

## DRAFT

### PNG AUSTRALIA TRANSITION TO HEALTH (PATH) PROGRAM

Investment Design Title: PNG Australia Transition to Health (PATH) Program		
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#### A. Executive Summary

##### Strategic context

Papua New Guinea is Australia's nearest neighbour and largest aid recipient. Despite particularly rapid – if volatile – economic growth, PNG is classified as “low human development” ranked 153 out of 189 countries and a Gender Inequality Index of 159 out of 160. Life expectancy for men and women has improved, and there have been reductions in maternal and child mortality, but not as rapidly as comparable countries, nor at the expected level for a country of PNG's income. PNG was unable to achieve any of the health-related Millennium Development Goals and is ranked second lowest in the Pacific after Kiribati in terms of Universal Health Coverage. Government of PNG (GoPNG) currently funds around 80% of Total Health Expenditure so what it does – or does not do – has important consequences for health outcomes. PNG has a rapidly growing population which puts additional pressure on this public health system which is still fragmented and fragile in several respects. As with all countries, the health sector operates within a broader political system that can both help, or hinder, improved health access and outcomes. [Annex 1](#) elaborates.

PNG has good goals for the health sector and has committed to substantial reform of its health system. The theme of PNG's current National Health Plan is “*Back to basics: strengthened primary health care for all and improved services delivery for the rural majority and urban disadvantaged*”. PNG has also undertaken a range of health sector reforms over past decades including the decentralisation of health service planning and delivery to provinces, including through Provincial Health Authorities (PHAs). The newly appointed PNG Minister for Health and HIV/AIDS has a clear reform agenda for the health sector that Australia supports. However, both GoPNG and Australia know from experience that past reform efforts in PNG have not fully achieved traction or sustainability. Additional financing, by itself, is not the solution to PNG's health challenges, nor is further technical assistance or the provision of long-term advisers although all these can be helpful.

Australia cannot and should not try to do everything in the health sector of PNG: instead, Australia should target its support geographically to maximise impact, whilst also helping PNG make better use of its own existing financial and human resources in the health sector. Australia's relations with PNG have, particularly since the recent White Paper, been transitioning from a donor – recipient relationship to an economic and strategic partnership. Australia can best assist PNG by helping PNG use its own financial and human resources in the health sector to achieve more effective, efficient, equitable and sustainable outcomes in the health sector. Australia can do that directly, through policy influence, technical assistance, and carefully targeted direct funding of essential services; and indirectly through Australia's membership and cofinancing with multilateral development banks and the UN. Australia can be particularly helpful by concentrating its support on a few

selected provinces in PNG, piloting, testing and demonstrating how health services can be made more accessible and effective especially through primary health care for the large rural population. A focus on selected provinces, and a focus on “action learning” can build the evidence base for stronger policies and programs by GoPNG, DFAT, and other development partners.

Section B and C of this IDD elaborates.

### **The PNG Australia Transition to Health Program (PATH)**

**These abovementioned themes all come together in the design for the PNG Australia Transition to Health (PATH) Program.** The reference to “transition” is deliberate. First, as noted, Australia is transitioning its overarching bilateral relationship with PNG away from a donor-recipient relationship to an economic and strategic partnership. Second, within the health sector itself, PNG is continuing to transition the delivery of health services to a provincially based, less centralised, model with an increased focus on primary health care in rural areas, with greater integration with provincial and regional hospitals. A key vehicle for achieving that transition are the Provincial Health Authorities (PHAs) reforms. Third, DFAT has made it clear that Australia cannot – and should not – continue to fund directly all, or even major parts, of service delivery that is ultimately the responsibility of a sovereign government like PNG. There is therefore a need to progressively transition some services currently funded by Australia through grants under the PNG Partnership Fund (PPF) and other mechanisms across to GoPNG as PNG’s own systems strengthen. Any such transition of currently funded DFAT programs to PHAs in selected provinces would, of course, need to be done in an orderly, planned, phased and developmentally effective way and only where PHAs and service providers such as churches had been strengthened sufficiently to take on those responsibilities. The fourth reason why “transition” is important in this design is that experience shows that the transition from one existing program to another new one, whoever the managing contractor might be, can be particularly problematic and expensive. That is especially the case when there are “legacy” or ongoing programs and technical assistance to continue and novate in the new program. For all these reasons, “transition” has a deliberate and important meaning within the PATH design.

**The PATH design specifically contributes to GoPNG health goals and the DFAT Health Portfolio Plan.** While DFAT supports the PNG health sector via Australia’s contributions to multilateral development banks and the UN, PATH will be the main vehicle for Australia to provide *direct bilateral assistance* to the health sector of PNG. That means the PATH design must clearly align with GoPNG and DFAT goals. As seen in PATH’s program logic (See Chart 1 in the IDD), PATH has two End of Investment Outcomes (EOIOs). The PATH Managing Contractor will be accountable to DFAT for achieving those two EOIOs by 2025. Those two EOIOs are:

- PHAs are more able to lead provincial health reforms and manage effective, efficient and equitable essential health services in selected provinces.
- DFAT funded health services are improving access; influencing PHA performance; and transitioning to PHA management in selected provinces.

As shown in the program logic both EOIOs align with and contribute directly to the overarching goal of the GoPNG National Health Plan as well as the objectives of the DFAT Health Portfolio Plan. Section C, D and E of this IDD and [Annex 2](#).

**To achieve the End of Investment Outcomes PATH has specific and targeted intermediate outcomes (IO’s).** To strengthen PHA leadership and management in selected provinces PATH has three intermediate outcomes:

- 1.1 PHA Boards and management capable of leading reforms and managing provincial health resources;
- 1.2 More policy relevant information available to drive performance; and
- 1.3 More women in management roles influencing policy, planning, and budgeting of health.

**To achieve the second End of Investment Outcome that relate to DFAT and GoPNG funded essential health programs, PATH has three intermediate outcomes:**

- 2.1. Increased access to services for women, disabled and poor;
- 2.2 Increased coverage and efficiency of key essential health services; and
- 2.3 Improved compliance with International Health Regulations in relation to laboratory's, TB, and malaria.

**Each of the intermediate outcomes has illustrative outputs that PATH could pursue.** The outputs are illustrative because while the End of Investment and Intermediate Outcomes are strategic and fixed, the Managing Contractor needs to be innovative and proactive in identifying specific approaches and outputs to achieve these outcomes, and that would then be reviewed and endorsed by DFAT (and GoPNG) during the approval of the Annual Plan.

**A critical element of the PATH design are 5 specific “drivers”: ways of purposefully achieving the EOIOs and IOs that draw on a range of delivery modalities and approaches that go beyond traditional technical solutions to aid problems.** These 5 drivers of change are shown at the right-hand side of Chart 1 in the IDD. These approaches draw on emerging insights to effective aid around adaptive programming (testing, assessing, learning, adapting); problem based iterative programming; thinking and working politically; leveraging partners; coalition building and policy engagement. See [Annex 11](#). As with the EOIOs and IOs, these 5 drivers are not mutually exclusive. They can and should work together to support achievement of the EOIOs and IOs. The “drivers” specifically help to build the evidence base for influencing and strengthening policy and programs of PHAs and service providers in selected provinces, DFAT’s own directly funded programs, and the programs of other development partners including the multilateral development banks and the UN family.

#### **Implementation and governance**

**PATH will be accountable to DFAT, which retains control of strategic directions and policy – but with appropriate opportunity for consultation with GoPNG.** The PATH Managing Contractor (MC) is expected to be innovative, flexible, and proactive in how it addresses specific challenges. However, that scope for flexibility and innovation occurs within the strategic framework set by DFAT, in consultation with GoPNG. Governance arrangements need to be effective, clear and also efficient for all parties: the Annual Plan is the best vehicle for achieving this. Section E and [Annex 3](#) elaborates.

**Monitoring, evaluation and learning (MEL) is central to the design and expected management of PATH.** The MEL enables PATH to simultaneously meet two separate requirements. The first is that PATH directly and demonstrably contributes to the DFAT Health Portfolio Plan and, through that, also contributes to the GoPNG NHP. This gives PATH strategic focus and direction, which is articulated in the two EOIOs. The second requirement is that, within that fixed strategic focus, PATH is nevertheless also an “adaptive program”: a design approach that specifically encourages a measure of flexibility, under guidance and approval of DFAT, to respond to rapidly changing circumstances in PNG; the piloting and testing of innovative approaches; and generating and using evidence and lessons to achieve the EOIOs. Effective MEL is essential for this adaptive approach. To ensure the MEL is used and gets a degree of traction, the MC will be tasked to track and document the extent to which evidence and learning under PATH is used to influence policy and programs. Section F of this IDD and [Annex 4](#) elaborates.

**The PATH designs builds on, but is different to, current investments.** PATH will build on the work of DFAT’s current health investments – the Health and HIV Implementation Service Provider (HHSIP) and the health components of the PNG Partnership Fund (PPF). Indeed, several of the existing programs should be continued by PATH as they are of such high priority to both DFAT and GoPNG, including TB prevention and control, maternal and child health and immunisation. However, PATH also has specific new features. These include: a much clearer, specific, proactive and outcome-oriented approach to gender equality and social inclusion, especially through the Women in Leadership initiative ([Annex 5](#) elaborates). PATH also has a sharper focus on supporting primary health care in selected provinces through PHAs; and a much stronger focus on MEL as a means of improving policies and programs: [Annex 6](#) elaborates.

#### **Budget and resourcing.**

This design proposes a 5-year program budget of \$183m (excluding management costs)<sup>1</sup>. This reflects the strategic incorporation of the PPF health funding into PATH and the required financing to deliver the Program's EOIOs, IOs and change drivers. A key element of the proposed budget is the expectation of a careful, gradual reduction in the level of funding from DFAT for direct service delivery activities in the areas of family planning, immunisation, TB and HIV. This is purposefully designed to be gradual to maximise the chances of alternative sources of funding being identified for the services – ideally from GoPNG – but recognising this will be challenging given the current and projected financial challenges for the GoPNG. However, it is an important signal for Australia to send and provides a basis for ongoing policy dialogue. Another key feature of the budget is the modest, but dedicated funding provided to the 5 change 'drivers' within PATH. This signals the importance of these drivers to the program approach. Section H and [Annex 7](#) elaborates.

## Risks

The PATH program is rated "very high risk" under DFAT's risk management and safeguards tool: this is not unexpected given the nature of the PNG health sector, but PATH has important and practical strategies to mitigate those risks. The design identifies 5 "very high risks" currently, and before any intervention is made through DFAT policy dialogue or by PATH. A realistic assessment concludes that two of those risks – a decrease in the GoPNG health budget and the unavailability of essential drugs and commodities - are likely to remain "very high risk" status. The PATH MC should obviously take mitigation measures, and DFAT should continue to have policy dialogue with GoPNG about those issues. The risk assessment concludes the other 3 "very high risk" categories can be reclassified as "high risk" as a result of DFAT policy dialogue and specific PATH mitigation measures. Similarly, the risk assessment identifies a number of "high risk" and "medium risk" areas. However once again DFAT policy dialogue and PATH's own actions would reduce the rating to a lower level of risk. Section J of this IDD and [Annex 13](#) elaborates.

It is important to note that the biggest risk to health outcomes in PNG, and to Australia's reputation (and national interest) is to have a "business as usual" - or worse a "do nothing" – response. That is because PNG clearly faces significant health challenges ([Annex 1](#)). A "business as usual" approach will see further deterioration of the health outcomes in PNG especially in the light of rapid population increases. GoPNG needs – and has asked for – support to implement its reform agenda including from Australia, its largest bilateral development partner. It is in Australia's broader diplomatic and strategic interest to respond. Section C elaborates.

The National Department of Health has reviewed this draft design and provided comments. NDOH supports the strategic directions and program logic set out in this design. GoPNG also expressed the importance of management & leadership training both at PHAs and NDOH, the need for directing long term advisory (LTA) support to PHAs; a focus on providing an integrated package of support; the need for ongoing support to health sector training institutions and basic education; and the need to support PHAs in health workforce capacity building and planning. NDOH requested DFAT's continued support for the HSIP trust account as a mechanism for pooling donor funding. DFAT has advised GoPNG that many of these suggestions can either continue or start to support through HHISP and the PPF, before integration into the new managing contractor, PATH, and some will continue to be supported by broader Australian Government programs (eg Australia Awards).

## B. Development Context and Situational Analysis (What problem are we addressing?)

### The overarching strategic context

Papua New Guinea is Australia's nearest neighbour and largest aid recipient. It is a lower-middle income country, with volatile economic growth per capita due to a high dependence on international commodity prices and lumpy investments in natural resources. GDP growth per capita has ranged from 4.97% in 2000 to 12.9%, one of the highest rates in the world, in 2014. GDP growth per capita has also been negative for nearly half (8 out of 17) years since 2000 (1). There is limited data on the extent and depth of poverty in PNG but the

<sup>1</sup> The design team has estimated the management costs for the program and provided these to DFAT.

World Bank estimates that around 87% of the population lived below \$ 5 per day in 2011 (1). The World Bank further estimates that the incidence of “hardship and vulnerability” – meaning people are unable to meet basic needs – is around 40% in PNG, around double the incidence in the rest of the Pacific (2).

**PNG has a generally low ranking on global indices tracking development.** PNG did not fully achieve any of the international Millennium Development Goals (MDGs) including the MDGs related to health, education or gender (though it came close to achieving malaria-related targets). The UNDP’s Gender Inequality Index ranks PNG 159 out of 160 countries. The broader UNDP Human Development Index, a composite measure of income per capita, education and life expectancy classifies PNG as “low human development” and ranks it 153 out of 189 countries and territories. PNG was also ranked 138 out of 175 by Transparency International in 2018 in terms of perceptions of corruption. PNG is lagging behind other Pacific Island countries in terms of the Sustainable Development Goals (SDGs) for health and making progress towards Universal Health Coverage (UHC). The latest World Bank and WHO report tracking progress towards UHC ranks PNG second lowest (after Kiribati) in the Pacific for UHC service coverage, and more on par with Sub-Saharan African countries such as Benin, Senegal, Togo, Sudan and Zimbabwe.<sup>2</sup>

**Rapid population growth has strategic implications for broader socio-economic development.** PNG currently has an estimated population of 8.6 million, more than double that in 1980. PNG continues to have a high total fertility rate of 3.5 children per woman of reproductive age. Less than one third (31%) of women currently married or in union aged 15-49 years use modern methods of contraception (3). The large cohort of pregnancies, new-borns, infants and children put significant additional financial and other demands on an already stretched health system resulting in high rates of maternal mortality. Rapid population growth also puts pressure on budgets and services in other sectors including the education sector. Furthermore, the large cohort of children and adolescents – over one third (35%) of the population are aged 14 years or younger – adds to the (often unemployed) “youth bulge”. Importantly, the large cohort of young people postpones options for PNG to achieve a demographic dividend: arguably one of the most strategic and far-reaching opportunities any country can have to drive socio-economic development (4, 5).

**Politics and institutions need to, and to a large extent do, reflect the great ethnic, cultural and linguistic diversity of the country, including through decentralisation of political power and delivery of services, including health services.** PNG has developed its own form of democracy since gaining independence in 1975. The public political space can be described as transactional, driven more by personalities, shifting alliances, and patronage than by established political parties or party policies common to some other democracies. Formal institutions (laws, policies, standards) in isolation have limited ability to overcome these social and cultural patterns (6). Formal institutions are intertwined with social and cultural mores in a myriad of ways (7). In the health sector for example, kinship and social relations are likely to be equally important determinants of health worker and client behaviour as technical information, training or guidelines (8). Women are rarely involved in national, provincial, district or even village level decision making. There is currently no female member of Parliament. Nor does the large cohort of young people, or minority groups including the disabled, have meaningful political voice in the country. The political system facilitates a high turnover of politicians at each election and this has implications for public policy and long-term planning. On average, over half of all politicians lose their seat during an election (9). The high turnover of politicians during an election incentivises them to use the relatively large District Service Improvement Program (DSIP) and Provincial Service Improvement Program (PSIP) grants, and other resources, to “buy” immediate support from local clans and supporters rather than take a broader or longer term view (10). Managing regional tensions within the nation – including most noticeably Bougainville – continues to be an important issue.

**PNG continues to face significant health challenges.** Life expectancy for men and women have improved but not as rapidly as comparable countries, nor is it at the expected level for a country of PNG’s income: see [Annex 1](#). Historically, there has been progress in addressing specific diseases (e.g. malaria and HIV) – but this has

<sup>2</sup> Benin and Senegal are given a score of 41, the same as PNG. Togo scores 42, and Sudan scores 43, and Zimbabwe scores 55, all above that of PNG. Yemen scores 39, below that of PNG

been largely buttressed by significant vertical donor support and has not been sustained beyond the life of external financing and delivery. For example, at one stage PNG was reducing malaria incidence faster than any other country in the world but this has not been sustained (11). PNG now faces formidable challenges in terms of communicable diseases (including sexually transmitted infections, increasing HIV infections, and drug resistant TB and HIV); under-nutrition (PNG is ranked fourth in the world for stunting); and maternal, newborn and child health. Polio re-emerged in 2018. Neglected tropical diseases in PNG include leprosy and filariasis. PNG also faces a rapidly rising challenge of Non-Communicable Diseases (NCDs): including heart disease, cancers, and diabetes - which puts new and different strains on an already fragile health system. There is little reliable data on the burden of mental health in PNG: an issue of increasing relevance not only because of the intrinsic importance of good mental health but because mental health is now a formal part of SDG 3 and progress – or the lack of it – in preventing and treating it is being tracked internationally. This is exacerbated by high rates of gender-based violence.

**There has been some progress, and significant external assistance, but PNG still has generally disappointing results in terms of the functioning of the health system.** Immunisation rates are generally low – down to 9% coverage for measles in the lowest coverage province and a national coverage of 34%.<sup>3</sup> Rural aid posts and facilities have closed, decreasing access and increasing inequity given that around 80% of the population live in rural areas. Across a broad range of service coverage and infrastructure indicators PNG is performing poorly – both in absolute terms and compared to neighbouring countries and global averages. See [Annex 1](#). The coverage and access to such some essential services have also either been unacceptably low over time (e.g. rural outreach clinics per 1000 population) or have risen and fallen dramatically over time: see [Annex 1](#). There are also significant socio-economic differentials in health service use: the poorest quintile is most vulnerable to illness yet has the lowest utilization rates of healthcare facilities (12, 13).

**Three longstanding, underlying, factors continue to weaken the health system.** First, and perhaps most importantly, essential pharmaceutical drugs and equipment are routinely unavailable at many health facilities due to a complex web of political-economy factors that have been difficult to resolve for many years (14, 15). Second, GoPNG financing for health is volatile and has been declining in real (adjusted for inflation) and per capita terms. The recent change of Government in PNG, and postponement of decisions on key resource projects, may further delay any increase in budget resources that could be allocated from GoPNG to the health sector. This matters because GoPNG finances, with external support, around 80 % of Total Health Expenditure. Furthermore, what is budgeted then often fails to reach front-line health services in a predictable or timely manner due to blockages and leakages in a decentralised financial system (16-18). Public financial management is generally weak: the World Bank's latest Country Policy and Institutional Assessment (CPIA) rating PNG a relatively low 3.2 and 2.9 out of a maximum rating of 6 for public financial management, and public administration, respectively. The third underlying factor that weakens the health system concerns the size and nature of the health workforce. PNG has one of the lowest ratios of health workers per 1000 population in the region: see [Annex 1](#). The health workforce is also rapidly ageing (19) but young health graduates are often unable to enter the workforce due to funding and administrative constraints. Political economy factors, including politicians giving priority to physical infrastructure such as roads, means these and other underlying challenges have remained unresolved for many years.

**The environment for aid policy and programming is changing.** Poverty levels; rapid population growth; growing fiscal deficits and tax revenue are highly dependent on volatile commodity prices. Limited institutional capacity means PNG still has access to development assistance. Partly through active encouragement and co-financing from Australia, the Asian Development Bank (ADB) and World Bank are both increasing the scope and size of their lending and policy engagement in the health sector of PNG. China has entered the health sector, including as a trilateral partner with GoPNG and Australia to address malaria. The Fleming Fund, and the Australian Indo-Pacific Centre for Health Security, are both designing new programs to address antimicrobial resistance and health security respectively. On the other hand, some development partners such as GAVI and the Global Fund

<sup>3</sup> Indicator: % Measles vaccine coverage for children <1yr (2017) PNG 2017 Sector Performance Annual Review.

continue to consider transitioning out of PNG given that country's "graduation" from low income to lower-middle income status. GoPNG itself is also making decisions that shape the environment for aid expenditure in health including, for example, reviewing and updating the National Health Plan (2011-2020) as well as various contributing strategies such as those for human resources for health strategy and health information. The recently appointed Minister for Health and HIV/AIDS, the Hon Elias Kapavore, announced in June 2019 a significant reform agenda with a focus on the size and structure of NDOH; the increasingly important role of Provincial Health Authorities; and improvements in drug supplies, health standards and referral systems (20).

**Australia is purposefully transitioning its bilateral relationship with PNG: this has implications for the design and delivery of Australian aid to that country, including this design.** Supporting PNG's security, stability and prosperity remains one of Australia's highest foreign policy priorities. Australia's recent Foreign Policy White Paper acknowledges a stable and prosperous PNG is clearly in Australia's national interest. Australia's relationship is transitioning from a donor-recipient relationship to a partnership, based on mutual economic and strategic interests. Australia's health sector support takes forward the priorities for health cooperation outlined in the Papua New Guinea Australia Partnership for Development (2013). This recognised that the way in which Australia partners with PNG in supporting the health sector is changing to focus on assisting PNG prioritise and utilise its own resources more efficiently. Australia is PNG's major partner in the health sector: our assistance makes a significant contribution to the broader bilateral relationship.

**The new design – to be called the PNG Australia Transition to Health ("PATH") Program reflects four key aspects of 'transition'.** First, as noted immediately above, Australia is transitioning its overarching bilateral relationship with PNG away from a donor-recipient relationship to an economic and strategic partnership. Second, within the health sector itself, PNG is continuing to transition the delivery of health services to a provincially based, less centralised, model with an increased focus on primary health care in rural areas, with greater integration with provincial and regional hospitals. A key vehicle for achieving that transition are the Provincial Health Authorities (PHAs) (21). Third, DFAT has made it clear that Australia cannot – and should not – continue to fund directly all, or even major parts, of service delivery that is ultimately the responsibility of a sovereign government like PNG. There is therefore a need to progressively transition some services currently funded by Australia through grants under the PNG Partnership Fund (PPF) and other mechanisms across to GoPNG as part of PNG's own systems. Any such transition of currently funded DFAT programs to PHAs in selected provinces would, of course, need to be done in an orderly, planned, phased and developmentally effective way and only where PHAs and service providers such as churches had been strengthened sufficiently to take on those responsibilities. The fourth reason why "transition" is important in this design is that experience shows that the transition from one existing program to another new one can be particularly problematic and expensive (22). That is especially the case when there are "legacy" or ongoing programs and technical assistance to continue and novate in the new program. For all these four reasons, "transition" has a deliberate and important meaning within the PATH<sup>4</sup> design.

### **Evidence base/Lessons Learned**

**The design for PATH has specifically taken into account independent evaluations and lessons learnt – or not learnt - in the health and other sectors of PNG.** These include evaluations from within PNG (23, 24); from Australia (25-28); from other development partners (15, 16, 18, 29-32) and from the international literature (11, 33-35) about the health sector but also development more broadly in PNG. The DFAT Portfolio Plan also systematically assessed the lessons learnt from past health sector assistance in PNG. See [Annex 8](#). A consistent theme running through all these exercises is that PNG is a particularly challenging environment to work in for a wide range of reasons. These reasons include political factors (personality driven rather than party policy driven politics); socio-cultural (widely diverse cultural and linguistic systems); geographic (including mountainous and remote islands); gender inequality and gender-based violence; social exclusion particularly for minority populations including people with disability; and financial / economic circumstances (varying economic growth rates as a result of volatile commodity prices).

<sup>4</sup> PATH is also intended to be easier and more intuitively understood than HHISP or similar acronyms used in the health sector of PNG

Despite the challenges, all evaluations confirm the importance of continuing to work in PNG given the size of the population and the levels of hardship in society. Key lessons relevant to future support include the importance of politically informed analysis, dialogue and programming; the need to balance investments in state and non-state providers (the churches provide on average 50% of health services, more in some provinces); better targeted and supported technical assistance; and a strong emphasis on learning to inform policy and programming. Importantly, all evaluations and lessons also urge realism in terms of what can be achieved with aid, particularly within relatively short time periods. That, also, guides the design of PATH.

**PATH will have a particularly strong monitoring, evaluation and learning (MEL) framework to track progress and learn lessons.** DFAT's Office of Development Effectiveness (36) found Australian aid investments with higher-quality monitoring systems exhibit three distinct characteristics<sup>5</sup>. Those three characteristics have specifically informed the PATH design. Furthermore, PATH makes MEL a key part of performance management and policy dialogue. It does this by requiring the Managing Contractor (MC) to provide specific and tangible evidence that the insights and lessons arising from MEL are then actively being used to shape and improve policies and current and future investments. Section F of this IDD and [Annex 4](#) elaborates.

**The PATH design specifically responds to issues raised, and lessons learnt, with respect to DFAT's experience with "facilities" and "flexible programs".** The design has taken into account the recent independent review of facilities, and the corresponding DFAT Management response (37), as well as the experience of several facilities operating in PNG and other countries. As a result, PATH purposefully seeks a more explicit focus on strategic intent of the investment while still allowing an appropriate measure of flexibility and responsiveness in how these are achieved. The design also has more explicit mechanisms for driving – and measuring – the effectiveness, efficiency, equity and value for money of the PATH investment itself and that of the MC. PATH has specific strategies for managing the transition program from the existing facility, and the first year of the program: issues which evaluations show have been sometimes problematic and costly to DFAT and MC..

**The design also has a more explicit, visible, and *outcome-oriented* approach to Gender Equality and Social Inclusion (GESI).** For example, PATH has "Women in Leadership" as one of the key Intermediate Outcomes, with meaningful but achievable indicators attached that, if not achieved, will affect the MC's overall payments. This is intended to avoid the problem of some other programs that GESI is either mainstreamed so much that it, in effect, disappears, or that GESI is confined – and therefore marginalised - to a small fund within a design. As well as pursuing a specific Gender Equality outcome, PATH also integrates GESI considerations throughout the design. See also separate discussion on GESI in Section C and G below and details in [Annex 5](#).

## C. Strategic Intent and Rationale (Why?)

### Strategic Setting and Rationale for Australian/DFAT Engagement

DFAT has an approved, over-arching, framework for the aid program. The 2017 White Paper (38) states that supporting a stable and prosperous PNG is one of Australia's most important foreign policy objectives. It is in Australia's shared interest with PNG to remain PNG's preferred bilateral partner to ensure regional security as well as advance Australia's economic interests in the region. The Australian Government's development policy (39) and new performance framework (40) also outline strategic objectives of promoting Australia's national interest by contributing to sustainable economic growth and poverty reduction.

**DFAT's economic and strategic partnership with PNG has three development objectives: PATH contributes to all three.** DFAT's three development objectives in PNG are promoting effective governance; enabling economic growth; and enhancing human development (41). PATH demonstrably and directly contributes to objective 3

<sup>5</sup> The ODE report states "Systems are outcome focused, from beginning to end. They both measure and guide progress towards achieving intended outcomes; Systems and data are quality assured through the application of quality standards and contestability mechanisms. External resources and independent perspectives are drawn on to quality assure methods and data. Systems use monitoring data well, serving different purposes and needs. Multiple stakeholders use the information that the system produces often for multiple purposes."

- enhancing human development – by helping to improve health outcomes. That, in turn, contributes to other aspects of human development including increased capacity for education, empowerment of women and the broader benefits to women, including adolescent girls, of modern family planning. PATH's contribution to improved health also contributes to outcome 1 - promoting effective governance – to the extent that health services plan, prioritise, and manage financial and human resources more effectively, efficiently, equitably, transparently and on the basis of evidence and learning. PATH also contributes to outcome 2 – enabling economic growth – by contributing to a healthier workforce with reduced absenteeism. PATH further contributes to economic growth to the extent that an improved primary health care system averts, or at least postpones, the incidence of preventable diseases that involve large – but largely preventable - demands on public revenues: multi-drug resistant TB and polio being just two examples.

**PATH directly and explicitly contributes to DFAT's PNG Health Sector Portfolio Plan 2018-23.** The Health Sector Portfolio Plan links directly to GoPNG strategies and priorities in areas where Australia can best contribute. The Portfolio Plan sets out three broad sectoral outcomes for DFAT's work across the health sector in PNG:

- › **Outcome 1 – Health Security and major communicable disease control:** By 2023, the National Department of Health, selected Provincial Health Authorities (PHAs) and provincial hospitals and primary health care centres improve prevention, detection and response to high burden communicable diseases and health security threats.
- › **Outcome 2: Improved rural primary health care through stronger health systems:** By 2023, selected Provincial Health Authorities and District Development Authorities, the National Department of Health and other national ministries improve utilisation of government finance and improve health worker recruitment to better equip rural primary health care centres to deliver essential care including antenatal care and integrated child care.
- › **Outcome 3 – Integrated, client-centred sexual, reproductive and family planning service delivery:** By 2023, selected government, church and non-government clinics delivering improved quality client centred, integrated HIV, reproductive health, and voluntary family planning services.

**Importantly the Health Portfolio Plan also constrains design choices.** In articulating the above outcomes, the Portfolio Plan recognises that DFAT cannot respond to all the needs and priorities in the PNG health sector. Hence important areas such as nutrition and non-communicable disease are not in the direct scope for future DFAT support.<sup>6</sup> Similarly, the Health Portfolio Plan directs future support to both the national level and selected provinces. The design of PATH works within these parameters.

### **Gender, innovation and cross-cutting themes<sup>7</sup>**

**Women and the disabled face particular and significant challenges and barriers on the demand side in terms of accessing essential health services.** This is clear from [Annex 1 and 5](#). PATH therefore directs the MC, through specific intermediate outcomes, to work with PHAs to identify specific barriers that prevent women, the disabled, and the poor from accessing essential health services, particularly primary health care services. PATH similarly directs the MC to then use a problem driven approach to analysing and removing such specific barriers and bottlenecks that will then be tracked via the MEL.

**Women also face particular challenges and barriers on the supply side in terms of influencing and deciding plans, priorities and budgets.** Research shows that, as at June 2014, only 7% of executive level managers in the PNG

<sup>6</sup> Having said that, PATH - and other DFAT investments in the health sector can support GoPNG efforts to address under-nutrition and the rise of NCDs at the margin, without losing the Portfolio Plan focus. For example, within the existing budget envelopes and programs PATH could include recognition of under-nutrition and NCD risk factors as part of integrated in-service training programs. PATH could help the capacity of front-line health workers to recognise and respond to the risk factors for under-nutrition and for NCDs as part of PATH's End of Investment Outcome 2. PATH could also consider supporting the evidence base for better tobacco control and legislation through the "drivers" including operational research and also its support to the national level thereby reducing a major risk factor for NCDs and raising revenue for the GoPNG which can be used for the health sector. PATH should also consider the opportunities, feasibility, and budget implications of expanding the First 1000 days program as part of PHA outreach services. That would then improve maternal and new-born health thereby helping to avert damaging and often irreversible health and cognitive damage to new-borns and children. Improved maternal and child nutrition would also be a strategic investment in laying a foundation for health security.

<sup>7</sup> This section focuses on gender: a fundamental challenge in PNG. Other cross-cutting issues are covered in Section G below.

National Public Service and only 18% of the senior level managers were women. At the provincial level no women held any executive level positions, comprising only 10% of middle management and 6% of senior management roles in provincial administrations (42). This is even though GoPNG has stated policies requiring more women in management positions. It is particularly important that PATH facilitates more women in leadership because the majority of health workers in PNG, especially rural nurses and midwives, are female yet are rarely in management positions or able to influence or decide on planning, priority setting, and resource allocation decisions that directly affect women. PATH specifies women in leadership as a specific intermediate outcome because, given the slow progress in implementing GoPNG's own requirements for increasing the role of women in decision making, this is now judged to be the best way to get traction. The international literature also shows that having women in decision-making roles can improve the access, accessibility, effectiveness, and equity of services (43-46).

**The use of a demand and supply approach to improving Gender Equality and Social Inclusion (GESI) is fully consistent with GoPNG and DFAT policies.** The Program's GESI approach is aligned with GoPNG PNG National Health Plan, MTDP III; the NDoH Gender and health policy strategy; and the Gender Equity and Social Inclusion Policy. The GESI approach is also consistent with DFAT's Gender Equality and Women's Empowerment strategy (2016), Development for All; Disability Inclusion Strategy (2015-20) and the Foreign Policy White Paper (2017) particularly relating to enhanced participation and empowerment of women and people with disability; women's leadership role and gender-based violence. The GESI approach in this design is also consistent with the OECD / DAC minimum criteria. See [Annex 5](#) for further details.

#### **Linkages and leverage between PATH and other investments in PNG**

**PATH complements DFAT's other bilateral, and multilateral, investments especially those in the PNG health sector.** DFAT has significant development assistance programs in infrastructure (including electrification, roads, and water); governance (including economic governance); gender (Pacific Women); law and justice; and other sectors. DFAT has substantial, ongoing, investments, both as a shareholder, and as a co-financing / parallel financing partner, with the ADB and World Bank, both of which are increasing their concessional financing, and policy dialogue, in the health sector of PNG, including rural health. DFAT is also a member, "shareholder" and contributor of direct financing to other international organisations working in the health sector of PNG including, in alphabetical order: GAVI; Global Fund; UNFPA; UNICEF and WHO. A recent evaluation found DFAT's contributions to the multilateral banks and international organisations working in the health sector of PNG to be broadly effective and efficient but that there were opportunities for better linkages and leverage (47).

#### **D. Proposed Outcomes and Investment Options (What?)**

The program logic for the proposed program is summarised in Chart 1 below and described in the ensuing sections. It is also more fully explained in [Annex 2: a key and fundamental part of this overall design document](#). It is important to note that whilst the Program's End of Investment and Intermediate Outcomes (EOIOs) are set, the program logic includes only illustrative examples of what the outputs might look like. They are illustrative because the final outputs will be identified and developed by the MC based on PATH's testing and learning from implementation experience and the necessary adaptation (see footnote 15) to changing circumstances in PNG. The MC's suggested outputs will then be considered and approval by DFAT (and GoPNG) as part of the Annual Plan governance arrangements (see Section E and [Annex 3](#)).

**The starting point for the overall design is PATH's direct alignment with GoPNG and DFAT goals and objectives.** As can be seen at the top of Chart 1, PATH has a single goal that is taken directly from GoPNG's current National Health Plan (NHP).<sup>8</sup> The objectives that are directly taken from the DFAT Portfolio Plan for Health. PATH's goal is to contribute to GoPNG's current NHP goal:

<sup>8</sup> The NHP 2011-2020 is currently being reviewed and updated. The new 10-year NHP for 2021-2030 is currently scheduled to be finalised by August 2020. It is the purpose and nature of an "adaptive program" (see footnote 13) like PATH that this Design can and should be then aligned with the

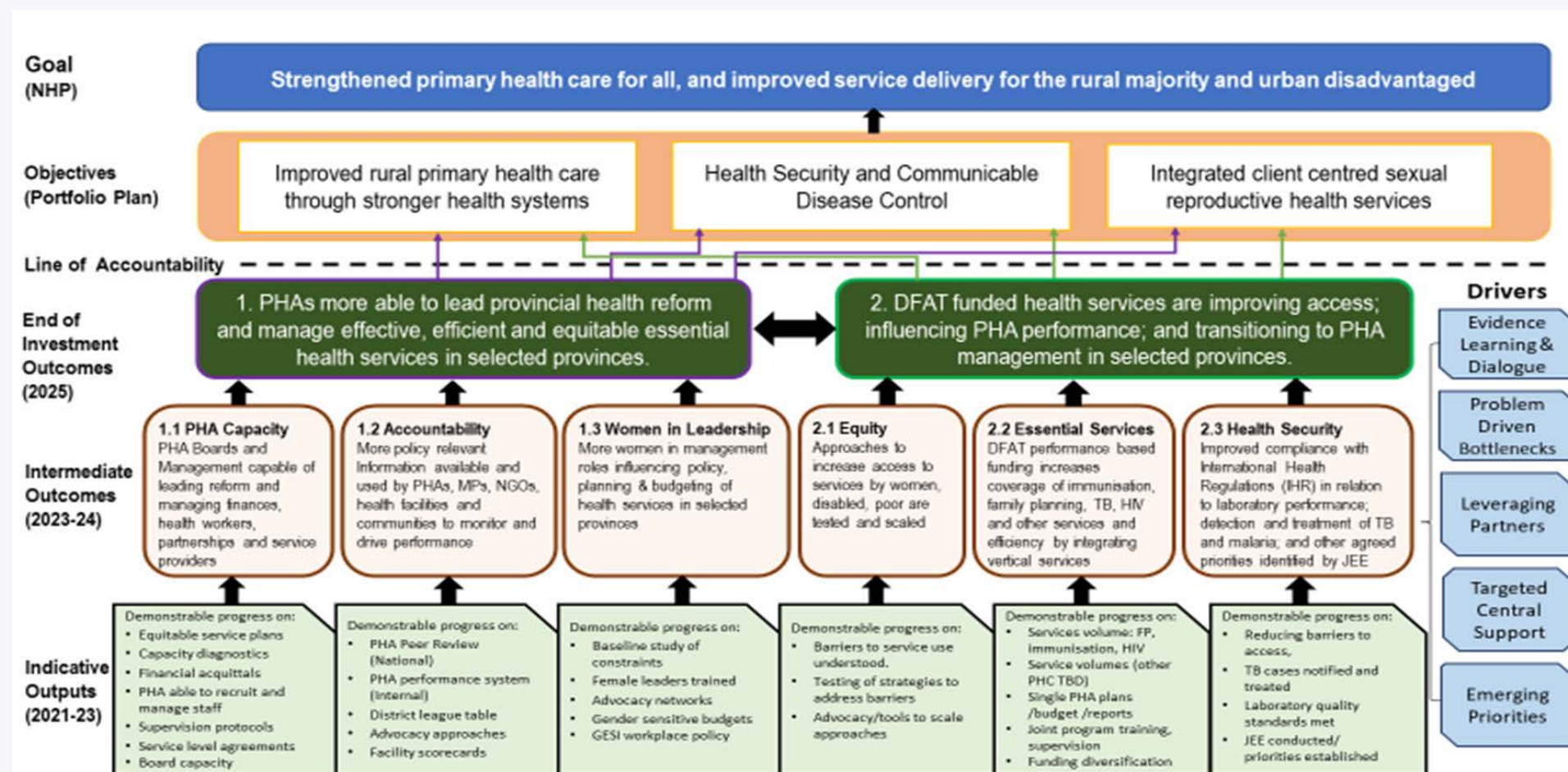
*“Strengthened primary health care for all, and improved service delivery for the rural majority and urban disadvantaged.”*

The strategic importance of primary health care in health systems, especially in low- and middle-income countries, is well established (48-52). There is also good international evidence that coordination of primary and hospital care and integrating vertical services into packages of essential services improves the efficiency and effectiveness of health services more broadly (53-56).

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new NHP with agreement of GoPNG and DFAT via the Annual Plan governance arrangements. Current indications are that future GoPNG health policy will remain broadly consistent with current priorities.

Chart 1: PATH Program Logic



PATH then has a direct alignment with DFAT's three core objectives as stated in the Health Portfolio Plan. These three objectives – improved primary health care systems; health security and communicable disease control; and integrated sexual and reproductive health services – are underpinned by two complementary EOIO's that the MC will be accountable to DFAT (and GoPNG) for achieving by 2025. These EOIO's contribute to the 3 Portfolio Plan objectives by strengthening the capacity of PHA's to fulfil their functions of leading provincial health reforms and managing primary and secondary referral level services (EOIO 1) and the financing - and progressive transition - of communicable and reproductive health care services to PHA management (EOIO 2).

The first EOIO is that: *PHAs are more able to lead provincial health reforms and manage effective, efficient and equitable essential health services in selected provinces.* PHAs are the principal vehicle for delivering health services in PNG – either directly or via contracted churches and NGOs. The importance of PHAs cannot be overstated. The Minister for Health Kapavore has stated that “the PHA Act of 2007 has been developed and is a major Government reform agenda to address the health systems fragmentation.....all PHAs will be declared by the end of June 2019”(20). However, while PHAs offer much potential for increasing primary and other essential health care closer to the population, there are gaps and bottlenecks in the leadership, managerial, financial, and technical capabilities required to achieve GoPNG goals for health. It is therefore strategically important and relevant to support them. The design intention of this EOIO is to improve the leadership and management performance of PHAs. This includes key organisational capacities of board function, planning, budgeting, financial management, human resources, stakeholder engagement, and service provider and facility performance management. However, PHAs are a means to an end – improved service delivery – and not an end in themselves. The EOIO is therefore designed to provide the organisational foundation within PHAs to progressively integrate the direct service delivery functions supported under EOIO 2, enabling each province, over time, to establish an effective, equitable and sustainable health system.

The second EOIO is “*DFAT funded health services are improving access; influencing PHA performance; and transitioning to PHA management in selected provinces.*” This EOIO recognises that, due to lack of GoPNG capacity and robust public financial management, DFAT currently directly funds through grants to NGOs and churches the delivery of some essential health services. The design intention of this EOIO is, in the first instance, to increase the coverage, accessibility, and value for money of existing DFAT funded health services: an important outcome in its own right over the life of PATH. However, the more strategic and longer-term intent of EOIO 2 is to generate evidence, learnings and practices that not only further improves DFAT's own existing programs but – importantly - can be used as part of DFAT's policy dialogue to help PHAs themselves improve their own performance, thereby making PHAs more capable of taking over current DFAT funded programs over time. This will be achieved through (i) understanding and addressing barriers of specific marginalised groups to accessing services and disseminating such insight in a way that is useful – and used – by key stakeholders including PHA's; (ii) direct performance-based funding to expand coverage and accessibility of some services; and (iii) progressively shifting the delivery of services into core PHA systems (covering both direct and contracted delivery). A key strategic intent of this EOIO is also to diversify the funding sources for health services away from DFAT to encompass PHAs, churches, MPs/districts, private sector, and other donors.

It is essential to understand that these two EOIOs interact with each other and are not mutually exclusive. This is illustrated by the two-way arrow between the two EOIOs in Chart 1, confirming that the arrows of causality operate both ways. More specifically, selected PHAs that are more able to lead provincial health reforms and manage effective, efficient and equitable essential health services (EOIO 1) will be, by definition, more capable of taking over (“transitioning”) essential health service delivery such as immunisation, family planning, malaria and TB currently funded by DFAT and managed via NGOs and contractors. On the other hand, the evidence and learning on improvements in service delivery that DFAT currently funds – which is to be part of the “adaptive program” of PATH - can then be used to leverage improvements in under-performing PHAs. This could include, for example, evidence and learning on how to enhance uptake of services by specific groups. Or it could involve the evidence of increased effectiveness and reduction in costs by having joint / shared training and supervision for disease programs. To the extent that those lessons influence and improve PHA

management efficiency, then they also increase scope to transition across to PHAs activities currently being directly financed by DFAT.

**The goals, objectives and EOIOs are relevant, strategic, ambitious, coherent, yet achievable.** They are *relevant* because GoPNG's current NHP <sup>9</sup> has a consistent theme of providing more effective, efficient and equitable health services, particularly to rural areas where over 80% of the population lives. This is to be achieved primarily through more effective PHAs. It is also clear from Section B and C above that health systems, including in Provinces, still need further reform. The PATH goals and objectives are *strategic* because they align with and support the central directions and focus of both GoPNG and Australia in the health sector of PNG. The goals and objectives are *ambitious* because they directly address the need to strengthen PHA management and delivery of services while simultaneously continuing a level of essential services funded directly by Australia via PATH. They are also *innovative* and diverge from the business as usual approach. The PATH design has a deliberate and purposeful plan to use the lessons, analysis and evidence from DFAT's direct funding to support and inform the reform process of PHAs themselves. This then brings greater *coherence* to the program. DFAT directly supported programs will not be acting – or be perceived to be acting – in isolation from or parallel to PHA's. As PHAs become stronger and more accountable, DFAT can then progressively transition directly funded activities across to better performing PHAs. Such a process is *achievable* because PATH focuses on selected provinces, has identified specific “drivers” of change (see below) and will always be making a *contribution* to the higher-level goals and objectives: PATH aims to make a serious and meaningful contribution within 5 years to PHAs and service delivery in selected provinces.

**Australia cannot, and should not, seek to do everything, everywhere in PNG therefore DFAT and PATH should focus on “selected Provinces”.** The “selected Provinces” that PATH will support will be finalised through formal discussions between GoPNG and DFAT, but this design suggests there are some key selection criteria that would make the best use of DFAT's investments. This does not exclude contributing to other Provinces<sup>10</sup> and the national health system more broadly but having a focus on selected Provinces does give clarity of purpose, as per the request from Australian Foreign Minister Marise Payne to have more geographical focus in the health portfolio. The DFAT, and PATH, focus on a select number of particular provinces can pilot and test innovations and interventions - at scale - that can then have a potential demonstration effect and influence on other provinces in PNG. The selection criteria for the selected provinces to receive more intensive PATH input could include the burden of disease/population health needs for PNG citizens and for neighbouring countries such as Australia; capacity/readiness for support and likelihood of progress and reform; potential for synergies with other development partners including ADB and World Bank; opportunities for positive externalities (e.g. reduced incidence of communicable diseases in a neighbouring Province and / or broader lessons and learning that could then apply to PNG more broadly).

### **Six intermediate outcomes that contribute to the two EOIOs**

The program logic shown in Chart 1 has six intermediate outcomes that are within the span of influence of the PATH MC. As with the two EOIOs, these 6 intermediate outcomes are not mutually exclusive. Indeed, they complement and support each other. In essence, as shown in Chart 1 the intermediate outcomes seek to achieve demonstrable and meaningful change in six domains.

**To strengthen PHA leadership and management (EOIO 1), PATH identifies the following three intermediate outcomes (IOs):**

*IO 1.1 PHA Boards and management are capable of leading reforms and managing finances, health workers, partnerships and service providers;*

<sup>9</sup> See footnote 8 on how PATH will respond to the development and finalisation of a new NHP covering 2021-2030.

<sup>10</sup> That would particularly be the case if current health programs supported by Australia under the PNG Partnership Fund (PPF) including family planning and immunisation were brought into PATH because those programs extend to many provinces.

*IO 1.2 More policy relevant information is available - and used - by Government, PHAs, MPs, NGOs, health facilities and communities to monitor and drive performance;*

*IO 1.3 More women in management roles influencing policy, planning and budgeting of health services in selected provinces.*

To deliver quality and accessible essential health services that are influencing PHA performance transitioning to PHA management (EOIO 2), PATH identifies the following three intermediate outcomes (IOs):

*IO 2.1 Approaches to increase access for services by women and girls, disabled and other marginalised groups including the poor are tested and scaled;*

*IO 2.2 DFAT performance-based funding increases coverage of immunisation, family planning, HIV and other services and improves efficiency by integrating vertical services. (For example, DFAT can use performance-based funding to shape the market including by encouraging joint - rather than currently separate – training, supervision and M&E for disease prevention and control, thereby reducing duplication and costs).*

*IO 2.3 Improved compliance with International Health Regulations (IHR) in relation to laboratory performance; and detection and treatment of TB and malaria; and other agreed priorities identified by Joint External Evaluation (JEE).*

PATH's program logic identifies a range of 'indicative' outputs which could contribute towards each of the programs Intermediate Outcomes. The PATH MC will need review and update these based on understanding of context and learning from implementation. The design envisages a series of important, reasonably predictable, key outputs in the first year or so <sup>11</sup> of PATH during the inception / early implementation phase, as set out in [Annex 9](#). Beyond this, the design identifies a range of indicative substantive outputs for the implementation of the Program (See the Program Logic Chart 1 above and [Annex 2](#)). Given the intention that PATH is an adaptive program<sup>12</sup>, in a fast-changing environment like PNG, with a design that is being written some 12-18 months prior to implementation, the MC should review these outputs and any new outputs on a regular basis to determine what is the best way to achieve the IOs and ultimately EOIOs. Changes to the outputs would then need to be reviewed and approved by DFAT (and GoPNG) through the governance arrangements for PATH including the Annual Plan process.

### **Five critical “drivers of change”**

PATH also has 5 drivers of change: ways of purposefully achieving the EOIOs and IOs that draw on a range of delivery modalities and approaches that go beyond traditional technical solutions to aid problems. These five drivers of change are shown at the right-hand side of Chart 1. These approaches draw on emerging insights to effective aid around adaptive programming (testing, assessing, learning, adapting); problem based iterative programming; thinking and working politically; coalition building and policy engagement. As with the EOIOs and IOs, these 5 drivers are not mutually exclusive. They can and should work together to support achievement of the EOIOs and IOs. See [Annexes 2 and 11](#).

#### **Driver 1: Strengthened evidence base as a basis for more informed policy dialogue.**

There are clear and important gaps in basic data, evidence and information in PNG. There is a need for targeted operational research: what works, for whom, when, why and at what cost to PNG? GoPNG cannot afford to finance programs that are ineffective or inefficient, especially with the prospects of a health budget that is declining in real (adjusted for inflation) per capita terms. PNG has many good strategies and policies, but which then fail to get traction due to poor implementation and follow-through. The root causes and bottlenecks of this are not always known. Furthermore, policy makers in PNG, and sometimes development partners, are not always clear about the impact and lessons to be learned from development programs.

<sup>11</sup> Annex 9 outlines a possible inception phase however this design recommends that tenderers specify how long the inception phase should be.

<sup>12</sup> See footnote 15.

**PATH will be required, and resourced, to increase the evidence base for better policy and programming.** In doing so, the design aims to avoid purely “academic” research, or analysis that does not get read, let alone used. To incentivise the MC to make operational research or policy analysis practical, useful, and used, PATH therefore includes indicators in the MEL to track the extent to which operational research and learning is actually used to influence policies, programs and budgets. Suggestions are also made as to how knowledge and learning can better reflect the diverse views and experiences of women and marginalised groups. The design also directs PATH to coordinate and collaborate with the pipeline of analytical work being undertaken by the World Bank, ADB, and other partners. Strengthening the evidence base for policy and programming will be a public good that will assist not just GoPNG officials at national and provincial levels. It will also strengthen the Australian High Commission’s capacity for policy dialogue and influence; improve civic and social accountability through a more informed citizenry; and offer lessons and insights about service delivery to regional neighbours.

#### **Driver 2: Reduced bottlenecks to deliver better health services using a problem driven approach**

**PATH cannot and should not try to strengthen the whole of the PNG health system: it can however support a “problem-driven” approach to help remove or relieve specific bottlenecks that impede service delivery.** It is intended that the GoPNG, DFAT and the MC collectively identify a small set of key bottlenecks or ‘knotty’ – but solvable - problems early in life of PATH. Possible examples, among many possible, include the late or partial release of PHA funds from Treasury; non-approval of PHA staffing establishments; or unwillingness / inability of PHA staff to conduct joint supervision or outreach. Specific outcomes in relation to these targeted areas should be defined and guide whole-of-program effort, including learning/testing, MEL, advocacy, technical assistance, and funding incentives. Addressing system bottlenecks will require PATH to work cross-sectorally in a politically and culturally attuned manner. It will require network building and working collaboratively across the DFAT portfolio, with GoPNG, and other development partners.

**Addressing the bottlenecks that cause long delays in the release of funds to Provinces is one example where PATH could make a strategic, yet achievable, difference.** It is clear that one common reason why PHAs do not receive, and are then not able to utilise, funds in a timely manner is that they have not been able to properly acquit earlier expenditures (16, 18, 29, 30). This results in long delays before funds can be released to PHAs and used. It is quite feasible within the resource envelope and the time frame envisaged for PATH that this bottleneck could be eased, if not eliminated. PATH could for example start the process of relieving that bottleneck by using a pool of short-term advisers, including PNG nationals trained in accountancy and experienced in the PNG system, to train and mentor PHA officials on how to properly acquit previous expenditures in a timely and correct manner. This technical effort would be coupled with fostering supportive relationships in key agencies, and the use of performance information to incentivise action. DFAT policy dialogue and funding incentives could also play a role. This would not solve all the constraints and weaknesses of a PHA. However, it would relieve one important and needlessly delaying common bottleneck at the PHA level thereby improving the flow and disbursement of funds that can be used for service delivery. Improving the process of timely acquittals also has the added benefit of improving public financial management, transparency and accountability more generally.

#### **Driver 3: Leveraging partnerships and improved aid coordination.**

**Australia is the largest bilateral financier of the health sector so is well placed to leverage its investments with United Nations and multilateral agencies and others working in the health sector of PNG.** There have been some missed opportunities to do so to date (47). Importantly the ADB and World Bank both have large policy based and/or performance based concessional loans being rolled out in the PNG health sector, supported in both cases by strong analytical work and policy dialogue. This provides opportunities for PATH to use its own proposed investments in action learning and operational research to complement ADB and World Bank work as would be set out in the Annual Plan. PATH can also leverage and link with other DFAT investments under the Health Portfolio Plan: [Annex 10](#) provides a summary of current DFAT investments in the health sector. There are also opportunities for DFAT to leverage its investments in other sectors including governance and

economic management; programs including the Precinct which strengthens leadership capacity; and Pacific Women with its focus on gender equality.

**There is also significant scope to improve aid coordination – both within the health sector and at subnational level between related sectors – thereby extracting improved impact from all aid flows.** NDoH has specifically requested assistance from Australia in this area. Better coordination extends to partnerships with donors (traditional and new), churches, the resources sector, and other private sector and NGO providers of health which are an important feature of the health system. This all highlights the importance of better aid coordination, especially with the unwelcome possibility of reduced budgetary resources going to the health sector. PATH can be a strategic contributor by providing secretariat support to NDoH aid coordination responsibilities and by building PHA capacity to coordinate aid.

#### **Driver 4: Targeted support to the national level to enable more effective performance and leadership by PHAs**

**GoPNG, the DFAT Health Portfolio Plan, and therefore PATH focus on provincial level service delivery but there is still an important role for targeted support at the national level that is critical to provincial health performance.** Key issues for PHAs and their partners to improve health service provision in the province include the quantity and timing of financial transfers; recruitment, training and retention of health workers; and development and implementation of national policies and standards. These issues require decisions, guidance or action taken at national level, particularly by NDOH, Departments of Personnel Management, Planning and Finance and Treasury. They also require close attention to the role that national gender equality policies may play in driving more inclusive provincial workplace cultures. PATH therefore intends to continue to provide targeted support to NDOH, including through a limited number of long-term advisers. However, PATH should increasingly shift and transition over time to a model involving short term (and some long term) advisers (potentially organised around regional ‘flying squads’) providing national support to NDOH, PHAs and, where necessary, their agents including churches. This model is, in principle, *potentially* more likely to support capacity *building* and are less likely to result in capacity *substitution*.

#### **Driver 5: DFAT and NDoH able to respond quickly to rapidly emerging issues while still maintaining overall focus and strategic direction.**

**GoPNG will continue to request ad hoc assistance from Australia to address rapidly emerging health needs.** Indeed, this may increase the focus on PATH as it is likely that PATH will be the principal – perhaps only – bilateral “window” that GoPNG will have to make ad-hoc or urgent requests in the health sector.<sup>13</sup> A lesson from previous facilities and adaptive programs is that such responsiveness can be very helpful but they can also lead to small, fragmented, funding with little overall focus (22). Worse, it can over time reward what is simply poor planning and poor budget management. To avoid these problems but retain prudent responsiveness, PATH will have a mechanism and budget to respond to rapidly emerging needs and opportunities, while still retaining strategic focus: see next paragraph.

**DFAT and NDOH will need to decide on the eligibility criteria for responding to requests under Driver 5 within the first 2 months of mobilisation.** These criteria could include that priority will be given to proposals clearly contributing to the Health Portfolio Plan or progressing an agreed, new reform opportunity. There should also be minimum financial thresholds to avoid micro-requests e.g. ad hoc funding of fuel for vehicles. Criteria could restrict proposals that seek to fund travel. Furthermore, all proposals to this mechanism might need to be approved by both the Head of Mission and the Secretary of NDOH. (This, by itself, will encourage middle managers in NDOH, DFAT and other organisations to critically assess the appropriateness of their request, and not simply request urgent funding due to lack of planning or poor financial management). Unexpended funds at the end of a financial year would not be allowed to accumulate but would be redirected to the highest priorities under the Program.

<sup>13</sup> That would certainly be the case if the health activities, and the modalities for “market shaping” and tendering currently being funded by PPF were brought in under PATH.

## Delivery Approach

**The need for strategic focus but also “structured flexibility”<sup>14</sup> and responsiveness.** The Health Portfolio Plan has three key outcomes that cascade down to the two End of Investment Outcomes and 6 Intermediate Outcomes set for PATH: see Chart 1. This provides strategic focus and purpose. However, it is also clear that PATH should have a degree of “structured flexibility” and responsiveness. That is because there are so many variables and “unknowns” in PNG. For example, the new PNG National Health Plan is still to be developed; there is a major NDOH reorganisation; the roll out of PHAs is meant to accelerate in coming months but this raises several institutional and other unknowns; and the history of PNG is that health emergencies occur (e.g. polio and earthquakes).

**There are also important changes among development partners that require a degree of structured flexibility and responsiveness while retaining strategic focus.** For example, ADB and World Bank are engaging in large new loans which include substantive policy triggers and incentives for performance. Health security is a key priority for Australia. The Fleming Fund and Australia’s Indo-Pacific Centre for Health Security are increasing their engagement with PNG while other agencies such as GAVI and the Global Fund are seeking ways to transition out of PNG. It is not clear at this stage exactly what, where or how these partners will support PNG. It is also not clear what GoPNG financial allocation to the health sector will be over the life of the new facility, but interviews clearly suggest a continued decline in real, per capita, government spending in health. There continues to be a significant element of political unpredictability in PNG, including a change of PNG Prime Minister and Minister for Health during the span of the PATH design. The future of Bougainville is unknown.

**A “facility” - or an “adaptive program” - is therefore the obvious – indeed only – viable option.** Traditional projects that specify outputs and activities do not provide the flexibility or prompt responsiveness required by DFAT or NDOH. A facility<sup>15</sup> can. At a practical level, DFAT directed the PATH design to be developed so as to replace the existing HHISP – a facility that has been operating since 2012. HHISP currently supports several programs and initiatives that PATH should continue and build on. However, terminology is also important. It is more accurate to describe PATH as an “adaptive program”.<sup>16</sup> That is particularly because PATH will do significantly more than identifying and procuring Advisers and / or managing grants: features of certain types of facilities in other countries. A key element of the design is the articulation of clear end of investment outcomes and intermediate outcomes, without locking in how these will be delivered.

**The PATH MC will need to both continue some streams of work that are well established and at the same time develop and test new approaches for more challenging areas.** They will need the experience and capacity to both design and/or implement already well established and successful activities (such as TB and malaria), and to develop and test new approaches for more challenging areas (such as Women in Leadership and strengthening PHAs). The MC will also need to develop and agree annual plans for the program which clearly specifies flexible and adaptive approaches, activities and outputs and has clear and transparent feedback loops and decision-making processes. Annex 8 summarises how PATH will be different from how DFAT has invested in health programs hitherto while still continuing some streams of current work.

<sup>14</sup> “Structured flexibility” means that there is still a meaningful degree of focus retained, and that PATH does not become distracted or distorted by extraneous, inappropriate, or very small ad-hoc requests for financing or assistance.

<sup>15</sup> The Independent Evaluation of Facilities defined a Facility as “an aid delivery mechanism that provides flexible (adaptive and responsive) services managed in an integrated way. Objectives (or end-of-facility outcomes) are specified, but the pathways to deliver them are left unspecified. They can: enable collaborative and responsive partnership approaches to gain traction; allow activities to experiment and adapt based on progress, demand and contextual changes; and provide the opportunity for outcome-focused coherence across sectors, enabling the whole to be more than the sum of the parts.”

<sup>16</sup> Adaptive programming or management acknowledges from the start that while the outcome to be achieved may be known, the specific strategies and combination of interventions that will work to address complex development challenges need to be developed. Program design builds in deliberate processes of testing and experimentation, with structured MEL providing feedback to learn from experience. This can be done by testing interventions iteratively or in parallel, to scale up those which are working and curtail those which are not. It can focus on identified problems and look for innovative ways to address these. There should be regular strategic reviews based on rapid feedback mechanisms, to allow adaptation. The flexible and evolving nature of this approach requires capable MEL capacity within the MC and trust among the partners. Further information available at (DFID *Top Tips How to design and manage Adaptive Programmes*, 2016 - update forthcoming)

The PATH MC will need to be able to adapt strategies on specific – but tractable – problems and bottlenecks in the light of implementation experience. The design recognises that there has been sustained DFAT and other development support to the PNG health sector for decades which has not always resulted in broad based health system improvement. This support has predominantly been focussed on technical improvements and development of formal policy and service delivery systems. There is a design intent that PATH will more systematically focus on specific problem-solving rather than broader – and sometimes diffuse – “health system strengthening”. PATH will also more specifically consider issues of political economy and cultural context (including gender equality and social inclusion) in the management and delivery of the Program, including through its “driver” of strengthening: see [Annex 11](#).

**There is significant scope for PATH to improve efficiency and value for money.** Replacing the process-heavy and resource-intensive use of Tasking Notes by a higher-level Annual Plan with strategic line items will potentially free up the MC - and Post – resources to some degree. A determined focus on competitive grants rather than sole sourcing (where appropriate) will further drive value for money. The design will have a clear statement of roles and responsibilities between Post and MC, as well as a broader statement of principles on “ways of working” aimed at reducing transaction costs, encouraging prudent risk-management, and ensuring there are “no surprises” from the MC. See [Annex 3](#) which provides details on governance.

## **E. Implementation Arrangements (How will DFAT engage?)**

### **Governance arrangements and structure**

Interviews during the design mission confirm there is a balance to be struck here. On the one hand, there are several existing overarching governance arrangements to plan and review aid investments between Australia and GoPNG, and with other development partners.<sup>17</sup> On the other hand, it is clear GoPNG still does not believe it has a good insight into Australia’s (or others’) contributions. GoPNG clearly also need to be involved in overall planning and priorities of programs, especially given the envisaged size of PATH, but NDoH is overwhelmed by the amount of engagement by development partners. While final approvals and accountability will always rest with DFAT, the design recommends a process of engaging GoPNG – including selected priority provinces – in the development of PATH’s annual plans, and their review. Detail of the PATH’s governance arrangements are set out in [Annex 3](#).

PATH also involves specific governance processes between the MC and the Australian High Commission (AHC) so as to facilitate effectiveness and efficiency in program delivery. DFAT reviews confirm the importance of having clearly defined roles and responsibilities between the MC and DFAT at Posts overseas (22). The PATH design therefore includes a proposed statement of roles and responsibilities: see [Annex 3](#). This suggested framework should be reviewed, adapted and agreed between MC and DFAT within the first 3 months of PATH implementation. In addition to this more formal delineation of roles and responsibilities, PATH also proposes that the MC, GoPNG and the AHC staff that are involved in PATH meet in the first 3 months of implementation to develop an agreed “ways of working” document. The aim of the document is to agree on the substance and “tone” of the relationship between all parties. It could, for example, specify the commitment by all parties to have a “no surprises” approach to the relationship; to avoid micro-management and avoid a default risk-averse approach to program management, and for PATH itself to reflect the outcomes and outputs including, for example, increasing the participation of women and socially excluded in decision-making.

### **Early activities**

A recent DFAT review confirms the importance of managing the start-up phase of programs in a proactive and careful way (22). This is particularly important for PATH where there will inevitably – and intentionally – the continuation of certain programs and positions between HHISP and PATH. [Annex 9](#) therefore lists a suggested list of proposed indicative outputs that PATH should deliver in the first 12 months of its existence. The MC’s Inception Plan will detail the outputs in the PATH inception phase. Transition arrangements between HHISP

<sup>17</sup> They do not always work well. The facility can be helpful here by providing secretarial support to the Health Sector Aid Coordination Committee.

and PATH are also identified as a potential risk factor in the risk matrix. As noted throughout this design, PATH gives particular and explicit importance to building evidence and learning as a basis for policy dialogue and ongoing program improvement at the level of both EOIO 1 and 2. With that in mind, PATH should consider early in the first year what baselines are required, and to what extent PATH can use existing baselines and data sources of GoPNG, individual PHAs, and / or those of development partners.

### **Policy dialogue**

**A key theme running throughout the PATH design is that Australia can best demonstrate development effectiveness and broader diplomatic partnerships by helping GoPNG make better use of its own financial and human resources.** PNG in general and PHAs in particular cannot afford to waste those resources on policies and programs that do not work in an effective, efficient, equitable and sustainable way. There is clearly a need in PNG – including especially at the PHA level – to have a more accurate, more inclusive, more timely, more relevant, and more used evidence base to better inform policy and programs (18). EOIO 1 and 2 both aim to achieve that, through each of the intermediate outcomes, and each of the “drivers” specified in this design. However, generating evidence and insights, while key, is a necessary – but not sufficient – condition for improving policies and programs. As noted in DFAT’s latest review of policy influence (57), as well as the international literature more broadly (58-66), such evidence and insight needs to be presented to the right people (which may well include community groups); at the right time in the political and budget cycles; by the right (i.e. credible) source; and in a way that stakeholders prefer to receive and digest information if the evidence and learnings are to influence policies and programs (62). PATH will be accountable for supporting DFAT’s policy engagement in this way.

**There are other opportunities for PATH and DFAT to further strengthen policy influence and outcomes in PNG.** For example, the ADB and the World Bank both have relatively large, policy based, concessional loans in the health sector in PNG that are designed around applied analytical work. WHO, UNICEF, and UNFPA each have developed strong analytical and program insights into health challenges and opportunities in PNG. There is scope for DFAT with the assistance of PATH to make better use of DFAT’s obvious convening power to better leverage and complement those multilateral relationships as a basis for policy dialogue (47). There are also opportunities to strengthen institutional links between PNG research institutions, including the PNG Institute for Medical Research (IMR), and Australian institutions engaged in applied research. Over the medium to longer term, DFAT (and potentially PATH) can further strengthen the use of evidence-based policy and learning by continuing to provide short- and long-term scholarships to PNG nationals – including women and the disabled – so that there is more home-grown demand for, and capacity to deliver, better policies and programs. As per above, PATH could also deploy a small team of advisers (a “flying squad”) that provides specialist policy and programming advice at key times in the planning and budgeting cycles of PHAs and provinces. [Annex 12](#) provides details on key policy dialogue priorities related to PATH and how PATH can support DFAT in this area.

### **Profile and public diplomacy**

**Australia already has a high profile in PNG: PATH can contribute to that in a constructive and appropriate way.** PATH is intended to be the main direct bilateral program that DFAT has to respond to health needs in PNG. The direct funding of key programs including prevention and control of TB, HIV, immunisation, and family planning under EOIO 2, combined with the strengthened MEL envisaged under PATH, will generate evidence and stories about lives saved and illnesses averted among the poor and marginalised. The strengthening of rural primary health care services under EOIO 1 will demonstrate Australia’s focus on helping PNG get better outcomes from its own financial and human resources. The increased participation of women in leadership roles (intermediate outcome 1.3) and women and the marginalised accessing essential services (intermediate outcome 2.1) are important themes of public diplomacy (if publicised carefully in the PNG context).

## Sustainability

PATH purposefully involves a transition of health services, including a planned, progressive, transition of currently funded DFAT programs across to GoPNG. It is not realistic to think PATH or any other health program could achieve full GoPNG ownership and sustainability at this stage given the various financing, resourcing, institutional and capacity constraints. However, neither is it desirable – or necessary – for Australia to directly fund large programs which should be planned and managed by GoPNG. PATH therefore has at the core of the design a program logic which seeks to transition PHAs to a more capable and sustainable level (EOIO 1) as well as progressively transitioning, where appropriate, programs currently funded directly by DFAT across to GoPNG (EOIO2). Importantly, this logic is backed up with a gradual, but meaningful, scaling back of direct DFAT funding for service delivery over the life of the Program wherever that is possible, and a corresponding focus on encouraging a diversification of funding sources for service delivery (including the GoPNG, MPs/district funding, private sector and other donors).

### F. Monitoring and Evaluation (How will DFAT measure performance?)

Monitoring, Evaluation and Learning (MEL) is essential to an “adaptive program”<sup>18</sup> such as PATH operating in PNG. The MEL enables PATH to simultaneously meet two separate requirements. The first is that PATH directly and demonstrably contributes to the DFAT Health Portfolio Plan and, through that, also contributes to the GoPNG National Health Plan. This gives PATH strategic focus and direction, which is articulated in the two EOIOs. The second requirement is that, within that fixed strategic focus, PATH is nevertheless also an “adaptive program”: a design approach that specifically encourages a measure of flexibility to respond to rapidly changing circumstances in PNG; the piloting and testing of innovative approaches; and generating and using evidence and lessons to achieve the EOIOs. Effective MEL is essential for this adaptive approach.

The PATH MEL provides accountability but also incentivises performance. DFAT reviews show that M&E frameworks do not always drive a “performance culture” within the MC (or even DFAT itself); do not always incentivise lesson-learning as the basis for better policy dialogue and program improvement; do not give good insight into GESI; and do not give good insight into efficiencies or value for money (67). PATH addresses each of these issues, while retaining the flexibility and responsiveness required in an adaptive program.

PATH has design features to ensure that the MEL gets traction in terms of influencing and improving policy and programs. The PATH “drivers” can each contribute to building the evidence base and lesson-learning. PATH also has a dedicated budget to support applied operational research and action learning. Perhaps most importantly, the PATH MEL itself tracks the extent to which analysis and learnings generated are actually then being presented, considered and used by intended stakeholders to improve policies and programs. This will incentivise the MC to make sure action research and lesson learning is relevant to the specific needs of policy makers and program managers, and is presented in a way, and at a time, most useful to them.

Key aspects of the MEL approach include:

- Alignment with measures of results in the National Health Plan and DFAT Health Portfolio Plan;
- Use of existing national and provincial data collection systems where possible; and work with others on joint approaches where these need to be developed or strengthened, but with particular attention to generating gender-disaggregated data;
- More proactive, explicit, and timely assessment of the extent to which PATH is influencing policy and service delivery and access in provinces;
- Assessing experience from testing strategies and approaches, with findings and proposed adaptations and changes discussed in six monthly reviews involving DFAT, GoPNG and the MC;

<sup>18</sup> See footnote 15 for a definition and explanation of adaptive programming.

- Reviewing performance and value for money of the MC, with a Performance Assessment Framework;
- A separately contracted M&E provider will review MEL plans, conduct independent evaluations and provide M&E support to DFAT, including on M&E oversight of PATH.

**Annex 4** has further details on MEL, including a proposed MEL framework that the MC will need to refine and to incorporate outputs and targets during the early implementation phase.

## **G. Gender, Disability and Other Cross Cutting Issues**

### **Gender equality, disability and social inclusiveness**

PATH intentionally identifies substantive, tangible, outcomes designed to improve gender equality and social inclusiveness. There are barriers and bottlenecks that women and the disabled face in terms of accessing both (i) essential services and (ii) positions of decision-making authority. Intermediate outcome 1.3 specifically tasks the MC to identify ways that result in “more women in management roles influencing policy, planning and budgeting of health services in selected provinces”. Intermediate outcome 2.1, which focuses on equity, will be specifically measured by “approaches to increase access for services by women, the disabled, and poor are tested and scaled up”. **Annex 5** provides specific details.

### **Indigenous Participation**

There is potential for PATH to develop useful links and lessons between Indigenous Australians and PNG as part of the contractor’s *Indigenous Participation Plan*. For example, the MC could draw on potential Australian lessons from policy work (led by the National Aboriginal Community Controlled Organisation) and implementation (led by local aboriginal community-controlled organisations) in delivering primary health care services with and for Aboriginal and Torres Strait Islander people in rural, remote and low resources settings. There may also be relevant lessons from both PNG’s Village Health Volunteers (VHV) and Australia’s Aboriginal Liaison Officers (ALOs). Both work directly with Papua New Guineans and Aboriginal and Torres Strait Islanders (respectively) to facilitate and demand access to health services, in a culturally sensitive way. There may be lessons on how to better deliver health information to language-diverse, low literacy, remote and rural communities in terms of format, language, and distribution methods. There may be lessons with respect to gender and disability including ways to overcome gender and disability stereotypes and barriers to accessing health or being more meaningfully involved in decision making about health programs. There may also be lessons to share in terms of governance and community participation and decision making. The MC should meaningfully explore potential areas further in their Indigenous Participation Plan.

### **Climate change and disaster risk**

There is a rich and growing literature on the possible impacts of climate change and disasters on health. This includes through direct pathways such as the possible spread of mosquito borne diseases but also through indirect pathways such as changes in food production, water availability, poverty and vulnerability etc (68-71). There is, however, very limited analysis of the effects of climate change on health in PNG (72, 73). PATH could potentially support applied operational research on that issue through its focus on health security (IO 2.3) as well as through the “drivers” such as evidence and learning for policy. The Australia Pacific Climate Partnership Support Unit can work directly with the PATH MC to facilitate the integration of climate change across the program, including into the program’s MEL system. The WHO’s Operational Framework for building climate resilient health systems is also a useful framework to guide future investments in the health sector.

### **Private sector and civil society**

There is scope for PATH to work with and leverage the private sector / civil society in PNG. There is a small, but growing, domestic for-profit private sector health sector, including private hospitals in major centres, in PNG. Little, however, is known about the nature and quality of that private sector: PATH could support applied operational research to start to build the evidence base for better GoPNG policies and regulation of that

sector. Australian and other mining / resource companies are active in directly providing health services at their sites. The structure of PHAs also requires private sector involvement on Governance boards to bring modern management skills and business-like approaches to the operations of PHAs. The value of this is evident in some provinces, including in Hela Province. There are therefore important and useful lessons to capture from that experience. More broadly, the majority of health services in many rural provinces are managed and provided by churches and other civil society groups on behalf of GoPNG: PATH will both directly support these groups and assist in capturing and learning from their approaches. There are also important opportunities for PATH to pilot and test more “social accountability” and community engagement – including through community scorecards – as part of PATH’s support to reforming and strengthening provincial health systems.

**PATH can use evidence and policy analysis to leverage politicians’ use of available resources.** The District, and Provincial, Service Improvement Program (DSIP and PSIP) funds provide significant funding at a sub-national level for essential services. They are intended to enable politicians to respond to local priority needs. However, these important funds do not necessarily prioritise essential health services or public goods (74, 75). One analysis (34) found that only around one quarter (26%) of those involved in health clinics believe that the allocation of DSIP funds is fair and that only one third of DSIP funded health clinics were completed in full and on time: a much lower percentage than schools funded under the DSIP. Funds tend to go to visible “hard infrastructure” projects rather than much needed - and much desired - improved outreach health services. PATH could therefore use the “evidence, learning and dialogue” driver to work with politicians and community groups to establish the evidence that using DSIP / PSIP funds to expand essential health service delivery benefits a significantly larger number of people in the district. This, in turn, benefits the MP’s profile and credibility. It also indirectly strengthens over time the visibility and therefore “legitimacy” of government. By diversifying the funding sources to Provincial and district health services it also enables DFAT to transition services it currently funds across to GoPNG sources where that belongs.

## **Innovation**

**There are important and substantive innovative aspects in the design of PATH.** One central theme running throughout the design of this Program is that while the EOIOs and IOs are defined and set, and ‘indicative outputs’ nominated, the MC will have the flexibility to critical review and identify how best to achieve those outcomes. This purposefully and deliberately encourages the MC to be innovative, in consultation with DFAT and the GoPNG. Another central theme running throughout the Design is the importance of learning from experience. More specifically, there is not just a focus on using M&E for ongoing learning and performance management. Instead, and in an innovative development, there is also a requirement for the Program as a whole, and activities within it, to explicitly track the extent that M&E and action learning has, *itself*, then helped shape policies, programs, budgets and program performance.

**Another factor encouraging innovation is the central focus on engaging in “selected Provinces”.** This encourages – indeed requires – innovation given the vastly different social, cultural, economic and institutional settings between, and within, Provinces in PNG. There are many opportunities to test and assess interventions. For example, in the early 2000s public hospital accreditation relied on a voluntary peer review process that resulted in a star rating for the hospital based on compliance with evidence-based standards. The accreditation system led to significant improvements in overall performance of those health facilities that participated. PATH could, for example, pilot and compare the use of accreditation and “star ratings” systems for a range of individual health facilities and hospitals. These and similar innovative approaches would directly support Minister Kapavore’s recent reform agenda including, for example, improved application of national standards, role delineation and improved referral systems of health services(20).

**The variety of program stakeholders can also drive innovation.** Churches, mining companies, MPs, and development partners (including ADB and World Bank through large policy-based lending) are each using different and innovative approaches to health service delivery and reform that DFAT, given its convening power in PNG, can leverage and complement. PATH’s emphasis on “evidence, learning and dialogue” as one of five key “drivers” of reform and change in the health sector could assist in supporting and disseminating this work.

## H. Budget and Resources (What will it cost?)

### Budget

A 5-year program budget of \$183m (excluding management costs) is proposed for PATH.<sup>19</sup> This reflects the strategic incorporation of the PPF health funding into PATH and the required financing to deliver the Program's EOIOs, IOs and change drivers. A key element of the proposed budget is the expectation of a careful, gradual reduction in the level of funding from DFAT for direct service delivery activities in the areas of family planning, immunisation, TB and HIV. This is purposefully designed to be gradual to maximise the chances of alternative sources of funding being identified for the services – ideally from GoPNG – but recognising this will be challenging given the current and projected financial challenges for the GoPNG. However, it is an important signal for Australia to send and provides a basis for ongoing policy dialogue. Another key feature of the budget is the modest, but dedicated funding provided to the 5 change 'drivers' within PATH. This signals the importance of these drivers to the program approach. An illustrative breakdown of the main program activities and cost components of PATH is at [Annex 7](#).

### Resources

**PATH will have resourcing implications for the MC and DFAT.** The MC and the Australian High Commission (AHC) are in the best position to judge how PATH could affect the current number<sup>20</sup>, and level, of staff resources. That is because they are both in the best position to know what current staff do, and cost, and their own organisation's personnel and financial policies and constraints concerning new staffing structures. What is clear is that there will be a need for some different skills and expertise than hitherto. For example, it is clear from this design that both the MC and the AHC staff will need to have ready access to<sup>21</sup> expertise in not just monitoring and evaluation but also knowledge management and knowledge brokering if PATH is to achieve the learning and policy influence envisaged for it. Both will also need to have expertise in GESI, given the prominent and specific role of improving access for women and disadvantaged groups to both decision making and essential services (intermediate outcomes 1.3 and 2.1 respectively). The AHC would benefit from having ready access to contract management expertise, particularly in the first year or so of PATH, to ensure that programs currently supported by HHISP are novated across to PATH effectively and efficiently. The AHC will require access to change management expertise so that as staff resources are freed up from existing tasks – including process-intensive tasking notes – staff are better equipped to manage MEL, GESI, knowledge management / brokering and policy influence.

## I. Procurement and Partnering

**PATH will be delivered through a Managing Contractor (MC).** The Program will continue a number of existing priority investments, for example the Trilateral Malaria Project and the Tuberculosis Program in Western Province, as well as new investments that the MC will develop and implement using an adaptive programming approach. The MC will have significant flexibility to design and implement strategies and activities to achieve the End of Investment and Intermediate Outcomes. The draft Pricing Schedule proposes that a proportion of the MC's Management Fees be linked to key milestones, Partner Performance Assessment and also Payment by Results/Outcomes. DFAT will procure the services of an MC, selected through a competitive DFAT-managed open tender process. A draft Statement of Requirements and Pricing Schedule have been developed and provided to DFAT. PATH complements, coordinates with, and supports, the PNG government system but does

<sup>19</sup> The design team has estimated the management costs for the program and provided these to DFAT.

<sup>20</sup> The AHC currently has 19 staff, including both Australian diplomatic staff and locally engaged PNG citizens, working on the health sector.

<sup>21</sup> "Ready access to" does not necessarily mean full time employed staff within the MC or AHC. It could mean access to short term or long-term advisers or panels of advisers, including of course, PNG national experts.

not directly apply Australian government aid funds through that system with the potential exception of channelling certain funds through the HSIP Trust Account for limited purposes.<sup>22</sup>

## **J. Risk Management and Safeguards (What might go wrong?)**

The PATH program is rated “very high risk” under DFAT’s risk management and safeguards tool this is not unexpected given the nature of the PNG health sector, but PATH has important and practical strategies to mitigate those risks (See Annex 13). More specifically, the risk identifies 5 “very high risks” currently, and before any intervention is made. A realistic assessment concludes that two of those risks – a decrease in the GoPNG health budget and the unavailability of essential drugs and commodities - are likely to remain “very high risk” status. PATH MC should obviously take mitigation measures, and DFAT should continue to have policy dialogue with GoPNG about the issues. However, those two challenges are so deep-seated and historic that it is not particularly realistic to think PATH – or any development partner – can significantly resolve the issues within the life span of PATH. On the other hand, the risk analysis does conclude that the “very high risk” associated with NDoH and PHA capacity, and current systems to disburse funds to PHA can both be reduced to “high” risk through mitigation measures and work from PATH. The “very high” risk that PHAs and other institutions in selected provinces may not be willing – or able – to increase the role of women and other groups in decision making is able to be reduced to a “moderate” risk given the particular focus on that issue in IO 1.3.

The risk assessment concludes there are a number of “high risk” and “medium risk” areas but in the many cases DFAT policy dialogue and PATH’s own actions would reduce the rating to a lower level of risk. More specifically, there are 9 areas judged to be “high risk”; 2 of which are likely to retain that classification but 7 of which can be reduced to “medium” risk as a result of DFAT policy dialogue and proposed PATH mitigation measures. The two issues that are likely to retain their “high risk” status concerns coordination among central agencies in Port Moresby (NDoH and Treasury etc) and the ability of PHAs to recruit and retain health worker staff. Again, DFAT should continue to have these issues on the policy agenda with GoPNG and there are mitigation measures that PATH can take. But the issues are similarly beyond the direct span of influence of PATH so the risk rating remains. Other “high risks” can be reduced to “medium risks” through PATH. There are also 7 areas judged to be “medium risk”. In 2 of those cases the risks can be reduced to “low risk”.

It is important to note that the biggest risk to health outcomes in PNG, and to Australia’s reputation (and national interest) is to have a “business as usual” - or worse a “do nothing” – response. That is because PNG clearly faces significant health challenges (Annex 1). A “business as usual” approach will see further deterioration of the health outcomes in PNG especially in the light of rapid population increases. GoPNG needs – and has asked for – support to implement its reform agenda including from Australia, its largest bilateral development partner. It is in Australia’s broader diplomatic and strategic interest to respond.

<sup>22</sup> The HSIP Trust Account is a long-standing commercial bank account managed by the GoPNG but under close scrutiny of donors, including DFAT. If DFAT funds through PATH were to be recommended for disbursement through the HSIP Trust Account a fiduciary risk assessment would be conducted.

## ATTACHMENTS

Acronyms

Annex 1: PNG Health Outcomes and Challenges

Annex 2: Program Logic

Annex 3: Governance Arrangements

Annex 4: Monitoring, Evaluation and Learning Approach

Annex 5: Gender, Equity and Social Inclusion

Annex 6: What will be different in PATH?

Annex 7: Budget

Annex 8: Lessons Learnt from previous health programs in PNG

Annex 9: Proposed first year outputs in PATH

Annex 10: Summary of DFAT PNG health investments

Annex 11: Approaches to socio-political complexity in PNG

Annex 12: Policy Dialogue Matrix

References

### Provided Separately

Annex 13: Safeguard and Risk Management Matrix

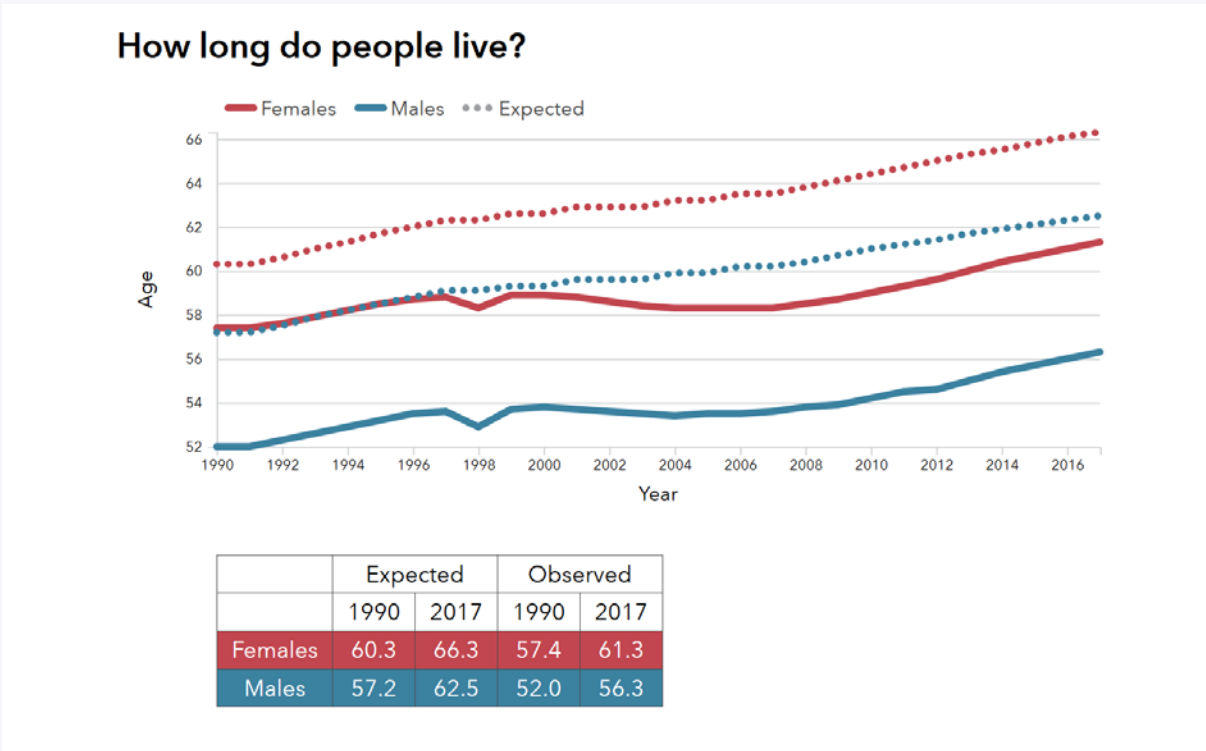
Statement of Requirements and Pricing Schedule

## ACRONYMS

ADB	Asian Development Bank
AHC	Australian High Commission in Port Moresby
CHS	DFAT Indo-Pacific Centre for Health Security
CPIA	Country Policy and Institutional Assessment
DDA	District Development Authority
DFAT	Department of Foreign Affairs and Trade, Government of Australia
DHS	Demographic and Health Survey
DSIP	District Services Improvement Program
DS TB	Drug susceptible Tuberculosis
EOIO	End of Investment Outcome
GAVI	Global Alliance for Vaccines and Immunization
GESI	Gender Equality and Social Inclusion
GoPNG	Government of PNG
HHSIP	Health and HIV Implementation Service Provider
HSACC	Health Sector Aid Coordination Committee
IDD	Investment Design Document
IHR	International Health Regulations
IMR	Institute for Medical Research
IO	Intermediate Outcome
JEE	Joint External Evaluation (for global health security)
LES	Locally Engaged Staff
MC	Managing Contractor
MDGs	Millennium Development Goals
MDR TB	Multi-Drug Resistant Tuberculosis
MEL	Monitoring, Evaluation and Learning
MP	Member of Parliament
MTDP III	Medium Term Development Plan, Government of Papua New Guinea
NCDs	Non-Communicable Diseases
NDOH	National Department of Health, Government of Papua New Guinea
NGOs	Non-Government Organisations
NHP	National Health Plan
ODE	Office of Development Effectiveness, Department of Foreign Affairs and Trade
PAF	Performance Assessment Framework
PASA	Program of Advisory Services and Analytics (World Bank)
PATH	PNG Australia Transition to Health
PEPE	PNG Promoting Effective Public Expenditure Project
PHA	Provincial Health Authority
PNG	Papua New Guinea
PPF	PNG Partnership Fund
PSIP	Provincial Services Improvement Program
SDGs	Sustainable Development Goals
SPAR	Sector Performance Annual Report
TB	Tuberculosis
UHC	Universal Health Coverage
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
VHV	Village Health Volunteers, Papua New Guinea
WHO	World Health Organization

# ANNEX 1: PNG HEALTH OUTCOMES AND CHALLENGES

Chart 1 Life expectancy in PNG: males and females



Source: Institute for Health Metrics and Evaluation (76)

Table 1 PNG has higher rates of premature death (measured as years of lives lost) than comparable countries.

## How do causes of premature death compare to those in other locations?

This table shows the top 10 causes of premature mortality (YLLs). It can be used to compare YLLs across locations relative to the group average. Comparison groups were chosen based on the GBD regional classifications, known trade partnerships, and socio-demographic indicators.

	Ischemic heart disease	Stroke	COPD	Lower respiratory infect	Neonatal disorders	Asthma	Diarrheal diseases	Diabetes	Road injuries	Congenital defects
Papua New Guinea	6,442.4	4,792.2	4,549.7	3,386.0	2,491.1	2,087.1	2,083.3	1,780.8	1,665.6	1,233.1
Comparison group mean (Low SDI)	2,534.4	1,779.4	1,589.6	2,893.7	3,718.5	616.3	2,733.8	568.9	886.5	1,034.0
Cote d'Ivoire	2,728.7	2,101.5	458.5	3,769.0	4,376.9	297.8	2,578.4	659.6	841.6	1,228.7
Eritrea	2,289.6	2,255.2	653.6	4,071.2	3,256.4	400.7	4,018.0	1,015.5	1,297.9	1,157.0
Kiribati	4,171.9	4,284.9	775.7	1,740.5	3,056.1	1,280.3	1,359.7	4,430.8	559.4	1,463.4
Nepal	3,010.3	1,320.6	1,584.2	1,684.0	2,543.9	492.2	1,148.6	511.1	1,029.7	300.8
Rwanda	975.0	1,276.4	559.1	2,733.1	2,663.5	234.7	1,682.6	647.3	1,173.4	1,177.7
Solomon Islands	5,048.5	3,198.1	990.9	3,681.9	1,376.1	453.0	396.2	2,085.7	1,035.6	712.3
Tanzania	1,821.6	1,178.4	346.2	3,092.8	3,292.5	194.4	1,418.0	645.4	577.9	1,759.1
The Gambia	3,085.9	2,152.3	553.4	2,985.9	3,342.8	283.0	1,570.1	684.8	754.7	716.4
Togo	2,412.5	1,920.4	523.7	2,772.1	3,422.7	288.4	2,457.6	568.0	839.0	796.7
Yemen	5,743.6	2,454.7	485.9	1,135.5	3,291.8	346.6	1,473.5	379.5	1,826.6	1,176.9

■ Significantly lower than mean
 ■ Statistically indistinguishable from mean
 ■ Significantly higher than mean

Age-standardized rate per 100,000, 2017

Source: Institute of Health Metrics and Evaluation (76)

Table 2: PNG and Regional Comparison of Health Service Access and Infrastructure

Country/ Region	Family Planning Needs Satisfied (%)	Women Receiving ANC Four or More Times from Any Provider (%)	Skilled Birth Attendance at Delivery (%)	DPT3 Immunization Coverage among 1-year-olds (%)	Population Using Improved Drinking- water Sources (%)	Population Using Improved Sanitation Facilities (%)
Cambodia	56	89	89	89	76	42
Fiji	44	98	100	99	96	91
Micronesia, Fed. Sts.	55	80	100	72	89	57
Kiribati	22	88	80	87	67	40
Lao PDR	50	53	42	89	76	71
<b>PNG</b>	<b>32</b>	<b>66 [63]</b>	<b>53 [37]</b>	<b>62</b>	<b>40</b>	<b>19</b>
Samoa	27	93	83	66	99	91
Solomon Islands	35	91	86	98	81	30
Timor-Leste	22	84	30	76	72	41
Tonga	34	99	98	82	100	91
Tuvalu	31	93	98	96	98	n.a.
Vanuatu	49	76	89	64	95	58
Vietnam	76	96	94	97	98	78
EAP	48	89	85	85	86	69
Low-income	30	80	58	80	72	36
Lower- middle- income	48	86	78	84	85	61

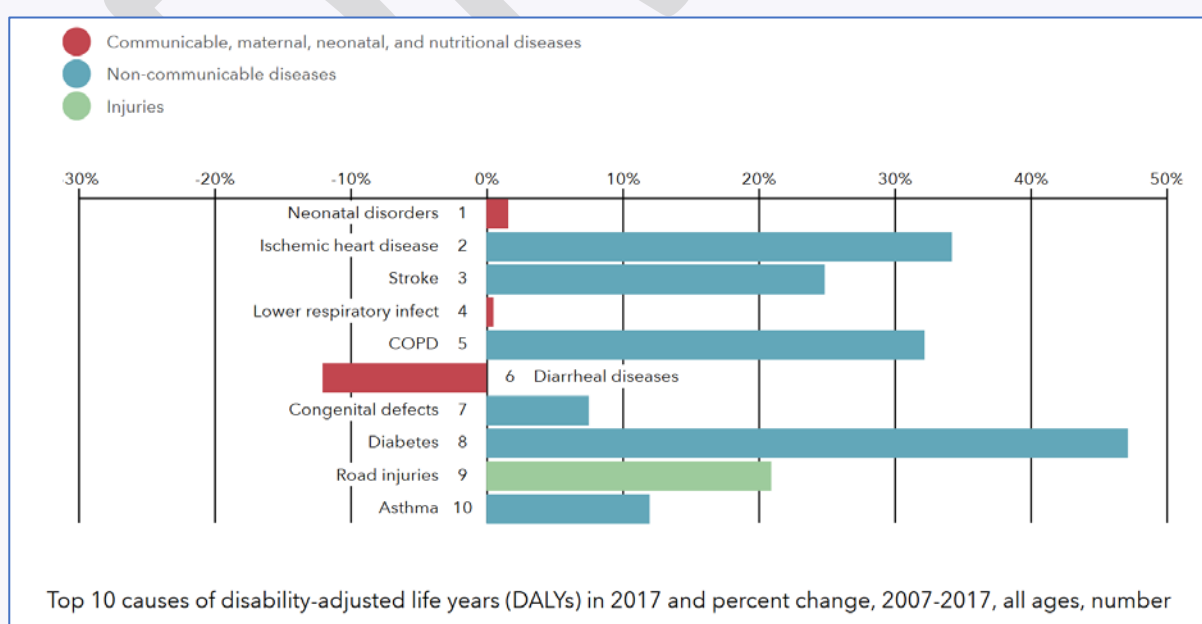
Source: World Health Organization and World Bank 2017.

Note: (i) DPT3: Diphtheria, pertussis, tetanus. (ii) 2015 data from PNG Government's NHIS in square brackets [ ] if available. (iii) n.a. not available.

Source: World Bank (2017) Health Financing Assessment: Papua New Guinea

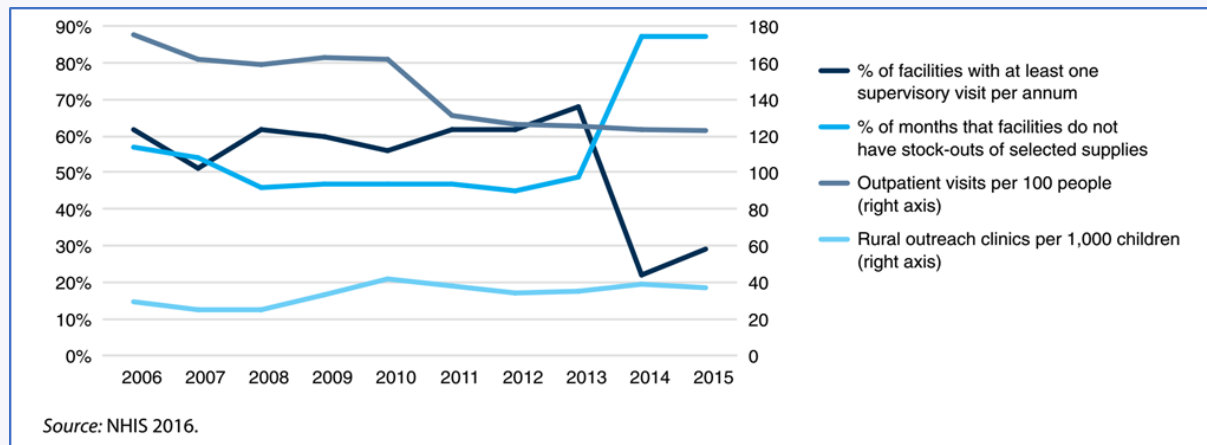
Like most low- and middle-income countries globally, PNG has a rapidly changing burden of disease and changes in the main causes of premature death and disability. These changes put additional pressure on the health system, further emphasising the need for GoPNG to make better and best use of its own existing financial and human resources in the health sector. Chart 2 below provides the latest evidence for PNG, based largely on modelling through the Global Burden of Disease studies.

Chart 2: Top 10 causes of premature death and disability in PNG, and percentage change over 10 years 2007-2017.



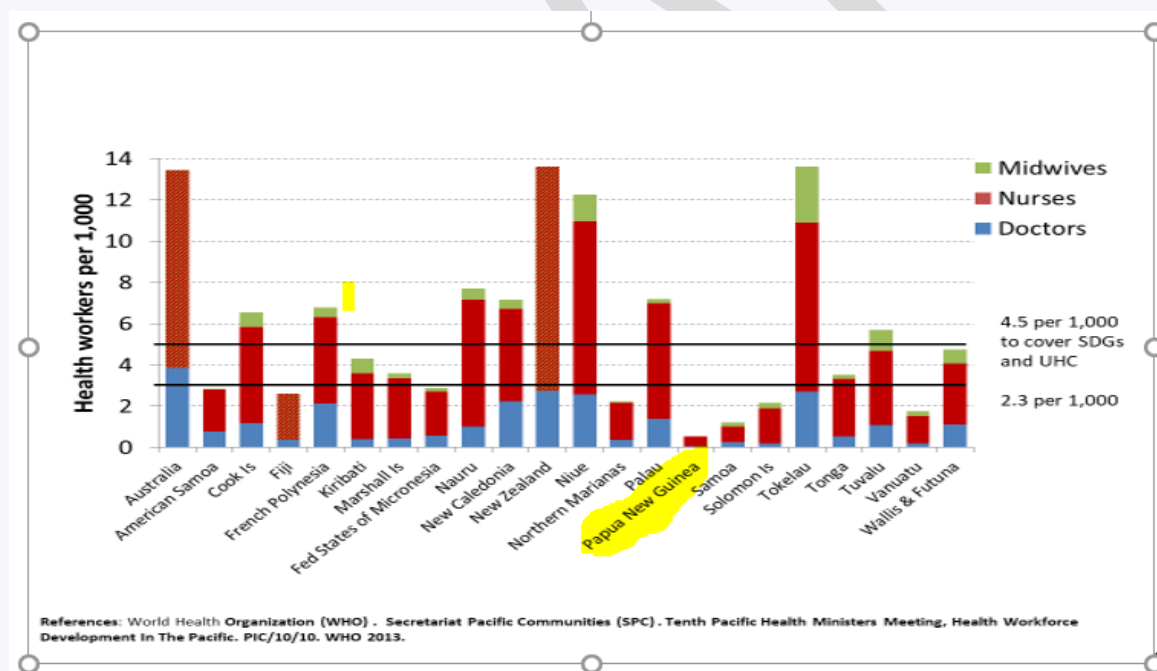
Source: Institute of Health Metrics and Evaluation (77)

Chart 3: Selected indicators of health system performance



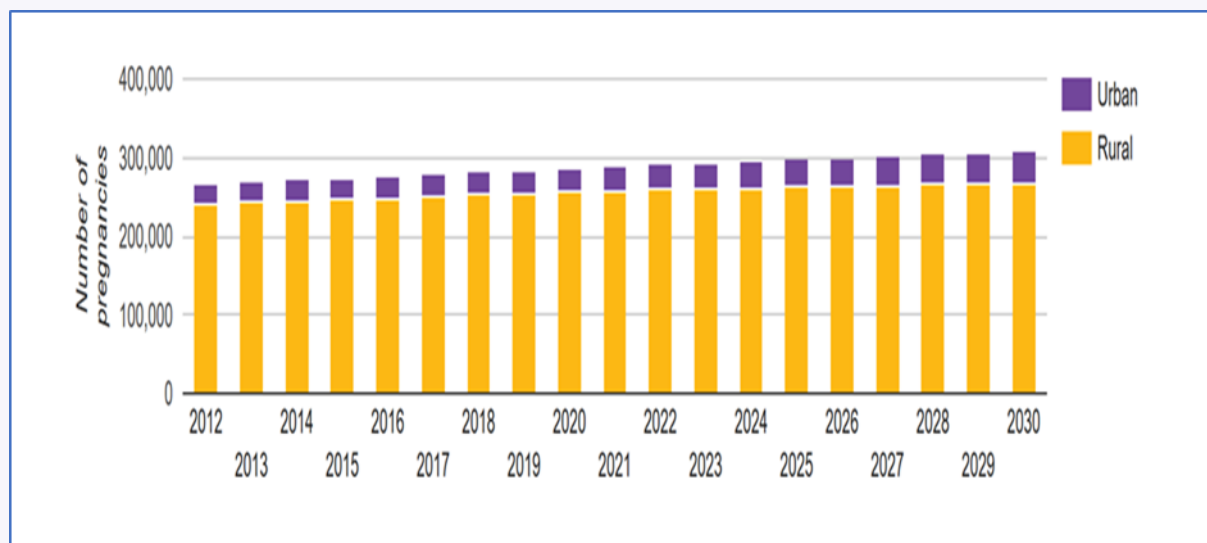
Source: World Bank (12, 13)

Chart 4: Health workforce per 1000 population is lower in PNG than other countries in the region



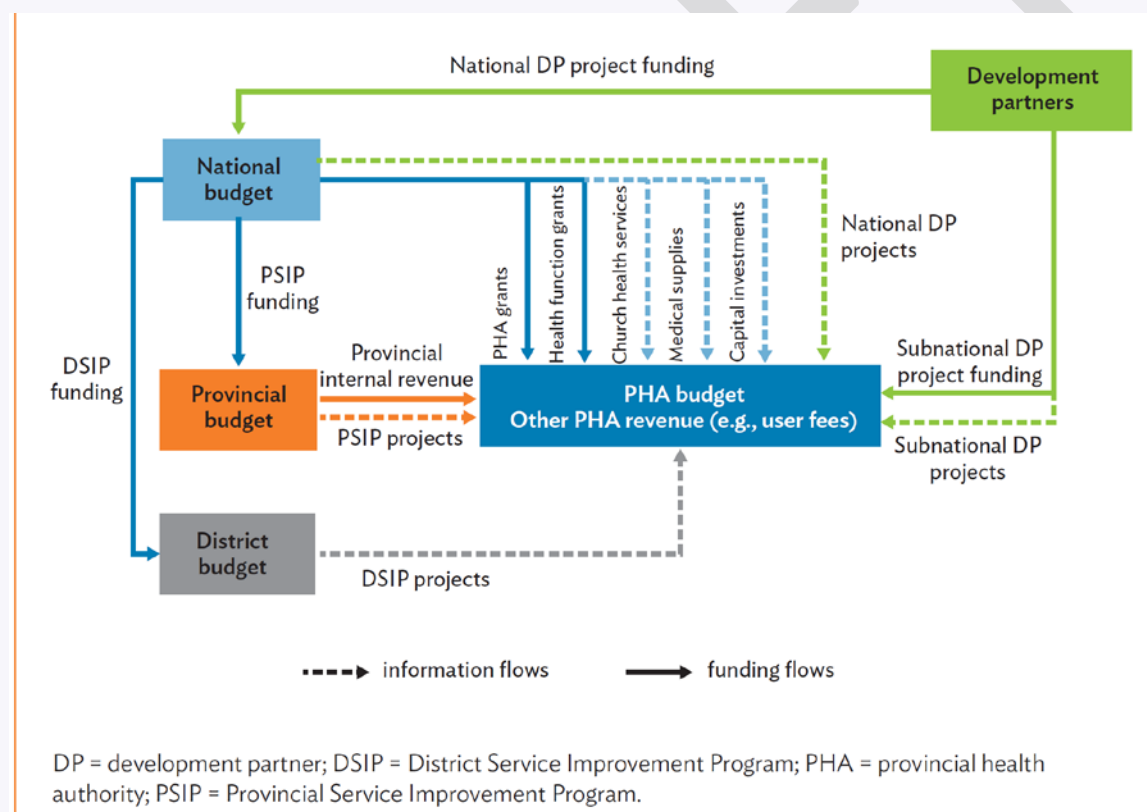
Source: UTS /WHO Collaborating Centre for Nursing, Midwifery and Health Development,

Chart 5: the importance of rural health services for maternal, new-born and child health



Source: UNFPA

Chart 6: Funding and information flows for Provincial Health Authorities.



Source: Asian Development Bank (18).

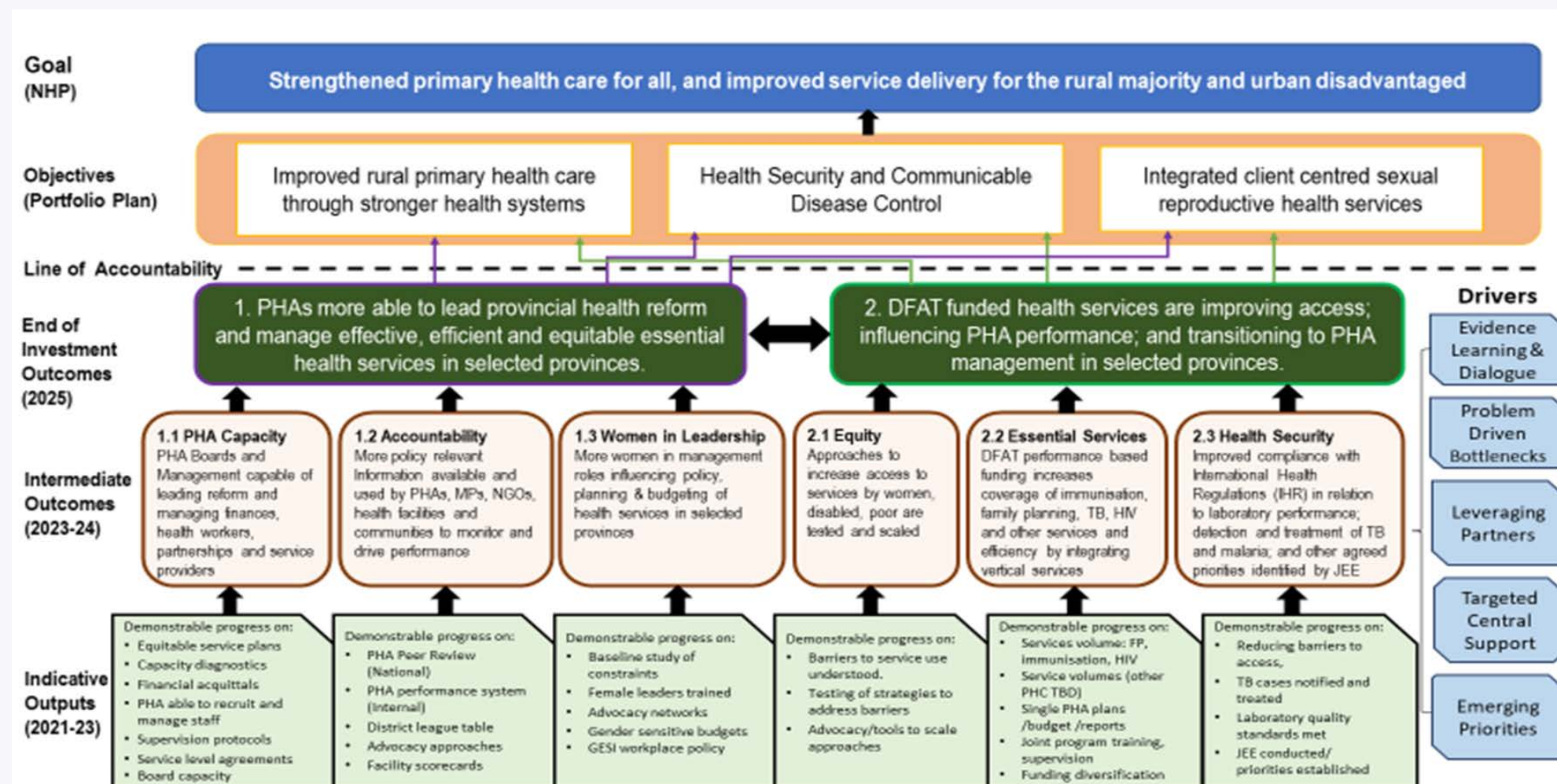
### Box 1: Key Findings from Demographic and Health Survey (DHS) 2016-18 for Papua New Guinea.

The following are some highlights from the recently released DHS survey (2016-2018):

- The overall under-5 mortality rate was 49 deaths per 1,000 live births during the 5 years immediately preceding the survey. In 2006 it was 74.7 /1000
- The infant mortality rate was 33 deaths per 1,000 live births. In 2006 it was 56.7 / 1000
- 35 percent of children aged 12-23 months have received all basic vaccinations, and 20% have received all age-appropriate vaccinations. Twenty-four percent of children in Papua New Guinea have not received any vaccinations.
- The Total Fertility Rate is 4.2 in 2016. The 2006 PNG DHS indicated that the TFR was 4.4 births per woman (National Statistical Office 2009).
- Fertility is low among adolescents age 15-19 (68 births per 1,000 women) but the proportion of teenagers who had begun childbearing rises rapidly with age, from 3% at age 15 to 27% at age 19.
- 30.5 percent of married women used a modern method of contraception in 2016. 24.3 percent did so in 2006. Sexually active unmarried women are half as likely to use a method of contraception as currently married women.
- Twenty-six percent of currently married women have an unmet need for family planning services.
- Comprehensive knowledge of HIV among 15-24-year olds<sup>1</sup> is 24% amongst women and 26% amongst men
- 59 percent of women aged 15-49 have ever experienced physical or sexual violence. The proportion of women who have experienced physical or sexual violence increases from 43% among those age 15-19 to 65% among those age 30-39 before declining to 62% among those age 40-49.

Source: National Statistics Office, GoPNG 2019

## ANNEX 2: PROGRAM LOGIC



## EOIO 1: PHAs more able to lead provincial health reforms and manage effective, efficient, and equitable essential health services in selected provinces

### Problem statement

PHAs are a key part of the PNG health system since 2007, intended to improve health outcomes, responsiveness, and accountability at Provincial levels. There is broad consensus that the PHA model for service delivery in the province is desirable and has the potential to lead to more integrated, equitable and efficient services. However, implementation of the reform has been slow. Some PHAs have not yet become operational, while those that have vary in performance, with mixed leadership and management capacity. Common – but not universal – systems issues faced by PHAs include inadequate and delayed recurrent and development funding; insufficient autonomy and flexibility to discharge their responsibilities in relation to public sector workforce; and unclear reporting and accountability relationships with other agencies and communities. Feedback and accountability between the PHA and both the Provincial Government and the NDoH is variable, as are accountability mechanisms between PHA and the communities they serve. Internal governance of PHAs is dependent on the performance of externally appointed, often private sector led PHA Boards and new leadership teams, most of which do not have adequate representation and decision-making roles for women or the socially excluded. Some PHAs have tested service provider, facility and community-based accountability approaches, however these have been limited. The relationship between PHAs and District Development Authorities and Local Level Governments (LLG) is unclear.

### Strategic Intent

The design intention of this EOIO is to improve the management performance of PHAs. Its foci are the key organisational capacities of planning, budgeting, financial management, human resources, stakeholder engagement, and service provider and facility performance management. The EOIO is designed to provide the organisational foundation within PHAs to progressively integrate the direct service delivery functions supported under EOIO 2, enabling each province to establish an effective, equitable and sustainable health system.

### Program Logic

#### Contributing to the Goal

If the core organisational systems of PHAs are effective and equitable, then PHAs will have the capacity to fulfil their role as the principal health service coordinating, financing and contracting service delivery body (EOIO). If PHAs can effectively and equitably coordinate, finance and contract/deliver health services they will contribute to a stronger rural health care system that is inclusive and has the ability to detect and respond to disease outbreaks (Objective). A stronger rural health system will in turn contribute to improved health for the rural majority and urban disadvantaged (Goal).

#### Achieving the End of Investment Outcomes

Three intermediate outcomes (IOs) will contribute to making PHAs organisationally effective and equitable:

***IO 1.1: PHA Boards & management are more capable of leading reforms and managing finances, health workers and service providers.***

This IO contributes to the EOIO through providing and enabling the core technical systems and capacities necessary for a PHA to: plan equitable services; manage funds; recruit, deploy, pay, performance manage, and terminate health workers; establish productive relationships with stakeholders (churches, NGOs, private sector, MPs, district administrations, local governments); and establish and monitor service provider performance (state and non-state).

This IO will be achieved through the following indicative outputs:

- Equitable health service plans established;
- Core PHA system and staff capacity diagnostic completed;
- Annual PHA financial acquittal completed and submitted;
- Barriers to PHAs' ability to appoint staff and manage their performance resolved;
- PHA staff competent in finance, HR, and contract management;
- PHA Board capacity increased
- Supervision protocol developed and used with monitoring of follow up actions taken;
- Partnership structures and processes established;
- Service level agreements for facilities and non-state providers established that include coverage, quality and equity improvements.

***IO 1.2: More policy relevant Information available and used by National Government, PHAs, MPs, NGOs, health facilities and communities to monitor and drive performance.***

This IO contributes to the EOIO by strengthening the evidence base for better policy and programming decisions at the provincial level. It recognises that technical capacity (IO 1.1) is necessary - but not sufficient - to improve organisational performance. This IO recognises there are multiple points where information (disaggregated by age, sex and disability) could be used to provide an incentive to drive PHA performance. For example, the National Government could assess all PHAs against a standard set of performance criteria which are published as a league table or a star rating system. Similarly, PHAs and communities can use performance information to stimulate district and facility performance.

This IO will be achieved through the following indicative outputs:

- National peer based PHA performance assessment/grading system established and operationalised;
- Internal provincial health and PHA performance assessment framework in place and used by Board and Managers;
- District and facility performance league tables established and used;
- Advocacy approaches for health service funding established and used;
- Health facility community scorecard system established and used.

***IO 1.3: More women in management roles influencing policy, planning and budgeting of health services.***

This IO contributes to the EOIO by increasing the diversity of the management teams of PHAs and other health services providers (churches, NGOs, private sector) within the province. This, in turn, will contribute to management being more effective and more likely to prioritise service delivery to women and girls and minority and marginalised groups.

This IO will be achieved through the following indicative outputs:

- Baseline study of women in leadership roles conducted, including constraints to increasing numbers;
- Potential female leaders competent in management, budgeting, financing, human resources, including gender sensitive planning and budgeting;
- All leaders and managers sensitised to diversity and unconscious bias in staff recruitment and management practices;
- Male advocacy network established in selected PHAs and promoting Gender Equality;
- Professional women's organisations and coalitions twinned with Australian bodies;
- GESI workplace policy agreed and in place in selected PHAs.

## Drivers

PATH's drivers could contribute to the achievement of this EOIO in several ways. The following are illustrative examples – the final selection should be made by the managing contractor.

- Evidence, Learning and Dialogue: PATH could identify the costs, and cost-effectiveness, of scaling up outreach programs. While unit costs for the outreach may well increase (because they involve more remote areas) it may mean that cost-effectiveness and equity increase even more (because of the burden of disease in such remote areas). Such a finding would help PHAs make more evidence-based decisions and a more rational allocation of scarce resources.
- Problem driven bottlenecks: Work to address delays in the approval of key health worker staff establishment by central departments. PATH would add value to this common and important bottleneck because it is a problem requiring agreement of multiple actors and therefore currently becomes too hard for any one agency to resolve. PATH could also identify and assess the specific barriers that women and the disabled face that prevent them from being in leadership positions. The findings and performance would then be discussed in bi-annual program governance meetings
- Partnerships/Central Support: Leveraging of large policy-based lending from ADB and WB investments to PHAs. DFAT could for example fund some applied operational research on the real-time lessons to be learned from the scaling up ADB and World Bank programs: what works, when, under what circumstances, for whom and at what cost. Such lessons could be then used by other PHAs to make more evidence-based decisions.

## Key Assumptions

- Better managed PHAs will lead to stronger health services.
- Stronger health services will improve detection and response to disease outbreaks.
- Information/evidence strategically used will exert positive influences on PHA and district performance.
- Community pressure will lead to improved service delivery performance.
- Negative male views on roles of women in management can be overcome.
- More women in leadership roles improves organisational performance and service delivery equity.
- Direct service delivery activities (under EOIO 2) will support (not undermine) PHA organisational development.

## **EOIO 2: DFAT funded health services are improving access; influencing PHA performance; and transitioning to PHA management in selected provinces**

### Problem statement

Numerous GoPNG, DFAT, and other reports have identified a wide range of complex challenges to the sustainable and equitable delivery of health services in PNG (see Sections B above). There are three specific problems where PATH can make a meaningful contribution in this area. The first is that access to health services are not as equitable or as inclusive as they should be. Women and girls, the poor, the disabled, the geographically isolated, and other marginalised groups face barriers to accessing essential care. The second problem is that health services in PNG are not as efficient as they could be partly because many large and important programs are delivered as “vertical” programs i.e. as a single disease program or type of service supported by specific training, logistics, information systems etc. These

programs are often financed by donors and delivered or managed via external delivery agents outside Government and provincial systems. Examples include family planning, HIV, TB and malaria. The third problem is the risk to PNG and neighbours of outbreaks of infectious diseases, including drug resistant strains of antibiotics and anti-retrovirals.

DFAT needs to address these issues, while at the same time transitioning more of the programs it currently funds directly across to GoPNG, including particularly PHAs, in a planned and purposeful way over time.

### Strategic Intent

The design intention of this EOIO is to increase the coverage, accessibility and sustainability of DFAT funded health services while at the same time generating evidence and learnings that can help PHAs themselves improve their own performance, thereby making them more capable of taking over current DFAT programs over time. This will be achieved through (i) understanding and addressing barriers of specific marginalised groups to accessing services and disseminating such insight in a way that is useful – and used – by key stakeholders including PHAs; (ii) direct performance-based funding to expand coverage and accessibility of some services; and (iii) progressively shifting the delivery of services into core PHA systems (covering both direct and contracted delivery). A key strategic intent of this EOIO is also to diversify the funding sources for health services away from DFAT to encompass PHAs, churches, MPs/districts, private sector, and other donors.

### Program Logic

#### Contributing to the Goal

If PHAs' core management systems and capacity are strengthened (EOIO 1), and DFAT funded health services are incentivised to reach the poor/underserved and to progressively integrate with PHA financing and delivery functions (EOIO 2), and PATH generates – and proactively disseminates – new and reliable evidence based on its own experience about what works, when, why, for whom, at what cost which influences PHA practice (Driver 1), then DFAT services will be more effective, inclusive and sustainable. If essential health services are more effective, inclusive and sustainable, then they will contribute to improved rural health care and the detection of and response to disease outbreaks (Objective). This will in turn contribute to improved health for the rural majority and urban disadvantaged (Goal).

#### Achieving the End of Investment Outcomes

Three intermediate outcomes will contribute to achieving this EOIO:

***IO 2.1: Approaches to increase access for services by women and girls, disabled and other marginalised groups including the poor are tested and scaled.***

This IO contributes to the EOIO through the assessment, testing, adapting and scaling of approaches that remove barriers to women and girls, the disabled and other marginalised groups using health services when required.

This IO will be achieved through the following indicative outputs:

- Understanding the barriers to use of health services by specific population groups (women, adolescents, disabled, poor, older people, people with HIV) in selected provinces;
- Development, testing and evaluation of strategies to address identified barriers;
- Advocacy and tools for scaling of promising approaches within PHA and other provincial health stakeholders' plans, budgets and monitoring mechanisms.

***IO 2.2: DFAT performance-based funding increases coverage of immunisation, family planning, HIV and other services and improves efficiency by integrating vertical services.***

This IO contributes to the EOIO through supplementing PHA service delivery capacity via direct financing of service providers to deliver specified essential services (HIV prevention and treatment, immunisation and family planning). Service providers will be incentivised via performance-based contracts to demonstrate good practice in providing quality services; reaching relevant marginal/hard to reach groups; and to demonstrate linkages with, and support to/from, PHAs. DFAT funding for these services will gradually decrease over the life of the program, requiring both efficiency gains and increasing levels of financial commitment from other partners

This IO will be achieved through the following indicative outputs:

- Service providers meeting agreed service volumes in family planning acceptors; immunised children; and anti-retroviral (ARV) clients;
- Service volumes for other primary health care services funded by DFAT (to be defined)
- PHA led annual service delivery plans and budgets containing GoPNG and DFAT funding;
- PHA reports reflect all services provided across the province including DFAT-funded services;
- PHA supervision visits, in-service training and outreach covering multiple programs;
- PHA has plans to diversify funding to sustain service delivery as DFAT funding declines.

***IO 2.3: Improved compliance with International Health Regulations (IHR) in relation to laboratory performance, and detection and treatment of TB and malaria, and other agreed priorities identified through the Joint External Evaluation of IHR.***

This IO contributes to the EOIO by direct financing of service providers to buttress PNG's delivery of the emergency TB response in Western province. PATH should 'nudge' DFAT's TB support towards greater PNG ownership and management but given the lack of a PHA in Western province and the emergency nature of TB in PNG, the main emphasis should be on maintaining and efficiently expanding the coverage of the TB program to other parts of Western province. This investment, along with the trilateral malaria program which will be managed under PATH, should also contribute to strengthening the capacity of PNG laboratories to test and provide results to support ongoing disease control programs (including drug sensitivity) and the surveillance and response to disease outbreaks. There may also be other health security priorities identified following the Joint External Evaluation (JEE) planned in 2020.

This IO will be achieved through the following indicative outputs:

- Service providers meeting agreed service volumes – TB cases notified; patients successfully treated;
- Barriers and enablers for equitable participation of men and women accessing TB services understood and addressed;
- Quality standards for malaria diagnosis met in provincial laboratories and selected facilities;
- JEE conducted and priorities for DFAT support established
- Targeted support for findings of Joint External Evaluation planned and delivered.

## Drivers

PATH's drivers could contribute to the achievement of this EOIO in several ways. The following are illustrative examples – the final selection should be made by the managing contractor.

- Learning and Dialogue: Assessment and testing of overcoming barriers to marginal populations' access to services. Funding diversification raised in senior level meetings.
- Bottlenecks: Conduct of in-service training/supervision/outreach requiring cross unit cooperation.

- Partnerships: Leveraging and coordination of CHS and Fleming Fund support for laboratory strengthening.
- Central Support: Central Public Health Laboratory support for provincial laboratory capacity.

#### Key Assumptions

- More efficient and equitable services will improve health outcomes.
- Efficiency and effectiveness will be increased if program functions (e.g. training, outreach) support multiple (rather than single) services.
- Demand side strategies (awareness, outreach, community support/participation) will increase use of services by women and girls and minority marginalised groups.
- Externally financed and delivered services will be progressively managed and funded by the government and other partners.
- Performance based funding will incentivise service providers to extend services to underserved and to better link with Government systems.

## ANNEX 3: PATH GOVERNANCE ARRANGEMENTS

This Annex supplements the governance arrangements and structures already set out in Section E of the IDD. The Annex identifies recommended principles for the governance arrangements of PATH; the Annual Plan as the principal vehicle for governance arrangements of PATH; a proposed “Roles and Responsibilities” table for PATH and a proposed “ways of working” mechanism.

These proposed governance arrangements will need to be reviewed and confirmed by GoPNG, DFAT and the PATH Managing Contractor (MC) in the first 3 months of PATH’s operations.

### Recommended principles for the governance arrangements of PATH

- Australia’s relationship with PNG is transitioning from a donor-recipient relationship to a partnership, based on mutual economic and strategic interests. That overarching transition flows through to the governance arrangements of PATH.
- PATH works within the Health Portfolio Plan and the governance arrangements between GoPNG and DFAT managing that overall Plan
- There should be alignment between PATH and GoPNG systems and priorities as far as possible, while recognising that PATH is formally and contractually accountable to DFAT.
- The governance arrangements should provide timely and transparent sharing of information and, where agreed, genuine shared decision making, between GoPNG and DFAT but without overburdening the staff and systems of each other’s organisations.
- Joint monitoring between GoPNG, and DFAT, of PATH activities is a particularly effective and efficient way of strengthening the knowledge base for health reform in PNG.
- There should be regular and timely exchanges of information between PATH and other bilateral and multilateral development efforts in the health sector, but again without overburdening staff and systems.
- PATH is an “adaptive program”. That means that while the goal, objectives and end of investment and intermediate outcomes are fixed, the PATH MC has the flexibility – indeed obligation – to adjust inputs, within the existing budget, in the light of changing circumstances and lessons generated from the Monitoring Evaluation and Learning (MEL) framework. The MC is encouraged to propose to DFAT, particularly via the Annual Plan process and six-monthly reviews, changes to activities and outputs in the light of changing circumstances and the MEL findings. DFAT can then endorse or suggested alternative approaches to the MC, normally through the Annual Plan process, and taking into account the views of GoPNG during the Annual Plan process and progress reviews.
- GoPNG, DFAT and PATH will agree on clearly defined roles and responsibilities in relation to the governance of the program including limits on authority and decision making within the first three months of PATH being in operation.
- GoPNG, DFAT and PATH management will each use best endeavours to facilitate PATH achieving its goals and outcomes.

### Governance Arrangements and Structures for PATH

The overall governance arrangements for PATH are set out in Figure 1.

Figure 1: Diagrammatic Overview of proposed Program Governance Arrangements for PATH

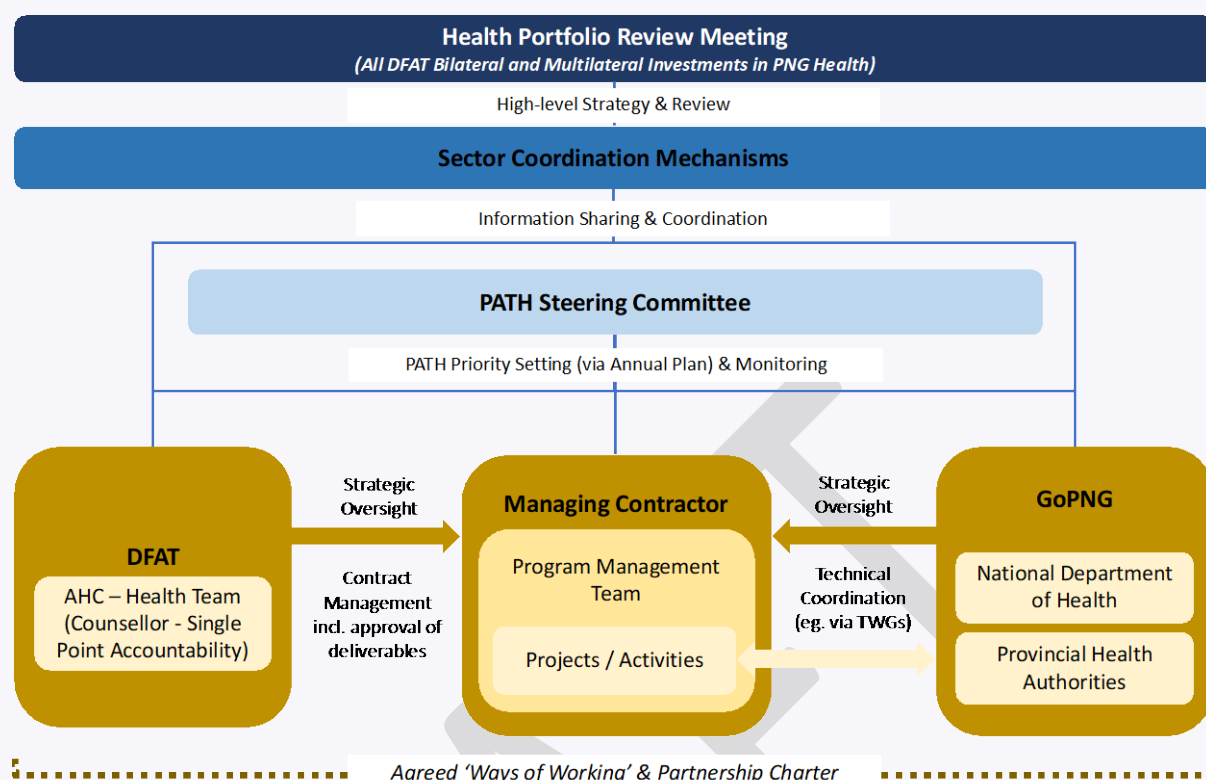


Figure 1 shows that PATH fits within the overarching, existing, governance arrangements involving DFAT and the GoPNG for the Health Portfolio Plan. This will enable DFAT and GoPNG to ensure that all of DFAT's investments in the health sector, including PATH, are well-coordinated and provide coherence across the health sector.

Figure 1 also shows that there is a specific governance mechanism for PATH: the PATH Steering Committee. It is appropriate and necessary to have a specific governance mechanism for PATH in the form of this Steering Committee for three reasons. First, PATH is the main vehicle for DFAT to provide bilateral investments in the health sector of PNG. DFAT will therefore wish to reflect the partnership principles at the core of the relationship with PNG by consulting PNG on PATH priorities, performance and future directions. Second, PATH's contribution in selected provinces directly supports the centrepiece of PNG's approach to the health sector: strengthened primary health care and improved service delivery for the rural majority and urban disadvantaged. Third, it is appropriate and necessary to have a specific governance mechanism for PATH given the financial size of PATH.

A PATH Steering Committee will be established to provide strategic guidance and decision making about priorities, budgets, and program activities of PATH activities. The Steering Committee should comprise senior representatives from DFAT, GoPNG/NDoH and the MC. DFAT and NDoH can, at their discretion, invite representatives from other development partners and / or PHAs (including service providers such as churches or NGOs) to participate in Steering Committee meetings to help understand issues.

The goal and purpose of the Steering Committee is to allow DFAT to approve the PATH Annual Plan (including proposed priorities, activities budgets and resourcing, risks and risk managements, lessons learned, program performance and reporting) after consultation with GoPNG and PATH management. Given the partnership principles between Australia and PNG it is expected that decisions will be made by mutual agreement between DFAT and GoPNG. In the (unlikely) event of no agreement being reached, DFAT's position will stand as it is accountable to the Australian Parliament for the use of Australian taxpayer funds.

The PATH Steering Committee should meet on a 6-monthly basis when PATH is in the Inception Phase, and annually thereafter. Either party – DFAT, GoPNG or the PATH MC can request an out of session meeting if there are urgent or substantive issues to discuss.

PATH activities will be included in the normal information sharing and coordination mechanisms that are constituted by GoPNG, DFAT, and other development partners. These mechanisms include the Health Sector Aid Coordination Committee (HSACC) which is chaired by the Minister for Health and HIV/AIDS. PATH can provide technical assistance and other support to help strengthen NDoH capacity for aid coordination.

DFAT and the MC will identify the frequency and nature of more routine reviews of PATH programs. These could be monthly.

For individual activities managed by PATH, coordination will be maintained through relevant GoPNG and development partner mechanisms. For example, support to the National TB Program will be coordinated through the TB Technical Working Group and the Emergency TB Response Committee. Coordination will need to be maintained at both national and sub-national levels.

## **The Annual Plan as the basis for planning, decision making, and reporting as the core business of the PATH Steering Committee**

PATH planning and reporting (See Figure 2) systems rely on Annual Plans which enable both the GoPNG and DFAT to agree on strategic priorities for PATH in the coming year and beyond; the main intended activities and outputs and how they will be tracked; the broad financing and resourcing requirements; and identification of the finance, planning and resourcing implications for GoPNG. The Annual Plan for the Program will be developed in consultation with relevant GoPNG stakeholders and other partners including multilateral agencies and will ultimately be approved by DFAT after consultation with GoPNG / NDoH. The Annual Plan should be developed within the context of a broader 5-year strategy (with a possible extension of 3 years) to guide achievement of goals and objectives over the medium term.

PATH will report on performance on a six-monthly basis to GoPNG and DFAT. This reporting will be in accordance with the agreed Annual Plan and other agreed reporting framework requirements. The report should include both discrete annual reporting requirements as well as year to date reporting for performance where appropriate based on MEL systems (see Annex 4) and the PATH 5-year strategy. PATH reporting should be developed to inform broader information needs and reporting requirements of DFAT and the GoPNG.

Planning and reporting should be undertaken at intervals and in formats that align with the GoPNG and DFAT planning and budgeting cycle, including their annual planning and budgeting deadlines and maintenance of the health sector medium-term expenditure framework.

## **PATH Roles and responsibilities**

DFAT reviews confirm the importance of having clearly defined roles and responsibilities between the MC and DFAT Posts. Potential roles and responsibilities of DFAT, GoPNG and the MC in the implementation of PATH are detailed below in Table 1. These are illustrative but serve as a basis for discussions and agreement between DFAT, GoPNG and the MC to be undertaken in the first 3 months of PATH implementation

Table 1: Roles and Responsibilities of Program Partners by Function

	General Principles and comments	GoPNG Role	DFAT Role	Contractor Role
<b>Strategy &amp; Leadership of PATH</b>	<ul style="list-style-type: none"> <li>• Roles and responsibilities to be refined &amp; agreed in first 3 months</li> <li>• 'Ways of working' to be workshopped in first 3 months</li> </ul>	<ul style="list-style-type: none"> <li>• Set overall sectoral strategies and policies</li> <li>• Consult on facility strategy and priorities</li> <li>• Lead sector coordination</li> </ul>	<ul style="list-style-type: none"> <li>• 'Policy dialogue'</li> <li>• PATH strategy setting in consultation with GoPNG (eg province selection; thematic priority setting)</li> <li>• Support sector coordination</li> </ul>	<ul style="list-style-type: none"> <li>• Inform and make recommendations to GoPNG and DFAT on PATH's strategy</li> <li>• Tactical strategy to achieve outcomes and use adaptive management to promote learning.</li> </ul>
<b>Planning &amp; Budgeting</b>	<ul style="list-style-type: none"> <li>• Joint planning and review including national and subnational stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>• Consult on annual plans and budgets (national &amp; subnational)</li> </ul>	<ul style="list-style-type: none"> <li>• Review and approve annual plans and budgets</li> </ul>	<ul style="list-style-type: none"> <li>• Prepare draft annual plans and budgets.</li> </ul>
<b>Grant Management</b>	<ul style="list-style-type: none"> <li>• Competitive, large-scale, results-focused, innovative</li> <li>• Alignment to PATH strategies</li> <li>• Coordinated transition and phasing of existing grants.</li> </ul>	<ul style="list-style-type: none"> <li>• Participate in grant design and selection</li> <li>• Joint monitoring.</li> </ul>	<ul style="list-style-type: none"> <li>• Participate in grant selection</li> <li>• Oversight and joint monitoring.</li> </ul>	<ul style="list-style-type: none"> <li>• Technical advice and support</li> <li>• Financial management/oversight</li> </ul>
<b>TA Management</b>	<ul style="list-style-type: none"> <li>• Use of different TA options including twinning etc.</li> <li>• Shared TA across provinces</li> <li>• Leveraging local expertise / institutions.</li> </ul>	<ul style="list-style-type: none"> <li>• Long term TA planning</li> <li>• Approve TOR (for high-value inputs)</li> <li>• Participate in selection</li> <li>• Joint performance management</li> </ul>	<ul style="list-style-type: none"> <li>• Approve TOR (for high-value inputs)</li> <li>• Participate in selection</li> <li>• Joint performance management</li> </ul>	<ul style="list-style-type: none"> <li>• Technical oversight &amp; leadership (including GESI, decentralisation)</li> <li>• Recruitment, orientation, performance management</li> <li>• Approve workplans.</li> </ul>

	General Principles and comments	GoPNG Role	DFAT Role	Contractor Role
<b>Monitoring Evaluation and Learning</b>	<ul style="list-style-type: none"> <li>• Both MEL of PATH itself, and broader learning and results management of operational research</li> <li>• Using shared mechanisms and government systems</li> <li>• Inform and coordinate with M&amp;E contractor.</li> </ul>	<ul style="list-style-type: none"> <li>• Set sectoral and sub-sectoral monitoring and evaluation systems (eg NHIS; PHA review)</li> <li>• Consult on PATH MEL</li> <li>• Participate in joint processes.</li> </ul>	<ul style="list-style-type: none"> <li>• Approve PATH MEL framework and deliverables.</li> <li>• Participate in joint M&amp;E processes.</li> <li>• Commission and use independent evaluations of PATH.</li> <li>• Contract and manage independent M&amp;E provider for overall DFAT health portfolio investments.</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure MEL is actively and purposefully used for program improvement and to generate evidence that can be used to strengthen policy and programs to achieve both EOIOs 1 and 2.</li> <li>• Have a clear knowledge management / knowledge brokering strategy and expertise</li> <li>• Conduct Studies to inform strategy selection and learning. (eg women in leadership)</li> <li>• Context monitoring.</li> </ul>
<b>Learning, Analysis, Communications &amp; Knowledge for policy and practice</b>	<ul style="list-style-type: none"> <li>• Identify 1<sup>st</sup> year priorities in design. (Eg equity in health using DHS)</li> <li>• Concise and 'user friendly' formats for DFAT and NDoH needs.</li> <li>• Increased focus on identify options and solutions, and support for testing.</li> <li>• Strategy testing and learning.</li> <li>• Draw on experience across health sector and across sectors and elsewhere (eg Pacific Women)</li> </ul>	<ul style="list-style-type: none"> <li>• Identify priorities and make requests for analysis and policy options and products.</li> <li>• Provide information and data for analysis.</li> <li>• Approvals where necessary.</li> <li>• Participation in joint activities.</li> </ul>	<ul style="list-style-type: none"> <li>• Identify priorities and make requests for analysis and policy options and products.</li> <li>• Facilitate cross-sectoral, cross-program, and cross-agency learning &amp; activities.</li> </ul>	<ul style="list-style-type: none"> <li>• Undertake analysis and prepare products.</li> <li>• Use findings to shape workplans and technical advice and support.</li> <li>• Partnerships and leverage other programs / orgs.</li> <li>• Take on lessons learnt from implementation of other like facilities.</li> </ul>

General Principles and comments	GoPNG Role	DFAT Role	Contractor Role
		<ul style="list-style-type: none"> <li>• Use findings to inform strategy setting and ‘policy dialogue’</li> </ul>	
<b>Contract Management and Cross-cutting</b>	<ul style="list-style-type: none"> <li>• Continue to promote GESI within GoPNG and PHAs</li> </ul>	<ul style="list-style-type: none"> <li>• Contract management including internal reviews and approvals, Contractor performance management, and Aid Quality Check preparation.</li> <li>• Promote gender equality and social inclusion and other Australian Govt priorities</li> </ul>	<ul style="list-style-type: none"> <li>• Assume responsibility, including financial responsibility, for implementation of program activities as agreed through Annual Plan.</li> <li>• Use approaches that build capacity and sustainability</li> </ul>

## PATH “Ways of working”

It is useful to complement the formal roles and responsibilities set out in Table 1 above with a statement of principles and mutual expectations about “ways of working”. A “ways of working” document can then help to set a productive “tone” to the relationship.

The following provides a suggested draft “Ways of Working” that should be reviewed, workshopped, and approved between DFAT in Port Moresby and the PATH MC within the first three months of the commencement of PATH.

PATH has a contract that sets out the legal obligations of the Managing Contractor (MC) and DFAT. PATH also has proposed governance arrangements (see above) and a proposed description of roles and responsibilities (see Table 1 above) that will need to be reviewed and agreed to in the first three months of PATH implementation.

The purpose of this “Ways of Working” annex is to facilitate a professional, constructive, and smooth relationship between MC and DFAT by specifying mutual expectations of each other. This draft “ways of working” draft sets out proposed details of ongoing day-to-day collaboration between PATH Program staff and DFAT personnel and the mutual expectations of each Party. The text in this Annex is a draft that should be used as a basis for review, discussion and agreement between MC and DFAT in the first three months of PATH implementation. This proposed “ways of working” draft has been developed on the basis of DFAT’s experience and lessons with programs of a similar nature to PATH<sup>23</sup>.

The status of this draft “Ways of Working” is that, once reviewed and agreed between MC and DFAT, it complements – but does not substitute for – the contract or the DFAT Aid Statement of Principles.

The scope of these “Ways of Working” applies to the relationship between DFAT and the PATH MC, as that is the relationship governed by the contract. However, the principles set out in this document, once approved, would apply in the vast majority of cases to the relationship between DFAT, the MC, and GoPNG and other development partners.

## Draft principles

### General

- The focus of the relationship between DFAT and PATH is at the outcome level and aimed at oversight of the progress towards achieving the end of investment outcomes.
- AHC role is primarily at strategic level of guidance, oversight, performance management and policy engagement. PATH role is primarily operational, management, implementation and delivery of activities. Both should maximise the value of their respective roles and respect each other’s. At oversight/governance meetings AHC and PATH will agree overall strategy and consider and agree the level of risk that is acceptable.
- Recognise that collaboration and coordination between AHC and PATH personnel are critical to the success of the program and in the best interests of Australia and PNG.
- Commit to ensuring the relationship is constructive, respectful, positive and mutually beneficial.
- The ‘no surprises’ principle applies to both entities. More specifically, problems that do arise in either entity will be identified early, with options presented for managing the issue. If an issue cannot be resolved in a mutually satisfactory way promptly, each party is then under a clear obligation to elevate the issue up to the next management level in each organisation so as to achieve a mutually satisfactory

<sup>23</sup> Department of Foreign Affairs and Trade. Independent Review of Facilities: Review and Management Response Canberra 2018 Canberra 2019 [Available from: <https://dfat.gov.au/about-us/publications/Pages/independent-review-of-facilities-review-and-management-response.aspx>]

solution. Problems should not be allowed to continue unresolved or not brought to management attention

- Mutually - effective working relationships rely upon clarity in expectations and processes. These should be documented to ensure all expectations are clear and agreed.
- Strong accountability measures discussed and agreed to ensure AHC trust in PATH management.
- PATH is designed as an adaptive program that involves continuous learning and feedback. The MC must therefore have strong MEL to track progress and make program corrections. At the same time, the adaptive nature of PATH means that the MC has the scope – even the obligation – to trial and pilot different approaches; to be innovative; and to take *prudent* risks.
- Each party will be transparent and open in providing feedback to each other
- Delivery of some End of Investment Outcomes will require AHC and PATH to work in close partnerships with other key partners, in particular UN agencies and the multilateral development banks. This requires clear, timely communication between AHC and PATH to present a consistent approach.
- Timely and efficient communications between AHC and PATH are essential to ensure smooth delivery and implementation – in particular for critical strategies and decision points.

#### **Policy Advice**

- DFAT has responsibility for overall strategic direction of PATH and in respect of health policy discussions with GoPNG. However, PATH puts a strong emphasis on action learning and problem solving that can then be used as a basis for policy influence. It is expected that the Contractor will have valuable expertise and insights into health policy from its interactions with GoPNG and other stakeholders. DFAT may call on this expertise in appropriate circumstances.

#### **Monitoring Evaluation and Learning (MEL)**

- Recognise that the critical role of MEL in the successful implementation of PATH given the emphasis within PATH on strengthening the evidence base for policy and program improvements, and the adaptive nature of PATH (see also “general” above)
- The MC will cooperate fully with the DFAT M&E service provider

#### **Value for Money (VFM)**

- Whilst the PATH contractor was awarded the PATH contract as representing the best Value for Money (VFM), it is DFAT’s expectation that the Contractor will, in the implementation of PATH, take decisions that represent VFM in respect of both program activities and the Contractor’s management costs. Similarly, DFAT recognises that the MC’s capacity to achieve VFM can be strengthened if DFAT continues to provide clear, timely and consistent advice, including at the time of a handover of responsibilities from a departing, to an incoming, officer.

#### **Risk**

- Risks are identified and managed proactively through appropriate risk mitigation measures.
- Both DFAT and the MC will consider piloting and testing more high risk activities where both agencies consider there are potentially significant outcomes in terms of policy and program “rewards” and benefits.
- DFAT and the MC recognise that in an adaptive program, some activities may fail and that this is part of the learning and adaptive process.

### **National Expertise**

- PATH will promote the use of PNG nationals recognising the “value-add” their skills, technical expertise, insights, experience, relationships and networks can bring to the health sector. This will also be important to build local capacity and expertise.

### **Identifying opportunities**

- Both DFAT and PATH will proactively scan the operating environment, in particular activities being undertaken by other development partners, to identify and communicate potential opportunities which PATH may exploit or leverage to contribute to the achievement of program outcomes.

### **Contract Management**

- DFAT (AHC) will appoint a Senior Responsible Officer (SRO) as the focal point for all matters related to management of the PATH contract and the Contractor will nominate a staff member as (focal point) contract manager.
- All queries and issues on the contract and its management will initially be communicated through the two nominated contract managers and this will be made clear to both DFAT and PATH staff.
- Both the SRO and the MC’s contract manager will use their best endeavours to minimise micro-management from either agency.
- DFAT will identify lead staff for each of the outcome areas who will liaise with PATH leadership on technical content.
- DFAT and the MC both expect that documents (reports, Plans, etc) submitted to each other, especially those defined in the Statement of Requirements, will be subject to quality control to minimise repeated iterations/revision by both parties and associated costs and delays.

### **Decision response times**

- Both Parties commit to responding to all communications requiring decisions, and/or requests for information in a timely manner. Where there is likely to be a delay in responding to request/making decisions each party will provide advice to the other together with an indicative time when the decision will be made or information provided.

### **Encouraging PHA partnerships**

- Both Parties recognise the need for PHAs and other health delivery organisations (e.g. churches, DDAs) to develop partnerships to enable the delivery of better coordinated, more efficient and integrated health services and to make maximum use of all health funding resources.

## ANNEX 4: MONITORING, EVALUATION AND LEARNING (MEL) APPROACHES AND ARRANGEMENTS

### Role and scope of MEL

Helping PHAs in selected provinces make better use of their own resources is a key theme running through PATH: strengthening the evidence base and adaptive learning through strong MEL is a key part of that. The PATH design makes clear that Australia cannot and should not try to do everything in the health sector of PNG. The key to improved health access and outcomes over the medium to longer term in PNG is to help PNG make better use of its own existing financial, human, and other resources in the health sector. Australia is in a good position to assist in that endeavour both through the PATH program itself acting as a catalyst for improvement and also through Australia's support in other sectors such as economic governance and Australia's work with multilateral agencies working in the health sector of PNG.

The MEL framework is specifically and intentionally designed to generate evidence and learning in a way that improves policies and programs. PATH involves a transition from a 'business as usual' approach to one that is more effective, efficient, equitable and sustainable over time. It does that by using the "drivers" to generate evidence and learning that can be captured in the MEL. Generating such evidence and learning will then be used as an important foundation for policy influence and knowledge brokering. The PATH design enables and encourages that through:

- Direct support, including through technical assistance and studies, for building evidence and learning to improve PHA management of essential health services in selected provinces, as articulated in End of Investment Outcome (EOIO) 1.
- Continuous improvement of access to and efficiency of DFAT funded health services as articulated in EOIO 2.
- Using the lessons from testing approaches and continuous improvement that occur in DFAT funded programs under EOIO 2 as the evidence base for deeper and more convincing policy dialogue and practical learning with PHAs (EOIO 1).

There are incentives within PATH to make sure evidence and learning is then actually used to improve policies and programs both within PHAs (EOIO 1) but also DFAT directly funded programs (EOIO2). The recent DFAT Office of Development Effectiveness review on policy influence notes "it is not enough to have something to offer by way of evidence or knowledge. Knowledge brokering requires a deliberate strategy for how this will be used to influence policy"<sup>24</sup>. The PATH Managing Contractor (MC) will need to develop such a strategy and link it to MEL. A key theme and innovation within PATH is that the MC is required not only to generate evidence and learning but also to develop indicators that such evidence and learning was then actually considered and used by decision-makers. This is intended to incentivise the MC to proactively think about how best to generate and present evidence and learning in ways that it gets traction.

The MEL approach also provides the basis for assessing performance of the MC and demonstrating it is delivering value for money. This will be reflected in a Performance Assessment Framework and indicators of operational efficiency, in line with DFAT requirements for facilities and flexible programs.

### Approach to monitoring and lesson-learning

Regular reviews of the Program will include analysis of data from diverse sources and reviews of progress towards intended outputs and outcomes, with structured assessment of what is working and what needs to change. It is envisaged that this type of assessment will be done by the MC at least quarterly. This is part of

<sup>24</sup> 1. Department of Foreign Affairs and Trade Office of Development Effectiveness. Policy influence: lessons from a synthesis of 2017 evaluations. Canberra 2019.

the adaptive program approach to testing what works to address particular problems, learning from experience and adapting. It is expected that the Program will present results to DFAT and NDOH as part of regular PATH reviews every 6 months.

**The approach to monitoring is to use existing national systems where possible, and work with others on joint approaches where these need to be developed or strengthened.** Examples include:

- using health and system performance data from the National Health Information System (NHIS), providing extra analysis if required e.g. for disaggregated data on service use by sex and age;
- supporting a national approach to assessing PHA and province performance, to build up a national system which is led and owned by the NDOH and uses national standards, involving other key partners such as ADB and World Bank;
- using provincial financial and HR information systems, with support if needed to ensure their effective introduction and use. This could include for example, analysis to generate data on the costs of scaling up outreach services;
- using the Joint External Evaluation (JEE) process and tool to assess progress on the health security agenda (the first JEE is planned in 2020, which would provide a baseline, and the assessment could be repeated in 2025);
- Working with partners active in the province to agree on joint M&E plans and encourage joint field visits.

**Additional monitoring of how the Program is influencing service delivery and access is proposed.** This would maintain the focus on results at the service delivery level, including to assess and verify whether activities to strengthen management and leadership and improve social accountability are getting through to services 'on the ground'. This could involve surveys in facilities and local communities and address both supply side and demand side constraints. On the supply side the surveys could assess the availability and quality of services (e.g. whether outreach patrols offer integrated services; whether appropriate treatment was provided), staff, facilities (such as clean water) and medical supplies. Demand side issues could include feedback from a range of stakeholders in the community (women, adolescent girls and boys, persons with disability) on whether services and access have improved. Detailed methods will need to be designed. For example, it could involve visiting a sample of health facilities in the selected provinces, with province and district staff, and include interviews with local communities, building on approaches used in monitoring the Rural Health Program managed by ADB (co-financed by DFAT). The approach should be coordinated with monitoring and validation by other programs including new ADB and World Bank health programs. The results will provide information for adaptation and for the evaluation of PATH.

**Thematic studies and assessments will be required for design and monitoring of some interventions.** A tool for assessing staff attitudes and culture in PHAs and key providers is required as the basis for work on women in leadership and provincial leadership more broadly. This should build on other assessment tools used in PNG for management training and consider standard approaches (such as 360° assessment). Targeted studies can be used to understand barriers to access for vulnerable populations and whether access has improved over time. Baseline studies will be required for the selected provinces, as well as reviews of evidence available and gaps requiring further analysis (see suggested list in Annex 9).

**The MEL Framework sets out proposed indicators for the objective, end of investment outcomes, intermediate outcomes and drivers of change as well as for key assumptions underlying the program logic.** It also suggests measures of inputs, value for money and performance of the MC. This framework is advisory, to be refined once the Program starts. The selected contractor will develop a detailed MEL plan in the inception phase, with targets reflecting proposed activities and outputs as well as outcomes. The Performance Assessment Framework (PAF) will also be agreed during the inception phase, using the balanced scorecard approach if this

is adopted by DFAT. If the Program includes a range of service delivery grants, there should be scope for some shared and integrated elements of MEL rather than each grant having its own MEL.

## Budget and responsibilities for MEL

The MC will require in-house MEL capacity to support the adaptive approach and regular monitoring. This requires a budget for monitoring and learning, estimated at around \$1m per year to include one MEL post, survey work in provinces, studies for design and follow up, and field monitoring visits to provinces. Additional resources required for action research, analysis and communication of findings will be budgeted for within the main budget for the Program.

## Evaluation

Independent evaluations will be conducted by the contractor for the 'Human Development M&E Services (PNG)' which DFAT is recruiting for PNG. Based on the draft service order for this function, it is expected that this contractor will plan and conduct

- a mid-term review of the PATH program;
- mid and end-term evaluations of TB investments (which will be partly under PATH);
- efficiency review of PPF and review of PPF health grants;
- mid-term and end of plan evaluations of the Health Portfolio Plan, which will presumably consider PATH's role and contribution.

This contractor will also quality assure the MEL plans developed by the MC.

The evaluations should be able to attribute impact to the Program in some areas, while in other areas they will need to focus on PATH's contribution. Draft evaluation questions identify areas for exploration. For example, if the TB program expands its reach into previously unserved areas and provides other services alongside TB detection and treatment, then the increase in numbers reached with these services can largely be attributed to the Program. Similarly, gains from work on laboratory system investments are likely to be largely attributable. In contrast, performance of management and leadership in PHAs and provincial health providers are likely to be affected by diverse factors, contextual changes and other programs alongside PATH. For these outcomes, the evaluators will need to identify how to assess PATH's contribution to performance.

The evaluations will use data and evidence collected through the MEL systems and from external sources, as well as direct interviews with stakeholders and qualitative analysis. Key questions proposed for evaluation are set out below.

## Key Evaluation Questions

1. Were grants, activities, analysis and monitoring well designed and implemented to address access for women and other disadvantaged groups, meeting DFAT standards for GESI? Were disadvantaged groups and barriers to their access to services identified appropriately? (GESI)
2. What is the specific evidence that learning, analysis, action research and evidence generation activities have been responsive to needs of DFAT and NDOH, informed policy and practice, and contributed to improving Program effectiveness during implementation? Has national capacity been developed for these roles? (Driver of Change (DOC)1)
3. Were important bottlenecks and management issues identified and tackled inclusively, based on sound analysis of context in the selected provinces? Is there evidence of impact on improving provincial health systems and women in leadership? (DOC 2)
4. Has work on aid coordination at national and provincial levels and collaboration with national departments and other partners been successful in enabling greater impact and well aligned

support? What are lessons from efforts to bring in other partners, DFAT supported programs and DFAT post staff to contribute to PATH outcomes? What is the evidence of PATH's leverage or influence on other programs that has enhanced their impact? (DOC 3&4)

5. Has PATH adapted to changing context, emerging issues and findings, while also retaining focus on the objectives and the EOIOs? Have the adaptive approach and flexible funds been used strategically or is it leading to ad hoc responses? Does DFAT feel it has the flexibility it needs to target resources and respond to events? How did the management arrangements and ways of working promote this and are there lessons for future working? (DOC 5, learning by doing/take risks/adaptive management)
6. How has the Program contributed to the capacity of PHA management and leadership in the selected provinces? Is there evidence of improving effectiveness, efficiency and equity in service delivery and access as a result? (EOIO 1)
7. Is there evidence of improving management and accountability in the provinces selected for management support? How has PATH contributed to this? How well has the Program adapted and innovated to address the constraints and complexities of different provinces? (IO 1.1, 1.2)
8. Has there been progress on increasing women's role in leadership in the selected provinces (or elsewhere)? How far did the Program (with other sources of support) contribute to this? Were there unintended outcomes from working on this? How did the Program manage its Do No Harm approach? (IO 1.3)
9. What changes in service coverage and access have been identified connected with service delivery grants and moving away from vertical programs towards more integrated PHC? How far can increases in service uptake be attributed to the Program? (EOIO 2)
10. Has there been effective learning on how to enhance access for women and other disadvantaged groups, what works and at what cost? Have successful approaches been shared and scaled up? If not, what are the constraints? (IO 2.1 access)
11. Have the service delivery grants met their objectives for expanding service access and capacity? Have performance-based approaches contributed to this and to provider and PHA incentives to work together? Has the Program demonstrated efficiency gains, for example from greater integration in service delivery and better coordination of services at provincial level? (IO 2.2)
12. How well has the support for control of TB in Western province achieved its objectives and developed capacity to manage multi drug resistant TB? How useful are other investments in health security and laboratories: do they address important gaps identified in the JEE, build on existing DFAT investments and contribute to sustainable laboratory and surveillance systems? (IO 2.3)
13. Has the mix of inputs led to efficient management and cross-Program synergies and coherence? Has PATH demonstrated value for money in delivering the Program in useful ways? (VFM)
14. Are the approaches supported by PATH likely to have sustained effects? Is enough attention being given to sustainability in terms of developing a health system that the provinces can continue to finance and manage? (sustainability)
15. How effectively has PATH influenced NDOH and provincial health systems to consider climate risks and identify ways to build resilience in their health plans, policies and operations? (CC)

#### Framework of monitoring indicators and sources

The table below provides indicators, methods and uses of information for monitoring, in the standard format for the IDD. It includes monitoring of outcomes, selected key assumptions, indicators of value for money and elements of the draft performance assessment framework for facilities. Monitoring of outputs and activities will need to be incorporated once the MC is in place and specific outputs have been identified. Indicators for

each province, with baselines and targets will need to be quantified in the inception phase and updated as part of annual planning.

Existing national indicators have been selected when possible; those used in the NDOH assessments of sector performance are marked with a \*. As a new National Health Plan (NHP) is in development, the national health sector indicators may be updated.

**NB:** The specific target for each indicator will be set by the MC in the inception phase. The target should articulate a realistic but achievable level of improvement over a baseline over the 5-year life of the program, with annual milestones which set out progress towards the target. The targets/milestones should be jointly agreed between the MC, DFAT and GoPNG and reflect each party's specific accountabilities.

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	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
Broader goal	PNG National Health Plan (NHP) objective: Strengthened primary health care for all, and improved service delivery for the rural majority and urban disadvantaged.	NHP indicators including: maternal and child mortality rates*; malaria incidence*; child malnutrition*; % of births at health facilities supervised by skilled personnel*; vaccine coverage*; % of outbreaks/urgent events assessed by NDOH within 48 hours*	Health system data collected from health services and administrations through National Health Information System (NHIS)  Sector performance annual review (SPAR)  Census in 2020	Delays in data outputs; poor data quality	NDOH runs NHIS and conducts analysis for SPAR, data from provinces & health facilities.  National Statistical Office conducts census & DHS  PATH support if needed to analyse NHIS, DHS etc by province, & by sex, age etc.	Use new NHP baselines; and Demographic and Health Survey (DHS) analysis.	NHP targets	DFAT internal strategy & policy dialogue  Provincial planning & reporting  PATH review & adjustment of program strategies
Objectives	DFAT Health Portfolio Plan (HPP) objectives: Improved rural primary health care through stronger health systems; health security and communicable disease control; and integrated, client-centred sexual & reproductive health (SRH) services.	HPP indicators including maternal & child mortality rates*; TB mortality rates; TB incidence & prevalence; coverage with essential services by province including: measles & DTP3 vaccine coverage*; couple years protection per thousand women*; % of antenatal care cases receiving STI treatment & PMTCT (all by gender & age as appropriate)	DFAT HPP: annual reviews and evaluations  National Health Information System (NHIS) collects monthly data on service use.  Studies on access for vulnerable users e.g. transgender women; adolescents.  Facility/community survey on service	Delays in data analysis at national level  Limited capacity for data analysis & QA at Province level  Time lag in getting census data to estimate coverage rates	Independent Human Development M&E Contractor  Program to commission small studies on vuln groups  Service delivery grants collect data on users  PATH to establish facility/ community data collection in selected provinces (coordinated with ADB & others)	SPAR data at baseline  DHS data on coverage by province  Facility/community service availability survey results in selected provinces	HPP targets	Policy dialogue; future plans; provincial planning; communications on results

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
		Service availability /quality indicators e.g. no., sex & skills of staff; drugs & supplies; TB treatment success rate*	availability, quality & access					
End of Investment Outcomes	1. PHAs are more able to lead provincial health reforms and manage effective, efficient and equitable essential health services in selected provinces.	<p>Province performance, incl. staffing, functioning of PHA &amp; committees, performance against National Health Service Standards</p> <p>Gender equity issues reflected in HR policies and corporate plan of PHAs (esp FSV policy and referral pathways)</p> <p>Total budget allocation per capita*</p> <p>Province health expenditure as % of estimated need*</p> <p>Average outpatient visits per person by province, gender, age*</p> <p>Outreach clinics per 1000 children under 5*</p> <p>% of issues identified during supervision resolved in x months</p>	<p>PHA performance assessment using shared review mechanism (e.g. revive/adapt peer review approach previously used for hospitals)</p> <p>PHA policies and resources for FSV etc</p> <p>Self-assessment at PHA and districts, using standard tools</p> <p>Facility/community survey on service availability, quality &amp; access</p> <p>Case studies in provinces of mgt &amp; leadership performance e.g. use of information for mgt action; follow up to</p>	<p>Other partners willingness to share review mechanisms</p> <p>PHA interest in self assessments</p>	<p>Support NDOH-led review of PHA performance, with other partners' involved, (to ensure common approach and ownership)</p> <p>Program to develop tool for PHA self-assessment with NDOH and other partners</p> <p>Provinces collect data for NHIS on services etc</p>	<p>PHA perf assessment at start, once method agreed</p> <p>Status of HR policies</p> <p>Funding levels</p> <p>NHIS data</p> <p>Baseline review of supervision</p>	<p>See note ** above. Specific target for each indicator will be set by the MC in the inception phase</p>	<p>Use performance assessment results to drive improvements within Provinces</p> <p>Share good practice in management and gender equity approaches across provinces</p>

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
			supervision findings					
	2. DFAT funded health services are improving access; influencing PHA performance; and transitioning to PHA management in selected provinces	<p>No. of FP services; people treated for HIV/STI; children immunised (DTP3, measles); children treated for malnutrition &amp; pneumonia by sex, age &amp; disability in DFAT grant-supported provinces</p> <p>Number of services delivered to disabled, adolescents, key populations, etc</p> <p>FSV referrals to &amp; from SRH services</p> <p>Evidence of coordination &amp; integration in service delivery in provinces</p>	<p>NHIS data by age &amp; gender by province.</p> <p>Provincial reports on integrated activities and services with lessons learnt.</p> <p>PPF grant recipients report on services delivered and use by disabled &amp; target groups</p> <p>Service level agreements analysed by type of provider (church, other private, public) and scope of services</p>	<p>As above</p> <p>Disability not in routine data</p> <p>Vuln groups not readily identified</p>	<p>NHIS and grant recipients collect data on users.</p> <p>Work with NDOH to include disability as well as sex &amp; age in routine data and analyse at province &amp; national levels</p> <p>Contractor to arrange surveys on community access &amp; service availability</p>	<p>NHIS data for 2020.</p> <p>TB program baselines.</p> <p>Review of integration scope &amp; experience with provinces</p>		NDOH and other provinces learn from lessons on inclusive access and effects of integration
Intermediate outcomes	1.1 PHA Boards & management are more capable of leading reforms and managing finances, health workers, partnerships and service providers	<p>Funding of provincial health services by source; allocation by district and level (hospitals, PHC)</p> <p>% of allocated provincial level health funds that are spent*</p>	<p>Routine management systems for finances and HR</p> <p>PHA reporting to Board at least annually, including on finances, recruitment, staff turnover, systems</p>	<p>Roles of PHA versus DDAs remain unclear</p> <p>Central constraints on recruitment etc limit PHA</p>	<p>PHA financial systems with support for analysis if required</p> <p>PHA HR MIS</p> <p>Field visits to PHAs &amp; districts</p>		<p>See note ** above. Specific target for each indicator will be set by the MC in the</p>	<p>DFAT use findings to inform policy dialogue</p> <p>MC use to inform adaptive strategies, scale up effective models</p>

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
		Performance mgt of PHA staff operational % of planned nurse & midwife recruitment completed No. & % of qualified health workers in hospitals vs PHC % of health facilities that received at least one supervisory visit* Progress towards service level agreements between PHA and providers Evidence of gender budgeting in health.	for managing performance etc. PHA plans and budgets (annual). Facility/community survey on service availability, quality & access	ability to manage Available health staff & finances allocated to hospitals rather than PHC			inception phase	
	1.2 More policy relevant information is available and used by Gov't, PHAs, MPs, NGOs, health facilities and communities to monitor and drive performance	Data & performance comparisons between & within provinces are shared with managers, MPs, communities etc Evidence of use of PHA data in decision making by PHA Board and others Awareness of MPs of health performance of their district % of districts allocating DSIP funds to health	NDOH reports with rating of PHAs' performance Data on performance available in PHA, districts & health facilities PHA minutes on decisions taken Evidence on social accountability & community feedback	Availability of quality and timely data Low incentives to use data or change conditions Health competing for funds with education, infrastructure	NDOH review of PHA performance Field visits to PHAs, districts & facilities	Baseline collected at start	See note ** above	Ministers, NDOH, National Economic & Fiscal Commission & others to use data to stimulate changes in performance DFAT use findings to inform policy dialogue MC use to inform adaptive strategies, scale up effective models

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
		Lessons on social accountability shared	mechanisms shared with provinces					
	1.3. More women in management roles influencing policy, planning & budgeting of health services in selected provinces	<p>Numbers of women in management (by level and role) in public, church, NGO health sectors and on key committees.</p> <p>Male advocacy networks active in provinces.</p> <p>Evidence of progress towards GESI conducive workplace culture &amp; GESI policies being implemented</p>	<p>HR Management Info System (MIS) data on numbers by level/role.</p> <p>Qualitative study of male advocacy networks.</p> <p>Qualitative survey on barriers to women in leadership/mgt</p> <p>Self-assessments of workplace culture &amp; staff attitudes at PHA and district offices.</p>	<p>Women in mgt exposed to violence/ harassment</p> <p>HRH reforms do not stipulate at least 30% women in mgt rule (CEDAW/ DPM)</p>	Program working with interested provinces to establish approach & monitor activities and results	Baseline from HR MIS & assessments on numbers, levels, attitudes & barriers.	See note ** above	<p>DPM/PHA use in planning</p> <p>MC use to adapt program with experience as learn from implementation</p> <p>DFAT use for policy dialogue &amp; in managing other related programs</p>
	2.1 Approaches to increase access for services by women and girls, disabled and other marginalised groups including the poor are tested and scaled	<p>Analysis of barriers to access by sex, age, disability etc</p> <p>Evidence from testing effects of strategies on uptake of services by vulnerable groups</p> <p>Evidence that findings have been used to scale up or adjust services</p>	<p>Studies on access for vulnerable users e.g. transgender women; urban poor; adolescents.</p> <p>Grant recipients report on service use by target groups</p> <p>Facility/community surveys include feedback on</p>	<p>Diversity across provinces and groups may limit replication</p> <p>Willingness to address some key groups</p>	<p>MC to commission relevant studies and surveys</p> <p>Grant recipients provide data on service users and how they adapted services</p> <p>Field visits to service providers</p>	Baselines from service providers or studies	See note ** above	Use evidence to inform all relevant provinces and NGOs on effective methods, costs and what has not worked well

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
			access and barriers to use.					
	2.2 DFAT performance-based funding increases access to immunisation, HIV, Family Planning, and other services and improves efficiency by integrating vertical services.	<p>Volumes and quality of services provided</p> <p>Progress towards a 'one stop shop' for clients to access mix of services needed</p> <p>Extent grant-funded services are reflected in province annual plans, budgets &amp; reports</p> <p>% of supervision, outreach, transport, in-service training that are integrated</p>	<p>Grant recipients report on services delivered, quality indicators &amp; users</p> <p>PHA plans, budgets &amp; reports</p> <p>Engagement of grant recipients in joint planning and reporting with PHA</p> <p>Facility/community survey on availability, quality &amp; access</p>	Perf based funding incentivises direct delivery more than work with PHA	<p>Grant recipient collect data on services &amp; users</p> <p>Field visits to PHAs</p>	Baselines from service providers, in grant agreements	See note ** above & include targets in grant agreements	Use as basis for performance based support; to demonstrate results; & to identify how to improve future grants
	2.3 Improved compliance with International Health Regulations (IHR) in relation to laboratory performance; detection and treatment of TB and malaria; and other agreed	<p>TB treatment success rate in Program areas*</p> <p>TB case notification rate (DS &amp; MDR TB)*</p> <p>Trilateral Malaria project indicators (phase 2 in design)</p> <p>Outcome measures for other health security interventions e.g. no. of provinces with labs</p>	<p>TB program data.</p> <p>Trilateral project reporting</p> <p>JEE rates national lab system &amp; other IHR capacities for health security<sup>25</sup> (JEE planned in 2020, could repeat in 2025)</p>	<p>JEE delayed or not done in 2020 &amp; 2025.</p> <p>Poor coord'n with Centre for Health Security (CHS)</p>	<p>TB program &amp; implementers collect routine data</p> <p>JEE involves various external partners following initial self-assessment</p>	<p>TB plan baseline</p> <p>Trilateral Malaria project baseline</p> <p>JEE in 2020</p>	<p>TB plan targets</p> <p>Trilateral project targets</p> <p>Targets set for other health security outcomes</p>	Use to identify scope for more efficient operation within PATH & with others including WB Emergency TB Project, CHS, Fleming Fund implementation agency

<sup>25</sup> JEE is Joint External Evaluation of the international Health Regulations (IHR) which looks at multiple aspects of health security in human health and beyond. PNG is planning to conduct a JEE in early 2020. The design of work on health security under PATH will be based on priorities identified in the JEE process and roles of others. Repeat of the JEE in 2025 would provide a tool for assessing results across partners.

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
	priorities identified by Joint External Evaluation (JEE).	able to conduct at least 5 core tests to diagnose priority diseases; quality of surveillance sites	Monitoring for health security interventions to be defined (TBD).					
Drivers of change	1. Strengthened evidence base as a basis for more informed policy dialogue & practice	<p>Learning products by type, &amp; awareness of relevant audiences of products available</p> <p>Evidence of application of findings/lessons in policy &amp; practice</p> <p>Evidence of response to requests from NDOH, PHAs etc</p> <p>Evidence on benefits &amp; cost implications of integrated services, supervision etc</p>	<p>MC reports on how knowledge outputs were requested &amp; evidence of use for policy, planning, budgeting or to shape Program activities.</p> <p>Studies &amp; analysis to show effects of more integration in service delivery &amp; system functions, with cost implications.</p>	Hard to attribute changes to specific products	MC to collect & analyse information on awareness, uptake & use of evidence and learning		See note ** above	<p>Lessons fed back on best ways to select and communicate learning, analysis and synthesis of knowledge</p> <p>MC performance awards to reflect uptake of learning</p>
	2. Reduced key bottlenecks to deliver better health services using a problem driven approach	<p>Common bottlenecks identified that constrain provinces' performance e.g. slow release of funds to PHAs; low employment of graduating nurses &amp; midwives due to bottlenecks and delays in the approval &amp; funding of positions.</p> <p>Women &amp; reps of people with disability</p>	<p>Evidence of agreement between provinces and NDOH on 2 or 3 critical issues.</p> <p>Evidence that Program, working with others (within or beyond health sector), has resolved issue such as slow release of funds and / or low</p>	<p>Will and ability of others to work together on tricky issues</p> <p>Will of GoPNG to resolve issues</p> <p>Some bottlenecks not resolved</p>	<p>MC to report on selection process, how addressed and whether resolved</p> <p>Field visits to PHAs</p>	Specific baseline for each bottleneck	See note ** above	Use during implementation to adapt approach

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
		consulted on bottlenecks that reduce their access and use of essential services  Specific indicators TBD for selected bottlenecks to show issue resolved through working with relevant partners.	employment of nurses & midwives in rural areas.  Evidence that women are key members of teams identifying & resolving bottlenecks					
	3. Leveraging partnerships & improved aid coordination	Health Sector Aid Coordination Committee (HSACC) meeting regularly with appropriate attendance  TWG on gender & inclusion established under HSACC  Number & contributions of partners to province health sector by type (private sector, DP, church etc)  Joint M&E framework & joint field reviews in selected provinces	HSACC minutes  Province data on financial & service delivery partners, partnership committee minutes, service level agreements with church & NGO providers, ways of working.  Program records on engagement of other DFAT funded programs (such as Pacific Women; governance programs; ADB health programs)	Only info exchange in HSACC & TWGs, rather than real coord'n & joint working  Willingness & ability of other programs to respond	MC with NDOH review of HSACC & with PHAs of Province partnership committees  Periodic self-assessment of performance of HSACC & province committees  MC feedback on flexibility & willingness of other partners to collaborate  Field visits to PHAs	Baseline review of membership, roles, etc	See note ** above	Feedback across provinces on good practice  DFAT can use to encourage participation of other programs and agencies it funds
	4. National level enabled to	To be determined	Performance reporting of	Demands for national level support pulls	Progress review by NDOH with MC			Adapt workplan with experience as learn from implementation

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
	support provincial health systems		outcomes in specific areas	focus away from PHAs				
	5. DFAT/NDOH able to respond to emerging issues	Budget available for response  Scale and value of responses to emerging issues, relevance to program outcomes	Uncommitted budget line in annual budget.  MC's reports on agreed activities in response to emerging needs	Demand for diverse support - hard to make strategic	MC to report on agreed activities  Field visits as appropriate			DFAT to review implications of responses selected. May adjust decision process
Outputs	To be defined	TBD	Six monthly report		MC to report		See note ** above	DFAT, NDOH & MC to review progress vs plans, agree adaptation
Activities	To be defined	TBD	Six monthly report		MC to report			
Inputs	Expenditure	Expenditure against agreed annual budget  Number & value of off-budget changes in-year	MC annual plan, budget and quarterly expenditure report		MC to report	Budget	Target for variance	DFAT use in dialogue and for accountability
Key Assumptions	Provincial gov't & MPs are willing to provide necessary support for PHC	Commitments & actual expenditure on health by source  Allocation between hospital & PHC	Financial data in supported PHAs, provinces & districts; compared with other provinces	Province gov'ts reduce funding for PHC once PHA set up	Province financial data analysed (MC can support analysis)	Levels in year 1 in selected provinces	See note ** above	Use in dialogue and as context for results
	Essential drugs and supplies are available	% of months that province facilities do not have stock-outs of all selected medical supplies for more than a week in month*	NHIS for provinces & SPAR  Facility/community surveys of service availability	Lack of drugs reduces uptake of services	Province mgt information & MC reports to highlight critical gaps	NHIS data for 2020 for selected provinces	NHP targets	Use as context for assessing service delivery results & to inform policy dialogue

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
	Better managed PHAs will lead to stronger health services	Improvement in key indicators in mgt support provinces compared to others	End of project analysis using agreed PHA performance measures	Context changes & province differences mask effects of better mgt	MC to generate evidence & analysis			May be useful to indicate value of mgt strengthening
	Information/ evidence strategically used will exert positive influences on PHA and district performance	Whether learning outputs have been adopted by PHAs and districts and if not, why not	MC records where learning has/has not been taken up, analyses reasons why (e.g. whether understood incentives & what is convincing to different audiences)	PHA lack incentives or flexibility to use evidence provided	MC to plan for how to maximise use of learning & monitor whether or not it was used Field visits to PHAs	Expected uptake of learning by PHAs & districts	See note ** above	Use lessons on uptake to adapt subsequent learning approaches & communications strategies
	More women in leadership roles improves organisational performance & service equity	Evidence whether more women in mgt is contributing to equity in decisions on services	MC to consider ways to build evidence on impact of more women on mgt decisions	Women managers unable to influence key decisions	MC to build review of this into design to generate evidence			Use evidence to promote women in leadership within PNG & beyond
	Efficiency & effectiveness will be increased if program functions (e.g. training, outreach) support multiple services	Evidence on gains in efficiency & cost implications of sharing functions (e.g. joint supervision) & delivery of services (e.g. multi-purpose outreach)	Lessons learned & costs assessed of more integrated approaches, incl. how to address barriers, effects on inclusive access	May be against some interests	MC to collect and share evidence	Baseline of extent of program-specific activities in province at start	See note ** above	Use to demonstrate how / why to develop more efficient and integrated approaches, to build sustainable provincial health services
	Externally financed services will increasingly	Plans in place to replace funding from DFAT of key	Review of PHAs' health plans &	PHA unable to secure enough funds	MC to analyse province health	Extent of PHA contribution to specific	See note "" above	Use for policy dialogue with PHAs, central gov't

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
	be managed & funded by the gov't & other partners	interventions & to manage the services within the province health system	budgets by funding source	or has other priorities	plans & budgets by source of funds	services e.g. FP, immunisation		departments & other funders
	Performance based funding will incentivise service providers to extend services to under-served & link with Gov't systems	Evidence of increased access by under-served groups & links with PHA can be linked to the agreed performance criteria & funding available	Grant recipients to report on performance	Risk PBF will distort efforts or encourage misreporting	MC to monitor & evaluate response to incentives & assess extra costs of reaching target groups	Baseline for services by target group Baseline nature of links with PHA	See note ** above	Use for design of future grants  PHAs can use for assessing costs of reaching under-served groups
Value for money	Contractor identifies and takes actions to improve efficiency.	Mgt costs as % of total spend.  Examples of actions to increase efficiency.	MC's budgets, financial reports  MC to collect VFM examples	% mgt costs is a limited measure	MC's reporting on finances & narrative reports on VFM processes & results	Mgt cost as % of total each year as agreed in contract	% mgt costs at or below original budget	DFAT oversight
	Economy in program operations and management	Procurement outcomes for major purchases/ contracts.  Economy in staffing e.g. TA team shared by provinces; short term vs long term TA.	Tender evaluation reports  Staffing report  Staffing report, use of TA, local and international	Lowest cost tender may not be best value	MC's reporting demonstrates economy in approach		See note ** above	DFAT oversight
	Cost - effective strategies identified and scaled up	Evidence shared on results and costs of strategies tested.  Evidence that MEL findings have been used (by the Program & in provinces).	Learning & analysis outputs include costs as well as effects  Audiences reached with learning	Gains & costs may vary with context	MC reports & knowledge products  PHA reports on policies adopted & changes introduced		See note ** above	Learn & adapt from experience.  Share findings across provinces, allowing for context

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
			results & follow up of use					
Facility performance (for PAF)	Learning and adapting	Records of structured reviews (at least 6-monthly) on progress and how to adapt  Regular progress updates on bottlenecks  Evidence that less cost-effective approaches have been cut or amended in an efficient way.	MC team reviews and six-monthly reviews with DFAT & NDOH  Review & feedback on individual bottlenecks with partners involved		MC to organise reviews as part of adaptive management			Use for monitoring contractor performance, through an agreed Performance Assessment framework (PAF). DFAT is considering a balanced scorecard approach, which will include these and other indicators as well as other qualitative assessments, and results measures from above.
	Operations	Outputs delivered on time & within budget.  Financial reports accurate & on time.  Procurement processes ensure value & follow rules.  Equity of inclusion in recruitment & procurement (local market, women, etc).  Staff breakdown by level disaggregated by gender, disability, etc	Quarterly financial & activity reports.  MC's self-assessment reports & audits.  Staffing reports, by broad levels (e.g. leadership, technical, support staff) in MC & sub-contractors		MC & audit reports	Agreed processes in tender/contract	Perform as in contract & DFAT policies	

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
		Compliance with PSEAH & other DFAT policies <sup>26</sup>						
	Stakeholders & partnerships	Participation in & frequency of governance meetings. Examples of leverage & joint working across DFAT-supported programs, churches & private sector.	Meeting reports, with assessment of how strategic meetings are.  MC to analyse joint working, leverage & identify barriers to better leverage.		Minutes of governance meetings  MC reports on joint working & leverage	See note ** above	Show increase in leverage over time	

Abbreviations: Gov't = Government; mgt = management; coord'n = coordination; DTP3 = 3<sup>rd</sup> dose of Diphtheria, Tetanus & Pertussis vaccine. Acronyms: DS = drug susceptible; FSV = family & sexual violence; MC = managing contractor; MDR TB = multi drug resistant TB; PHC = primary health care; PMTCT = prevention of maternal to child transmission of HIV; STI = sexually transmitted infections

<sup>26</sup> DFAT Preventing Sexual Exploitation, Abuse and Harassment (PSEAH) Policy is being introduced in October 2019. Other policies include the disability inclusive strategy, child protection, gender equality and women's empowerment strategy. These are likely to be a requirement of the MC contract.

## ANNEX 5: GENDER EQUALITY AND SOCIAL INCLUSION (GESI)

### Introduction

This annex presents an overview of key gender equality and social inclusion (GESI) issues in the health sector in Papua New Guinea as they relate to the PATH design. It highlights key evidence where available and sets out illustrative actions to meet the End of Investment Outcomes. It concludes with an overview of key operational expectations of the Managing Contractor in addressing GESI internally through its own personnel and workplace arrangements.

### Situation analysis of GESI in the health sector in Papua New Guinea

#### Overview

PNG cultural and geographic diversity combine to present significant challenges to equitable and inclusive health service delivery. There are several underlying reasons for gender and social inequalities. First, remote locations and rugged geographic terrain in PNG pose challenges for service delivery, raise the costs of service delivery, and can leave the rural majority excluded from access to services. For example, 48% of births in rural areas were assisted by skilled health personnel against 88% in urban areas (1). Second, economic and budget volatility has meant the closure of rural health facilities: in 2018 (2) 26% of aid posts were recorded as closed. Volatile but recently diminishing allocation of funds and complex, fragmented, financing arrangements can lead to inequity in essential services. The PNG Sector Performance Annual Report (SPAR) highlights that one district in Enga (Wabag) recorded 61% of births occurring in health facilities, while in the neighbouring district Kandep it was only 4% (3). Similar complexities challenge simple or linear arguments linking poverty and poor health: a recent report reveals that the rate of child malnutrition, particularly stunting, is high across all wealth quintiles: 55% in the lowest wealth quintile and 36% in the highest wealth quintile' (4). Above all inequity is driven by deeply gendered socio-cultural mores which result in women's lower social, economic, educational and health status. Limited decision-making power, lower literacy and education, and limited access to resources for health and transport costs, combined with polygamy, high burdens of unpaid domestic labour (5) bride price and high rates of gender-based violence all serve to disadvantage women. These disparities underpin the need for context specific responses.

#### Maternal Health

According to the most recent available Demographic and Household Survey (2006), the maternal mortality rate was 733 per 100,000 live births, although the actual figure is subject to much debate and variation. The latest WHO estimate for PNG puts the rate at 215/100,000 live births – but with an uncertainty range of 98 to 457 (6). A 2013 synthesis of PNG survey, facility and community-based data, estimated a national maternal mortality rate of around 545/100,000 live births, equating to 1,147 deaths annually (7). Contributing to this high level of maternal mortality are: low rates of facility-based delivery at 40% (SPAR 2018); low ANC attendance of 60% of at least one visit (SPAR 2018); relatively high rates of teenage pregnancies with a birth rate of 52.7 births per 1,000 women of ages 15-19 (8) and unmet need for contraception at 27.4% (9).

#### Family Planning

The Contraceptive Prevalence Rate (CPR) based on the 2006 Demographic Health Survey was 32% among married women. Modern methods were used by 24% of couples. The usage of long-acting reversible contraception was only 0.4%. The SPAR data suggest that increases in the prevalence rates of modern contraceptive methods have been minimal although these data are likely to be outdated since there is no population data available on the prevalence rate of implants since they were introduced in 2011.

## Violence Against Women and Children

Gender-based violence (GBV) is considered to be endemic in PNG (10). Existing data suggest that 65.5 % of women in rural and urban areas are affected by domestic violence and 62 % of sexual abuse cases have involved children (10). This has economic consequences as well as presenting a serious barrier to access and delivery of services. In 2015 a study of three businesses operating in PNG showed that female staff subjected to gender-based violence lost an average of 8.3 work days a year. One of the companies estimated the cost in lost staff time as three million kina or 9 % of the total salary bill. Given that GBV is understood to affect a third of all women in PNG there is good reason to assume the same impact will be felt in the public domain (11). Gender Based Violence intersects with other issues such as HIV, TB and disability (12).

## HIV

An estimated 48,000 people in PNG are living with HIV and this number has increased by 26% between 2010-2017. The epidemic is concentrated among key populations namely women and girls who sell and exchange sex, and men of diverse sexualities. Of the total, 59 % are women of 15 years and over (16). Stigma in healthcare settings is a problem for women and girls who sell and exchange sex with up to 45% feeling they need to hide their involvement in sex exchange when accessing services (17), while 48% of men of diverse sexualities reported the same. The Integrated Bio Behavioural Survey (18) reveals HIV prevalence rates as high as 19% in some Highlands regions and ART resistance rates of up to 16% in Port Moresby and 5% in Mt Hagen representing a significant health security concern. Vertical transmission from parent to child remains stubbornly high at almost 30%.

## Sexually Transmitted Infections (STI)

Estimates of the three major STIs of chlamydia, gonorrhoea and syphilis show high and increasing rates of infection (19). Estimated incidence of chlamydia was 27,000 per 100,000 people aged between 15-49 years; of gonorrhoea 48,000 per 100,000 and infected people an increase of 27% since 2011. PNG's estimated prevalence of syphilis among pregnant women was 4.6%, significantly higher than the estimated regional prevalence of 0.24%. These data point to the need for more efforts to improve access to condoms as a preventative measure as well as early treatment.

## Tuberculosis (TB)

The incidence of TB has been estimated at 432 per 100,000 (range 352–521) with an estimated mortality rate of 40 per 100 000 (excluding HIV). Papua New Guinea currently has the second highest TB incidence in the WHO Western Pacific Region (20). A recent report from Daru (21) noted the average ratio of notified male to female TB cases in PNG from 2010 – 2015 was 1.07 (range 1.01 - 1.15) with similar rates in National Capital District (NCD). This is significantly lower than the global average in low-income countries of two male cases for every one female TB cases. The reasons for this are uncertain and warrants close examination. Evaluation of DFAT's contribution to TB prevention and control in PNG (21) is already showing positive evidence of service integration and of GESI issues. More specifically, it involves the inclusion of adolescents through the uptake and access to contraception which is offered through the counselling and education activities. The same study showed linkages between TB disclosure and experience of violence. For example: *'In National Capital District GBV is linked to the stigma of TB. Women and adolescents are mostly vulnerable to violence as they are accused of bringing the disease into the household.'*

## Disability

There has been no prevalence study on disability as yet but the WHO global estimate of 15% of the population is generally accepted (13). This suggests approximately 1,275,000 people in PNG are living with some form of disability or impairment. Some data emerging from smaller studies points to higher levels, for example a study of 690 men and women in Western Highlands and West Sepik Provinces reported 29% and 25% of women living with a disability and 30% and 12% of men respectively (14). Furthermore, the WHO estimates globally that only about 2% of persons with disability are receiving services (13).

There is very little reliable data on mental health as a disability. That is increasingly relevant in terms of public policy and international commitments given that mental health is now a specific area to be addressed and tracked as part of the Sustainable Development Goals and achieving Universal Health Coverage.

In many areas cultural and traditional norms have a great influence over lives of people with disabilities often excluding them from community life, education or employment and attaching shame to their families (15). A new Disability Authority Bill is currently awaiting endorsement and seeks to ‘break barriers that prevent Persons with Disability from enjoying equal rights to every aspect of political social economic and cultural life, and creating opportunities for their equal access to health, education and other services’. PATH should be able to use that Bill, when passed, as an entry point for analysis and investments.

Women and girls with disabilities are at greater risk from all forms of violence than are those without disabilities and disability is both a cause and consequence of gender-based violence. Consultations with representatives from various disabled persons networks in PNG highlighted the need for increased community-based rehabilitation services and the importance of meaningful participation of the disabled, for example engagement of those affected by polio as advocates in immunisation campaigns.

## What PATH can do

The PATH design specifically seeks to improve equity by increasing access for services by women, the disabled and the poor (Intermediate outcome 2.1) and thereby addressing key demand side barriers. At the same time, PATH also specifies intermediate outcome 1.3 which explicitly aims for “more women in management roles influencing policy, planning, and budgeting of health services in selected provinces”.

### Service Access

The framework below (Table 1) offers illustrative examples of how gender inequality and social exclusion constrain access to and use of health services and possible mitigation strategies that PHAs will need to implement and where PATH can be proactively supporting PHAs including through both of the End of Investment Outcomes; the Intermediate Outcomes; the Outputs and the “drivers” shown in the program logic. Table 1 shows that barriers on both the demand side and the supply side affect accessibility, affordability, availability and acceptability.

**Table 1: Gender Equality and Social Inclusion issues relating to Supply and Demand of Health Service Delivery to be delivered by PHAs and where PATH can be supportive<sup>27</sup>**

Access constraints	Supply Side	Demand Side	Illustrative mitigation strategies that PHAs can take
<b>Geographic accessibility</b>	Service location Facilities are not always designed to be physically accessible for persons with disability	Poor road network Transportation costs (esp. for women with limited access to resources) Traditional healers preferred where closer Lack of access for persons with disability (physical)	<ul style="list-style-type: none"> <li>Evidence based advocacy for improved gender and disability sensitive infrastructure with MP's/PHAs</li> <li>Enhanced outreach and mobile services</li> </ul>
<b>Availability</b>	Qualified and available human resources (retention of staff at rural areas is an issue) Opening hours Waiting time Drugs and supplies Limited Community based Rehabilitation Services Weak Family and sexual violence (FSV) referral system inter-and intra-health system for FSV	Limited information on health care services and providers Lack of confidence in health facilities Service hours conflict with other duties esp women (gardening/childcare etc) Low literacy rates (men/women)	<ul style="list-style-type: none"> <li>Improved behaviour change communications within PATH supported service delivery</li> <li>Community consultations and patient participation</li> <li>Enhanced outreach services</li> <li>Integration of referral systems/training for Family and Sexual Violence and links with Provincial Family and Sexual Violence Action committees within PHA and PATH supported services</li> </ul>

<sup>27</sup> Adapted from Thomas D, GESI annex to Vanuatu Health design and Jacobs, B., et al. 2011. Addressing access barriers to health services: an analytical framework for selecting appropriate interventions in low-income Asian countries. Health Policy and Planning 27:288–300.doi:10.1093/heapol/czr038.

Access constraints	Supply Side	Demand Side	Illustrative mitigation strategies that PHAs can take
<b>Affordability</b>	Cost of services and products even though primary health services are meant to be free. Public financing of the public health system	Even small user-fees will act as a barrier to accessing essential care, or a source of impoverishment, for poor people, including especially women and the disabled,	<ul style="list-style-type: none"> <li>• Better and more predictable financial management and release of funds in a timely manner – as is GoPNG policy - will reduce the necessity for user fees.</li> <li>• Routine gender and inclusion analysis of budget allocations</li> </ul>
<b>Acceptability appropriateness</b>	Staff attitudes towards patients e.g. unmarried mothers, sexually active adolescents, people of diverse sexualities, survivors of gender-based violence, sex workers, persons with disability etc) Lack of female doctors Security issues for female staff Relatively more men than women at rural areas Lack of transparency of prices and pricing of service	Women may need spousal approval to access service Cultural practices conflict with Public Health advice Low self-esteem and lack of assertiveness Stigma (eg; people with HIV or TB; persons with disability, transgender women health needs overlooked) Low confidence in public services; frequent stock outs; facility closures Security issues for women in transit.	<ul style="list-style-type: none"> <li>• Community conversations/Family Teams approach (Pacific Women)</li> <li>• Inservice training for staff on implications of GESI for service delivery and management</li> <li>• Focus on women in leadership</li> <li>• Evidence based advocacy for disability inclusion</li> <li>• Peer educators and advocates</li> <li>• Enhanced social accountability Feedback loops from community to services/community scorecards</li> <li>• PHA HRH planning with gender focus including gender budgeting</li> <li>• Safeguarding policy to protect female workers</li> <li>• Male advocacy networks</li> <li>• Building the evidence base on barriers to uptake for women and girls and minority populations.</li> </ul>

## Women in Leadership

Evidence supporting women in leadership programmes in general shows that gender diversity across management leads to increased creativity, productivity, innovation and improved financial performance (24,25,26).

Momentum is building internationally to focus more on supporting women in leadership positions in the health sector spearheaded by UN and WHO 'Women leaders in global health initiative' (27). The evidence base in low and middle-income countries in the sector is generally underdeveloped. However, randomized trials from India, Afghanistan and Bangladesh have shown that women in leadership positions in governmental organizations implement different policies than men and that these policies are more supportive of women and children (28,29). Analysis of research in three countries (Cambodia, Kenya and Zimbabwe) showed that 'while health systems depend on women as providers of health care, they rarely lead within the systems they contribute so much to. Where they do lead, they often utilise different styles and set different priorities that are arguably more responsive to health needs of the full spectrum of people women, men, girls, boys and people of other genders'(30).

In PNG several studies have confirmed the global evidence: women account for 38% of all public sector employees (n=96,986), with representation primarily in the service professions (31). In total, women represent 61.6% of the total health workforce but they are poorly represented at the provincial level in management positions. According to one study (32) 'only 24% of administrative positions are held by women. The number of women rapidly diminishes with seniority, such that women occupy 18% of all senior management appointments and 7% of all executive appointments. Women fare poorly at the provincial level ... with very few occupying critical decision-making positions. They currently hold no executive level appointments, only 6% of senior management and 10% of middle management appointments in provincial administrations'.

A recent review of women's participation in the PNG economy, which focused on the public sector (33) summarised the key barriers which women face to achieving greater participation in the public service. These include limited opportunities for higher education, scholarships, and professional development; discriminatory practices in recruitment, employment and remuneration; sexual harassment and bullying in the workplace,

including inadequate policies and guidelines for reporting and response; gender-based violence in the home and community; safety and security concerns in public spaces including transportation to and from work; high unpaid labour and carer responsibilities to balance with formal employment; and jealousy and suspicion from both male partners and the wives and girlfriends of male colleagues. Sharp et al. (34) found that some women choose to leave secure public sector jobs to pursue informal business activities as a viable alternative to formal employment because they experienced discrimination, felt marginalised and were undervalued.

PATH specifies women in leadership as a specific intermediate outcome under EOIO 1 'PHAs are more able to effectively, efficiently and equitably manage essential health services in selected provinces' for the following reasons:

- to support the implementation of GoPNG and DFAT policies which both have requirements for increasing the role of women in leadership and decision making (35,36)
- to localise and build on the evidence base on the impact of women in leadership in the sector which is beginning to show positive co-relations between women in leadership and improved health outcomes; and
- to contribute to the global movement towards enhancing women's leadership roles in the sector through 'institutionalizing women's leadership, addressing gender biases and inequities in the health labour market, and tackling gender concerns in health reform processes' (37).

'Considering that the health sector employs a large proportion of women, women still have fewer opportunities than their male counterparts to occupy leadership positions within the health sector (National Department of Health, 2013b). There is a need to create a conducive environment that tolerates women and encourages and supports them to apply for other types of health professions and management positions. In the HR Policy (Government of Papua New Guinea, 2013b), Strategy 3.2.8.1 details "The health sector will promote gender equality principles in all aspects of work, including training, recruitment, selection, placement, promotion and professional development in consistence with the Gender Equity and Social Inclusion Policy and Health Sector Gender Policy." Within the context of implementing this Policy, a monitoring framework for gender equity has been included in the HR Policy 2013, namely: number of policies reviewed to facilitate gender equality; and issues of gender equality are addressed in all Human Resource policies. However, it falls short of actually measuring changes in the %age of women in leadership and management positions.'

WHO Health in Transition in PNG. 2018 (35)

Research shows it is critical to tailor context specific approaches to the particular socio-cultural context within which the various Women in Leadership programmes operate (e.g. matrilineal provinces may offer different perspectives and opportunities than patrilineal) and to acknowledge the fact that women are not a homogenous group. As noted in recent research: *'Generally, there is an assumption that the interests of women are uniform...although [in reality] the differences such as ethnicity, language, culture and tradition override their roles as women* (38). In focusing on women in leadership in the health sector it is important to ensure that their diverse realities are taken into account whether it be age, sexuality, marital status, tribal affiliation, ability, educational, economic health status etc (39).

The Managing Contractor of PATH will need to develop a specific strategy for achieving intermediate outcome 1.3. The Program logic has an illustrative list of outputs which would demonstrate progress in achieving that outcome.

### Disability

Discussions with representatives of the PNG Assembly of Disabled Persons undertaken as part of the PATH design highlighted that *'There is a lack of engagement of people with disability and lack of understanding of their health needs'* and *'there is little understanding of how disability connects with health'*. One respondent noted that the health sector focuses largely on clinical and medical services and facility-based responses concluding *'we are looking at birth and deaths but not the life in between'*. PATH can respond to these issues

through enhanced advocacy for disability inclusive services under intermediate outcome “1.2 Accountability”. In so doing it will also contribute to the implementation of the imminent PNG Disability Bill. Furthermore, under Intermediate Outcome “1.3 Women in Leadership”, PATH can make deliberate efforts to partner with the emerging Women with Disability Network.

On the demand side and under Intermediate Outcomes 2.1 Equity and 2.3 Health Security, PATH can contribute to the evidence base on disability and health through discrete studies, focusing on disability and perceptions of disability as a barrier to accessing health services. In light of the findings disability inclusive strategies can be designed to overcome these barriers.

PATH will also include the requirement for direct funded service delivery partners to demonstrate both strategies for effectively reaching people with disability with services, and setting and meeting targets for delivering services to people with disability. As part of its advocacy and capacity building support for PHAs, PATH will also work to encourage PHAs to set out similar requirements in its service delivery service level agreements.

#### **GESI Evidence Base**

There is limited collection and analysis of sex and age disaggregated data and the National Health Plan notes that ‘more health information broken down by sex is essentially needed (22). As for social exclusion data, standard measurements of equity are not systematically captured (23), disability data is scant and data on GBV is not yet part of the NHIS. PATH can play an important catalytic role in advocating for and contributing to the GESI evidence base as well as supporting Central and Provincial partners in GESI analysis. More accurate and timely GESI data can help shape policy and programs.

#### **OECD compliance.**

PATH is ranked as GE Significant (marked 1) under the OECD DAC markers, meaning that gender equality is an important and deliberate objective, but not the principal reason for undertaking the project/programme. There is one explicit gender equality outcome, (Women in Leadership) backed by gender-specific indicators. Gender equality and disability are also incorporated across the M&E framework across both of the End Of Investment Outcomes and throughout the program logic.

The program complies with the minimum standards set by OECD: i) Gender analysis has informed the design as is evident in this IDD as well as this Annex. Gender and social inclusion analysis is also specified as a requirement of the managing contractor as a start-up activity across the two EOIOs and in selected provinces. A Do No Harm approach is specified in the MEL framework and risks assumptions and mitigation strategies have been included.

Sex disaggregated data is provided in the design where possible and have been included as mandatory for all data collection activities under PATH. There is explicit instruction for MC to monitor and report on the gender equality and social inclusion results achieved by the project in the evaluation phase.

#### **Integration of GESI into the management by the Managing Contractor (MC)**

The MC will need to develop a specific GESI policy early in the life of PATH that provide the best means of achieving the End of Investment Outcomes, the Intermediate Outcomes and the suggested outputs as set out in the PATH program logic. This will require GESI expertise with the PATH MC team and access to additional GESI expertise where necessary throughout the programme lifetime. The personnel policies within the PATH MC team should exhibit “best practice” and model GESI principles including equality of opportunity and parity of positions and pay across MC personnel.

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## ANNEX 6 WHAT WILL BE DIFFERENT IN PATH?

**HHISP commenced operations in 2012: much has changed in PNG and DFAT since then, so PATH will be different from HHISP.** Whoever manages PATH it will be important to build on the successes and accomplishments of HHISP; PPF; previous DFAT investments in the health sector including for example the Capacity Building Service Centre; accomplishments by other development partners; and accomplishments by DFAT and partners in other sectors including economic governance and public sector management. Indeed, that is inevitable to an extent as many of the current investments and support provided by HHISP and PPF continue to be high priorities for both GoPNG and DFAT itself. However, changed circumstances and priorities in PNG and Australia since HHISP began operations in 2012 means that PATH will have new features.

**There is a sharper focus on three health outcomes.** The DFAT Health Portfolio Plan was developed and approved after HHISP commenced. The Portfolio Plan gives an overarching direction to all of DFAT's investments in the health sector of PNG, of which PATH is part. This has implications for what PATH does, and what it does not do.

**There is an unambiguous focus on provinces, and within that a sharper focus on selected Provinces.** As noted already around 80% of the population live outside urban areas and that is where essential health services are delivered (or not). The roll out of PHAs is increasing and PHAs clearly have an increasing role in overall planning and managing services but have limited capacity to do so, particularly in the context of decentralisation reforms. In contrast to previous PNG health designs that aimed to support the whole sector through NDOH, PATH identifies provincial health functions and services as its central focus – with the central level playing a necessary but supporting role. It is envisaged that around 80% of the PATH budget will be allocated and spent on support for provincial level activities and efforts, particularly through PHAs. While this is not dramatically different from current allocations, there will be more focus on achieving outcomes in selected provinces (with some support provided for all provinces).

**The balance between systems and service delivery: the importance of “reform”.** Despite the need, the history to date suggests PATH should not focus just on “health systems strengthening” where “results” are hard to see or explain. On the other hand, nor should it do only direct service delivery, bypassing and potentially hollowing-out what GoPNG and PHAs should themselves do. The wording of the EOIOs therefore captures that balance between direct service delivery via grants on a substantial scale and Provincial health systems being reformed in selected Provinces.

**A clearer, stronger, more integrated outcome focus, including for Gender Equality and Social Inclusion (GESI), including persons with disability.** Despite a wealth of good work and outputs by individual programs and people, it is hard to see the overall “results” or coherent narrative of the investments to date. PATH therefore has a stronger and more unified outcomes focus. PATH specifically seeks to not only expand services for women (including adolescent girls) and the disabled but also aims to increase the participation of women and the disabled in decision-making. GESI can get lost if “mainstreamed”. The design response is to therefore have specific gender equality and social inclusion *outcomes and indicators* to be pursued and prioritised by the MC, the achievement of which will then help to determine if the MC receives its performance payment.

**The role of “drivers of change” within the design, especially the underlying theme of analysis, learning, communications and knowledge management.** There is a particular need for operational learning which helps translate the proliferation of often quite well thought-through strategies into actual programs. Generating and disseminating evidence and knowledge at the time, and in the way, that people want to receive it, including the GoPNG planning and budget cycles and systems, will require astute “knowledge management” by the MC.

**The importance of Monitoring, Evaluation and Learning (MEL).** MEL is particularly important because PATH will have flexibility and therefore needs to be accountable for focused “results”. The MEL needs to provide feedback and learn from experience in timely ways that allow PATH to adapt activities and strategies, as well as providing a basis for assessing the MC's performance. There should be more field visit monitoring, evaluation and learning, and a budget line for MEL.

## ANNEX 7 BREAKDOWN OF PATH COSTS BY END OF INVESTMENT OUTCOME AND FORM OF COSTS

All figures are in current Australian dollars.

		Personnel	Adviser Support	Grants	Procurement	Operational	Total
		Costs	Costs			Costs	
<b>EOIO 1</b>	<b>PHA Management</b>						
IO 1.1	Management Systems	9,800,000	4,200,000		400,000	5,600,000	20,000,000
IO 1.2	Accountability	1,750,000	750,000	4,250,000		750,000	7,500,000
IO 1.3	Women in Leadership	2,100,000	900,000	2,500,000		1,000,000	6,500,000
<b>EOIO 2</b>	<b>Service coverage and transition</b>						
IO 2.1/2.2	Equity and Performance Funding			62,000,000			62,000,000
IO2.3	Health Security	3,500,000	1,500,000	45,000,000	2,500,000	7,500,000	60,000,000
<b>Drivers</b>							
Driver 1	Learning, Analysis and Dialogue	1,400,000	600,000	2,000,000		1,000,000	5,000,000
Driver 2	Problem Driven Bottlenecks	2,450,000	1,050,000			1,000,000	4,500,000
Driver 3	Leverage and Partnerships	1,400,000	600,000			500,000	2,500,000
Driver 4	Targetted Central Support	3,500,000	1,500,000	2,000,000		500,000	7,500,000
Driver 5	Emerging Priorities			2,500,000			2,500,000
<b>M&amp;E</b>		1,400,000	600,000	2,000,000		1,000,000	5,000,000
<b>Totals</b>		<b>27,300,000</b>	<b>11,700,000</b>	<b>122,250,000</b>	<b>2,900,000</b>	<b>18,850,000</b>	<b>183,000,000</b>
<b>%</b>		<b>14.92%</b>	<b>6.39%</b>	<b>66.80%</b>	<b>1.58%</b>	<b>10.30%</b>	<b>100.00%</b>

### Notes

The costs shown are indicative. The Contractor will be responsible for deciding the modality(s) (TA, Contracts, etc) through the Annual Planning process.

The (Contract) Pricing Schedule will include flexibility for the Contractor to move funds between individual budget lines with DFAT approval

Personnel Costs include remuneration and allowances of Long term and Short Term Advisers (both ARF and Non ARF) as well as the costs of other (non ARF) personnel e.g. Locally Engaged Staff

Adviser Support are the costs as defined in DFAT's Adviser Remuneration Framework (ARF) for example, housing costs, per diems, international travel, etc)

Operational Costs are the costs associated with the implementation of program activities (e.g, vehicle running costs and maintenance, provincial office rental is required, workshops, training)

### Assumptions

Significant Operational costs as TA will be deployed in selected provinces either long term or based in Port Moresby with frequent travel to provinces

Adviser Support Costs estimated at ca 30% of TA costs

Level of Performance Grants (PPF ) grants (existing and new) is an estimate

TA costs to maintain Performance based grants scheme included in Program Management Costs

No Major procurement envisaged apart from vehicles for Advisers that will undertake work in provinces and contracts with organisations to undertake research and M&E baseline surveys.

		Base Yr Exp <sup>1</sup>	Year 1	Year 2	Year 3	Year 4	Year 5	Total	
<b>END OF INVESTMENT/INTERMEDIATE OUTCOMES</b>									
<b>EOIO 1</b>	<b>PHA Leadership and Management</b>	-							
IO 1.1	<b>Systems</b>	-							
	Personnel/Adviser Support Costs <sup>2</sup>	2,000,000	2,800,000	2,800,000	2,800,000	2,800,000	2,800,000	14,000,000	
	Grants <sup>3</sup>	4,500,000							
	Procurement <sup>4</sup>		150,000	100,000	50,000	50,000	50,000	400,000	
	Operational Costs <sup>5</sup>	600,000	1,000,000	1,200,000	1,200,000	1,200,000	1,000,000	5,600,000	
	<b>sub-total</b>	<b>7,100,000</b>	<b>3,950,000</b>	<b>4,100,000</b>	<b>4,050,000</b>	<b>4,050,000</b>	<b>3,850,000</b>	<b>20,000,000</b>	<b>11%</b>
IO 1.2	<b>Accountability</b>								
	Personnel/Adviser Support Costs		500,000	500,000	500,000	500,000	500,000	2,500,000	
	Grants		850,000	850,000	850,000	850,000	850,000	4,250,000	
	Procurement								
	Operational Costs		150,000	150,000	150,000	150,000	150,000	750,000	
	<b>sub-total</b>	<b>0</b>	<b>1,500,000</b>	<b>1,500,000</b>	<b>1,500,000</b>	<b>1,500,000</b>	<b>1,500,000</b>	<b>7,500,000</b>	<b>4%</b>
IO 1.3	<b>Women in Leadership</b>								
	Personnel/Adviser Support Costs		600,000	600,000	600,000	600,000	600,000	3,000,000	
	Grants		500,000	500,000	500,000	500,000	500,000	2,500,000	
	Procurement								
	Operational Costs		200,000	200,000	200,000	200,000	200,000	1,000,000	
	<b>sub-total</b>	<b>0</b>	<b>1,300,000</b>	<b>1,300,000</b>	<b>1,300,000</b>	<b>1,300,000</b>	<b>1,300,000</b>	<b>6,500,000</b>	<b>4%</b>
<b>EOIO 2</b>	<b>Service coverage and transition</b>								
IO 2.1/2.2	<b>Equity and Performance Funding</b>								
	Personnel/Adviser Support Costs								

		Base Yr Exp <sup>1</sup>	Year 1	Year 2	Year 3	Year 4	Year 5	Total	
	Grants - PPF HIV <sup>6</sup>	4,500,000	4,000,000	4,000,000	3,000,000	3,000,000	3,000,000	17,000,000	
	Grants - PPF FP <sup>6</sup>	8,000,000	7,000,000	7,000,000	6,000,000	6,000,000	6,000,000	32,000,000	
	Grants - PPF Immunisation <sup>6</sup>	3,500,000	3,500,000	3,500,000	2,000,000	2,000,000	2,000,000	13,000,000	
	Procurement								
	Operational Costs								
	sub-total	16,000,000	14,500,000	14,500,000	11,000,000	11,000,000	11,000,000	62,000,000	34%
IO 2.3	<b>Health Security</b>								
	Personnel/Adviser Support Costs <sup>7</sup>	400,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	5,000,000	
	Grants - TB NCD <sup>8</sup>	5,000,000							
	Grants - TB Daru/Western Province <sup>9</sup>	10,000,000	9,000,000	9,000,000	9,000,000	9,000,000	9,000,000	45,000,000	
	Procurement <sup>10</sup>		500,000	500,000	500,000	500,000	500,000	2,500,000	
	Operational Costs <sup>11</sup>	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	7,500,000	
	sub-total	16,900,000	12,000,000	12,000,000	12,000,000	12,000,000	12,000,000	60,000,000	33%
<b>Change Drivers</b>									
1	<b>Learning, Analysis and Dialogue</b>								
	Personnel/Adviser Support Costs		400,000	400,000	400,000	400,000	400,000	2,000,000	
	Grants		400,000	400,000	400,000	400,000	400,000	2,000,000	
	Procurement								
	Operational Costs <sup>12</sup>	450,000	200,000	200,000	200,000	200,000	200,000	1,000,000	
	sub-total	450,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	5,000,000	3%
2	<b>Problem Driven Bottlenecks</b>								
	Personnel/Adviser Support Costs		700,000	700,000	700,000	700,000	700,000	3,500,000	

		Base Yr Exp <sup>1</sup>	Year 1	Year 2	Year 3	Year 4	Year 5	Total	
	Grants								
	Procurement								
	Operational Costs		200,000	200,000	200,000	200,000	200,000	1,000,000	
	sub-total	0	900,000	900,000	900,000	900,000	900,000	4,500,000	2%
3	<b><u>Leverage and Partnerships</u></b>								
	Personnel/Adviser Support Cost <sup>13</sup>	400,000	400,000	400,000	400,000	400,000	400,000	2,000,000	
	Grants								
	Procurement								
	Operational Costs		100,000	100,000	100,000	100,000	100,000	500,000	
	sub-total	0	500,000	500,000	500,000	500,000	500,000	2,500,000	1%
4	<b><u>Targeted Central Support</u></b>								
	Personnel/Adviser Support Costs <sup>14</sup>	2,500,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	5,000,000	
	Grants <sup>14</sup>	1,040,000	400,000	400,000	400,000	400,000	400,000	2,000,000	
	Procurement								
	Operational Costs <sup>14</sup>	140,000	100,000	100,000	100,000	100,000	100,000	500,000	
	sub-total	3,680,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	7,500,000	4%
5	<b><u>Emerging Priorities</u></b>								
	Personnel/Adviser Support Costs								
	Grants <sup>15</sup>	800,000	500,000	500,000	500,000	500,000	500,000	2,500,000	
	Procurement <sup>15</sup>	1,000,000							
	Operational Costs <sup>15</sup>	100,000							
	sub-total	1,900,000	500,000	500,000	500,000	500,000	500,000	2,500,000	1%
<b>MONITORING</b>									

		Base Yr Exp <sup>1</sup>	Year 1	Year 2	Year 3	Year 4	Year 5	Total	
	Personnel/Adviser Support Costs		400,000	400,000	400,000	400,000	400,000	2,000,000	
	Grants		400,000	400,000	400,000	400,000	400,000	2,000,000	
	Procurement								
	Operational Costs		200,000	200,000	200,000	200,000	200,000	1,000,000	
	sub-total	0	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	5,000,000	3%
	<b>PROGRAM TOTAL</b>	<b>46,030,000</b>	<b>38,650,000</b>	<b>38,800,000</b>	<b>35,250,000</b>	<b>35,250,000</b>	<b>35,050,000</b>	<b>183,000,000</b>	

### Assumptions

- <sup>1</sup> Base Exp = Annual Average Expenditure in 1-2 years preceding start of PATH from HHSIP and PPF.
- <sup>2</sup> Base year exp advisers/local staff in Western, Morobe, Bougainville and Hela Provinces. PATH assume TA will continue and be more intensive.
- <sup>3</sup> Base year exp grant to Oil Search for PHA strengthening. PATH assumes funds will be reallocated to TA and operational expenses to strengthen PHAs.
- <sup>4</sup> Procurement in support of provincial advisers (transport, office etc).
- <sup>5</sup> Operational funds for local organisational and service improvement activities.
- <sup>6</sup> Current PPF Service Delivery Grants. PATH assumes these will continue but funding gradually decreased and alternative funding sought.
- <sup>7</sup> Base year exp is for CPHL LTA. PATH assumes this will continue and be supplemented with additional laboratory strengthening TA.
- <sup>8</sup> Base year exp is for TB support to NCD. PATH assumes this funding will not continue as World Bank will take over TB support for NCD.
- <sup>9</sup> Base year exp is for TB support to Daru. PATH assumes this will continue but at lower level due to efficiencies and expand to Western Province.
- <sup>10</sup> Procurement in support of laboratory strengthening.
- <sup>11</sup> Base year exp is for Trilateral Malaria Project. PATH assumes this will continue at the same level.
- <sup>12</sup> Base year exp is for reviews and public diplomacy. PATH assumes these kinds of activities will continue at slightly lower levels.
- <sup>13</sup> Base year exp is for LTA in aid coordination. PATH assumes TA will continue.
- <sup>14</sup> Base year exp is for variety of LTA (legal, audit, Exec support, Med Supplies) and grants (Nursing Council/UPNG). PATH continues funding at lower rate.
- <sup>15</sup> Base year exp is for variety of grants (POM general, YWAM and snakebite) and infrastructure. PATH continues funding at lower rate.

## ANNEX 8: LESSONS FROM PAST EXPERIENCE

The following lessons from previous Australian and other donor support to the PNG health sector. The bulk of these lessons are drawn from DFAT's analysis in preparing the Health Portfolio Plan. Some lessons have been updated in the light of designing PATH

**There are good global models of supporting national leadership without investing Australian aid money into weak public financial management systems.**

There have been previous attempts at a Sector Wide Approach in PNG, which whilst leveraging some improvements, have failed to achieve broad-scale policy, financing and coordination reforms. Currently the GoPNG finance and planning systems did not meet donor requirements for budget support. A key lesson to be learnt is that there are models from other countries of supporting national leadership, national plans and results frameworks that do not require using national financial management systems that GoPNG and Australia can learn from and adapt. These models include, for example include alignment of donor funding with Government systems via sector coordination and information sharing.

Investing in strengthening rural primary health care requires a politically astute and engaged approach, not a standard programmatic approach to health service delivery. Decentralisation is a critical factor for local governance and leadership of health services, financing health care, and planning and managing health services and the health workforce. The Government of PNG has identified the roll out of Provincial Health Authorities as a key priority. The newly appointed Minister for Health and HIV / AIDS, the Hon Elias Kapavore, says PHAs are “a major reform agenda to address the health system fragmentation” and that “all PHAs will be declared by the end of June 2019”.<sup>29</sup> This approach has the potential to better coordinate the budgeting and expenditure of decentralised resources.

**Focusing on a few selected provinces can provide lessons “at scale” that can then be adapted and adopted by other provinces. DFAT, and the PATH design, focus investments in a selected number of provinces.** This concentration of effort and investment, supported by the strong monitoring evaluation and learning (MEL) approach taken by PATH, has the potential to showcase examples and proof of concept of interventions that can be adopted by other provinces. Within the investments provinces, strengthening rural primary health care will need to coordinate closely with relevant governance programmes and engage directly in the decentralisation process. Unblocking these obstacles is crucial to making progress on rural primary health care but cannot be managed as a regular contracted out health project. DFAT's approach will be to work with government in the selected provinces at all levels, national, provincial and district, to use evidence and best practice to support NDoH and broader government streamline to achieve health outcomes.

**Policy engagement requires a clear objective, a recognition of fragmented political context, acceptance that the process will likely not be linear, or simply amenable to purely technical solutions, and needs the flexibility to respond swiftly to often-fleeting windows of political opportunity.** DFAT has considerable experience of working with PNG on policy related issues. Experience suggests that within PNG the political context is often fragmented, highly transactional rather than policy based, that decentralised power is high and very important, personal relationships are vital, and there is often a relative ineffectiveness of formal institutions. The lesson to be learned is that an effective policy approach must be rooted in a realistic analysis of the political economy around health and government delivery of services. To operate effectively in PNG, there needs to be clear objectives and a clear framework for monitoring progress and then ensuring there are strong incentives and accountabilities to make sure monitoring lessons then influence policy and

<sup>29</sup> Hon Elias Kapavore MP, Minister for Health and HIV / AIDS, [The National](#) 14 June 2019 page 55.

programs. The MEL framework in PATH does that. Another lesson from PNG – and other programs in other countries – is that while it is important to have strategic focus it is also important to retain flexibility within that strategic framework to respond to often fleeting windows of political opportunity. A linear, project style approach will often run into unexpected blockages, while a more dynamic, “adaptive” approach – with DFAT oversight and agreement in consultation with GoPNG - can take advantage of a favourable context when that exists.

**Addressing gender issues is important and requires better approaches. PNG has particular challenges with respect to improving gender equality and social inclusiveness (GESI):** see [Annex 4](#) for details. Past programs in PNG or in other countries by DFAT or other development partners have had only mixed success. GESI programs can be so “mainstreamed” that they become diluted and lose visibility and traction. Or GESI programs can be made a separate standalone project component and become disconnected / marginalised from the main program. GoPNG has some good policies on gender, but they are not getting traction. PATH therefore has a specific approach to GESI involving reducing bottlenecks and barriers that women and the disabled face on both the demand side of health care (accessing services etc) and the supply side of health care (women in leadership and decision making roles).

**Investing in expanding coverage of critical interventions requires working with non-state as well as state health care providers – but sustainability needs to be carefully planned and monitored.** Many of the most effective services with promise for scalability are delivered at local level by non-State actors – especially the churches - and the private sector, not government. The implication of this for DFAT investments is that support to scaling up coverage of critical health interventions, especially for maternal and child health and family planning, should work with both state and non-state actors and ensure both are linked appropriately at district and provincial level within subnational public health plans.

**Future technical assistance and long-term advisers to NDOH and other agencies will have clearer objectives agreed with NDOH to monitor and demonstrate impact.** The provision of technical assistance (advisors) to the NDOH and other agencies within the health sector has had mixed impact. Some individual advisers have achieved significant results in building capacity of individuals, proposing policy and system changes, and affecting policy reform when working closely with the PNG system. However, sustainable results have been limited. Technical assistance needs to be better targeted and more emphasis needs to be given to building capacity of counterparts rather than capacity substitution. An appropriate balance between short- and long-term advisers need to be struck. Support also needs to be provided to help advisers understand, negotiate and capitalise on the political economy context.

**Managers of investments should be accountable to show that they have learned from past projects. Investments should focus explicitly on addressing the specific bottlenecks that are hindering progress.** Australia, and other development partners have achieved positive results in specific initiatives that improve service delivery for women and children, but these have largely been isolated, short term, and not sustainable when funding ceases. Monitoring and evaluation in PNG and elsewhere have sometimes tended to be compliance focused rather than a means of generating evidence and learning that can influence policies and improve program performance. The PATH “drivers” and the PATH framework for MEL specifically incentivises key stakeholders to proactively – and demonstrably – learn lessons.

**Program implementation is challenging and requires experienced and senior project leadership and management. The DFAT overall health program in PNG is complex with currently many projects.** DFAT is developing a clear transition plan including the leadership, policy engagement and relationship management capability required to deliver. It will be vital for the DFAT health team to provide leadership and effective management to narrow the focus around clear outcomes, manage effective relationships with partners to be accountable and to deliver. The DFAT team will develop clear annual workplans to manage the transition envisaged within this plan, including the leadership, policy engagement and relationship management skills required to deliver.

## ANNEX 9 PROPOSED PROGRAM OUTPUTS IN THE FIRST 12 MONTHS

Activities	Specific Outputs (as per Draft Statement of Requirements)
<b>Mobilisation (0-3 Months)</b>	
<ul style="list-style-type: none"> <li>MC office established and program management, administrative and support staff recruited</li> <li>MC's corporate systems operational</li> <li>Successful handover of HHISP assets to MC</li> <li>DFAT (AHC) Transition Plan is operational</li> <li>DFAT MC introductions to relevant Stakeholders (NDOH) selected PHAs.</li> <li>Existing TB and Malaria Activities novated/transferred to MC</li> <li>Development of Eligibility Criteria for "Emerging Issues" fund</li> <li>Confirmation from DFAT/GoPNG on priority provinces for PATH</li> <li>Risk Management workshop</li> </ul>	<ul style="list-style-type: none"> <li>MC Inception Plan</li> <li>Program Operations Manual</li> <li>Risk Management Plan</li> <li>"Ways of Working" Workshop and document agreed between DFAT and MC</li> <li>"Roles and responsibilities" document agreed between DFAT, MC and NDOH</li> <li>Preventing Sexual Exploitation, Abuse and Harassment (PSEAH) Policy and procedures</li> <li>Program Delivery Strategy, reflecting MC approach to achieving the EOIO, IO and drivers.</li> </ul>
<b>3-6 Months</b>	
<ul style="list-style-type: none"> <li>Meetings between DFAT, NDOH and selected PHAs for 2021 Annual Plan discussions</li> <li>MC Delivery Strategy outlining approach and resourcing to achieve EOIO, IOs and Program drivers</li> </ul>	<ul style="list-style-type: none"> <li>Draft Annual Plan (2021)</li> <li>Workplace Health and Safety Plan</li> <li>Communications Strategy</li> <li>MEL Plan including revised program logic</li> <li>Gender Equity and Social Inclusion Plan</li> <li>Child Protection Assessment and Management Plan</li> </ul>

<ul style="list-style-type: none"> <li>accepted and recruitment of technical assistance commenced</li> <li>Review of Policy Dialogue matrix and strategies</li> <li></li> </ul>	<ul style="list-style-type: none"> <li>6 Monthly Progress reporting commences</li> </ul>
<b>6-12 Months</b>	
<ul style="list-style-type: none"> <li>6 monthly consultations on Annual Plan Review</li> <li>Initial consultations on 2022 Annual Plan 2022</li> <li>DFAT contracted M&amp;E provider undertaken analysis of MC's MEL plan</li> <li>DFAT and MC discussions with PNG Partnerships Fund contractor re novating of PPF agreements and handover of materials<sup>30</sup></li> </ul>	<ul style="list-style-type: none"> <li>Initial discussions on Annual Plan 2022</li> <li>PATH MC develops Guidelines for new PPF scheme</li> </ul>

<sup>30</sup> The actual timing of the novation of agreements, including TB, Malaria and PPF agreements is indicative at this stage and depends on a number of factors including the timing of redesigns for the Malaria and TB activities and the extension of the PPF agreement.

Indicative Program Activities (6-12 Months) <sup>31</sup>	
IO 1.1: Management Systems	<p>A stocktake/baseline for each selected province in terms of:</p> <ul style="list-style-type: none"> <li>• Recent and expected funding by source;</li> <li>• Financial and service delivery plans</li> <li>• Health workforce by gender/management positions</li> <li>• The range of providers active in the province and how far they are reflected in province health plans and budgets; and</li> <li>• Functioning of key coordination and management mechanisms including partnership committees.</li> </ul>
IO 1.2: Accountability	<ul style="list-style-type: none"> <li>• Initial assessment/baseline of selected PHA's performance</li> <li>• Examine selected PHAs Performance Framework and its implementation.</li> </ul>
IO 1.3: Women in Leadership	<ul style="list-style-type: none"> <li>• Initial audit/baseline of number and levels of women staff in key departments and boards: this will include church health services and possibly private sector</li> <li>• Mapping of leadership training/programmes available to the provincial health system by government (including Precinct) and major partners well as active alumni networks in the provinces or regions</li> </ul>
IO 2.1 Equity	<ul style="list-style-type: none"> <li>• Assessment of barriers/constraints to health services commenced</li> </ul>
IO 2.2 Performance Funding	<ul style="list-style-type: none"> <li>• PPF agreements transferred/novated to, and managed by, MC.</li> <li>• Development of Performance based Grant Scheme for Service delivery based on PPF model</li> </ul>
IO 2.3 Health Security	<ul style="list-style-type: none"> <li>• (Redesigned) TB program transferred/Novated and managed by MC</li> <li>• (Redesigned) Trilateral Malaria Project successfully transferred/Novated to, and managed by, MC</li> </ul>
Drivers	
Evidence, Learning and Dialogue	<ul style="list-style-type: none"> <li>• MC has mobilised resources including technical assistance to operationalise the Driver and an initial "agenda" of key research/policy topics for analysis identified in 2021 Annual Plan or as (later) addition to the Plan.</li> </ul>

<sup>31</sup> Program activities would be discussed in Annual Plan consultations with key stakeholders including PHAs and agreed through the Annual Plan process

<b>Problem Based Bottlenecks</b>	<ul style="list-style-type: none"> <li>MC has mobilised resources including technical assistance, as agreed through the Annual Plan, to operationalise the Driver and initial work on identifying and assessing priority bottlenecks (agreed through Annual Plan).</li> </ul>
<b>Leveraging Partners</b>	<ul style="list-style-type: none"> <li>MC has mobilised resources including technical assistance to operationalise aid coordination and establish relationships with key partners</li> </ul>
<b>Targeted Central Support</b>	<ul style="list-style-type: none"> <li>MC has mobilised resources including technical assistance to operationalise the Driver as agreed through Annual Plan.</li> <li>Relationships/networks with NDOH, other PNG agencies (e.g. DNP, DPM, Treasury, Finance) and other relevant DFAT programs (e.g. PGF) established</li> </ul>
<b>Emerging Priorities</b>	<ul style="list-style-type: none"> <li>Criteria for use of Emerging Priorities funding developed by MC and agreed by DFAT.</li> <li>Funding allocation for responding to Emerging Priorities included in (Interim) Annual Plan for 2021</li> </ul>

## ANNEX 10: SUMMARY OF DFAT INVESTMENTS IN THE PNG HEALTH SECTOR

### PORTFOLIO PLAN: PNG HEALTH SECTOR PROGRAM 1 JULY 2018 – 2023 CURRENT INVESTMENTS (\$217.8 MILLION)

	DFAT-WHO PNG Bilateral Relationship	UNICEF - EENC	World Bank TB Project	World Bank PASA	World Bank IMPACT Health	Health Services Sector Development Program
Multilateral	\$17.5 million	\$2.9 million	\$20 million	\$0.0 million (2018-2020)	\$1 million (2018-2026)	\$50 million
	2018-2022	2018- 2021	2018 -2022	2018-2020	2020-2026	2018-2023
	<p>Convers multiple areas, including:</p> <ul style="list-style-type: none"> <li>• Safer Pregnancy and voluntary family planning.</li> <li>• Health Security</li> <li>• Systems Strengthening</li> </ul>	<p>Through the One UN agreement includes:</p> <ul style="list-style-type: none"> <li>• Scale up the delivery of early essential newborn care in PNG.</li> <li>• Integrates maternal and neonatal care at the facility level and improve maternal and neonatal survival rates.</li> </ul>	<p>Part of WB Multi Donor Trust Fund.</p> <ul style="list-style-type: none"> <li>• \$8million co-financing – to be paid through MTDf and managed directly by WB</li> <li>• \$12million parallel financing – flexible and managed by DFAT</li> </ul>	<p><b>Part of WB Multi Donor Trust Fund</b></p> <p>This program of work is to support improvements in prioritisation, planning and accountability for service delivery in the PNG health sector, through technical assistance and analytical work. DFAT's contribution is administered through the World Bank (WB) Pacific Facility 4 Trust and Multi Donor Trust Fund resources earmarked to improve frontline service delivery, and ultimately health outcomes.</p>	<p>IMPACT Health, a proposed US\$30 million operation (IDA-18), will support the Government of Papua New Guinea and specifically the National Department of Health and selected Provincial Health Authorities, with strengthening the delivery of frontline health services in selected provinces. DFAT funds support the Project Preparation Grant – AUD 1.02m). Future co-financing to be considered.</p>	<p>Through the ADB covering:</p> <ul style="list-style-type: none"> <li>• National framework &amp; public financial management - technical assistance and M&amp;E (\$0.5 million)</li> <li>• Subnational health system management – organizational &amp; professional development (\$10 million)</li> <li>• Health service delivery – construction of health centers &amp; CHPs (\$21.5 million)</li> <li>• Flexible maintenance fund for refurbishments of health facilities (\$1 million)</li> <li>• Management costs (\$1 million)</li> </ul>

## Bilateral

Health & HIV Implementation Services Provider (HHISP)
<b>\$55.5million</b>
<b>2018-2020</b>
Flexible facility mechanism funded at \$30.5 million (Sept 2018-Sept 19) and \$25 million (Sept 2019-Sept 2020). Funding consists of a range of grants, programs, technical assistance, minor procurement and management fees.
Grant funding consists of: <ul style="list-style-type: none"> <li>\$16.9million in 2018/19, including \$4.5m to Burnet, \$3.7m to World Vision (Western Province TB support), and \$1.8m to World Vision, \$1.8m to FHI360, \$1m for Childfund (NCD TB Grants), plus a range of smaller grants.</li> <li>\$12.2m in 2019/20 including anticipated \$3.3m World Vision and \$2.6m to Burnet for Western Province TB support, plus a range of smaller grants.</li> </ul>
Other programs and TA are: <ul style="list-style-type: none"> <li>Trilateral Malaria Project (\$5.5m 2016-2019)</li> <li>TB Program Delivery &amp; Support (Grant &amp; TA)</li> <li>EPI In-line Support (HR)</li> <li>PHC Delivery &amp; Support (TA and grant)</li> <li>Legislation &amp; Policy Frameworks (TA)</li> <li>Medical Supply Distribution (TA)</li> <li>Laboratory Services (TA)</li> <li>Financial Management &amp; Control (TA)</li> <li>Regulation of nurse workforce (TA)</li> <li>National Department of Health (TA)</li> <li>Provincial support: Morobe, AROB, Western (TA)</li> <li>Targeted hospital support (TA)</li> <li>University of PNG (Grant and TA)</li> </ul>

PNG Partnership Fund (PPF)
<b>\$54.2 million</b>
<b>2018-2020</b>
Competitive grants program currently funding: <ul style="list-style-type: none"> <li>Catholic Health Services (\$13.8m)</li> <li>Marie Stopes (\$23m)</li> <li>Oilsearch Foundation (\$7.4m)</li> <li>Routine Immunisation Support (\$10m to 2021)</li> </ul>

Scholarships (Short Course)
<b>\$2.7 million</b>
<b>2018-2019</b>
<ul style="list-style-type: none"> <li>Graduate Certificate in Health Economics</li> <li>Certificate in Family and Child Health</li> <li>Support provincial health planning and coordination – including financial planning and management</li> </ul>

Clinical Support Program
<b>\$6 million</b>
<b>2018-2021</b>
<ul style="list-style-type: none"> <li>Managed and coordinated by the Royal Australasian College of Surgeons.</li> <li>Focus on professional development and upskilling at ANGAU Hospital, Port Moresby General Hospital and UPNG's School of Medicine and Health Sciences through short term deployment of Australasian health specialists.</li> </ul>

Health Program M&E Services Provider
<b>\$8 million</b>
<b>2019-2023</b>
HDMESP will provide high-quality advice and independent monitoring and evaluation services at the investment and whole-of-program level to the Health, and Education and Leadership programs in PNG. It will support the health program with 6 key functions: <ul style="list-style-type: none"> <li>Advise and verify baselines and M&amp;E frameworks of investments</li> <li>Conduct annual reporting on Portfolio Program progress</li> <li>Produce high quality, tailored communications products based on analysis</li> <li>Quality assure analyses and reports produced by DFAT, and by partners</li> <li>Conduct independent evaluations of DFAT investments</li> <li>Ad hoc M&amp;E support to PNG Government partners.</li> </ul>

## ANNEX 11: PATH APPROACHES TO SOCIO-POLITICAL COMPLEXITY IN PNG

This Annex outlines how the PATH design has considered the particular social and political context in PNG. In particular, it describes in more detail the recommended approaches and delivery modalities for PATH which go beyond traditional technical assistance and that respond to the aid and development challenges arising from the particular PNG context. This Annex draws on emerging insights into PNG governance and development (1, 3, 5, 7, 8, 10, 21) and effective aid and development practice including in relation to thinking and working politically (2, 4, 6, 9, 17, 18, 20, 22); coalition building and policy engagement (16, 18); and complexity science (12, 15).

This Annex does not offer a blueprint of what needs to be done in this domain. Rather it outlines the rationale for why different aid approaches are required for certain aspects of the PNG health context, and based on international experience, provides a menu of the type of approaches available and examples of how they could be applied within PATH.

It should be noted the final decision on if or how these various approaches are applied will be made by the Managing Contractor (MC) in consultation with DFAT and the GoPNG. Moreover, this Annex does not argue that these approaches are the only ones to be used in PATH. It is envisaged the MC will need to identify and implement a range of modalities that are best suited to the particular development problem to be addressed within PATH.

### Background

The PNG health sector has made some important progress but it is also clear that over the past two decades (at least) has not demonstrated significant and sustained positive change. There have been 'spurts' of progress (largely through vertical funded/delivered programs) but this progress has not been sustained and has not translated into broad based system performance. (Refer IDD Section B – Situational Analysis) This lack of progress has occurred notwithstanding significant external and domestic funding for health and periods of relative political stability and health sector improvement efforts. Historically health sector improvement efforts in PNG have tended to focus predominantly on the supply side changes of the health sector with a particular functional orientation on issues structures, skills, formal systems and functions, and services. (5) (Even then, disruptions and unpredictability of drug supplies and essential commodities such as condoms have undermined provision of essential health services). Whilst these supply side initiatives are important, there has been less attention on how informal institutions and systems (e.g kinship, political leaders, traditional beliefs, private/informal providers) shape and influence change. In terms of aid, there have been some use of more politically or contextually attuned approaches, but these have not been applied in a systematic fashion. (3)

In addition PNG often has had many good policies and insightful evaluations. Furthermore, politicians, bureaucrats and development partners often have a good sense of *what* needs to be done: the challenge is knowing *how* to implement good policies and reforms in affordable, technically feasible, politically acceptable, cost-effective, and institutionally sustainable ways. This "policy to implementation gap" is a well-recognised challenge in most developing countries (Thomas and Grindle) and has been central to the experience of health sector reform in PNG. PATH's focus on addressing specific problem-driven bottlenecks, and proactively strengthening the evidence base for policy and programs, seeks to reduce the policy to implementation gap.

### The importance of program sensitivity to the PNG social and political context

PNG is characterised by historical, geographic and cultural diversity. Despite periods of relative stability in recent times, there has been significant periods of shifting alliances and political instability. (8) Society is

shaped by ‘wantokism’<sup>32</sup> and a ‘big man culture’ that lead to a particular Papua New Guinean form of clientelism. (8) Formal institutions have limited ability to overcome these social and cultural patterns. (7) Indeed, the formal institutions are intertwined with social and cultural mores in many different ways. (7 and IDD Section B).

The health sector in PNG is framed and constrained by this interplay of formal and informal institutions. Denoon, writing 30 years ago foreshadowed:

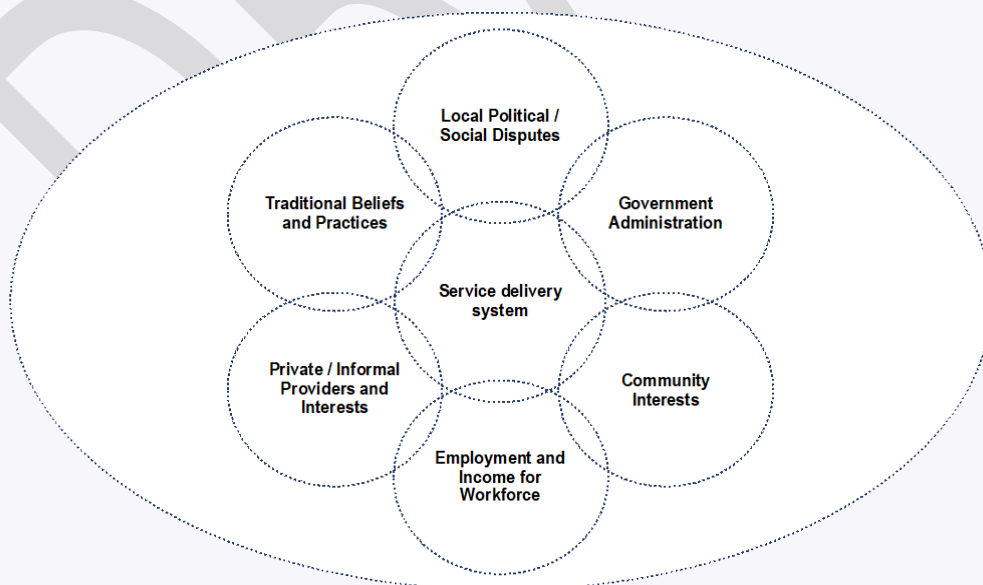
Of all the countries on earth, Papua New Guinea has the most vigorous tradition of parochial debate and local responsibility. If public health education could be harnessed to that parochial tradition, the effect would be powerfully therapeutic.... Without the creative impact of an organised public opinion, even the impressive services which the country now enjoys, must decline into a series of ritualised functions, whose original purpose recedes in the memory, which satisfies only the therapists, and which might even become (as in earlier days) the object of suspicion and superstition.<sup>33</sup>

Writing 30 years later, the ADB describes some of the negative outcomes foreseen by Denoon:

The health sector in PNG contends with a range of contextual factors—systemic, geodemographic, and unforeseen/external—that can individually and collectively inhibit the delivery of quality services. These factors can act as a disabler to the genuine ambitions of the health sector in promoting better population health outcomes. A critical systemic factor in PNG is the complex regulatory and governance architecture both within the health domain (i.e., the health system organization and legal framework) and others that are situated in the wider government domain (i.e., the country’s decentralization framework). A multitude of actors and service delivery arrangements add complexity, with incoherent reform initiatives risking to open further entry points for fragility.<sup>34</sup>

Figure 1 below illustrates this interconnectedness by describing some of the systems (formal and informal) of which the formal health sector institutions form part.

*Figure 1: Illustrative depiction of the different systems constituted by PNG health sector institutions*



<sup>32</sup> Wantok (or “one talk”) refers in essence to a preference for, and priority to, allocating resources to one’s own close ethnic, tribal, or language (“one talk”) group.

<sup>33</sup> Denoon (1989) p. 122

<sup>34</sup> ADB (2019).

These systems (with varying purposes) in aggregate determine the behaviour of health sector stakeholders and need to be considered in any endeavour to change institutional behaviour and improve health system performance. It is essential that reform efforts in PNG take account of the interconnectedness (both positive and negative) between the formal health system and these other systems of which it is part.

## Overview of approaches to development in complex settings

There are a range of emerging approaches to development intended to deal with the type of socio-political complexity facing PNG reform and development efforts.

*Table 1: Examples of approaches to development that respond to socio-political complexity*

<i>Arm's Length Aid</i> (4)	Proposes that non-government organisations, in some cases, will have space and credibility to identify and respond to certain development problems which may be difficult for donors or contractors to address. Their advantages appear to include a greater ability draw on and generate local knowledge; sufficient autonomy to be pragmatic and imaginative in responding to problems as posed on the ground; and being accountable to local actors.
<i>Development Entrepreneurship</i> (9)	The method targets reform objectives that are both technically sound (high impact, liable to be taken to scale and sustainable beyond donor funding) and politically possible (offering a reasonable prospect of being introduced). It is distinguished by five features: an approach to the choice of objectives; the use of entrepreneurial logic with a bias towards iterative 'learning by doing'; a method for selecting and working with self-motivated partners; a partnership approach for donors; and a set of programme management tools.
<i>Adaptive Programming</i> (20)	Adaptive programming suggests, at a minimum, that development actors react and respond to changes in the political and socio-economic operating environment. It emphasises learning and the development practitioner is encouraged to adjust their actions to find workable solutions to problems that they may face. It emphasises learning through doing, including intervention designs that involve multiple 'bets' and parallel and/or sequential experiential learning strategies.
<i>Coalitions for Change (CfC)</i> (18)	CfC encourages civil society, private sector, academe, and government to work together and bring about public policies that contribute to development reform priorities. It achieves its objectives through: engaging experienced local experts; evidence and analysis to inform policies; building capacity for policy dialogue; creating avenues to improve policy discourse; and generating and communicating lessons in building coalitions, thinking and working politically, and developing policy.
<i>Problem Driven Iterative Adaption</i> (2)	This approach proposes that efforts should aim to solve specific problems in a way that responds to local contexts. It encourages continuous experimentation and learning, iteratively incorporating lessons learnt into new solutions. It requires engagement of broad sets of agents to ensure that reforms are viable, legitimate, politically supportable and practically implementable.

These approaches vary however have several similar elements that are relevant for PATH, including:

- emphasis on learning and adaption in program delivery;
- recognition that complexity is inherently unpredictable and therefore short feedback loops and appropriate responsiveness and adaptation based on this feedback is essential;
- a determination that context sensitivity is essential; ‘external actors’ can only play a limited role in driving systems change; and
- the importance of local or locally experienced expertise and networks.

## PATH design features that respond to the complex PNG environment

### Program Objective & EOIOs

PATH aims to work within and improve provincial health systems and improve access and equity of health services. The framing of this objective statement is intended to encompass both the formal service delivery systems as well as the other formal and ‘informal’ systems that impact on service delivery. It encompasses the formal institutions of government (including PHAs) at all levels of government (insofar as they relate to service access) as well as non-government institutions and communities. PATH is also intended to have a more direct role in service delivery through grant funding. These service delivery grants are intended to achieve service delivery outcomes at scale whilst also providing a footprint for program learning and adaptation, and to provide entry points for systems change. These investments in direct services are intended to be balanced with investment in more ‘high-risk, high-reward’ strategies that target significant systems change.

### Strengthened evidence base for more informed policy dialogue

Essential to learning and adaptation is feedback loops and evidence on what is working and isn’t working. The learning, analysis, communication, and knowledge function within the Program is intended to support this learning and feedback within the program (along with M&E), as well as for other partners in the health sector, including NDoH and DFAT. The analysis may draw on international experience, however it should not necessarily be focussed on ‘best practice’, but rather focus on understanding the particular PNG context in question and what will work in that context. Communication strategies should consider how information is presented and understood by policy makers.<sup>(14)</sup> Information should also consider socio-political considerations, particularly issues of access and inclusion.

Examples of how information and analysis could be used in PATH include:

<b>Informing and Enabling MPs</b> (8)	PATH can play a role in making information available on how systems are working, or not working, to leverage change in the system. The District, and Provincial, Service Improvement Program (DSIP and PSIP) funds provide significant funding at a sub-national level for essential services. Funds tend to go to visible “hard infrastructure” projects improved outreach health services. PATH could work with politicians and community groups to establish the evidence that using DSIP / PSIP funds to expand essential health service delivery benefits a significantly larger number of people in the district. This, in turn, benefits the MP’s profile and credibility.
<b>Peer Review and Visibility</b> (12)	PATH can play a role in facilitating peer review and increasing public and political visibility of performance. This approach was used in the PNG health sector in the early 2000s as part of a system for public hospital accreditation. The accreditation processes relied on a voluntary peer review process that resulted in a star rating for the hospital (based on compliance with evidence-based standards). External support was provided for training and mentoring of surveyors (all of whom were practising hospital executives in PNG) and some secretariat support. The

	accreditation system was embraced and enthusiastically supported by provinces and public hospitals.
<b>Community Scorecard Initiatives (22)</b>	Community scorecard and other social accountability strategies can be supported as a complement to other convention accountability systems. They can be used to assess community satisfaction, convene community groups mobilise collective action and joint problem solving and reflect on the performance of public services. Their immediate impact is likely to be more local however over time and in combination with other strategies and support can motivate systems change.

### Reduced bottlenecks to deliver better health services using a problem driven approach

Part of the design intention in setting key bottlenecks to be addressed is that it will require the Program to deal with and overcome potential bureaucratic as well as socio-political obstacles. It is intended that the bottlenecks that are identified operate as leverage points within the system and through change in the bottlenecks the Program can realise significant impact on service delivery. Achievement of this outcome and solving bottlenecks will require both technical skills within the program, as well as political skills and networks to navigate the necessary changes. Addressing bottlenecks is likely to require the MC, DFAT and GoPNG to work collaboratively and in partnership with other local and international partners. It will need to be supported by appropriate program management and M&E systems (see below).

An illustration of how a politically informed approach is required to reduce service delivery bottlenecks is:

<b>Addressing key workforce shortages</b>	PATH can work with relevant stakeholder to address key workforce shortage at provincial level. Evidence on the problem would need to be collected and potentially generated and inform the approach (including both formal and informal system issues). It is likely to require approvals and support from central agencies including DPM for any staffing establishment limits and Department of Finance for financing requirements. This engagement will require use of relevant networks and draw on and apply the available evidence in an effective manner (that responds to their perspectives). PATH can build coalitions across provinces and other stakeholders and work at national level to progress the agenda with central agencies. There may be a range of other related strategies and requirements including working with NDoH on pre-service development, DPM on other compliance issues, Provincial and District Administrators on staff management and administrative support, as well as other government departments, professional associations, and unions on industrial relations matters and other relevant issues. Technical inputs could be provided where required including to ensure rigorous process and avoid contestation and unnecessary politicisation. Continuous M&E and learning and adaptation of the strategy would be required to navigate the complexity underpinning the targeted outcome/s.
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### National level enabled to support provincial health systems

Whilst the focus of PATH is on PHAs and services delivery the design recognises that these are part of broader systems. Key issues for PHAs and their partners to improve health service provision in the province require a range of decisions, guidance or action to be taken at national level, particularly by NDOH, Departments of Personnel Management, Planning and Finance and Treasury. These issues include quantity and timing of financial transfers; recruitment, training and retention of health workers; and development and

implementation of national policies and standards. Effective support to provinces therefore requires engagement at the national level that has both technical and political dimensions.

An example of a potential area of national support that will contribute to PHA performance and improved service delivery is:

<b>Streamlining Health System Architecture</b> (13)	<p>PATH may provide support at the national level to support legislative reform, including in relation to the health system architecture, in order to enable subnational-health system performance. The law defines what different government institutions can and cannot do, and what they are required to do. Law also establishes the frameworks through which funding and information is channelled; and provides the foundation for how the workforce is appointed and regulated. Law can also enable government to form reliable partnerships and engage with the churches, the private sector and other non-state partners. It is essential that the law is developed in a manner that promotes coordination, accountability and performance in the health system. It is also essential that the law is implementable and responds to and harnesses informal institutions including cultural norms and practices. The current laws that define the PNG health system have been passed over many years and have made the system complex and hard to govern. In relation to PHAs, legislative issues include the need for a consistent and permanent approach (PHAs are currently voluntary), allocation of appropriate autonomy to PHAs in HR and financial matters, clarity on roles and responsibilities and their relationship with other government bodies including DDAs, enabling flexibility in the structure of PHAs, and securing adequate financing. The National Department of Health is currently progressing a review into PNG health related law with a view to move towards more integrated health governance and service delivery.</p>
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#### DFAT/NDoH able to respond to emerging issues

This design element acknowledges that a continuing relationship of trust and responsiveness is necessary to effective Program strategy and implementation. This requires working together on pressing issues for one or more of the Program partners. This design element recognises that particular events (whether natural disasters, outbreaks, or institutional problems (eg strikes)) can either regress the system or may create juncture for positive change. DFAT having the flexibility to mitigate or maximise the impact of these events is a sound Program and developmental strategy.

<b>Responding to opportunities for reform</b>	<p>There are many areas of the PNG health system that have been resistant to reform. During the course of PATH there may be an unexpected opportunity to progress particular reforms that previously was not possible. This may be because of leadership change, particular political appetite or related agendas, a particular crisis or other significant catalyst for change. This will require PATH to monitor the broader health system and political environment and be nimble enough to identify and respond to potential opportunities for change. As an example, medical supplies are an area that is currently and for many years has been a difficult area due to particular vested interests. (11) If the political environment in relation to these interests were to change and there was high-level support for reform, and the agreement of both DFAT and GoPNG, PATH may consider responding to this opportunity.</p>
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## **Program Management**

Program management arrangements need to support autonomy and flexibility, not only at the level of the Program/contractor but also at the activity or even individual level within PATH. This may include practical measures such as allocation of small activity budgets under the control of certain positions. This can be matched by appropriate accountability measures; however these measures should not stifle flexibility by imposing unnecessary processes and approvals. It is important that the systems and culture of PATH does not place undue expectations on short term results and allows for experimentation and testing in those areas of program delivery that it is needed. M&E systems that promote learning and reflection (as well as performance accountability) are essential and should not be limited to program activities and factors but extend to contextual factors and assumptions to inform program learning and adaptation.

## **Political informed gender programming**

Gender, equity and social inclusion programming within PATH will inform and needs to be informed by a socially and politically informed approach. In all contexts and at all levels, the complexities of power relationships and politics are gendered. Making headway on complex development challenges therefore requires PATH to engage with the interplay of power, politics and gender. Relevant strategies include: supporting inclusive local leadership; bringing together political and gender analysis and making it useful/using it for decision making; identifying and using locally identified entry points, networks and experience for gender action; ensuring M&E systems and feedback loops contain gender issues; and ensuring that PATH internally ensures that its staff work in a politically informed and gender aware manner.(6)

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## ANNEX 12: POLICY DIALOGUE MATRIX

Related End-of-Investment Outcome (EOIO) and Intermediate Outcome (IO)	Problem/ Issue	Policy outcomes sought. <sup>35</sup>	Program entry points for policy dialogue	Influential stakeholders	Resources required	Policy dialogue lead within AHC	Partnership engagement lead within MC/implementing partner
<p><b>End of Investment Outcome 1</b></p> <p>PHAs more able to lead provincial health reform and manage effective, efficient and equitable essential health services in selected provinces.</p> <p><i>IO 1.1 PHA Boards and Management capable of leading reform and managing finances, health workers, partnerships and service providers.</i></p> <p><i>IO 1.2 More policy</i></p>	<p>PHAs are intended by GoPNG to be the principal vehicle for planning and delivering (directly or via churches etc) essential health services. However, many provinces and PHAs lack key organisational capacities of planning, budgeting, financial management, human resources, stakeholder engagement, and service provider and facility performance management.</p> <p>PHA performance is also likely to be constrained by a range of whole of sector</p>	<ul style="list-style-type: none"> <li>GoPNG fully establishes and provides necessary policy, legal and technical support for PHAs.</li> <li>PHA Boards established with effective and broad representation, including private sector, women and disability groups.</li> <li>PHAs involve churches and NGOs in health service planning and delivery, including via service level agreements.</li> <li>Dept of Personnel Management approves PHA staff establishments.</li> <li>Dept of Treasury a) releases budgeted recurrent health funds for PHAs on time and in full; and b) provides funds for approved</li> </ul>	<p><b>EOIO 1 directly strengthens PHA performance.</b> It does so through the following entry points.</p> <p>Each of the “<b>drivers of change</b>” are intentionally designed to strengthen the evidence base for PHA planning and management. This particularly occurs through <b>driver 1</b> (evidence learning and dialogue); <b>driver 2</b> (addressing problem driven bottlenecks); <b>driver 3</b> (leveraging the</p>	<p>Within GoPNG there are several key stakeholders. These include Minister and Secretary for National Department of Health for policy and regulation. Department of National Planning and Monitoring (DNPM), Department of Treasury (DOT) and Department of Finance (DOF) for priority setting and resource allocation.</p>	<p><u>Annex 7</u> identifies the likely financial cost of each of the drivers and the MEL. The PATH Managing Contractor, and staff at the Australian High Commission, will need to be resourced, trained, or</p>	<p>Minister and Counsellor at Australian High Commission backed by HOM.</p>	<p>Team Leader for PATH.</p> <p>Secretary of PNG National Department of Health.</p> <p>Heads of PHAs in selected Provinces where PATH is working.</p> <p>Heads of NGOs including churches that are delivering essential services.</p>

<sup>35</sup> **Note:** These are the strategic policy outcomes that DFAT is seeking over the longer term. They are unlikely to be achieved in full during the life of PATH. However, PATH is designed in such a way that the Managing Contractor could and should be able to support DFAT's own policy dialogue to make measurable progress and influence on each of these issues during the life of PATH.

Related End-of-Investment Outcome (EOIO) and Intermediate Outcome (IO)	Problem/ Issue	Policy outcomes sought. <sup>35</sup>	Program entry points for policy dialogue	Influential stakeholders	Resources required	Policy dialogue lead within AHC	Partnership engagement lead within MC/implementing partner
<p><i>relevant Information available and used by PHAs, MPs, NGOs, health facilities and communities to monitor and drive performance.</i></p> <p><b>IO 1.3</b> More women in management roles influencing policy, planning &amp; budgeting of health services in selected provinces</p>	<p>issues including likely declining GoPNG budget for health and poorly performing medical supplies procurement and distribution.</p>	<ul style="list-style-type: none"> <li>• PHA HR staff establishments.</li> <li>• Provincial Governments provide agreed internal revenue to PHAs.</li> <li>• NDOH transparently improved the procurement and distribution of medical supplies to provincial health services.</li> <li>• GoPNG establishes and uses national PHA performance monitoring framework</li> <li>• PHAs establish partnership committees to seek broad partner input to PHA management and services.</li> <li>• PHAs encourage community scorecards in health facilities.</li> <li>• PHAs agree to develop and implement equal opportunity employment policies and practices.</li> <li>• GoPNG maintains, and if possible, increases overall health budget, particularly for provincial and rural health services.</li> </ul>	<p>analytical and policy work of ADB, World Bank, WHO and others); and <b>driver 4</b> (targeted central support and advisers to share national lessons). <b>Driver 5</b> allows PATH to invest in emerging priorities.</p> <p><b>PATH management, and PATH short term / long term advisers,</b> are specifically accountable / equipped to use the evidence and learnings from these drivers as a basis for informed policy dialogue with PHAs and to support DFAT staff at Post.</p> <p><b>The MEL</b> specifically tracks the extent to which evidence and policy influence is actually getting traction.</p> <p>Policy influence is an</p>	<p>Department of Personnel Management (DPM) for health workforce.</p> <p>Department of Provincial and Local Government Affairs (DPLGA) and Provincial and Local Level Service Monitoring Authority (PLLSMA) for Provincial policies.</p> <p>PHA Boards.</p> <p>Members of Parliament.</p> <p>Direct service providers including nurses association, and churches.</p> <p><b>Other influential stakeholders.</b> These include</p> <p>Multilateral development</p>	<p>have access to specialist advice and expertise in terms of knowledge-brokering. They will also need to be capable of “working politically”. For example, this could include presenting evidence and learnings to local Members of Parliament in more persuasive ways to MPs as to how they can use the DSIP and PSIP to</p>		<p>Heads of multilateral agencies (ADB, World Bank, WHO and UN family) based in Port Moresby.</p>

Related End-of-Investment Outcome (EOIO) and Intermediate Outcome (IO)	Problem/ Issue	Policy outcomes sought. <sup>35</sup>	Program entry points for policy dialogue	Influential stakeholders	Resources required	Policy dialogue lead within AHC	Partnership engagement lead within MC/implementing partner
			ongoing process. However, <b>strategic opportunities to elevate and review the effectiveness and impact of policy influence</b> include the Annual Planning process; joint monitoring missions with GoPNG and multilateral partners; and mid term reviews and evaluations.	partners. They also include community groups (especially for scorecards) and local media.	expand / improve essential services to constituents		
<p><b>End of Investment Outcome 2.</b></p> <p>“DFAT funded health services are improving access; influencing PHA performance; and transitioning to PHA management in selected provinces.”</p> <p><i>IO 2.1 Approaches to increase access to services by women, disabled, poor are tested and scaled.</i></p> <p><i>IO 2.2 DFAT</i></p>	<p>DFAT directly funds a number of high priority essential health services including maternal and child health services; TB prevention and control and health security / public health more broadly.</p> <p>There are two issues that arise, both of which require - and are amenable to - policy dialogue and influence.</p> <p>First, there is always room for <b>improved access and</b></p>	<ul style="list-style-type: none"> <li>• NDOH and PHAs plays an active role in adopting and sharing lessons learnt from PATH funded service and improvement efforts (proof of concept)</li> <li>• PHAs actively seeking alternative funding sources for provincial health services (private sector, other donors, provincial govt’s, MPs).</li> <li>• PHAs incorporate equity strategies into provincial planning and delivery.</li> <li>• DFAT funded delivery partners (NGO, church and PHAs)</li> </ul>	<p><b>EOIO 1 (see above) directly influences policy change</b> and capacities in selected provinces and PHAs through the drivers of change.</p> <p><b>EOIO 2 indirectly provides an entry point for policy dialogue</b> by generating evidence and lessons on how to improve effectiveness, efficiency, equity and sustainability of DFAT’s own directly</p>	<p>All of the above.</p> <p>However, other influential stakeholders under this EOIO will also now include those NGOs and agencies that DFAT directly funds and which will continue under PATH.</p> <p>Another potential set of stakeholders will be those agencies involved in health security and</p>	<p>As above.</p>	<p>As above</p>	<p>All of the above.</p> <p>However, other influential stakeholders under this EOIO also now include those NGOs and agencies that DFAT directly funds and which will continue under PATH.</p> <p>Another</p>

Related End-of-Investment Outcome (EOIO) and Intermediate Outcome (IO)	Problem/ Issue	Policy outcomes sought. <sup>35</sup>	Program entry points for policy dialogue	Influential stakeholders	Resources required	Policy dialogue lead within AHC	Partnership engagement lead within MC/implementing partner
<p><i>performance-based funding increases coverage to immunisation, family planning, TB, HIV and other services and efficiency by integrating vertical services.</i></p> <p><i>IO 2.3 Improved compliance with International Health Regulations (IHR) in relation to laboratory performance; detection and treatment of TB and malaria; and other agreed priorities identified by JEE</i></p>	<p><b>performance</b> in DFAT funded programs. This is particularly the case in ensuring programs are effectively reaching the poor, women and disabled.</p> <p>The second issue is the need for Australia to <b>progressively transfer and transition</b> programs currently directly funded by DFAT across to PHAs in selected provinces where that is appropriate (i.e. PHAs are now capable, particularly as a result of EOIO 1 above).</p>	<p>demonstrate practical service integration (e.g joint program training, supervision etc)</p> <ul style="list-style-type: none"> <li>• DFAT funded delivery partners (NGO, church and PHAs) demonstrate innovative strategies to reach poor, marginalised groups.</li> <li>• GoPNG supports conduct of PNG Joint External Evaluation and follow-up actions.</li> <li>• NDOH and PHAs convene regular partner coordination meetings to share information, lessons and better target support.</li> </ul>	<p>funded programs. These are lessons that the PATH Managing Contractor (MC) is required and incentivised to share with PHAs and other stakeholders (including multilateral development partners).</p> <p>The PATH MC is also required to be abreast of evidence and policy learnings arising from the multilateral development partners, private sector (eg mining companies) and other stakeholders. The MC is then to demonstrate it has used that evidence and learnings to engage in policy influence and policy dialogue with PHAs and to have supported DFAT at Post in such endeavours.</p>	<p>laboratory strengthening including the DFAT Indo Pacific Centre for Health Security and the Fleming Fund.</p>			<p>potential set of stakeholders will be those agencies involved in health security and laboratory strengthening including the DFAT Indo Pacific Centre for Health Security and the Fleming Fund.</p>

ANNEX 13: SAFEGUARDS AND RISK MANAGEMENT MATRIX

PROVIDED SEPARATELY

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