PNG AUSTRALIA TRANSITION TO HEALTH (PATH) PROGRAM

Investment Design Title: PNG Australia Transition to Health (PATH) Program	
Start date: July 2020 (est)	**End date:** June 2025 (est)
Total proposed DFAT funding: TBA	**Total proposed funding from all donor/s:** TBA
Current program fund annual allocation: TBA	**AidWorks investment number:** N/A
Overall Risk Profile: High	**Value** TBA
Concept approved by: James Gilling, FAS, PBD, OTP	**Concept endorsed by AGB:** Yes
Quality Assurance completed: Internal Reference Group, two independent appraisals, formal peer review	
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A. Executive Summary

Strategic context

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

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

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

provinces in PNG (up to a total of 6), piloting, testing and demonstrating how health services can be made more accessible and effective especially through primary health care for the large rural population. A focus on a small number of selected provinces, and an adaptive programming approach can build the evidence base for stronger policies and programs by GoPNG, DFAT, and other development partners with respect to other provinces nation-wide.

Section B and C of this IDD elaborates.

The PNG Australia Transition to Health Program (PATH)

These abovementioned themes all come together in the design for the PNG Australia Transition to Health (PATH) Program. The reference to "transition" is deliberate. First, as noted, Australia is transitioning its overarching bilateral relationship with PNG away from a donor-recipient relationship to an economic and strategic partnership. Second, within the health sector itself, PNG is continuing to transition the delivery of health services to a provincially based, less centralised, model with an increased focus on primary health care in rural areas, with greater integration with provincial and regional hospitals. A key vehicle for achieving that transition are the Provincial Health Authorities (PHAs) reforms. Third, DFAT has made it clear that Australia cannot – and should not – continue to fund directly all, or even major parts, of service delivery that is ultimately the responsibility of a sovereign government like PNG. There is therefore a need to progressively transition some services currently funded by Australia through grants under the PNG Partnership Fund (PPF) and other mechanisms across to GoPNG as PNG's own systems strengthen. Any such transition of currently funded DFAT programs to PHAs in a small number of selected provinces would, of course, need to be done in an orderly, planned, phased and developmentally effective way and only where PHAs and service providers such as churches had been strengthened sufficiently to take on those responsibilities. Modelling suggests that, starting with current levels of funding and an assumed phased reduction of DFAT-funded existing services, PATH could support PHAs to reach over 850,000 people for family planning and maternal and child health (MCH) services, as well as tens of thousands of PNG citizens for other essential services, over the initial five years of PATH, as well as strengthen health security and key aspects of the PNG health system more broadly: see "profile and public diplomacy" at page 22. The fourth reason why "transition" is important in this design is that experience shows that the transition from one existing program to another new one, whoever the managing contractor might be, can be particularly problematic and expensive. That is especially the case when there are "legacy" or ongoing programs and technical assistance to continue and novate in the new program. For all these reasons, "transition" has a deliberate and important meaning within the PATH design.

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

- PHAs are more able to lead provincial health reforms and manage effective, efficient; equitable and quality essential health services in selected (up to 6) provinces.
- DFAT-funded health services are demonstrating efficient and effective models of service delivery, influencing PHA performance; and building sustainability by transitioning to PHA management in selected (up to 6) provinces.

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

To achieve the End of Investment Outcomes PATH has specific and targeted intermediate outcomes (IO's). To strengthen PHA leadership and management in selected (up to a total of 6) provinces PATH has three intermediate outcomes, in essence:

1.1 PHA capacity: PHAs Boards and management capable of leading reforms and managing finances, health workers, partnerships, quality assurance and service providers;

1.2 Accountability: More policy relevant information available and used by Government, PHAs, MPs, NGOs, health facilities and communities to monitor and drive performance and quality improvement; and

1.3 Women in Leadership: More women in management roles influencing policy, planning, and budgeting of health services in selected provinces.

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

2.1. Equity: Approaches that increase access to quality essential services by women and girls, people with disability and the poor are tested and scaled;

2.2 Essential services: DFAT-funded services demonstrate good practice in providing quality services, reaching marginal/hard to reach groups, and demonstrates linkages with and support to/from PHAs, including improved efficiency by integrating vertical services; and

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

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

A critical element of the PATH design are 5 specific "drivers": ways of purposefully achieving the EOIOs and IOs that draw on a range of delivery modalities and approaches that go beyond traditional technical solutions to aid problems. These 5 drivers of change are shown at the right-hand side of Chart 1 in the IDD. These approaches draw on emerging insights to effective aid around "adaptive programming". Adaptive programming or management acknowledges from the start that while the outcome to be achieved may be known, the specific strategies and combination of interventions that will work to address complex development challenges are developed during implementation. Underpinned by a deep investment in local relationships, problems and solutions are locally-driven and interventions are informed by real-time contextual and political analysis. Solutions are tested, assessed, analysed and adapted allowing for sustainable solutions to emerge.

The five drivers involve the proactive use of evidence, learning and dialogue; addressing problem-driven bottlenecks; leveraging partners; targeted national level support; and responding to emerging priorities. Each driver requires skilled understanding and capacity for political economy analysis of the incentives and disincentives for implementing reform: See Annex 11. As with the EOIOs and IOs, these 5 drivers are not mutually exclusive. They can and should work together to support achievement of the EOIOs and IOs. The "drivers" specifically help to build the evidence base for influencing and strengthening policy and programs of PHAs and service providers in the small number of selected provinces, DFAT's own directly funded programs, and the programs of other development partners including the multilateral development banks and the UN family.

Implementation and governance

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

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

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

Budget and resourcing

This design proposes a 5-year program budget of $183m (excluding management costs)[1] with clear provision for a 3-year extension at similar funding (total of 8 years for an estimated total cost of $293m (excluding management costs). Such an approach and timeframe enables the transition features to take root in the difficult environment of PNG. However, it also simultaneously gives DFAT the leverage and capacity to scale down, fundamentally redesign, or even close PATH if there is not "satisfactory" progress (with "satisfactory" determined by DFAT and GoPNG. This resourcing and time frame reflect the strategic incorporation of the PPF health funding into PATH and the required financing to deliver the Program's EOIOs, IOs and change drivers. A key element of the proposed budget is the expectation of a careful, gradual reduction in the level of funding from DFAT for direct service delivery activities in the areas of family planning, immunisation, TB and HIV. This is purposefully designed to be gradual to maximise the chances of alternative sources of funding being identified for the services – ideally from GoPNG – but recognising this will be challenging given the current and projected financial challenges for the GoPNG. However, it is an important signal for Australia to send and provides a basis for ongoing policy dialogue. Another key feature of the budget is the modest, but dedicated funding provided to the 5 change 'drivers' within PATH. This signals the importance of these drivers to the program approach. Section H and Annex 7 elaborates.

Risks

The PATH program is rated "very high risk" under DFAT's risk management and safeguards tool: this is not unexpected given the nature of the PNG health sector, but PATH has important and practical strategies to

[1] The design team has estimated the management costs for the program and provided these to DFAT.

mitigate those risks. The design identifies 5 "very high risks" currently, and before any intervention is made through DFAT policy dialogue or by PATH. A realistic assessment concludes that two of those risks – a decrease in the GoPNG health budget and the unavailability of essential drugs and commodities - are likely to remain "very high risk" status. These are both serious and likely risks that have challenged GoPNG, Australia, and other development partners for some years, and are beyond the direct control of DFAT. The PATH MC should obviously take mitigation measures, and DFAT should continue to have policy dialogue with GoPNG about those issues. Ultimately, if unavailability of drugs, or basic GoPNG financing, continues to undermine reform, then DFAT can consider all options when deciding on the nature of any possible extension beyond the initial 5 years. The risk assessment concludes the other 3 "very high risk" categories can be reclassified as "high risk" as a result of DFAT policy dialogue and specific PATH mitigation measures. Similarly, the risk assessment identifies a number of "high risk" and "medium risk" areas. However once again DFAT policy dialogue and PATH's own actions would reduce the rating to a lower level of risk. Section J of this IDD and Annex 13 elaborates, including how the MC is to manage and implement safeguard issues including environmental and social safeguard policy.

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

Consultation

The design for PATH was the result of an extensive process of consultations with DFAT, GoPNG, multilateral agencies working in the health sector in PNG, private sector providers, churches and NGOs, and community groups. **The National Department of Health has reviewed this draft design and provided comments.** Details of the consultation process are in Annex 14.

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

The overarching strategic context

Papua New Guinea – Australia's nearest neighbour and largest aid recipient – has a mixed but generally disappointing record compared to other similar countries, including in the areas of health and human development. PNG is a lower-middle income country, with volatile economic growth per capita due to a high dependence on international commodity prices and lumpy investments in natural resources. GDP growth per capita has ranged from 4.97% in 2000 to 12.9%, one of the highest rates in the world, in 2014. GDP growth per capita has also been negative for nearly half (8 out of 17) years since 2000 (1). There is limited data on the extent and depth of poverty in PNG but the World Bank estimates that around 87% of the population lived below $ 5 per day in 2011 (1). The World Bank further estimates that the incidence of "hardship and vulnerability" – meaning people are unable to meet basic needs – is around 40% in PNG, around double the incidence in the rest of the Pacific (2).

PNG has a generally low ranking on global indices tracking development. PNG did not fully achieve any of the international Millennium Development Goals (MDGs) including the MDGs related to health, education or gender. The UNDP's Gender Inequality Index ranks PNG 159 out of 160 countries. The broader UNDP Human Development Index, a composite measure of income per capita, education and life expectancy, classifies PNG as "low human development" and ranks it 153 out of 189 countries and territories. PNG was also ranked 138 out of 175 by Transparency International in 2018 in terms of perceptions of corruption. PNG is lagging behind other Pacific Island countries in terms of the Sustainable Development Goals (SDGs) for health and making progress towards Universal Health Coverage (UHC). The latest World Bank and WHO report tracking progress

towards UHC ranks PNG second lowest (after Kiribati) in the Pacific for UHC service coverage, and more on par with Sub-Saharan African countries such as Benin, Senegal, Togo, Sudan and Zimbabwe.[2]

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

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

PNG continues to face significant health challenges. Life expectancy for men and women have improved but not as rapidly as comparable countries, nor is it at the expected level for a country of PNG's income: see Annex 1. Historically, there has been progress in addressing specific diseases (e.g. malaria and HIV) – but this has been largely buttressed by significant vertical donor support and has not been sustained beyond the life of external financing and delivery. For example, at one stage PNG was reducing malaria incidence faster than any other country in the world but this has not been sustained (11). PNG now faces formidable challenges in terms of communicable diseases (including sexually transmitted infections, increasing HIV infections, and drug resistant TB and HIV); under-nutrition (PNG is ranked fourth in the world for stunting); and maternal, new-born and child health. Polio re-emerged in 2018. Neglected tropical diseases in PNG include leprosy and filariasis. PNG also faces a rapidly rising challenge of Non-Communicable Diseases (NCDs): including heart disease, cancers, and diabetes - which puts new and different strains on an already fragile health system. There is little reliable data on the burden of mental health in PNG: an issue of increasing relevance not only because of the intrinsic importance of good mental health but because mental health is now a formal part of SDG 3 and progress – or the lack of it – in preventing and treating it is being tracked internationally. There are complex two-way interactions between mental ill-health and gender-based violence.

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

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

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

The environment for aid policy and programming is changing. Poverty levels; rapid population growth; growing fiscal deficits and tax revenue are highly dependent on volatile commodity prices. Limited institutional capacity means PNG still has access to development assistance. Partly through active encouragement and co-financing from Australia, the Asian Development Bank (ADB) and World Bank are both increasing the scope and size of their lending and policy engagement in the health sector of PNG. China has entered the health sector, including as a trilateral partner with GoPNG and Australia to address malaria. The Fleming Fund, and the Australian Indo-Pacific Centre for Health Security, are both designing new programs to address antimicrobial resistance and health security respectively. On the other hand, some development partners such as GAVI and the Global Fund continue to consider transitioning out of PNG at some point – albeit perhaps after 2025 - given that country's "graduation" from low income to lower-middle income status. GoPNG itself is also making decisions that shape the environment for aid expenditure in health including, for example, reviewing and updating the National Health Plan (2011-2020) as well as various contributing strategies such as those for human resources for health and health information. The Government of Papua New Guinea announced in June 2019 a significant reform agenda with a focus on the size and structure of NDOH; the increasingly important role of Provincial Health Authorities; and improvements in drug supplies, health standards and referral systems (20).

Australia is purposefully transitioning its bilateral relationship with PNG: this has implications for the design and delivery of Australian aid to that country, including this design. Supporting PNG's security, stability and prosperity remains one of Australia's highest foreign policy priorities. Australia's recent Foreign Policy White Paper acknowledges a stable and prosperous PNG is clearly in Australia's national interest. Australia's relationship is transitioning from a donor-recipient relationship to a partnership, based on mutual economic

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

and strategic interests. Australia's health sector support takes forward the priorities for health cooperation outlined in the Papua New Guinea Australia Partnership for Development (2013). This recognised that the way in which Australia partners with PNG in supporting the health sector is changing to focus on assisting PNG prioritise and utilise its own resources more efficiently. Australia is PNG's major partner in the health sector: our assistance makes a significant contribution to the broader bilateral relationship.

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

Evidence base/Lessons Learned

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

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

PATH will have a particularly strong monitoring, evaluation and learning (MEL) framework to track progress and learn lessons. DFAT's Office of Development Effectiveness (36) found Australian aid investments with

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

higher-quality monitoring systems exhibit three distinct characteristics[5]. Those three characteristics have specifically informed the PATH design. Furthermore, PATH makes MEL a key part of performance management and policy dialogue. It does this by requiring the Managing Contractor (MC) to provide specific and tangible evidence that the insights and lessons arising from MEL are then actively being used to shape and improve policies and current and future investments. Section F of this IDD and Annex 4 elaborates.

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

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

C. Strategic Intent and Rationale (Why?)

Strategic Setting and Rationale for Australian/DFAT Engagement

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

DFAT's economic and strategic partnership with PNG has three development objectives: PATH contributes to all three. DFAT's three development objectives in PNG are promoting effective governance; enabling economic growth; and enhancing human development (41). PATH demonstrably and directly contributes to objective 3 - enhancing human development – by helping to improve health outcomes. That, in turn, contributes to other aspects of human development including increased capacity for education, empowerment of women and the broader benefits to women, including adolescent girls, of modern family planning. PATH's contribution to improved health also contributes to outcome 1 - promoting effective governance – to the extent that health services plan, prioritise, and manage financial and human resources more effectively, efficiently, equitably, transparently and on the basis of evidence and learning. PATH also contributes to outcome 2 – enabling economic growth – by contributing to a healthier workforce with reduced absenteeism. PATH further contributes to economic growth to the extent that an improved primary health care system averts, or at least postpones, the incidence of preventable diseases that involve large – but largely preventable - demands on public revenues: multi-drug resistant TB and polio being just two examples.

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

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

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

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

Gender, innovation and cross-cutting themes[7]

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

Women also face particular challenges and barriers on the supply side in terms of influencing and deciding plans, priorities and budgets. Research shows that, as at June 2014, only 7% of executive level managers in the PNG National Public Service and only 18% of the senior level managers were women. At the provincial level no women held any executive level positions, comprising only 10% of middle management and 6% of senior management roles in provincial administrations (42). This is even though GoPNG has stated policies requiring more women in management positions. It is particularly important that PATH facilitates more women in leadership because the majority of health workers in PNG, especially rural nurses and midwives, are female yet are rarely in management positions or able to influence or decide on planning, priority setting, and resource allocation decisions that directly affect women. PATH specifies women in leadership as a specific intermediate outcome because, given the slow progress in implementing GoPNG's own requirements for increasing the role of women in decision making, this is now judged to be the best way to get traction. The

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

[7] This section focuses on gender: a fundamental challenge in PNG. Other cross-cutting issues are covered in Section G below.

international literature also shows that having women in decision-making roles can improve the access, accessibility, effectiveness, and equity of services (43-46).

The use of a demand and supply approach to improving Gender Equality and Social Inclusion (GESI) is fully consistent with GoPNG and DFAT policies. The Program's GESI approach is aligned with GoPNG PNG National Health Plan, MTDP III; the GoPNG National Disability Policy 2015-2025; the NDoH Gender and health policy strategy; and the Gender Equity and Social Inclusion Policy. The GESI approach is also consistent with DFAT's Gender Equality and Women's Empowerment strategy (2016), Development for All 2015-2020; Strategy for strengthening disability inclusive development in Australia's aid program (2015-20) and the Foreign Policy White Paper (2017) particularly relating to enhanced participation and empowerment of women and people with disability; women's leadership role and gender-based violence. Both PNG and Australia have ratified the UN Convention on the Rights of People with Disabilities (UNCRPD). The GESI approach in this design is also consistent with the OECD / DAC minimum criteria. See Annex 5 for further details.

Linkages and leverage between PATH and other investments in PNG

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

D. Proposed Outcomes and Investment Options (What?)

The program logic for the proposed program is summarised in Chart 1 below and described in the ensuing sections. It is also more fully explained in Annex 2: a key and fundamental part of this overall design document. The Program's End of Investment (EOIOs) and Intermediate Outcomes (IOs) are set, with specific and measurable targets to be established in the M&E framework during the inception phase. However, the program logic includes only illustrative examples of what the outputs might look like. They are illustrative because the final outputs will be identified and developed by the MC based on PATH's testing and learning from implementation experience and the necessary adaptation (see footnote 15) to changing circumstances in PNG. The MC's suggested outputs will then be considered and approval by DFAT and GoPNG as part of the Annual Plan governance arrangements (see Section E and Annex 3). DFAT's long-term objectives are clear, but the design permits flexibility on how those objectives are achieved.

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

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

[8] The NHP 2011-2020 is currently being reviewed and updated. The new 10-year NHP for 2021-2030 is currently scheduled to be finalised by August 2020. It is the purpose and nature of an "adaptive program" (see footnote 16) like PATH that this Design can and should be then aligned with the new NHP with agreement of GoPNG and DFAT via the Annual Plan governance arrangements. Current indications are that future GoPNG heath policy will remain broadly consistent with current priorities.

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

PATH then has a direct alignment with DFAT's three core objectives as stated in the Health Portfolio Plan. These three objectives – improved primary health care systems; health security and communicable disease control; and integrated client centred sexual and reproductive health services – are defined in detail in the Portfolio Plan, and its associated M&E framework. Both will be available during the tender process. Each of the three objectives are underpinned by two complementary EOIOs that the MC will be accountable to DFAT and GoPNG for achieving by 2025. PATH's EOIOs must directly contribute to the Portfolio Plan and its objectives. It is expected it will do this by strengthening the capacity of PHA's to fulfil their functions of leading provincial health reforms and managing primary and secondary referral level services (EOIO 1) and the financing - and progressive transition - of communicable and reproductive health care services to PHA management (EOIO 2).

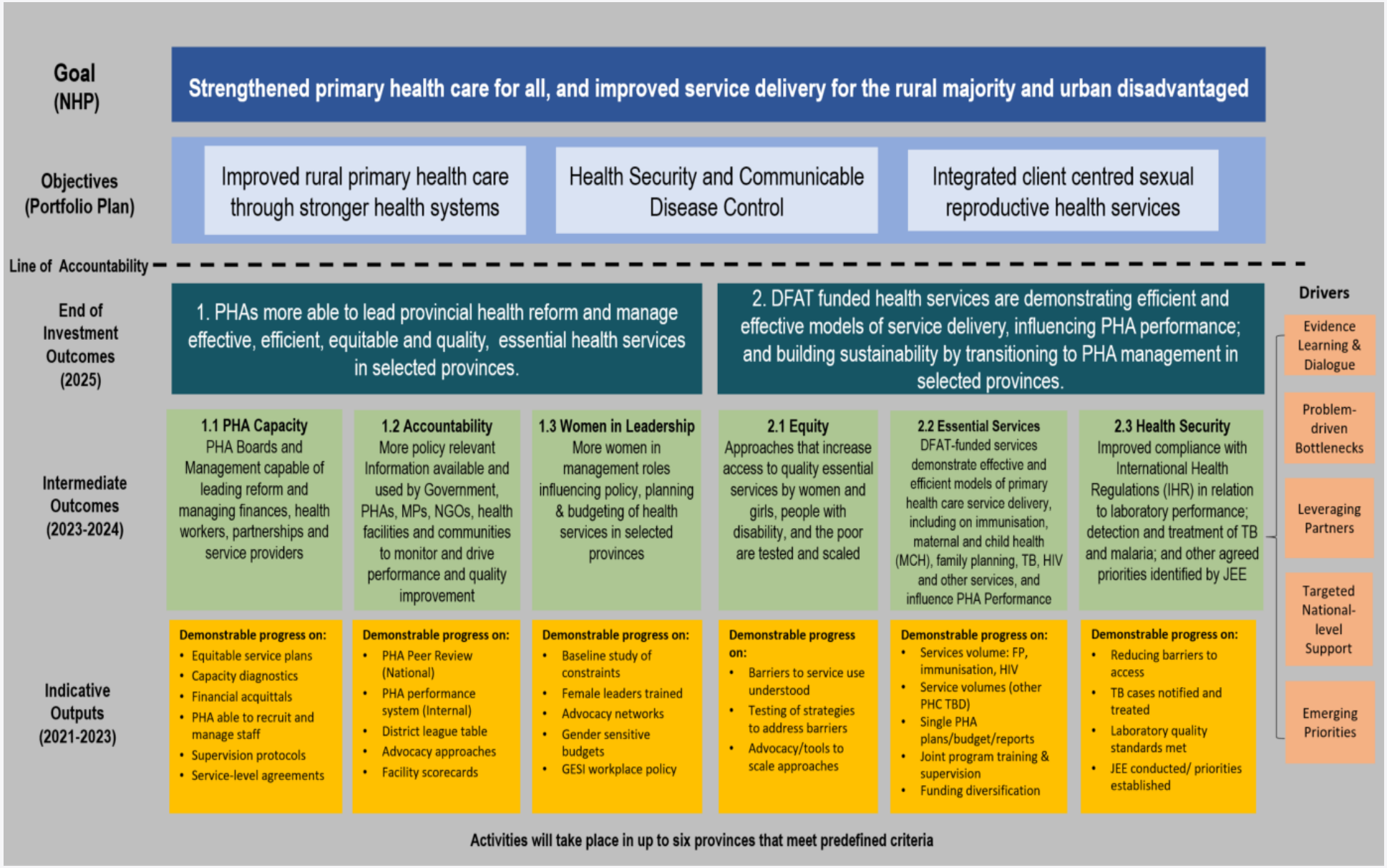
The first EOIO is that: *PHAs are more able to lead provincial health reforms and manage effective, efficient, equitable and quality, essential, health services in selected* (up to a total of 6) ***provinces***. PHAs are the principal vehicle for delivering health services in PNG – either directly or via contracted churches and NGOs. The importance of PHAs cannot be overstated. The Government of PNG has stated that "the PHA Act of 2007 has been developed and is a major Government reform agenda to address the health systems fragmentation……..all PHAs will be declared by the end of June 2019"(20). However, while PHAs offer much potential for increasing primary and other essential health care closer to the population, there are gaps and bottlenecks in the leadership, managerial, financial, and technical capabilities required to achieve GoPNG goals for health. It is therefore strategically important and relevant to support them. The specific provincial-level interventions will depend on local circumstances in each PHA and will be further specified through the Annual Planning process. This flexibility is crucial to the adaptive development approach. The design intention of this EOIO is to improve the leadership and management performance of PHAs. This includes key organisational capacities of board function, planning, budgeting, financial management, human resources, stakeholder engagement, and service provider and facility performance management. However, PHAs are a means to an end – improved service delivery – and not an end in themselves. The EOIO is therefore designed to provide the organisational foundation within PHAs to progressively integrate the direct service delivery functions supported under EOIO 2, enabling each province, over time, to establish an effective, equitable and sustainable health system.

The second EOIO is "*DFAT funded health services are demonstrating efficient and effective models of service delivery; influencing PHA performance; and building sustainability by transitioning to PHA management in selected* (up to a total of 6) ***provinces****."* This EOIO recognises that, due to lack of GoPNG capacity and robust public financial management, DFAT currently directly funds through grants to NGOs and churches the delivery of some essential health services. DFAT-funded health services are defined in the Portfolio Plan, and will include services such as immunisation, maternal and child health, family planning, TB, and HIV. The design intention of this EOIO is, in the first instance, to demonstrate models of efficient and effective service delivery. Within the parameters of available budgets, these should increase the coverage, accessibility, and quality of health services above the baseline of services provided by the PNG Government, rather than substituting for Government-funded services. However, the more strategic and longer-term intent of EOIO 2 is to generate evidence, learnings and practices that can be used to help PHAs themselves improve their own performance, thereby making PHAs more capable of taking over current DFAT funded programs over time. This will be achieved through (i) understanding and addressing barriers of specific marginalised groups to accessing services and disseminating such insight in a way that is useful – and used – by key stakeholders including PHAs; (ii) continuation of performance-based funding to expand coverage, quality and accessibility of selected essential services including, for example, family planning and (iii) progressively shifting the delivery of services into core PHA systems covering both direct and contracted delivery. A key strategic intent of this EOIO is also

to diversify the funding sources for health services away from DFAT to encompass PHAs, churches, MPs/districts, private sector, and other donors.

It is essential to understand that these two EOIOs interact with each other and are not mutually exclusive. This is illustrated by the two-way arrow between the two EOIOs in Chart 1, confirming that the arrows of causality operate both ways. More specifically, selected PHAs that are more able to lead provincial health reforms and manage effective, efficient and equitable essential health services (EOIO 1) will be, by definition, more capable of taking over ("transitioning") essential health service delivery such as immunisation, family planning, malaria and TB currently funded by DFAT and managed via NGOs and contractors. On the other hand, the evidence and learning on improvements in service delivery that DFAT currently funds – which is to be part of the "adaptive program" of PATH - can then be used to leverage improvements in under-performing PHAs. This could include, for example, evidence and learning on how to enhance uptake of services by specific groups. Or it could involve the evidence of increased effectiveness and reduction in costs by having joint / shared training and supervision for disease programs. To the extent that those lessons influence and improve PHA management efficiency, then they also increase scope to transition across to PHAs activities currently being directly financed by DFAT. Annex 2 gives further explanation as to how EOIO 1 and 2 interact with each other, thereby providing further coherence to the PATH design.

Chart 1: PATH Program Logic



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

Australia cannot, and should not, seek to do everything, everywhere in PNG therefore DFAT and PATH should focus on a small (up to a total 6) **number of "selected Provinces".** The "selected Provinces" that PATH will support will need to be finalised through formal discussions between GoPNG and DFAT, utilising the following proposed key selection criteria: the burden of disease/population health needs for PNG citizens; capacity/readiness for support and likelihood of progress and reform through good leadership at provincial level; potential for synergies with other development partners including ADB and World Bank; opportunities for positive externalities (e.g. reduced incidence of communicable diseases in a neighbouring Province and countries, including Australia); potential for broader lessons and learning that could then apply to PNG more broadly; established history of Australian engagement in the health sector of that Province. In line with these criteria, the following provinces have been indicatively selected (pending negotiation with GoPNG), in no particular order: Morobe province, Western province, the Autonomous Region of Bougainville and one province in the highlands region (to be confirmed). Up to two additional provinces (comprising a total of 6) may be included in this priority list pending further discussion with GoPNG and available budget. Note that this does not preclude PATH, or other DFAT investments, from contributing to other Provinces and the national health system more broadly. But having a focus on selected Provinces does give clarity of purpose (including for the tender process), as per the request from Australian Foreign Minister Marise Payne to have more geographical focus in the health portfolio.

Six intermediate outcomes that contribute to the two EOIOs

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

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

IO 1.1 PHA capacity. PHA Boards and management are more capable of leading reforms and managing finances, health workers, partnerships, quality assurance, and service providers;

[9] See footnote 8 on how PATH will respond to the development and finalisation of a new NHP covering 2021-2030.

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

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

To achieve EOIO 2 – DFAT funded health services are demonstrating efficient models of service delivery; influencing PHA performance; and building sustainability by transitioning to PHA management, PATH identifies the following three intermediate outcomes (IOs):

IO 2.1 Equity: approaches to increase access to services by women and girls, people with disability and the poor are tested and scaled;

IO 2.2 Essential services: DFAT-funded services demonstrate good practice in providing quality services, reaching marginal / hard to reach groups, and demonstrates linkages with and support to/from PHAs, including improved efficiency by integrating vertical services.

*(*For example, DFAT can use performance-based funding to shape the market including by encouraging joint - rather than currently separate – training, supervision and M&E for disease prevention and control, thereby reducing duplication and costs*).*

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

PATH's program logic identifies a range of indicative outputs which could contribute towards each of the programs Intermediate Outcomes. The PATH MC will need to review and update these based on understanding of context and learning from implementation. The design envisages a series of important, reasonably predictable, key outputs in the first year or so [10] of PATH during the inception / early implementation phase, as set out in Annex 9. Beyond this, the design identifies a range of indicative substantive outputs for the implementation of the Program (See the Program Logic Chart 1 above and Annex 2). Given the intention that PATH is an adaptive program, in a fast-changing environment like PNG, with a design that is being written some 12-18 months prior to implementation, the MC should review these outputs and any new outputs on a regular basis to determine what is the best way to achieve the IOs and ultimately EOIOs. Changes to the outputs would then need to be reviewed and approved by DFAT and GoPNG through the governance arrangements for PATH including the Annual Plan process.

Five critical "drivers of change"

PATH also has 5 drivers of change: ways of purposefully achieving the EOIOs and IOs that draw on a range of delivery modalities and approaches that go beyond traditional technical solutions to aid problems. These five drivers of change are shown at the right-hand side of Chart 1. As shown in Chart 1, the five drivers are available to shape and support each of the Intermediate Outcomes, albeit at different times and in different ways depending upon individual circumstances. This, in turn, then supports the End of Investment Outcomes. These five drivers draw on emerging insights to effective aid around adaptive programming (see Annex 4 for a definition). The five drivers involve the proactive use of evidence, learning and dialogue; addressing problem-driven bottlenecks; leveraging partners; targeted national level support; and responding to emerging priorities. As with the EOIOs and IOs, these 5 drivers are not mutually exclusive. They can and should work together to support achievement of the EOIOs and IOs. See Annexes 2 and 11.

[10] Annex 9 outlines a possible inception phase however this design recommends that tenderers specify how long the inception phase should be.

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

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

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

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

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

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

Driver 3: Leveraging partnerships and improved aid coordination.

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

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

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

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

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

GoPNG will continue to request ad hoc assistance from Australia to address rapidly emerging health needs. Indeed, this may increase the focus on PATH as it is likely that PATH will be the principal – perhaps only – bilateral "window" that GoPNG will have to make ad-hoc or urgent requests in the health sector.[11] A lesson from previous facilities and adaptive programs is that such responsiveness can be very helpful but they can also lead to small, fragmented, funding with little overall focus (22). Worse, it can over time reward what is simply poor planning and poor budget management. To avoid these problems but retain prudent responsiveness, PATH will have a mechanism and budget to respond to rapidly emerging needs and opportunities, while still retaining strategic focus: see next paragraph.

DFAT and NDOH will need to decide on the eligibility criteria for responding to requests under Driver 5 within the first 2 months of mobilisation. These criteria could include that priority will be given to proposals clearly

[11] That would certainly be the case if the health activities, and the modalities for "market shaping" and tendering currently being funded by PPF were brought in under PATH.

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

Delivery Approach

The need for strategic focus but also "structured flexibility"[12] and responsiveness. The Health Portfolio Plan has three key outcomes that cascade down to the two End of Investment Outcomes and six Intermediate Outcomes set for PATH: see Chart 1. This provides strategic focus and purpose. However, it is also clear that PATH should have a degree of "structured flexibility" and responsiveness. That is because there are so many variables and "unknowns" in PNG. For example, the new PNG National Health Plan is still to be developed; there is a major NDOH reorganisation; the roll out of PHAs is meant to accelerate in coming months but this raises several institutional and other unknowns; and the history of PNG is that health emergencies occur (e.g. polio and earthquakes).

There are also important changes among development partners that require a degree of structured flexibility and responsiveness while retaining strategic focus. For example, ADB and World Bank are engaging in large new loans which include substantive policy triggers and incentives for performance. Health security is a key priority for Australia. The Fleming Fund and Australia's Indo-Pacific Centre for Health Security are increasing their engagement with PNG while other agencies such as GAVI and the Global Fund are seeking ways to transition out of PNG, albeit perhaps after 2025. It is not clear at this stage exactly what, where or how these partners will support PNG. It is also not clear what GoPNG financial allocation to the health sector will be over the life of the new facility, but interviews clearly suggest a continued decline in real, per capita, government spending in health. There continues to be a significant element of political unpredictability in PNG, including a change of PNG Prime Minister and Minister for Health during the span of the PATH design. The future of Bougainville is unknown.

A "facility" - or an "adaptive program" - is therefore the obvious – indeed only – viable option. Traditional projects that specify outputs and activities do not provide the flexibility or prompt responsiveness required by DFAT or NDOH. A facility[13] can. At a practical level, DFAT directed the PATH design to be developed to replace the existing HHISP – a facility that has been operating since 2012. HHISP currently supports several programs and initiatives that PATH should continue and build on. However, terminology is also important. It is more accurate to describe PATH as an "adaptive program".[14] That is particularly because PATH will do significantly more than identifying and procuring Advisers and / or managing grants: features of certain types of facilities

[12] "Structured flexibility" means that there is still a meaningful degree of focus retained, and that PATH does not become distracted or distorted by extraneous, inappropriate, or very small ad-hoc requests for financing or assistance.

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

[14] Adaptive programming or management acknowledges from the start that while the outcome to be achieved may be known, the specific strategies and combination of interventions that will work to address complex development challenges need to be developed. Program design builds in deliberate processes of testing and experimentation, with structured MEL providing feedback to learn from experience. This can be done by testing interventions iteratively or in parallel, to scale up those which are working and curtail those which are not. It can focus on identified problems and look for innovative ways to address these. There should be regular strategic reviews based on rapid feedback mechanisms, to allow adaptation. The flexible and evolving nature of this approach requires capable MEL capacity within the MC and trust among the partners. Further information available at Annex 4.

in other countries. A key element of the design is the articulation of clear end of investment outcomes and intermediate outcomes, without locking in how these will be delivered.

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

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

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

High-level Monitoring, Evaluation and Learning (MEL) capacity is fundamental to the success of this delivery approach. It will be essential to have clear targets in the MEL framework, to use evidence-based performance information from the MEL to adapt strategies to achieve End of Investment Outcomes, and to support the five critical 'Drivers of Change' (particularly 1 and 2). As set out in Annex 4, the Program design builds in deliberate and structured processes for testing and experimentation, to ensure continuous improvement and programmatic adaptation. A key theme and innovation within PATH is that the MC is required not only to generate evidence and learning but also to demonstrate that such evidence and learning was then actually considered and used by decision-makers (to be monitored through the MEL Framework). The MEL Framework sets out proposed indicators for PATH's objectives, EOIO, intermediate outcomes and drivers of change as well as for key assumptions underlying the program logic. It also suggests measures of inputs, value for money and performance of the MC itself. The MEL Framework will need to be confirmed at mobilisation phase, in consultation with DFAT, GoPNG and the MC, with support and quality assurance from the Human Development M&E Services Provider. A minimum MEL budget has been outlined in this design (in addition to grant-level M&E that is undertaken as part of the standard delivery of the grants).

E. Implementation Arrangements (How will DFAT engage?)

Governance arrangements and structure

Interviews during the design mission confirm there is a balance to be struck here. On the one hand, there are several existing overarching governance arrangements to plan and review aid investments between Australia and GoPNG, and with other development partners.[15] On the other hand, it is clear GoPNG still does not believe it has a good insight into Australia's (or others') contributions. GoPNG clearly also need to be involved in overall planning and priorities of programs, especially given the envisaged size of PATH, but NDoH is overwhelmed by the amount of engagement by development partners. While financial approvals and contractual accountability must rest with DFAT, the design governance arrangements include high-level GoPNG representation (at both a national and provincial level) on the Steering Committee, which will provide strategic guidance and decision making about priorities, budgets, and PATH program activities. DFAT will engage with GoPNG on the selection of priority provinces, the MC will engage with GoPNG on the development of PATH's annual plans, and their review. Detail of the PATH's governance arrangements are set out in Annex 3.

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

Early activities

A recent DFAT review confirms the importance of managing the start-up phase of programs in a proactive and careful way (22). This is particularly important for PATH where there will inevitably – and intentionally – be the continuation of certain programs and positions between HHISP, PPF and PATH. Annex 9 therefore lists a suggested list of proposed indicative outputs that PATH should deliver in the first 12 months of its existence. The MC's Inception Plan will detail the outputs in the PATH inception phase. Transition arrangements between HHISP, PPF and PATH are also identified as a potential risk factor in the risk matrix. As noted throughout this design, PATH gives particular and explicit importance to building evidence and learning as a basis for policy dialogue and ongoing program improvement at the level of both EOIO 1 and 2. With that in mind, PATH should consider early in the first year what baselines are required, and to what extent PATH can use existing baselines and data sources of GoPNG, individual PHAs, and / or those of development partners.

Policy dialogue

A key theme running throughout the PATH design is that Australia can best demonstrate development effectiveness and broader diplomatic partnerships by helping GoPNG make better use of its own financial and human resources. PNG in general and PHAs in particular cannot afford to waste those resources on policies and programs that do not work in an effective, efficient, equitable and sustainable way. There is clearly a need in PNG – including especially at the PHA level – to have a more accurate, more inclusive, more timely, more relevant, and more used evidence base to better inform policy and programs (18). EOIO 1 and 2 both aim to achieve that, through each of the intermediate outcomes, and each of the "drivers" specified in this design. However, generating evidence and insights, while key, is a necessary – but not sufficient – condition for

[15] They do not always work well. The facility can be helpful here by providing secretarial support to the Health Sector Aid Coordination Committee.

improving policies and programs. As noted in DFAT's latest review of policy influence (57), as well as the international literature more broadly (58-66), such evidence and insight needs to be presented to the right people (which may well include community groups); at the right time in the political and budget cycles; by the right (i.e. credible) source; and in a way that stakeholders prefer to receive and digest information if the evidence and learnings are to influence policies and programs (62). PATH will be accountable for supporting DFAT's policy engagement in this way.

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

Profile and public diplomacy

Australia already has a high profile in PNG: PATH can contribute to that in a constructive and appropriate way. PATH is intended to be the main direct bilateral program that DFAT has to respond to health needs in PNG. The direct funding of key programs including prevention and control of TB, HIV, immunisation, and family planning under EOIO 2, combined with the strengthened MEL envisaged under PATH, will generate evidence and stories about lives saved and illnesses averted among the poor and marginalised. More specifically, modelling suggests that, even with phased reduction of budget and existing services under the PPF program, over 850,000 people in PNG could be reached with family planning and maternal and child health services over the first 5 years of PATH; over 105,000 people will be tested for HIV; and over 22,000 children will receive pentavalent 3 immunisations.[16] Determining exact service delivery levels to be delivered under the PATH program will need to be an iterative process which responds to PHA-driven service planning, PHA readiness to increasingly take on service delivery and available funding. Strengthened health security in PNG (Intermediate outcome 2.3) will have resonance in Australia (and Indonesia). The strengthening of rural primary health care services under EOIO 1 will also demonstrate Australia's focus on helping PNG get better outcomes from its own financial and human resources. The increased participation of women in leadership roles (intermediate outcome 1.3) and women and the marginalised accessing essential services (intermediate outcome 2.1) are important themes of public diplomacy (if publicised carefully and sensitively in the PNG context).

Sustainability

PATH purposefully involves a transition of health services, including a planned, progressive, transition of currently funded DFAT programs across to GoPNG. It is not realistic to think PATH or any other health program could achieve full GoPNG ownership and sustainability at this stage given the various financing, resourcing, institutional and capacity constraints. However, neither is it desirable – or necessary – for Australia to directly

[16] The modelling has been done for DFAT by an independent adviser as part of the design process. DFAT may choose to make the modelling available on request after the bidding process for PATH has finished and the contract has been awarded. The phased reduction of existing services under PPF occurs for two main reasons. First, the strategic intent of PATH is to transfer and transition existing basic services currently funded by Australia over to PHAs in selected provinces wherever PHC governance and capacities allow. Second, reducing funding for direct service delivery in a phased manner creates financial space for PATH to invest in other specific and targeted strategies to achieve the End of Investment Outcomes, the six specific Intermediate Outcomes, and the five drivers that are all key to PATH.

fund large programs which should be planned and managed by GoPNG. PATH therefore has at the core of the design a program logic which seeks to transition PHAs to a more capable and sustainable level (EOIO 1) as well as progressively transitioning, where appropriate, programs currently funded directly by DFAT across to GoPNG (EOIO2). Importantly, this logic is backed up with a gradual, but meaningful, scaling back of direct DFAT funding for service delivery over the life of the Program wherever that is possible, and a corresponding focus on encouraging a diversification of funding sources for service delivery (including the GoPNG, MPs/district funding, private sector and other donors).

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

Monitoring, Evaluation and Learning (MEL) is essential to an "adaptive program" [17]such as PATH operating in PNG. The MEL enables PATH to simultaneously meet two separate requirements. The first is that PATH directly and demonstrably contributes to the DFAT Health Portfolio Plan and, through that, also contributes to the GoPNG National Health Plan. This gives PATH strategic focus and direction, which is articulated in the two EOIOs. The second requirement is that, within that fixed strategic focus, PATH is nevertheless also an "adaptive program": a design approach that specifically encourages a measure of flexibility to respond to rapidly changing circumstances in PNG; the piloting and testing of innovative approaches; and generating and using evidence and lessons to achieve the EOIOs. Effective MEL is essential for this adaptive approach.

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

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

Key aspects of the MEL approach include:

- Alignment with measures of results in the National Health Plan and DFAT Health Portfolio Plan;
- Use of existing national and provincial data collection systems where possible; and working with others on joint approaches where these need to be developed or strengthened, but with particular attention to generating gender and age disaggregated data and studies on disability;
- More proactive, explicit, and timely assessment of the extent to which PATH is influencing policy and service delivery and access in provinces;
- Assessing experience from testing strategies and approaches, with findings and proposed adaptations and changes discussed in six monthly reviews involving DFAT, GoPNG and the MC;
- Reviewing performance and value for money of the MC, with a Performance Assessment Framework;
- A separately contracted M&E provider will review MEL plans, conduct independent evaluations and provide M&E support to DFAT, including on M&E oversight of PATH.

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

[17] See footnote 15 and Annex 4 for a definition and explanation of adaptive programming.

MEL budget is estimated to be at least 4.5% of the PATH budget, allowing for the MEL earmarked budget and the learning and analysis budget. There will be additional monitoring inputs built into service delivery grants, and the independent evaluation and monitoring proposed separately by DFAT.

G. Gender, Disability and Other Cross Cutting Issues

Gender equality, disability and social inclusion

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

Indigenous Participation

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

Climate change and disaster risk

There is a rich and growing literature on the possible impacts of climate change and disasters on health. This includes through direct pathways such as the possible spread of mosquito borne diseases but also through indirect pathways such as changes in food production, water availability, poverty and vulnerability etc (68-71). There is, however, very limited analysis of the effects of climate change on health in PNG (72, 73). PATH could potentially support applied operational research on that issue through its focus on health security (IO 2.3) as well as through the "drivers" such as evidence and learning for policy. The Australia Pacific Climate Partnership Support Unit can work directly with the PATH MC to facilitate the integration of climate change across the program, including into the program's MEL system. The WHO's Operational Framework for building climate resilient health systems is also a useful framework to guide future investments in the health sector. PNG is prone to natural disasters including earthquakes, and volcanoes. DFAT and GoPNG may therefore decide to use the health security intermediate outcome, and the "emerging priorities" driver, and the accompanying budgets, to help prevent and respond to adverse health outcomes from natural disasters. In doing so, it should be borne in mind that the poor, people with disabilities and the sick are usually disproportionately affected by natural disasters.

Private sector and civil society

There is scope for PATH to work with and leverage the private sector / civil society in PNG. There is a small, but growing, domestic for-profit private sector health sector, including private hospitals in major centres, in PNG.

Little, however, is known about the nature and quality of that private sector: PATH could support applied operational research to start to build the evidence base for better GoPNG policies and regulation of that sector. Australian and other mining / resource companies are active in directly providing health services at their sites. The structure of PHAs also requires private sector involvement on Governance boards to bring modern management skills and business-like approaches to the operations of PHAs. The value of this is evident in some provinces, including in Hela Province. There are therefore important and useful lessons to capture from that experience. More broadly, the majority of health services – and in some provinces up to 80% - in many rural provinces are managed and provided by churches and other civil society groups on behalf of GoPNG. PATH will both directly support these groups and assist in capturing and learning from their approaches. There are also important opportunities for PATH to pilot and test more "social accountability" and community engagement – including through community scorecards – as part of PATH's support to reforming and strengthening provincial health systems.

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

Innovation

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

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

The variety of program stakeholders can also drive innovation. Churches, mining companies, MPs, and development partners (including ADB and World Bank through large policy-based lending) are each using different and innovative approaches to health service delivery and reform that DFAT, given its convening

power in PNG, can leverage and complement. PATH's emphasis on "evidence, learning and dialogue" as one of five key "drivers" of reform and change in the health sector could assist in supporting and disseminating this work. Broader developments in PNG outside the health sector can also facilitate innovation in the health sector. The future submarine cable, and expansion of internet services and electricity across PNG, can help modernise access to and delivery of health services. Other developments in technology and innovation, including use of e-health and mobile phones, offer the potential to leap-frog existing ways of accessing and delivering health services.

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

Budget

One option is to have a $30m per year program over 4 years, totalling $120 million. Such a program would, in effect, simply extend the existing scale of the Health and HIV Implementation Services Provider (HHISP) which has been operating since 2012. Importantly, however, the level of ongoing commitments – either contractually or in terms of political priorities for both Australia and PNG – means PATH would have very little if any financial headroom to shift resources more in line with the Health Portfolio Plan or respond to new initiatives and opportunities identified in the PATH program logic. For example, the largest existing program under HHISP involves expenditure on health security, including the TB response in Western Province. Given the importance of that program to human health – and the priorities of both countries – it is hard to see significant options for cutting or phasing down the program in the short to medium term under PATH[18].

A preferred option, with efficiency and effectiveness benefits to DFAT, is to integrate the health programs, budgets, and funding modalities of the existing PNG Partnership Fund (PPF) [19] into PATH[20]. The business case for such a consolidation is that:

- **Integrating the health components of PPF into PATH brings greater coherence and critical mass to PATH**. For example, PPF funded immunisation programs would directly complement and reinforce PATH's focus on health security and communicable disease control (EOIO 2). Immunisation is a core PHA service delivery accountability (EOIO 1) that can link with other services including maternal and child health (EOIO 2). PPF also funds family planning and reproductive health which would directly complement and support PATH's focus on further expanding access to essential services for women and their families (EOIO 1 and 2).
- **There would be increased scope for policy influence and knowledge brokering**. A central theme running through PATH is the increased use of evidence and learning to improve policies and programs in both EO1O 1 and 2. The inclusion of PPF health programs such as immunisation, HIV, and family planning / reproductive health would give PATH the on the ground experience, evidence, and credibility to influence policy and programs, especially among PHAs which are at the front line of delivering health services in PNG. PPF's funding modalities would also be used by PATH, including the use of competitive grants; a focus on outcomes; and brokering / consolidating partnerships among NGOs, civil society and government. This would also provide a rich environment for generating evidence and lesson-learning that PATH and DFAT can use in policy dialogue to help improve the performance of PHAs.
- **There would be more scope to increase the flexibility and responsiveness that DFAT is seeking, as well as achieving some economies of scale**. Consolidating the PPF health programs with PATH provides more scope for program flexibility and responsiveness. There should also be economies of scale by

[18] The design team has done an analysis, which inevitably involve a number of assumptions given decisions are yet to be made about certain existing programs, of the extent of existing lock-in when transitioning from HHISP to PATH and that analysis is available to DFAT on request.

[19] The PPF funds approximately $20 million per year to support essential health services, the balance supports activities in the education sector.

[20] The PPF (and its associated health grants) is due to end in April 2020. DFAT is processing a 2-year extension of the PPF until April 2022 to ensure continued service delivery while PATH is tendered and mobilised. Transition timeframes will be determined once PATH is contracted. Programming of the $20 million, as the extended grants end, will be made as per the proposed program logic and planning / budgeting arrangements outlined in this document.

consolidating two of DFAT's current funding streams for the health sector – HHISP and PPF – into one program.

The design team is also of the view that 4 years in PNG is a relatively short period for a program to demonstrate results: a longer-term commitment of 5 years plus an option of an additional 3 years (total of 8 years) is recommended. A key lesson that emerged from previous assistance to the PNG health sector is that the sector is complex, relationships and understanding are critical, and change is slow and requires sustained commitment. Another key finding from DFAT's experience with facilities (22), is that they can be slow to start, often using much of the first year for mobilisation and transition. It is also possible that a longer-term commitment from DFAT may encourage a broader array and possibly new contractors to enter the PNG market. For all these reasons, an initial contract period of 5 years, with a clear option that DFAT and GoPNG can extend PATH for a further 3 years subject to satisfactory progress[21] of PATH is therefore strongly recommended.

Based on the above, a 5-year program budget of $183m (excluding management costs) is proposed for PATH.[22] This reflects the strategic incorporation of the PPF health funding into PATH and the required financing to deliver the Program's EOIOs, IOs and change drivers. A key element of the proposed budget is the expectation of a careful, gradual reduction in the level of funding from DFAT for direct service delivery activities in the areas of family planning, immunisation, TB and HIV. This is purposefully designed to be gradual to maximise the chances of alternative sources of funding being identified for the services – ideally from GoPNG – but recognising this will be challenging given the current and projected financial challenges for the GoPNG. However, it is an important signal for Australia to send and provides a basis for ongoing policy dialogue. Another key feature of the budget is the modest, but dedicated funding provided to the 5 change 'drivers' within PATH. This signals the importance of these drivers to the program approach. An illustrative breakdown of the main program activities and cost components of PATH is at Annex 7.

Resources

PATH will have resourcing implications for the MC and DFAT. The MC and the Australian High Commission (AHC) are in the best position to judge how PATH could affect the current number[23], and level, of staff resources. That is because they are both in the best position to know what current staff do, and cost, and their own organisation's personnel and financial policies and constraints concerning new staffing structures. What is clear is that there will be a need for some different skills and expertise than hitherto. For example, it is clear from this design that both the MC and the AHC staff will need to have ready access to[24] expertise in not just monitoring and evaluation but also other aspects inherent in adaptive programming approach including design, knowledge management and knowledge brokering, and relationship building if PATH is to achieve the learning and policy influence envisaged for it. Both will also need to have expertise in GESI, given the prominent and specific role of improving access for women and disadvantaged groups to both decision-making and essential services (intermediate outcomes 1.3 and 2.1 respectively). The AHC would benefit from having ready access to contract management expertise, particularly in the first year or so of PATH, to ensure that programs currently supported by HHISP are novated across to PATH effectively and efficiently. The AHC will require access to change management expertise so that as staff resources are freed up from existing tasks – including process-intensive tasking notes – staff are better equipped to manage MEL, GESI, knowledge management / brokering and policy influence. The Post should also have access to short term and long-term advisers where specialised skills such as knowledge management and operational research are required. See also Annex 12 which identifies resources required for policy dialogue

[21] DFAT, GoPNG and the MC that is awarded the contract will need to identify and agree on what the key performance measures currently part of the PATH design will be used to assess what "satisfactory progress" will mean in practice.

[22] The design team has estimated the management costs for the program and provided these separately to DFAT.

[23] The AHC currently has 19 staff, including both Australian diplomatic staff and locally engaged PNG citizens, working on the health sector.

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

I. Procurement and Partnering

PATH will be delivered through a Managing Contractor (MC). The Program will continue a number of existing priority investments, for example the Trilateral Malaria Project and the Tuberculosis Program in Western Province, as well as new investments that the MC will develop and implement using an adaptive programming approach. The MC will have significant flexibility to design and implement strategies and activities to achieve the End of Investment and Intermediate Outcomes. The draft Pricing Schedule proposes that a proportion of the MC's Management Fees be linked to key milestones, Partner Performance Assessment and Payment by Results/Outcomes. DFAT will procure the services of an MC, selected through a competitive DFAT-managed open tender process. A draft Statement of Requirements and Pricing Schedule have been developed and provided to DFAT. PATH complements, coordinates with, and supports, the PNG government system but does not directly apply Australian government aid funds through that system with the potential exception of channelling certain funds through the HSIP Trust Account for limited purposes.[25]

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

The PATH program is rated "high risk" under DFAT's risk management and safeguards tool: this is not unexpected given the nature of the PNG health sector, but PATH has important and practical strategies to mitigate those risks (See Annex 13). More specifically, the risk analysis identifies 5 "very high risks" currently, and before any intervention is made. A realistic assessment concludes that two of those risks – a decrease in the GoPNG health budget and the unavailability of essential drugs and commodities – are likely to remain "very high-risk status". These two challenges are so deep-seated, historic, and consequential that it is not likely that PATH – or any development partner – will resolve the issues within the lifespan of PATH. However, DFAT should continue to have direct policy dialogue with GoPNG about the issues, and continue to work with, and leverage, other development partners. This includes the ADB and World Bank both of which have large policy-based loans to the PNG health sector that take into account the risks of GoPNG funding shortfalls and systematic drug shortages. Furthermore, DFAT will continue to fund – albeit at lower levels than currently - direct service delivery through the PPF grants until at least April 2022, at which point DFAT will commission an independent mid-term review of PATH. DFAT direct funding, via PATH, of essential services such as immunisation, family planning and TB / HIV is therefore insulated to an important degree from the effects of GoPNG budget reductions and / or drug shortages up until April 2022. The mid-term review shortly thereafter will then enable DFAT to exercise its prerogative to reduce or change the scope of PATH if there is a sustained, systematic and widespread shortage of drugs; widespread corruption in the health sector; or an unacceptable reduction in GoPNG financial commitment to the health sector. Significant GoPNG budget reductions and /or continued systematic drug shortages would clearly and significantly affect DFAT's ability to achieve EOIO 1. It would also have adverse effects on achieving EOIO 2, although DFAT's own direct funding, and own direct purchasing of drugs, of key services such as immunisation would mitigate some of those consequences. It is due to these consequences that the risk rating remains very high. However, as this IDD makes clear and especially in Annex 2 and 3, the managing contractor is accountable to DFAT and GoPNG for adapting its response in light of a changed environment. DFAT therefore has management options for responding to the context as appropriate. DFAT also retains the option to reduce or change the scope of PATH (for example, adapting strategies or continuing direct funding of services under EOIO 2) at mid-term review helps to protect Australia's investment in certain essential health services especially in selected provinces more broadly. In summary, the midterm and 5-year reviews, both provide a strong *incentive* for both GoPNG and the Managing Contractor to proactively manage those risks, while the adaptive management features of PATH provides the *mechanism* to do so.

The risk analysis also concludes that the "very high risk" associated with NDoH and PHA capacity, and current systems to disburse funds to PHA can both be reduced to "high" risk through mitigation measures and work from

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

PATH. The “very high” risk that PHAs and other institutions in selected provinces may not be willing – or able – to increase the role of women and other groups in decision making is able to be reduced to a “moderate” risk given the particular focus on that issue in IO 1.3.

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

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

ATTACHMENTS

Acronyms

Annex 1: PNG Health Outcomes and Challenges

Annex 2: Program Logic

Annex 3: Governance Arrangements

Annex 4: Monitoring, Evaluation and Learning Approach

Annex 5: Gender, Equity and Social Inclusion

Annex 6: What will be different in PATH?

Annex 7: Budget

Annex 8: Lessons Learnt from previous health programs in PNG

Annex 9: Proposed first year outputs in PATH

Annex 10: Summary of DFAT PNG health investments

Annex 11: Approaches to socio-political complexity in PNG

Annex 12: Policy Dialogue Matrix

Annex 13: Safeguard and Risk Management Matrix (provided separately to DFAT)

Annex 14: Consultation Process

Annex 15: Response to DFAT and Peer Reviewers feedback on draft design document

References

Provided Separately

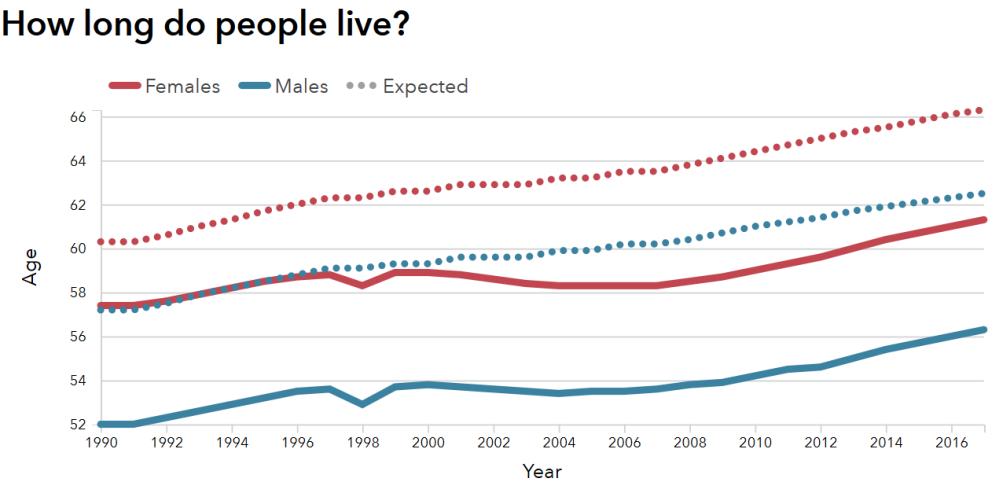
Statement of Requirements and Pricing Schedule

ACRONYMS

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

ANNEX 1: PNG HEALTH OUTCOMES AND CHALLENGES

Chart 1 Life expectancy in PNG: males and females



	Expected		Observed	
	1990	2017	1990	2017
Females	60.3	66.3	57.4	61.3
Males	57.2	62.5	52.0	56.3

Source: Institute for Health Metrics and Evaluation (76)

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

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

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

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

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

Age-standardized rate per 100,000, 2017

Source: Institute of Health Metrics and Evaluation (76)

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

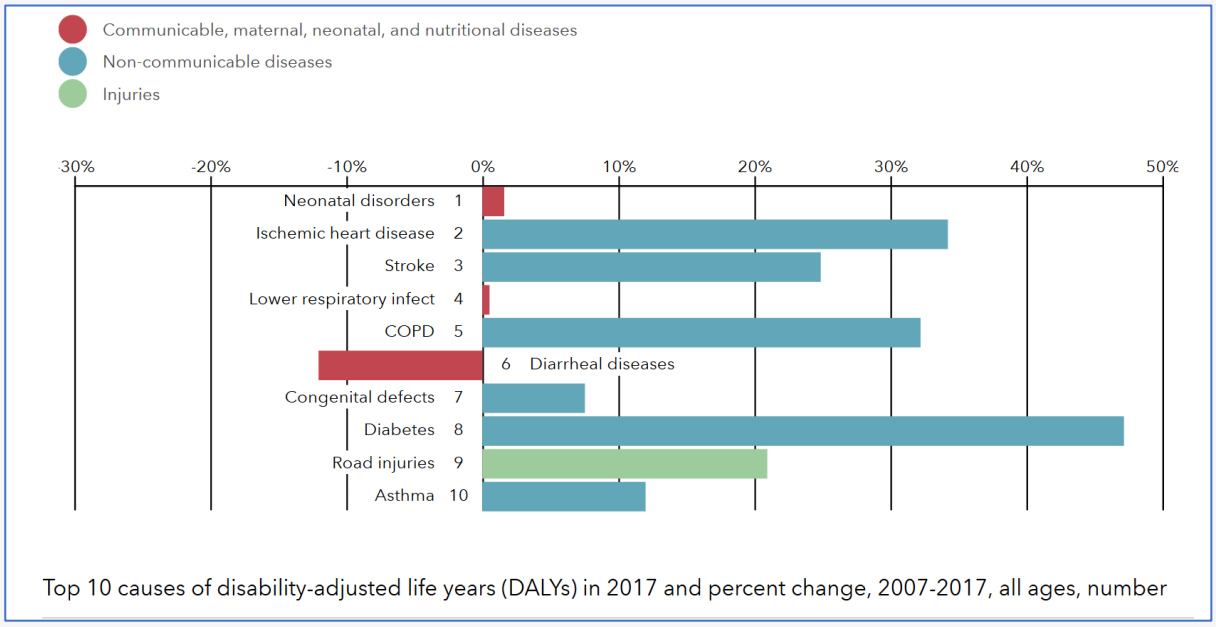
Country/ Region	Family Planning Needs Satisfied (%)	Women Receiving ANC Four or More Times from Any Provider (%)	Skilled Birth Attendance at Delivery (%)	DPT3 Immunization Coverage among 1-year-olds (%)	Population Using Improved Drinking-water Sources (%)	Population Using Improved Sanitation Facilities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

Source: World Health Organization and World Bank 2017.
Note: (i) DPT3: Diphtheria, pertussis, tetanus. (ii) 2015 data from PNG Government's NHIS in square brackets [ ] if available. (iii) n.a. not available.

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

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

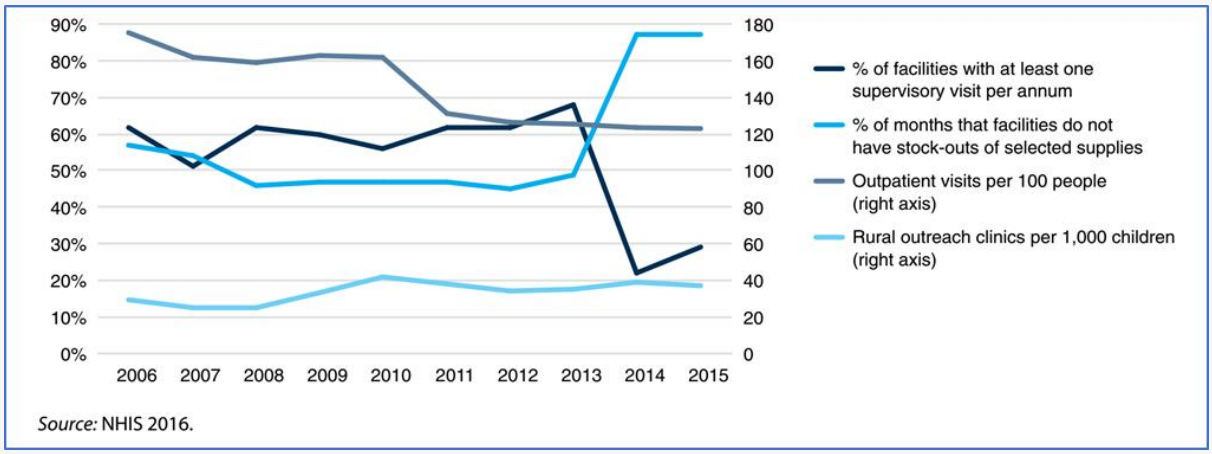
Chart 2: Top 10 causes of premature death and disability in PNG, and percentage change over 10 years 2007-2017.



Top 10 causes of disability-adjusted life years (DALYs) in 2017 and percent change, 2007-2017, all ages, number

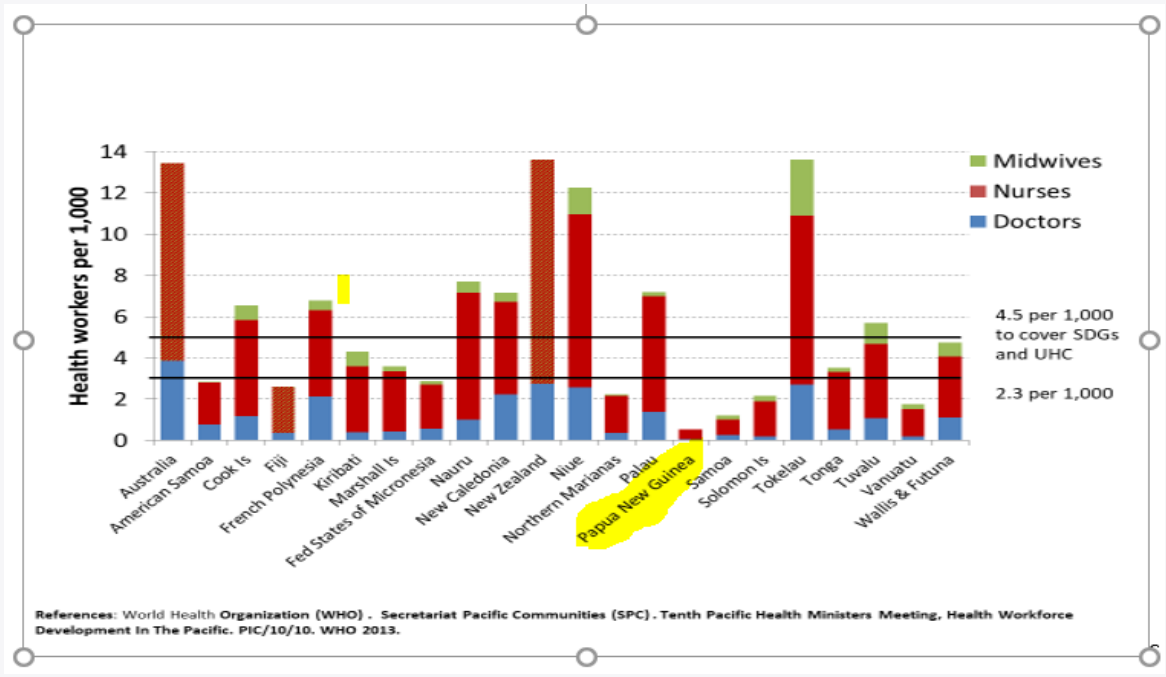
Source: Institute of Health Metrics and Evaluation (77)

Chart 3: Selected indicators of health system performance



Source: World Bank (12, 13)

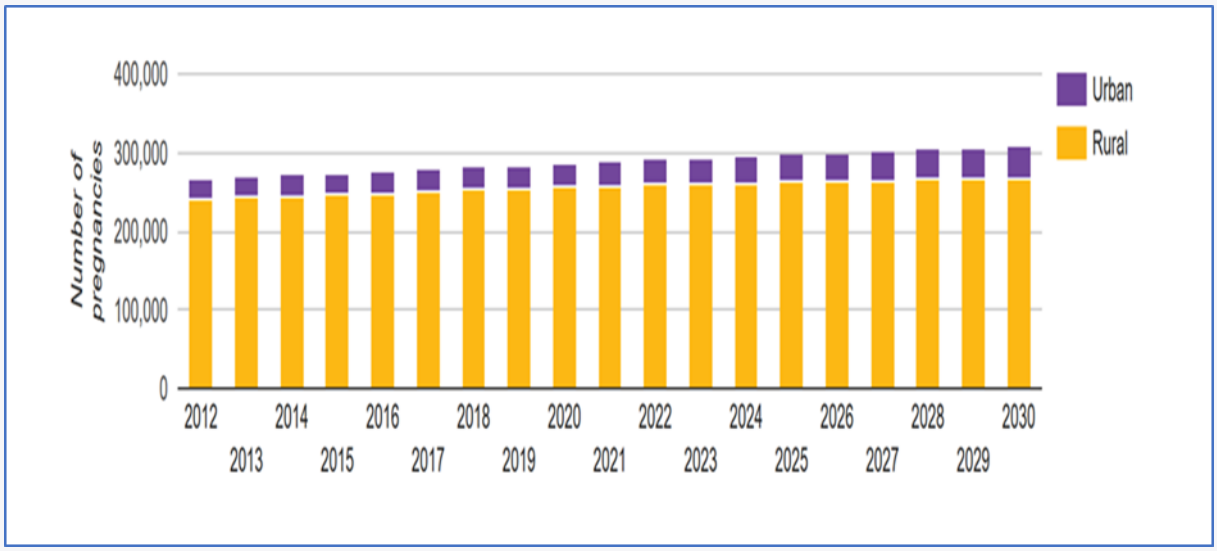
Chart 4: Health workforce per 1000 population is lower in PNG than other countries in the region



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

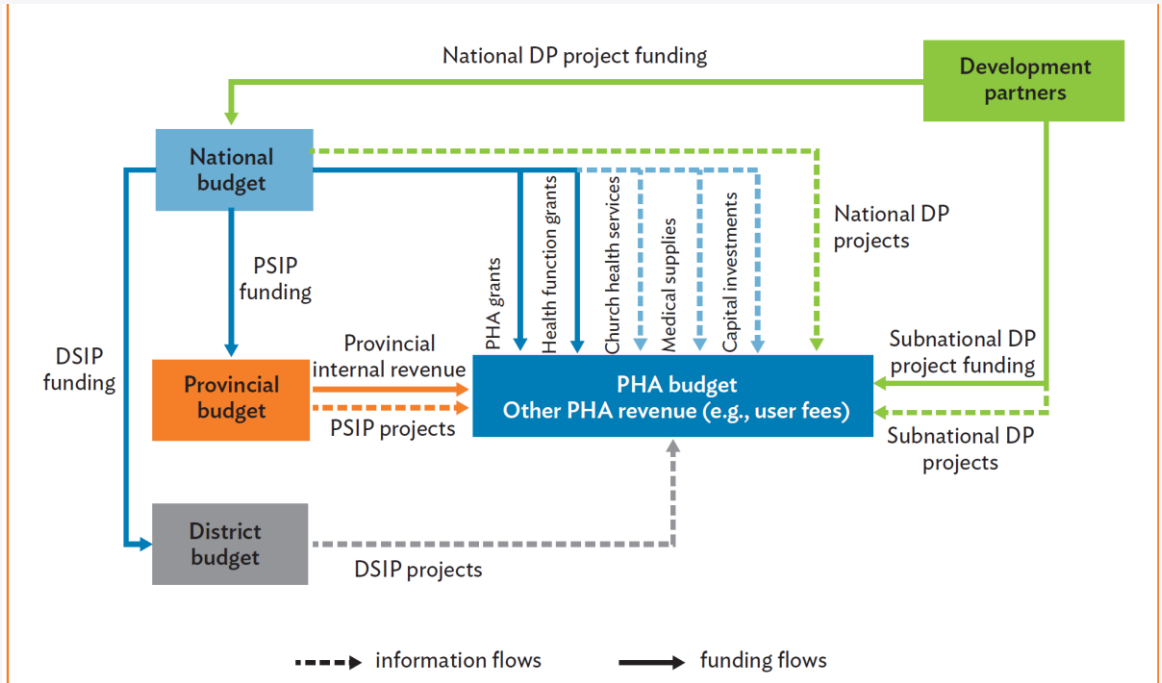
Note: It is worth noting that PNG has trained more midwives since this data and graph was prepared. However, we use this graph, despite it being a little dated, because it is the latest graph that the design team is aware of that provides comparable data on health worker density to other countries.

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



Source: UNFPA

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



DP = development partner; DSIP = District Service Improvement Program; PHA = provincial health authority; PSIP = Provincial Service Improvement Program.

Source: Asian Development Bank (18).

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

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

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

Source: National Statistics Office, GoPNG 2019

ANNEX 2: PROGRAM LOGIC

This annex provides more details on the PATH program logic. This annex begins by setting out some of the key principles of the PATH program logic, demonstrating where and how the design "fits together" and provides overall coherence. It also sets out the intent of the proposed timing and duration of PATH. The annex then explains in more detail:

- how each of the two End of Investment Outcomes responds to a specific problem statement in the health sector of PNG;
- the strategic intent of how and why the PATH design then responds to those specific problem statements;
- the program logic of the response: including how the intermediate outcomes directly contribute to the End of Investment Outcomes.
- explanations and examples of how the five "drivers" contribute to the intermediate, and end of investment, outcomes.
- the key assumptions underlying the program logic.

The PATH design and program logic reflects a number of key design principles. First, PNG is a complex environment to be working in, with significant differences between and within provinces, and often rapid changes over time. This requires an adaptive program approach to adjust to the changing circumstances; to learn from experience; and to proactively use the PATH monitoring evaluation and learning (MEL) system to improve performance (see footnote 14 in the IDD and Annex 4 for further details about adaptive programming).

Second, PATH is designed in such a way that Australia, through DFAT, can help to strengthen the capacity of PNG's own health system to deliver essential services (through supporting PHAs in selected provinces as set out in End of Investment Outcome 1), while *simultaneously* continuing to provide direct support for quality, essential health services, including immunisation, family planning, maternal and child health, TB and HIV control, and health security (as set out in End of Investment Outcome 2). It is essential to the understanding of PATH that these two End of Investment Outcomes are linked through adaptive programming and a strong MEL. For example, as adaptive programming and a strong MEL strengthens a PHA (EOIO 1) then services currently being funded directly by DFAT (EOIO2) can be transferred across to GoPNG. Similarly, as adaptive programming and a strong MEL improves the effectiveness, efficiency, equity and quality of services directly funded by DFAT under EOIO2, lessons can be learned, adapted, and scaled up in terms of how PHAs in selected provinces are, themselves, "more able to lead provincial health reform" which is the essence of EOIO 1. This interaction between EOIO 1 and 2 brings coherence and dynamic opportunities to how an MC can work in PNG.

A third key design principle is the level of ambition of PATH: an issue which is clearly linked to the duration and time scale of PATH. The EOIOs, and the intermediate outcomes, have been carefully worded to get the right balance between, on the one hand, the level of ambition expected from a program of this size and budget and, on the other hand, the realities of reform and change in a complex and varied environment like PNG. Achieving a balance between ambition, and what is achievable / feasible, is also linked to the duration of PATH. The design therefore recommends DFAT and GoPNG agree to a five-year program, but with the clear option of a three-year extension. In design terms, the three-year extension is therefore expected to occur, making PATH

an eight-year program. (The EOIOs, and the Intermediate Outcomes, could, in practice, simply have their end-dates extended by three years as they are worded in such a way that they would still be relevant at the end of eight years) However, and importantly, that three-year extension, while expected, would not be automatic. Instead, it would be contractually contingent upon DFAT and GoPNG making an explicit decision at the time that PATH was making "sufficient progress" in terms of the EOIOs and intermediate outcomes. What "sufficient progress" means in practice would involve the existing EOIOs and intermediate outcomes but would need to be confirmed as the key "triggers" for any possible extension by DFAT, GoPNG, and the MC at the start of the contract. Having such an arrangement thereby gives PATH MC, and the PHAs, the clear and expected *prospect* of an eight-year program. But it also provides additional incentive for the PATH MC – and indeed GoPNG with respect to key issues such as improving the availability of drugs and providing adequate GoPNG public health financing.

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

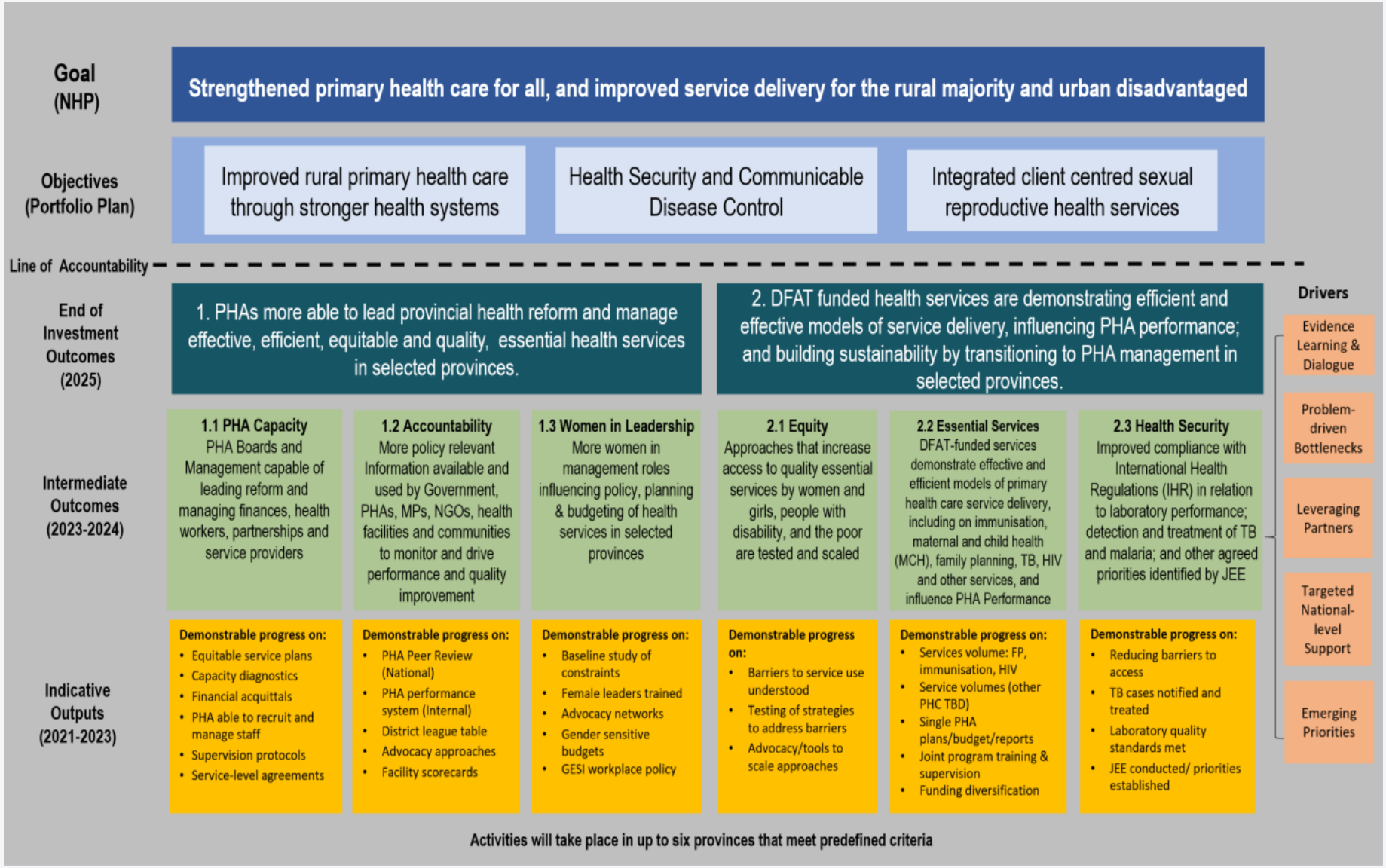
Problem statement

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

Strategic Intent

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

CHART 1: PATH PROGRAM LOGIC



Program Logic

Contributing to the Goal

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

Achieving the End of Investment Outcomes

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

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

This IO contributes to the EOIO through providing and enabling the core technical systems and capacities necessary for a PHA to: plan equitable services; manage funds; recruit, deploy, pay, performance manage, and terminate health workers; establish productive relationships with stakeholders (churches, NGOs, private sector, MPs, district administrations, local governments); and establish and monitor service provider performance (state and non-state) to ensure quality of essential services. The PATH design expects that the successful contractor will have a strong presence and capacity to support PHAs in the small number of selected provinces under PATH. This expectation arises given the significant focus on PHAs in selected provinces in EOIO 1; the need to understand the political economy and "work politically" (see Annex 11); and the possibility that the MC may wish to use local expertise who have strong networks and capacity to influence and support reform. Having said that it is important to note that, under an adaptive program, the MC has discretion to use whatever mix of technical assistance and advice is considered appropriate and effective in the individual circumstances. The MC can therefore decide the balance between long term and short term advisers; international advisers and PNG national advisers, and the mix between consultants from commercial firms versus NGOs and volunteers. The MC will then need to make their own assessment as to the relative costs - and benefits - of various approaches and sources of inputs. The MC will be ultimately accountable to DFAT and GoPNGfor such choices the MC makes.

This IO will be achieved through the following indicative outputs:

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

IO 1.2: Accountability: More policy relevant information available - and used - by National Government, PHAs, MPs, NGOs, health facilities and communities to monitor and drive performance and quality improvement.

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

This IO will be achieved through the following indicative outputs:

- National peer based PHA performance assessment/grading system established and operationalised;
- Internal provincial health and PHA performance assessment framework in place and used by Board and Managers;
- District and facility performance league tables established and used;
- Advocacy approaches for health service funding established and used;
- Health facility community scorecard system established and used, including on perceptions of quality of services (e.g. cleanliness of facilities).

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

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

This IO will be achieved through the following indicative outputs:

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

Drivers

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

- Evidence, Learning and Dialogue: PATH could identify the costs, and cost-effectiveness, of scaling up outreach programs. While unit costs for the outreach may well increase (because they involve more remote areas) it may mean that cost-effectiveness and equity increase even

more (because of the burden of disease in such remote areas). Such a finding would help PHAs make more evidence-based decisions and a more rational allocation of scarce resources.

- Problem driven bottlenecks: Work to address delays in the approval of key health worker staff establishment by central departments. PATH would add value to this common and important bottleneck because it is a problem requiring agreement of multiple actors and therefore currently becomes too hard for any one agency to resolve. PATH could also identify and assess the specific barriers that women and people with disability face that prevent them from being in leadership positions. The findings and performance would then be discussed in bi-annual program governance meetings
- Partnerships. Leveraging of large policy-based lending from ADB and WB investments to PHAs. DFAT could for example fund some applied operational research on the real-time lessons to be learned from the scaling up ADB and World Bank programs: what works, when, under what circumstances, for whom and at what cost. Such lessons could be then used by other PHAs to make more evidence-based decisions.
- Targeted national level support. GoPNG policy is clearly to move the locus of effort in terms of delivering actual health programs and services to the provinces and PHAs. NDOH will have more of an overview, regulatory setting, and aid coordination role. DFAT, and other development partners, needs to adjust to these changes. This is not to exclude support at the national level: hence "targeted national level support" is one of the five main drivers in PATH. DFAT and GoPNG could, for example, consider TA and capacity building at the national level (NDoH) to improve aid coordination and transparency between GoPNG and all development partners – an issue that GoPNG has referred to several times – which would have downstream benefits for all provinces and PHAs. DFAT and GoPNG could also consider collating and assessing the lessons of reform at PHA level from different provinces. DFAT could also act as a catalyst for strengthening what "national level support" means in practice. For example, DFAT could consider supporting better and more applied use of operational research and evidence as a basis for better policy and planning by sharing PATH's own operational research not only with NDoH but with, for example, the PNG Institute for Medical Research (IMR). Strengthening, where appropriate, the "home grown" generation and use of evidence via IMR, perhaps through institutional linkages with Australian universities and institutions, would be a potentially important part of national level support for NDoH, PHAs, development partners and other stakeholders.

Key Assumptions

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

EOIO 2: DFAT funded health services are demonstrating efficient and effective models of service delivery, influencing PHA performance; and building sustainability by transitioning to PHA management in selected (up to a total of 6) provinces

Problem statement

Numerous GoPNG, DFAT, and other reports have identified a wide range of complex challenges to the sustainable and equitable delivery of health services in PNG (see Section B above). There are four specific problems where PATH can make a meaningful contribution in this area. The first is that access to health services are not as equitable or as inclusive as they should be. Women and girls, the poor, people with disability, the geographically isolated, and other marginalised groups face barriers to accessing essential care. The second problem is that health services in PNG are not as efficient as they could be partly because many large and important programs are delivered as "vertical" programs i.e. as a single disease program or type of service supported by specific training, logistics, information systems etc. These programs are often financed by donors and delivered or managed via external delivery agents outside Government and provincial systems. Examples include family planning, HIV, TB and malaria. The third problem is the risk to PNG and neighbours of outbreaks of infectious diseases, including strains that are resistant to antibiotics and anti-retrovirals. The fourth challenge is ensuring that essential services meet minimum standards of quality, including adherence to diagnosis and treatment protocols.

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

Strategic Intent

The design intention of this EOIO is to, within available budget, increase the coverage, accessibility, quality and sustainability of health services available to PNG while at the same time generating evidence and learnings that can help PHAs themselves improve their own performance, thereby making them more capable of taking over current DFAT programs over time. This will be achieved through (i) understanding and addressing barriers of specific marginalised groups to accessing services and disseminating such insight in a way that is useful – and used – by key stakeholders including PHAs; (ii) continuing, where appropriate, existing direct performance-based funding such as used by DFAT funded Marie Stopes[26] to deliver services which would otherwise not be available in PNG; and (iii) progressively shifting the delivery of DFAT-funded services into core PHA systems (covering both direct and contracted delivery). A key strategic intent of this EOIO is also to diversify the funding sources for health services away from DFAT to encompass PHAs, churches, MPs/districts, private sector, and other donors.

The MC will need to manage this transition carefully to minimise the risk that the number, coverage, and quality of essential services do not fall during the transition period. DFAT will provide separately the details of the number and nature of services currently being provided under PPFgrants for all provinces that potential contractors can use for planning purposes. The successful MC will need to have a way of demonstrating to DFAT and GoPNG that a particular PHA has, often with PATH's earlier support, achieved sufficient capacity to now plan manage and implement PPF services itself that can

[26] For example, Marie Stopes International, with DFAT funding support, uses a performance and incentive based "community-based mobilisers" approach to increase outreach and equity of advice on sexual reproductive health and family planning services in PNG. In essence, community organisers are paid K3 per client for 1-29 clients generated, rising to K5 per client for 50 or above clients generated. This has been found to incentivise CBMs to increase outreach to more remote villages, some of which involve up to 10 hours of walking to reach.

be transferred over from DFAT. Transferring those PPF grants will then help to free up existing PPF resources under EOIO 2 that can be used to invest in support for EOIO 1. There is also scope for improving the quality and access of existing services through increased use of performance-based grants; the use of the five drivers to ensure coverage and services; and integrating existing "vertical" programs so as to free up resources for further outreach.

Program Logic

Contributing to the Goal

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

Achieving the End of Investment Outcomes

Three intermediate outcomes will contribute to achieving this EOIO:

IO 2.1: Equity: approaches to increase access for quality essential services by women and girls, people with disability and other marginalised groups including the poor are tested and scaled.

This IO contributes to the EOIO through the assessment, testing, adapting and scaling of approaches that remove barriers to women and girls, people with disability and other marginalised groups seeking to use essential, quality health services when required.

This IO will be achieved through the following indicative outputs:

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

IO 2.2: **DFAT funded services demonstrate good practice in providing quality services, reaching marginal/hard to reach groups, and demonstrate linkages with and support to/from PHAs, including improved efficiency by integrating vertical services.**

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

This IO will be achieved through the following indicative outputs:

- PHA led annual service delivery plans and budgets containing GoPNG and DFAT funding;
- PHA reports reflect all services provided across the province Including DFAT-funded services;
- PHA supervision visits, in-service training and outreach covering multiple programs;
- PHA has plans to diversify funding to sustain service delivery as DFAT funding declines.

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

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

Laboratory support is part of the overall response to health security because it is a necessary (but admittedly not sufficient) condition and strategic investment to making progress on health security. Without better laboratory support, PNG - and its development partners - will not have the evidence base to track trends and so prioritise the use of scarce resources. Laboratory support is also specifically referred to because PNG is currently unlikely to be able to improve laboratories easily or in a timely fashion by themselves given their existing financial and human resource constraints. That means that DFAT (and other development partner) support is potentially well placed to add strategic value; be a catalyst for change; and shorten the time period by which PNG can reach IHR status.

This IO will be achieved through the following indicative outputs:

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

Drivers

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

- Learning and Dialogue: Assessment and testing of overcoming barriers to marginal populations' access to services. Funding diversification raised in senior level meetings.
- Bottlenecks: Conduct of in-service training/supervision/outreach requiring cross unit cooperation.
- Partnerships: Leveraging and coordination of CHS and Fleming Fund support for laboratory strengthening.
- Targeted national level support: Central Public Health Laboratory support for provincial laboratory capacity.

Key Assumptions

- More efficient, equitable and quality services will improve health outcomes.
- Efficiency and effectiveness will be increased if program functions (e.g. training, outreach) support multiple (rather than single) services and achieve government or international quality standards.

- Demand side strategies (awareness, outreach, community support/participation) will increase use of services by women and girls and minority marginalised groups.
- Externally financed and delivered services will be progressively managed and funded by the government and other partners.
- Performance based funding will incentivise service providers to extend services to underserviced and to better link with Government systems.
- It is possible that the Joint External Evaluation (JEE) will produce a number of specific recommendations which may create expectations for support but also opportunities for useful activities. PATH, being an adaptive program, has the capacity to respond. However, such decisions should be made by DFAT and GoPNG in the context of the governance arrangements for PATH and in particular the Annual Plan process where all requests and opportunities can be assessed and then prioritised in the light of budget and other resources.

ANNEX 3: PATH GOVERNANCE ARRANGEMENTS

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

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

Recommended principles for the governance arrangements of PATH

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

Governance Arrangements and Structures for PATH

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

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

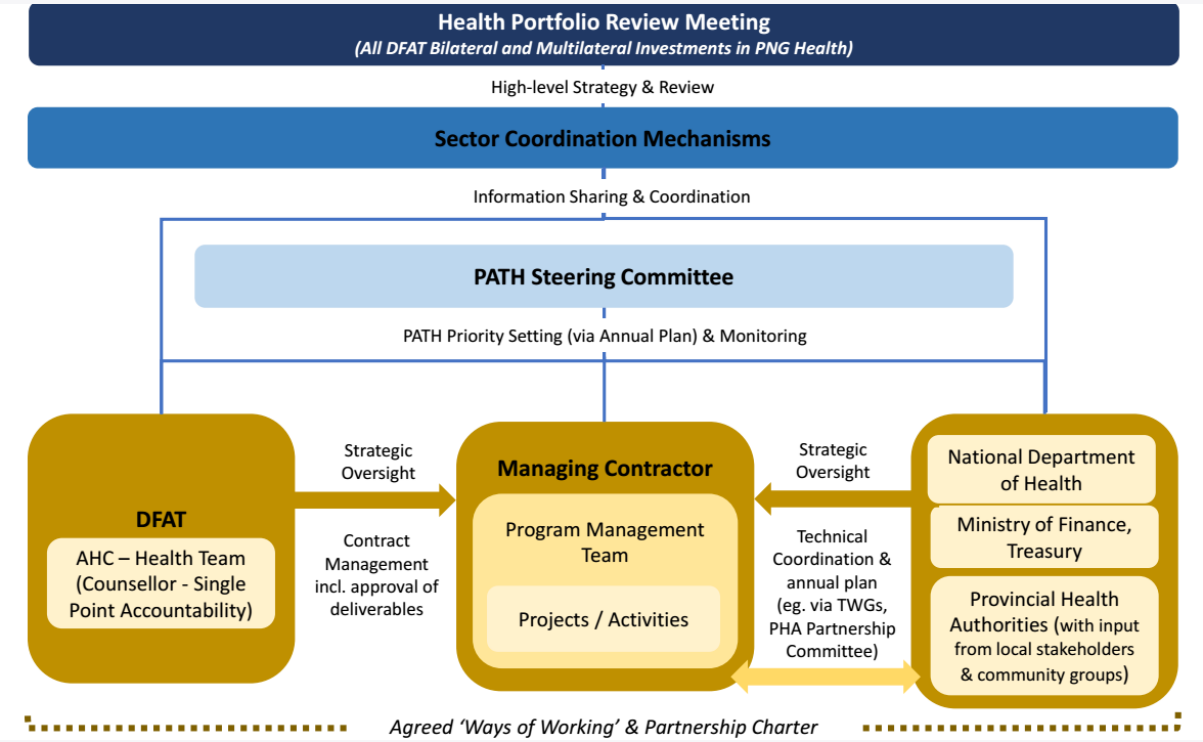


Figure 1 shows that PATH fits within the overarching, existing, governance arrangements involving DFAT and the GoPNG for the Health Portfolio Plan. This will enable DFAT and GoPNG to ensure that all of DFAT's investments in the health sector, including PATH, are well-coordinated and provide coherence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

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

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

The goal and purpose of the Steering Committee is to approve the PATH Annual Plan (including proposed priorities, main activities, budgets and resourcing, risks and risk managements, lessons

learned, program performance and reporting). Given the partnership principles between Australia and PNG it is expected that decisions will be made by mutual agreement between DFAT and GoPNG.

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

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

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

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

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

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

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

Planning and reporting should be undertaken at intervals and in formats that align with the GoPNG (and where possible DFAT) planning and budgeting cycle, including their annual planning and budgeting deadlines and maintenance of the health sector medium-term expenditure framework. Annual work planning for activities in targeted provinces will occur at the provincial level. The PHAs are responsible for developing their own Provincial Annual Plans. The MC can of course support the PHAs in that exercise, as requested by the PHAs, as part of achieving EOIO 1; Intermediate Outcome 1.1; and using any or all of the five drivers. Where possible, solutions to problems should be locally-generated and driven. The MC, in consultation with the PHA, should explore opportunities to facilitate this through PHA Partnership Committee and/or other mechanisms, whereby local stakeholders can contribute. Local stakeholders could include PHA staff, community members, churches, NGOs, elected representatives and other Provincial and District officers. Local solutions may be developed by non-government local stakeholders.

PATH Roles and responsibilities

Principles for the architecture of governance in an adaptive program

DFAT reviews, and international experience more broadly, suggest that adaptive programs like PATH should reflect certain principles, including the architecture of governance, if they are to yield their potential benefits. Such principles cannot be too prescriptive given the wide variety of experiences of adaptive management (see Annex 4 including the references from the international literature at footnote 30) as well as the wide variety of circumstances between and within provinces of PNG. Nevertheless, based on DFAT reviews and the international literature, the PATH design does aim to reflect the following principles: see Box 1 below.

Box 1: Principles that inform the architecture of adaptive program governance

The introduction of program management skill sets well matched for an adaptive program in the PNG context. Whilst this design does not provide specific staffing requirements, the PATH staffing composition will need to respond to the particular role of the contractor. Relevant aspects of the design include promotion and use of PNG nationals recognising the "value-add" their expertise, relationships and networks offer; and the central role of MEL in relation to program management and improvement including ongoing tactical strategy by the contractor and adaptive management: see also Statement of Requirements.

The importance of context and locally, community-driven approaches. Essential to learning and adaptation for PATH will be feedback loops and evidence on what is working and isn't working in the particular contexts within which it is operating. This is reflected in the MEL processes for PATH, the structure and flexibility in the program logic, as well as indicative approaches and interventions. These include community based and other social accountability strategies which seek to mobilise collective action and joint reflection and problem solving to improve the performance of public services.

The recalibration of expectations on program results to be ambitious but realistic. Expectation on results for PATH need to be carefully calibrated for two reasons: (1) the challenges of operating in the complex and varied environment of PNG and (2) the adaptive program modality which emphasises experimentation and learning. It is important that the systems and culture of PATH do not place undue expectations on short term results and allow for experimentation and testing in those areas of program delivery that it is needed. The proposed time period for PATH – five years with the provision for a three-year extension if DFAT and GoPNG are satisfied with progress to date – facilitates that approach.

A practical approach to political economic analysis that results in change. This is reflected in the approach to MEL which requires specific evidence that learning, analysis, action research and evidence generation activities have informed policy and practice. It is also reflected in the drivers of change and in particular in the intention for PATH to address bottlenecks. This will require PATH to deal with and overcome socio-political obstacles and will incorporate political economic analysis as well as political skills and networks to navigate the necessary changes. DFAT's experience is that an adaptive program needs a structured process for driving locally generated solutions: without a structured approach, there is a risk that the design will drive externally imposed solutions. The MC will need to demonstrate such a structured approach and integrate it into its Annual Plan in terms of priorities, programs and the allocation of financial and human resources. Some successful examples from DFAT that the MC might therefore wish to consider in its own design work under PATH include an iterative process for driving locally owned solutions similar to the approach outlined in the DFAT supported Innovation for Indonesian school children (INNOVASI) program.[27] Stakeholder mapping prior to and during program

[27] Details available at https://dfat.gov.au/about-us/publications/Pages/indonesia-inovasi-design-document.aspx

implementation is also important. The DFAT supported kina for kina program provides a good example of strategy testing.[28]

Specific roles and responsibilities under PATH

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

[28] Details available at https://png.embassy.gov.au/pmsb/714.html.

Table 1: Roles and Responsibilities of Program Partners by Function

	General Principles and comments	GoPNG Role	DFAT Role	Contractor Role
Strategy & Leadership of PATH	• Roles and responsibilities to be refined & agreed in first 3 months • 'Ways of working' to be workshopped in first 3 months	• Set overall sectoral strategies and policies • Consult on facility strategy and priorities • Lead sector coordination	• 'Policy dialogue' • PATH strategy setting in consultation with GoPNG (e.g. province selection; thematic priority setting) • Support sector coordination	• Inform and make recommendations to GoPNG and DFAT on PATH's strategy • Tactical strategy to achieve outcomes and use adaptive management to promote learning
Planning & Budgeting	• Joint planning and review including national and subnational stakeholders	• Review and approve annual plans and budgets (national & subnational)	• Review and approve annual plans and budgets	• Prepare draft annual plans and budgets
Grant Management	• Competitive, large-scale, results-focused, innovative • Alignment to PATH strategies • Coordinated transition and phasing of existing grants	• Participate in grant design and selection • Oversight and joint monitoring	• Participate in grant selection • Oversight and joint monitoring	• Technical advice and support • Financial management/oversight
TA Management	• Use of different TA options including twinning etc. • Shared TA across provinces • Leveraging local expertise / institutions	• Long term TA planning • Approve TOR (for high-value inputs) • Participate in selection • Joint performance management	• Approve TOR (for high-value inputs) • Participate in selection • Joint performance management	• Technical oversight & leadership (including GESI, decentralisation) • Recruitment, orientation, performance management • Approve workplans

	General Principles and comments	GoPNG Role	DFAT Role	Contractor Role
Monitoring Evaluation and Learning	• Both MEL of PATH itself, and broader learning and results management of operational research • Using shared mechanisms and government systems • Inform and coordinate with M&E contractor	• Set sectoral and sub-sectoral monitoring and evaluation systems (e.g. NHIS; PHA review) • Consult on PATH MEL • Consult on use of evaluations of PATH • Participate in joint processes	• Approve PATH MEL framework and deliverables • Participate in joint M&E processes • Commission and use independent evaluations of PATH • Contract and manage independent M&E provider for overall DFAT health portfolio investments	• Ensure MEL is actively and purposefully used for program improvement and to generate evidence that can be used to strengthen policy and programs to achieve both EOIOs 1 and 2 • Have a clear knowledge management / knowledge brokering strategy and expertise • Conduct Studies to inform strategy selection and learning (e.g. women in leadership) • Context monitoring
Learning, Analysis, Communications & Knowledge for policy and practice	• Identify 1st year priorities in design. (e.g. equity in health using DHS) • Concise and 'user friendly' formats for DFAT and NDoH needs • Increased focus on identify options and solutions, and support for testing. • Strategy testing and learning • Draw on experience across health sector and across sectors and elsewhere (e.g. Pacific Women)	• Identify priorities and make requests for analysis and policy options and products • Provide information and data for analysis. • Approvals where necessary • Participation in joint activities • Use findings to inform strategy setting and policy	• Identify priorities and make requests for analysis and policy options and products • Facilitate cross-sectoral, cross-program, and cross-agency learning & activities • Use findings to inform strategy setting and 'policy dialogue'	• Undertake analysis and prepare products • Use findings to shape workplans and technical advice and support • Partnerships and leverage other programs / orgs • Take on lessons learnt from implementation of other like facilities

	General Principles and comments	GoPNG Role	DFAT Role	Contractor Role
Contract Management and Cross-cutting		• Continue to promote GESI within GoPNG and PHAs	• Contract management including internal reviews and approvals, Contractor performance management, and Aid Quality Check preparation. • Promote gender equality and social inclusion and other Australian Govt priorities	• Assume responsibility, including financial responsibility, for implementation of program activities as agreed though Annual Plan. • Use approaches that build capacity and sustainability
Risk Management	The Steering Committee is responsible for systematically tracking and acting on risk as part of the annual planning process	• Promptly bring to the attention of the Steering Committee, including through out of session advice or meetings, information about changed risk profile that GoPNG is aware of that could affect PATH and its operations	• The recommended DFAT establishment review on the number, level and nature of in-house DFAT staff, and externally available staff, to manage PATH should identify which particular positions are responsible for tracking and monitoring different implementation risks • DFAT should systematically assess the MC risk management plan during the Annual Planning	• It is a key and intentional part of an adaptive program, and the associated MEL, for the PATH MC to trial, test, and learn from experience as a means of improving performance and reducing risks • There should be a "no surprises" policy. That means that the MC should promptly bring any changes in the risk profile to the attention of DFAT (and GoPNG, and

General Principles and comments	GoPNG Role	DFAT Role	Contractor Role
		session, taking into account DFAT's own M&E experience of PATH but also DFAT's knowledge of the broader operating environment in PNG • While the Annual Plan should be the more formal and systematic assessment of the MC's risk management plan, it would be prudent for DFAT to also discuss and review overall risks with GoPNG and the MC at more regular intervals including quarterly review meetings if they are introduced	implementing partners including NGOs) • The MC should keep its risk register up to date and should be systematically reviewed as part of the Annual Plan discussions • The MC itself is in the best position to identify what particular risks each individual member of staff is responsible for monitoring and managing • The MC should use and apply the DFAT fraud control toolkit

PATH "Ways of working"

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

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

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

The purpose of this "Ways of Working" annex is to facilitate a professional, constructive, and smooth relationship between MC and DFAT by specifying mutual expectations of each other. This draft "ways of working" draft sets out proposed details of ongoing day-to-day collaboration between PATH MC Program staff and DFAT personnel and the mutual expectations of each Party. The text in this Annex is a draft that should be used as a basis for review, discussion and agreement between MC and DFAT in the first three months of PATH implementation. This proposed "ways of working" draft has been developed on the basis of DFAT's experience and lessons with programs of a similar nature to PATH[29].

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

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

Draft principles

General

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

[29] Department of Foreign Affairs and Trade. Independent Review of Facilities: Review and Management Response Canberra 2018 Canberra2019 [Available from: https://dfat.gov.au/about-us/publications/Pages/independent-review-of-facilities-review-and-management-response.aspx

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

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

Policy Advice

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

Monitoring Evaluation and Learning (MEL)

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

Value for Money (VFM)

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

Risk

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

National Expertise

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

Identifying opportunities

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

Contract Management

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

Decision response times

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

Encouraging PHA partnerships

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

DFAT oversight capacity

As is evident from the sub-sections above on Roles and Responsibilities, Ways of Working and Draft Principles, DFAT will need to ensure the deployment of staff capable of managing a complex, wide-ranging and dynamic program, as well as undertaking effective policy dialogue with the Government of PNG and sub-national stakeholders. This will necessarily require skills in the following areas: health sector, M&E, knowledge management and brokering, political thinking and engagement, contract management and strong stakeholder engagement skills.

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

PATH as an adaptive program

PATH is an adaptive program. Adaptive programming or management acknowledges from the start that while the outcome to be achieved may be known, the specific strategies and combination of interventions that will work to address complex development challenges need to be developed. Program design builds in deliberate processes of testing and experimentation, with structured MEL provides feedback to learn from experience. This can be done by testing interventions iteratively or in parallel, to scale up those which are working and curtail those which are not. It can focus on identified problems and look for innovative ways to address these. There should be regular strategic reviews based on rapid feedback mechanisms, to allow adaptation. The flexible and evolving nature of this approach requires capable MEL capacity within the MC and trust among the partners. [30]

Role and scope of MEL

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

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

- Direct support, including through technical assistance and studies, for building evidence and learning to improve PHA management of essential health services in selected provinces, as articulated in End of Investment Outcome (EOIO) 1.
- Continuous improvement of access to, efficiency, and quality of DFAT funded health services as articulated in EOIO 2.

[30] Further information available at the following sources:

DFID *Top Tips How to design and manage Adaptive Programmes, 2016* - update forthcoming

Duncan Green, "Old Wine in New Bottles? 6 ways to tell if a programme is really 'doing development differently', 2018.

Working Group on Adaptive and Flexible Programs, "Finding Solutions to Local Problems in Education", 2018.

Matt Andres, Lant Pritechett, Michael Woolcock "Building State Capability", 2017

USAID, "Discussion Note: Adaptive Management, 2018.

Page 22, Overseas Development Institute "From political economy analysis to doing development differently', 2016.

- Using the lessons from testing approaches and continuous improvement that occur in DFAT funded programs under EOIO 2 as the evidence base for deeper and more convincing policy dialogue and practical learning with PHAs (EOIO 1).

There are incentives within PATH to make sure evidence and learning is then actually used to improve policies and programs both within PHAs (EOIO 1) but also DFAT directly funded programs (EOIO2). The recent DFAT Office of Development Effectiveness review on policy influence notes "it is not enough to have something to offer by way of evidence or knowledge. Knowledge brokering requires a deliberate strategy for how this will be used to influence policy".[31] The PATH Managing Contractor (MC) will need to develop such a strategy and link it to MEL. A key theme and innovation within PATH is that the MC is required not only to generate evidence and learning but also to develop indicators that such evidence and learning was then actually considered and used by decision-makers. This is intended to incentivise the MC to proactively think about how best to generate and present evidence and learning in ways that it gets traction.

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

Approach to monitoring and lesson-learning

Regular reviews of the Program will include analysis of data from diverse sources and reviews of progress towards intended outputs and outcomes, with structured assessment of what is working and what needs to change. It is envisaged that this type of assessment will be done by the MC at least quarterly. This is part of the adaptive program approach to testing what works to address particular problems, learning from experience and adapting. It is expected that the Program will present results to DFAT and NDOH as part of regular PATH reviews every 6 months.

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

- using health and system performance data from the National Health Information System (NHIS), providing extra analysis if required e.g. for disaggregated data on service use by sex and age;
- supporting a national approach to assessing PHA and province performance, to build up a national system which is led and owned by the NDOH and uses national standards, involving other key partners such as ADB and World Bank and at province level, involving key partners and representative groups;
- using provincial financial and HR information systems, with support if needed to ensure their effective introduction and use. This could include for example, analysis to generate data on the costs of scaling up outreach services;
- ensuring that the MEL complements, but does not duplicate, other M&E systems: especially those that DFAT itself manages. For example, the MC for PATH should make sure that the approved MEL aligns with and does not create gaps or duplication with M&E on health security issues that are already be monitored in PNG by the DFAT supported Centre for Health Security;
- using the Joint External Evaluation (JEE) process and tool to assess progress on the health security agenda (the first JEE is planned in 2020, which would provide a baseline, and the assessment could be repeated in 2025);

[31] Department of Foreign Affairs and Trade Office of Development Effectiveness. Policy influence: lessons from a synthesis of 2017 evaluations. Canberra 2019.

- working with partners active in the province to agree on joint M&E plans and encourage joint field visits, including community stakeholders where appropriate e.g. representatives from women's groups and persons with disability.

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

Thematic studies and assessments will be required for design and monitoring of some interventions. A tool for assessing staff attitudes and culture in PHAs and key providers is required as the basis for work on women in leadership and provincial leadership more broadly. This should build on other assessment tools used in PNG for management training and consider standard approaches (such as 360° assessment). Targeted studies can be used to understand barriers to access for vulnerable populations, such as attitudes towards disability, and whether access has improved over time. Baseline studies will be required for the selected provinces, as well as reviews of evidence available and gaps requiring further analysis (see suggested list in Annex 9). The MC is expected to establish monitoring of approaches and activities that provides rapid feedback on their results to enable adaptive management. This may include qualitative and narrative methods such as feedback of participants, expert reviews, community feedback and stories of change.

An adaptive approach requires processes of testing, learning and iteration to find solutions: implementation, monitoring and learning need to happen at the same time, so solutions can adapt and respond to feedback on what is working and what is not in real time. Specific tools and methods, including outcome mapping, sense making, strategy testing and other qualitative reflection and interpretation processes, have been developed to support this process with timely data. Monitoring processes are also required to support PATH to monitor how they are using learning to achieve outcomes and to capture the rationale for decisions.

The MEL Framework sets out proposed indicators for the objective, end of investment outcomes, intermediate outcomes and drivers of change as well as for key assumptions underlying the program logic. It also suggests measures of inputs, value for money and performance of the MC itself. This framework is advisory, to be refined once the Program starts. The selected contractor will develop a detailed MEL plan in the inception phase, with targets reflecting proposed activities and outputs as well as outcomes. The Performance Assessment Framework (PAF) will also be agreed during the inception phase, using the balanced scorecard approach if this is adopted by DFAT. If the Program includes a range of service delivery grants, there should be scope for some shared and integrated elements of MEL rather than each grant having its own MEL.

Responsibility and budget for MEL

The MC will require in-house MEL capacity to support the adaptive approach and regular monitoring. In line with thinking on adaptive management, the monitoring and learning should be implemented by and within the MC and involve key programme staff (not a separate or independent MEL function[32]). It is envisaged that there would be one MEL specialist working in the MC senior team to enable and support effective design and use of MEL. Monitoring would draw on various methods and tools, some of which would be funded as part of routine information systems and processes, while others would be commissioned with funding from PATH.

The MC will require resources for monitoring and learning. The PATH budget includes $1m per year earmarked for MEL, intended to include one senior MEL post, survey work in provinces, studies for design and follow up, and field monitoring visits to provinces. Additional resources to this MEL budget will contribute to MEL and enable adaptation in the light of experience – particularly the budget for action research, analysis and communication of findings (another $1m per year), and the monitoring built into service delivery grants. There is additional funding for independent evaluations by the M&E service provider discussed below. The budgets for MEL can be reviewed once the detailed MEL plan is completed, to see whether more resources are required.

Evaluation

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

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

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

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

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

Key Evaluation Questions

1. Were grants, activities, analysis and monitoring well designed and implemented to address access for women, girls, people with disabilities and other disadvantaged groups, meeting DFAT standards

[32] Whilst monitoring is 'in house', there is some positive experience (reported by DFID) of involving a 'critical friend' in progress reviews to generate debate on progress and opportunities for improvement. This might be an experienced person from within the MC organisation but not the program team.

for GESI? Were disadvantaged groups and barriers to their access to services identified appropriately? (GESI)

2. What is the specific evidence that learning, analysis, action research and evidence generation activities have been responsive to needs of DFAT and NDOH, informed policy and practice, and contributed to improving Program effectiveness during implementation? Has national capacity been developed for these roles? (Driver of Change (DOC 1)
3. Were important bottlenecks and management issues identified and tackled inclusively, based on sound analysis of context in the selected provinces? Is there evidence of impact on improving provincial health systems and women in leadership? (DOC 2)
4. Has work on aid coordination at national and provincial levels and collaboration with national departments and other partners been successful in enabling greater impact and well aligned support? What are lessons from efforts to bring in other partners, DFAT supported programs and DFAT post staff to contribute to PATH outcomes? What is the evidence of PATH's leverage or influence on other programs that has enhanced their impact? (DOC 3&4)
5. Has PATH adapted to changing context, emerging issues and findings, while also retaining focus on the objectives and the EOIOs? Have the adaptive approach and flexible funds been used strategically or is it leading to ad hoc responses? Does DFAT feel it has the flexibility it needs to target resources and respond to events? How did the management arrangements and ways of working promote this and are there lessons for future working? (DOC 5, learning by doing/take risks/adaptive management)
6. How has the Program contributed to the capacity of PHA management and leadership in the selected provinces? Is there evidence of improving effectiveness, efficiency and equity in service delivery and access as a result? (EOIO 1)
7. Is there evidence of improving management and accountability in the provinces selected for management support? How has PATH contributed to this? How well has the Program adapted and innovated to address the constraints and complexities of different provinces? (IO 1.1, 1.2)
8. Has there been progress on increasing women's role in leadership in the selected provinces (or elsewhere)? How far did the Program (with other sources of support) contribute to this? Were there unintended outcomes from working on this? How did the Program manage its Do No Harm approach? (IO 1.3)
9. What changes in service coverage, quality and access have been identified connected with service delivery grants and moving away from vertical programs towards more integrated PHC? How far can increases in service uptake be attributed to the Program? (EOIO 2)
10. Has there been effective learning on how to enhance access for women, girls, people with disabilities and other disadvantaged groups, what works and at what cost? Have successful approaches been shared and scaled up? If not, what are the constraints? (IO 2.1 access)
11. Have the service delivery grants met their objectives for expanding service access and capacity? Have performance-based approaches contributed to this and to provider and PHA incentives to work together? Has the Program demonstrated efficiency gains, for example from greater integration in service delivery and better coordination of services at provincial level? (IO 2.2)
12. How well has the support for control of TB in Western province achieved its objectives and developed capacity to manage multi drug resistant TB? How useful are other investments in health security and laboratories: do they address important gaps identified in the JEE, build on existing DFAT investments and contribute to sustainable laboratory and surveillance systems? (IO 2.3)

13. Has the mix of inputs led to efficient management and cross-Program synergies and coherence? Has PATH demonstrated value for money in delivering the Program in useful ways? (VFM)
14. Are the approaches supported by PATH likely to have sustained effects? Is enough attention being given to sustainability in terms of developing a health system that the provinces can continue to finance and manage? (sustainability)
15. How effectively has PATH influenced NDOH and provincial health systems to consider climate risks and identify ways to build resilience in their health plans, policies and operations? (CC)

Mid-term Review

DFAT should initiate a mid-term review (on current planning, this would be around September 2022) to assess progress to date, and prospects for achieving the PATH goals, EOIOs, and intermediate objectives. DFAT can then decide to continue, modify or otherwise change PATH after consultation with GoPNG and other key stakeholders.

Framework of monitoring indicators and sources

The table below provides indicators, methods and uses of information for monitoring, in the standard format for the IDD. It includes monitoring of outcomes, selected key assumptions, indicators of value for money and elements of the draft performance assessment framework for facilities.

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

Monitoring of outputs and activities will need to be incorporated once the MC is in place and specific outputs have been identified. As noted above, the adaptive approach requires monitoring of outputs and implementation to provide findings and feedback in 'real time', especially where new approaches are being tested, in order to inform reviews and adaptation.

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

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

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

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
		(all by gender & age as appropriate) Coverage indicators for people with disability, other vulnerable groups Service availability /quality indicators e.g. no., sex & skills of staff; drugs & supplies; TB treatment success rate*	Facility/community survey on service availability, quality & access		PATH to establish facility/ community data collection in selected provinces (coordinated with ADB & others)			
End of Investment Outcomes	1. PHAs are more able to lead provincial health reforms and manage effective, efficient and equitable essential health services in selected provinces	Province performance, incl. staffing, functioning of PHA & committees, performance against National Health Service Standards Gender equity & disability issues reflected in HR policies and corporate plan of PHAs (esp FSV policy and referral pathways) Total budget allocation per capita* Province health expenditure as % of estimated need*	PHA performance assessment using shared review mechanism (e.g. revive/adapt peer review approach previously used for hospitals) PHA policies and resources for FSV etc Self-assessment at PHA and districts, using standard tools Facility/community survey on service availability, quality & access	Other partners willingness to share review mechanisms PHA interest in self assessments	Support NDOH-led review of PHA performance, with other partners involved, (to ensure common approach and ownership) Program to develop tool for PHA self-assessment with NDOH and other partners Provinces collect data for NHIS on services etc .	PHA perf assessment at start, once method agreed Status of HR policies Funding levels NHIS data Baseline review of supervision	As above. Specific target for each indicator will be set by the MC in the inception phase	Use performance assessment results to drive improvements within Provinces Share good practice in management and gender equity approaches across provinces

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
		Average outpatient visits per person by province, gender, age* Outreach clinics per 1000 children under 5* % of issues identified during supervision resolved in x months	Case studies in provinces of mgt. & leadership performance e.g. use of information for mgt. action; follow up to supervision findings					
	2. DFAT funded health services are demonstrating efficient and effective models of service delivery, influencing PHA performance; and building sustainability by transitioning PHA management in selected (up to 6) provinces.	No. of FP services; people treated for HIV/STI; children immunised (DTP3, measles); children treated for malnutrition & pneumonia by sex & age in DFAT grant-supported provinces Number of services delivered to people with disability, adolescents, key populations, etc FSV referrals to & from SRH services Service quality indicators e.g. accurate diagnosis. Evidence of coordination & integration in service delivery in provinces	NHIS data by age & gender by province. Provincial reports on integrated activities and services with lessons learnt. PPF grant recipients report on services delivered and use by people with disability & target groups Service level agreements analysed by type of provider (church, other private, public) and scope of services	As above Disability not in routine data Vuln. groups not readily identified	NHIS and grant recipients collect data on users and quality indicators. Work with NDOH and provinces to agree approaches to monitoring access for people with disability PHAs and NDOH to analyse coverage by sex & age using routine data with support if needed Contractor to arrange surveys on community access & service availability	NHIS data for 2020 TB program baselines Baseline survey of persons with disability (including mental disability) and other target groups relevant to different services Review of integration scope & experience with provinces		NDOH and other provinces learn from lessons on inclusive access and effects of integration

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
Intermediate outcomes	1.1 PHA Boards & management are more capable of leading reforms and managing finances, health workers, partnerships, quality assurance and service providers	Funding of provincial health services by source; allocation by district and level (hospitals, PHC) % of allocated provincial level health funds that are spent* Performance mgt. of PHA staff operational % of planned nurse & midwife recruitment completed No. & % of qualified health workers in hospitals vs PHC % of health facilities that received at least one supervisory visit* Progress towards service level agreements between PHA and providers Evidence of gender budgeting in health & consideration of needs of people with disability	Routine management systems for finances and HR PHA reporting to Board at least annually, including on finances, recruitment, staff turnover, systems for managing performance etc Analysis of PHA plans and budgets (annual) Facility/community survey on service availability, quality & access	Roles of PHA versus DDAs remain unclear Central constraints on recruitment etc limit PHA ability to manage Available health staff & finances allocated to hospitals rather than PHC	PHA financial systems with support for analysis if required PHA HR MIS Field visits to PHAs & districts Participant feedback from managers, leaders & staff affected by reforms or interventions. NDOH review of PHA performance PHA, district and survey staff visits to facilities & communities		As above Specific target for each indicator will be set by the MC in the inception phase	DFAT use findings to inform policy dialogue MC use to inform adaptive strategies, scale up effective models
	1.2 More policy relevant information is available and used by Gov't,	Data & performance comparisons between & within provinces are	NDOH reports with rating of PHAs' performance	Availability of quality and timely data	NDOH review of PHA performance	Baseline collected at start	As above	Ministers, NDOH, National Economic & Fiscal Commission & others to use data to

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
	PHAs, MPs, NGOs, health facilities and communities to monitor and drive performance	shared with managers, MPs, communities etc Evidence of use of PHA data in decision making by PHA Board and others Awareness of MPs of health performance of their district % of districts allocating DSIP funds to health Lessons on social accountability shared	Data on performance available in PHA, districts & health facilities PHA minutes on decisions taken Evidence on social accountability & community feedback mechanisms shared with provinces	Low incentives to use data or change conditions Health competing for funds with education, infrastructure	Field visits to PHAs, districts & facilities PATH TA feedback on use of data Qualitative and narrative methods to learn from social and community mechanisms.			stimulate changes in performance DFAT use findings to inform policy dialogue MC use to inform adaptive strategies, scale up effective models
	1.3. More women in management roles influencing policy, planning & budgeting of health services in selected provinces	Numbers of women in management (by level and role) in public, church, NGO health sectors and on key committees Male advocacy networks active in provinces Evidence of progress towards GESI conducive workplace culture & GESI policies being implemented	HR Management Info System (MIS) data on numbers by level/role Qualitative study of male advocacy networks Qualitative survey on barriers to women in leadership/mgt Self-assessments of workplace culture & staff attitudes at PHA and district offices	Women in mgt. exposed to violence/ harassment HRH reforms do not stipulate at least 30% women in mgt. rule (CEDAW/ DPM)	Program working with interested provinces to establish approach & monitor activities and results MC commissioned learning methods that provide timely feedback	Baseline from HR MIS & assessments on numbers, levels, attitudes & barriers	As above	DPM/PHA use in planning MC use to adapt program with experience as learn from implementation DFAT use for policy dialogue & in managing other related programs

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
	2.1 Approaches to increase access for services by women and girls, people with disability and other marginalised groups including the poor are tested and scaled	Analysis of barriers to access by sex, age, disability etc. Evidence from testing effects of strategies on uptake of services by vulnerable groups Evidence that findings have been used to scale up or adjust services	Studies on access & barriers for vulnerable users e.g. transgender women; urban poor; adolescents Grant recipients report on service use by target groups Facility/community surveys include feedback on access and barriers to use	Diversity across provinces and groups may limit replication Willingness to address some key groups Possible community backlash or resistance towards marginalised groups	MC to commission relevant studies and surveys Grant recipients provide data on service users and how they adapted services Field visits to service providers	Baselines from service providers or studies	As above	Use evidence to inform all relevant provinces and NGOs on effective methods, costs and what has not worked well MC use to inform adaptive strategies and scale up effective models
	2.2 Essential services: DFAT-funded services demonstrate good practice in providing quality services, reaching marginal/hard to reach groups, and	Volumes and quality of services provided Progress towards a 'one stop shop' for clients to access mix of services needed Extent grant-funded services are reflected in province annual plans, budgets & reports % of supervision, outreach, transport, in-service training that are integrated	Grant recipients report on services delivered, quality indicators & users PHA plans, budgets & reports Engagement of grant recipients in joint planning and reporting with PHA Facility/community survey on availability, quality & access	Performance based funding incentivises direct delivery more than work with PHA Over-reporting risk for results-based payment (ie gaming the system / fraud)	Grant recipient collect data on services & users Field visits to PHAs MC to coordinate shared monitoring across grants MC to commission experts / TA to review lessons on integration and access World Bank/gov't work on verification	Baselines from service providers, in grant agreements PHA baseline assessment to include extent of verticality in program management, transport, supplies and service delivery	As above & include targets in grant agreements	Use as basis for performance-based support; to demonstrate results; & to identify how to improve future grants MC use to inform adaptive strategies, scale up effective models

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
	demonstrates linkages with and support to/from PHAs, including improved efficiency by integrating vertical services.							
	2.3 Improved compliance with International Health Regulations (IHR) in relation to laboratory performance; detection and treatment of TB and malaria; and other agreed priorities identified by Joint External Evaluation (JEE)	TB treatment success rate in Program areas* TB case notification rate (DS & MDR TB) * Trilateral Malaria project indicators (phase 2 in design) Outcome measures for other health security interventions e.g. no. of provinces with labs able to conduct at least 5 core tests to diagnose priority diseases; quality of surveillance sites	TB program data Trilateral project reporting Expert reviews on progress and quality JEE rates national lab system & other IHR capacities for health security[33] (JEE planned in 2020, could repeat in 2025) Monitoring for health security	JEE delayed or not done in 2020 & 2025. Poor coord'n with Centre for Health Security (CHS)	TB program & implementers collect routine data JEE involves various external partners following initial self-assessment MC to organise expert reviews / TA inputs	TB plan baseline Trilateral Malaria project baseline JEE in 2020	TB plan targets Trilateral project targets Targets set for other health security outcomes	Use to identify scope for more efficient operation within PATH & with others including WB Emergency TB Project, CHS, Fleming Fund implementation agency

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

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
			interventions to be defined (TBD).					
Drivers of change	1. Strengthened evidence base as a basis for more informed policy dialogue & practice	Learning products by type, & awareness of relevant audiences of products available Evidence of application of findings/lessons in policy & practice Evidence of response to requests from NDOH, PHAs etc Evidence on benefits & cost implications of integrated services, supervision etc	MC reports on how knowledge outputs were requested & evidence of use for policy, planning, budgeting or to shape Program activities Studies & analysis to show effects of more integration in service delivery & system functions, with cost implications	Hard to attribute changes to specific products	MC to collect & analyse information on awareness, uptake & use of evidence and learning		Specific target for each indicator will be set by the MC in the inception phase, in liaison with DFAT and GoPNG	Lessons fed back on best ways to select and communicate learning, analysis and synthesis of knowledge MC performance awards to reflect uptake of learning Use findings during implementation to adapt approaches
	2. Reduced key bottlenecks to deliver better health services using a problem driven approach	Common bottlenecks identified that constrain provinces' performance e.g. slow release of funds to PHAs; low employment of graduating nurses & midwives due to bottlenecks and delays in the approval & funding of positions Women & reps of people with disability consulted on bottlenecks that reduce their access	Participative methods, expert reviews or feedback while implementing approaches, to allow continuous adaptation with experience Evidence of agreement between provinces and NDOH on 2 or 3 critical issues Evidence that Program, working	Will and ability of others to work together on tricky issues Will of GoPNG to resolve issues Some bottlenecks not resolved	MC to report on selection process, how addressed and whether resolved Field visits to PHAs	Specific baseline for each bottleneck		Use during implementation to adapt approach

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
		and use of essential services Specific indicators TBD for selected bottlenecks to show issue resolved through working with relevant partners.	with others (within or beyond health sector), has resolved issue such as slow release of funds and / or low employment of nurses & midwives in rural areas Evidence that women are key members of teams identifying & resolving bottlenecks					
	3. Leveraging partnerships & improved aid coordination	Health Sector Aid Coordination Committee (HSACC) meeting regularly with appropriate attendance TWG on gender, disability & inclusion established under HSACC Number & contributions of partners to province health sector by type (private sector, DP, church etc) Joint M&E framework & joint field reviews in selected provinces	HSACC minutes Province data on financial & service delivery partners, partnership committee minutes, service level agreements with church & NGO providers, ways of working Program records on engagement of other DFAT funded programs (such as Pacific Women; governance	Only info exchange in HSACC & TWGs, rather than real coord'n & joint working Willingness & ability of other programs to respond	MC with NDOH review of HSACC & with PHAs of Province partnership committees Periodic self-assessment of performance of HSACC & province committees MC feedback on flexibility & willingness of other partners to collaborate Field visits to PHAs	Baseline review of membership, roles, etc.	As above	Feedback across provinces on good practice DFAT can use to encourage participation of other programs and agencies it funds MC use to inform adaptive strategies and scale up effective models

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
			programs; ADB health programs)					
	4. National level enabled to support provincial health systems	To be determined	Performance reporting of outcomes in specific areas	Demands for national level support pulls focus away from PHAs	Progress review by NDOH with MC			Adapt workplan with experience as learn from implementation
	5. DFAT/NDOH able to respond to emerging issues	Budget available for response Scale and value of responses to emerging issues, relevance to program outcomes	Uncommitted budget line in annual budget. MC's reports on agreed activities in response to emerging needs	Demand for diverse support – hard to make strategic	MC to report on agreed activities Field visits as appropriate			DFAT to review implications of responses selected. May adjust decision process
Outputs	To be defined	TBD	Six monthly report		MC to report		Agreed annually	DFAT, NDOH & MC to review progress vs plans, agree adaptation
Activities	To be defined	TBD	Six monthly report		MC to report			
Inputs	Expenditure	Expenditure against agreed annual budget Number & value of off-budget changes in-year	MC annual plan, budget and quarterly expenditure report		MC to report	Budget	Agreed annually Target for variance	DFAT use in dialogue and for accountability
Key Assumptions	Provincial gov't & MPs are willing to provide necessary support for PHC	Commitments & actual expenditure on health by source Allocation between hospital & PHC	Financial data in supported PHAs, provinces & districts; compared with other provinces	Province gov'ts reduce funding for PHC once PHA set up	Province financial data analysed (MC can support analysis)	Levels in year 1 in selected provinces	PHA budget allocation	Use in dialogue and as context for results

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
	Essential drugs and supplies are available	% of months that province facilities do not have stock-outs of all selected medical supplies for more than a week in month*	NHIS for provinces & SPAR Facility/community surveys of service availability	Lack of drugs reduces uptake of services	Province mgt information & MC reports to highlight critical gaps	NHIS data for 2020 for selected provinces	NHP targets	Use as context for assessing service delivery results & to inform policy dialogue
	Better managed PHAs will lead to stronger health services	Improvement in key indicators in mgt. support provinces compared to others	End of project analysis using agreed PHA performance measures	Context changes & province differences mask effects of better mgt.	MC to generate evidence & analysis			May be useful to indicate value of mgt. strengthening
	Information/ evidence strategically used will exert positive influences on PHA and district performance	Whether learning outputs have been adopted by PHAs and districts and if not, why not	MC records where learning has/has not been taken up, analyses reasons why (e.g. whether understood incentives & what is convincing to different audiences)	PHA lack incentives or flexibility to use evidence provided	MC to plan for how to maximise use of learning & monitor whether or not it was used Field visits to PHAs	Expected uptake of learning by PHAs & districts	Specific target for each indicator will be set by the MC in the inception phase	Use lessons on uptake to adapt subsequent learning approaches & communications strategies
	More women in leadership roles improves organisational performance & service equity	Evidence whether more women in mgt. is contributing to equity in decisions on services	MC to consider ways to build evidence on impact of more women on mgt. decisions	Women managers unable to influence key decisions	MC to build review of this into design to generate evidence			Use evidence to promote women in leadership within PNG & beyond
	Efficiency & effectiveness will be increased if program	Evidence on gains in efficiency & cost implications of sharing functions (e.g. joint supervision & training)	Lessons learned & costs assessed of more integrated approaches, incl. how to address	May be against some interests	MC to collect and share evidence including on cost implications of integration	Baseline of extent of program-specific activities &	As above	Use to demonstrate how / why to develop more efficient and integrated approaches, to build

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
	functions support multiple services	& delivery of services (e.g. multi-purpose outreach)	barriers, effects on inclusive access			services in province at start		sustainable provincial health services
	Externally financed services will increasingly be managed & funded by the gov't & other partners	Plans in place to replace funding from DFAT of key interventions & to manage the services within the province health system	Review of PHAs' health plans & budgets by funding source	PHA unable to secure enough funds or has other priorities	MC to analyse province health plans & budgets by source of funds	Extent of PHA contribution to specific services e.g. FP, immunisation	As above	Use for policy dialogue with PHAs, central gov't departments & other funders
	Performance based funding will incentivise service providers to extend services to under-served & link with Gov't systems	Evidence of increased access by under-served groups & links with PHA can be linked to the agreed performance criteria & funding available	Grant recipients to report on performance	Risk PBF will distort efforts or encourage misreporting	MC to monitor & evaluate response to incentives & assess extra costs of reaching target groups	Baseline for services by target group Baseline nature of links between providers & PHA	As above	Use for design of future grants PHAs can use for assessing costs of reaching under-served groups
Value for money	Contractor identifies and takes actions to improve efficiency	Mgt. costs as % of total spend. Examples of actions to increase efficiency.	MC's budgets, financial reports MC to collect VFM examples	% mgt. costs is a limited measure	MC's reporting on finances & narrative reports on VFM processes & results	Mgt. cost as % of total each year as agreed in contract	% mgt. costs at or below original budget	DFAT oversight
	Economy in program operations and management	Procurement outcomes for major purchases/ contracts. Economy in staffing e.g. TA team shared by provinces; short term vs long term TA.	Tender evaluation reports Staffing report Staffing report, use of TA, local and international	Lowest cost tender may not be best value	MC's reporting demonstrates economy in approach		Compare with plan / budget & global reference prices	DFAT oversight

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
	Cost - effective strategies identified and scaled up	Evidence shared on results and costs of strategies tested. Evidence that MEL findings have been used (by the Program & in provinces).	Learning & analysis outputs include costs as well as effects Audiences reached with learning results & follow up of use	Gains & costs may vary with context	MC reports & knowledge products PHA reports on policies adopted & changes introduced			MC and partners learn & adapt from experience and scale up effective models Share findings across provinces, allowing for context
Facility performance (for PAF)	Learning and adapting	Records of structured reviews (at least 6-monthly) on progress and how to adapt based on experience and adaptive management approach adopted MC has timely data & qualitative feedback available to inform reviews / adaptation Regular progress updates on bottlenecks Evidence that less cost-effective approaches have been cut or amended in an efficient way	MC team reviews and six-monthly reviews with DFAT & NDOH Review & feedback on individual bottlenecks with partners involved MC monitoring plans & material presented to inform reviews / adaptation		MC to organise reviews as part of adaptive management MC ensures timely data and feedback available and analysed to inform reviews			Use for monitoring contractor performance, through an agreed Performance Assessment framework (PAF). DFAT is considering a balanced scorecard approach, which will include these and other indicators as well as other qualitative assessments, and results measures from above
	Operations	Outputs delivered on time & within budget Financial reports accurate & on time	Quarterly financial & activity reports. MC's self-assessment reports & audits		MC & audit reports	Agreed processes in tender/contract	Perform as in contract & DFAT policies	

	Desired result	Indicator	Data collection method & frequency	Risks	Who will collect & analyse the data	Baseline	Target	Use
		Procurement processes ensure value & follow rules Equity of inclusion in recruitment & procurement (local market, women, etc.) Staff breakdown by level disaggregated by gender, disability, etc. Compliance with PSEAH & other DFAT policies[34]	Staffing reports, by broad levels (e.g. leadership, technical, support staff) in MC & sub-contractors					
	Stakeholders & partnerships	Participation in & frequency of governance meetings. Examples of leverage & joint working across DFAT-supported programs, churches & private sector	Meeting reports, with assessment of how strategic meetings are MC to analyse joint working, leverage & identify barriers to better leverage		Minutes of governance meetings MC reports on joint working & leverage		Show increase in leverage over time	

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

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

ANNEX 5: GENDER EQUALITY AND SOCIAL INCLUSION (GESI)

Introduction

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

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

Overview

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

Maternal Health

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

Family Planning

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

Violence Against Women and Children

Gender-based violence (GBV) is considered to be endemic in PNG (10). Existing data suggest that 65.5 % of women in rural and urban areas are affected by domestic violence and 62% of sexual abuse cases have involved children (10). This has economic consequences as well as presenting a serious barrier to access and delivery of services. In 2015 a study of three businesses operating in PNG showed that female staff subjected to gender-based violence lost an average of 8.3 working days a year. One of the companies estimated the cost in lost staff time as three million kina or 9 % of the total salary bill. Given that GBV is understood to affect a third of all women in PNG there is good reason to assume the same impact will be felt in the public domain (11). Gender Based Violence intersects with other issues such as HIV, TB and disability (12). Gender based violence has obvious, direct, substantive, and largely preventable health and emotional costs to those affected. However, gender-based violence also raises the financial cost to the public health system. Health workers, especially in primary care settings, are often the "first responders" to women and girls presenting as a result of gender based violence: this has implications for the mental health and well-being of such front line health workers especially if they are regularly required to respond to traumatic gender based violence.

HIV

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

Sexually Transmitted Infections (STI)

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

Tuberculosis (TB)

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

Disability

There has been no prevalence study on disability as yet but the WHO global estimate of 15% of the population is generally accepted (13). This suggests approximately 1,275,000 people in PNG are living with some form of disability or impairment. Some data emerging from smaller studies points to higher levels, for example a study

of 690 men and women in Western Highlands and West Sepik Provinces reported 29% and 25% of women living with a disability and 30% and 12% of men respectively (14). Furthermore, the WHO estimates globally that only about 2% of persons with disability are receiving services (13).

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

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

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

What PATH can do

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

Service Access

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

Table 1: Gender Equality and Social Inclusion issues relating to Supply and Demand of Health Service Delivery to be delivered by PHAs and where PATH can be supportive[35]

Access constraints	Supply Side	Demand Side	Illustrative mitigation strategies that PHAs can take
Geographic accessibility	Service location Facilities are not always designed to be physically accessible for persons with disability	Poor road network Transportation costs (esp. for women with limited access to resources) Traditional healers preferred where closer Lack of access for persons with disability (physical)	• Evidence based advocacy for improved gender and disability sensitive infrastructure with MP's/PHAs • Enhanced outreach and mobile services
Availability	Qualified and available human resources (retention of staff at rural areas is an issue) Opening hours Waiting time Drugs and supplies Limited Community based Rehabilitation Services	Limited information on health care services and providers Lack of confidence in health facilities Service hours conflict with other duties esp. women (gardening/childcare etc) Low literacy rates (men/women)	• Improved behaviour change communications within PATH supported service delivery • Community consultations and patient participation • Enhanced outreach services • Integration of referral systems/training for Family and

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

Access constraints	Supply Side	Demand Side	Illustrative mitigation strategies that PHAs can take
	Weak Family and sexual violence (FSV) referral system inter-and intra-health system for FSV		Sexual Violence and links with Provincial Family and Sexual Violence Action committees within PHA and PATH supported services
Affordability	Cost of services and products even though primary health services are meant to be free. Public financing of the public health system	Even small user-fees will act as a barrier to accessing essential care, or a source of impoverishment, for poor people, including especially women and people with disability	• Better and more predictable financial management and release of funds in a timely manner – as is GoPNG policy - will reduce the necessity for user fees. • Routine gender and inclusion analysis of budget allocations
Acceptability appropriateness	Staff attitudes towards patients e.g. unmarried mothers, sexually active adolescents, people of diverse sexualities, survivors of gender-based violence, sex workers, persons with disability etc) Lack of female doctors Security issues for female staff Relatively more men than women at rural areas Lack of transparency of prices and pricing of service	Women may need spousal approval to access service Cultural practices conflict with Public Health advice Low self-esteem and lack of assertiveness Stigma (e.g.; people with HIV or TB; persons with disability, transgender women health needs overlooked) Low confidence in public services; frequent stock outs; facility closures Security issues for women in transit	• Community conversations/Family Teams approach (Pacific Women) • Inservice training for staff on implications of GESI for service delivery and management • Focus on women in leadership • Evidence based advocacy for disability inclusion • Peer educators and advocates • Enhanced social accountability Feedback loops from community to services/community scorecards • PHA HRH planning with gender focus including gender budgeting • Safeguarding policy to protect female workers • Male advocacy networks • Building the evidence base on barriers to uptake for women and girls and minority populations

Women in Leadership

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

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

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

A recent review of women's participation in the PNG economy, which focused on the public sector (33) summarised the key barriers which women face to achieving greater participation in the public service. These include limited opportunities for higher education, scholarships, and professional development; discriminatory practices in recruitment, employment and remuneration; sexual harassment and bullying in the workplace, including inadequate policies and guidelines for reporting and response; gender-based violence in the home and community; safety and security concerns in public spaces including transportation to and from work; high unpaid labour and carer responsibilities to balance with formal employment; and jealousy and suspicion from both male partners and the wives and girlfriends of male colleagues. Sharp et al. (34) found that some women choose to leave secure public sector jobs to pursue informal business activities as a viable alternative to formal employment because they experienced discrimination, felt marginalised and were undervalued.

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

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

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

WHO Health in Transition in PNG. 2018 (35)

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

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

Disability

Discussions with representatives of the PNG Assembly of Disabled Persons undertaken as part of the PATH design highlighted that '*There is a lack of engagement of people with disability and lack of understanding of their health needs' and 'there is little understanding of how disability connects with health'.* One respondent noted that the health sector focuses largely on clinical and medical services and facility-based responses concluding *'we are looking at birth and deaths but not the life in between'.* PATH can respond to these issues through enhanced advocacy for disability inclusive services under intermediate outcome "1.2 Accountability". In so doing it will also contribute to the implementation of the imminent PNG Disability Bill. Furthermore, under Intermediate Outcome "1.3 Women in Leadership", PATH can make deliberate efforts to partner with the emerging Women with Disability Network.

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

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

GESI Evidence Base

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

OECD compliance.

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

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

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

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

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

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ANNEX 6 WHAT WILL BE DIFFERENT IN PATH?

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

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

PATH has been intentionally designed to be an adaptive program from the outset. Many DFAT programs in the health sector, including HHISP, have encouraged projects and programs to be flexible, adjusting to changed circumstances. PATH is different in that it is designed to be an "adaptive program" – rather than a "facility" – from the outset. Annex 4 sets out the definition of an adaptive program, and shows how various characteristics such as testing, learning, and subsequent adapting involve more than just being flexible. The PATH design takes into account DFAT (and other development partners) experience with different types of adaptive programs. This has helped shape the program logic of PATH: see Annex 2; the architecture of governance for an adaptive program: see Annex 3 on governance; the Monitoring, Evaluation and Learning (MEL) approach: see Annex 4 on MEL; and the Statement of Requirements.

There is an unambiguous focus on provinces, and within that a sharper focus on selected Provinces. As noted already around 80% of the population live outside urban areas and that is where essential health services are delivered (or not). The roll out of PHAs is increasing and PHAs clearly have an increasing role in overall planning and managing services but have limited capacity to do so, particularly in the context of decentralisation reforms. In contrast to previous PNG health designs that aimed to support the whole sector through NDOH, PATH identifies provincial health functions and services as its central focus – with the central level playing a necessary but supporting role. It is envisaged that around 80% of the PATH budget will be allocated and spent on support for provincial level activities and efforts, particularly through PHAs. While this is not dramatically different from current allocations, there will be more focus on achieving outcomes in selected provinces (with some support provided for all provinces). The selection of provinces for focus will be for DFAT and GoPNG to decide, rather than the PATH design. Having said that, this design does set out in body of the design some suggested criteria for selection of the key provinces. Support to selected provinces will include provincially based people that will have an important role in brokering relationships within the province and enabling and supporting more targeted interventions and assistance delivered through PATH and other development partners.

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

A clearer, stronger, more integrated outcome focus, including for Gender Equality and Social Inclusion (GESI), including persons with disability. Despite a wealth of good work and outputs by individual programs and people, it is hard to see the overall "results" or coherent narrative of the investments to date. PATH therefore has a stronger and more unified outcomes focus. PATH specifically seeks to not only expand services for women

(including adolescent girls) and people with disability but also aims to increase the participation of women and people with disability in decision-making. GESI can get lost if "mainstreamed". The design response is to therefore have specific gender equality and social inclusion *outcomes and indicators* to be pursued and prioritised by the MC, the achievement of which will then help to determine if the MC receives its performance payment.

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

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

The introduction of program management skill sets well matched for an adaptive program in the PNG context. Whilst this design does not provide specific staffing requirements, the PATH staffing composition will need to respond to the particular role of the contractor. Relevant aspects of the design include promotion and use of PNG nationals recognising the "value-add" their expertise, relationships and networks offer; and the central role of MEL in relation to program management and improvement including ongoing tactical strategy by the contractor and adaptive management.

The importance of context and community-driven approaches. Essential to learning and adaptation for PATH will be feedback loops and evidence on what is working and isn't working in the particular contexts within which it is operating. This is reflected in the MEL processes for PATH, the structure and flexibility in the program logic, as well as indicative approaches and interventions. These include community based and other social accountability strategies which seek to mobilise collective action and joint reflection and problem solving to improve the performance of public services.

The recalibration of expectations on program results to be ambitious but realistic. Expectation on results for PATH need to be carefully calibrated for two reasons: (1) the challenges of operating in the complex and varied environment of PNG and (2) the adaptive program modality which emphasises experimentation and learning. It is important that the systems and culture of PATH do not place undue expectations on short term results and allow for experimentation and testing in those areas of program delivery that it is needed. The proposed time period for PATH – five years with the provision for a three-year extension if DFAT and GoPNG are satisfied with progress to date – facilitates that approach.

A practical approach to political economic analysis that results in change. This is reflected in the approach to MEL which requires specific evidence that learning, analysis, action research and evidence generation activities have informed policy and practice. It is also reflected in the drivers of change and in particular in the intention for PATH to address bottlenecks. This will require PATH to deal with and overcome socio-political obstacles and will incorporate political economic analysis as well as political skills and networks to navigate the necessary changes. DFAT's experience is that an adaptive program needs a structured process for driving locally generated solutions: without a structured approach, there is a risk that the design will drive externally imposed solutions. Some successful examples from DFAT that the MC might therefore wish to consider in its own design work under PATH include an iterative process for driving locally owned solutions similar to the approach outlined in the DFAT supported Innovation for Indonesian school children (INNOVASI) program.[36] Stakeholder

[36] Details available at https://dfat.gov.au/about-us/publications/Pages/indonesia-inovasi-design-document.aspx

mapping prior to and during program implementation is also important. The DFAT supported kina for kina program provides a good example of strategy testing.[37]

[37] Details available at https://png.embassy.gov.au/pmsb/714.html.

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

All figures are in current Australian dollars.

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

Notes

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

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

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

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

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

Asumptions

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

Adviser Support Costs estimated at ca 30% of TA costs

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

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

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

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

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

		Base Yr Exp [1]	Year 1	Year 2	Year 3	Year 4	Year 5	Total	
	Grants								
	Procurement								
	Operational Costs		200,000	200,000	200,000	200,000	200,000	1,000,000	
	sub-total	**0**	**900,000**	**900,000**	**900,000**	**900,000**	**900,000**	**4,500,000**	**2%**
3	**Leverage and Partnerships**								
	Personnel/Adviser Support Cost[13]	400,000	400,000	400,000	400,000	400,000	400,000	2,000,000	
	Grants								
	Procurement								
	Operational Costs		100,000	100,000	100,000	100,000	100,000	500,000	
	sub-total	**0**	**500,000**	**500,000**	**500,000**	**500,000**	**500,000**	**2,500,000**	**1%**
4	**Targeted national level support**								
	Personnel/Adviser Support Costs[14]	2,500,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	5,000,000	
	Grants[14]	1,040,000	400,000	400,000	400,000	400,000	400,000	2,000,000	
	Procurement								
	Operational Costs[14]	140,000	100,000	100,000	100,000	100,000	100,000	500,000	
	sub-total	**3,680,000**	**1,500,000**	**1,500,000**	**1,500,000**	**1,500,000**	**1,500,000**	**7,500,000**	**4%**
5	**Emerging Priorities**								
	Personnel/Adviser Support Costs								
	Grants[15]	800,000	500,000	500,000	500,000	500,000	500,000	2,500,000	
	Procurement[15]	1,000,000							
	Operational Costs[15]	100,000							
	sub-total	**1,900,000**	**500,000**	**500,000**	**500,000**	**500,000**	**500,000**	**2,500,000**	**1%**
MONITORING									

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

Assumptions

[1] Base Exp = Annual Average Expenditure in 1-2 years preceding start of PATH from HHSIP and PPF.

[2] Base year exp advisers/local staff in Western, Morobe, Bougainville and Hela Provinces. PATH assume TA will continue and be more intensive.

[3] Base year exp grant to Oil Search for PHA strengthening. PATH assumes funds will be reallocated to TA and operational expenses to strengthen PHAs.

[4] Procurement in support of provincial advisers (transport, office etc).

[5] Operational funds for local organisational and service improvement activities.

[6] Current PPF Service Delivery Grants. PATH assumes these will continue but funding gradually decreased and alternative funding sought.

[7] Base year exp is for CPHL LTA. PATH assumes this will continue and be supplemented with additional laboratory strengthening TA.

[8] Base year exp is for TB support to NCD. PATH assumes this funding will not continue as World Bank will take over TB support for NCD.

[9] Base year exp is for TB support to Daru. PATH assumes this will continue but at lower level due to efficiencies and expand to Western Province.

[10] Procurement in support of laboratory strengthening.

[11] Base year exp is for Trilateral Malaria Project. PATH assumes this will continue at the same level.

[12] Base year exp is for reviews and public diplomacy. PATH assumes these kinds of activities will continue at slightly lower levels.

[13] Base year exp is for LTA in aid coordination. PATH assumes TA will continue.

[14] Base year exp is for variety of LTA (legal, audit, Exec support, Med Supplies) and grants (Nursing Council/UPNG). PATH continues funding at lower rate.

[15] Base year exp is for variety of grants (POM general, YWAM and snakebite) and infrastructure. PATH continues funding at lower rate.

ANNEX 8: LESSONS FROM PAST EXPERIENCE

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

There are good global models of supporting national leadership without investing Australian aid money into weak public financial management systems. There have been previous attempts at a Sector Wide Approach in PNG, which whilst leveraging some improvements, have failed to achieve broad-scale policy, financing and coordination reforms. Currently, the GoPNG finance and planning systems does not meet donor requirements for budget support. A key lesson to be learnt is that there are models from other countries of supporting national leadership, national plans and results frameworks that do not require using national financial management systems that GoPNG and Australia can learn from and adapt. These models include, for example include alignment of donor funding with Government systems via sector coordination and information sharing.

Investing in strengthening rural primary health care requires a politically astute and engaged approach, not a standard programmatic approach to health service delivery. Decentralisation is a critical factor for local governance and leadership of health services, financing health care, and planning and managing health services and the health workforce. The Government of PNG has identified the roll out of Provincial Health Authorities as a key priority. The Government of PNG states PHAs are "a major reform agenda to address the health system fragmentation" and that "all PHAs will be declared by the end of June 2019".[38] This approach has the potential to better coordinate the budgeting and expenditure of decentralised resources.

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

Policy engagement requires a clear objective, a recognition of fragmented political context, acceptance that the process will likely not be linear, or simply amenable to purely technical solutions, and needs the flexibility to respond swiftly to often-fleeting windows of political opportunity. DFAT has considerable experience of working with PNG on policy related issues. Experience suggests that within PNG the political context is often fragmented, highly transactional rather than policy based, that decentralised power is high and very important, personal relationships are vital, and there is often a relative ineffectiveness of formal institutions. The lesson to be learned is that an effective policy approach must be rooted in a realistic analysis of the political economy around health and government delivery of services. To operate effectively in PNG, there needs to be clear objectives and a clear framework for monitoring progress and then ensuring there are strong incentives and accountabilities to make sure monitoring lessons then influence policy and programs. The MEL framework in PATH does that. Another lesson from PNG – and other programs in other countries – is that while it is important to have strategic focus it is also important to retain flexibility within that strategic framework to respond to often fleeting windows of political opportunity. A linear, project style approach will often run into unexpected blockages, while a more dynamic, "adaptive" approach –

[38] Hon Elias Kapavore MP, Minister for Health and HIV / AIDS. The National 14 June 2019 page 55.

with DFAT oversight and agreement in consultation with GoPNG - can take advantage of a favourable context when that exists.

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

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

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

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

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

ANNEX 9 PROPOSED PROGRAM OUTPUTS IN THE FIRST 12 MONTHS

Activities	Specific Outputs (as per Draft Statement of Requirements)
Mobilisation (0-3 Months)	
• MC office established and program management, administrative and support staff recruited • MC's corporate systems operational • Successful handover of HHISP assets to MC • DFAT (AHC) Transition Plan is operational • DFAT MC introductions to relevant Stakeholders (NDoH) selected PHAs. • Existing TB and Malaria Activities novated/transferred to MC • Development of Eligibility Criteria for "Emerging Issues" fund • Confirmation from DFAT/GoPNG on priority provinces for PATH • DFAT, GoPNG and MC to identify which of the existing indicators will be used to judge the "success" of PATH at the end of 5 years, which can then be used to determine if PATH should be extended for a further 3 years, as expected. • Risk Management workshop • MC to prepare Environmental and Social Management Framework and a Child protection risk assessment. Under health and safety, consider the disposal of medical waste, and any asbestos issues in local health clinics/hospitals. • MC to prepare a "sustainability plan", while recognising the limits of sustainability inherent in health sector reform in PNG.	• MC Inception Plan • Program Operations Manual • Risk Management Plan • "Ways of Working" Workshop and document agreed between DFAT and MC • "Roles and responsibilities" document agreed between DFAT, MC and NDOH • Preventing Sexual Exploitation, Abuse and Harassment (PSEAH) Policy and procedures • Program Delivery Strategy, reflecting MC approach to achieving the EOIO, IO and drivers. • MC to prepare Environmental and Social Management Framework and a Child protection risk assessment. phase. Under health and safety, consider the disposal of medical waste, and any asbestos issues in local health clinics/hospitals • Documented agreement between DFAT, GoPNG and MC on which of the existing indicators will be used to judge the "success" of PATH at the end of 5 years, which can then be used to determine if PATH should be extended for a further 3 years. • Draft sustainability plan prepared by MC for consideration by DFAT and GoPNG.
3-6 Months	
• Meetings between DFAT, NDOH and selected PHAs for 2021 Annual Plan discussions • MC Delivery Strategy outlining approach and resourcing to achieve	• Draft Annual Plan (2021) • Workplace Health and Safety Plan • Communications Strategy • MEL Plan including revised program logic • Gender Equity and Social Inclusion Plan

Activities	Specific Outputs (as per Draft Statement of Requirements)
EOIO, IOs and Program drivers accepted, and recruitment of technical assistance commenced. This will include options by the MC to identify how the earlier PPF programs, now incorporated into PATH, will be managed between the (limited number) of priority provinces and the other provinces at a national level) • Review of Policy Dialogue matrix and strategies	• Child Protection Assessment and Management Plan • 6 Monthly Progress reporting commences
6-12 Months	
• 6 monthly consultations on Annual Plan Review • Initial consultations on 2022 Annual Plan 2022 • DFAT contracted M&E provider undertaken analysis of MC's MEL plan • DFAT and MC discussions with PNG Partnerships Fund contractor re novating of PPF agreements and handover of materials[39]	• Initial discussions on Annual Plan 2022 • PATH MC develops Guidelines for new PPF scheme

[39] The actual timing of the novation of agreements, including TB, Malaria and PPF agreements is indicative at this stage and depends on a number of factors including the timing of redesigns for the Malaria and TB activities and the extension of the PPF agreement.

Indicative Program Activities (6-12 Months) [40]	
IO 1.1: Management Systems	A stocktake/baseline for each selected province in terms of: • Recent and expected funding by source; • Financial and service delivery plans • Health workforce by gender/management positions • The range of providers active in the province and how far they are reflected in province health plans and budgets; and • Functioning of key coordination and management mechanisms including partnership committees.
IO 1.2: Accountability	• Initial assessment/baseline of selected PHA's performance • Examine selected PHAs Performance Framework and its implementation.
IO 1.3: Women in Leadership	• Initial audit/baseline of number and levels of women staff in key departments and boards: this will include church health services and possibly private sector • Mapping of leadership training/programmes available to the provincial health system by government (including Precinct) and major partners as well as active alumni networks in the provinces or regions
IO 2.1 Equity	• Assessment of barriers/constraints to health services commenced
IO 2.2 Performance Funding	• PPF agreements transferred/novated to, and managed by, MC. • Development of Performance based Grant Scheme for Service delivery based on PPF model
IO 2.3 Health Security	• (Redesigned) TB program transferred/Novated and managed by MC • (Redesigned) Trilateral Malaria Project successfully transferred/Novated to, and managed by, MC
Drivers	
Evidence, Learning and Dialogue	• MC has mobilised resources including technical assistance to operationalise the Driver and an initial "agenda" of key research/policy topics for analysis identified in 2021 Annual Plan or as (later) addition to the Plan.
Problem Based Bottlenecks	• MC has mobilised resources including technical assistance, as agreed through the Annual Plan, to operationalise the Driver and initial work on identifying and assessing priority bottlenecks (agreed through Annual Plan.
Leveraging Partners	• MC has mobilised resources including technical assistance to operationalise aid coordination and establish relationships with key partners
Targeted national level support	• MC has mobilised resources including technical assistance to operationalise the Driver as agreed through Annual Plan. • Relationships/networks with NDOH, other PNG agencies (e.g. DNP, DPM, Treasury, Finance) and other relevant DFAT programs (e.g. PGF) established
Emerging Priorities	• Criteria for use of Emerging Priorities funding developed by MC and agreed by DFAT. • Funding allocation for responding to Emerging Priorities included in (Interim) Annual Plan for 2021

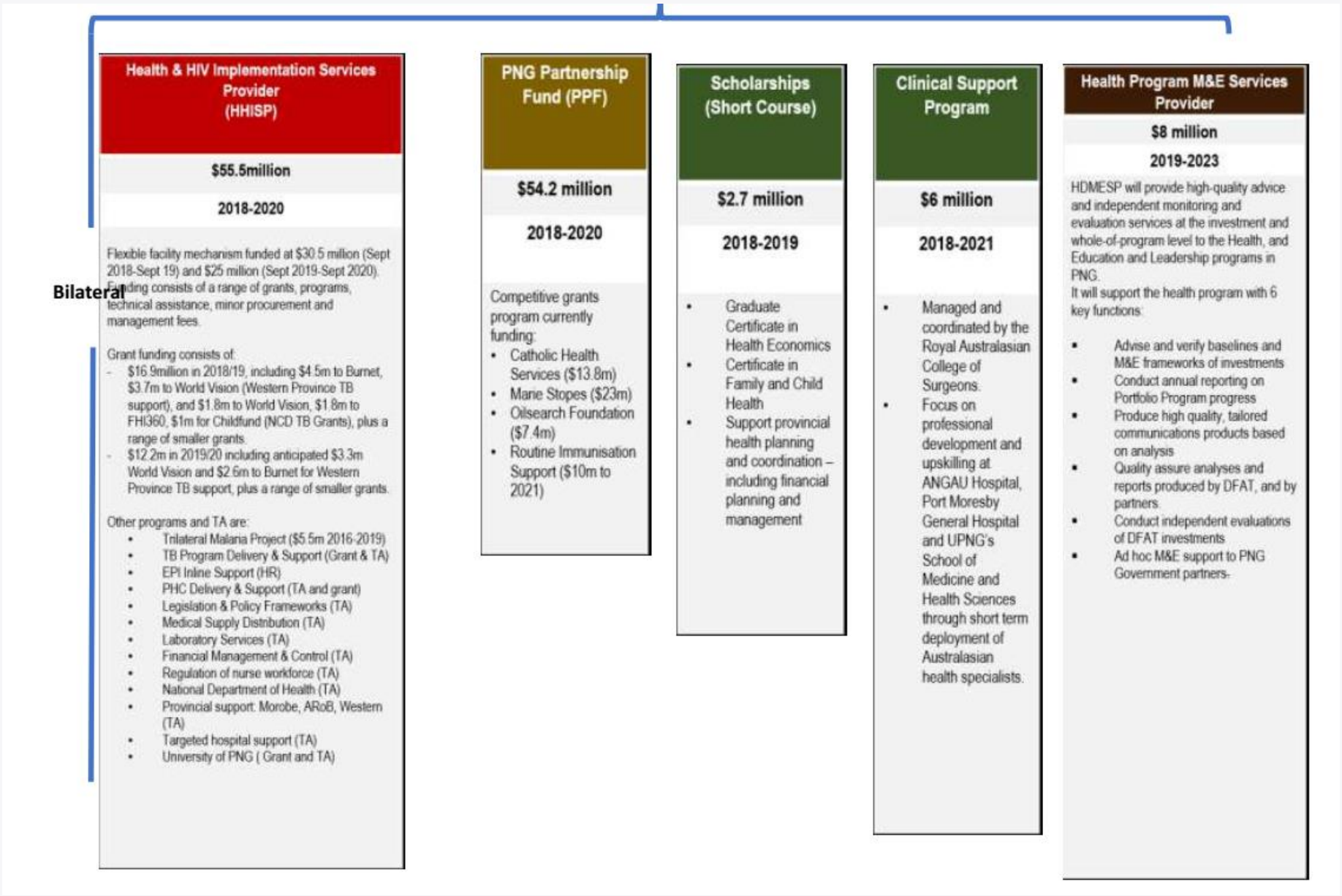
[40] Program activities would be discussed in Annual Plan consultations with key stakeholders including PHAs and agreed through the Annual Plan process

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

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

Multilateral

DFAT-WHO PNG Bilateral Relationship	UNICEF - EENC	World Bank TB Project	World Bank PASA	World Bank IMPACT Health	Health Services Sector Development Program
$17.5 million	$2.9 million	$20 million	$0.0 million (2018-2020)	$1 million (2018-2026)	$50 million
2018-2022	2018- 2021	2018 -2022	2018-2020	2020-2026	2018-2023
Convers multiple areas, including: • Safer Pregnancy and voluntary family planning. • Health Security • Systems Strengthening	**Through the One UN agreement includes:** • Scale up the delivery of early essential newborn care in PNG. • Integrates maternal and neonatal care at the facility level and improve maternal and neonatal survival rates.	**Part of WB Multi Donor Trust Fund.** • $8million co-financing – to be paid through MTDF and managed directly by WB • $12million parallel financing – flexible and managed by DFAT	**Part of WB Multi Donor Trust Fund** This program of work is to support improvements in prioritisation, planning and accountability for service delivery in the PNG health sector, through technical assistance and analytical work. DFAT's contribution is administered through the World Bank (WB) Pacific Facility 4 Trust and Multi Donor Trust Fund resources earmarked to improve frontline service delivery, and ultimately health outcomes.	IMPACT Health, a proposed US$30 million operation (IDA-18), will support the Government of Papua New Guinea and specifically the National Department of Health and selected Provincial Health Authorities, with strengthening the delivery of frontline health services in selected provinces. DFAT funds support the Project Preparation Grant – AUD 1.02m). Future co-financing to be considered.	**Through the ADB covering:** • National framework & public financial management - technical assistance and M&E ($6.5 million) • Subnational health system management – organizational & professional development ($10 million) • Health service delivery – construction of health centers & CHPs ($31.5 million) • Flexible maintenance fund for refurbishments of health facilities ($1 million) • Management costs ($1 million)


Bilateral
Health & HIV Implementation Services Provider (HHISP)
$55.5million
2018-2020
Flexible facility mechanism funded at $30.5 million (Sept 2018-Sept 19) and $25 million (Sept 2019-Sept 2020). Funding consists of a range of grants, programs, technical assistance, minor procurement and management fees.
Grant funding consists of:
- $16.9million in 2018/19, including $4.5m to Burnet, $3.7m to World Vision (Western Province TB support), and $1.8m to World Vision, $1.8m to FHI360, $1m for Childfund (NCD TB Grants), plus a range of smaller grants.
- $12.2m in 2019/20 including anticipated $3.3m World Vision and $2.6m to Burnet for Western Province TB support, plus a range of smaller grants.
Other programs and TA are:
• Trilateral Malaria Project ($5.5m 2016-2019)
• TB Program Delivery & Support (Grant & TA)
• EPI Inline Support (HR)
• PHC Delivery & Support (TA and grant)
• Legislation & Policy Frameworks (TA)
• Medical Supply Distribution (TA)
• Laboratory Services (TA)
• Financial Management & Control (TA)
• Regulation of nurse workforce (TA)
• National Department of Health (TA)
• Provincial support: Morobe, ARoB, Western (TA)
• Targeted hospital support (TA)
• University of PNG (Grant and TA)
PNG Partnership Fund (PPF)
$54.2 million
2018-2020
Competitive grants program currently funding:
• Catholic Health Services ($13.8m)
• Marie Stopes ($23m)
• Oilsearch Foundation ($7.4m)
• Routine Immunisation Support ($10m to 2021)
Scholarships (Short Course)
$2.7 million
2018-2019
• Graduate Certificate in Health Economics
• Certificate in Family and Child Health
• Support provincial health planning and coordination – including financial planning and management
Clinical Support Program
$6 million
2018-2021
• Managed and coordinated by the Royal Australasian College of Surgeons.
• Focus on professional development and upskilling at ANGAU Hospital, Port Moresby General Hospital and UPNG's School of Medicine and Health Sciences through short term deployment of Australasian health specialists.
Health Program M&E Services Provider
$8 million
2019-2023
HDMESP will provide high-quality advice and independent monitoring and evaluation services at the investment and whole-of-program level to the Health, and Education and Leadership programs in PNG.
It will support the health program with 6 key functions:
• Advise and verify baselines and M&E frameworks of investments
• Conduct annual reporting on Portfolio Program progress
• Produce high quality, tailored communications products based on analysis
• Quality assure analyses and reports produced by DFAT, and by partners
• Conduct independent evaluations of DFAT investments
• Ad hoc M&E support to PNG Government partners.

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

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

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

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

Background

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

In addition, PNG often has had many good policies and insightful evaluations. Furthermore, politicians, bureaucrats and development partners often have a good sense of *what* needs to be done: the challenge is knowing *how* to implement good policies and reforms in affordable, technically feasible, politically acceptable, cost-effective, and institutionally sustainable ways. This "policy to implementation gap" is a well-recognised challenge in most developing countries (19) and has been central to the experience of health sector reform in PNG. PATH's focus on addressing specific problem-driven bottlenecks, and proactively strengthening the evidence base for policy and programs, seeks to reduce the policy to implementation gap.

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

PNG is characterised by historical, geographic and cultural diversity. Despite periods of relative stability in recent times, there has been significant periods of shifting alliances and political instability. (8) Society is shaped by 'wantokism' [41]and a 'big man culture' that lead to a particular Papua New Guinean form of

[41] Wantok (or "one talk) refers in essence to a preference for, and priority to, allocating resources to one's own close ethnic, tribal, or language ("one talk") group.

clientelism.(8) Formal institutions have limited ability to overcome these social and cultural patterns.(7) Indeed, the formal institutions are intertwined with social and cultural mores in many different ways. (7 and IDD Section B).

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

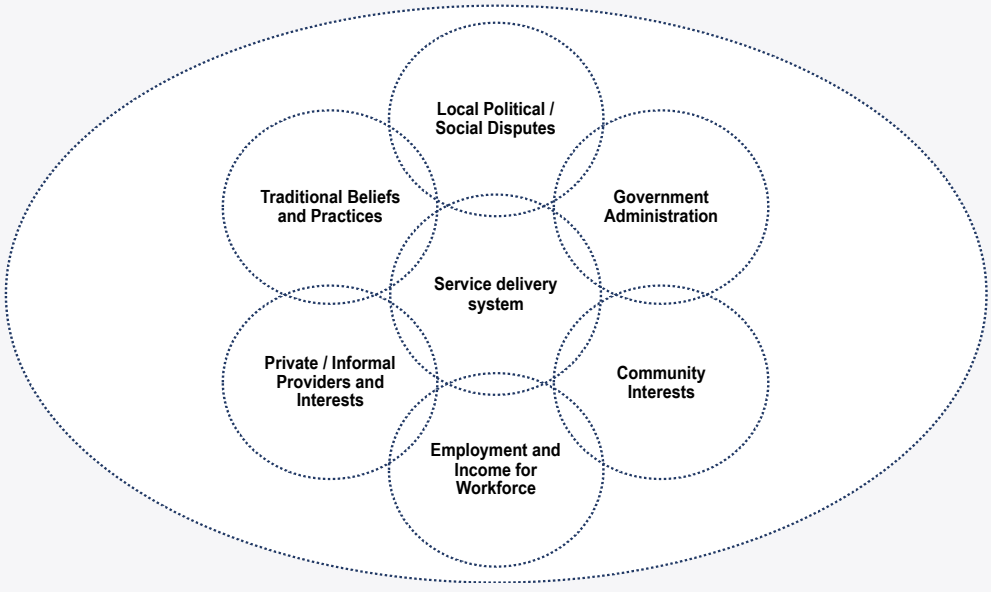
> Of all the countries on earth, Papua New Guinea has the most vigorous tradition of parochial debate and local responsibility. If public health education could be harnessed to that parochial tradition, the effect would be powerfully therapeutic…. Without the creative impact of an organised public opinion, even the impressive services which the country now enjoys, must decline into a series of ritualised functions, whose original purpose recedes in the memory, which satisfies only the therapists, and which might even become (as in earlier days) the object of suspicion and superstition.[42]

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

> The health sector in PNG contends with a range of contextual factors—systemic, geodemographic, and unforeseen/external—that can individually and collectively inhibit the delivery of quality services. These factors can act as a disabler to the genuine ambitions of the health sector in promoting better population health outcomes. A critical systemic factor in PNG is the complex regulatory and governance architecture both within the health domain (i.e., the health system organization and legal framework) and others that are situated in the wider government domain (i.e., the country's decentralization framework). A multitude of actors and service delivery arrangements add complexity, with incoherent reform initiatives risking to open further entry points for fragility.[43]

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

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



These systems (with varying purposes) in aggregate determine the behaviour of health sector stakeholders and need to be considered in any endeavour to change institutional behaviour and improve health system

[42] Denoon (1989) p. 122

[43] ADB (2019).

performance. It is essential that reform efforts in PNG take account of the interconnectedness (both positive and negative) between the formal health system and these other systems of which it is part.

Overview of approaches to development in complex settings

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

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

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

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

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

PATH design features that respond to the complex PNG environment

Program Objective & EOIOs

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

Strengthened evidence base for more informed policy dialogue

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

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

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

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

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

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

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

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

National level enabled to support provincial health systems

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

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

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

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

DFAT/NDoH able to respond to emerging issues

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

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

Program Management

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

Political informed gender programming

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

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ANNEX 12: POLICY DIALOGUE MATRIX

Related End-of-Investment Outcome (EOIO) and Intermediate Outcome (IO)	Problem/ Issue	Policy outcomes sought.[44]	Program entry points for policy dialogue	Influential stakeholders	Resources required	Policy dialogue lead within AHC	Partnership engagement lead within MC/implementing partner
End of Investment Outcome 1 PHAs more able to lead provincial health reform and manage effective, efficient and equitable essential health services in selected provinces. *IO 1.1 PHA Boards and Management capable of leading reform and managing finances, health workers, partnerships and service providers.* *IO 1.2 More policy*	PHAs are intended by GoPNG to be the principal vehicle for planning and delivering (directly or via churches etc) essential health services. However, many provinces and PHAs lack key organisational capacities of planning, budgeting, financial management, human resources, stakeholder engagement, and service provider and facility performance management. PHA performance is also likely to be constrained by a range of whole of sector	• GoPNG fully establishes and provides necessary policy, legal and technical support for PHAs. • PHA Boards established with effective and broad representation, including private sector, women and disability groups. • PHAs involve churches and NGOs in health service planning and delivery, including via service level agreements. • Dept of Personnel Management approves PHA staff establishments. • Dept of Treasury a) releases budgeted recurrent health funds for PHAs on time and in full; and b) provides funds for approved	**EOIO 1 directly strengthens PHA performance.** It does so through the following entry points. Each of the "**drivers of change"** are intentionally designed to strengthen the evidence base for PHA planning and management. This particularly occurs through **driver 1** (evidence learning and dialogue); **driver 2** (addressing problem driven bottlenecks); **driver 3** (leveraging the	**Within GoPNG** there are several key stakeholders. These include Minister and Secretary for National Department of Health for policy and regulation. Department of National Planning and Monitoring (DNPM), Department of Treasury (DOT) and Department of Finance (DOF) for priority setting and resource allocation.	Annex 7 identifies the likely financial cost of each of the drivers and the MEL. The PATH Managing Contractor, and staff at the Australian High Commission, will need to be resourced, trained, or	Minister and Counsellor at Australian High Commission backed by HOM.	Team Leader for PATH. Secretary of PNG National Department of Health. Heads of PHAs in selected Provinces where PATH is working. Heads of NGOs including churches that are delivering essential services.

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

Related End-of-Investment Outcome (EOIO) and Intermediate Outcome (IO)	Problem/ Issue	Policy outcomes sought.[44]	Program entry points for policy dialogue	Influential stakeholders	Resources required	Policy dialogue lead within AHC	Partnership engagement lead within MC/implementing partner
relevant Information available and used by PHAs, MPs, NGOs, health facilities and communities to monitor and drive performance. *IO 1.3 More women in management roles influencing policy, planning & budgeting of health services in selected provinces*	issues including likely declining GoPNG budget for health and poorly performing medical supplies procurement and distribution.	PHA HR staff establishments. • Provincial Governments provide agreed internal revenue to PHAs. • NDOH transparently improved the procurement and distribution of medical supplies to provincial health services. • GoPNG establishes and uses national PHA performance monitoring framework • PHAs establish partnership committees to seek broad partner input to PHA management and services. • PHAs encourage community scorecards in health facilities. • PHAs agree to develop and implement equal opportunity employment policies and practices. • GoPNG maintains, and if possible, increases overall health budget, particularly for provincial and rural health services.	analytical and policy work of ADB, World Bank, WHO and others); and **driver 4** (targeted national level support and advisers to share national lessons). **Driver 5** allows PATH to invest in emerging priorities. **PATH management, and PATH short term / long term advisers**, are specifically accountable / equipped to use the evidence and learnings from these drivers as a basis for informed policy dialogue with PHAs and to support DFAT staff at Post. **The MEL** specifically tracks the extent to which evidence and policy influence is actually getting traction. Policy influence is an	Department of Personnel Management (DPM) for health workforce. Department of Provincial and Local Government Affairs (DPLGA) and Provincial and Local Level Service Monitoring Authority (PLLSMA) for Provincial policies. PHA Boards. Members of Parliament. Direct service providers including nurses association, and churches. **Other influential stakeholders.** These include Multilateral development	have access to specialist advice and expertise in terms of knowledge-brokering. They will also need to be capable of "working politically". For example, this could include presenting evidence and learnings to local Members of Parliament in more persuasive ways to MPs as to how they can use the DSIP and PSIP to expand /	As above	Heads of multilateral agencies (ADB, World Bank, WHO and UN family) based in Port Moresby.

Related End-of-Investment Outcome (EOIO) and Intermediate Outcome (IO)	Problem/ Issue	Policy outcomes sought.[44]	Program entry points for policy dialogue	Influential stakeholders	Resources required	Policy dialogue lead within AHC	Partnership engagement lead within MC/implementing partner
			ongoing process. However, **strategic opportunities to elevate and review the effectiveness and impact of policy influence** include the Annual Planning process; joint monitoring missions with GoPNG and multilateral partners; and midterm reviews and evaluations.	partners. They also include community groups (especially for scorecards) and local media.	improve essential services to constituents		
End of Investment Outcome 2. "DFAT funded health services are demonstrating efficient and effective models of service delivery, influencing PHA performance; and building sustainability by transitioning to PHA management in selected provinces." *IO 2.1 Approaches to increase access to services by women, people with disability,*	DFAT directly funds a number of high priority essential health services including maternal and child health services; TB prevention and control and health security / public health more broadly. There are two issues that arise, both of which require - and are amenable to policy dialogue and influence. First, there is always room for **improved access and performance** in DFAT	• NDOH and PHAs plays an active role in adopting and sharing lessons learnt from PATH funded service and improvement efforts (proof of concept) • PHAs actively seeking alternative funding sources for provincial health services (private sector, other donors, provincial govt's, MPs). • PHAs incorporate equity strategies into provincial planning and delivery. • DFAT funded delivery partners (NGO, church and PHAs) demonstrate practical service	**EOIO 1 (see above) *directly* influences policy change** and capacities in selected provinces and PHAs through the drivers of change. **EOIO 2 *indirectly* provides an entry point for policy dialogue** by generating evidence and lessons on how to improve effectiveness, efficiency, equity and sustainability of DFAT's own directly funded programs.	All of the above. However, other influential stakeholders under this EOIO will also now include those NGOs and agencies that DFAT directly funds and which will continue under PATH. Another potential set of stakeholders will be those agencies involved in health security and laboratory	As above. As above.	As above As above.	All of the above. However, other influential stakeholders under this EOIO also now include those NGOs and agencies that DFAT directly funds and which will continue under PATH. Another potential set of

Related End-of-Investment Outcome (EOIO) and Intermediate Outcome (IO)	Problem/ Issue	Policy outcomes sought.[44]	Program entry points for policy dialogue	Influential stakeholders	Resources required	Policy dialogue lead within AHC	Partnership engagement lead within MC/implementing partner
poor are tested and scaled. *IO 2. Essential services: DFAT-funded services demonstrate good practice in providing quality services, reaching marginal/hard to reach groups, and demonstrates linkages with and support to/from PHAs, including improved efficiency by integrating vertical services.* *IO 2.3 Improved compliance with International Health Regulations (IHR) in relation to laboratory performance; detection and treatment of TB and malaria; and other agreed priorities*	funded programs. This is particularly the case in ensuring programs are effectively reaching the poor, women and people with disability. The second issue is the need for Australia to **progressively transfer and transition** programs currently directly funded by DFAT across to PHAs in selected provinces where that is appropriate (i.e. PHAs are now capable, particularly as a result of EOIO 1 above).	integration (e.g. joint program training, supervision etc) • DFAT funded delivery partners (NGO, church and PHAs) demonstrate innovative strategies to reach poor, marginalised groups. • GoPNG supports conduct of PNG Joint External Evaluation and follow-up actions. • NDOH and PHAs convene regular partner coordination meetings to share information, lessons and better target support.	These are lessons that the PATH Managing Contractor (MC) is required and incentivised to share with PHAs and other stakeholders (including multilateral development partners). The PATH MC is also required to be abreast of evidence and policy learnings arising from the multilateral development partners, private sector (e.g. mining companies) and other stakeholders. The MC is then to demonstrate it has used that evidence and learnings to engage in policy influence and policy dialogue with PHAs and to have supported DFAT at Post in such endeavours.	strengthening including the DFAT Indo Pacific Centre for Health Security and the Fleming Fund.			stakeholders will be those agencies involved in health security and laboratory strengthening including the DFAT Indo Pacific Centre for Health Security and the Fleming Fund.

Related End-of-Investment Outcome (EOIO) and Intermediate Outcome (IO)	Problem/ Issue	Policy outcomes sought.[44]	Program entry points for policy dialogue	Influential stakeholders	Resources required	Policy dialogue lead within AHC	Partnership engagement lead within MC/implementing partner
identified by JEE							

ANNEX 13: SAFEGUARDS AND RISK MANAGEMENT MATRIX

PROVIDED SEPARATELY

ANNEX 14: CONSULTATION PROCESS

PATH was developed through a process of consultation with key stakeholders. This included consultation with the following:

In Canberra

- DFAT Canberra (several divisions, including Office for Development Effectiveness)
- Indo-Pacific Centre for Health Security
- Managers of existing facilities in Asia and the Pacific (some by telephone)

PNG national officials and other stakeholders in Papua New Guinea

- Minister for Health and HIV/AIDS
- Secretary of the National Department of Health
- National Department of Health (NDOH Executive Management Team and key divisions)
- Provincial Health Authority Morobe
- Angau Hospital
- District Development Authority Morobe
- Department of Personnel Management
- Christian Health Services
- Catholic Health Services
- PNG disability group

Other officials and stakeholders in Papua New Guinea

- Australian High Commission staff including managers of main aid-funded programs in PNG
- Managers and senior staff of HHISP, PPF, and Abt
- Asian Development Bank, and managers of ADB's RPHSDP project
- UNICEF
- World Bank
- World Health Organization
- Oil Search Foundation

The Design Team[45] invited those interviewed to a de-briefing of initial findings and recommendations prior to the departure of the Design Team from Port Moresby and provided a similar debriefing to DFAT staff on return to Canberra and prior to the drafting of the main IDD.

The National Department of Health has reviewed this draft design and provided comments. NDOH supports the strategic directions and program logic set out in this design. GoPNG also expressed the importance of management & leadership training both at PHAs and NDOH, the need for directing long term advisory (LTA) support to PHAs; a focus on providing an integrated package of support; the need for ongoing support to health sector training institutions and basic education; and the need to support PHAs in health workforce

[45] In alphabetical order, by surname: Ian Anderson (Team Leader); Kate Butcher (gender and social inclusion specialist); Luke Elich (health governance / institutional specialist); Jacqueline Herbert, A/g Counsellor, Australian High Commission; Laury McCulloch (contracting specialist) and Veronica Walford (health systems / M&E specialist). The team was also supported by Andrew McNee, Director of the DFAT Specialist Health Service. The team was able to draw on advice from Martin Taylor, DFAT health advisor, and Laura-Carolin Brandes, DFAT Investment Design Section, Ms Elva Lionel, Deputy Secretary, NDOH accompanied the design team to Morobe interviews.

capacity building and planning. NDOH requested DFAT's continued support for the HSIP trust account as a mechanism for pooling donor funding. DFAT has advised GoPNG that many of these suggestions can either continue or start to be supported through HHISP and the PPF, before integration into the new managing contractor, and some will continue to be supported by broader Australian Government programs (e.g. Australia Awards).

DFAT provided appraisal comments in July. DFAT arranged a formal peer review in August 2019.

Further details are available on request.

ANNEX 15: RESPONSES TO REVIEWERS FEEDBACK ON DRAFT DESIGN DOCUMENT

DFAT/Stakeholder Comments/Questions	Design Team Responses
RECOMMENDATIONS FROM THE PEER REVIEW PROCESS.	
RELEVANCE	
Improve narrative in design on the quality of services; the role of the program at the national level (policy/investments/liaison/dialogue) to support provincial level outcomes; and the rationale for choosing 'selected provinces'.	**Agreed with respect to quality of services**. Quality of services was always implicit: quality of services is now made explicit in the program logic and therefore throughout the narrative text. The design document discuss proposes criteria for **selecting provinces**. These will need to be confirmed by DFAT in consultation with the PNG Government during the mobilisation phase. The IDD also makes it even more explicit what the recommended selection criteria could be for selecting provinces, while recognising that decision is ultimately a political decision to be made by DFAT and GoPNG.
Consider the need for a separate box in the program logic to capture what the program is doing at the national level and/or a separate annex for investment 'drivers', with additional information on the national narrative and directly linked to Intermediate Outcomes (IO).	**Agreed in part with respect to the role of the national level**. GoPNG policy is clearly to move the locus of effort in terms of delivering actual health programs and services to the provinces and PHAs. NDOH will have more of an overview, regulatory setting, and aid coordination role. DFAT, and other development partners, needs to adjust to these changes. This is not to exclude support at the national level: hence "targeted national level support" (what was previously referred to as simply "central support") is one of the five main drivers in PATH. Annex two now has a distinctly separate, and enlarged, description of how the "targeted national level support" could work. Given that elaboration, and the clearer use of the term "targeted national support" as one of five key drivers that support all of the EOIOs and intermediate outcomes, we do not see it as necessary to have a separate box in the program logic.
Strengthen rationale for choosing 'selected provinces'	**Agreed with respect to strengthening the rationale and technical criteria for choosing the selected provinces.** Page 14 of the IDD with the revised paragraph that begins "Australia cannot, and should not, seek to do everything, everywhere in PNG therefore DFAT and PATH should focus on selected Provinces" makes it even clearer what the criteria for province selection is.

DFAT/Stakeholder Comments/Questions	Design Team Responses
and give some indication or signal about the number of "selected provinces".	**Agreed with respect to the number of "selected provinces".** As a result of discussions in the AGB, the IDD now refers to "up to a total of 6" when it refers to "selected provinces". Furthermore, the IDD also now explicitly says on page 15 the following text, immediately following the suggested technical criteria for selecting provinces: "in line with these criteria, the following provinces have been indicatively selected (pending negotiation with GoPNG), in no particular order: Morobe province, Western province, the Autonomous Region of Bougainville and one province in the highlands region (to be confirmed). Additional provinces (up to a total of 6) may be included in this priority list pending further discussion with GoPNG and available budget. Note that this does not preclude DFAT from contributing to other Provinces[46] and the national health system more broadly.
Update design with an assessment on financial flows to provinces	**Agreed in part**. The PATH design already highlights the key issue of poor funding flows from central to provincial levels. The PATH design also already cites the use of bottleneck analysis to help unblock key bottlenecks (e.g. the *relatively* straightforward example cited in the design from Hela province of improving the quality of acquittals that then lead to improved funding flows to that Province). The design also already notes the importance of "leveraging partners" as one of five key drivers. In practice, this means working with the ADB, and World Bank, large, policy based, loan programs to the health sector as both of these banks have the potential to improve funding flows through policy dialogue and TA. The design also already highlights the importance of "working politically", including through highlighting to MPs how better use of DSIP and other MP funds can improve essential health services but also generate broader legitimacy and support for the MP. Furthermore, in the revised IDD we have now also made it clearer and more explicit that the 5-year program, with the *possibility* of an extension for a further 3 years, gives DFAT a basis for further incentivising GoPNG to improve the funding flows to provinces over time. Continued leakages and blockages in funding flows from central to provinces and PHAs (and continued shortages of essential drugs) would be a trigger for DFAT to consider not extending PATH the extra 3 years.
Consider amending the End of Investment Outcomes (EOIO) and IO to incorporate quality of services.	**Agreed with respect to quality of services**. Quality of services was always implicit: quality of services is now made explicit in the program logic and therefore throughout the narrative text.

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

DFAT/Stakeholder Comments/Questions	Design Team Responses
EFFECTIVENESS	
Draw out PNG's PBF experience in relation to the proposed approach in the design. Provide a list of people consulted throughout the design process.	**Agreed to an extent.** The original TORs for the design did not task the design team to look at this issue so it was not addressed in any depth during the relatively short design period. However, new footnotes 28 and 29 summarise what is known about Marie Stopes experience with performance-based financing. **Agreed to an extent.** Annex 14 provides details on the consultation process. Including a detailed list of each individual consulted is possible but adds further pages to what is already a long document.
Review and reframe the program logic, including current EIOIOs, within an 8-year timeframe.	**Agree, but only in part**. If what is being suggested that PATH be *automatically* made an 8-year program *from inception*, then this is a significant request, with important and substantive implications for DFAT budgets but also the incentives and performance of both the MC and the GoPNG. However, the IDD has been revised to make it clearer that an 8-year program is *expected* but the revised design also makes it very clear that this should not be automatic. Rather, it is a decision that DFAT (and GoPNG) should make based on an assessment as to how "successful" PATH has been. In other words, the PATH design states that the EOIOs are achievable in five years but, even if not, and there is sufficient progress, then the design supports a 3-year extension. This approach is reflected throughout the IDD. The first pages of Annex 2 also explain the justification for this approach of a 5 + 3-year program in more detail. Given the importance of this issue, the design teams' response in Annex 2 is copied below: **"A third key design principle is the level of ambition of PATH: an issue which is clearly linked to the duration and time scale of PATH.** The EOIOs, and the intermediate outcomes, have been carefully worded so as to get the right balance between, on the one hand, the level of ambition expected from a program of this size and budget and, on the other hand, the realities of reform and change in a complex and varied environment like PNG. Achieving a balance between ambition, and what is achievable / feasible, is also linked to the duration of PATH. The design therefore recommends DFAT and GoPNG agree to a five-year program, but with the clear option of a 3-year extension. In design terms, the 3-year extension is therefore expected to occur, making PATH an 8-year program. (The EOIOs, and the Intermediate Outcomes, could, in practice, simply have their end-dates extended by 3 years as they are worded in such a way that they would still be relevant at the end of 8 years). However, and importantly, that 3-year extension, while expected, would not be

DFAT/Stakeholder Comments/Questions	Design Team Responses
	automatic. Instead, it would be contractually contingent upon DFAT and GoPNG making an explicit decision at the time that PATH was making "sufficient progress" in terms of the EOIOs and intermediate outcomes. What "sufficient progress" means in practice would involve the existing EOIOs and intermediate outcomes but would need to be confirmed as the key "triggers" for any possible extension by DFAT, GoPNG, and the MC at the start of the contract. Having such an arrangement thereby gives PATH MC, and the PHAs, the clear and expected *prospect* of an 8-year program. But it also provides additional incentive for the PATH MC – and indeed GoPNG with respect to key issues such as improving the availability of drugs and providing adequate GoPNG public health financing".
Clarify what we were getting for our funding (pub test), particularly with the addition of PPF funding. Incorporate what will be achieved through PPF (as outlined in the presentation by Design Team Leader Ian Anderson (IA) at the beginning of the peer review) Integrate the two high level risks in the design into the logic outputs	Agreed. See the revised text in the main IDD under the heading "profile and public diplomacy" on page 20. Agreed to a degree. Both of the key risks (continued shortages of essential drugs at health facilities, and reduced allocation of GoPNG funding to the health sector) are implicit in the two EOIO, and the intermediate outcomes, as worded. This is especially true with respect to Intermediate Outcome 1.1 which refers to PHA Boards and Management being "more capable of leading reform and managing finances, health workers, partnerships and service providers". However, we caution against making progress on drug supply and financial allocations to the health sector more explicit in the logic outputs. That is because both issues are – as explained in the IDD and risk matrix – largely beyond the span of control of PATH (or indeed any development partner) so there is an inherent risk that the design establishes outputs that are impossible to achieve. Furthermore, discussions with DFAT Canberra and the Post during the design mission made it clear that Australia should (i) not directly try to involve itself in the longstanding drug availability issue and (ii) would be prepared to keep raising funding allocations to the health sector during high level consultations but would be reluctant to be more assertive.

DFAT/Stakeholder Comments/Questions	Design Team Responses
Consider extending the design timeframe	**Having said that, there are things DFAT can and should do to keep highlighting the importance of these two risks, and to manage them**. As explained in the revised Risk Register, these include policy dialogue at the time of the Australia / PNG High Level Consultations as well as through the Annual Plan. DFAT could - and should – also take into account the situation with respect to GoPNG financing for health, and drug availability, when it is considering the possible extension of PATH for a further 3 years beyond the initial 5 years. DFAT could validly argue that a sustained, systematic, and widespread reduction in public expenditure for health, or systematic and sustained unavailability of drugs, meant DFAT exercises its prerogative to reduce the scope of PATH in any 3-year extension or even to terminate PATH at the end of 5 years. DFAT can and should also leverage its existing investments relating to economic management / governance in PNG. DFAT, and to an extent the Contactor, can utilise and leverage DFAT's membership of and cofinancing with the ADB and World Bank, both of which have large policy based loans to the PNG health sector which involve GoPNG commitments to funding the health sector ("leveraging partners" is one of 5 specific drivers identified within PATH). PATH direct funding of "problem driven bottlenecks" and operational research can and should be used to better identify the root causes – many of which are political economy issues – see Annex 11 – of these challenges. To an extent the essential health services provided under PATH, including immunisation, and prevention and treatment of TB, helps to mitigate the adverse effects of any reduced funding from GoPNG. See also preceding discussion on page 5 of this comments matrix. The Risk Register has also been updated to reflect these points. **Agreed.** See discussion on page 20 of this comments matrix. See also the first two pages of Annex 2 of the IDD where the issue of timing and duration is dealt with in depth.
Transactional vs transformational outcomes to be made more explicit	**Disagree in part**. It is true that EOIO 1 ("PHAs more able to lead provincial health reform….") and EOIO 2 ("DFAT funded health services are improving …..") involve different objectives and different means of engaging. It is also true that PATH largely involves capacity building and TA to support EOIO 1, while involving direct funding of essential services in EOIO 2. But we think it is not helpful, accurate or useful to characterise the distinction between EOIO 1 as essentially "transformative" and EOIO 2 as essentially "transactional". Indeed, part of the essential coherence of the PATH design comes from the fact that EOIO 1 and 2 are closely linked, both intentionally involving elements of transformative and transactional elements. We therefore explain this in more detail in the revised IDD at the bottom of page 12 (see paragraph beginning "It is essential to understand that these two EOIOs interact with each other and are not mutually exclusive". We also give a much more detailed explanation of our position on the first 2 pages of Annex 2.

DFAT/Stakeholder Comments/Questions	Design Team Responses
Incorporate proposed information on the architecture of the adaptive approach (SB to share further information).	**Agreed to a large extent**. Annex 3 on governance arrangements now includes a new section on principles that inform the architecture of adaptive program governance: see especially Box 1 in that Annex. There are also consequential changes to Annex 4 on MEL, and changes to the Statement of Requirements (SoR) with respect to the skill and expertise mix required by the MC. A new clause 5.2 b of the SoR also requires the MC to have a system for proactively designing and implementing an adaptive program. This is to be integrated into the MC's Implementation Plan and subsequently the Annual Plans. The SOR also requires that the system for adaptive management reflects the principles of adaptive management provided by DFAT and set out in Box 1 of Annex 3.
Peer reviewers agreed the rating on the proviso the following changes are made to the design: (i) program logic incorporates 8-year timeframe and integrates high-level risks (ii) architecture on adaptive management approach is included; and (iii) more evidence on what we mean by PBF	Re (i) see pages 134 and 135 (comments matrix) and in particular the first two pages of Annex 2. Re (ii) See significant changes and elaboration in Annex 6. Re (iii) See comments about PBF on pages 133 (comments matrix).
Backing the Provinces – At the moment the Provincial Health Authorities seem like the right focus for the program, but the design could add a discussion of the increasing flow of resources going to DSIP, and identify that adjustments will need to be made if in future it seems clear that the flow of money to the districts (at the expense of provinces) is increasing. The design could also look at aligning Province choice with the Provinces chosen for Kina-for-Kina, given it is working on leveraging DSIP funding for developmental purposes.	**This comment is noted.** The relationships between PHAs and DDAs, including access to DSIP funding, is highlighted as a key issue in the design. The design team however also recognise that DSIP is highly political and potentially subject to change given political developments in government in PNG. A direct focus on Provinces is consistent with moves to strengthen provincial level government. This will be an important area for PATH to continue to monitor and adapt to as part of program management and learning. It is also worth noting that DSIP funding has actually decreased (PGK10 million to PGK2 million) following the last election and that there is a large demand on these funds from a range of sectors including health. The majority of funding goes to other sectors and, while PATH will need to undertake advocacy efforts to try bringing more of this funding envelope into health, we cannot rely on this as a source of health funding. The previous kina-for-kina arrangement has several challenges and was not as successful as hoped due to the lack of PNG funding. New kina-for-kina arrangements are being trialled in the governance program, however it is too early to tell whether this model is working and therefore should be replicated across other programs like PATH.

DFAT/Stakeholder Comments/Questions	Design Team Responses
EFFICIENCY	
In the 'Ways of Working', provide where possible a detailed input and resourcing schedule that articulates the internal transaction costs (DFAT and MC) and define the expected efficiency dividends of PATH. As part of Annex 3, provide further details on which positions will be continued/novated from existing programs and identify and new positions/roles to be part of PATH team.	**Good idea, but this is not possible.** It was not in the original Terms of Reference for the design, and there was not sufficient time in – country, to identify the transaction costs and expected efficiency dividends. What was clear from the design mission was that (i) such transaction costs are not being tracked or managed either by the MC or DFAT (ii) the anecdotal evidence was that they were potentially significant in certain cases. **Disagree that this is the responsibility of a design: this should be done by bidders.** It is up to potential bidders – not the design team or DFAT – to identify options as to which positions will be continued / novated. Those options will then need to be discussed and agreed between DFAT and GoPNG.
Clarify: (i) ability of the program to absorb further funds; (ii) DFAT in-house resourcing to manage the new investment;	**Re (i) agree in principle but this is better done at the inception phase once it is clear what provinces are to be selected for specific support by PATH.** That is particularly because different provinces have quite different populations, health burdens, and capacities to absorb funding. **Re (ii) disagree that this is the responsibility of a design: this is best done by DFAT itself.** The existing IDD says in the section on resourcing that: "The MC and the Australian High Commission (AHC) are in the best position to judge how PATH could affect the current number[47], and level, of staff resources. That is because they are both in the best position to know what current staff do, and cost, and their own organisation's personnel and financial policies and constraints concerning new staffing structures. What is clear is that there will be a need for some different skills and expertise than hitherto……". The IDD does already make it clear however that DFAT staff, especially at Post, should have access to short term and long term advisers employed under PATH so as to ensure DFAT at Post has access to the best available technical expertise on health policy and programming, and to be able to conduct policy dialogue on the basis of up to date evidence, especially that which is generated from PATH itself. To properly identify, and cost, the in-house resourcing required, DFAT itself needs to undertake an Establishment Review that can assess existing roles and functions and compare them to expected new roles and functions as identified in the IDD. DFAT then needs to decide how realistic

[47] The AHC currently has 19 staff, including both Australian diplomatic staff and locally engaged PNG citizens, working on the health sector.

DFAT/Stakeholder Comments/Questions	Design Team Responses
(iii) opportunities to complement with low cost TA or AVI/volunteer.	/ feasible those changes are in the light of other pressures and demands from other areas and other sectors of the Australian High Commission in Port Moresby, as well as pressures and constraints faced by DFAT's other diplomatic posts overseas and in Canberra. The Risk Register now specifically recommends that DFAT undertake an Establishment Review **Re (iii) Agree**. See response at the bottom of page 26 of the Comments Matrix and also the new text in Annex 2.
Revise governance arrangements to remove GoPNG from planning to allow participation and responsiveness to a broader group of stakeholders	**Disagree strongly about removing GoPNG from planning**. As noted in the IDD, Australia and PNG have entered a new phase in the relationship, one based much more on "partnership" as distinct from a "donor recipient relationship". If those commitments from both governments are genuine, then GoPNG clearly needs to be involved in meaningful – but efficient – way in what is Australia's largest bilateral program for health in PNG: PATH. Discussions during the design mission identified that having GoPNG consulted meaningfully during the Annual Plan process is the preferred (PNG) or acceptable (Post) position. The consideration of the Annual Plan is the most appropriate – yet efficient – mechanism for the governance arrangements because it provides an opportunity for strategic engagement (reviewing the past year's activities and considering future years) but which simultaneously gets genuine traction on the ground because it focuses on priorities for coming years and changes in financial and human resources. **Agreed, with some hesitation, that governance arrangements should allow for participation and responsiveness to a broader group of stakeholders** There is always a balance to be struck between having, on the one hand, just the key agencies (DFAT and GoPNG) involved in the direct governance of PATH so as to ensure focus and accountability of PATH and, on the other hand, broadening participation in governance to ensure all relevant voices are heard but possibly diluting efficient decision making and accountability. DFAT has however asked that the Steering Committee that reviews the Annual Plan be expanded to include GoPNG Ministry of Finance, and Treasury, as well as the CEOs or their representatives of the PHAs of selected Provinces. Annex 3 on governance and especially clause 6.1 of the SoR has been amended to reflect DFAT's request. The text has also been amended, at DFAT's request, now read "DFAT and NDoH can, at their discretion, invite representatives from other development partners (including service providers such as churches or NGOs) **community representatives or other relevant stakeholders** to participate in Steering Committee meetings to help understand issues" (bold text is new).

DFAT/Stakeholder Comments/Questions	Design Team Responses
MONITORING AND EVALUATION	
Additional funding for M&E	**Agreed: a clarification in the IDD addresses this**. As noted on page 27 of this Comments Matrix, and now as explained in the last paragraph in Section F of the revised IDD, the MEL budget is already estimated to be at least 4.5% of the overall PATH budget, allowing for the MEL earmarked budget and the learning and analysis budget. There will be additional monitoring inputs built into service delivery grants. Plus, there is a separate budget arrangement for independent evaluations.
Strengthen narrative on monitoring [The design team noted budget is actually more like 4.5 per cent if you add up M&E for PPF activities and funding for learning]	**Agreed.** See revisions to Annex 4. We recognise that an adaptive approach requires processes of testing, learning and iteration to find solutions. Implementation, monitoring and learning need to happen at the same time, so solutions can adapt and respond to feedback on what is working and what is not in real time. Specific tools and methods, including outcome mapping, sense making, strategy testing and other qualitative reflection and interpretation processes, have been developed to support this process with timely data. Monitoring processes are also required to support Programs to monitor how they use learning to achieve outcomes and to capture the rationale for decisions. These points are now reflected in Annex 4 (IDD).
GENDER EQUALITY AND CROSS CUTTING	
Draw out health as a front line service and first responder for gender based violence	**Agreed.** Section G of the IDD and Annex 5 make this point more explicit.
Outline potential cost of GBV on health services [agreed to provide further details in writing]	**Agreed.** See Annex 5 which now explicitly refers to the (emotional) and financial cost of GBV. The design team is not aware of any specific studies that estimate the financial cost of GBV to the health system (or individuals). This could be an area of operational research that PATH could investigate.
INNOVATION AND PRIVATE SECTOR	

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Support an iterative approach to innovation through annual work planning within the facility and through any incentive funding that may be available. The design could consider where there are opportunities to leap frog some of the development issues and use technology Explore applied operational research opportunities to start to build the evidence base for better GoPNG policies and regulation	**Agree in principle.** The design already makes it very clear that PATH is an adaptive program, and that innovative programs and interventions should be trialled and tested through the MEL, including with an explicit focus on lesson-learning. We would be cautious about a specific fund for "innovation" – if that is what is being suggested. That is because in some ways the key barriers to better services and flow of funds in PNG is not so much the need for innovation per se, but rather the need for health workers and health systems to, in effect, implement existing standard operating procedures (washing hands in health clinics; acquitting expenditures properly; undertaking supervision visits in the way they were intended; etc). **Agreed, but this is already a key part of PATH.** Operational research and learning to inform the evidence base for policy and practice is already a very central part of the IDD. This is clear from Annex 2 on the program logic (including especially the discussion about the "evidence learning and dialogue"); Annex 4 on MEL; Annex 6 on "what will be different in PATH?"; Annex 11 on approaches to socio-political complexity in PNG; and Annex 12 on the Policy Dialogue matrix. We do not see a need to make that theme stronger or more explicit in the design
RISK MANAGEMENT AND SAFEGUARDS AND SUSTAINABILITY	
Update design to reflect ACD feedback on safe guards and to strengthen narrative on leveraging PNG and donor funding.	**Agreed.** See revisions to the Risk Register including cell 8 M with respect to the prospect of GoPNG reducing public expenditure to the health sector. See also revisions to the Statement of Requirements; changes to the safeguard screening; and row 27 and 28 of the Risk Register with respect to Child Protection and Environmental screening respectively.
APPRAISAL COMMENTS	
RELEVANCE	
The PATH design suggests transition of GF/Gavi is imminent – I think the GAVI transition plan (with HSS support) is up until at least 2025, and GF predicted graduation is likely beyond that. The multilateral partners will be active for the duration of the PATH investment (phase 1) and probably phase 2.	**Agreed.** References to GAVI and GFATM corrected to make it clear graduation is still under review and may not occur until after 2025.

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Details of **consultations** with PNG stakeholders including government, civil society and private sector are not included in the PATH design document (that I could find in an Annex), however I am aware they occurred, quite extensively. **Addition**: A consultation list would be good (and apologies if it exists). Provide brief information on consultations undertaken with relevant GoPNG stakeholders, PHAs, etc in developing the program logic and testing assumptions, etc	**Agreed**. Page 5 in the Executive Summary outlines the consultation process. Annex 14 then provides details. The Executive Summary notes that GoPNG was given an opportunity to review and comment on the final draft design: GoPNG response is summarised in Annex 14.
The design could elaborate on what mechanisms/actions and structural changes will be used (even in a subset of PHAs) to remove identified bottlenecks. How will problems, such as the gaps in in the leadership, managerial, experience be addressed? The design doesn't mention any specific scaffolding for the design e.g., the use of programs such as IMPACT for example or technology to improve financial flows	**Agree in principle but disagree at the level of detail suggested.** The actual mechanisms will depend upon the specific challenge and the specific PHA and province, neither of which have been identified or agreed at the time of the design. Furthermore, it is the nature of an adaptive program that while the design sets specific goals and intermediate outcomes, the successful managing contractor is responsible – and accountable to DFAT and GoPNG – for identifying the details of the actual approach and how that approach will then be adapted for purposes of continuous improvement over time.
Update the design (and logic) with a narrative about quality of services (inc. service standards and performance in the context of PHAs and DFAT funded services), the role of the program in national policy level investments/liaison/dialogue to support the provincial level outcomes, the rationale for choosing 'selected' provinces including reference to HMIS data where robust, include policy and program areas where other resources can be leveraged.	**Agree to making "quality" more explicit.** "Quality" was always implicit in the design. There is now a more explicit reference to quality of services, including *clinical* quality of services, in the program logic of the IDD and the narrative text. In doing so, we differentiate between the quality of services that are more directly under the contractual control of DFAT, including services provided by NGOs contracted to DFAT, and the quality of services that are more directly under the control of PHAs where more indirect methods such as operational research, and technical assistance apply. The issue of service standards of Provinces is quite complex: DFAT has direct control of the service standards of those services it currently directly funds via PPF grants but can only try and influence (and cannot control) the service standards etc provided by independent PHAs. However, there is new text on pages 42 of the IDD about what the MC can be held to account for, and what it can only influence.

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	Agreed in part with respect to the role of the national level. GoPNG policy is clearly to move the locus of effort in terms of delivering actual health programs and services to the provinces and PHAs. NDOH will have more of an overview, regulatory setting, and aid coordination role. DFAT, and other development partners, needs to adjust to these changes. This is not to exclude support at the national level: hence "targeted national level support" (what was previously referred to as simply "central support") is one of the five main drivers in PATH. Annex two now has a distinctly separate, and enlarged, description of how the "targeted national level support" could work. Given that elaboration, and the clearer use of the term "targeted national support" as one of five key drivers that support all of the EOIOs and intermediate outcomes, we do not see it as necessary to have a separate box in the program logic. **Agreed in part with respect to which provinces are to be selected, and why**. The revised IDD makes it even clearer what the criteria for province selection is and, with advice from the Post, confirms that there will be "up to a total of 6" selected provinces, with an indication of what those Provinces *might* be. However, the decision about exact provinces is clearly a decision for DFAT and GoPNG, not the design team.
EFFECTIVENESS	
The PHA strengthening objectives seem quite dependent on the suggested indicative output of "PHA (being) able to recruit and retain staff". I understand this to be quite difficult to overcome, and yet seemingly essential to PHA management goals of PATH. **Comment:** Design would be strengthened by including evidence where PHAs have been able to overcome national constrains to health workforce (both administrative and clinical) – as this particular bottleneck feels like a particularly sticky one in PNG.	**Agreed: evidence of successful models of recruitment and retention are scarce, but PATH does have mechanisms – including bottleneck analysis, operational research, adaptive management, and "ways of working" to better understand the root causes of the problem and trial innovative solutions.** Recruitment – and retention – of staff is a clear problem. There is not a lot of evidence, beyond Hela Province where private sector personnel were brought in, that the Post or the design team is aware of in terms of good models to build on. It is however worth noting – and we reflect this briefly in the IDD that: • Health sector specific regulations have recently been introduced in early 2019 that increase autonomy of PHAs in relation to recruitment and performance management etc of the health sector workforce. (Previously this has been regulated under PSMA as if they were public service). This is an important policy change that offers more potential than there has been in the past to work on the issue. • As noted in the IDD, significant parts of the rural services are delivered by churches and other partners, so the issue of rural retention is closely with the partnership agenda, and sustainability of partners. This is a major part of the program and may get synergies across outcome areas.

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	• In Hela Province, PNG officials have brought in private sector and expatriate positions to fill important gaps. This has also happened in Morobe, PMGH, and in Western Province. It is not particularly clear what the value for money or efficacy of these arrangements are – they could be very positive given the alternatives, but they might also not be particularly cost-effective. However, it is one strategy being employed outside the usual systems and processes to get capable people in provinces. This would be yet another subject for good quality applied operational research where PATH would add value to policy making. • There is also a line of thinking at community level and community mobilisation. Where this works well communities are obviously a more permanent feature of the local setting and offers a different perspective on retention. • In Western Province the hospital CEOs had a bigger influence in attracting and retaining staff. One clear example is from Daru General Hospital where the CEO was able to attract in a short period (possibly less than 2 years) at least one specialist doctor in each of the main disciplines of medicine i.e. paediatrics, surgery, OBGYN and internal medicine, with some departments having more. Additionally, with DFAT financial support, the hospital and provincial health were able to attract and retain staff to support the TB response. The hospital provided incentives for the doctors though I am not sure how these were funded besides the DFAT supported incentives for TB. Poor recruitment and retention not only reduce the capacity for coverage of essential services, it is also a waste of important financial and human resources, compounded by a gender characteristic. The health workforce, the majority of whom are female, is a relatively large part of government expenditure, second to the education sector. To the extent that newly graduating health workers cannot be placed in employment, or existing health workers cannot be retained, is a major and ultimately preventable source of waste and structural inefficiency in the health system. There is therefore a financial and economic incentive for GoPNG to resolve the problem of recruitment and retention. • Poor recruitment – and retention – of staff is a key bottleneck: PATH's "problem driven bottleneck" driver provides an opportunity to identify options for analysing the root cause and feasible options for reducing the problem. ADB and to an extent World Bank policy-based lending can also be leveraged to help. The “working politically” approach (see annex 11) is also relevant as there are clear benefits to politicians – and PNG officials – if communities see more health workers providing essential services in rural areas. Practical solutions can be developed and even scaled up given the proposed 8-year (5 years initially plus a possible extension of another 3 years) duration of PATH. This is now reflected in cells 12 M and 19 M of the Risk Register.

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On transition issues (including as described in Annex 12), the design suggests a gradual transition from Aus-funded service delivery to capable PHAs – principally with PHAs absorbing the service delivery grants for immunisation / FP / SRHR under PPF. Noting that most of the PPF services are national, yet the PATH investment focusses on selected provinces (not yet selected, but probably less than 3 or 4 provinces). There are therefore different transition risks from DFAT Programs in unsupported PHAs to PHAS included in PATH. The design could recognise this	**Agreed.** This is now explicitly included (see actions in the first 3-6 months) of Annex 9 – the proposed first year outputs of PATH. This will be for the PATH MC to manage. **Agreed**. See new row 29 in the Risk Register on how that implementation risk can be managed. See also the new text on pages 42.
On influence and risk. The design assumes the facility is able to hire/use influential and effective TA at provincial level – when we know that is quite a rare combination (influential and effective….). Hired TA and the MEL approach also require the facility to be able to commission relevant applied research, generate useful information and use their reputation / expertise and/or relationships to influence decisions to achieve the six intermediate outcomes. The design assumes GoPNG /PHA demand for this knowledge on and could provide some evidence of specific demands. Similarly, more evidence (at peer review discussion or in the design) for where this has worked in health in PNG would	**Agreed that achieving TA influence and effectiveness at provincial level can be problematic.** It is also worth noting that the PATH design has four key features that should keep a focus on the importance of having effective TA at provincial level that meets local demands. More specifically, the PATH design: (i) uses the intermediate outcomes to focus PATH MC attention on specific issues that can help transform PHAs (ii) gives particular emphasis to analysing and relieving specific bottlenecks of direct concern and interest to individual PHAs, including through a "working politically" approach (iii) uses an adaptive learning approach, with a MEL that then requires the MC to explicitly track and demonstrate that lessons are being learned and adapted both by PHAs and by the MC itself (iv) leveraging policy based lending of the ADB and World Bank that are also responding to the needs of PHAs. **The risk of not being able to hire / use influential and effective TA at the provincial level is for the MC to manage**. However, it is worth noting that the MC has every incentive - including the possibility of the 3-year extension for a total of 8 years - to hire good quality staff, including at provincial level. The clarity of goals and outcomes; the "structured flexibility" inherent in an adaptive program; the intellectual and professional satisfaction of a strong MEL with clear budget for operational learning; and the prospect that the "Ways of Working" document will give PATH staff a work environment that rewards proactive thinking and avoids

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be helpful, as well as how we/the Facility will judge absorptive capacity of PHAs for TA -	micro-management and tasking notes all combine to make an assignment with PATH particularly attractive for anyone interested in development. The Risk Register has been updated to reflect this. Post advises that there is increasing requests from DNPM and NDoH for more investment level reporting and inclusion on monitoring activities, to help with PNG Government internal reporting and budget/planning processes. In NDoH's case, this demand is being generated by new work around health sector aid coordination (which DFAT is also supporting) and will likely to increase over the medium term. It is not possible at this stage to identify specific demands from PHAs when the "selected Provinces" have not yet been confirmed and will be DFAT and GoPNG to decide. Post advises their experience from in line TA for Morobe and Western Province TA is that this has effectively contributed to overall health managed at the PHA level as well as the delivery of our existing investments.
Will there be a TA Team Leader overseeing provincial teams, separate to the NDoH adviser?	Re the possibility of the TA overseeing provincial teams, the PATH design deliberately does not prescribe such arrangements. It is of course a likely and common-sense arrangement. Nevertheless, it is an important characteristic of an adaptive program like PATH that such decisions should be for the successful PATH MC to decide and then be accountable for. The more DFAT prescribes such arrangements, the more DFAT itself – rather than the MC which is best placed to decide and manage the situation – takes on the implementation risk. See also new text on page 40 of the IDD concerning the number of PATH MC staff that might / should be located at provincial levels. Internal discussion within the PATH design team was that a "flying squad" of long term and short-term advisers would appear to be a potentially effective and efficient approach. That is because the "flying squad" could comprise TA expertise (including PNG expertise) on core bottleneck issues such as financial flows and recruitment / retention of staff. The flying squad could also share lessons of successes and failures from one PHA / Province to another. But this will be for the PATH MC to decide, not the design per se.
While recognising that the context is different the reform 'journey' undertaken by Cambodia	Agreed in principle: but the actual extent of performance-based funding should be appropriate to the nature of the original problem and the capacity for performance-based funding to change behaviour and outcomes.

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to put in place performance-based financing to Cambodia's primary and secondary health system based on results and could provide valuable lessons for the design. The design could consider increasing the emphasis on results-based financing mechanisms – consider steps toward using similar mechanisms as those used in Cambodia.	We note that there is a generally positive (although certainly not universal) assessment of different types of performance based and outcome-based funding in the international literature, including with respect to particular countries such as Cambodia. However, the design team is firmly of the view that performance based funding is a means to an end, not an end in itself, and its potential for success is largely contingent upon what the root cause of the particular problem is, and the capacity of local stakeholders and their advisors to design and manage such interventions. We further believe the extent to which specific performance-based funding – or indeed other individual intervention measures and approaches – are to be used is the policy and contractual responsibility of the PATH MC. It is the nature of an adaptive program like PATH that the design specifies the goals and intermediate outcomes, but deliberately leaves *how* those goals and outcomes are to be achieved to the successful MC.
There is significant risk associated with leaving the key design elements to a Managing Contractor -- the design could consider more prescriptive so as to lead the contractor to a "new" model and approach.	Disagree. The key design elements in an adaptive program such as PATH are the specification of the goals, objectives, end of investment outcomes and indicative outcomes. That has been done in the PATH design, in a way that is fully consistent with the DFAT health portfolio plan for PNG, and the GoPNG input and feedback during the design mission. The design also provides some indicative outputs to help potential bidders and key stakeholders visualise what is relevant and possible to achieve. However, it is the explicit and intended purpose of an adaptive program that *how* those goals, outcomes and outputs are to be achieved are for the PATH MC to develop (in consultation with and with the approval of the Australian High Commission and GoPNG. Importantly, "risks" are actually transferred back to DFAT itself the more prescriptive the design is, especially in a very unpredictable, varied, and changeable environment such as PNG. The Risk Register now records this potential risk given that it was raised in the peer review process. However, the Risk Register also explains (see row 22 and especially cell M22) why this is not a particular risk. It also explains why having a more prescriptive approach transfers implementation risks that are – intentionally - best placed to be managed by the Contractor back into DFAT which is not well placed to manage such direct implementation issues.
In line with SDG-3.8*, the design should consider including some discussion on the	Agreed. The program logic, and the narrative text, now specifically includes several new references to "quality" of services (which was implicit before). See also above re quality of services

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quality of services and how, if at all, the quality aspects might be specifically addressed by PATH. [*Sustainable Development Goals 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all]	
If feasible, review and clarify assumptions for IO1.3 and transitioning of activities to PHA (under EOIO2) in the IDD. Setting of targets and timelines of outcomes can be done during the inception phase.	**Agree, but this should be done by the MC during the early implementation phase.** At this stage in the design process, no firm decision has been made by Australia or the GoPNG as to which PHA's, or even which Provinces, will be targeted for specific support. Given the great diversity of circumstances between, and within, provinces of PNG, it is not feasible to go beyond what is said in the design as to the key assumptions of making progress with IO1.3 (Women in Leadership) and / or progress under EOIO2 (DFAT funded health services improving access, influencing PHA performance; and transitioning PHA management in selected provinces. Having said that, the Indicative Outputs set out in the program logic do provide strategic, but realistic and feasible, examples of what *could* be achieved and – implicitly – what a priori assumptions would be likely to be involved in achieving those indicative outputs.
Recommend that the scope of the logic consider the 5+3 year timeframe. This can be done in two ways: 1. review and reframe the current EOIOs with an 8 year (2028) timeframe, or 2. revise the program logic to include outcomes in 2025 and 2028 reflecting the contracting and option periods.	**Agree but with a qualification.** We make it clearer in the Executive Summary and in the body of the revised IDD text and especially in the first 2 pages of Annex 2 that the program is very much expected to be an 8 year program (5 years initially with the option to extend it for a further 3 years subject to DFAT and GoPNG assessment of performance) because the complex operating environment requires a longer term perspective. However, we are firmly of the view that this should remain an *option* for DFAT – and not something that can be mandated or fixed. That is because DFAT should use the option of an extension of 3 years to assess progress to date, both by the MC but also GoPNG commitments (including on improving the drug supply and commitment to allocating its own agreed budgetary resources to the health sector). What "progress" means in practice will need to be negotiated and agreed with the MC (and GoPNG) at the start of the new contract. We do **not agree** to reframing the EOIOs to an 8 year timeframe, or to include different outcomes for 2025 and 2028. That is so for three reasons. First, contractually, PATH is for 5 years with an *option* of an extension.

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	DFAT, and GoPNG, may well wish to adjust the EOIOs and Intermediate Outcomes at the 2025 stage. Second, it is not practical or feasible to speculate what the outcomes could or should be in the 3 year extension period when there has been no experience to draw on how effective the first 5 year period had been. Third, the current wording of the EOIOs, and the Intermediate outcomes, have been deliberately drafted in such a way that they give a clear sense of direction and change *but* are nevertheless sufficiently broad and flexible that they can capture progress as it occurs in different provinces and over future years. See also the introduction to Annex 2 on the PATH program logic.
Some of the potential synergies with other development partners including the multilateral development banks, are described but some of the details need correction. The overall program for Asian Development Bank's investment, Health Services Sector Development Program 2018-2023, is $404.5 million (Annex 10).	Noted and referred back to the Post. Annex 10 was prepared by the Post. The design team is of the view that the Post is in the best position to have access to the most up to date figures. We therefore refer these comments and possible need for correction about synergies, and the ADB figure, back to the Post to review and, if necessary, correct.
Please review the levels of the logic with a view to stepping it all up one level of ambition (i.e. new EOPOs and the current draft EOPOs would become IOs (intermediate outcomes), the current draft IOs would become outputs etc. The drivers are really useful to the ways of working. Please add quality to the EOPOs and IOs so it is not only access/equity and ensure performance incentives also link to quality including service standards (in PHAs and DFAT funded services). Integrate the two high level risks in the design (HR/workforce and pharmaceuticals) into the	Disagree. We believe the current formulation strikes the right balance between, on the one hand, being sufficiently ambitious to justify a program of this size and, on the other hand, the realities – and DFAT experience – of operating in the complex health sector of PNG. Agreed. Agreed to a degree. Both of the key risks (continued shortages of essential drugs at health facilities, and reduced allocation of GoPNG funding to the health sector) are implicit in the two EOIOs, and the

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logic, outputs even if as an advocacy/policy role, or donor coalition role, and/or direct investment.	intermediate outcomes, as worded. This is especially true with respect to Intermediate Outcome 1.1 which refers to PHA Boards and Management being "more capable of leading reform and managing finances, health workers, partnerships and service providers". However, we caution against making progress on drug supply and financial allocations to the health sector more explicit in the logic outputs. That is because both issues are – as explained in the IDD and risk matrix – are largely beyond the span of control of PATH (or indeed any development partner) so there is an inherent risk that the design establishes outputs that are impossible to achieve. Furthermore, discussions with DFAT Canberra and the Post during the design mission made it clear that Australia should (i) not directly try to involve itself in the longstanding drug availability issue and (ii) would be prepared to keep raising funding allocations to the health sector during high level consultations but would be reluctant to be more assertive. Having said that, and as noted previously in this Comments Matrix, there are things DFAT can and should do to keep highlighting the importance of these two risks, and to manage them. As explained in the revised Risk Register, these include policy dialogue at the time of the Australia / PNG High Level Consultations as well as through the Annual Plan. DFAT could - and should – also take into account the situation with respect to GoPNG financing for health, and drug availability, when it is considering the possible extension of PATH for a further 3 years beyond the initial 5 years. DFAT could validly argue that a sustained, systematic, and widespread reduction in public expenditure for health, or systematic and sustained unavailability of drugs, meant DFAT exercises its prerogative to reduce the scope of PATH in any 3-year extension or even to terminate PATH at the end of 5 years. DFAT can and should also leverage its existing investments relating to economic management and supporting economic growth in PNG. DFAT, and to an extent the Contactor, can utilise and leverage DFAT's membership of and cofinancing with the ADB and World Bank, both of which have large policy based loans to the PNG health sector which involve GoPNG commitments to funding the health sector ("leveraging partners" is one of 5 specific drivers identified within PATH). PATH direct funding of "problem driven bottlenecks" and operational research can and should be used to better identify the root causes – many of which are political economy issues – see Annex 11 – of these challenges. To an extent the essential health services provided under PATH, including immunisation, and prevention and treatment of TB, helps to mitigate the adverse effects of any reduced funding from GoPNG. See also preceding discussion on page 5 of this comments matrix. The Risk Register has also been updated to reflect these points.

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Maternal and child health although in the details of the activities does not make it into the logic and should be integrated into the logic. Please add in where the national level reform/dialogue/investment fits into the program logic. Please add the Incentives/performance financing approaches into the outputs/activities. Expand and clarify governance arrangements to ensure participation (even with observer status) of the WB/ADB, WHO, PGF economic governance program to promote informed sector wide policy and budget dialogue.	**Agreed.** **Agreed in part.** Please refer to page 1 of this Comments Matrix. **See new text at footnote 28 and 29 in the IDD.** **See previous comments on governance at pages 125 (Comments Matrix).**
EFFICIENCY	
As mentioned earlier the design relies heavily on a managing contractor's ability and expertise to work out the specifics of the "how" aspects. The design should consider being more prescriptive to ensure the resulting design isn't business as usual.	**Disagree.** See above comments on the nature of an adaptive program, which PATH is. See also the revised changes to the SoR clause 5.2 b about the responsibility of the MC to have a system for proactively implementing an adaptive program. The Risk Register also specifically addresses this issue
Annex 10 needs updating – either the entire Health Services Sector Development Program of $404.5m or the imbedded project investment of $104.5m	**This comment has been referred back to the Post which provided the data.** The Post is in the best position to update the data if they see the need.

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The text for the Gavi and the Global Fund needs to reflect the transition more accurately. *In July 2019, as part of a tailored strategy to address the challenges in Papua New Guinea and taking into account the request made by the Government of PNG to the Gavi Alliance Board in November 2018, PNG has been exceptionally granted an extension of the country's "Accelerated Transition" period (Phase 2) from 2020 to 2025. Similarly, there is no fixed date for PNG's transition from the Global Fund*.]	**Agreed in part.** The revised text makes it clearer that "graduation" is under consideration by GAVI and the Global Fund but final decisions have not been made. Given DFAT's page limitations for an IDD we do not have space to include the details as suggested.
In the 'Ways of Working', provide where possible a detailed input and resourcing schedule that articulates the internal transaction costs (DFAT and MC) and define the expected efficiency dividends of PATH.	**Good idea, but this is not possible.** It was not in the original Terms of Reference for the design, and there was not sufficient time in – country, to identify the transaction costs and expected efficiency dividends. What was clear from the design mission was that (i) such transaction costs are not being tracked or managed either by the MC or DFAT (ii) the anecdotal evidence was that they were potentially significant in certain cases. Post will undertake a Transition Planning process to identify the input and resourcing requirements for DFAT, although this will need to be rechecked once PATH is mobilised.
As part of Annex 3, provide further details on which positions will be continued/novated from existing programs and identify any new positions/roles to be part of the PATH team.	**This cannot and should not be determined at this stage.** Those decisions need to be made as part of a broader discussion and negotiation between Post, GoPNG at central and provincial level, and the successful PATH MC. The actual decisions will reflect decisions taken at the time as to what are the initial priorities, initial provinces, and budgets available at the time.
Please clarify the ability of the program to absorb further funds. The NGO/PPF dimension should be clarified as this is one third of potential spend ($120m v 180m).	**Agreed, however this is more appropriately dealt with as part of the Implementation Plan.**

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Similarly, please build in the potential in the design for a) emerging needs i.e. a humanitarian window for health responses during crises, and b) for more intensive provincial support i.e. a potential Bougainville 'window'. This would allow sufficient flexibility so that future sub design work could occur under this facility. It would also allow ease of programming if more funds were available to put through the facility in future years.	**Agreed, although there is already scope for this and we do not support the idea of a special and separate "window":** any future enhancements should be via the Statement of Requirements. Driver 5 - "emerging priorities" – specifically allows for PATH to address new emerging priorities. However, to allow for a surge capacity to address a sudden humanitarian crisis or other contingency, we have made a change to the Statement of Requirements noting the possibility of additional financing and functions. Specifically, clause 4.62 of the SoR states that "DFAT may also choose to use the existing "emerging priorities" (Driver 5) provision within the PATH design to rapidly scale up funding in the case of a humanitarian emergency or changed priorities that are agreed between DFAT and GoPNG." (We do not favour specifically referring to Bougainville per se, given the sensitivity of that subject, but responding quickly – perhaps as an interim measure while a more specific design response is developed - to a change in Bougainville is not excluded under driver 5). DFAT contract area should draw the possibility that DFAT *may,* at its discretion, rapidly scale up funding under Driver 5 in the event of humanitarian crisis or other rapidly changing situation to the attention of potential bidders so that they are aware of this possibility in advance. We do not support complicating the design with a special or separate financing "window".
Where can low cost local TA or AVI/volunteer programs complement or be used within this program – please outline in the design. Has DFAT got the resources to manage this from Post or are any additional positions required to be built into the design to be collocated at Post (LE or advisory) – please include.	**Agreed.** Annex 2 now includes the following statement: "It is important to note that, under an adaptive program, the MC has discretion to use whatever mix of technical assistance and advice is considered appropriate and effective in the individual circumstances. The MC can therefore decide the balance between long term and short-term advisers; international advisers and PNG national advisers, and the mix between consultants from commercial firms versus NGOs and volunteers. The MC will then need to make their own assessment as to the relative costs - and benefits - of various approaches and sources of inputs. The MC will be ultimately accountable to DFAT and GoPNG for such choices the MC makes.
MONITORING AND EVALUATION	
The design suggests the MC set specific targets for each indicator in the inception phase, agreed by MC, DFAT and GoPNG (reflecting each party's	**Agreed. Annex 9** adjusted to indicate that possibility.

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specific accountabilities). Comment: This will probably take a lot longer than anticipated in Annex 9 (12-month milestones).	
Draw on PNG HIS and GOPNG's own provincial datasets as much as possible/feasible in the initial MEF, and detailed MEF so as to not create parallel M&E systems in implementation.	**Already included.** The IDD already has a section titled "key aspects of the MEL approach" on page 23. Those key aspects begin with the following points: • Alignment with measures of results in the National Health Plan and DFAT Health Portfolio Plan; • Use of existing national and provincial data collection systems where possible; and work with others on joint approaches where these need to be developed or strengthened, but with particular attention to generating gender and age -disaggregated data;
Review the M&E Budget.	The MEL budget is already estimated to be at least 4.5%, allowing for the MEL earmarked budget and the learning and analysis budget. There will be additional monitoring inputs built into service delivery grants. Plus, there is a separate budget arrangement for independent evaluations. See similar comments on the M&E budget below.
A detailed quality assured MEF should be built into the statement of requirements ref annex 9. Also in this annex, refer to the minimum annual performance assessment with the QTAG.	**Agreed.** See new text in clause 8:14 (ix) (d) of the revised Statement of Requirements with respect to the quality assured MEF. With respect to the suggestion about QTAG, see also new text in clause 8.14 (iii)
The design suggests formal quarterly performance monitoring which is welcomed. The M&E will require in-house MEL, and this may end up representing the lion's share of M&E information in health – potentially affecting the impact of QTAG. Post to advise.	**We note that the Post is asked to advise on this.** The performance review of progress and lessons by DFAT (with the MC and GoPNG) is expected to be six monthly. **Posts advice:** PATH will represent roughly half of the health program once mobilised. Therefore, half of the program's M&E (for investments through UN, multilaterals, development banks etc) will still be outside of this managing contractor. The managing contractor will be required to undertake M&E for those programs and functions it delivers. The new Human Development M&E Services Provider will assist DFAT to monitor and report on all investments across the whole health portfolio (including but not limited to PATH), as well as provide DFAT advice on investment-level M&E.

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The terms of reference for expected evaluations/reviews are expected and are not included in the design – the design does discuss which evaluations will be conducted and by whom (contractor for the 'Human Development M&E Services (PNG)).	**We believe the nature, scope, purpose, terms of reference and timing of future evaluations / reviews are for DFAT to decide, rather than the design team.** There is also the *potential* for a conflict of interest if the PATH design team sets the terms of reference for an evaluation of PATH. There is a list of proposed evaluation questions set out in Annex 4.
Review the resourcing allocation for M&E, with an estimate of around 5% to adequately support the adaptive nature of the program. The guidance from DFAT is that this should be 5-7%. It is possible that (1) resourcing from the sub-contracting partners can be considered as part of the M&E noting this is not independent; (2) some of the resources from the budget could be considered as part of M&E, specifically in relation to human resourcing costs of 'Learning, Analysis and Dialogue' and 'Problem Driven Bottlenecks' which presumably will need to be integrated with M&E support in some manner.	**We agree that "around 5%" of the total PATH budget should be allocated to MEL, especially in an adaptive program like PATH where real-time learning is critical but note that at least 4.5% of the budget is already allocated to monitoring and learning, with further funding for evaluation**. In addition to the monitoring budget under program management ($1m per year), there is $1m per year budgeted for learning, analysis and dialogue, much of which will inform adaptive management and program strategy, and there will also be funding for monitoring within service delivery grants. This gives a budget of at least $10m (around 4.5% of the total), plus further funding for evaluations by the independent M&E contractor. The monitoring approach is for the MC to monitor 'in house' rather than having an independent monitoring provider, in line with international thinking on adaptive programs. This is expected to encourage self-critical reflection and flexibility in managing and adapting programs as experience evolves.
Strengthen the monitoring system including data collection methods outlined in the M&E sections. More specifically, the table on page 55 outlines the indicators and data collection methods. Within 'intermediate outcomes', the emphasis remains on evaluative questions / indicators without a balance of monitoring questions / indicators. That would provide information around what has changed after the fact (e.g. % of provincial level health funds expended as reported by the PHA Boards; or	**We do not consider this necessary or appropriate.** Other reviewers have assessed the MEL as being particularly strong and appropriate. The design team sees no need to be more specific on monitoring methods or indicators to monitor the implementation process (such as engagement with PHAs). It is the nature of an adaptive program that the design and program logic focus on objectives and outcomes, while the successful MC for the PATH program is responsible – and therefore accountable to DFAT – for selecting the appropriate data collection methods for monitoring implementation progress and outputs. These will vary depending upon the specific issues being addressed in different provinces and PHAs, and over time. The need to use monitoring methods that show progress with implementation and learn lessons in real time has been added in annex 4.

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number of women in management as reported by HR MIS, etc), though not necessarily monitoring of the engagement with PHAs to effect that change. In addition, under the 2nd driver of change related to problem driven approach, the methods are not identified as it just notes 'evidence of …' and again more related to external partners than PATH monitoring.	
Annex 12 describes DFAT responsibilities **for policy dialogue** but there doesn't seem to be much detail on corresponding implications for DFAT staff time /efforts / capabilities as required by this element of the Design Scoring Tool.	**The "resources required" column of Annex 12 already provides what data and insight is available in terms of resource implications for the Post, as does the end of Section H in the body of the IDD.** It should be noted that the Design explicitly envisages that, in addition to strengthening in-Post resources, that Post would have access to short term and long term advisers where specialist technical expertise was required including, for example, operational research and knowledge management: relevant skills for policy dialogue. Post is in the best position to identify and respond in terms of any further needs and details.
SUSTAINABILITY	
National level dialogue/programming on budget and resourcing (inc. HR) is vital to sustainability even with a focus at provincial level. Replication of PHA successes are dependent on these, as well as institutionalisation within church networks. A sustainability plan should be built into the statement of requirements found at annex 9. PHA reform and replication could be also potentially built into policy-based loans for	**Observation noted.** PATH does provide targeted central support as one of the five drivers. The evidence and learning and problem driven bottlenecks – two other "drivers" - also provides a platform for more evidence-based policy dialogue at the national level. A fourth driver is "leveraging partners": this provides PATH with significant scope to interact with and leverage the analytical and policy-based lending that both the ADB and World Bank will be supporting, and the analytical work and policy advice that the WHO provides. **Agreed.** See amendment to Table 4 (reporting) and a new clause 8.26 in the Statement of Requirements in Annex 9. **Agreed, but there is very limited scope for the PATH design to act on this itself.** PATH does not involve any direct policy-based loans: it is a 100% grant program. It is appropriate for the Post to encourage policy-based loans in the Post's dialogue with the ADB and World Bank, where that is considered sensible. The PATH MC

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further diversification of support/effort over time.	could assist the Post in having that dialogue with the ADB and World Bank via the findings generated from the various drivers. However, it is not appropriate for the PATH MC to be directly recommending policy-based loans to the ADB or World Bank: only DFAT at Post should be doing that. Post would need to take into account the mixed record on policy-based lending in low- and middle-income countries, including PNG.
Comment: as per earlier, the idea that DFAT can transition some of the health grants in the PPF to GoPNG is important, with gradual and transparent reduction of resources ($$). For the most part, success requires functioning PHAs to absorb financing (even if at reduced levels). However, the PHA element of the design (EOIO1) will target only a handful of provinces – so there is a potential for limited transition in lots of less-than-functioning PHAs.	**Noted.** This will be for the MC to address and manage once a decision has been made about the provinces
GENDER EQUALITY AND CROSS CUTTING ISSUES	
Attention to climate change as a cross-cutting issue didn't jump out at me.	**Comment noted.** We believe the references to climate change are appropriate given the focus of the TORs for the design, as well as the DFAT instruction to keep the IDD to a maximum of 25 pages. We also note the accompanying comment from DFAT when commenting on climate change that "the caveat being that the design is appropriately public-sector focussed for PHA and health service delivery."
Provide further information about the experiences of people with disabilities in accessing health services in the design: There is limited evidence provided in the document on the experiences of people with disabilities. It is acknowledged that there may be limited evidence available for the PNG context. There is,	**Agreed in part.** The majority of drafting changes with respect to disability have been accepted. In the time available the design team was not able to identify further information about the experiences of people with disabilities, particularly because there is so little reliable data available on that (including for mental health). PNG is an especially unique country with wide-ranging health challenges, so the design team is not convinced that adding additional examples from other countries is all that useful or relevant.

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however, more general and global information which would be provided to provide a synopsis of information about access to health for people with disabilities and demonstrate the need for the project to consider disability inclusive approaches. Some suggestions (including references) have been included in the marked-up design document to assist.	
Risks and safeguarding: There is currently no explicit consideration of risks or safeguarding that relate specifically to people with disability in the risk tool shared, although the design does acknowledge that there is a risk that PHAs may not be willing to increase the role of people with disabilities in decision making. The risk categories where disability could be considered more explicitly include in the operative environment, partner capacity and social safeguards section. Examples of potential risks and safeguarding issues might include: there is an increased demand but the supply is not yet inclusive or accessible reinforcing negative experiences for people with disabilities in accessing health services; referral mechanisms result in people with disabilities just being referred to disability services and not being provided with the mainstream health services they need; a lifecycle approach is not taken,	**For discussion with GoPNG.** The design team recognises the comments and insights about disability. However, the extent of the comments and recommendations goes beyond what the original TORs sought for the design, or the place of disability in the overall DFAT health portfolio plan. So as to not lose the comments on disability, the design team recommends that those comments and suggestions are discussed with GoPNG at the inception phase. If GoPNG see that as a priority over other issues, then DFAT and the PATH MC can respond accordingly.

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intersectionality is not considered and/or the diversity of disability is not considered and as a result, there continues to be marginalisation of certain groups; and increased access to health services increases the risk of safeguarding issues, including the potential risk of violence and abuse by health providers.	
Consider disability in the program outcome related to increasing women with disability in leadership: There is the opportunity to think about how women with disability can be recruited into the health workforce and into leadership positions, recognising that their engagement in the workforce can help to challenge and overcome deeply entrenched attitudinal barriers and, as a result, improve access for people with disability.	See above: to discuss with GoPNG
Strengthen approaches to participation and empowerment: The design mentions that the program intends to contribute to participation and empowerment of people with disability, women and other marginalised groups. However, there is limited information as to how the program intends to contribute to increased participation, empowerment and decision-making. It may be worth considering providing	See above: to discuss with GoPNG at the inception phase

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further information on this in the design and/or considering how this may look during the inception phase, how it will be reflected in the budget and how it can be reviewed by MEL processes.	
Consider linkages with the PNG Church Partnership Program: Considering churches provide an average 50% of health services in PNG, it is worth the Program considering how it can link with the PNG Church Partnership Program and draw links with their disability action plan.	**Agreed in principle.** As noted, the churches already provide on average 50% (much higher in some provinces) of health service delivery, contracted by GoPNG and PHAs. The PATH design takes that important arrangement into account as a fundamental part of the PNG health system. It will be up to the PATH MC to work with different provinces and PHAs s to the extent and nature of the linkages with the PNG Church Partnership Program, including with respect to disability.
Aid-Works theme functionality: Consider tagging the project with the 'disability-inclusive development' theme in AidWorks	**This has been referred to DFAT for decision.** It is not a design issue as such.
Family planning service access could be linked to greater access for young women i.e. 16-25yrs (key to female empowerment and workforce participation	**Agreed in principle.** Page 10 already refers to family planning services for adolescent girls. The design team recognises that adolescent girls (and boys) are often a neglected or even excluded group from sexual and reproductive health / family planning health services. There are clear public and private health benefits in reaching them. Having said that, further expansion of services to adolescent girls (and boys) would need to be in line with GoPNG / NDoH priorities and the priorities of PHAs and provinces.
INNOVATION AND PRIVATE SECTOR	
Like climate change, innovation and private sector didn't jump out at me in the design. The caveat being that the design is appropriately public-sector focussed for PHA and health service delivery. There are existing private	**Comment noted** including that the design is appropriately public sector focused. That is intentional. The PATH design is intended to be focused and should not give undue attention to all the many challenges facing the health sector of PNG, especially when those challenges are not a major theme of the overarching Portfolio Plan. Page 24 of the revised IDD gives more emphasis to the role of churches in delivering health services.

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sector partnerships under the PPF (NGOs) – with the design aiming to transition funding and administration of these service delivery agents to government. That likely leaves a significant role for private sector implementers in health in PNG.	The Design Team would, however, argue that having Women In Leadership as a specific EOIO; and requiring that the MEL tracks the degree to which knowledge products and learning actually gets traction, are innovative in design terms.
Opportunities around the future submarine cable may not yet be apparent – but could be built into future activities, as the program evolves through its annual work planning process. Support an iterative approach to innovation through annual work planning within the facility and through any incentive funding that may be available.	**Agreed.** Reference to the future submarine cable now included in the section on Innovation in the IDD on page 25.
RISK MANAGEMENT AND SAFEGUARDS	
This is a high-risk design (Investment risk summary overall risk rating: very high and very high). The operating environment, partner capacity and relations, and resources / management and planning drive the very high-risk rating for this investment. Treatment of risks in the matrix appear to reduce the risk rating in five of the seventeen risks identified (10, 14-17). Highlighted in yellow above, with resulting risk difference pasted in. The remaining risks appear somewhat resistant to treatments, which may	**These observations from DFAT are correct and reflect the design team's own assessment of the situation.** It is especially true that the risk of a decrease in the PNG budget to the health sector, and continued absence of essential drugs in health facilities are not just critical risks but, given past and current circumstances, quite likely to continue as problems. **Noted, but the Risk Register update changes some of the results**. The revised Risk Register identifies 22 separate risks. Of these, 15 (68%) are judged to be amenable to reducing the risk rating through the interventions identified in column M of the Risk Register. As a general comment, the PATH design does seek to leverage reform and improvement in the management of the health sector in selected provinces of PNG. It does that through the focus on a limited number of PHAs and provinces (where successes can be trialled, demonstrated and replicated); through the focus on "drivers" each of which are designed to get to the root

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reflect that fundamental factors are hard/impossible to shift, or our treatments aren't on the mark (despite the hypothetical nature of the exercise, many of these risks have been realised over last decade….).	cause of priority problems and bottlenecks; through the focus on adaptive management (learning and adjusting in the light of experience); the leveraging of larger policy based lending from the ADB and World Bank; and the attention given to political ways of working (Annex 11). It is also worth restating that PATH will, via the service delivery grants, be providing *some* operating funds and drugs. This will both provide immediate benefit to people and help ameliorate the short-term risk in many parts of PNG of lack of GOPNG inputs. This provides some measure of predictability and security of drug availability although this should not be overstated: it will not transform the system which is what is needed. Further, these will be provided on a gradually reducing basis to provide a responsible basis for PNG to increase funding. The PATH approach of working with PHA's also encourages the involvement of other partners to support health - private sector, churches etc. It is also important to note that the IDD and the Risk Register make it more explicitly clear that the 5 years plus *an option* of an additional 3 years does provide some potential leverage to DFAT to drive reform in the way envisaged under PATH. In the event that there is demonstrably little progress, either because of GoPNG / PHA failures or that of the MC, then DFAT does have the prerogative to reduce or even cancel the 3-year extension. These all combine in PATH to give DFAT some potentially powerful levers to achieve progress and reduce risks.
Resistant risks include two residual VERY HIGH risks, these are (#1) decrease in PNG budget (#3) health facilities do not have drugs. Risk treatments proposed include: (1) bilateral health policy dialogue (2) broader program dialogue (economic governance etc), (3) using influence with MDBs re: health sector funding and (4) direct PATH funding to essential health services.	Noted changes made. The fundamental issue for the design team, and more importantly for the AHC and the PATH MC, is what measures and levers are then still actually available in practice to overcome, or at least mitigate, these and other challenges. The realistic answer is that, short of suspending aid funding to the health sector of PNG (with obvious significant ethical, public health, and diplomatic implications) there are only limited countermeasures available to Australia, or the PATH MC. Having said that, in the revised IDD we have now also made it clearer and more explicit that DFAT does have actions it can take to manage the two main risks of GoPNG shortfalls in funding to the health sector and continued systematic shortages of drugs. Specifically, the risk section of the IDD now says: A realistic assessment concludes that two of those risks – a decrease in the GoPNG health budget and the unavailability of essential drugs and commodities - are so deep-seated, historic, and consequential that they remain "very high risk". DFAT should therefore continue to have direct policy dialogue with GoPNG about the issues, and continue to work with, and leverage, other development partners. This includes the ADB and World Bank both of which have large policy-based loans to the PNG health sector that take into account the risks of GoPNG funding shortfalls and systematic drug shortages. Furthermore, DFAT will continue to fund – albeit at lower levels

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	than currently - direct service delivery through the PPF grants until at least April 2022, at which point DFAT will commission an independent mid-term review of PATH. DFAT direct funding, via PATH, of essential services such as immunisation, family planning and TB / HIV is therefore insulated to an important degree from the effects of GoPNG budget reductions and / or drug shortages up until April 2022. The mid-term review at that point will then enable DFAT to exercise its prerogative to reduce the scope of PATH if there is a sustained, systematic and widespread shortage of drugs; widespread corruption in the health sector; or an unacceptable reduction in GoPNG financial commitment to the health sector. Based on this capacity to protect DFAT directly funded service delivery investments from the outset until at least September 2022, and then consider broader options at the time of the mid-term review, the risk rating has been reduced to 'high'.
Risk treatments don't seem to be reducing risks in the register.	Furthermore, the 5-year program, with the *possibility* of an extension for a further 3 years, gives DFAT a basis for further incentivising GoPNG to improve the funding flows to provinces over time. Continued leakages and blockages in funding flows from central to provinces and PHAs (and continued shortages of essential drugs) would be a trigger for DFAT to consider not extending PATH the extra 3 years. The discussion in the Risk Register about decreases in PNG budget and shortage of drugs has also been significantly expanded, including in the "Treatment" column (column M).
To what extent do we already do (1-4) and to what extent can PATH support DFAT on health budget allocations (not successful to date? Or have we averted worse outcomes with good dialogue and just haven't said it), and linkages to the influence of other DFAT levers….	**This has been changed.** Significant GoPNG budget reductions and /or continued systematic drug shortages would clearly and significantly affect DFAT's ability to achieve EOIO 1. It would also have adverse effects on achieving EOIO 2, although DFAT's own direct funding, and own direct purchasing of drugs, of key services such as immunisation would mitigate some of those consequences. It is due to these consequences that the risk rating remains very high. However, as this IDD makes clear and especially in Annex 2 and 3, the managing contractor is accountable to DFAT and GoPNG for adapting its response in light of changed environment. DFAT therefore has management options for responding to the context as appropriate. DFAT also retains the option to reduce or change the scope of PATH (for example, adapting strategies or continuing direct funding of services under EOIO 2) at mid-term review helps to protect Australia's investment in certain essential health services especially in selected provinces more broadly. In summary, the mid term and 5 year reviews, both provide a strong *incentive* for both GoPNG and the Managing Contractor to proactively manage those risks, while the adaptive management features of PATH provides the *mechanism* to do so.

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	There has been some limited progress in the past. DFAT has raised key issues including reductions in GoPNG public expenditure to the health sector, and the chronic shortages of drugs, with GoPNG as part of higher level policy dialogue during High Level Consultations, as well as through on the ground technical assistance in economic governance programs. DFAT has also supported the Asian Development Bank, WHO and the World Bank in their high level discussions, and capacity building, with GoPNG. However, the issues are particularly difficult to resolve, especially in an environment where GoPNG government revenue overall has been falling in recent years and public debt levels are high.
Review the program assumption, related risk and proposed treatment for 'women's representation in management roles (IO 1.3).' Suggest that there is a role for policy engagement in reinforcing the work the MC will be doing on IO 1.3. Recommend including 'targeted policy engagement' as part of the proposed treatment (Column M- Risk and Safeguards Screening Tool) and DFAT/GoA as part of Column N- responsible for implementing treatment.	**It is not clear to us what precisely this comment is actually asking or recommending.** However, we have reviewed the assumption and treatment of Women in Leadership (IO3). See also the comments in the updated Risk Register which says: "The PATH design specifically and intentionally elevates "Women in Leadership" to a specific intermediate outcome (IO 1.3) to give that theme focus and visibility. The "drivers" including evidence, learning and dialogue, but also problem driven bottlenecks also enable PATH to identify specific barriers to the better engagement of women and the socially excluded from decision making. The extended time frame of PATH (5 years plus an option of a further 3 years, for a total of 8 years) provides sufficient time to achieve the stated outcome of "more women in management roles influencing policy....." This last sentence has been added recently and is, in our view, an important factor in assessing likely progress for IO3
Strengthen the referencing to temporal risks of not achieving outcomes due to the timeframes of PATH and the ambitious systemic changes sought.	**Agreed.** See previous comments on pages 134 and 135 of this comments matrix about how the time frame for PATH has now been addressed. See also the first 2 pages of Annex 2.
That the start-up phase for the MC is a continuation of **over-assessment and over-consultation** by Australia, noting the process to revise the Health Sector Investment Plan which became the Health Portfolio Plan began in **2016**, and the previous design team (in 2017) canvassed many similar questions. From the	**Comment noted.** We do not see any reason to change the IDD, particularly in light of the adaptive program of PATH and the very strong MEL, both of which should help avoid the type of problems identified in that comment.

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outside – there seems to be a risk of Australia continually asking the same questions without demonstrable changes in how we deliver health aid in PNG. The proposed capacity diagnostics of eligible PHAs (see inputs for 1.1 on Annex 2, p34) have the potential to put us in a constant state of assessment (if they go on too long).	
Performance-based financing: IO2.2 – *DFAT performance-based funding increase coverage of immunisation, family planning, HIV and other services, and improves efficiency by integrating vertical services.* I'm not clear the nature of the performance-based financing proposed, and to what extent it is different or new to any mechanisms used under the PPF for FP/SRHR and immunisation. It would be useful if the design (or peer review discussion) could include relevant evidence on approaches in PBF that have worked in PNG to date, whether we are doing something more of the same, or there is something new about this element of EOIO 2.	See previous comments at page 133 of this comments matrix on performance based funding; see also new footnotes 28 and 29 on performance based funding in the revised IDD. It is then the responsibility of the MC to determine when and where performance-based funding is appropriate.
Are our hopes too high for health workforce reform: the PHA strengthening objectives seem quite dependent on the suggested indicative output of "PHA (being) able to recruit and retain staff". I understand this to be quite difficult to overcome, and yet seemingly essential to PHA management goals of PATH. Design would be strengthened by including evidence where PHAs have been able to overcome national constrains to health workforce (both administrative and	See comments on health workforce under "effectiveness"

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clinical) – as this particular bottleneck feels like a particularly sticky one in PNG (this comment appears in the design scoring template).	
The design doesn't specifically mention the use of technology to overcome any of the challenges in the PNG sector. The design should consider where there are opportunities to leap frog some of the development issues and use technology.	**Agreed.** Technology, including smartphones and internet, have potential. However, the TORs for the design did not task the design team to specifically address this, and the time available in-country, did not allow it. Most importantly, the use of technology will depend upon the specific policy and programming challenge to be addressed. That will vary from PHA to PHA and over time. It will be for the PATH MC to focus on those issues in liaison with individual PHAs. The final paragraph of the IDD under the section on "Innovation" has however been revised to reflect the points made by DFAT.
Effectiveness and Sustainability were downgraded to '4', not because they have not been adequately considered in the design, but rather because there is still a considerable knowledge gap on what some of the effective strategies, approaches and activities might be to achieving the identified program outcomes that may also sustain beyond the life of the investment. Adaptive programs by design require time and space to pilot, test, adapt and learn before ideas can successfully be scaled-up and the program duration of 5-years will likely prove to be challenging in this regard. As such, it has been recommended that the program duration be revised to 5+3 years to maximise Australia's contribution in this critical sector which will further advance Australia's bilateral relationship with PNG.	**Agreed.** See pages 134 and 135 above on the time frame (5 years plus the option to extend for a further 3 years, for a total of 8 years) for PATH and in particular the first two pages of Annex 2.

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Update the risk matrix with key risks in the assumptions in the program logic. Identify risks around government resourcing (budget, HR, pharmaceuticals for the program and for PHA performance).	**Agreed.** The risk Safeguard Screening has been updated in line with peer review comments on the Safeguards. The Risk Register has been revised to provide more detail on the management treatment of key, known, risks including the likelihood that GoPNG reduces the allocation of public expenditure to the health sector and / or that systematic and widespread drug shortages continue. The Risk Register has also been substantially revised and updated to include more specific "implementation risks" (although it could be noted that the Risk Register template does not have that as a specific category). These implementation risks include, for example, the possibility that the Contactor does not have the capacity / incentive to manage an adaptive program; or does not have the capacity to attract and retain long term or short-term advisers with the expertise / skills to influence outcomes in PNG. The Risk Register also elaborates on other "implementation risks" including the possibility that DFAT itself at Post is not resourced sufficiently in terms of numbers, or specific skills, to manage an adaptive program; and / or that PATH does not deliver value for money to DFAT.
Safeguards need to be assessed and updated in the design.	**Agreed.** See revised text in Annex 9 for actions to be completed within the first 3 months of PATH inception period. See also the revised Safeguard Screening tool which upgrades the risk rating for child protection before treatment to "high" and elaborates on the treatment options. Recommendations provided at the peer review on environmental protection and health and safety have all been reflected in the revised Safeguard Screening tool and Risk Register.
Ensure the design has an Environmental and Social Management Framework and a Child protection risk assessment, if not during design then during the 0-3 month inception phase.	**Agreed**. The Child protection risk assessment plan will now be done in the first 3 months (rather than first 6 months) of PATH (see Table 4 of the Statement of Requirements). The nature of the child protection risk assessment has also been made clearer and more explicit in terms of the content and risks involved (see revised clauses 8.22 and 8.23 of the SoR). Two new clauses (clause 8.24 and 8.25 of the SoR) have now been included to specifically refer to the DFAT Environmental and Safeguards Policy.
Under health and safety, consider the disposal of medical waste, and any asbestos issues in local health clinics/hospitals.	**Agreed.** See additional text on the Workplace Health and Safety Plan (currently page 13 of the revised Statement of Requirements)

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Risk management' is a notable absence from Table 1 in Annex 3 which sets out the roles and responsibilities of program partners by function. Although it is clear from the preceding text that the Steering Committee is responsible for acting on risk as part of the annual planning process, detail about who will manage activity-level risks and the need for DFAT to perform a quarterly review of investment level risks would strengthen the risk management narrative.	**Agreed in part.** Risk Management is now a separate section at the end of Table 1 in Annex 3 (Roles and Responsibilities) and this spells-out the broad responsibilities for monitoring and managing risk between GoPNG, DFAT and the MC. However, we do not think it is practical – but more importantly desirable – for the design team to try and specify at this stage who, at an individual level, will be responsible for monitoring and managing particular risks. That is better done in the case of DFAT as a result of the proposed Establishment Review that DFAT should undertake to assess the numbers of level of staff required to manage an adaptive program like PATH. The revised text in Annex 3 also explains that the MC itself is in the best position to identify what particular risks each individual member of staff is responsible for monitoring and managing. We note the suggestion of a quarterly review. Table 1 in Annex 3 has now been written to say: "While the Annual Plan should be the more formal and systematic assessment of the MC's risk management plan, it would be prudent for DFAT to also discuss and review overall risks with GoPNG and the MC at more regular intervals including quarterly review meetings if they are introduced."
Broadly, the risk register has been done well. A few things to review include 1. Have all key risks been identified and included in the risk register, particularly when considering assumptions underpinning the Program Logic as identified in the Annex 2 Program Logic? 2. The first risk event which is, 'there is a decrease in the PNG government health budget', is stated to be caused by a 'decrease in GoPNG revenue'. Is this the only source for this risk event? As the design acknowledges health financing is volatile, so is it possible that other	**1.Yes**. The risk register has been substantially reviewed and revised. **2. Agreed in part.** We think that, given the history to date, and the increasingly challenging outlook for the overall PNG economic environment, it is more accurate and more helpful to keep the risk of a decrease in the PNG government health budget as a separate, stand alone, risk. That is because the likelihood of a further decrease in the health budget - at least in real (adjusted for inflation) per capita terms – is already assessed as "almost certain" in the Risk Register. However, we do not think that "almost certain" risk should be conflated or confused with other risks that affect GoPNG budget allocations to the health sector which

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sources of risk relating to the overall health budget may also include, 'a change in GoPNG policy', 'a redirection of funds' etc. The design team should consider whether all risk sources for all risks have been identified as doing so is the best way to determine what needs to be controlled/treated – this includes system crises i.e. HR/workforce vacancies/service closures, and availability of pharmaceuticals.	have, in our view, much lower probabilities of occurring and different impacts. For example, the Risk Register acknowledges under the "Political" heading (see row 14 in the Risk Register) that GoPNG decisions could lead to changed priorities in the health sector. However, we judge that and similar risks to be "unlikely" for the reasons explained in the Risk Register. The revised Risk Register is now much more explicit and expansive in terms of the possible impact of and options to manage risks such as HR vacancies (either in the PHA / GoPNG system or vacancies that the MC itself may face in trying to recruit key staff) and the risk of drug shortages.
3. The fraud-fiduciary line may be strengthened by referring to the Fraud Control Toolkit as it articulates DFAT's requirements and expectations of its partners who manage and deliver programs on behalf of DFAT.	3. Agreed. The Roles and Responsibilities (Table 1 of Annex 3) discussion of risk management now includes a specific reference to the Fraud Control Toolkit as does the Risk Register (see revised cell 13 M of the Risk Register). The Statement of Requirements has also been revised at clause 8.12 (e) so that it requires the Contractor when preparing its Program Operations Manual to include "a Fraud, Safeguards and Risk Control Policy which incorporates how the program will be delivered in accordance with the DFAT environment and social safeguards and fraud and risk policies. **The program Operations Manual will take into account and apply the DFAT Fraud Control Toolkit**." (text in bold has been added to reflect the suggestion in item3.
4. For the risk event, 'no significant increase in women's representation in management roles', how does the inherent risk rating 'very high' reduce to 'medium' when the stated control is fairly weak?	4. The explanation is as follows. The PATH design specifically and intentionally elevates "Women in Leadership" to a specific intermediate outcome (IO 1.3) to give that theme focus and visibility. The "drivers" including evidence, learning and dialogue, but also problem driven bottlenecks which also enables PATH to identify specific barriers to the better engagement of women and the socially excluded from decision making. The extended time frame of PATH (5 years plus an option of a further 3 years, for a total of 8 years) provides sufficient time to achieve the stated outcome of "more women in management roles influencing policy....."
5. Risk number 9 is missing a timeframe for implementation	5.Agreed. As this is a longer-term issue, the timeframe in Column O of the Risk Register now reads "The PATH design specifically and intentionally elevates "Women in Leadership" to a specific intermediate outcome (IO 1.3) to give that theme focus and visibility. The "drivers" including evidence, learning and dialogue, but also problem driven bottlenecks also enable PATH to identify specific barriers to the better

DFAT/Stakeholder Comments/Questions	Design Team Responses
6. Safeguards need to be assessed and integrated into the design – see the attached comments from the safeguards section	engagement of women and the socially excluded from decision making. The extended time frame of PATH (5 years plus an option of a further 3 years, for a total of 8 years) provides sufficient time to achieve the stated outcome of "more women in management roles influencing policy.....". The last sentence has been added to make that point clearer. 6. Agreed. The Safeguard Screening and the Risk Register have been revised to reflect the comments made with respect to Safeguards.

CHS COMMENTS	
If PATH is working on selected provinces, need to align with effective PHAs and those where HSSIP and CHS have already invested – should note these e.g. Eastern Highlands (for CHS's PNG IMR support)	Agree in part. The PATH design sets out on page 15 the suggested criteria for selecting provinces. This includes "established history of Australian engagement in the health sector of that Province" which covers the point made. We would expect PATH would work in those provinces mentioned by CHS given the investments to date and the importance of health security to both Australia and PNG. However, the actual final selection of the provinces is something that only DFAT and GoPNG can do, taking into account broader political and diplomatic criteria, and the overall budget envelope. The PATH design cannot be too prescriptive on this. It can be argued that the bilateral program determines the geographical priority and CHS as a regional program should work to align with this, not the other way around. We understand that any decision about selected provinces will be partly determined by the DFAT Subnational Strategy which is currently being drafted.
If Program Logic IO2.3 Health Security focuses on lab performance, TB & malaria detection and treatment and other priorities identified in JEE (tbd), this will determine the other PHAs e.g. Western Province, NCD (for CPHL), might as well state this and then method by which we'll determine any other PHAs to support. Will we	As explained, this will be for DFAT and GoPNG to finalise. The design team envisages that it would be a mix of Provincial performers, given the need for DFAT and GoPNG to balance a number of competing factors when considering the final choice of provinces.

CHS COMMENTS	
just support best performing, those we're already funding, poor performers or a mix	
Which PHA's already getting best GoPNG funding flows? Consider further support for these and use their staff to mentor less functional PHAs.	**Suggestion noted.** In the time available since receiving this suggestion on 3 September we have not been able to assess which provinces receive the best GoPNG funding flows. The idea of funding those provinces that already receive the most funding would need to be reviewed very carefully as it (i) would almost certainly involve DFAT contributing to financial inequity between provinces, at least in the short to medium term (ii) may not necessarily then lead to lessons for other provinces as there may be other bottlenecks and issues that are inhibiting their reform other than "just" financing (iii) involve important 'missed opportunities' in poorer resourced provinces where there may be even more useful lessons for other provinces that can be adopted and scaled up, even without large financing. The PATH suggestion for more women in leadership, more operational research on relieving specific bottlenecks, more joint supervision and outreach visits etc could be common problems facing many provinces where reforms could be made without necessarily involving large financing flows.
GESI – Should be careful of what are realistic indicator targets for women in decision-making roles i.e. baseline (7% female executive level managers and 18% female senior level managers in National Public Service) moves to what in 5yrs? We'll be working in Provinces anyway, so need provincial baselines.	**Agreed in principle.** However, the Intermediate outcome for IO 1.2 has been worded so to achieve "more women in management roles". This wording intentionally does not involve a specific numerical target to be achieved so as to avoid unrealistic targets. But the narrative text of the IDD also makes it clear that the MC (and GoPNG) are not to then simply "game the system" by having some small, token, indicators and achievements. Real reform is required: what the actual numbers will be will depend upon the provinces chosen etc. The indicative outputs already specifically suggest in Annex 2 that a first action point for the MC should be that "Baseline study of women in leadership roles conducted, including constraints to increasing numbers".
Annex 10 – Summary of DFAT investment in PNG Health does not mention any CHS investments?	**Noted and agreed.** Annex 10 was provided by the Post. We request the Post to update it as the Post is in the best position to know what the latest situation is.
Section C Strategic intent: PATH complements DFAT's other PNG Health Investments – How	**Agreed.** The following text has now been included in Annex 4 on MEL:

CHS COMMENTS	
will MEL align with CHS MEL – i.e. via country plans and how will this be reported to show coordinated overall aid to PNG?	"ensuring that the MEL complements, but does not duplicate, other M&E systems: especially those that DFAT itself manages. For example, the MC for PATH should make sure that the approved MEL aligns with and does not create gaps or duplication with M&E on health security issues that are already be monitored in PNG by the DFAT supported Centre for Health Security"
Chart 4 p 31: This is from 2013 but discussions in the Centre had us wondering if PNG result is based on 2009 World Bank data, so it may be a bit old and data source should be checked and if that old that should be noted. Apparently, there were quite a few midwives trained earlier this decade which may not have been included and may make the PNG result look slightly better. Worth a check anyway	Noted. The Chart on health worker distribution is used - and we suggest is retained - because it is the latest available chart that we sought, and received, from the UTS/WHO Collaborating Centre on Nursing Midwifery and Health (i.e. the most authoritative source) that compares PNG to other countries. We are not aware of any other similar comparable update. We have however now inserted a sentence below the graph in the IDD saying "It is worth noting that PNG has trained more midwives since this data and graph was prepared. However, we use this graph, despite it being a little dated, because it is the latest graph that the design team is aware of that provides comparable data on health worker density to other countries"
JEE's will produce a number of specific recommendations and may create expectations for support but also opportunities for useful activities and PATH could build in some flexibility in anticipation of this	Agreed. That is one of the reasons why an adaptive program is particularly suitable to PNG. Having said that, DFAT and GoPNG will need to judge including any new activities that emerge from the JEE alongside other priorities that emerge from other areas in PNG (and indeed from DFAT itself). The IDD has been changed in Annex 2 to now read as follows: "It is possible that the Joint External Evaluation (JEE) will produce a number of specific recommendations which may create expectations for support but also opportunities for useful activities. PATH, being an adaptive program, has the capacity to respond. However, such decisions should be made by DFAT (and GoPNG) in the context of the governance arrangements for PATH and in particular the Annual Plan process where all requests and opportunities can be assessed and then prioritised in the light of budget and other resources".
Not quite clear where rationale for lab support comes from in design and if from CHS scoping studies, could make this clearer.	Agreed. We now include the following text in the revised IDD. "Laboratory support is part of the overall response to health security because it is a necessary (but admittedly not sufficient) condition and strategic investment to making progress on health security. Without better laboratory support, PNG - and its development partners - will not have the evidence base to track trends and so prioritise the use of scarce

CHS COMMENTS	
	resources. Laboratory support is also specifically referred to because PNG is currently unlikely to be able to improve laboratories easily or in a timely fashion by themselves given their existing financial and human resource constraints. That means that DFAT (and other development partner) support is potentially well placed to add strategic value; be a catalyst for change; and shorten the time period by which PNG can reach IHR status. "

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