

PNG Health System Capacity Development Program: Design and Implementation Framework

Acronyms

AAP	Annual Activity Plan
AGO	Attorney General's Office
AIP	Annual Implementation Plan
CBSC	Capacity Building Service Centre
CDC	Capacity Development Coordination
CDFF	Cooperative Donor Funding Facility
CMC	Churches Medical Council
CPP	Churches Partnership Program
CSOs	Civil Society Organisations
DCT	Development Cooperation Treaty
DNPM	Department of National Planning and Monitoring
DPLGA	Department of Provincial and Local Level Government Affairs
EPSP	Economic and Public Sector Program
GoPNG	Government of Papua New Guinea
HFG	Health Function Grant
HHISP	Health and HIV Implementing Services Provider
HRF	Health Resource Facility
HSCDP	Health System Capacity Development Program
HSIP	Health Sector Improvement Program
HSPC	Health Sector Partnership Committee
HSSP	Health Sector Support Program
IMR	Institute of Medical Research
M&E	Monitoring and Evaluation
MPAs	Minimum Priority Activities
MTDP	Medium Term Development Plan
NACS	National AIDS Council Secretariat
NDoH	National Department of Health
NEFC	National Economic and Fiscal Commission
NHIS	National Health Information System
NHP	National Health Plan
ORD	Office of Rural Development
PAF	Performance Assessment Framework
PCMCs	Provincial Coordination and Monitoring Committees

PHA	Provincial Health Authorities
PIP	Public Investment Plans
PLLSMA	Provincial and Local Level Service Monitoring Authority
QAE	Quality-at-Entry
SCT	Sector Coordination Team
SNP	Sub-national Program
SPSN	Strongim Pipol Strongim Nesen
SRAR	Sector Resource Allocation and Review
SWAp	Sector-wide Approach
TA	Technical Assistance
WHO	World Health Organisation

1. Analysis and Strategic Context

PNG–Australia partnership strategies 2011–2015

The *Papua New Guinea – Australia Partnership for Development: Health and HIV* schedule and the *Health Delivery Strategy 2011 - 2015* aim to improve maternal and child health outcomes and deliver increased services to the rural majority. AusAID's intention is to support the Papua New Guinea government's *National Health Plan 2011-2020* (NHP). This recognises that supporting the Government of Papua New Guinea (GoPNG) to create an efficient health system is the most effective and sustainable approach to delivering health services of an internationally accepted standard. To achieve this, they identify six priority results areas where Australian aid can make a difference: health financing, medical supplies, infrastructure, health workforce, public health and community mobilisation. This is supported by a mix of aid delivery mechanisms including direct financing, procurement services, capacity development and implementation support, scholarships, and service agreements with development partners and PNG training and research institutions.

Analysis of PNG health sector performance and capacity

The draft *PNG–Australia Health Delivery Strategy 2011–2015* finds that despite persistent efforts to improve PNG's health system, health outcomes remain unacceptably low. Access to and utilisation of health services varies considerably between and within provinces. It is significantly lower in rural areas where the majority of the population live, and women and children are the worst affected. While the context is different in every province, PNG's health system is affected severely by entrenched system-wide supply and demand constraints:

- > Physical and security barriers reduce access to and delivery of health services.
- > Health funding is generally not enough to meet the minimum cost of services. Funding also faces significant obstacles to reach front-line health facilities in timely manner.
- > Medical supplies are frequently out of stock, and are often of sub-standard quality.
- > Many health facilities require refurbishment to meet national standards, and there is inadequate staff housing in rural areas.
- > There are too few health workers of all cadres to meet the demands for health services, and many workers are approaching retirement or over retirement age.
- > Health workers and managers lack clarity on their roles, rights and responsibilities. They do not receive adequate supervision or on-the-job training.
- > Communities fail to use health services because of out-of-pocket costs, poor health seeking behaviour, poor physical access, and social determinants such as lack of education and violence against women and other law and order issues.

These significant constraints are further exacerbated by poor governance and political economy factors. Inter-governmental coordination between the National Department of Health (NDOH), central agencies and provinces on rural health service delivery priorities is unsatisfactory and limited. Leadership in government and public sector agencies at national and sub-national levels is short-term and politicised, making it difficult to progress long-term reforms on issues of national interest. Corruption and political interference is also common, especially in high risk areas such as health financing and procurement. And despite public pronouncements, plans and strategies for improving

health service delivery are rarely resourced properly. Finally, development partner coordination and delivery of aid in the health sector has not delivered benefits commensurate with the levels of investment.

Despite the overall decline in health indicators and the functioning of PNG's health system, there are some positive areas of change. Analytical work by the National Economic and Fiscal Commission (NEFC) has resulted in significant changes to the inter-government financing arrangements. Funding for health function grants (HFG) has significantly increased in recent years, and expenditure on recurrent rural health services in 2009 increased from 45 per cent to 60 per cent of the cost to deliver a minimum level of services across PNG. The creation of Provincial Health Authorities and piloting this new approach in three provinces creates an opportunity to better deliver health services under a single health institution with management and control of all health resources and services in the province.

The NHP is a good quality and fully costed plan. It links actual service outputs to costs and includes an achievable performance framework. Recent changes to the structure and representation of the high-level Health Sector Partnership Committee (HSPC) provide a means for all health stakeholders to influence the resourcing, implementation and monitoring of this plan.

Persistent gaps between planning and implementation (the missing middle)

One of the three thematic areas addressed in the 2010 *PNG Sector-wide Approach (SWAp) Re-alignment Review* was a focus on the institutional capacity and incentives need to improve implementation by bridging the 'missing middle' (i.e. the persistent gap between health sector plans and their implementation). This is particularly relevant to HSCDP's focus on facilitating capacity development and supporting the enabling environment underpinning effective service delivery implementation.

The World Health Organisation's (WHO) management capacity framework provides a useful distinction between capacity availability and the ability to use capacity effectively:

- > **Capacity availability:** having adequate amounts of various inputs, such as well trained managers/supervisors in critical positions (e.g. district officers, officers-in-charge) who oversee reasonable levels of staff, funds, infrastructure, medical supplies, etc; and
- > **Capacity utilisation:** the set of functional systems, procedures and processes, and the implicit and explicit incentives and motivators that make available capacity productive (e.g. supportive supervision, mentoring and professional support, clarity of roles, responsibilities and authority to manage services, and the systems to hold managers and units accountable for health results.¹

Two reviews on the 'missing middle' were conducted in 2010, of which the following 'enabling' or capacity utilisation issues were identified:

(a) Roles, rights and responsibilities: many health staff are uncertain of their roles, rights and responsibilities at all levels of the health system. There is a need to strengthen the relationship between provincial health offices and provincial administrations, and manage the changes that are needed in provinces to establish the PHAs. There is also a need to strengthen the role of the district health management team, who currently do not necessarily work as a team. They need a clear division of labour spending less time on curative care and more management and supervision. Finally, NDoH's role could be increasingly focused on facilitating horizontal cooperation with provinces to develop and implement common approaches for management of service delivery;

¹ McNee et al (2010) *Work Area 1: The 'Missing Middle': Institutional Capacity and Incentives for Implementation*, p1-2; Janovsky, Tulloch & Piel (2010) *PNG Health SWAp Review: The Missing Middle*, p1.

(b) Planning, resource allocation and use: planning systems are complex and time-consuming. They are not supported by the financial management systems. There are challenges in linking sector plans to overall provincial plans to budgets to spending. There is an over-emphasis on planning and less attention to translating plans into action, and annual activity plans (AAPs) are not linked to realistic budgets. Provincial health staff have limited control and influence over resource allocation, which is managed by the provincial administration. In addition to monitoring expenditure and targets there is a need for monitoring of administrative and management performance at different levels;

(c) Maintenance of infrastructure and equipment: health facilities without a consistent supply of running water, adequate sanitation, after-hours lighting and basic equipment are very common. Many buildings are in a state that makes them unappealing to patients, demoralising for health staff, and impossible to keep hygienic. There appears to be a greater emphasis on building new facilities in additional locations or to replacing existing ones, rather than ensuring that all facilities have the basic needs with routine and preventative maintenance funded and carried out;

(d) Putting 'back to basics' into practice: staff in many health facilities are trying to deliver health services without access to the basic tools needed for their work. In addition to the timely availability of funds and state of infrastructure, many facilities lack very basic equipment (such as mattresses, bed linen, bowls, dressing instruments, lighting) and access to timely drug supply;

(e) Staff motivation and performance: a wide range of human resources issues underpin poor health system performance in PNG:

- > Leadership is more about issuing directives than leading by example. Leaders have not had sufficient opportunity to be trained and coached in leadership skills.
- > A large number of the government staff are demoralised by the state of the system, and lack willingness to accept responsibility and accountability.
- > Poor employment, working and living conditions have eroded the motivation and commitment of many staff.
- > There are limited opportunities for continuing education and in-service training and almost none for peer collaboration and exchange. Comprehensive management training that includes leadership, planning, human resource management, financial management, information and communication management, adapted to each level of the health system, is missing.
- > Supportive supervision is very infrequent and poor. Where it does occur there is an emphasis on inspection and monitoring using checklists and little attention to mentoring. Many staff are reluctant to undertake supervisory roles because of their inability to resolve problems raised during visits, let alone have the funds and transport to get to the facility.
- > A common attitude seems to be that it is someone else's responsibility to fix problems. An active problem-solving approach in management would build confidence and improve services.
- > Disciplinary measures must be enforced. There is currently a strong tendency to ignore poor performance. Rewards could be used more creatively, such as extending annual awards for best performing and most improved provinces to lower levels of the system and focusing on rewarding management performance and innovation in problem-solving.

The missing middle review provide the following set of recommendations to address these issues: simplify planning and budgeting from the bottom up; establish systems of continuing education in the provinces; address basic minimum needs and fairness; improve living and employment conditions of

health workers; add new activities under the health Minimum Priority Activities (MPAs) funded by the function grants for supportive supervision and repair and maintenance; develop and implement a communication strategy on performance motivators and values; and strengthen PHA roll out. Many of these recommendations are directly relevant to the proposed focus of HSCDP.

Lessons learned from Australian aid

The *PNG–Australia Health Delivery Strategy 2011–2015* identifies lessons for Australian aid to better influence change in PNG's health system. This section focuses more narrowly on the specific lessons related to capacity development and Australia's dominant use of advisory support as the prime technical assistance (TA) input for capacity development (recognising this program is the main vehicle for deployment of future technical assistance to the health sector). This draws primarily from the experience from the Health Sector Support Program (HSSP) (1999–2005), the Capacity Building Service Centre (CBSC) (2005–2012) and recent independent reviews. These lessons provide an important foundation for future support. The aid program in PNG is committed to reducing the proportion of advisers and increasing funding for direct service delivery and other appropriate forms of capacity development.

Recent evaluations highlight the high proportion of aid delivered through advisers in PNG's health sector. From 1998 – 2008 approximately \$192 million or 47 per cent of the health program was provided in the form of funding individuals with advisory and in-line positions accounting for the most of it.² Technical advisers are expensive and many have not brought new knowledge and experience to the sector.³ The 2010 Development Cooperation Treaty (DCT) review recommended a more balanced approach, noting: 'On the one hand, further refinement of a capacity building model that has been discredited both internationally and within PNG will not suffice. On the other, it must be recognised that there will be ongoing demand and need for expertise to be financed by the aid program.'⁴

Box 1: DCT recommendations for more effective, efficient and sustainable approaches to using advisers in TA⁵

- > Agree on a common definition to measure the volume of advisers and regular monitor and report levels of advisory support;
- > Target the proportion spent on advisory support to decline and consider setting sectoral targets and identify cost-sharing mechanisms (such as salary supplementation);
- > Ensure that the primary line of reporting for aid-funded personnel is to GoPNG (not AusAID and the employer contractor);
- > Extend the average duration of long-term aid-funded personnel;
- > Reduce the focus of aid-funded positions on corporate processes and focus more in implementation, including increase proportion of positions outside of Port Moresby;
- > Pay greater attention to cost-effectiveness, and adopt measures such as using volunteers to drive down the cost of technical assistance;
- > Most importantly, pilot the use of aid-funded in-line positions.

² ODE (2009) *Evaluation of Australian Aid to Health Service Delivery in Papua New Guinea, Solomon Islands and Vanuatu: Working Paper 1: Papua New Guinea Country Report*, p22.

³ ODE (2009) *Australian Aid to Health Service Delivery in Papua New Guinea, Solomon Islands and Vanuatu: Evaluation Report*, p25.

⁴ Howes, Kwa & Lin (2010) *Review of the PNG–Australia Development Cooperation Treaty* (1999), p3.

⁵ Ibid, p2-3; 21-31.

The following lessons drawn from recent evaluations of Australian aid to PNG's health sector:

- (a) An evidence-based capacity diagnostic should underpin investments:** past approaches to deploying technical assistance, particularly advisory support, has been dominated by frequent and ad hoc requests rather than genuine needs assessments.⁶ It showed that in 2006 79 staff were novated across from the former Health Sector Support Program to CBSC, of which 21 were transferred either into similar if not identical roles and functions.⁷ A 2009 evaluation of CBSC found there was no evidence of analysis of what was needed to improve health outcomes in provinces, however the transfers of staff and new roles were just created.⁸ Diagnostics of need are critical and should be matched with a consideration of the alternatives to advisory support to demonstrate effectiveness of the proposed technical assistance approaches.⁹
- (b) Realistic assumptions are needed about the effectiveness of advisors in weak governance environments:** although there is no doubt that weak governance is a binding constraint to development in PNG, there is limited evidence to show that advisory support and other forms of technical assistance can improve this without political will. Australia's past approach to medical supplies reform failed because it focused only on technical aspects of the reform while government commitment to address corruption – the primary constraint – was lacking.¹⁰
- (c) Advisory support is most effective when proportionate to other required forms of aid:** a 2008 ODE evaluation notes the 'absence of sufficient non-salary operating budgets, and related shortages of drugs and frontline staff, has meant the investments in buildings, equipment and advisory support that account for most of Australia's aid inputs have inevitably struggled to achieve significant or sustainable impact on service delivery. Increased support for operating costs and provincial and district level may have created a more balanced pattern of spending in which services could have expanded, and the investment and advisory support that was provided might have achieved more.'¹¹
- (d) A greater proportion of technical assistance (and advisors) should be deployed at sub-national levels and focus on service-delivery implementation:** A 2009 evaluation of CBSC found that support is primarily concentrated at national levels, and while it is highly valued and its immediate effect is significant, the long-term impact is less identifiable.¹² At sub-national levels support was less focused and thinly spread. The attempt to support over twenty widely differing provinces proved too ambitious.¹³ The evaluation and the DCT review recommend a shift away from supporting 'back office' planning and management to 'front line' implementation of critical tasks for service delivery.¹⁴

⁶ ODE (2009) *Australian Aid to Health Service Delivery in Papua New Guinea, Solomon Islands and Vanuatu: Evaluation Report*, p23: notes there has been 'insufficient analysis of the nature of the capacity problem and the scope for addressing it ... A significant proportion of AusAID support for capacity building in each country has focused on trying to improve operations within the confines of existing policies and institutions, without explicit analysis or policy discussions on alternatives (p19). However, the DCT Review does note improvements in the 'increased emphasis on more disciplined assessment of the need for consultants prior to their hiring.'

⁷ Ibid, p5, 15.

⁸ Emmott, Lee & Wheelen (2009) *Capacity Building Service Centre: Independent Evaluation Report*, p13.

⁹ Howes, Kwa & Lin (2010) *Review of the PNG-Australia Development Cooperation Treaty* (1999), p23.

¹⁰ ODE (2009) *Australian Aid to Health Service Delivery in Papua New Guinea, Solomon Islands and Vanuatu: Evaluation Report*, p17.

¹¹ ODE (2009) *Evaluation of Australian Aid to Health Service Delivery in Papua New Guinea, Solomon Islands and Vanuatu: Working Paper 1: Papua New Guinea Country Report*, p11.

¹² Emmott, Lee & Wheelen (2009) *Capacity Building Service Centre: Independent Evaluation Report*, ii.

¹³ Emmott, Lee & Wheelen (2009) *Capacity Building Service Centre: Independent Evaluation Report*, i, p10-16.

¹⁴ Emmott, Lee & Wheelen (2009) *Capacity Building Service Centre: Independent Evaluation Report*, ii; Howes, Kwa & Lin (2010) *Review of the PNG-Australia Development Cooperation Treaty* (1999), p28.

- (e) Capacity development support should support the role of non-state actors in health service delivery:** past approaches to capacity development did not extend to the private sector, NGOs or the churches, despite the important role they play in rural health service delivery.¹⁵
- (f) Frequent changes in approaches undermine ownership and reduce impacts:** CBSC frequently changed its engagement approach at the provincial level. It moved from a single province focus to a regional focus and then back again. This hampered the effectiveness of support and was highly disruptive and confusing to provincial stakeholders who were not sufficiently consulted.¹⁶ CBSC's approach to monitoring and evaluation (M&E) has struggled to tell a performance story - it developed nine separate M&E frameworks over five years!¹⁷
- (g) All partners should support a single GoPNG-led capacity development plan:** PNG's health sector-wide approach (SWAp) should be the basis for determining what capacity building support is required and reflected in action plans. CBSC has been criticised for its parallel structures which are de-linked from annual planning and budgeting processes for the sector, and time-consuming for GoPNG to engage in.¹⁸ A narrow bilateral focus marginalised the role of other development partners, which contributed to the creation of another separate facility for technical assistance.¹⁹
- (h) A clear and realistic theory of change is needed and supported by effective M&E:** CBSC's design contained no explicit theory of change articulating how advisory support would result in an outcome of improved service delivery and ultimate impact on health status. It assumed, or ignored, factors beyond the health sector would not undermine its capacity to function (which did not hold true).²⁰ A more realistic (and consistent) approach to M&E is required, which specifies monitorable outcomes and tracks performance against baseline data.
- (i) Learn from successful experiences:** support to the NEFC's work on cost of services and changes to inter-governmental financing arrangements is widely recognised as Australia's most successful advisory support outcomes. This work was GoPNG lead over a long period of time with the NEFC responsible for gathering political support from the provinces (particularly those which were to lose funding) and central agencies. Advisory support was targeted at technical/expert aspects (i.e. calculating the cost of services, budget calculations, legislative drafting) with supporting capacity development aspects. Funding was also provided to facilitate and stimulate the 'marketing' of the changes across government. In combination the various types of technical assistance, under PNG leadership, achieved an impressive outcome. GoPNG is committed to increasing the function grants to provinces, and still doing so, and NEFC is continuing to undertake the research and advocacy roles developed at that time.²¹

¹⁵ Emmott, Lee & Wheelen (2009) *Capacity Building Service Centre: Independent Evaluation Report*, p7.

¹⁶ Emmott, Lee & Wheelen (2009) *Capacity Building Service Centre: Independent Evaluation Report*, p10-15.

¹⁷ Capacity Building Service Centre (2011) *Activity Completion Report*, p15-16.

¹⁸ ODE (2009) *Evaluation of Australian Aid to Health Service Delivery in Papua New Guinea, Solomon Islands and Vanuatu: Working Paper 1: Papua New Guinea Country Report*, p55; Emmott, Lee & Wheelen (2009) *Capacity Building Service Centre: Independent Evaluation Report*, i; ODE (2009) *Australian Aid to Health Service Delivery in Papua New Guinea, Solomon Islands and Vanuatu: Evaluation Report*, p17.

¹⁹ Emmott, Lee & Wheelen (2009) *Capacity Building Service Centre: Independent Evaluation Report*, i.

²⁰ Emmott, Lee & Wheelen (2009) *Capacity Building Service Centre: Independent Evaluation Report*, i-p3; Howes, Kwa & Lin (2010) *Review of the PNG-Australia Development Cooperation Treaty* (1999), p56.

²¹ Howes, Kwa & Lin (2010) *Review of the PNG-Australia Development Cooperation Treaty* (1999), p30.

2. Program Theory of Change

Rationale and Australian aid results focus

The rationale and purpose of the HSCDP is to facilitate implementation of rural health service delivery. It will achieve this by (a) strengthening the functions and systems of organisations and partners with the responsibility to influence or deliver health services and (b) addressing incentives to promote a stronger culture of implementation, performance and accountability (particularly at the district-level). HSCDP's approach is to reinforce GoPNG holistic strategies rather than develop ad hoc activities. It will minimise the use of parallel systems limiting them to agreed areas where there are genuine capacity gaps and/or high fiduciary and development risks of using GoPNG systems. The program will work towards rebuilding PNG systems and process, with other programs, and achieving greater integration as partner capacity increases. While HSCDP is a four-year contract, the strategic intent of the program is to provide capacity development over a longer-term period in line with the NHP 2011-2020.

The majority of Australian support in the PNG-Australia Health Delivery Strategy 2011-2015 directly supports key inputs of PNG's health system: financing, medical supplies, infrastructure and human resources for health (Box 2). The underpinning theory of change behind HSCDP is that these resources – capacity availability – are necessary but not sufficient to improve service delivery. Translating these resources into implementation requires systematic attention and support directed to the incentives and drivers of change. HSCDP is intended to provide enabling support across all result areas and is focused on medium-term capacity development improvements that can be sustained.

Box 2: High-level and intermediate development outcomes in PNG's National Health Plan (2011-2015)

High-level development outcomes:
> Proportion of deliveries being supervised by a trained nurse, midwife or doctor increased from 40 to 44 per cent (approximately 8,000 additional supervised deliveries per year);
> Couple years protection per 1,000 women of reproductive age increased from 81 to 125/1,000;
> Proportion of children receiving 3 doses pentavalent vaccine increased from 51 to 80 per cent;
> Proportion of children receiving measles vaccinations increased from 50 to 80 per cent;
Intermediate development outcomes:
> <u>Financing</u> : increase in provincial health expenditure to meet minimum cost of services (from 60 to 100 per cent);
> <u>Medical supplies</u> : proportion of months that all health facilities have selected medical supplies in stock increased from 47 to 85 per cent;
> <u>Infrastructure</u> : increased proportion of health facilities and staff housing refurbished and with running water supply and sanitation facilities in eight provinces;
> <u>Health workforce</u> : increased number and quality of doctors, midwives, nurses and community health workers training and better productivity of the existing health workforce;
> <u>Public health</u> : increased proportion of disease outbreaks / urgent events identified and assessed by NDoH within 48hours of receiving report of event;
> <u>Community mobilisation</u> : increased number of communities implementing grants in priority areas of maternal health, gender equality and water supply, sanitation and hygiene practice.

The capacity diagnostic process undertaken in 2011 (see below) will provide the basis to develop a full program logic and theory of change. Specific end-of-program outcomes, resources, activities and outputs required to achieve these will emerge from this design's second phase. It will also identify the specific focus of HSCDP support to government and non-state organisations at national and sub-national levels. However, in the interim, the following sub-sector objectives have been developed to narrow the program's strategic focus:

Box 3: Interim sub-sector objectives for HSCDP 2011-2015

Purpose
> To strengthen key partner performance, functions and systems, and incentives within PNG's health system to better deliver rural services (with a particular focus on five provinces);
Organisational capacity development objectives
> Priority provinces and PHAs with demonstrated capacity to manage, deliver (including to outsource) and monitor a minimum package of health services;
> NDoH with demonstrated capacity to perform core enabling functions (including sector coordination);
> Health worker training institutions with demonstrated capacity to perform core enabling functions (including sector coordination);
> Non-state actors (particularly the churches) with demonstrated capacity to deliver a minimum package of health services;
Health systems, functions and incentive objectives
> <u>Financing</u> : integrated and bottom-up approaches to all sources of health financing; increased direct facility financing in priority provinces;
> <u>Medical supplies</u> : strengthened NDoH capacity to transparently procure internationally quality assured medical supplies and manage outsourced supply chain; increased capacity of priority provinces to budget for drug distribution and manage pull system;
> <u>Human resources</u> : increased quality and capacity of pre-service training institutions to meet demand; comprehensive approaches to in-service training, supportive supervision and accountability in priority provinces;
> <u>Infrastructure</u> : increased capacity of priority provinces to fund and implement maintenance of health facilities and staff housing; rehabilitation of health infrastructure in Western Province;
> <u>Public health</u> : increased capacity of NDoH to manage disease outbreaks quickly and effectively; and strengthened approaches to water supply, sanitation and hygiene (WASH) and tuberculosis in Western province;
Cross-cutting capacity development objectives
> Increased number of public-private partnerships in priority provinces;
> Gender equality approaches reflected in district-level service delivery planning, strategies, implementation and reporting;
> Increased analytical and operational research evidence-base, and use of monitoring and evaluation (M&E), to inform strategies, implementation and promote accountability.

Program scope

The scope of the HSCDP is to deliver the majority of its support at the sub-national level, with modest support to national functions. This approach reverses a legacy of providing the majority of aid to the national-level which has limited responsibility for direct health service delivery. Provincial support will comprise approximately 75 per cent of the HSCDP operational budget (\$11.25m per year), focused on:

- > Intensive support to priority provinces (particularly Western province which is not covered in the Asian Development Bank's Rural Health Service Delivery Project) and the Autonomous Region of Bougainville;
- > Selective support accessible by all provinces based on emerging health sector priorities (e.g. 'hot spot' provinces of East Sepik, West Sepik, Enga, Gulf, Oro, and Southern Highlands; and the new provinces Jiwaka and Hela).

Support to national functions will comprise the remaining 25 per cent of the HSCDP operational budget, with approximately \$3.75m per year covering:

- > Key functions of NDoH (such as management of HSIP financing, procurement of medical supplies, sector-wide coordination and support to the HSPC and working groups, and M&E of the NHP and support to the independent annual health sector review (IAHSR); and other agencies such as the Churches Medical Council (CMC);
- > Quality improvement grants and technical assistance to health worker training institutions;
- > Analysis, operational research, diagnostics and activity design; and
- > Flexible funding at the discretion of the Secretary of Health (up to five per cent of annual budget as agreed by AusAID). Well-defined criteria for flexible funding will be determined and agreed as part of the diagnostic process of NDoH.

HSCDP support will explicitly complement and interact with other AusAID and development partner capacity development investments to avoid duplication. There are at least six areas where program coherence can be established (to be identified in detail as part of the capacity diagnostic process):

- (a) HIV services:** Australia's HIV program will operate in four out of the five priority geographical focus areas. There is an opportunity to develop more integrated approaches to health and HIV services delivered at health facilities. That program will be supported by the HHISP.
- (b) Community engagement:** AusAID's support to the Strongim Pipol Strongim Nesen (SPSN) and Churches Partnership Program (CPP) are focused on facilitating greater community mobilisation at sub-national levels to strengthen demand for health services. Through those programs there are opportunities to support the key focus areas of Australian assistance through civil society and church activities.
- (c) Public financial management and HR:** AusAID's Sub-national Program (SNP) and Economic and Public Sector Program (EPSP) can support the provinces, PHAs and the Department of Personnel Management to directly manage human resources, payroll and optimal staffing of the health delivery system. With Treasury and Department of Finance, and provinces, they can strengthen the monitoring of the function grants and other spending on health services as well as attempt to fix known constraints and bottlenecks in the governments budgeting and finance systems that prevent funding getting to the right facilities at the right time.

(d) Performance monitoring and accountability: the SNP and EPSP is providing support to key national departments and agencies and the provinces to improve performance information, including:

- > The Provincial and Local Level Service Monitoring Authority (PLLSMA) and the Department of Provincial and Local Government Affairs (DPLGA) as the PLLSMA Secretariat to undertake its role to coordinate and monitor the implementation of national policies
- > DPLGA through its various divisions building provincial budgeting, financial management, human resource management, reporting and other public administration capacities including revitalising section 114 and 119 reporting, establishing provincial coordination and monitoring committees (PCMCs), improving engagement with central agencies;
- > DNPM, with respect to reporting on the medium term development plan (MTDP) as its affects provincial performance;
- > Department of Treasury's provincial budgets division, to improve monitoring of the minimum priority activities (MPAs) and health function grants and engagement with provinces on all aspects of their spending on national priorities;
- > National Economic and Fiscal Commission (NEFC) to support implementation of the intergovernmental financing arrangements, prepare provincial expenditure reviews and conduct regional consultative forums with provinces;
- > Department of Implementation and Rural Development with respect to monitoring of use of district service improvement program (DSIP) funding; and
- > Auditor General's Office (AGO) to carry out the performance audit of provinces.

(e) Provincial and district health service coordination: in four out of the five priority provinces, HSCDP will develop coordinated approaches to district-level health service delivery in working with the Asian Development Bank, Korean International Cooperation Agency (KOICA) and the NDoH;

(f) Health infrastructure: the PNG-Australia Incentive Fund provides financing for infrastructure and capital investments for good performing organisations. Major health institutions and service delivery agents been successful applicants for hospitals and rural health services; and

(g) Analytical and operational research agenda: the World Bank, with UN agencies, has a lead role in undertaking high quality analytical and operational research.

3. Implementation approach

Facility-to-program progressive design

HSCDP will be a 'program' as an aid modality. Working within a clear framework, with agreed objectives and proper analysis activities will be chosen jointly with PNG to achieve expected results (outputs, intermediate and end-of-program outcomes). These will be selected on their ability to make the most effective contribution toward the PNG-Australia Health Delivery Strategy 2011-2015 high-level and intermediate development outcomes. However, given the phased approach of the design, HSCDP will initially share some features common to a 'facility' at least in the initial period. It is important to make these explicit and identify how this will operate in practice. AusAID has a mixed record on understanding and effectively applying facility approaches and the risks, particularly the strong demand driven processes of the program and the potential to 'drift' away from a coherent set of objectives..

Box 4: Features of program versus facility designs²²

Program approach	Facility approach
<ul style="list-style-type: none">> Design clearly articulates the objective that will be achieved within the life of the program (end-of-program outcome)> Stakeholders agree what they are trying to achieve (what behaviours will change, what specific aspects of institutional performance will improve).> There is a robust logic that identifies a series of interventions and outputs that together will achieve the defined end-of-program outcomes> Agreed points of entry and activity development processes usually based upon previous engagement in the sector	<ul style="list-style-type: none">> A small number of high-level objectives have been defined (usually on a sub-sectoral basis and relating to institutional performance outcomes)> A large pool of unallocated funds that is expected to support a set of small activities whose contribution to these objectives is often not clear> Elements of uncertainty about points of entry, who the stakeholders and partners may be, and what the key demand for assistance will be.> Each year or on an agreed basis a round of proposals are invited from key partners and assessed for funding and implementation

There is a mix of risks inherent to facility approaches and those which emerge because of a poor application of facility approaches. The latter is an increasingly common problem, where managers responsible for designs have often selected a facility approach without being fully aware of the relationship between the delivery mechanism(s) and the expected development outcomes.²³ In many facilities, the risk is that small activities are selected for funding which cannot possibly address the broad range of factors required to achieve the development objectives that have been articulated.

²² Dawson (2009) *Discussion Paper: Design, Monitoring and Evaluation of Facilities*.

²³ Ibid, p1-2; Pieper (2009) *Policy Note 2: Public Sector Capacity Development*, p9: 'Consider using delivery modalities that offer greater flexibility, but recognise that this requires even greater diligence in monitoring and assessing progress. Keeping the diagnostic analyses and resulting strategic directions in focus can become difficult when activities are structured very flexibly, with the risk that coherence becomes lost. Many early examples of 'facilities' to support public sector strengthening have suffered from increasingly indiscriminate use over time, diluting any impact on their primary agendas (e.g. improved governance).

Selecting a facility approach poses significant risks if the aim is to achieve specific development outcomes relating to some form of institutional capacity that leads to better performance.²⁴

The facility approach appears to be effective in two contexts:

- > **Responsive facility:** where the initiative is specifically and primarily required to be *responsive and flexible* to meet the changing needs of a partner government, especially during a time of reform or in a rapidly changing context. The facility approach is employed for a specific period to meet a need that then ends; and
- > **Facility with progressive engagement to a program:** where the initiative is being implemented in a setting where AusAID has limited knowledge of the context and would prefer to engage for a period of time before committing to a series of clearly articulated substantive institutional development objectives. In this case there is a progressive movement from a facility approach to a more clearly defined program. There would be a strong emphasis on systematic and high quality contextual evaluation or scanning that would feed into an annual reflection on the readiness to define development outcomes more carefully.²⁵

The HSCDP clearly fits into the latter part of this second category particularly at its inaugural stages. The diagnostic process – which serves the same purpose as contextual evaluation – will result in clearly articulated and measurable institutional development outcomes. These will provide the basis for the strategic focus of the program and identification of appropriate interventions and strategies for achieving change. It is expected that the transition from a facility to a program will be completed in 2012-13, based on:

- > AusAID and GoPNG have extensive experience working with each other in the health sector, they have the experiences of previous projects and programs all coupled with a strong desire to make significant change in how aid gets delivered.
- > Diagnostics and service agreements finalised with NDoH and four priority provinces and the Autonomous Region of Bougainville in 2012;
- > Diagnostics and service agreements finalised with all health worker training institutions (including approaches to in-service training) in 2012; and
- > A recognition that the program's on-going review and monitoring processes will regularly review the composition of the activities to see that in terms of contributing to objectives that program's results are greater than the sum of the activities.

The HSCDP will retain flexibility in a number of ways to ensure it remains responsive to local needs. Firstly, any additional diagnostics (and subsequent support) will be commissioned through the annual health sector planning and review processes. This recognises that 'even with the best diagnostics, it will not always be possible to understand and support capacity development in relation to all relevant aspects of an issue or system from the outset. At the same time, flexible and responsive approaches to activity design and delivery need to be applied within a coherent strategy that is built on an understanding of where we are heading.'²⁶

Secondly, while a strategic framework is important to retain focus, annual review processes can recommend different approaches to aid delivery if existing approaches are not delivering expected results. This reflects international experience that '...successful engagement in sector level change processes rarely comes about from a well-defined design alone but as a result of an on-going exchange

²⁴ Dawson (2009) *Discussion Paper: Design, Monitoring and Evaluation of Facilities*, p1-2.

²⁵ Dawson (2009) *Discussion Paper: Design, Monitoring and Evaluation of Facilities*, p3.

²⁶ Pieper (2009) *Policy Note 2: Public Sector Capacity Development*, p9.

and dialogue.²⁷ And thirdly, the Secretary of Health retains a modest annual budget (up to five per cent) to respond to any emerging issues (such as an immediate response to a disease outbreak).

Section 7 identifies a number of risks inherent in adopting a facility approach. AusAID will effectively manage these by ensuring sufficient staff are involved in the strategic management of the HSCDP at national and provincial levels²⁸; and by regularly monitoring these key risks as part of the M&E system.

Capacity development approach

The HSCDP will focus on capacity development at a range of levels – individual, group, organisational, sector, institutional and the systems which cut across these. This recognises that past development practice has focused largely on the individual ('counterpart') which has rarely lead to overall team or organisational improvements. Similarly, attention to internal organisational change (such as restructuring, planning and introduction of new technical systems) has had limited effect on organisation performance. Proper attention has not been given to wider constraints within and beyond the health sector – particularly culture, norms and values which shape attitudes, behaviours and incentives.²⁹ This also suggests that any technical assistance support will need to be planned alongside all other inputs, including government, required to ensure capacity development strategies have a sustainable impact.

Support through the HSCDP will be delivered according to the following ten guiding principles, which are based on AusAID and international experience of effective capacity development approaches (particularly the use of technical assistance and advisers). Box 5 identifies a limited number of definitions which are relevant to HSCDP:

Box 5: Key definitions related to capacity development³⁰

- > **Capacity:** the ability of people, organisations and society as a whole to perform appropriate functions effectively, efficiently and in a sustainable manner;
- > **Capacity development:** is the process by which people, organisations and society as a whole develop competencies and capabilities that will lead to sustained and self-generating performance improvement;
- > **Technical assistance:** the provision of expertise in the form of personnel, training and research. It comprises activities that augment the level of knowledge, skills, technical ability or productive aptitudes of people in developing countries (e.g. scholarships, institutional twinning and mentoring) as well as services (e.g. consultancies, technical support or the provision of expertise);
- > **Adviser:** someone who provides advice on the strategic direction, and/or supports the implementation of, Australia aid and whose professional fees or salary are paid from the official development assistance budget. The equivalent DAC term is 'Technical Assistance personnel'.

(a) Country ownership and management: the active role of PNG stakeholders in the selection of priorities, management, decision-making, resource allocation, monitoring and reporting of

²⁷ Land et al (2010) *Perspectives Note on Sector Capacity Development*, p18

²⁸ In addition to strategic oversight provided by the AusAID Program Director - Health, this program will be directly supported by a full time team based in Port Moresby consisting of a Senior Program Manager, Program Manager and Assistant Program Manager; and by AusAID provincial representatives based in all five priority provinces.

²⁹ Lyon (2009) *A Brief Account of Capacity Development in AusAID, 2004-2009*, p1.

³⁰ AusAID (2011) Operational Note of use of Advisers in the Aid Program.

HSCDP provides greater opportunity for local ownership and leadership, matching supply and demand, and reflecting national priorities set out in the NHP;³¹

(b) Coordination: the HSCDP meets three of the four criteria measured by the Paris Declaration on Aid Effectiveness which focus on coordinated capacity development programs. It will address the last criteria during implementation:

- ✓ Capacity development programs supports PNG's national development strategies;
- ✓ PNG exercises effective leadership over the capacity development program, supported by development partners;
- ✓ Development partners integrate their support within PNG-led programs to strengthen capacity development; and
- Arrangements for coordinating development partner contributions are in place;³²

(c) Transparency in costs: all support managed by HSCDP will involve transparency of costs to ensure GoPNG can compare alternatives and make better-informed decisions. In the case of advisers this reduces the perception of them as a 'free good';³³

(d) Design and diagnostics: HSCDP support will be based on independent diagnostics and design work as needed (see below). This will ensure that proposed activities are based on need, affordable and appropriate, are chosen based on their likelihood to achieve outcomes, and represent value for money. In all these areas, expectations must be realistic about the expected influence of aid;³⁴

(e) Use partner systems and processes as entry points: the HSCDP will ensure that more effective and resilient development gains will be made by helping to strengthen systems (particularly rebuilding current ones) that PNG itself relies on for the delivery of services, rather than by introducing stand-alone activities. This also includes building on existing PNG reforms and working with local champions to support change. The HSCDP will also take steps to transfer responsibility for financing and procuring capacity development support to GoPNG-based on a pragmatic approach (see below) and an agreed sharing of fiduciary risk;³⁵

(f) Mix of direct and indirect approaches: where advisers are proposed, the HSCDP will employ a mix of 'direct' (e.g. implementation role) and 'indirect' (e.g. facilitation role) approaches based on diagnostic findings. Annex 2 includes a capacity development framework for advisers identifying a spectrum of four types of support: capacity enabler, capacity substitution, capacity supplementation and capacity facilitation support. Clarity on the expected functions of advisers will be determined through development of a business case that looks at possible alternative capacity development inputs, then the preparation of terms of reference, including whether positions are focused on strategic policy advice; implementation/operational support; and skills transfer/acquisition;³⁶ Finally, the annual work plan will be developed with the counterpart organisation to meet the agreed need.

³¹ ECDPM (2007) *Policy Management Brief – Aid Effectiveness and the Provision of TA Personnel: Improving Practice*, p2.

³² Ibid.

³³ Ibid, p3; AusAID (2011) *Use of Advisers in the Australian Aid Program – Operational Policy: Adviser Planning, Selection and Performance Management*, p8.

³⁴ ECDPM (2007) *Policy Management Brief – Aid Effectiveness and the Provision of TA Personnel: Improving Practice*, p5; Pieper (2009) *Policy Note 2: Public Sector Capacity Development*, p5.

³⁵ Ibid, p3-4; Ibid p5-6.

³⁶ Morgan and Keogh (2011) *Reforming the Approach to Technical Assistance in Timor-Leste: Review of Current Practice and Options for Reform*, p15-20.

- (g) **Flexible and adaptable:** the HSCDP will balance the needs for a strategic focus and being responsive to changes in local context, including being realistic of the pace of implementation³⁷;
- (h) **Realistic and appropriate monitoring and evaluation (M&E):** capacity development is difficult to measure, and past approaches in PNG's health sector have focused on the extreme ends of the performance spectrum – activities (too process-oriented) or health service delivery impacts (unrealistic). The HSCDP will focus on developing realistic indicators of capacity development, appropriate levels of attribution, and realistic links to broader outcomes. It will use PNG's own information needs as the starting point and balance learning and accountability needs;³⁸
- (i) **Incentives matter:** identifying incentives and political economy issues are critical to improving performance (e.g. missing middle analysis) and depend heavily on understanding the local context. Capacity development support through HSCDP will explicitly address how best to promote incentives for change through the diagnostic and strategy / activity design processes (which will be based on the specific and unique needs of each organisation or province / district);³⁹ and
- (j) **Coherence is vital to success:** the greatest impact will come from coherent approaches that consider all parts of the system(s) and the linkages between them, understanding all of the factors affecting performance, and building on synergies.⁴⁰ As highlighted in Section 3, AusAID will promote coherence with HSCDP across a variety of its programs outside of the health sector, and with GoPNG and development partners.

Forms of aid

The HSCDP (through the HHISP contract) will have the capacity to manage two main forms of aid:

- (a) **Technical assistance:** a mix of capacity development options including but not limited to:
 - > Short and long term training opportunities;
 - > Peer learning and mentoring through exchange or secondment across organisations / provinces;
 - > Twinning between local and international organisations;
 - > Short and long-term aid-funded personnel, in either in-line or advisory positions; and
 - > Operational research, analysis, diagnostics and activity design.
- (b) **Grants:** these can be provided to non-state actors to directly deliver health services (delivered through the existing HIV and AIDS or SPSN grants programs) or to health worker training institutions to undertake quality improvement programs. In the first instance opportunities to establish GoPNG managed service agreements with non-state actors will be explored and direct contractual agreements with AusAID (or HHISP) will only be used at the request of GoPNG partners where insufficient capacity exists.

³⁷ Ibid, p7.

³⁸ Pieper (2009) *Policy Note 1: Capacity Development Overview*, p5; ECDPM (2007) *Policy Management Brief – Aid Effectiveness and the Provision of TA Personnel: Improving Practice*, p7.

³⁹ Pieper (2009) *Policy Note 1: Capacity Development Overview*, p7.

⁴⁰ Ibid.

The support proposed is intended to complement other forms of aid in the Australian health portfolio, such as financing, procurement, scholarships, and partnerships with PNG institutions and development partners.

Capacity diagnostic and design

The second phase of this design is a series of capacity diagnostics and associated activity-design work. The purpose is two-fold:

- > To develop (or provide resources to support) coherent approaches to strengthening the functions and incentives required for health service delivery implementation in selected areas (initially priority provinces and Bougainville, NDoH, and training institutions); and
- > To inform the scope and programming of the HSCDP.

As highlighted earlier, this includes diagnostics of the NDoH and AusAID's four priority provinces (Western Highlands, Eastern Highlands, Milne Bay and Western province) and the Autonomous Region of Bougainville. A diagnostic of all health worker training institutions will be completed in 2012.

A key feature of HSCDP is its ability to contract independent capacity diagnostics over the life of the program where new sectoral support is required (even if it is not to be delivered by HSCDP). While the scope of diagnostics and associated design work will vary on a case by case basis, the following eight principles describe the expected approach:

- (a) Joint approach:** all capacity diagnostics will be led by GoPNG (with NDoH taking a leadership role), and include representation from relevant stakeholders. In the case of provincial diagnostics, this will involve members⁴¹ from the health sector partnership committee (HSPC), provincial administrators and governors, PHA CEOs (where appropriate), and non-state actors.
- (b) Independence and technical expertise:** to avoid perceptions of conflict of interest with HSCDP as a delivery mechanism, and to demonstrate that all support is based on robust analysis, all diagnostics will be contracted to independent individuals or firms with the appropriate technical expertise to undertake diagnostics and/or design work. They will work in partnership with the stakeholders described above to undertake the relevant work jointly;
- (c) Methodology:** a detailed methodology for capacity diagnostics will be developed in consultation with the diagnostic team for the first mission in 2011. This will employ a 'mixed methods' approach – i.e. a mix of quantitative and qualitative data collection methods. This is the recommended international approach for such design and evaluation activities. This will be adapted as needed for future diagnostics based on individual circumstances. The methodology will be developed based on approaches and lessons from AusAID's EPSP program, which has undertaken capacity diagnostics of national agencies in 2011. HSCDP-commissioned diagnostics will be broader recognising that service delivery involves multiple agencies/systems to be effective;
- (d) Plans and priorities:** the starting point for capacity diagnostics are the relevant GoPNG health service delivery plans and priorities. For provincial diagnostics, the approach will be to start from National Health Service for Papua New Guinea 2011 – 2020 (which set out in detail the district-level service standards) and work backwards to identify strategies and support required to

⁴¹ Membership of the HSPC include senior representatives of NDoH, Finance, Treasury, Planning, and Provincial and Local Government Affairs, provincial representatives, development partners, churches and the private sector.

translate these into implementation, as well as considering the required whole-of-province and national functions;

(e) Capacity availability and utilisation: the assessment of existing capacity availability and utilisation will:

- > Assess existing capacity (resources and incentives for change), through a problem-based analysis as well as recognising strength-based approaches;
- > Utilise the existing information base, to avoid re-inventing the wheel, build on effective approaches and past lessons learned, and identify selective areas where in-depth analysis can best add value;
- > Identify opportunities to promote program coherence between PNG stakeholders, development partners, and across AusAID programs; and
- > Address political economy issues which affect health service delivery implementation;

(f) Strategies for change: diagnostics will identify how to most effectively implement PNG strategies for change (or identify where strategies need to be developed if they are absent), including identifying an appropriate theory of change and program logic – i.e. resources, activities outputs, intermediate outcomes and end-of-program outcomes. They will identify opportunities to promote gender equality in the analysis and design of plans, strategies and activities and M&E. In cases where diagnostic approaches identify the need for the development of long-term and broad institutional changes (e.g. comprehensive approach to human resource training) which are beyond the scope of HSCDP to support, AusAID and GoPNG will negotiate alternative options including if the area can be supported by AusAID;

(g) Service agreements: outcomes of the diagnostic process will include service agreements of up to four years negotiated between relevant parties (including NDoH and when appropriate the target provincial administrator as chief accountable officer as signatories) at the end of the diagnostic process and including these components:

- > Summary findings of diagnostic assessment;
- > GoPNG, provincial and AusAID financial and other resource inputs and commitments;
- > Agreed strategies and proposed interventions to accelerate progress;
- > Dependencies on other GoPNG agencies and AusAID programs;
- > Agreed joint result areas to be monitored;
- > An outline of the monitoring arrangements; and
- > Processes for regular engagement and performance review if required (for example, Western Province has its own health sector committee which meets quarterly).

(h) M&E: based on agreed strategies for change, M&E data will be drawn primarily from GoPNG systems and supplemented through HSCDP as required (particularly to determine the latter's contribution to capacity development changes). A baseline assessment will be conducted as part of the diagnostic process, including collection of sex-disaggregated data wherever possible.

Research and analytical agenda

AusAID will support the Health Sector Partnership Committee (HSPC) to develop a multi-year analytical and operational research agenda. This also includes support delivered outside HSCDP, such as financial partnerships with the World Bank, the World Health Organisation (WHO) and the

Institute of Medical Research (IMR). Where HSCDP is tasked by the HSPC, it will secure the most appropriate expertise required for analysis and operational research using a consortia approach (see Box 6 for DFID experience) and the successful experience of the research process within the PNG HIV program. This will allow PNG to access more diverse options which draw on international experience and best practice. However, if HSCDP is unable to secure appropriate expertise, AusAID can utilise its health resource facility (HRF) as an alternative mechanism.

Box 6: DFID's approach to research programme consortia⁴²

Research Program Consortia (RPC) are centres of specialisation around a particular research and policy theme. They are made up of a group of institutions, including institutions in developing countries, with a lead institution that has overall management and financial responsibility. RPCs should demonstrate that they have access to a variety of specialist skills, including in applied and operational research; communication and policy influencing; M&E frameworks, capacity building frameworks with developing countries; gender mainstreaming; and demonstrated management ability (personnel and financial management).

RPCs are designed to support the following development partner objectives:

- > Strike a balance between creating new knowledge and technology and getting knowledge and technology – both new and existing – into use;
- > Make the most of development partners' abilities to influence policy to make sure research makes an impact;
- > Use different methods of funding to join up national, regional and global research efforts, so that they are more relevant to what matters to developing countries; and to achieve a bigger impact on poverty reduction; and
- > Strengthen developing countries' capability to do and use research.

Management of technical assistance and use of advisers

The management of advisers by HSCDP will be directed by AusAID's *Use of Advisers in the Australian Aid Program: Operational Policy*. Key principles for management will be:

- (a)** Clear definition of the need for technical assistance and the expected results;
- (b)** Agreement, based on evidence, on the most appropriate form of technical assistance;
- (c)** Where an adviser is proposed, there must be agreement on:
 - > the type of adviser (i.e. in-line / off-line, international, national, regional);
 - > the adviser counterpart(s) and if the adviser role is a capacity enabler, substitution, supplementation or facilitation role;
 - > the position duration (i.e. short-term, long-term, part-time or intermittent);
 - > how the adviser is funded (i.e. co-contribution or bilateral funding only);
- (d)** Adviser terms of reference must be agreed by both parties and clearly:
 - > define in a measurable way the objectives, deliverables and outcome(s) required from the role;
 - > identify the full set of technical and capacity skills, cultural and language requirements and personal attributes, and these are to be incorporated in the selection criteria;

⁴² DFID (2009) *Research Programme Consortia: Terms of Reference*, p1-3.

- > define the position's performance management and reporting arrangements in a clear and measurable way;
- > reference the AusAID adviser remuneration framework (ARF) for all commercially contracted long- and short-term adviser positions (in particular reference the relevant discipline category and job level for the position and the AusAID performance assessment guidelines); and

(e) Adviser performance and ongoing position relevance will be jointly assessed on completion of assignment or on an annual basis, which ever occurs first, using the AusAID adviser performance assessment processes; these will be lodged in the AusAID performance register.

Performance management of advisers and quality assurance of technical assistance outputs has been identified as an ongoing issue across AusAID supported health programs in PNG and the Pacific. In addition to the approaches set out in AusAID's *Use of Advisers in the Australian Aid Program: Operational Policy*,⁴³ AusAID will propose that performance management of HSCDP advisory support is best addressed through a joint quarterly review mechanism led either by NDoH's strategic policy division or the Health Sector Capacity Development Coordination Working Group (CDC) with participation of development partners and the HHISP. The scope of this quarterly review mechanism should include all advisory support to the health sector to ensure a coherent and coordinated approach. AusAID will engage with NDoH and development partners in 2011 to discuss this approach and support the development of terms of reference.

AusAID will also use the CDC and development partner monthly forums to ensure that HSCDP technical assistance is planned alongside other development partner inputs, and that health stakeholders and development partners undertake formal quality assurance processes for all technical assistance deliverables.

Financing and procurement approach

As set out in the PNG-Australia Health Delivery Strategy 2011-2015, all Australian aid will be 'on plan' and 'on budget'. In the case of the HSCDP, with its primary focus on technical assistance, this will be an important strategy to ensuring GoPNG considers the opportunity cost of using technical assistance, particularly adviser assistance, alongside all other forms of aid.

AusAID's procurement and financing approach through HSCDP is for the HHISP to directly procure technical assistance on behalf of PNG health stakeholders; and to provide financing for purposes which cannot be reasonably accessed through either PNG's own sources (such as health function grants and internal revenue) or the Health Sector Improvement Program (HSIP) trust account. The areas where a direct financing approach may be adopted is direct grants to health worker training institutions to implement quality improvement programs (where there are no existing HSIP sub-accounts established) and direct grants to non-state actors. As noted earlier, the latter will be a last resort where service agreements are not possible, and will be managed through existing AusAID grant mechanisms.

This procurement and financing approach is justified because:

(a) The NDoH has recognised its limited capacity in this area and requested that AusAID directly manage the HSCDP contract.

(b) Recent assessments such as the financial audit of HSIP trust account and a health sector procurement capability and capacity assessment have unequivocally found that the NDoH and

⁴³ AusAID's policy states that advisers should in the first instance be accountable to, and managed by, the organisation(s) in which they are working, and that relevant partner country indicators and reporting systems should be used where possible.

other GoPNG agencies lack the capacity and skills to efficiently carry out procurement functions.⁴⁴ In the area of technical assistance, the contractor responsible for managing the Cooperative Donor Funding Facility (CDFF) also raised concerns with the NDoH about its ability to manage and finance adviser contracts.

- (c) Procurement was also confirmed by these assessments as a high fiduciary risk area for development partner funding.
- (d) There is a risk that providing direct financing through the HSCDP, other than that noted above, will create further complexity to an already weak financial system.
- (e) Experience with previous health sector technical assistance programs – HSSP and CBSC – shows that providing (modest) funding creates disincentives to make PNG's own systems work and is likely to weaken these in the long-term. The institutional costs are greater than the benefits. This is particularly a risk in well-performing provinces, such as Milne Bay, which has demonstrated its capacity to utilise existing systems to good effect and which would see this as a step backwards if this approach was adopted.

Ideally, GoPNG will take partial or full responsibility for managing procurement (see Box 7). This will allow it to use its own financial resources to access technical assistance and other support from a service provider with AusAID responsibility limited to managing a head contract. AusAID's goal and intention is to work progressively to hand over procurement functions, including identifying and monitoring milestones, by:

- > Strengthening HSIP staffing and management in NDoH and in provinces so that HSIP funding can be used for procurement of technical assistance; and
- > Identifying opportunities to strengthen GoPNG's own procurement functions as part of the diagnostic process.

Box 7: International experience on approaches to procurement of technical assistance

'Ideally, the involvement of development agencies in managing advisers should be limited. This is what is envisaged in the 'procurement' approach to technical assistance personnel management. It is characterised by direct client procurement of technical assistance, using a budget or pool provided by development agencies. The personnel/service provider then has a direct relationship with the client.'

In practice, there are only a few situations where conditions are adequate to fully transfer the management function, although smaller steps can be taken to shift elements of management responsibility to the country partner. In most countries, there is a need to explore interim solutions that distribute responsibilities between the development agency and country partner so as to progressively empower the latter.

Transferring responsibilities will require a pragmatic approach in adapting management arrangements to realities on the ground, including making an assessment of management and procurement capacity. Taking steps to transfer responsibility means helping countries to develop the requisite capacity to assume that responsibility. It is crucial here to develop the capacity for managing human resources as a critical area of public service management, as well as public financial management and procurement.'

ECDPM (2007) Policy Management Brief – Aid Effectiveness and the Provision of TA Personnel: Improving Practice, p3-4.

⁴⁴ Duesburys Nexia (2011) *HSIP Trust Account Financial Transaction Audit and Process Review Report*; Charles Kendall and Partners (2011) *Procurement Capacity and Capability Assessment in PNG's Health Sector*.

4. Governance and Management Arrangements

Governance and decision-making

The HSPC is the primary governance and decision-making body for the HSCDP. All major new investments must be approved by the HSPC. The HSPC is chaired by the Secretary for Health and is comprised of senior representatives from NDoH, Department of Finance (DoF), Department of Treasury (DoT), DNPM, and the Department Provincial and Local Government Affairs (DPLGA), provincial representatives, development partners, churches and the private sector. It was established in 2011, and is expected to meet on a quarterly basis. Box 8 highlights the specific functions of the committee:

Box 8: Terms of reference for Health Sector Partnership Committee

- > Providing advice and reviewing sector-wide budget priorities and expenditure performance; including health function grants and supplementary budgets;
- > Discussing strategic issues arising from quarterly expenditure and performance reviews;
- > Reviewing internal and external audit reports on health spending by NDoH, Provinces and PHAs;
- > Reviewing action and progress on the stated policy agenda;
- > Discussing and agreeing an annual health sector capacity development plan and recommendations to address ad hoc request for TA;
- > Monitoring progress of the capacity development plan against mutually agreed outcomes;
- > Discussing requirements for analytic work and considering findings and recommendations for capacity development and policy action;
- > Engaging the DPLGA and PLSSMA mechanisms for coordinating with Provinces and advocating NHP implementation issues;
- > Reviewing section 119, Churches Medical Council (CMC), Central agency and Development Partner reports and recommendations on sector capacity development support priorities;
- > Evaluating health sector partnership performance; and
- > Providing a forum for discussion and advocacy across the health sector stakeholders and interests.

The HSPC is supported by a Sector Coordination Team (SCT) located within the office of the Executive Manager for Strategy Policy in NDoH. The primary task of the SCT is to undertake all activities necessary for HSPC to perform its function according to its terms of reference, including facilitating collaboration and coordinates information sharing across the entire sector, with central agencies and with development partners. Specific tasks may include:

- > Preparing documentation and briefing papers, and ensuring availability of summary financial reports for quarterly HSPC meetings;
- > Establishing a comprehensive overview of sector programming in connection with the medium-term expenditure framework;
- > Serving as a clearing house for aid coordination issues;

- > Tracking donor proposals and projects which are not channelled through government systems and/or are executed by non-state actors;
- > Maintaining an overview of all activities undertaken by development partners in the health sector, including an overview of aid modalities used, and developing a registry system;
- > Compiling inventories and maintaining a library of analytic work and consultant reports sponsored by development partners; and
- > Organising and supporting IAHSR and health summits.

In collaboration with, and supported by the SCT, two interdepartmental working groups will undertake the technical tasks associated with the functions of the HSPC. These are the Sector Resource Allocation and Review (SRAR) working group, and the CDC working group. The SCT and CDC working group will be the primary points of engagement on all operational discussion with the HSCDP, including the development of technical proposals and monitoring progress. This will ensure that the operational requirements of HSCDP do not distract the strategic focus of HSPC deliberations, and HSPC involvement will only consider overarching approaches and high-profile investments.

The CDC is directly responsible for:

- > The development of a draft annual capacity development plan based on an annual sector review and capacity diagnostic;
- > The development of recommendations to ad hoc requests from the sector to NDoH for technical assistance; and
- > The coordination of commissioned analytical work, including sector performance reviews and evaluations, carried out by short-term consultants and national/international resource institutions.

Provinces are represented in the HSPC by DPLGA and engage with NDoH and central agencies through the PLLSMA health sub-committee on provincial capacity development needs and performance.⁴⁵ AusAID and development partners will engage with provinces through the NDoH taking the lead stewardship role in coordinating health capacity development needs (as per its mandate under the *National Health Act*).

Effective functioning of the HSPC and its working groups is critical to the success of the HSCDP. AusAID will work with GoPNG and development partners during the NDoH diagnostic process to assess existing strategies and resourcing requirements to ensure they are effective (and provide support if and where appropriate).

Annual implementation cycle

The HSCDP internal planning and budgeting will be guided by HSPC decisions and aligned to contribute to the timeframes required by NDoH annual implementation plan (AIP) (formerly known as annual activity plans), public investment plans (PIP) and provincial planning processes. The GoPNG budget cycle underlies these processes. These are currently being revised and this section will be updated based on this information. The two main planning and funding areas which provide the context for annual planning are:

- > **AIPs:** these include GoPNG recurrent financing and HSIP funding, and are prepared at national (NDoH) and provincial levels, with funding to be released in January each year; and

⁴⁵ At this stage it is unclear whether the PLLSMA health sub-committee will be distinct or integrated into the HSPC (the former more likely).

- > **PIPs:** these include NDoH managed capital investments from PNG's development budget (managed by DNPM).

Tasking HHISP

The primary mechanism for operationalising HSCDP will be tasking notes arising out of the HSPC approved plans or approved ad hoc requests, all within the program's annual budget. These can be authorised by the HSPC, and in specific circumstances, the Secretary of Health and by AusAID Program Director, Health:

- (a) Tasking notes through the HSPC:** this will be the primary mechanism for all tasking, and the only mechanism for large investments, based on agreed decisions reached through quarterly HSPC meetings. The SCT will be the area within NDoH responsible for issuing tasking notes to the HHISP;
- (b) Tasking notes through the Secretary for Health:** this may be used in two circumstances:
 - > Firstly, the Secretary for Health can issue tasking notes directly to HHISP in relation to use of flexible funds (criteria to be determined during NDoH diagnostic process); and
 - > Secondly, the Secretary for Health may, with the agreement of AusAID, issue tasking notes in the event that HSPC is not fully functioning or is not meeting quarterly, or cannot meet at short notice to ensure HSCDP programming can continue; and
- (c) Tasking notes through AusAID health program delegate:** AusAID can issue tasking notes to the HHISP to support the AusAID health program (including M&E, briefing, scoping exercises, facilitating contractor performance assessments and financial audits of other AusAID health programs), managed through a separate budget to HSCDP.

All tasking note requests will be lodged in a register managed by HHISP and published in annual performance reports.

Roles and responsibilities

Roles and responsibilities will be developed in detail during the first diagnostic process in 2011 (indicative areas summarised in Annex 1). Key roles and responsibilities include:

Government of PNG:

- > Responsibility for delivering the HSCDP rests with the GoPNG stakeholders participating in it;
- > The NDoH, health worker training institutions and five provinces (and others receiving assistance under this mechanism) are responsible for implementation; and
- > The HSPC sets the development agenda, plans and prioritises the activities, and reviews performance.

AusAID:

- > AusAID is PNG's development partner, who works with its PNG partners to influence strategic direction and performance. AusAID is providing significant finance for the program's activities. It has a strong interest in the successful delivery of the program;
- > AusAID is the implementer of some aspects of the PNG-Australia Health Delivery Strategy 2011-2015 (but not the elements supported by this mechanism);

- > AusAID, working with the HSPC and recipient stakeholders, is responsible for facilitating the quality of all activity designs; and
- > AusAID has engaged the HHISP to provide quality management services to support the implementation of this design. AusAID is responsible for overseeing the quality of the Contractor's contribution.

HHISP:

- > HHISP's core function is to support AusAID and GoPNG's role in implementing the program;
- > HHISP has no role in leading the activity. It is a response-inputs-supply-contractor, through provision of capacity building assistance to build GoPNG capacity to lead this improvement in areas agreed to between AusAID and GoPNG in annual planning processes; and
- > HHISP if requested, will provide advice on capacity development strategies and appropriate mixes of inputs, provided it does not take the responsibility from GoPNG implementing partners.

Services required from the HHISP will include, but are not limited to:

- > Grants contracting and management for GoPNG and non-state actors;
- > Aid-personnel (short and long-term) identification, contracting, logistics and HR management;
- > Identification and sub-contracting of capacity diagnostic, design and process improvement expertise;
- > Contracting of and managing other forms of technical assistance as agreed with GoPNG implementing partners.
- > Identification and sub-contracting of suitable research, twinning and training organisations;
- > Identification and sub-contracting of audit firms and expertise for contractor performance assessments;
- > Financing and M&E data collation from grants recipients and reporting; and
- > Events management and logistics,

Development partner coordination

The HSCDP will support a more coherent approach to health sector capacity development planning and resourcing in five ways. It will:

1. support and encourage HSPC to manage and coordinate development partner contributions;
2. use regular development partner monthly forums to provide updates on technical assistance to ensure there is harmonisation of inputs based on GoPNG priorities and to identify opportunities for joint or delegated analytical work (e.g. there is an opportunity to undertake a joint diagnostic of NDoH with AusAID, ADB and JICA in 2011).
3. jointly conduct with HSPC and other development partners' quarterly reviews of advisory support to strengthen sector-wide quality assurance and performance management issues.
4. undertake joint diagnostic processes and joint reviews to promote better coordination, particularly in provinces where AusAID, ADB and the NDoH are directly supporting district-level service delivery improvements.

5. provide a common and accessible mechanism for development partners to contract technical assistance as required.

Contracting arrangements

At the request of NDoH, contracting arrangements for HSCDP will be directly between AusAID and the ISP under a four-year contract. While the head contract will be between AusAID and the HHISP, there is flexibility so that GoPNG and other development partners can enter into individual agreements (operating as a multi-donor facility).⁴⁶ This is particularly important to ensure a more coordinated approach to provision of capacity development, and offer an opportunity to large users of the CDFF, such as the Clinton Foundation and the Global Fund, when that facility finishes in mid-2012.

Past experience of capacity development models in PNG's health sector indicate that expecting a single contractor to manage and deliver a wide variety of support may come at the expense of quality. This is premised on the notion that no single contractor is likely to be best placed to deliver on all required capacity development approaches and services. To address this challenge and ensure value for money in provision of capacity development support, AusAID will:

- > Directly contract partners with technical health expertise such as the World Bank, WHO and IMR;
- > Promote a consortia approach in the tender documentation for HHISP, strongly encouraging interested firms to demonstrate their ability to source and provide high quality, internationally experienced and value-for-money services and inputs in the areas outlined in Section 4 (forms of aid), including partnering with specialist firms and networks which are well placed to support HSCDP and the PNG health sector; and
- > Use the Health Resource Facility as an alternative source of technical assistance needs, where HSCDP is unable to secure appropriate expertise.

AusAID is seeking to procure high-quality services and will structure the basis of payment so that the profit component of the HHISP contract will be subject to risk where the performance criteria set out in Tasking Notes are not satisfied. As an incentive to focus the HHISP on quality services provision, the commercial risks to the HHISP will be minimised by full funding of personnel and overhead costs on a monthly reimbursable basis.

All existing aid-funded personnel positions provided by CBSC will be subject to the capacity diagnostic assessment in order to determine if novation of positions is justified.

⁴⁶ To manage a surge or decrease as a result of additional donor investments, HHISP will charge a nominal percentage to each investment to cover management and overhead costs (approximately 10 – 15 per cent).

5. Cross-cutting issues

Gender equality

Australia's overall approach to promoting gender equality in PNG's health system is set out in the *PNG–Australia Health Delivery Strategy 2011–2015*. And while the specific nature of support will be determined through the diagnostic process, the following three approaches will be particularly addressed through the HSCDP support:

- (a) Promote maternal health:** this will be achieved through provincial level support which is focused on resourcing and implementing interventions such as ante-natal care, supervised deliveries and family planning;
- (b) Increase women's role in the workforce:** the HSCDP will specifically target a greater proportion of women to be recruited to aid-funded personnel positions; women to be represented on key decision-making bodies such as the PHA boards and the HSPC and working groups; and women in under-represented health workforce positions (such as doctors and specialists);
- (c) Utilise diagnostic and design processes to promote gender equality:** this will be achieved by focusing on opportunities to strengthen sex-disaggregated data collection analysis at district, provincial and national levels. Greater use of sex-disaggregated data can then be used to inform approaches to increasing accessibility of health services; and by ensuring that gender is adequately addressed in planning, strategies, resource allocation (e.g. gender-responsive budgeting) and activity-design, and monitored through joint review processes.

Sustainability

The approach taken in the HSCDP represents an evolution towards a more sustainable model of capacity development. While its contracting arrangements are outside of PNG's procurement and financing systems, there are several important areas where it is progressive:

- > **Ownership:** unlike the previous 'partnership' model between AusAID, GoPNG and a managing contractor, the HSCDP is governed by PNG's forum for managing health sector performance;
- > **Alignment:** Unlike CBSC's parallel planning and reporting processes, the HSCDP will feed directly into GoPNG's planning and reporting processes;
- > **Coordination:** the HSCDP supports a single capacity development plan for the health sector, and provides a mechanism for development partner harmonisation;
- > **Sustainability:** Reduced reliance on international long-term advisers, and greater emphasis on national in-line positions (which can be supported with salary supplements to attract high quality personnel from the private sector);
- > **Procurement and financing:** identification of strategies and support so GoPNG can progressively manage key procurement functions and utilise its own or pooled financing;
- > **Partnerships:** An increased focus on partnership links through twinning, peer learning and mentoring, and international program consortia for short-term TA and research; and
- > **Mutual accountability and managing for results:** service agreements are based on evidence of reform and commitment to improved health services, and provide mutual accountabilities for GoPNG and AusAID to commit resources toward clear and measurable results.

6. Monitoring and evaluation

M&E of capacity development

Previous approaches to M&E of the health capacity development programs have not been fit-for-purpose. They have lacked effective theories of change from which to contextualise their role and the relative contribution of their support. They have tended to oscillate between an activity and process focus, neither of which adequately describes the behaviour or organisation changes occurring as a result of support or the Australian contribution to health service delivery performance targets. They also failed to take into account a much broader set of influences than the interventions of the program(s) alone. The lack of baseline and sex-disaggregated data are recurring problems for all AusAID health sector investments.

The HSCDP will develop an M&E approach which is focused on service five key purposes:

- (a) Strengthen PNG systems:** the HSCDP will identify opportunities to strengthen PNG's national health information system (NHIS) at national, provincial and district levels, including ensuring there is a downward flow of information to local levels;
- (b) Influence decision-making:** the HSCDP will collect and / or promote real-time performance information to ensure planning and resource allocation are constantly tailored to implementation experience and feedback from reviews;
- (c) Performance and accountability:** the HSCDP will support GoPNG strategies to increase the profile of performance and accountability in provincial and district-level health service delivery, including holding service providers to account through outsourced service agreements;
- (d) Learning and quality improvement:** the HSCDP will support GoPNG to adequately reflect on new strategies and pilots (e.g. direct facility financing, PHAs, and community health posts) before they are scaled up more widely; and
- (e) Aid contribution:** assess the relative contribution of the HSCDP to capacity development improvements in selective health partners, systems and functions' ability to implement or influence rural health service delivery.

It will be cognisant of the following principles and experience related to M&E of capacity development⁴⁷:

- > M&E should contribute to the process of capacity development through joint approaches;
- > M&E needs to be pragmatic and the costs should not outweigh the benefits (e.g. large, formalised systems can interfere or undermine capacity development);
- > M&E should be appropriate to the context and not place unnecessary burdens on organisations;
- > M&E will establish an agreed approach to measuring the development of capacity early in HSCDP's life, modifying it only as required to make it work. Baseline assessments will be made at an early date.
- > The duration between capacity development interventions and desired results can be long, which are at odds with results-based management approaches which tend to stress short-term results;

⁴⁷ Simister and Smith (2010) *Praxis Paper 23 – Monitoring and Evaluation of Capacity Building: Is It Really That Difficult?*, p7-8.

- > Results may be stretched across multiple organisations and there are practical difficulties in coordinating work;
- > M&E carried out to learn and improve performance will not necessarily meet the needs of accountability (and vice versa); and
- > Capacity is not a linear process, and organisations' capacities are constantly fluctuating.

HSCDP's M&E system

AusAID and GoPNG will jointly develop the HSCDP M&E system during 2011 arising out of the capacity diagnostic assessments in particular. Specific M&E expertise will be included in diagnostic missions to collect baseline information which will form the basis of an impact assessment in 2015. The risk of not developing an M&E system in this initial design is offset because it will be ready prior to implementation. It is reliant on the diagnostic for establishing a baseline, and existing health program staff have sufficient skills in developing and purchasing M&E systems.

The HSCDP M&E system will be structured at two-levels:

- (a) PNG's health sector performance:** key results areas identified in the NHP which are directly relevant to the strategic focus of HSCDP will be monitored using the NHP performance assessment framework (PAF) and relying on performance information collected through the NHIS and other relevant data sources (particularly those supported by AusAID's SNP and identified in Section 3). AusAID will encourage HSPC partners to include monitoring of the analytical agenda within the NHP PAF and review forums; and
- (b) HSCDP contribution and performance:** as identified in section 3, an appropriate theory of change and program logic will be developed during the diagnostic process to identify the capacity development results expected from the HSCDP support. It is anticipated that a mix of existing PNG information and additional information contracted by the HSCDP will be required to develop an effective capacity development M&E system. M&E will also include performance measures for analytical work (and associated quality assurance), risks identified in Section 9 to be monitored through each year; and relevant areas of program scope (e.g. proportion of program expenditure on advisers, national / provincial focus, and flexible / program transition).

M&E of the HSCDP will be collected through a mixed-methods approach. Internationally recommended tools for measuring capacity development performance which may be used include:

- > Organisational assessment or organisational capacity assessment tools;⁴⁸
- > Outcome mapping;⁴⁹ and
- > Performance story reporting and most significant change.⁵⁰

Roles and responsibilities

The roles and responsibilities of GoPNG, AusAID and the ISP, including for M&E, are set out in Annex 1 and will be determined in more detail during the diagnostic process. Primary responsibilities include:

- > **GoPNG:** managing, monitoring and reporting on the support provided through HSCDP through existing GoPNG mechanisms (to the extent possible);

⁴⁸ For a comprehensive list, including assessment of strengths and weaknesses, see Simister and Smith (2010) *Praxis Paper 23 – Monitoring and Evaluation of Capacity Building: Is It Really That Difficult?*, p11-14.

⁴⁹ See <http://www.outcomemapping.ca>.

⁵⁰ See <http://www.clearhorizon.com.au/flagship-techniques/participatory-performance-story-reportin/>

- > **HHISP:** synthesising GoPNG performance information relevant to the HSCDP investments and the inputs it manages, and feedback this back to health stakeholders, and commissioning M&E work as required; and
- > **AusAID:** analysis of overall HSCDP performance and linkages to performance reporting through the *PNG-Australia Health Delivery Strategy 2011-2015* performance management framework.

Resourcing

In addition to any M&E support identified through diagnostics and included in service agreements, the HSCDP will allocate 3 – 5 per cent of its overall annual budget toward M&E-related costs in line with accepted international standards. This will predominantly be focused on tracking and reporting on the performance of the program itself, but also include funding to commission case studies and other work as tasked by the HSCP or AusAID.

Review processes

There are six relevant review processes for HSCDP:

- (a) Overall health sector performance:** will be evaluated annually through the Independent Annual Health Sector Review (IAHSR), which will focus on a selective set of performance indicators and be complemented by specific focus areas for evaluation;
- (b) Provincial and organisation-specific reviews:** each year, NDoH, provinces and development partners will also undertake a joint annual formative review focused on the specific changes occurring across a set of targeted provinces or organisations where provincial service agreements are in place (including HSCDP). The primary focus on these reviews are on identifying opportunities to further strengthen health service delivery implementation and learn from successful approaches;
- (c) Partnership for development forums:** Australia's overall health support, including HSCDP, will be discussed at senior levels of government on an annual basis;
- (d) Adviser performance:** AusAID, GoPNG, development partners and the ISP will undertake joint quarterly reviews of adviser performance;
- (e) Independent evaluation:** The HSCDP will be evaluated as part of a cluster evaluation in mid-2013 and at completion in 2015. The formative evaluation will be focused on the relevance and efficiency of its support, with the summative evaluation focused on demonstrating effectiveness, impact and sustainability; and
- (f) Contractor performance assessment:** AusAID will commission an independent contractor performance assessment of the ISP on an annual basis.

Performance reporting

Based on the collection and synthesis of information presented above, the HSCDP will prepare a pithy, results-focused annual performance report as a contribution to the IAHSR reporting process and AusAID's annual quality processes. AusAID will have responsibility to incorporating this analysis to report its annual health sector contribution through the *PNG–Australia Health Delivery Strategy 2011-2015* performance management framework and sector performance review.

The HHISP will report on implementation and performance of HSCDP primarily using the M&E systems of (PNG) activity implementers, including reporting of adviser performance. AusAID will engage with HHISP and activity implementers to ensure adviser performance can be adequately and regularly tracked.

7. Risk Management

Approach to risk management

Australia's overall approach to risk management is implemented through the PNG-Australia Health Delivery Strategy 2011-2015. It considers development, reputational and fiduciary risks, and the extent to which high risk investments are likely to provide high returns. It is managed through a high-level risk management matrix, scenario analysis, and reflection on stop/go points of sensitive reforms.

The HSCDP will identify and monitor selective risks to its operational effectiveness and report against these on a six-monthly basis through its M&E framework.

Key risks and mitigation strategies

Specific risks around strategies, approaches and interventions will be identified, and risks mitigation strategies developed, during the capacity diagnostic process. The following nine risks relate to the overarching design and implementation framework:

- (a) Two-phase design process compromises quality:** there is a risk that the proposed approach could lead to a poor quality design and an inappropriate contractor to implement the program. However, the likelihood of a lack of continuity with the current Capacity Building Service Centre (CBSC) poses a greater risk. This is because of the disruption this would cause, and where continuing support is required, necessitate the creation of a large number of separate individual contracts which would impact on AusAID's capacity to effectively manage its other investments and tie up its efforts in program administration. Risks around design quality will be mitigated by ensuring a high quality diagnostic process takes place and that key decisions and information needs are established prior to program implementation. Regular performance reviews are scheduled throughout the life of the program;
- (b) The HSPC doesn't function effectively:** there is a risk that a poorly or inconsistently functioning HSPC could delay decision-making on HSCDP resources and affect program implementation. AusAID will manage this risk by using its position in enabling governance sectors to advocate for regular and senior participation by central agencies responsible for budget resources and sub-national actors responsible for implementation; and by investigating opportunities to strengthen the role of the HSPC, SCT and working groups to perform effectively;
- (c) The HSCDP doesn't facilitate development partner harmonisation:** there is a risk that development partners will continue to procure technical and other assistance through separate mechanisms, undermining a single capacity development mechanism for the sector. AusAID will actively use the development partner coordination forum and individual meetings with development partners to promote the use of the HSCDP for pooled approaches to capacity development;
- (d) Direct financing undermines PNG's systems:** there is a risk that funding provided through the HSCDP could displace PNG's efforts to effectively plan and budget using its own (or established donor) systems and/or add complexity to a weak system. This risk will be mitigated by only providing financing for purposes which cannot be reasonably accessed through either PNG's

own sources (such as health function grants and internal revenue) or the health sector improvement program (HSIP) trust account;

- (e) **The HSCDP supports low priority areas:** this risk will be managed through the capacity diagnostic process which will focus only on areas of agreed focus as set out by the *PNG–Australia Partnership for Development Health and HIV schedule*. A related risk is that a demand driven program, even following comprehensive diagnostics, may result in a set of activities, either individually or in aggregate, that does not appear to AusAID to contribute enough to its overall health development objectives. The practical issue is how can AusAID, working within Paris declaration principles, influence the direction selected by the HSPC? This risk can only be mitigated by AusAID fully participating in the process at all stages from when a proposed intervention is being formulated. Based upon experience in other sectors in PNG it is often too late if AusAID attempts to influence (change) priorities near the end of the approval process. This will be time intensive for AusAID health program staff given the HHISP's limited role;
- (f) **Growth in advisers:** this risk will be managed by identifying a cap for the proportion of Australian health aid which can be spent on advisory support, and monitoring and reporting on this back to GoPNG at relevant forums;
- (g) **Flexibility equates to loss of focus:** this risk will be managed by using the capacity diagnostic process to identify clear focus and result areas for Australian aid, while providing maximum flexibility about the types of aid which can be used. Further, any flexible funding mechanisms would be capped at a modest level to ensure overall HSCDP funding is well-targeted; and
- (h) **National focus:** there is a risk that Australian aid could return to high-levels of expenditure at national levels with limited impact on rural health service delivery. This risk will be managed by setting a nominal proportion for support to national functions, and monitoring expenditure to ensure this remains appropriate and proportionate.
- (i) **Insufficient AusAID engagement:** there is a risk that AusAID does not properly resource engagement on the HSCDP given its ambitious health portfolio, which compromises program effectiveness. This will be managed through additional staff resource bids which will include a full-time team of three staff based at Post, sharing of staff resources with the HIV program, and five development specialists based in all priority provinces and the Autonomous Region of Bougainville.

8. Budget framework and timeline

Budget framework

The overall budget for the HSCDP is AUD 60,000,000 over four years. This figure, approximately less than 20 per cent of the PNG–Australia Health Delivery Strategy 2011–2015 medium-term budget framework, has been chosen to ensure the overall health portfolio has an appropriate balance between support for capital, TA and recurrent expenditure. The overall figure may be increased or decreased as a result of the capacity diagnostic assessments if this is justified and subject to further approvals.

Box 9: Overall HSCDP budget 2011-2015

2011-12	2012-13	2013-14	2014-15
\$7,500,000	\$17,500,000	\$17,500,000	\$17,500,000

These costs are inclusive of contractor management costs which are estimated to be \$2,500,000 per year. The breakdown of the development budget for the program will be determined through the capacity diagnostic process, and refined/updated annually through the annual planning process. This will include detailed costs of all forms of aid delivered, costs against key functions and particular agency support, and costs for all aspects of contractor management. This will allow the program to easily report against support for particular functions, support provided at national and sub-national levels and the proportion of expenditure for each type of aid. This analysis will allow key stakeholders to ensure the program retains an appropriate sub-national and service delivery focus.

Annex 1 – Roles and responsibilities for effective implementation of HSCDP

GoPNG

- > Responsibility for delivering the HSCDP rests on the GoPNG stakeholders participating in it;
- > GoPNG is responsible for properly resourcing the NHP on an annual basis so that key enabling resources can support effective implementation of HSCDP;
- > The NDoH, health worker training institutions and five provinces (and others receiving assistance under this mechanism) are responsible for implementation; and
- > The HSPC sets the development agenda, plans and prioritises the activities, and reviews performance. The GoPNG will be responsible to staff, resource and lead participation of its representatives on the following health sector governance bodies:
 - o Health Sector Partnership Committee (HSPC);
 - o Sector Coordination Team (SCT) ;
 - o Sector Resource Allocation and Review (SRAR) Working Group; and
 - o Capacity Development Coordination (CDC) Working Group.

These bodies will be responsible for reviewing, coordinating and authorising tasking notes and support provided through HSCDP; and

- > SCT has responsibility for detailing the services required, timing and performance criteria for HSPC and Secretary for Health issued tasking notes,

AusAID

- > AusAID is PNG's development partner, who works with its PNG partners to influence strategic direction and performance. AusAID is providing significant finance for the program's activities. It has a strong interest in the successful delivery of the program;
- > AusAID is the implementer of some aspects of the PNG-Australia Health Delivery Strategy 2011-2015 (but not the elements supported by this mechanism);
- > AusAID has engaged the HHISP to provide the management services in this design. AusAID is responsible for overseeing the quality of the Contractor's contribution.
- > Perform stakeholder dialogue and program governance functions;
- > Facilitate development of high quality M&E plan with relevant stakeholders and external expertise as required;
- > Facilitate development of high quality activity design with relevant stakeholders and external expertise as required;
- > Responsible for ensuring that all tasking notes are properly approved by financial delegates to support timely reimbursement of HHISP operating costs;
- > Responsible for detailing the services required, timing and performance criteria for AusAID issued tasking notes;

- > Maintain a complete and up-to-date register of tasking notes issued and performances attained by HHISP to support performance reviews and any HHISP profit withholding calculation;
- > Responsible for appraising HSCDP reporting on a timely basis and providing direction, as needed;
- > Higher level analysis of monitoring and evaluation of HSCDP performance; and
- > Responsible for appraising the quality of HHISP performance.

ISP

- > Timely and effective mobilisation of the HHISP staff, offices and support facilities including security;
- > Prompt and timely responses to all tasking notes, supported by regular status updates;
- > Provision of services in accordance with performance criteria, as set out in tasking notes;
- > Implementation of HHISP annual plan;
- > Timely and effective management of grants;
- > Timely and accurate reporting of grants administration and use by recipients;
- > Timely and accurate collation and reporting of relevant M&E data (determined through diagnostic process and development of M&E plan)
- > Timely identification, recruitment, installation and on-going human resources and performance management, security and logistics support for any aid-funded personnel, consistent with terms and conditions under the ARF;
- > All procurement ensures optimal value for money and purchasing decisions conform to Procurement Principles as set out in Commonwealth Procurement Guidelines; and
- > Timely reporting to AusAID and other stakeholders on the use and impact of HSCDP activity.

Annex 2 –Menu of options for capacity development

Capacity development framework: adviser roles

	Capacity Enabler	Capacity Substitution	Capacity Supplementation	Capacity Facilitation
Purpose	<p>Technical, governance or activity management advice;</p> <p>To enable efficient use of donor resources;</p> <p>To liaise between donors and country partners to facilitate aid delivery.</p>	<p>Technical, organisational or governance advice;</p> <p>To help an organisation carry out its work in lieu of locally available personnel.</p>	<p>Technical, organisational or governance advice;</p> <p>To provide expert advice to a client on a defined area of specialisation not available locally.</p>	<p>Mentoring, coaching, confidence-building, change management;</p> <p>To assist capability development and enhance performance.</p>
Approach	Indirect	Direct	Direct or indirect	Ideally indirect
Role	<p>Provision of program management / specialist technical advice;</p> <p>Transitional boost to aid program delivery capacity not available, or needed long-term, in-house or locally;</p> <p>Always off-line.</p>	<p>Delivering services in the context of performing core functions;</p> <p>Providing capacity that does not exist locally (gap-filling);</p> <p>In-line.</p>	<p>Delivering services in context of supporting specific tasks;</p> <p>Adding to existing capacity in specialist areas;</p> <p>In- or off-line.</p>	<p>Facilitating change and / or service delivery;</p> <p>Strengthening and expanding existing capacity;</p> <p>Always off-line.</p>
Relationships	<p>AusAID staff or work unit;</p> <p>Country partners.</p>	Fills established position within partner organisation, so no counterpart.	Counterpart may be a country partner work unit or individual.	Must have a country partner counterpart (individual, work unit or system).

Capacity development options matrix

Individual capacity development options	
Diagnostic tools	
Psychological testing	
Job related learning	
Action learning	Coaching
Communities of practice	Exchanges
External training courses	Forums
Internal training courses	On the job training
Scholarships	Secondments
Self-directed learning	Work shadowing
Professional development	
International conferences	Internet forums
Mentoring	National sector-based conferences
Professional associations and / or networks	Seminars
Organisational strategies that directly support individual capacity development	
Apprenticeships	Cadetships
Customised leadership and management programs	Graduate programs
Institutional co-operation / twinning	Internships
Project teams and working groups	Team retreats
Training of trainers	Workshops
Team capacity development options	
Diagnostic tools	
Client / customer surveys	Psychological testing (for teams)
Team based learning processes	
Benchmarking	Coaching

Customised leadership and management programs	Institutional co-operation / twinning
IT systems design and implementation	Mediation
Operational planning	Process improvement / quality assurance processes
Project teams and working groups	Restructuring (work redesign within the team)
Reward and recognition programs	Simulations
Study tours	
Team based planning	
Monitoring processes	Team retreats
Workshops	
Organisational capacity development options	
Diagnostic tools	
Client / customer surveys	Human Resource Management Diagnostic Instrument (HRMDI)
Public Expenditure and Financial Accountability (PEFA) Assessment	Strategic / corporate planning
Training needs analysis (TNA)	
Organisational strategy	
Balanced scorecard	External diagnostic process
Monitoring process	New or changed legislation
Operational planning	Organisational communications processes
Organisational analysis / diagnostic processes	Process improvement / quality assurance processes
Project teams and working groups	Restructuring
Reward and recognition programs	Simulations
Strategic / corporate planning	
Organisational learning	
Benchmarking	Commissioned research
Institutional co-operation / twinning	IT systems design and implementation
Study tours	Training of trainers

Use of pre-existing research	Workshops
Workforce development	
Apprenticeships	Cadetships
Customised leadership and management programs	Graduate programs
Internal training courses	Internships
Sector wide capacity development options	
Diagnostic tools	
Client / customer surveys	Human Resource Management Diagnostic Instrument (HRMDI)
Strategic planning (sectoral)	
Sector wide workforce development	
Cadetships	Customised leadership and management programs
Exchanges	External training courses
Graduate programs	Internships
Mediation	Monitoring processes
New or changed legislation	Project teams and working groups
Reward and recognition programs	Secondments
Training of trainers	Work shadowing
Sector wide learning	
Commissioned research	Communities of practice
Forums	Institutional co-operation / twinning
Internet forums	National sector-based conferences
Professional associations and / or networks	Project teams and working groups
Seminars	Simulations
Study tours	Use of pre-existing research
Workshops	

Technical assistance resourcing options	
Financing	
General budget support	Sector budget support
Core contributions	Country partner funded
Facilities provision	Pooled funds
Personnel	
Consultancies	In-line personnel
International advisers	National advisers
Regional advisers	Volunteers
Whole-of-government advisers	
Programming	
Outsourcing of services	Projects
Scholarships	Specific-purpose programs and funds