, and into the priority programs in particular e.g. assisting the Department in its submissions for Global Fund monies;
- developing strategies and service delivery plans that can be taken forward in the provinces;
- developing accreditation frameworks and assisting in their implementation;
- setting standards, producing treatment guidance and guidelines, and developing clinical protocols;
- directly managing specific services where vacancies in staffing are producing wider system risks to the delivery of services e.g. EPI cold chain.

In all these areas, the Department has both the political mandate and a core business responsibility that cannot be discharged at the sub-national level. Setting a strategy, determining national standards, monitoring and reviewing progress made to meeting the standards, offering evidence-based guidance on treatment and care protocols that capture 'best practice'; all are the business of a central Department charged with the 'health of the nation'. Even so, TA on the above agenda can, of course, be supplied in different ways to strengthen capacity. Long or short-term advisers, international or national, is one way, but the capacity building menu can be seen to be much wider to effectively address quality of care concerns. Likewise, the management of specific areas of corporate business e.g. procurement, audit, capital works, can also be the subject of alternative modalities e.g. outsourcing, if long-term critical shortages exist and / or if these are deemed more cost-effective options.

Increased Co-ordination / Integration of Service Delivery.

One of the continuing key challenges in capacity building in PNG is to overcome the disconnect between the national and sub-national levels: with one level responsible for national policy making, providing overall strategic direction, mobilising resources, setting standards and monitoring improvements in the health status of the nation; and the other levels responsible for implementation. This picture is made even more complex in service delivery terms by the further disconnect within provinces, with a bifurcation of responsibility for public health and for provincial hospitals.

This horizontal and vertical disconnect has been addressed by NDOH, in different ways, with support both by CBSC and its predecessor HSSP. With increasing CBSC support, the Department took the opportunity to frame legislation leading to the establishment of unified Provincial Health Authorities that brought together the PHC and hospitals under one management structure. For instance, CBSC assisted in the legal framing and consultation processes leading to the Provincial Health Authorities Act (PHAA) in May 2007.

Since that time a Health Reform Unit has been established in the NDOH, largely with CBSC support, to determine an implementation strategy and to liaise closely with provinces interested in the creation of a unified PHA. To date, a majority of provinces have expressed an interest in going forward, and three are being actively supported in becoming the 'first wave'. This position is both a culmination of ten years of activity supported by AusAID, and yet only the beginning of a new approach to integrate health services at the sub-national level. A major change agenda faces these three provinces, and others to follow, that will likely require sustained support by AusAID and others to move from an essentially voluntary legal framework towards the delivery of seamless care at the community level.

Summary

At the national level, much of the work supported by CBSC over the last four years can be said to have been strategic, addressing the capacity constraints within the Department to take forward a major change agenda. This has included policy development; resource mobilisation; long-term, medium-term and annual planning; restructuring and re-profiling the NDOH labour force as part of a wider agenda of public sector reform; and addressing the fragmentation of service delivery in the provinces through the creation of a provincial health authority. All these roles and functions can be said to be the *necessary* core business of a National

Department and have been supported by a variety of both short and long-term TA (national and international). Even so, they are not, of themselves, *sufficient* to effect much needed changes at the service delivery level to either impact on the MDG or on the wider poverty agenda. For that to happen, capacity building support at the sub-national level is crucial, but that also goes well beyond systems strengthening (see below).

FINDINGS AT SUBNATIONAL (PROVINCIAL) LEVEL

The picture at subnational level is quite different from that at national level. One of the most notable aspects of CBSC support at provincial level is the amount of change it has undergone in the four years between 2005 and 2009. In comparison to support at national level which, in the context of one fairly small organisation, has progressively become more strategic, support at provincial level has sought to span 20 provinces with widely differing contexts and needs. Not surprisingly, central decision making, with approval through a Charter Board on which provinces are not represented, has not proven an effective way of determining need or response. What was clear to the team, even from limited field visits, was that there was, at best, a lack of clarity about how decisions were made and at worst, dissatisfaction with both process and outcome.

Why CBSC has not been able to achieve greater cohesion is partly explained by its history and the frequent changes which is worth detailing.

Transition from Projects to Capacity Building 2005-06

CBSC commenced, in 2005, with several advisers and in line positions being novated over from the closing Health Systems Strengthening Project (HSSP). Advisers used to working with significant goods and services under project mode suddenly found themselves expected to build capacity using only the resources available to their government counterparts. This led to a first year in which many advisers struggled to adapt to a new and more difficult role in which capacity building was limited by practical barriers including lack of computer and communications equipment, logistical problems such as travel delays and law and order problems, partner absenteeism and lack of time for engagement with advisers.[12] Overall, the transition from project to capacity building mode had taken longer and been more challenging than anticipated in the design.

From Provinces to Regional Capacity Building and Service Improvement Teams 2006-07

The other issue which became apparent in the first year was that provincial partners felt excluded from the planning and decision making overseen by the Charter Board at national level. This reflected a broader concern about processes of engagement in a decentralised system. Although partners saw consultation about their needs as well intentioned, the limited nature of the support on offer led to limited buy in. By 2007 CBSC had also undertaken an extensive capacity mapping exercise which exposed the enormity of the challenge and the inability to respond on the scale required to make a significant difference. At the same time there was growing concern about deteriorating health indicators. CBSC responded by seeking to substantially increase its effort in building capacity for service improvement especially at rural health facility level, and for the four public health strategic directions and the essential health services package.

At that time the effectiveness of CBSC was limited by weak leadership and a non-functional executive in the NDOH. Although it never came to fruition, the intent of NDOH was to restructure into a regional approach so, in order to support this, CBSC restructured into four Regional Capacity Building Teams (RCBTs). The teams were based in Mount Hagen, Madang, Port Moresby and Rabaul assisting provinces and hospitals in the four regions of Highlands, Momase, Southern and Islands respectively. Each RCBT comprised two international and

[12] CBSC *Annual M&E Report, 2006*

two national advisers with combined skills in public health, planning and data use; management, administration and finance; logistics and cold chain management; and health promotion. Additional support for hospitals was provided by two specialist Hospital Capacity Building Advisers. The rationale behind the restructure was sound. It aimed to provide a greater and more flexible range of skills than was possible by operating province by province, reduce dependency by having periodic visits rather than continuing presence, and help mobilise greater collaboration with health sector training institutions, NGOs, CBOs, and research groups.

In addition, four Service Improvement Teams (SITs) were established in February 2007 consisting of experienced public health clinical advisers supported by Papua New Guinean interns (recent graduates in health administration and management). They aimed to provide support at district level in health facility management and micro-planning; public health activities, outreach and supervision; and community linkages and mobilisation. These were based on the essential package of health services and strategic health directions in the areas of safe motherhood/reproductive health, STI/HIV/AIDS/TB, malaria and EPI. The approach, based on lessons learned from other projects and donor-supported programs, was to focus intensively on "prepared and ready" facilities for 8-12 weeks and then to support them as "twinning" sites for other health facilities in the district or province.

Progress under the RCBTs was variable. It took time for them to become functional and it proved difficult to establish a coherent program rather than a series of advisers providing discrete input. The teams also found that they spent a huge amount of time travelling which was expensive, exhausting, and subject to frequent disruptions. The time they were able to spend in provinces and districts was so limited that it satisfied neither partners nor advisers. Most importantly, workplans were often affected by difficulties accessing HSIP funds which meant that planned activities were cancelled and ad hoc ones instituted at short notice. This was borne out during this evaluation in that provinces varied in their support for RCBTs with some feeling under-served after the removal of province based support and others feeling satisfied with specific inputs. Progress of the SITs was also limited. As a model it seemed to work well where the environment was right and the teams were apparently enthusiastically received in that context. However, identifying facilities across PNG which met the criteria of staff with basic training, an operational infrastructure, and a supportive local and provincial government proved very difficult and served to highlight the depth and effect of systemic constraints to improved service delivery.

From RCBTs and SITs back to Provincial Advisers and SIIs 2008-09

RCBTs continued into 2008 using a range of capacity building approaches including advocacy, coaching, mentoring, on the job training, twinning, technical review, workshops, and material development. In March 2008 SITs were replaced by the Service Improvement Initiative (SII) which focused on a smaller number of selected districts and took a longer term approach to improving improve service delivery in terms of coverage, quality, and implementation of the strategic health directions.

In October 2008, for reasons which are not documented a decision was taken by AusAID, outside the Charter Board, that CBSC would discontinue its regional team approach in favour of placing advisers in to be defined priority provinces. Although the Charter Board endorsed AusAID's proposed new approach, both NDOH and JTAI saw this as a 'rubber stamp' in a process which was being determined outside the formal governance structure. Although the regional approach had proven problematic in terms of spreading advisory resources thinly, and had become costly in terms of travel and time, the decision to stop it came only a little over a year after introduction and after considerable expense setting up offices, communication, security and logistics arrangements. This was highly disruptive and confusing and none of those interviewed in the provinces understood why the decisions had been made

In January 2009 the Charter Board approved a new prioritisation, determined largely by AusAID, comprising:

- Five Priority (Impact) Provinces (Central, Milne Bay, West Sepik, Madang and Simbu)
- Two Special Needs Provinces (Autonomous Region of Bougainville and Western)
- Two provinces participating in PPII (Eastern Highlands and East New Britain)
- Support for cross-cutting issues across all provinces

In summary, considerable changes have been made over a four year period as shown in the timeline below:

Timeline showing the organisational evolution of CBSC

2005 **2006** **2007** **2008** **2009**

projects ⇒capacity building

Provinces ⇒RCBTs and SITs

SITs ⇒SIIs

4 RCBTs ⇒9 Provincial Advisers

⇒ ⇒ ⇒ *Progressive loss of public health focus in favour of planning and management* ⇒ ⇒ ⇒

To some extent this evolutionary change has been an inevitable process as transitions needed to be made from old ways of working to new and untested ones. Certainly this was the case in the first two years of CBSC from 2005-07 and this was in a context of limited strategic direction from NDOH. It was also a period of analysis and reflection with changes in structure reflecting attempts to address the huge challenge of effective service delivery. Regional teams were based on a clear rationale and the change from SITs to SIIs was clearly linked to lessons learned from experimentation with district approaches. Most of those changes took place based on experience from within CBSC and through the appropriate governance mechanism. In late 2007 a new Secretary was appointed with a reformist agenda and this led to significantly improved focus for CBSC at national level.

By the second half of 2008 the impetus for change came mainly from AusAID. It appeared to reflect AusAID's evolving programming at subnational level which may have had merit in terms of consolidation and coherence across all programs. However, the way in which it happened served to marginalise NDOH and the contractor and, from their perspective, substantially reduced the quality of the dialogue, resulting in a loss of focus and less thought-through strategies.

Over the last couple of years CBSC appears to have gained a negative reputation within AusAID. In some cases particular issues, such as a reference in an IMRG report[13] to 'recycling' of ineffective advisers, have been taken out of context and assumed to be widespread. Another perception has been that 'over-use' of TA may have been driven by the profit motive. These concerns were addressed in various contractor performance and audit reports but were found to be without foundation.[14] In part these issue have arisen because new staff in AusAID have been unfamiliar with the design of CBSC which essentially centred around TA as the main capacity building tool. Increasingly there has been criticism that CBSC is not strategic and that it has 'failed' because health indicators are not improving. Throughout this report the team suggest that the considerable influence on health systems, especially on indicators, lie beyond the influence of CBSC.

PUBLIC HEALTH FOCUS

As CBSC has evolved it appears to have increasingly focused on strengthening strategic decision making and management capacity rather than on delivery of public health services. During the provincial visits the team

[13] IMRG Report No3 (2007)

[14] *Contractor and partner Performance Assessment* July 2009, *Contractor Performance Audit Final Report,* Jan 2009

was struck by the fact that service delivery improvement or key health indicators for population based health that reflects the diversity of PNG between provinces were rarely mentioned in comparison with a strong emphasis on AAPs and the HSIP. Although these are important and necessary, they can be described as 'back office' functions rather than 'front office'. In other words, focus is very much on the *what* of capacity building rather than the *why.* It may be that there is an assumption that planning and management automatically result in improved service delivery and health status but this is neither stated nor tested.

In part the absence of clear public health focus has happened as a function of loose design and in part because the approach of 'responsiveness' means that the work of CBSC is to respond to what is requested rather than to question the nature or priority of the request. In this respect, two important assumptions underpin the design: that those requesting i) know what they want and ii) want the right thing. At national level there has been much greater clarity over the last two years and the previous section has shown how support has become increasingly strategic as a result. But at provincial level there is a greater tendency to accept national level priorities as the only priorities. No doubt there are many reasons for this, and some provinces may well be establishing their own priorities in addition, but the team did not come across evidence of analysis of what is additionally and specifically needed in the provinces visited to improve health outcomes.

In the design of CBSC there was provision for a technical (public health) specialist. In implementation this became a combined role of Team Leader and Chief Adviser and, by year 4, the leadership role was redefined as an entirely managerial Facility Manager. In the NDOH there was a CBSC senior health adviser whose inputs had been greatly appreciated and who was credited with significant positive influence at both national level and for the provinces. But in CBSC itself there was no role with oversight of public health. In the era of RCBTs, two of the four advisers were a clinical and a health promotion specialist and another focused on the logistics of EPI so the balance of input was public health rather than planning. Now that there is only one adviser per province, usually with a non-technical background in response to priorities around the AAP and HSIP fund flows, it is unclear where the province specific strategic focus on public health will come from and there is a danger that it will slip.

The other important influence has been AusAID's desire to bring coherence at subnational level. CBSC has suffered from many artificial and unhelpful polarisations, one of which is the extent to which it should focus on 'clinical' versus 'administrative' functions. As the debate has progressed concern has been expressed that CBSC is becoming too engaged in the financial reform process which more appropriately sits with SNS. In theory, if CBSC Advisers were engaged in reform of general provincial systems, this might give cause for concern. However, from what the evaluation team observed and discussed, the adviser's input is focused very broadly on supporting provincial health staff to implement the systems already in use or being introduced. This is very practical and much appreciated support to all levels of health staff and is highly unlikely to impinge on broader reform so duplication of effort therefore seems unlikely.

The Role of the Adviser at Provincial Level

The three provinces visited had experienced different models of support during the lifetime of CBSC. Sandaun had an HSSP adviser who became provincial adviser, then support from an RCBT based in Madang, then a return to a dedicated provincial adviser. East Sepik also had dedicated support following HSSP, then from the RCBT, but currently has no support. Western Highlands had HSSP then no provincial support, nominal inputs from the RCBT, and currently no dedicated adviser. Each of these provinces expressed strong preference for their own adviser. Of those receiving only regional support one province appreciated the inputs but found them limited and the other province said that regional inputs were too small to make any difference.

The most satisfied province was where the same adviser had remained for several years. All of those interviewed stressed how valuable it was to have someone they could turn to at any time who understood what was going on. This was also important in terms of establishing relationships of trust. At the same time several commented that there had been too many changes in CBSC, which was confusing, and one person (in a different province) said that they would rather have the money than an adviser. Another person pointed out that, whilst the adviser had done a great deal to help, the overall situation in the province hadn't changed in that there were still not enough staff, the infrastructure was in a poor state, and the funds still did not flow to health. This exemplifies perhaps the main dilemma and limitation of the capacity building approach, that it cannot address the chronic systemic problems which frustrate even the best attempts to deliver services and improve health status.

Advisers have both a strategic and a practical role. They have plans which are produced in consultation with, and signed off by, the provincial administration but they also offer a great deal of ad hoc support, often on very practical issues such as communication and computers. They use coaching and mentoring, role modelling, on the job training, facilitation, and other methods. Although the course of their work often involves extensive inputs they are not, in any way, functioning in an in-line role but rather provide advice and guidance on issues ranging from the new PHAA to advocacy on broader stakeholder consultation as well as practical support with communications and computers. In some cases the adviser can point to successes such as contracting out the distribution of drug kits or ITNs where previously they had languished for two years in a warehouse. But equally there are areas where advisers have neither control nor influence such as absenteeism and poor performance in the workforce, and financial decision making. Advisers across provinces seem to be very important in keeping the HSIP account open because inattention, which is a feature of work culture, can easily result in closure.

An example of how wide ranging the support is, and how it impinges on gender issues, came from an interview with the three women staff at province level. The adviser gave them access to his phone and email when male colleagues dominated the one office phone, ensured that they sat in the front of the car on field visits, opened space for them to talk in meetings when the male hierarchy closed it, and provided regular problem-solving assistance to the HSIP administrator. This kind of morale-boosting support is particularly important because women are such a small percentage of the workforce. And because, though the evidence is entirely anecdotal and not generalisable, the team noted that those women interviewed appeared more motivated to overcome the constraints to better service delivery.

Of the range of capacity building methodologies in use the two which were mentioned most often were mentoring and twinning. The term mentoring was not necessarily used but the value of someone who offered support and encouragement and who understood what the difficulties were came across clearly. Twinning, which often meant extended visits to another hospital or facility rather than an ongoing relationship, was very popular and those interviewed were able to give clear and convincing examples of how they had introduced change based on something they had seen elsewhere. In the most notable case, the provincial Vanimo General Hospital has attained a five star rating since visiting a hospital in Adelaide and they now run their own program in which other hospitals in several provinces are able to visit and understand how they have achieved this. This, again, is an example of what can happen in the best case scenario where there is committed leadership and political support. In another visit the evaluation team saw a district hospital which is closed to in-patients because of serious water supply and infrastructure problems. The same hospital had an aging workforce with insufficient numbers of younger staff coming through. Capacity building can do very little in such cases.

In at least two cases, young people who have worked with CBSC in an EPI logistics capacity and as an intern have gone on to take positions in provincial government and a leading NGO. Both spoke convincingly about what they had learned in working alongside international advisers and how their confidence had grown. Both had learned the importance of networking and were much more effective in their new jobs as a result of

contacts made through CBSC. Both had understood the importance of work planning and incorporated it routinely. And both saw themselves as leaders with responsibilities to develop their staff.

Focus and Spread of Inputs

Advisory support, and the associated Program Officer support, have always been spread very thinly at provincial compared with national level. Actual numbers and types of support are difficult to gather because information has been collected differently in each of the four years and the categorisations, such whether someone is advisory or in-line, long or short term and whether their base reflects their role (such as those providing support aimed at provinces but based at national level) are not easily compared. However, the following table gives a flavour of the support at provincial level in comparison with all CBSC staff:

	2006	**2007**	**2008**	**2009**
Advisers based in province	Not known	16 advisers and program staff in regional teams 4 advisers and 4 interns in SITs	8 long term 5 in-line	7 long term (3 existing, 4 new)
Total CBSC staff (incl support staff)	79 novated from projects	120	123 advisers and in-line staff	Around 86

In terms of numbers, the period of the RCBTs had the largest number of advisers but this was still very few in comparison with those at national level. In part this reflects the greater ease of identifying need and making requests at national level, combined with the lack of representation of the provinces on the Charter Board. But it also serves to demonstrate the logistical and managerial impossibility of having large numbers of advisers based across 20 provinces. Although AusAID has expressed concern about the concentration of advisers at national level, , attempts to find ways of addressing this have not been underpinned by systematic analysis. Similarly, there has been increasing discussion about absolute numbers of TA and a concern that there are 'too many'. But what constitutes 'too many' compared with 'enough' and what constitutes 'too long' or 'too short' compared with 'long enough' are issues that go beyond CBSC and are the subject of thinking within AusAID's research on capacity development. They have not been t, debated within CBSC but the dialogue might have been initiated had a way been found to incorporate DPs in the governance of CBSC.

What was clear from the provincial visits is that advisory support is spread too thinly. It also has no clear focus which means that, potentially, any kind of support can be requested. Compounding this has been AusAID's directive that all provinces should receive *some* support. In 2009 this means that, although advisers are now allocated to nine priority provinces, they still have to visit other provinces and offer something. This 'something' can be as little as a person sent on a non-certificate training course or a twinning visit arranged which, though worthwhile in themselves, raise questions about the efficiency of using expensive staff time for activities which are labour intensive but cost little.

As CBSC has been encouraged to broaden the menu of capacity building options, which it has done to a significant degree, it has become apparent that activities such as twinning require considerable staff time to plan and organise. At present CBSC is not sufficiently resourced to do this on any significant scale and to undertake more such work would require more staff based in the provinces rather than Port Moresby. Such an experience would ultimately reflect the experience of RCBTs which was found not to be an efficient model.

Q2: TO WHAT EXTENT HAS CBSC SUPPORTED THE SWAP?

The Design Document noted that international experience was turning against project-based assistance by DPs and towards a sector-wide approach (SWAp). This reflected a concern that DP assistance was not having the impact hoped for or expected, given the amount of resources allocated. This concern had already reflected itself in PNG by the late 1990s, leading to the adoption of a number of principles and practices that culminated in a particular form of SWAp, known as the Health Sector Improvement Program (HSIP). A further step in that direction was the agreement signed between GoPNG and AusAID in 2005 to establish the CBSC to support the SWAp and the PNG health plan.

A separate review of the SWAp would be needed to determine its effectiveness to date. Nonetheless, it is still possible for the team to draw on global experience and lessons learned in order to identify the core characteristics of a health SWAp. This list can then be used as a template by the team to identify where CBSC support has been forthcoming and to what effect. While this approach might suggest areas where the SWAp process could be further strengthened in PNG, that is not the evaluation team's main purpose. Rather, it is to determine in what ways, and to what extent, CBSC has been able to effectively support the SWAp over the last four years.

To the extent that a SWAp is perceived to be much more than a financing and procurement mechanism designed simply to channel and co-ordinate DP resources into the health sector, it is important to see that a well designed and functioning SWAp is likely to exhibit a majority of the following seven key ingredients:

Government leadership, strengthened co-ordination mechanisms inside central government and with development partners, and broad stakeholder involvement from outside the government sector

It would be incorrect for CBSC to claim too much credit for movement on this dimension, though it has supported major initiatives at restructuring the NDOH, and on thinking through a re-profiling of the Department's labour force, together with support to a piece of major legislation to reconfigure health service delivery at the sub-national level. Support to the Executive in the discharge of its leadership functions has also assisted. Yet weak links still persist between the Department and a number of the central agencies, all of whom have a significant effect on the performance of the health sector. CBSC has not yet been actively engaged in seeking to strengthen those links. Overall, any movement at this level is dependant not least on the willingness of all key players to do business in a different way i.e. sector-wide rather than government-wide or Department-specific. As SWAps develop, it is to be expected that co-ordination mechanisms will be refined through signed formal agreements (e.g. joint commitments on aid effectiveness, memoranda of understanding, codes of conduct), through sector-wide policy dialogue (on long-term health plans, health financing prospects) and through regular forums for monitoring performance against plan intent (e.g. half yearly summits). Some evidence of CBSC support can be seen on a number of these fronts, though IMRG has reported that PNG is atypical of many nations in development, with few bilateral DPs present, and AusAID by far the largest player in overall aid support.

Agreed national health policy and long-term health sector plans

Policy dialogue on the sector is a crucial component of the SWAp in which DPs can contribute to the development of the long-term strategic intent of government in the health sector. CBSC has provided significant support to the planning effort of the NDOH to develop the Strategic Plan 2006-2008 (later extended to 2010), the Corporate Plan 2009 -2013, the Health Sector Review 2001-2009, and the annual sector reviews. Lately, the investment has been in developing a new national health plan 2011-2020. Early work has concentrated on objectives and strategies, with key considerations on the requirements needed to deliver the strategic intent. Active participation is encouraged through the participation of focus groups established for each core function and disease entity. That work and support continues.

An identified resource envelope requirement (financial, human, physical) and a rolling medium term expenditure framework that will support the plan

Over the last four years, intermittent support has been provided under the umbrella of CBSC support, but much remains to be done on finalising and approving the new national health plan, to ensure that it is both realistic in resource terms and cost-effective in service terms. The NDOH acknowledges that it is relatively weak in specific skills on some of the tasks that will need to be carried out, though a number of DPs have already expressed an interest in supporting the necessary analytical work. For example, the health economics unit is staffed by one person, albeit supported by a New Zealand TA in the field of financing and MTEF design. Further, work force planning is dependent on the specification of the model of care to be adopted at local level and on the intent in strengthening hospital services through the country, including by new-build and renovation. Again, some of that work has been supported in the past by CBSC; and, other work is still ongoing, for example, on hospital design and functionality. Nonetheless, it would be surprising if not more TA support was required to help produce a ten year plan that can talk in an integrated way about physical, financial and human requirements.

An overall work plan that builds on facility-based and organisational plans

A great deal of work has taken place, much of it supported by CBSC, to design, develop, and produce AAPs, and to utilise them to monitor annual performance. For credibility of the process overall, resources must then be seen to flow in ways that are captured in the plans, so that the plans indicate a declaration of intent to make things happen, and are deliverable. That translation is still to be assured.

Shared processes & approaches for implementing the health sector strategy and the work program

Many of the processes currently followed have been the subject of TA support, not least from CBSC sources. The annual plan approval process, the six monthly summit reviews, the agreed KRA and KPI indicators, and the creation of technical working groups in selected fields suggest that this ingredient is well developed. The financing and funding constraints continue to be a significant challenge at sub-national level to the implementation of the national strategy, as is the human resource 'crisis' reflected in critical shortages of specific cadres of health worker and the lack of a functioning 'referral' network.

Commitment to greater reliance on government systems of financial management, audit, procurement, medical supplies and logistics

In the Design Document, it was envisaged that the creation of the HSIPMB would plan, manage and monitor all DP-funded activity. Over time, it was also envisaged that the Branch's various functions (e.g. purchasing, payments, reporting) would be integrated into the relevant core NDOH entities (e.g. finance, supplies, management information system) or into procurement centres within the Department. While the aid modalities in PNG have moved from project financing to program funding, and then through the HSIP to pooled funding (albeit largely earmarked), the movement to sector budget support or to general budget support has been much less evident. CBSC can only respond to requests from government on the aid modalities currently exercised, and a significant proportion of CBSC's overall resources has therefore been deployed in supporting HSIPMB to directly manage the core management support systems. This has led to a parallel system to that pertaining within the Department itself. Movement into transferring these functions into government itself is very recent e.g. financial management and audit. In other respects that movement is more muted e.g. in procurement, though the long-term intent is still clear.

Co-ordinated support to capacity building

In a number of countries where SWAps constitute the new way of doing business, attempts have also been made to better co-ordinate TA. Several countries have sought to set up a pooled approach for TA in which the government itself manages a pooled fund for TA, according to agreed procedures and procurement arrangements. Some have simply confined the pool to long-term international TA. Others have required a three year plan to be drawn up that would be linked to the national health plan requirement and be a by-

product of the MTEF process. The rolling 3 year cycle of the MTEF would also permit TA requirements to be updated annually and to be reprioritised as necessary.

Few examples exist globally of a fully operational TA pooled fund, for several reasons. One lies in the risk of compartmentalising TA requirements rather than seeing such requirements in the wider context of overall priorities. Another reason is that where the arrangement can be seen to clearly respond to the priority needs of government, government may still have severe capacity constraints to managing such a process itself (of identification, selection, recruitment, management and retention). Another approach that still leaves the government in the driving seat is to have a 'virtual' pool, whereby steps of the process are administered by the DPs (e.g. identification of potential TA; procurement handled by one or more DPs) on a case by case basis.

In PNG, clearly the DP providing the majority of TA is AusAID, and it is essentially providing a 'real pool' through CBSC. The risk is that TA support among all the DPs is not well co-ordinated in its identification of need, nor in terms of its recruitment and, even more importantly, in its conduct. Complementary expertise can be brought to bear on TA by DPs working together with government, but it does require more harmonisation than may exist at present.

SUMMARY

This section of the Report has sought to re-present the evaluation findings set out earlier, but in a way that also reveals CBSC's specific contribution to the development of the SWAp. It is clear to the team that the SWAp in PNG is still seen more in terms of an arrangement for harnessing and releasing resources into the health sector through the HSIP. As noted, a more mature SWAp is potentially much more than that, with key ingredients identified as above. Even so, GoPNG and its Partners are exhibiting a number of characteristics that would typify a maturing SWAp, and CBSC has played its part in supporting the development of a number of the key building blocks (albeit not always explicitly with a SWAp in mind). Further progress awaits the desire of government, DPs, churches, and other non-governmental organisations, to take the partnership to another level. That level would require all parties to exclusively support a single sector-wide plan, with buy-in to national structures, processes and systems i.e. by moving towards further harmonisation and alignment. A shared dialogue on, a robust approach to, and approval of the next ten year health plan might present such an early opportunity.

WHAT HAS BEEN LEARNED ABOUT CAPACITY DEVELOPMENT IN CBSC?

CAPACITY DEVELOPMENT APPROACHES CAN CHANGE

An ADB report in 2003 described TA in the NDOH as '*a very costly workforce whose objectives and expected results are not formally agreed upon; which may not always provide capacity building; which sometimes simply substitutes for local staff; whose performance is not measured by NDOH; and whose presence may de-motivate national staff. It reflects the unilateral planning and implementation practices of donor partners which the HSIP/SWAp hopes to curtail*'.[15] By 2009, whilst some of these criticisms remain, considerable progress has been made. All TA have formalised objectives and expected results although measurement continues to be challenging, and all understood, and tried to practice, capacity building. In-line TA certainly add, rather than build, capacity but this has been openly acknowledged and consciously decided, in some cases with DPs.

[15] *Development of a Sector Wide Approach in Health in PNG Final Report* ADB, 2003

The picture now is far more complex than the somewhat artificial distinctions between advisory and in-line, national and international, clinical and administrative imply. For every advantage perceived at any point in a spectrum of support there is a disadvantage. Where questions were asked about preferences for one form of TA over another there were a wide range of answers. Some prefer international TA for their experience and being outside the system, others prefer national TA for the opposite reason. Some women said that national TA (assumed to be male) would not change anything in terms of gender. Some believed that change could only come from within, others that it needed a 'push' from outside. Most appreciated TA, whether national or international, but some come clearly rejected advice which involved change of any kind, preferring to maintain the status quo.

CAPACITY DEVELOPMENT MAY BECOME RATHER THAN START AS STRATEGIC

What has been hoped for, and CBSC was a potential vehicle to achieve it, is an overarching capacity development strategy which would guide NDOH and its DPs. The experience of CBSC is that this is a far more complex undertaking than any partner has understood. Capacity development continues to be an elusive concept, meaning different things to different individuals or agencies. For most it is substantially about skills and organisational change and it is fair to say that the means of addressing these has been significantly improved through CBSC. In line with new thinking on capacity development, much coming through AusAID's ongoing applied research program and the *Making a Difference*[16] course, CBSC has responded to real needs at national and subnational levels and considerable investment has been made in improving working relationships between advisers and counterparts.

This has been important in addressing many of the past failures of the TA counterpart model which has been in use globally since the 1950s, but has been found to have made little impact in helping countries develop sustainable and resilient organisations able to manage their own processes of change. But the experience of CBSC, and of AusAID contractor managed projects more broadly, has been of trying to improve on what is recognised globally as a weak modality rather than to change the modality itself. Given that it is still an important model for AusAID (TA accounts for around 50% of country program expenditure, around twice the unweighted average compared with other donors[17]) then it makes sense to try to improve upon it. Underpinning AusAID's reliance on TA is the view, explicit in the design of CBSC, that project-based aid and TA is a 'safe' option in terms of minimising risk. But this is now changing and AusAID has aspirations to adopt a more strategic and integrated approach to TA and to reduce the overall volume of it. CBSC has been able to contribute to the former if not yet, by virtue of design, to the latter.

STUDIES ENLIGHTEN

A study for AusAID on counterpart relationships in PNG painted an improving picture in terms of individual relationships which improved individual competencies.[18] But both advisers and counterparts are ill-equipped to deal with capacity and complex change issues, in part because public sector change in any country is hugely difficult. Morgan identified, in PNG, two different ways of looking at capacity development. One, the most common and the norm internationally, focused on organisational engineering. It believes capacity is built through problem identification, results-oriented planning, restructuring, strategising, training, performance management and so on. The alternative view sees organisations as complex systems which emerge over time in response to deep political, social and cultural dynamics.

[16] *Making a Difference* is a course designed and run by AusAID to support improved capacity building relationships between advisers and counterparts. It has been positively evaluated in PNG and Solomon Islands

[17] *Annual Review of Development Effectiveness*, AusAID 2007

[18] *Improving Counterpart Relationships in PNG* Peter Morgan, 2008

A recent, comprehensive, global study on capacity development, which also includes AusAID-funded case studies in PNG, supports the view that key aspects of organisational and system capacity do not necessarily result from a purposeful and planned intervention but emerge from a complex and difficult to describe process of learning and adaptation.[19] The study suggests that the aid industry's generally poor record in capacity development will only be improved when capacity development emphasises possibilities and probabilities rather than predictable results and when it seeks to shape and influence processes driven by local contextual factors including politics and culturally defined norms, values and practices.

HOW CBSC EVIDENCE SHAPES AGAINST RESEARCH

Although none of the advisers interviewed used the kind of analysis above, the likelihood is that, if presented with it, they would smile knowingly. At province level, one adviser described the way in which he sought to have, actually had, and could not have influence, and the range of ways in which he worked with different types and levels of staff. The richness of the discussion clearly conveyed his appreciation of the complexity of building capacity in a province which is not performing well. As a result of having built up solid relationships of trust he is now privileged to be invited to certain meetings in which sensitive issues such as financing are discussed, where previously he would have been excluded.

During field visits the evaluation team heard, time and again, that it was not policies or funds that were the problem. Several people argued that both were there, and were enough. The problem was that policies were not implemented and funds did not go where they were supposed to go. Rather, the problem was identified as 'leadership' and this appeared to combine weakness in terms of providing direction as well as tendencies to use funds for purposes other than intended. The team were also advised, sometimes with amusing anecdotes, that 'we PNG people need to be told what to do otherwise we don't do it'. But a common saying in PNG- that you can't kill a snake by cutting off its tail – is also an acknowledgement that, unless corruption is addressed as the head of the snake, little will change. These are all issues deeply affected by politics and culture, neither of which are amenable to technocratic interventions.

At a conference on policy making in PNG[20] there was general agreement that, when a policy did not appear to be working, the tendency was to change structures and institutions rather than seek to change behaviours. There was also discussion about the fact that 'work is for producing food' meaning that people tend not to work voluntarily unless there is a practical, visible and positive result from doing so. The kind of capacity building often practised by development professionals was likened to building a canoe to display under the house (as opposed to using it for fishing or transport). In the health sector it is widely acknowledged that service provision by the churches is more accessible and of higher quality and this is explained in terms of greater motivation of staff and sense of mission which is reflected in their longer term commitment and greater willingness to work in remote areas. In addition there is more certainty and timeliness around financing arrangements, a higher degree of control over personnel, better supervision, better maintenance, transport, radio networks and independence in the management of individual health facilities. A prominent official in NDOH observed that a government worker in the church system would thrive whereas a church worker in the government system would fail.

But, although there is greater capacity in the church sector, this is not the result of a capacity development strategy or plan. Rather, capacity has emerged on a pragmatic and ad hoc basis in response to specific issues identified for improvement. The churches are also better at exchanging practices and information with other institutions and cooperating on an as-needed basis. They appear to do this on the basis of their authority and legitimacy in society and their commitment to it.

[19] *Capacity development: between planned interventions and emergent policy processes – implications for development cooperation* Policy Management Brief No 22, ECDPM, 2009

[20] Cited in *A review of capacity, change and performance issues in PNG's Health Sector* ECDPM Discussion Paper 57F

HOW IS THIS RELEVANT TO THE FUTURE?

In addition to evidence gained in the evaluation, CBSC reports discuss and analyse many issues that support a complex systems perspective although they are not presented in that way. Often they are presented in the standard development jargon of 'constraints' and 'risks'. This becomes relevant to the extent that, if it is accepted that capacity development can be unpredictable and disorderly, emerging through an unplanned and uncontrollable process, then the CBSC 'strategy' of responsiveness can be seen as the right one. The skill required is then to work out which of the many requests can be 'shaped and influenced'. The work at national level over the last two years is a good example of this because it was not planned to be strategic but it *became* so. Similarly, but through a different pathway which has demonstrated the value of continuity in the creation of personal relationships, the work in Sandaun has become increasingly strategic.

There are several implications for practice from this new way of thinking about capacity development which are useful in thinking about CBSC. They are presented in the following table:

How to Improve Support for Capacity Development

- **focus even more strongly on ownership** because change is fundamentally political
- approach capacity development as a **process of learning and experimentation** rather than as predetermined activities
- **take a more evolutionary approach to design** – be clear about the desired direction of change but with space for adaptation
- invest more in **understanding the political, social and cultural context**
- conduct capacity diagnostics from a **perspective of strengths rather than weaknesses**
- be prepared to accept a higher degree of risk and failure in order to **encourage innovation and learning**
- **be more realistic about the scope of external intervention** – external partners are marginal actors compared with the influence of exerted by underlying domestic processes and forces

Adapted from *Capacity Development: between planned interventions and emergent policy processes: implications for development cooperation* ECDPM Policy Management Brief 22

CONCLUSIONS

This section seeks to draw conclusions based on the findings already presented and on additional evidence gathered by the team. These are structured according to the AusAID format for evaluation reports, using the five OECD DAC criteria of relevance, effectiveness, efficiency, impact and sustainability, with the additional AusAID criteria of gender equality, monitoring and evaluation, and analysis and learning.

RELEVANCE

The vision shared between the Government of Australia and the Government of Papua New Guinea is that of working together to achieve improved development outcomes and sustainable improvements in the quality of life of all Papua New Guineans. Perceived to be in line with that vision, the explicit purpose of CBSC is to build

capacity to support the health system, with an implicit but unproven hypothesis that capacity building automatically equates to improved performance. Viewed only at a rather simplistic level, the CBSC was seen to be highly relevant.

However, on closer scrutiny, and as noted through the evaluation report, capacity building should be seen as much more than the provision of national and international TA, whether operating at national or sub-national levels. Further, declaring that CBSC's focus was to be primarily with the government sector narrowed its potential and relevance overall. From AusAID's perspective TA was the main 'game in town,' which therefore determined the scale and composition of TA that CBSC would be expected to supply.

Paradoxically, at the national level a good deal of the support has been widely recognised to be highly relevant and strategic, in strengthening the NDOH in the performance of its core business in: policy and planning; corporate services; and, public health and standards. Its support to the SWAp has been strong in some areas but conspicuously less so in others e.g. human resource and financial planning; co-ordination within and outside government; gender mainstreaming; policy advocacy of civil society.

Less relevant, certainly, in capacity building terms, was the agreement made between AusAID and NDOH to continue to fund a significant number of in-line positions, and to create yet others to administer donor support. These were 'hands on' posts and reflected: in part, an apparent inability of NDOH to appoint (and, perhaps, an unwillingness more centrally to fund) established posts at levels that would attract a good range of candidates; and, in part, the reluctance of DPs to pass aid support through government channels. Maybe a third of all TA can be said to fall into these two categories, working across a range of activities from STI prevention activities to financial management. That they were perceived to be of critical importance by NDOH (and by some DPs) is not in question, nor in question is the value of many of the skills they provided. Much more of an issue is the relevance of such postings funded through a capacity building program.

At the provincial level, the in-line issue does not arise and there appears to be agreement from the majority of stakeholders that the support advisers provide overall is highly relevant. Where stakeholders were committed to change they strongly favoured international TA because of the new knowledge and skills they bring with them. That there have been islands of excellence is an indication that other support, such as twinning, can also be highly relevant. However, in contrast to national level, support at provincial level is thinly spread, and has become increasingly focused on planning and management. Relevance, in terms of an overall public health perspective, may therefore be diminishing.

EFFECTIVENESS

Although the Design Document did produce a logical framework, with four main objectives, this framework was quickly found unworkable and discarded in favour of a looser arrangement that was seen to be more flexible and responsive to the needs of government. Although major attempts have been made by the Contractor and by AusAID and NDOH to redefine the objectives through KPAs and KRAs, the fact that the mid-term review was never completed is significant in itself, serving to perpetuate the lack of clarity over direction and an appropriate route map. Undertaken independently and early enough a MTR had the potential to overcome many of the weaknesses which were identified by all partners but about which no resolution could be found through the Charter Board. It was possible, in consequence, to broadly justify all TA positions on the basis that they were supporting one or more entities in the government sector: individuals, groups and agencies i.e. that they met the requirement at 'purpose' level.

Considerable attempts were made to put in place a process that would be both systematic and sustainable for the identification of 'need' for capacity building e.g. capacity mapping, AAPs. Ultimately these proved to have

limited usefulness in determining priorities and, with a change of senior leadership in NDOH, an approach of direct responsiveness to the senior executive of the NDOH emerged, at least at national level. The pro-activeness of CBSC was less evident, in consequence, perhaps, on some key issues. This is not entirely surprising. Given that a pool of money was being made available by a DP, with conditions attached to its use, the requests made would tend to match those conditions. Whether capacity building needs could be better met by strengthening existing national institutions including training schools, for example, was largely 'off limits'. In cost-effectiveness terms, this question was seemingly not raised in the design phase; and hence could not be addressed or answered by CBSC itself or by NDOH subsequently.

At the national level, it is clear that much of the effort and support has been highly valued in its own terms, enabling the Department to increasingly deliver on its core business. Policies have been written, plans have been produced, standards have been set and disseminated, global funds have been secured, cold-chains are operating, procurement has taken place and goods distributed, and expenditures accounted for. In short: the immediate effect is identifiable and significant. Major gaps remain, nonetheless, in not pro-actively supporting the SWAp e.g. in both improving co-ordination within and outside the government sector, and in supporting technical work on the human resource 'crisis' and financial sustainability.

The longer term effect at national level is less discernable. This is only four years into a long-term process but some deliverables made now does not guarantee their sustainability in the future. Specifically, there are major reservations about the extent to which these gains will continue should assistance cease or be realigned, coupled with reservations about the perceived heavy weight given to TA at the central vis-à-vis the provincial level.

At provincial level, effectiveness was considerably weakened by frequent changes in direction - both by the changes themselves and by the way in which they were initiated. In spite of this, and perhaps because some of the best advisers have remained throughout, there is evidence of effectiveness if measured by the objectives that were set, jointly, in the annual plans. But answering the effectiveness question - did the activity achieve its objectives? – is complicated by the fact that much of what advisers do, but which is critically important in the development of soft skills such as leadership and values, cannot easily be captured either in objectives or in the monitoring and evaluation of them.

EFFICIENCY

There are two aspects of efficiency to be considered. The first is of allocative efficiency which seeks to identify whether, relative to the overall expenditure, any reallocation of monies would have yielded a greater return. This evaluation team was not tasked to address that question, and it would have required a review across all aspects of AusAID's support to the health sector. Notwithstanding, the evaluation team has real concern as to whether, given the health situation in PNG, an allocation of this magnitude on a specific form of capacity building targeted at a single beneficiary, could ever have been justified.

If matters of allocative efficiency are beyond the remit of the evaluation team, and they are, the second issue is that of technical efficiency: were the resources used in an efficient way that would yield 'value for money'?

Once again, however, design issues colour the answer. The establishment of a program of largely TA but with few or no immediate tools provided to directly influence events, is puzzling to those unfamiliar with AusAID (because substantially less TA is used by most other donors), and a better balance would arguably have achieved more. The allocation made as between staff costs and ongoing costs (largely immediate operating expenses) gave little flexibility to engage in a much wider menu of options that could have improved efficiency e.g. in different forms of training and skill development, including the basic training of front line staff;

encouraging public / private partnerships; promoting incentive schemes, or, directing investments in high priority infrastructure and equipment.

At the national level, within the parameters set, the view of the evaluation team is that the identification, recruitment and placement of TA was taken through a highly proficient and efficient process. That may not have been the picture early in the programme with the change of modus operandi from HSSP. Certainly, the IMRG Report No.3 had raised concerns e.g. on recruitment, performance management, while noting that CBSC was ahead of other DPs in its engagement with NDOH on the actual selection process itself. Our observations are that those TA operating at the NDOH, and in the provinces, do so, in the majority of cases, with considerable skill and sensitivity. Their outputs are highly valued by government also.

What is still a big question is the extent to which knowledge and skills have been transferred in an efficient manner. If no immediate counterpart capacity exists, as characterises the majority of situations, then the one-to-one transfer of knowledge cannot happen. Where it does, such as in the national health radio network and STI program, the evaluation team were provided with ready examples of where both parties were benefiting and significantly so. Even in these cases there were periods of high risk related to staff movement.

Also, despite very limited non-staff resources available, the levels of technical efficiency among in-line staff have been high at the national level, whether in terms, for example, of keeping the EPI unit operational, or in meeting the ongoing requirement for support to HSIP and finance for the delivery of goods and services to the provinces.

Assessing efficiency at the provincial level is more challenging. The main input has been advisory time and this could potentially have been reduced had the advisers been Papua New Guinean rather than international. As mentioned in relation to relevance, those stakeholders seeking change were strongly in favour of international TA. The same stakeholders felt that the advantages of Papua New Guineans in terms of their understanding of the context would be over-ridden by their susceptibility to negative influences. All these views, however, are in the context of TA as a 'free good'.

The focus on developing advisers to work with a gender lens can also be viewed as an efficiency.

IMPACT

Evaluating impact was not the main objective of this evaluation for two reasons. First, CBSC has only been in operation for four years and has almost another year to run. It was therefore agreed, at evaluation planning stage, that the most appropriate form of evaluation would be interactive for the purpose of program improvement rather than impact. Second, a full impact evaluation is impossible because the design did not specify, either qualitatively or quantitatively, what outcomes were envisaged and there was no baseline against which to evaluate nor a counterfactual to establish what would have happened without intervention. Furthermore, the provinces are too different to draw comparisons and there were several changes of direction which, implicitly rather than explicitly, affected the outcomes desired.

This is not to suggest that CBSC has not had impact. Indeed, the evaluation team has presented evidence elsewhere in the report which indicates that there is likely to be impact and that some of it has the potential to be sustainable. But, in common with many development interventions, such impact cannot easily be quantified in the absence of planning for impact evaluation from the outset.

SUSTAINABILITY

Sustainability is the 'crunch' issue for the evaluation team: will the benefits of the program continue after funding ceases? This question should have been addressed before now: through a mid-term review; and, through an exit strategy. Neither has materialised.

At the national level, the evaluations team's response is a very qualified 'yes'. Much of the work undertaken over the last four years has been in putting policies, plans and procedures in place, and developing the capability of the NDOH to operate on its own. Even here, however, sustainability of the gains made will be dependent in large part on their congruence with the wider movement to public sector reform and, hence, the support offered by Finance, Provincial and Local Government, Personnel Management, and Planning.

Specifically, at the national level, a succession of planning activities have taken place such that the process of planning is becoming 'bedded in'; whether the expertise now exists within the public service is another matter. Likewise, other gains that have been made e.g. in terms of supporting resource mobilisation efforts in gaining access to global funds, may have been made through an inclusive process, but are not yet embedded despite some real effort to do so.

Yet, one criticism of CBSC advisers has been that they may have taken on too much of the 'hands-on' function, thereby displacing the public service from discharging the necessary functions of government. Evidence on this matter is hard to come by, though it is likely at least to be the case that where a specific expertise is known then it will likely be utilised. Substituting for existing capacity should always be episodic rather than continuous, to avoid dependency.

More worryingly, all the in-line positions being met from the CBSC budget are a reflection of the lack of counterpart capacity. In the extreme case of the EPI Unit there are no public service staff currently employed. As noted in the ODE Report (June 2009), filling such posts through CBSC monies may be a pragmatic way around the bureaucratic constraints of the government system , but is neither cost-effective nor sustainable. Again, while operating manuals, procedures and protocols can be set down and disseminated, these fall far short of the knowledge acquisition and transfer that would have been hoped for. Whether many of these CBSC-supported posts will shortly be transferred into the government service remains an open question presently: dependent partially upon the final outcome of the NDOH organisational review and restructuring, and crucially on the gradings that these will be accorded to attract, recruit and retain well qualified staff.

At the provincial level sustainability is almost impossible to assess, in part because of the frequent change in approach taken; and in part because, even without that, support is too thin to be effective on the scale required to impact on service delivery and health status. At the same time, there were several convincing examples witnessed by the team. Some individuals demonstrated remarkable motivation for their work, and improved ability to perform in their role, as a result of their experience in CBSC. How they choose to use this personal growth is unrelated to CBSC but reflective of the enabling environment, their personal integrity and broader cultural issues. Support to the church for healthy villages appears to have high sustainability owing to their rootedness and credibility within communities. And, the achievements of the five star hospital are sustainable given continuation of the favourable circumstances which supported those achievements.

Overall, therefore, at provincial level sustainability is determined more by the very conditions that form the operating environment for CBSC and over which CBSC has little control. These are often portrayed as risks when, in reality, they constitute the normality of the context.

GENDER EQUALITY

The design document for CBSC made no specific reference to gender so the requirement to address gender issues stems from a contractual requirement to further AusAID policy in all cross-cutting areas. Although little of the support provided by CBSC focuses on directly on gender there is documentary evidence, in Annual Reviews and Annual Capacity Building Improvement Plans, of consistent and continuous attempts to develop an approach to gender equality. In 2006 analysis was confined to iterating a commitment to sustain gains under HSSP. By 2007 there was analysis of strategic gender needs being addressed through activities and specific initiatives such as tasking the planning team to build capacity to mainstream gender and to encourage the collection of gender disaggregated data. In addition there were plans to build the capacity of CBSC staff to utilise a gender lens in their work. Actual activities included in service training on gender based violence and workshops on family based violence support centres as well as the development of a guidance manual for health workers. Although small, these activities are important. During a visit to Whagi district in Western Highlands the evaluation team discussed conflict in the province and learned that rape was the second most common cause of violence, after land disputes and ahead of alcohol. It is therefore a crucial issue affecting men and women which is structurally perpetuated in the form of 'payback'.

The 2008 CBIP allocated greater space to gender with a detailed tabular analysis of whether and how CBSC activities addressed practical or strategic gender needs. Consequently, the Annual Review for that year demonstrates significantly increased commitment to gender. New staff orientation included working with a gender lens along with technical support to develop the skill sets in their work. Sex disaggregated data was also provided on staffing. Internal evaluation utilised the Most Significant Change methodology which showed that a significantly higher percentage of women receiving CBSC support were more confident or had higher morale, and had improved skills and abilities. This was validated during a field visit for this evaluation when a labour ward sister was able to give many examples of how she had changed her practice as a result of coaching and role modelling from a clinical adviser.

The latest CBIP 2009-10 describes further activities to advance gender equality including conducting a gender Stocktake to determine levels of gender sensitivity in NDOH and to utilise the results to develop a training program. Previous work on the gathering of gender disaggregated data in NDOH will be continued into data analysis and application. The work of the Gender Violence Project Officer in the Family Health Branch is ongoing. However, with no reference to gender in the National Health Plan or Strategic Plan, and with no counterpart to work with, she is the main person driving the program. Whilst her commitment to the issue and her drive to find it a place within NDOH is admirable, the approach of driving from below, from a non-core position, is unlikely to be sustainable. This exemplifies the greater challenge faced by CBSC about the extent to which it should be responsive rather than directive. If it is entirely responsive there would be no gender focus but, in prioritising gender and placing a person in an in-line position, there are questions of sustainability.

International experience is instructive in considering the limitations of CBSC in promoting gender equality in health. Whilst there is relative consensus in the international health community that gender is a fundamental aspect of health equity, experience to date with sector approaches is that it is very difficult to move from theory to practice. In SWAps, a precondition for developing gender-responsive policy frameworks and strategies is in-depth understanding of gender differences and inequalities as they impinge on the situation of men and women in the sector.[21] In PNG, at present, there is no such analysis nor any intention to move towards one. In that context, whilst CBSC support appears important, it is a small contribution in an unfavourable institutional environment. The lack of activity on gender across GoPNG is, in part, a reflection of the lack of women's voice in decision making in the country. That reflects, more broadly, cultural barriers towards the participation and rights of women.

[21] *Gender Equality in Sector Wide Approaches A Reference Guide*. Development Assistance Committee, OECD, June 2002

The evaluation rating for gender equality in CBSC reflects the commitment to incorporate a gender perspective, the progress made in doing so, and the learning emerging which will inform future decision making. In the four dimensions of gender equality – access, decision making, women's rights, and capacity building – the contribution of CBSC is tiny, and mainly not measurable, in the greater context.

Monitoring and Evaluation

The CBSC Briefing Note prepared for the evaluation team describes the challenge of monitoring and evaluating a program which does not have defined objectives and which aims to be responsive.[22] It describes a '*continual struggle for M&E, compounded by multiple ambitions and perspectives on what CBSC is or should be, what it is reporting on, what it is accountable for, and whether it was internally or externally oriented*'. These dilemmas were clear to the evaluation team. In addition, the monitoring and evaluation of capacity building is notoriously difficult and work to find appropriate methodologies, some of it supported by AusAID, is still in its infancy.

In the early stages of CBSC most effort went into fulfilling the requirements of the contract. This was largely focused on accountability rather than learning and was later contracted to an independent assessor. The remainder of the function, managed internally, was framed around a new program logic intended to be capable of demonstrating outcomes. However, this was developed under pressure of time with the result that the program logic was a linear model which was unsuited to the complexity of CBSC and which was not well understood nor representative of how advisers saw their work. During the last two years, after frequent adaptations to the Key Results Areas and Key Performance Indicators, the M&E framework has become workable and useful although it continues to suffer from lack of overall program definition and continuing change at provincial level. The current approach benefits from greater prioritisation by the Charter Board and more explicit objectives and activities.

The documentation provided by CBSC is of a high standard. Whilst it has been criticised for being voluminous, and certainly given the time constraints of the Charter Board that may be fair, for an evaluation team the various reports tell a clear and comprehensive story. They describe the challenges and the various attempts and methods to respond. What CBSC is actually doing is now clearer, reflecting both increased program definition over time and greater focus on outputs. It is important to recognise that any program seeking to build capacity is likely to evolve over time and that monitoring will need to change with it. However, too frequent change, as has been the case in CBSC, can be damaging, distracting and undermining.

In the design it was envisaged that CBSC would eventually align with GoPNG systems. This was overly ambitious and has not been realised, in the same way that CBSC has not moved under the HSIP Management Charter Board. There are now attempts to utilise the Performance Framework of the NDOH Corporate Plan 2009-13 and other sectoral and priority health program M&E mechanisms where appropriate, such as for HIV/AIDS. Incorporation at provincial level is more challenging owing to the many aspects of decentralisation which are not yet clearly defined. Entry points are with both the Provincial Governments and the DPLGA.

CBSC reports quarterly to the Charter Board and the format of the report has undergone change in 2009. For a program involved in capacity development, which is a very long term process, the evaluation team considers that quarterly reporting is too frequent. It puts undue pressure on contributors to identify achievements in an environment in which change is very slow and often imperceptible, and reporting takes time which could be more efficiently used. The Charter Board also tends not to meet quarterly. It would appear that the main

[22] *CBSC: Overview, TA Case Studies, and M&E Framework* CBSC Briefing Note 25 Sept 2009

demand for quarterly reports is from AusAID. Whilst it is appreciated that AusAID may need regular 'updates' for internal purposes it would be more appropriate to find a means of obtaining the information which did not intrude on what should be CBSC's main attempt to align reporting with GoPNG requirements.

Analysis and Learning

The design of CBSC proposed an action-reflection model of M&E which would meet the twin needs for learning and accountability. There were three assumptions behind this: that learning could be directed back into planning and management systems; that a climate could be created which permitted examination of success and failure in capacity building; and that the demands of accountability would not undermine learning. What is striking to the evaluation team is that, although there is evidence that learning has certainly been directed back into planning and management, and that learning has been a priority in spite of the demands of accountability, the climate for examining success and failure has not been achieved. In stark contrast, and for reasons which elude the evaluation team, CBSC has faced continual criticism[23] and has operated in an often hostile climate. In part this can be explained by design weakness (lack of focus and dominance of the TA model) and the nebulous nature of capacity building. The exclusion of DPs in the governance mechanism has also prompted criticism.

Evidence that CBSC is both learning and seeking to learn can be found in, for example, the revision of reports from advisers to permit reflection on wider issues of ownership, culture and values. The use of Most Significant Change methodology and the publication of Capacity Building Stories sheds light on the widely varying contexts and conditions under which capacity building succeeds or fails. CBSC has also drawn attention to the fact that its contribution to capacity building in the health sector is modest and often reactive and that its M&E system only tells part of a wider story which can only be captured, eventually, in NDOH and wider GoPNG monitoring and evaluation systems.

Although a great deal of learning has happened within CBSC it is not clear how far this has been utilised by NDOH and AusAID. Within AusAID there is a strong focus on improving reporting in order to demonstrate results which, though important, needs to be accompanied by realism about what can be achieved given the design of the program and the context of what is generally acknowledged to be a failing health system in PNG. One of the routes to realism, and to more careful design in the future, is the learning that arises from four years of implementation of CBSC. Many of the criticisms of CBSC, both verbal and written, do not appear to take account of this, especially those aspects which are beyond the control of CBSC concerning the influence of politics and culture in the PNG setting. To date, most of AusAID's support to the health sector has been on the supply side but it will also be necessary to understand and address the demand side and which advisers in the provinces are well placed to begin to shed light on.

AusAID could also further institutional learning by linking to analysis such as Francis Fukuyama's of governance reform. Of particular interest for capacity building in health is his identification of important generic obstacles to donor-supported reform. These include the lack of fit between formal institutions and the underlying society, and the inadequate transmission mechanisms to develop local ownership of reform processes.[24] Appreciation of this is particularly important when supply side efforts to improve on health are based on reform of institutions which may not be the best starting point for service delivery at facility level.

[23] CBSC has been criticised in the ODE Report and IMRG Reports as previously referenced. During interviews the same criticisms were voiced by several stakeholders. What was concerning, from an evaluation perspective, is that the criticisms were either generic – about the ineffectiveness of TA globally rather than in CBSC per se – or about particular issues, of which a criticism that CBSC 'recycled' poorly performing advisers had stuck. The latter has been used out of proportion and generalised from a tiny number of cases (perhaps even only one).

[24] Fukuyama, Frances *Governance Reform in PNG* August 2007

EVALUATION CRITERIA RATINGS

Evaluation Criteria	Rating (1-6)	Comments
Relevance	4 *adequate*	Relevance has been constrained mainly by design weaknesses
Effectiveness	4 *adequate*	Short term effectiveness is limited by longer-term sustainability,
Efficiency	4 *adequate*	Efficiency is limited by the dominance of TA in design
Sustainability	3 *less than adequate*	Specific gains might be sustainable but the overall conclusion after four years is less optimistic
Gender Equality	5 *good quality*	Reflects commitment to incorporate gender and increasing evidence of improvement in practice over time
Monitoring and Evaluation	4 *adequate*	Limited by frequent change and broader challenges of monitoring capacity development
Analysis and Learning	5 *good quality*	Reflects serious commitment to learning and continuous improvement

OPTIONS FOR THE FUTURE

This section of the report responds to the forward looking component of the TOR. Given that this is the part of the evaluation of most interest to all stakeholders, and that the issues are complex, the options are elaborated in some detail. This is divided into two parts: options in which CBSC is the starting point; and options which go beyond CBSC.

For the future, the team is of the view that any consideration on CBSC must be seen in the light of the overall needs of the health sector. Health indicators have not improved over the last ten years, some have plateaued, but others are deteriorating. With CBSC such a significant component of AusAID support there has also been increasing concern that it appeared to have no impact on health indicators. It would therefore be difficult to argue either for a continuation of TA on the present scale or for continuation of a model which narrows the definition of capacity building so that it precludes means of addressing other critical capacity shortages in, for example, medical supplies, appropriately qualified health personnel, functioning facilities, etc, which can directly improve service delivery and hence have direct impact upon mortality and morbidity.

While investments in planning and management systems, and in human capital to improve those systems, are *important* into the long term, they are *not sufficient*. There is a clear opportunity cost in the lost opportunity to deliver goods and health services to people who need them most. Of course, there is a balance to be struck in giving greater attention to the development of policies, plans, monitoring instruments, etc on the one hand, and strengthening controls on the other (in purchasing, financial management and audit). Yet, scaling up on either of those may face diminishing returns relative to the health gains of scaling up on service delivery.

CBSC AS THE STARTING POINT

CBSC was created as a mechanism that would facilitate and manage all AusAID-funded TA to the health sector, including in-line positions. Over time, and not within the first five years, an expected outcome was that HSIPMB would take on the management of advisers. This was, and still is, a longer term goal worth pursuing

over the medium term (5-10 years) and CBSC would be expected to make progress towards achieving that goal.

Since that time, what has happened is that the scale, distribution and skill mix of TA has changed. Back in 2003, over 234 TA inputs were provided to the health sector through the various AusAID projects, of which 180 were long-term and over one third were international. Today, the picture is very different, with some 86 posts filled through CBSC (excluding support and JTAI staff). These cannot be easily categorised , as has been discussed earlier in the report.

The current contract for CBSC, which has the potential to be extended, expires in August 2010. As a formal MTR was never conducted, this Evaluation forms the only independent report of progress made over the last four years. Both the IMRG Report No 3 of 2007 and the ODE report of 2009 (referenced elsewhere) made assessments of CBSC. However, those reports addressed a significantly broader agenda – the HSIP and all AusAID support to the health sector in the last ten years respectively – so the reports do not do, and could not have done, justice to the complexity of CBSC. This evaluation is, therefore, the first time that CBSC has been evaluated in its own right. Had there been a MTR available to the ODE team, which had evidenced the complexity of the issues, different conclusions might have been drawn.

The case for TA can always be generated, and creating a large pool of available monies often means that it is so utilised. For reasons also advanced above e.g. the time limited nature of some posts, the future filling of in-line posts from government resources, the need for such a volume of positions in the future should be much lower than at present.

OPTION 1: CLOSE CBSC IN AUGUST 2010

CBSC is due to finish in August 2010 and AusAID, prior to the evaluation, had already signalled that this is what would happen. As yet, however, there is nothing else in its place. A clear program of work already exists in the CBIP 2009-2010 and, at provincial level, the process of recruiting and placing advisers in the new priority provinces, is not even complete. As the deadline for closure approaches it will be increasingly difficult to deliver on what has already been promised and key personnel are likely to seek and obtain alternative employment. Although the team was asked to review the CBSC exit strategy as part of its ToR, the uncertainty surrounding the decision making process for discontinuation meant that no such strategy has been developed (and review is anyway a management rather than an evaluation function). This suggests that, at present, the only reality for CBSC is uncertainty.

At the same time, a number of key initiatives that have had their gestation earlier in the decade are only coming to fruition now, and a closure decision in the next few months may leave the gains made rather vulnerable and at a critical stage. Reference can be made especially, but not exclusively, to the work still needed to produce the next National Health Plan, the ongoing need to finalise and 'bed in' a restructured and reprofiled NDOH, and the translation of the PHAA into the 'first wave' Authorities.

At this stage, with significant change taking place in NDOH, there is strong ownership of CBSC at national level. It is becoming clearer where TA can and cannot be effective and there is a momentum for reforms which could be far reaching if implemented. To discontinue CBSC at this stage would be to compromise what is a potentially strong partnership between AusAID and NDOH.

This option is **not recommended,** as either acceptable or appropriate.

OPTION 2: EXTEND CBSC FOR 2 YEARS (TO 2012)

If, as the evaluation team believes, some of the key initiatives are worthy of continued support, some transitional arrangements are required until AusAID has had the opportunity of reviewing, with government, all its aid modalities in the health sector, and effecting a design (or portfolio of support) that better reflects and addresses the health development situation in PNG. Any such 'design' is a lengthy process and the team was advised that this could take up to 2 years. In the meantime, it might be expected that the remaining nine months of the CBSC contract would be an opportunity to develop, through the Charter Board, a zero-based budgeting approach for an extension of 2 years. 'Zero-based' would mean that each activity for continued support would have to be justified; nothing that currently is supported would thus be automatically included in a 2-year extension.

It is for GoPNG to take the lead in identifying why and where AusAID support might be most welcomed over 2010–12, and in what forms and ways. At the end of this section, however, the evaluation team offers some pointers on what their agenda of the discussions might include.

Three further key issues will need to be addressed soonest, in the context of a 2-year extension: firstly, the issue of in-line positions; secondly, the broadening of the menu of capacity building options; and, thirdly future governance arrangements.

In-line Positions

CBSC currently provides support for 86 positions, based at national or sub-national level. A considerable number of these positions at national level are occupying in-line positions in health priority programmes eg EPI, or are in positions that support the HSIP mechanism of DP disbursement to the health sector. Any decisions on their future, therefore, are inevitably bound up with either the restructuring of the NDOH or with the review and redesign of HSIP. Given the imminent completion of the CBSC programme in mid-2010, urgent action will be needed to bring these matters together if the transitional arrangements are to run smoothly.

Broadening of the menu of capacity building options

The evaluation team has expressed its concern throughout this report at the rather narrow interpretation placed on capacity building in the original CBSC design. The provision of TA does have an important part to play, but has probably been overplayed in PNG across all its sectors, including health. Beyond CBSC, it will be important to address other capacity-enabling strategies through financial support to existing institutions and facilities, and through support to physical infrastructure and human resource development. That may not be so easy to plan for and implement in a 2-year extension, but should not be ruled out automatically if NDOH (and provinces) articulate their needs in ways that can be supported rapidly, through CBSC.

More likely, is that CBSC could support a suite of more immediate initiatives that could potentially build capacity in ways that promise longer-term sustainability. Interestingly, many of the 'dishes' on the menu were first identified back in 2005-6 within the CBSC's first reflection report, when attention was drawn to the limited menu of capacity building options then available. An extended menu was recommended. The latest 2009/10 CBSIP systematically identifies a range of non-TA options at the provincial level, including: CHW in-service training, preceptor programmes and clinical attachments for rural workers, twinning programmes across PNG, clinical outreach support, repair and maintenance work on infra structure, refurbishment of rural laboratories etc. Also proposed in the final 12 months for TA and non-TA support are integrated outreach patrols, district management strengthening, a package of refresher training for CHWs, specialist support on hospital infection control and waste management, and care and management of clinical equipment.

At the national level, 2009-10 has also seen a partial departure from detailed TA programming, with the creation of a national fund, the decision for its allocation being delegated to the SEM, within parameters on what can and cannot be supported through the CBSC funds, including rigid compliance with the NDOH

Corporate Plan 2009 -13. This innovation broadly corresponds to sector budget support and should be evaluated carefully, not least for its potential to be rolled out over the next 2 years at provincial and district levels also. Direct support to other national and provincial institutions e.g. training schools, business and medical schools, could be included to strengthen their capacity to better respond to national and local requirements and needs.

Future Governance Arrangements

An integral part of the rationale for a two year extension would be to trial new governance arrangements. The Charter Board structure was not as intended from design and has not worked well for any of the partners. The nominal engagement of other central agencies such as planning and finance, and other agencies such as DPLGA and DPM has failed to capitalise on their key roles. The absence of any 'provincial' voice on the overall direction of CBSC is also questionable. Moreover, the exclusion of DPs from the debate about the use and quantum of TA has also limited potential for discussion of what is an important debate in PNG, given the history of TA as a dominant mode and the resentment of contractor-based models. The Charter for CBSC provides for the Charter Board dissolving itself in favour of an alternative arrangement, and the evaluation team believes that this option should be utilised. There are several possibilities for incorporating decision making into existing structures such as the HSIP, the NDOH Executive Committee or maybe the National Health Board. Assessment of these is beyond the remit of the evaluation team and rightly falls to the Charter Board partners, in consultation with DPs, to determine.

An extension is recommended by the team on the basis that CBSC has the potential, given a reasonable period of time, to re-orient itself positively in support of the design of alternative support. What constituted a reasonable period of time was not unanimously agreed within the evaluation team, with some believing that up to five years would be needed to effect transition of TA management into GoPNG. However the team agreed unanimously that two years was an acceptable minimum.

CONSIDERATIONS DURING AN EXTENSION OF CBSC

On the basis of what has been learned during the evaluation, the team offer the following considerations to assist GoPNG in identifying what kind of support might be most appropriate from 2010-12

National policy and strategic direction NDOH is reaching a critically important phase in its design of the next 10-year health plan. For that to be robust, significant technical support will likely be required over key aspects of its design and implementation: developing a workforce plan that will enable the future stock of human resources to deliver it; identifying a resource envelope that will be required and available to finance the plan; determining basic (essential) packages of care that will be deliverable at each category of facility (and especially health posts, rural hospitals) specified in technical, workforce, consumables and financial terms; translating the plan into a 3-year strategic plan and complementary MTEF, and with one year national action plans and a means for monitoring performance; and, providing advocacy for the implementation of the plan, building on wide consultative exercises carried out in its design.

Development of the SWAp It is shortly intended to carry out a review of the SWAp. Previous reports have expressed particular concerns that the SWAp has not been sufficiently strategic in its intent, has not engaged well with other organs of government, both centrally and sub-nationally, or with DPs, and has had limited engagement with the non-governmental sector and with civil society. Those concerns manifest themselves today, and argue for a more inclusive dialogue to shape the future of the PNG health sector. Carrying that agenda forward, with support as and if necessary, would be crucial for wide ownership of the 10-year plan and for its implementation.

Organisational review, restructuring and reprofiling of the NDOH While the structure of the new executive function has been approved, and positions have been filled, continuing uncertainties exist over substantive posts and consequent approvals of gradings remain work in progress. This is a significant technical task to complete, and a major management of change programme to complete successfully, with or without external support.

Unifying public health and hospital services within a provincial health authority framework Considerable effort has been made, and concrete decisions made to make the voluntary PHAA a reality. To date, the majority of provinces have expressed interest, and a first wave (three in total) have stepped forward and signed up to an implementation programme. This will require considerable effort and energy by all those at and within the three provinces concerned, for them to become 'beacons' of knowledge and skills in translating this specific piece of legislation into practice. Significant external support may be needed to assist that process. Ensuring this major reform initiative links with other government intentions to decentralise to provincial and local level governments will be crucial, a complexity attached by both political and administrative considerations.

Against that agenda, it is for government to determine what it wishes to accomplish, and over what time-scale. It is also for government to determine where support would add value and to look for external support from a range of quarters, including CBSC. In addition, reference should be made of other sources including: modelling costs and efficiency in PHC (supported by ADB); MDGs study (UNICEF); facility level costings (NEFC); district and facility services delivery funding (AusAID); health partnerships study (ADB, WHO); and, community health posts (ADB). A further menu of analytical and advisory work is proposed by the World Bank, to include: health payroll costings and projections; public sector financed health expenditures; user fees; hospital costing and cost recovery; private sector provision; health financing and utilisation of health care. Also, the IMRG in its final draft report (May 2009), proposed a further set of review studies of: achievements of the NHP 2001-2010; HISP agreement; costing minimum standards; resource envelope study; and, a broader study of changes affecting the delivery of health care e.g. decentralisation and implementation of the Reform of Intergovernmental Governance Arrangements (RIGFA). Simply mapping the above, emphasises the need for a zero-based approach, to avoid duplication and to harmonise efforts.

SPECIFIC DESIGN CONSIDERATIONS AT PROVINCIAL LEVEL

The following discussion aims to inform future design in a way that keeps public health considerations centre stage. During the evolution of CBSC to date the public health focus appears to have waned in comparison to a strengthening of support for policy, planning and management aspects.

Any strategy for strengthening a health system should be a comprehensive and coherent approach which identifies interactions in the structure of the public health system and the requirements for adequate functioning of positions at various levels. The focus for performance outcomes of the health system should be on identified and perceived requirements to address the needs of the population to improve health status. These needs can be identified based on objective information (surveys, HIS, etc) or perceived needs as indicated by government, professionals, and the community.

Obtaining appropriate management and functioning of a structure to deliver health services in PNG is possible through implementation of the PHAA. The Act corrects the current disjointed and dysfunctional structure with respect to roles, responsibilities and authority between the different levels of the health system. It also introduces merit based selection and pay of the senior provincial management. The voluntary nature of the agreement between the Provincial Governor and the NDOH to carry out the Act is conducive to high degrees of ownership and sustainability because it requires negotiations for a partnership agreement in the context of comprehensive multisectoral government wide public administrative reform processes. Supporting provinces

to realise the PHAA with increased resource allocation, both financially and with well trained staff, would seem the obvious next step. Providing support for capacity building to give substance to the spirit of the reforms, in combination with additional resource allocation for service delivery, would fulfil one of the requirements for cost effective and coherent implementation of essential health sector activities. Implementing various approaches separately, or in parallel, would result in outcomes substantially less than can be potentially achieved, the latter being more than sum of the separate variables.

Support to implement the PHAA should be based on costed provincial and district health plans that have been drafted in a participatory manner with all stakeholders including communities. Such plans should:

- present a province with specific analysis of bottlenecks and opportunities to improve service delivery for priority health outcomes
- reflect comprehensive approaches for human resource requirements, infrastructure development, medical supplies provision, equipment, transport, etc.
- provide an analysis and menu of capacity building options at individual, facility and broader institutional level
- complement other allocated resources in a meaningful way
- indicate where and how to comprehensively address the social determinants for health and governance aspects in cooperation with other sectors that affect the health outcomes of the population.

Future support should not seek to build capacity in isolation from strengthening the enabling environment in which skills can be applied within an improved health system. Some aspects to be considered are, for example, to initiate and maintain motivation of staff by providing an appropriate mix of incentives through adequate pay levels, continuous training opportunities, supportive supervision and a career development pathway. Support to the enabling environment should cover appropriate infrastructure, medical supplies, equipment, running costs, etc.

In addition, a functioning referral system to back up health workers in case of complications that surmount his/her abilities is essential. Nothing is more detrimental for the credibility of a public health system in the eyes of the population than not being able to provide assistance in situations which are known to be resolvable.

Financial, geographical and cultural barriers to health services also need to be addressed to enable meaningful interaction of potential clients with the public health system. Intersectoral cooperation needs to be facilitated to tackle causes of ill health that are outside the direct remit of public health authorities.

The Services Improvement Initiative (SII) represents a comprehensive approach for service delivery at the district level. Narrowing the focus for improved health service provision might initially be appropriate when having to consider the availability and allocation of scarce resources. This could be done by focussing on establishing a Continuum of Care (CoC) for Reproductive, Maternal, Newborn and Child Health (RMNCH), including a functioning referral system, which would offer the conduit to address high maternal mortality which is a nationally identified priority. The CoC should enable women to become pregnant when they wish, provide a minimum number of antenatal care controls that result in professionally supervised deliveries, essentially include adequate referral in case of complications, offer postnatal care and child health activities, vaccinations and monitoring of nutritional status. Such a CoC could subsequently become the backbone of a district Primary Health Care system by widening the scope and linking up with disease control programs, non-communicable disease programs, health promotion, etc for comprehensive improved service delivery to obtain better health outcomes of the population.

To establish a CoC is a complicated and challenging endeavour that will require good management skills to build and allocate resources adequately and monitor the achievement of intended health outcomes. Capacity

building of individuals can ensure that the managerial and service delivery skills are present but will need to be accompanied by a broad enabling environment as described above.

Even with significant improvements in the government sector, service provision can only be scaled up by recognising the complementary role of the churches and contracting them to provide services using performance based outcomes. This possibility already exists with the establishment of the Public Private Partnership unit of NDOH. The process should be part of the PHAA implementation and led by the PHA that will have the oversight to set provincial service delivery and outcome targets for both government and nongovernment entities, and to ensure a complementary and coherent approach.

OPTIONS BEYOND CBSC

It is clear to the team that the gravity of the health situation in PNG cannot be addressed by continuation of the present 'silo' approach to supporting the health sector. Concern about deteriorating health indicators is also expressed at the highest political level in Australia. One of the major design weaknesses of the CBSC was that it was not nested in an overall development framework which included service delivery outputs. While the design was considered far sighted at the time, and there were advantages to AusAID continuing use of a managing contractor and 'project mode', it closed down any consideration of realigning over time the overall AusAID support to achieve allocative efficiency.

To aim for a more rational (i.e consistent and comprehensive) approach to AusAID's resource allocation to PNG's health sector, the team believes that a wider debate is now required that sees capacity building within the wider context of overall health sector needs and requirements. This may come through a robust approach by the NDOH to the production of its next 10 year Health Plan, that would seek to identify both the gaps in funding and the gaps in capacity (be they financial, workforce, facility construction, goods and services, or other e.g. transport).

This is not to say that one aspect of AusAID's future support may not be in capacity building, and through TA. Indeed, AusAID may have a comparative advantage over other DPs in this regard. Rather, the team's view is that TA can only be a part of the answer to the problems and challenges faced by the PNG health sector. Likewise, TA is only one way forward to capacity building. If, for example, capacity in the government sector is lacking in some key skill areas e.g. in epidemiology, health economics, it may be more sustainable to build up capacity in a range of PNG's national and provincial institutions e.g. in Institutes of Public Health, Business School, Departments of Economics, than to continue to rely on international consultants, or twinning arrangements with overseas academic institutions. Likewise, placing scarce but highly skilled health professionals at the national level (and away from their clinical practice in the provinces) may also not be the most cost-effective approach to developing national policies, clinical standards and treatment protocols in each and every branch of medicine. Use of proven transferable models or templates, and the use of expert panels may be more appropriate.

These two examples simply serve to illustrate that capacity building is much more than the provision of TA. Outsourcing the activity does not mean, for example, that NDOH has weakened its core function. The message from the team is that if the budget can be freed up to think about an 'a la carte' (pick and choose) rather than a 'table d'hôte' (predetermined) menu to capacity building, then value for money considerations would be better met.

Any consideration of options for the future needs to take into account the expectation of a continued government agenda for change, and to anticipate the on-going health sector specific initiatives and challenges.

The team had limited time available for a wider environmental scanning, but believes that four major factors need to be brought into focus in generating options:

The implications of the May 2009 Health Sector Review

Any future initiatives on capacity building per se, need to be considered against a backcloth of the May 2009 NDOH Report which noted that the health status of Papua New Guineans is reportedly the lowest in the Pacific region and that this profile has not changed significantly in the last decade, with the major reasons for death and morbidity remaining relatively unchanged. Major system constraints are identified in the Department's Review, including: decentralised government challenges; a deteriorating infrastructure; an ageing workforce; a breakdown in getting medical supplies to health facilities; and, a declining funding base (coupled with continued population pressures).

The continuing challenges of Decentralisation

The Organic Law changes that took place in 1996, including the decentralisation of government responsibilities and financing, are alleged to have seriously compromised the functionality of health services. Significant confusion still exists over the precise allocation of responsibilities between national and sub-national tiers of government, and a further key debate remains about the relationship between the provincial and district levels.

The Provincial Health Authority Act

The passage of the PHAA has opened up the prospect of new ways of working that may lead to the ultimate integration of public health and hospital services at all levels (provincial, district, local). Achieving that result will likely require both extensive technical and administrative support and close attention to deep-seated political, social and cultural patterns, for it to become a reality.

Public Sector reform

NDOH has taken significant steps to embrace public sector reform by tackling its own weak performance through a proposed restructuring and reprofiling. That process is ongoing, and is dependent on the willingness of other agencies responsible for finance, planning, and personnel to permit implementation and on the direction of subsequent public sector reform. That all restructuring proposals within government are on hold at the moment, pending conclusions on the future macro-economic environment and the public purse, suggests that time scales for implementation cannot be easily assured.

SUPPORTING OTHER DEVELOPMENT PARTNERS

The number of, and relationship between, DPs in PNG is unusual compared with many other developing countries with similar human development indicators. Australia is by far the largest bilateral donor, reflecting the historical relationship with PNG and the fact that it is a neighbouring country with strategic interests.

In the scoping mission, prior to the evaluation, one of the main questions concerning DPs was how they could work more productively as a group given this imbalance. There was great interest in the subject of the evaluation because all DPs endeavour to build capacity and want to find out how to do so more effectively. WHO was also sufficiently engaged in the issues that it seconded a staff member to the evaluation team and that added considerable value.

Although the intention in the design of CBSC was that DPs would contribute substantially through the SWAp process, the complication of the governance arrangement and the lack of progress towards NDOH managing TA through HSIPMB effectively excluded DPs from decision making. In addition to indentifying a new governance arrangement if CBSC is extended for two years, which would involved DPs, the team believe that it would be appropriate to support DPs to have a greater voice at the table. This can be done by channelling additional funding through DPs so that they can develop their programs and recruit additional staff if

appropriate. In addition to bringing more specialist health expertise into the mix it has the advantage to AusAID of being a low risk, low maintenance option in a context where staff resources are limited.

ANNEXES

ANNEX 1 TERMS OF REFERENCE

Independent Evaluation Report - Capacity Building Service Centre

August 2009

AusAID is undertaking an independent evaluation of the Capacity Building Service Centre (CBSC) in PNG. The CBSC is implemented by JTA International. It is due for completion at the end of July 2010.

The aim of the Independent Evaluation Report (IER) is to:

e) evaluate the effectiveness of the CBSC;
f) enable AusAID and GoPNG to reflect and act on the lessons from the CBSC;
g) inform the design of future assistance to the health sector, and improve AusAID's ability to help GoPNG meet its development challenges in the context of a sector wide approach with development partners; and
h) inform AusAID's Annual Review of Development Effectiveness report, Annual Thematic Performance Reports, Annual Program Performance Reports and Country/regional strategy reviews.

1 Background

1.1 The Governments of Papua New Guinea (GoPNG) and Australia agreed on a sector wide approach (SWAp) for the provision of development assistance to PNG's health sector. The GoPNG, represented by the Department of National Planning and Monitoring (DNPM) and the National Department of Health (NDOH), and the Government of Australia, represented by the Australian Agency for International Development (AusAID) agreed to establish the Capacity Building Service Centre (CBSC) to support the SWAp and the PNG Health Plan 2001-2010.

1.2 The goal of the CBSC is to support the health sector of PNG in order to improve the health of all Papua New Guineans. The purpose of the CBSC is to develop competencies and capabilities at the individual, organisational and system levels in the PNG health sector.

1.3 AusAID contracted JTAI as the Service Centre provider in 2005 for a period of five years. The contract has an upper limit of $70 million. CBSC is located in Port Moresby, but has also provided some assistance at subnational level through advisers working with provinces. It is under direction of the Service Centre Board with representation from NDOH, DNPM, AusAID and JTAI adopting a "partnering approach". The Board agrees to CBSC's priorities and these are put into operation through annual Capacity Building Implementation Plans. CBSC provides capacity building support to the health sector, which includes the provision of technical assistance and other forms of capacity building support.

1.4 In November 2007 the Independent Monitoring Review Group (IMRG) conducted its third review of the health SWAp with a focus on improvements to its governance and operations and a review of technical assistance (TA) provided to the health sector. The review noted that CBSC is the largest contributor of technical assistance in PNG's health sector. And that while CBSC's design is based largely on sound principles, implementation has proven to be difficult. The IMRG identified specific challenges for CBSC including its recruitment and selection processes, 'recycling' of advisors, internal consultation processes, accountability to national and provincial health systems, dependence on the counterpart system, and the partnering arrangement.

1.5 In 2009 Office of Development Effectiveness evaluated AusAID's support to health service delivery in PNG. The evaluation noted that technical assistance accounted for nearly half of AusAID expenditure in the sector. Although it had made positive contributions, the evaluation found that the results were not commensurate with the level of spending devoted to it.

1.6 The CBSC is due to reach completion in July 2010 and there are currently moves within the health sector to re-align the SWAp to reflect GoPNG governance arrangements for service delivery as specified in the Organic Law and a more inclusive arrangement with other stakeholders in health service delivery. Modalities for future capacity building assistance to support health service delivery

are under consideration by the service delivery team in AusAID, led by the Sub National team. This IER is one of several inputs that will contribute to an AusAID strategy for coherent cross-sectoral assistance to support Provincial and District governments deliver improved services. Capacity building assistance to assist the NDOH deliver its responsibilities should be embedded within the overall NDOH-led process of sector reform and development, and within the partnership arrangements related to the SWAP. Lessons learned from the CBSC should inform these reforms.

2 Objectives and Scope of the IER

2.1 The CBSC will be assessed and rated against eight criteria: the five OECD/DAC criteria of relevance, effectiveness, efficiency, impact and sustainability; and the three additional AusAID criteria of monitoring and evaluation, gender equality and analysis and learning. The rating scale used is 1 – 6, with 6 indicating very high quality and 1 indicating very low quality. A rating below 4 indicates that an activity has been rated as less than satisfactory against a criterion. The evaluation team should draw on the attached evaluation questions (appendix A) to rate CBSC against.

2.2 In addition, the evaluation team will address the following issues of particular significance to the CBSC:

a) Assess the impact of the CBSC's operations towards improvements in the ability of the health sector to deliver improved health services, with reference to the Key Result Area 1 (appendix B);
b) Assess the effectiveness of the 'partnering approach' in the design of the program. Did this approach enhance the decision making role of the GoPNG? Was it effective within the SWAp?
c) Assess the models for providing CBSC support at subnational level and comment on effectiveness within PNG's decentralised system of service delivery.
d) Assess the extent to which CBSC has contributed to sustainable capacity within the National Department of Health, and the extent to which NDoH is able to take up functions that have been performed by CBSC-funded staff, including in-line positions and long term advisers, after July 2010. (This includes capacity of the Health Sector Improvement Program Management Branch (HSIPMB);
e) Based on the lessons learnt, provide guidance on the most appropriate method of capacity building at both the national and sub-national level in the context of a SWAp arrangement. Recommend whether AusAID's support to the CBSC model of capacity building support should continue beyond July 2010;
f) Describe any risks associated with the wind-down and closure of CBSC. Provide an assessment of the exit strategy for the CBSC.

3 Process and Approach

3.1 The evaluation will have both review and forward looking components.

3.2 The review aspects of the evaluation will include:

a) A review of relevant documentation (see reading list, Attachment C). There has been a number of assessments and reviews of the CBSC, including independent audits, rapid reviews, and output from the CBSC itself. It is important that the evaluation team is fully aware of all relevant information prior to the mission.
b) In country, the team will hold meetings with AusAID Port Moresby, counterpart and stakeholder agencies and staff and management of the CBSC. The team should use this occasion to investigate key evaluation issues related to CBSC's functions, management approach, KRAs, and identify issues for further investigation;
c) Meet with PNG counterparts in the Sector including DNPM, NDOH and the MSIP Management Branch to discuss the purpose of the IER and gather additional information to report on the CBSC's objectives, impact and sustainability. Given the need to assess at subnational levels field visits will be required;

3.3 The forward looking component will include:

a) Consultation with AusAID, health SWAp representatives, DNPM representatives, NDOH representatives and development partners. The discussion should focus on the impact of CBSC, capacity building and TA on sector performance development, and recommendations to feed into future SWAp planning;

3.4 Present an aide memoire at the end of the mission to DNPM, NDOH, PNG Post and key stakeholders;

3.5 Present a seminar/workshop in AusAID, Canberra at a date and venue to be advised by AusAID.

4 IER team composition

4.1 The IER will be undertaken by a principal evaluation team of two experts consisting of a monitoring and evaluation (M&E) specialist and a health specialist. The team will be led by the M&E specialist.

4.2 Two representatives from PNG will join the evaluation mission, one from the national level of NDOH or DNPM, and one from the provincial level. The team will also be accompanied by a Canberra based officer from AusAID's PNG program who will provide support and policy advice to the team.

5 Roles and Responsibilities of the IER team

5.1 An M&E specialist will be the team leader and will be responsible for managing, compiling and editing inputs from the other team members to ensure the quality of reporting outputs. The team leader will also be responsible for the overall management and direction of the evaluation's activities, representing the evaluation team and leading consultations with government officials and other donor agencies.

5.2 A health specialist from a partner donor such as UNDP or World Health Organisation will work as team member under the overall supervision of the team leader.

5.3 One representative from a provincial government health department will work as team member under the overall supervision of the team leader.

5.4 One representative from the national level of the NDOH will work as team member under the overall supervision of the team leader.

5.5 The evaluation team will work under the management of the Evaluation Officer, Program Quality and Review Section, AusAID Canberra.

6 Specification of the Team

6.1 The external review team will consist of two persons who will have the following skills and experience between them:

a) Experienced in programme design and evaluation with extensive experience in evaluating international health programs;
b) Knowledge of program based approaches, including sector wide approaches, in the health sector is essential;
c) Experience of working in a SWAP with multiple stakeholders, including the PNG SWAp, is desirable
d) Understanding of the health development context in the Asia Pacific, including PNG;
e) Sound knowledge of health systems, capacity development approaches and effective approaches for supporting health service delivery in a developing country context;
f) Experience of working with AusAID and knowledge of AusAID evaluation processes is desirable;
g) Good communication skills, and the capacity to prepare succinct and well structured reports;
h) Familiarity with cross-cutting issues including gender.

7 Duration

The evaluation is estimated to take 31 days of the team leader's time and 17 days of the health specialist's time. The research will require the IER team members to be in PNG for 12 days. Including the feedback from AusAID, the evaluation will take nine weeks.

Task	Location	Input (days)	
		Team leader	Health specialist
Document review	**Home office**	**4**	**2**
Draft methodology	**Home office**	**1**	
AusAID Briefing. Consultations with the Evaluation Officer, Program Quality and Review Section; Health Adviser, HHTG; PNG Program	**Canberra**	**2 (+ travel)**	
Evaluation mission – includes preparation and presentation of aide memoire	**PNG**	**12 (+ travel)**	**12**
Draft report	**Home office**	**7**	**3**
Feedback from AusAID		**(15)**	
Participate and present at peer review	**Canberra**	**2 (+ travel time)**	
Final report	**Home office**	**3**	
TOTAL DAYS		**31**	**17**

8 Output

The evaluation team shall submit the following outputs:

a) a draft methodology for agreement by AusAID prior to commencement;
b) an aide memoire at completion of the mission prior to leaving PNG;
c) a draft report for consideration by AusAID within seven working days of completion of the field study to PNG to the Evaluation Officer, Performance Quality and Review Section, AusAID Canberra. Feedback from AusAID will be provided within three weeks of receiving the draft report, followed by a peer review at which the team leader will present their findings; and
d) a final report for endorsement by AusAID, DNPM and NDOH three days after the peer review.
e) The evaluation team will prepare a report of 25 pages maximum of text in accordance with AusAID's Guidelines for IER reporting. The structure of reporting should be based on AusAID's Guidelines for IER reporting as stipulated in AusAID's 'Rules and Tools' for the 'Completion and Evaluation of an Aid Activity'. (Guidance documentation to support the preparation of the IER will be provided by AusAID). Lessons and recommendations should be clearly documented in the report.

Appendix A Questions for an Independent Completion Report

Relevance

- Were the objectives relevant to Australian Government and partner government priorities?
- Were the objectives relevant to the context/needs of beneficiaries?
- If not, what changes should have been made to the activity or its objectives to ensure continued relevance?

Effectiveness

- Were the objectives achieved? If not, why?
- To what extent did the activity contribute to achievement of objectives?

Efficiency

- Did the implementation of the activity make effective use of time and resources to achieve the outcomes?
  Sub-questions:
  - Was the activity designed for optimal value for money?
  - Have there been any financial variations to the activity? If so, was value for money considered in making these amendments?
  - Has management of the activity been responsive to changing needs?
  - Did the activity suffer from delays in implementation? If so, why and what was done about it?
  - Did the activity have sufficient and appropriate staffing resources?
- Was a risk management approach applied to management of the activity (including anti-corruption)?
- What were the risks to achievement of objectives? Were the risks managed appropriately?

Impact (if feasible)

- Did the activity produce intended or unintended changes in the lives of beneficiaries and their environment, directly or indirectly?
- Were there positive or negative impacts from external factors?

Sustainability

- Do beneficiaries and/or partner country stakeholders have sufficient ownership, capacity and resources to maintain the activity outcomes after Australian Government funding has ceased?
- Are there any areas of the activity that are clearly not sustainable? What lessons can be learned from this?

Gender Equality

- What were the outcomes of the activity for women and men, boys and girls?
- Did the activity promote equal participation and benefits for women and men, boys and girls?

Sub-questions:

- Did the activity promote more equal access by women and men to the benefits of the activity, and more broadly to resources, services and skills?

- Did the activity promote equality of decision-making between women and men?
- Did the initiative help to promote women's rights?
- Did the initiative help to develop capacity (donors, partner government, civil society, etc) to understand and promote gender equality?

Monitoring and Evaluation

– Does evidence exist to show that objectives have been achieved?
– Were there features of the M&E system that represented good practice and improved the quality of the evidence available?
– Was data gender-disaggregated to measure the outcomes of the activity on men, women, boys and girls?
– Did the M&E system collect useful information on cross-cutting issues?

Analysis & Learning

– How well was the design based on previous learning and analysis?
– How well was learning from implementation and previous reviews (self-assessment and independent) integrated into the activity?

Lessons

– What lessons from the activity can be applied to (select as appropriate: further implementation/designing the next phase of the activity/applying thematic practices [i.e. working in partner systems/environment/fragile stages] to the rest of the program/designing future activities).

Appendix B Key Result Areas (KRAs) for the Program

KRA 1: To increase the capacity of the health sector to deliver quality health services to the people of PNG. The specific statements setting out what CBSC program activity is expected to achieve follow:
- Systems to support increased coordination between provincial hospitals and provincial health services strengthened
- Improved capacity of GoPNG health authorities to implement priority health programs
- Sustainable networks are developed in the health sector that enable capacity development consistent with the Strategic Directions
- Strengthened capacity of GoPNG health authorities to provide and support quality health services
- Improve the strategic decision making capacity of GoPNG health authorities
- Improved capacity of the health sector to manage resources for health services according to national standards (including Finance Management act, General Orders, Health Sector HR policy, HSIP procedures manuals)

Appendix C

- PNG-Australia Partnership for Development (available from the internet)
- The original CBSC design document
- The most recent contract and scope of service between AusAID and CBSC
- *Working Paper 1: Papua New Guinea Country Report,* June 2009, AusAID ODE
- Contractor Performance Audit of the PNG CBSC – Final Audit Report. January 2009
- Desk Review – CBSC
- Rapid Review – CBSC, October 2008
- Papua New Guinea Independent Monitoring Review Group (Health) Report no. 3 Review of the Sector-Wide Approach and Technical Assistance November 2007
- Papua New Guinea Independent Monitoring Review Group (Health) Report No. 6
- Health service delivery costing - PNG /Australia Partnership for Development schedules, May 2009
- the Sub-National Strategy terms of reference
- P4D costing table outlining service delivery responsibilities under the Organic Law

ANNEX 2 EVALUATION PLAN

This Evaluation Plan is presented in two parts. Part 1 is that presented to Stakeholders in Port Moresby following a Scoping Mission by the Team Leader and John Francis of AusAID. Part 2 contains details of the methodology and issues as actually undertaken with the full team during the Fieldwork component of the Evaluation

1: EVALUATION PLAN FOR CBSC AS PRESENTED TO STAKEHOLDERS ON 24 AUGUST 2009

Introduction
This document is an evaluation plan for the Capacity Building Service Centre (CBSC). It has been developed in Port Moresby through consultation with the three partners (GoPNG, AusAID, JTAI) and Development Partners (ADB, UNCIEF, UNFPA). It aims to build commitment to the evaluation processes and to utilisation of the evaluation findings by ensuring that key stakeholders have a common understanding of what the evaluation hopes to achieve and the products it will deliver.

Evaluand
The object of the study is the CBSC. It is a standalone project agreed between the Governments of Australia and Papua New Guinea (GoPNG), which was designed within the overall framework of the Health Sector Improvement Program (HSIP/SWAp) and in support of the GoPNG Health Plan 2001-2010. It commenced in mid 2005 for a five year period. It is governed by a Charter which defines a partnership approach between three parties: AusAID; GoPNG represented by the Department of National Planning and Management (DNPM) and the National Department of Health (NDOH); and JTA International Pty Ltd (JTAI) as the management contractor.

The *goal* of CBSC is to support the health sector of PNG in order to improve the health of all Papua New Guineans.
The *purpose* of CBSC is to develop competencies and capabilities at the individual, organisational and system levels in the health sector.

Decisions need to be made about the future of the CBSC which is due to reach completion in July 2010. The evaluation is taking place after four years in order to provide information to inform decision making about the future. The context is one in which GoPNG is developing a New National Health Plan and AusAID is developing a new strategy for assistance in the health sector.

Purpose and Orientation
The TOR for the evaluation state that it aims to fulfil several purposes:

i) evaluate the effectiveness of the CBSC
j) enable AusAID and GoPNG to reflect and act on the lessons from the CBSC
k) inform the design of future assistance to the health sector, and improve AusAID's ability to help GoPNG meet its development challenges in the context of a sector wide approach with development partners
l) inform AusAID's Annual Review of Development Effectiveness report, Annual Thematic Performance Reports, Annual Program Performance Reports and Country/regional strategy reviews.

These purposes contain elements of an *Impact* orientation in that they require a summative review of the period 2005-2009 oriented to learning and accountability. However, impact evaluations are usually undertaken after a project is complete and are most rigorous where there is both a baseline and a counterfactual (what would have happened without the project). In this case the impact question which would need to be answered would be a cause and effect one - has capacity in the health sector increased as a result of CBSC?. The evaluation cannot answer this question because four years is too short a period in which to evaluate a subject which is acknowledged to require a long term approach.

Therefore, the evaluation will mainly use the *Interactive (or participatory)* form which is oriented to program improvement. This form is suited to a program in development, which is effectively the case as capacity building will continue to be an objective of all development partners even if the modality for supporting it changes. The interactive form recognises the importance of evaluation being undertaken by those close to the intervention and is appropriate in this evaluation which has a mixed team of independent consultants and GoPNG and AusAID officials.

Client and Audiences

The client is AusAID. Primary audiences are the partners in the Charter and Development Partners in the SWAp. These audiences have different needs in relationship to the evaluation as shown in the following table

Primary Audiences	What they would like to know from the evaluation
GoPNG	
NDOH Management	Where has CBSC fallen short of expectations? What exactly do we mean by strengthening systems? What will happen if it ends?
DNPM Management	What exactly is CBSC supposed to do? How does it link to the SWAp? How can it assist governance at the provincial level?
AusAID	
Health Team – PNG	Which capacity building approaches work best in a SWAp? Should support to the CBSC model be continued? How can development partners be more involved?
Sub national Team – PNG	What capacity building approaches have worked at subnational level?
Program & Quality Review - Canberra	How does CBSC rate on the criteria of relevance, effectiveness, efficiency, impact and sustainability, gender equality, analysis and learning, and monitoring and evaluation
Development Partners	
Development partners	Has capacity been developed in a sustainable way? Has there been too much reliance on external TA? How can smaller DPs work with AusAID in a more integrated way?
The Contractor	
JTA International	How should we address in-line issues? Was it realistic to expect Government to manage CBSC?

Evaluation Focus

CBSC is a complex project aiming to address a complex issue. In a context of limited time resources, and with an objective of learning, it is more appropriate to focus on fewer areas so that the issues can be explored in more depth. After consultation, the focus areas which will most effectively meet the needs of all stakeholders are:

- the effectiveness of different approaches used in capacity building
- the ways in which CBSC has or has not supported the use of government systems and processes at national and subnational level
- what next – building on what seems to be working or a fundamental re-think about the way we approach capacity issues?

Key Evaluation Questions

1. To what extent did CBSC achieve its purpose of increasing the capacity of the health sector to deliver quality health services?
    - what models of capacity building have been used?
    - has 'responsiveness' supported strategic capacity development?
    - how has CBSC approached:
        - advisory compared with in-line positions?

- clinical compared with administrative interventions?
- the balance between international and Papua New Guinean TA?

2. To what extent has CBSC supported the SWAp?
   - what processes have been used to set priorities?
   - how have government systems been supported at subnational levels?
   - how has the concept of partnership evolved?

3. How can capacity development be supported in future?
   - what does successful capacity development look like?
   - is CBSC an appropriate model to build upon?
   - if yes, what changes would improve it?
   - if no, what are the risks of discontinuing?

Data Management

Key Question	Data Collection Instrument
1. To what extent did CBSC achieve its purpose of increasing the capacity of the health sector to deliver quality health services?	*Document review* Annual Reviews, Board Quarterly Reports, Briefs, Analyses, Storybook, M&E reports, Audit Report, AusAID Capacity Building Documents, GoPNG Health Plan *Interviews* • advisors in in-line and advisory roles, international and national • counterparts, teams, managers, associated government officials *Case studies* Successful and unsuccessful interventions (possibly including hospitals)
2. To what extent has CBSC supported the SWAp?	*Document review* Board Reports, Management Group Minutes, IMRG Report, AusAID partnership documents, ODE Review, plus others as above *Interviews* • GoPNG officials of: HSIPMB; Central Agencies, DPLGA • NDOH officials at central, province and district levels • advisors and in-line TA • AusAID officials where appropriate • CBSC staff *Case Studies* as above
3. How can capacity development be supported in future?	*Interviews* • individual with NDOH, AusAID and JTA staff • group with MAG and available Board members

Data Analysis

Preliminary analysis will be done by each team member familiarising themselves with available documents in accordance with their specific role on the team prior to the team convening.

During fieldwork data will be analysed daily through a process of daily reflection and progressive focusing. Initially data will be gathered widely and this will be systematically focused so that data collection narrows over time. After each interview analysis will take place so that questions for the next are informed by what has been discovered previously.

After fieldwork is complete the team will systematically analyse both fieldwork and documentary evidence in order to answer the key questions. These will be tested, if possible, with a specially convened Expert Reference Group in Port Moresby.

Team Composition

At the end of the Scoping Mission the confirmed team members were:

Sue Emmott	Team Leader and Capacity Development (Independent Consultant)
Paul Weelen	Health Systems (Independent – from WHO)
Igo Gari	Government Systems (NDPM Evaluation Department)

NDOH and AusAID will confirm additional members

Timeline

Date (2009)	Where	Who	What
10-13 Aug	Home	Team Leader (SE)	Draft Evaluation Plan preparation for Scoping Mission
14 Aug	Sydney	SE, Patricia Lyon, Peter Lindenmayer	Briefing and input into draft Evaluation Plan
16-21 Aug	Port Moresby	SE, John Francis Stakeholders	Stakeholders input to Evaluation Plan and presentation of final draft for feedback
24 Aug	Auckland	Team Leader	Finalisation of Plan and submission to AusAID
28 Sept to 9 Oct (tbc)	Port Moresby and provinces	Team	Evaluation fieldwork Presentation of preliminary findings and conclusions Preparation of Aide Memoire
21 Oct (tbc)	Home	Team Leader Team members	Compile and submit first draft of report
22 Oct - 13 Nov (tbc)		Stakeholders	Feedback on First Draft
20 Nov (tbc)		Team Leader	Finalisation of Report

Dissemination

Dissemination will be through a range of approaches intended to provide the maximum amount of information in the most timely manner and in a way which recognises the time pressures of stakeholders. The following are suggestions:

- workshop with an Expert Reference Group - to be nominated by NDOH and DPLGA and including academics in order to get expert comment on the conclusions and recommendations and options for the future
- presentation and in depth discussion with the Board (if feasible)
- debriefing meeting for all stakeholders at the end of fieldwork to present preliminary findings, conclusions and recommendations and get input to the first draft
- distribution of the written report
- presentation at the November Summit if requested
- production of one-pagers on selected issues of interest if requested

Codes of Behaviour/Ethical Considerations

The review will be conducted in line with DAC Evaluation Quality Standards and AusAID Performance Assessment and Evaluation Policy. There are no specific ethical issues anticipated in this evaluation.

PART 2: SUPPLEMENT TO THE EVALUATION PLAN COMPLETED DURING AND AFTER THE FIELDWORK PERIOD

Key Evaluation Questions

The key evaluation questions were reviewed periodically during fieldwork, and checked against the TOR in order to determine their ongoing relevance. All sub-questions have been addressed in the evaluation report

although some proved to more significant than others. Under Q1 - the extent to which CBSC has achieved its purpose - the sub-questions on which capacity building models have been used, and the in-line/advisory, clinical/ administrative, international/national TA , were not significant issues for any of those interviewed. Answers to those questions therefore appear at various points in the report rather than as separate sections. On Q2 – the extent to which CBSC has supported the SWAp – the sub-questions were found to relate more to Q1 and have been answered in that context.

Data Management

Excellent case study material was produced or facilitated by CBSC staff. This has all been considered and taken account of in the report. However, for reasons of time and space they do not appear as identifiable case studies but in references to support to the PHAA, radio network, the role of Policy Officers, and support to the Global Fund.

Data Analysis

In the absence of a current logframe, program logic or theory of change, the team devised criteria for analysis of the two main questions. The criteria for Q1 were drawn from the original logframe and from guiding principles contained in the Design Document. These are included in full as an Annex at the end of this Plan. The criteria for Q2 were based on characteristics of health SWAps globally and the response to the question is structured accordingly in the report.

Timeline

In order to incorporate the proposed Expert Reference Group the period in Port Moresby was extended by 3 days. In the end the Expert Group did not eventuate, partly because this period was extremely busy for NDOH and partly because such a group is unprecedented and it proved difficult to explain what its purpose was, requiring preparation of briefing materials which would have distracted the evaluation team from its main purpose. However, the additional time was invaluable for the team. In order to do justice to the provincial support of CBSC, three team members spent most of their time in the provinces. The additional days ensured that findings could be shared and analysed in the necessary depth.

Team Membership

Sue Emmott (Team Leader) and Paul Weelen (WHO Cambodia) were the only original team members. The composition changed as follows:

Ken Lee became a third international member on the team
William Kewa replaced Igo Gari, representing DNPM
Sarah Leslie replaced John Francis, representing AusAID Program Quality and Review, PNG Branch (Canberra)
NDOH was unable to identify a representative to join the team at that very busy time. However, the Secretary ensured that the evaluation team was able to meet each member of the SEM individually and all other relevant staff, demonstrating strong commitment to the evaluation process.

Limitations to the Evaluation

Absence of Program Logic

Evaluation of any program which does not have either a logframe, an explicit program logic or even an implicit theory of change (ToC) is very difficult. The evaluator has the choice of seeking to construct a ToC with the program stakeholders and this was considered during the scoping mission. However, the root problem is that the design was not explicit about how the inputs (predominantly TA) would result in the intermediate outcome of improved service delivery. The closest the evaluation could come to a program logic is specified in the annex but this does not go far enough to use as criteria for success. Effectively there is a 'black box' between the inputs and the expected outcomes and this has been one of the main challenges for CBSC in explaining what it is about. During the scoping mission and document review it became clear that concerted attempts have been made by CBSC to provide a ToC for the purposes of M&E. This has been only partially successful so the

evaluator concluded that the evaluation team could not improve on it and devised other success criteria as indicated in the section on Data Analysis and detailed in the Annex.

Time and choice of field visit locations

The time allowed for the fieldwork component of the evaluation was insufficient to do justice to the work of CBSC in the provinces. Although the team split in order to cover as many activities as possible – with two members covering national level inputs from Port Moresby and three members visiting the provinces - the time allowed was insufficient to plan to visit more than four provinces. This affected the criteria for selection of provinces and meant that it could not be random because of flight schedules. In addition, the criteria had to include availability of people to interview who had experience of CBSC which meant that, in some cases, assessment of current activities was more straightforward than past ones. Those interviewed with longer experience did not distinguish between HSSP (which preceded CBSC) and CBSC itself especially where the same adviser was novated over. Further complicating analysis of the interview evidence was that some interviews were very short, during stopovers in flights for example, or in an airport lounge.

The provinces selected were Sandaun, East Sepik and Western Highlands. Central was also scheduled, specifically to look at the effect of the Service Improvement Initiative, but unfortunately this was cancelled by the provincial administration because there were three other AusAID missions at the same time. The PHA, who had been keen to participate in the evaluation was unable to influence this decision. In addition the team was able to meet some stakeholders and the new adviser in Madang during a stopover. Although some very rich data was gathered systematically in the three provinces and opportunistically in other cases, and every attempt has been made by the team not to infer generalisability, the reader should also be cautious in drawing his or her own conclusions.

Maintaining focus

The timing of the evaluation was about eight months before the scheduled completion of CBSC. It was planned to inform the new AusAID Health Strategy for PNG, which was in process at the same time, and necessary because there had been no formal midterm review. At the same time AusAID was undertaking a major study of options for the Subnational Strategy (SNS). This led, from the evaluator's perspective, to a tendency to merge purposes which would have been better addressed through different processes.

Reflections on the Evaluation

In retrospect it might have been advisable, prior to the commissioning of the evaluation, to undertake an evaluability assessment. The primary purposes of such an assessment are:

- to refine program logic by seeking to explicate the underlying cause and effect relationships. This helps to establish indicators as evidence for determining whether intended or unintended outcomes are achieved

- understand the perceptions of stakeholders of what the program is meant to achieve, their concerns about program progress and interest in evaluation information.

To some extent the second of those purposes was intended during the scoping mission. That mission had not been planned but had resulted because getting the full team together at an earlier time proved impossible and AusAID wanted to get the process underway. But it had great advantage in giving stakeholders an opportunity to input. In particular the DPs appreciated the opportunity and became more engaged in the process as a result. For NDOH it raised the profile of the evaluation and engaged them in what had previously been instigated and seen as an AusAID-led process. It may also, by virtue of stated independence and a commitment to a process which was 'fair' have lessened the considerable anxiety about the potential closure of CBSC within NDOH and CBSC itself.

AusAID might consider seeking specific feedback from partners and stakeholders about this process.

ANNEX: FRAMEWORK FOR EVALUATING Q1: THE EXTENT TO WHICH CBSC ACHIEVED ITS PURPOSE

Theory of Change (or Program Logic)
Evaluation is difficult because there is no explicit Theory of Change. The closest logic we have can be drawn from some of the guiding principles in the Design Document:

- A problem exists, the extent of the problem is largely known, and the causes understood;
- The problem is affecting the efficient and effective use of public resources and/or the delivery of services;
- GoPNG does not have the internal resources to bring about change;
- The agency is committed to change and is constrained by lack of knowledge and/or skills;
- The problem is amenable to solution by the use of external inputs;
- **The most appropriate external input is use of a technical assistance adviser**

Assumptions indentified in the Logframe which we can assess:

Level	Purpose/Objective	Assumptions
Purpose level	To develop the competencies and capabilities of individuals, groups and agencies in the health sector.	Factors beyond the health sector do not undermine the ability of improved health sector capacities to bring about improved health service functioning
Component 1	Appropriate TA framework	GoPNG health sector agencies have the capacity to engage in technical assistance processes
Component 2	Appropriate recruitment and management	Quality advisers are available in the market place and can be attracted to work in PNG including new players and women Agencies willing to accept shared responsibility for performance assessment GoPNG obtains budget to absorb in line positions
Component 3	High quality capacity building	Lack of capacity building is a key reason for lack of competent health sector staff Learning can be directed back into planning and management systems A climate is created that allows examination of success and failure in capacity building in the PNG context
Component 4	Effective CBSC management	Accountability demands will not overburden Contractor or undermine the learning approach of this activity

SUCCESS CRITERIA - TO WHAT EXTENT DID CBSC ACHIEVE .....
A qualitative shift in way advisers and partners work • persistent and uncompromising emphasis on 'developing competencies and capabilities of individuals, groups and agencies in the health sector which will lead to sustained and self generating performance improvement' • using GoPNG systems (principally HSIP) in order to (i) operate as their partners do; and (ii) act as one internal pressure for GoPNG systems to work by not creating alternative systems
Intended Scope The majority of advisers to NDOH branches and provinces but with benefit to hospitals, church health services, NGOs, CBOs.
Was it led by the guiding principles: • TA will support and arise out of the requirements of the National Health Plan or Annual Activity Plans. • All TA activities and costs will be included in the HSIP and budget, and reflected in the annual sector budgets. • GoPNG, in consultation with development partners, will define technical assistance priorities of the heath sector. • NDOH will move towards establishing capacity for managing technical assistance

• A joint review of progress in the areas supported by TA will be carried out annually.
Governance • CBSC established using a Partnership Approach (Board and Management Advisory Group) which provides a flexible and responsive way of jointly establishing: objectives; management, co-ordination and reporting arrangements; and performance measurement of all parties at all levels • CBSC will eventually report to HSIPMB and help build its capacity over time to plan and manage TA • Integration into GoPNG and DP planning and monitoring cycles.
Management • Source, manage and support national and international advisers who have credible technical qualifications and skills, excellent interpersonal skills, a strong commitment to and skills in capacity building, and an interest in the development of PNG
Learning • CBSC leads the way in developing and synthesising knowledge, skills, methodologies and techniques on capacity building
M&E • M&E framework places capacity building as the key achievement to be measured, not policies written, outputs etc. • Joint review of progress carried out annually and MTR • Use existing data collection systems as far as possible – high level impact indicators of National Health Plan and Performance Monitoring Framework • Independent assessment through the IMRG

ANNEX 3 PEOPLE INTERVIEWED

Name	*Position and Organisation*
	PORT MORESBY
National Department of Health	
Dr Clement Malau	*Secretary, NDOH*
Mark Mauludu, LM	*Deputy Secretary, National Health Policy & Corporate Services Division, NDOH*
Dr Paison Dakulala	*Deputy Secretary, National Health Services Standards, NDOH*
Elizabeth M. Gumbaketi	*Executive Manager, Strategic Policy, NDOH*
Dr Goa Tau	*Executive Manager, Medical Standards Division, NDOH*
Enoch Posanai	*Executive Manager, Public Health, NDOH*
Paul Dopsie	*Executive Manager, Corporate Services, NDOH*
Hinabokiole Kama	*Policy Officer, NDOH*
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Susan Ferguson	*Gender Advisor, AusAID*
Jim Tulloch	*Principal Health Advisor, AusAID, Canberra*
Beth Slatyer	*Health Advisor, AusAID, Canberra*
Anne Malcolm	*Program Director, HIV/AIDS, AusAID*
Richard Slattery	*SNS Program, AusAID*
JTAI Capacity Building Service Centre	
Jane Thomason	*Chief Executive Officer, JTA International*
Roger Butterick	*Provincial Coordination Advisor, CBSC*
Kellie Woiwod	*Reporting and Monitoring Manager, CBSC*
Moses Angasa	*Project Coordinator, Program Monitoring and Evaluation, CBSC*
Pascoe Kase	*Long Term Advisor for Provincial Health Authorities, CBSC*
Rob Akers	*Facility and Service Design Advisor, CBSC*
Lucas Michael *Joe Demas*	*RWG Team Leader and HR Advisor, CBSC* *Health Development Advisor, CBSC*
Dr Lahui Geita *Julienne Omaro*	*Technical Maternal Advisor, CBSC* *Safe Motherhood Programme Officer, CBSC*
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Ben Day *Tony Keissler* *Kate Lollback*	*Policy Officer, Deputy Secretary NHP &CS, CBSC* *Policy Officer, Deputy Secretary (NHSS), CBSC* *Policy Officer to Executive Manager, Corporate Services, CBSC*
Hitolo R. Moka *Dieselo Bigilale*	*Finance Program Officer, CBSC* *Senior Contract Administrator, HSIPMB, CBSC*
Peter Bire	*Health Reform Associate, CBSC*
Pauline Kenna	*Gender Violence Program Officer, CBSC*
Anna Maalsen	*Disease Control Project Manager, CBSC*
Stephen Groves	*Radio Advisor, CBSC*

Dr. Greg Law	*Sexual Health Advisor, CBSC*
Development Partners	
Asger Rhyl *Dr. Gilbert Hiawalyer* *Dr Eigil Sorensen* *Dr Andre Ernst Reiffer* *Bertrand Desmoulins* *Thazin Oo*	*Country Representative, UNFPA* *Assistant Representative, UNFPA* *Country Representative, WHO* *Senior Programme Management Officer, WHO* *Head Representative, UNICEF* *Deputy Representative, UNICEF*
Pati Gagau	*Manager, NZAID*
Jeremy Syme	*Project Manager, ADB*
Churches Medical Council	
Joseph Sika	*Executive Secretary, Churches Medical Council*
PROVINCES	
Madang Province (stopover)	
Wayne Murray	*Provincial Health Capacity Building Adviser*
Paul Mabang *Arthur Walgon* *Martha Tadoan* *Galug Sual* *Christine Gawi*	*a/Ass Dir Health* *a/Ass Dir Health* *a/Health Information Officer* *a/HRM* *a/CEO Modilou Hospital*
Sandaun Province	
Lou Badui	*District Administrator*
Gibson Benjamin	*District Health Manager*
Brett Kirkwood	*Provincial Health Capacity Building Adviser*
Albinus Latosi *Danny Waiet* *Dennis Momipa* *Benjamin Yinil*	*CBSC Project Officer* *Provincial Health Information Officer* *Non attached Officer* *Water Supply Officer and Global Fund Coordinator*
Douglas Apeng	*Provincial Health Planner*
Anna Diaku *Joanne Yawi* *Esther Afaar*	*In Service Training Officer* *Health Promotion Officer* *Administrator HSIP*
Joseph Sungi	*Provincial Administrator*
Elias Kapavori *Adrian Lohumbo* *Deli Wangama*	*a/CEO Vanimo General Hospital* *a/District Finance Asst* *a/Director Nursing Services*
Daleya Dibili *Thalia Wat*	*CBSC Program Officers (based in Port Moresby)*
East Sepik Province	
Ted Jones	*Finance and Audit Adviser*
Albert Bunat	*Provincial Health Adviser*
Mark Nagaki *Anton Kafur*	*Environmental Health Officer* *Project Officer (HSIP and Global Fund)*
Sr Alependava *Mark Kapundu* *Conrad Kambi*	*Family Health Coordinator* *Health Promotion Officer* *Disease Control Officer*
Dr Lousi Semiak *Sr Veronica Wunum* *Francis Numburu* *Gerard Somoso* *Thomas Mave*	*CEO Boram General Hospital* *D/Dir Nursing Services* *Facility Manager* *Medical Records* *Medical Records*
Maprik District	
Kenny Masalan *Michael Tamakain*	*District Health Manager* *Hospital Secretary*

Rondy Ktumasi *Raymond Pohonai*	*Sister in Charge, Labour Ward* *District Family Health Services Coordinator*
Brugam District	
Nickson Semblab	*Church Health Services Secretary (Evangelical Church)*
Western Highlands Province	
Freda Pyano *Mufi Korowa* *Glenda Kondie*	*Human Resources and Finance Officer* *District PHS* *Health Promotion Coordinator*
James Kintwa *Sr Regina Koi* *Michael Dokup*	*CEO Mt Hagen Hospital* *Dir Nursing Services* *Dir Medical Services*
N Whagi District	
Jenny Waiep	*District Health Officer*
Head Teacher	*N Whagi Health Promoting School*

ANNEX 4 DOCUMENTS REVIEWED

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