



PNGAus Partnership

Papua New Guinea–Australia Health Partnership Strategy 2024–2034



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Contents

- Executive Summary.....1**
- 1. Introduction and Strategic Context4**
 - 1.1. Purpose and Scope.....4
 - 1.2. Why Australia Should Invest4
 - 1.3. Our Partnership Principles6
 - 1.4. PNG Health Sector Context7
- 2. How Australia Will Contribute to PNG’s Health Development Outcomes10**
 - 2.1. Goal and Objective11
 - 2.2. Strategy Theory of Change.....13
 - 2.3. Investment Pillars.....14
- 3. How Australia Will Deliver on Our Strategy15**
 - 3.1. Governance Arrangements15
 - 3.2. Risk Management.....15
 - 3.3. Performance and Communications.....15
- Annexes16**
 - Annex 1 – PNG–Australia Health Partnership Strategy Development16
 - Annex 2 – Lessons and Approaches18
 - Annex 3 – PNG–Australia Health Partnership Strategy Objective and End of Strategy Outcomes, including Illustrative Indicators.....21
 - Annex 4 – Health Partnership Strategy Indicative Monitoring and Evaluation Framework28
 - Annex 5 – Risk Matrix.....40
 - Annex 6 – Glossary42
 - Annex 7 – References.....43
- Endnotes45**

Table of Figures

- Figure 1: PNG–Australia Health Partnership Strategy 2024–2034 Logic..... 3
- Figure 2: PNG–Australia Health Partnership Strategy 2024–2034 Logic..... 12
- Figure A1: Stages of developing PNG–Australia Health Partnership Strategy Logic and Theory of Change.... 16
- Figure A2: PNG–Australia Health Partnership Strategy 2024–2034 Logic 17



Abbreviations and Acronyms

Term	Definition
AHC	Australian High Commission
AIP	Annual Implementation Plan
ANC	Antenatal Care
ART	Antiretroviral Therapy
AUSMAT	Australian Medical Assistance Team
CEO	Chief Executive Officer
COVID-19	Coronavirus Disease 2019
CSEP	Comprehensive Strategic and Economic Partnership
DFAT	Department of Foreign Affairs and Trade [Australia]
DHS	Demographic and Health Survey
DPP	Development Partnership Plan or <i>Australia–PNG Development Partnership Plan 2024–2029</i>
eNHIS	Electronic National Health Information System
EOSO	End of Strategy Outcome
GEDSI	Gender Equality, Disability and Social Inclusion
GoA	Government of Australia
GoPNG	Government of Papua New Guinea
HDMES	Human Development Monitoring and Evaluation Services
HI4HSS	Health Infrastructure for Health System Strengthening
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HPP	Health Portfolio Plan 2018–2023 or <i>Portfolio Plan: PNG Health Sector Program 2018–2023</i>
HPP MTR	<i>Health Portfolio Plan Mid-Term Review (2022). Final report</i>
HPS-SC	Health Partnership Strategy Steering Committee
HRIS	Human Resources Information System
HSS	Health System Strengthening
ICT	Information and Communications Technology
IDP	<i>International Development Policy</i> [Australia]
IO	Intermediate Outcome
ISDS	Integrated Service Delivery Support
ITN	Insecticide-Treated Bed Net
KI4C	Knowledge and Innovation for Change
LLG	Local-Level Government
MDR-TB	Multi-Drug-Resistant Tuberculosis
MEF	Monitoring and Evaluation Framework
MEL	Monitoring, Evaluation and Learning
MELP	Monitoring, Evaluation and Learning Plan
MOU	Memorandum of Understanding
MTDP	<i>Medium Term Development Plan IV 2023–2027</i> [Papua New Guinea]
NCD	Non-Communicable Disease
NDoH	National Department of Health [Papua New Guinea]
NHIS	National Health Information System
NHP	<i>National Health Plan 2021–2030</i> [Papua New Guinea]
NSO	National Statistical Office of Papua New Guinea



Term	Definition
OECD DAC	Organisation for Economic Co-operation and Development, Development Assistance Committee
PAF	Performance Assessment Framework
PATH	Papua New Guinea–Australia Transition to Health
PHA	Provincial Health Authority
PHC	Primary Health Care
PNG	Papua New Guinea
TB	Tuberculosis
UHC	Universal Health Coverage
UNDP	United Nations Development Programme
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Foreword

The traditional *kundu* drum resonates across the 21 provinces of Papua New Guinea (PNG) and the Autonomous Region of Bougainville. It heralds important events and inspires, excites, and draws people together. The drum is an appropriate metaphor for our 10-year *Papua New Guinea–Australia Health Partnership Strategy 2024–2034* (henceforth referred to as the ‘Strategy’), which also aims to inspire, excite, and harmonise efforts in the PNG health sector, by using Australia’s resources and partnerships to support the Government of Papua New Guinea (GoPNG)’s leadership. We invite all members of the health community to engage and collaborate to realise our shared vision of improved health outcomes for all Papua New Guineans. Together, we can ensure that our joint strategic initiatives resonate across and help bring positive change to Papua New Guinea.





Executive Summary

Section 1 – Introduction and Strategic Context

Introduction: The *Papua New Guinea–Australia Health Partnership Strategy 2024–2034* (the Strategy) guides the DFAT bilateral health program in Papua New Guinea (PNG). Developed in response to the conclusion of the *Health Portfolio Plan 2018–2023* (HPP), the introduction of *Australia’s International Development Policy* (IDP) in 2023, and the release of the *Australia–PNG Development Partnership Plan 2024–2029* (the Development Partnership Plan or DPP), the Strategy supports the goal of the Government of PNG’s (GoPNG) *National Health Plan 2021–2030* (NHP), for ‘Preventing ill health, identifying and addressing health risks and emerging diseases, and providing accessible, quality healthcare for all’¹. While focusing on the bilateral health program, the Strategy should also inform and enhance the complementary regional and global health investments made by DFAT. Health investments to be delivered under the Strategy will be designed over the period 2024–2026.

Rationale for DFAT’s investment: The aim of *Australia’s International Development Policy* is to foster a stable and prosperous Indo-Pacific region². It emphasises the critical role of health in promoting resilience and economic growth. The Strategy acknowledges the need for long-term, evidence-based investments in health system strengthening to build capacity and resilience, alongside immediate high-impact interventions to address pressing health needs. By contributing to greater resilience within the PNG health system, our investments help to protect against health challenges in Australia and the region.

Australia’s comparative advantage: Australia is the largest development partner and has been a longstanding and trusted partner in the PNG health sector. Australia’s extensive engagement with the Government of PNG at all levels was further enhanced during the COVID-19 pandemic, affirming our status as a reliable strategic partner. The flexibility of Australia’s approach allows for adaptability to emerging issues and PNG’s priorities, supporting long-term systemic efforts. Leadership in donor coordination, Australia’s technical capacity, and our network of bilateral, regional and global investments, provide the opportunity to influence and leverage resources to address critical health needs and improve health outcomes in PNG.

Our partnership principles: The Strategy is guided by Australia’s IDP commitments and the DPP principles, and draws on lessons from previous sector plans and investments. This Strategy seeks to align Australia’s investments to support Government of PNG leadership, and champion locally led development by supporting PNG’s sovereign responsibility to deliver health services in line with its NHP. The Strategy will promote effective, accountable and sustainable development, through supporting evidence-based, flexible interventions designed to strengthen health outcomes. The Strategy acknowledges the need to ensure inclusive development by integrating gender equality, disability, and social inclusion (GEDSI), and climate change considerations. The Strategy emphasises creative and adaptive approaches to navigate the complexities of the health sector and enhance the health system capacity to respond to PNG’s challenging context, by taking calculated risks and using a politically-informed approach.

PNG health sector context: Good health is essential for economic growth, poverty reduction, and reducing inequality. In PNG, health outcomes are well below regional and income peers. PNG’s health system is fragile and under-resourced. In 2021, PNG ranked 192 out of 194 countries on the Universal Health Coverage Service Coverage Index.³ PNG continues to have high levels of communicable diseases and rates of non-communicable diseases (NCDs) are rising rapidly. Reproductive, maternal, neonatal and child health outcomes have stagnated or declined over the

past decade. Large differences are present in health service use: people in the lowest income quintile are the most vulnerable to illness, yet they have the lowest health care utilisation rates.

Multiple health system challenges impact service delivery outcomes. PNG faces significant health workforce constraints at all levels, such as insufficient numbers of personnel, an underutilised and unevenly distributed workforce, and lack of training. Health policies and standards are not consistently communicated and applied across the health sector. Provincial Health Authorities (PHAs) are mandated to manage and deliver health services, but they are not yet fully functional. Health infrastructure, particularly at lower-level facilities and in rural and remote areas, does not generally meet service standards, and supplies and equipment are often inadequate. Health promotion is often not prioritised and there is limited community engagement in the design and delivery of and patient feedback on health services. Innovative local approaches to health care, which are effective and economical, are not identified and scaled. This combination of factors affects the quality and access to and reach of health care for much of the population, and especially for those who are the most vulnerable – people in rural and remote areas, people with disability, and special populations such as people living with or at risk of HIV/AIDS.

The PNG NHP highlights the need for strengthened health leadership at all levels to address current health sector challenges. Chief among these is the need for more effective and accountable management practices, and an orientation towards delivery of equitable, quality health care. More effective, evidence-based planning, and stronger engagement with partners within and outside the health sector, will be needed to harness partner efforts and available resources as efficiently as possible.

Section 2 – How Australia Will Contribute to Development Outcomes

Strategy Theory of Change: Given this context and Australia’s intent to support GoPNG’s achievement of the PNG NHP objectives and priorities, the overarching long-term Goal of the Strategy is taken directly from PNG’s NHP, as shown in **Figure 1**. Australia’s health investments delivered in support of the Strategy will contribute to this overarching Goal. The Strategy Objective is derived from DPP Outcome 3.1.

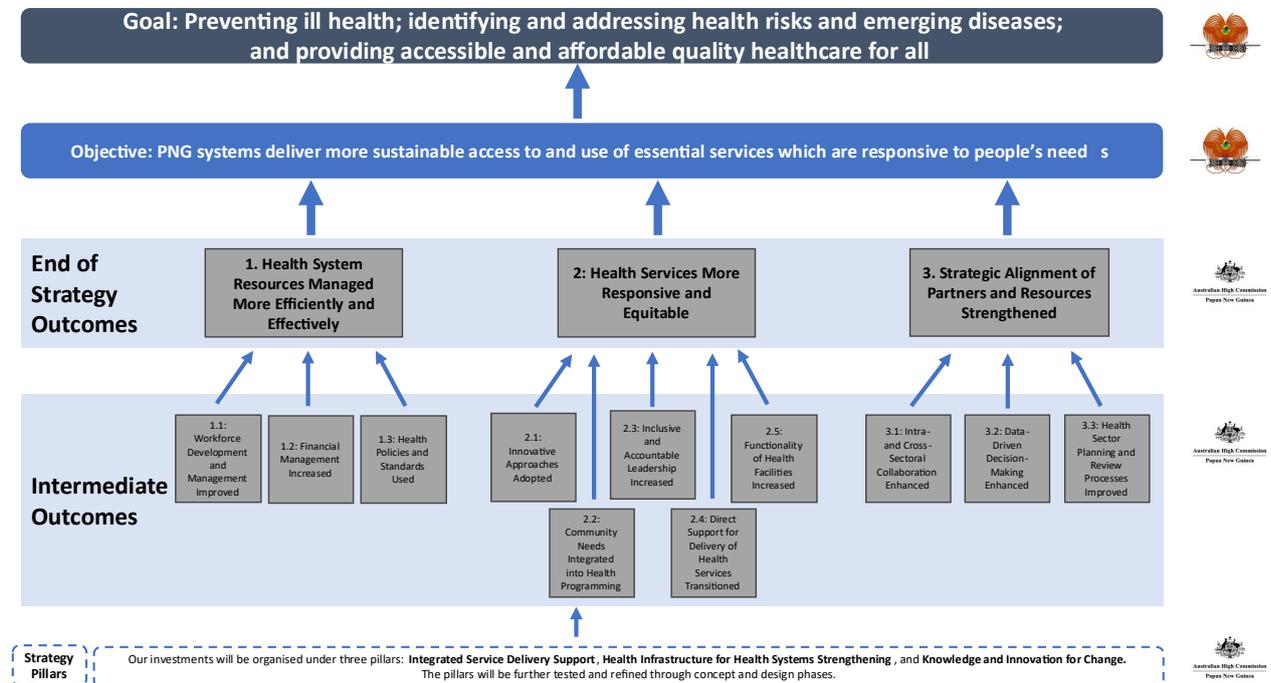
The Strategy is based on the logic that PHAs that are supported by partners to perform their mandated functions, manage finite resources well, and provide services that are responsive to need, will be able to provide more accessible and affordable quality health care for families and communities and thus improve health outcomes. The primary pathways of change are captured by the three End of Strategy Outcomes (EOSOs), which interact to promote and enhance the functionality of PHAs for service delivery. The Strategy recognises: (1) PHAs as the mandated authority for health service delivery in PNG; (2) support needs will differ for each PHA depending on maturity, local context/actors and joint PNG and Australia priorities; and (3) effective PHAs rely on effective national-level legislation and oversight.

The main focus for measuring performance of Australia’s bilateral health program will be at the Intermediate Outcome (IO) level.

Strategy Pillars: The Strategy organises investments across three interconnected pillars: Integrated Service Delivery, Health Infrastructure for Systems Strengthening, and Knowledge and Innovation for Change. Direct service delivery supplementation will be provided to PNG’s essential health services over the medium-term, while working towards PHAs being resourced to manage these services directly. Australia will continue to invest in infrastructure development in a way that maximises opportunities to create jobs and economic opportunities across PNG and support the systems that underpin the functionality of health infrastructure. Australia will also support PNG institutions and individuals to promote good ideas, research, and policy initiatives to improve knowledge generation

in the sector, and urgent activities to prevent and respond to health emergencies. In response to the complex and interrelated challenges the PNG health sector faces, we will focus on policy and programmatic synergy across all three pillars. This integrated approach will support the achievement of integrated outcomes that are more than the sum of individual investments.

Figure 1: PNG–Australia Health Partnership Strategy 2024–2034 Logic



Section 3 – How Australia Will Deliver on Our Strategy

Governance arrangements: A PNG–Australia Health Partnership Steering Committee between GoA and GoPNG will provide strategic guidance, and risk management. Pillar design will specify governance arrangements for each pillar to monitor performance and ensure integration of investments across the pillar.

Risk management: The Risk Matrix (see **Annex 5**) outlines the key risks to implementing the Strategy. Assumptions and risks will be tracked and analysed, to anticipate new risks or changes in risk-levels and take proactive mitigation and management measures.

Performance and communications: DFAT is committed to rigorous monitoring, evaluation and learning (MEL) and will use a core set of Strategy indicators. The PNG–Australia Health Partnership Strategy indicative Monitoring, Evaluation and Learning Plan (MELP) – which will be refined through forthcoming designs - will describe how performance will be measured, to ensure effective monitoring and evaluation of EOSOs and IOs. The indicative MELP includes data collection and analysis methods of performance indicators and contextual factors to understand operational contexts, with a focus on continuous learning and improvement.



1. Introduction and Strategic Context

1.1. Purpose and Scope

The Australian Department of Foreign Affairs and Trade (DFAT) bilateral health portfolio in Papua New Guinea (PNG) is Australia's largest suite of country-specific health investments in terms of value, breadth and depth. The conclusion of DFAT's *Health Portfolio Plan 2018–2023* and many of the associated investments, the release of *Australia's International Development Policy*, and the finalisation of the *Australia–PNG Development Partnership Plan 2024–2029*, present an opportunity to develop a new plan to guide DFAT's PNG health investments now and into the future.

The Strategy will guide Australia's bilateral health investments in PNG over the next decade, from 2024 to 2034. The Strategy outlines why and how Australia will continue to work in support of the leadership of the GoPNG to deliver on its *National Health Plan 2021–2030* goal of 'Preventing ill health, identifying and addressing health risks and emerging diseases, and providing accessible and affordable quality healthcare for all'⁴.

The Strategy was developed through a multi-staged approach, involving ongoing engagement with the Australian High Commission (AHC) Health team and extensive consultation with AHC partners in-country to identify critical priorities and build on lessons learned through evaluations of our investments. Further details of the development process are provided in **Annex 1**.

The focus of the Strategy is on DFAT's bilateral health program. Although the Strategy does not address DFAT's regional and global health programs, it should inform and support the complementarity of efforts across these programs.

Over the period 2024 to 2026, many of DFAT's existing bilateral health investments conclude, presenting an opportunity to undertake new design processes, which will ensure future investments are better coordinated, for maximum impact.

1.2. Why Australia Should Invest

1.2.1. Rationale for Australia's Investment

Alignment with Australia's and PNG's policy commitments

The central objective of the new IDP is to advance a peaceful, stable, and prosperous Indo-Pacific region. PNG is our closest neighbour and our largest development partner in the region. It is in Australia's interests, as a good neighbour and historic and future partner in the region, that PNG has a healthy and educated, thriving population. The IDP highlights good health as a building block for state and community resilience, and essential for economic growth, poverty reduction and reducing inequality. Healthier individuals and communities are more likely to contribute to a country's economic and social development. This is evident in PNG, and the Government of PNG identifies improved health care as a priority.

Access to quality affordable health care is a priority articulated in PNG's *Medium Term Development Plan IV 2023–2027* (MTDP). The PNG–Australia Comprehensive Strategic and Economic Partnership (CSEP) commits to working together to strengthen health systems and deliver high-quality health services to contain disease outbreaks. The AHC's Development Partnership Plan is the overarching document that outlines the priorities for the development program. The DPP Outcome 3.1 is '*Supporting PNG to increase access to and use of essential services, including health and education, which are well-maintained and responsive to people's needs*'. Australia's bilateral support to the PNG health sector, guided by this Strategy, will contribute directly to the achievement of this outcome and also supports the MTDP and the CSEP.



Investing in PNG's health is an investment in our region

PNG's vulnerability to health emergencies and the fragility of the health system was highlighted during COVID-19, with disruption of routine health services, ranging from HIV and TB detection and treatment to sexual and reproductive health. The pandemic demonstrated how easily and quickly a disease can transcend country borders and have devastating social and economic impacts. By contributing to greater resilience within the PNG health system, our investments will help to protect Australia and the region from the health challenges that pose a threat to regional stability.

1.2.2. Australia's Comparative Advantage

A long standing and trusted partnership

Australia is in a strong position in the health sector in PNG: the COVID-19 pandemic reinforced our unique partnership with PNG as a reliable strategic partner and friend. Australia is committed to maintaining and further strengthening our partnership with GoPNG at all levels. Australia needs to continue to target support to PNG's priorities and areas where Australia has comparative advantage within those priorities.

Flexibility

Australia has demonstrated ability to be flexible and responsive to emerging issues and GoPNG priorities. Australia's systems, staff and support on-the-ground enables flexibility and responsiveness. The bilateral program continues to provide targeted support in areas of need, recognising this contributes to trust, credibility and partnerships that support long-term engagement in systems work with PNG.

Technical assistance and expertise

Australia funds a wide range of highly-valued technical advisory support – within provinces, departments and Ministries – as well as partnerships between Australian and Papua New Guinean health and research institutions to support capacity across the health sector, including in infectious disease control, health workforce, immunisation, health information management, leadership and management, medicines regulation, health financing, and reproductive, maternal and child health. Australian technical capabilities, including AUSMAT teams and short-term specialist partnerships, such as with the Royal Australasian College of Surgeons, and government-to-government partnerships from agencies such as the Therapeutic Goods Administration with the National Department of Health, are highly valued and unique to the PNG–Australia partnership.

Supporting GoPNG in partner coordination

As the largest development partner in PNG and chair of the Health Development Partners group, Australia has an important role to play in enhancing coherence through donor coordination and supporting, alongside GoPNG, harmonisation of partner efforts in alignment with national and provincial priorities. Australia's large presence provides an important opportunity to support key government action on areas of need, as does our funding for technical partners and experts, such as World Health Organization (WHO), who have an on-the-ground presence in PNG.

Breadth and depth

Australia has a broad and deep presence in PNG in its bilateral investments. The scope and scale of Australia's investments in a wide range of sectors and government agencies in PNG provide us with the ability to work across sector programs and agencies, as well as using whole-of-government approaches to address issues. Our bilateral program is complemented by Australia's regional and global investments in PNG - PNG is the single biggest Pacific recipient of assistance through Australia's Partnerships for a Healthy Region initiative, which will support PNG to build resilient and equitable health care systems with a focus on sectoral priorities including lab strengthening; field

epidemiology; and support for new diagnostics, therapeutics, and vaccines. The Australian Non-Government Organisation (NGO) Cooperation Program will also retain its significant focus on health programming in PNG in recognition of the critical role NGOs play in complementing provincial governments' rural health service delivery efforts. Australia's significant investments in global health funds and multilateral partnerships present opportunities to leverage to support better outcomes for PNG. For example, Australia can harness resources and learning from our global support for new diagnostics, therapeutics, and vaccines, particularly for those diseases with a high burden in PNG. Australia's engagement in multiple sectors in PNG, including on issues of agriculture and food security, will also support us to integrate a One Health approach.

1.3. Our Partnership Principles

Our delivery of the Strategy will be guided by Australia's commitments outlined in the IDP, the principles of the Australia–PNG DPP, and is informed by the lessons garnered during implementation of previous sector plans and investments (see **Annex 2**). The following principles capture these lessons and commitments and will be embedded in the design of our investments.

PNG leads – Locally led development

Australia recognises the sovereign responsibility of the GoPNG to deliver health services to its population, and its leadership and vision. The GoPNG knows its health system and the challenges within the health sector, as articulated in the NHP. Australia's role is to support PNG to achieve its NHP goals by bringing resources to shared development priorities, based on where our comparative advantage lies, and Australia's stated goals in PNG and the region: namely a safe, secure and prosperous PNG and Pacific region.

We will work in partnership with the PNG Government and local organisations to align Australian investments to local development strategies, policies, and programs. Australia will support and strengthen Papua New Guinean organisations and communities to drive the development agenda and lead and set priorities. We will engage local expertise as much as possible. We will look for locally led innovations and initiatives that can catalyse change and encourage positive engagement of individuals and communities with the health system.

DFAT will engage more substantially with PHAs, including jointly developing province-specific partnership frameworks that outline the details of DFAT-supported activities, and maintaining regular dialogue.

We will build flexibility into the design of investments, to respond to health emergencies and to support emerging priorities and opportunities as they develop.

Effective, accountable and sustainable

Australia is committed to delivering high-quality development assistance that meets our international commitments and the Australian public's expectations of transparency and accountability. Our investments will be informed by evidence, monitoring, evaluation, and learning, with strong governance mechanisms to track progress and course-correct when necessary.

Strengthening health systems to deliver integrated, quality primary health care is recognised as the most sustainable and efficient way to achieve Universal Health Coverage (UHC).⁵ Our interventions will focus on expanding locally appropriate models of care to deliver high-impact health interventions, such as routine immunisation and family planning services, that are cost-effective and can address the major causes of morbidity and mortality in PNG. We will work such that each element of our health support for PNG builds on the other, so that the whole is greater than the sum of its parts. We will design our investments to be complementary across the health system.

Building on the successes of and lessons from our current investments, our infrastructure investments will prioritise sustainability. We will work with the GoPNG to prioritise ongoing maintenance of facilities, a key challenge in PNG, and workforce planning and recruitment. Adequate skilled health staff are essential to functionality of health facilities, and we will work with GoPNG to develop strategies to attract, retain and motivate health staff to address these gaps.

We know that achieving improved health outcomes will require an orientation towards the social determinants of health and working with partners across multiple sectors.⁶ We will work across sectors so that Australia’s investments in related areas are aligned and complementary, in particular where they relate to the critical elements of gender equality, water and sanitation, and nutrition. We will look for opportunities to influence other elements of Australia’s broad and deep support for PNG’s economic growth; for example, engaging with Treasury and Finance to focus attention on the need to increase per capita health spending and improve the efficiency of its allocation and use.

Inclusive development: GEDSI and climate change

The IDP places gender, disability, and climate change at the centre of Australia’s development program, underpinning our commitment to quality, equity, and inclusion. Gender norms and inequalities have a critical influence on health risks, health-seeking behaviour and health outcomes, while people with disability and other marginalised groups face significant disadvantage due to discrimination, poverty, and health system barriers. At the same time, there is increasing evidence that the global challenge of climate change is a major threat to human health, compounding the vulnerability of disadvantaged groups and weaknesses in health systems.⁷

We will ensure that GEDSI and climate change barriers are assessed as part of investment design, to understand the drivers and barriers to equitable and inclusive access and outcomes for women and girls, people with disability, and people who are vulnerable and marginalised. We will implement a ‘twin-track’ approach to GEDSI and climate change. This will comprise targeted actions to address the needs of disadvantaged groups, as well as mainstreaming GEDSI and climate change issues throughout our investments.

Politically-informed approaches

Implementing the Strategy in the social and political context of PNG will require a clear-eyed and realistic assessment of where investments are most likely to lead to improvements in the health system. In the context of a fragile and under-resourced health sector, maximising the impact of our investments will require a politically-informed approach that is tailored to specific local conditions. It will require thinking creatively and taking calculated risks to address system bottlenecks where there is a genuine, demonstrated appetite for reform. We will look for opportunities to strengthen what is working and be ready to adapt our approaches when they are failing to deliver anticipated results.

1.4. PNG Health Sector Context

Overall context

PNG is Australia’s nearest neighbour. It is geographically and culturally diverse with a largely rural-dwelling and young population.⁸ Despite a wealth of primary resources, PNG faces significant development challenges and ranks 154 out of 193 countries on the Human Development Index.⁹ The country is ranked 158 out of 189 countries for gender equality¹⁰ and is assessed as the least safe country globally for women and girls, children, people with disability, and other marginalised groups.¹¹ The impacts of climate change are increasingly threatening progress towards health targets, and increasing environmental hazards and exacerbating inequality due to the disproportionate impact on vulnerable populations and individuals.¹²



PNG health system

The PNG health system operates in a decentralised system and is based on a primary health care (PHC) model. Provincial Health Authorities are responsible for the delivery of rural health services that are provided through their hospitals, health centres, community health posts and aid posts. Transition to the PHA model commenced with three pilot PHAs established in 2007, and PHAs in the other provinces were established between 2018 and 2022. The National Department of Health (NDoH) oversees the healthcare system: developing health policy and standards for levels of health care; providing technical advice and support to provinces, monitoring performance and maintaining the National Health Information System.

As at 2024, the GoPNG funds 71 per cent of health services. This includes funding to churches that deliver almost half of the country's services, mainly in rural areas. Private health providers are a small portion of the market, servicing larger towns and communities close to resources project sites. With the removal of user fees for primary health care, out-of-pocket health expenditure is low.¹³ Nonetheless, the availability of quality services close to where people live is a problem, reflected in PNG's low ranking (192 out of 194 globally) for universal health coverage.

Nominally, 20 per cent of the annual funding allocations to Members of Parliament through the District Service Improvement Programs (currently PGK20 million per year), and Provincial Service Improvement Programs (PGK5 million per district), is earmarked for health. However, these funds are not always used to support health service delivery costs.

The NDoH estimates that over the next eight years an average increase of around PGK2 billion per year is required on top of the average annual health sector budget of PGK2.5 billion, to operationalise the National Health Plan. Australia (and other partners) cannot fill that funding gap but can make a meaningful contribution by bringing resources to selected strategies.

Australia is PNG's largest development partner in health. Multiple other development partners contribute funding and other resources to the PNG health sector including United Nations agencies (WHO, UNICEF, UNFPA, and UNOPS), Gavi, the Global Fund to Fight HIV, TB and Malaria, the World Bank, and the Asian Development Bank. The United States has a small footprint but is expanding, with new funding for health security initiatives. New Zealand contributes to immunisation jointly with Australia and Gavi. China engages in the health infrastructure space and has a longstanding technical and training partnership with Port Moresby General Hospital. There are many international and local non-government organisations operating in the health sector. Large resource firms, including Santos, ExxonMobil, and Total Energies, commit funds for projects primarily in the locations where they operate. All bring resources and expertise to the sector. However, health allocations from the GoPNG and external financing have yet to translate into improved population health outcomes.

PNG health outcomes

Improvements in PNG's life expectancy¹⁴ and under-five mortality rate¹⁵ have been slower than economic and regional peers and the country continues to face pressing health challenges. There are major disparities in health access and outcomes between rural and urban areas.¹⁶ Supervised childbirth deliveries have fallen from approximately 45 per cent in the 2000s to around 35 per cent since 2015, with the most remote villages recording skilled birth attendance rates of around 10 per cent.¹⁷ The Total Fertility Rate is substantially higher than other lower middle-income countries (4.8 compared to 2.8).¹⁸ Measles immunisation rates have fallen from around 60 per cent in the early 2000s to a low of 32 per cent in 2017, before rising to 38 per cent in 2021.¹⁹ There are continuing high levels of communicable disease, including multi-drug-resistant TB infections (MDR-TB)²⁰, and PNG is one of the few countries in the world recording rising numbers of HIV infections.²¹ NCDs are rapidly increasing²², and the country is ranked 182 out of 183 countries on the NCD Preparedness

Index.²³ The double burden of poor nutrition is evident, with 42 per cent of children under five years of age stunted²⁴, and 38 per cent of population estimated to be obese by 2035.²⁵

PNG health system challenges

PNG has enormous potential for better health outcomes. Committed health workers deliver services in very remote locations using the equipment and expertise they have to hand – sometimes at their own expense. This section outlines some of the key challenges to achieving the health outcomes that so many Papua New Guineans work hard to realise.

- **Skilled health workforce:** PNG’s health workforce of 6.47 physicians, nurses and midwives per 10,000 population²⁶ is far below the recommended ratio of 44.5 per 10,000 for the achievement of universal health coverage.²⁷ Furthermore, the current health workforce is relatively underutilised and inequitably distributed, with doctors and skilled nurses concentrated in urban areas, in part due to a lack of incentives in place to encourage more to work in rural and remote parts of the country.²⁸ The diminishing investment in training institutions and limited opportunities for continued professional development and upskilling have contributed to a decline in the standard of health service delivery. Lack of accurate information for human resources planning, and limited coordination between institutions, has resulted in a growing mismatch between health workforce demand and supply.²⁹
- **Allocation and management of finances:** Although total health expenditure has increased since 2000, health sector funding has not kept up with the demands of a growing population and is not optimally allocated to support frontline health service delivery.³⁰ In the last decade, PHAs were established to decentralise national health service delivery and reduce health system fragmentation. There is consensus that this is the right pathway for service delivery, but only some PHAs are functioning well, with many experiencing weaknesses in governance, administrative and financing arrangements.³¹ There are well-documented difficulties with dependable flows of financing, as well as the timely and accountable use of the funds that are available.³²
- **Policy development and implementation:** Despite recent progress in developing policy and legislation to guide administration of the health system and formalise GoPNG health commitments, application remains patchy.³³ This impacts the efficient mobilisation of health system resources to address critical health needs. It is further compounded by inadequate coordination between the NDoH, central agencies, and provinces, and lack of clarity in respective roles and responsibilities to progress long-term reforms on issues of national interest.³⁴
- **Delivery of health services:** With a lack of access to health information and education, many people in PNG have limited knowledge of disease prevention and how to protect their health. This has significant implications for future health outcomes, from prevention of childhood illnesses to the rising level of non-communicable disease. At the community level, there is limited active engagement of PNG communities in health promotion and in the oversight of health services. Health outreach has stagnated for more than a decade.³⁵ Services are not designed to ensure equitable access and outcomes for women and girls, rural residents, and people who are vulnerable or marginalised, preventing them from receiving the care they need. Although making up over 20 per cent of the population, there are few specific services for adolescents.³⁶
- The availability of quality medical supplies continues to be compromised by poor procurement practices and insufficient planning and budgeting. This leads to periodic stock outs around the country and PNG often pays much higher pharmaceutical prices than other countries.
- **Health leadership:** Strengthening health leadership at all levels, and particularly the capacity of PHAs to respond to local priorities, will be critical to support the GoPNG to deliver on the goals of the National Health Plan.³⁷ In addition to systems limitations, PNG health managers need support to effectively address the magnitude of the daily health service challenges that they face. This

includes the ability to reach across the multiple institutions necessary to deliver health services and undertake the change management processes needed to implement reforms. The influence of gender norms is reflected in the low number of women in key leadership and decision-making roles at all levels.

- **Health infrastructure:** Many district hospitals and rural health facilities need major repairs to meet essential service quality and patient safety standards.³⁸ A lack of basic equipment and supplies further constrains the delivery of adequate quality healthcare services. A little over half the health clinics had year-round access to water; some 40 per cent had electricity and refrigeration, 30 per cent had access to fuel, about 20 per cent had beds with mattresses and a kitchen, and only 33 per cent could make patient transfers.³⁹ The sector has recently seen increased government funding for capital works, focused mainly on new and/or upgrades to tertiary hospitals, without the requisite funding for increased staff and the operational budget. This places further pressure on PHAs' budgets, with funding for larger hospitals being prioritised over funding for rural services.
- **Partner coordination:** Coordination between national and provincial levels of government on rural health service delivery priorities can be an obstacle to progressing reforms. There is evidence that more effective coordination between the range of PNG health partners engaged in services delivery can lead to significantly improved health outcomes⁴⁰; however, partner involvement in planning and performance review across PHAs is not consistent. Strengthening health outcomes will also require broad multisectoral collaboration, although efforts to engage outside the health sector to mobilise support for provincial health priorities are limited.
- **Data for decision-making:** The rollout of the electronic National Health Information System (eNHIS) in all provinces in PNG has significantly advanced the capacity of PHAs for monitoring and reporting health service data. The eNHIS produces reasonable quality service data, but data can be better used in a timely and effective way to inform policy, planning or accountability.⁴¹ The lack of evidence-informed reporting and requests to central government impede successful advocacy for additional resourcing to address critical health sector needs, and is also a barrier to effective decision-making.
- **Strategic and operational planning:** Despite having a defined structure to support decentralised planning in the health sector, there is significant scope for more effective operational planning to support identification of health needs and more effective allocation and management of available resources and inputs to meet those needs.⁴² This is partly attributed to gaps in middle-level management skills in such areas as planning, budgeting, and monitoring and evaluation.⁴³ Development partners are also encouraged to better coordinate and plan their inputs based on the priority investment areas identified in the NHP and MTDP.⁴⁴

2. How Australia Will Contribute to PNG's Health Development Outcomes

Over the last decade, on average Australia has provided AUD100 million per year to the PNG health sector through the DFAT bilateral program. This funding has supported the delivery of essential services for sexual, reproductive, maternal and child health, and infectious disease prevention and control; enabled responses to health emergencies, including COVID-19; refurbished and built health facilities, large and small; trained new health workers and upgraded their skills; brought additional expertise to the sector; strengthened health institutions; and bolstered other fundamental health system elements that underpin effective operation. Australia's health program support over many years has made a significant contribution to increasing and maintaining positive TB treatment outcomes, improved access to family planning and HIV Antiretroviral Therapy (ART) treatment, and has contributed to improved immunisation coverage. The Strategy intends to build on the lessons

learned through this work to increase the impact and effectiveness of our support to the GoPNG. Lessons learned are outlined in **Annex 2**.

Australia's Strategy proposes that a mix of service delivery and systems strengthening support will remain at the heart of our approach. Persistent gaps in service coverage warrant the continuation of support for essential service delivery, but with clear parameters around the circumstances and how and where that should happen. Australia will also continue to support an infrastructure pipeline, designed to concurrently advance the strengthening of health systems to improve the supply and delivery of quality, affordable primary health care. The ability to respond flexibly and quickly to emerging issues, and to bring in valuable technical expertise, is an advantage the Australian partnership in health brings to the table.

Australia's portfolio of investments over the lifetime of this Strategy will be more streamlined and connected than the current suite of health investments. Australia's investments will integrate GEDSI more deliberately with a focus on where there is scope to influence change, where the interventions are backed by political will and are more likely to be sustainable, and where investments will have a strong impact relative to inputs (i.e. curriculum reform; improved budget submissions; infrastructure planning; research on cost-efficient service delivery models). Where locally-led reform efforts in priority areas gain traction, Australia will be open to supporting these efforts.

2.1. Goal and Objective

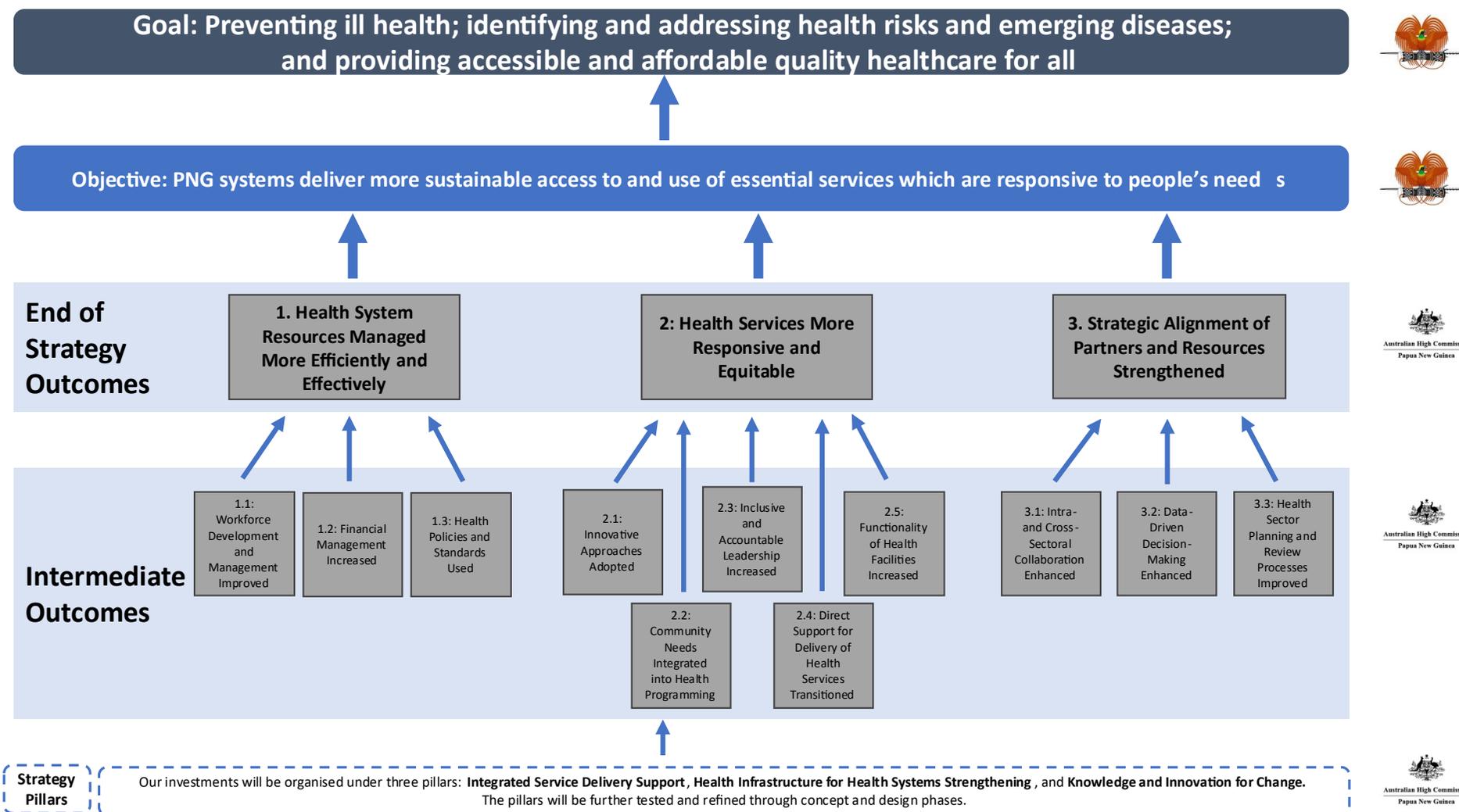
Australia's intent is to continue to support GoPNG achievement of the PNG NHP objectives and priorities. The overarching long-term Goal of the Strategy is taken directly from the NHP: *'Preventing ill health, identifying and addressing health risks and emerging diseases, and providing accessible and affordable quality healthcare for all'*⁴⁵. This Goal emphasises a comprehensive approach to improving public health across multiple critical dimensions, and promotes inclusive, equitable and person-centred health care, leaving no-one behind. The Strategy Objective is derived from DPP Outcome 3.1, which aims to support PNG systems to deliver more sustainable access to and use of essential services that are responsive to people's needs.

This alignment leverages Australia's resources to support GoPNG policy objectives and provides support in concert with the established plans of the GoPNG, reinforcing our commitment to strengthening the existing system. Australia's health investments delivered in support of the Strategy will contribute to this overarching Goal and Objective.

The Strategy Goal and Objective demonstrate our policy intent and ensure relevance to the PNG health sector and context. They are, however, above the 'line of accountability' for DFAT and its investments. Recognising that other development partners may also contribute to achieving End of Strategy Outcome targets, the primary focus for measuring the performance of Australia's bilateral health program will be at the Strategy Intermediate Outcome level.

The Strategy Logic diagram is shown in **Figure 2**, with further detail, including illustrative indicators, provided in **Annex 3**.

Figure 2: PNG–Australia Health Partnership Strategy 2024–2034 Logic





2.2. Strategy Theory of Change

This Strategy is based on the logic that well-managed PHAs can perform their mandated functions, manage finite resources well, and provide services that are responsive to need, will be able to provide more accessible and affordable quality health care for families and communities, thus improving health outcomes. Support to the National Department of Health and PHAs is therefore central to improving health outcomes. The Strategy recognises: (1) PHAs as the mandated authority for health service delivery in PNG; (2) support needs will differ for each PHA depending on maturity, local context/actors and joint PNG and Australia priorities; and (3) effective PHAs rely on effective national-level legislation and oversight.

The success of the Strategy will be contingent on three pathways for change that interact to promote and enhance the functionality of PHAs for service delivery: support for more efficiently and effectively managed health system resources (EOSO1); support for more responsive and equitable health services (EOSO2); and strengthened strategic alignment of partners and resources (EOSO3). Together, these capture the intent that Australia uses its portfolio of investments to support PHAs, work with GoPNG to improve its ability to lead and manage services, and progressively align Australian-funded services with routine GoPNG systems.

EOSO1: The first pathway for change is for PNG’s health system resources to be managed more efficiently and effectively. Change will be realised when PHAs have effective systems to oversight resources, and sufficient resources to meet the PHA’s expected outcomes. Through our investments, Australia can encourage this by directly providing a range of assistance (financial, technical, operational) and by supporting activities that strengthen PHAs capacity to manage their own resources, that enable the implementation of health policies. This will enable critical health system resources to be more effectively and efficiently managed and allocated to better support quality frontline health service delivery.

EOSO2: The second pathway is for health services to be more responsive and equitable. Change will be realised when PHAs see benefits from including broad community needs in resource allocation and make changes that allow this to happen systematically. Australia will continue to provide direct support to deliver integrated health services and infrastructure in partnership with PHAs, while building capacity of PHAs to sustain responsive systems into the future. Additionally, Australia can encourage this by facilitating PHA/GoPNG application of innovative local and international approaches to inclusive service delivery and leadership and by providing support in accordance with GoPNG’s policies and standards for infrastructure and service delivery. This will enable the delivery of functional, fit-for-purpose facilities and promote quality models of care, supporting PHAs to be better able to anticipate and adapt to existing and future population health needs.

EOSO3: The third pathway is to strengthen the strategic alignment of partners and resources. Change will be realised when PHAs recognise and steer the health partners and resources that exist outside of their organisational boundaries towards PHA priorities by incorporating these into PHA governance, planning and programming mechanisms. Through our investments and by working closely with PHAs, Australia can support this by ensuring that our province specific programs work within PHA management governance and structures such as health sector planning and review processes; by influencing and leveraging in health partner resources; encouraging multisectoral collaboration; and supporting the use of evidence and data for decision-making, thus enabling the PHA to set evidence informed priorities and steer partners and resources towards these, consequently improving health outcomes.

2.3. Investment Pillars

To organise our approach, our investments will be organised across three interconnected pillars. This structured approach ensures that we have a middle ground between our high-level strategy and our operational plan, which is delivered through selected modalities for delivery under each pillar. According to our experience and lessons learned through implementing our investments, this approach will give us the best chance of success, both in terms of policy and programming.

The approach to partnership across each of the pillars will be refined through program designs. Program designs will delve into the main challenges of each focus area, the results we want to see, and the problems Australia is best placed to support PNG to address. It will determine which modalities (e.g. grants, technical assistance, and direct financing) are best to achieve the results, linking investments back to short-term outcomes, and the broader Strategy. Our approach will be adaptable and responsive to the complex health landscape in PNG. Programs will be designed to be complementary across the Health Portfolio and DFAT's bilateral and regional investments. By integrating our efforts across results, pillars and modalities, our Strategy and programs will address the multifaceted health challenges faced by PNG.

Pillar 1: Integrated Service Delivery: This pillar is focused on increased coverage of quality, equitable and people-centred services addressing high-priority health needs. Direct service delivery supplementation will be provided to PNG's essential health services over the medium-term (at least 5 years), while working towards PHAs being resourced to manage these services directly.

In line with the PNG National Health Plan and global best practices, support will be designed to enable people-centred and equitable services adapted to community needs. Support could include staff, expertise and/or logistical support that enables PNG health staff to deliver an increased level and quality of integrated, people-centred health services in priority health areas, provinces or regions with high unmet needs.

The pillar design will shift Australia's support from delivering targeted, vertical, or disease-specific services towards supporting GoPNG to develop and deliver more integrated service delivery models.

Pillar 2: Health Infrastructure for Systems Strengthening: A combined infrastructure and systems strengthening pillar recognises that functional health facilities require both infrastructure and health systems improvements, and workforce allocation. Conversely, many health systems issues are more easily addressed alongside investment in bricks and mortar. Infrastructure investments are a tangible reflection, and opportunity to understand and address, health systems strengthening needs. Well run facilities restore confidence to communities in the quality and affordability of services, and improve health-seeking behaviour to access these services.

High-level interest and engagement on health infrastructure means that infrastructure is an entry point that anchors support to strengthen provincial planning, finance and budget functions, health human resources, and health information systems. Australia will continue to invest in infrastructure development in a way that maximises opportunities to create jobs and economic opportunities across PNG.

Pillar 3: Knowledge and Innovation for Change: This pillar will support PNG partners to solve health problems, by supporting changemakers and generating knowledge and innovation, building evidence, and funding for change. Papua New Guinean grown innovations or approaches are most likely to be effective to influence or implement change in PNG. This pillar will support PNG institutions and individuals to promote good ideas, research, and policy initiatives to improve knowledge generation in the sector, and urgent activities to prevent and respond to health emergencies.



3. How Australia Will Deliver on Our Strategy

3.1. Governance Arrangements

A PNG–Australia Health Partnership Steering Committee will provide strategic oversight for the partnership to enable high-level bilateral dialogue on the implementation, overall progress and risks of all programs funded by Australia. The Steering Committee will discuss and address overarching issues of concern regarding implementation of the Strategy, related successes and lessons, and potential gaps or new opportunities for investments.

To operationalise the strategy, the AHC team will be responsible for monitoring performance against the Strategy’s IOs and EOSOs, regular internal AHC review of the collective contribution of all investments towards achieving the Strategy’s IOs and EOSOs, mitigation of related risks, and providing input for decision-making at the investment and Strategy levels.

GoPNG will lead sector-level governance mechanisms to coordinate with implementing partners and key technical stakeholders and ensure strategic alignment of DFAT-supported activities with the NHP and relevant health policies and standards.

The AHC will engage in development partner coordination mechanisms in the health sector, alongside GoPNG, to promote alignment and a ‘joined up’ approach across related efforts in PNG.

To ensure that projects are on track to deliver results in accordance with the Strategy’s partnership approaches and commitments, there will be investment or project-level governance to trigger regular progress reviews at this level. Operational governance for specific investments will be determined during design.

3.2. Risk Management

The Risk Matrix (**Annex 5**) outlines the key risks to implementing the Strategy. Risk management will track critical assumptions including considering contextual factors outside our control. Triggers will be identified for each context indicator. We will analyse our assumptions regularly or upon detection of an unforeseen change in the context.

3.3. Performance and Communications

Australia is committed to measuring its performance on delivering this Strategy through establishing and implementing rigorous MEL. The indicative MEF (**Annex 4**) includes illustrative indicators to measure performance at the Objective, EOSO and IO levels, to be refined through forthcoming designs. The MELP, to be developed within the first six months of the Strategy implementation, will ensure rigorous oversight and effective MEL of progress against the EOSOs and IOs.

The Strategy Pillar designs will identify shorter-term outcomes and outputs, as well as activities that will contribute to achieving the Objective, EOSOs and IOs in this Strategy. Investment-level MELPs will ensure organised tracking of indicators and adaptation at the activity level. Evaluations will be conducted for accountability and learning over the duration of the Strategy.

The MELP should be used as a ‘living document’ to guide ongoing MEL of the EOSOs and IOs, and to ensure that efforts across the DFAT Health team are aligned with the Strategy Goal, Objective, EOSOs and IOs, while allowing the flexibility needed to adapt to specific contexts and needs.

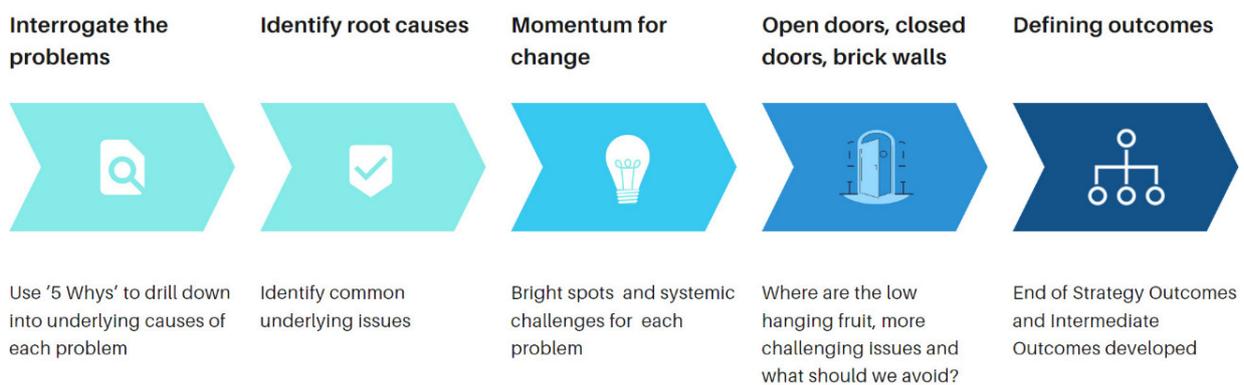
Improving transparency and communicating our success will be achieved through publishing evaluations, regular and streamlined reporting at both a whole-of-Strategy and program level to GoPNG partners, and information sharing through thematic networks and in-country coordination mechanisms.

Annexes

Annex 1 – PNG–Australia Health Partnership Strategy Development

This Strategy is informed by information that has been collected and analysed from evaluations, reviews and papers commissioned since 2021; scoping and monitoring across multiple Provincial Health Authorities (PHAs) by the Australian High Commission health team; formal and informal consultation with key stakeholders; discussions in national-level technical working groups; PHA forums; steering committees; and donor coordination groups. The Strategy was then refined through a multi-staged approach that followed the process illustrated in **Figure A1**.

Figure A1: Stages of developing PNG–Australia Health Partnership Strategy Logic and Theory of Change



Broad-based consultations identified eight problem statements, considering a diverse range of perspectives, setting the foundation for follow-on analysis. A smaller core team conducted a contextual analysis for each identified problem and added a ninth problem. This team explored the sequence of events leading to each problem, the conditions allowing their occurrence, and their interconnections with other issues, outlining the problem's environment and the factors that contribute to its existence. This set a broad and informative stage, showing how and where interventions might be needed. To ensure focus on root causes rather than effects (or symptoms), the team drilled down, applying the 'five whys' technique to each problem statement, to move from understanding the problem to deeply analysing why it persists. These insights were then organised into a problem tree differentiating between root causes, systemic problems, and their effects.

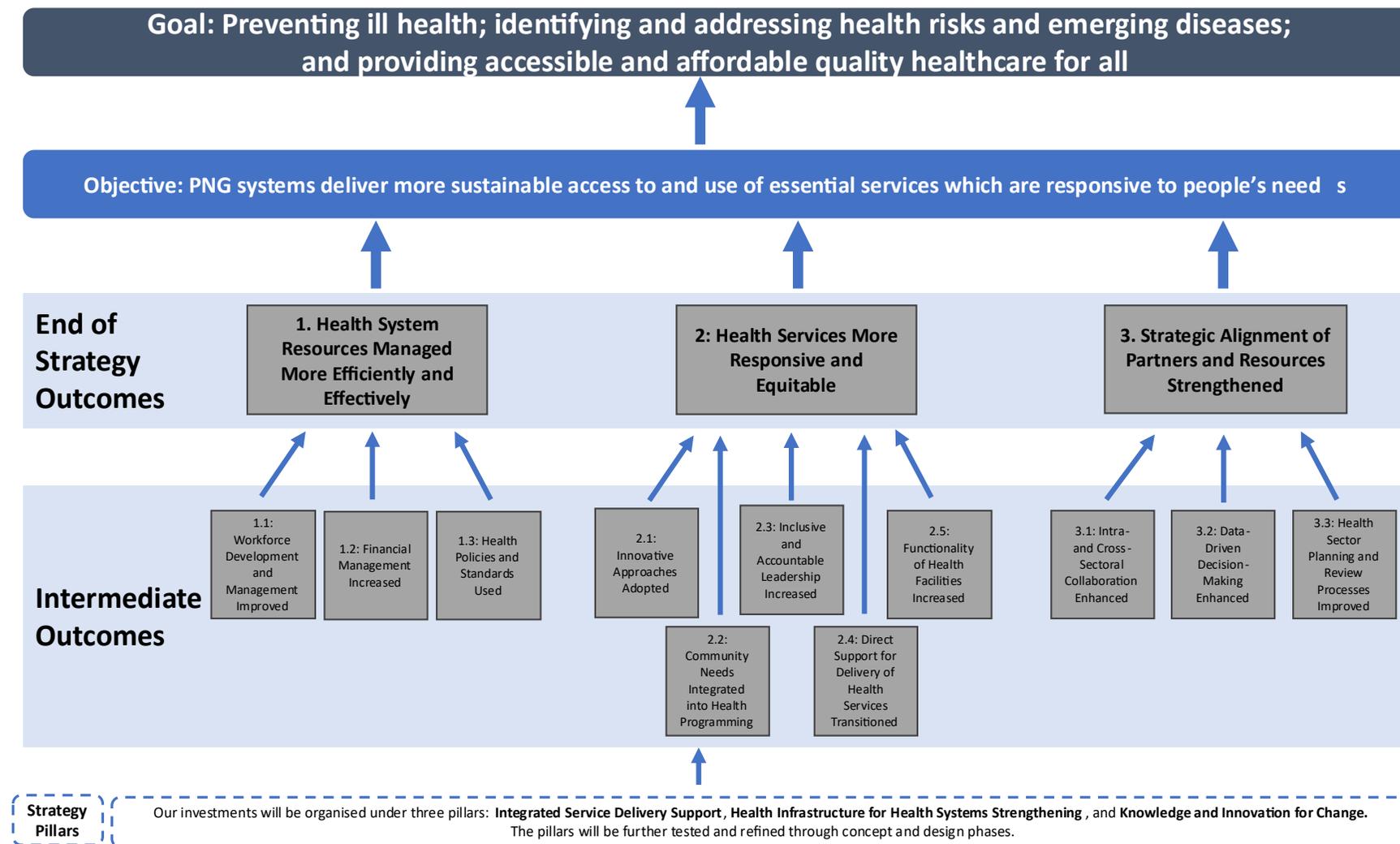
With a clear understanding of the problems and their root causes, the core team assessed the momentum for change by exploring the dynamics within the context, including:

- Dynamic areas where change could have a ripple effect
- Bright spots representing existing successes to build upon
- Stagnant areas where the system appeared resistant to change
- Strategic entry points.

This approach grounded the Theory of Change in detailed contextual understanding and assessment of the momentum for change, ensuring that the strategic interventions are based on evidence and responsive to local realities.

This approach grounded the Logic and Theory of Change, found in **Figure A2**, in detailed contextual understanding and assessment of the momentum for change, ensuring that the strategic interventions are based on evidence and responsive to local realities.

Figure A2: PNG–Australia Health Partnership Strategy 2024–2034 Logic





Annex 2 – Lessons and Approaches

The following lessons and insights about the bilateral portfolio informed decisions about the Strategy Pillars and will inform DFAT bilateral health program investments in PNG.

Lesson 1: Positive sustainable change takes a long time to realise.

A longer-term timeframe required for change to occur in the health sector needs to be balanced against the need to deliver tangible improvements to health along the way. The often overly ambitious expectations of programs and activities designed over three to five-year timeframes are mostly unmet: there is insufficient time and resources provided for programs to implement substantive activities in a complex, fragile and fluid context.

Approach: The Strategy spans a 10-year period. It is expected that the first phase of the Strategy will focus on transitioning from the existing portfolio of investments into a more coherent, integrated and streamlined arrangement. Designs of new programs will commence in 2024 and program implementation will be in place by 2026.

A mid-term review in 2029 will provide decision-makers with information on how to approach the second phase of the Strategy. The contracting arrangements under each new program will be designed to match the timeframe and intent of the Strategy, so that contracts can be amended and/or extended at the mid-point. The Strategy entails supplementary support to service delivery and longer-term system strengthening, which are required for sustainable change.

Lesson 2: Investments need to be restructured into a coherent set of programs.

The Health Portfolio Plan 2018–2023 evolved over time, with programs and projects designed at various points or being carried over from the AHC’s prior Health Plan. This constrained the alignment of investments to the Health Portfolio Plan 2018–2023 outcomes, which meant the portfolio was a collection of projects rather than a coherent set of programs. Several investments and projects ended in 2023. PATH is the only ongoing investment scheduled to end in 2025. This presents an opportunity to sequence future designs in alignment with the DPP and this Strategy.

Approach: Three investment priority areas will be designed with realistic outcomes and direct links to the DPP outcomes that support the implementation of the PNG NHP. The terms of reference for the designs will include standardisation of approaches to MEL, GEDSI, budgeting, and reporting. This will enhance coherence across investments and streamline performance management.

Lesson 3: A transformative approach to GEDSI is required to advance universal health care.

The pathway to universal health coverage requires significant improvements in GEDSI. For existing investments with positive benefits, the focus and approach to GEDSI have been increasing services for women and other vulnerable and marginalised groups.

Approach: The new programs will intentionally consider actions that enhance drivers for and address barriers to equitable access and outcomes for women and girls, people with disabilities, and people who are vulnerable or marginalised, within the scope of their design. Performance assessment of these programs will require MEL to have explicit GEDSI indicators and accountabilities. This is consistent with the PNG NHP vision of ensuring a healthy and prosperous nation where health and well-being are enjoyed by all.

Lesson 4: Direct service delivery can achieve results but is often inefficient and is not sustainable.

Australia’s investments in direct service delivery supplementation were successful in increasing service coverage for specific and targeted groups of people (particularly people with TB, HIV and other sexually transmitted infections, immunisation of the population, and family planning and

neonatal care). However, there are efficiency and sustainability concerns with this approach, because these grants are still primarily delivered as parallel programs without sufficient government oversight. Some supplementary support to enable service coverage is needed to ensure indicators do not slip, but how DFAT provides that support needs to change.

Approach: Funding to support service delivery will be reorientated in two ways. First, support will be moved towards an integrated, people-centred model of health care that reinvigorates essential public health functions and delivers quality primary health care services where people live. This reorientation aligns Australia’s support with the PNG model for delivering primary health care, addresses inefficiencies, and deliberately considers the different needs of women, men, girls, and boys, to achieve equitable access to services and thus advance progress towards universal health coverage. Second, the model for delivering supplementary grant financing will require more explicit engagement with PHAs for planning and decision-making about what services, where, and by what partners.

Lesson 5: Infrastructure investment offers both opportunities and risks for health service delivery.

Investment in infrastructure is a priority for both governments, but increases recurrent costs required for operations, maintenance, and human resources. The health budget has yet to see the requisite increase in recurrent funds to enable newly constructed facilities to operate optimally. Investment in urban tertiary infrastructure diverts resources from rural locations and public health programs, hampering progress towards universal health coverage. Poorly planned and poorly built structures with equipment that cannot be serviced are also problematic. Significant co-investment in planning, budgeting, human resources, upskilling, and change management, is required if outcomes from the investment are to be realised.

At the same time, health infrastructure presents an opportunity to generate political interest in health, because leaders are keen to engage in the development and planning of new facilities in their electorates. However, when planning is focused on constructing a single facility, the opportunity is missed to capitalise on that engagement to mobilise resources and plan for the facility’s functioning in relation to the broader network of facilities.

Approach: Funding for health infrastructure will be used as an entry point to engage leaders in decisions for broader health system support, focusing on planning, budgeting, human resources, and information systems. DFAT will bring expertise and support to assist PHAs in planning for the increased costs of the new facilities to ensure they can be functional when complete. This includes supporting change management for clinicians to operate in facilities that offer an opportunity for improved models of care.

Lesson 6: Flexibility in responding to emerging and unplanned priorities is important.

One of DFAT’s comparative advantages is its ability to respond quickly to unplanned priorities. This agility was evident during the COVID-19 pandemic: DFAT mobilised surge resources, procured vital equipment and personal protective equipment, and channelled funds directly to PHAs for emergency response plans. It is important to keep our funding and contracts flexible to support new priorities and opportunities as they develop and to respond to health emergencies.

Approach: DFAT will establish a flexible program that will deliver PNG demand-driven grants rounds, can procure technical assistance, goods and services if required, and commission research, policy pieces and other work, including on GEDSI and climate change, and contribute to the sector’s and team’s evidence base for decisions.

Lesson 7: Greater engagement with subnational authorities will foster more meaningful partnerships.



DFAT engagement in health is substantial. DFAT personnel participate in national meetings and forums and have sound relationships with the NDoH staff and Port Moresby-based stakeholders. Engagement with provincial counterparts and stakeholders is more limited. Implementation of donor-funded initiatives in provinces needs to be more cohesive and visibly aligned with PHA plans. NDoH colleagues may lack clarity on what donors are funding and may struggle to keep up with the demands of donor-funded projects. DFAT’s desire to remain a trusted, reliable, and transparent partner requires the DFAT PNG Health team to engage more systematically with sector stakeholders and lead discussions on Australia’s policy contributions, performance management, and key decisions.

Approach: DFAT will establish partnership frameworks that outline ways of working and that can serve as an anchor for dialogue with NDoH and PHAs. These frameworks will, at a minimum, outline DFAT-funded activities (bilateral and regional), provide progress information to PHAs, and detail how and when engagement with DFAT will happen.



Annex 3 – PNG–Australia Health Partnership Strategy

Objective and End of Strategy Outcomes, including Illustrative Indicators

Strategy Objective

The Strategy Objective ‘PNG systems deliver more sustainable access to and use of essential services which are responsive to people’s needs’ is derived from DPP outcome 3.1. Supporting GoPNG with this Objective ensures that the people who need services the most – including the 85 per cent of the population that reside in rural areas – have access to integrated, person-centred primary health care close to their homes.

The Objective will be realised when the following EOSOs are realised by PNG:

- EOSO1: Health system resources are more efficiently and effectively managed.
- EOSO2: Health services are more responsive and equitable.
- EOSO3: Strategic alignment of partners and resources is strengthened.

Illustrative indicators

We will know if the Objective is being achieved by tracking progress against the following illustrative indicators, to which Australia, the GoPNG, and other partners contribute:

- UHC Service Coverage Index: Reproductive, maternal, newborn and child health – family planning, antenatal care and delivery, Penta 3 immunisation, care-seeking behaviour for child pneumonia.
- UHC Service Coverage Index: Infectious diseases (tuberculosis treatment, HIV Antiretroviral Therapy, use of insecticide-treated bed nets for malaria prevention, adequate sanitation).
- UHC Service Coverage Index: NCDs (prevention and treatment of raised blood pressure, prevention and treatment of raised blood glucose, tobacco (non-smoking)).

A Monitoring and Evaluation Framework (MEF), including illustrative indicators at Objective, EOSO and IO levels is provided in **Annex 4**. The majority of illustrative indicators and targets are taken from NDoH’s *Indicator Compendium – Monitoring and Evaluation Framework for the National Health Plan 2021–2030*.

Our Strategy establishes clear outcomes that guide how we will contribute to the Goal and Objective. The three EOSOs described below target the critical health sector challenges underpinning weak health outcomes in PNG and describe the areas that our efforts will support.

EOSO1: Health system resources managed more efficiently and effectively – The focus of this EOSO is enabling more efficient prioritisation and management of critical health resources, necessary for the effective functioning of the health system and delivery of sustainable primary health care. The Strategy proposes that if targeted support is provided to strengthen the systems and capacity to manage financial and human resources and enable the rigorous application of health policy and standards, then critical health system inputs will be more effectively and efficiently managed and allocated, to better support quality frontline health service delivery.

EOSO2: Health services more responsive and equitable – The focus of this EOSO is on enhancing the ability of health services to provide quality, integrated care that addresses current and evolving health needs. The Strategy proposes that if targeted support is provided so that community needs are integrated into programming, PHA leadership is more inclusive and accountable, functionality of health facilities is increased, with the adoption of innovative approaches to catalyse change, then

health services will become more responsive and equitable, effectively meeting the diverse needs of the population, and ensuring fair access for all. Australia will continue to provide direct support to deliver integrated health services in partnership with PHAs, supplementing existing services to address critical health needs and gradually transitioning towards sustainability.

EOSO3: Strategic alignment of partners and resources strengthened – The focus of this EOSO is to enhance strategic planning, coordination, and the leveraging of diverse partner resources to address critical health priorities. The Strategy proposes that if health partner and multisectoral collaboration is strengthened, data-driven decision-making is enhanced and health sector planning and review processes are improved, then the strategic alignment of partners and resources will be strengthened, ensuring that all efforts are focused on improving health outcomes in PNG.

Detailed EOSOs and Intermediate Outcomes

A detailed description of EOSOs and IOs is provided below, with illustrative indicators, that will guide the measurement of performance against the Strategy.

End of Strategy Outcome 1: Health System Resources Managed More Efficiently and Effectively

The Strategy will guide investments designed to support more efficient prioritisation and management of financial, human, and material resources, to enable effective functioning of the health system and delivery of sustainable primary health care. Important structural changes within the health system, including NDoH and PHA restructuring and recruitment for new roles, rollout of human resources and financial management systems, and the introduction of PHA manuals to support implementation of PHA Chief Executive Officer (CEO) legislation, have already begun and will support this outcome.

We see this EOSO being realised when the following IOs are achieved by PNG:

- IO1.1: Workforce development and management improved
- IO1.2: Financial management increased
- IO1.3: Health policies and standards used.

Additionally, to realise this EOSO, we believe that certain conditions must be met: GoPNG demonstrates the political will and commitment to increase investment and prioritisation of the health system; donors continue to advocate for more significant health system investment; and support from technical partners aligns with the NHP, NDoH systems, and PHA priorities.

Illustrative indicators

We will know if EOSO1 is being achieved through the following illustrative indicators to which Australia, the GoPNG and its partners will contribute:

- Percentage of total provincial expenditure on health that is expended within the district level or in direct support of facilities.
- Percentage of provincial health expenditure (government and development partner contributions) estimated as minimum health expenditure required.
- Total amount of funds (government and development partner contributions) that the country allocates to the health sector per capita per annum.

Intermediate Outcome 1.1: Workforce Development and Management Improved

The Strategy will guide investments designed to support improved human resources management and workforce development to optimise the recruitment, development, and retention of health



personnel, and support the development of a skilled, incentivised, and motivated workforce to deliver quality care. Workforce development includes pre-service undergraduate, and in-service training. Initiatives such as the Daru Centre of Excellence and new training curricula for nurses and community health workers are beginning to align workforce skills with contemporary health demands. Political backing, such as inclusion of workforce priorities in Ministerial plans, can underscore a strong foundational commitment to health workforce development.

Illustrative indicators

Illustrative indicators that will inform progress on IO1.1 include:

- Percentage of provinces implementing Human Resources Information System (HRIS).
- Number of health workers per 10,000 population. Health worker cadres measured are: medical officers, health extension officers, nurses, midwives, and community health workers.

Intermediate Outcome 1.2: Financial Management Increased

The Strategy will guide investments designed to enhance the health system’s ability to manage and allocate its financial resources efficiently, ensuring long-term operational stability, including budgeting, allocation, and flow of financial resources from the PNG Treasury and non-government sources to the health facility level. Financial management encompasses the financial management systems of PHAs and the flow of resources from the national level to PHAs. Ongoing Public Financial Management training emphasises the commitment to more robust financial management within the health system.

Illustrative indicators

An illustrative indicator that will inform progress on IO1.2 is:

- Proportion of PHAs that have introduced facility-based budgeting to optimise the use of finances, staff, and resources, and to increase transparency with stakeholders to improve the efficiency and accountability of their health facilities.

Intermediate Outcome 1.3: Health Policies and Standards Used

The Strategy will guide investments designed to promote effective communication, understanding and implementation of health policies and standards (established benchmarks of quality and safety) within the health system. DFAT-funded legal and policy advisers in the NDoH have supported updating health policies, which gives momentum for the application and use of policies and standards across the health system.

Illustrative indicators

Illustrative indicators that will inform progress on IO1.3 include:

- Percentage of provinces that have developed, endorsed and maintained strategic plans (Corporate Plans and Provincial Health Service Plans) to support implementation of the NHP.
- Number of relevant policies or laws reviewed and developed for the improvement of health standards.

End of Strategy Outcome 2: Health Services More Responsive and Equitable

The Strategy will guide investments designed to enhance the ability of health services to address current and evolving health needs, including the effects of climate change, prioritising community engagement, and ensuring that services are tailored to the diverse needs of individuals and communities, emphasising under-served, socially excluded, and vulnerable populations. We are building on efforts such as the development of GEDSI policies by PHAs and inclusion of GEDSI Officers in PHA structures, which have the potential to address gender-based barriers to equity.



We envisage this EOSO being realised when the following IOs are achieved:

- IO2.1: Innovative approaches adopted
- IO2.2: Community needs integrated into health programming
- IO2.3: Inclusive and accountable leadership increased
- IO2.4: Direct support for delivery of health services transitioned
- IO2.5: Functionality of health facilities increased.

In addition to achieving these IOs, the realisation of this EOSO depends on several critical conditions. Past successful health sector innovative approaches and technologies, once proven, can be effectively scaled and replicated. The NDoH, PHAs, and donors demonstrate targeted political engagement to ensure that health services adapt to and meet the diverse and evolving needs of all segments of the population.

Illustrative indicators

We will know if EOSO2 is being achieved through the following illustrative indicators to which Australia, the GoPNG and its partners will contribute:

- Percentage of integrated outreach clinics conducted. Integrated outreach clinics are provided to children and adults and involve delivery of essential health services, including for reproductive, maternal and child health, immunisations, health promotion and others.
- Percentage of births that occur in health facilities.
- Percentage of women who received ANC four times or more at a hospital, health centre or outreach clinic during pregnancy.
- Percentage of pregnant women that attended at least one ANC visit at a health facility.

Illustrative indicators will be reviewed during the design to ensure cross-cutting issues like climate change, gender, disability and social inclusion are appropriately measured.

Intermediate Outcome 2.1: Innovative Approaches Adopted

The Strategy will guide investments designed to develop and trial transformative policies, funding models, methodologies, technologies, and approaches to enhance the effectiveness of health services. These can be promising approaches or technologies that are already happening, or proven approaches that are ready to be scaled, and includes supporting locally developed initiatives that can improve quality and equity of health care. Some new approaches have created momentum for changed perspectives and knowledge.

Illustrative indicators

An illustrative indicator that will inform progress on IO2.1 is:

- Number of new technologies or health innovations ready and suitable for scaling.

Intermediate Outcome 2.2: Community Needs Integrated into Health Programming

The Strategy will guide investments designed to promote community engagement and involvement in designing, implementing, and evaluating health care, ensuring that health care responds to diverse needs of the community and is contextually appropriate. It recognises communities as partners in health, sharing responsibility for health outcomes alongside health professionals, and builds on recent development of policies such as the one relating to Village Health Assistants, and integration of community feedback mechanisms that make health services more aligned with local needs.

Illustrative indicators

Illustrative indicators that will inform progress on IO2.2 include:

- Number of village health assistants per 1,000 population.
- Availability of national strategy or policy for including local communities in stakeholder discussions on policies and planning.
- Proportion of provinces delivering clinical services through community-based rehabilitation outreach programs.
- Percentage of PHAs with Annual Implementation Plans (AIPs) developed with community representatives (women’s groups, civil society organisations, disability groups, ward counsellors, local-level government (LLG) presidents).

Intermediate Outcome 2.3: Inclusive and Accountable Leadership Increased

The Strategy will guide investments designed to promote leadership and policies that value diverse perspectives and backgrounds; and a culture within health institutions that reflects and respects the diversity of the communities they serve, with a focus on women in leadership. It will ensure leaders are held accountable for their decisions and policies, ensuring that leaders are answerable for their actions and decisions, especially in terms of transparency and ethical conduct in health service management. It builds on the enhancement of laws aimed at improving the health system governance.

Illustrative indicators

An illustrative indicator that will inform progress on IO2.3 is:

- Percentage of women and persons living with disability in decision-making bodies and leadership roles who believe their influence on healthcare policies, planning, and equity in service delivery has increased over time.

Intermediate Outcome 2.4: Direct Support for Delivery of Health Services Transitioned

The Strategy will guide investments designed to provide direct donor support to enhance the reach of health services in areas of high unmet need, aiming for seamless integration with GoPNG systems. The transition of health service support to GoPNG systems is planned as a gradual and sustainable process, structured over time to ensure continuity.

Illustrative indicators

Illustrative indicators that will inform progress on IO2.4 include:

- Percentage of births that occur in health facilities.
- Percentage of all forms of TB cases registered in a given year who successfully complete anti-TB treatment (six months of short course, with or without bacteriological evidence of success).

Intermediate Outcome 2.5: Functionality of Health Facilities Increased

The Strategy will guide investments designed to ensure that health facilities are accessible and capable of providing effective, affordable, and quality integrated health care, including essential services, according to national standards, such as health promotion, outreach, and referrals. To function, health facilities will need to be adequately staffed, equipped, operated, and maintained to provide essential services in accordance with National Health Service Standards and the needs of catchment populations.

Illustrative indicators

Illustrative indicators that will inform progress on IO2.5 include:

- Percentage of health posts open. Health posts provide the primary level of health care for most of the population. A functioning health post brings accessibility of healthcare services to local villages and hence provides an opportunity to improve health and well-being.
- Number of functional public and private health posts, health centres, district/rural hospitals, provincial hospitals, and specialised/teaching and research hospitals, per 10,000 population.
- Proportion of health facilities of levels 2–6 with running water and sanitation facilities at the time of data collection.

End of Strategy Outcome 3: Strategic Alignment of Partners and Resources Strengthened

The Strategy will guide investments designed to encourage that all partners in the health sector – from policymakers to healthcare providers and across all sectors – to work cohesively toward NHP objectives driven by need and based on evidence. It includes collaboration with multisectoral stakeholders, strengthening evidence-based planning and maximising potential partner resources so that they align to strategic priorities. Partners and resources include the network of individuals, organisations, resources, and relationships that can contribute to improved health outcomes in PNG. This includes mobilising partner resources from a variety of sources to the support achievement of NHP objectives.

We envisage this EOSO being realised when the following IOs are achieved:

- IO3.1: Intra- and inter-sectoral collaboration enhanced
- IO3.2: Data-driven decision-making enhanced
- IO3.3: Health sector planning and review processes improved.

To achieve this EOSO, several conditions must be met; for example, national and provincial planning and review systems are established by GoPNG, and partners align their resources towards a unified National Health Plan.

Illustrative indicators

We will know if EOSO3 is being achieved through the following illustrative indicators to which Australia, the GoPNG and its partners will contribute:

- Proportion of policies, strategies or plans developed outside the health sector by the education, agriculture, information and communications technology (ICT), commerce and trade sectors, in water, sanitation, and hygiene (WASH), and climate change, and by the National Maritime Safety Authority, and Police Departments, which outline or address health issues in alignment with the priorities of the NHP.
- Percentage of provinces that have conducted annual reviews of their strategies and plans through development of Annual Management Reports.

Intermediate Outcome 3.1: Intra- and Inter-Sectoral Collaboration Enhanced

The Strategy will guide investments designed to support structured partnerships and collaborative frameworks, inside and outside the system, across different sectors contributing to one health plan. Building on the momentum from initiatives including the Chief Executive Officers Forum, this outcome leverages established platforms to enhance collaboration across sectors and within the health sector.

Illustrative indicators

Illustrative indicators that will inform progress on IO3.1 include:

- Percentage of partners providing financial and technical support for health services and development that have signed a Memorandum of Understanding (MOU) with NDoH.
- Number of public-private partnership-level agreements signed at the provincial level.

Intermediate Outcome 3.2: Data-Driven Decision-Making Enhanced

The Strategy will guide investments designed to strengthen the role of data in health decision-making processes, ensuring that strategies and interventions are based on empirical evidence and real-time insights through data analysis and use. Leveraging the advances made through the implementation of eNHIS and the NDoH MEF, this includes strengthening the systems used to collect, analyse, and report health data, and more effective use of eNHIS data for planning and monitoring within the health system.

Illustrative indicators

An illustrative indicator that will inform progress on IO3.2 is:

- PHA timeliness and accuracy of eNHIS reporting.

Intermediate Outcome 3.3: Health Sector Planning and Review Processes Improved

The Strategy will guide investments designed to promote the application and strengthening of existing health system strategic planning and review mechanisms, allowing for continuous evidence-based learning and adaptation. Improving these processes will contribute to ensuring that PHA health programs are well-planned, and regularly evaluated and adjusted based on performance and emerging trends. It will capitalise on the momentum from the support being provided by DFAT and other development partners to strengthen PHA planning.

Illustrative indicators

Illustrative indicators that will inform progress on IO3.3 include:

- Percentage of PHAs that have developed AIPs where community representatives (women's groups, civil society organisations, disability groups, ward counsellors, LLG presidents) are engaged during planning and preparation activities.
- Percentage of provinces with a partners' forum established, and a partners' forum established at the national level.

Annex 4 – Health Partnership Strategy Indicative Monitoring and Evaluation Framework

This Indicative Monitoring and Evaluation Framework provides overall guidance and outlines aggregate indicators designed to measure the overall high-level outcomes of investments. Where there are targets, they were drawn from NDoH's *National Health Plan 2021–2030*. Australia's own targets will need to be developed and refined through forthcoming designs.

Objective: PNG systems deliver more sustainable access to and use of essential services which are responsive to people's needs

Indicators	Definition	Rationale	Targets ¹	Baseline	Source	Comments
UHC Service Coverage Index: Reproductive, maternal, newborn and child health – family planning, antenatal care and delivery, Penta 3 immunisation, care-seeking behaviour for child pneumonia	An average coverage of reproductive, maternal, newborn and child health services using four tracer indicators: 1. Family planning: percentage of women of reproductive age (15–49 years) who are married or in union who have their need for family planning satisfied with modern methods. 2. Pregnancy and delivery care: percentage of women aged 15–49 years with a live birth in a given time period who received ANC four or more times. 3. Child immunisation: percentage of infants receiving three doses of diphtheria-tetanus-pertussis containing vaccine. 4. Child treatment: percentage of children under 5 years of age with suspected pneumonia in the two weeks preceding the survey taken to an appropriate health facility or provider.	These indicators align with the broader health system goals of reducing morbidity and mortality among the most vulnerable populations – children and mothers. By focusing on these groups, the health system addresses key areas that typically indicate overall health system performance.	By 2025: 61 By 2030: 88	48	UHC global estimates	Frequency: Biennial
UHC Service Coverage Index: Infectious diseases (tuberculosis treatment, HIV Antiretroviral Therapy, use of insecticide-treated bed nets for malaria)	An average coverage of infectious disease services using four tracer indicators: 1. Tuberculosis treatment: percentage of incident TB cases that are detected and successfully treated. 2. HIV/AIDS ART (TB): percentage of people living with HIV currently receiving TB.	This index assesses the health system's capacity to manage and control infectious diseases, which are significant public health challenges.	By 2025: 63 By 2030: 80	46	UHC global estimates	Frequency: Biennial

¹ Where there are targets, they were drawn from NDoH. (n.d.). *Indicator Compendium – Monitoring and Evaluation Framework for the National Health Plan 2021–2030*. Australia's own targets will need to be developed and refined through forthcoming designs.

Indicators	Definition	Rationale	Targets ¹	Baseline	Source	Comments
prevention, adequate sanitation)	<p>3. Malaria insecticide-treated bed nets (ITNs): percentage of population in malaria-endemic areas who slept under an ITN the previous night (only for countries with a high malaria burden).</p> <p>4. Adequate sanitation: percentage of households using at least basic sanitation facilities.</p>					
UHC Service Coverage Index: Non-communicable diseases (prevention and treatment of raised blood pressure, prevention and treatment of raised blood glucose, tobacco (non-smoking))	<p>An average coverage of NCD interventions using three tracer indicators:</p> <p>1. Hypertension (blood pressure): Age-standardised prevalence of non-raised blood pressure (systolic blood pressure <140 mmHg or diastolic blood pressure <0 mmHg) among adults aged 18 years and older.</p> <p>2. Diabetes (Fasting Blood Glucose): Age-standardised mean fasting plasma glucose (mmol/L) for adults aged 18 years and older.</p> <p>3. Tobacco: age-standardised prevalence of adults >=15 years not using tobacco in last 30 days (SDG indicator 3.a.1.)</p>	NCDs such as cardiovascular diseases and diabetes are major contributors to global morbidity and mortality. This index provides insight into the health system's capacity to prevent and manage NCDs through early detection, appropriate treatment, and risk factor control.	<p>By 2025: 64</p> <p>By 2030: 80</p>	50	UHC global estimates	Frequency: Biennial



End of Strategy Outcome 1: Health system resources managed more efficiently and effectively

Indicators	Definition	Rationale	Targets	Baseline	Source	Comments
Government (functional grants) and partner funded contributions that are expended	Percentage of total provincial expenditure on health that is expended within the district level or in direct support of facilities.	By tracking how much of the provincial health budget is actually spent at the district level or directly on health facilities, the effectiveness of resource distribution and utilisation closer to the point of service delivery can be assessed.	2025: 100%, 2030: 100%	80%	Numerator: NDoH Treasury Department report	Frequency: Annual
Provincial health expenditure (government and development partner contributions) as a percentage of estimated minimum health expenditure required	Percentage of provincial health expenditure (government and development partner contributions) estimated as minimum health expenditure required.	This indicator helps gauge the adequacy of funding relative to what is necessary for maintaining basic health standards, considering both government and donor contributions.	2025: 90% 2030: 100%	66%	Numerator: NDoH Treasury Department report	Frequency: Annual
Total budget allocation (Health Services Improvement Program and GoPNG) per capita	Total amount of funds (government and development partner contributions) that the country allocates to the health sector per capita per annum.	This indicator is a measure of the overall investment in the health sector, indicating the financial priority given to health in national and regional budgets.	2030: 210	193	Numerator: NDoH Treasury Department report Denominator: Total population	Frequency: Annual



Intermediate Outcome 1.1: Workforce development and management improved

Indicators	Definition	Rationale	Targets	Baseline	Source	Comments
Provinces implementing Human Resource Information System (HRIS)	Percentage of provinces implementing HRIS.	The HRIS is crucial for effective workforce management, as it enables the systematic tracking, management, and planning of health worker data. Implementing the HRIS across provinces indicates a strategic approach to enhancing the human resource capabilities within the health system.	2025: 50%, 2030: 100%	N/A	NDoH ICT report	Frequency: Annual
Density of health workers per 10,000 population (stratified by cadre)	Number of health workers per 10,000 population. Health worker cadres measured are: medical officers, health extension officers, nurses, midwives, and community health workers.	This is a key metric for understanding workforce adequacy and is directly linked to the health system's capacity to provide comprehensive, timely, and effective health services.	2025: 1.8 2030: 2.0	1.0	Numerator: NDoH human resources report/database Denominator: Census population projections	Frequency: Annual

Intermediate Outcome 1.2: Financial management increased

Indicators	Definition	Rationale	Targets	Baseline	Source	Comments
PHAs that have introduced facility-based budgeting	Proportion of PHAs that have introduced facility-based budgeting to optimise the use of finances, staff and resources, and to increase transparency with stakeholders to improve the efficiency and accountability of their health facilities.	Facility-based budgeting increases transparency and accountability, ensuring that financial resources are used effectively and stakeholders can see and influence how funds are allocated and spent.	2025: 21 2030: 21	7.0	NDoH Treasury Department report	Frequency: Annual

Intermediate Outcome 1.3: Health policies and standards used

Indicators	Definition	Rationale	Targets	Baseline	Source	Comments
Provinces that have policies, strategies and plans to implement the <i>National Health Plan 2021–2030</i>	The percentage of provinces that have developed and endorsed strategic plans (Corporate Plans and Provincial Health Service Plans) to support implementation of the National Health Plan.	This indicator measures the alignment of provincial health systems with national health objectives, which is key to translating the NHP into actionable, localised strategies.	2025: 100%, 2030: 100%	0	Strategy and Policy Division (NDoH) reports, PHA reports	Frequency: Annual
Legislation reviewed and developed to support implementation of the National Health Plan	Count of laws reviewed and developed (NHAA 1997, Public Hospital Act 1994, PHAA 2007, Public Health Act 1973, Medical Registration Act 1980, Medicine Cosmetic Act 1999, Radiation Safety and Control Act 2019, Specialist Hospital Bill, Baby Feed Supplies Act).	This indicator serves as a direct measure of policy enactment and reform, which supports the enforcement of standards and the implementation of policies designed to improve health outcomes.	By 2030: 5	0	Strategy and Policy Division (NDoH) reports	Frequency: Every 5 years



End of Strategy Outcome 2: Health services more responsive and equitable

Indicators	Definition	Rationale	Targets	Baseline	Source	Comments
Integrated outreach clinics conducted	Percentage of integrated outreach clinics conducted. Integrated outreach clinics are provided to children and adults and involve delivery of essential health services including for reproductive, maternal and child health, immunisations, health promotion and others.	This indicator measures the availability and frequency of integrated outreach clinics for remote populations.	2025: 80% 2030: 100%	60%	Numerator and denominator: NHIS	Frequency: Annual
Percentage of supervised births at health facilities	Percentage of births that occur in health facilities.	A high percentage of births in health facilities indicates that pregnant women are receiving the necessary medical support during delivery, reflecting the health system's capacity to provide equitable and responsive care.	2025: 71% 2030: 80%	36%	Numerator: NHIS, Demographic and Health Survey (DHS) Denominator: Census population projections, DHS	Frequency: Annual
Pregnant women having at least four ANC visits	Percentage of women who received antenatal care four times or more at a hospital, health centre or outreach clinic during pregnancy.	This indicator reflects the system's responsiveness to the needs of pregnant women and its ability to provide equitable access to essential prenatal services.	2025: 75% 2030: 83%	49%	Numerator and denominator: NHIS	Frequency: Annual



Intermediate Outcome 2.1: Innovative approaches adopted

Indicators	Definition	Rationale	Targets	Baseline	Source	Comments
Number of new technologies or health innovations ready and suitable for scale	<p>Transformative: Completely novel approaches that create entirely new value; often considered big steps forward; may carry more risk, uncharted innovations territory, have less of an evidence base, and be more difficult or costly to take forward.</p> <p>Incremental: Iterations or improvements of existing programs or processes often more easily implemented and more commonly successful; usually considered 'not risky'.</p> <p>Adjacent: Expanding existing programs, services, or products to another program, organisation, country/region, or context; in other words, adapting an existing idea to a new context; often involves bringing existing expertise into a new context or addressing the current context using new expertise.</p>	This measure not only tracks the introduction of innovations but also their feasibility and readiness for broader deployment, ensuring that new technologies can transition from development stages to practical, scalable applications.	TBD	Based on how many new technologies were introduced and scaled in the past year	Innovation Hubs and Research Institutions	

Intermediate Outcome 2.2: Community needs integrated into health programming

Indicators	Definition	Rationale	Targets	Baseline	Source	Comments
Number of village health assistants per 1,000 population	The number of village health assistants per 1,000 population. *Village health assistants are health workers who provide health education, referral and follow-up, case management and basic preventative health care and home visiting services to specific communities (Village Health Assistant Policy).	By quantifying the density of these health workers, the indicator reflects the health system’s capacity to deliver localised, community-focused health services that bridge the gap between healthcare facilities and rural or under-served communities.	2025: 1.0 2030: 2.0	N/A	Numerator: Human resources records, PHA/NDoH reports Denominator: Census population projections	Frequency: Annual; Disaggregation: By province and district
Availability of national strategy or policy for including local communities in stakeholder discussions	Availability of national strategy or policy for including local communities in stakeholder discussions on policies and planning.	This indicator assesses the institutional framework in place to ensure community involvement in health decision-making.	2025: Yes 2030: Yes	No	NDoH report	Frequency: Annual
Provinces delivering clinical services through community-based rehabilitation outreach	Proportion of provinces delivering clinical services through community-based rehabilitation outreach programs.	This indicator offers a measure of how the health system extends its reach beyond traditional health facilities into community settings.	2025: 68% 2030: 100%	32%	Numerator: National Orthotic and Prosthetic Services program report	Frequency: Annual; Disaggregation: By community-based rehabilitation outreach programs and clinical services, By age and gender
Provincial Health Authorities that have developed Annual Implementation Plans with community engagement	Percentage of PHAs that have developed AIPs where community representatives (women’s groups, civil society organisations, disability groups, ward counsellors, LLG presidents) were engaged during planning and preparation activities.	Involving diverse community representatives ensures that the planning process is inclusive and reflective of the community’s health needs and priorities.	2025: 100% 2030: 100%	N/A	Numerator: PHA or NDoH reports	Frequency: Annual

Intermediate Outcome 2.3: Inclusive and accountable leadership increased

Indicators	Definition	Rationale	Targets	Baseline	Source	Comments
Percentage of women and persons with disabilities in decision-making bodies and leadership roles who believe their influence on healthcare policies, planning, and equity in service delivery has increased over time	Decision-making bodies and leadership roles: Refers to positions within the health sector that have significant authority and responsibility for making strategic decisions, including policy formulation, resource allocation, and program oversight. Influence on healthcare policies, planning, and equity in service delivery: Measures the effect that individuals in leadership roles have on shaping healthcare directives, strategic decisions, and ensuring that these policies promote fairness and accessibility in health service distribution across different population groups.	This indicator measures whether women and persons with disabilities believe they are integrated into health governance roles, not just in terms of representation but in their actual influence on shaping healthcare policies and ensuring equitable service delivery.	TBD	TBD	PATH PHA/BDoH/ NDoH GEDSI Support Workplans <i>Sapotim Lida</i> Program reports	Frequency: 6-monthly, Annually Disaggregation: By province or NDoH, By organisation type, By position type, By type of influence

Intermediate Outcome 2.4: Direct support for delivery of health services transitioned

Indicators	Definition	Rationale	Targets	Baseline	Source	Comments
Supervised births at health facilities	Percentage of births that occur in health facilities.	Increasing supervised births in health facilities is a measure of improved health service delivery, ensuring safer childbirth and reducing maternal and neonatal mortality.	2025: 71%, 2030: 80%	36%	Numerator: NHIS, DHS Denominator: Census population projections, DHS	Frequency: Annual; Disaggregation: By province and district
TB treatment success rate for all forms of TB bacteriologically confirmed and clinically diagnosed, new and relapse cases	Percentage of all forms of TB cases registered in a given year who successfully complete anti-TB treatment (6 months of short course, with or without bacteriological evidence of success).	By focusing on treatment completion rates, you can gauge the effectiveness of interventions designed to enhance patient adherence and the overall capacity of health services to manage TB care.	2025: 85%, 2030: 95%	73%	TB Program for both numerator and denominator	Frequency: Annual; Disaggregation: By province, sex and age

Intermediate Outcome 2.5: Functionality of health facilities increased

Indicators	Definition	Rationale	Targets	Baseline	Source	Comments
Health posts open	Percentage of health posts open. Health posts provide the primary level of health care for most of the population. A functioning health post brings accessibility of the healthcare services to local villages and hence provides an opportunity to improve health and well-being.	This indicator measures the availability and operational status of health posts in facilities, which is a direct measure of health service accessibility for the local population.	2025: 80%, 2030: 100%	0.5	Numerator and denominator: National Inventory of Health Facilities	Frequency: Annual
Health facilities per 10,000 population in targeted provinces	Total number of functional public and private health posts, health centres, district/rural hospitals, provincial hospitals, and specialised/teaching and research hospitals per 10,000 population.	This indicator measures the density of functional health facilities across different levels of care, reflecting the health system's capacity to serve its population.	By 2025: 3.5 By 2030: 5	2.8	Numerator: National Inventory of Health Facilities Denominator: Census population projections	Frequency: Annual, Disaggregation: By province
Health facilities that have running water and sanitation	Proportion of health facilities of levels 2–6 with running water and sanitation facilities at the time of data collection.	This indicator measures the infrastructural readiness of health facilities to provide safe and effective care. Facilities equipped with proper sanitation and water facilities are better prepared to maintain hygiene standards, prevent infection transmission, and provide dignified care.	By 2025: 75 By 2030: 100	49	National Inventory of Health Facilities	Frequency: Annual, Disaggregation: By province

End of Strategy Outcome 3: Strategic alignment of partners and resources strengthened

Indicators	Definition	Rationale	Targets	Baseline	Source	Comments
Policies, strategies and plans developed outside the health sector with priorities aligned to the NHP	Proportion of policies, strategies or plans developed outside the health sector by the education, agriculture, information, ICT, commerce and trade sectors, in WASH, and climate change, and by the National Maritime Safety Authority and Police Departments, which outline or address health issues in alignment with the priorities of the NHP.	By tracking how frequently other sectors incorporate health issues in line with the National Health Plan, this indicator highlights the success of cross-sectoral collaboration and the incorporation of health as a universal priority.	2025: 80% 2030: 100%	N/A	NDoH reports	Frequency: Every 3 years
Provinces that have conducted annual reviews of their strategies and plans to implement the National Health Plan	Percentage of provinces that have conducted annual reviews of their strategies and plans through development of Annual Management Reports.	Conducting annual reviews helps ensure that strategies remain relevant and effective, facilitating timely adjustments in response to changing health needs.	2025: 100% 2030: 100%	0	Strategy and Policy Division (NDoH) reports, PHA reports	Frequency: Annual

Intermediate Outcome 3.1: Intra- and cross-sectoral engagement enhanced

Indicators	Definition	Rationale	Targets	Baseline	Source	Comments
Partners that are supporting health services and development with a signed MOU with NDoH	Percentage of partners providing financial and technical support for health services and development that have signed an MOU with NDoH.	By documenting the proportion of partners with signed MOUs, this indicator assesses the level of structured engagement and commitment between the NDoH and its external supporters.	2025: 100% 2030: 100%	N/A	Numerator and denominator: NDoH reports	Frequency: Annual
Public-private partnership service-level agreements signed at the provincial level	Number of public-private partnership-level agreements signed at the provincial level.	By counting the number of such agreements, the indicator provides insight into the extent and effectiveness of shared resources and responsibilities between the public and private sectors at the local level.	2025: 30% increase 2030: 50% increase	N/A	PHA and NDoH reports	Frequency: Annual

Intermediate Outcome 3.2: Data-driven decision-making enhanced

Indicators	Definition	Rationale	Targets	Baseline	Source	Comments
PHA timeliness and accuracy of eNHIS reporting	<p>Provincial Health Authority: Regional administrative bodies responsible for the management and delivery of health services within a province.</p> <p>eNHIS (Electronic National Health Information System): A digital platform that collects, stores, and processes health data across different levels of the health system to support management, surveillance, and decision-making.</p> <p>Timeliness: Refers to the speed at which data is reported after the information is collected, indicating the promptness of data entry into the eNHIS.</p> <p>Accuracy: Refers to the correctness and precision of the data reported, reflecting the reliability of the information entered into the eNHIS.</p>	This indicator gauges how promptly and accurately PHAs manage health data, crucial for ensuring that decisions are informed by reliable and current information.	TBD	TBD	eNHIS – SPAR report	This indicator is already reported on and more details will be added upon implementation

Intermediate Outcome 3.3: Health sector planning and review processes improved

Indicators	Definition	Rationale	Targets	Baseline	Source	Comments
PHAs that have developed Annual Implementation Plans with community engagement	Percentage of PHAs that have developed AIPs where community representatives (women’s groups, civil society organisations, disability groups, ward counsellors, LLG presidents) are engaged during planning and preparation activities.	Engaging a diverse range of community representatives in the planning process ensures that the health strategies and actions are aligned with the actual needs and preferences of the local populations they serve.	2025: 100% 2030: 100%	N/A	Numerator: PHA or NDoH reports	Frequency: Annual
Partners’ forum established at provincial and national levels	Percentage of provinces with a partners’ forum established, and partners’ forum established at the national level.	The existence of such forums indicates a structured approach to collaborative planning and resource sharing, crucial for integrated and cohesive health service delivery.	2025: 100%	N/A	NDoH/PHA reports	Frequency: Annual

Annex 5 – Risk Matrix

The following is a summarised matrix of the major risks to the Strategy.

#	Risk	Consequence	Likelihood	Risk Rating	Influence	Mitigation
1	Emergence of a health emergency or disaster in PNG.	High	Possible	Medium	Medium	DFAT investments will minimise the risk by supporting resilience in the health system and specific efforts (e.g. support for surveillance systems and promoting community awareness; and support to respond to emergencies/disasters).
2	PHA leaders lack commitment to or authority to action reform.	Medium	Likely	Medium	High	DFAT and implementing partners will minimise the likelihood of this risk by engaging PHA leadership continuously and providing targeted capacity building.
3	Changes in key leadership roles disrupt ongoing health sector initiatives.	High	Possible	Medium	Medium	DFAT will minimise the impact of this risk by using Australia's convening power to establish strong relationships with a broad range of stakeholders to maintain continuity despite leadership changes.
4	Insufficient GoPNG health sector funding of the health sector hinders effective implementation.	Very High	Likely	High	Low	Although the likelihood of this risk is partly dependent on PNG's fiscal stability, DFAT will advocate for sustained and increased, effectively allocated financial commitments, and encourage alternative funding sources, including public-private partnerships in contract arrangements.
5	Lack of robust governance structures prevents the enforcement of accountability measures.	High	Likely	High	Medium	DFAT investments will minimise this risk by supporting capacity building initiatives for health governance structures, promoting the adoption of best practices in accountability and transparency.
6	Institutional resistance to change impedes the adoption of innovative approaches.	Medium	Likely	Medium	Medium	DFAT investments will use Australia's convening power to bring diverse stakeholder groups together around new approaches and technologies for equitable, effective health care.
7	Conflicting priorities among stakeholders, including government and non-government institutions, and private sector partners, leads to challenges in collaboration.	High	Possible	Medium	Medium	DFAT investments will promote regular coordination meetings to align strategies among stakeholders.
8	Changing management arrangements disrupts the effectiveness of the eNHIS.	High	Unlikely	Medium	Medium	DFAT and its partners will provide for the eNHIS through technical support and regular training and system maintenance.
9	Weaknesses in infrastructure (e.g. poor roads and unreliable internet and electricity) limit the effectiveness of the Strategy.	Medium	High	Medium	Medium	DFAT more broadly provides support for infrastructure improvement. The Strategy prioritises approaches to increase reach of health services in remote and rural areas.
10	Difficulty in attracting and retaining skilled personnel leads to staffing gaps, hindering effective implementation.	Medium	Likely	Medium	Medium	DFAT supports GoPNG initiatives aimed at improving working conditions, offering competitive salaries, and implementing targeted recruitment and retention strategies.

The risk rating in the matrix above is built on the key shown below. Consequence and likelihood were rated separately – the risk rating is a combination of the two based on the key. Influence was then rated, and the overall mitigation developed as the last step.

		PROBABILITY		CONSEQUENCES		
LIKELIHOOD	Almost Certain <i>More than 80% chance of occurring</i>	Medium	Medium	High	Very High	Very High
	Likely <i>60-80% chance of occurring</i>	Medium	Medium	High	High	Very High
	Possible <i>40-60% chance of occurring</i>	Low	Medium	Medium	High	High
	Unlikely <i>20-40% chance of occurring</i>	Low	Low	Medium	Medium	High
	Rare <i>Less than 20% chance of occurring</i>	Low	Low	Low	Medium	Medium

Annex 6 – Glossary

OECD DAC Evaluation Criteria

Term	Definition
Coherence	The compatibility of the intervention with other interventions in a country, sector or institution.
Effectiveness	The extent to which the intervention achieved, or is expected to achieve, its objectives, and its results, including any differential results across groups.
Efficiency	The extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way.
Impact	The extent to which the intervention has generated or is expected to generate significant positive or negative, intended or unintended, higher-level effects.
Relevance	The extent to which the intervention objectives and design respond to beneficiaries, global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change.
Sustainability	The extent to which the net benefits of the intervention continue or are likely to continue.

DFAT Terminology

Term	Definition
Activity	Actions taken or work performed through which inputs are mobilised to produce specific outputs (and outcomes). A single investment may include multiple activities.
End of Strategy Outcome (EOSO)	The desired development change among counterparts, change agents or beneficiaries that can be achieved by DFAT and its partners within the timeframe of the Strategy.
Goal	Generally, partner government priorities stated in national development plans, sector plans, or international treaties and obligations.
Input	The financial, human, material and intellectual resources used during the implementation.
Intermediate Outcome (IO)	The short- and medium-term effects of an investment's outputs. Short-term effects include, for example, changes in counterpart or beneficiary knowledge, attitudes, and skills, while medium-term effects reflect changes in behaviour, practice, and decisions. The achievement of single IOs is a necessary, but not sufficient, condition for the achievement of the EOSO.
Key Assumptions	The necessary and sufficient conditions for success.
Line of Accountability	Line between what DFAT is solely accountable for (below the line) and what DFAT and its many partners contribute to (above the line).
Modality	Aid modalities can range from traditional forms of assistance, such as grants or loans, to more innovative approaches that leverage partnerships with the private sector, civil society organisations, or other stakeholders. Aid modalities may involve direct budget support, sector-wide programs, project-based interventions, or targeted support for specific sectors or outcomes.
Objective	Australia's development cooperation objectives, found in DFAT's policy, including Country/Regional Plans, which contribute to the achievement of partner government priorities.
Output	The physical products, goods and services delivered by an investment implementing team. Outputs are delivered to influence the performance or behaviour of counterparts or change agents.
Program/ Investment	A commitment of resources, and a scope of work to achieve defined outcomes. 'Program' used interchangeably with 'Investment'.
Risk	Assumptions that have a significant negative effect and are unlikely to hold.

Annex 7 – References

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