Human Development Monitoring and Evaluation Service

MID-TERM REVIEW

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REPORT PREPARED BY:
Rebecca King, Senior Consultant – Alinea International

Cover Image: Raggiana Bird-of-Paradise, Niall D Perrins, Varirata National Park

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EXECUTIVE SUMMARY

The Human Development Monitoring and Evaluation Services (HDMES), established in 2019, was designed to provide independent monitoring, evaluation, and learning (MEL) support to DFAT's Health and Education investments in Papua New Guinea. Managed by Adam Smith International (ASI) in partnership with Clear Horizon, HDMES has delivered over 300 products in 6 years, including evaluations, quality assurance, capacity-building initiatives, and communication materials. Its core aim is to enable evidence-based programming and improve reporting on Australian aid effectiveness.

HDMES's demand-driven model offered flexibility and technical expertise which was particularly useful during the Covid-19 pandemic, but has also led to reactive, fragmented engagement and missed opportunities for portfolio-level learning. While contributing to program improvements—particularly in the health sector—HDMES's effectiveness has been constrained by inconsistent product quality, uneven understanding of the local context, staffing turnover, and administrative inefficiencies. The 2022 remediation plan addressed several performance issues, though some challenges persist in product quality and utility, ambiguity in mandate and scope, administrative and tasking burden, staffing turnover and renumeration constraints and variable engagement from DFAT.

GEDSI integration has seen uneven progress. Tools like the GEDSI Toolkit and capacity-building workshops added value but were inconsistently applied and underutilised, with limited sustained influence on program practices. HDMES's safeguarding measures aligned well with DFAT standards but similarly lacked systematic tracking of impact.

Efficiency has been mixed. While the hybrid delivery model provided operational agility, high administrative burden, contract rigidity, and consultant recruitment challenges limited cost-effectiveness and timeliness at times. Budget execution has generally been strong in Health but variable in Education.

The review recommends that DFAT shift from a reactive, task-based model to a proactive, portfolio-level MEL facility that prioritises learning, adaptive management, and local capacity development. Options for the future include retaining the current model, transitioning to a proactive MEL facility, or internalising MEL functions within DFAT.

Recommendations

Medium priority – plan and stage
High priority – urgent action required

Area	Recommendation	Responsible	Priority
Relevance	Develop and implement a proactive, portfolio-level MEL strategy with clear learning objectives.	DFAT	High
Effectiveness	Establish a formal recommendation tracking system to monitor and support the uptake of evaluation findings.	HDMES	High
Effectiveness	Strengthen portfolio learning through synthesis reports, learning reviews, and joint reflection workshops.	DFAT / HDMES	High
Efficiency	Optimise hybrid delivery by increasing in-country presence and strengthening local MEL capacity.	DFAT / ASI / HDMES	Medium
Efficiency	Streamline administrative processes, tasking, and QA through standardised tools and clearer templates.	DFAT / ASI / HDMES	High
Efficiency	Explore ARF flexibility or alternative contracting to improve recruitment of high-calibre consultants.	DFAT / ASI	Medium

Area	Recommendation	Responsible	Priority
GEDSI	Develop a structured and approved GEDSI Toolkit implementation plan focused on practical integration and uptake monitoring.	HDMES / DFAT	Medium
Governance	Re-establish a formal partnership governance mechanism between DFAT and ASI.	DFAT / ASI	High
Governance	Clarify HDMES's mandate and scope, including design and research roles.	DFAT	High

ABBREVIATIONS

AHC	Australian High Commission
AIHSS	Accelerated Immunisation and Health Systems Strengthening Program
ARF	Adviser Remuneration Framework
ASI	Adam Smith International
CBA	Cost-Benefit Analysis
DFAT	Department of Foreign Affairs and Trade
ELP	Education and Leadership Program
EOIO	End-of-Investment Outcome
FIMR	Final Independent Monitoring Report
GEDSI	Gender Equality, Disability and Social Inclusion
GoPNG	Government of Papua New Guinea
HDMES	Human Development Monitoring and Evaluation Services
HSIP	Health Sector Improvement Program
HSSDP	Health Systems Strengthening and Delivery Program
IMR	Independent Monitoring Report
IP	Implementing Partner
M&E	Monitoring and Evaluation
MEL	Monitoring, Evaluation, and Learning
MEF	Monitoring and Evaluation Framework
MTR	Mid-Term Review
OPD	Organisation of Persons with Disabilities
PATH	PNG-Australia Transition to Health
PIE	Partnership for Improving Education
PNG	Papua New Guinea
PSEAH	Preventing Sexual Exploitation, Abuse and Harassment
QA	Quality Assurance
STA	Short-Term Adviser
TVET	Technical and Vocational Education and Training

INTRODUCTION

The Human Development Monitoring and Evaluation Services (HDMES) was established in 2019 to provide DFAT with independent MEL support for its Health and Education investments in Papua New Guinea (PNG). Projects for the Health sector make up approximately 70% of activities and budget, with the remaining 30% for Education and Leadership (E&L).

Delivered through a partnership between Adam Smith International (ASI) and Clear Horizon, HDMES operates under a demand-driven model with both in-country and remote personnel. Clear Horizon is a subcontractor to ASI, contributing technical services, particularly in MEL. An initial governance structure included biannual strategic management meeting involving HDMES and senior DFAT staff, fortnightly operational meetings and joint annual work planning including planned and ad-hoc demand driven tasks.

Initially designed to run between July 2019 – June 2023, with a costed extension to June 2025. HDMES was allocated AUD14,529,125 over the 2019–2025 period, having expensed AUD12,573,987 representing 87% of funds according to the 2024 Investment Monitoring Report. A further 12-month extension to June 2026 has been approved.

HDMES does not deliver development outcomes directly but supports DFAT's investment performance through evidence generation, evaluation, capacity building, and communications.

Its two End-of-Investment Outcomes (EOIOs) are.

EOIO1: Australian High Commission (AHC) and implementing partners (IPs) use evidence to improve programming.

EOIO2: AHC supported to better communicate the results of Australian development assistance.

HDMES has six intermediate outcomes (IOs) which together work towards achieving both program EOPOs.

IPs improve their monitoring, evaluation and learning (MEL) systems.
AHC and IPs are equipped with evidence to improve programming.
AHC improves portfolio reporting.
AHC and other stakeholders have access to relevant analysis.
AHC is provided with and distributes targeted communication and knowledge products.
AHC and other stakeholders have improved MEL knowledge and skills.

Since its inception, HDMES has delivered a substantial volume of work, including evaluations, quality assurance, MEL capacity development, and communications products. Between 2019 and 2024, HDMES completed 125 Education and Leadership products and 168 Health products, with 11 products cancelled. In 2025 to date, HDMES has completed 11 of 12 Health products (1 in progress) and 10 of 16 Education and Leadership products, with 6 currently in progress.

While contributing to MEL improvements, the program has faced performance challenges. In 2022, HDMES received an Investment Requiring Improvement (IRI) rating due to poor product quality and use of external consultants lacking contextual knowledge. A remediation plan was implemented across governance, personnel, and evaluation management, with most actions completed but ongoing concerns noted. A revised program logic (2023) retained a focus on enabling evidence use and communications, while removing Government of PNG (GoPNG) engagement. Staffing turnover in 2024 affected continuity and product delivery, though mitigated by remote support.

The program was designed for 6 full-time in-country staff, including 2 international personnel (Team Leader and M&E Specialist) and 4 locally engaged staff (Policy and Research Officers, Finance & Admin). However as of June 2025, HDMES has 4 full-time in-country staff (Team leader, vacant; 1 Policy and Research Officer; and 2 Finance and Office Managers, 1 on maternity leave). Clear Horizon is not continuing in their role.

HDMES operates in a context of increasing expectations on aid quality amid limited MEL capacity in the region, complex program environments, and geopolitical pressures in the Pacific. Evaluations of DFAT's PNG portfolio highlight challenges in generating reliable performance data due to weak MEL systems, lack of baselines, and limited partner engagement. This mid-term review provides an opportunity to assess HDMES' value-add, address persistent inefficiencies, and inform future investment quality support for DFAT's Health and E&L programs in PNG.

PURPOSE

The purpose of the Mid Term Review is to assess the performance of HDMES (2019–2024) against its EOIOs with a focus on:

- Effectiveness and efficiency. This includes assessing progress toward and attainment of outputs, issues, and challenges and how they were addressed.
- Strategic relevance and value-add to the Health and E&L investments.
- GEDSI integration.
- Guidance for future MEL support and investment planning, both for the HDMES extension and beyond.

This MTR covers all HDMES activities from 1 July 2019 to 31 December 2024, focusing on two EOIOs and six Intermediate Outcomes. The review will also look at HDMES' Contributions to DFAT's Health and E&L investments in PNG, implementation of the 2022 remediation plan, functionality of the demand-driven operating model and GEDSI integration and capacity building.

In this context, "portfolio-level" refers to work or analysis that can provide strategic oversight across a group of investments (e.g., all DFAT education programs in PNG), enabling cross-cutting insights, performance reflection, and coordinated planning. Results that can be attributed to a specific thematic portfolio (i.e., Health) have been labelled as such (i.e., Health portfolio-level). None of the references to portfolio-level outcomes refer to a combined Education/Health portfolio or AHC-wide approach unless specified.

KEY REVIEW QUESTIONS

Criteria	**Key Review Questions**
Relevance	1. Is there adequate evidence to demonstrate that the choice of delivery approaches, IPs and suite of modalities was suitable for achieving some of the investment's intended outcomes? 2. How did the program adapt to the changing needs of the context?
Effectiveness	3. To what extent has HDMES achieved its EOIOs and intermediate outcomes? 4. How is advice from HDMES being used by AHC and IPs?
Efficiency	5. To what extent is HDMES being delivered efficiently, in a timely and cost-effective way? 6. What factors are facilitating or impacting efficiency?

Criteria		Key Review Questions
	7.	What are the advantages and disadvantages of the operating model of HDMES, particularly in relation to its staffing model (e.g. staffing structure, remote/in-country support) and coordination between ASI and Clear Horizon?
GEDSI	8.	How has HDMES implemented GEDSI considerations and strategies, including facilitating the E&L and Health programs to improve GEDSI?
Future Guidance	9.	Based on the evidence above, what options should PNG Post consider for strengthening MEL support to Health and E&L portfolios?

METHODOLOGY

The study employed a mixed-methods approach comprising document review, 27 key informant interviews, and thematic analysis. The document review covered a wide range of materials, including Independent and Final Independent Monitoring Reports (IMRs, FIMRs), consultant reports, evaluation outputs, capacity-building materials, communications products, steering group terms of reference, remediation action updates, detailed annual and four-year work plans, risk and gender strategies, sustainability and safeguards plans, results frameworks, and routine reports (monthly, quarterly, annual) provided by DFAT. Financial records were analysed to assess cost-effectiveness, budget accuracy, and resource utilisation.

Semi-structured key informant interviews were conducted in person and virtually with internal and external stakeholders involved in HDMES delivery, guided by a standardised question set. In total interviewees included people from ASI (2), Clear Horizon (1), HDMES current and former staff (7), Short-Term Adviser (STAs), (1), IPs (4), current and former DFAT Health (8) and DFAT Education (4) staff. Data from all sources were synthesised through thematic analysis mapped to EOIOs and key review questions.

STRENGTHS AND LIMITATIONS

The quality of evidence supporting the conclusions in the HDMES Mid-Term Review can be rated as moderate—sufficient for informed decision-making, but with notable limitations.

Strengths

1. **Triangulated Sources**: Conclusions draw from multiple data sources—including internal DFAT records, published HDMES products and interviews from stakeholders across implementing partners, DFAT Post, current and former HDMES staff and STAs. This helps validate claims through diverse perspectives.
2. **Consistent Stakeholder Feedback**: The interview summaries provided repeated and corroborated evidence across most stakeholders about key themes such as:
    - Variable product quality and consultant performance.
    - Mixed utility and uptake of GEDSI tools.
    - The bureaucratic burden of tasking and delivery inefficiencies.
    - Value added from meta-analyses and strategic reviews.
    - DFAT need, engagement and utilisation of HDMES.
3. **Documented Outputs and Achievements**: HDMES's timeline and role documentation offer clear evidence of outputs (400+ products), capacity-building sessions, and quality assurance (QA) engagement with programs like PIE, PATH, and AAPNG.

Limitations

1. **Lack of Systematic Feedback or Uptake Data:** Many conclusions—especially around effectiveness and GEDSI impact—rely on anecdotal accounts or impressions, as HDMES lacks:
    - A formal recommendation tracking system.
    - Systematic post-product feedback or utilisation metrics.
    - Clear documentation on GEDSI influence beyond tool development.
2. **Data Gaps on Outcomes vs Outputs**: While the volume of work is well-documented, evidence of impact (e.g., actual changes in DFAT or IP decision-making, capacity improvement) is less concrete. This is a common limitation in reviews where feedback loops are informal or undocumented.
3. **Potential Bias in Perceptions**: Some interviewees expressed strongly negative or conflicted views and representativeness may be uneven—especially on themes like GEDSI and local or national capacity building.

OVERALL ASSESSMENT OF EVIDENCE QUALITY

Criterion	Rating	Explanation
Credibility	High	Based on official documents and stakeholder interviews
Representativeness	High	Balanced mix of stakeholders across DFAT, HDMES, ASI, CH, STAs and IP.
Triangulation	Moderate	Multiple data types used, but uptake and influence tracking is limited. Some data sources may be biased.
Outcome-level Evidence	Low-Moderate	Strong on outputs; anecdotal evidence for application and impact.
Data Quality/ Completeness	Moderate	Some data gaps, especially on follow-up and feedback loops

FINDINGS

RELEVANCE

Are the a) delivery approaches, b) implementing partners and c) suite of modalities suitable for achieving some of the investment's intended outcomes?

HDMES's delivery approaches and suite of modalities were generally appropriate to achieving several of the investment's intended outcomes, particularly at the program inception. The centralised, independent MEL service provider model—managed by Adam Smith International in partnership with Clear Horizon—was well-suited to DFAT's needs for flexibility, independent technical oversight, and coverage of complex MEL tasks. This suitability in the initial stage of HDMES was reinforced in interviews with stakeholders, annual program reporting, and evidence for the demand and uptake of services.

The model's demand-driven nature aligned with DFAT's compliance and reporting requirements and allowed for a wide range of services, including evaluations, appraisals, cost-benefit analyses, and portfolio reviews. It helped fill a critical gap in DFAT's capacity to manage MEL functions. The inclusion of both remote and in-country personnel, along with access to a panel of MEL specialists, gave the program reach and agility, particularly during COVID-19 and post-pandemic recovery periods.

However, the demand-driven model and increasingly diminished governance (i.e., the lack of management committee meetings and joint planning) sometimes resulted in reactive, fragmented taskings, reducing the potential for proactive, portfolio-level support. Early challenges, including staffing gaps, uneven product quality, and delays also undermined the program's relevance and effectiveness, resulting in a low IRI rating and prompting a 2022 remediation plan. Internal QA systems were strengthened in response to DFAT concerns about consultant quality, and the consultant pool was broadened to include specialist firms and individuals better matched to sector needs. These adaptations reflect a responsiveness to both operational constraints and shifts in strategic focus, however according to stakeholder feedback, the extent to which these measures have fully addressed underperformance remains mixed.

The effectiveness of the partnership between Clear Horizon and ASI varied depending on tasking and specific team members. Feedback in stakeholder interviews suggested that while ASI supported in an administration role, leveraging more of their established systems and processes (as a large organisation) would have greatly improved both operations and quality of products. Clear Horizon's technical inputs (when well-managed) were seen as valuable.

Although HDMES removed its formal focus on engagement with the GoPNG in 2023, it is worthwhile noting that its outputs were broadly aligned with PNG's development priorities. Evaluations such as the Health Portfolio Plan Mid-Term Review and Health Sector Improvement Program assessments, as well as tools like provincial profiles, supported DFAT programming consistent with PNG's Vision 2050 and Medium-Term Development Plan. In some cases, evaluations incorporated consultations with provincial authorities and national departments, ensuring that local context informed programming despite limited institutional collaboration. HDMES staff interviewed for this report did note that removing this focus also removed some of the perceived utility and relevance of the program, ultimately lowering staff retention citing a lack of broader 'purpose' for the work.

How did the program adapt to the changing needs of the context?

HDMES demonstrated adaptability in response to contextual shifts, particularly during the COVID-19 pandemic. It pivoted swiftly to remote delivery models, introduced a COVID-19-specific Performance

Assessment Framework, and implemented a business continuity plan to sustain MEL functions during travel restrictions.

While HDMES provided valuable technical translation and quality assurance support at inception, the model struggled to adapt to evolving DFAT priorities for pragmatic, strategic support over technical M&E excellence. A lack of buy-in from some AHC staff further limited its integration into broader operations. The program responded to DFAT's evolving strategic priorities by expanding its product suite (e.g., cost-benefit analyses, infographics) and by placing greater emphasis on value for money and GEDSI integration. However, stakeholder interviews noted that these attempts were often unsuccessful due to overlap with other initiatives and inconsistent demand signals from DFAT. Similarly, DFAT's task-focused engagement with the service, combined with minimal capacity to engage in reflective learning, constrained HDMES' ability to adapt. The changing needs and adjustment in scope of HDMES' work over time lead to confusion within DFAT and HDMES regarding the programs purpose.

While HDMES adapted operationally and strategically in some areas, further work is needed to embed lessons learned, address inclusion gaps, and clarify its role as a proactive learning partner.

RECOMMENDATIONS

1.1. **Shift to a proactive, portfolio-level MEL strategy with clear learning objectives:** DFAT's current approach—focused on responding to individual service requests and discrete tasks—has resulted in reactive, fragmented engagement with HDMES that misses opportunities for portfolio-level learning. Should the program continue beyond the extension year, DFAT could consider establishing a proactive MEL strategy for the Health and Education portfolios that combines responsive services with clear learning objectives and a structured learning agenda, rather than using it primarily for compliance and reporting. This would strengthen the link between MEL activities, reflection, and adaptive management, and could include periodic learning reviews, synthesis reports, and closer integration of evaluations with programming decisions.

1.2. Position HDMES as a strategic partner: DFAT's Investment Concept Note describes HDMES as providing oversight to whole-of-Portfolio M&E for both Health and Education. In order to achieve this goal, DFAT should engage HDMES earlier in planning cycles, empowering the program to advise on MEL priorities and approaches, beyond technical compliance.

1.3. Keep the independent, centralised MEL service with flexible modalities: The independent structure provided necessary oversight and technical expertise, with the flexibility to cover a wide range of MEL tasks. The inclusion of both remote and in-country personnel, as well as access to a specialist panel, remains valuable for reach and agility, particularly in crisis contexts. This capacity for operational agility should be retained and built upon by strengthening local capacity to lead tasks.

1.4. Stronger mechanisms for engaging GoPNG and local actors: To better align with DFAT's M&E Standard 5 (Use of Local Systems) – which states that "where feasible, monitoring should draw on and strengthen partner government systems and data sources" – DFAT and HDMES could create opportunities for structured local consultation and capacity strengthening within planned MEL activities, documenting the results. While formal GoPNG engagement is no longer an intended outcome, this approach would support localisation priorities and enable local staff to play a more meaningful role.

EFFECTIVENESS

To what extent has HDMES achieved its EOIOs and intermediate outcomes?

HDMES has made some measurable, but uneven, progress toward achieving its EOIOs and associated intermediate outcomes.

EOIO1: AHC and implementing partners (IPs) use evidence to improve programming.

HDMES produced a substantial body of work that contributed to evidence-based decision-making. Key outputs included major evaluations, cost-benefit analyses, appraisals, meta-analyses, and reviews, such as the TVET review, the health strategy meta-analysis, and the PIE CBA. In 2024 alone, HDMES delivered 66 of 77 planned products, encompassing technical advisory inputs, QA, and significant reviews (e.g., PATH Mid-Term Review, HSIP Technical Assistance review). Interviews with DFAT staff found that HDMES products of the life of the program supported adjustments to key investments. Notable outcomes include the redesign of the Health Portfolio following SRHIP and PSF evaluations, and the modification or discontinuation of underperforming mechanisms, such as the GEDSI Tuition Subsidy in the Education and Leadership portfolio.

Intermediate outcomes relating to MEL system improvement and evidence use were more consistently achieved in the health sector. Here, HDMES played a visible role in strengthening IP MEL systems through targeted feedback, QA processes, and facilitation of reflection and learning. Examples include HDMES's QA of reports and evaluations for partners like PATH and AIHSS, and its support for portfolio-level learning in areas such as immunisation and health service delivery.

In contrast, progress in Education was less consistent, with the exception of evaluations for PIE, with HDMES less engaged by DFAT. While HDMES produced high-quality outputs, these were sometimes viewed by stakeholders as overly complex or insufficiently tailored to sector needs, limiting their perceived strategic value.

These projects were cited by DFAT as useful, well-received, or impactful in informing decision-making:

Project / Evaluation	Why
TVET Strategic Review	Positioned DFAT on TVET reform, informed Joint Statement of Intent; well-received despite minor delays
PNG Secondary Education Program (PSEP) evaluation	Helped confirm inadequacy of design, supported advocacy and program redesign
Education in Emergencies Program Evaluation	Reinforced existing beliefs on scope and effectiveness
Meta-Analysis of Health Evaluations and facilitated reflection	Supported health strategy design and strategic portfolio planning. Helped team think at portfolio level, beyond individual activities
Health Portfolio Plan Review	Contributed to redesign of health portfolio, well received at DFAT
PATH Annual Report Appraisal	Useful product despite delays, demonstrated consultant expertise
Cost Benefit Analysis for PIE	Data used by World Bank to support $100M loan case which was a positive unintended outcome

Project / Evaluation	Why
Monitoring training for DFAT Staff	Helped strengthen field-level monitoring and reflection
GEDSI Toolkit training	Enhanced partners' skills in gender data collection and reporting. Encouraged broader GEDSI thinking

EOIO2: AHC is supported to better communicate the results of Australian development assistance.

This outcome has been partly achieved. Under EOIO2, HDMES contributed through the development of IMRs, FIMRs, provincial profiles, infographics, and tailored communication products that enhanced DFAT's capacity to report on aid effectiveness, particularly in Health. The program developed templates and briefings that were used to communicate results to internal and external audiences. However, communication products were less visible or utilised in the Education sector, and uptake beyond core program teams was reported by DFAT as limited. While according to DFAT, products were generally of acceptable quality, challenges emerged—for instance, the HSIP TA evaluation was not published due to quality concerns and the provincial profiles were noted as laborious requiring replacement of consultants, underscoring ongoing issues in QA and consultant performance.

The program also invested in capacity building, delivering over 18 sessions that reached more than 60 DFAT and partner participants. These included workshops on field monitoring, the GEDSI toolkit, value-for-money analysis, theory of change, and MEL frameworks. Post-training feedback found that participants reported enhanced understanding of MEL concepts, increased ability to unpack program indicators and outcomes, and appreciation for practical, applied training approaches. However, areas for improvement included the need for more content on technical topics (e.g. MEF, PFM), better time management, and stronger facilitation aligned with workshop focus areas. Despite these contributions, HDMES's achievement of its EOIOs has been constrained by several systemic challenges including;

- Product quality and relevance occasionally varied, reflecting differences in consultants' domain expertise and depth of contextual understanding or a lack of adaption to the context.
- Engagement processes were sometimes perceived by DFAT as administratively burdensome, which, while designed to ensure rigour, had the unintended effect of slowing delivery and reducing flexibility in meeting evolving needs.
- Leadership transitions, including high initial turnover and an extended period to appoint a new Team Leader, impacted continuity and momentum at critical stages of delivery.
- Recruitment processes, including adherence to the Adviser Remuneration Framework (ARF), at times posed challenges in securing suitable high-quality candidates in a timely manner.
- At points, interpersonal dynamics between HDMES leadership and DFAT presented challenges to collaboration and constructive dialogue, stemming from different expectations regarding utility and technical quality as well as HDMES mandate and scope.
- There has at times been ambiguity regarding HDMES's mandate, particularly around the extent to which the service could contribute to program design or undertake research activities, leading to differing expectations between stakeholders.

According to DFAT and IP staff, the most commonly reported issues with projects included; unclear recommendations for improvement, lack of consultation or input from partners into Terms of Reference, inappropriate application of benchmarks, products being perceived as a compliance exercise or presenting unclear value add for partners, misalignment with program logic, overly long or complex reports requiring multiple iterations, burdensome engagement despite clear guidance, and the perception that projects were duplicative or that they required additional tools to interpret.

HDMES has not yet institutionalised a systematic mechanism to track how recommendations are implemented across the portfolio, despite repeated requests from DFAT. This limits visibility of how its outputs contribute to sustained improvements in programming and outcomes.

How is advice from HDMES being used by AHC and IPs?

Advice and products generated by HDMES have been used by AHC and IPs in several meaningful ways, though use has varied in depth and impact. On the positive side, HDMES outputs have directly informed programming decisions and adjustments. For example, the PNG Secondary Schools Partnership evaluation provided evidence that contributed to program refinements. Similarly, findings from the evaluation of the Saving Lives, Spreading Smiles immunisation initiative supported DFAT's decision not to continue funding the activity, aligning investment decisions with evidence on relevance and effectiveness. In the Health sector, HDMES advice has been particularly influential in shaping portfolio redesigns and informing new investments, with cost-benefit analyses, meta-analyses, and technical advisory inputs feeding into strategic discussions and policy settings.

HDMES also supported DFAT's efforts to meet compliance, reporting, and accountability requirements. IMRs, FIMRs, and other QA-reviewed products helped ensure that reporting to Canberra and other stakeholders was robust, credible, and aligned with DFAT standards. Communication materials, such as infographics and provincial profiles, have been used to present aid results to both internal and external audiences, although the extent of their use in external communications was often unclear from the documentation and could not be recalled by participants in interviews.

In contrast, some HDMES products, such as IMRs, were viewed within DFAT as discouraging critical thinking and program learning, adding work without delivering sufficient learning value. DFAT tasked HDMES with drafting some IMRs, including its own IMR—a practice that raised potential conflict of interest concerns if not carefully managed. This reflects challenges with how DFAT commissioned and utilised MEL support, rather than issues of HDMES quality.

The opportunity to reflect at the portfolio level was acknowledged by DFAT as valuable, such as during the Health Meta-Analysis, but rarely realised in practice due to limited capacity reported by DFAT and some IPs to absorb learning and integrate recommendations into practice.

DFAT's own lack of clarity in TORs, slow feedback, Counsellor and First Secretary turnover and shifting objectives were identified as barriers (by most stakeholders interviewed) to effective use of MEL products for learning. This sometimes created a mismatch between HDMES outputs and DFAT's actual needs for strategic learning. In summary, while there was interest in learning and reflection at DFAT/AHC, this was often hampered by structural, procedural, and cultural factors that emphasised compliance over deeper learning, inconsistent follow-through on reflective practices, and variable leadership support.

Feedback mechanisms capturing how HDMES advice influenced decisions or was applied in practice have been inconsistent, relying largely on anecdotal evidence. Despite substantial outputs and advisory support, the absence of a formal recommendation tracking system limited follow-through on lessons learned. This gap weakened the program's ability to close the feedback loop and demonstrate sustained, portfolio-level impact.

RECOMMENDATIONS

2.1. Clarify Mandate and Scope: DFAT to review and clearly define the service's mandate—especially regarding design and research functions—to ensure alignment of expectations across stakeholders. Develop a shared understanding (documented in guidance notes or frameworks) of the boundaries between MEL, design, and research support.

2.2. Rebalance focus from technical M&E excellence toward pragmatic, user-focused outputs: Encourage products and processes that prioritise practical application, value-for-money, and usability, reducing emphasis on technical depth where it does not add practical value. Revise TORs and guidance to ensure MEL products are fit-for-purpose, accessible, and directly linked to program decision-making and operational realities, especially in Education.

2.3. Strengthen evidence use and portfolio-level learning: Establish a formal recommendation tracking system to monitor and support implementation of evaluation findings at the portfolio level. Complement this with quarterly DFAT-HDMES learning check-ins, portfolio learning reviews, synthesis reports, and reflection workshops to embed learning and drive adaptive management. Explore joint reflection sessions between DFAT and HDMES to recalibrate ways of working and build mutual trust.

2.4. Sustain and deepen MEL contributions to strategic adjustments: Continue using MEL to inform portfolio redesigns and major programming decisions, building on successes in areas like health portfolio redesign. Ensure future evaluations are aligned with strategic goals and include actionable recommendations specifying 'who, what, by when.' Move beyond sporadic, ad hoc use of tools and frameworks (i.e., GEDSI toolkit). Promote consistent, systematic application to strengthen coherence and impact across programs.

2.5. Improve communication and uptake of MEL products: Consider developing tailored communication strategies, including sector-specific approaches to ensure outputs such as infographics are visible, accessible, and used.

2.6. Enhance capacity strengthening for DFAT and implementing partners: The suite of workshops (e.g., GEDSI toolkit, value-for-money, theory of change) added value and helped build MEL literacy among DFAT and partner staff. These initiatives should be continued and, where possible, expanded with refinements to address technical depth and facilitation quality. For example, offering structured mentorship that pairs workshops with follow-up coaching. Prioritise adaptive MEL and evidence use skills.

2.7. Stabilise and Support Leadership and Team Continuity: Prioritise succession planning and timely recruitment for key leadership positions to mitigate the impact of turnover. Provide stronger backstopping and institutional memory mechanisms (e.g., document management systems, handover protocols) to ensure continuity despite staff changes.

2.8. Address ARF-Related Recruitment Challenges: Work with DFAT to explore flexibilities within the ARF where feasible or consider alternative contracting options for specialised skills that are hard to source under existing arrangements. Maintain a proactive consultant pipeline to avoid last-minute sourcing that compromises quality.

EFFICIENCY

To what extent is HDMES being delivered efficiently, in a timely and cost-effective way?

HDMES was designed as a scalable, head-deed model to deliver M&E services across sectors. The efficiency of HDMES delivery has been mixed. In practice, its narrow focus (70% Health and 30% Education) made the model administratively burdensome relative to the volume of work. While outputs like health meta-analyses and evidence matrices were timely and well-targeted, quality assurance gaps, particularly prior to 2023, resulted in substandard outputs that required repeated revisions and heavy DFAT oversight, diverting resources from higher-value activities

The total investment allocation for HDMES described in the Jan-Dec 2024 IMR was $14,529,124.58, with a total of $12,573,987.17 expensed (86%). In terms of budget execution, the Health portfolio consistently spent more than 95% of forecasted expenditure since 2023, while ELP underspending reflected staffing gaps and fewer activities. In 2024, Health achieved 112% of its 2024 activity forecast and Education 97%, with overall HDMES budget execution at 97%. Data on forecasted and actual expenditure for each project or service order was not available. Overall spend during the contract extension reflects approximately 86% expenditure. Additional invoices expected in final months.

Year	Contracted Budget (AUD)	Forecasted Expenditure (AUD)	Actual Expenditure (AUD)	Percent Spent (% of contracted[1])	Notes
2019	$12,000,000	$12,000,000	N/A	N/A	Initial contract value. No Annual report available. Delays in Aid Status approval.
2020	$2,659,064	N/A	$1,305,994	49%	Underspend occurred due to COVID-19, unfilled positions (and remote delivery), lower than expected engagement by ELP.
2021	$2,378,631	N/A	$1,002.589	42%	Excluding Management fees. Caused by impacts of COVID-19 restrictions, and a remote working environment
2022	$2,391,833	N/A	$2,079,850	87%	Excluding Management fees. Remote working, underspend on advisors and a greater reliance on STAs
2023	$2,505,308	$1,829,343	$1,696,883	68%	Excluding Management fees.
2024	$2,642,801	$2,642,801	$2,535,820	96%	High efficiency in budget execution.

What factors are facilitating or impacting efficiency?

A range of factors has shaped HDMES's efficiency, both enabling and constraining its performance. From 2019 to 2021, factors that led to the 2022 Investment Requiring Improvement rating included:

- Unclear guidance on when and how HDMES should be engaged (for example, the rules governing its role in IMRs were inconsistently applied).
- Ambiguity about legitimate scopes of work and appropriate levels of resourcing to match actual demand.
- Contractual rigidity. The 'body-shop' or 'clearing house' model, with uncompetitive fixed rates, constrained HDMES' ability to flexibly access its broader network of top-tier consultants, often resulting in reliance on second-tier candidates, delayed recruitment and issues with value for money.
- Over-reliance on external consultants and remote operations (initially due to Covid-19), reducing contextual insight and relationship-building.
- Coordination challenges between ASI and Clear Horizon, with depleted technical capacity hampering QA despite some initial process improvements.
- Leadership and staffing challenges, including high turnover in key roles and repeated interim appointments to the Team Leader position, affected continuity and contributed to delays in tasking and approvals. Staff attrition limited perceived career development opportunities. Concerns about management approaches were cited by former staff as factors impacting morale, retention, and overall efficiency, often necessitating increased DFAT oversight to ensure quality standards.
- Administrative processes, including service order approvals, invoicing, and document management, were frequently described by DFAT as cumbersome and impediments to timely delivery.

[1] Budget release, work planning and forecasting are undertaken against financial year, not calendar year, which can result in some challenges to reporting on a 'contracted' budget as, contractually, these are defined across financial year.

From 2022 onwards, HDMES undertook several measures aimed at improving efficiency, including.

- Cost-saving approaches, including greater use of remote delivery, piggybacking of short-term assignments and flexible contracting.
- Milestone-based contracts strengthened payment controls, though initial weak quality benchmarks led to delays and multiple product revisions.
- Improved internal QA, clearer consultant engagement and an updated operations manual
- The adoption of hybrid remote/in-country working models, which helped navigate logistical challenges (e.g., visa delays) and improve consultant availability.
- Enhanced in-country staffing, which supported the resumption of face-to-face activities and reduced delivery times.

However, efforts to adapt and streamline administrative processes, such as revising service orders and terms of reference, had limited success, with DFAT staff reporting only modest reductions in burden.

What are the advantages and disadvantages of the operating model of HDMES, particularly in relation to its staffing model (e.g., staffing structure, remote/in-country support)?

HDMES's operating model demonstrated both notable strengths and significant limitations, particularly in relation to its hybrid staffing structure and delivery approach. The mix of international experts, local staff, and short-term advisers allowed HDMES to scale up or down in response to varying portfolio demands without accruing high fixed costs, managing peak demands cost-effectively. This flexibility was praised by DFAT during the COVID-19 pandemic. The model's adaptability supported some successful initiatives, such as collaborative portfolio reviews and strategic evaluations that informed program redesigns. In-country staff and local consultants were acknowledged by DFAT and IPs for contributing contextual insights, though this input varied depending on the consultant or task.

However, the model also presented clear drawbacks. The heavy reliance on remote-first delivery, particularly in the early years, often reduced contextual understanding and hampered relationship-building and quality control. Several partners and DFAT staff highlighted variability in product quality and the burden placed on them to extract useful insights from overly dense or misaligned reports. Recruitment challenges linked to the ARF pay scale further limited access to high-quality, appropriately experienced consultants.

Feedback from DFAT pointed to a lack of effective briefing and quality assurance processes, with some consultants demonstrating limited understanding of DFAT systems, resulting in inefficient task delivery and additional work for DFAT to bring outputs to standard. Top-down governance structure reportedly constrained locally led approaches, dampening morale and opportunities for advancement as reported by former HDMES staff. The cost of maintaining an office in Port Moresby, including international staff, became difficult to justify as DFAT demand for HDMES services declined due to these persistent issues.

Finally, participants noted that while HDMES's staffing model aimed for flexibility, it lacked the proactive systems, frameworks, and continuity needed to consistently meet DFAT's evolving requirements and deliver high-value outputs.

RECOMMENDATIONS

3.1. Option to optimise the hybrid delivery and staffing model through strengthened local capacity, refined governance, and enhanced consultant capability. Retain and refine the hybrid remote/in-country model to preserve flexibility and cost efficiency in peak periods, while significantly increasing in-country presence and local engagement. This will strengthen contextual understanding, relationship-building, and product quality. Invest in local capacity development to build and retain a strong pool of local MEL experts,

reducing reliance on international consultants. Improve governance structures to empower local staff, foster innovation, and promote program ownership.

3.2. Streamline administrative processes and tools: Simplify and standardise service orders, tasking, and approvals using clear templates and toolkits to reduce delays, lower transaction costs, and improve efficiency for both DFAT and contractors.

3.3. Strengthen consultant briefing, QA, and contextual relevance: ASI should strengthen briefing, screening, and set early-stage QA benchmarks to reduce variability in product quality and ensure outputs consistently reflect the local context and are practically applicable. Address recruitment challenges by exploring adjustments to pay scales within the ARF and approaches to attract high-quality, contextually knowledgeable consultants.

3.4. Sustain and enhance cost-saving and accountability measures: Continue to use output-based contracts, performance-linked payments, and milestone-based contracts to drive accountability, financial control, and efficiency, while identifying further opportunities to strengthen these mechanisms.

3.5. Establish a formal partnership governance mechanism: Create structured governance arrangements between DFAT, ASI, and Clear Horizon to improve coordination, ensure consistent QA, and promote shared accountability and responsiveness. Clarify roles, responsibilities, and collaboration processes through updated organisational charts, assignment briefs, regular internal debriefs, and shared calendars to ensure alignment and efficient operations.

GEDSI

How has HDMES implemented GEDSI considerations and strategies, including facilitating the E&L and Health programs to improve GEDSI?

HDMES has made meaningful, though uneven, contributions to GEDSI integration. It developed a comprehensive GEDSI Strategy, supported by practical tools such as the GEDSI Toolkit and Assessment Rubric, to embed GEDSI in MEL practice and partner engagement. These tools were applied inconsistently by HDMES and STAs across evaluations, QA processes, and capacity building.

In 2023 HDMES facilitated a series of GEDSI capacity-building workshops targeting PATH staff, Provincial Health Authority Boards, and Pacific Adventist University participants. These sessions aimed to build understanding of GEDSI principles, identify program gaps, and support planning for improved GEDSI integration. Feedback indicated that participants gained valuable insights into practical approaches for strengthening GEDSI outcomes. HDMES also provided GEDSI advisory support during formal reviews and appraisals, such as the Australia Awards PNG GEDSI Strategy and TVET design reviews, and incorporated GEDSI considerations into portfolio reviews and IMRs. A notable example of influence was the GEDSI Tuition Subsidy Review, which informed DFAT's decision to discontinue the subsidy due to its limited inclusion impact.

In Health, HSSDP highlighted GEDSI-linked initiatives arising from pilot use of the GEDSI tool:

- A consultancy to develop a National Rehabilitation Plan and Implementation Strategy (due October 2025) aimed at guiding hospital redevelopment and workforce planning for new health cadres such as occupational therapists and speech pathologists.
- Implementation of a new module in the National Health Information System for reporting orthotics and prosthetics provision for people with special needs.
- Set a target of 50% women's representation in the Health Executive Leadership Development Program (achieved 42%).

Despite these efforts, HDMES's impact on strengthening GEDSI practice across DFAT programs has been limited. The 2024 IMR rated progress on GEDSI standards as "less than adequate," citing inconsistent use of tools and limited uptake of recommendations. The GEDSI Toolkit was valued in some contexts, by HSSDP and PATH, but viewed as overly M&E-focused and not easily adaptable across sectors.

In Education, internal resistance and lack of clarity on the toolkit's purpose constrained its use, with DFAT stakeholders noting overlap with the GEDSI helpdesk. There was minimal direct capacity building for Organisations of Persons with Disabilities (OPDs) or women's groups, limiting HDMES's support for locally led inclusion efforts. However, several evaluations and reviews integrated disaggregated data and GEDSI analysis, helping to highlight gender and inclusion gaps in DFAT-supported programs.

HDMES's safeguarding measures complemented its GEDSI work. The program-maintained alignment with DFAT's safeguarding policies, including PSEAH and child protection standards. HDMES developed its own internal Safeguarding Policy and Code of Conduct, provided PSEAH training to all staff (with positive feedback on improved awareness from 2023 sessions), and integrated safeguarding measures into its Risk Management Plan. The GEDSI Toolkit and QA processes were also designed to help assess and mitigate harm related to gender or disability.

While HDMES has laid important groundwork for GEDSI integration and safeguarding, evidence of its sustained influence on program-level practice and implementing partner capacity remains limited. Stronger engagement with local organisations, clearer strategies for applying tools across sectors, and deeper support for women's participation and locally led approaches would enhance the program's future impact on GEDSI outcomes.

RECOMMENDATIONS

4.1. Where feasible, deepen engagement with local inclusion actors: Few evaluations demonstrated direct engagement of women or people with disabilities as participants or co-evaluators. If appropriate, establish formal mechanisms to involve OPDs, women's organisations, and other local groups in MEL design, data collection, analysis, and co-evaluation. Ensure all evaluation ToRs specify gender- and disability-sensitive methodologies and explicitly document the participation of marginalised groups.

4.2. Roll out a structured GEDSI Toolkit implementation plan: The GEDSI Toolkit, while technically sound, was seen by IPs and DFAT as too focused on M&E processes and not adaptable across sectors. Toolkit uptake is limited and under-monitored. Modify the GEDSI Toolkit and Assessment Rubric so they are less compliance-oriented and more focused on supporting operational integration, sector-specific needs, and practical implementation. Strengthen uptake through clear targets for workshop delivery, integration into MEL frameworks and program designs, and monitoring of partner usage. Engage the DFAT GEDSI helpdesk to reduce duplication, improve communication and guidance to clarify the tools' purpose and how they support program objectives and daily practice.

4.3. Enhance capacity building and practical support: Continue and refine GEDSI workshops for DFAT, implementing partners to improve sector relevance and support operational integration. Provide further assistance to help translate GEDSI findings into program adaptations and track influence through tools like a GEDSI influence tracker, with results included in Annual Management Reports. Improve guidance and messaging so DFAT staff and IPs understand how GEDSI tools should be applied, how they support program objectives, and how to integrate them into daily work.

FUTURE GUIDANCE

Based on the evidence above, what options should PNG Post consider for strengthening MEL support to Health and Education and Leadership portfolios?

Drawing on the MTR findings, the following options are recommended for strengthening DFAT PNG Post's MEL support for Health and E&L portfolios. These options balance short-term adjustments and medium-long term strategic reforms:

Short-term (0–12 months)

- **Shift towards proactive, portfolio-level MEL planning:** Develop a clear MEL strategy that links MEL activities to learning objectives, reflection cycles, and adaptive management needs. Initiate quarterly learning reviews and synthesis reports with clearer articulation of product use and outcomes, beyond outputs. Expand post-delivery engagement with implementing partners to support the use of evaluation findings and strengthen learning uptake.
- **Formalise capacity strengthening at AHC** to own and shape MEL processes and outputs. Embed technical expertise within the AHC to improve real-time support and ensure ownership, as opposed to a purely demand-driven external service. Consider mandating STAs to train and mentor local staff at both HDMES and AHC.
- **Reinstitute quarterly steering committee meetings** with ASI, the Health and Education Counsellors and HDMES to ensure more robust governance. Combine steering committee meetings with quarterly joint learning sessions between DFAT, IPs, and the MEL provider to embed learning in decision-making cycles.
- **Establish a recommendation tracking system:** Create a simple, systematic tool to monitor uptake of HDMES recommendations, actions taken, and their influence on programming.
- **Refine tasking and QA processes:** Simplify and standardise service order templates and TOR development. Strengthen consultant and partner briefing and embed early-stage review protocols to improve efficiency and product quality.
- **Set clearer QA benchmarks**, including expectations for practical application and contextual relevance, to improve the consistency and usefulness of MEL products and address longstanding issues with variable quality and heavy DFAT oversight requirements.
- **Enhance communication and usability of outputs:** Develop tailored communication plans for MEL products, ensuring they are sector-relevant, practical, and widely accessible for DFAT and implementation partners. Include user-friendly formats (e.g., infographics, short briefs, dashboards) and tailored communication for different audiences.
- **Clarify HDMES mandate and scope:** Conduct a joint review between DFAT and HDMES to clearly define service boundaries, including roles in design, research, and MEL. Clarify HDMES' role as a "critical friend", "thought partner" or service delivery "body shop".

Medium-long term (1–3 years)

The medium to long term options for strengthening MEL support to Health and Education and Leadership portfolios They are evidence-based recommendations for meeting the EOPOs, providing options that include continuing HDMES (in some form) and some alternatives All options are acknowledged to be beyond the scope of the current contract term and likely depend on short term improvements and the results of DFAT's efforts to clarify HDMES' mandate.

There continues to be a clear need for high-quality MEL systems support, coupled with limited capacity within DFAT (in terms of time, technical expertise). A critical design choice for DFAT will be deciding whether to maintain an in-country MEL specialist team or shift to an operations team focused on managing processes and logistics. This decision should reflect DFAT's vision for balancing contextual knowledge, cost-effectiveness, and the level of independent technical scrutiny required to meet its objectives. Over the next

one to three years and beyond, DFAT should pursue a strategic shift in how MEL support is structured and delivered, building on lessons from HDMES while addressing persistent challenges.

Option 1: Maintain HDMES as a task-based, demand-driven service

Under this option, DFAT would retain HDMES in its current form — a largely reactive, task-based service that provides ad-hoc MEL support in response to DFAT service orders. The model would continue to engage a mix of remote and in-country personnel, drawing on an external consultant pool for specific assignments. This approach would preserve the flexibility to commission discrete MEL activities as needed, without requiring significant redesign of existing structures or governance arrangements. Feedback from interviews with DFAT and HDMES suggested that HDMES could be engaged across multiple thematic sectors (not just health or education) to expand the opportunity for cross-sectoral learning and ensure consistency in M&E standards across AHC aid programs. Expanding to other sectors would also serve to overcome the issue of lower demand, particularly from the Education portfolio.

However, this option comes with well-documented limitations. The demand-driven model has contributed to reactive, fragmented engagement, often missing opportunities for portfolio-level learning and strategic MEL alignment. Continuing this model would likely perpetuate challenges observed during the first phase — including high staff turnover, inconsistent consultant quality, and limited contextual understanding. The approach also risks sustaining a compliance-driven MEL culture rather than fostering reflective learning or adaptive management. Moreover, DFAT would continue to expend significant effort overseeing quality, tasking, and follow-up without achieving the transformative MEL capacity strengthening that is increasingly required in PNG's complex operating environment.

Option 2: Establish a Proactive, Portfolio-Level MEL Facility

This option would shift MEL support from a largely reactive, task-based service to a proactive facility that combines demand-responsive tasks with a structured learning agenda aligned to DFAT's strategic priorities — such as health systems strengthening, education quality, GEDSI integration, and localisation. The facility would embed periodic portfolio-level learning reviews, synthesis products, and regular reflection workshops as core deliverables, going beyond compliance-focused reporting to actively support adaptive management.

A formal recommendation tracking system would monitor and report on the uptake of MEL findings, helping ensure that evidence leads to action. The model would increase in-country leadership roles to enhance continuity, reduce reliance on short-term advisers, and strengthen relationships. International consultants would be required to work alongside local MEL professionals, promoting skills transfer and contextual relevance. Flexibility for remote delivery would remain, where it is cost-effective.

Contracting would move from the current "body shop" model to a panel-based or framework agreement, drawing on a diverse pool of specialist firms, national bodies, and individual consultants. This would provide greater flexibility in matching expertise to task needs and enable competitive remuneration structures (with possible ARF adaptations) to attract high-calibre, contextually knowledgeable experts.

While this option offers stronger alignment with DFAT's strategic goals and aid effectiveness principles, it would require sustained investment in local capacity, careful management of the panel arrangement, and active DFAT engagement to maximise its benefits.

Option 3: Build on HDMES with locally embedded MEL capacity and a training/GoPNG engagement arm

This option envisions transforming HDMES into a more proactive and embedded support mechanism. The model would retain the independent, centralised MEL function but pivot towards greater in-country presence. This would involve recruiting and building a stronger cadre of local MEL staff who would be embedded within

DFAT's programs and work closely with implementing partners. A central recommendation is to reform the MEL operating model, so it moves beyond fragmented, demand-driven tasking and ad hoc service orders. Instead, MEL services would focus on delivering proactive, portfolio-level learning that directly supports DFAT's program objectives.

The model could also include a dedicated arm for training, mentoring, and on-the-job capacity building — targeting both DFAT and implementing partner staff, as well as structured engagement with (GoPNG) agencies to strengthen national MEL systems. HDMES could establish long-term partnerships with PNG universities, think tanks, or OPDs and invest in fellowships, internships, and mentoring programs to grow a cadre of local MEL professionals.

This scenario offers significant potential benefits: deeper contextual knowledge, stronger relationships with stakeholders, better continuity, and alignment with localisation priorities. It would enhance DFAT's capacity to support program learning and adaptive management and help deliver on commitments to locally led development and capacity strengthening.

However, this option also presents challenges. It would require significant investment in staff recruitment, training, and systems to support local MEL leadership. Sustaining high-quality local teams may be constrained by capacity gaps, recruitment difficulties, and competitive local labour markets. The hybrid governance model — blending local staff with independent experts — would need careful design to avoid duplicative structures or confusion about roles. Achieving meaningful GoPNG engagement may be difficult given past sensitivities and limited institutional MEL capacity within government agencies. Furthermore, DFAT would need to invest in building and managing new partnership arrangements and oversight structures.

Option 4: Discontinue HDMES and internalise MEL systems strengthening within DFAT AHC

This option proposes discontinuing HDMES as an external facility and embedding MEL systems strengthening functions within DFAT AHC itself. DFAT would recruit or designate in-house MEL personnel, supported by ad-hoc independent expertise as needed. The internal MEL unit would directly manage evaluations, learning processes, and capacity building, enabling tighter integration of MEL functions with program management and policy dialogue. This would reduce reliance on external contractors and enable DFAT to set priorities more directly aligned with its internal needs and pace.

The key advantages of this approach are greater control, more streamlined processes, and potential cost savings over time as DFAT builds internal capacity. It could promote stronger integration of MEL into program design and decision-making cycles and ensure that learning and reflection are not outsourced but owned within DFAT.

However, this model comes with significant risks. Building and sustaining an internal MEL capability that can deliver the breadth of services currently provided by HDMES (e.g., technical reviews, meta-analyses, cost-benefit analyses, complex evaluations) would be resource-intensive and may not be feasible within current staffing ceilings or skill sets at Post. There is a risk of losing independent, external validation of MEL products — a feature valued by DFAT and external stakeholders. This model could also reduce access to specialised expertise and limit DFAT's flexibility to scale up MEL functions for major reviews or crisis responses. Finally, without careful design, this option could exacerbate workload pressures on AHC staff without delivering the expected gains in quality or efficiency.

Each option presents trade-offs between flexibility, quality, cost, capacity, and alignment with DFAT's strategic priorities for localisation and aid effectiveness. A clear decision on the preferred model will need to weigh these factors against DFAT's resourcing, risk appetite, and longer-term vision for MEL in Papua New Guinea.

ANNEXES

ANNEX 1. RECOMMENDATIONS LIST

These recommendations stem directly from the evidence. The relevance and utility of these recommendations are subject to DFAT's plans for the program beyond the extension period.

Ref	Recommendation	Responsible
1.1	Shift to a proactive, portfolio-level MEL strategy with clear learning objectives	DFAT
1.2	Position HDMES as a more strategic partner	DFAT
1.3	Keep the independent, centralised MEL service with flexible modalities	DFAT
1.4	Stronger mechanisms for engaging GoPNG and local actors	DFAT + HDMES
2.1	Clarify Mandate and Scope	DFAT
2.2	Increase focus towards pragmatic, user-focused outputs	HDMES
2.3	Strengthen evidence use and portfolio-level learning	DFAT
2.4	Sustain and deepen MEL contributions to strategic adjustments	HDMES
2.5	Improve communication and uptake of MEL products	HDMES + DFAT
2.6	Enhance capacity strengthening for DFAT and implementing partners	HDMES
2.7	Stabilise and Support Leadership and Team Continuity	ASI
2.8	Address ARF-Related Recruitment Challenges	DFAT + ASI
3.1	Option to optimise the hybrid delivery and staffing model through strengthened local capacity	HDMES + DFAT + ASI
3.2	Streamline administrative processes and tools	HDMES
3.3	Strengthen consultant briefing, QA, and contextual relevance	HDMES
3.4	Sustain and enhance cost-saving and accountability measures	HDMES + DFAT
3.5	Establish a formal partnership governance mechanism	DFAT + HDMES
4.1	Where feasible, deepen engagement with local inclusion actors	HDMES
4.2	Roll out a structured GEDSI Toolkit implementation plan	HDMES
4.3	Enhance capacity building and practical support	HDMES