INDEPENDENT EVALUATION OF DFAT'S MULTILATERAL PARTNERSHIPS IN THE HEALTH SECTOR OF PNG

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Contents

Acronyms, glossary and currencies.

ADB	Asian Development Bank
AHC	Australian High Commission in Port Moresby
AMR	Anti-Microbial Resistance
ARV	Anti-retroviral treatment (for HIV/AIDS)
CCM	Country Coordinating Committee of the Global Fund
CHC	Community Health Centre
CHP	Community Health Post
CPP	Church Partnership Program
DALYs	Disability Adjusted Life Years. DALYs are a notional measure that seeks to estimate the sum of healthy lives lost to premature death as well as years of living with a disability.
DDA	District Development Authority
DFAT	Department of Foreign Affairs and Trade. (Government of Australia)
DHM	District Health Manager
DHS	Demographic and Health Survey
DNPM	Department of National Planning and Monitoring of the Government of PNG.
EENC	Early Essential Newborn Care. This is a UNICEF initiative
EPI	Expanded Program of Immunisation. WHO advises that 'The first diseases targeted by the EPI were diphtheria, whooping cough, tetanus, measles, poliomyelitis and tuberculosis. Additional vaccines have now been added to the original six recommended in 1974. Most countries, including the majority of low-income countries have added hepatitis B and Haemophilus influenzae type b (Hib) to their routine infant immunisation schedules and an increasing number are in the process of adding pneumococcal conjugate vaccine and rotavirus vaccines to their schedules". Further details are available at: http://www.who.int/immunization/programmes_systems/supply_chain/benefits_of_immunization/en/
FSC	Family Support Centre
GBV	Gender Based Violence
GFATM	Global Fund to Fight AIDS TB and Malaria (now referred to as The Global Fund)
GoPNG	Government of Papua New Guinea
HIV / AIDS	Human immunodeficiency virus infection and acquired immune deficiency syndrome
HSPC	Health Sector Partnership Committee
IMAM	Integrated Management of Severe Acute Malnutrition
IHME	Institute of Health Metrics and Evaluation
MDR-TB	Multi Drug Resistant Tuberculosis
NDOH	National Department of Health, Government of Papua New Guinea
NHP	National Health Plan of the Government of Papua New Guinea (2011-2020)
MPA	Minimum Priority Activities
MTR	Mid Term Review
MDPs	Multilateral Development Partners. For the purposes of this evaluation, the MDPs are, in alphabetical order, the Asian Development Bank; the Global Fund to Fight AIDS, TB and Malaria ("The Global Fund"); UNFPA; UNICEF; the World Bank; and the World Health Organization (WHO).
Neonates	Newborn baby up to 4 weeks of age
NHAP	National HIV / AIDS Program

Opportunity cost	*The Economist* magazine defines opportunity cost as "The true cost of something is what you give up to get it. This includes not only the money spent in buying (or doing) the something, but also the economic benefits that you did without because you bought, or did, that particular something and thus can no longer buy, or do, something else"
PF4	Partnership Framework 4 (an agreement between Australia, New Zealand and the World Bank for the World Bank to undertake analytical work on the Pacific Island economies.
PNG	Papua New Guinea
Pentavalent	Pentavalent vaccine protects against five major infections: diphtheria, tetanus, pertussis (whooping cough), hepatitis B and Haemophilus influenza type b (Hib)
PR	Principal Recipient (of Global Fund grants)
PPP	Purchasing Power Parity. PPP stands for purchasing power parity. The formal definition according to the IMF is "The rate at which the currency of one country would have to be converted into that of another country to buy the same amount of goods and services in each country". In general terms, PPP is an approach that takes into account the fact that while poorer countries tend to have a lower level of income per head, they may also have much lower costs and prices: $ US 10 in a poor country may well buy more food (although perhaps of a lower quality) than $US 10 in a rich country. PPP also aims to reduce the impact of commercial exchange rate variations. PPP approaches usually use purely notional ''International dollars'' – shown as $ I – to distinguish PPP estimates from $US. Further details are available at: http://www.imf.org/external/pubs/ft/fandd/basics/ppp.htm
PHA	Provincial Health Authority
P4D	Health and HIV Partnership for Development
RPHSDP	Rural Primary Health Services Delivery Project (project managed by the Asian Development Bank, co-financed with the Government of Australia and the OPEC Fund for International Development)
Sensitivity and specificity	Sensitivity and specificity are technical terms helping to explain the predictive power of a medical test. The following description of the difference between the two terms is taken directly from https://www.med.emory.edu/EMAC/curriculum/diagnosis/sensand.htm **Sensitivity**: If a person has a disease, how often will the test be positive (true positive rate)? Put another way, if the test is highly sensitive and the test result is negative you can be nearly certain that they don't have disease. A Sensitive test helps rule out disease (when the result is negative). Sensitivity rule out or "Snout". Sensitivity= true positives/(true positive + false negative) **Specificity**: If a person does not have the disease how often will the test be negative (true negative rate)? In other terms, if the test result for a highly specific test is positive you can be nearly certain that they actually have the disease. A very specific test rules in disease with a high degree of confidence Specificity rule in or "Spin". Specificity=true negatives/(true negative + false positives)
SIREP	Special Integrated Routine Expanded Programme of Immunisation Strengthening Programme in PNG (an initiative supported by the WHO)
SUN	Scaling Up Nutrition. PNG joined the SUN movement in April 2016. Further details about SUN are available at: http://scalingupnutrition.org/about-sun/the-vision-and-principles-of-sun/
TB	Tuberculosis
UNFPA	United Nations Population Fund

UNICEF	United Nations Children’s Fund
WHO	World Health Organization

Currencies

All $ are current, Australian dollars, unless otherwise shown.

All $US are current United States dollars

PNG Kina 1 = $ 0.40

$US 1 = $ Australian 1.31

Executive Summary

How six multilateral development partners improve health outcomes in PNG, with DFAT support, is a strategically important issue. That is because 81.3% of total health expenditure in PNG comes from the Government of PNG (GoPNG) with the support of those development partners. What GoPNG spends, where, when, how and on what is therefore critical to addressing important health challenges in PNG. Importantly, the six multilateral development partners (MDPs) subject to this evaluation[1] each have the capacity to substantively support and influence GoPNG's own efforts. The MDPs do so in different ways, according to their own mandates and comparative advantage. While all six MDPs provide technical advice, and contribute to PNG health policy, the Asian Development Bank, Global Fund to Fight AIDS, TB, and Malaria, and the World Bank provide large concessional financing. UNFPA, UNICEF, and WHO tend to focus more on technical assistance, training, and in some cases supply of commodities. When well-coordinated, the impact of these six agencies can be larger than the sum of their parts. DFAT, which has provided $111.9 million to the 6 MDPs over the period 2011 – 2017, is in a particularly good position to further leverage and magnify the important role played by the MDPs through judicious use of grant financing and policy dialogue. As direct ''shareholders'' in the six MDPs, it is also in the national interest of the Governments of PNG, Australia, and other bilateral governments to ensure these MDPs are fulfilling their potential in PNG.

The MDPs have a generally good record in terms of their overall effectiveness in the PNG health sector, but important challenges remain. There are some notable achievements in terms of outcomes and outputs that are explained in this Report. These achievements include the ADB's rural health clinics; Global Fund's contribution to reducing malaria; UNICEF's interventions to reduce newborn deaths and severe acute malnutrition; UNFPA's provision of family planning commodities; and WHO's response to multi-drug resistant TB (MDR-TB). World Bank has also generated analytical work and evidence which has shaped broader GoPNG policies. All of these notable achievements have involved, and been welcomed by, GoPNG. All of these achievements also involve direct – and often substantial – financing from DFAT. That being said, important challenges remain. Immunisation rates have essentially stagnated for decades, and in some cases declined. PNG has the 4th highest rate of stunting in the world. Maternal mortality remains one of the highest in the world. Policy dialogue with GoPNG has had only modest success: health expenditure per capita has been volatile and decreasing in real, per capita terms in recent years. Stock outs of essential drugs have the potential to undermine the development effectiveness of much of what GoPNG, DFAT, and the MDPs are seeking to achieve. Addressing these challenges can only be done by PNG itself, and it will take time. But the MDPs, and DFAT, can be catalysts and supportive of change and so need to remain engaged.

There is a generally positive finding with respect to the other elements of this evaluation, although there is still room for improvement. There is substantial evidence confirming MDPs manage the fiduciary risk of using DFAT funding in PNG well, compared to the existing alternatives, albeit by having to often use parallel systems outside GoPNG's fragmented, decentralised, health financing system. The overheads MDPs charge DFAT appear to provide reasonable value for money compared to some other alternatives. On the other hand, value for money also – indeed primarily – involves ''managing for results'' through robust monitoring and evaluation systems and here the relationship between MDPs and DFAT is weak. There is good evidence that the MDPs are targeting the poor in terms of the priority provinces they work in as well as targeting vulnerable groups including women. Sustainability is a long-term challenge in PNG, but some MDPs are working creatively to manage that issue. MDPs

[1] In alphabetical order: the Asian Development Bank; the Global Fund to Fight AIDS, TB and Malaria ("The Global Fund"); United Nations Population Fund (UNFPA); UNICEF; World Bank; and World Health Organization (WHO).

have some innovative approaches, including working with the private sector. All MDPs are able to attract high quality specialist and technical staff for *short term* assignments in PNG. Some MDPs are able to attract, and retain, similarly high quality *long term* staff to PNG - those who understand the importance and satisfaction of working in such a unique environment. But more needs to be done in terms of finding ways to keep attracting high quality, energetic, development professionals to PNG.

Monitoring and evaluation (M & E) remains the weak point. DFAT has correctly, and frequently, identified M&E as the weak point in health programs it supports to PNG. The weaknesses continue. With some exceptions (eg ADB) too many reports from too many MDPs are descriptive and input-focused, rather than analytical and output / outcome focused. There is a lack of gender-disaggregated data from the MDPs, surprising given the gender challenges in PNG. To address these, and other, ongoing problems of M&E, DFAT will need to develop a clearer, overarching - as well as individual agency level- results framework that sets out what DFAT expects MDPs to achieve when using its funds. DFAT also needs to be equipped, including with technical expertise where that is necessary, to be able to more proactively manage its ongoing relations with the MDPs and achieve a sharper results focus.

Going forwards, there are challenges. The broader challenges include the macroeconomic and fiscal situation facing PNG, particularly in the face of a rapidly rising population in PNG; stubborn weaknesses in health financing and the provision of essential drugs to front line services; and a double burden of controlling communicable (including drug-resistant) diseases alongside the rapid rise of expensive to treat non-communicable diseases. PNG is experiencing fiscal stress and falling government revenue as a result of falling commodity prices. Large, concessional financing from the ADB and World Bank can therefore make an important, early and direct contribution to supporting much needed health expenditure in PNG. Having said that, development partners should monitor their financing contributions to PNG so as to ensure that it is additional to, and not a substitute for, GoPNG's own expenditure effort in the health sector over the medium to long term. Generally stagnant levels of immunisation, and in some cases such as measles, *declining* levels of immunisation, is a worrying reflection of the capacity of the health system more generally, and the ability to manage health security challenges more specifically. This challenge is magnified by the fact that the Global Fund is considering prioritising funds to other countries in the region with even higher disease burdens but – revealingly – better capacity to absorb funds. While GAVI was not part of this evaluation, the possibility that it might 'transition'' (in effect, ''graduate'') PNG from its support adds to the challenge of improving immunisation coverage. The MDPs themselves face the challenge of finding even more effective ways to help support the policies and programs of PNG and, at a practical level, ensuring high quality and effective staff are deployed to PNG.

But there are also opportunities. PNG has a new Minister for Health who is clearly determined to improve health outcomes. PNG has had an ''unprecedented'' reduction in the prevalence of malaria, and appears to have avoided the early projections of an HIV AIDS crisis: two welcome and substantive developments that are thereby freeing up financial and other resources to focus on other challenges. The ADB is considering a substantial concessional loan to PNG with important policy based triggers that can incentivise reforms in the health sector. The World Bank, with support and encouragement from DFAT, has recently finalised a concessional credit to address MDR-TB. The World Bank is also considering the possibility of a results based concessional loan that could, like the ADB, further incentivise and drive reforms in public financial management in the health sector. The ''One UN'' approach appears to be working collaboratively and well in PNG, and each of the individual UN agencies have sound policies and country strategies for engaging in PNG although continued effort is needed to ensure effective implementation and actual execution of those strategies. DFAT itself is

clearly committed to supporting GoPNG reform efforts in the health (and other) sectors. This includes the potential for further engaging with MDPs. Having a stronger, more explicit, more purposeful results framework at an overarching program level with the MDPs, and with individual MDPs, will be an important part of that forward program further enabling the contributions of the six MDPs to be more than the sum of their parts. It will, however, require a transition plan so that MDPs, and DFAT itself, are equipped to achieve the intended results. This independent evaluation provides some findings and recommendations on how DFAT can then maximise the development impact from any such future engagement with multilateral development partners.

Chapter 1 Background

The background and purpose of this evaluation

The Australian Department of Foreign Affairs and Trade (DFAT) has commissioned an independent evaluation of its partnerships with six multilateral agencies that work to support health outcomes in Papua New Guinea. The six agencies are, in alphabetical order: the Asian Development Bank (ADB); Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); United Nations Population Fund (UNFPA); UNICEF, World Bank and World Health Organization (WHO).[2] As part of its bilateral aid program to PNG, DFAT has provided a total of $ 111.9 million grants to these six multilateral development partners (MDPs) over the period 2011-2016.[3] The overall goal has been to increase and extend each agency's own support to the health sector of PNG. Details of the specific allocation to each agency are set out in Table 1 below. In addition, Australia has continued to provide ''core funding'' to each of the agencies by virtue of Australia being a member of that organisation. Importantly, GoPNG is supportive of Australia's partnership with the MDPs. More specifically, the GoPNG Department of National Planning and Monitoring (DNPM) submitted, as part of this Evaluation that ''the GoPNG encourages trilateral or even quadrilateral Partnerships to mobilise resources to finance large impact projects and avoid thinly spreading resources hence Australia's partnerships with MDPs is commendable and encouraged''.

Table 1

Allocation of DFAT expenditure to the 6 MDPs subject to this Evaluation

Agency	Amount paid 2011-2017
Asian Development Bank	$73,769,800*
World Health Organisation	$16,937,547^
UNFPA	$10,000,000
UNICEF	$8,891,317
World Bank	$2,301,336
TOTAL	**$111,900,000**

* Paid in USD, with exchange rate averaged as at August 2017

^ Includes an amounts provided for a midwifery education program implemented by WHO

The primary purpose of this independent evaluation is to evaluate the overall development effectiveness of the agencies' operations in PNG so as to inform DFAT's possible future support to those organisations. The Terms of Reference (TORs) for the evaluation are at Annex 1. Paragraph 14 of the TORs state that the evaluation should focus on:

a) **assessing how multilateral agencies have performed in PNG**, relative to their individual mandates, roles and responsibilities. The evaluation will give first priority to assessing the development effectiveness of those programs that multilateral partners are delivering that involve direct Australian Government aid funding. However, the evaluation will, to the extent that time then permits, also provide insights into the broader development effectiveness of those multilateral agencies' own programs in PNG.

[2] DFAT also provides core funding to UNAIDS and to the Vaccine Alliance (previously known as GAVI), both of which have a program presence in PNG. However, to keep the evaluation focused and manageable in the time allowed for the evaluation, DFAT focused on those 6 partnerships where there is direct DFAT bilateral funding to the agencies and / or a more significant direct partnership with DFAT in PNG.

[3] In some cases the direct grants to the agencies were for a shorter period. For example, direct grants to UNICEF began in 2015, and the grant to UNFPA to support the Demographic and Health Survey was approved in 2016.

b) **what lessons can be learned to inform future DFAT support to multilateral partners**? How well-placed each of those multilateral organisations are to providing value-added programs for the future priority areas of DFAT's program."

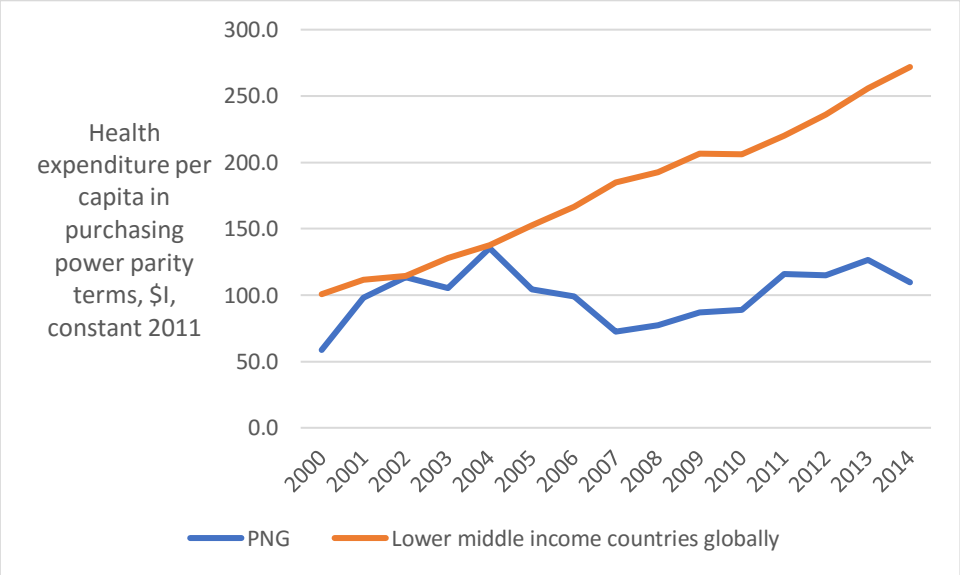
The strategic importance of multilateral development partners support to achieving improved health outcomes in PNG.

Government expenditure dominates health expenditure in PNG: how multilateral development partners support government expenditure is therefore a strategically important issue. Expenditure from Government of Papua New Guinea (GoPNG), including that provided by development partners, accounts for more than 81.3% of total health expenditure in PNG. This is a much higher level of government expenditure in the health sector than the 37% average for lower middle income[4] countries globally (1). But while GoPNG expenditure dominates health expenditure, the actual levels of health expenditure per capita in PNG are significantly less than the average for lower middle income countries globally: see Chart 1. It therefore follows that the extent to which multilateral partners can support and leverage both the quantity - and the quality (including effectiveness and equity) - of GoPNG's own expenditure will make a material difference to health outcomes in PNG.

Chart 1

Health expenditure per capita is lower in PNG than comparable lower-middle income countries globally

Source: World Bank *World Development Indicators (1)*



Despite progress in some areas, PNG faces significant public health challenges that require government attention. PNG continues to face several important health challenges. (2-11) More specifically, and despite recent successes in reducing malaria, PNG was the only Pacific Island country not able achieve any of the Millennium Development Goals (MDGs), including MDGs 4,5, and 6 of

[4] A lower-middle income country is currently defined by the World Bank as having a Gross National Income per capita of between $US 1006 and $US 3955 in 2016.

reducing, respectively, child mortality, maternal mortality, or communicable diseases. [5] (12) Despite at times rapid economic growth, PNG has the fourth highest rate of stunting (i.e. short for age: an indication of chronic malnutrition) in the world (13, 14) and stagnant levels of immunisation coverage. PNG is now also facing a double burden of disease, with a pronounced rise in non-communicable diseases co-existing with an unfinished agenda of maternal mortality and communicable diseases. (7, 15). More broadly, the 2015 mid-term review of the National Health Plan 2011 – 2020 found that while some provinces and districts were performing particularly well, overall progress in achieving the National Health Plan at a national level was ''sluggish" due particularly to a "a failure to build the necessary workforce, and to direct the increased financial resources in the planned direction" (16). All of these challenges involve public health and public financing policy where the role of government is critical. MDPs can be particularly helpful if they are strategic and effective in their support.

There are also broader reasons why the contribution of multilateral development partners is strategically important. The Governments of PNG, and Australia, are direct ''shareholders'' and ''owners''[6] of the six MDPs that are operating in PNG that are the subject of this evaluation. [7] As such, it is in the direct national interests of GoPNG and GoA to have those organisations perform to their full potential in PNG, and elsewhere in the region. The MDPs have, in principle, a comparative advantage and value-adding role in helping PNG limit the spread of multi-drug resistant tuberculosis; malaria; HIV and other communicable diseases to neighbouring countries.

Approach and method

The evaluation used a mixed methods approach. The Evaluation Team[8] used a mixed methods approach involving literature reviews (peer-reviewed and grey area); examination of publicly available budget documents; and semi-structured interviews. The interview questions for multilateral agencies[9] is at Annex 2. These questions were provided in advance to all stakeholders interviewed. We interviewed 84 government and other officials in PNG over the period 16-27 October, of whom 45 (53%) were female: details in Annex 3. To encourage candour, we advised all those interviewed, in advance, that their responses would be anonymous. We specifically sought *documentary* evidence that would provide an objective and verifiable line of sight between the MDPs' inputs and tangible changes in GoPNG's policies, programs, outputs, and outcomes. We also requested, and then examined, DFAT's original documents that approved grants to MDPs in PNG. Such documents are relevant as they provide the original legal basis, justification, and expectations of outputs and outcomes for Australian government expenditure from each of the agencies in question.

There are strengths to the approach used. We obtained good access to senior officials in GoPNG, and direct access to the resident heads of each MDP agency based in Port Moresby. All interviewees were candid and constructive in their comments. Many interviewees provided detailed documentary evidence in the form of memoranda, reports, or emails substantiating their claims of being helpful and influential to GoPNG. We inspected hospitals, health posts, and health centres in two quite different

[5] PNG and Solomon Islands did not achieve the MDG 4 target of reducing child mortality by 2/3 between 1990 and 2015; PNG and the Federated States of Micronesia did not achieve MDG 5 of reducing maternal mortality or increasing coverage of skilled birth attendance; and PNG did not achieve MDG 6 of reducing communicable diseases including HIV.

[6] Including by contributing sovereign-country backed callable capital to the ADB and World Bank and as sovereign state members of the United Nations, of which UNICEF and WHO are agencies, as well as sovereign state members of the ADB, GFATM, and World Bank.

[7] In alphabetical order the multilateral agencies subject to this evaluation are: Asian Development Bank, Global Fund to Fight AIDS, Tuberculosis and Malaria; UNFPA; UNICEF, World Bank and World Health Organization.

[8] Ian Anderson, Director, Ian Anderson Economics Pty Ltd, as Team Leader and Ms Renee Martin, Monitoring and Evaluation specialist, Senior Manager, Economics and Policy, PricewaterhouseCoopers (Consulting) Australia Pty Ltd

[9] The interview questions to multilateral development partners tracked the specific questions of the TORs. A similar approach was used to develop the

provinces - Milne Bay Province and Western Highlands Province - so as to better understand the effectiveness of MDP programs at the sub-national level. In doing so we were able to speak to front-line health workers in remote and rural settings, as well as local village community leaders.

There are inevitable limitations to the evaluation. There are several confounding factors which means it is not possible to directly attribute the work of the MDPs to higher level health outcomes such as life expectancy or maternal mortality. That is because key health outcomes such as life expectancy and maternal and child mortality are affected by several factors outside the health sector per se including the levels and nature of: poverty and hardship; girls' education; water and sanitation; food security; physical security; and physical access to health and other basic services. Other confounding factors include changes in the economic situation in PNG; and, the role of other development partners outside of the scope of this evaluation (including bilateral partners such as USAID but also NGOs and private foundations). Several initiatives that involve a degree of DFAT funding are joint programs between the multilaterals, especially under a ''One UN" approach, so it can be difficult – although not impossible - to disentangle the contribution of any one particular agency. Examples of this at the outcome level include the reduction of malaria which involved significant contributions from GFATM but in collaboration with WHO, while at the program level the Essential Early Newborn Care intervention is implemented predominantly by UNICEF but in collaboration with WHO. Other limitations to the evaluation include the fact that there is obviously no counterfactual – what would have happened in the absence of the MDPs' engagement. There were also few randomised control trials – an approach providing a higher level of rigour in evaluation (17-23) – although UNICEF and ADB provided some refreshingly useful (and ethical) case / control trials and controlled experiments. One MDP, in commenting on its work in PNG, noted that "some of the most important functions such as exercising influence, providing leadership and building institutional and individual capacity are difficult to quantify yet are critical to technical cooperation with Governments." We agree, but development partners are increasingly being asked to demonstrate ''results'' and value for money, which is why we looked wherever possible for documentary evidence of influence and effectiveness.

There were also limitations in terms of the timeliness, relevance, and even availability of certain key documents from the MDPs. Some agencies provided regular, useful, and usable reporting on performance to DFAT and GoPNG: the ADB RPHSDP project being a good example. However, the reports of other agencies were often very input focused (''number of people trained", ''number of workshops held'') with little substantive or verifiable evidence of the actual quality and consequences of operations, including those involving direct DFAT funding. The reports from some agencies lacked sufficient details, regularity, or timeliness to allow a strong, evidence based, assessment as to whether they were delivering what DFAT had intended via a grant, or whether the agency in question was actively and energetically ''managing for results'' as distinct from more descriptive and procedural based reporting. Further details are provided below under the heading Monitoring and Evaluation. We also sought to see the records of the Demographic Health Survey project steering committee given that DFAT had provided $10 million to UNFPA to support that activity and it had been a problematic exercise. Our request was declined by DFAT on the grounds that the steering committee reports were sensitive.

Structure of this report

This report is structured as follows. Chapter 2 addresses the first main question set out in paragraph 14 of the TORs: "assessing the development effectiveness of those programs that multilateral partners are delivering that involve direct Australian Government aid funding". Chapter 2 deliberately repeats each of the sub-headings (effectiveness, efficiency, equity, sustainability and monitoring and

evaluation) as well as the specific question stated in the TORs and then provides a summary of the findings. The detailed evidence behind each of those findings, and detailed, specific assessment of each MDP is set out in Annex 4. Chapter 3 briefly addresses the second main question of the TORs: what lessons can be learned to inform future DFAT support to multilateral partners? Chapter 4 provides a summary of the findings and recommendations.

Chapter 2 Main findings on how multilateral agencies have performed in PNG

The TORs for the evaluation state that the first key evaluation question is "assessing how multilateral agencies have performed in PNG, relative to their individual mandates, roles and responsibilities. The evaluation will give first priority to assessing the development effectiveness of those programs that multilateral partners are delivering that involve direct Australian Government aid funding. However, the evaluation will, to the extent that time then permits, also provide insights into the broader development effectiveness of those multilateral agencies' own programs in PNG. "

Effectiveness

What was the quality of their overall engagement in PNG[10], including when engaging in policy dialogue and providing technical advice?

An overarching question is whether MDPs' contributions are ''additional'' to, or substitute for, GoPNG's own expenditure effort in the health sector. This is a difficult question to answer. That is partly because reporting of total public health expenditure rarely shows the breakdown between GoPNG ''own resources'' generated through domestic taxation and other government revenue, and how much is contributed from multilateral and bilateral development partners. The question is also difficult to answer because it depends upon what funding was used ultimately used for. Bilateral and multilateral financing that is genuinely additional to GoPNG own resources is, prima facie, available to expand essential health services. But if bilateral and multilateral financing displaces GoPNG's own financing to the health sector (known as ''fungibility'') then it is possible that there will be no expansion of health services. More importantly, the overall development effectiveness then depends upon what the GoPNG resources that are withdrawn from the health sector are then spent on.

Given the importance of this issue we sought information on financing trends from GoPNG, and development partners, to the health sector over the period 2011 – 2017. The information we were seeking is not available. What is clear is that GoPNG funding for health, and indeed other sectors, is decreasing sharply. More specifically, GoPNG's budget statement states (page 52) that the Kina 1,221 million ($ 500 million) total funding for health in 2017 involves a reduction of 20.5% from the 2016 Supplementary budget (24). Other Budget papers also state (page 415) that estimated expenditure for the National Department of Health – a key agency for DFAT and MDPs – is projected to decline from Kina 619.8 million in 2016 to Kina 382.4 million in 2020 (25). There is some published research discussing what the 20.5 % funding cuts to the GoPNG health budget in 2017, on top of earlier significant cuts in 2015 and 2016, may have been used for (26). Following the review mission, the 2018 PNG National budget was released. It indicated the 2018 budget for the health sector is estimated to be PGK 1,505.9 million, an increase of 23 percent on the 2017 budget. However, as in previous years, this is an estimate and it remains to be seen how much of the 2018 budget is actually released.

Much needed essential services during a fiscal crisis, or enabling substitution and a lack of sustainability? There is no doubt that PNG has been facing significant fiscal constraints as a result of declining commodity prices, especially LNG and oil. PNG Government revenue, adjusted for inflation, is below what it was in 2006 (27). In such circumstances it is arguably legitimate – even essential – for MDPs, supported by DFAT, to increase financial and other support for basic services including the roll

[10] This includes the effectiveness of multilateral partners at: building, maintaining and effectively harnessing relationships with key stakeholders to effect influence and/or change; and engaging at both policy and programmatic levels to drive reform and improvements.

out of rural health clinics [11](ADB); addressing multi-drug resistant TB in Daru (WHO); and support for essential newborn care and reducing severe acute malnutrition (UNICEF). Over the longer term, however, MDPs and DFAT will need to guard against additional funds *enabling* GoPNG to withdraw funds from the health sector in a permanent or semi-permanent way. Such an outcome is clearly not in GoPNG's own interests: it would significantly reduce political and policy ''ownership'' by GoPNG of health outcomes of its people; would hollow out the domestic ''pipes and plumbing'' of GoPNG's own health system; and would imperil long term financial and other sustainability. Nor would any entrenched fungibility be in the interests of bilateral and multilateral development partners which need to demonstrate they are not just supporting the PNG health system, but working with GoPNG to *transform* it so that improved health outcomes are genuinely owned and sustained by GoPNG.

Finding and recommendation 1.

MDPs and bilateral partners can provide much needed additional, short term financial and other assistance when there is a particular fiscal problem. However, over the medium to long term financial and other support from bilateral and multilateral agencies should be additional to, and not a substitute for, the domestically generated expenditure effort of Government of PNG for reasons of development effectiveness and long-term sustainability.

We **recommend** that DFAT, in collaboration with the National Department of Health, the Department of National Planning and Monitoring, and key development partners establish procedures to better monitor whether aid funding is additional to, or potentially a substitute for, GoPNG financing to the health sector.

The quality of engagement by the MDPs has been mixed: a reflection of their different entry points for engaging with GoPNG; the scale and nature of their operations; and strengths and weaknesses in their approaches. Each of the six MDPs have different entry points and means for engaging with health outcomes in GoPNG, as well as budgets and staffing profiles in Port Moresby. Such differences affect the nature of their engagement with GoPNG and the likelihood of demonstrating tangible ''results'' in the period 2011-2017 under review. As this chapter shows, the Asian Development Bank has one of the larger investments ($US 80 million total, with the majority of the funding coming from DFAT) involving construction of 32 health facilities at the sub-national level. The ADB project can point to significant and substantial – and visible - outputs and outcomes, largely because it is a (well managed) ''project''. On the other hand, UN agencies – especially WHO, UNFPA and UNICEF – emphasise that they are technical assistance agencies, advising but not directly ''implementing'' activities on the ground per se (although there are exceptions). The World Bank has focused to date on upstream analytical work, especially health financing. Their effectiveness is therefore to be gauged more by the degree to which they can influence GoPNG policies and programs.

The differences in scope – and scale – between the six MDPs means the quality of engagement, and evidence of development effectiveness, vary between the agencies. Annex 4 provides a detailed assessment of the overall effectiveness of each organisation, together with a summary of the evidence to support that assessment. The following section provides an overview summary of the strengths and limitations of each MDP's engagement that involved DFAT funding over the period 2011-2017. The agencies are assessed in alphabetical order.

[11] The term ''clinics'' in this context refers to both Community Health Posts and Community Health Centres.

Asian Development Bank

The largest single Australian Government engagement with MDPs in the health sector in PNG is the Asian Development Bank managed Rural Primary Health Services Delivery Project (RPHSDP). The RPHSDP involved at the design stage total financing of over $US 80 million, of which $US 20 million was financing from the Asian Development Bank's concessional window (the Asian Development Fund); $US 40 million from the Australian Government via DFAT; $US 10 million from GoPNG; and $US 11.2 million from other sources including the OPEC Fund for International Development[12]. As at March 2017, the total concessional financing is $US 97.6 million, with DFAT providing an additional grant of $US 17.6 million over the original $US 40 million for further expansion of rural health services in DFAT priority provinces.[13] As such, the RPHSDP is the largest single grant provided by Australia, via DFAT, to a MDP in the health sector in PNG. DFAT's total grant of $US 57.6 million (approximately AUD 75.6 million) is also the largest component of the RPHSDP. The stated aim of RPHSDP is to "strengthen the rural health system in selected areas of Papua New Guinea by increasing the coverage and quality of primary health care … in partnership with state and non-state service providers…" (28) RPHSDP involves six specific outputs, including development of national standards and policies for community health posts and aspects of health system strengthening including human resource development. Details of progress as at June 2016 in all components are available from the ADB Mid-Term Evaluation Report (28). We focused on output 4, - upgrading selected rural health facilities – as this was the largest single financial component of RPHSDP.

There is good evidence that the 32 RPHSDP supported health facilities will provide a significant and visible increase in primary health care services in rural areas that would not have occurred otherwise. RPHSDP involves construction and equipping of 32 new rural health facilities. This target is likely to be met (on time and within budget) by the end of 2017. In the course of the Evaluation we inspected two health facilities in Milne Bay province and two in Western Highlands province, with 3 of the 4 facilities being located in remote rural areas. There is clear evidence the new health facilities significantly increased the level and availability of primary health care services compared to the existing situation. For example, the new facilities provide separate, equipped, maternity delivery rooms 4 and 6 bed wards to enable overnight stays and 24 hour care ; private consultation rooms, as distinct from patients being interviewed in public in the foyer; medical waste incinerators[14]; and good, physically safe, housing for nursing staff adjacent to the facilities to enable 24 hour care. In most cases, none of those attributes had existed before hand. The new facilities also provide a visible, significant improvement compared to existing conditions; were properly equipped with vaccine refrigerators that, on the basis of a random inspection, were regularly monitored for temperature control. . The facilities are part of the provincial health referral and outreach network so sick patients can access higher level care at the provincial network and similarly, staff are delivering mobile vaccinations, antenatal care etc in the community. This contributes to sustainability. We interviewed local community leaders who confirmed they were consulted on the location and operations of the health posts and were pleased with the finished products.

There is also clear evidence that RPHSDP has shrewd and effective engagement strategies with other stakeholders in PNG, has delivered value for money (albeit after some otherwise avoidable

[12] The overall project also involves in-kind support from JICA volunteers and the WHO

[13] Specifically, the additional $US 17.6 million provided by Australia via DFAT will support the establishment of a district health centre in Western Province; the refurbishment / extension of two district health centres and a number of urban clinics in Morobe, as well as additional e-health information roll out in Western, Morobe, and National Capital District.

[14] Although one medical waste incinerator was poorly located and too close to the facility itself.

mistakes); and has robust monitoring and evaluation. See the discussion under separate headings later in this report with respect to efficiency and monitoring and evaluation for evidence of this.

However, continued lack of essential drugs is likely to critically undermine the development effectiveness of this large investment. Field visits conducted as part of this evaluation confirmed that RPHSDP health posts, including those within a few kilometres of the provincial capital where it might be expected supply chains would operate reasonably well, ran out of a range of essential drugs within a month of the facility opening and still had basic shortages: see pictures below.

Importantly, many of the drug stock outs or shortages were essential to addressing the key burdens of disease in PNG including misoprostol (an essential drug to reduce life-threatening bleeding during child birth): flucloxacillin and amoxcillin (antibiotics to treat infections): and paracetamol for pain relief and to reduce fever. In one facility condoms were freely and prominently available but in other facilities condoms were not.

Photographs 1: The development effectiveness of new health centres can be undermined by drug-stock outs

Source: Evaluation Visit

The sustained lack of essential drugs to hospitals and clinics is a well-known and widespread issue in PNG affecting many facilities, and is beyond the span of control of RPHSDP or the ADB or, indeed, any other MDP or bilateral partner, including Australia. However, the sustained lack of essential drugs is also a crucial factor potentially undermining the overall development effectiveness of this large investment. That is because absence of essential drugs means patients face three unpalatable choices: (i) return to the village with no drugs and no treatment (ii) pay out of pocket for drugs from a private pharmacy (iii) bypass the more cost-effective health post and seek treatment at the higher cost hospital, assuming it had the drugs in question. Each of those choices undermine the broader development effectiveness, health outcomes, and value for money of this otherwise well designed and well implemented investment involving ADB, DFAT, GoPNG and others.

Finding and recommendation 2.

There is substantial evidence to show that the ADB Rural Primary Health Services Delivery Project (RPHSDP) is currently a well-designed, well-managed, effective, efficient, and equitable intervention that can expand essential health care services to some of the poorest and most vulnerable populations in PNG, including especially rural women and children. Medical supplies, including drugs, is a core responsibility of GoPNG, not development partners. Prolonged stock-outs of essential drugs undermines the development effectiveness, efficiency, equity, and sustainability of the ADB RPHSDP.

We **recommend** that in considering any future co-financing or other support, DFAT should explicitly assess, as part of its risk management and value for money considerations, the extent to which continued stock outs of drugs and essential commodities fundamentally undermines effectiveness, efficiency equity and sustainability of DFAT's overall investment in rural based health services.

The Asian Development Bank has a large portfolio of investments in other sectors of PNG that also contribute to health access and outcomes: more could be made of these synergies. The ADB is currently PNG's largest multilateral development partner, with cumulative lending, grant and technical assistance to PNG exceeding $US 2.4 billion to date (29). Of that amount, $US 209 million (8.4%) has been provided to the health sector (29). However, ADB has a large portfolio of investments in other sectors, all of which can directly or indirectly affect health access and outcomes, especially in a country where 85% of the population live in rural areas. For example, ADB has provided over $US 1.5 billion (61% of ADB total cumulative support) to the transport sector in PNG; nearly $US 200 million has been allocated to the agriculture, natural resources and rural development sector; $US 132 million has been provided to public sector management; $US 63 million to education and $US 50 million to water and other infrastructure services (29). Working across sectors is challenging in PNG, especially when many services are the responsibility of individual provinces and districts in a decentralised setting. Nevertheless, there are potentially significant direct benefits to PNG, and the development effectiveness of DFAT and MDP investments, in making sure that opportunities for coherence and complementarities between sectors are recognised and developed. It is not particularly apparent that the linkages between these investments – for example that $ US 1.5 billion in transport helps improve access to health services – are being fully exploited in policy and programming discussions between ADB, GoPNG, and development partners. DFAT also has a prominent role in most sectors: see Exhibit 5 in Chapter 3. That means that DFAT can support GoPNG and other stakeholders to exploit existing and future large investments and linkages between sectors that can improve health outcomes in PNG.

Finding and recommendation 3.

Multilateral agencies such as the Asian Development Bank now, and possibly the World Bank in future, have a relatively large financial footprint, and policy engagement, in several sectors including transport and public sector management. This can directly, and indirectly, contribute to better and more equitable health outcomes in PNG.

We therefore **recommend** that DFAT, as a significant bilateral development partner in PNG, work with the National Department of Health; the Department of National Planning and Monitoring; the Asian Development Bank; the World Bank and other development partners to more explicitly identify and exploit linkages, complementarities, and coherence between sectoral investments that affect health sector outcomes in PNG.

Global Fund to Fight AIDS TB and Malaria: "The Global Fund"

There is good evidence to show that the Global Fund to Fight AIDS TB and Malaria ("The Global Fund") has directly contributed to substantial progress at the outcome level. At the output level, Hetzel and colleagues refer (page 695) in the *Bulletin of the World Health Organization* to the "unprecedented decline in malaria prevalence throughout Papua New Guinea, including epidemic-prone highland areas" from 11.1% in 2008/9 to 0.9% in 2013/14. (30) They also note (page 701) the reduction in malaria in PNG "is a greater reduction than the 26% observed in Africa between 2000 and 2016. Moreover, the prevalence (in PNG) in 2014 was lower than that in other countries in the Asia–Pacific region, including the neighbouring Papua province of Indonesia." The authors clearly attribute much of the success to the large-scale distribution of insecticide treated bed nets, including in particular the leading role played by the Global Fund (but in collaboration with NDOH and with the support of WHO and others).

There is also good evidence to show that the Global Fund achieves substantial results at the output level in the area of HIV / AIDS, and TB and also works hard to build local capacity. The latest reports show that the Global Fund support has been very important in ensuring that people with HIV/AIDS in PNG are currently on antiretroviral therapy; 13,900 new smear-positive TB cases have been detected and treated; 13.3 million insecticide treated nets have been distributed to reduce malaria; and that the Global Fund has invested over $US 218 million in PNG to date (31). The latest Global Fund Country Coordinating Mechanism (CCM) request for renewal (32) also cites several examples where agreed performance indicators had been exceeded, often by a wide margin. For example, the CCM states (page 7) that in the previous 18 months "the target percentage of adults and children on Anti-retroviral therapy (ART) in nine high-burden provinces who had TB status assessed and recorded during their last visit" had been exceeded by 220%. The CCM report states that in PNG ''the number of antenatal services that offer routine testing is now nearly 300, having increased more than five-fold from 2007 to 2011" including through Global Fund support and that, partly through more people being on ART, there is some evidence of HIV incidence stabilising. There is independent evidence (33) to show that the Global Fund also takes seriously the role of monitoring and evaluation and building local capacity: see also the discussion below under Monitoring and Evaluation.

However, there are still some issues concerning the absorptive capacity and sustainability of Global Fund interventions. One senior GoPNG official likened the Global Fund ''to a very large tanker entering the harbor, but we in government being just a wooden wharf''. There appears to be some residual concern in Government that the Global Fund provided levels of financing to PNG that were well in excess of GoPNG managerial and fiduciary capacity to absorb, resulting in funds having to be returned

to the Global Fund. There is a major question about the sustainability of Global Fund support, including for ART and prevention of HIV, particularly when it is clear that several hospitals and health clinics have not had a reliable supply of condoms for around two years. A recent analysis by Rudge et al in *Health Policy and Planning* finds that:

> Global Fund-supported activities were found to be largely integrated, or at least coordinated, with the national HIV and TB programmes. However, this has reinforced the vertical nature of these programmes with respect to the general health system, with parallel systems established to meet the demands of programme scale-up and the performance-based nature of Global Fund investment in the weak health system context of Papua New Guinea. The more parallel functions include monitoring and evaluation, and procurement and supply chain systems, while human resources and infrastructure for service delivery are increasingly integrated at more local levels.
>
> Positive synergies of Global Fund support include engagement of civil-society partners, and a reliable supply of high-quality drugs which may have increased patient confidence in the health system. However, the severely limited and overburdened pool of human resources has been skewed towards the three diseases, both at management and service delivery levels. There is also concern surrounding the sustainability of the disease programmes, given their dependence on donors. Increasing Global Fund attention towards health system strengthening was viewed positively, but should acknowledge that system changes are slow, difficult to measure and require long-term support. (34)

United Nations Population Fund (UNFPA)

UNFPA has played a central role in provision of essential family planning commodities, directly contributing to improved health in PNG. A senior GoPNG official specifically referred to the important role UNFPA played in provision of family planning commodities. UNFPA provided the equivalent of $US 4.5 million worth of family planning commodities, including female condoms, over the period 2013-2017, representing around 81.7 % of total expenditure on family planning commodities in PNG. This has been a strategically important contribution given that less than one in four eligible families in PNG have access to modern family planning.[15] UNFPA has used modelling to estimate the impact of its family planning work in PNG: see Table 2 below. While estimating actual impact is always going to be difficult, especially in PNG where baseline and trend data may be missing, UNFPA have used a reputable and transparent basis for their modelling. [16] In doing so, UNFPA have sought to give attention to higher level impacts, and outcomes, and not just inputs. UNFPA also present policy relevant and informative data on issues such as pregnancy and health care in a user-friendly way: see Exhibit 1 below.

[15] There are significant shortages and stock-outs of condoms and other essential health products and pharmaceutical drugs especially in rural health centres in PNG. This reflects financing, institutional, and procurement difficulties within the PNG health system per se, rather than UNFPA

[16] UNFPA uses the Impact 2 Model developed by Marie Stopes International.

Table 2

Estimated impact of UNFPA's support for family planning in PNG in 2016

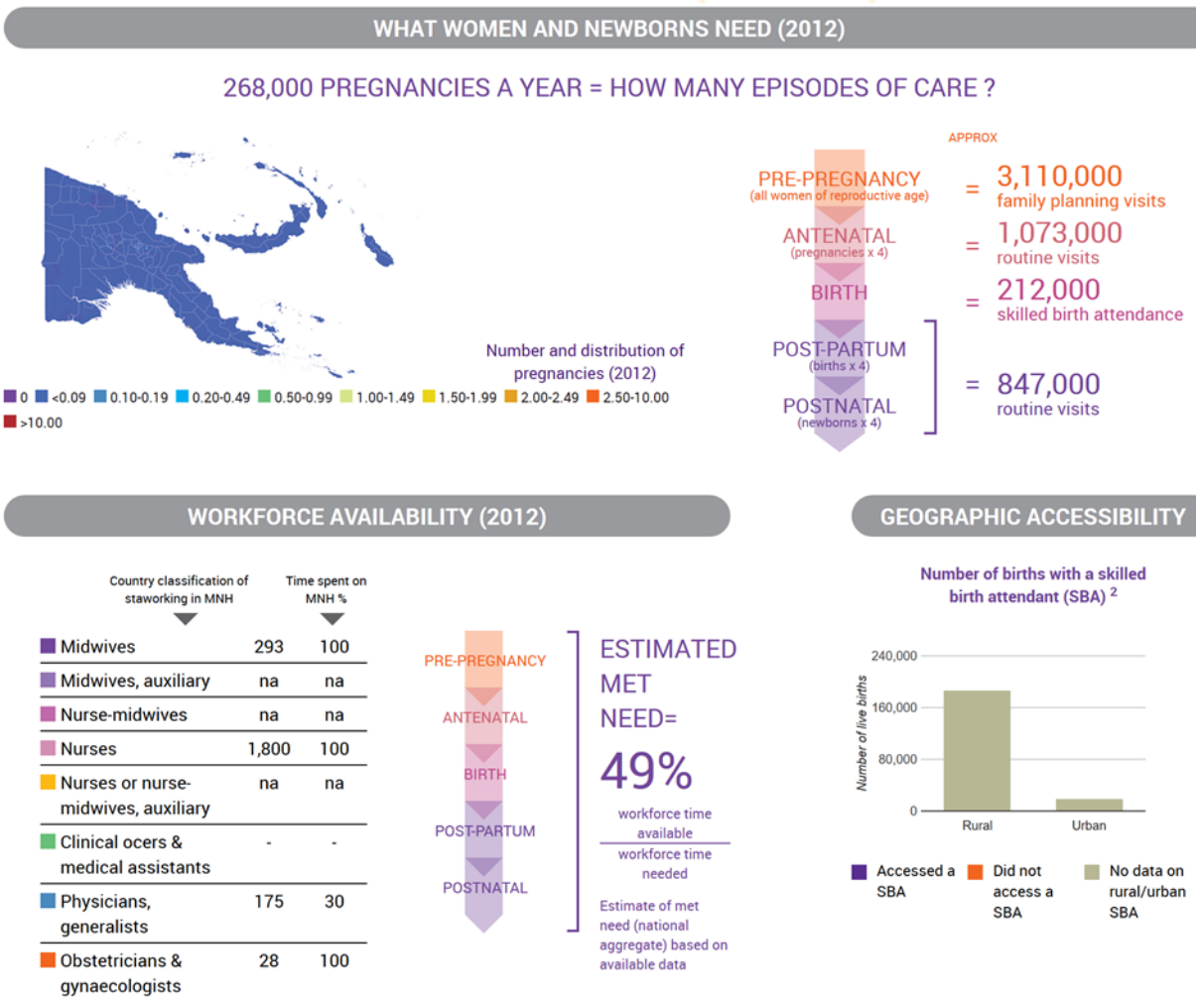
Source: UNFPA (35)

Maternal deaths averted	143
Child deaths averted	1,637
Unsafe abortions averted	7,780
Abortions averted	52,251
Unintended pregnancies averted	130,628
Healthy years of life saved (women)	8,240
Healthy years of life saved (children)	138,382
Direct health care costs saved ($US)	$US 2,432,087

Exhibit 1

Pregnancy and midwifery in PNG

Source: UNFPA (36)



UNFPA also generates research and contributes to policy development of relevance to PNG. UNFPA generates useful research at a global level on issues that are relevant to PNG including reducing maternal mortality; reducing gender based violence; adolescent sexual health and the profound economic implications and opportunities of fertility control and the ''demographic dividend''(37-42). UNFPA has also produced some important, policy-oriented, research on population trends in the Pacific, including PNG (43-45). GoPNG representatives also spoke favourably about UNFPA's technical and policy contribution to the Ministerial Taskforce on Maternal Health in Papua New Guinea. An examination of that report (46) confirms that UNFPA documents and research are referenced several times, and that UNFPA, along with WHO, was part of the Secretariat for the Ministerial Task Force. UNFPA also contributed directly to the PNG National Population Policy.

UNFPA staffing levels are relatively low in PNG given the maternal mortality and other health and population challenges. UNFPA's website confirms that PNG's maternal mortality ratio of 773/100,000 is one of the highest in the world, with around 1,300 women dying every year of (largely preventable) pregnancy related causes (47). UNFPA's website also notes that PNG is ranked 140/155 in the global gender inequality index (48) where a ranking of 1 (Switzerland) has least gender inequality. UNFPA also notes PNG has a relatively high population growth rate of 3.1% and, partly as a consequence, one of the highest proportions of youth in the Pacific: 58% of PNG's population is less than 25 years (49, 50). This pronounced ''youth bulge" has direct implications for future maternal and child health care, education, and the potential for any demographic dividend in PNG. Given those challenges, it is reasonable to ask if UNFPA's PNG office is adequately staffed and resourced. The office currently has a relatively small ''footprint'' in PNG, having just 2 international staff, and 4 national staff, and an average annual expenditure of only around $US 3-4 million per year.

UNFPA support for a Demographic and Health Survey (DHS) has been problematic. A DHS is arguably one of the most important and strategic investments a country can make in the health sector. That is because, carefully managed, a DHS can provide the critical evidence base on a wide range of health access and outcomes -including insights into maternal mortality; equity of access to services; and actual expenditure on health – all of which can be essential to Ministries of Planning and Ministries of Health in then allocating scarce health resources to where they are needed most. See Box 1 below. At the request of GoPNG, Australia has provided $ 10 million to support the DHS. The project has had significant delays. The original intention was that the data collection phase would be completed by December 2016. However, at April 2017 only 289 population sample clusters had been undertaken, with 511 still to be undertaken, but $US 5.5 million of the $ US 7.3 million budget for the DHS had been expended. It is important to note that prime responsibility for the delays and cost overruns rest with GoPNG rather than UNFPA. That is because strategic management and oversight of the DHS is, formally, the responsibility of a National Steering Committee, co-chaired by the Secretary of the PNG Department of National Planning and Monitoring, and the Secretary of the NDOH. UNFPA has used its own resources, and leveraged the financial and advisory resources of other UN agencies to help bring the DHS project back on track. Nevertheless, UNFPA is inevitably associated to some extent with the problems now being managed. That is because UNFPA was responsible for providing the key technical advice and support to the National Statistics Office (NSO) of PNG. UNFPA was also aware – or certainly should have been – of the capacity weaknesses in NSO when originally designing the level of support that UNFPA would inevitably need to provide to that agency.

Box 1.

Demographic and Health Survey in PNG.

Source: UNFPA (51)

"Special surveys such as the Demographic Health Survey are needed to provide good quality and timely national and sub-national health and population, which can be used for policy formulation, development planning and tracking of results. The current 2016 DHS is the third in the series. It is being implemented in the 22 Provinces to cover a total household of 19,200……The conduct of the 2016 DHS is crucial to establishing baseline indicators for the Sustainable Development Goals (SDGs), especially Goals 3, 4 and 5. The findings of the survey will be used as key benchmarks for the localisation of SDGs for Papua New Guinea. The 2016 survey incorporates a module on gender and gives greater attention to sub-national analysis. Among others, the 2016 survey will generate data on maternal mortality, infant and child mortality, fertility, contraceptive knowledge and use, maternal and child health, and gender….An international firm with considerable expertise and experience in this field - ICF Macro - has been engaged by the Government of PNG from the preparatory stages of the survey to be the main technical partner to guide the survey process (protocol, training, data collection, data processing, quality assurance, analysis and dissemination). The National Statistical Office is the implementer of the survey while UNFPA manage the project fund and provide operational support for quality outcome. The DHS is funded by the Australian Department for Foreign Affairs and Trade (DFAT) to the tune of AUD 10 million."

There have been some communication issues between DFAT and UNFPA. UNFPA provided DFAT with 5 reports outlining issues with the DHS and met on 8 occasions, however, DFAT did not feel these reports or meetings provided adequate information, or presented a clear path forward to enable the DHS to be completed as planned. Communication has improved since early 2017, with agreed measures to make sure the DHS is produced to the required standard. The lesson is clear: *two way communication* between DFAT and UNFPA is particularly important when $10 million grant funding is involved, and there are delays and other problems. There is also another example of communication issues that potentially colours the current relationship between DFAT and UNFPA. In essence, DFAT was invited to comment on UNFPA's draft overall country strategy to PNG for the period 2018-2022. DFAT made 11 substantive suggestions to UNFPA on their draft country strategy, which were sent to UNFPA New York by DFAT Canberra[17]. Examination of the final UNFPA country strategy (52) suggests none of these recommendations were incorporated in the final UNFPA country strategy for PNG. This again points to the need for very clear, *two way* communication between DFAT and UNFPA.

[17] These included the need for UNFPA to better take into account the tight fiscal environment, and difficult mid-term economic outlook in PNG, when considering its country strategy. It also included recommendations concerning the UNFPA results framework. For example: "Some of the targets are quite ambitious, and without much analysis of why the current levels are so low or exactly how UNFPA plan to achieve them, it is difficult to know how realistic they are. It would be good to see the interim targets too (if these are available) and receive progress reports on them."

Finding and recommendation 4.

UNFPA has a potentially very important role to play in PNG, given its mandate and comparative advantage in areas such as reducing maternal mortality, unmet need for contraception, and gender based violence: all issues of importance in PNG. UNFPA also has a potentially significant contribution to make in terms of analytical and policy work on the implications of demographic change in PNG. DFAT states that, despite Post following up, it was not initially kept promptly or properly advised of the then emerging delays and problems with the Demographic and Health Survey (DHS) which involved $10 million grant from Australia.

We therefore **recommend** that a clearer and explicit set of mutual expectations about communication and responsiveness be included in any future partnership agreement between DFAT and UNFPA.

UNICEF

There is evidence to show that UNICEF, in collaboration with WHO, and with direct financial support from DFAT, is achieving demonstrable health outcomes through its Early Essential Newborn Care (EENC) program and Integrated Management of Severe Acute Malnutrition (IMAM). As explained in Annex 5, around 5000 – 6000 neonates (that is, newborns and those up to 4 weeks of age) die in PNG each year. Such deaths can often be prevented by inexpensive changes in the practices of newborn care, and reducing acute malnutrition.[18] There is evidence that the UNICEF led EENC program is achieving tangible results at the outcome level (53, 54): see in particular Box 2 below. As part of the evaluation, we also confirmed that UNICEF has achieved substantial results at the output level. More specifically, over 830 nurses and front-line staff have been trained – and, importantly, then tested to ensure they had acquired sufficient competency – in EENC approaches. We interviewed a nurse in a remote health centre in Western Highlands province who had been trained on EENC approaches who could describe in detail how her own care practices for mothers and newborns had changed to safer and more effective practices. We were also advised by the government staff at Mt Hagen hospital that there had been 304 premature births between May and August in 2017. None had died, in his view as a direct result of EENC training, compared to the 4-5 neonatal deaths normally expected in a cohort of that size.

[18] Including, for example, ''kangaroo care'' or promoting close physical contact between mother and baby to, among other things, reduce neonatal hypothermia; the early initiation of breastfeeding; and the early and correct use of neonatal resuscitation.

Box 2

Evidence of effectiveness at the outcome level. UNICEF's Early Essential Newborn Care Program and Integrated Management of Severe Acute Malnutrition.

Source: UNICEF (53)

In 2016, UNICEF Papua New Guinea continued rapid scaling up of newborn survival interventions package (Early Essential Newborn Care) from 32 health facilities in 2015 to 175 (now 185 in 2017) health facilities (56 per cent of total health facilities in 11 provinces), benefiting 82,000 newborns. UNICEF Papua New Guinea supported establishing a state-of-art special care unit for improving early essential newborn care at the provincial hospital in Goroka. Management of severe acute malnutrition expanded to 15 out of the 32 hospitals and to 69 health centres in 29 districts under five provinces (Enga, Madang, Morobe, National Capital District and Simbu). Because of these interventions, the case fatality rate associated with malnutrition in implementing health facilities decreased by 50 per cent. In four UNICEF supported provincial hospitals, on average, the case fatality rate of severe acute malnutrition decreased from 24 per cent in 2015 to 16 per cent in 2016.

UNICEF has also deployed an innovative approach to reducing neonatal deaths, backed up by and supported by rigorous, ethical, case / control scientific trials to assess the effectiveness and impact of the approach. As noted in Annex 5 "hypothermia[19] prevention and management can save up to 42% of the (5000 – 6000) neonatal deaths, as well as ensuring healthy growth and development of the baby. Hypothermia mostly occurs in Low Birth Weight babies and pre-mature births in resource-poor settings. The hypothermia bracelet is a simple, innovative bracelet attached to the wrist of the newborn which then continuously detects the temperature of the neonate and alerts the mother and / or medical staff in the event of neonatal hypothermia." Importantly, UNICEF is collaborating with NDOH and other institutions to evaluate the effectiveness and impact of the hypothermia bracelet using carefully designed but ethical case / control studies: details are in Annex 5.

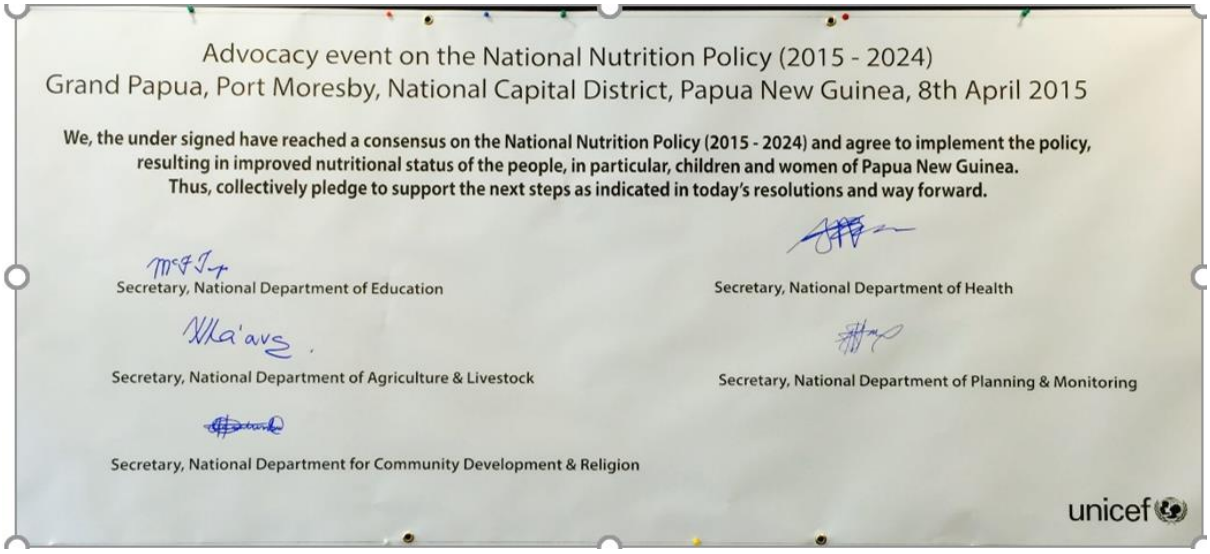
UNICEF has also been proactive in promoting improved nutrition in PNG, although the real test will come in terms of actual implementation by GoPNG and other stakeholders. PNG has high levels of undernutrition, including having the 4th highest rate of stunting (short for age) in the world. Undernutrition imposes large, but largely preventable, health and economic burdens on PNG (13, 14). There is evidence that UNICEF played a central role in an April 2015 high level advocacy meeting in PNG to address the situation. Among other things, UNICEF encouraged and supported a signed commitment, at Secretary level, among five key National Departments (see Exhibit 2 below) to achieve a more coherent approach to planning and budgeting to address undernutrition in PNG, with UNICEF serving as the policy Secretariat. UNICEF also supported the development of the National Nutrition Policy (2016-2026), the first of its kind in PNG. PNG, with UNICEF support, joined the international Scaling Up Nutrition (SUN) movement in 2016 (55) which, in principle, could provide advocacy, accountability, and profile to improving nutrition in PNG. The risk, of course, is that sound policies and international commitments remain unfunded mandates and do not get implemented in practice. UNICEF has, however, awarded a contract to the American Institute of Research to develop a Strategic Action Plan for addressing undernutrition, including with costing estimates.

[19] When the temperature of the baby falls below 36.5ºC (97.7ºF)

Exhibit 2

Advocacy support and engagement with multi-sectoral stakeholders by UNICEF

Source: UNICEF, Port Moresby



However, M&E reporting could be improved, especially when using DFAT grants. On the one hand, some UNICEF reporting is detailed and informative. The 35 page UNICEF Annual Report (53) is comprehensive, and includes an analysis of outcomes and outputs with sufficient detail to give a good overall understanding of UNICEF's work in PNG. On the other hand, reporting by UNICEF of the way it is managing the $4.3 million grant from Australia for nutrition improvement, and the $4.6 million Early Essential Newborn Care (EENC) is weak in parts. More specifically, reporting on gender and social inclusion in those reports is too general to be useful. [20] Furthermore, a comparison of the November 2015 and the May 2016 UNICEF reports to DFAT on nutrition reveals virtually identical wording under the headings of risk management, gender and social inclusion, and partnership engagement from one report to the next. There is similar identical wording between the six-monthly UNICEF reports on EENC. Overlap, and even some repetition of text, is understandable - to an extent - in a six-monthly reporting cycle. However, in a rapidly changing and complex environment such as PNG, it is of concern that reporting of issues such as risk management are not updated when DFAT grant funds are involved. DFAT itself also believes that the overall reporting and management relationship could be stronger. For example, the original intention was to have a six-monthly senior level joint review between DFAT and UNICEF of the program supported by DFAT. This, according to DFAT, subsequently became only an annual review.

[20] The text on gender and social inclusion in the November 2015, and the May 2016 report, for nutrition reads as follows: "Gender equality is an overarching principle of UN assisted programmes. These activities will promote a better nutritional status of young children both boys and girls as well as women and adolescent girls through greater access to specific nutrition interventions at health facility, community and household levels. The monitoring and evaluation system will be strengthened to provide sex and age disaggregated data where necessary. UNICEF will advocate for the proactive involvement of communities and families (both women and men) in scaling up nutrition interventions, and promote the empowerment of women through the community based organizations with whom we partner."

UNICEF considers its M&E reporting to be strong. UNICEF advised us that UNICEF provides ''detailed technical reports at mid-year in addition to the annual progress report as per the agreed M&E and reporting framework under One-UN. UNICEF also organised regular bilateral meetings with DFAT health team to review the progress of projects following submission of the detailed technical report. The DFAT health colleagues are also invited to attend the joint programme review meeting between NDOH and UNICEF at mid-year and end-year".

What is clear is that DFAT at Post believes reporting from UNICEF should be more informative and outcome focused. DFAT staff acknowledged that while there were informal contacts with UNICEF, they did not have a strong sense of UNICEF's overall effectiveness. Our interviews suggest this is partly a reflection of very high workloads in DFAT and UNICEF in Port Moresby. But it also reflects a lost opportunity to engage strategically and systematically with each other, and with GoPNG, something that both DFAT and UNICEF say – genuinely – that they are committed to doing. It is also encouraging to see that during the Evaluation UNICEF specifically recommended a stronger joint accountability framework, including more joint reviews and joint field visits. See also the analysis below under the heading of Monitoring and Evaluation.

The World Bank

There is good evidence that the World Bank's analytical work has been influential, particularly in terms of health financing policy and planning. NDOH, and DFAT staff at Post, verified that the 2011 World Bank report *PNG Health Workforce Crisis: A Call to Action* (56) provided the evidence base of a ''crisis'' in the publicly financed health workforce in PNG, a crisis arising from constraints in training; an ageing health workforce; and increased demand for health services. There is evidence that that Report has directly shaped GoPNG health workforce planning, particularly through the Bank's analytical work on costing scenarios to address the crisis. There is also evidence that the report directly influenced DFAT's health workforce training decisions for PNG. Interviewees in PNG – including at a provincial level – also cited the 2013 World Bank report *Below the Glass Floor (57)* that analyses health financing at sub national levels providing data and analysis that was unlikely to have been otherwise available.[21] It is worth noting that *Below the Glass Floor* was part funded by AusAID (now DFAT) and that the report itself states that AusAID provided close oversight in all stages of the study, from conceptual design to strong involvement in the internal peer review process. Other interviewees also noted that the 2014 report *Assessment of Health Financing Options: PNG* (58) had been instrumental in helping PNG decide that Social Health Insurance was an inappropriate and unrealistic health financing policy option for PNG given, among other things, the large informal sector in PNG. Most of these cited World Bank reports in PNG, including also shorter *Knowledge briefs* (59-61), involve prominent joint ''badging'' of World Bank and Australian aid logos. More broadly, GoPNG interviewees considered the World Bank had convening power in PNG, including direct access to a range of Ministers and portfolios including those responsible for macroeconomic policy and national budgets.

[21] The title *Below the Glass Floor* is explained in the report in the following way. "Much is heard and read of *glass ceilings*, that notion that there is a real, yet invisible, barrier for some groups in moving upward in a particular field. In a financial sense, an analogy can be drawn to a *glass floor*, a seeming reluctance to move deeper, to develop an evidence-based understanding of what is actually happening on the ground at the service delivery level. Sometimes this reluctance is due to the perception of time and effort involved in undertaking such analysis, or it may be shadowed behind a need to 'stay strategic'. Ultimately, little is more important than finding relevant ways to explore what is actually happening on the ground. High level planning is not an end-game in itself but merely the precursor to the real action that happens at the frontline.

[21] The TORs specific that this "Includes all necessary parts of the health system, such as the National Department of Health, other key agencies such as Department of Treasury and Department of Personnel Management and other relevant stakeholders.

There is some question about the World Bank's overall profile, and direct impact in terms of implementation in the health sector, although this may change with a proposed credit to address TB. The World Bank does not have a particularly high profile in the health sector of PNG. This is partly explained by the fact that the World Bank's own country strategy acknowledges that ''the World Bank Group plays *a niche role* in social sectors including education, health, and social protection, through carefully defined analytical work that catalyses innovation and leverages program financing from larger partners and Government."(italics added) (62). The World Bank also currently has only two people working full time on health issues in-country. [22] One interviewee speculated that (thorough, but long) World Bank reports ''can sit on the shelf'' and therefore could lack traction. The GoPNG Department of National Planning and Monitoring stated, as part of this Evaluation:

> "With respect to the funding towards the World Bank's Pacific Facility 4 Multi-Donor Trust Fund, there has been some good analytical work and assessment done in the heath sector. However, should there be future funding to the facility, it should be directed towards implementing the recommendations from these studies to achieve or address the challenges identified in the sector, i.e., improving the Public Finance Management (PFM) in the sector at the National level and down to the subnational levels."

At a practical level, DFAT requested that the World Bank assign someone with financing expertise to help NDOH improve health financing and public financial management in a practical way, using funding provided by Australia and New Zealand under the PF4 Agreement. There have been three people fill this position over a 12 month period (a high staff turnover), including one on a fly-in-fly-out basis. With DFAT encouragement, World Bank have recently appointed a junior Health Economist to work in NDOH full time on practical issues of budget planning and preparation. There is evidence that he and / or his predecessor helped NDOH to simplify and rationalise budget preparations from 45 separate templates to a single unified system, and worked collaboratively with NDOH to develop a more systematic and transparent way of assessing and prioritising specific project proposals in the health sector.

The World Bank's footprint in terms of implementation and incentivising reform may well increase in coming years. The World Bank board has approved a $US 15 million credit, actively encouraged and supported by DFAT, to help prevent and control MDR-TB in PNG. However, during interviews a senior GoPNG official wondered aloud why, given the scale of the TB challenge in PNG, the credit could not have been much larger, even in the order of $US 200 million. The World Bank subsequently advised that the $US15 million credit is, in their judgement, an appropriate level at this stage as the World Bank starts to engage more substantively in the health sector and was the balance of funds available to PNG under IDA 17. The World Bank also advised that it is actively considering the possibility of larger concessional credit to the PNG health sector. Such a credit could well be designed in such a way that disbursement of World Bank funds would be triggered by the prior achievement of agreed, specific, results including, for example, timely release of operational funds to health facilities etc. This would be designed to help incentivise public financial management reform and health system strengthening.

The World Health Organization

The WHO is well regarded by NDOH and other development partners. Senior officials in NDOH spoke warmly about WHO's role in supporting the reduction of malaria, multi-drug resistant tuberculosis, HIV/AIDS, and WHO's contributions to tobacco control legislation. Senior officials also commented

[22] A Senior Health Specialist in the World Bank office in Port Moresby and a World Bank Health Economist working in the NDOH.

favourably on the ease of access to WHO technical advice. They said this was partly explained by ''the masterstroke'' of having a significant number of international and local WHO advisers co-located in the NDOH building in Port Moresby. Interviews with other stakeholders further confirmed the general impression that WHO was a high profile, trusted, agency. Several interviewees, including from DFAT, spoke favourably about the early and significant impact the mobilisation of a WHO international expert had had in formulating, and then leading, an emergency response to the challenge MDR-TB. In Daru they noted there had been noticeable results including stronger and more comprehensive infection controls to reduce MDR-TB infection among health workers[23] and better monitoring and follow up of MDR-TB patients. As a result, there had been no new health care workers infected with any form of TB after 2015: prior to that 12 health care workers had been infected with MDR-TB. WHO states that it has, in addition to contributing to the malaria, MDR-TB, HIV/AIDS and tobacco agendas, been influential in several other areas (63). These include WHO special efforts to improve immunisation in 8 low performing provinces and 16 hard to reach districts. WHO also refers to extensive training of PNG staff in a range of health-related disciplines. WHO also refers to technical assistance / analytical work including support for the 2012 National Health Accounts: a potentially key document for policy dialogue as it shows all sources, and uses, of health expenditure including government, development partners, private sector and civil society, and direct out of pocket expenditure.

However, WHO's monitoring and evaluation systems, and its reporting to DFAT, are not sufficiently robust, analytical, or timely to be able to independently verify this generally favourable impression. More specifically, we did not see specific evidence of M&E that would underpin a thorough assessment of the performance of the WHO. There are various aspects to this. In the 2015 WHO Progress Report WHO itself notes that 'the M&E framework for the partnership relies on National Health Information System (NHIS) data which is of poor quality, incomplete, unreliable and is not submitted in a timely manner to facilitate timely decision making. In the context of reporting on the WHO-DFAT Partnership, information from the Sector Performance Annual Report is generally considered not fit for purpose'. We also sighted evidence of recent communications (September 2017) between WHO and DFAT which indicates DFAT's dissatisfaction with the overall quality of WHO's six monthly progress report including, in DFAT's assessment, a lack of measurement of performance against planned outputs. DFAT has asked for more substantive and informative reporting in the six monthly reporting but, at the time of submitting this Report we did not see a revised WHO report and so cannot make comment on whether WHO was responsive to the DFAT request.

WHO states that it does have strong M&E. In the course of this Evaluation WHO provided detailed statements (available on request) on its reporting. Among other things, WHO states that it ''submits Annual Reports to DFAT in compliance with the reporting arrangements stipulated in the Partnership Agreement (between DFAT and WHO) and that the report ''is formatted according to DFAT'S proposed outline". Furthermore, WHO also states that ''The WHO core functions are not fully captured in the M&E framework of the previous Partnership Agreement (between DFAT and WHO). For the next partnership phase, the WHO will work with DFAT to ensure that these are properly accounted for in the design of the M&E". Furthermore, WHO has separately suggested that DFAT could improve its engagement with WHO to achieve better results with an 'agreed performance framework for M&E'. It is also important to note that WHO has also stated the following:

> Apart from what is required in the Partnership agreement between WHO and DFAT, the WHO has its own monitoring and evaluation system which can easily be used to support

[23] Including establishment / strengthening of infection Control Standard Operating Procedure; the presence of an infection control focal person; conduct of regular infection control audit.

the M&E work for DFAT-funded activities. The WHO has a results-based management system that looks into inputs, expected results, outcomes and impact. At the initial stages of program planning, the system allows for risk assessment. The internal systems can readily provide a comprehensive understanding of the status of work done by WHO through mechanisms for expected results monitoring, midterm review and end-of-biennium assessment. All these are in place to support the broader mandate and responsibility of WHO to Member States including Papua New Guinea. Should elements of these existing M&E activities be considered to improve the monitoring and evaluation of DFAT-supported activities, there is no reason for them not to be made available and used to verify favourable impression of WHO and its work.

There is clearly significant room for improvement in the reporting relationship – and expectations about the nature of reporting - between DFAT and WHO. Our own assessment is that WHO is a well-regarded, trusted, source of technical advice by GoPNG. In detailed discussions, it was clear WHO can demonstrate important achievements, including in responding to challenging areas of MDR-TB and immunisation. We also accept WHO's statement (see preceding paragraph) that it has a results based management system. However, having said all that, we did not see specific evidence of the results based management ourselves. Nor, more importantly, has DFAT, although DFAT has asked for that. Given the importance of demonstrating ''results'' – including to the largest bilateral development partner which has been asking for more informative reporting, we also noted with some interest WHO's apparently less than fulsome statement that ''there is no reason for them (i.e. elements of the results based M&E activities) not to be made available'' to DFAT. We acknowledge that WHO itself sees the Annual Report to DFAT as the more substantive reporting vehicle, with the six monthly reporting be used, as WHO states: ''as a step-in-progress document to improve the format of the Final Report''. On the other hand, we also note DFAT's clear statements to WHO that the six-monthly reports are not sufficiently performance focused or informative. As such, it does not provide reliable or timely insight into progress or emerging risks. More importantly, DFAT states that ''the only report (WHO) provided was a four year report from 2013-2016. There are no annual reports provided annually between 2013 and 2016". This does not provide reliable or timely insight into progress or emerging risks.

DFAT is particularly entitled to expect clearer and more meaningful M&E from WHO when DFAT is, in effect, ''purchasing'' specific outputs and outcomes through country specific grants. The Australian Government, through DFAT, makes regular ''core contributions'' to the global operations of WHO and other MDPs. In principle, Australia is normally prepared to then rely on those agencies' corporate M&E reports as the vehicle for verifying effectiveness and accountability. However, when DFAT makes additional, specific purpose grants to an MDP operating in PNG, it is entitled to expect timely and more detailed reporting about the development effectiveness, value for money, and risk management associated with the DFAT grant. This has not always been the case with WHO. Going forward, WHO has stated its willingness to improve M&E reporting to DFAT, including through better use of its own results based management system. DFAT has also made it clear in other fora that it wishes to minimise the use of parallel or duplicative systems, and does not seek ''reporting simply for reporting's sake''. There are therefore opportunities for a stronger and more performance focused M&E system being negotiated between DFAT and WHO prior to any new Partnership Agreement being finalised.

Finding and Recommendation 5

GoPNG clearly regard WHO as a particularly accessible and trusted source of technical advice. When interviewed, WHO can also explain in convincing terms its efforts and contributions to the health sector in PNG. However, the absence of an overarching performance framework undermines the ability to assess the effectiveness of DFAT's investment in the WHO in PNG. We find that WHO's M&E as it relates to the performance of the DFAT's grants to WHO needs significant improvement. We also believe that going forward there is a need for clarity amongst both partners about expectations for timing and content of reporting.

We therefore **recommend** that, while there is significant scope to improve the results framework with virtually all MDPs, there is a particular need to establish a more results based agreement between DFAT and WHO, prior to any new Partnership Agreement being finalised, given the importance of central position of WHO in PNG health policy dialogue and programming.

Did they effect sufficient influence and/or change?

The United Nations Annual Progress Report provides a mixed picture of MDP ''influence''. The Health Chapter of the United Nations Annual Progress Report for 2015(64) tracks 64 output indicators in the health sector. Of these 64 indicators, 8 or 12.5 % record ''no data'' or ''no new data'' for 2015; 34 or 53 % record a status of ''delayed'' and only 22, or 34 %, record a status of ''completed''. The UN's report concludes that 4 out of 16 outputs were ''completed'' at the ''overall assessment'' level[24], and 12 were delayed. How should this rather sombre position be interpreted? To begin with, it is important to note that these indicators are often part of global or regional commitments that GoPNG itself has entered into such as the current Sustainable Development Goals (SDGs) and previous Millennium Development Goals (MDGs). They can be particularly ambitious – even aspirational – targets.[25] Other indicators are largely beyond the direct span of control of MDPs which are, after all, technical assistance agencies: GoPNG is always being the main implementer, as is formally acknowledged in the UN report. Furthermore, while four UN agencies - UNICEF, UNFPA, WHO and the International Organisation for Migration – support the NDOH, so do 11 other groups of stakeholders outside the UN system[26].

UN agencies are partially accountable for progress at the output level. Nevertheless, MDPs are clearly seeking to support and influence GoPNG achievement of health outcomes. Furthermore, the

[24] The four areas which the UN Annual Progress Report finds outputs were completed at the overall level are as follows. **Output 8.3**. Provincial hospitals, district health centres and communities have the capacity to detect and treat malnutrition cases among children under five (staff trained and supervised on severe acute malnutrition (SAM) management, commodities and supplies for therapeutic feeding available, VHVs/CBDs/CBOs trained and supervised to detect and refer malnutrition cases at the community level). **Output 8.8** The national health system has effective leadership, capacity to coordinate, steer, and regulate the health sector, through good governance and evidence based decision making to deliver people centred health services. **Output 8.9** Improved access to health technologies, pharmaceutical policy and capacity of the procurement and distribution system within the health sector through improved procurement, distribution, and quality assurance testing. **Output 8.10**. National capacity for the prevention and control of disease, disability and premature death from chronic non-communicable diseases developed.

[25] For example, the baseline for the proportion of births attended by a skilled birth attendant was 40% in 2014. The target was an increase to 60% in 2015 – just one year later - which is a particularly ambitious increase. Perhaps not surprisingly, the actual status for that indicator at 2015 was recorded as ''delayed'' with the proportion of births attended by a skilled birth attendants reaching only 44%.

[26] The other agencies are University of PNG, UNITECH, Pacific Adventist University, YWCA, National Broadcasting Corporation of PNG, National Department of Education, Church Health Services, Church Health Facilities, Provincial Hospitals, Provincial Health Authority, and Provincial Health Offices.

UN report itself does specifically refer to the 64 indicators as ''*Inter-agency* outcome indicators'' (italics added). This means UN agencies have agreed to contribute to achieving those health indicators and are therefore at least partially accountable for achieving them. The narrative text of the UN Report provides a convincing case that UN agencies directly influenced policies and programs in at least four important areas. These are the establishment of 17 hospital based Family Support Centres (including for victims of sexual abuse); development of the Antimicrobial Action Plan; development of guidelines, policy, training and management of MDR-TB; and development of the District Health Manager's Guide Book. However, beyond those four cases it is difficult, from the report itself, to establish with any confidence, the exact contribution of the UN agencies. More broadly, in the absence of any counterfactual, it is not possible to say with any rigour if the 64 indicators would have been worse, the same, or even (conceivably) better than currently reported. We therefore took a closer look at one particularly strategic, longstanding, and challenging issue in PNG – immunisation – to look for evidence of MDPs effecting influence and / or change.

Generally stagnant immunisation rates over decades are a particular challenge in PNG that raise questions about MDP influence. Achieving – and sustaining – adequate levels of immunisation coverage for children and others is an essential, and usually affordable and cost-effective, intervention even in low-income countries. Immunisation coverage is also a useful proxy indicator of the overall effectiveness of a country's health system. Low or stagnant immunisation coverage is a warning sign for those – including DFAT – concerned about broader health security issues. There have been some successes. Polio has been eliminated in PNG, and UNICEF "has provided technical and financial support to the Government to achieve the maternal and neonatal tetanus elimination …..despite huge challenges such as the poor geographical access and limited financial and human resources, the entire country has successfully completed the first round of (tetanus) vaccination for women of reproductive age (14-45 years) with more than 80% coverage nationwide coverage."(65) Nevertheless, it is very concerning that immunisation rates against other basic diseases have stagnated or fallen to particularly low levels over many years in PNG. More specifically, latest advice from WHO indicates that the national coverage for routine measles immunisation fell from 54% in 2008 to 35% in 2015, albeit with an increase to 70% in 2013. The national coverage of the third dose of pentavalent vaccine[27] is relatively low at just over 60% in 2016, albeit an increase from just over 50% in 2010, but falling to as low as 25% coverage in the Southern Highlands. The third dose of oral polio vaccine coverage fell from 70% in 2010 to 58% in 2016.

Does this mean MDPs failed to affect sufficient influence and change? This is difficult to answer categorically as there is no counterfactual. Furthermore, MDPs such as WHO are technical advisory agencies, not program ''implementers'" per se. What the evidence does show is that low and stagnant immunisation rates reflect broader and deeper health system challenges in PNG rather than immunisation campaigns per se. These challenges include access difficulties (only around 40% of the total population have ready access to a fixed health facility, meaning around 60% of the population have to rely on outreach patrols). Decentralisation has meant provinces may only have one official responsible for immunisation throughout the province, and provincial and district politicians may not give immunisation a priority for the release of funds. Around 30% of health facilities do not have an adequate cold chain facility for storing vaccines.

There is evidence that the MDPs – especially WHO – did display a sense of urgency about the immunisation challenges and have taken specific steps to influence improvements, but more does need to be done. At the end of 2014 WHO and UNICEF brought together all provincial leaders and

[27] Pentavalent vaccine protects against five major infections: diphtheria, tetanus, pertussis (whooping cough), hepatitis B and Haemophilus influenza type b (Hib)

developed a nationwide *Special Integrated Routine Expanded Program of Immunisation Strengthen Program in PNG (SIREP).* In essence, SIREP prioritises immunisation campaigns and allocates scarce resources to priority provinces, districts, and areas with low coverage and high numbers of unvaccinated children. There is some emerging evidence SIREP is increasing coverage in these areas. UNICEF has also actively supported immunisation policy and advice (66). GAVI, the Vaccine Alliance, states it has a total of $US 31.4 million commitments to vaccination in PNG over the period 2001-2021 (67). Given the existing low rates of immunisation in PNG, it can be argued that GAVI needs to continue its efforts to influence and affect change in PNG, and should not ''transition" (in effect, "'graduate'') its support for PNG too quickly simply based on PNG's per capita income level. There is good evidence that DFAT has been actively advocating that GAVI remain engaged in PNG until immunisation rates improve. Such efforts should continue, particularly in the light of the Australian Government's focus on health security(68).

Finding and recommendation 6.

Immunisation rates are low, and have stagnated, and in other cases such as routine measles coverage have fallen, in PNG. Increasing the immunisation coverage rates is a critical part of improving health outcomes and equity in PNG. It is a key indicator of overall health system performance. It is also a key building block for contributing to health security in PNG, and the region. The prime responsibility for improving immunisation rates rests with GoPNG, including at the sub-national level. However, all MDPs are in a good position to advocate and support improved immunisation coverage. DFAT, in turn, is in a good position to leverage the work of MDPs to improve immunisation coverage

We **recommend** that DFAT, as part of the Australian Government's focus on health security, give particular attention to leveraging the existing efforts of WHO, and other UN agencies including UNICEF, to raise immunisation levels in PNG. DFAT should also continue to liaise at the highest levels to ensure GAVI remains engaged in PNG until essential vaccination coverage rates increase substantially and in a sustainable way.

Were they able to sufficiently navigate PNG's health system[28] and political economy context to achieve results? Why/why not – what were the facilitating and inhibiting factors?

There is evidence that MDPs can successfully navigate PNG's health system and political economy environment. Evidence of success include the legitimate, but nevertheless shrewd, negotiations by managers of the ADB RPHSDP to encourage local politicians and officials to first improve rural roads and bridges so as to enable heavy equipment access to the construction site. Not only did this demonstrate ''ownership'' and commitment by local stakeholders, it improved access to the health centres for the surrounding catchment area. There is evidence from Steering Committee reports and field interviews that ADB RPHSDP also formed good partnerships with provincial authorities and was able to successfully navigate PNG procurement procedures. One interviewee also said the ADB's RPHSDP communication with stakeholders had been ''outstanding''. UNICEF was also effective in securing support for nutrition from five agencies (National Department of Health, Department of Education, Department of Agriculture and Community Development, and the Department of National Planning and Monitoring: see Exhibit 1 above). As noted previously, WHO has been able to cultivate a good deal of trust and collegiality with NDOH, partly through having a relatively large number of technical staff physically co-located in the NDOH building, giving NDOH staff easy and immediate

[28] The TORs specific that this "Includes all necessary parts of the health system, such as the National Department of Health, other key agencies such as Department of Treasury and Department of Personnel Management and other relevant stakeholders.

access to WHO expertise. WHO also advises that it has "'supported the NDOH to develop the comprehensive multiyear plan for EPI program (cMYP 2016-2020) where economic analysis was done to forecast the funding requirement of the country for the EPI program from 2016-2020. The cMYP has also indicated the role of …..sub national level institutions to improve the coverage to reduce morbidity and mortality from vaccine preventable diseases"' (63). There was insufficient time for us to assess how effective that particular support has been. But the fact that WHO included a specific economic analysis and engaged sub-national institutions indicates WHO did seek to address some of the key political economy challenges in PNG.

But there are also examples of MDPs not adequately understanding PNG's health system and / or political economy environment. The original design of the ADB RPHSDP failed to take into account the likelihood that land disputes would arise when siting new health posts: a surprising oversight given the well-known history of land disputes in PNG that then initially caused two years delay (since made up) in the start of construction. As noted earlier, UNFPA encountered difficulties in its relations with the National Statistics Office in terms of planning and managing the roll out of the Demographic and Health Survey. It appears from the evidence available to the evaluation team that UNFPA also significantly under-estimated the financial and logistical difficulties of accessing more remote parts of PNG despite that being a well-known challenge in PNG. Furthermore, it appears UNFPA did not fully anticipate the delays that would arise as a result of the PNG national elections in 2017, despite it being known those elections would be held during that year. In its latest country strategy for PNG, UNFPA did not specifically identify the tight fiscal environment, and broader difficult macroeconomic environment, as a risk factor or constraint for its country strategy. (DFAT did bring that, and other limitations in the UNFPA draft country strategy to the attention of UNFPA, but the documentary evidence suggests those points were not then reflected in the final UNFPA strategy).

Was their engagement focussed on the right areas?

The MDPs programs do broadly align well with the existing national health priorities of the Government of PNG. The National Health Plan 2011-2020 (69) establishes a clear vision and series of strategies for improving health outcomes in PNG. This is summarised in the Exhibit 3 below. The NHP and its 8 key result areas are supplemented by 27 specific indicators [29] that are demonstrably relevant to specific health outcomes, as well as health system strengthening, in PNG. There is clear evidence that each of the six organisations subject to this evaluation have written program strategies and agreements that directly align with the overarching vision and goals of the current NHP. Each of the six organisations can also demonstrate a clear and direct link to specific Key Result Areas and / or to one or more of the 27 indicators, based on that organisation's mandate and comparative advantage. In addition, WHO is intending to give increasing attention to the health impacts of climate and environmental change which would seem appropriate given the impact of recent El Nino events in parts of PNG. WHO also helped put the threat of antimicrobial resistance [30] on the policy agenda in PNG. This culminated in the completion of the PNG Country Situation Analysis and the drafting of the National Action Plan on Anti-Microbial Resistance 2017-202. Given the large health and economic costs of AMR (70-72), this is clearly a case of focusing on ''the right things''. If adequately funded and

[29] Of these 27 indicators, 6 deal with service delivery including access to services such as the number of aid posts open. 6 indicators deal with child health (eg immunisation); 6 deal with governance (including provincial financing and medical supplies); 5 deal with maternal health; 2 deal with partnerships (including with NGOs and churches) and 2 deal with disease control.

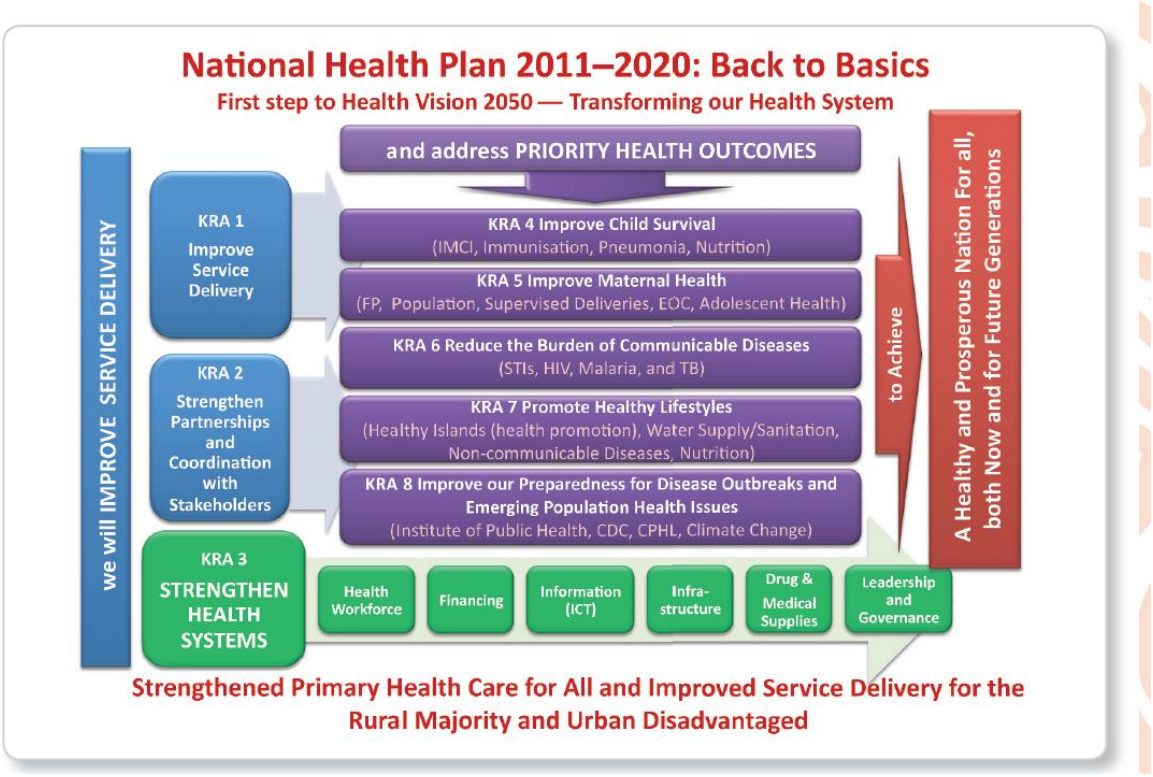
[30] WHO defines Anti-Microbial Resistance as follows: "Antimicrobial resistance (AMR) is the ability of a microorganism (like bacteria, viruses, and some parasites) to stop an antimicrobial (such as antibiotics, antivirals and antimalarials) from working against it. As a result, standard treatments become ineffective, infections persist and may spread to others". Further details at http://www.who.int/antimicrobial-resistance/en/

implemented in practice, such a National Action Plan would further strengthen health security in PNG. At a broader level, there are formal mechanisms in place for GoPNG to regularly (often annually) review with development partners where development partners put their efforts and resources.

Exhibit 3

The PNG National Health Plan overview

Source: Government of Papua New Guinea National Health Plan 2011-2020.(69)



There is, however, room for debate as to whether GoPNG – and the six MDPs – are adequately addressing some of the old drivers of the burden of disease in PNG such as under-nutrition. More specifically, PNG has the 4th highest rate of stunting (short height for age) in the world, with under-nutrition imposing significant health and broader economic costs in PNG (13). Under-nutrition always involves a multi-sectoral approach including, for example, improvements in food security, water and sanitation, and education. However, reducing undernutrition is also a fundamental part of any country's health system. Improving maternal nutrition is a particularly important health intervention for both mother and infant (73-78). Reducing childhood malnutrition is captured under objective 4.4 of the NHP and the NHP specifically tracks the prevalence of underweight children and proportion of neonatal low birth weight. PNG formally joined the Scaling Up Nutrition (SUN) movement in April 2016 which, in theory at least, adds to the commitment and accountability of PNG to reduce malnutrition.

Against that background, it could be argued that nutrition has not figured as prominently in the work of the six MDPs – or for that matter Australia's bilateral program(79) – as might be expected. On the one hand, UNICEF has supported nutrition policies and programs: see Exhibit 2, and the World Bank used a nutrition expert to advise PNG in terms of World Bank engagement in the agriculture

sector. However, given that UNICEF estimates that nearly half of all deaths in children under five years old globally are due to undernutrition, the question remains as to whether GoPNG, and the MDPs, are not focusing on undernutrition in PNG to the extent that is needed when nearly one in every two children are under-nourished. This is a particularly relevant question given the Australian Government's renewed focus on strengthening health security more broadly in the region: health security cannot be achieved when nearly half of children in PNG remain malnourished.

There is also room for debate as to whether PNG and the development partners are sufficiently focused on some of the new and emerging drivers of the burden of disease in PNG including tobacco use: the largest single cause of premature death and disability in PNG. Tobacco use is an important driver of the burden of disease, with the Institute of Health Metrics and Evaluation estimating it is the leading cause of premature death and disability in PNG (15). The World Bank also notes that PNG is one of the ten countries with the highest rates of tobacco use in the world (61), and that the poorest quintile, and least educated, in PNG have the highest rates of tobacco use (80). Despite the fact that some have argued that tobacco taxes are the single best health policy in the world (81), tobacco per se is not specifically referred to in the NHP nor its use tracked as an indicator.[31] This means tobacco control does not necessarily get the policy attention the evidence suggests it deserves in the work programs of the six MDPs. Having said that, there is evidence WHO directly supported GoPNG in developing a tobacco policy strategy and budget changes, and the ''One UN'' has used World Tobacco Day to advocate against tobacco use. Alcohol consumption – a potential driver of NCDs, traffic and other accidents and gender based violence, is also high in PNG. One interviewee argued strongly there was insufficient focus on alcohol control, including among the MDPs. Although not an immediate problem, it can be argued that PNG – and the bilateral and multilateral development partners – needs to anticipate the health financing and health system implications of an ageing population in PNG, including the likely rise in the incidence of dementia and other mental health issues (82, 83).

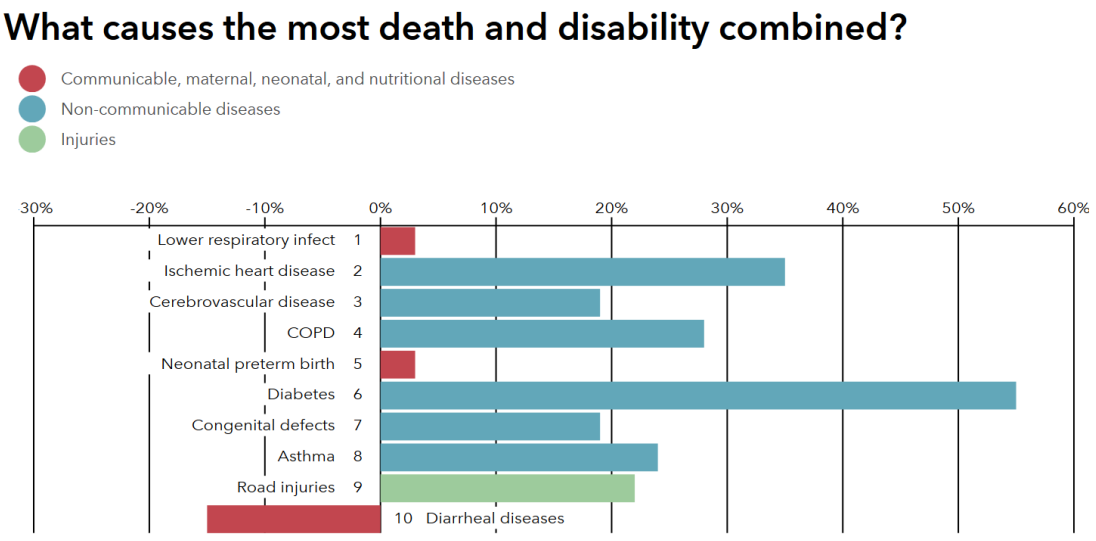
GoPNG, and the development partners, are not as focused on the rise of Non-communicable diseases (NCDs) as the evidence would warrant. It can also be argued that GoPNG, and its supporting MDPs, could be giving more policy and programming attention to the rising burden of NCDs, including cardiovascular disease and diabetes. NCDs can impose significant health, financial, social and economic costs on countries, especially in the Pacific where Government bears the major cost of prevention and treatment. NCDs are rising rapidly in PNG. The Institute for Health Metrics and Evaluation (IHME) estimates that NCDs, including especially diabetes, are among the leading causes of premature death and disability (known as Disability Adjusted Life Years or DALYs), and the fastest growing cause of DALYs, in PNG: see Exhibit 4 below. These estimates should be treated with some caution because the basic epidemiological data in PNG is patchy and because the IHME estimates inevitably involve modelling and a significant level of assumptions. Nevertheless, the basic point is clear: PNG is unlikely to escape the rapid rise of often expensive to treat NCDs that is occurring in most low and middle income countries, including in the Pacific (84-86). The NHP does refer to controlling NCDs under the Key Result Area 7 of *Promoting Healthy Lifestyles* as well as Objective 7.4. But there is no specific indicator to track NCDs in the NHP. WHO has programs on NCD prevention and control, but there is only limited evidence this is a prominent part of the work program or policy dialogue of the other MDPs, perhaps reflecting their own mandates and comparative advantage.

[31] The 2017 National Budget Speech, delivered on 1 November 2016, states (page 7) that '' tobacco excise base rates will have a one-off increase". That speech also announces (page 7) that "the 2017 Budget will increase the alcohol indexation cap from 2.5 per cent to a fixed rate of 5 per cent biannually''. This is also useful from a public policy perspective given the role that alcohol plays as a risk factor for Non-Communicable Diseases as well as domestic violence and accidents.

Exhibit 4

The rise of Non-communicable diseases in PNG

Source: Institute for Health Metrics and Evaluation (15)



Top 10 causes of disability-adjusted life years (DALYs) in 2016 and percent change, 2005-2016, all ages, number

Finding and recommendation 7.

GoPNG and development partners are already appropriately focused on several key health challenges in PNG including maternal mortality. But there are many other challenges. DFAT cannot, and should not, try to support every priority and challenge arising in the PNG health sector. However, DFAT is the largest bilateral partner to the health sector in PNG, and one committed to helping improve health outcomes over the longer term. DFAT therefore needs to continue to work with GoPNG, and the other development partners, to ensure the allocation of any resources DFAT directly provides to MDPs are addressing ''the right things''. This includes health system strengthening (especially that scarce health resources are continuing to address the critical drivers of the preventable burden of disease in PNG).

We **therefore recommend** that, as part of its consideration of priorities in any new partnership agreement, DFAT, in collaboration with NDOH and other development partners, specifically review whether the appropriate level of financial resources and attention are being allocated to ''the right things'' as referred to in the TORs for this evaluation. Specifically, that DFAT review whether there is sufficient focus in any partnership agreement to (i) critical aspects of health system strengthening, including public financial management and availability of essential drugs (ii) an unfinished agenda of traditional health challenges, including under-nutrition and immunisation and (iii) new health challenges including Non-communicable diseases

To what extent did organisations support pro-poor approaches and rural / urban inequalities?

There is clear evidence of commitment to support pro-poor approaches and address rural / urban inequalities. The GoPNG National Health Plan 2011-2020, with its ''back to basics'' theme and key performance indicators, specifically aims to improve essential services to the majority of people in PNG, with a particular emphasis on restoring essential services to the people living in rural areas: see Exhibit 2. The National Health Plan also gives significant priority to Key Result Areas 4 (child survival);

5 (improve maternal health) and 6 (reduce the burden of communicable diseases), all of which disproportionately affect the poor and marginalised, including especially women. Although much of PNG is poor, those MDPs that have a particular provincial focus have identified provinces with particular health burdens and / or special interests.

Are multilateral partners sufficiently leveraging their significant global resources (expertise, financing etc.) to address priority PNG health issues?

Yes, especially for short term assignments and issues: the issue is more problematic in terms of longer term in-country engagement. There were several examples of MDPs drawing on their considerable global resources to support PNG. WHO for example has mobilised a leading international expert on multi-drug resistant TB to lead the work on the emergency response to MDR-TB. WHO also brought in experts from Geneva and the regional headquarters in Manila to help PNG review and strengthen the review of the *Tobacco Control Act of 1987:* an important contribution given that WHO notes PNG was ranked 5th in the world for prevalence of tobacco consumption. WHO states that over the last 4 years there were at least 20 visits from WHO/HQ (63).WHO further advised that in 2016/17 it was able to mobilise around $US 8 million from various sources external to PNG to help fund programs on leprosy and other neglected tropical diseases where, in WHO's experience, there is little donor interest. The World Bank has deployed international health financing experts from Washington DC to work on short term health financing assignments; and UNFPA has now drawn on its global financial and technical expertise to help regain momentum on the delayed Demographic and Health Survey.

On the other hand, most MDPs concede that it is difficult – or at least particularly expensive - to leverage and attract highest quality staff, including those with families, to take up long-term postings in PNG. WHO's health security post has, for example, remained vacant for some time, despite being advertised twice, and DFAT has had concerns that the interim measures taken to fill the position – welcome as they be – still leave important coverage gaps in terms of the breadth of health security issues[32] On a separate but related matter, GoPNG officials specifically commented that in the past (but not at present) MDPs have assigned people – even to very senior positions – who appear to see the posting as a "retirement posting". This statement was not a comment about age or seniority. Rather, it was about the *perception* at least that some staff in previous periods lacked sufficient drive and energy. WHO confirmed, in writing, that it does not view the PNG post as a retirement posting in any way at all; that the PNG country office has one of the youngest staff profiles in the Western Pacific Region; and that a 2014 audit of the WHO Western Pacific region had found PNG to have some of the best technical officers in the region deployed there. The original World Bank advisor on financing who was stationed in NDOH was there on a ''fly in fly out'' basis. The ADB does not have its own full team staff member (as distinct from the consultants managing RPHSDP) specialising in health posted to PNG. The Global Fund business model is built around the concept of knowledgeable local authorities being the Principal Recipient of Global Fund grants, and therefore not requiring a Global Fund official

[32] More specifically, WHO advises that the post of health security was advertised globally in April 2017, prior to the post becoming vacant in May 2017. A second round of advertisements was then conducted and a candidate is schedule to move to PNG on 1 January 2018. WHO further advises that it took specific mitigation strategies to provide for a level of continuity in disease outbreaks and environmental health. This included the country office engaging 4 senior epidemiologists for a period of 259 person days of consultancy. These staff worked on a typhoid outbreak in Port Moresby; a measles outbreak in West Sepik District; a Haemorrhagic Syndrome in Morobe province; and preparations for the Asia Pacific Economic Conference (APEC) in 2018. DFAT has nevertheless expressed concerns that these interim measures involving epidemiologists to fill the position DFAT is supporting will not cover the full span of health security issues facing PNG including, for example, infection control, port of entry, laboratories etc). DFAT is also concerned that the difficulty in filling the health security position on a full time regular basis involves a lack of continuity in the management of health security issues.

to be stationed permanently in country. (Telephone interviews with the Global Fund official in Geneva confirms, however, that he visits PNG regularly and clearly has a solid knowledge and understanding of the country).

Efficiency

How effective were the governance and planning arrangements of the multilateral partners? Did these meet PNG Government, and also DFAT's needs?

There is evidence that MDPs have achieved efficiency gains and value for money. After initial delays and cost over-runs the ADB RPHSDP is now well placed to finalise the construction and handover to GoPNG of 32 rural health centres by early 2018, on time, and on budget. RPHSDP also leveraged in other public expenditure from local Members of Parliament own electoral and community development grants to build access roads to the clinics prior to construction. RPHSDP also designed the 32 centres with a specific eye to reducing long term maintenance and recurrent costs through use of steel frames (not wood that is prone to rot in tropical conditions) with a design life of 40 years. The project also maximises use of off-grid solar electricity. Minimising maintenance and recurrent costs is important given that GoPNG is responsible for 100% of the operational budget for the 32 centres and they do – as intended – increase access to health services by rural people. To the extent the 32 rural health centres are accessible and used, there will be substantial gains in efficiency – and equity – to the PNG health system as patients then use more appropriate, lower level facilities rather than hospitals. It could also be noted that, despite a series of follow up from DFAT, the ADB headquarters have been slow in approving the $US 17.6 million grant provided by Australia for expanding the ADB RPHSDP: such delays undermine program efficiency. [33] The Global Fund has been cost-conscious about the overheads of Principal Recipients.[34] The World Bank facilitated a review and streamlining of budget preparation templates, improving workflow efficiency and reducing the risk of coding errors (and fraud). UNICEF's Essential Early Newborn Care program focuses on low cost / no cost interventions [35] that avert much more expensive and intrusive remedial measures.

Procurement of vaccines and medical equipment was efficient and effective when using UN systems: it would appear to be much less so now. Several independent interviewees said that UNICEF's purchasing of vaccines, and UNFPA's purchasing of family planning commodities, had been particularly efficient (obtaining WHO confirmed best prices) and effective (good quality, reliably delivered). However, several interviewees also said current purchasing of drugs and medical supplies from the local domestic market involved significant losses in efficiency and value for money, with one interviewee saying drugs purchased that way cost 15 to 20 times more than the international price, and there were concerns about drug quality (with one interviewee stating that patients were being prescribed with double doses of the available antibiotics to compensate for their poor efficacy – this is problematic in light of increasing AMR). DFAT is supporting NDOH to strengthen its pharmaceutical services systems. This is coordinated through WHO. A significant achievement is DFAT's support towards the establishment of PNG's first Medicines Quality Control Laboratory. The laboratory is intended to enhance NDOH pharmaceutical quality assurance activities, including detection of substandard or falsified medicinal products. Finding and Recommendation 2 already emphasises that

[33] DFAT provided the funds to ADB in Manila in March 2017. However, as at 22 November 2017 the funds had not been formally approved or released to the project in PNG.
[34] The Global Fund has used World Vision, Oil Search, Population Services International, and Rotarians Against Malaria (RAM) as principal recipients for current grants. New grants in January 2018 will use World Vision and RAM.
[35] Including ''kangaroo care'' involving close contact between mother and newborn to keep the newborn warm, and the early initiation of breastfeeding.

prolonged – but even short term - stock-outs of essential drugs and commodities is a critical factor undermining the efficiency and value for money of GoPNG, DFAT, and MDP investments.

MDPs provide value for money to DFAT (and GoPNG) in terms of managing fiduciary risk, and charging reasonable overheads, but value for money depends more fundamentally on managing for results. Transparency International ranks PNG as 136 out of 176 countries in terms of the corruption perception index. MDPs therefore have strong and actively managed procedures for managing fiduciary risk of their own, and DFAT, funds. [36] The 'One UN'' partnership charges DFAT 7 % for overheads: this appears to be reasonable value for money compared to some other alternatives. Having said that, value for money value also – indeed primarily – involves ''managing for results'' through robust monitoring and evaluation systems and here the relationship between MDPs and DFAT is generally weak, and surprisingly so in some cases. See the discussion under the heading of Monitoring and Evaluation below. Importantly, M&E reports from MDPs generally give scant attention or reporting on how they have improved efficiency in their own operations or achieved value for money.

How effectively did multilateral partners engage with each other and PNG Government stakeholders to reduce bureaucratic transactional costs for partners and increase their effectiveness?

MDPs are generally working well together in PNG. Transaction costs will always be relatively high in PNG given the relatively large number of MDPs, NGOs and others involved in the health sector; the fact that health services have been devolved to 22 different provinces; and that travel and communication in PNG is often time consuming and expensive. We found little *formal* evidence of joint reviews to reduce transaction costs, as first envisaged under the *Paris Declaration on Aid Effectiveness* and subsequent international commitments. However, we did find numerous examples of WHO, UNICEF, UNFPA and Global Fund working together informally, and well, with each other in areas such as immunisation, family planning, and malaria reduction. See for example Box 3 below. There is also evidence that those agencies worked well with (and therefore helped to reduce transaction costs) with other important stakeholders such as the churches and private sector, including Oil Search Foundation (see Annex 6), to deliver immunisation and other health services. We found evidence that the "One UN" approach is taken seriously by those agencies in PNG. The ADB and World Bank are working cooperatively together and are likely to have complementary approaches to policy based and / or performance based concessional credits. Several MDPs work in the same priority provinces but we did not hear of any evidence that this involved duplication of effort between MDPs or particularly burdensome transaction costs, even for small numbers of often stretched provincial health workers.

[36] This includes the use of parallel systems, rather than using GoPNG's own systems which, it can be argued, does little to strengthen GoPNG's health systems or ''ownership''. Using MPD procurement and other systems to manage fiduciary risk also often means bureaucratic churn and delays which, in principle, reduces the operational efficiency of MDPs. However, these are arguably acceptable given the need to ensure international and bilateral aid funding is accountable.

Box 3

An example of joint reviews at the working level that improve coordination and coherence and reduce transaction costs. The following example and text was provided by WHO.(63)

In September 17–28, 2013, representatives of the World Health Organisation (WHO), United Nations Children's Fund (UNICEF), Global Alliance for Vaccines and Immunisations (GAVI), the United States Centers for Disease Control and Prevention (CDC), Oil Search Health Foundation Ltd., and the Chair of Technical Advisory Group (TAG) on Immunisation for the Western Pacific Region of the WHO conducted a review of the Expanded Programme on Immunisation (EPI) in Papua New Guinea (PNG) at the request of the National Department of Health (NDOH). During the review, the teams visited a total of 11 provinces, 22 districts and 38 health facilities in the country, accompanied by NDOH counterparts and Provincial Family Health Coordinators.

But there is still room for improvement. It was interesting, and noticeable, that several MDPs were critical of what they saw as the slow and bureaucratic processes of *other* MDPs, and the transaction costs that imposed on their own organisations. However, each MDP was equally willing to defend their own organisation's sometimes bureaucratic approaches given the fiduciary risks and sometimes fragile GoPNG health system. GoPNG officials in Port Moresby also generally welcome the support provided by MDPs but expressed concern that they are not kept fully aware of each agencies' programs or how those activities directly contribute to the GoPNG own National Health Plan 2011-2020.

How could DFAT improve its own engagement with multilateral partners to achieve better results, particularly in planning and ongoing monitoring processes? Was the multilateral partner's own risk monitoring and management sufficiently integrated into their planning, and to what extent were risks reported to DFAT?

This question is addressed under the heading of Monitoring and Evaluation: see below.

Sustainability

To what extent did multilateral partners build the capacity of PNG Government partners and systems in the long term? Why or why not? How can this be improved?

There is evidence of MDPs building capacity – or at least taking into account the challenges of sustainability – in PNG. The UNICEF focus on Early Essential Newborn Care, supported by WHO, is now being integrated into the pre-service training for medical students at University of Papua New Guinea (54). This is a more sustainable and locally owned way of building capacity and critical mass of expertise than one-off, partner-financed, training. WHO has deployed an international expert to lead and support GoPNG responses to MDR-TB in Daru. The Global Fund's model deliberately uses senior and locally based stakeholders as part of its country coordinating committee to manage its programs (although capacity constraints and past fiduciary issues means the Global Fund has used Oil Search Foundation, Rotary and World Vision as its Principal Recipients in PNG). The ADB RPHSDP explicitly and intentionally designed and built rural health centres in such a way that they minimised requirements for maintenance and operational funding: issues that had undermined the physical sustainability of health facilities in the past. We confirmed through site visits that RPHSDP deliberately uses steel (not wood that can be affected by termites); are hurricane resistant in risk areas; use solar energy and low maintenance batteries, and have a design life of 40 years. We further confirmed in site visits that RPHSDP actively, and continuously, involved village community leaders in the design

and operation of rural facilities. The World Bank now deploys a full time health economist to work in the NDOH to help strengthen public financial management capacities.

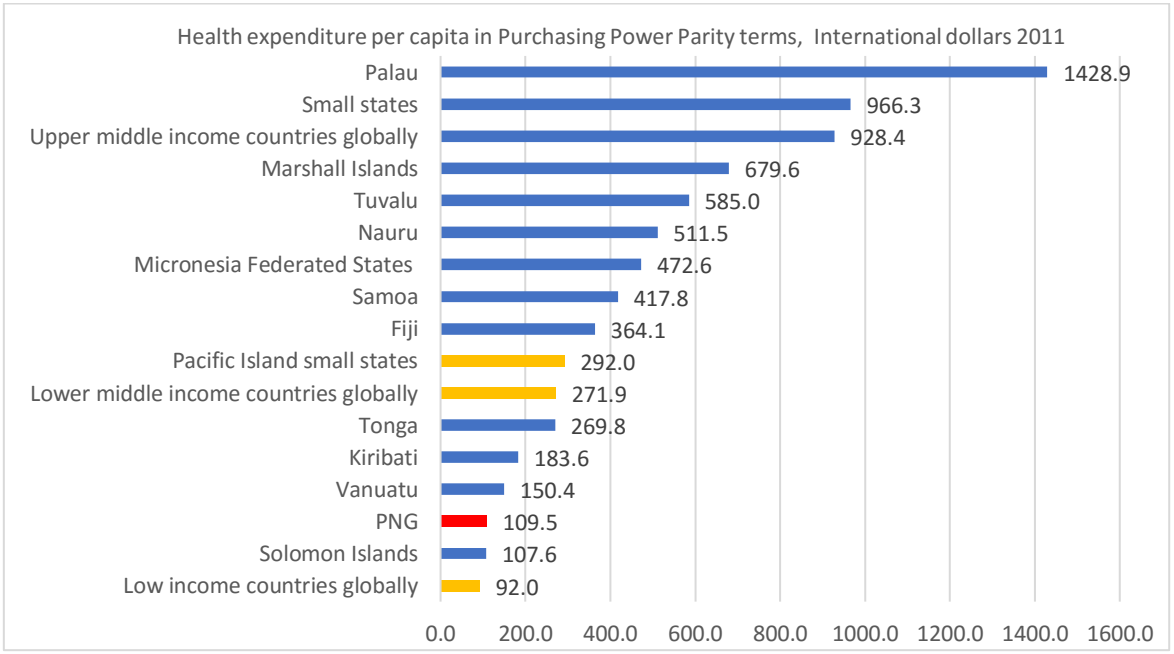
However, MDPs also argue they have no choice but to sometimes use their own parallel systems. Fiduciary risks, and capacity constraints – especially at the sub national level that is responsible for the delivery of health services – means that MDPs argue they are often obliged to use their own parallel systems, rather than GoPNG systems. MDPs, and DFAT, acknowledge that using GoPNG's budget, procurement, and M&E systems would help strengthen those systems. But they also point to current gaps and weaknesses that prevent them from using such systems.

The most fundamental and strategic risk to the sustainability of MDPs' efforts in the health sector lies with GoPNG's own future decisions about health financing. GoPNG (including with financing support from development partners) accounts for 81.3% of total health expenditure in PNG (1). At the same time, PNG (red bar in Chart 2 below) spends much less on health than other Pacific Island countries (blue bars); or the Pacific Island small states average, or the average for lower middle income countries globally (orange bars). DFAT's *Health Delivery Strategy 2011 -2015* notes that "health services in PNG have been chronically underfunded, falling from about K60 per capita in the 1980s to under K40 per capita now" (87). Since then, GoPNG's own budget expenditure on health was cut by 21% in the 2017 budget, on top of earlier reductions (88). Some analysts question whether there has been a ''lost decade'' in terms of health outcomes, partly due to under-investment in the health sector (10). The World Bank estimates (page 19) that PNG would need to spend approximately $US 809 per capita (2005 dollars) to reach human development targets (health but also education) compared to $US 351 per capita now. (89). In short, the most fundamental risk to the sustainability of MDP's, and DFAT's, current and future investments in the health sector is the extent to which GoPNG can mobilise, and then allocate, their own tax and other revenues and allocate it to the health sector. It is for that reason that the first recommendation of this Evaluation deals with the need to better track whether MDP, and DFAT, contributions are additional to GoPNG efforts over the longer term.

Chart 2

Health expenditure per capita, PNG (red bar) and comparable countries.

Source: World Bank (1)



Did multilateral support encourage or disenfranchise PNG ownership of health issues?

There is evidence that MDPs, often with DFAT support, have helped enfranchise PNG ownership of health issues through generating data and evidence. MDPs have helped provide reliable, timely, data that then allows GoPNG decision makers to make their own evidence-based and informed decisions. There are many examples: the WHO analytical work to establish National Health Accounts; the World Bank's work on public expenditure flows to sub-national districts(57), and the health workforce (56); UNICEF's case / control approach to testing the efficacy of its newborn care program; and, if completed on time and well, UNFPA support to providing an up to date and reliable Demographic and Health Survey.

MDP training, and technical assistance, can also facilitate increased GoPNG ownership. MDPs, often with DFAT support, have invested relatively large amounts of time and money in numerous training programs. Where such training leads to a change in actual competencies and practice (as UNICEF achieves through testing of those trained) then there is the potential for empowerment. We did note, however, that the weak, descriptive, input-focused *reporting* of training by some MDPs meant that it was not possible to assess of those trained did actually learn, and used, new approaches. Nor was it possible to determine from their M&E reporting the extent to which females, or people from poorer and remote provinces, were receiving training: cohorts that *prima facie* could be expected to potentially benefit a great deal from empowerment and enfranchisement. The extent to which technical assistance, including especially the use of international advisors, empowers or disenfranchises local officials – especially in aid-dependent countries - has long been recognised internationally as a large and complex issue (90-93). We could not examine this in any depth in the time available for this evaluation. Officials from some MDPs did, however, observe that rapid staff turnover of those trained could erode the effects of training.

Equity and Gender Equality

Equity and gender equality is an important priority for the GoPNG, but much remains to be done. The midterm review of the National Health Plan 2011–2020 states (page 2) " the NHP has a strong focus on the rural majority and the urban poor, but there is no evidence that a significant shift in focus towards these groups has occurred."(16) Gender is a particularly challenging issue in PNG in the health sector, and beyond the health sector. Also, women make up a large proportion of the front-line work force either as nurses / midwives or community health workers. A health system that functions reasonably well therefore provides valuable, *formal sector*, employment for women including in rural and remote areas where formal sector employment opportunities may be limited. Conversely, unavailability of drugs or operational expenses disempowers nurses and midwives. Gender issues also extend beyond the health sector per se. No female MPs in Parliament means that there is limited attention to the public health issues that are priorities to women as part of the national dialogue. The lack of female engagement in political decision-making flows through to district and sub national levels too: one refreshing exception we encountered being a female member of the village health committee in Milne Bay.

Did our support through the multilateral agencies make a difference to gender equality and empowering women and girls?

Each of the multilateral agencies have, at an overarching level, a commitment to and the necessary strategies/policies to support gender equality. This is aligned with DFAT's Gender Equality and Women's Empowerment Strategy (2016) which establishes gender equality and women's empowerment as a priority for development. For example:

- Gender equity is one of the five drivers of change in the **Asian Development Bank** Strategy 2020. The Operational Plan for Gender Equality and Women's Empowerment 2013-2020 sets out the strategic directions and guiding framework for advancing gender equality agenda and delivering better gender equality outcomes by 2020. Country gender strategies and gender action plans (GAP) for projects are essential to the ADB's ability to measure performance against its ambition for better gender equality outcomes and there is an explicit commitment to monitoring and reporting on GAP implementation progress.

- At a global level the **GFATM's** approach to gender is outlined in its Gender Equality Strategy: Action Plan 2014-16. As a way of demonstrating its commitment to the principles outlined in that strategy, the GFATM has been steadily increasing investments in programs for women and girls, and as of 2015, the cumulative investment amounted to almost 60 percent of total spending[37]. This allocative prioritisation recognises that women and girls are disproportionately affected by HIV, TB and malaria and, in an effort to ensure appropriate targeting of country allocations, each funding request requires an analysis of the role of gender in the epidemics and in each country context.

- **UNFPA's** core mandate prioritises gender equality and the empowerment of women and girls UNFPA supports sexual and reproductive health services to: enable women to deliver safely; make voluntary family planning information and services available to millions of couples; and protect the health and rights of adolescents so they may realise their full potential. UNFPA provides informative estimates, based on modelling, of health outcomes for women at the impact level including deaths averted): see Table 2.

- The promotion of gender equality and the empowerment of women and girls is central to the mandate of **UNICEF** and its focus on equity. UNICEF's Gender Action Plan 2014-2017 includes a programmatic framework for both targeted gender priorities and the full integration, or mainstreaming of gender in programs.

- The **World Bank's** Gender Strategy (2016-2023) focuses on three domains of gender equality: human endowments, notably education and health; economic opportunity; and, voice and agency (expressed through ability to exercise control on key decisions such as child-bearing and ability to have voice and influence in political processes). Central to the Bank's approach to gender equality is a country driven approach. The World Bank Country Partnership Strategy for PNG 2013-2016 includes analysis of the gender dimensions of PNG's development challenges and within that suggests priority actions to increase access to education, health and HIV-AIDS treatment.

- The **WHO** has a Gender, equity and human rights (GER) roadmap for action, 2014-2019 which is a 5 year plan to ensure an integrated approach for gender responsive, equity enhancing, and rights based WHO programs.

In PNG, the programming activities of the multilateral agencies are supportive of gender equality and the empowerment of women and girls, but there is limited evidence of gender being given prominence in program design, delivery or M&E, and very few examples of reporting that supports assessment of the gendered impact of activities (because of lack of gender disaggregated data).

Each of the MDP programs are considered below.

[37] https://www.theglobalfund.org/en/women-girls/

The ADB's RPHSDP

As part of the design documentation for the ADB's RPHSDP, a specific operational response to addressing gender equity was developed – the Gender Action Plan (GAP). The RPHSDP's approach to gender equality was informed by a rigorous Country Gender Assessment (38). The GAP contains 20 elements, progress against which is reported at the meetings of the Project Steering Committee (which is chaired by the Secretary of the Department of Health and which comprises representatives from Department of National Planning and Monitoring (DNPM), Treasury, and NDOH, ADB, DFAT, OFID, WHO, UNICEF and JICA).

A specific requirement in the GAP is to ensure that "baseline and periodic monitoring surveys collect, analyse and report sex disaggregated data for all project outputs". To embed this commitment to gender equality in action, the RPHSDP employs a Gender Advisor and there is evidence of his active contribution to national efforts on gender equality e.g. through participating in the drafting and preparing to pilot the National Gender Health Training Curriculum and involvement in the review of the Clinical Guidelines to respond to Family and Sexual Violence (FSV) through the Health sector.

In the Medium Term Review of the RPHSDP an assessment of compliance with each of the proposed activities/targets was produced which found compliance or partial compliance with each of the elements: Annex 7). In addition, annual reports of performance against the elements of the GAP have been published for 2014, 2015 and 2016.

We find strong evidence of a commitment to gender equality was built into the design of the RPHSDP and that there is an ongoing commitment to transparent reporting of achievement (or lack thereof) against each of the elements contained in the Gender Action Plan that relates to this investment. The project is contributing to gender equity through better, gender sensitive policies and health promotion activities, by supporting improved human resource capacity at the community level to provide quality health services that address the specific needs of women and men as well as through the design of health facilities that account for the gender specific needs of its users.

Global Fund

In PNG, violence against women and gender-based violence are significant factors in making women more at risk of contracting HIV, especially in the context of the high rates of other sexually transmitted infections (STIs). Women who experience gender-based violence are both underserved in terms of HIV prevention and access to services. The 2013 GFATM Round 10 Funding Request for PNG explicitly addresses this issue by committing to addressing gender-based violence through creating a sustained environment that is supportive of women's rights and prioritises advocating for change within local level government and communities. The Phase 2 program has 9% of its budgeted activities devoted to supporting activities that prevent violence against women. The associated M&E Plan also includes equity orientated data disaggregation (gender, age, geography) as part of the indicator data collection requirements and definitions.

UNFPA

UNFPA's mandate and core country programming themes in PNG (sexual and reproductive health, gender equality and population dynamics) are all aligned with gender equality and empowerment of women and girls. DFAT supports the UNFPA's core operations through funding allocated at an organisational level.

[38] Papua New Guinea Country Gender Assessment 2011-2012 (ADB and World Bank co-funded)

The scope of this engagement limits our review to essentially that of DFAT's direct grant with UNFPA under the Partnership agreement, and therefore primarily as it relates to the DHS. Whilst the implementation of the DHS has proven problematic, its completion is an essential contribution to gender assessment for policy and programming prioritisation in PNG. As noted previously in Box 1, the DHS will generate data on infant and child mortality, adult mortality including maternal mortality, fertility, contraceptive knowledge and use, maternal and child health, and gender. This will support strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.

UNICEF

DFAT's support for UNICEF's project to revitalise and scape-up nutrition interventions in PNG aims to support improved and equitable access to nutrition specific interventions by children under five and pregnant and lactating women in six provinces. It targets 500,000 children under five and 84,000 women. The program aims to promote a better nutritional status of young children, both boys and girls, as well as women and adolescent girls through greater access to specific nutrition interventions at health facility, community and household levels. Whilst it is stated that "the monitoring and evaluation system is strengthened to provide sex and age disaggregated data where necessary" project reporting does not include gender disaggregated output or outcome information. Whilst we acknowledge the link between maternal nutrition, healthy babies and economic productivity, we cannot conclude at this stage that this project has had any real impact on gender equality or empowerment of women and girls because activities that have been described as having been undertaken include training of health workers, participation in international meetings and confirmation of a national nutrition strategy. Even where possible and relevant, the reporting has no sex disaggregation and there is scant detail and very summary information included in the 'Gender and Social Inclusion' section of the reports**.**

WHO

The 2012-2016 WHO-DFAT Partnership states that that the partnership program addresses gender equality primarily through strengthening service delivery policies and interventions which improve maternal health and health outcomes for girls and women in PNG. Key interventions, as stated by WHO, include:

- Supporting the establishment of 17 hospital-based Family Support Centres (FSCs). WHO advises that ''currently, 12 FSCs are providing the essential services for survivors of sexual and gender-based-violence. Access to services at the FSCs has increased over time. For example, the data from Mt Hagen Hospital Family Support Centre shows substantial increase in the number of victims of rape and sexual assault accessing services, from 322 in 2015 to 408 in 2016. Between 2014 and 2016, the same FSC was able to provide a total of 580 voluntary counselling and testing (VCT) and 372 post-exposure prophylaxis (PEP) given. However, the Organisation does not routinely collect data on gender-related indicators. We will assist the NDOH in conducting more systematic data collection on these in the next phase of partnership."

- Working with the Reproductive Health Training Unit (RHTU) to strengthen family planning, reproductive health (RH) and adolescent sexual and reproductive health policies/packages related in-service training and service providers

- Improving health outcomes for girls through increasing national immunisation coverage, and targeting malnutrition, stunting and diarrhoeal disease (all to be reported through sex-disaggregated data)
- Promoting gender equality in all relevant steering committees and working groups
- Strengthening provincial reporting of maternal mortality audits.

That being said, the budget allocation associated with the program's key result area (KRA) 5 – Improve Maternal Health – represents just 11% of DFAT's overall investment in the WHO PNG partnership and, within this KRA, there are no funds committed against "operational research on key maternal health and reproductive issues including domestic and gender based violence and male involvement in family and RH".

Surprisingly, there was no gender disaggregated information provided in the WHO-DFAT Partnership 2013-2015 Progress Report, but it was stated that "efforts were made to mainstream gender equality and human rights in program development and service delivery" and that a "workshop was conducted to introduce gender, equity and human rights (GER) and to mainstream gender in program development. Other GER-related activities included training for health workers in Port Moresby and gender based violence (GBV) training for staff from 13 Family Support Centers".

In discussions with the WHO team in PNG[39], we were told that WHO has made a difference to gender equality and empowering girls through:

- its Fellowships and Training capacity building program which continues to promote gender equality and empower female health professionals in PNG
- training of more than 50 public health managers and policy makers from the Southern and Highlands regions in 2016 to mainstream gender equity and human rights in public health programs.
- on-going gender mainstreaming training for public health managers and policy makers to enhance the acceleration of both Universal Health Coverage and SDGs.
- development and piloting of Health Sector Training curriculum on Gender equity and human rights mainstreaming and GBV prevention in two DFAT supported Family Support Centres in Daru and Arawa.
- development of a Health Sector Gender Policy (2014)
- clinical guidelines on Gender equity and GBV prevention developed in 2015-2016
- National Action Plan on Gender Equity and GBV prevention developed in 2016
- National computerised GBV data-based sex and age disaggregated reporting system developed in 2017
- National Referral Pathway for treatment of survivors of sexual violence for medical, legal and social services developed in 2017

We acknowledge that there has been a lot of training, and people attending workshops. However attendance at a training session or workshop does not necessarily equate to increased knowledge or

[39] Provided by WHO representative

competencies (one reason why UNICEF's specific testing of knowledge and competence after training is welcome). This appears to have been partly recognised by WHO: in its 2016-2020 Country Cooperation Strategy with PNG, there is an acknowledged need to translate the range of policies, strategies and clinical standards that have been developed into operational plans in provinces and districts as the basis for sustained implementation.

The World Bank

The World Bank's country Partnership Strategy in PNG (2013-2016) states that "gender issues will be "front and centre" throughout its program. DFAT's investment with the Bank is through Pacific Facility 4 (PF4) and a Multi Donor Trust Fund which serve as an integrated way to support a program of advisory services and health sector analytical work to provide a national evidence base for improved investments by GoPNG and other partners.

Analytical work has largely focused on system efficiencies and health financing. This has been complemented by the activities of a Public Financial Management specialist who has been working primarily with the NDOH to improve its capacity to monitor expenditure and promote efficiency in financial management. Providing the technical assistance to the NDOH to 'effectively monitor funding flows from central agencies to front line services' should have positive implications for gender equality because it will mean more funds are reaching sub-national service delivery points where women are both users of and workers in the health system.

How could DFAT assist and leverage multilateral agencies to improve equity of health care provision and gender equality?

MDPs performance reporting, including much better use of gender disaggregated data, needs to improve. DFAT's prioritisation of the health of women, children and vulnerable groups and its sub-national focus on health service delivery improvement is aligned with a commitment to improving equity of health care provision and gender equality. That being said, it will be difficult to monitor progress towards this ambition without better reporting and then use of gender disaggregated data and a more rigorous application of gender assessments when making programming and policy decisions. DFAT should require that gender be more thoroughly addressed – and reported - in program design documents; that there is an insistence on gender disaggregated data in program reporting; and that program evaluations (mid-term and end) include a gender assessment. Performance around gender equality should be considered as an element in any contracting that links payment to performance. Of course, in strengthening the assessment and reporting of gender issues, it will be important not to create parallel reporting systems. Instead, GoPNG's own M&E systems for analysing trends in gender should be used wherever that provides reliable, timely, and actionable data. Where there are remaining gaps, other approaches will be needed, but should be done so with an eye to avoiding parallel systems. It is also important that the data collected is – and is seen to be – a management tool for better decision making and resource allocation, and is not seen as some form of passive reporting.

Finding and recommendation number 8.

At a strategic level GoPNG and each of the multilateral agencies are committed to gender equality and empowering women and girls. This is a challenging area in PNG and will take time to improve. However, there was nevertheless limited operational level evidence that MDP efforts having made a real difference to gender equality. The Asian Development Bank's RPHSDP is the investment with the most sophisticated approach to gender in its design, delivery and M&E. UNFPA provides estimates of the impact its family planning and other interventions on number of maternal deaths averted and other gender related data: see Table 2. The majority of project level reporting reviewed from other agencies did not contain sufficient – and in some cases any - gender disaggregated data. There was also an absence of thorough gender lens analysis in the reporting. DFAT is entitled to expect clear and more informative M & E reporting from MDPs, including evidence that the M & E is being used for overall performance management from MDPs, on such an important issue as gender in PNG especially when MDPs are directly using DFAT funds. Strengthening M&E reporting for gender should, where possible, engage and use GoPNG M&E systems, and avoid parallel reporting systems.

We recommend that DFAT, GoPNG and MDPs meet to agree on a more explicit, insightful and regular means of reporting on gender disaggregated data, extracted from existing M&E systems wherever possible, as a basis for better planning and management.

Monitoring and evaluation

DFAT itself clearly recognises that monitoring and evaluation – and especially managing for and demonstrating ''results'' – has been a weakness in the health program in PNG. The evidence for that is clear. More specifically, DFAT's 2011-2015 strategy to PNG (87) says:

- "M&E and reporting of results is critical to the success of the aid program. However, to date it has been the weakest part of the health portfolio"'
  "Poor quality monitoring & evaluation affects AusAID's ability to tell a coherent story, hold PNG to account, and maintain public goodwill for the aid program in PNG". (DFAT needs to have) "more cross-program field monitoring visits (managed through a whole-of-program monitoring plan), and developing an internal operational research agenda to understand and address incentives and barriers to improved service delivery".

DFAT's subsequent draft Health Sector Investment Plan, covering the period 2016-2020, does recognise the challenge and envisages a way forward. It says (page 14) "We will generate credible information about our investments in the health sector and use that information to manage program performance, demonstrate accountability and act transparently. We will validate the cumulative effect and broader significance of investment achievements at a sectoral level through impact evaluations, which will inform long-term strategy and decision making. Reliable performance and financial information will be used to guide discussions with the PNG Government about our partnership in the sector. We will publish our progress against sector objectives in the annual Aid Program Performance Report (APPR)." The reference to ''validating the cumulative effect and broader significance of investment achievements at a sectoral level…" is a particularly welcome and relevant initiative with respect to the $111.9 million investment with the 6 MDPs (a larger amount of investment if GAVI and UNAIDS was included). We understand there has not, to date, been an exercise to "'validate the cumulative effect and broader significance" of investments in the health sector, although this Independent Evaluation is part of that plan.

The latest DFAT Aid Programme Performance Report for PNG also acknowledges the importance of performance monitoring. More specifically, that report concludes (page 5) that programs in the

''human relations pillar" – which includes the health sector but also education – are rated amber, as distinct from green or red[40]. An amber rating means ''Progress is somewhat less than expected at this stage of implementation and restorative action will be necessary if the objective is to be achieved. *Close performance monitoring is recommended*" (italics added).

M&E should be much more than administrative ''reporting''; it is an essential tool for performance management and demonstrating to all stakeholders ''results''. Ideally, DFAT would be able to rely on the M&E systems of GoPNG and / or of the MDPs themselves to satisfy itself its investments with MDPs are achieving what was intended, and provide value for money. The environment in PNG does not allow that yet. DFAT therefore has to have a degree of parallel reporting. That, in turn, involves its own financial and management costs. It is therefore important that resources devoted to M&E yield a payoff in terms of improving and demonstrating "'results'' [41] to DFAT, the MDPs, and the GoPNG more broadly. There are innovative, low-cost, real-time, and ethical ways of capturing insights into the effectiveness, and cost-effectiveness, of scaling up of health services that could and should be used more in PNG (18-20, 23, 94, 95).

Against that background, we assessed the monitoring and evaluation aspects of DFAT's partnerships with the six MDPs. The following are the first three questions in the TORs we were asked to address. Given a degree of overlap between these questions, we have grouped them together, and then assessed each MDP.

To what extent did the monitoring and evaluation systems of the WHO, World Bank, ADB and UNICEF provide DFAT with timely reporting and strategic insight into the effectiveness of the DFAT grants?

To what extent are the existing or planned monitoring and evaluation systems of the six organisations likely to provide timely, reliable and valid insights into priority areas of interest to future DFAT programs?

To what extent do existing monitoring and evaluation systems of the six organisations facilitate lesson-learning and continuous improvement of their own activities?

The reporting produced by ADB's RPHSDP is timely, thorough, and provides DFAT with insights about the effectiveness of its investment in this program. This investment benefits from clarity of design from the outset. It was informed by an evidence base that considered both the health needs of the country and the political economy in which the investment was to be delivered. Its governance structures were designed to ensure 'ownership' at the right levels (down to the Village Health Committee level) and delivery risk that spans the public and private sectors. DFAT can demonstrate how this investment is aligned with its commitment to improved health outcomes at the sub-national level and how it contributes to its overarching goals for health investments in PNG. The design includes measurable outcomes and there is an appropriate allocation within the budget (approximately 20%) to 'Project monitoring, evaluation and management'. ADB's Mid Term Review of RPHSDP (28) is comprehensive, informative, and lends itself to managing for results. We sighted the minutes of Project Steering Committee meetings and confirmed that the RPHSDP M&E system generated timely

[40] A rating of green means "Progress is as expected at this stage of implementation and it is likely that the objective will be achieved. Standard program management practices are sufficient." A rating of red means "'Progress is significantly less than expected at this stage of implementation and the objective is not likely to be met given available resources and priorities. Recasting the objective may be required."'

[41] The meaning of "Results'' will vary according to the type of intervention. Some results will be outputs, including analytical reports on health financing or the Demographic and Health Survey. Some results will be outcomes, including health workers better able to manage neonatal birth complications or infection control for Multi-Drug Resistant TB. Some results will be at a higher impact level, including lives saved and deaths averted.

and relevant information to managers that then enabled corrective action by managers. The RPHSDP approach to gender is particularly substantive and informative (see Annex 7).

Similarly, we **find the Global Fund M&E process and reporting rigorous**. The Fund uses the National Strategic Plan as its investment framework. It requires 6 monthly reporting describing achievement against indicators and financial utilisation. Disbursements are results based which can, potentially at least, incentivise performance. A number of 'checks and balances' are built into the process, including allocation of a percentage of the grant amount to M&E (up to 7.5% in the Round 10 grant) and use of the local fund agent to verify the data reported by the Principal Recipient.

Importantly **the Global Fund M&E aims to capture outcomes and impact as well as process**. For example, the Mid-term review (MTR) of the Global Fund Round 9 grant highlighted the need for strengthened surveillance and M&E based on the fact that the lack of evidence and reporting was inhibiting the ability to measure progress and enable the reorientation of services in line with the emerging data. Based on this finding, the next phase of the Global Fund grant was targeted towards developing capacity around surveillance and M&E through both the recruitment and provision of human resources and capacity building support to the NDOH Surveillance Team, including M&E Officers at the provincial level. There was also the continued inclusion of the WHO Technical Assistance for Strategic Information and Monitoring. The MTR also found that effective implementation of the National M&E Framework was lagging behind due to capacity constraints at different levels. For instance, most service providers did not have dedicated M&E staff. There are also other challenges such as lack of training in M&E, lack of adequate budgetary allocation for M&E activities, inability of strategic information systems to collect indicators at the clinic level, and limited dissemination and then translation of research findings into programming.

World Bank progress reporting is generally thorough and candid. There is an acknowledgement that there have been challenges in making a meaningful impact through advisory services (TA) and Advisory and Analytics work (ASA). Information provided in the progress report thus focuses on outputs (i.e. the papers and policy briefs that were produced under the auspices of the PF4 and multi-donor trust fund). There is a political economy lens applied to the reporting which demonstrates a sound understanding of the fiscal and operating climate in which decisions affecting health sector service delivery and financing are being made. The progress report includes a 'scorecard' where progress against each of the elements of the ASA and TA are graded – 6 of the 8 elements are graded 'amber'. A 'lessons learned' chapter in the report provides pragmatic suggestions for ways to increase the likelihood of the analytics work being reflected in policy. Page 86 of the World Bank Country Strategy to PNG has an insightful and candid table showing the evolution of the World Bank's own understanding of risks it has in PNG (62). Importantly, there is some discussion about how to maximise the health sector support work to feed into the significant scale up of IDA funding in PNG.

The M&E reporting by the UN agencies is complicated to a degree by the variety of agreements in place. There are global partnership frameworks, local overarching contracting arrangements associated with DFAT's investments through the One UN Fund (supporting United Nations Development Assistance Framework – UNDAF) and specific investment level contracts which proscribe reporting (and this M&E requirements)**.** The following elaborates with respect to each UN agency.

DFAT has a partnership framework with **UNICEF** at a global level to underpin its core funding contribution. This framework outlines the principles that are at the foundation of the partnership and the shared objectives associated with this arrangement. In this agreement it is stated that "AusAID will rely principally on UNICEF's own monitoring and evaluation systems, in particular UNICEF's own

annual report". The core activities of UNICEF in PNG fall under the UNDAF (as is the case for the other UN agencies). The inter-agency indicators associated with the health cluster of activities under this framework are aligned with objectives of the PNG Medium Term Development Plan (MTDP). But achievement against these indicators is representative of efforts that extend beyond the UN partners to include the GoPNG and others. In addition to core funding, DFAT has also agreed to support UNICEF to implement specific nutrition and newborn care projects – which have their own set of indicators and reporting requirements that are in addition to those in the partnership framework. Indicators are specific to these investment and reporting is that has been sighted is at a very operational level.

Oversighting and assessing performance against the various expectations outlined across these arrangements is further complicated by the fact that responsibility for contracting and communicating with UNICEF spans a number of teams within the Australian High Commission in Port Moresby (Operations and Health) as well as Canberra based 'multilateral' teams and of course Australia's representative at the UNICEF Executive level. Within this web of reporting requirements and relationships it is not then surprising that it is difficult for DFAT to decipher which elements of their investments with UNICEF are effective and which need further attention. This is, however, not an intractable problem. DFAT staff at the Australian High Commission in Port Moresby will be able to establish a hierarchy of reporting that meets DFAT'S requirements for informative and accountable reporting from UNICEF.

It was difficult to determine whether or not UNICEF's nutrition and EENC projects were effective just by reading progress reports. M&E information contained in the associated reports was largely activity based with limited evidence to support a positive assessment of the investment. Discussions with UNICEF staff led to the production of evidence that supports a positive assessment of these investments, indicating a mismatch between reporting and reality. There is significant opportunity for UNICEF to improve its reporting so that the effectiveness of its activities are better understood by DFAT, GoPNG and other MDPs. In the progress reporting for the EENC grant most reporting is at the output level (number of people trained) and it is difficult to delineate performance within and across the reporting periods. Furthermore, addressing risk management, sustainability, gender and partner engagement has not been substantively updated across two years of reporting.

That being said, we did observe application of elements of the EENC package at the sub-national level and community health post nurses/midwives were confident that babies' lives had been saved because of application of the EENC package. We also reviewed literature describing the scientific approach being applied to the operational research into the effectiveness of the Hypothermia Alert Device which is an innovative element of the EENC package and which has the potential to save more babies' lives and change mothers' behaviours. The reporting relating to nutrition also largely focused on activities and outputs (e.g. training, international meetings and workshops). However, over the reporting period 2015-2017, the quality of project reporting significantly improved and the most recent project reporting provides insights about the effectiveness of the project e.g. the case fatality rate associated with severe acute malnutrition (SAM) among hospitalised children in four provincial hospitals reduced on average from 24.3 per cent in 2013 to 10.7 per cent in 2016. It also highlights areas in which it has been difficult to get traction. Importantly, plans for 2016-17 have been informed by lessons learned. There is evidence that UNICEF has catalysed a multisectoral approach to the challenge (emergency) of nutrition.

UNFPA has useful and informative reporting at the outcome, and even impact level, but two-way communication between DFAT and UNFPA should be improved. The ''opening'' UNFPA website for Papua New Guinea (96) does not provide much detailed or substantive data on UNFPA's operations in PNG. However, clicking on the ''data'' tab provides a good deal of useful and informative data about

UNFPA's program in PNG including at the input, output, outcome and even impact level: see Table 2. Clicking on the ''topics'' tab also provides updates on four specific themes relevant to PNG: sexual and reproductive health; gender; population trends; and young people. UNFPA's progress reports on the 2016 Demographic and Health Survey, which involves $10 million DFAT funding, are generally adequate. However, DFAT believes UNFPA could have done more to alert DFAT to delays and funding issues within the PNG National Statistics Office which was the implementing agency for the DHS. There are other examples of two way communication issues between DFAT and UNFPA, as noted under the preceding heading of effectiveness.

M&E as it relates to the performance of the WHO investment needs improvement. It is clear that DFAT's investments with WHO are aligned with the objectives of the Australia-PNG Health Delivery Strategy 2011-2015. We also note that in the funding approvals that provide the legal basis for DFAT's investment in these projects there is an acknowledgement of the need to improve M&E. For example, as it relates to WHO, it is stated that 'global, regional and country office assessments have identified M&E and performance reporting as an area for improvement [and that] AusAID and WHO will work together to ….establish clear expectations on performance reporting to meet AusAID's minimum quality standards'. Despite this acknowledged need for improvement, we did not see evidence of M&E that would underpin a thorough assessment of the performance of the WHO. We sighted evidence of recent communications between WHO and DFAT which indicates DFAT's concerns with the quality of WHO's six monthly progress report including a lack of measurement of performance against planned outputs. We did not see a revised WHO report at the time of submitting this report and so cannot make comment on whether WHO was responsive to this feedback. At a broader level it is encouraging to note WHO's stated position that DFAT could improve its engagement with WHO to achieve better results with an 'agreed performance framework for M&E'.

How could DFAT better monitor and evaluate the programs of the six organisations?

DFAT can use its funding to obtain more useful, and usable, M&E reports from MDPs. The preceding assessment shows that there is a good deal of variability in the M&E reporting of the MDPs. There is substantial room for improvement, particularly with respect to the reporting by some MDPs. Finding and Recommendation 8, below, brings that analysis together.

Finding and Recommendation 9.

Monitoring and evaluation – particularly as a means of proactively managing for and demonstrating ''results'' – remains a challenge, with a good deal of variability in the quality and timeliness of MDP reporting on the use of DFAT grants. The ADB's RPHSDP, the Global Fund, and to an extent the World Bank and UNFPA provided reporting that was a good basis for assessing and managing progress of their programs and activities. UNICEF reporting, and to an extent WHO reporting, missed some key opportunities to explain substantive progress at the higher output, outcome and even impact level, relying too much on descriptive reporting of inputs (number of people trained, number of workshops held etc). Few partners, other than ADB and UNFPA, reported gender disaggregated data in a substantive or meaningful way. MDPs reporting on financial disbursements of the DFAT grant is generally good but more could be done by all MDPs to demonstrate how they are achieving efficiencies and value for money with the DFAT grants.

We therefor **recommend** that DFAT should make it clearer to MDPs that it sees M&E, especially with respect to the direct grants it provides, as a strategic management tool rather than a means of routine reporting. DFAT should, particularly as future funding commitments are being negotiated, reach agreement on the nature and frequency of reporting key indicators. Those indicators will need to vary from MDP to MDP, and from activity to activity. However, the indicators would normally include analysis – and not just a descriptive account – of how the DFAT grant is specifically contributing to agreed goals; emerging risks and risk-mitigation strategies; and provide management level insight into efficiency and value for money of how the MDP used the DFAT grant. Future M&E reports should also normally have gender-disaggregated data as a matter of course. A percentage of the value of the DFAT grant (at least 5%) should be specifically and routinely (there may be possible exceptions for smaller activities) allocated to improve the depth of analysis of M&E.

Unanticipated issues.

The evaluation report should also communicate any unanticipated but important issues that emerge during the process of answering the above questions.

We did not find any particularly important unanticipated issues that need to be communicated.

Chapter 3 Lessons to be learned for the future

What lessons can be learned to inform future DFAT support to multilateral partners?

Based on the assessments in Chapter 2, and Annex 4, we suggest seven specific lessons can be learned to inform future DFAT support to multilateral partners.

First, what GoPNG itself does – or does not do – will always have a substantial effect on health outcomes in PNG. That is because public expenditure (that is, GoPNG expenditure, including external financing) contributed 81.3 % of total health expenditure in PNG in 2014 (latest year available), a particularly high *relative* level by international standards. PNG has a level of public expenditure that is more than double the global average for other lower-middle income countries (37%) and is substantially higher than the level of public expenditure in even upper middle income countries (55%) (1). Paradoxically, GoPNG also has, at the same time, a low *absolute* level of health expenditure per capita: see Chart 2. Putting these two factors together, it is clear that what GoPNG does – or does not do – in terms of health expenditure will always have a substantial effect on health outcomes in PNG.

Second, MDPs are, potentially, then very well placed to support GoPNG's own efforts in the health sector. GoPNG officials made it clear during the evaluation that PNG is facing multiple challenges in the health sector. PNG is facing serious fiscal constraints: the ADB, and now the World Bank, are both considering potentially large concessional loans and credits to address priority health challenges. GoPNG officials recognise that they need access to evidence based policy advice and technical assistance that draws on international experience: all MDPs have a comparative advantage in their specialised areas. GoPNG officials also recognise that they need support from MDPs in actual implementation of large scale national programs including reduction in malaria (the Global Fund) and responding to the threat of multi-drug resistant TB (WHO). The financial – and policy – engagement of both the ADB and the World Bank will also significantly increase in PNG once loans and credits in the pipeline are approved and activated

Third, Australia can play a particularly catalytic role in leveraging and magnifying the impact of MDPs. The GoPNG is, and must always remain, the centrepiece of strategy, implementation, and coordination of the health sector in PNG. In support, the (slightly dated) Exhibit 5 below shows, the Australian aid program [42] is an important part of not just the health sector of PNG, but virtually all sectors. This, along with Australia's long and deep knowledge of, and commitment to, PNG, means DFAT will continue to have a particularly influential and catalytic role in supporting GoPNG. Managed well, DFAT engagement will be able to magnify the already significant influence of MDPs. Findings and recommendations 1-8 already identify specific actions that DFAT can take to further improve the development effectiveness of its current level of engagement with the MDBs. Finding and recommendation 9, therefore confirms that there is a very strong a priori basis for DFAT to continue to engage with the MDPs.

Fourth, GoPNG itself welcomes Australia's partnership agreements, but wishes to see clearer reporting of budget flows. As noted in Chapter 1, GoPNG is supportive of Australia's partnership agreements with the MDPs. More specifically, the GoPNG Department of National Planning and Monitoring (DNPM) submitted, as part of this Evaluation that ''the GoPNG encourages trilateral or even quadrilateral Partnerships to mobilise resources to finance large impact projects and avoid thinly spreading resources hence Australia's partnerships with MDPs is commendable and encouraged''. Having said that, DNPM also noted that there was a possibility of unintentional double counting of Australia's aid effort in PNG appearing on GoPNG's budget statements and financial records. This

[42] The exhibit refers to AusAID but the Australian aid program is now managed as part of the Australian Department of Foreign Affairs and Trade (DFAT).

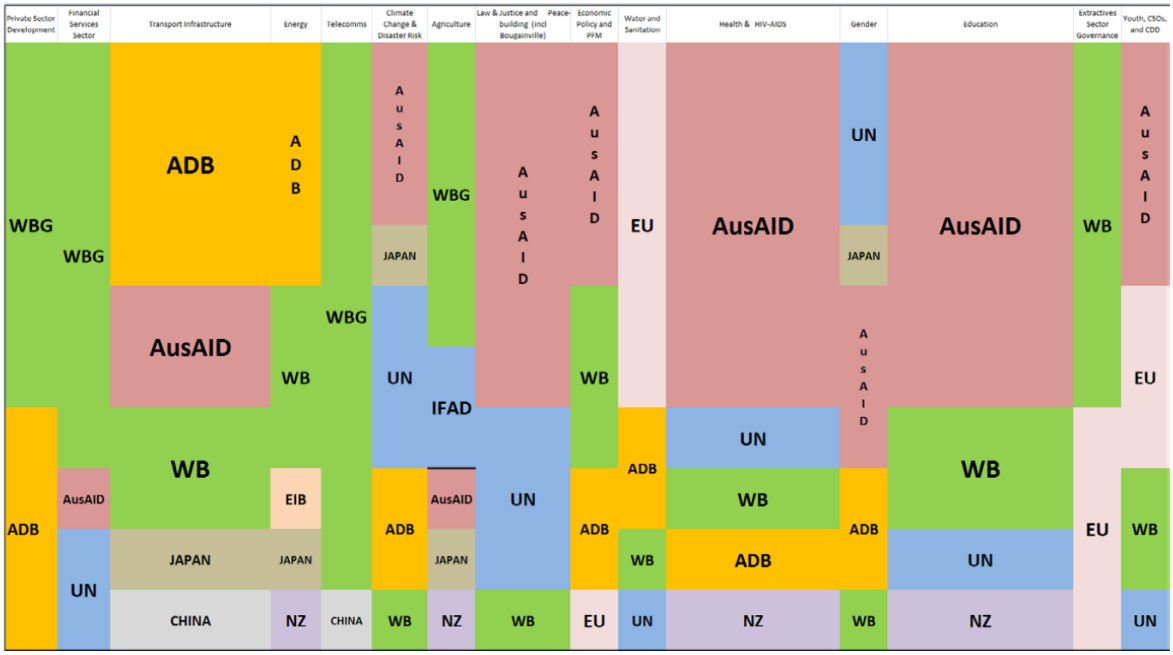
could occur if DFAT includes its grants to MDPs when it notifies GoPNG of its total aid contribution to PNG, and if the individual MDPs similarly include Australia's contribution as part of *their* reporting. DNPM also notes that it is particularly important for GoPNG to be able to distinguish Australia's *grant* financing to the ADB and World Bank from the *loan* programs of those two MDPs. DNPM notes that DFAT's support through MDPs should reflect GoPNG core priorities. [43] DNPM considers it should be a party to all of DFAT's Partnership Agreements so as to facilitate early GoPNG engagement in design and implementation of projects and programs.

Exhibit 5

Australia plays an important supporting role in all sectors, including health

Source: World Bank Country Strategy to PNG

This graphic visually maps partners activity in PNG, with the width of each column scaled to the total size of Official Development Assistance (ODA) in that sector (comparative to other columns) and the vertical size of each partners' "block" indicated the share of total sector activity contributed by that partner. The four largest sectors (in terms of ODA plus GoPNG 'spend') are education, health and HIV-AIDS, transport infrastructure, and law and justice.



[43] The Evaluation did not find any evidence that this was not happening. DFAT's health priorities in PNG, and those of the MDPs, are formulated in close consultation with GoPNG and reflect the current priorities of GoPNG as set out in the National Health Plan.

Finding and Recommendation 10.

DFAT has several choices in how it engages in the health sector of PNG. However, based on this Independent Evaluation, there is a clear business case for Australia to consider continuing to actively support the MDPs in PNG in future. That business case rests on 5 facts (1) What GoPNG itself does – or does not do – will always have a substantial effect on health outcomes in PNG. That is because total GoPNG public expenditure (including aid funding) contributes over 80% of total health expenditure in PNG, a rate more than double that of other lower middle income countries globally. (2) MDPs play a very significant role in supporting and shaping that expenditure via significant concessional financing; policy advice; technical assistance and actual implementation. (3) Australia is the largest bilateral funder to the health sector in PNG, and will probably remain so for many years. Australia cannot and should not do everything in the health sector, but it can leverage and magnify the work of MDPs if there is a strong results framework in place (4) Australia (and PNG) are direct ''shareholders'' of each of the MDPs operating in PNG. It is in the direct national interest of Australia (and PNG, as well as other governments) to have those MDPs operating effectively and efficiently in PNG (5) importantly, GoPNG itself states that Australia's partnerships with MDPs is ''commendable and encouraged'' (albeit possibly requiring some fine tuning in terms of how financial flows are recorded in GoPNG's financial statements).

We therefore **recommend** that, based on the findings of this Independent Evaluation, DFAT actively consider continuing to support MDPs in PNG in its future program to the health sector, provided performance management and reporting of DFAT grants improves. In doing so, DFAT should continue to liaise closely with GoPNG to ensure priorities continue to be aligned with GoPNG's strategic objectives, and that recording of financial contributions by Australia and the MDPs are accurately reflected on GoPNG's financial statements

Fifth, DFAT can significantly strengthen the development effectiveness of its partnership with, and substantial financial contributions to, MDPs by having a more explicit, overarching, results framework for engaging with multilaterals. Several interviewees, including DFAT staff themselves, stated that the support to the six multilaterals was, currently, more a collection of individual ''projects'' or funding modalities, rather than a coordinated program with an explicit, coherent, strategy or vision. Indeed, this evaluation of six multilateral partners could, on that basis, have just as easily extended to include DFAT's engagement and core funding to UNAIDS and GAVI, both of which are engaged in the health sector of PNG.[44] Others stated that efforts had been made to have an overarching framework, but that this had been complicated by a changed programming and policy environment in recent years. Furthermore, DFAT was working on an overarching framework in the context of the next generation of programming for health in PNG. While recognising the primary role of NDOH in donor coordination, representatives from one MDP also recommended that DFAT ''bring all partners together at the onset" and that DFAT should "establish an agreed performance framework for monitoring and evaluation". Other interviewees suggested that DFAT, in collaboration with NDOH, was in the best position to convene an annual or semi-annual workshop that brought together the MDPs, other stakeholders from the public and private sectors engaged in health, with – importantly – the managers from Provincial Health Authorities and front-line service providers from sub-national areas.

Sixth, DFAT can strengthen the effectiveness, efficiency and accountability of MDPs if it has the right resources, at the right time, to engage in policy dialogue and results management. Health issues in PNG are technically complex. The public health challenges – including reducing multi-drug resistant

[44] It did not, partly for practical reasons, including the amount of time allocated to the evaluation.

TB - and health systems challenges – including health financing, public financial management, and procurement – are just a few examples. Each of the MDPs are organised around very specific technical expertise to respond to those, and similar challenges. For DFAT to engage in substantive, specific, policy dialogue with NDOH, and / or each of the MDPs, it therefore needs to be able to engage at that technical level. This does not necessarily mean staff at the Post need always to be health specialists. But they do need to have rapid access to specialist expertise when needed. Furthermore, if DFAT is to test and verify the performance of MDPs, manage for results, and be accountable for the public expenditure of aid funds, staff need to have the time, and the travel budget, to examine developments at the provincial and sub-national level where service delivery occurs.

Seventh, DFAT could further strengthen its influence on the performance of MDPs by having a clearer and more direct line of communication about the successes – and weaknesses – of MDPs on the ground in PNG with the headquarters of those MDPs. The DFAT post in Port Moresby is in an excellent position, and certainly more than any other OECD bilateral partner, to make informed comment and provide specific examples of the strengths – and weaknesses – of all six MDPs in PNG. It is not at all clear that such insights are being strategically and proactively conveyed to the Australian representatives in the Executive Boards of those six MDPs. Some state that Australia's experience with MDPs at a country level is fed into the Executive Board, others do not think this is the case. Australia (and GoPNG, along with other bilateral governments) are direct ''shareholders'' in each of the six MDPs. It is in everyone's interests that the Executive Boards, and managers, at headquarters of those agencies are kept directly informed of successes – and weaknesses of MDP operations on the ground.

Finding and recommendation 11.

DFAT can significantly strengthen the development effectiveness of its partnership with MDPs by having a more explicit, overarching, results framework for engaging with multilaterals. Efforts to do this in the past should be renewed: current thinking and planning by Post of the future program provides an opportunity to do this.

Health issues in PNG are technically complex. DFAT can therefore strengthen its engagement with MDPs and health outcomes if it has the right resources, at the right time, to engage in policy dialogue and results management. DFAT could further strengthen its influence on the performance of MDPs by having a clearer and more direct line of communication about the successes – and weaknesses – of MDPs on the ground in PNG with the headquarters of those MDPs.

We therefore **recommend:**

1. That DFAT's partnership with MDPs move from a collection of individual ''projects'' or funding arrangements to a more coordinated overarching program (or even portfolio) with an explicit, coherent, strategy or vision.
2. That if DFAT is to engage in policy dialogue in the technically demanding and complex area of health sector support and reform, that staff are appropriately resourced (and then made accountable) including with access to technical expertise, and resources, to strategically examine developments at the provincial and sub-national level where service delivery occurs.
3. That clearer and simpler arrangements are made so that DFAT's insights into the on the ground strengths - and weaknesses - of MDP operations in PNG are being strategically, proactively and consistently conveyed to the Australian representatives in the Executive Boards of those six MDPs.

How well-placed each of those multilateral organisations are to providing value-added programs for the future priority areas of DFAT's program.

The MDPs are generally well-placed to provide value-added programs to future health priorities of DFAT's program, provided there is a stronger framework for performance management. Chapter 2 shows that each of the six MDPs have a clear comparative advantage and mandate for responding to important current and future priority health challenges in PNG. A consistent theme running throughout this Evaluation is that although individual MDPs have such a comparative advantage, there needs to be a stronger framework for performance management relationship between DFAT and the MDPs when using DFAT funds. Recommendations 1-8 provide specific ways this can be improved.

Special mention should be made of health security: a key priority for any future Australian program in PNG and the region. Two points are worth noting. First, MDPs have different levels of mandate and comparative advantage in terms of health security. National, regional and global health security, and responding to health emergencies, is clearly a priority for WHO, especially following experiences with Ebola. Other agencies, including the ADB and World Bank, and arguably the Global Fund and UNFPA, have a less *direct* mandate and comparative advantage in responding to health security. Second, field visits to rural hospitals and health clinics undertaken as part of this evaluation confirmed the importance of strengthening very basic aspects of health security in PNG. More specifically:

- There is no isolation ward for patients with multi-drug resistant TB (MDR-TB) in one very large hospital visited. Patients, including a commercial sex worker with co-infection of HIV, are being treated in their villages. MDTRB patients in another hospital visited absconded and returned to their village before treatment was completed, partly because the food provided in the hospital was inadequate.

- There have been no condoms in one large hospital, or certain health facilities visited, for up to 2 years, despite PNG having high rates of sexually transmitted infections and HIV.

- Vaccination coverage against important diseases has been stagnant or falling for many years.

- There were persistent, and lengthy (up to 6 month) stock outs of basic drugs in several health facilities inspected.

- Around half of all children are malnourished (13) and PNG has the 4th highest rate of stunting (short for age) in the world (14): a sign of chronic undernutrition. Under-nutrition undermines the capacity of a population – especially mothers, infants and children, to resist any disease outbreak.

The policy implications for DFAT are clear. First, GoPNG – not DFAT or the MDPs – has the prime responsibility for resolving those abovementioned gaps and weaknesses in the health system. Second, DFAT can play an important supportive role in a PNG led program to address those health system weaknesses. Third, the Australian Government is giving increased attention to health security (68). Fourth, as DFAT designs new country, and regional, health security initiatives it will be therefore important to continue to recognise, and be realistic about, the often fundamental weaknesses and fragility of the existing health system in PNG. One medically trained observer noted the importance of strengthening health security in PNG that therefore ''addressed the endemic (eg TB) and not just the exotic (eg Ebola)".

Finding and recommendation 12.

MDPs have different levels of mandate, comparative advantage, and expertise with WHO having arguably the strongest direct interest in national, regional and global health security, and responding to health emergencies. While all have an interest, and would be affected by, a major pandemic, the MDPs have different capabilities. Field visits to rural hospitals and health clinics undertaken as part of this evaluation confirmed the importance of strengthening very basic aspects of health security in PNG including basic drug supplies; immunisation coverage and under-nutrition. Endemic diseases are a threat to health security as much as exotic diseases are.

We therefore **recommend** that DFAT specifically assess the different mandates, comparative advantage and expertise of MDPs when considering health security issues in PNG. Furthermore, in developing health security strategies and interventions in PNG, programs specifically take into account the relatively low level and fragile nature of existing health security characteristics in PNG, including low levels of immunisation; nutrition, drug and other medical supplies in much of PNG and the relatively high level of endemic, not just exotic, diseases in PNG.

Chapter 4: Summary of findings and recommendations.

The Table below provides a consolidated list summarising the key findings, and the recommendations. The Table also shows the page number of the report where additional evidence and justification can be found in this report to support the finding and recommendation.

Recommendation Number and key issue	Summary of the key finding	Recommendation	Page number of the Report
1. Additionality versus substitution of aid funding to the health sector over the long term.	MDPs and bilateral partners can provide much needed additional, short term, financial and other assistance when there is a particular fiscal problem. However, over the medium to long term, financial and other support from bilateral and multilateral agencies should be additional to, and not a substitute for, the domestically generated expenditure effort of Government of PNG for reasons of development effectiveness and long term sustainability.	That DFAT, in collaboration with the National Department of Health, the Department of National Planning and Monitoring, and key development partners establish procedures to better monitor whether aid funding is additional to, or potentially a substitute for, GoPNG financing to the health sector.	15
2. Future DFAT consideration of support to ADB's Rural Primary Health Services Deliver Project and links to drug supply.	There is substantial evidence to show that the ADB's Rural Primary Health Services Delivery Project (RPHSDP) is currently a well-designed, well-managed, effective, efficient, and equitable intervention that can expand essential health care services to some of the poorest and most vulnerable populations in PNG, including especially rural women and children. Medical supplies, including drugs, are a core responsibility of GoPNG, not development partners. Prolonged stock-outs of essential drugs undermines the effectiveness, efficiency, equity, and sustainability of ADB RPHSDP	That in considering any future co-financing or other support, DFAT should explicitly assess, as part of its risk management and value for money considerations, the extent to which continued stock outs of drugs and essential commodities undermines effectiveness, efficiency, equity, and sustainability of DFAT's overall investment in rural based health services.	18

Recommendation Number and key issue	Summary of the key finding	Recommendation	Page number of the Report
3. Leveraging multi-sectoral engagement.	Multilateral agencies such as the Asian Development Bank now, and possibly the World Bank in future, have a relatively large financial footprint, and policy engagement, in several sectors, including transport and public sector management. This can directly, and indirectly, contribute to better and more equitable health outcomes in PNG.	DFAT, as a significant bilateral development partner in PNG, should work with the National Department of Health; the Department of National Planning and Monitoring; the Asian Development Bank; the World Bank; and other development partners to more explicitly identify and exploit linkages, complementarities, and coherence between sectoral investments that affect health sector outcomes in PNG.	19
4.UNFPA	UNFPA has a potentially very important role to play in PNG, given UNFPA's mandate and comparative advantage in areas such as reducing maternal mortality, unmet need for contraception, and gender based violence: all issues of importance in PNG. UNFPA also has a potentially significant contribution to make in terms of analytical and policy work on the implications of demographic change in PNG. DFAT states that, despite Post following up, it was not initially kept promptly or properly advised of the then emerging delays and problems with the Demographic and Health Survey (DHS) which involved $10 million grant from Australia.	A clearer and explicit set of mutual expectations about communication and responsiveness be included in any future partnership agreement between DFAT and UNFPA.	24
5. WHO	GoPNG clearly regard WHO as a particularly accessible and trusted source of technical advice. When interviewed, WHO can also explain in convincing terms its efforts and contributions to the health sector in PNG. However, the absence of an overarching performance framework undermines the ability to assess the effectiveness of DFAT's	While there is significant scope to improve the results framework with virtually all MDPs, there is a particular need to establish a more results based agreement between DFAT and WHO prior to any new Partnership Agreement being finalised, given the importance of central position of WHO in PNG health policy dialogue and programming.	31

Recommendation Number and key issue	Summary of the key finding	Recommendation	Page number of the Report
	investment in the WHO in PNG. WHO's M&E as it relates to the performance of the DFAT's grants to WHO needs significant improvement. Going forward there is a need for clarity amongst both partners about expectations for timing and content of reporting.		
6. Low stagnant, and in some cases falling immunisation levels	Immunisation rates are low, and have stagnated, and in other cases such as routine measles coverage have fallen in PNG. Increasing the immunisation coverage rates is a critical part of improving health outcomes and equity in PNG. It is a key indicator of overall health system performance. It is also a key building block for contributing to health security in PNG, and the region. The prime responsibility for improving immunisation rates rests with GoPNG, including at the sub-national level. However, all MDPs are in a good position to advocate and support improved immunisation coverage. DFAT, in turn, is in a good position to leverage the existing work of MDPs to improve immunisation coverage.	DFAT, as part of the Australian Government's focus on health security, give particular attention to leveraging the existing efforts of WHO and other UN agencies including UNICEF to raise immunisation levels in PNG. DFAT should also continue to liaise at the highest levels to ensure GAVI remains engaged in PNG until essential vaccination coverage rates increase substantially and in a sustainable way.	33
7. DFAT support for current and future health priorities	GoPNG and development partners are already appropriately focused on several key health challenges in PNG including maternal mortality. But there are many other challenges. DFAT cannot, and should not, try to support every priority and challenge arising in the PNG health sector. However, DFAT is also the largest bilateral partner to the health sector in PNG, and one committed to helping improve health outcomes over the longer term. DFAT therefore needs to continue to work with	As part of its consideration of priorities in any new partnership agreement that DFAT, in collaboration with NDOH and other development partners, specifically review whether the appropriate level of financial resources and attention are being allocated to ''the right things" as referred to in the TORs for this evaluation. Specifically, that DFAT review whether there is sufficient focus in any partnership agreement to (i) critical aspects of health system strengthening, including public financial management and availability of essential drugs (ii) an	37

Recommendation Number and key issue	Summary of the key finding	Recommendation	Page number of the Report
	GoPNG, and the other development partners, to ensure the allocation of any resources DFAT directly provides to MDPs are addressing ''the right things''. This includes health system strengthening as well as addressing the critical drivers of the preventable burden of disease in PNG.	unfinished agenda of traditional health challenges, including under-nutrition and immunisation and (iii) new health challenges including Non-communicable diseases.	
8. Gender	At a strategic level GoPNG and each of the multilateral agencies are committed to gender equality and empowering women and girls. This is a challenging area in PNG and will take time to improve. However, there was nevertheless limited operational level evidence that MDP efforts having made a real difference to gender equality. The Asian Development Bank's RPHSDP is the investment with the most sophisticated approach to gender in its design, delivery and M&E. UNFPA provides estimates of the impact its family planning and other interventions on number of maternal deaths averted and other gender related data: see Table 2. The majority of project level reporting reviewed from other agencies did not contain sufficient – and in some cases any - gender disaggregated data. There was also an absence of thorough gender lens analysis in the reporting. DFAT is entitled to expect clear and more informative M & E reporting from MDPs, including evidence that the M & E is being used for overall performance management from MDPs, on such an important issue as gender in PNG especially when MDPs are directly using DFAT funds. Strengthening M&E reporting for gender should,	That DFAT, GoPNG and MDPs meet to agree on a more explicit, insightful and regular means of reporting on gender disaggregated data, extracted from existing M&E systems wherever possible, as a basis for better planning and management.	49

Recommendation Number and key issue	Summary of the key finding	Recommendation	Page number of the Report
	where possible, engage and use GoPNG M&E systems, and avoid parallel reporting systems.		
9. M & E by the Multilateral Development Partners needs to improve.	Monitoring and evaluation – particularly as a means of proactively managing for and demonstrating ''results'' – remains a challenge, with a good deal of variability in the quality and timeliness of MDP reporting on the use of DFAT grants. The ADB's RPHSDP, the Global Fund, and to an extent the World Bank and UNPA provided reporting that was a good basis for assessing and managing progress of their programs and activities. UNICEF reporting, and to an extent WHO reporting, missed key opportunities to explain substantive progress at the higher output, outcome and even impact level, relying too much on descriptive reporting of inputs (number of people trained, number of workshops held etc). Few partners, other than ADB, reported gender disaggregated data in a substantive or meaningful way. MDPs reporting on financial disbursements of the DFAT grant is generally good but more could be done by all MDPs to demonstrate how they are achieving efficiencies and value for money with the DFAT grants.	(i) DFAT make it clearer to MDPs that it sees M&E, especially with respect to the direct grants it provides, as a strategic management tool rather than a means of routine reporting. (ii) DFAT reach specific agreement on the nature and frequency of reporting key indicators should, particularly as future funding commitments are being negotiated. Those indicators will need to vary from MDP to MDP, and from activity to activity. However, the indicators would normally include analysis – and not just a descriptive account – of how the DFAT grant is specifically contributing to agreed goals; emerging risks and risk-mitigation strategies; and provide management level insight into efficiency and value for money of how the MDP used the DFAT grant. (iii) Future M&E reports should also normally have gender-disaggregated data as a matter of course. (iv) A percentage of the value of the DFAT grant, normally at least 5%, should be specifically and routinely allocated to improve the depth of analysis of M&E. There may be possible exceptions for smaller activities.	54

Recommendation Number and key issue	Summary of the key finding	Recommendation	Page number of the Report
10. Possible future engagement with MDPs	DFAT has several choices in how it engages in the health sector of PNG. However, based on the findings of this Evaluation, there is a clear business case for Australia to consider continuing to actively support the MDPs in PNG in future, assuming performance management and M&E improves. That business case rests on 4 facts: (1) What GoPNG itself does – or does not do – will always have a substantial effect on health outcomes in PNG. That is because total GoPNG public expenditure (including aid funding) contributes over 80% of total health expenditure in PNG, a rate more than double that of other lower middle income countries globally. (2) MDPs play a very significant role in supporting and shaping that expenditure via significant concessional financing; policy advice; technical assistance and actual implementation. (3) Australia is the largest bilateral funder to the health sector in PNG, and will probably remain so for many years. Australia cannot and should not do everything in the health sector, but it can leverage and magnify the work of MDPs if there is a strong results framework in place. (4) Australia (and PNG) are direct ''shareholders'' of each of the MDPs operating in PNG. It is therefore in the direct national interest of Australia (and PNG, as well as other governments) to have those MDPs operating effectively and efficiently in PNG.	That, based on the findings of this Evaluation, that DFAT actively consider supporting MDPs in PNG in its future program to the health sector, provided performance management and reporting of DFAT grants improve. In doing so, DFAT should continue to liaise closely with GoPNG to ensure priorities continue to be aligned with GoPNG's strategic objectives, and that recording of financial contributions by Australia and the MDPs are accurately reflected on GoPNG's financial statements.	57

Recommendation Number and key issue	Summary of the key finding	Recommendation	Page number of the Report
	5) Importantly, GoPNG itself states that Australia's partnerships with MDPs is ''commendable and encouraged'' (albeit possibly requiring some fine tuning in terms of how financial flows are recorded in GoPNG's financial statements).		
11. Actions that DFAT itself can take to strengthen performance management.	1. DFAT can significantly strengthen the development effectiveness of its partnership with MDPs by having a more explicit, overarching, results framework for engaging with multilaterals. Efforts to do this in the past should be renewed: current thinking and planning by Post of the future program provides an opportunity to do this. 2. Health issues in PNG are technically complex. DFAT can therefore strengthen its engagement with MDBs and health outcomes if it has the right resources, at the right time, to engage in policy dialogue and results management. 3. Australia could further strengthen its influence on the performance of MDPs by having a clearer and more direct line of communication about the successes – and weaknesses – of MDPs on the ground in PNG with the headquarters of those MDPs.	1. DFAT's partnership with MDPs move from a collection of individual ''projects'' or funding arrangements to a more coordinated overarching program with an explicit, coherent, strategy or vision. 2.If DFAT is to engage in policy dialogue in the technically demanding and complex area of health sector support and reform, that staff are appropriately resourced (and then made accountable) including with access to technical expertise, and resources to strategically examine developments at the provincial and sub-national level where service delivery occurs. 3.That clearer and simpler arrangements are made so that DFAT's insights into the on the ground strengths - and weaknesses - of MDP operations in PNG are being strategically, proactively, and consistently conveyed to the Australian representatives in the Executive Boards of those six MDPs.	59

Recommendation Number and key issue	Summary of the key finding	Recommendation	Page number of the Report
12. Health security.	1. MDPs have different levels of mandate, comparative advantage, and expertise with WHO having arguably the strongest direct interest in national, regional and global health security, and responding to health emergencies. While all have an interest, and would be affected by, a major pandemic, the MDPs have different capabilities. 2. Field visits to rural hospitals and health clinics undertaken as part of this evaluation confirmed the importance of strengthening very basic aspects of health security in PNG including basic drug supplies; immunisation coverage and under-nutrition.	1. DFAT specifically assess the different mandates, comparative advantage and expertise of MDPs when considering health security issues in PNG. 2. In developing health security strategies and interventions, programs specifically take into account the relatively low level and fragile nature of existing health security characteristics in PNG, including low levels of immunisation; nutrition, drug and other medical supplies in much of PNG. Endemic diseases are a threat to health security as much as exotic diseases are.	60

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Annex 1 Terms of Reference for the Independent Evaluation

A. BACKGROUND

1. DFAT will undertake an independent evaluation to examine DFAT's partnerships with select health multilateral partners working in Papua New Guinea.

2. Multilateral organisations included in this evaluation are: the Asian Development Bank (ADB), World Health Organization (WHO), World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNICEF and United Nations Population Fund (UNFPA).

3. With the exception of Global Fund who receive multilateral core funding from Australia, these organisations have been selected given they receive support from DFAT's bilateral health program. All are key partners in PNG working on critical issues/bodies of work that align with DFAT's proposed future health program and are therefore relevant to this evaluation.

4. A total of AUD111.9 million has been provided to these multilateral partners over the life of their programs (excluding GF) through DFAT's bilateral program. Australia is also contributing $200 million in core funding to GF during 2014-16.

5. A summary of our support to these multilateral agencies is as follows:
   a) Australia's partnership with ADB funds the implementation of the Rural Primary Health Service Delivery Project (RPHSDP). Australia funds USD40 million of the USD80 million project over 2011-12 to 2019-20. The RPHSDP aims to strengthen the rural health system by increasing the coverage and quality of primary health care in eight provinces. The project is co-financed between Australia, PNG, JICA, ADB, WHO and the OPEC fund for International Development.
   b) The partnership with the WHO PNG aims to support their work with the PNG National Department of Health (NDoH), including through the provision of technical and policy support for communicable diseases, immunisation, maternal and child health and health systems strengthening. DFAT also provides core funding to WHO PNG. Australia invested AUD9.2 million (2012-16) in this partnership over four years. A no-costed extension was approved to support WHO's work until January 2018, when a new phase of support to WHO will commence.
   c) Funding to the World Bank – AUD3 million over three years (2015-17) – is delivered through the Pacific Facility Phase IV (PF4) which is managed from the World Bank offices in Sydney. It enables the World Bank to contribute options for strengthening the health financing system, improving the level and distribution of financing and analysing equity in health care use and financial protection across households.
   d) Australia provided funding to the United Nations Population Fund (UNFPA) of AUD10 million in 2016. UNFPA provides technical support for the Demographic Health Survey (DHS) project through their PNG country office.
   e) Australia provides AUD4.3 million to UNICEF (2015-17) to address key areas in the nutrition space including policy development, capacity building (clinical and management), community engagement and distribution of nutrition supplementation.
   f) To accelerate the end of AIDS, TB and Malaria, Australia has contributed AUD563.4 million to GF since 2004, including a commitment of AUD200 million during 2014-16.

6. Our funding partnerships with these multilateral agencies have not been independently evaluated previously. The agreements that each agency are engaged under do not specify when independent evaluations should take place. The ADB Co-financing Agreement (attached) states that "each Party shall inform the other Party of any reviews missions undertaken by it related to the Grant". The UN Partners are funded under the One UN agreement (attached).

B. PURPOSE AND AUDIENCE

7. The primary purpose of this evaluation is to evaluate the overall policy development effectiveness[45] of the selected health multilateral partners operations in PNG so as to inform DFAT's possible future support to these multilateral partners.

8. A design process for future DFAT engagement in the PNG health sector has identified five key portfolio areas (*see the Design Document*) – safer pregnancies and childbirth, and voluntary family planning; health security; health systems strengthening; policy dialogue; and sector coordination[46]. While individual designs will identify the exact investments, mechanisms and delivery partners DFAT will fund in these areas, it is likely that this will include support to multilateral partners. The findings of this evaluation will inform DFAT's future support to these multilateral partners, with the overall goal of achieving better health results with our funding.

9. The Health Counsellor and other managers within the Australian High Commission Port Moresby will be the primary user of the evaluation findings. Evaluation findings will be used to inform future program decisions and will be shared with multilateral partners (ADB, WHO, World Bank, UNFPA, Global Fund and UNICEF), the PNG Government, and other relevant stakeholders involved in the implementation of Australian assistance to PNG's health sector.

10. DFAT will develop management responses to the evaluation findings.

11. The evaluation report will be published on the DFAT website.

C. KEY EVALUATION QUESTIONS AND SCOPE

12. The evaluation will assess the overall performance of multilateral partners using the following five evaluation criteria: effectiveness, efficiency, sustainability, gender equality and monitoring and evaluation.

13. The Team Leader will address the questions listed below. If there is insufficient time to fully answer the question posed, the Team Leader will identify options for DFAT to separately address the issues as it proceeds to the future design stage.

14. The key evaluation questions will focus on
    c) assessing how multilateral agencies have performed in PNG, relative to their individual mandates, roles and responsibilities. The evaluation will give first priority to assessing the development effectiveness of those programs that multilateral partners are delivering that involve direct Australian Government aid funding. However, the evaluation will, to

[45] Defined in terms of the criteria set out in paragraph 12 below i.e. effectiveness, efficiency, sustainability, gender equality and equity and monitoring and evaluation.
[46] DFAT will not take a lead but will seek to improve coordination through our work.

the extent that time then permits, also provide insights into the broader development effectiveness of those multilateral agencies' own programs in PNG.

d) What lessons can be learned to inform future DFAT support to multilateral partners? How well-placed each of those multilateral organisations are to providing value-added programs for the future priority areas of DFAT's program.

15. The below guiding questions are provided as an additional reference to the evaluation team when developing the Evaluation Methodology Plan.

Effectiveness

- What was the quality of their overall engagement in PNG[47], including when engaging in policy dialogue and providing technical advice? Did they effect sufficient influence and/or change? Were they able to sufficiently navigate PNG's health system[48] and political economy context to achieve results? Why/why not – what were the facilitating and inhibiting factors?
- Was their engagement focussed on the right areas? To what extent did organisations support pro-poor approaches and rural / urban inequalities?
- Are multilateral partners sufficiently leveraging their significant global resources (expertise, financing etc.) to address priority PNG health issues?

Efficiency

- How effective were the governance and planning arrangements of the multilateral partners? Did these meet PNG Government, and also DFAT's needs?
- How effectively did multilateral partners engage with each other and PNG Government stakeholders to reduce bureaucratic transactional costs for partners and increase their effectiveness?
- How could DFAT improve its own engagement with multilateral partners to achieve better results, particularly in planning and ongoing monitoring processes?
- Was the multilateral partner's own risk monitoring and management sufficiently integrated into their planning, and to what extent were risks reported to DFAT?

Sustainability

- To what extent did multilateral partners build the capacity of PNG Government partners and systems in the long term? Why or why not? How can this be improved?
- Did multilateral support encourage or disenfranchise PNG ownership of health issues?

Equity and Gender Equality

- Did our support through the multilateral agencies make a difference to gender equality and empowering women and girls?
- How could DFAT assist and leverage multilateral agencies to improve equity of health care provision and gender equality?

[47] This includes the effectiveness of multilateral partners at: building, maintaining and effectively harnessing relationships with key stakeholders to effect influence and/or change; and engaging at both policy and programmatic levels to drive reform and improvements.

[48] Includes all necessary parts of the health system, such as the National Department of Health, other key agencies such as Department of Treasury and Department of Personnel Management and other relevant stakeholders.

Monitoring and evaluation

- To what extent did the monitoring and evaluation systems of the WHO, World Bank, ADB and UNICEF provide DFAT with timely reporting and strategic insight into the effectiveness of the DFAT grants?
- To what extent are the existing or planned monitoring and evaluation systems of the six organisations likely to provide timely, reliable and valid insights into the five key priority areas of interest to future DFAT programs (paragraph 12 refers)
- To what extent do existing monitoring and evaluation systems of the six organisations facilitate lesson-learning and continuous improvement of their own activities?
- How could DFAT better monitor and evaluate the programs of the six organisations?

16. The evaluation report should also communicate any unanticipated but important issues that emerge during the process of answering the above questions.

D. EVALUATION PROCESS AND TIMEFRAMES

17. The evaluation will consist of a desk review and interviews with stakeholders and partners. A proposed list of stakeholders and partners to meet is available in Annex 1.

18. The expected period for the evaluation is from 2 October 2017 – 7 November 2017, with a 14 working days mission in PNG from 28 September – 16 October 2017. The total evaluation period includes time for desk review, preparation of the evaluation, in-country mission (14 working days) and preparation of reports up to 32 input days of work with detailed tasks as provided on the matrix below:

No	Tasks	Number of allocated day (s)	Indicative Date
1	Conduct a desk study to review relevant program documentation provided by DFAT and advise DFAT of any additional documents or information required prior to the in-country mission	5	2-6 October 2017
2	Develop an evaluation methodology plan, which outlines the key respondents, how key evaluation questions will be answered and by whom, structured interview instruments to be developed, preparation of logistics / scheduling and production of a brief issues paper.	2	9-10 October 2017
3	Travel time from the country of residence	1 (15 October)	15 – 30 October 2017

4	Discussions with DFAT program staff and Senior Management	1 (16 September)	
5	Discussions with Department of Health	1 (17 October)	
6	Conduct meetings with stakeholders in Port Moresby	4 (18-20 October)	
7	Conduct meetings with Stakeholders in Province 1 – (Morobe most probably)	2 (23-24 October)	
8	Conduct meetings with stakeholders in Province 2 - TBA	2 (25-26 October)	
9	Conduct additional meetings in Port Moresby as required	1 (27 Oct)	
10	Conduct preliminary analysis of the interview results and prepare an aide memoire for submission at the end of the in-country mission, which outlines the major findings and preliminary recommendations of the evaluation for presentation to DFAT-Australian Aid Program	2 (28-29 Oct)	
11	Presentation of the aide memoire to DFAT Post including Senior Management and Travel time to the country of residence	1 (30 Oct)	
12	Further data analysis and drafting of the evaluation report	5	
13	Submission of draft report		10 November 2017
14	Receive consolidated comments on draft report		31 October 2017
15	Preparation of final report	Up to 5, depending on extent of changes required	
16	Submission of final report		27 November 2017
	Total number of days	32	

E. REPORTING REQUIREMENTS

19. Evaluation Plan

This plan will outline the scope and methodology of the evaluation. The plan will include methodology to be used for assessing the outcomes of the programs; the process for information collection and analysis, including tools such as questionnaires and/or questions to be asked during discussions; identification of any challenges anticipated in achieving the evaluation objectives; allocation of tasks of the evaluation team; key timelines, a consultation schedule identifying key stakeholders to be consulted and the purpose of consultations; and other activities/research to be undertaken. It is expected that the Evaluation Plan will be submitted to DFAT-Australian Aid Program by 26 September 2017. The Evaluation Plan will be no more than five pages.

20. Aide Memoire

On the last day of the in-country mission (30 October 2017), the Team Leader will submit and present an Aide Memoire of up to 5 pages with key findings. The Aide Memoire will be prepared in dot-points based on DFAT-Australian Aid Program's Aide Memoire for Review guidelines (see Annex 2). The evaluator will have approximately two days to work on the Aide Memoire prior to presenting it to DFAT-Australian Aid Program.

21. Reporting

At the conclusion of the evaluation, the Team Leader should produce the following:

a. The first draft of the evaluation report should be submitted to the First Secretary, Health, DFAT-Australian Aid Program - PNG, for comments approximately one week after the end of the in-country visit. The evaluation report should be a brief (up to 25 pages, including the Executive Summary), clear and cogent summary of the evaluation outcomes, focusing on a balanced analysis of relevant issues and recommendations for improvement. Annexes should be limited to those that are essential for explaining the text.
b. The final evaluation report should be submitted to DFAT-Australian Aid Program within seven days of receiving final comments from DFAT-Australian Aid Program.

F. TEAM COMPOSITION

22. The Independent Evaluation Team will comprise three members: a Team Leader (D4), a Team Member (C4) and an Observer (a DFAT officer). The team should possess the following skills and experience:

a. Strong understanding and experience in evaluation methods and processes with proven skills and experience in conducting reviews and performance evaluations.
b. Demonstrated ability to draw on international best practice to inform advice.
c. Strong analytical and report writing skills, particularly in transforming data and/or information into constructive and informative reports.
d. Excellent communication skills, particularly in a cross-cultural setting, and the ability to clearly explain monitoring and evaluation principles.
e. A forward looking perspective in terms of looking for lessons and implications to inform future programming.
f. Sound knowledge of DFAT-Australian Aid Program corporate policy on quality reporting system and business process as for aid delivery.
g. Familiarity with cross cutting issues such as disability inclusive development, anticorruption issues, and gender
h. A general understanding of PNG's social and political context.

G. ROLES AND RESPONSIBILITIES OF TEAM MEMBERS

23. The Team Leader will be ultimately responsible for delivering a quality evaluation report and should effectively utilise the expertise of the Team Member in meeting the Terms of Reference and contractual obligations.

24. The Team Leader will be responsible for the following outputs:
    a. Develop the overall approach and methodology for the evaluation;
    b. Manage and direct the Evaluation Team;
    c. Represent the Evaluation Team and lead the Evaluation Team's consultations;
    d. Manage, compile and edit inputs from other Evaluation Team members, ensuring high quality of all reporting outputs;
    e. Produce the Aide Memoire, based partly on inputs from the Team Member;
    f. Produce the draft Independent Evaluation Report; and
    g. Produce the final Independent Evaluation Report.

25. The Team Leader will lead the evaluation process, including participating in the inception briefing, assigning tasks and responsibilities to the Team Member, and presentation of initial evaluation findings in an Aide Memoire.

26. Under direction of the Team Leader, the Team Member will be responsible for providing advice and written inputs on the technical substance of relevant activities to the Team Leader, as instructed by the Team Leader, in order to meet the objectives and reporting requirements of the evaluation.

27. The Team Member, under the direction from the Team Leader will:
    a. Assist the Team Leader during evaluation activities; and

    b. Provide inputs into the aide memoire, the draft Independent Evaluation Report and the final Independent Evaluation Report as directed by the Team Leader.

28. The Observer will have strong knowledge of the program and provide context, background and advice to the Evaluation Team. The Observer will participate in interviews and discussions but will not be required to contribute to the drafting of the report.

H. OUTPUTS

29. DFAT requires the following outputs, all reported in English and in a clear, concise and useful manner:
    - Evaluation Methodology Plan – submitted electronically to DFAT five days prior to the initial meeting with DFAT in Port Moresby.
    - Aide Memoire – no more than five pages on key findings during the mission and presented to DFAT on the final day in Port Moresby.
    - Draft Independent Evaluation Report – should not exceed 25 pages excluding annexes, submitted electronically.
    - Final Independent Evaluation Report – should not exceed 25 pages excluding annexes, submitted electronically.

Annex 2: Survey Questionnaire provided to Multilateral Development Partners in advance, and used as a guide during interviews

The following is the Survey Questionnaire provided in advance to MDPs, and used as a basis for the interviews. A similar Survey Questionnaire was provided to officials from the Government of Papua New Guinea officials, but slightly reworded to reflect their different role and perspective.

Background to the Evaluation

The Australian Department of Foreign Affairs and Trade (DFAT) has commissioned an independent evaluation of DFAT's multilateral partnerships in the health sector of PNG. The evaluation is being conducted by Ian Anderson (Director, Ian Anderson Economics Pty Ltd) and Ms Renee Martin, Senior Manager, Economics and Policy, PricewaterhouseCoopers Consulting (Australia) Pty Limited. A DFAT officer will be accompanying the evaluators while in PNG.

The evaluation will involve interviews during October with officials from the Government of PNG in Port Moresby and in selected provinces; with DFAT staff; and with officials from the six multilateral organisations directly supported by DFAT. The six multilateral organisations are, in alphabetical order: the Asian Development Bank (ADB), Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); UNICEF; UNFPA; World Bank; and the World Health Organization (WHO).

The Terms of Reference for the Evaluation essentially focuses on assessing the development effectiveness of those programs that multilateral partners are delivering in PNG in the health sector that involve direct Australian Government aid funding and, if time permits, also to provide insights and lessons into the broader development effectiveness of those multilateral agencies' own programs to inform possible future DFAT support.

Set out below are the specific questions we would like to discuss when meeting with your organisation. We have divided the questions into two parts, so as to capture evidence on the two slightly separate, but clearly linked, questions that DFAT wishes to focus on.

We are particularly keen to base the conclusions and recommendations of the evaluation on hard evidence as much as possible. With that in mind, we are giving particular focus in trying to obtain *written, documentary evidence* that support your views and statements. We are especially keen to see documentary evidence of how your organisation has been able to directly help strengthen the policies, programs, practices and budgets of the GoPNG. Such documentary evidence could include official reports but could also include letters and memoranda; minutes of meetings; and email exchanges.

The number of questions reflects the need to be comprehensive and systematic. However, we also recognise that those being interviewed may not necessarily have detailed first- hand knowledge of a particular question, or there may not be time to answer each question during the interview. We can discuss, and agree, at the outset of each interview where the focus should be. Interviewees are welcome to provide written responses to particular questions in the week after the interviews.

Key questions on assessing the development effectiveness of those programs that multilateral partners are delivering in the PNG health sector that involve direct Australian government aid funding.

Effectiveness

- What was the quality of your organisation's overall engagement in PNG[49], including when engaging in policy dialogue and providing technical advice?
- Is there any evidence that financial support provided by your organisation, including financial support that is provided to you from DFAT, has substituted or displaced expenditure effort from the GoPNG?
- What is the specific evidence that your organisation was able to effect sufficient influence and/or change?
- What is the evidence that your organisation was able to sufficiently navigate PNG's health system[50] and political economy context to achieve results? Why/why not – what were the facilitating and inhibiting factors?
- What is the evidence that your organisation's engagement was focussed on the "right areas"?
- To what extent did your organisation support pro-poor approaches and rural / urban inequalities?
- What is the evidence that your organisation was able to leverage its significant global resources (expertise, financing etc.) to address priority PNG health issues?
- To what extent did your organisation learn from and / or leverage the other 5 multilateral agencies when implementing its own programs in PNG?
- Can you give an example where your organisation has conducted a political economy analysis of a particular program, and explain to what extent that analysis shaped or improved your organisation's approaches?

Efficiency

- How effective were the governance and planning arrangements for activities your organisation implemented with DFAT funding? To what extent do you think these governance and planning arrangements meet PNG Government, and also DFAT's needs? To what extent do they meet your own organisation's needs?
- What is the evidence that your organisation (and others) were able to reduce bureaucratic transactional costs for GoPNG and your own organisation?

[49] This includes the effectiveness of multilateral partners at: building, maintaining and effectively harnessing relationships with key stakeholders to effect influence and/or change; and engaging at both policy and programmatic levels to drive reform and improvements.

[50] Includes all necessary parts of the health system, such as the National Department of Health, other key agencies such as Department of Treasury and Department of Personnel Management and other relevant stakeholders.

- How could DFAT improve its own engagement with multilateral partners to achieve better results, particularly in planning and ongoing monitoring processes?

Sustainability

- What is the evidence that your organisation built the capacity of PNG Government and systems for the long term?
- What are the opportunities and constraints to building capacity and sustainability? How can this be improved?
- What is the evidence that multilateral support encourages PNG ownership of health issues?

Equity and Gender Equality

- What is the specific evidence that DFAT support to your organisation made a difference to gender equality and empowering women and girls?
- How could DFAT better assist and leverage multilateral agencies to improve equity of health care provision and gender equality?

Monitoring and evaluation

- What is the evidence that your organisation's monitoring and evaluation system provided DFAT with timely reporting and strategic insight into the effectiveness of the DFAT grants and / or problems that arose?
- What is the evidence that your organisation's monitoring and evaluation system directly led to lesson-learning and ''continuous improvement" or mid-course correction of activities?
- The *Paris Declaration* and subsequent agreements encourages joint reviews with government and with other development partners. How many joint reviews did your organisation participate in over the life of the funding agreement with DFAT? What is the evidence that they improved development effectiveness?
- How could DFAT better monitor and evaluate the programs of the six organisations?

Provincial focus

- Does your organisation have a focus on particular provinces? If so which ones? What is the rationale for choosing that particular province(s)? Is it because your organisation has a particular knowledge or comparative advantage in addressing the challenges of that particular province(s)?

- Do you have any particular ''success'' stories – or frustrations – to share with respect to support your organisation has provided at the provincial level? We are particularly interested in any such developments in Bougainville; Eastern Highlands, Western Highlands, Milne Bay and Western Province as these are the current DFAT priority provinces.

- Do you have any lessons or recommendations on how DFAT – or GoPNG - could better facilitate multilateral partners to focus more on meeting the health challenges at a provincial level?

Possible future priorities and programs.

Without committing DFAT or your own organisation to the future, please provide responses to the following questions

- What are likely to be core priorities for your organisation (i) globally and (ii) in PNG over the coming 5 years

- Where do you think your organisation has the strongest comparative advantage and expertise in terms of current and future health challenges in PNG?

- All organisations – multilateral and bilateral, including DFAT – are under pressure to better demonstrate ''results'' and value for money in their operations across the board, but also in PNG. Are you aware of any special initiatives or innovations that will strengthen your organisation's capacity to demonstrate ''results'' and value for money in PNG over the coming years?

- What are likely to be the provincial priorities of your organisation over the coming five years?

Other

Do you have any final comments or observations to make?

Thanks, next steps and future follow up

Thank you for the time and effort you have put into this important evaluation. We hope the process has been helpful to you as well.

If you have additional comments or documents to provide please send them to Ian Anderson (ian.anderson.economics@gmail.com) and Renee Martin (renee.e.martin@pwc.com)

We will be submitting a draft report to DFAT in November. We envisage sharing a draft report to all those organisations interviewed to allow for fact checking and final comments. The final evaluation report, together with DFAT management response, will be posted online at the DFAT Canberra website when the evaluation is completed.

Annex 3: Summary of agencies and individuals interviewed.

The following table summarises the list of agencies (listed in alphabetical order) interviewed.

Agency (in alphabetical order)	Number of persons interviewed	Of which were female
Asian Development Bank		
Country Director, Papua New Guinea Resident Mission	1	
Australian Department of Foreign Affairs and Trade		
Minister Counsellor	1	
Counsellor	1	1
First Secretary, Aid Coordination	1	
First Secretary, Quality & Coordination	1	
First Secretary, Sub-national	1	1
First Secretary, Disease Control & Risks	1	
First Secretary, Quality & Program Effectiveness	1	1
Second Secretary, Policy & Reform	1	
Senior Program Managers	2	2
Program Managers	3	2
Assistant Program Managers	5	3
Government of Papua New Guinea National Department of Health		
Deputy Secretary	1	
Executive Manager, Strategic Policy Division.	1	
Global Fund to Fight AIDS TB and Malaria		
GFATM manager in Geneva (by telephone)	1	
Milne Bay Provincial Health Authority		
Chief Executive Officer, Milne Bay Provincial Health Authority	1	
Milne Bay Alotau Hospital TB ward (GFATM project recipients)		
District Health Manager, Alotau District	1	
Alotau Hospital Administrator	1	
Alotau Hospital Medical Registrar	1	1
Alotau Hospital, Director Curative Health.	1	1
Alotau Hospital, Hospital Matron	1	1
Alotau Hospital, Ward Manager, TB MultidrugResistant Ward	1	
Alotau Hospital, Unit Manager, Internal Medicine.	1	
Milne Bay Bubuleta Community Health Post		
District Health Manager Alotau District	1	
Health Extension Officer	1	1
Nursing officers / Midwives	2	2
6 Community Health Workers	6	6
3 Village Health Volunteers	3	3
Administrative support / driver	1	1

Milne Bay Bubuleta community leaders		
Chairperson, Community Health	1	
Councillor	1	
Health post committee member	2	
Ward member.	1	1
Milne Bay Gurney Community Health Post		
Chairman, Gurney CHP	1	
HEO	1	1
Sister In Charge	1	1
Oil Search Foundation		
Executive Director	1	1
Head of Health	1	1
Head of Grants	1	
Rural Primary Health Service Delivery Project		
Project Manager	1	
Finance and Procurement Specialist	1	
Architect	1	1
UNFPA		
UNFPA Country Representative to PNG	1	
UNFPA Assistant Representative to PNG	1	
UNICEF		
Chief, Child Survival and Development, PNG	1	
UNICEF representative, Western Highlands Province	1	
Western Highlands Province		
CEO Tambui Divisional Development Authority	1	
District Health Promotion Officer	1	1
Deputy CEO, Western Highlands Province Provincial Health Authority	1	
Director, Public Health, Provincial Health Authority	1	
Health Extension Officer (GFATM TB project recipient, Mt Hagen central hospital)	1	1
Health Extension Officer Tsinjipai Community Health Post	1	1
Health Extension Officer Alkena Community Health Post	1	1
3 Community Health Worker Mt Hagen, Tambul, Alken	3	3
World Bank		
Country Manager PNG	1	1
Senior Health Specialist, PNG	1	1
Junior Public Financial Management Specialist	1	

World Health Organization		
WHO Representative	1	
Programme Management Officer	1	1
Medical Officer Maternal and Child Health and Sexual and Reproductive Health	1	1
Medical Officer TB	1	
Technical Officer Pharmaceuticals	1	
Technical Officer Human Resources for Health	1	
Technical Officer Gender equity and human rights	1	1
Technical Officer Emergencies	1	1
Technical Officer Expanded Programme of Immunisation	1	
Total	**84**	**45**

Annex 4 Detailed analysis of each organisation

Please see the text on the following pages

ASIAN DEVELOPMENT BANK

Key findings at the strategic level:

- The weaknesses in overall health financing from GoPNG, including drug stock-outs, undermine the effectiveness, efficiency, equity and sustainability of the ADB RPHSDP
- There is significant value associated with using PFM performance as conditions that underpin support for health sector financing
- Insights about the reality of sub-national health service delivery are available in the RPHSDP project reports and mid term review that should be considered by DFAT as it programmes and prioritises resources

Key findings at operational level:

- RPHSDP success has in large part been due to an effective project support unit (PSU) that is embedded in the DoH. Reliance on particular individuals within this PSU presents a risk in terms of sustained capacity
- The PSU assumed a high degree of accountability for project performance as illustrated through regular and comprehensive project reporting on activities, outputs and finances and evidence of mid-course corrections based on lessons learned
- There is little capacity for provincial M&E and hence the PSU has had to take the lead on data collection, preparation of reports and risk management, reporting and mitigation.

	Areas of perceived strength	Areas for improvement
Effectiveness	• Strong alignment with national and DFAT priorities: rural health service delivery • Ability to leverage co-investors is demonstrative of effectiveness • Enables a larger dialogue around concessional financing for health	
Efficiency	• RPHSDP on track to deliver on time and on budget • Rapid mobilisation of a capable Project Support Unit that is embedded in NDoH • Evidence of active risk monitoring and management, with changes to approach as the operating environment demands	
Sustainability		• The RPHSDP design sees government responsible for funding operating expenditure for the health posts. But in 2017 there was no appropriation from the national budget for counterpart funding. This shortfall is evidenced in excellent facilities that lack medicines, some essential equipment and staffing shortfalls.
Equity and gender	• Strong reporting against the Gender Assessment Plan which highlights some progress and provides some gender disaggregated data	
M&E	• Timely and thorough project level reporting with provincial report cards which enable a deep dive • Comprehensive mid-term review with frank and implementable recommendations	
Provincial	• Active in all DFAT priority provinces	

Well placed for future programming

Sound basis for future programming but requires some improvement

Requires significant attention before considering future programming

GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

Key findings at the strategic level:

- GFATM contributions have enabled ongoing attention to malaria, TB and HIV/AIDS in PNG but at the same time there is dependence on ongoing funding
- GFATM's model of performance based disbursement has driven the development of capacity to respond to its rigorous M&E and reporting requirements. However, this capacity has been developed outside of the health system*

Key findings at operational level:

- GFATM is an essential partner in the emergency response to MDR-TB
- Lack of in-country presence can undermine deep understanding of the realities of program delivery in PNG, but we recognise this is the GFATM model, and can be managed if there is a strong Country Coordinating Committee and also frequent visits from GFATM in Geneva, both of which are currently the case
- Perception by some key stakeholders in PNG that GFATM systems can be overwhelming in PNG where there are capacity constraints etc. Also a perception among some key stakeholders that GFATM can be an inflexible, process/form driven organisation

	Areas of perceived strength	Areas for improvement
Effectiveness	• Major funder of the National Malaria Control Program: malaria incidence almost halved since 2004, prevalence reduction from 11.1% (2008/9) to 0.9% (2013/14) largely due to aggressive mosquito net distribution program. • Significant driver of continued action in the TB, HIV and malaria space in PNG.	
Efficiency	• Grant implementation benefits from strong leadership of the CCM • GFTAM grants focused in areas where DFAT doesn't program – good complementarity • Consolidation of PRs for greater cost effectiveness • Collaboration with MDPs, WHO and civil society	
Sustainability	• Global Fund supported activities coordinated, with the national malaria, HIV and TB programmes	• Reinforces vertical/disease focused programs despite efforts to improve health strengthening more broadly • Performance based funding in a weak health system drives parallel functions including monitoring and evaluation, and procurement and supply chain systems • Dependence on the funding but domestic fiscal constraints might prevent PNG from being able to meet its co-financing requirement to be eligible for GFATM support.
Equity and gender	• Proposals and reporting have a mandatory requirement for a gender analysis, based on age- and sex-disaggregated data.	
M&E	• Results based disbursements • 5% of grant allocated to M&E • Use the national reporting system and with verification of performance • Differentiation between process M&E and outcome and impact M&E	
Provincial	• National coverage	

* Hetzel et al. Evaluation of the Global Fund supported national Malaria Control Program in PNG 2009-2014 PNG Med J 2014 Mar-Dec; 57 (1-4) :7-29

Well placed for future programming | Sound basis for future programming but requires some improvement | Requires significant attention before considering future programming

UNFPA

Key findings at the strategic level:

- UNFPA is an important technical partner for DFAT in light of alarmingly high maternal and child mortality rates with an important 'underwriting role' when access to sexual and reproductive health commodities is unreliable in the government health system.
- A complexity of issues have contributed to difficult and delayed implementation of the DHS. UNFPA does appear to have taken the need to resolve the challenges very seriously with fundraising from internal sources and across the UN system and a commitment to regular performance reporting to DFAT and significant attempts to invigorate the DHS Steering Committee.

Key findings at operational level:

- There is a need to strengthen the relationship between UNFPA and DFAT – both at the country level and at the headquarters levels. Despite providing feedback on the UNFPA Country Program (2018–2022) (via headquarters) the UNFPA PNG team was not aware of this having been provided and it appears as though the feedback did not influence the final product.

	Areas of perceived strength	Areas for improvement
Effectiveness	• Has provided essential family planning commodities – the value of which accounts for nearly 82% of total expenditure on family planning commodities in PNG (2013–17) • Contribution to the Ministerial Taskforce on Maternal Health in PNG and the National Population Policy	• The DHS implementation is over budget and has exceeded timelines – related to capacity constraints at the NSO, ineffectual project governance and both an initial under-estimation of budget and then funding shortfalls (related to GoPNG's expected financial contribution) that have hampered implementation
Efficiency	• Has been playing a 'backstopping' role, providing contraceptive commodities in stock outs (e.g. Mt Hagen) • Quick appointment of key personnel for project delivery	• Dysfunctional DHS steering committee – despite UNFPA efforts very difficult to get NSO and Dept of Planning to convene the meetings
Sustainability	• Key areas of focus: reducing maternal mortality; reducing gender based violence; adolescent sexual health; and the demographic dividend, are all areas that have economic implications for PNG	• Limited organisational 'footprint' with a small staff size and operating budget constrains potential impact
Equity and gender	• Gender and equity is a core organisational level focus for UNFPA	
M&E	• Evidence of course-correction during the DHS implementation – strengthened UNFPA engagement with the NSO, revision of timelines and completion dates (with costing for outstanding activities) In the new country program 2018 – 2022: • 7% of the regular resources will be allocated to M&E activities • A costed monitoring plan will be developed to monitor all indicators of the integrated results and resources framework • A review of UNFPA staff needs will be undertaken to ensure the right combination of competencies, experience and skill sets are in place to fully deliver, monitor and evaluate the proposed programme	• Need for clarity around DFAT's reporting expectations associated with the One UN agreement
Provincial	• Milne Bay, Eastern Highlands and Bouganville (focus provinces for 2018–22 country program) – 3 of DFAT's priority provinces	

Well placed for future programming | Sound basis for future programming but requires some improvement | Requires significant attention before considering future programming

UNICEF

Key findings at the strategic level:

- UNICEF Early Essential Newborn Care (EENC) and Integrated Management of Severe Acute Malnutrition (IMAM) training and provision of essential equipment has contributed to enhanced capacity among service providers and has resulted in less deaths amongst newborns than would otherwise have occurred
- UNICEF's efforts around nutrition have resulted in positive, multi-sectoral policy level developments and there is limited, but encouraging evidence of impact of its Integrated Management of Severe Acute Malnutrition program. There does remain a significant way to go before nutrition is seen as a priority issue at the sub-national level
- UNICEF has supported refrigeration for vaccines at the provincial level, but immunisation rates are low and stagnant. Childhood immunisation is core to UNICEF's mandate and stronger efforts (in collaboration with the WHO and national and provincial governments as well as other development partners) should be prioritised

Key findings at operational level:

- Quality of reporting for UNICEF investments is variable and has until recently been lacking in precision. However, there is evidence at of a highly effective EENC program with support for the Hypothermia Alert Device. There is also early evidence of some success on the nutrition agenda.
- There is a need to revitalise the relationship between DFAT and UNICEF so that there is a mutual understanding of M&E and reporting expectations and, where possible, joint program reviews

	Areas of perceived strength	Areas for improvement
Effectiveness	• Evidence of impact (through demonstrated behaviour change) of EENC training at sub-national level • UNICEF's Hypothermia Alert Device is an example of an effective innovation that will save lives • UNICEF has supported multi-sectoral acknowledgement of nutrition as a key development challenge (at the policy level and through PNG's joining of the Scaling Up Nutrition movement) • The Integrated Management of Severe Acute Malnutrition (IMAM) program has contributed to reduction in the case fatality rate of Severe Acute Malnutrition (SAM) at four hospitals from 24% in 2015 to 16% in 2106	• Whilst nutrition has been discussed at the policy level there is a lack of evidence of it being prioritised in implementation by GoPNG • One of UNICEF's three focus areas is immunisation – whilst there is evidence of UNICEF supported refrigeration for cold chain storage of vaccines, and the Special Integrated Routine Expanded Program of Immunisation Strengthen Program in PNG (SIREP) immunisation rates in the country nevertheless are low and stagnant
Efficiency	• Demonstrated responsiveness to provincial level request for supplementation – nutrition, EENC • Collaboration with WHO and NDoH to set policies and roll out EENC training to the sub-national level	• No evidence of active risk management and monitoring • Limited evidence of proactive systemic and strategic engagement with DFAT
Sustainability	• Assessment of training participants for competence at the conclusion of EENC training • At end of 2014 UNICEF and WHO brought together all provincial leaders and developed a nationwide *Special Integrated Routine Expanded Program of Immunisation Strengthen Program in PNG (SIREP)* • EENC training is being built into the ongoing, basic, curriculum for health workers in PNG	
Equity and gender	• Nutrition, EENC and immunisation activities promote better health outcomes for young children both boys and girls, as well as women and adolescent girls	• No gender disaggregated data in progress reports
M&E	• Scientific rigour applied to assessment of Hypothermia Alert Device (RCT, peer review of evaluation)	• Activity level reporting for EENC and nutrition program that is cumulative across reporting periods and, in some cases, lacking baselines • Very limited or sometimes no financial reporting in progress reports
Provincial	• EENC in Bouganville, Western Highlands Province and Eastern Highlands Province • Nutrition program in Western and Eastern Highlands	

Well placed for future programming | Sound basis for future programming but requires some improvement | Requires significant attention before considering future programming

WORLD BANK

Key findings at the strategic level:

- World Bank has generated some high quality analytical work that has influenced GoPNG and development partners (eg health workforce study, and *Below the Glass Floor* analysis of health financing at the sub-national level.
- The World Bank is re-engaging with PNG and considers health a niche sector. Experience with the MDR-TB loan and a deep technical understanding of health financing in the country could inform a more significant sectoral commitment in the future
- Despite limited financial contributions in the health sector, the World Bank is able to convene decisions makers across Government, and in a range of sectors, to focus attention on key financing challenges

Key findings at operational level:

- The World Bank's participation in the health sector has been limited to that of provider of technical assistance over the past few years. Quality and evidence based outputs have not always translated into action. Capacity constraints in NDoH and especially at the sub-national level constrain the impact of advisory services / analytical work. Recent provision by World Bank of a full time health economist in NDOH has the potential to help improve translation of World Bank analytical work into tangible outputs and outcomes within NDoH and beyond.

	Areas of perceived strength	Areas for improvement
Effectiveness	• Highly responsive to NDoH requests for technical assistance e.g. Health Facility Efficiency Study to determine the costs and basic needs of health facilities • High quality analytical reports, particularly on health financing and public financial management (albeit in what the World Bank itself acknowledges is currently at a ''niche level'') • Embedded technical assistance in the NDoH has improved capacity around the budget process	• Limited absorptive capacity in the NDoH and especially at the sub-national level constrains the impact of advisory services/analytical work
Efficiency	• Ability to convene decision makers from beyond the NDoH to address health system funding e.g. involvement of the National Economic and Fiscal Commission, Department of Treasury and Department of National Planning and Monitoring • Collaboration with ADB to ensure complementarity of approaches	
Sustainability	• Technical program of work has focused on efficiency measures which could be supported long term should recommendations be implemented • Opportunity to leverage deep understanding of the PNG health system to inform frameworks/PFM triggers associated with provision of concessional financing to support the health system broadly in PNG • Some indications of capacity building in the NDoH re ability to analyse performance and expenditure data	• Forward plan is focused around the production of more analytical reports rather than on implementation
Equity and gender	• Per the Bank's new Country Strategy "gender issues will be front and centre throughout the WB program" – this is a solid commitment and will be important to monitor going forward	
M&E	• Formal WB Program Review conducted in December 2015 and another one underway in November 2017	• Reporting largely focused at the activity level
Provincial	• National / system level focus	

Well placed for future programming | Sound basis for future programming but requires some improvement | Requires significant attention before considering future programming

WORLD HEALTH ORGANIZATION

Key findings at the strategic level:

- The technical contributions of the WHO are well regarded by the NDoH and other MDPs
- WHO's leadership around vertical disease issues (HIV, malaria and MDR-TB) has contributed to positive outcomes in these areas
- Despite WHO's commitment to consultative policy design, there is a perception that policies and strategies are being made in Port Moresby and with limited awareness of these policies at the sub-national/health service delivery level
- Lack of a solid performance framework for DFAT's bilateral contribution to WHO in PNG has contributed to disparate expectations between DFAT and WHO about M&E and reporting. There is a need to re-energise the relationship between DFAT and WHO: confirm expectations about reporting; performance; M&E

Key findings at operational level:

- Protracted timeframes associated with recruitment of quality staff (with interim consulting contracts awarded to cover the roles) can undermine effectiveness, efficiency and sustainability of the particular elements of the WHO program that are dependent on that leadership and specific expertise e.g. health security.
- Underspending (planned v's actual in the partnership design budget) against budget line items that are being directly funded by DFAT for communicable disease and disease outbreaks needs to be brought closer into alignment with DFAT's health security priorities
- No separate budget line item for M&E

	Areas of perceived strength	Areas for improvement
Effectiveness	• Strong relationship with NDoH • Mobilisation of strong technical response to MDR-TB (guidelines, policy, training and management) and contribution to successful HIV and malaria programs • WHO provided leadership (with UNICEF) to address the poor record of immunisation in PNG • WHO technical advice and support for Tobacco Control Act, Child Health Plan and Strategic Implementation Plan 2009-2020; National TB Strategic Plan 2015-2020; Health Workforce Enhancement Plan 2011-2016 etc	• Protracted recruitment processes constrain Organisation's ability to lead, manage and sustain a comprehensive and coherent technical agenda
Efficiency	• Collaboration with NDoH as co-chair of Emergency Response to MDR-TB • Technical contribution to GFATM and GAVI submissions/project oversight. • Collaboration with the World Bank to conceptualise the 'Emergency TB project' • Successful partnership with UNICEF on EENC	• Little evidence of risk monitoring, management and reporting
Sustainability	• Work of the Specialist MDR-TB resource widely lauded for catalysing progress in Daru	• Limited evidence of WHO's contribution to supporting the response to MDR-TB (through capacity building) beyond identified 'hotspots' (and particularly in two DFAT priority provinces, Milne Bay and Western Highlands) • Poor record of translation of policy to costed and then funded implementation plans
Equity and gender	• Supported the Health Gender Policy 2014 • Collaborating with the NDOH to build capacity of health sector workers to promote and implement gender-responsive approaches • Supported 17 hospital based Family Support Centres to provide services for survivors of sexual and gender based violence.	• We note that the WHO states that it "does not routinely collect data on gender related indicators" but that the Organization will assist the NDOH in conducting more systematic data collection in the next phase of the partnership.
M&E	• Commitment to capturing WHO's core functions (e.g. exercising influence, providing leadership and building institutional capacity) in the M&E framework for the next partnership agreement with DFAT	• Activity and output level reporting that is not timely and without a overarching performance framework • One UN framework only requires annual reporting (but DFAT received only one report on the partnership that covered 2013-16) • No separate budget line item for M & E
Provincial	• Focus is at the Central level which should mean national level benefit	• Despite WHO staff undertaking more than 220 duty travels to provinces in 2016 /17, There is a perception among some health sector stakeholders at the sub-national level that WHO is "Port Moresby centric" .

Well placed for future programming | Sound basis for future programming but requires some improvement | Requires significant attention before considering future programming

Annex 5: Improving Neonatal Survival in PNG: statement provided by UNICEF

Improving Neonatal Survival in PNG

An Implementation Research on Improved Hypothermia Management to Reduce Neonatal Morbidity and Mortality applying a Hypothermia Alerting Device (Bebi Kol Kilok)

New-borns with hypothermia (low body temperature) are likely to have issues of poor weight gain, hypoxia (less oxygen), hypoglycaemia (less glucose), conditions that can cause death. Preventing hypothermia is, therefore, essential for all new-borns. Regular/continuous temperature monitoring is the most effective way to prevent hypothermia by enabling early intervention ensuring the healthy growth of the new-born baby. Temperature monitoring however is often difficult, not only immediately after birth in health facilities where nurses are few, but more critically on return from hospital at home where parents don't have adequate skills or tools to measure when their new-born baby might get cold. The simplest and most cost-effective way to address hypothermia is skin-to-skin contact, also known as Kangaroo Mother Care (KMC).

In Papua New Guinea, around 5,000-6,000 neonates die every year, mainly from preventable causes. Hypothermia[51] prevention and management can save up to 42% of the neonatal deaths, as well as ensuring healthy growth and development of the baby. Hypothermia mostly occurs in Low Birth Weight (LBW) babies and pre-mature births in resource-poor settings.

The hypothermia bracelet, locally renamed as Bebi Kol Kilok, is a simple, innovative device, which detects and alerts in the event of neonatal hypothermia, facilitating improved thermal care of new-borns. With UNICEF's technical support, an Implementation Research (IR) is being conducted by the National Department of Health (NDoH) in partnership with Paediatric Association of PNG, University of PNG, Port Moresby General Hospital, Goroka Hospital, and a local community in Henganofi District of Eastern Highlands Province (EHP). The overall objective of the study is to understand and validate the relevance, feasibility, effectiveness and scalability of applying the device among rural and urban high risk new-borns in PNG to reduce hypothermia and related complications.

This life-saving device is put on the baby's wrist immediately after birth. It monitors a newborn continuously for one month both at the health facility and at home. If the baby is hypothermic, the device sounds an alarm enabling the parent to trigger Kangaroo Mother Care (KMC) including breastfeeding and swaddling before severe hypothermia can cause death. If the alarm continues despite warming the baby, the parents are advised to seek skilled care before an infection can become severe.

[51] When the temperature of the baby falls below 36.5ºC (97.7ºF)

The above mentioned Implementation Research (IR) is a case control study being conducted in 3 locations: i) Port Moresby General Hospital, ii) Goroka Provincial Hospital and iii) Henganofi district of Eastern Highland Province. Newborns less than 2.5kg irrespective of gender and location (urban and rural) are qualified for this study. To date, 250 LBW new-borns have been enrolled as cases wearing the Bebi Kol Kilok bracelet and 125 LBW new-borns without bracelet in the control group. Mothers of both groups have received training on thermal care and other essential new-born care. After discharging from hospital, the bracelets are being used at home by the parents for four continuous weeks. Data collection takes place every week.

The early findings of the IR are encouraging. Its reliability as a device shows 97% sensitivity and 93% specificity to accurately detect the hypothermia with its alerting mechanism. The device is triggering behavioural changes, facilitating decision making and encouraging good KMC practices and breastfeeding. Mother's acceptance, usage and compliance rate is 100 percent. There is a significant improvement in KMC practices by the mothers (case group is average 5.6 hours/day; and control group is average 0.6 hour/day), as well as difference in weight gains between case (daily average 35.2gms) and control group (daily average 25.3gm).

The ongoing study is scheduled to conclude by end of this year and a dissemination of findings is planned early next year. It is expected that the study findings will inform the policies and programming for early essential new-born care (EENC), a flagship programme of the health sector in PNG, to reduce the high new-born mortality rate in PNG, stagnant for almost a decade.

Annex 6. Partnerships between Oil Search Foundation and UNICEF, with support from the Australian Government, to increase immunisation coverage.

PRESS RELEASE

FOR IMMEDIATE RELEASE
10th July 2017

Partnership efforts to power Immunisation coverage for children in Hela

TARI, HELA PROVINCE, PAPUA NEW GUINEA

Children and pregnant mothers of Hela, will now benefit from refrigerators for storing vital vaccines for life-threatening diseases like TB, pneumonia, whooping cough, diphtheria, measles, polio and tetanus.

Oil Search Foundation, working with UNICEF and other partners, delivered 11 vaccine fridges to health facilities in a program that will boost immunisation for children under five years and protect pregnant mothers against these diseases.

“Today we openly shed tears of joy for this gift we received from UNICEF and Oil Search Foundation. Thank you! Is all we can say – only God knows the gratitude in our hearts,” said an emotional officer in charge of Wanikipa Health Centre, Johnsy Inni. “We have not received any such equipment for health service delivery in Wanikipa in the past, you are the first to come to us.”

Wanikipa village is remotely located on the borders of Hela, Enga, Sandaun and Western Provinces that lacks proper road access besides many other basic infrastructure and services.

“The Health centre was opened in 2002,” said Mr Inni. “It had some medical equipment but that has deteriorated over time. For the last five years we did not have a vaccine fridge to store vaccines so immunisation activities have been very poor.”

Hela has below-average immunisation coverage and the 11 fridges will greatly improve the health of the province’s children, says OSF Chief Executive Officer Kymberley Kepore. “Immunisation is critical to the survival of children and these fridges will help the National, Provincial and District Health immunisation program to prevent outbreaks of diseases like measles and others.”

Hela Provincial Health Authority CEO Dr Gunzee Gawin praised the partnership between UNICEF and OSF to deliver this critical health equipment to the 300,000 plus people of Hela.

OSF purchased the fridges for about US$150,000 and transported them to the province. They come with 22 vaccine cool boxes, 44 vaccine carriers and 11 solar generators with their panels.

The last of the fridges were delivered by helicopter to remote health facilities at Wanikipa, Pandauaka, Paga and Kopiago in Hela Province last month.

The delivery of these fridges resulted from the work of an Inter-Agency Coordinating Committee that includes partners UNICEF, WHO, the Australian Government (DFAT), Global Alliance for Vaccine Initiative, Global Fund and OSF. In 2016 the committee identified the deteriorating cold chain facilities in the province as an improvement area needed to raise the health indicators of the province. OSF purchased the fridges from UNICEF before coordinating their transportation and distribution in the province working closely with local partners including district and provincial health authorities.

Earlier this year, the Australian Government also donated five vaccine fridges for the province. Combined with these, the platform is now set for all partners to work together to deliver improved immunisation to the children of Hela.

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Wanikipa Health Centre OIC Johnsy Inni (Green shirt centre with hands raised) and others thanking the OSF team which delivered their vaccine fridges by helicopter last week.

About the Oil Search Foundation
The Oil Search Foundation is a development partner in Papua New Guinea delivering signature

programmes and grant management solutions to support the national development agenda in the areas of health, leadership and education, and women's protection and empowerment.

Established and principally supported by Oil Search, the Oil Search Foundation has a comparative advantage working in the Papua New Guinea Highlands and Gulf region.

As a development partner, the Oil Search Foundation concentrates on building partner capacity to deliver services, directing the country's resources towards national priorities that are most beneficial to communities, and engaging with stakeholders at all levels to support Papua New Guinea achieve its own development goals.

Annex 7: ADB analysis and reporting on gender.

Per the RPHSDP Midterm review

STATUS OF COMPLIANCE WITH GENDER ACTION PLAN (GAP)

Proposed Activities and Targets	Status at Mid Term
Output 1: National support for policy development: National and selected provincial and district governments implement policies and standards for community health posts (CHPs).	
1. Ensure that CHP policies and standards include specific strategies such as necessary equipment for delivery, health workers' skills for antenatal care, and delivery to improve women's access to primary health care and reproductive health care	The social/gender/community development reported to PSC 9 that the National Health Promotion Policy 2015 has been completed. The PSU has forwarded the draft to all Project provinces and members of the donor partners health forum for comment and feedback to the NDOH Health Promotion & Education Branch. Gender and sex considerations were integrated into the policy statements and strategies. Gender and sexuality considerations are being factored into the National Village Health Volunteer Policy. The MTR finds compliance with this element of the GAP.
2. Ensure that CHP policies and standards include specific monitoring and evaluation tools to measure improvement in women's access to health care including maternal and child care	The social/gender/community development reported to PSC 9 that PSU members have participated in a data definition / collection workshop hosted by UNICEF, WHO, and the Family & Population Health Services Branch in relation to family and sexual violence. Women's access to health and child care awareness was factored into the National Health Service Standards (staffing numbers/occasions of service). The MTR finds compliance with this element of the GAP
Output 2: Sustainable partnerships between provincial governments and non-state actors	
3. Ensure that alliance agreements include provision to monitor equitable access to health services for women	The social/gender/community development reported to PSC 9 that PSU members have provided gender awareness to committees and were provided with an orientation to the Terms of Reference for Partnership Committee functioning. Awareness has not been provided to all committees. The MTR finds partial compliance with this element of the GAP.
4. Ensure that at least 40% of established partnerships include NGOs or other local organizations that provide services to women as the primary target or client group	The social/gender/community development reported to PSC 9 that Partnership committees are yet to have equitable gender representation, however advocacy continue. The MTR does not understand what this indicator means. All NGOs or other local organizations would provide services to women as a primary target.
5. Establish partnership board/health partnership board in each province with equal representation of men and women from wards in the CHP	The MTR finds partial compliance with this element of the GAP as not all committees have equal participation of women and men. Women participation was low in Enga.
6. Provide gender awareness training to all partnership board members as part of management training catchment area	The social/gender/community development reported to PSC 9 that PSU members have provided gender awareness to committees and were provided with an orientation to the Terms of Reference for Partnership Committee functioning. Awareness has not been provided to all committees. The MTR finds partial compliance with this element of the GAP (all but one provincial health partnership committee has participated in an orientation for gender and health).
Output 3: Human resource development in the health sector	
7. Identify and recommend eligible and interested females from rural areas to participate in community health worker and nursing officer training (50% of trainees will be female).	The numbers of men and women attending training courses are recorded by the PSU. The MTR finds compliance with this element of the GAP.
8. Develop specific measures such as equal working environment and security, and recommend to retain trained female staff and to improve performance of health workers	The social/gender/community development reported to PSC 9 that the Project has provided technical support to the NDOH in development of the Management Guidelines for Family and Sexual Violence, through participation in writing and editing workshops, as well as close editing and commenting on the various drafts. The MTR finds compliance with this element of the GAP.
9. Develop training programs for all health workers on maternal and child health care and family planning to improve health care for women	The MTR finds compliance with this element of the GAP. EoMC, EOC, IMCI, domestic violence, sexual health and gender awareness courses have been delivered.
10. Ensure integrated family health care by community health workers (through outreach activities), including antenatal care and family planning (two outreach activities are conducted per community, per year).	Terms of Reference for a Health Promotion course have been developed. Antenatal care and family planning (two outreach activities are conducted per community, per year) will be delivered from completed CHPs. None have been commissioned at midterm. The MTR finds this element of the GAP will be relevant later in Project Implementation.
Output 4: Community health facility upgrading	
11. Ensure that existing facilities are renovated or new CHPs are built with separate rooms/spaces for women's private consultation and examination and for childbirth	CHP designs include separate rooms/spaces for women's private consultation and examination and for childbirth. The MTR finds compliance with this element of the GAP
12. Ensure that all CHPs and renovated health facilities are provided with medical equipment and supplies necessary for antenatal care, childbirth, postnatal care, and other reproductive care services	The CHP standard equipment list includes items necessary for antenatal care, childbirth, postnatal care, and other reproductive care services. A loan covenant is that CHPs will be provided supplies. The MTR finds compliance with this element of the GAP
Output 5: Health promotion in local communities	
13. Through existing programs by NGO, churches, or civil society, introduce a village health volunteer (VHV) program to conduct outreach and health promotion activities in rural communities. Ensure that these activities are conducted for both men and women (at least 30% of activities are conducted for men).	A village health volunteer (VHV) program will be rolled out once the village health volunteer (VHV) curriculum has been piloted. The MTR finds partial compliance with this element of the GAP
14. Develop VHV training modules on antennal care, safe birth, and postnatal care, including when and how to refer pregnant women with risk factors to health facilities for delivery. Include training	A village health volunteer (VHV) curriculum has been developed with GoPNG and WV. The MTR finds compliance with this element of the GAP

modules on family planning, child immunization, STIs, HIV/AIDS, domestic violence, and gender awareness	
15. Train village leaders in healthy community development on primary health care and gender awareness	All 32 CHP sites have been able to participate in community consultation using the NDOH preferred model of community engagement known as Community Action Participation (CAP). Consultation sound representation of women and men from different age cohorts, and although documentation of this was not always accurate, safe-space for women to talk was provided and their concerns recorded. The MTR finds compliance with this element of the GAP
Output 6: Project management and Monitoring and Evaluation	
16, Ensure the employment of social/gender/community development specialists to oversee the implementation, monitoring, and reporting of the GAP at both the national and provincial levels	A social/gender/community development specialist has been engaged. The MTR finds compliance with this element of the GAP
17. Provide or organize gender awareness training to all staff members of the PSU, all management staff in participating provinces, non-state providers in alliance agreements	The social/gender/community development reported to PSC 9 that PSU members have received gender awareness training. The MTR finds compliance with this element of the GAP.
18. Train management staff in provinces and districts, non-state health providers, and those in health worker training and health promotion activities on collection of sex-disaggregated data and monitoring of these data	The MTR finds partial compliance with this element of the GAP.
19. Ensure that all district and community consultations include equal representation of men and women	The MTR finds partial compliance with this element of the GAP.
20. Ensure that baseline and periodic monitoring surveys collect, analyze and report sex-disaggregated data for all project outputs.	The formative evaluation is reporting using sex-disaggregated data for all project outputs. The MTR finds compliance with this element of the GAP.