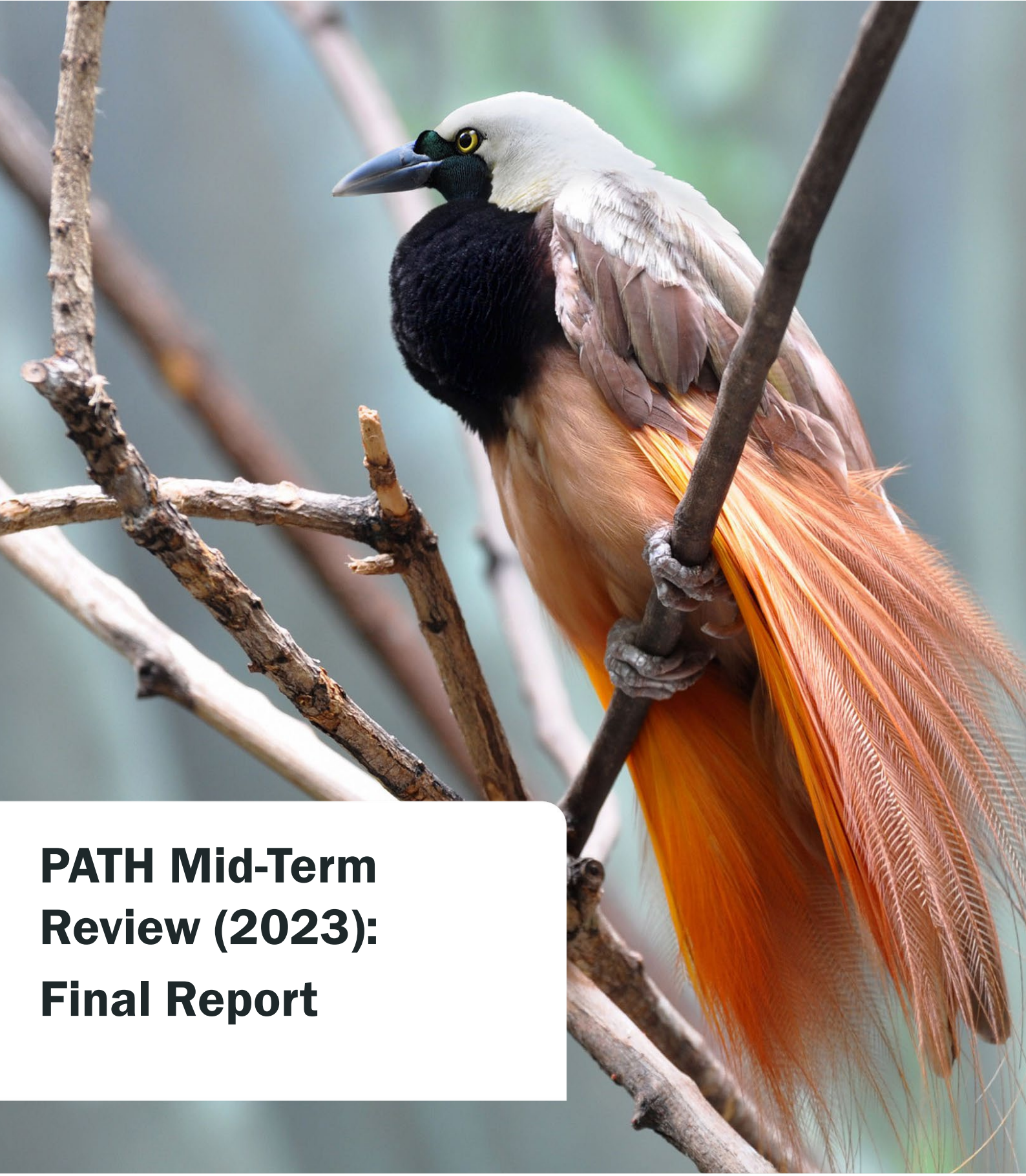


PATH Mid-Term Review (2023): Final Report

Human Development Monitoring and Evaluation Services

April 2024

Papua New Guinea–Australia Transition to Health (PATH) Mid-Term Review (2023)

Final Report

Document review and authorisation

Version	Date distributed	Issued to	Comments
Version 1.0	8 March 2024	Jason Court	1st Draft of Report
Version 1.1	23 March 2024	Jason Court	1st Draft of Report with amended Recommendations
Version 1.2	9 May 2024	Jason Court	Final Draft of Report

Key information	Details
Author(s)	Mary Larkin, Beth Elson, Tony Kiessler
Reviewer(s)	Liesel Seehofer, Laura Rachel Naidi, Sarah Leslie
Submission date	8 March 2024
Reference no.	–
Disclaimer	This document has been produced with information supplied to Human Development Monitoring and Evaluation Services (HDMES) by the specified sources/data collection methods. While we make every effort to ensure the accuracy of the information contained in this report, any judgements as to the suitability of the information for the client's purposes are the client's responsibility. HDMES extends no warranties and assumes no responsibility as to the suitability of this information or for the consequences of its use.

Contact details

Details	Human Development Monitoring and Evaluation Services (HDMES)	Australian High Commission (AHC)
Name	Liesel Seehofer	Ramez Alhazzaa
Job title	Monitoring and Evaluation Specialist (Health)	First Secretary, Health
Telephone	+675 7033 1561	+675 7200 7850
Email	Liesel.Seehofer@hdmes-png.com	Ramez.Alhazzaa@dfat.gov.au

Contents

Abbreviations and Acronyms

Term	Definition
ADB	Asian Development Bank
AHC	Australian High Commission [Port Moresby]
AIHSS	Accelerated Immunisation and Health Systems Strengthening
AMTWP	Adaptive Management and Thinking and Working Politically
ARoB	Autonomous Region of Bougainville
BDoH	Bougainville Department of Health
CCHS	Catholic Church Health Services
CSO	Civil Society Organisation
DAC	Development Assistance Committee [OECD]
DFAT	Department of Foreign Affairs and Trade [Australia]
DQA	Data Quality Audit
EPS HSIP	Expanded Program of Support for the Health Services Improvement Program
EOIO	End of Investment Outcome
eNHIS	Electronic National Health Information System
FHO	Frontline Health Outcomes
GAVI	Gavi, The Vaccine Alliance
GBV	Gender-Based Violence
GEDSI	Gender Equality, Disability, and Social Inclusion
GESI	Gender Equality and Social Inclusion
GoA	Government of Australia
GoPNG	Government of Papua New Guinea
HDMES	Human Development Monitoring and Evaluation Services
HECS	Health Education and Clinical Services
HHISP	Health and HIV Implementation Services Provider
HIV	Human Immunodeficiency Virus
HPP	Health Portfolio Plan
HSIP	Health Services Improvement Program
HSSDP	Health Services Sector Development Program
ICT	Information and Communication Technology
IDD	Investment Design Document
IO	Intermediate Outcome
ISP	Implementing Service Provider
KPI	Key Performance Indicator
KRQ	Key Review Question
M&E	Monitoring and Evaluation
MC	Managing Contractor
MEDI	Monitoring, Evaluation and Data Initiative [PHA]
MEL	Monitoring, Evaluation and Learning
MELC	Monitoring, Evaluation and Learning Coordinator
MERL	Monitoring, Evaluation, Research and Learning
MERLA	Monitoring, Evaluation, Research, Learning and Adaptation
MIS	Management Information System

Term	Definition
MSPNG	Marie Stopes Papua New Guinea
MTF	Ministerial COVID-19 Vaccination Task Force
MTR	Mid-Term Review
NCC	National Coordination Centre for COVID-19
NDoH	National Department of Health
NGO	Non-Government Organisation
NHIS	National Health Information Service
NHP	National Health Plan
NOPS	National Orthotic and Prosthetic Services
OECD	Organisation for Economic Co-operation and Development
OIC	Officer-in-Charge
PAF	Performance Assessment Framework
PAS	Performance and Adaptive Systems
PATH	Papua New Guinea–Australia Transition to Health
PEPPI	PHA Embedded PATH Personnel Initiative
PF	Provincial Facilitator
PFM	Public Financial Management
PHA	Provincial Health Authority
PHASP	PHA Support Project
PHIO	Provincial Health Information Officer
PNG	Papua New Guinea
PPF	PNG Partnership Fund
PSC	Program Steering Committee
PSF	Partnering for Strong Families
PWD	Persons with Disabilities
RID-TB	Reducing the Impact of Drug-Resistant Tuberculosis in Western Province
SEM	Senior Executive Management
SGBV	Sexual and Gender Based Violence
SHWE	Strengthening Health Workforce Education in PNG
SLA	Service-Level Agreement
SLP	Sapotim Lida Project
SLSS	Saving Lives Spreading Smiles
SPAR	Sector Performance Annual Review
SRHIP	Sexual and Reproductive Health Integration Project
SRMNCH	Sexual, Reproductive, Maternal, Neonatal and Child Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
TMP	Trilateral Malaria Project
TOR	Terms of Reference
TWG	Technical Working Group
UN	United Nations
VFM	Value for Money
WHO	World Health Organization
WPHA	Western Provincial Health Authority

Executive Summary

Introduction

The Mid-Term Review (MTR) of the Papua New Guinea (PNG)–Australia Transition to Health (PATH) Program provides an impartial and external review of progress and performance of the PATH program to date. The MTR covers the PATH inception and implementation period, August 2020 to December 2023. It has assessed PATH's progress towards achieving its End of Investment Outcomes (EOIOs), and considered the appropriateness of management arrangements, the program design, and implementation approaches. The review focused on relevance; effectiveness; gender equality, disability and social inclusion (GEDSI); efficiency; sustainability; and monitoring, evaluation, research, learning and adaptation (MERLA).

Program overview

PATH is an AUD200 million investment funded by the Australian Government under the PNG–Australia Partnership for Development. PATH is intended to be a five-year investment with a possible three-year extension. Implemented by Managing Contractor, Abt Associates (Abt), PATH aims to work collaboratively with the Government of Papua New Guinea (GoPNG) to improve coverage of essential, inclusive, quality health services through effective and efficient program interventions. As one of the largest investments of the Department of Foreign Affairs and Trade (DFAT) in the health sector in PNG, PATH is expected to contribute to achieving the objectives of the Health Portfolio Plan 2018–2023 (HPP) of the Australian High Commission (AHC). PATH's focus on capacity building at the subnational level is intended to support the development of PNG's decentralised health system. As an 'adaptive program' it is intended to implement a flexible, responsive, evidence-based approach to strengthening systems for health service delivery, with a focus on maternal and child health, sexual and reproductive health, health security, and delivery of equitable, inclusive health services. Although PATH works across all provinces in PNG through the activities of the health project grantees, it has a particular focus on six demonstration provinces/regions, comprising the Autonomous Region of Bougainville (ARoB), and East New Britain, Morobe, Western, Western Highlands, and West Sepik Provinces, where it delivers targeted interventions to strengthen Provincial Health Authority (PHA) leadership and management, promote women in leadership, and support PHA capacity to plan, budget, deliver and coordinate health services.

Evaluation approach

The evaluation used a mixed methods approach, including a review of over 70 documents, interviews with 102 key stakeholders, and field visits to a PATH demonstration province and a comparator non-demonstration province. The Review Team analysed and synthesised relevant qualitative and quantitative data from documents and interviews to identify key themes. Triangulation between different data sources and stakeholders was conducted to ensure rigour, verify findings, provide multiple perspectives, and reduce the potential for bias. Analysis of data included causal analysis and process mapping, case study development and contribution analysis.

Findings of the review

Relevance – Key Review Question (KRQ)1

Alignment of the PATH design and implementation strategy with policy priorities

The PATH program design is strongly aligned with Government of Australia (GoA), GoPNG, and global health and development priorities, including the National Health Plan 2021–2030 (NHP) and its aim of 'leaving no one behind'. It reflects the transition towards a GoA and GoPNG partnership for

development, and supports DFAT's intention to move away from funding direct service delivery in PNG to supporting the GoPNG to use its resources more effectively and efficiently to deliver essential health services. The MTR found, however, that PATH's strategic direction remained unclear to key National Department of Health (NDoH) stakeholders. Furthermore, while recognising the disrupting effect of the COVID-19 pandemic on PATH's collaboration with GoPNG, the PATH Program Steering Committee (PSC) has not functioned as an effective mechanism through which GoPNG provides strategic leadership for the program. Meeting only annually, and without adequate information concerning the program, PSC members were unable to comment on PATH's performance.

Collaboration and coordination with health sector partners

Although PATH staff are engaging with health sector partners through NDoH-led national Technical Working Groups (TWGs), there was limited evidence of structured coordination and collaboration with other health sector partners to leverage additional support and engage in analytical work, as intended by the program design. An exception to this was the establishment of a COVID-19 taskforce, which saw PATH playing a key role in supporting national and provincial coordination of the pandemic response as part of the AHC response to the COVID-19 pandemic.

Relevance of key PATH program components

The MTR considered the relevance of key aspects of the PATH program design, including Adaptive Management and Thinking and Working Politically (AMTWP), transition to PHA management, and the selection of demonstration provinces. It found that:

- AMTWP added a layer of complexity and resource requirements to an already high-risk implementation context and, without a clear and established understanding of elements of the program, the proposed AMTWP approach contributed to the lack of a coherent direction.
- Although the concept of transition is supported by NDoH and PHAs, what it means in practice is still not widely understood by internal and external PATH stakeholders. Its elevation to a central organising principle for PATH also risks the program focusing on the alignment of DFAT investments to GoPNG systems, rather than sharpening PATH's focus on whether the program is achieving health outcomes.

Effectiveness – KRQ2

At the time of the MTR, PATH did not have an established Performance Assessment Framework (PAF), and Monitoring, Evaluation, Research and Learning (MERL) Framework, and there is little cumulative data available and no baseline against which to measure progress for most of the Intermediate Outcome (IO) and EOIO indicators in the PAF (see **Annex 5**). The MTR has therefore relied on qualitative data gathered through PATH documents and interviews conducted by the Review Team to respond to this KRQ. Changes made to bring clarity to the original PATH Program Logic, moving from an initial six to three IOs, were also taken into account. The current PATH Program Logic (May 2023) is shown in **Annex 1**.

Overall, the MTR found that PATH has produced some positive results under EOIO1, and continued the delivery of health projects under EOIO2. However, there has been underperformance across all IOs, and limited focus on aspects of PATH that could address some of the systemic barriers at PHA and national levels. As a result, the likelihood of PATH achieving substantial progress towards its EOIOs and transition by 2025 is weak.

IO1: PHA Leadership

There is evidence that PATH is gradually achieving some positive results under IO1, but the initial design intentions under this IO have not been delivered. PHA leadership capacity building activities were commenced at an early stage of the program but were disrupted, partly due to the COVID-19 pandemic and leadership changes, and have not been restarted. PATH support to PHAs is now largely focused on the operational level. Without a clear strategy and capacity building framework and due to varying PHA readiness, the effectiveness of PATH's interventions across PHAs have been variable. Some progress has been achieved under the PHA Support Project, particularly in relation to monitoring, evaluation and learning (MEL) capacity building at provincial and national levels (see case study provided in **Annex 7**). The work of PHA embedded MEL coordinators has been supported by the efforts of PATH's nationally based Performance and Adaptive Systems (PAS) team, in collaboration with NDoH and other key monitoring and evaluation (M&E) TWG stakeholders, to build MEL capacity within the health sector. It also highlights the importance of vertical alignment for the effectiveness of PATH's capacity building activities. However, despite progress in some areas, PHAs considered that the support provided by PATH was gap-filling rather than contributing to sustainable improvements in PHA capacity.

IO2: Sapotim Lida Project

Implementation of the Sapotim Lida Project (SLP) has been slower than planned and relationships between implementing partners were still being established at the time of writing the MTR report. Therefore, the MTR was not able to identify if specific results had been achieved. For PATH's approach to be successful, SLP needed to address all three levels of women in leadership in parallel. However, in practice, PATH and SLP took a sequential approach, focusing first on women leaders in PHAs, and investing minimally in building community empowerment and leadership to hold providers to account. Interviewees reported that SLP does not work across the PATH portfolio; for example, the project does not yet engage directly with PATH grantees, despite acknowledgement of the opportunity to use their reach into communities to further the broader leadership ambitions of the SLP strategy. To match the ambition of the design, and the size of budget allocated to it, the roll-out of SLP should have been at more advanced stage by the time of this review.

IO3: Healthcare Workforce

Delivery of essential health services under this IO is producing PATH's most concrete and measurable results. PATH's Frontline Health Outcomes (FHO) and Health Security projects have contributed to the achievement of the HPP outcomes and are delivering essential health services in target provinces. However, PATH has not demonstrated that it can 'value add' to those projects. There is little sign of using evidence from PATH service delivery projects to 'influence' PHA performance as intended by the PATH design. Similarly, testing and scaling up models of inclusive equitable health care to support PHA delivery of more effective health services for disadvantaged groups has not been pursued. PATH's new IO3, with its focus on ensuring that healthcare workers 'are performing mandated functions for targeted diseases/supports'[1] appears to set a new direction for the program that PATH and many of its grantees are not equipped to deliver.

Has the PATH model supported effective health system strengthening and health service delivery?

PATH was designed to use an adaptive management approach to develop, test and take to scale strategies to determine how it would reach the program goals and outcomes. 'Drivers of change' that 'go beyond traditional technical solutions to aid problems' were to be used to achieve progress

[1] As described in the PATH PAF – 23042023 PATH PAF_final to AHC.

towards IOs and EOIOs[2]. The original PATH drivers comprised: 'the proactive use of evidence, learning and dialogue; addressing problem-driven bottlenecks; leveraging partners; targeted national-level support; and responding to emerging priorities'[3]. Key features of the PATH design that were considered to differentiate the program from the preceding PNG Partnership Fund (PPF) and Health and HIV Implementation Services Provider (HHISP) were a clear, specific, and 'outcome-oriented approach to gender equality and social inclusion', a stronger focus on supporting PHAs to deliver essential health services and strong program monitoring and learning to drive program development.

The MTR found that many of these approaches were either not established or not delivered. This was due to a range of factors, including instability in program leadership, severe disruption due to the COVID-19 pandemic, and a lack of a vision to bring cohesion to the various program components. Without a practical understanding of program objectives, and an agreed vision of what success would constitute for the program, PATH has faced difficulties in bringing program components together to deliver on the initial design objectives.

Without a solid strategy and a relationship of trust with the AHC needed to agree on a way forward for the program, the MTR found that there is little opportunity for PATH to initiate those approaches, or to achieve useful outcomes in the remaining program period. There was recognition among interviewees that PATH is largely focused on responding to service requests from the AHC, rather than operating as an adaptive program. Since late 2022, PATH has made efforts to address the silos and lack of communication between and within its workstreams, which have undermined the effectiveness and potential of the program. They include fortnightly cohesion meetings and plans to increase collaboration and coordination across PATH workstreams. However, this work commenced late in the PATH timeline and progress has therefore been limited. Further efforts are required to implement the structural changes to the program needed to achieve potential synergies and greater effectiveness.

GEDSI – KRQ3

PATH's GEDSI unit described its core functions as: targeted GEDSI investments (including the Sapotim Lida Project); mainstreaming GEDSI; and to support 'equitable health systems efforts' by working with implementing partners to strengthen their GEDSI and health equity progress[4]. During the Inception Phase, PATH reported how it had been mainstreaming 'strategies for GEDSI to deepen access and inclusion of the vast rural population, especially women, girls and persons with disabilities'. In practice, this work was carried out by the grantees and, apart from referring to the grantees' own progress reports, PATH lacked a systematic method for collecting data or feedback from them to assess their achievements in either GEDSI or health equity, or what further support may be required. Many of the grantees would have carried out this work anyway, as part of their mission. While PATH provided the resources for this work to continue, it is not possible to identify the added value that PATH delivered to enhance these endeavours. Furthermore, it has not been possible for the MTR to ascertain how much budget was allocated to these objectives. In summary, there is weak evidence that the GEDSI Strategy has been successfully implemented across PATH.

Efficiency – KRQ4

PATH reports that it is meeting selected Value for Money (VFM) criteria, but from a more substantive viewpoint PATH has been unable to demonstrate progress against the objectives for which it was

[2] Page 3, PATH Investment Design Document (IDD), DFAT, n.d.
[3] Page 3, PATH IDD, DFAT, n.d.
[4] Page 26, PATH Six-Monthly Report (January to June 2023) – Submission Date 28 August 2023.

established. The MTR found that the leadership of PATH significantly influenced the way that PATH was implemented, collaboration between key PATH stakeholders, and the extent to which PATH has used its resources effectively. PATH successfully managed its start-up and the transition of projects from the PPF and HHISP to the program. However, the MTR found that initial leadership of PATH was poor and key management systems were not established. The deficient performance of PATH, some of which was directly influenced by the COVID-19 pandemic, affected the AHC's trust in PATH's ability to deliver. This has undermined the partnership approach that is key to effective and efficient implementation of a development facility.

The MTR found that the PATH Managing Contractor (MC) did not ensure the type of standard management approaches used to establish a well-resourced and structured organisation were applied early in the program, indicating a lack of corporate accountability. The failure to do this contributed to excessive workloads and inadequate support for staff development, which exacerbated staff turnover and a lack of adequate staff skills and resourcing. Localisation of staff appears to be restricted to recruitment of PNG staff, without support for their professional development. Although some assistance has been provided by the MC to fill gaps in human resourcing, this has not been adequate to address organisational needs.

Current PATH leadership[5] is attempting to bring greater structure and effectiveness to the program, but recurring organisational challenges, including extended vacancies and lack of key program systems, remain barriers to progress. Weaknesses in management of projects are being addressed with additional resources for contract management, but grantees report that they are facing an increasing burden of compliance and reporting that affects efficient project delivery. In the view of the Review Team, given the challenges that PATH faces, progress appears to be occurring too slowly and partially to result in any meaningful changes before the next phase of the program.

Sustainability – KRQ5

PATH's main approach to achieving program sustainability is through a 'transition agenda'. However, PATH neglected to implement its initially-proposed approach to transition for much of the program period. With a revised strategic framework in 2023, PATH has a renewed focus on this objective. The program was beginning to roll out transition strategies at the time of the review, but practical pathways for its achievement are still to be defined. Furthermore, many aspects of the original PATH model are no longer being implemented and PATH's capacity building and health systems strengthening support has not provided the organisational foundation for transition. The likelihood is therefore low of substantial progress towards the ambitious capacity building objectives and the system-level changes needed to advance transition.

MERLA – KRQ6

PATH has struggled to convert its highly conceptual design to a clearly understood and accepted Program Logic. Over the first three years of the program, PATH was without an agreed Performance Assessment Framework, agreed indicators to guide measurement of program performance, and a baseline[6]. The challenges faced by PATH include IOs and EOIOs that are vague or not clearly defined, a lack of leadership and the management structures within PATH needed to support roll-out of an approved MERL Framework, inadequate resourcing for PATH's substantial MEL functions, and frequent turnover and extended gaps in the leadership of the PAS team. Without at least a clear and

[5] Commencing November 2022.

[6] Abt has confirmed (16 April 2023) that a revised PAF was accepted by the AHC at the end of 2023 and that this was used to produce the 2023 Annual Report).

agreed definition of program success and what PATH is expected to achieve, it is unlikely that a Program Logic and MERL Framework can be agreed.

The failure to establish the MERL Framework in the early stages of the program has had far-reaching effects. A functioning MERL Framework is central in the implementation of an AMTWP approach, to guide program learning, reporting and accountability. Consequently, PATH's inability to deliver reports to DFAT standards[7] has undermined its relationship with the donor. Without a MERL Framework to provide an organising framework, PATH has been unable to capitalise on the significant amount of health service data generated by grantees to describe its achievements. Bringing consistency to the great variety in how grantees report and the types of approaches implemented by grantees – and also how accurate data can be captured – are further challenges that PATH faces.

Summary of findings

While PATH has demonstrated some positive achievements, it has failed to deliver many elements of the original program design and is unlikely to achieve its IOs and EOIOs by the end of the program period.

The design of PATH was complex and highly ambitious, and the EOIOs did not clearly state the objectives to be achieved. Similarly, the purpose of some program mechanisms, such as drivers of change, and objectives and expectations regarding transition, were not defined. The lack of clarity around pathways to achieving IOs and the adaptive management approach added further complexity, and did not contribute to greater effectiveness, efficiency or responsiveness of PATH to its operating context. The AHC, PATH, and successive technical specialists have not yet brought clarity to the Program Logic and specifically what PATH aims to achieve.

NDoH and PHAs expressed their appreciation for the longstanding commitment and support provided by DFAT to the development of the health sector in PNG. However the MTR found that the PATH Program Steering Committee did not function as an effective governance mechanism or as a way of bringing together key stakeholders within GoPNG to provide direction to the program, a critical element of the PATH design.

The PATH program, overall, has not been implemented in an effective and efficient manner. Apart from the delivery of health services and health systems support via grants – many of which were in place prior to commencement of the program – substantial strategies for achieving proposed IOs have not been developed, were significantly delayed, or not adequately structured to achieve the design intentions.

PATH's successive failure to deliver has undermined the AHC's trust in PATH, necessary to the efficient operation of this model. The MTR found that the partnership between the AHC and PATH (including the PATH MC), which is central to the effective implementation of this model, was not collegial and cooperative, but more transactional.

The leadership of PATH for much of the program was inadequate and the MC did not ensure that standard management practices were implemented. The impact of COVID-19 seriously disrupted the program, including leading to gaps in senior management. Although the MC provided some additional operational support, it was not sufficient to address program needs. Current PATH leadership is attempting to bring greater structure and effectiveness to the program; however, key

[7] HDMES feedback on PATH January to June 2023 Progress Report, May 2023; HDMES feedback on PATH 2022 Annual Progress Report, March 2022; HDMES feedback on PATH 2021 Annual Progress Report, May 2023.

systems and processes, including a MERL Framework that should have been established during the inception to provide the foundation for the program, are not yet in place.

Recommendations

KRQ1: Relevance

Immediate term

- **PATH** to work with the AHC to improve functionality of the Program Steering Committee.
- **PATH** to develop, resource and implement a plan to strengthen coordination with NDoH, and other GoPNG and key health sector stakeholders. This could be included as an addendum to the Ways of Working document, but will need to include dedicating senior management focus required for effective engagement and communication with key health sector stakeholders.

Beyond PATH's initial phase

- **AHC** to examine:
  - alternative approaches for investment governance and coordination mechanisms that are more likely to achieve the intended partnership outcomes.
  - resources needed to sustain the effectiveness of these mechanisms.

KRQ2: Effectiveness

Immediate term

- **PATH** to document PHA Support Project practices (including PHA Embedded PATH Personnel Initiative (PEPPI), and Monitoring, Evaluation and Data Initiative (MEDI) projects), to identify positive approaches and evidence to guide future program activities.
- **Abt and PATH** to review the grantee performance management approach used by the FHO and Health Security teams, to ensure that it:
  - is focused on providing effective oversight and support to grantees to deliver quality health project and contract outcomes – and the teams are adequately resourced to do this.
  - does not impose unreasonable compliance and reporting demands that have the potential to undermine grantees' program delivery capacity.
- **PATH** to engage a full-time, senior health technical adviser to:
  - drive the program in developing technically sound program strategies and frameworks, including the program MEL framework.
  - assess the health technical needs across the PATH program, identify any additional program technical support needed, and provide related recommendations to PATH and the AHC.
- Reallocate a proportion of the **SLP** underspend to fund community health leadership initiatives, with the objective for women leaders to better advocate for their communities, to improve equitable and accountable services.
- The GEDSI Hub should be taken back under direct management by the PATH GEDSI team, to deepen their NDoH relationships where the hub is located, and thereby achieve the program's GEDSI, women in leadership, and equity objectives.

Beyond PATH's initial phase

- **AHC** to commission a redesign of the PATH program and re-tender for a subsequent phase of the program, addressing the same substantive objectives of PATH, but with a clearly defined Program Logic and strategies co-designed with key PHA and GoPNG stakeholders.

This includes a focus on:

- PHA capacity building that:
  - uses evidence-based approaches to government health sector capacity building
  - is adequately resourced
  - is implemented by agencies with demonstrated skills in conducting capacity building in the specific technical areas in the PNG context.
- Essential Services and Health Security components that:
  - have clearly defined health outcomes and a strategy to guide how this is to be achieved within the program
  - are oriented to implementing existing NDoH strategies in an effective, efficient and innovative manner
  - apply a supportive, quality-focused approach to performance management
  - have full-time, dedicated health and GEDSI technical assistance to provide oversight and effective support for quality improvement, learning and development.
- A reoriented Women in Leadership component that includes:
  - a major focus on community leadership, especially women, persons with disabilities (PWD), and marginalised groups
  - emphasis on co-designing public health and fostering accountability.

KRQ3: GEDSI

Immediate term

- **AHC/PATH** to allocate a portion of the budget underspend (e.g. SLP) for GEDSI mainstreaming activities for grantees.
- **PATH** to work in partnership with grantees and civil society organisations (CSOs) to develop activities for GEDSI-transformative approaches, especially gender-based violence (GBV), which simultaneously feed into other program goals.
- **PATH** to establish a mechanism whereby the GEDSI team can influence other parts of the program (e.g. through quality assurance of all activities that have been tagged as relevant to GEDSI; also through allocating budgets and tasks to grantees).

Beyond PATH's initial phase

- **AHC/DFAT** to include in the design scope of future programs:
  - When working with NDoH partners (such as National Orthotic and Prosthetic Services (NOPS)), a requirement to advocate for people with disabilities at the policy level and in the way community-level services are provided.
  - Efforts to stimulate community initiatives for targeted preventative campaigns, especially for childhood diseases that may lead to lifelong disability if untreated.

KRQ4: Efficiency

Immediate term

- **PATH** to seek suitable technical assistance to design and establish internal management and communication systems to improve program effectiveness and efficiency.
- **Abt Associates** to provide the necessary specialist support and resourcing to PATH to implement the above recommendation.

- **AHC** to review its approach to managing facilities and determine the resources needed to support this approach.

Beyond PATH's initial phase

- **AHC/DFAT** to include requirements in new investment agreements:
  - that the incoming MC: (1) conducts a workplace assessment and job analysis; and (2) uses this evidence to ensure investments are adequately resourced to deliver on their objectives
  - that the MC establishes a comprehensive capacity building framework and staff localisation policy during the investment inception period.

KRQ5: Sustainability

Immediate term

- **PATH** to complete the collection of transition baseline data from grantees and provide a summary report to the AHC detailing the current prospects and challenges relating to transition of grantee programs to PHA management.

  This can be used by the AHC/DFAT as input for the proposed assessment below.

Beyond PATH's initial phase

- **AHC/DFAT** to undertake through HDMES, or a third party, an examination of the concept of transition to clearly define, specifically and in practical terms:
  - what transition aims to achieve, who is to benefit and for what purpose
  - whether transition is an efficient, effective and appropriate development approach to achieving those outcomes
  - a mechanism through which such a process could realistically be achieved in the context of the health sector in PNG.
- **AHC/DFAT** to clarify their expectations concerning investment sustainability – what is feasible to achieve within the given timeframe.

KRQ6: MERLA

Immediate term

- **PATH and AHC** to decide on the approach to reporting against IOs and EOIOs in the final PATH Completion Report.

Beyond PATH's initial phase

- **AHC** to include in the design scope for a future program:
  - a structured but 'light touch' learning and adaptation approach as a core element to guide monitoring, partner collaboration and quality improvement
  - a structured and evidence-based capacity building framework to guide, implement and assess the results of capacity building activities conducted.
- **AHC** to commission an M&E specialist organisation to investigate and advise on options for (1) aligning grantee reporting with eNHIS/NDoH systems; and (2) a MERL Framework in any future facility-like investments.

1. Introduction

The Mid-Term Review of the Papua New Guinea–Australia Transition to Health Program provides an impartial and external review of progress and performance to date in implementing the PATH program. The MTR assessed PATH's progress towards achieving its End of Investment Outcomes and considered the appropriateness of management arrangements, the program design, and implementation approaches. The review focused on relevance, effectiveness, GEDSI, efficiency, sustainability and MERLA. The MTR covers the PATH inception and implementation period, August 2020 to December 2023.

1.1. Background

PATH is an AUD200 million five-year investment funded by the Australian Government under the PNG–Australia Partnership for Development. As an 'adaptive program' it is intended to implement a flexible, responsive, evidence-based approach to strengthening systems for health service delivery, with a focus on maternal and child health, sexual and reproductive health, health security, and leadership of women and people with disabilities. With adaptive management as its driving mechanism, the PATH model is intended to go beyond an administrative facility approach, by developing, testing and taking to scale evidence-based and locally tested strategies through which the EOIOs can be achieved.

Implemented by Managing Contractor, Abt Associates, PATH aims to work collaboratively with the Government of PNG to improve coverage of essential, inclusive, quality health services, through effective and efficient program interventions. Although PATH works across all provinces in PNG through the work of the grantees, it has a particular focus on six demonstration provinces/regions, comprising the Autonomous Region of Bougainville, and East New Britain, Morobe, Western, Western Highlands, and West Sepik Provinces. In these provinces it delivers targeted interventions to strengthen PHA leadership and management, and support PHA capacity to plan, budget, deliver and coordinate health services. By combining the individual grants with the PHA system strengthening in demonstration provinces, the intention was to enable PATH to maximise its impact and 'build the evidence base' to support more effective policy program implementation in PNG more broadly[8].

The PATH Program Logic is provided in **Annex 1**. PATH's two EOIOs are:

> **End of Investment Outcome 1:** Provincial Health Authorities (PHAs) more able to lead provincial health reform and manage effective, efficient, equitable and quality health services in selected provinces.
>
> **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.

The EOIOs are underpinned by three IOs[9]:

> **IO1.1: PHA Leadership:** Leaders and technical personnel in PHAs and the Bougainville Department of Health (BDoH) are performing mandated functions.
>
> **IO1.2: Women in Leadership:** More women in leadership positions are influencing health care decisions.

[8] Pages 2-2, PATH IDD, Department of Foreign Affairs (DFAT), n.d.
[9] According to the PATH Logic Diagram, final version 11 May 2023.

IO1.3: Health Care Workforce: Health care service delivery managers, practitioners and research personnel are performing mandated functions.

The PATH design (2019) outlined a model for health systems strengthening with a deliberate focus on various aspects of 'transition': moving away from a 'donor-recipient relationship' with the GoPNG to a bilateral partnership, and strengthening GoPNG capacity to lead the delivery of inclusive, integrated rural primary health care within a decentralised PNG health sector[10]. The merits of this approach will be explored through the KRQs, alongside the evolution and adaptation of the model in response to the demands of the implementation context (see section 4.2). There have been issues of continuity for monitoring the implementation and performance of PATH since inception, due to an evolving Program Logic and MERL Framework. A new Program Logic was finalised in May 2023.

1.2. Evaluation Purpose and Key Review Questions

The MTR is an important part of managing the overall performance of PATH and has considered implementation of the program from August 2020 to December 2023, results achieved to date, and highlighted key lessons to inform critical decisions going forward.

The purpose of the review is to:

- **Assess PATH's performance** in terms of relevance, effectiveness, efficiency, and approaches to sustainability, GEDSI, and MEL.
- **Make recommendations** on how PATH's implementation could be enhanced in its remaining time (to end of 2025) to efficiently and effectively meet its EOIOs and IOs, and for AHC beyond completion of PATH's initial phase.

The MTR focuses on the appropriateness and suitability of the PATH model and approach as Australia's principal investment for health sector support in Papua New Guinea. Noting the large number of projects implemented by PATH, the MTR is not intended to provide a comprehensive assessment of the performance of individual projects, several of which have been the subject of evaluations[11]. Rather, the main focus will be on assessing the performance of PATH as a delivery mechanism, using key achievements, challenges and lessons from individual projects as illustrative examples.

The MTR considers and reports progress against six KRQs, which are underpinned by sub-KRQs that provide the lines of inquiry for the review (see **Table 1**), examining PATH's performance from different perspectives.

[10] Page 2, PATH IDD, DFAT, n.d.

[11] Evaluations have been conducted for the Accelerated Immunisation and Health Systems Strengthening project (2023), Partnering for Strong Families project (2022), and Sexual and Reproductive Health Integration Project (2023).

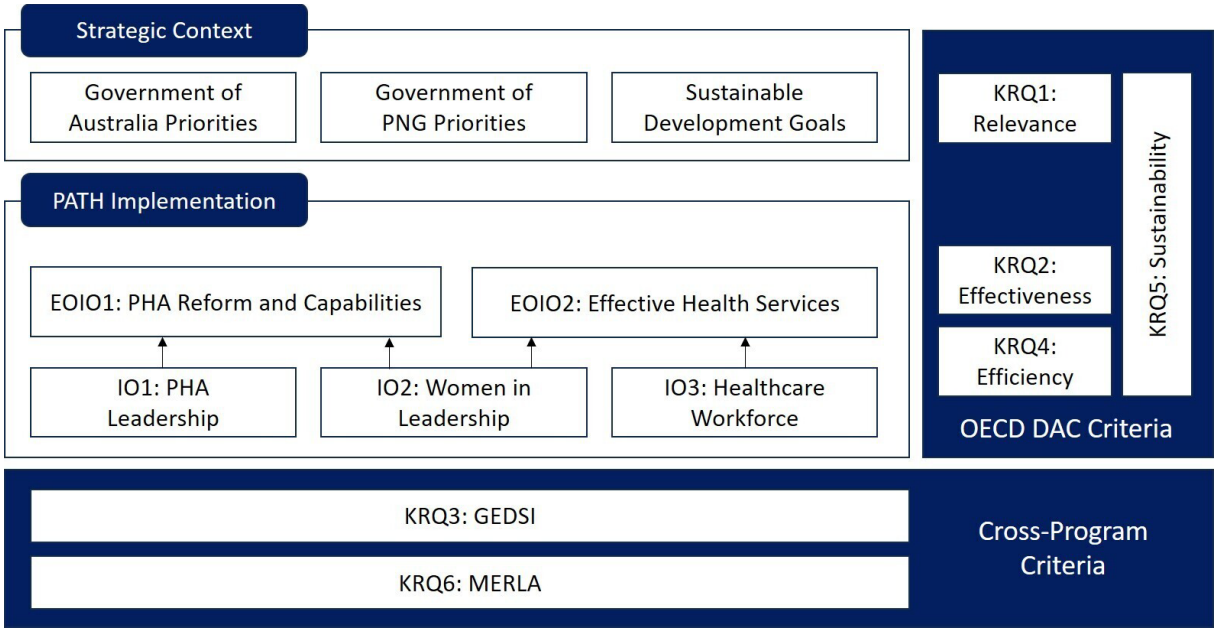
Table 1: PATH Mid-Term Review Questions

KRQ	Focus	Question
KRQ1	Relevance	To what extent are PATH's focus areas relevant to the PNG context, and aligned with Government of Australia and Government of PNG development priorities (including the Health Portfolio Plan and the new National Health Plan)?
KRQ2	Effectiveness	To what extent is PATH making progress towards its IOs and EOIOs, the broader Health Portfolio Plan's outcomes, and contributing to improved health outcomes?
KRQ3	GEDSI	To what extent is PATH adequately considering and addressing the needs of women and girls, people with a disability, and other marginalised groups?
KRQ4	Efficiency	To what extent is PATH being delivered efficiently in alignment with DFAT's value for money principles?
KRQ5	Sustainability	What have been the different approaches, achievements, challenges and lessons learned among PATH projects in embedding sustainability?
KRQ6	MERLA	To what extent are PATH's monitoring and evaluation arrangements fit-for-purpose, including M&E arrangements of key PATH activities delivered by grantees?

2. Methodology

The PATH program implementation and design, including the adapted Program Logic (developed in May 2023), was reviewed to assess performance, achievements and gaps. The Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) Criteria and DFAT M&E Standards (included in **Annex 2**) provided the normative framework for this assessment, while the DAC Gender Equality Standards have been used as a framework for assessing elements of PATH related to gender equality, as shown in **Figure 1**. This iterative analysis used qualitative and quantitative data, document review, and interviews with key internal and external stakeholders. Data was analysed to identify key themes, formulate findings, and draw out lessons on recommendations to support improved performance and evolve PATH's approach.

Figure 1: Conceptual framework for the PATH Mid-Term Review

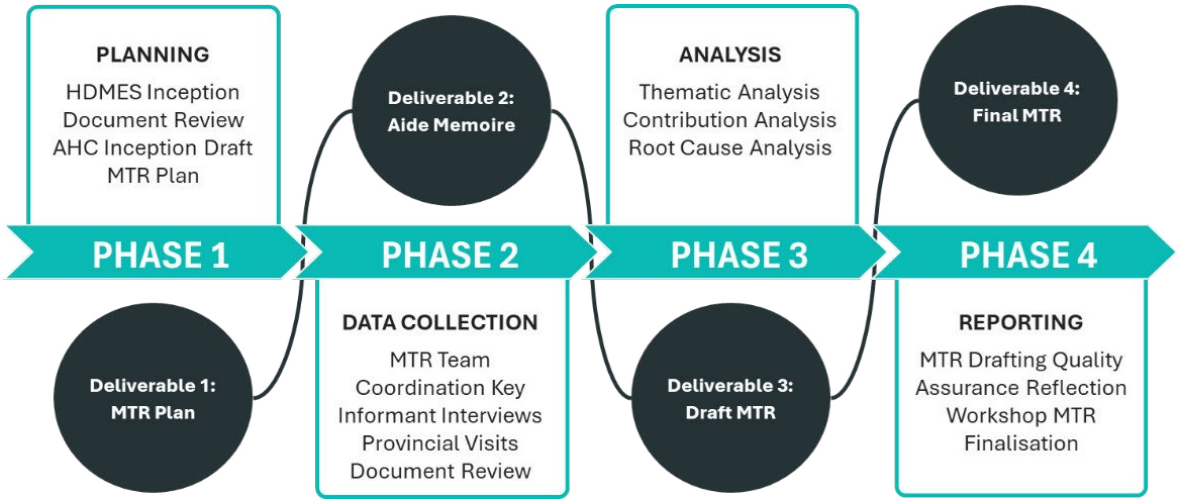


Due to a lack of program data, an underdeveloped program MERL Framework, and the absence of standard frameworks for key program elements such as capacity building, the MTR methodology that was initially proposed was simplified. The different stages and deliverables of the MTR are outlined in **Figure 2** below.

Comparative analysis was used to identify potential factors contributing to achievements in PATH intervention sites. Targeted case studies were developed to explore PATH's work in particular locations studied as part of the evaluation, and contribution analysis[12] was applied to assess the extent of PATH's contribution relative to other programs or factors for any achievements seen in these locations.

Preliminary review findings were presented to key AHC staff in an Aide Memoire presentation on 1 December 2023 to seek initial feedback. A subsequent summary presentation was provided to PATH leadership.

Figure 2: PATH Review Phases



Phase 1: Planning

Planning for the MTR involved a preliminary document review and development of the Review Plan. The KRQs proposed by the AHC provided the basis for sub-KRQs, which were used to identify lines of inquiry and data collection requirements, and to develop a methodology for the review. The MTR sub-questions are summarised in Section 4.2.

Phase 2: Data Collection

The data collection phase comprised both document review and analysis, interviews with identified key informants, and a focus on three provinces where PATH has implemented activities: two demonstration provinces and a comparator. Provinces were selected by the Review Team in consultation with the AHC to include a mix of contexts and support a comparison between demonstration and non-demonstration provinces. Members of the Review Team (Team Leader, Health Systems Specialist, and Organisational Capacity Specialist) conducted in-country data collection in November 2023. The GEDSI component of the review was based upon the modified application of the HDMES GEDSI Toolkit, and interviews were predominantly conducted remotely by the GEDSI Specialist with in-country support from other Review Team members. The Review Team

[12] Better Evaluation. (2022). *Contribution analysis*. [Web page updated 2 November 2021]. https://www.betterevaluation.org/methods-approaches/approaches/contribution-analysis

provided regular updates to the AHC and sought guidance on emerging issues in regular meetings conducted during this phase of the review.

Literature Review

The Review Team analysed and synthesised relevant documents against the sub-KRQs. This included documents related to the PATH design and strategies, implementation, performance and results; and also literature related to approaches used by the program. Existing qualitative and quantitative data and gaps were identified, and triangulation across different sources (including the eNHIS) was performed. A list of key documents reviewed is outlined in **Annex 3**.

Key Informant Interviews

The Review Team undertook semi-structured interviews with key stakeholders, summarised in **Table 2** below. Approximately 102 interviews were undertaken. Interviews with key stakeholders were conducted to further understand the PATH design and the way that PATH was implemented across the program period; and to investigate strategic and operational issues related to program performance. Interviews were conducted face-to-face and remotely, using electronic conference media (Teams, Zoom, and Webex). A list of key stakeholders interviewed is provided in **Annex 4**.

Table 2: Number of interviews conducted by stakeholder group

Stakeholders	Interviews
National level	**77**
AHC	14
Abt Associates	6
PATH Program (current and former)	32
Implementing Service Providers (ISPs) and PNG health sector stakeholders (Burnet Institute, Marie Stopes PNG, University of Technology Sydney, Health Services Sector Development Program, World Health Organization, and HPP Design team)	20
Steering Committee	5
Provincial level	**25**
ARoB	4
East Sepik	14
Western	7
Total interviews	**102**

Phase 3: Analysis

Data analysis was iterative, using data collected through document analysis, interviews and health sector reporting to draw reasonable conclusions about PATH's contribution to the sector and program-specific results. Triangulation between different data sources and stakeholders was conducted to ensure rigour, verify findings, provide multiple perspectives, and reduce the potential for bias.

The analytical approaches in this review included:

- **Thematic analysis:** Data was mapped against KRQs to identify key themes and assess program performance against objectives. Analysis was focused on seeking data-driven responses to the sub-KRQs that underpin the review.

- **Causal analysis and process mapping**: The review used process and causality mapping to understand program changes over time and the contribution of various factors contributing to identified outcomes.
- **Case study*:*** A case study methodology was used to highlight specific positive program achievements that are attributable to PATH.
- **Contribution analysis*:*** A basic contribution analysis was undertaken of PATH achievements. Issues explored using this methodology were identified through program interviews. Additional in-depth interviews with key informants were conducted to collect data for the analysis. Contributions were explored in the context of quantitative data from eNHIS and other sources to contextualise results. This informed an overall contribution rating based on a rubric.

2.1. Ethical Considerations

The evaluation complied with DFAT policies and standards for the conduct of ethical research, and was conducted according to the Australian Evaluation Society's Guidelines for the Ethical Conduct of Evaluations and the Code of Ethics. The Review Team sought informed consent from all evaluation participants prior to undertaking interviews. Data has been stored in a secure manner to maintain confidentiality, and all data used in the report has been de-identified.

2.2. Limitations

Responding to the KRQs required assessment of broad areas of activity across PATH's complex design and delivery context. Preliminary document analysis and interviews highlighted the lack of a completed MERL Framework, Performance Assessment Framework, and program baseline. Program data was not collected at the EOIO or IO levels over the program implementation period. This was a serious limitation to the assessment of program performance. In the absence of key performance information, the MTR has largely relied on qualitative data collected through multiple stakeholder interviews to respond to this area of inquiry and to 'tell the story' of PATH.

Extended periods with lack of a clear structure, plan, or framework to guide implementation and assessment of some key elements of the program, such as PHA Capacity Building, also led to challenges in assessing performance of individual PHAs and comparing performance between PHAs. Aspects of the proposed MTR methodology have been amended as a result of these and other gaps in the program M&E frameworks and available data.

PATH is a large and complex investment, with program activities implemented in all provinces in PNG, including the six demonstration provinces. The collection and analysis of data by the Review Team was necessarily restricted by resourcing and time constraints. Detailed assessment of PATH Frontline Health Outcomes projects was outside the scope of the MTR; however, interviews with FHO stakeholders and previous evaluations of PATH FHO projects[13] informed this aspect of the review.

A further complicating factor was the delayed access by the Review Team to key PATH documents. While all attempts were made to ensure that selected key informants and focus provinces were suitably representative of the broader PATH program, it is nevertheless inevitable that the review has not captured all relevant experiences of PATH internal and external stakeholders.

[13] Evaluations included: AIHSS project (2023), PSF project (2022), and SRHIP (2023).

3. Findings

3.1. Key Review Question 1: Relevance

To what extent are PATH's focus areas relevant to the PNG context, and aligned with Government of Australia and Government of PNG development priorities (including the Health Portfolio Plan and the new National Health Plan)?[14]

Summary: The PATH program design is strongly aligned with GoA, GoPNG and global health and development priorities and good practice. In particular, it reflects the intention to advance the partnership between the GoA and GoPNG. The MTR found that the PATH Program Steering Committee, which was the key mechanism for program governance and accountability to the GoPNG, was not effective. Engagement between PATH and its GoPNG counterpart agency, NDoH, was weak. Although PATH personnel engaged in Technical Working Groups, PATH was weak in the coordination and collaboration with other health sector partners that was intended to leverage support and enable PATH to engage in analytical work. Despite this, PATH's establishment of a COVID-19 taskforce in response to the AHC's request for support to the COVID-19 response resulted in PATH supporting national and provincial pandemic coordination.

This section also considered the relevance of some key aspects of the program design, including Adaptive Management and Thinking and Working Politically, transition, and the selection of demonstration provinces. The appropriateness of an AMTWP approach is questionable in the context of such a large and complex program, operating in a high-risk context. Furthermore, the appropriateness of elevating the concept of transition to a central operating principle is questionable, with concerns it places focus on effective DFAT programs rather than on delivering improvements to the PNG health sector.

SQ1.1 How well is PATH advancing Australia's, PNG's and global health priorities?

PATH alignment with GoA and GoPNG and global health and development priorities

The PATH program design cuts across a broad range of GoA, GoPNG and global health and development priorities (as shown in **Figure 3**). A central purpose is to contribute to the 'transition agenda' described in the AHC's HPP for PNG. As such, it is intended to support a partnership between the Government of Australia and the Government of PNG, rather than a donor-recipient relationship. Accordingly, as outlined in the HPP, it is intended that the GoA will support the GoPNG to use its resources more efficiently and effectively, rather than funding third parties to provide direct service delivery[15]. PATH's EOIO1 and EOIO2 are also meant to contribute directly to the objectives and the three outcome areas of the HPP[16].

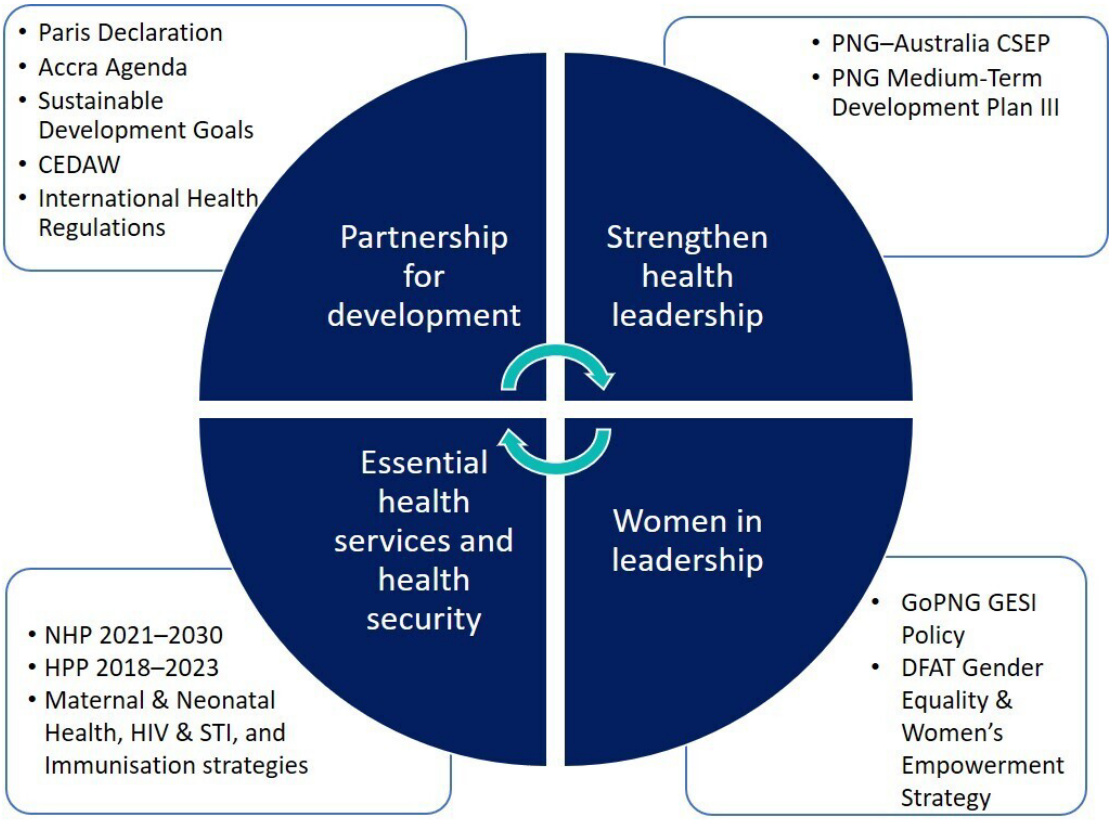
These objectives are aligned with the Papua New Guinea–Australia Comprehensive Strategic and Economic Partnership (CSEP, 2020), and the objectives of the GoPNG Medium Term Development Plan III (2018–2030)[17]. At the international level, supporting the autonomy of GoPNG for service delivery is aligned with the objectives of the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008).

[14] Relevance (DAC criteria): 'The extent to which the intervention objectives and design respond to beneficiaries', global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change'. Better Criteria for Better Evaluation, p.7.
[15] Pages 32 and 52, Health Portfolio Plan 2018–2023, DFAT.
[16] PATH Investment Design Document, n.d.
[17] Version modified 15 February 2022.

With its main focus on supporting PHAs to deliver on their mandate to manage effective subnational health service delivery, a key intention of PATH is to promote the PNG health sector decentralisation agenda – a further aspect of the 'transition' to be supported by PATH – and to strengthen PHA governance.

The EOIO focuses on improving PHA capacity to deliver effective, efficient, equitable and quality essential health services, and also potentially aligns with the overarching GoPNG and global objectives of Universal Health Coverage.

Figure 3: Alignment of PATH key program themes with health and development policies



This objective and PATH sub-projects are broadly aligned with the goals of the National Health Plan, and are intended to assist GoPNG with its priorities to meet its commitments to deliver against the Sustainable Development Goal (SDG) targets. Through its Frontline Health Outcomes projects, PATH supports elements of the Maternal and Neonatal Health Strategy (through Partnership for Stronger Families (PSF)), the National STI and HIV Strategy 2018–2022 (through Sexual and Reproductive Health Integration Project (SRHIP)), and aligns with the National Immunisation Strategy (through Accelerated Immunisation and Health Systems Strengthening (AIHSS)). PATH is also intended to assist PNG to meet its commitments under the International Health Regulations, through its Health Security workstream (Trilateral Malaria Project (TMP), Tuberculosis (TB) projects, and COVID-19 project).

Equitable access to health services is at the heart of the PATH program and is intertwined with GEDSI goals. This supports the goal of the NHP to have 'strengthened primary health care for all, and improved service delivery for rural majority and urban disadvantaged'[18]. This not only relates to

[18] Page vii, GoPNG, National Health Plan 2021–2030. Volume 1 Policies and Strategies.

ensuring service delivery meets the needs of women, girls and people with disabilities, it also highlights the importance of designing and delivering services in an equitable way.

Leadership by GoPNG

The PATH Program Steering Committee, jointly chaired by the AHC and NDoH and involving representatives of GoPNG central agencies[19], is the peak program governance body and a key mechanism for promoting GoPNG ownership, setting PATH's strategic direction and realising the partnership approach[20].

The review found that the PSC has been only partially successful in facilitating the involvement of key GoPNG stakeholders in decision-making concerning the PATH program strategy. This was partly due to the disruption of COVID-19 and lack of continuity in attendance of GoPNG representatives at PSC meetings, but was also hampered by poorly organised meetings and provision of lengthy, unclear reports. PATH has attempted to enhance PSC member engagement, through activities such as joint visits of PSC to demonstration provinces; however, regular and strategic collaboration and coordination with these key stakeholders is still weak.

GoPNG members of the PSC who were consulted as part of the review generally expressed support for the higher-level objectives of PATH to support PHA capacity building and health service delivery. Nevertheless, the key concept of transition and why this was a priority for DFAT was not well understood. It was also unclear to these key stakeholders how PATH had realised and performed against its objectives, including the extent to which it had contributed to relevant population health outcomes. NDoH key stakeholders expressed a concerning absence of engagement by PATH with their offices, and were unaware of PATH's activities or program direction. It was therefore difficult for a number of those interviewed to comment on program relevance or the extent to which PATH had advanced GoPNG development objectives.

SQ1.2: How is PATH meeting specific PNG health and development needs and complementing other development partner programs (including Global Fund, Gavi, United Nations, Asian Development Bank, World Bank, and USAID).

As one of DFAT's largest investments in the health sector in PNG, it was expected that PATH would use its influence to engage with major donors, health agencies and programs; and explore opportunities to promote common objectives. The Review Team found several examples of alignment between the work of PATH and other donors:

- PHA Support Project staff, particularly Monitoring, Evaluation and Learning Coordinators (MELCs), have supported health facilities and provincial staff to effectively use the electronic National Health Information System (eNHIS). Although not necessarily providing strategic inputs, by emphasising the importance of reporting, providing training, and ensuring that equipment is functioning, they are assisting to bed down this important Asian Development Bank (ADB)/DFAT national health system investment in demonstration provinces.
- The AIHSS project brings together Gavi, the New Zealand Ministry of Foreign Affairs and Trade, and DFAT, with UN technical agencies, under a common strategy to deliver immunisation activities in over half of PNG provinces.

[19] Department of National Planning and Monitoring, Department of Provincial and Local-level Government Affairs, Department of Treasury, Department of Finance, and Department of Personnel Management.

[20] As noted in its Terms of Reference (29 June 2021), the PATH Program Steering Committee is 'responsible for oversight of PATH Program implementation and performance management. It will provide high level policy advice and strategic direction to ensure it is delivering on the development policies and priorities of the governments of PNG and Australia'.

PATH has also had a focus on facilitating health sector coordination, as reflected by one of the drivers – Driver 3: Leveraging partnerships and improved aid coordination[21]. Some assistance to facilitate communication between donors and NDoH was provided by the PATH Executive Support Adviser placed in the department, but this was ad hoc rather than structured support to NDoH. Additionally, the program worked with the World Health Organization (WHO) and NDoH through the national M&E TWG. At the subnational level, an objective of the PHA Support Project is to strengthen partner coordination. PATH managers and grantees also participate in TWGs[22], enabling PATH to contribute to sectoral strategies and align PATH projects to efforts in the respective technical areas. Responding to the coordination needs of the COVID-19 pandemic, at DFAT's request, PATH provided secretariat support, as well as advisory, operational and technical assistance to the peak national coordinating bodies, the PNG Ministerial COVID-19 Vaccination Task Force (MTF), and the GoPNG National Control Centre for COVID-19 (NCC) through the establishment of a COVID-19 taskforce. Planning and partner coordination in demonstration PHAs and the NCC was supported with the deployment of COVID-19 Task Force Provincial Advisers[23], and PATH was selected as the 'lead partner' to support coordination of the COVID-19 response in four provinces[24] and ARoB[25].

Despite PATH's success in accommodating DFAT's need to focus on COVID-19, a more strategic and consistent approach to coordination and collaboration with development partners, as initially envisaged, was not apparent. There was no evidence that linkages between PATH and other DFAT investments in infrastructure, governance, gender, and other sectors had been explored, to leverage support to meet PATH objectives. It emerged from interviews that one of the barriers to coordination was the lack of a clear PATH program strategy that could be articulated to external partners and thus assist in identifying potential areas of collaboration.

Similarly, the opportunity to 'coordinate and collaborate with the pipeline of analytical work being undertaken by the World Bank, ADB, and other partners'[26] envisaged in the PATH design was not realised. Feedback from stakeholders indicated that communication with PATH was informal and focused on information sharing rather than investigating potential opportunities for collaboration. Other key national stakeholders noted that, despite their efforts, they had not been able to engage in any way with PATH.

SQ 1.3: How is the PATH design appropriate (and still relevant) to the development context, practical, adaptive/reflexive to changing circumstances (including COVID-19 response) and resilient to demands?

PATH as an adaptive program and its relevance to the development context

An adaptive management approach and use of drivers of change (see **Table 3**) were central to the PATH design, to be realised through an AMTWP approach. The effectiveness of how the AMTWP approach was implemented within the PATH program is discussed later in the report. The question of whether using the AMTWP approach was the right thing to do in the context of the PATH program, the health system, and the implementation context of PNG – that is, the relevance of the AMTWP approach – is considered here.

[21] Page 3, PATH IDD, DFAT, n.d.
[22] PATH is involved in national TWGs for TB, Malaria, HIV, and Sexual, Reproductive, Maternal, Neonatal and Child Health (SRMNCH).
[23] ARoB, East New Britain, Morobe, Western, Western Highlands, and West Sepik Provinces.
[24] Morobe, Western, Western Highlands, and West Sepik Provinces.
[25] As noted in the PATH COVID-19 Taskforce Closure Report – September 2021–December 2022, Page 10, the 'COVID-19 Provincial Lead Partner model' was introduced by the Ministerial COVID-19 Vaccination Task Force in March 2022 'to leverage existing partners working across the country to strengthen partner coordination and provincial access to resources available for COVID-19 response activities'.
[26] Page 17, PATH Investment Design Document.

In theory, the AMTWP approach involves local leadership in identifying barriers, priorities and approaches suited to realising program objectives[27]. Rather than using a top-down and technocratic approach, it is intended to be responsive to complex implementation contexts and conditions of uncertainty. Using politically aware decision-making can further contribute to developing and implementing activities that better address the specific challenges and potential entry points of the operating context. It is therefore expected to lead to more effective and sustainable outcomes[28]. It may also be considered particularly suited to a program such as PATH that seeks to navigate complex health system challenges and drive change at national through to local levels, across its six demonstration provinces.

Nevertheless, previous experience in implementing an AMTWP approach has demonstrated the challenges of doing so successfully, particularly in the context of 'high value, high profile, multi-sector and multi-project Facilities'[29]. It is questionable whether introducing a somewhat experimental approach, which added a further layer of complexity and uncertainty to this large program[30], and increased internal demands on the program team in a high-risk implementation context, has been an appropriate means of producing responsive program strategies.

Furthermore, there did not appear to be a shared understanding among key PATH stakeholders of how the AMTWP approach would be used to achieve program objectives. The presence of existing projects that 'locked up' a large proportion of the program budget was previously highlighted as limiting the flexibility required to implement this approach[31], and was raised as a concern by several interviewees. AHC stakeholders, in particular, held a different view, considering that these projects could have served as a platform for engagement with PHAs, as well as for demonstrating efficient and effective models of care that will gradually transition to PHA management. The lack of a shared understanding among key stakeholders, at least in the first years of the program, likely contributed to a lack of coherent direction and the reported 'siloing' of FHO 'legacy' projects within the PATH program.

Although the MTR does not take a position on whether adaptive management of any type[32] is a useful approach to apply within a large facility such as PATH, the experience of PATH underlines the complexity of this approach and the need to carefully consider the conditions required for it to be effective at all stages: from design through to implementation. Without those conditions in place, as demonstrated by the PATH program, AMTWP is unlikely to contribute to program success.

Transition to PHA management of health services – concept of transition

Transition as a key element of the PATH program is seen by stakeholders consulted by the Review Team as appropriate and relevant, to the extent that it supports a partnership approach between the two governments, and a departure from the approach of funding external organisations to deliver services in parallel to the GoPNG health system. As noted above, these objectives are aligned with

[27] As described by the PATH Adaptive Management Guidance Note, November 2020, this includes the 'PNG Government and partners, both women and men; not external actors'.

[28] Green, D. (May 2021). *Review of 'Implementing adaptive management: A front-line effort. Is there an emerging practice?'* Governance and Development Soapbox. https://abtgovernance.com/2021/05/06/review-of-implementing-adaptive-management-a-front-line-effort-is-there-an-emerging-practice/

[29] Teskey, G. & Tyrell, L. (2017). *Thinking and working politically in large, multi-sector facilities: Lessons to date*. Governance Working Paper Series, Issue 2, November 2017. https://abtassocgovernancesoapbox.files.wordpress.com/2017/11/abt-associates-governance-working-paper-series-issue-no-2-final-171120.pdf

[30] The DT Global *Guidance Note on Adaptive Management* states that 'Adaptive management has mainly been used as a whole program approach, with varying success, often on medium sized programs up to around AUD$25m'. https://dt-global.com/wp-content/uploads/2023/09/dt-global-guidance-note-introduction-to-adaptive-management.pdf

[31] See https://dt-global.com/wp-content/uploads/2023/09/dt-global-guidance-note-introduction-to-adaptive-management.pdf

[32] As noted in an overview of Adaptive Management (DT Global, n.d., *Guidance Note on Adaptive Management*), there are various models and degrees to which programs can implement an adaptive management approach.

GoA, GoPNG and international commitments to effective development practice. The associated move towards direct financing of PHAs, rather than funding non-government organisations (NGOs), to support program delivery is also welcomed by PHAs.

Whether transition of 'service delivery management and implementation from an external contracted implementing organisation to PHAs and the BDoH' should be 'at the heart of PATH's strategic focus'[33] – stated in the updated PATH Strategic Framework – is another question. In the opinion of the Review Team, this greatly overstates the intended role of this aspect of transition in the program. As demonstrated in PATH's EOIO statements, 'transitioning to PHA management in selected provinces' is only a part of EOIO2 – and not an end in itself. Thus, while developing a strategy for this aspect of transition is positive and long overdue, it is not sufficient to drive the strategic direction of the program overall. As observed in a 2023 review of the PATH Theory of Change[34], to do so risks directing the program focus to the extent to which DFAT-funded projects are aligned or integrated with PHA management systems, rather than how PATH can more effectively contribute to health system strengthening, increase access to quality health services, and achieve improved health outcomes for the people of PNG. Indeed, the Review Team found that PATH lacks a clear focus on whether the program is using its resources most effectively to achieve priority quality, inclusive health system, and health services outcomes.

3.2. Key Review Question 2: Effectiveness

To what extent is PATH making progress towards its IOs and EOIOs, the broader Health Portfolio Plan's outcomes, and contributing to improved health outcomes?

EOIO1: PHAs more able to lead provincial health reform and manage effective, efficient, equitable and quality essential health services in selected provinces.

EOIO2: 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.

The review found that while there are positive areas of development, particularly related to MEL activities and capacity building at provincial and national levels, progress against IO1 objectives of building PHA leadership capacity has not met initial expectations. Under IO2, implementation of the Sapotim Lida Project is at an early stage and relationships between implementing partners were still being established at the time of writing the MTR report. Delivery of essential health services under IO3 is producing PATH's most concrete and measurable results. FHO and Health Security projects have contributed to HPP outcomes; however, PATH's approach to these activities has primarily been one of contract management, with quality improvement measures undertaken only during project redesign.

Additionally, there is little sign of using evidence from PATH service delivery projects to 'influence' PHA performance, as intended by the PATH design. Similarly, testing and scaling up models of inclusive equitable health care to support PHA delivery of more effective health services for disadvantaged groups has not been pursued. At the time of the review, PATH was rolling out long-delayed strategies to support the transition of health services to PHA management. However, the review found that many aspects of the original PATH model are no longer being implemented. With

[33] Page 8, PATH Strategic Framework 2023–2025 – Final Draft – 28 April 2023 (Revised 9 May 2023).
[34] PATH, Rapid Appraisal Note: PATH Theory of Change, 15 March 2023.

underperformance across all IOs and limited focus on aspects of PATH that could address some of the systemic barriers at PHA and national levels, the likelihood of substantial progress towards transition by 2025 is weak. With such limited progress towards its three IOs, PATH is also unlikely to meet its EOIOs by the end of the current phase of the program in 2025.

The absence of an established PAF and MERL Framework throughout the program period has made it challenging to assess progress towards the PATH EOIOs and IOs. Examination of PATH's performance against its EOIO and IO indicators in the latest version of the PAF provided to the Review Team (August 2023 version) shows there is little data available against the majority of indicators at any level in the PAF (see **Annex 5**.) The review therefore relied on qualitative data from PATH reporting and MTR interviews to make an assessment of PATH's progress towards its EOIOs and IOs.

Changes have been made to the original PATH Program Logic to bring greater clarity to its expression of strategic intent over the program period. As shown in the PATH executive position vacancies table (October 2020–June 2023) in **Annex 13**, this has seen the six IOs in the original design increased to seven[35], and then consolidated and reduced to five and then three – IO1: PHA Leadership; IO2: Women in Leadership; and IO3: Health Care Workforce – in a revised logic model finalised in May 2023. **KRQ2** therefore focuses on progress towards EOIOs and the current IOs, but also discussed the former IOs (Equity, Accountability, and Bottlenecks), and how well they have been addressed within the overall program. The current PATH Program Logic (May 2023) is shown in **Annex 1**.

SQ2.1: To what extent has PATH contributed to strengthening specific PHA leadership functions, and how effective has the explicit and proactive inclusive leadership program been in this process? (IO1)

Summary: The MTR found that PATH's initial design intentions under this IO have not been delivered. Activities to support PHA leadership capacity building were commenced at an early stage of the program, but were disrupted, partly due to the COVID-19 pandemic and leadership changes, and have not since been restarted. PATH support to PHAs is now largely focused on the operational level. Without a clear capacity building framework, and due to varying PHA readiness, the effectiveness of this intervention across PHAs has been variable. A case study of where PATH MERL support has contributed to improved PHA performance is provided below. Overall, however, PHAs considered that the support provided by PATH was gap-filling rather than contributing to systemic and therefore sustainable improvements in PHA capacity.

IO1: PHA Leadership: Leaders and technical personnel in PHAs/BDoH are performing mandated functions.

IO1 design intention

PATH's IO1 directly contributes to and overlaps with the intention of EOIO1 to improve the leadership and management performance of PHAs in demonstration provinces[36]. It encompasses strengthening the operation of the PHA Boards and PHA governance, public financial management (PFM), human resources, partner engagement, and frontline health management and performance[37]. This substantial agenda was to be achieved through a range of capacity building interventions that included 'twinning relationships and educational resources' to 'develop PHA board and management leadership skills, management and coordination capacity'[38], as well as leveraging resources of

[35] As shown the in the PATH Guiding Strategy V1.0 (page 5).
[36] Page 47, DFAT–Abt PATH Contract – DFAT Agreement Number 76315.
[37] Pages 11–12, PATH Guiding Strategy V1.0.
[38] Page 7, PATH Guiding Strategy V1.0.

partners in target provinces. Efforts to strengthen use of 'policy relevant information' to drive PHA performance and quality improvement were to be implemented alongside these leadership-focused activities. Promotion of women in leadership, primarily under IO2, is intended to lead to more inclusive PHA management. Addressing bottlenecks and strengthening the 'connectors' within different levels and agencies in the health system was proposed to further support the effectiveness of activities implemented under IO1[39].

Leadership and capacity building activities commenced but not pursued.

In its first year, PATH worked with the six target PHAs/BDoH to conduct a range of assessments, including Inception Roadshows, Problem Identification Workshops, and stakeholder mapping. GEDSI stocktakes to identify barriers to women's leadership and equitable access to health services, and to develop potential entry points and activities for their mitigation, were also commenced[40]. There was some crossover between IO1 and IO2: Women in Leadership, with PATH supporting delivery of the Elevate Leaders Program to PHA staff who wished to apply for the Western Highlands PHA CEO position[41]. The MTR found, however, that these planning and problem identification activities with PHAs were not continued. Additional PHA leadership training and the proposed mentoring in partnership with Ninti One have also not been pursued. Factors likely to have contributed to the disruption of this range of activities include the impact of the COVID-19 pandemic, and turnover of key PATH personnel; travel to provinces was restricted and staff turnover affected continuity of planned activities under this IO. The lack of tenured, functioning PHA Boards in all demonstration provinces has also been a major barrier to working with PHA leadership; although it is feasible that PATH could have continued to engage for this purpose with PHA Senior Executives. The Health Services Sector Development Program (HSSDP) has continued to roll out management training to PHA leaders, perhaps something that PATH could have leveraged given that it is also funded by DFAT. However, there was collegiwith HSSDP or other health sector partners.

PHA capacity building activities conducted by PATH – the PHA Support Project

PATH has progressively developed initiatives with an overall focus on building the capacity of PHAs to deliver health services more effectively and efficiently in general, rather than specifically strengthening leadership functions. PATH reported that these activities were 'formalised' in 2023 as the PHA Support Project (PHASP), comprising the PEPPI, the MEDI, and a PFM Initiative, made up of the Expanded Program of Support for the Health Services Improvement Program (EPS HSIP) and PFM components of the AIHSS project. These projects are described further in **Annex 6**. This nomenclature appears to bring a more coherent structure to PATH's work in this area, which was previously operating as a collection of disconnected activities. However, at the time of writing, a strategy for the program was still under development and thus it is not yet clear how the PHASP will be more than the sum of its parts. Notably, PATH's initial ambitious PHA capacity building agenda is now much reduced.

Results achieved under IO1

After the loss of the Provincial Performance Facilitation Lead in 2021, who reportedly provided valuable one-on-one guidance to PHA Support teams, PATH support to the Provincial Facilitators (PFs) and MELCs positioned in provinces was minimal. Interviews indicated that PHA-based teams were largely left to establish relationships with PHA management and identify how they could assist in building PHA capacity. PHAs similarly report that they were given little explanation of the purpose

[39] Abt Associates. Locally generated and scaled health systems reform – Papua New Guinea–Australia Transition to Health (PATH) Program. Schedule 2. Technical Proposal, May 2020, RFT# DFAT 114.
[40] Page 13, PATH Annual Report 2021 – Final (Resubmission 16 May 2023).
[41] The training was delivered in partnership with Ninti One, The University of Queensland, and the Australasian College of Health Sciences.

of PATH's PHA Support or the role of these personnel. Both parties have therefore struggled to engage in a strategic manner and develop a cohesive program of work for much of the program period. As a result of these factors, PFs and MELCs have tended to provide administrative or technical support for various PHA-identified priorities. A structured capacity building plan with clear objectives, which was agreed with PHAs and combined with training for PHA embedded staff on how to deliver the specific inputs – and combined with regular coordination and knowledge sharing between PHASP national and provincial teams – would have given direction to and increased the effectiveness of these inputs.

PATH PHA-based staff reported that the level of support from PATH has improved over time, with regular program meetings to share lessons learned and guidance from PATH management to assist in delivering their work. Provision of greater structure to PEPPI staff, such as an activity plan with annual key performance indicators (KPIs), has also helped staff to identify work priorities. PFs are tasked with supporting the development of a range of strategic and operational documents, including Annual Implementation Plans (AIPs), budget reports, and draft corporate and health services plans. It is intended that, in doing so, they will also ensure that strategic documents are aligned with National Health Plan priorities. However, progress in developing these documents has been slow[42]. From 2022–2023, MELCs have supported audits of data quality in four of the six demonstration PHAs/BDoH, providing training and mentoring support, and developing Terms of Reference for PHA/BDoH M&E Committees. PFs and MELCs in some PATH demonstration provinces are assisting with coordination and prioritisation of GEDSI activities conducted under the Sapotim Lida Project.

Interviews with stakeholders indicate that the coherence and effectiveness of program inputs has largely depended on the skills of individual advisers and the extent to which PHAs in demonstration provinces are able to direct this support. Furthermore, the extent and the pace at which PHA Support Project objectives, such as the development of PHA Partnership Committees, can be advanced also relies on the prioritisation of these objectives by PHA senior management. Thus it was observed that the effectiveness of this intervention across PHAs has been variable.

The Review Team heard several positive examples of the work of the PATH PHA-embedded staff. In ARoB, the MELC has bolstered the limited BDoH resources to support effective and timely eNHIS reporting. In Western Province, assistance provided by the PHA Support Project, and the MELC in particular, is recognised as providing important support to strengthen provincial planning, monitoring and reporting.

Western Province Case Study – MEL capacity building

The contribution of PATH support to improved PHA reporting in Western PHA (WPHA), which interviewees (PATH and WPHA alike) associated with an increase in WPHA's 2022 Sector Performance Annual Review (SPAR) ranking, is explored in a case study in **Annex 7**. Improvements in telecommunications infrastructure and the roll-out of eNHIS tablets played a decisive role in improving routine health system reporting in Western Province, but PHA use of the system remained a challenge. The case study found that the PATH MELC's proactive approaches to capacity building, data management and supervision have contributed to more complete and accurate reporting, which was absent in prior years. Recruitment of an assistant Provincial Health Information Officer (PHIO) and training staff have boosted the capacity of the WPHA MEL unit. Greater attention to reporting at the health facility level, including participating in supervisory visits, has led to greater motivation among PHA staff. Attention to each stage of the reporting and analysis process has

[42] As noted in the Draft PATH Six-Monthly Report (January to June 2023), 23 August 2023.

helped to 'close the loop' from data input to its use. By providing this comprehensive capacity building support to the province, PATH appears to have played an important role in increasing the effectiveness, utility and sustainability of these earlier interventions delivered under HSSDP.

Weak vertical alignment

As noted in the case study, the presence of the PATH Public Health Adviser in Western Province, who has been able to bring issues to the attention of the PHA senior executive management (SEM), albeit in an informal manner, has also been influential – however, not all PHAs have the benefit of advisers able to exert this influence. This points to another key gap identified by several stakeholders: the lack of vertical alignment between PATH's work with NDoH at the national level and work with PHAs. Stronger coordination and advocacy with NDoH and partners at the national level, for example, to ensure that PATH objectives were understood and supported could have encouraged PHA engagement on agreed governance and management priority areas. An exception is the MEDI project, implemented by the PATH Port Moresby-based PAS team, which was able to establish this connection.

MEDI project

This stream of work was initially intended to support IO1.2: Accountability, which contributed to EOIO1 by ensuring that there is 'more data and evidence available for planning, budgeting and monitoring… [so] that more policy relevant information is used by government, PHAs, MPs, health facilities and NGOs support decision-making and to drive performance improvement'[43]. Increased access to health data and more effective use of this data also formed one of the initial five Drivers of Change (see **Table 3**)[44].

The PAS team effectively leveraged the partnership approach central to the PATH design, and successfully linked key issues and responses at the national level with the PHA subnational level. The PAS team consistently participated in the national M&E TWG and regularly cascaded information and facilitated technical M&E learning and development at the PHA level through the PATH PFs and MELCs. PAS team members are working with NDoH, WHO, World Bank, ADB, and Vital Strategies, through the M&E TWG, to develop technical guidelines, operating procedures and quality assurance tools[45]. In interviews, WHO stakeholders recognised PATH as playing an important role in advancing this work. It is intended that these tools will be used across the sector to strengthen and increase NDoH, PHA and key partner appetite for use of routine health data to inform decision-making, planning, budgeting and monitor implementation of AIPs.

Training activities conducted by the PAS team working with MELCs aimed to increase PHA knowledge and understanding of the significance of having effective M&E systems in place to allow for better record-keeping and accountability to NDoH. Other training has introduced the recently-developed technical tools and procedures, such as Data Quality Audits (DQAs). DQAs have since been conducted in ARoB, West Sepik, and East New Britain Provinces. A detailed description of activities conducted by the MEDI project is provided in **Annex 8**.

[43] Page 7, PATH Guiding Program Strategy V1.0.
[44] 'Evidence learning and dialogue: PHAs access to cost and health outcomes data to make critical decisions and measure effectiveness, efficiency, and sustainability of healthcare programs' (page 8, PATH Guiding Program Strategy V1.0).
[45] The development of a Data Quality Audit tool informed by WHO on 2022 and piloted in two PATH demonstration provinces (ARoB and West Sepik) in 2022. The DQA was then formally approved by NDoH in 2023. The Standard Operating Procedures for the DQA are currently in development at the time of writing, for a wider national roll-out to other PHAs.

PHA assessment of PATH provincial support

Through this work, PATH has demonstrated the potential to encourage PHA compliance with legislated planning and reporting requirements, facilitate improved practices and promote change through a combination of national-level advocacy and technical support linked to PHA/BDoH embedded staff. However, the Review Team found that, more commonly, support provided to the PHA is considered to be 'gap-filling' or 'providing an extra pair of hands' at the administrative or operational level. This support is welcome and appreciated by PHAs, but its effectiveness in building PHA capacity in a measurable, systemic and sustainable manner across the program has not yet been established. Several PHA respondents identified system-level strengthening, including establishing information systems and addressing major gaps in human resourcing for the PHA as a future priority to support PHA effectiveness.

SQ 2.2 What progress has been made in creating the enabling environment for women leaders to thrive and what kinds of interventions have proven to be most effective? (IO2)

Summary: For PATH's approach to be successful, the Sapotim Lida Project needed to address all three levels of women in leadership in parallel. However, in practice, PATH and SLP took a sequential approach, focusing first on women leaders in PHAs, and investing minimally in building community empowerment and leadership to hold providers to account. Interviewees reported that SLP does not work across the PATH portfolio; for example, the project does not yet engage directly with PATH grantees, despite acknowledging the opportunity to use their reach into communities to further the broader leadership ambitions of the SLP strategy. Implementation of the SLP has been slower than planned and the MTR was not able to identify that specific results have yet been achieved.

IO2: Women in Leadership: More women in leadership positions are influencing health care decisions.

IO2 design intention

The PATH design identified the need to address the inadequate representation and decision-making roles for women and representatives of socially excluded groups in PHA Boards and leadership teams. Besides the rights-based argument for equity, the design posited that this 'will contribute to management being …more likely to prioritise service delivery to women and girls and minority and marginalised groups'. In tacit acknowledgement of this simplification, the design proposed additional monitoring to assess and verify whether activities to strengthen management and leadership and improve social accountability are getting through to services 'on the ground'. This invites a broader system view that looks beyond the placement of women in leadership positions, to consider the accompanying conditions that would lead to improved services and stimulate the design of innovative interventions to test what works. This is referred to in the SLP design, building on the lessons from the Pacific Women Shaping Pacific Development program, that gender-transformative change in PNG must be mutually reinforcing at multiple levels[46].

Sapotim Lida Project

IO2 is to be mainly achieved through the Sapotim Lida Project, a three-year project (March 2022 until June 2025) with a dedicated budget of AUD6.3 million[47]. The SLP design was participatory, enriched by consultations with key partners to achieve broad consensus of the project, with wide-ranging informants, including organisations representing people with disabilities, and community

[46] Pacific Women Shaping Pacific Development. (2021). Gender Transformative Change Brief in PNG.
[47] PATH. (2021). Sapotim Lida Leadership Program Design Document 2021–2025.

organisations. Despite this, PATH's most recent progress report states the design '…lacked clarity and a clear implementation vision…', although this view was not supported by all PATH informants[48].

Although the wording for IO2 is specific to women in leadership, PATH's broader GEDSI efforts are described as being 'housed and centred in IO2'[49]. This illustrates the way SLP overlaps with PATH's broader GEDSI goals and implies a degree of joint responsibility for IO2 across the GEDSI team, and other PATH investments[50]. SLP is also intended to contribute to IO areas for equitable access to health services, and strengthening the provincial health system capacity, in addition to its women's leadership agenda[51]. Moreover, the GEDSI Hub, which is within the SLP, is designed to act as a centralised resource to support PATH's GEDSI activities and policy development in the six demonstration provinces and NDoH[52]. This appears to be partly a consequence of most of the budget for GEDSI in PATH being allocated to the Sapotim Lida Project[53].

Roll-out of SLP

The roll-out of SLP has been slow, and the budget absorption significantly lower than planned. However, the six PHAs and NDoH have all agreed to a workplan that includes the following categories of activities under the SLP Menu of Service Areas: (1) GEDSI Policy Review and Application; (2) Leadership and Governance[54]; (3) GEDSI Sensitisation and Awareness; and (4) Community Engagement and Coalition Building. While only one of the service areas is directly relevant to leadership, the other areas have the potential to improve the conditions for women's leadership. For example, policies to strengthen transparency, accountability and safe workplaces have benefits for all aspects of health service delivery, but are especially important for ensuring women are able to pursue leadership careers without discrimination and harassment. Nonetheless, the MTR found there was a blurring of lines of responsibility for delivering the GEDSI Strategy, and SLP made it hard to allocate resources, which contributed to missed opportunities to integrate work with other parts of the PATH program. For example, according to some interviewees, there has been limited involvement by PATH's GEDSI team in provincial-level SLP activities since the project launch. Within the intersection of SLP and GEDSI, the MTR still found some encouraging feedback from PHAs, with some describing the SLP project as 'new and enlightening', leading to clinicians and PHA staff planning to incorporate GEDSI in their work.

The team composition of PATH's implementing partner in SLP, CARE, was changed from what was originally envisaged in the design, which contributed to implementation delays. For example, changes included increasing from two to three advisers to cover all six provinces, but posting them in the provinces instead of at the GEDSI Hub in Port Moresby as originally planned. Additional challenges arose from how CARE interfaces with other parts of PATH, which by extension includes the nature of their engagement with PHAs[55]. The MTR found contrasting narratives about the origin of this problem. One explanation is that PATH failed to establish clear ways of working regarding these relationships. On the other hand, the PATH team was concerned that CARE was approaching some PHAs directly, rather than working through the PHASP. While progress is being made to improve collaboration, one interviewee portrayed the gaps in respective roles and responsibilities as leading to insufficient engagement with NDoH from both PATH and CARE.

[48] Page 8, PATH Six-Monthly Report (January–June 2023), August 2023.
[49] PATH Six-Monthly Report (January–-June 2023), August 2023.
[50] For example, the six provincial workplans agreed under SLP are titled *'PHA SLP annual GEDSI workplan'*.
[51] PATH 2021 Progress Report, Annex 10 GEDSI.
[52] PATH. (2021). *Sapotim Lida Leadership Program Design Document 2021–2025*.
[53] The budget for SLP and GEDSI is discussed under 'Efficiency'.
[54] Includes 'Conduct GEDSI training needs analysis and staff audit' and 'Delivery of a senior women executive course in PHAs'.
[55] For example, the PHASP, PATH grantees, and other PATH work in NDoH.

SLP focus narrowed to PHA leadership

The SLP design identified three entry points to support women in leadership: at the senior level; the middle and lower workforce level; and at the community level. However, implementation narrowed the focus to PHA leadership. The only non-PHA focused activities reported in PHA SLP workplans is the participation in the delivery of two annual events as part of the '20 days of activism'[56]. The community level is especially important: the design highlights the need to support 'women users of the system to advocate for their health needs and the health needs of their families', noting that, by 'taking a broad definition of women's leadership, it is anticipated that women can become more active participants in the health system rather than just workers and users of it'. This could have included community-based organisations led by women and people with disabilities, as well as other influencers in the community. This approach to empowerment from the grassroots level, whereby women are recognised as already in positions of influence in health-seeking behaviour, rather than as passive recipients of health services or, worse, as victims of marginalisation, is supported by empirical evidence and explicated by the GEDSI Stocktake[57]. Furthermore, it is relevant to other objectives of PATH, especially equitable services and accountability.

Incorporating women in leadership in IO1

Improving leadership is a theme that runs through all of PATH and it may have been more effective to embed the 'women in [PHA] leadership' strand into the project's leadership activities in IO1, especially considering so much of SLP is coordinated through the PHASP. This would have required additional in-house GEDSI resources and appropriate technical expertise, but would have enabled PATH to thread women's leadership, and the broader ambition of inclusive leadership, more effectively through all parts of the PATH program. For example, prior to SLP, PATH delivered the Elevate Leaders Program, in partnership with Ninti One in Western Highlands PHA, with both men and women as participants. This received positive feedback from participants for its attention to gender-specific issues and for providing a safe environment for discussion[58]. Despite this track record, and being mentioned in the SLP design as a service provider, PATH did not invite Ninti One to provide any further training or mentoring.

While supporting women leaders does require additional resources and system-level change that tackles gender-based discrimination, the work should not be carried out in isolation from the system itself. To do so risks creating a parallel system for women that will not survive beyond the program. The challenge is to simultaneously empower women to thrive within the system as it is, while also reforming that system and the social norms that inform behaviour. This is better achieved in partnership with the existing players in the system, in an integrated leadership improvement program in which all participants have a stake.

Integration of GEDSI Hub at NDoH

The GEDSI Hub is situated in NDoH as the nerve centre for SLP, as well as PATH's broader GEDSI work. Its purpose is to provide technical support to NDoH and the six demonstration provinces in the preparation of their annual SLP/GEDSI workplans, the disbursement of the SLP/GEDSI discretionary fund, and to facilitate collaboration with other national government initiatives and programs. This relies on building relationships with NDoH counterparts and seeking entry points for advancing GEDSI issues in policy and practice. It is not clear why a component with such salience to the program and its relationship with government was outsourced to a third party (CARE) as part of the SLP contract. This has proved unsatisfactory for both PATH and CARE. The latter observed that they needed more

[56] Listed under the 'Community Engagement and Coalition Building' Service Area.
[57] For example: Thompson, B. et al (2016), and O'Mara-Eves, A.et al. (2015).
[58] 2021 Annual Progress Report, Annex 10 GEDSI.

visibility from the PATH GEDSI team at the hub to support SLP, and to use their influence with key policy decision-makers to engage more on SLP implementation (for example, the NDoH discretionary fund uptake was lower than anticipated). This arrangement may also explain the MTR finding that PATH's GEDSI team does not have strong relationships within NDoH that would be expected at this stage of the program. Moreover, the slow progress in starting up SLP had a knock-on effect on aspects of the program that had been bundled with the CARE contract, including the GEDSI Hub.

Among the advantages of keeping the GEDSI Hub within the direct management of PATH, instead of outsourced to a third party, was the opportunity for PATH team members to have cultivated relationships with counterparts. This would have enabled a deeper understanding of where the levers and incentives for change are for GEDSI, especially those that fall outside NDoH authority, and may lie with other departments such as the Department of Finance. Acquiring institutional knowledge and using connections and synergies is an effective way for the program to achieve both its GEDSI objectives (women in leadership and mainstreaming) and broader EOIOs. Moreover, directly managing the GEDSI Hub at NDoH would signal to counterparts the importance of PATH's direct relationships with NDoH and across GoPNG more broadly.

Despite the shortcomings of the outsourced model for the hub, the relationship building between CARE and NDoH has evolved in an organic way, with a plan for NDoH to continue the women in leadership work beyond the project, which may provide some sustainability. Continuous lobbying has resolved an initial lack of clarity regarding how the GEDSI Hub would engage with NDoH staff, especially given NDoH had one GEDSI focal point. NDoH has revised its structure to support SLP/GEDSI, including recruiting five people to support this work, with a budget approved by Department of Personnel Management, and recruitment is in progress at the time of the MTR. CARE has also supported NDoH to review GEDSI policies and provided ongoing consultation on proposed changes. CARE will support the roll-out of Sexual and Gender Based Violence (SGBV) Clinical Guidelines to PHAs in early 2024.

SQ2.4 To what extent has PATH contributed to the increased delivery of inclusive and equitable health services and strengthened supervision, health workforce capacity building and ICT capacity in health facilities? (IO3)

Summary: PATH's FHO and Health Security projects have contributed to the achievement of the HPP outcomes and are delivering essential health services in target provinces, but PATH has not demonstrated that it can 'value add' to those projects. A number of key activities proposed by PATH, such as testing and scaling up effective, efficient and inclusive health services have not been conducted. PATH's new IO3: Health Workforce appears to set a new direction for the program that PATH and many of its grantees are not equipped to deliver.

IO3: Health Care Workforce: Health care service delivery managers, practitioners and research personnel are performing mandated functions.

IO2.1: Equity: Locally led approaches that increase access to quality and integrated essential services by women and girls, people with a disability and marginalised populations are tested and scaled in selected provinces.

IO2.2: Essential Services: Efficient and effective integrated locally led models of primary healthcare service delivery are demonstrated with PHAs, local governments and partners in selected provinces.

IO2.3: Health Security and Pandemic Response: Improved provincial health system capabilities to plan and implement selected measures in compliance with International Health Regulations for the prevention and detection of and response to TB, malaria, HIV, and COVID-19, and other emerging priorities in selected provinces.

IO3 design intention

- IO3, as defined at the time of the review, brings together the original IO2.2: Essential Services, and IO2.3: Health Security and Pandemic Response. Under these two IOs, PATH was required to transition to PATH the essential health service projects implemented under the PPF and health security projects managed under the HHISP– and to deliver and manage these projects and ensure their integration into PATH, so that they aligned and contributed to its IOs and EOIOs[59].
- Under IO2.2, PATH was intended to 'design strategies, activities and outputs to ensure that DFAT-funded services demonstrated effective and efficient models of service delivery and influence PHA delivery of health services'[60].
- In addition to managing health security projects under IO2.3, it was intended that PATH would: coordinate with health security partners and related programs; design and manage new activities as identified[61]; support and strengthen the eNHIS and use of health data for monitoring infectious diseases; and conduct capacity building to strengthen surveillance[62].
- PATH's original multi-layered strategy intended to further contribute to the increased delivery of efficient and equitable health services through supporting PHAs to become more effective and equitable organisations[63]. This was to be conducted, primarily, through interventions under EOIO1 and the 'drivers of change'[64], addressed under **SQ2.5.**

Table 3: PATH Drivers of Change[65]

PATH Drivers of Change	Details
Evidence, learning and dialogue	Strengthened evidence base to inform policy dialogue decision-making and measure effectiveness, efficiency, and sustainability of healthcare programs.
Problem-driven bottlenecks	Bottlenecks are reduced using a problem-driven and inclusive approach, when they are those hindering the ability to develop systems to deliver equitable and effective health services.
Leveraging partners	Partnerships are leveraged, and aid coordination improved among development partners and bilateral and multilateral agencies.
Targeted national-level support	Targeted support to the national level to enable more effective, equitable performance and inclusive leadership by PHAs.
Emerging priorities	DFAT and NDoH are able to respond quickly to rapidly emerging issues, while still maintaining overall focus and strategic direction.

Increasing coverage of inclusive and equitable health services

PATH's clearest contribution to the delivery of inclusive and equitable health services is through the health service delivery and health system support projects implemented under PATH's Frontline Health Outcomes and Health Security workstreams under IO3. A list of projects implemented under this IO[66] is provided in **Annex 9**. These projects consume approximately 60 per cent of the PATH budget[67], and address critical health needs for underserved, mostly rural populations in all provinces of PNG. The distribution of all PATH projects across provinces is shown in **Annex 10**.

[59] Page 55–56, DFAT–Abt PATH Contract – Agreement Number 76315.
[60] Page 55–-56, DFAT–Abt PATH Contract – Agreement Number 76315.
[61] Page 56, DFAT–Abt PATH Contract – Agreement Number 76315.
[62] Page 14, PATH Guiding Strategy V1.0.
[63] PATH Guiding Program Strategy V1.0.
[64] Page 41, PATH IDD, DFAT, n.d., PATH Guiding Program Strategy V1.0.
[65] As described in DFAT–Abt PATH Contract (page 56) and PATH Guiding Program Strategy V1.0 (page 8).
[66] As of December 2023.
[67] Page 19, PATH Strategic Framework 2023–2025 – Final Draft – 28 April 2023 (Revised 9th May).

Through FHO projects, PATH has demonstrably contributed to increased coverage and accessibility of essential health services in implementation provinces. Health security projects have provided a wide variety of health system support and technical assistance to strengthen testing, surveillance and treatment of infectious diseases[68]. PATH has delivered against the HPP's three Outcome areas via these projects, as outlined in the HPP Mid-Term Review[69]. Yet, without an established MERL Framework and program baseline, the MTR was unable to assess trends in coverage or scale of health service delivery over the program implementation period[70]. By providing essential services to underserved groups and, in particular, delivering outreach to rural areas, these services can be characterised as inclusive and equitable. However, as noted in evaluations of FHO projects[71], the extent to which GEDSI and equity are effectively incorporated in PATH projects is weak and requires a far more deliberate, evidence-based and well-resourced approach.

Inclusive and equitable health services

PATH's objectives under the original IO2.2: Essential Services intersected with IO2.1: Equity, under which 'approaches that increase access to quality essential services by women and girls, people with disability and the poor' would be tested and scaled[72]. As there did not appear to be a defined program of work under the Equity IO, it was removed during the strategic review process in 2022, with the understanding that 'developing and disseminating new models of integrated care' would be incorporated into IO2.2.

The MTR found only limited evidence that PATH has attempted to develop new models or approaches to strengthening inclusive, integrated health service delivery, or to test and scale these models[73] – despite the centrality of equitable health provision to the goal of the program, and its intersection with GEDSI. Where PATH grantees have been actively involved in improving equitable service delivery, they have demonstrated innovative ways to approach challenges of access and discrimination that were already active prior to PATH. Outreach services are being implemented by some grantees; for example, Marie Stopes PNG (MSPNG) and Susu Mamas under PSF. Notably, Youth With A Mission operates a marine patrol that provides an integrated health service to those community members who, often due to issues related to GEDSI, are otherwise unable to access health services at the established venues.

Mainstreaming GEDSI in health services

Delivering outcomes for improved health equity could be considered, at least in part, the responsibility of the GEDSI unit. As depicted in **Annex 11**, the parameters of the GEDSI unit encompassed both mainstreaming and 'equitable health services', through supporting the grantees in their work[74]. However, it is not clear how the GEDSI workstream intended to implement activities that were designed to improve service delivery for marginalised and disadvantaged people. An informant noted a risk of GEDSI becoming a 'box-ticking exercise', rather than the program paying attention to the substantive issues that affect access to services, and equitable, inclusive service delivery. PATH acknowledges this in its latest progress report, stating the program has '…shifted its

[68] Health system support provided includes training, professional development, supporting provincial planning, providing equipment and medical supplies, establishing community treatment networks and salary support for key technical positions in national research and disease control organisations.
[69] See pages 26 to 31, draft HPP Mid-Term Review 2022.
[70] It may be possible to do this by performing a project by project assessment, but this is outside the scope of the current MTR.
[71] Evaluations include AIHSS (2023), PSF (2022), and SRHIP (2023).
[72] DFAT–Abt PATH Contract – DFAT Agreement Number 76315.
[73] PATH conducted a scalability assessment with Western Highlands PHA focused on the AIHSS project model. This process was intended to trial the scalability tool rather than the project, recognising that the AIHSS project was already being implemented in 12 provinces/ARoB.
[74] While the intention was to support all grantees with health equity, GEDSI mainstreaming was forecast to take place in only half of the grantees.

GEDSI focus from compliance-oriented inputs and outputs to a broader agenda centred on mainstreaming GEDSI and improving the capacity of the PATH GEDSI unit to support a focus on health equity across and within PATH investments'. The Review Team did not find evidence that this 'shift' has taken place; thus progress will need to be monitored.

Additionally, at the time of writing, PATH reported that it is developing a 'Health Equity Strategic Framework and a clear and appropriate monitoring and evaluation approach within PATH and PFs and MELCs, and ISPs'[75], which should clarify PATH's approach to achieving equity-related objectives. To be effective, it is likely that this will need to be supported with dedicated implementation and technical resources.

Again, almost three and a half years into a program in which integration of GEDSI and equitable delivery of health services are core elements, and necessary to achieve EOIOs, these developments are excessively delayed. Given their centrality to PATH, the Review Team found these gaps and delays almost bewildering, but characteristic of the lack of leadership and, at times, dysfunction, within the PATH program. Despite having talented individuals among its personnel, the MTR found that these individuals were sometimes not employed in positions matched to their technical skills (further discussed in **KRQ4**).

Importantly, the lack of a health technical lead within the PATH program was found to be a major gap in what is one of DFAT's largest health sector investments in PNG. Indeed, this left PATH with an almost complete absence of health technical guidance for the program as a whole. As found in previous FHO project evaluations, the PATH support for FHO and Health Security projects was almost entirely based on contract management. Project management was weak; and opportunities for learning and collaboration within or between projects and workstreams, and PATH's capacity to oversee the quality of health services delivered, were limited[76]. Although the role of Independent Strategic Health Adviser[77] could have played a role in providing high-level support to PATH in this area, this adviser was not recruited until a part-time appointment to this role in late 2023.

Strengthened supervision, health workforce capacity building and ICT capacity in health facilities (IO3)

In theory, the recently formulated IO3 and associated indicators in the draft PAF (May 2023) provide a basis for measuring progress at the IO level, and hence PATH's progress towards achieving program objectives.

IO3: Health Care Workforce indicators:

- IO3.1: Increase over time in number of mobile patrols, outreach patrols, and innovative delivery mechanisms, especially for underserved populations.
- IO3.2: Increase over time in number of health facilities that receive at least 1 supervisory visit per annum.
- IO3.3: Number of health-focused ICT interventions introduced, rolled out or improved in health facilities.
- IO3.4: Percentage of healthcare workers/researchers participating in formal training sessions receiving Demonstrated Competency Certificates.

[75] Page 18, PATH Six-Monthly Report (January to June 2023), 8 February 2023 (revised from 28 August 2023).
[76] As noted in the AIHSS evaluation (2023), some PATH managers responsible for this project did not have the technical skills to interpret health data, and nor did they have familiarity with technical aspects of how these services should be managed and delivered.
[77] Page 51, DFAT–Abt PATH Contract – DFAT Agreement Number 76315.

Contributing to a well-performing PNG health workforce (IO3 in the Program Logic approved by the AHC in 2023) is positive and will likely lead to improved delivery of essential health services, but it is likely to take a long time to see the impact of such work. This may be a helpful change of direction (rather than attempting to 'influence PHA performance'); as well as being suitable for an adaptive program that is expected to clarify its logic as it proceeds. Nevertheless, the revised PAF (May 2023) appears to 'retrofit' an M&E framework to existing project activities conducted under IO3. More than clarifying strategic objectives to guide programming and activity implementation, it has provided a pragmatic means of linking projects into a framework. Although worthwhile, workforce development projects, such as the Health Education and Clinical Services (HECS) and Strengthening Health Workforce Education in PNG (SHWE), do not obviously contribute to the previous IO4, IO5, and EOIO2 strategic objectives of demonstrating inclusive, effective and efficient models of essential health care.

Conversely, not all of the projects currently under IO3 have a strategic focus or clearly defined approach to strengthening health workforce capacities. Under the AIHSS project, for example, grantees reported providing mentoring and other capacity building support to personnel in PHAs to improve PFM and M&E skills. However, the specific focus of mentoring and how the need for mentoring was identified (e.g. through a training needs analysis), how it will be delivered and by whom, and the associated results, are not reported. Training workshops are also a common feature of PATH projects; yet how specific topics are addressed and evidence of how they will contribute to project outcomes is often not provided[78]. Similarly, supervisory activities conducted or supported by PATH projects are often not clearly defined, do not use a consistent approach or terminology, and are poorly reported[79]. As a result, it is not possible to assess the value or impact of this training, or whether PATH resources were used in an effective manner, or whether it has contributed to outcome level results. This highlights the fact that, at the time of the MTR, PATH had no stated strategy or framework to guide how it would plan and deliver capacity building and health system strengthening activities. It is the view of the MTR that without a structured approach it is likely that these activities will continue to be ad hoc and are unlikely to deliver demonstrable development results.

Several FHO and Health Security projects are using a far more structured and competency-based approach to training and capacity development[80]. However, the extent to which these inputs are leading to sustainable results in the absence of an enabling environment is limited. A lesson highlighted in previous evaluations is that health worker training, even if resulting in improved competencies for those personnel, is not effective in the absence of adequate health facility infrastructure and medical supplies[81] – something that is not being addressed by PATH. Whether the capacity building interventions being conducted by PATH are substantially and efficiently addressing relevant workforce development needs is another consideration. For example, the Trilateral Malaria Project reports training microscopists in all provinces of PNG. This is no doubt contributing to improved capacity of those now-certified microscopists. However, in a context where there are major gaps in coverage of microscopy personnel, the inputs provided by the TMP may not be

[78] PATH program reports often simply relay the number of people who have received some type of assistance at some time during the reporting period.

[79] The purpose of reported supervisory visits conducted by PATH projects, for example, can vary between following up on outstanding acquittals to monitoring quality of immunisation activities and providing on-the-job training to health care workers.

[80] Examples from current projects include: Competency-based family planning training provided to health care workers by MSPNG as part of the PSF project; training provided in the lead up to external competence assessment for malaria microscopists conducted by the TMP; and SRHIP competency-based M&E training to build competency of CCHS staff.

[81] The evaluation of the PATH Saving Lives and Spreading Smiles (SLSS) program found that, although obstetric care training delivered to health care workers was of high quality, it was difficult to apply this training without a properly equipped and maintained facility. Furthermore, without addressing the barriers to women attending health facilities for delivery, training health care workers was unlikely to be sufficient to increase numbers of safe deliveries in project areas.

adequate to develop the quality-assured testing capacity at district and provincial levels that is intended by the project[82]. As noted in the Draft Mid-Term Review of the National Malaria Strategic Plan 2021–2025, to do so 'will require the recruitment and training of a large number of new microscopists and the expansion of the current supervisory system' [83].

If PATH is to pursue this logic, it will need to: be strengthened with the application of consistent national standards, such as the PNG National Health Service Standards and Reaching Every District approach for immunisation; apply evidence-based approaches to design and deliver capacity building support; and be implemented as part of a structured and comprehensive capacity building strategy to strengthen health workforce performance. Equally, if health workforce strengthening is to be a focus, PATH will need to consider the balance of these activities with service delivery, the design focus (not just evolution) of projects, and the most appropriate delivery partners.

This raises a further critical issue that was found by the MTR, which is the relatively weak focus of PATH on assessing the quality of both health and capacity building services. Although PATH recruited a technical lead in late 2023 for the AIHSS Phase 2 project, not all FHO projects have this level of support or a structured approach to assessing quality of services delivered under PATH.

SQ2.3 How effective has PATH's capacity building and health systems strengthening support been (or is likely to be) at enabling transition to PHA management? (IO1, IO2, IO3)

Summary: Capacity building and health systems strengthening support provided by PATH has not provided the organisational foundation for transition. It appears that the strategic intent of PATH to do so was not well understood, and transition under PATH has been significantly delayed.

Capacity building conducted under EOIO1 was intended to provide the 'organisational foundation' for the transition of PATH projects to PHA management proposed under EOIO2[84]. Transition was always intended to be progressive and not something that could be achieved within the five-year PATH program period. Nevertheless, the MTR found little progress towards transition has been achieved. As described under **SQ2.1**, the extent of capacity building inputs and activities delivered by PATH has not met initial ambitions. Evidence available to the MTR indicates that outcomes have been limited (as discussed under **SQ2.1, SQ2.2 and SQ2.3**), and progress to date has been inadequate to bring about sustainable change. For example, PHA progress towards functional PFM systems – an area where PATH has provided multiple inputs and reports examples of improved PHA use of funding – has been described by PATH personnel as a 'long road'.

Abt Associates initially proposed that Transition and Sustainability Plans would be established for all PATH interventions. As outlined in the PATH Technical Proposal, this was to include 'proper baselining of capacity at program outset, and financial modelling to estimate the cost of health delivery and options for over time shifting aspects of DFAT-funded activities into GoPNG recurrent expenditure'[85]. PATH's initial draft MERL Framework (2021) included annual measurement of PHA Transition Readiness and Self-Reliance[86]; however, there was no evidence that transition plans were developed. Stakeholder interviews further indicate that PATH and the Managing Contractor did not have a clear understanding of the expected interaction between EOIO1 and EOIO2. Health service

[82] As captured by the TMP EOIO1 Improved diagnosis and real-time surveillance of malaria at the national, provincial and district levels.
[83] A review of laboratory capacity in PNG found that a rapid increase in recruitment and training of microscopists and expansion of supervisory networks are needed to develop adequate 'quality assured' testing capacity in provincial and district hospitals – 'Draft Mid-Term Review of the National Strategic Plan for Malaria, October 2022' (quoted in Trilateral Malaria Project 2022 Annual Report (page 12)).
[84] Page 39, PATH IDD, DFAT, n.d.
[85] Page 10, Abt Associates, Locally generated and scaled health systems reform – Papua New Guinea–Australia Transition to Health (PATH) Program. Schedule 2. Technical Proposal, May 2020, RFT# DFAT 114.
[86] PATH MERL Framework Annex 2 – PAF Matrix.

delivery and health security projects were 'siloed' in PATH, rather than being integrated into the program overall. A gradual reduction of funding to FHO projects, and progressive transfer of funding to PHAs to support transition (or to fund other components of PATH), as proposed in the original design, did not take place[87]. Although some groundwork was conducted[88], the proposed approach of developing and piloting and scaling up successful models of health care provision to be managed by PHAs[89] was not pursued.

PHA capacity building and transition has been an element of PATH projects delivered under IO3/EOIO2, and the AIHSS, PSF and SRHIP projects included transition and integration objectives as part of the pre-PATH project design. Evaluations of these projects[90] found that activities intended to advance transition – such as PHA PFM capacity building and integrating training activities with GoPNG systems – had not been advanced. This was partly due to delayed implementation by grantees, who did not necessarily have the skills, clear direction or organisational incentives to undertake the planned system strengthening and capacity building activities. In other instances, obtaining PHA commitment to transition objectives – particularly around transition of financing – was challenging. Redesign of projects is expected to address some of these weaknesses. The Review Team found that while PATH was, necessarily, attending to AHC timelines for contracting and start-up of the program, PATH still lacks a strategy to address the very significant bottlenecks and health system barriers to progressing the proposed transition to PHA management.

The revised PATH Strategic Framework 2023–2025 (Final Draft – 28 April 2023) emphasises the 'centrality' of transition to the PATH strategy and reaffirms PATH's commitment to achieving this objective. According to the May 2023 Transition Framework, PATH projects are required to move towards alignment and integration with GoPNG 'routine health systems', including health service delivery, financing and governance systems[91]. At the time of the review, baseline data was being collected and roll-out of a Transition Tracking Tool to partners had commenced. While this is a positive development, it is now over three years into the program period and thus is much delayed.

Good practice and lessons from the transition and capacity building activities conducted by PATH projects are that a staged, consistent and long-term commitment is necessary to achieve sustainable health systems change. Suspending support or attempting to advance transition without the necessary PHA capacity can undermine these gains and disrupt access to essential services[92]. Critical health system weaknesses, including inadequate human resource capacity at all levels, extended stock-outs in medical supplies, as well as delays in transfers of recurrent funding to PHAs, and the commitment of PHAs themselves, are major barriers to these efforts. It is moot now whether more focused work by PATH to address some of these bottlenecks, leverage partner support and conduct national-level advocacy could have better supported PHA readiness for transition. Without such efforts, progress to transition will be held back.

[87] Pages 2 and 22, PATH IDD, DFAT, n.d.
[88] PATH completed a 'Stocktake of Primary Healthcare Models' (30 June 2021) to assist in identifying integrated and sustainable models of care.
[89] Page 5, PATH Guiding Strategy V1.0 states that PATH will 'facilitate and prepare PHAs and provincial health departments for this outcome through the testing and scaling of models of integrated and quality primary health care that are aimed at increasing access to all PNG people with a focus on those who often have the most barriers to access including women, girls, persons with disabilities and persons who are disenfranchised'.
[90] Evaluations conducted include: AIHSS (2023), PSF (2022), and SRHIP (2023).
[91] Page 4, PATH Transition Framework: Working with government to improve health system integration, efficiency and performance, Version 1.0, May 2023.
[92] Page 40, Burnet Institute, RID-TB Phase 11B 2022: Annual Report (January–December 2022).

SQ2.5 To what extent has the PATH model supported increased effectiveness of health system strengthening and efficient and effective health service delivery activities – including effective coordination of these efforts across the PATH program? (IO1, IO2, IO3)

Summary: PATH was designed to use an adaptive management approach to develop, test and take to scale strategies to determine how it would reach the program goals and outcomes, and use drivers of change to achieve progress towards its IOs and EOIOs. Unlike the previous PPF and HHISP models, it was intended to use an 'outcome focused' approach to GEDSI and equity. Strong MEL systems were intended to drive program development and provide evidence to support PHAs to effectively plan and deliver health services. The MTR found that many of these approaches were either not established or not delivered. This was due to a range of factors, including instability in program leadership, the severe disruption of the COVID-19 pandemic, and a lack of a vision to bring cohesion to the various components of the program.

Without a practical understanding of program objectives and an agreed vision of what success would constitute for the program, PATH has faced difficulties in bringing program components together to deliver on the initial design objectives. Even with an agreed PAF, PATH does not yet have a solid strategy for delivery of the program and is still establishing systems that should have been in place early in the program period and are necessary for delivery of the PATH model. The MTR found that there is little opportunity for PATH to develop those approaches and achieve useful outcomes in the remaining program period. There is recognition among interviewees that PATH is now operating more as an enabling facility than an adaptive program, with the objective of managing existing contracts and responding to requests from the AHC.

Unlike a typical administrative facility-based model[93], PATH was designed to use an adaptive management approach in which it was to develop, test and take to scale strategies to determine how it would reach the program goals and outcomes. According to an adaptive programming approach, progress towards IOs and EOIOs can be facilitated through nominated 'drivers of change' that 'go beyond traditional technical solutions to aid problems'[94]. The original PATH drivers comprised 'the proactive use of evidence, learning and dialogue; addressing problem-driven bottlenecks; leveraging partners; targeted national-level support; and responding to emerging priorities'[95]. Key features of the PATH design that were considered to differentiate the program from the preceding PPF and HHISP were: a clear, specific and 'outcome-oriented approach to gender equality and social inclusion'; a stronger focus on supporting PHAs to deliver essential health services; and the centrality of MEL to provide evidence of 'what works' to drive program development and provide evidence to support PHAs to effectively plan and deliver health services[96].

The Review Team found that core elements of the original PATH model were either not established or are no longer being implemented by PATH:

- The proposed adaptive management approach was not taken forward and an agreed MERL Framework is not yet in place. The latter was a core element for adaptive management, as it was expected to: (1) guide testing, developing and scaling effective and efficient models of service delivery; and (2) build an evidence base to be shared with other partners in the health sector.

[93] This refers to a typical facility intended to achieve development outcomes, rather than an 'enabling' facility that provides purely administrative/logistical services to DFAT (DFAT, 2020, Guidance Note: Performance Assessment Framework for Facilities, September 2020).
[94] Page 3, PATH IDD, DFAT, n.d.
[95] Page 3, PATH IDD, DFAT, n.d.
[96] Page 4, PATH IDD, DFAT, n.d.

- Other aspects of the PATH model, including GEDSI, delivery of essential health services, and the PATH MERL Framework, are discussed earlier under this KRQ and under KRQ3 and KRQ6, respectively.
- Although several of the proposed drivers of change are being addressed, there has not been a clearly defined approach to strategy development in this area. The Bottlenecks workstream, for example, produced a mapping and issues paper, but not a strategy that the AHC considered was appropriate and practical. Development of a Health Efficiency Assessment tool, with the intention of encouraging PHAs to review efficiency of health service delivery and the associated allocation of PHA resources to community-level health services, was discontinued following the 2022 PATH strategic review.

Despite the development of multiple strategies, priorities and frameworks to define various aspects of the program, the strategic review found that these documents and approaches were often inconsistent and overlapping[97]. The strategic review found that this led to confusion rather than providing a strong basis for delivering the ambitious PATH program agenda of problem-driven health system strengthening, and effective and efficient health service delivery.

Combined with instability in program leadership and the severe disruption of the COVID-19 pandemic, the lack of a vision that would bring cohesion to the various components of the program appears to be a key factor preventing the program from 'finding its feet'. Without a practical understanding of program objectives and an agreed vision of what success would constitute for the program, PATH has faced difficulties in bringing program components together to deliver on the initial design objectives. The absence of this shared understanding has also been a critical barrier to the acceptance of proposed strategies or program activities as relevant and useful elements of the PATH program.

Revised PATH model

The PATH Program Logic was revised with the objective of providing a more coherent and focused framework for achieving PATH's objectives. Bottlenecks, Equity and Accountability IOs, also reflected in the drivers of change, were removed as IOs with the intention that they would be mainstreamed. As described earlier under this KRQ, this has only been partially successful.

Still without a solid strategy to deliver on its objectives and focused on rebuilding its internal systems, there is limited time for PATH to implement the proposed approaches and achieve useful outcomes. Furthermore, without a health strategy, or adequate health technical assistance for much of the program, PATH is not taking an adequately strategic view of the health needs and how they can be addressed. Instead, it is largely involved in revising the designs of existing health projects. There is a recognition among interviewees that PATH is functioning more as a traditional facility than an adaptive program, with the objective of managing existing contracts and responding to requests initiated by the AHC. Furthermore, by elevating transition to a central position in the PATH strategy, the program risks being focused on how well DFAT-funded projects align to GoPNG systems, rather than how well it can support the GoPNG to achieve critical health outcomes.

Coordination across the PATH program

Efforts have been made by PATH to address the silos and lack of communication between and within its workstreams that have undermined the effectiveness and potential of the program. Program cohesion meetings have been conducted fortnightly since February 2022 to share information

[97] Consultant report, 2022.

between workstreams. The PATH Improvement Plan notes that the FHO team has begun engaging with the Port Moresby-based PHASP and Health Security Leads to ensure that activities are communicated to PFs and MELCs. However, this work is commenced late in the PATH timeline and is not adequate to strengthen coordination across the program. Some PHASP provincially based staff interviewed are closely involved in PATH health project delivery; others are still not aware of the objectives of some projects operating in their provinces. Not having this information affects the standing of PATH PHASP staff in the PHA, as well as representing a lost opportunity for improved partner coordination.

Similarly, several grantees interviewed reported that they did not have contact with PHA teams in the provinces in which they were working. Communication between IO3 projects is also weak, and opportunities to enhance effectiveness have been missed. A grantee explained that when they visit Western Province, where PATH has a significant footprint, they do not engage or coordinate with other PATH projects to share resources or develop joint strategies to reach underserved communities.

There is also an opportunity to look at synergies between different types of health projects. While a main focus of the TMP is building laboratory capacity for malaria testing in PNG, for example, prevention and treatment of this leading cause of mortality in PNG is equally important[98]. There may be opportunities for PATH to leverage the work of grantees engaged at the community level to distribute information and conduct integrated services. There are limits to what can be delivered within available resources, but this potential is not being pursued while PATH remains, necessarily but belatedly, focused on establishing internal systems to meet its existing commitments.

3.3. Key Review Question 3: GEDSI

To what extent is PATH adequately considering and addressing the needs of women and girls, people with a disability, and other marginalised groups?

Summary: PATH's GEDSI unit described its core functions as: targeted GEDSI investments (including the Sapotim Lida Project); mainstreaming GEDSI; and to support 'equitable health systems' efforts by working with implementing partners to strengthen their GEDSI and health equity progress. During the Inception Phase, PATH reported how it had been mainstreaming 'strategies for GEDSI to deepen access and inclusion of the vast rural population, especially women, girls and persons with disabilities'. In practice, this work was carried out by the grantees and, apart from referring to the grantees' own progress reports, PATH lacked a systematic method for collecting data or feedback from them to assess their achievements in either GEDSI or health equity, or what further support may be required. Many of the grantees would have carried out this work anyway, as part of their mission. While PATH provided the resources for this work to continue, it is not possible to identify the added value that PATH delivered to enhance these endeavours. Furthermore, it has not been possible for the Review Team to ascertain how much budget was allocated to these objectives. In summary, there is weak evidence that the GEDSI Strategy has been successfully implemented across PATH.

[98] Seidahmed, O., Jamea, S., Kurumop, S., Timbi, D., Makita, L., Ahmed, M., Freeman, T., Pomat, W., & Hetzel, M.W. (2022, 21 November). Stratification of malaria incidence in Papua New Guinea (2011–2019): Contribution towards a sub-national control policy. *PLOS Glob. Public Health*, *2*(11), e0000747. doi: 10.1371/journal.pgph.0000747. PMID: 36962582; PMCID: PMC10022348

PATH's intention was to integrate GEDSI efforts across all program operations and management, with the principle that PATH acknowledges GEDSI as a priority in all workstreams and operational units[99]. In the PATH Program Logic, GEDSI is present in at least two places: IO2 regarding women in leadership; and as a cross-cutting theme of the whole program.

PATH's GEDSI Strategy is informed by detailed analytical work (the 'GEDSI Stocktake') and lessons learned from essential health services programs, and gender programs such as Pacific Women Shaping Pacific Development. It defines six 'pathways' to achieving its objectives[100]: Leadership and Representation; Accountability and Networks; Equitable and Essential Services; Knowledge, Understanding and Communications; GEDSI Minimum Standards for COVID-19; and GEDSI and Safeguarding Mainstreaming. The GEDSI Stocktake focused on PATH's six demonstration provinces, and consultations were held with a variety of stakeholders including Provincial Administration Gender Equality and Social Inclusion (GESI) Managers, Provincial Disabled Persons Organisations, and the Provincial Councils of Women.

PATH's GEDSI unit described its core functions as: targeted GEDSI investments (including SLP)[101]; mainstreaming GEDSI; and to support 'equitable health systems efforts' by working with implementing partners to strengthen their GEDSI and health equity progress[102]. During the Inception Phase, PATH reported how it had been mainstreaming 'strategies for GEDSI to deepen access and inclusion of the vast rural population, especially women, girls and persons with disabilities'[103]. In practice, this work was carried out by the grantees and, apart from referring to the grantees' own progress reports, PATH lacked a systematic method for collecting data or feedback from them to assess their achievements in either GEDSI or health equity, or what further support may be required. Many of the grantees would have carried out this work anyway, as part of their mission. While PATH provided the resources for this work to continue, it is not possible to identify the added value that PATH delivered to enhance these endeavours. Furthermore, it has not been possible for the Review Team to ascertain how much budget was allocated to these objectives. In summary, there is weak evidence that the GEDSI Strategy has been successfully implemented across PATH**.**

SQ3.1: How well has the PATH model led to the adoption of GEDSI-transformative approaches in addition to supporting health service provision?

PATH's GEDSI Strategy recognises the global evidence that gender-transformative change must occur at multiple levels, and more specifically that development programs must take explicit actions to enable this change. This entails understanding and confronting the gendered conditions, including pervasive violence and discrimination, which deplete the health of women and girls and also inhibit their access to health services. Example actions cited include: increasing opportunities for women to take on leadership roles; transforming social norms and practices; and working in partnership with local organisations and community groups to achieve change.

The need for GEDSI-transformative approaches to be included in health service delivery programs was also raised in recent evaluations. For example, the PSF evaluation (a service delivery grantee under PATH) noted that while PSF had been 'directly focused on addressing barriers faced by women', it had neither directly addressed social norms around gender, nor implemented a gender-transformative approach[104]. Moreover, the AHC's Health Portfolio Plan (HPP) Review found that HPP

[99] Abt Associates, Locally generated and scaled health systems reform – Papua New Guinea–Australia Transition to Health (PATH) Program. Schedule 2. Technical Proposal, May 2020, RFT# DFAT 114.
[100] GEDSI Strategy (April 2021).
[101] The Sapotim Lida Project is discussed under IO2 (KRQ2) in the MTR report.
[102] PATH Six-Monthly Report (January–June 2023).
[103] PATH Progress Report (2021).
[104] Partnering for Strong Families (PSF) Evaluation (2022).

and its investments (the largest of which is PATH) predominantly focused on service provision[105]. The review observed that 'there was no focus on agency and voice; social norms; institutional policies and practices; and safeguarding'.

The program team acknowledges the requirement to demonstrate GEDSI-transformative approaches, but there is weak evidence that this is leading to a change of strategy. According to PATH's own 'GEDSI effectiveness screening' using the HDMES GEDSI Toolkit, no aspects of PATH are 'GEDSI responsive' or 'GEDSI transformative' [106]. It is notable that PATH rated SLP, a program aimed wholly at supporting women in leadership, as no more impactful for GEDSI than any other project in PATH's portfolio. Nonetheless, PATH anticipates that SLP will 'transition to Responsive quite quickly and aspire to reach Transformational'[107]. PATH is undertaking what it calls a GEDSI 'crosswalk' to compare elements of the GEDSI Strategy to the HDMES GEDSI Toolkit. However, it is not clear how this alignment will lead to a different approach, or whether this will lead to more ambitious GEDSI mainstreaming across all projects. The other references to 'crosswalk' in the progress report seem to frame this as being a reporting mechanism, rather than a guide to action[108].

SQ3.2: How has PATH included social norms change and Gender-Based Violence (GBV) prevention and response as cross-cutting GEDSI actions (as outlined in the GEDSI Strategy), and how effective has this been?

The GEDSI Stocktake highlighted the importance of exploring the intersection of GBV with health as an essential component for PATH's overall strategy[109]. This was acknowledged in PATH's GEDSI Strategy, where social norms and GBV are described as cross-cutting themes. This implies they should be nested within all activities and are thus essential for achieving PATH's GEDSI objectives. For example, Pathway 3: Essential and Equitable Services, states that PATH will identify and test 'locally-led community-based approaches that identify barriers and address social norms to increase safe and equitable access to quality and integrated essential services' and 'services will also be supported to prevent and respond to GBV through their health delivery'. However, the program lacked a plan as to how these issues would be tackled in practice. For example, the grantees may have their own tried and tested approaches to these issues, which PATH could have been assessed and replicated where they showed promising results.

The GEDSI Stocktake also identified the relationship between GBV and women in leadership**,** noting that GBV 'was unanimously identified among respondents as a widespread issue that impacts women's leadership potential and career advancement within the public service'. The SLP design reflected this understanding of how GBV needs to be addressed, and undertook PHA workplace policy reviews, including policies related to workplace safety. However, there is limited evidence that at the cross-cutting level the program developed a mechanism for addressing the gendered conditions that both expose women and girls to poor health and violence, but also inhibit their access to health services.

Despite GBV being a pervasive and growing problem in PNG, with implications for all aspects of PATH's work, the program has taken a narrow approach to addressing it. PNG has one of the highest

[105] Health Portfolio Plan Mid-Term Review (2022).
[106] The GEDSI Toolkit, developed by HDMES for AHC, consists of seven 'GEDSI Domains', each exploring a different aspect of equality and inclusion, measures approaches on a continuum, from 'GEDSI negative', towards 'neutral', 'sensitive', 'responsive' and 'transformational'. Transformative approaches address 'underlying causes of gender inequality and social exclusion and changes inequitable norms, access, structures, systems and power'.
[107] PATH Progress Report January–June 2023 (February 2024 version).
[108] For example: 'once completed, the crosswalk will be used to determine how PATH will report on GEDSI to ensure alignment with the HDMES tool' (PATH Progress Report January–June 2023, p.39).
[109] Page 14, PATH GEDSI Stocktake, 2021.

rates of GBV in the world. The pernicious and multi-generational effects of violence against women and girls represent an obstacle to social and economic development and therefore oblige all development programs to design a response[110]. This is of direct relevance to a health program, as NDoH reported that the thousands of recorded cases of sexual and physical violence place burdens on health facilities, and yet these are just 'the tip of the iceberg', implying that many injuries are not being treated at all. GBV was included in the SLP/GEDSI Workplans for PATH's six demonstration provinces and NDoH, but with quite a limited scope. For example, PATH supported NDoH to roll out SGBV Clinical Guidelines to PHAs[111]. However, although data systems are in place in PHAs to track counselling provided to survivors of SGBV, no clients received this service in the first six months of 2023. Furthermore, PATH has not yet identified the reasons for this, nor developed a plan to ensure PHAs develop the skills and knowledge to support survivors of SGBV[112].

SQ3.3: To what extent has PATH set out a process whereby the health system interprets the needs of all citizens, ensuring for example that women and girls (including those with disabilities) are supported as active participants in health systems, not just beneficiaries?

PATH's GEDSI Strategy recognised the important role that citizens can play in improving the accessibility, quality and fitness of health services, and the need for accountability. However, PATH has been slow to implement a response, or build on the work grantees are already doing in this area. The PATH design, and the GEDSI Stocktake, recognise this is fundamental to meaningful change. The 2020 PATH Annual Report stated that 'Health is often viewed as a service that is provided to communities (something that is done to people) as opposed to something that is owned by communities and is within their direct influence' requiring PATH '…to connect the PHA and health system with community-based solutions'[113]. The importance of empowering communities and households to interpret their health needs and shape the services provided to them is widely supported by global evidence[114]. The Accountability and Networks pathway of the GEDSI Strategy states the program will deliver 'initiatives that seek to improve feedback mechanisms between communities and the provincial health system to identify and address barriers to equitable access'. According to the GEDSI team, this would look at demand (as well as supply) for health services. However, this has not translated into action, with most effort focused on PHAs and policy support. A more sophisticated approach to mainstreaming GEDSI in this context would recognise the grantees as the 'gateway' to reaching communities. This would reflect the findings of the early analytical work, whereby PATH could support and facilitate a sense of partnership between the communities and providers of health services. This should be aimed at empowerment in the sense of acknowledging operating in a context of constrained resources, logistical challenges, and significant public health problems. This intervention would invite grantees to access additional funds to cover the cost of working with communities (such as meetings with women's groups and providing targeted health information materials), which could be covered by the underspend in the overall GEDSI budget[115].

Addressing disability in PATH

PATH's design outlines how the program should advance the rights and opportunities for people with disabilities, in terms of equity of access to health services and support to become leaders. This is

[110] This was emphasised by the NDoH submission to the PNG 2023 Permanent Parliamentary Committee on Gender Equality and Women's Empowerment, where the National Department of Health testified that 'rates of physical violence – against all people – are increasing exponentially, a catastrophic human rights violation alarming for a country not at war'.
[111] Minutes from SLP Working Group meeting (October 2022).
[112] Page 123, PATH Six-Monthly Progress Report 2023. Annex PSF.
[113] Page 20, PATH Frontline Health Outcomes Annual Report for January to December 2020.
[114] For example: O'Mara-Eves, et al. (2015). The effectiveness of community engagement in public health interventions for disadvantaged groups: a meta-analysis. *BMC Public Health*, *15*, 129.
[115] This point recognises that PATH projects, such as AIHSS, have not always included a budget for GEDSI-related activities.

exemplified in the broader GEDSI focus of PATH and the original version of IO 2.1[116]. Moreover, the PATH design required the program to identify specific barriers that prevent women, people with disability, and the poor, from accessing essential health services. This also highlighted the importance of understanding how women and girls with disabilities are at greater risk from all forms of violence, and how disability is both a cause and consequence of gender-based violence. This reflected how GESI and GBV are prominent in GoPNG discourse, but the policy implications of disability are less well understood. The design also highlighted the importance of meaningful participation of people with disabilities, who had reported that health facilities were often inaccessible to people with a disability due to 'attitudinal and infrastructure barriers'.

However, despite the directions of the design and a sound analysis of the problem, PATH lacked a strategy for working with people with disabilities (for example, to improve the availability and accessibility of services), and public health interventions to prevent people (especially children) acquiring a disability. An internal document noted that: 'given the size and scale of PATH, the approaches and achievements related to disability inclusion appear to be relatively minor and isolated. Significantly more work is required to develop a clear and comprehensive approach to understanding, working with, and achieving results for people with disability'. Subsequently, the focus on disability inclusion was strengthened through a contract amendment in early 2023, amending GESI to become GEDSI, and requiring PATH to mainstream disability as well as gender[117].

Nonetheless, the program has made some achievements regarding disability. For example, NDoH agreed to the addition of an indicator and data collection for disability inclusion in the NDoH MERL Strategic Plan and with the eHealth Steering Committee[118]. MTR interviews highlighted the important role PATH played in this success, and the opportunity this now provides for disability advocacy at the subnational level, using the new indicator as an incentive to nudge PHAs as they need to report against it[119]. However, there is little evidence of PATH using this success to inform and strengthen its approach to disability inclusion across the system, despite the need for improved services, advocacy and support by the National Orthotic and Prosthetic Services at the subnational level[120]. According to one GoPNG interviewee, there were missed opportunities for PATH to help NOPS capitalise on the advocacy opportunity this new indicator presented – for example, PATH could have acted as a conduit to help NOPS connect with PHAs, grantees, and community groups. This would have chimed with the program design, which noted the opportunity for PATH to address the need for increased community-based rehabilitation services.

Working with grantees to integrate GEDSI

The service delivery grantees that PATH inherited had different approaches to GEDSI in their design and execution, often with limited integration but with some good activity examples. During the period covered by the MTR, a number of these grants have been evaluated, highlighting areas where GEDSI could be improved[121]. There is limited evidence of PATH acting on these recommendations,

[116] IO2.1: Equity – Approaches that increase access to quality essential services by women and girls, people with disability, and the poor are tested and scaled.
[117] Section 17: Statement of Requirements GEDSI. PATH Head Contract Amendment (February 2023). PATH's original Head Contract explicitly included disability under GESI, but did not state that disability would be mainstreamed.
[118] NHP Indicator 7: Proportion and number of Provinces with health rehabilitation assistive technology and community-based rehabilitation programs delivered through clinical services, with data disaggregated by province, sex, and age.
[119] This activity is in the NOPS workplan funded through the SLP; however, is not focused on women in leadership, so was included under GEDSI rather than IO2.
[120] Based on an interview with senior field-based PATH team member.
[121] For example, AIHSS, PSF2, SRHIP, and SLSS, as well as Australia's five-year PNG Health Portfolio Plan 2018–2023 (HPP).

aside from the AIHSS redesign for its Phase 2[122]. In this case, PATH assigned dedicated GEDSI expertise to the design, leading to a stronger focus on GEDSI in the results framework.

However, PATH saw the grantees more as service providers and implementers, instead of partners in achieving shared goals, including GEDSI. According to one informant, PATH was designed specifically around the technical needs of the six selected provinces, and did not consider how the grantees perceived GEDSI as part of their mission and how PATH would influence them to do so. There is scant detail in the design, Abt's proposal, or the GEDSI Strategy, to indicate how the program would assess the grantees' level of commitment to GEDSI. The GEDSI Strategy states grantees are responsible for 'Integrating GEDSI analysis and activities into program delivery and grant/contract management where agreements are developed across PATH', but that implies an earlier step whereby PATH leads a discussion and agreement for change.

It is evident from grantee comments that the PATH team was not proactive in working with them to co-design shared commitments and strategies that incorporate GEDSI and Women in Leadership themes. Instead, the GEDSI team focused on 'small-scale' ways to influence them, as if to make more meaningful amendments to grant agreements would be outside the team's authority. This consisted of reviewing grantee progress reports to propose tactical interventions where GEDSI could be inserted into activities. This is a laborious process that is opportunistic rather than strategic, and in the absence of additional funding from PATH, the capacity (and, presumably, willingness) for grantees to integrate requests is limited.

The GEDSI team believed they had limited scope and opportunity to build in GEDSI themes outside of a formal grant evaluation and redesign process, despite recognising PATH's service delivery grants are an important means by which the program can operationalise its GEDSI objectives. The Review Team has not been able to ascertain if this perception of the sub-contracts being 'locked' was correct. Grantees make up approximately 60 per cent of the PATH budget, have extensive reach across the six provinces and beyond, and in most instances longstanding relationships with PHAs, sub-provincial level health providers, as well as community groups. It would therefore be unusual if PATH did not have authority to review and amend grant agreements, even those novated from previous programs, without having to engage in a complete redesign, as in the case of AIHSS.

GEDSI team structure and management

The GEDSI team remained relatively stable during the MTR period, compared with the high turnover seen in other workstreams and the SEM team. However, that changed in 2023, with the original GEDSI Lead leaving in March and the new lead arriving in August. The Disability Coordinator position was also vacant for some of 2023, including during the MTR interviewing period. The new member of the team was due to start before the end of 2023 in an expanded GEDSI Coordinator role. This position will continue to have a focus on disability inclusion; however, given the expanded job title there is a risk that will not happen. Members of the GEDSI team acknowledged a degree of confusion across PATH regarding GEDSI mainstreaming and SLP, so clarifying respective roles and responsibilities within the GEDSI team is necessary. Implementing an effective cross-cutting strategy for GEDSI across a large program requires a well-resourced and high-performing team, with sufficient authority to influence activities that have systemic resonance yet may appear to colleagues to fall outside the remit of the GEDSI team.

In the case of PATH, the GEDSI team was partly hampered by the nature of the results framework that implied GEDSI goals in the Intermediate Outcome without spelling them out, and also by a modality of outsourcing that drew resources away from mainstreaming activities. The challenges

[122] AIHSS is the only grantee to undergo a formal redesign during the MTR reporting period.

faced by the GEDSI team in directing activities in other parts of the program, and making timely decisions on budget reallocations, may be partly attributable to the way roles and responsibilities for GEDSI are defined in the program strategy. This describes how 'the PATH program' is responsible for 'direct engagement at every level with PNG counterparts and downstream partners (grantees and subcontractors) on GEDSI', but does not specify who in the program is accountable for this. Similarly vague roles are assigned to the GEDSI team and 'all other PATH workstreams and operational teams', who will deliver 'GEDSI-targeted activities in collaboration with the GEDSI workstream'. Meanwhile, 'downstream partners and key civil society stakeholders' are deemed responsible for 'integrating GEDSI analysis and activities into program delivery'. The assumption that 'mutual accountability' would ensure GEDSI goals are kept in view was not, in practice, sufficient to overcome the weaknesses of an ambiguous management framework where responsibilities are distributed across all parts of the program – and to stakeholders – without measurable outputs embedded in schemes of work. The likely outcome is that everyone's job became no one's priority.

Classification of PATH according to the DAC marker

PATH classifies itself as 'significant' for gender equality under the OECD DAC markers, meaning that gender equality is an important and deliberate objective of PATH, but not the principal reason for undertaking the program. At the project level, both the Sapotim Lida Project and PHASP are classified in the recent progress report as 'principle' (this should read 'principal')[123], which means gender equality is the main objective of the project or fundamental to its design and objectives. In the case of the PHASP implemented under IO1 this is not accurate, and in any case both projects are rated as 'sensitive' by the GEDSI Toolkit, which is not compatible with a 'principal' rating in the OECD DAC markers.

Furthermore, the finding of the MTR is that there is insufficient evidence that PATH meets the minimum definition set by OECD for the 'significant' ranking. Further details are provided in **Annex 12** of this report. In summary, the shortcomings are related to the absence of M&E indicators, data disaggregation, and a method for measuring GEDSI performance targets.

3.4. Key Review Question 4: Efficiency

To what extent is PATH being delivered efficiently in alignment with DFAT's value for money principles?

Summary: PATH reports that it is meeting selected VFM criteria, but from a more substantive viewpoint PATH has been unable to demonstrate progress against the objectives for which it was established. Failure to deliver key work products has also led to increased transaction costs and undermined the relationship between PATH and the AHC. The MTR found that the leadership of the PATH significantly influenced the way that PATH was implemented, collaboration between key PATH stakeholders, and the extent to which PATH has used its resources effectively. PATH successfully managed its start-up and the transition of projects from the PPF and HHISP to the program; however, the MTR found that initial leadership of PATH was poor. The deficient performance of PATH, some of which was directly influenced by the COVID-19 pandemic, affected the AHC's trust in PATH's ability to deliver. This has undermined the partnership approach that is key to effective and efficient implementation of a development facility. The MTR found that the PATH Managing Contractor did not provide the type of standard management approaches used to establish a well-resourced and

[123] This is one of several errors in the February 2024 revision to the January–June 2023 Progress Report. It also transposes the GEDSI Codes for 'principal' and 'significant'. These careless errors undermine the report's credibility.

structured organisation, indicating a lack of corporate accountability. The failure to do so contributed to excessive workloads and inadequate support for staff development, which in resulted in greater staff turnover and a lack of adequate staff skills and resourcing. Although assistance has been provided by the MC to fill gaps in human resourcing, much of this failed to hit the mark. Localisation of staff appears to be restricted to recruitment of PNG staff, without support for their professional development.

Current PATH leadership is attempting to bring greater structure and effectiveness to the program, but recurring organisational challenges, including extended vacancies and lack of key program systems, remain barriers to progress. Weaknesses in management of projects are being addressed with additional resources for contract management, but grantees report that they are facing an increasing burden of compliance and reporting that affects efficient project delivery. In the view of the Review Team, given the challenges that PATH faces, this appears to be occurring too slowly and partially to result in any meaningful changes before the next phase of the program.

SQ4.1: How does PATH demonstrate value for money for DFAT? (including KPIs as a measure of performance and accountability)

PATH performance against DFAT mandatory VFM performance indicators

One of the purposes of adopting a facility program delivery model is its perceived potential to increase the efficient use of resources and reduce the related transaction costs for DFAT[124]. PATH reports annually on its performance against DFAT mandatory VFM indicators in its annual VFM report to DFAT, and has demonstrated examples of cost consciousness (e.g. through moving to a shared services platform, and reducing internet, staffing and accommodation costs), with substantial expected savings in 2023 of AUD1.2 million[125]. It is of note, however that PATH reports fluctuation in Administrative Costs as a percentage of Total Expenditure from 24 per cent in 2021 to 32 per cent in 2023. This places PATH at the higher end of expenditure for this category of expenditure[126], but the program's non-operating expenditure is broadly consistent with previous years[127].

PATH performance against program KPIs

PATH performance is also managed through the use of KPIs, agreed annually between PATH and DFAT. An average of four to five KPIs have been set per quarter, related to delivery of key work products that are essential for the oversight, management and accountability of the program products[128]. Approximately 70 per cent of KPIs have been accepted by DFAT for payment, with PATH also noting in successive program reports that 'the timeliness and quality of contractually mandated reports' has been a challenge[129]. As shown in **Table 4**, there have been delays of over a year in submission of successive Annual Reports. Rewriting and resubmitting these products has led to inefficiency and significantly increased transaction costs for both PATH and the AHC[130]. Finalising a Ways of Working document to guide the relationship between the AHC and PATH, and development of the program MERL Framework and Strategic Plan, have also required recruitment of consultancy support and the involvement of GoPNG stakeholders. MTR interviewees indicated that PATH's

[124] Pieper, L. (2018, 7 May). *Review of selected DFAT facilities – Independent Consultant Report to DFAT*, page 1. https://www.dfat.gov.au/sites/default/files/independent-facilities-review.pdf
[125] Page 71, Annex 7: Value for Money Report, PATH 2023 Annual Report, 28 February 2024.
[126] An Australian National Audit Office review of Australia's Official Development Assistance delivered through a facility found that, of the 20 facilities reviewed, 14 to 21 per cent of expenditure is on administration (see https://www.anao.gov.au/work/performance-audit/value-money-the-delivery-official-development-assistance-through-facility-arrangements).
[127] Page 61, Annex 7: Value for Money Report, PATH 2023 Annual Report, 28 February 2024.
[128] The number of KPIs ranges from 21 in 2020–2021 to 16 in the 2022–2023 financial year – as described in KPI Summary 2 August 2023 (provided by PATH 24 August 2023).
[129] Page 36, draft PATH Annual Report 2023, 28 February 2024; Page 8, PATH Annual Report 2022 – Final Draft – 28 February 2023.
[130] Page 36, draft PATH Annual Report 2023, 28 February 2024; Page 8, PATH Annual Report 2022 – Final Draft – 28 February 2023.

repeated failure to meet acceptable standards for contract and KPI-related deliverables was a major cause of frustration for the AHC and affected trust between the partners. PATH's unsatisfactory performance is further highlighted in Aid Quality Checks[131]. Combined with the lack of evidence that PATH has achieved its outcomes, it is therefore challenging to demonstrate that the program has delivered value for money.

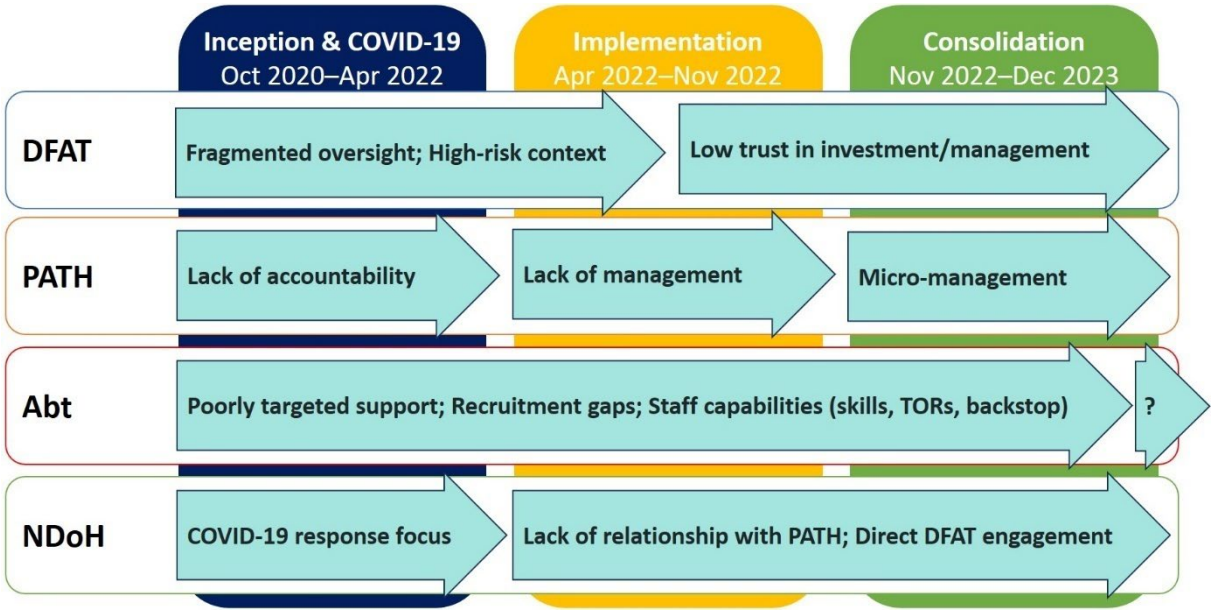
Table 4: PATH Annual Reports – Dates submitted and accepted by AHC

Annual Report	First submission	Accepted as final
2020	1 March 2021	Inception Report submitted December 2020 covering the period until 30 Jun 2021. FHO Annual Report submitted 1 March 2021.
2021	31 January 2022	May 2023.
2022	28 February 2023	Submitted. Revisions still underway. Not yet accepted.

SQ4.2: To what extent is PATH collaborating and coordinating effectively and efficiently with internal and external stakeholders?

The key PATH stakeholders who play a part in the leadership of the program, and how they interacted throughout the program period, are shown in **Figure 4**.

Figure 4: Leadership of the PATH program from inception to December 2023



DFAT leadership of PATH

The MTR found that DFAT's involvement in PATH during its initial stages was characterised by a level of fragmentation, as it attempted to support program start-up and respond to the disruption of the program due to COVID-19. This included high levels of turnover, and challenges in deployment and recruitment. Concurrently, the AHC was operating in a high-risk environment with reduced local resources, needing to assemble, deploy and manage DFAT's support to GoPNG to respond to the COVID-19 pandemic. Interviewees observed that this influenced the oversight of the program and

[131] Annual Investment Monitoring Reports.

the AHC's approach to PATH during that period. The MTR found that, moving into the post-COVID-19 era, this did not turn around. The way in which DFAT engages with PATH now is characterised by that early poor performance, and this has led to a very low level of trust by the AHC in PATH and its ability to deliver results. This has a strong influence on the communication between the AHC and PATH and has undermined the potential of PATH to enable a more responsive and flexible approach to implementation.

PATH program leadership

Evidence of the lack of accountability of PATH's leadership during the inception period and during the initial COVID-19 response was stark. The PATH Team Leader was described by former employees as being more focused on issues outside PATH and, in terms of PATH, being 'missing in action' during this critical period. This was damaging to PATH, and the relationship with the AHC and with NDoH. Within PATH, this meant that there was not an adequate focus on establishing the systems and processes that needed to be in place in any project, but particularly for a large, complex and ambitious program such as PATH, to make the various components of the program work together in a coherent way. This stage should have been used to move from a highly conceptual design to a program with agreed and clearly understood objectives, and establish the essential frameworks needed to achieve those objectives, but this did not take place. Without a shared vision, different programs and workstreams were unable to articulate or work together to realise the vision and, importantly, develop and follow a systematic, practical and staged approach to realise key concepts like transition.

The MTR found that PATH has struggled to recover from this failure. this was not supported by what MTR interviewees observed was a laissez faire leadership approach during the subsequent implementation phase. The systems and processes that were central to the effective operation of the program were not established. The Review Team found little evidence of focused efforts to bring direction to the program and establish management systems during this period.

PATH moved into a period of greater stability at the end of 2022, with the recruitment of a permanent Team Leader and PAS Lead. This has allowed the program to gradually establish internal systems and frameworks around some of its program activities and address project evaluation recommendations [132]. The management focus, however, is at the operational rather than strategic level. This is due to the need to improve, and in some cases establish internal management systems as outlined in PATH's Service Improvement Plan[133]. This period is characterised by a level of micro-management, with attention to addressing some of the criticisms of PATH and bringing greater cohesion to the PATH team. Still, without key systems such as the program MERL Framework, and faced with the continuing challenges described below, this appears to be occurring too slowly and partially to result in any meaningful changes before the next phase of the program.

PATH Managing Contractor, Abt Associates

The MTR found that the PATH Managing Contractor did not provide the type of targeted support needed to address initial program development needs and management gaps. Abt did provide assistance, but some of that support failed to hit the mark or didn't produce products that proved particularly useful in assisting PATH along the way. Technical assistance was initially provided to develop guidance to implement the AMTWP approach but, as described elsewhere in the report, the approach outlined was never established. The MC appointed one of PATH's technical advisers to the

[132] Evaluations of AIHSS (2023), PSF (2022), and SRHIP (2023), made a range of recommendations around contract management, sustainability and transition, GEDSI and integration of primary health care.
[133] PATH Service Improvement Plan – November 2022–March 2023.

role of Acting Team Leader following the departure of the initial Team Leader. The Contractor Representative also visited PATH in Port Moresby to provide support following the departure of the initial Team Leader but, reportedly, this created a level of confusion regarding levels of authority within the program team and did not provide the clear and consistent direction that PATH needed. As shown in **Annex 13**, there was no permanent PATH Team Leader for almost nine months[134]. Recruiting staff to specialised roles in PNG was understandably highly challenging in the context of the COVID-19 pandemic. However, given the high profile and high value of the PATH investment, it would have been appropriate for the Managing Contractor to demonstrate stronger efforts to recruit and deploy a permanent Team Leader.

NDoH

NDoH is a critical stakeholder for the PATH program and is expected to provide strategic leadership and guidance, engage in decision-making about program direction, and monitor performance. Interviews with NDoH stakeholders indicated that during the early stages of PATH, the NDoH focus was on responding to the COVID-19 pandemic. Hence the attention of NDoH to the PATH program, apart from addressing its concerns about PATH leadership, was more limited than might otherwise be the case. Without this relationship, the MTR heard that NDoH senior leadership are approaching DFAT with requests rather than talking to PATH. This may entrench PATH's lack of visibility to NDoH.

SQ4.3: How well have PATH program resources been allocated and used to achieve the proposed program objectives and outcomes (as determined by DFAT and the program design)?

Human resources

The Review Team found that a range of weaknesses in planning and establishing essential management systems, significantly worsened by the impact of the COVID-19 pandemic, produced a highly challenging context for program implementation.

While the Abt bid for the PATH program nominated a group of experienced and competent individuals for identified roles, it was found that workforce planning had not been conducted to assess overall personnel and capacity needs for implementing the PATH program. Key job roles and Terms of Reference (TORs) reviewed were overloaded, with extremely high demands on some positions, indicating that job analysis was weak or inconsistent.

PATH has experienced extended gaps and turnover in permanent appointments to key senior management throughout its implementation period, as illustrated in **Annex 13**. The Provincial Performance Lead role, expected to drive the development and performance of the majority of activities conducted under IO1, was not filled by a formal candidate for approximately half of the program period examined (from October 2020 to June 2023). Similarly, there have been extended gaps in the critical role of PAS Lead and frequent turnover in this position. An interviewee commented that they had worked under five PAS Leads during their time with PATH. Recognising the challenges of performing recruitment due to the impact of the COVID-19 pandemic, it appears that the Managing Contractor has struggled to recruit replacements. In some cases, these gaps were addressed through the appointment of short-term advisers (STAs), support provided from the Abt office, or through moving less experienced staff into these roles. However the rationale for some appointments, in which individuals have moved from program-level roles to key senior executive management roles, such as the Team Leader and Program Delivery Lead, was not clear to the Review

[134] The PATH Team Leader departed on 15 February 2022 and a new permanent Team Leader was commenced on 11 November 2022 (information supplied by PATH, 24 August 2023).

Team. High levels of turnover in the program more widely – 41 per cent in 2021, increasing to 64 per cent in 2022[135] – and absenteeism have further reduced PATH's capacity to manage the program workload, and affected the level of project management skills and PATH's ability to undertake some of the complex and highly technical work needed to establish effective internal systems.

Team management and information sharing

The Review Team found that under PATH's first Team Leader, routine internal management systems, such as regular management and team meetings, were very weak to absent. Not all workstream leads were included in SEM meetings and there were reportedly no structured means of providing direction or sharing information among the PATH team more widely. A manager interviewed by the Review Team noted that they were not aware that an SEM team existed during their first months working with PATH. Interviewees confirmed that workstream leads and senior managers were not aware of the monthly spend of the projects that they managed. Without such basic elements in place, it is understandable that PATH did not perform to the standard required and struggled to implement some of the more complex elements of the design.

There have been focused efforts since late 2022 to establish standard management systems within PATH. Nevertheless, mid-level interviewees reported that management decisions and information about issues affecting their work are often not clearly or consistently communicated. A greater focus on communication within workstreams and across PATH as a whole, not only among attendees of fortnightly meetings, is needed. Monthly whole-of-PATH meetings were suggested as a way of informing staff of the work being conducted by the program and key priorities for the period ahead, as this is not currently taking place.

Localisation of PATH staff

The PATH program design has a strong focus on supporting locally driven solutions to local issues visible throughout the program, its adaptive management approach, and its EOIOs. PATH has embraced localisation through the employment of a high percentage of PNG staff in the program and, in 2023, 82 per cent of PATH project staff were 'recruited locally'[136]. While the focus on recruitment of PNG staff is commendable, it did not appear that PATH's localisation strategy extended beyond recruitment. The MTR found that the necessary systems and support were not provided to local staff to assist them to perform effectively in their roles. Abt reports that it has a local staff training budget and a PATH staff member has used this to support post-graduate education. However, PATH does not currently have a capacity building plan for its staff: either national or international. PATH staff reported that they had received very little training and what had been delivered by PATH was largely focused on compliance-related issues rather than professional skills development. Furthermore, while PATH has employed highly skilled and experienced PNG staff, it has not always employed those staff in roles suited to those skills. For example, the Health Security Lead, who has strong health technical skills, is employed in a contract management role. This role has provided the opportunity for the staff member to gain experience in a new area, but provides very limited opportunities to use their expertise. In other cases, staff have struggled with what they have experienced as an unreasonably high workload and expectations of senior roles, in an organisation that is operating with weak internal management systems. Rather than building local capacity and expertise, this is likely to undermine the professional development and morale of young PNG professionals recruited to those roles.

[135] Page 56, PATH Six-Monthly Report (January to June 2023), 28 August 2023.
[136] Page 70, PATH Annual Report 2023, 28 February 2024.

Grants management/management of grantees

The PATH MC proposed that PATH would use a performance management approach to ensure that grantees delivered value for money. However, previous FHO project evaluations (AIHSS and PSF) have found that PATH demonstrated weak contract management, with limited attention to achievement of project IOs and EOIOs. Since late 2022, PATH began to strengthen systems and personnel for budget and contract management, including a 'Contracts Tracker', employing additional contract management staff, and establishing routine reviews with grantees of expenditure. This will no doubt contribute to improved management practices. Nevertheless, an inspection of grantee contracts by the Review Team found that agreements lack realistic performance improvement criteria and a clear delineation of performance delivery standards. Instead there is a major focus in these contracts on reporting and compliance. This does not support a greater quality and health outcome focus to delivery of grants. Several grantees further noted that there are increasing and excessive demands related to compliance and reporting from PATH, requiring additional grantee resources to provide a response. While grantees emphasised their commitment to meeting DFAT requirements, they expressed concern that this may affecting the efficient and effective delivery of projects. The Review Team acknowledges that this may be due to AHC requirements, rather than those of PATH specifically. Nevertheless, an approach that is more focused on delivery of quality project outcomes is more likely to result in improved performance.

3.5. Key Review Question 5: Sustainability

What have been the different approaches, achievements, challenges and lessons learned among PATH projects in embedding sustainability?

Summary: PATH's main approach to achieving program sustainability is through a 'transition agenda', but it neglected to implement its initially proposed approach to transition for much of the program period, and subsequently project progress towards transition objectives was slow. With a revised strategic framework in 2023, PATH has renewed focus on this objective, but practical pathways for its achievement are still to be defined. The likelihood is low of substantial progress towards the ambitious capacity building objectives and the system-level changes needed to advance transition.

SQ5.1: How well has 'transition' to PHA management been realised within the PATH program and Frontline Health Outcome interventions?

Original plan for transition

The HPP proposed that DFAT investments begin to move away from 'substituting services towards assisting PNG prioritise and utilise its own resources more efficiently'[137] and included a staged reduction in funding for SRMNCH investments. It was expected that the PATH program would play a significant role in advancing this agenda.

The Technical Proposal submitted by the PATH Managing Contractor outlined an approach to progress transition with the ultimate objective that health services are 'owned, led and resourced by local providers, particularly PHAs' [138]. It included:

- Requiring 'evidence of how partners are co-designing activities, coordinating with, and building the capability of PHAs, faith-based organisations, and CSOs to take on aspects of delivery'[139].

[137] Page 6, HPP 2018–2023.
[138] Page 10, Abt, Locally generated and scaled health systems reform. Schedule 2. Technical Proposal. May 2020, RFT# DFAT 114.
[139] Page 10, Abt, Locally generated and scaled health systems reform. Schedule 2. Technical Proposal. May 2020, RFT# DFAT 114.

- Developing Transition and Sustainability Plans for all PATH-financed activities conducted by PHAs or delivery partners. Plans were to include 'clear and realistic goals' and incentives to transition services to PHA management with timelines for moving aspects of financing to PHAs.
- Monitoring progress against these plans and a set of 'financial and administrative self-reliance' indicators to assess transition 'readiness' and progress towards sustainability[140].

Realisation of the planned approach

Despite these initial commitments, the 'transition approach' was slow to progress. The development of a transition policy by DFAT as proposed under the HPP, which provided an overarching framework for DFAT-funded investments in the PNG health sector, did not take place. There was no PATH program-level strategy or clear definition of the purpose and approach to transition within PATH until the third year of the program. There was little planning or coordination to support Frontline Health Outcomes projects to advance transition objectives at either the program or project level. Evaluations of the PSF (2022) and AIHSS (2023) projects found that elements of the projects were delayed, such as PHA PFM capacity building and alignment of capacity building activities with PHA systems[141]. Unsurprisingly, therefore, the PATH strategic planning process conducted in May 2022 found that there was 'no shared understanding of the agenda and approach to transition DFAT-funded services and programs to PHA management and financing systems'[142] among GoPNG national and subnational counterparts.

Recent progress towards transition

A PATH Transition Framework (May 2023) has now been developed, and identifies potential areas of alignment between projects and PHA systems that all PATH projects will be expected to advance over time. By the end of 2023, at the time of the review, introductory workshops were being held with PATH PHA partners. A Transition Tracking Tool was being disseminated to guide PATH projects to set targets for transition, intending to support development of transition baseline data. Evaluation recommendations for PATH projects[143] intended to undertake transition are being (or are planned to be) incorporated in project design documents, and various aspects of transition are being progressed by individual projects, with active follow-up by PATH project managers. Strategies currently being implemented by key PATH FHO and Health Security projects and implementation challenges are outlined in **Annex 14**. This summary highlights the fact that much of the progress in building PHA capacity remains fragile, and systemic challenges that affect the ability of PHAs to deliver essential, quality health services continue – many of which are beyond the scope of the project or capacity of implementing partners to address.

Although these examples demonstrate a program-level commitment to transition, much more is needed to guide and support concrete progress towards PATH's transition objectives. The draft Transition Framework does not provide a cohesive strategy or guidance for how alignment and, eventually transition objectives, are to be achieved. Although potential entry points within PHA systems are listed in the Transition Framework, specific pathways and timelines for transition of service delivery projects are yet to be established with partner PHAs. The Transition Framework recognises that it is 'almost always advisable' that a readiness assessment is conducted as part of the transition process. Lessons from previous transition efforts are that transition must be based on a practical understanding of PHA organisational and contextual challenges to undertake a change

[140] Page 10, Abt, Locally generated and scaled health systems reform. Schedule 2. Technical Proposal. May 2020, RFT# DFAT 114.
[141] Pages 19–20, HDMES, Accelerated Immunisation and Health System Strengthening Evaluation, June 2023.
[142] Page 104, PATH Strategic Plan 2022–2025 – July 2022 Draft.
[143] Evaluations include: HDMES. (2022). *Partnering for Strong Families Evaluation*; HDMES. (2023). *Accelerated Immunisation and Health Systems Strengthening Program (AIHSS) Evaluation*; HDMES. (2023). *Sexual Reproductive Health Integration Project Evaluation*.

management process. This includes identification of the capacity building needs of the organisation and how they will be addressed in a comprehensive manner. The potential of 'incentives and conditionality' to facilitate transition is recognised[144] but, as pointed out by implementing partners, a more substantial strategy for ensuring institutional leadership and ownership of the change process is essential for success. A further issue that has not been explored is the extent to which GEDSI, health service quality and equity objectives can be addressed in this transition process. It is also concerning that much of the responsibility for identifying a pathway and process to increase the alignment and integration of the project with PHA systems appears to rest with the project delivery partners, rather than the PATH program overall, as originally intended. Consideration should also be given as to whether organisations that specialise in health service delivery possess the necessary skills to lead and implement change management and capacity building efforts in areas outside their technical expertise[145].

An example from the FHO workstream regarding PHA strengthening and transition is the AIHSS Phase 1. According to the findings of the AIHSS evaluation, and consultations conducted by the Review Team, PHAs welcome direct donor funding and the decision-making autonomy that such an approach provides to the PHA. It can also highlight and bring resources to address previously tolerated PHA capacity development gaps, such as slow acquittal of funding. Nevertheless, weaknesses in internal management, even in the more capable PHAs, continued to be an obstacle to effective use of this funding. Management of donor-funded projects also requires additional administrative skills and resources that overstretched PHAs are unlikely to possess. Lack of familiarity with donor project reporting, for example, was highlighted as a challenge by one of the better-performing PHAs and disrupted consistent project implementation[146]. Regular, ongoing follow-up from PATH project managers was needed to resolve emerging bottlenecks and challenges involved in managing project finances. Progressing the transition process will therefore require that PHAs have additional dedicated resourcing and that PATH has the capacity to undertake the necessary additional level of monitoring and management required.

KRQ5.2 What specific measures has PATH supported that will enable achievements and progress to be sustained beyond the initial phase of the investment? (OECD DAC Criteria 6 – sustainability)

The transition of PATH service delivery projects is both a PATH objective and one of the key strategies for sustainability under this project. The PATH program design outlines the logic for achieving transition and sustainable outcomes. PATH's EOIO1 is intended to 'provide the organisational foundation within PHAs to progressively integrate the direct service delivery functions supported under EOIO 2'[147]. In addition to delivering health services, projects delivered under EOIO2 are expected to 'generate evidence, learnings and practices that can be used to help PHAs themselves improve their own performance'[148], particularly to strengthen delivery of equitable, inclusive health services. This will be supported by action to address bottlenecks, and policy-relevant information and partnerships between government, donors and key implementing agencies. Gender equity in PHA leadership will be promoted and GEDSI will be integrated across PATH activities. It is

[144] Page 10, PATH Transition Framework: Working with government to improve health system integration, efficiency and performance – May 2023.
[145] As demonstrated during AIHSS Phase 1, PHAs who received focused capacity building support from financial services firm Deloitte were able to demonstrate specific improvements in financial systems needed to meet HSIP compliance requirements.
[146] Page 29, HDMES, AIHSS Program Evaluation, June 2023.
[147] Page 12, PATH IDD, DFAT, n.d.
[148] Page 12, PATH IDD, DFAT, n.d.

expected that this process will enable each province, progressively, to 'establish an effective, equitable and sustainable health system'[149].

Before examining the specific measures undertaken by PATH to deliver these outcomes, it is worthwhile reviewing the soundness of this Program Logic. It is clear that without functioning PHA organisational and health delivery systems, the objective of transition cannot be achieved. Indeed the approach of funding third parties to direct service delivery was reportedly adopted precisely because of this lack of PHA capacity. Nevertheless, no matter how effective the PATH program and its processes are, it cannot be responsible for addressing gaps in the PNG health system single-handedly[150]. It is also questionable whether, relatively well-resourced organisations working within quite different organisational environments to that of PHAs can provide 'learnings and practices' that are considered relevant by PHAs. As noted by a key informant, while development partners are welcomed by PHAs, their support is seen as additional to the PHA's core business of managing an organisation to deliver health services. The idea that the transition process will enable the establishment of an effective, equitable and sustainable health system in target provinces appears to invest the program with an unrealistic level of agency, with overly ambitious expectations about the achievements and progress towards sustainability that it can achieve. Another critical concern is that the transition objective is more focused towards the sustainability of DFAT investments, rather than the achievement of sustainable health outcomes.

In any case, as described under KRQ2: Effectiveness, much of the potential under EOIO1 to support PHA readiness for transition has not yet been realised at a strategic or practical level within PATH. There are some notable exceptions, such as the EPS HSIP and the MEDI project, but proposed approaches to build leadership and management skills under this EOIO, such as twinning relationships, training and provision of educational resources[151] [152], were not progressed. There has also been little structured coordination with donors, UN agencies and other key stakeholders to leverage resources that can contribute to shared capacity building objectives. Although the AMTWP approach should, in theory, be particularly suited to understanding the complex challenges existing in the PNG health system, and developing responses that could progress transition, it has not been realised within the PATH program.

For much of the program, FHO and Health Security projects were 'siloed' from the rest of the program. Although PATH has reportedly increased its focus on collaboration across workstreams, communication between the PHA Support team and PATH FHO and Health Security projects is variable. The Review Team heard that in ARoB the PATH MELC coordinates regularly with the AIHSS ISP but, in other cases, communication between the PHA Support personnel and PATH projects based in the province is largely focused on scheduling provincial visits to demonstration provinces. The Review Team found limited evidence of engagement between these two program streams, either at the national or provincial level, to coordinate in a more strategic manner or advance shared objectives for transition or aspects of this agenda.

Addressing a range of critical bottlenecks, or systemic challenges in the health sector, has not been progressed by PATH. However, as noted by the AIHSS project evaluation, doing so will be necessary for the successful and sustainable transition of health services to PHA management[153]. The Review

[149] Page 12, PATH IDD, DFAT, n.d.
[150] This could include organising or leveraging the partnerships and resources to do so (rather than achieving change through PATH implementation alone.
[151] These strategies were described in the PATH Guiding Program Strategy V1.0 (page 7).
[152] Although PHA leadership training was conducted in Western Highlands Province, it was conducted in the early stages of the PATH program, and activities to promote leadership capacity building across demonstration provinces were not progressed.
[153] Page 32, HDMES, AIHSS Evaluation, June 2023.

Team observed, for example, that even relatively high-performing PHAs with strong governance and management systems in place continued to face extended vaccine stock-outs that disrupted delivery of immunisation services for several months at a time. Identifying alternatives to donor financing for health service delivery, central to transition and sustainability of this approach, remains another critical challenge to be tackled. PATH implementing partners further noted their limited influence on the extent to which PHA leaders take the action necessary to support transition objectives. Even with apparent PHA commitment, broader organisational or sectoral interests may be prioritised before these objectives. This suggests that advocacy by DFAT to champion and encourage NDoH and PHAs to embrace transition objectives can play an important role in backing up the work being conducted by PATH at the program and project level.

Without developing, resourcing and rolling out strategies to address these issues, the likelihood that the transition process will be achieved and lead to sustainable, quality health outcomes is weak. The likelihood also seems limited that initiatives (such as the EPS HSIP, MEDI, and efforts by PHA Support teams in demonstration provinces) will be retained without ongoing technical support and resourcing to embed changes. Where efforts by PHA Support teams have led to increased skills and resources for PHA capacity, and PHA/BDoH leaders recognise the importance of these efforts, and they have the resources and drive to continue to support them – as could be the case with MEL capacity building in Western Province – there is potential for improved practices to be retained. However, as interviewees noted, PHAs have a 'long road' to build PFM capacity; and ongoing, dedicated, integrated efforts are likely to be needed to secure change.

Returning to the 'logic' of transition embedded in the PATH design: whether proposed transition objectives are indeed feasible, even over the long term, will also require a more practical, detailed examination of each project and the potential for 'transition to occur; what that would look like; how it could influence improved practice within the PHA; and how, specifically, the agreed objectives will be achieved, by whom, over what timeframe and what support is needed'. Whether this is the best use of what are likely to be substantial DFAT resources and the most effective strategy for achieving PHA system strengthening, or alternative partnership objectives, is another critical question.

SQ5.3 How appropriate and sustainable are PATH's governance arrangements and approach to relationship management in advocating and supporting health sector development in PNG (including structure, function and purpose of key governance mechanisms).

The PATH Program Steering Committee, discussed earlier under KRQ1: Relevance, is the primary program governance body, and 'responsible for the overall oversight' of the PATH Program[154]. It was intended to provide 'high level policy advice and strategic direction to ensure [that PATH] is delivering on the development policies and priorities of the governments of PNG and Australia'[155]. This involves assisting in program planning, performance monitoring, risk management, and ongoing review and priority setting: all key functions critical to program effectiveness, GoPNG ownership of the PATH program strategy and outcomes, and the sustainability of PATH. However, also noted under KRQ1, the PSC mechanism has not functioned as planned and PSC members consulted by the Review Team were not satisfied with the level of information that they had concerning PATH and its performance.

Although the NDoH specifically requested the establishment of a Program Coordinating Committee – a standard governance structure intended to supplement the PSC with quarterly meetings to

[154] Draft PATH Program Committee Terms of Reference (version dated 14 September 2021).
[155] Draft PATH Program Committee Terms of Reference (version dated 14 September 2021).

consider program governance issues at more practical, programmatic level – this body has not yet met. The Review Team heard that organising such meetings was considered a responsibility of the NDoH. Nevertheless, the absence of functioning program governance bodies, which should be supported by regular and ongoing communication with key PSC stakeholders, has left PATH without the GoPNG engagement and involvement expected to promote the program's partnership objectives at this level. Along with achieving essential health outcomes, this is arguably one of the primary strategic objectives of this significant health sector investment in PNG.

3.6. Key Review Question 6: MERLA

To what extent are PATH's monitoring and evaluation arrangements fit-for-purpose, including M&E arrangements of key PATH activities delivered by grantees?

Summary: PATH has struggled to convert its highly conceptual design to a clearly understood and accepted Program Logic. For the first three years of the program it has been without an agreed Performance Assessment Framework, agreed indicators to guide measurement of program performance, and a baseline. The challenges faced by PATH include: IOs and EOIOs that are vague or not clearly defined; a lack of leadership and the management structures within PATH needed to support roll-out of an approved MERL Framework; inadequate resourcing for PATH's substantial MEL functions; and frequent turnover and extended gaps in the leadership of the PAS team.

The failure to establish the MERL Framework in the early stages of the program has had far-reaching effects. A functioning MERL Framework is central in the implementation of an AMTWP approach, and guiding program learning, reporting and accountability. PATH's inability to deliver reports that meet DFAT standards has undermined its relationship with the donor. Without a MERL Framework to provide an organising framework, PATH has been unable to capitalise on the significant amount of health service data generated by grantees to describe its achievements. Bringing consistency to the great variety in how grantees report and types of approaches implemented by grantees – and how accurate data can be captured – are further challenges that PATH faces.

SQ6.1 How appropriate is PATH's MERLA Strategy and Performance Assessment Framework in guiding the measurement and assessment of program performance and results (including the evolution of this approach over time)?

DFAT's Design, Monitoring and Evaluation and Learning Standards[156] require a Monitoring, Evaluation and Learning Plan for DFAT-funded investments, beginning with a clear and plausible Program Logic that is understood and agreed by key stakeholders. Meeting this requirement, and converting a highly conceptual design into a clearly understood and measurable Program Logic, is a challenge that PATH has struggled to resolve.

The Program Logic model for PATH included in the original Investment Design Document should have enabled and supported the development of a MERLA Plan within the first six months of the program[157]. According to DFAT MERL standards, the PAF provided in the design document should be 'used to set early performance expectations during the design stage' and then 'updated and operationalised at inception'[158]. However a problematic lack of clarity in the definition of EOIOs, IOs and key concepts, as well as the logical pathway to reaching outcomes was identified during PATH's

[156] DFAT, September 2023, page 7.
[157] According to DFAT MERL Standards. The initial Program Logic model is shown in Annex 2: Program Logic, page 38, PATH IDD.
[158] DFAT, September 2023, page 7.

Inception Phase[159], and this has continued to be raised as a concern by subsequent PAS teams[160]. Although initial recommendations to address and clarify the expression of key components of the Program Logic were not adopted, PATH produced a draft Guiding Program Strategy (April 2021) and draft Performance Assessment Framework and MERL Strategy (February 2021) that attempted to resolve these issues. The draft PAF produced during the inception period included key indicators of performance, and targets and milestones against which progress in achieving the program design could be measured. The MERL Strategy described the interaction between MERL functions and learning and reflection cycles needed to support an adaptive management approach. In June 2021, there was regular engagement with the AHC to refine iterations of these frameworks and a draft MERL Framework was finalised in September 2021.

Interviews indicated that several factors mitigated against the uptake and implementation of the proposed MERL Strategy and PAF. Key among these was that DFAT authorisation had not been secured and the leadership required to drive their implementation within the program was absent. Reportedly, this resulted in a lack of traction for the activities that did take place, such as planning workshops with workstream leads to roll out elements of the MERL Framework. Successive PAS Leads observed that resources available to the PAS unit were constrained to implement a complex and large program of work, including bringing together disparate health service delivery, health security and capacity building projects under a single MERL Framework and PAF. This lack of resourcing is evidenced by the relatively small MEL budget of between two and four per cent[161], compared to DFAT guidance that up 10 per cent of the total budget for adaptive programs should assigned to MEL expenditure[162]. In addition, COVID-19-related disruption necessitated remote delivery of important technical inputs, prevented delivery of planning with key provincial stakeholders, and led to the early departure of the initial PAS Lead. Subsequent challenges with finding a PAS Lead has meant that PATH has been without a lead for this critical workstream for almost half of the implementation period. The loss of other key PATH personnel, such as the PHA Provincial Performance Lead[163], was another factor considered to affect continuity in the implementation of proposed program approaches. Implementing a MERL Framework in an effective manner would also have required functional management systems to support and facilitate workstream planning, communication and coordination to collect, analyse and report on relevant data. Feedback provided by a range of interviewees indicate that such systems did not operate effectively for much of the program period.

The failure to implement the MERL Framework and PAF have had far-reaching effects on PATH's progress and its ability to describe any program achievements. Without a comprehensive approach to measuring progress and collecting data across the program, PATH was not able to present to its stakeholders a clear narrative of performance in annual reporting, demonstrate the value of the program in meeting key development challenges, or illustrate progress towards meeting the EOIOs and IOs over time. PATH annual reporting and, potentially, planning would likely have been greatly improved if the program had adopted a clear set of targets[164], indicators and baseline against which it could measure success; and could have elevated the reporting from simply relaying numbers of health services delivered.

[159] As described in the PATH IDD Performance Assessment Framework Appraisal Report, 30 October 2020.
[160] As outlined in the 'Rapid Appraisal Note: PATH Theory of Change', an internal review produced by PATH in 2023.
[161] Page 19, PATH Strategic Framework – Final Draft 28 April 2023 (Revised 9 May 2023).
[162] Page 9, DFAT. Monitoring, Evaluation and Learning – Guidance Note for Partner-led Designs. https://indopacifichealthsecurity.dfat.gov.au/sites/default/files/2023-09/DFAT%20Partnerships%20for%20a%20Healthy%20Region%20-%20MEL%20Guidance%20Note%20Sept%2023_Final.docx
[163] Now titled the 'PHA Capacity Support' workstream.
[164] Although targets are not necessarily appropriate for an adaptive approach, in the absence of other measures, they could have provided some benchmark for measuring progress.

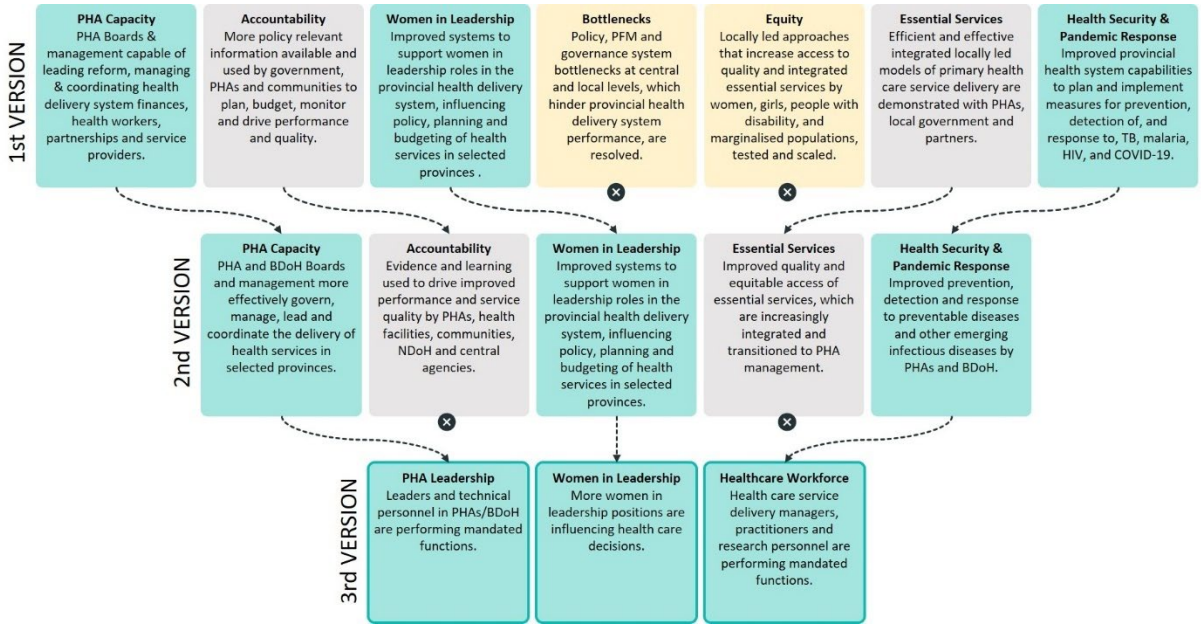
A program of the size and complexity of PATH should also have had well-established systems and processes to collect program performance data into a management information system (MIS), so that the data could be analysed and reported on a routine basis; and potentially used to identify patterns affecting program performance. At the time of writing, the MIS was still in development. These systems would have responded to the data needs of the PAF to demonstrate progress towards achieving the EOIOs and IOs; but since PATH did not implement its MERL Plan or PAF in the early stages, these key monitoring and reporting systems could not be established. The procedures that were established, such as collating project service data on a monthly basis, were inadequate for the scale of the investment and did not connect and capitalise on the results being achieved by grantees. Likewise, there was no established framework through which PHA capacity building support could be assessed, or an approach that could be used to monitor progress towards PATH's GEDSI and Equity outcomes.

Another key factor needed to establish these central elements was an agreed understanding of what 'success' would look like for the PATH program and its complex EOIOs and IOs; and an ability within the program to determine, at least as a starting point, a practical description of the way in which those outcomes would be achieved. It can be argued that doing so is less the role of a PAS team or a program PAF and MERL Framework than the program leadership, including both PATH and DFAT, working with key internal and external stakeholders to clarify and define the specific changes to be achieved.

Current status of the MERLA Strategy and PAF

The PATH Program Logic was revised as part of an extended review and planning process conducted in the first half of 2022, resulting in a streamlined version of the initial set of reworded IOs (from seven to five), with a description of the pathways through which they could be achieved. This was subsequently adapted to improve logical flow, and strengthen program coherence and implementation, as well as monitoring, evaluation and reporting. These changes have been captured in a revised PATH Program Logic and PAF, with three remaining IOs leading to EOIOs. Changes to the IOs across the iterations of the Program Logic are shown in **Figure 5**. PATH's progress in establishing key elements of a performance framework over the program period are shown in **Figure 6**.

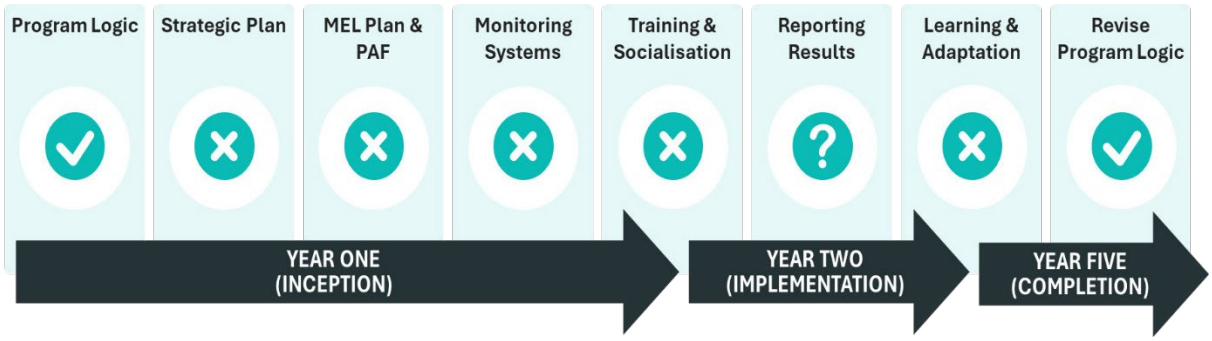
Figure 5: Iterations of the PATH Intermediate Outcomes



Note: The circle cross icon indicates areas in the logic diagram that were dropped in sequential versions.

The revised framework has been welcomed by some as progress towards better articulation of the work of PATH, and progress towards program objectives. However, PATH is now moving into its fourth year and substantial work remains to be done to operationalise this PAF[165]. No baseline for the program yet exists, and the PATH MIS is still a work in progress. Both PATH and AHC leadership have indicated that their focus is to address functional aspects of the program, rather than clarify its aspirations and the program-level health and development objectives to be achieved. While it is undoubtedly necessary and important to do so, this leaves the program still attempting to frame its somewhat nebulous EOIOs and disconnected elements to enable measurement of overall program performance.

Figure 6: PATH progress in establishing the critical elements to demonstrate performance



SQ6.2: To what extent does PATH's MERLA strategy test innovative approaches, enable continuous improvement of the model and guide adaptation (including sharing lessons learned with PHAs and NDoH)

Adaptive management was intended to be the mechanism through which strategies and activities to enable progress towards PATH IOs and EOIOs would be developed, monitored and adapted. According to the original program design, EOIOs and IOs would remain fixed and an adaptive management approach would be used to develop pathways to reach those IOs, using defined 'drivers of change'.

To function effectively, adaptive management should be underpinned by a strong and sophisticated MERLA system that supports team and program learning, planning and the integration of data to inform responsive program adaptation[166]. PATH's original PAF was intended to support the measurement of progress and identify lessons to inform adaptation across the different investment sub-programs. This included 'iterative continuous improvement, scalability and efficiency and adaptive management appraisal', sessions for program learning and reflection, and strategy testing[167]. The PATH monitoring process was 'intended to generate learning through applying AMTWP concepts and tools to 'test' the theory of change against the accumulating evidence for how change is, or is not, happening'[168].

As observed earlier, PATH does not yet have a fully operational MERL Framework. Similarly, implementation of the AMTWP approach, did not appear to take off in any concrete way. Efforts to generate locally driven strategies for program interventions, such as provincial-level problem identification sessions and internal learning and reflection sessions were commenced but not

[165] The PAF was subsequently accepted by the AHC in late December 2023 (Abt Associates, 16 April 2024).
[166] Rogers, P. and Macfarlan, A. (2020). What is adaptive management and how does it work? Monitoring and Evaluation for Adaptive Management Working Paper Series, Number 2, September. https://www.betterevaluation.org/monitoring_and_evaluation_for_adaptive_management_series
[167] Slide 9, 210930, PATH PAS slides V3.
[168] PATH Monitoring, Evaluation, Research and Learning Framework, September 2021.

pursued. There was no evidence that the concept of scalability had been pursued as an element of the program[169]. Dedicated support that might have enabled staff to understand and engage with this innovative approach was limited: few staff interviewed reported receiving training or participating in learning sessions concerning adaptive management. This included workstream leads who were intended to coordinate collaborative learning and development sessions[170].

The Thinking and Working Politically component of AMTWP, also critical to determining 'problems' and defining effective approaches to change that would be implemented, was not defined in PATH's AMTWP guidance. There was no evidence that staff were trained or supported to apply this approach. Given its importance as a strategy for working successfully within the 'socio-political complexity' of PNG[171], this was another major gap.

PATH's focus on implementing with a flexible and adaptive approach and the concept of adaptive management was reportedly a source of confusion for PATH program staff[172]. It appeared to distract from the need for a rigorous and clear strategic plan and performance framework, or was used to explain why clearly defined programmatic objectives and pathways were not in place.

Provincial Monitoring, Evaluation and Learning Coordinators

The Provincial MELCs located in each of the demonstration provinces supported improved data collection and analysis in PHAs, but were not used in the collection and reporting of PATH program performance data. The training and support provided to MELCs through PATH for much of the program was inadequate and inconsistent. MELCs tended to develop their skills through the training and support provided to provinces (such as national eNHIS and information technology training workshops, for example). The lack of a clear workplan or TOR in the early years of implementation for MELCs wasted a valuable resource for the program that could have been better used connecting PHA performance to PATH's results through systematic and coordinated support and capacity building on M&E, data and results. Such a focus should have been mapped and articulated in the PATH Strategic Plan – which was never fully realised as a planning and strategy document to guide a more sophisticated level of engagement for the program.

SQ6.3 How appropriate and effective were the M&E arrangements for PATH activities delivered by grantees?

The grantees present PATH with a significant opportunity to capitalise on quantifiable outputs to demonstrate the impact of the program. In the 2022 Annual Report, PATH presents an impressive selection of quantitative health services data to demonstrate the impact of the program (see 3.4 Effectiveness). However, these achievements are not measured against program targets or quality standards to provide the context of the achievement. Without clear targets, it is unclear whether PATH has intended to effect a particular change, or whether that intended effect has been achieved.

PATH grantees currently include PHAs, international and local NGOs, church health services, Australian and PNG educational institutions, and medical and research institutions. Each of these organisations has its own approach to collecting, using and reporting data; and their level of resourcing and effectiveness in doing so is varied. Project-level MERL Frameworks can also vary in quality and are often targeted at addressing project M&E needs, rather than those of PATH more broadly. Given that the majority of activities conducted under PATH are delivered under these

[169] The Review Team found evidence of a single scalability assessment of the AIHSS project conducted with Western Highlands PHA to trial the assessment framework.
[170] Refer to AMTWP Guidance Note.
[171] As stated in Annex 11: PATH Approaches to Socio-Political Complexity in PNG, page 103, PATH IDD.
[172] Consultant report, 2022.

grants, it is essential that there is adequate and consistent reporting from these projects, which is captured by PATH and used to report program achievements.

The current PAF has identified common activities conducted across PATH projects and used these as indicators under IO3. However, there is no consistent way to describe these activities. There are a wide variety of capacity building and training activities conducted by projects across PATH, and an inconsistent approach to measuring beneficiaries and outcomes. Similarly, the definition of 'supervision' can vary greatly across projects. NDoH itself does not have a standard definition of an outreach clinic that can be used by PHAs and PATH projects such as AIHSS that support the delivery of outreach. The AIHSS evaluation found that in some provinces Implementing Service Providers had planned to conduct approximately four outreach events per year (one per quarter), while others stated that they planned to conduct over 6,000 outreach events per quarter[173]. This clearly makes it challenging to understand and compare performance across project provinces. The PATH project MERL Framework explains that 'as projects are redesigned… the project milestones and targets should be adjusted to reflect the anticipated contribution to PATH achievements and performance overall'[174]. Not only would such a process take an extended period to be completed (as all projects go through a redesign process), but without an established PAF and a reasonable and practical set of common indicators there is no standard to which they should be aligned. The problem of recognising and capturing the achievements of PATH activities thus remains a concern.

Many of these projects, such as AIHSS and PSF, should be reporting their service data via the eNHIS, as well as to PATH as part of project reporting, and PATH has commenced using eNHIS data to report its achievements. The eNHIS provides a consistent framework for reporting health data, particularly delivery of services. However, there is currently no system within PATH to monitor and confirm that project data is being reported in a regular, complete and timely manner to the eNHIS. Stakeholders observed that projects can sometimes fail to report their data via the eNHIS for a period of several months. This potentially skews the eNHIS data being reported. Furthermore –and importantly – if PATH intends to use eNHIS routine data in its reporting, it will need to have a valid method of determining the contribution of PATH projects to overall eNHIS results. Currently this is not a feature of the program MERL Framework, and partner reporting does not always align to the eNHIS, making it difficult to determine where and to what extent a project has contributed to certain health outputs.

4. Summary of Findings

While PATH has demonstrated some positive achievements, it has failed to deliver many elements of the original program design and is unlikely to achieve its IOs and EOIOs by the end of the program period.

The design of PATH was highly ambitious. The EOIOs were not well defined and did not clearly state what success would look like. The purpose of some program mechanisms, such as drivers of change, were not well defined. The objectives and expectations regarding transition were not clearly stated. The Adaptive Management and Thinking and Working Politically approach added further complexity and did not contribute to greater effectiveness, efficiency or responsiveness of PATH to its operating context. The AHC, PATH, and successive technical specialists have not yet brought clarity to the Program Logic and specifically what it aims to achieve.

[173] Page 53, HDMES, AIHSS Evaluation, June 2023.
[174] Page 10, PATH MERL Framework and Approaches Guidance Note, February 2021.

NDoH and PHAs expressed their appreciation for the longstanding commitment and support provided by DFAT to the development of the health sector in PNG. However the MTR found that the PATH Program Steering Committee did not function as an effective governance mechanism or as a way of bringing together key stakeholders within GoPNG to provide direction to the program. Notwithstanding the challenges of bringing together stakeholders in the context of the COVID-19 pandemic, for a program such as PATH that was based on the importance of furthering a partnership with the GoPNG, this is a failure in terms of governance and accountability.

The MTR further found that the partnership between the AHC and PATH (including the PATH Managing Contractor), which is central to the effective implementation of this model, was not collegial and cooperative, but more transactional. The impact of the COVID-19 pandemic, which was borne by DFAT and the PATH project, overwhelmed both stakeholders. Once COVID-19 had passed, there was not a realignment to recognise what had been lost and agree on a way forward, and the relationship was fraught.

The PATH program, overall, has not been implemented in an effective and efficient manner. PATH reports that it is meeting selected VFM criteria, but PATH has been unable to demonstrate substantive progress against the objectives for which it was established. PATH's successive failure to deliver has undermined the AHC's trust in PATH, necessary to the efficient operation of this model. The leadership of PATH for much of the program was inadequate, and the Managing Contractor did not ensure that standard management practices were implemented. The impact of COVID-19 seriously disrupted the program, including leading to gaps in senior management.

Current PATH leadership is attempting to bring greater structure and effectiveness to the program; however, key systems and processes, including a MERL Framework that should have been established during the inception period to provide the foundation for the program, are not yet in place.

PATH engaged with partners at the technical level; however, relationships with senior GoPNG and health sector stakeholders have not been fostered, and the program, how it operates, and its rationale, are not well understood. Although there have been some exceptions, the MTR did not find evidence of a program-level strategy to leverage resources or engage partners in achieving change.

Programs to support PHA capacity building are not adequately structured to achieve the ambitious results intended. A case study of MEL capacity building support in Western PHA found that concrete results had been achieved using a structured capacity building approach, combined with adequate infrastructure and SEM support for this work. PATH engagement in MEL capacity building at the national and provincial levels, in collaboration with relevant health sector partners, supported this work. Although the extent of achievements under EOIO1 have not been commensurate with the scale of the PATH program, this highlights the critical importance of a well-targeted, structured and integrated approach to PHA capacity building.

The GEDSI component of the program was only partially addressed and, outside of the services and support delivered through FHO and Health Security grantees under their contracts with the Managing Contractor, PATH has not made a substantial contribution to achieving the delivery of effective, efficient and inclusive health services in target provinces.

Transition of these investments to PHA management was neglected during the first three years, and elements of PATH that were intended to support transition, such as addressing bottlenecks, are not effective or no longer in place. The MTR found that it is unlikely that PATH will achieve substantial progress towards transition by the end of the program period.

5. Recommendations

Based on the findings of the MTR, the Review Team makes the following recommendations for the immediate term and beyond PATH's initial program phase.

KRQ1: Relevance

Immediate term

- **PATH** to work with the AHC to improve functionality of the Program Steering Committee.
- **PATH** to develop, resource and implement a plan to strengthen coordination with NDoH, and other GoPNG and key health sector stakeholders.

  This could be included as an addendum to the Ways of Working document, but will need to include dedicating senior management focus needed for effective engagement and communication with key health sector stakeholders.

Beyond PATH's initial phase

- **AHC** to examine:
  - alternative approaches for investment governance and coordination mechanisms that are more likely to achieve the intended partnership outcomes.
  - the resources needed to sustain the effectiveness of these mechanisms.

KRQ2: Effectiveness

Immediate term

- **PATH** to document PHA Support Project practices (including PEPPI and MEDI projects), to identify positive approaches and evidence to guide future program activities.
- **Abt and PATH** to review the performance management approach used by the FHO and Health Security teams, to ensure that it is:
  - focused on providing effective oversight and support to grantees to deliver quality health project and contract outcomes – and is adequately resourced to do this.
  - does not impose unreasonable compliance and reporting demands that have the potential to undermine grantees' program delivery capacity.
- **PATH** to engage a full-time, senior health technical adviser to:
  - drive the program in developing technically-sound program strategies and frameworks, including the program MEL framework.
  - assess the health technical needs across the PATH program, identify any additional program technical support needed, and provide related recommendations to PATH and AHC.
- Reallocate a proportion of the **SLP** underspend to fund community health leadership initiatives, with the objective for women leaders to better advocate for their communities, to improve equitable and accountable services.
- The GEDSI Hub should be taken back in-house and managed by the PATH team, to deepen their NDoH relationships and thereby achieve the program's GEDSI, women in leadership and equity objectives.

Beyond PATH's initial phase

- **AHC** to commission a redesign of the PATH program and re-tender for a subsequent phase of the program, addressing the same substantive objectives of PATH, but with a clearly defined Program Logic and strategies co-designed with key PHA and GoPNG stakeholders.

  This includes a focus on:

  - PHA capacity building that:
    - uses evidence-based approaches to government health sector capacity building
    - is adequately resourced
    - is implemented by agencies with demonstrated skills in conducting capacity building in the specific technical areas in the PNG context.
  - Essential Services and Health Security components that:
    - have clearly defined health outcomes and a strategy to guide how this is to be achieved within the program
    - are oriented to implementing existing NDoH strategies in an effective, efficient and innovative manner
    - applies a supportive, quality-focused approach to performance management
    - has full-time, dedicated health and GEDSI technical assistance to provide oversight and effective support for quality improvement, learning and development.
  - A reoriented Women in Leadership component that includes:
    - a major focus on community leadership, especially women, PWD, and marginalised groups
    - emphasis on co-designing public health and fostering accountability.

KRQ3: GEDSI

Immediate term

- **AHC/PATH** to allocate portion of the budget underspend (e.g. SLP) for GEDSI mainstreaming activities for grantees.
- **PATH** to work in partnership with grantees and CSOs to develop activities for GEDSI-transformative approaches (especially GBV), which simultaneously feed into other program goals.
- **PATH** to establish mechanism whereby the GEDSI team can influence other parts of the program (e.g. allocating budgets and tasks to grantees).

Beyond PATH's initial phase

- **AHC/DFAT** to include in the design scope of future programs:
  - When working with NDoH partners (such as NOPS), a requirement to advocate for people with disabilities at policy level and in the way community-level services are provided.
  - Efforts to stimulate community initiatives for targeted preventative campaigns, especially for childhood diseases that may lead to lifelong disability if untreated.

KRQ4: Efficiency

Immediate term

- **PATH** to seek suitable technical assistance to design and establish internal management and communication systems to improve program effectiveness and efficiency.

- **Abt Associates** to provide the necessary specialist support and resourcing to PATH to implement the above recommendation.
- **AHC** to review its approach to managing facilities and determine the resources needed to support this approach.

Beyond PATH's initial phase

- **AHC/DFAT** to include requirements in new investment agreements:
  - That the incoming MC: (1) conducts a workplace assessment and job analysis; and (2) uses this evidence to ensure investments are adequately resourced to deliver on their objectives.
  - That the MC establishes a comprehensive capacity building framework and staff localisation policy during the investment inception period.

KRQ5: Sustainability

Immediate term

- **PATH** to complete the collection of transition baseline data from grantees and provide a summary report to the AHC detailing the current prospects and challenges relating to transition of grantee programs to PHA management.

  This can be used by the AHC/DFAT as input for the proposed assessment below.

Beyond PATH's initial phase

- **AHC/DFAT** to undertake through a specialist organisation an examination of the concept of transition to clearly define, specifically and in practical terms:
  - what transition aims to achieve, who is to benefit and for what purpose.
  - whether transition is an efficient, effective and appropriate development approach to achieving those outcomes.
  - a mechanism through which such a process could realistically be achieved in the context of the health sector in PNG.
- **AHC/DFAT** to clarify their expectations concerning investment sustainability – what is feasible to achieve within the given timeframe.

KRQ6: MERLA

Immediate term

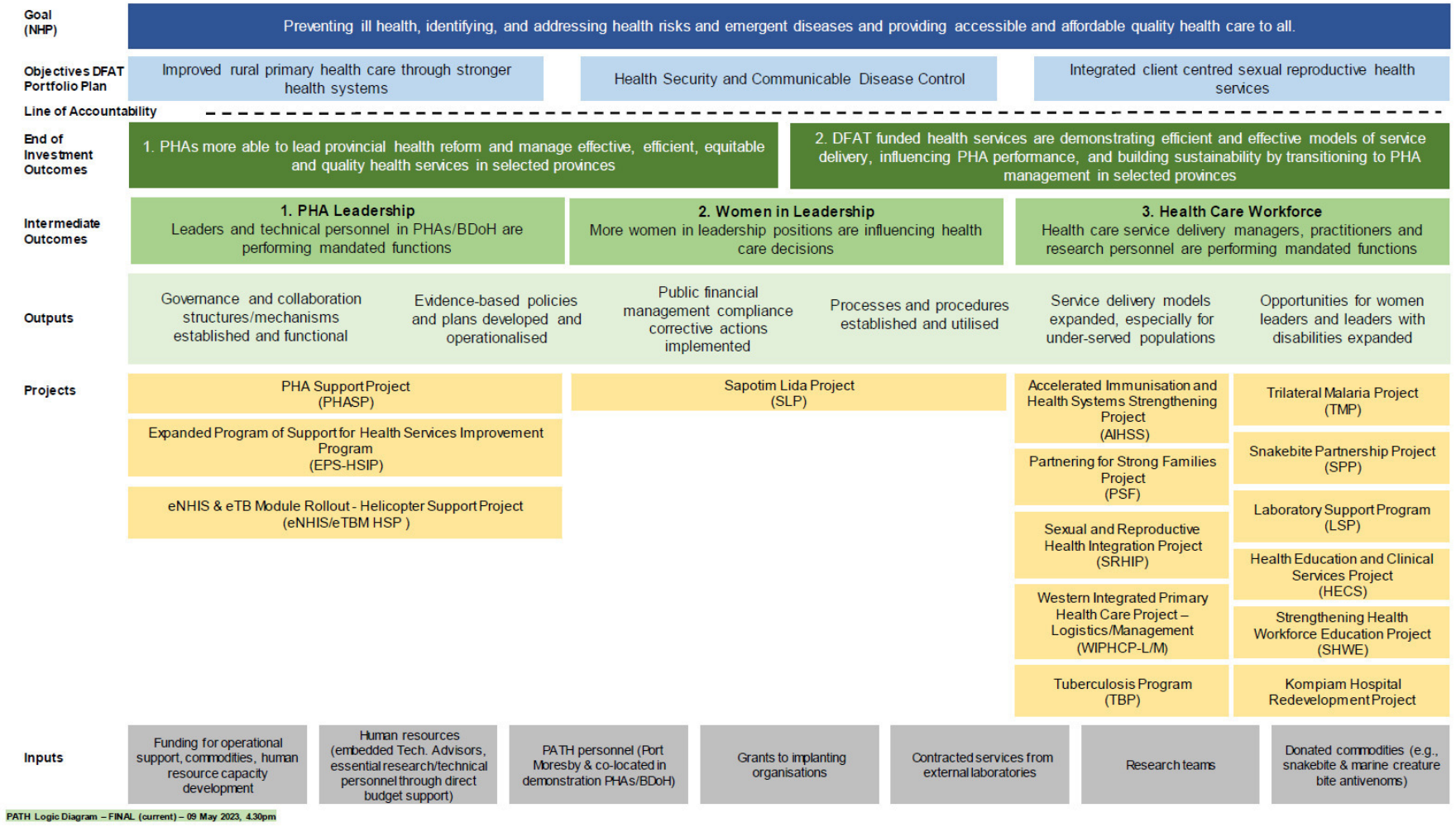
- **PATH and AHC** to decide on approach to reporting against IOs and EOIOs in the final PATH Completion Report.

Beyond PATH's initial phase

- **AHC** to include in the design scope for a future program:
  - a structured but 'light touch' learning and adaptation approach as a core element to guide monitoring and quality improvement.
  - a structured and evidence-based capacity building framework to guide, implement and assess the results of capacity building activities conducted.
- **AHC** to commission a specialist organisation to investigate and advise on options for (1) aligning grantee reporting with eNHIS/NDoH systems; and (2) a MERL Framework in any future facility-like investments.

Annexes

Annex 1 – PATH Program Logic (2023)



Annex 2 – Assessment against DFAT M&E Standard 10: Independent Evaluation Reports

Introduction

No.	Element	Reference in report
10.1	The executive summary provides all the necessary information to enable primary users to make good quality decisions	Executive Summary
10.2	The introduction provides a brief summary of the investment or program	1. Introduction
10.3	A brief summary of the methods employed is included	2. Methodology
10.4	Key limitations of the methods are described, and any relevant guidance provided to enable appropriate interpretation of the findings	2. Methodology

Findings and analysis

No.	Element	Reference in report
10.5	The report addresses all key evaluation questions	3. Findings of the Mid-Term Review
10.6	The overall position of the author is clear, and their professional judgements are unambiguous	3. Findings of the Mid-Term Review
10.7	There is a clear line of sight from the key evaluation questions to the evidence presented, the findings, conclusions, and recommendations	3. Findings of the Mid-Term Review
10.8	The report identifies the strength of evidence that supports the conclusions and judgements made	3. Findings of the Mid-Term Review
10.9	The relative importance of the issues communicated is clear to the reader	3. Findings of the Mid-Term Review
10.10	There is a good balance between operational and strategic issues	3. Findings of the Mid-Term Review
10.11	Alternative points of view are presented and considered where appropriate	3. Findings of the Mid-Term Review
10.12	Complicated and complex issues are adequately explored and not oversimplified	3. Findings of the Mid-Term Review
10.13	The role of context and emergent risks to program performance are analysed	3. Findings of the Mid-Term Review
10.14	It is possible to trace the factors, over time, that have led to the current situation	3. Findings of the Mid-Term Review
10.15	Robust evidence and neutral language are used to communicate findings, not emotive arguments	3. Findings of the Mid-Term Review
10.16	The implications of key findings are fully explored	3. Findings of the Mid-Term Review

Recommendations and lessons

No.	Element	Reference in report
10.17	There is a limited number of feasible recommendations	5. Recommendations
10.18	Individual positions have been allocated responsibility for responding to recommendations	5. Recommendations (organisations allocated responsibility)
10.19	Where there are significant cost implications of recommendations, these have been estimated	N/A
10.20	The circumstances under which any important lessons are transferable are described	Lessons are included throughout the report, not an explicit section
10.21	Management responses outline whether DFAT agrees with the recommendations, and how and when recommendations will be implemented	For DFAT to address
10.22	The final Evaluation Report and management response are published within the timeframes outlined in the DFAT Development Evaluation Policy	For DFAT to address

Annex 3 – List of Documents Reviewed

Document category	Document name
DFAT	• 2012–2021 Pacific Women in PNG Performance Report • 2018–2022 Gender Action Plan • 2019–2020 Gender Action Plan Report • 2020 PNG–Australia Comprehensive Strategic and Economic Partnership (CSEP) • 2022 Disability Inclusive Development Standard Brief • 2023 Design and Monitoring, Evaluation and Learning Standards (September) • 2023 Australian International Development Policy
PATH program level	• PATH Investment Design Document • 2020 Abt Associates Locally generated and scaled health systems reform – PNG–Australia Transition to Health (PATH) Program. Schedule 2. Technical Proposal, May, RFT# DFAT 114 • 2020 PATH Adaptive Management Guidance Note • 2020–2021 PATH Financial Quarterly Report (October 2020–March 2021) • 2020 PATH Financial Year (October) • 2020 PATH Frontline Health Outcomes Annual Report (January–December) • PATH Guiding Program Strategy V1.0 –Draft • 2021 Policy Dialogue Process for PATH – Draft • 2021 Terms of Reference – Co-Program Delivery Lead – FHO and HSPR/PHA, GESI and Safeguarding Lead, Performance Adaptive Systems Lead, Operations Lead and Team Leader • 2021 PATH Performance Assessment Framework – Draft • 2021 PATH MERL Framework – Draft • 2021 Quarterly Progress report (January–March) • 2021 PATH Six Monthly Report (January–June) Narrative V3 • 2021 PATH Annual Report – Final submission • 2021 AHC-PATH Bilateral Ways of Working (28 February) • 2021 Mapping Paper for Bottlenecks in Rural Health Service Delivery (15 October) Final • 2021 Intervention Scalability Assessment of the Accelerated Immunisation and Health Systems Strengthening (AIHSS) program – Western Highlands Provincial Health Authority • 2021 PATH Financial Year – June 2021 • 2021–2023 PATH Steering Committee meeting minutes • PATH Service improvement Plan – November 2022 – March 2023 • 2022 PATH Strategic Plan 2022–2025 • 2022 Value for Money Annual Report • 2022 PATH Quarterly Progress Report (Q1) January–March • 2022 PATH Quarterly Progress Report (Q2) April–June • 2022 PATH Financial Year – June 2022 • 2022 PATH Annual Report – Final draft • 2023 PATH Performance Assessment Framework – Draft • 2023 PATH Logic Diagram – Final (11 May) • 2023 PATH/AHC Ways of Working (May)

Document category	Document name
	• 2023 PATH Transition Framework: Working with government to improve health system integration, efficiency, and performance – V1.0 (May) • 2023 PATH Six-Monthly Report (January–June 2023) Draft • 2023 PATH Financial Year – 2023 • 2023 Key Performance Indicators (KPI) Summary
PATH project level	• 2021–2025 Sapotim Lida Program Final Design • 2021–2025 – GEDSI Stocktake Mind Map – PATH – FINAL • 2021 PATH Annual Report Narrative: GEDSI and Safeguarding • 2021 PATH Provincial GEDSI Stocktake Report • 2021 PATH Provincial GEDSI Stocktake Report Annexes • 2021-2025 PATH GEDSI Strategy • 2022 WIL and Equity IO PATH Quarterly Report (January–March) • 2022 WIL and Equity IO PATH Quarterly Report (April–June) • 2022 GEDSI Working Group meeting minutes • PATH COVID-19 Taskforce Closure Report – September 2021–December 2022
HDMES evaluations and other	• 2021 *Wok Bung Wantaim* Evaluation Report • 2022 Partnering for Strong Families Evaluation • 2022 Health Portfolio Mid-Term Review • 2023 Accelerated Immunisation Health Systems Strengthening Evaluation Report • 2023 Sexual and Reproductive Health Integration Project (SRHIP) Evaluation Report • HDMES GEDSI Toolkit • HDMES feedback on PATH January to June 2023 Progress Report, May 2023 • HDMES feedback on PATH 2022 Annual Report, March 2022 • HDMES feedback on PATH 2021 Annual Report, May 2023
AHC Health Portfolio Plan	• 2018–2023 Health Portfolio Plan
National strategic development plans	• PNG Medium-Term Development Plan III 2018–2030 – Revised (February 2022)
PNG health sector plan/ strategies	• 2021 PNG National Health Plan 2021–2030 • 2018 National STI & HIV Strategy 2018–2022 • 2019 Maternal and Neonatal Health Strategy • 2021 National Immunisation Strategy 2021–2025
International strategies	• 2005 Paris Declaration on Aid Effectiveness • 2008 Accra Agenda for Action
PNG health sector reviews/ assessments	• 2019 Sector Performance Annual Review – NDoH – FINAL • 2020 Sector Performance Annual Review – NDoH – FINAL • 2021 Sector Performance Annual Review – NDoH – FINAL • 2022 Sector Performance Annual Review – NDoH – FINAL

Document category	Document name
Referenced articles	• 2020 *Australian National Audit Office, Value for Money in the Delivery of Official Development Assistance through Facility Arrangements*, Thursday 16 April 2020. Auditor General Report No. 32 of 2019–20 at https://www.anao.gov.au/work/performance-audit/value-money-the-delivery-official-development-assistance-through-facility-arrangements • 2021 Green. D., *Review of 'Implementing adaptive management: A front-line effort. Is there an emerging practice?'* at https://abtgovernance.com/2021/05/06/review-of-implementing-adaptive-management-a-front-line-effort-is-there-an-emerging-practice/. (May) • 2017 Teskey G. & Tyrell L., *Thinking and working politically in large, multi-sector Facilities: Lessons to date*. Governance Working Paper Series, Issue 2, (November) • 2015 O'Mara-Eves, et al. The effectiveness of community engagement in public health interventions for disadvantaged groups: a meta-analysis. *BMC Public Health*, *15*, 129. • 2018 Pieper, L., *Review of selected DFAT Facilities – Independent Consultant Report to DFAT* at https://www.dfat.gov.au/sites/default/files/independent-facilities-review.pdf • 2021 Rosewell A., Shearman P., Ramamurthy S., & Akers R., Transforming the health information system using mobile and geographic information technologies, Papua New Guinea, *Bulletin of the World Health Organization*, 2021, 1 May, *99*(5):381-387A. doi: 10.2471/BLT.20.267823. Epub 2021 2 March. PMID: 33958826; PMCID: PMC8061671 • 2016 Thompson B., Molina Y., Viswanath K., Warnecke R., Prelip M.L., Strategies to Empower Communities to Reduce Health Disparities, *Health Affairs Journal* (Millwood). 2016, 1 August, *35*(8):1424-8. doi: 10.1377/hlthaff.2015.1364 • 2020 Rogers, P. & Macfarlan, A., *What is adaptive management and how does it work?* Monitoring and Evaluation for Adaptive Management Working Paper Series, Number 2, September. https://www.betterevaluation.org/monitoring_and_evaluation_for_adaptive_management_ series

Annex 4 – MTR Key Informant Interviews

Organisation	Name and position
DFAT Port Moresby	Anna Gilchrist, First Secretary Daniel Tovakuta, Program Manager Dianne Barclay, Minister Counsellor Dianne Dagam, Senior Program Manager Gaye Moore, First Secretary, Gender and Strategy Gertrude N'dreland, Program Manager Jacqueline Herbert, Former PATH Contract Manager Jason Court, First Secretary Kate Butcher, Gender Adviser Lara Andrews, Counsellor, Health Lorna Maso, Program Manager, Gender and Strategy Lyn Bae, Senior Program Manager Nikki Wright, Former PATH Contract Manager Silentia Tulem, Assistant Program Manager
DFAT Canberra	Linda Chen, Assistant Director Human Development Policy and Programs (PNG Economic and Operational Branch)
ABT Associates	Anna Skelton, Ex Acting Operations Lead Bruce Bailey, Ex MERL MIS Technical Adviser Geoff Scahill, Ex Contractor Representative Jacqui De Lacy, Ex Contractor Representative James Gilling, Contractor Representative Jim Rock, Ex Health Systems Efficiency Adviser
PATH program	**Current staff – PATH program** Anne Marie Reerink, Adviser GEDSI Danny Beiyo, Senior Manager, Reproductive, Maternal, Neonatal and Child Health Donna Wilson, Senior Manager Program Delivery and Cohesion Elizabeth Boyd, Adviser Planning and Financial Management (HSIP) Emelyn Valaun, Senior Manager, Performance and Adaptive Systems Lisa Ijape, Senior Manager, PHA Support Project Lucy Dryden, Senior Program Manager, Trilateral Malaria Project Luke Elich, Adviser Transition Geoff Miller, Co-Lead Program Delivery HSPR and PHA Godwin Kudzotsa, GEDSI Lead Karley Walton, Operations Lead Kelwyn Browne, PHA Adviser Joshua Gewasa, Monitoring, Evaluation, Research and Learning Coordinator John Indoro, Provincial Facilitator Nancy Aboga, Senior Manager Gender Equality and Social Inclusion, Disability, Quality Sally Bannah, Team Leader Sammy Bogen, ARoB Provincial Facilitator Serah Kurumop, Monitoring, Evaluation, Research and Learning Coordinator Dr Stella Jimmy, Health Security Lead Stella Rumbum, Co-Lead Program Delivery FHO and Health Security Vanessa Paraka, Senior Manager, Women In Leadership **Former staff – PATH program** Ayesha Lutschini, GEDSI Lead Angelique Giranah, Senior Program Manager, AIHSS

Organisation	Name and position
	Dr Ellen Kulumbu, National Bottlenecks Reform Lead Gabriel Crick, Adviser Health Security and Pandemic Response (NDoH) Janee Crane, MERL Adviser Jeremy Symes, COVID/PHA Adviser – ARoB Dr Louise Maher, Short-Term Adviser PAS Dr Michelle Budwitz, Performance and Adaptive Systems Lead Paul Crawford, M&E Specialist Peter Thomspon, Operations Lead Ulla Keech, MERL and GEDSI Adviser Dr Valerie Haugen, Performance and Adaptive Systems Lead
PATH Sapotim Lida Working Group	Almah Kuambu, Technical Adviser, National Orthotic and Prosthetic Services – NDoH Lavinia Magir, CARE International, GEDSI Hub Program Director
PATH Steering Committee	James Agigo, DPLGA Tom Tiki, Deputy Secretary, Department of Finance
National Department of Health	Ken Wai, Deputy Secretary, Public Health Elva Lionel, Health Policy and Corporate Services
ARoB PHA	Matther Monei, Deputy Health Secretary Finance Manager Michaelyn Pau, Secretary of Bougainville Catholic Health Services Rosemary Ravap, Nursing Officer (AIHSS)
East Sepik Province PHA	Matthew Kaluvia, CEO Dr Jimmy Kambo, Director Curative Services Cletus Bon, Director Public Health Christopher Kabaru, Director Corporate Services Hicks Kurughin, Finance Manager Finance team (x 5 Officers) Director Nursing Services HSIP Officer AIHSS Program Officer Jasper Dawo, Manager ICT/M&E
Western Province PHA	Dr Niko Wuatai, CEO Dr Miriam Boga, Director Curative Services Dr Mathias Bauri, Director Public Health Arthur Amot, Director Corporate Services Lucy Morris, Manager Health Programs Tauleva Galeva, Provincial Rural District Health Coordinator Peary Dore, Manager GESI
WHO	Anna Maalsen, Universal Health Coverage and Health Systems Madeleine Salva, RMNCH Technical Officer Dr Mollent Okech, Technical Adviser Health Systems Strengthening Priya Mannava, Health Information, M&E – Vital Strategies
Susu Mamas PNG	Theresita Waki, General Manager
Marie Stopes PNG	Angelyn Famudi, MSPNG Country Director David Ayres, Ex-MSPNG Director

Organisation	Name and position
Burnet Institute	Khai Huang, Physician and Technical Director RID-TB project Sarah Korver, Project Manager RID-TB project
HPP Design Lead	Andrew McNee
Other stakeholders	Professor Glen Mola, Head of Reproductive Health and O&G, UPNG SMHS Geno Roalakona – PNG Snakebite Partnership Team Michele Rumsey, UTS – Strengthening Health Workforce Education (SHWE) Project Jo Thomson, Learning 4 Development (L4D) Rob Akers, Health Services Sector Development Program (HSSDP) Jenna Hawes, Ninti One Elizabeth Morgan, Oil Search Foundation Ricarde Lacort Monte, GAVI

Annex 5 – PATH Results Achieved against PAF EOIO and IO Indicators

EOIO1: PHAs more able to lead provincial health reform and manage effective, efficient, equitable and quality health services in selected provinces.

Indicator

- PHA headquarters (HQ) leaders and technical personnel believe their knowledge, skills and performance in key areas, including strategic management, governance structures/mechanisms, policy development and operationalisation, data management and analytics, and public financial management, have improved due to PATH.
- PHA/BDoH HQ leaders believe the knowledge, skills and performance of downstream healthcare service delivery managers and healthcare practitioners have improved due to PATH.
- Research laboratory and university leaders believe researchers' knowledge, skills and performance in targeted areas and service volume have improved due to PATH.
- Positive changes in selected SPAR indicators over time (from 2017 to PATH inception to late 2024) in selected demonstration PHAs/BDoH and non-demonstration PHAs.

Performance expectation	Data collection method	Data reported/comments
EOIO 1.1: Increase over time in leaders' and technical and research and university personnel's positive perception about continuous improvement in their organisation.	• Survey of PHA/BDoH personnel and selected stakeholders. • Interviews with PHA/BDoH, laboratory and university personnel, and selected stakeholders. • PHA Support Plans updated and reviewed.	No perception surveys, interviews yet conducted.
EOIO 1.2: Improvement over time on selected SPAR indicators.	• Trend analysis of selected SPAR indicators relevant to EOIO1 and EOIO2 in demonstration PHAs/BDoH and selected non-demonstration PHAs.	PATH reported[175] no clear or consistent trends from SPAR data supporting evidence for improvements over time. 2023 and 2021/2022 comparisons considered problematic due to COVID-19 pandemic 'data noise'.

IO1: Leaders and technical personnel in PHAs/BDoH are performing mandated functions.

Indicator

PATH contributes to enhancing PHA HQ/BDoH:

- Personnel leadership and management knowledge, skills and performance in key areas, including strategic management, governance structures/mechanisms, policy development and operationalisation, data management and analytics, and public financial management.
- Use of data to make evidence-informed strategic decisions about specified healthcare services for diverse populations, especially underserved populations.

[175] Page 2, PATH Six-Monthly Report (January to June 2023), 8 February 2023 (revised from 28 August 2023).

- Capacity to engage with the NDoH (including national-level Working Groups) and lower levels of the provincial health system for strategic thinking, problem-solving and service delivery.
- To increase their finances.
- Selected elements of health service delivery investments are transitioned to PHAs/BDoH without disruption of or negative impact on service delivery.

Performance expectation	Data collection method	Data reported/comments
IO 1.1: Progress over time in targeted elements from PATH PHA/BDoH Support Workplan.	Maintain and review: PHA/BDoH Support Workplans (updated).	PATH reports 98% of planned activities by Provincial Facilitators and Monitoring, Evaluation and Learning Coordinator (8 February 2023)[176] – however, this appears to be process/output level rather than outcome level indicator. No examination of increase in knowledge, skills and performance available.
IO 1.2: PHAs/BDoH increasingly use health system data for policy development, strategic planning and service delivery improvement.	PHA Support Plans updated regularly and content aggregated and synthesised.	As above. No examination of increased use of health data available.
IO 1.3 Progress over time against PATH Transition Plan elements.	Desk review of reports and aggregation of data.	Transition baseline currently being developed.

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 provinces.

Indicator

PATH contributes to:

- Enhancing effective and efficient administration of medical test, medical treatments/ interventions, and health education activities.
- Increasing the number of medical tests, medical treatments/interventions, and health education activities.

Performance expectation	Data collection method	Data reported/comments
EOIO 2.1: Increased number of medical tests conducted.	• Project Indicator Performance Sheets maintained, analysed and aggregated. • eNHIS data analysed and aggregated.	• No baseline available. • January–June 2023: 22,248 medical tests conducted.

[176] Page 1, PATH Six-Monthly Report (January to June 2023), 8 February 2023 (revised from 28 August 2023).

Performance expectation	Data collection method	Data reported/comments
EOIO 2.2: Increased number of medical treatments administered.	As above.	• No baseline available • January–June 2023: 469,839 medical treatments administered.
EOIO 2.3: Increased number of people reached through health education activities.	As above.	• No baseline available. • January–June 2023: 350,351 beneficiaries of health education activities.

IO2: More women in leadership positions are influencing healthcare policies, planning, budgeting, and inclusive services.

Indicator

PATH contributes to:

- Enhancing leadership of women and persons with disabilities in decision-making bodies.
- Increasing women and persons with disabilities in leadership roles.
- Improving feedback mechanisms between communities and the provincial health system to address barriers and build on boosters (successes) locally.
- Improving knowledge and evidence generation for GEDSI in PNG's health system.
- Embedding GEDSI and safeguarding practices into PATH programming, planning, operations, and culture.
- Implementing PATH minimum GEDSI standards for supported COVID-19 response and vaccine roll-out efforts.

Performance expectation	Data collection method	Data reported/comments
IO 2.1: Increase over time in specified elements in PATH PHA/BDoH/NDoH GEDSI Support Workplans.	• PHA/BDoH/NDoH Support Workplans updated and analysed. • SLP Reports analysed.	• Appears to be process/output rather than outcome indicator.
IO 2.2: Percentage of women and PWD in decision-making bodies and leadership roles who believe their influence on healthcare policies, planning, and equity in service delivery has increased over time.	• Survey. • Key Informant Interviews.	–

IO3: Health care service delivery managers, practitioners and research personnel are performing mandated functions for targeted diseases/supports.

Indicator

PATH contributes to:

- Building healthcare service delivery personnel and researchers' competencies in targeted skills.
- Improving availability and quality of healthcare data overall and for targeted diseases/supports.
- Demonstrating success in the continuum of care for targeted diseases/support areas.

Performance expectation	Data collection method	Data reported/comments
IO 3.1: Increase over time in number of mobile patrols, outreach patrols, and innovative delivery mechanisms, especially for underserved populations.	• Progress reports, eNHIS downloads.	• No baseline available. • Clear and consistent definition of mobile patrols, outreach patrols/supervisory visits/ICT interventions not available and applied (in PATH projects or by NDoH). • Process for assessing contribution of PATH to eNHIS reported outcomes not yet developed.
IO 3.2: Increase over time in number of health facilities that receive at least 1 supervisory visit per annum.	• SPAR review. • eNHIS data capture and aggregation.	• No baseline available • Clear and consistent definition of supervisory visits not available and applied (in PATH projects or by NDoH) • Process for assessing contribution of PATH to eNHIS reported outcomes not yet developed
IO 3.3: Number of health-focused ICT interventions introduced, rolled out or improved in health facilities.	• Meeting Minutes reviewed and information aggregated. • Implementation Contractors' reports reviewed and information aggregated. • eNHIS.	• No baseline available. • Clear and consistent definition of ICT interventions not available and applied (in PATH projects or by NDoH). • Process for assessing contribution of PATH to eNHIS reported outcomes not yet developed.

Annex 6 – Components of the PHA Support Project (PHASP)

PHA Embedded PATH Personnel Initiative (PEPPI)

The PHA Support team, now referred to as the PEPPI, has become the primary mechanism through which PATH provides capacity building support to PHAs/BDoH in the six demonstration provinces. A Provincial Facilitator and Monitoring, Evaluation and Learning Coordinator are based in each of the six demonstration provinces (depending on staff availability and PHA/BDoH preferences), overseen by a Port Moresby-based Senior Program Manager. The aim of the PF role is to facilitate demand-driven support to PHAs in these provinces/ARoB, deliver capacity building inputs, coordinate grantee activities with PHAs/BDoH, conduct strategic engagement (influencing) and assist to develop key planning and reporting documents. The role of the MELC is to support effective M&E across the PHA, including implementation of the electronic National Health Information System, reporting against the National Health Plan indicators and the PHA Annual Implementation Plan, providing training as necessary, and strengthening data quality and use of data for decision-making.

Public Financial Management (PFM) Initiative

The Expanded Program of Support for the Health Services Improvement Program (EPS HSIP) was established under PATH to provide targeted PFM capacity building support in both demonstration and non-demonstration provinces. It encompasses the already existing technical assistance provided to the NDoH to support operation of the HSIP Trust Account, with an additional component of subnational support. This is intended to equip PHAs to effectively use donor funding via the NDoH-managed HSIP Trust Account and, in doing so, support PFM capacity building more generally within the PHA. The EPS HSIP, combined with PFM work conducted by AIHSS capture PATH's efforts to address the bottleneck of limited PFM capacity at the PHA level.

PHA Monitoring, Evaluation and Data Initiative (MEDI)

This initiative, led by the PATH Performance and Adaptive Systems team, involves engaging with NDoH and key development partners in efforts to strengthen the quality of health information systems within respective PATH demonstration provinces, for consistency with national standards. Work in demonstration provinces is conducted in partnership with PATH embedded staff. Key activities include providing technical advice, supporting training, and developing national standard operating procedures and quality assurance tools for use by PHAs.

Annex 7 – Case Study of PATH Support to Western Province

Introduction

This case study describes how PATH has worked in Western Province PHA, and looks in detail at a particular improvement seen in PHA reporting, and analyses how PATH has contributed to that improvement.

The situation in Western PHA

The situation before PATH started working in Western PHA (WPHA)

WPHA was established in September 2019, with the responsibility for providing quality health services to the population in Western Province. Before 2021, SPAR reports from previous years had identified the WPHA as performing poorly and stagnant. Reporting rates for Western Province from 2016 to 2019 were consistently below regional and national averages, ranging between 70 and 80 per cent (SPAR, 2020). Core indicators, including antenatal clinic coverage, supervised deliveries, and immunisation, reflected low and fluctuating performance during this period.

Western Province was among the initial 14 provinces to transition to the electronic National Health Information System in 2019, with the roll-out of tablet-based data collection linked to an integrated online reporting platform. This followed establishment of telecommunications towers in the provinces in 2012–2017. The eNHIS roll-out expanded access to data and reporting tools, and has increased the timeliness and quality of routine health reporting across PNG. However, ensuring that PHA staff are able to fully use these systems has remained a challenge.

Improvements in reporting

There was a substantial improvement in WPHA's reporting performance from 88 per cent in 2019 to 93 per cent in 2020 (SPAR Report 2020). Reporting performance has further increased to 97 per cent in 2021, and reached 100 per cent in 2022. In interviews with key stakeholders, improved reporting was recognised as an important factor contributing to the increase in WPHA's SPAR ranking from 21 of 22 provinces in 2020 to 15 of 22 provinces in 2022. There is a shared sentiment that the increase in reporting rates indicates progress towards more complete and accurate reporting, which was absent in prior years. Greater attention to reporting at the health facility level has led to greater motivation among staff. Attention to each stage of the reporting and analysis process has helped to 'close the loop' from data input to use of data. An improvement in reporting can help improve the PHA's ability to manage health services by ensuring data is available to PHA senior management in a timely way to support them to make evidence-based decisions about service provision. Overall, the improvement in reporting was rated as a significant change against a rubric (see **Annex 12** for details of this rubric), reflecting that the change is supporting health service delivery improvements, but there are significant questions about the likelihood of the sustainability of the change.

PATH's contribution to the change

Interviews with both PATH provincial team and PHA staff revealed that the PATH MEL Coordinator's proactive approaches to capacity building, data management and supervision have contributed to the improvement in reporting rates. There is a shared sentiment that the increase in reporting rates indicates progress towards more complete and accurate reporting, which was absent in prior years. Greater attention to reporting at the health facility level has led to greater motivation among staff. Attention to each stage of the reporting and analysis process has helped to 'close the loop' from data input to use of data.

Activities conducted by the MELC included:

- Training and capacity building – PATH MELC conducted basic Microsoft Excel training for the PHIO, and facilitated recruitment of a new assistant PHIO, to enhance their skills in data management. She then provided training on data entry, and supported these staff to conduct visualisation of data, leading to increased data quality checks and identification of errors by the team.
- M&E training – MELC initiated M&E training for the PHIO and health facility Officers-in-Charge (OICs), covering basic data management and eNHIS tablet usage, resulting in improved reporting rates and completeness of reporting from the facility level. The previous eNHIS training the PHIO had received was in 2019 when the eNHIS had been rolled out in WP.
- Dashboard development – MELC developed a dashboard for WPHA, facilitating data visualisation and reporting, which was taken on by the PHIO for reporting the COVID-19 dashboard.
- WhatsApp group for regular reporting – A WhatsApp group was used to remind health facility OICs to submit eNHIS reports, swiftly address identified gaps, and provide visibility on timely data submission.
- Supervisory visits – PATH MELC conducted integrated supervisory visits to health facilities, including feedback sessions with health facility OICs on eNHIS data reporting, which were not happening previously, leading to improved data management practices.
- Feedback and reporting to SEM – PATH MELC implemented a process of quarterly reporting to SEM using data from the National Health Information System (NHIS), which was not previously occurring, allowing for data-driven decision-making within the PHA. This included enhancing data visibility across clinical teams.
- HR/staffing – Contributed to the development of job descriptions and competencies for M&E roles within the PHA.
- Other: Policy Integration – PATH MELC's work with the GEDSI Committee led to the integration of GEDSI principles into policy development within the PHA, demonstrating progress towards inclusive health service delivery.

Interviews with the PATH PHASP team based in Western Province indicated the important role of the PATH Public Health Adviser in securing support for proposed changes. As his work involved regularly engagement with the WPHA CEO and SEM, the Public Health Adviser was able to bring issues to their attention and advocate for their adoption. The MELC generally did not engage at this level and being able to influence PHA decision-makers helped to progress some of the actions above. Overall it was determined that PATH's contribution to the change was significant, with the change unlikely to have happened without PATH's engagement; recognising there were also many other actors who contributed to the change.

While these improvements have been commended by the CEO as significant strides in PHA performance, concerns persist regarding ongoing structural issues within the healthcare system, potentially jeopardising the sustainability of these achievements. Sustaining these gains depends on the SEM continuing to prioritise M&E and reporting within the PHA. Human resource planning and upskilling of PHA staff are also critical areas needing attention to maintain high reporting rates and the effective use of health data, which can translate into improved planning and targeting of health resources and lead to overall improvements in service delivery outcomes.

Despite this advancement, the PHA faced challenges due to the absence of a dedicated M&E Officer. The responsibility fell upon the PHIO to manage M&E tasks. Concerns arose regarding the PHIO's competency and capacity to effectively execute these responsibilities. Moreover, the lack of refresher training for health facility staff since the 2019 eNHIS roll-out further exacerbated reporting challenges and the PHIO's workload, rendering them handicapped in fulfilling their duties effectively.

Annex 8 – PATH MEDI Project – Progressive Results

PATH conducts ongoing engagement with NDoH and key development partners in efforts to strengthen health information systems within respective PATH demonstration provinces. A PHA/BDoH MERL systems appraisal conducted by PATH found that all demonstration provinces have one or more systems and processes established to ensure PHA accountability and continuous monitoring of various health program implementation. However, there are significant gaps in the availability of skilled MEL staff and effective governance mechanisms to drive MEL/eNHIS at subnational level, and poor data management practices.

At national level, PATH has actively participated in the NDoH M&E TWG since 2021.

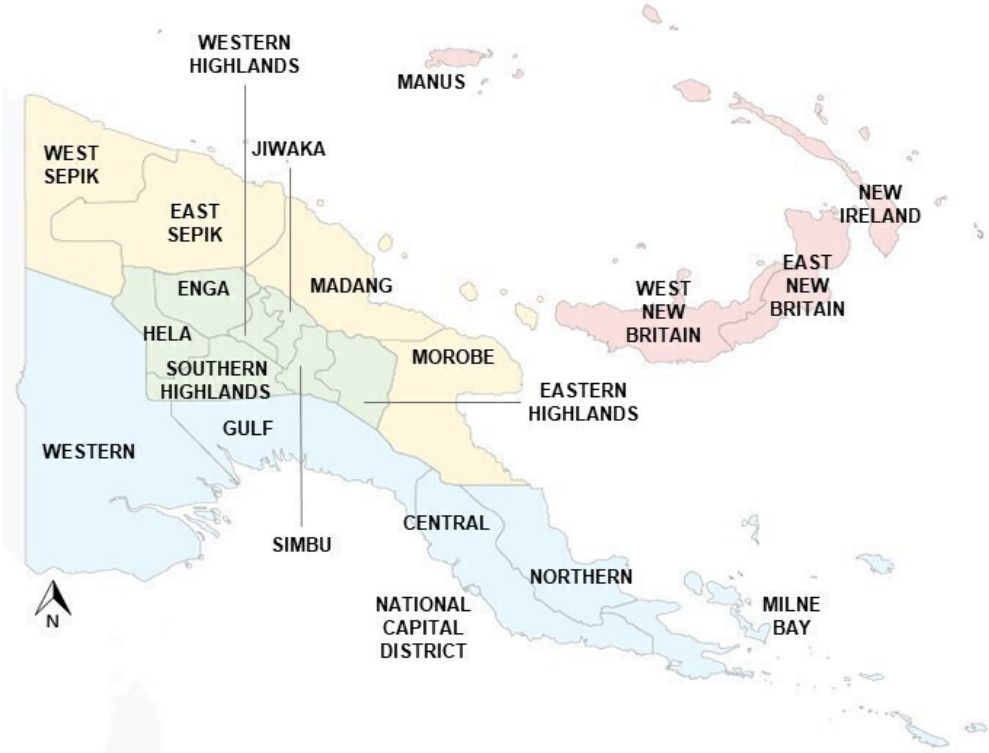
1. From 2021 to 2023, the MEDI project/PAS team provided technical advisory support in the six demonstration provinces, through engagement with MELCs and PHA ME teams. This informed and influenced development of technical documents and tools at national level for use across the sector.
2. Technical documents developed (2021–early 2023), approved and launched in 2023 include the: (1) Routine Health Information Data Management Standard Operating Procedure; (2) Data Quality Audit Tool; (3) Data Quality Audit Tool Standard Operating Procedure; and (4) PHA report template.
3. In 2022, PATH with WHO co-funded an eNHIS workshop and co-facilitated selected sessions during the workshop. PATH funded participation of all six MELCs in demonstration provinces in the workshop.
4. In 2023, PATH: (1) supported the launch of the National Health Plan 2021–2030 Monitoring and Evaluation Framework and Monitoring and Evaluation Toolkit during the NHIS workshop; (2) facilitated selected sessions; (3) funded two demonstration provinces (ARoB/West Sepik Province) to present some lessons and successes of their work (this included establishment of Provincial M&E Coordination Committee and conduct of Data Quality Audits); and (4) launched strategic documents with PHA SEM, middle management, and district and PATH grantees.
5. Collaborated with partner, Vital Strategies, to deliver data analytics training for three demonstration provinces and a Data Analytics Symposium. The purpose of the training was increasing knowledge and skills of PHA SEM/middle management and M&E teams on using available routine health data on eNHIS and other program data platforms to inform decision-making and influence policy development. The Data Analytics Symposium provided an opportunity for PHA staff to collaborate, learn from each other, and build confidence in data analysis, interpretation, and use, and providing feedback. A follow-up Data Analytics Symposium and training is planned for the first quarter of 2024.

Annex 9 – PATH Projects Conducted under IO3

- **AIHSS1:** Accelerated Immunisation and Health Systems Strengthening Project Phase 1
- **PSFP2:** Partnering for Stronger Families Project Phase 2
- **SRHIP2:** Sexual and Reproductive Health Integration Project Phase 2
- **WRIPHCP:** Western Rural Integrated Primary Healthcare Project
- **HECSP3:** Health Education and Clinical Services Project Phase 3
- **SHWEP:** Strengthening Health Workforce Education Project
- **KHRP:** Kompiam Hospital Redevelopment Project
- **TMP:** Trilateral Malaria Project
- **RID TBP2:** Reducing Impact of Drug-Resistant Tuberculosis Project (Phase 2)
- **STOP TBP2:** Strengthening Community Response to Stop Tuberculosis in Western Province Project Phase 2
- **CTHP:** Child Tuberculosis/Human Immunodeficiency Virus (TB/HIV) Project
- **eTBMP:** Electronic Tuberculosis Module Project
- **C-19SSSP:** COVID-19 Supplementary Surge Support Project
- **C-19SEROS-PNGIMR:** COVID-19 Seroprevalence Study – PNG Institute of Medical Research National (Rapid Diagnostic Testing/RDT)
- **PNGSPP-UMCCTL:** PNG Snakebite Partnership Project – University of Melbourne Charles Campbell Toxicology Laboratory
- **Laboratory Support Projects:** Several laboratory support initiatives
- **PNG Pharmaceutical Society**

Annex 10 – Location of PATH projects Implemented by Province (as at August 2023)

Map is reproduced from Annex 1, Draft PATH Six-Monthly Report (January to June 2023), Submission Date 28 August 2023.



NATIONAL
- HECSP3 (UPNG SMHS)
- EPSHSIP (PATH)
- SHWEP (UTS)
- LSP (C-19SEROS-PNGIMR, C-19WGSP-UMDI, MALP-CPHL, MALP-PNGIMR, PNGSPP-UMCCTL, TBP-PNGIMR, TBDSTP-QMRL)
- NHSP (NDoH, Office of Minister, UNAIDS)

ISLANDS

***ARoB**
- PHASP (PATH)
- EPSHSIP (PATH)
- eTBMP (PNGRSC)
- SLP (CARE)
- AIHSS (BCHS)
- SRHIP2 (CCHS)

***EAST NEW BRITAIN**
- PHASP (PATH)
- EPSHSIP (PATH)
- eTBMP (PNGRSC)
- SLP (CARE)
- AIHSSP (EHPHA)

MANUS
- EPSHSIP (PATH

NEW IRELAND
- EPSHSIP (PATH)
- MALSS (TMP PNGIMR)
- C-19SS (PNGIMR)

***WEST NEW BRITAIN**
- EPSHSIP (PATH)

MOMASE

EAST SEPIK
- EPSHSIP (PATH)
- AIHSSP (STC)
- SRHIP2 (CCHS)

MADANG
- EPSHSIP (PATH)
- AIHSSP (WVPNG)
- PSFP2 (MSPNG)
- SRHIP2 (CCHS)
- MALSS (TMP PNGIMR)
- C-19SS (PNGIMR)

***MOROBE**
- PHASP (PATH)
- EPSHSIP (PATH)
- eTBMP (PNGRSC)
- SLP (CARE)
- AIHSSP (WVPNG)
- PSFP2 (MSPNG)
- SRHIP2 (CCHS)
- MALSS (TMP PNGIMR)
- C-19SS (PNGIMR)

***WEST SEPIK**
- PHASP (PATH)
- EPSHSIP (PATH)
- SLP (CARE)
- AIHSSP (CHAI)
- SRHIP2 (CCHS)
- MALSS (TMP PNGIMR)
- C-19SS (PNGIMR)

HIGHLANDS

EASTERN HIGHLANDS
- EPSHSIP (PATH)
- PSFP2 (MSPNG)
- AIHSSP (EHPHA)
- SRHIP2 (CCHS)

ENGA
- EPSHSIP (PATH)
- KHRP (EBHS)

HELA
- EPSHSIP (PATH)

JIWAKA
- EPSHSIP (PATH)
- AIHSSP (STC)

SIMBU
- EPSHSIP (PATH)
- PSF (MSPNG)
- MALSS (TMP PNGIMR)
- C-19SS (PNGIMR)

SOUTHERN HIGHLANDS
- EPSHSIP (PATH)
- AIHSSP (OSF)
- SRHIP2 (CCHS)

***WESTERN HIGHLANDS**
- PHASP (PATH)
- EPSHSIP (PATH)
- SLP (CARE)
- AIHSSP (WHPHA)
- PSFP2 (MSPNG)
- SRHIP2 (CCHS)

SOUTHERN

CENTRAL
- EPSHSIP (PATH)
- AIHSSP (CHAI)
- PSFP2 (MSPNG)
- SRHIP2 (CCHS)

GULF
- EPSHSIP (PATH)
- AIHSSP (OSF)

MILNE BAY
- EPSHSIP (PATH)
- MALSS (TMP PNGIMR)
- C-19SS (PNGIMR)

NCD
- PHASP (PATH)
- EPSHSIP (PATH)
- PSFP2 (MSPNG)
- SRHIP2 (CCHS)
- CTHP (PSPNG)
- MALSS (TMP PNGIMR)
- C-19SS (PNGIMR)
- C-19 SSSP (NSJC PNG)

NORTHERN (ORO)
- EPSHSIP (PATH)

***WESTERN**
- PHASP (PATH)
- EPSHSIP (PATH)
- eTBMP (PNGRSC)
- SLP (CARE)
- AIHSSP (WVPNG)
- SRHIP2 (CCHS)
- WRIPHCP (YWAM)
- RID TB2 (BI)
- STOP TB2 (WVPNG)
- MALSS (TMP PNGIMR)
- C-19SS (PNGIMR)

Annex 11 – GEDSI Mainstreaming and Equity IO3 Projects

Delivering outcomes for improved health equity could be considered, at least in part, the responsibility of the GEDSI unit. The parameters of the GEDSI unit encompassed both mainstreaming and 'equitable health services', through supporting the grantees in their work. The shaded boxes in the **Table 5** show how promoting equitable health services was intended to be present across all projects and grantees, whereas GEDSI mainstreaming was forecast to take place in only half of the grantees.

GEDSI unit work parameters[177]

Program elements intended to be part of projects are shaded in blue [B].

Table 5: GEDSI health equity focus

Projects/Grantees	GEDSI mainstreaming	Equitable health services
PHASP	[B]	[B]
EPSHSIP	–	[B]
eTBMP	[B]	[B]
NHSP	[B]	[B]
AIHSS	–	[B]
PSFP2	–	[B]
SRHIP2	[B]	[B]
WRPIHCP	–	[B]
TMP	[B]	[B]
CTHP	[B]	[B]
RID TBP2	[B]	[B]
STOP TBP2	[B]	[B]
C-19SSSP	–	[B]
C-19SEROS-PNGIMR	–	[B]
PNGSPP-UMCCTL	–	[B]
Laboratory Support Projects	–	[B]
HECSP3	–	[B]
SHWEP	[B]	[B]
KHRP	–	[B]

[177] PATH Six-Monthly Progress Report (January–June 2023), August 2023.

Annex 12 – OECD DAC Gender Marker Classification

PATH classifies itself as 'significant' for gender equality under the OECD DAC markers, meaning that gender equality is an important and deliberate objective of PATH, but not the principal reason for undertaking the program. Within PATH, the Sapotim Lida Project is classified as a GEDSI 'principal' program, which means gender equality is the main objective of the project or program and is fundamental to its design and objectives.

The finding of the MTR is that there is insufficient evidence that PATH meets the minimum definition set by OECD for the 'significant' ranking. This is explored in detail in the tables at the end of this annex, where the minimum standard for a 'significant' ranking is shown shaded in blue and marked [B].

There is good evidence that **gender analysis**, such as the GEDSI Stocktake conducted in PATH's six demonstration provinces, has **informed** PATH's GEDSI **Strategy** and the SLP **design**.

A **Do No Harm approach** is specified in the MERL Framework and the assumptions and mitigation strategies for risks have been included and are reported on in each progress report. For example, PATH's risk management framework outlines three risks (including mitigation strategies) related to the Sapotim Lida Project and to gender equality mainstreaming.

PATH has a specific **Intermediate Outcome on Women in Leadership**, IO2, and is managing implementation of a women's leadership program (Sapotim Lida Project). However, the Sapotim Lida MERL Framework was still in draft form in 2022 and due to be finalised in the first quarter of 2023. At the point of the MTR, this was still in draft mode with 'PATH and CARE working together to articulate Sapotim Lida outputs and intended outcomes'[178]. Therefore, SLP currently lacks a formal evidential basis for measuring its progress towards meeting the Intermediate Outcome.

The GEDSI Strategy requires that 'PATH teams collect and report **data disaggregated by sex, age, and disability** at a minimum, and ensure that data collection also reflects other GEDSI priorities according to the program'. 'PATH MERL Frameworks include both targeted and integrated GEDSI indicators, and both qualitative and quantitative data that measures the impact on gender and social power relations.' The 2022 Investment Monitoring Report confirms that 'the majority of PATH activities provide sex disaggregated data'. However, it also notes that 'there are very few qualitative and quantitative indicators specifically related to gender equality'. Some members of the GEDSI team said they found it challenging to make GEDSI visible, especially in PATH's MERL.

Therefore, while the minimum standard for data is met, the program is unlikely to meet the ambition of the GEDSI Strategy in terms of measuring progress on gender equality.

The OECD DAC Standard requires that **GEDSI performance targets are monitored and reported** against in annual reports. PATH provided two indicators of how GEDSI is present in the program, which have been reported:[179]

(1) Target: 80 per cent of PATH's program activities have a primary or secondary objective that addresses GEDSI.

Result: 83 per cent of grantees polled consider GEDSI as either a principal or a significant objective for their implementation.

[178] Email from PATH GEDSI team.

[179] Most recent data is from the PATH 2022 Progress Report.

(2) Target: PATH's program budget will have an annual combined GEDSI spend (principal and significant) at a minimum of 10 per cent.

Result: Programmatic expenditure for the full calendar year had a combined spend (principal and significant objective) of 64 per cent. GEDSI principal was at 5 per cent expenditure and GEDSI significant at 59 per cent of expenditure.

The Review Team has not been able to verify the PATH reporting against either of these targets. It is not clear what methodology was used for 'polling' the grantees, or how consistently their objectives are weighted and measured. With regard to the second target, there is no gender tagging in the budget reports, so the 64 per cent figure cannot be verified.

Even if these targets were independently verifiable, it is unlikely that they would meet the standard required for a GEDSI performance target. Measuring the **intention** of grantees is not the same as setting targets and measuring **performance**. Similarly, assuming that if a sub-project has any bearing on GEDSI then its entire budget is assigned as 'GEDSI spend' is too broad and vague to be informative. For example, a focus on maternal and child health does not result in an implicit focus on gender, and there is a risk of reinforcing gender stereotypes if gender equality considerations and the cultural context are not factored into health service design.

Details of the rubric used in this report to analyse change

Note: The minimum standard for a 'significant' ranking is shaded in blue and the column is marked [B] in the heading.

Significance of the Change Rubric

Not significant	Significant [B]	Highly significant
There is limited/no evidence of a change between the initial situation and the eventual result. There is limited/no evidence of sustainability, and/or higher order outcomes being likely to be achieved over the long term.	The change between the initial situation and the eventual result is of an incremental nature. There is some evidence on the likelihood of the change being sustainable, and/or whether higher order outcomes are likely to be achieved over the long term.	The change between the initial situation and the eventual result is considerable. There is strong evidence that the change is likely to be sustainable, and/or lead to higher order outcomes over the long term.

Significance of PATH's Contribution Rubric

Not significant	Significant [B]	Highly significant
Without PATH, the change would probably have happened anyway.	PATH's investment made a substantial contribution to a key part of the change, and it would not have occurred in the same way without PATH. Other actors also made a significant contribution.	The change would not have occurred without PATH's investment.

Strength of Evidence Rubric

Weak evidence	Adequate evidence	Strong evidence [B]
• Evidence is derived from one source or no source. • Data collection and analysis methods are partially or not transparent. • Most important claims are not clearly supported by evidence. • Sources of potential bias have not been identified.	• Evidence is derived from two sources (including primary and secondary; quantitative and qualitative data). • Data collection and analysis methods are partially transparent. • Most but not all important claims are clearly supported by evidence. • Sources of potential bias have been identified but no or little effort has been made to limit them.	• Evidence is derived from at least three credible sources (including primary and secondary; and qualitative and quantitative data). • Data collection and analysis methods are transparent. • All of the important claims are clearly supported by evidence. • Sources of potential bias have been identified and significant efforts have been made to limit them.

Annex 13 – PATH Executive Position Vacancies – October 2020–June 2023[180]

Year	2020			2021												2022												2023						Formal candidate in role
Month	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Percent of total months
Team Leader	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	79%
Planning & Design Facilitator evolved into Chief of Staff role Sept 2021				1	2	3	4	5	6			7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	85%
Performance and Adaptive systems Lead	1	2	3	4	5	6	7	8			9	10	11		12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	58%
GESI & Safeguarding Lead	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30				91%
Program Delivery Lead (In Jan 2023 this became two Co-Lead Program delivery								1	2	3	4				5	5	6	7	8	9	10	11	12	13	14	15	16							60%
Co-Lead Program delivery (New role) Front Health Outcomes (FHO) commenced Jan																												1	2	3	4	5	6	100%
Co-Lead Program Delivery (New-role) HSPR & PHA (commenced Jan 23)																												1	2	3	4	5	6	100%
National Bottlenecks Reform Lead					5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26								85%
Provincial Performance Facilitation Lead	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	Recruitment in progress								18	19	20	21	22	23	24	25	52%
Frontline Health Outcomes Lead	1	2	3							4	5	6	7	8	9		10	12	13	14	15	16	17	18	19	20	21	22	23	24				57%
Health Security Lead				1	2	3	4	5		6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	97%
COVID 19 Taskforce Lead (new position Sept 21 - Dec 22),												1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16							100%
Operations Lead	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	64%

KEY:

- Permanent Placement (Formal recruitment)
- PATH Internal arrangements - job sharing/temporary appointments
- STA support
- Not a position on the Executive Team/Redundant Position
- Vacant/Recruitment on Progress

[180] Sources: PATH Organisational Charts 10 February 2021, 21 November 2022, 28 February 2023, and 15 August 2023.

Annex 14 – PATH Service Delivery Projects – Transition, Sustainability Approaches and Challenges

PATH project	Current approach to transition and sustainability	Challenges
AIHSS: Aims to increase access to integrated immunisation services, particularly via outreach, in project provinces.	The project intends to transition from funding and management of the project via ISPs (mostly NGOs) to direct funding to PHAs via the HSIP Trust Account. Responding to the findings of the 2023 project evaluation, the design of the AIHSS project Phase 2 places a stronger focus on PFM capacity building than was implemented in Phase 1. Implementing partners will be required to produce a transition plan at the start of the project, outlining how activities would be maintained by the PHA at the end of the program period.	Health system strengthening approaches were not well defined or resourced for the majority of PHAs in Phase 1 of the project. The focus on addressing system-level weaknesses and bottlenecks affecting delivery of immunisation services also needs strengthening. A structure for measuring effectiveness of capacity building activities (not just number of competency certificates) should be put in place. Increasing delivery of integrated maternal and child health services was largely overlooked in Phase 1 and the approach in Phase 2 unclear. Plans for addressing equity and GEDSI are not yet in place. Continued funding to maintain outreach services is needed and critical health system barriers (e.g. affecting sustainable financing) have not yet been addressed.
PSF: Aims to increase access to quality family planning services in target provinces. Key modalities are direct service delivery and training.	A key project strategy to promote sustainability is the provision of competency-based training to enable health care workers to deliver long-term family planning methods in GoPNG clinics. In response to findings of the 2021 evaluation, a new model for the National Family Planning Training Program has been developed. It includes an increased focus on transitioning family planning/sexual and reproductive health services to government ownership and better embeds training and quality assurance practices with national and provincial health authorities. Training and support to integrate GEDSI into outreach services is underway. The design for the next phase of the project is currently being finalised.	Although Memoranda of Understanding are being put in place, the commitment of PHAs to progressing the agreed transition has been a barrier. An enabling environment for delivery of health services, particularly health facility infrastructure and continuity of family planning commodity supply, are systemic challenges to be addressed.
SRHIP: Aims to increase quality and sustainability of HIV/STI services delivered by Catholic Church Health Services (CCHS).	SRHIP involves a planned transition from standalone HIV/STI services to integration with CCHS primary health care clinics, with a major focus on increasing quality and sustainability of HIV/STI services. Good progress on functional integration and strengthening M&E systems has been achieved.	Integration is planned with GoPNG/PHA system through Service Level Agreements (SLAs). SLAs to include CCHS performance and PHA funding commitments, critical for sustainable funding to these services. There have been delays in progressing SLAs. Delivery of STI services and integration with reproductive health services are less successful.

PATH project	Current approach to transition and sustainability	Challenges
	A recent SRHIP focus is to strengthen the approach to SRH, key populations, and GEDSI. The SRHIP HIV Counselling Toolkit, jointly developed with peer-led organisation Igat Hope, is to be rolled out nationally.	
RID-TB: Aims to address TB emergency in Western Province through providing technical assistance, PHA and clinical capacity building support and system design.	Project interventions are intended to build the capacity of Western PHA to deliver effective TB clinical services. The project plans to implement a TB elimination strategy in Western Province to reduce levels of TB and Multi-Drug-Resistant TB in the province. A reduced complex TB burden, requiring intensive and costly treatment will result in a more manageable situation for Western PHA.	Transition of project roles to WPHA before necessary staff are in place has been disruptive and required the project to provide additional interim staffing to delivery services.
Western Integrated Primary Health Care Project – Logistics/Management (WIPHCP-L/M): Aims to improve access to primary health care services and information in rural areas through integrated outreach patrols.	Outreach is combined with mentoring for health care workers to build capacity. Ongoing advocacy by the project has led to establishing a PHA routine immunisation stakeholders coordination meeting, to assist in scheduling integrated outreach.	One-to-one capacity building is key to this approach, but requires a persistent and long-term commitment. Ongoing support is needed to strengthen service coordination and planning. This is a low-cost model, but PHA commitment to funding services is needed. PHA bottlenecks (e.g. slow processing of paperwork) and system challenges (stock-outs) are continuing barriers to effective delivery of services.

Annex 15 – Accessibility: Written version of Figure 1 on Page 12

Title: Conceptual framework for the PATH Mid-Term Review

The Strategic Context included:

- Government of Australia Priorities
- Government of PNG Priorities; and
- Sustainable Development Goals.

PATH Implementation included two EOIOs, and three IOs. IO1, PHA Leadership, and IO2, Women in Leadership, fed into EOIO1, PHA Reform and Capabilities. IO2, Women in Leadership, and IO3, Healthcare Workforce, fed into EOIO2, Effective Health Services.

KRQ!, on relevance, examined the Strategic Context. KRQ2, on effectiveness, and KRQ4, on efficiency, focused on PATH Implementation. KRQ5, on sustainability, focused on Strategic Context and PATH Implementation.

Cross-Program Criteria included KRQ3, on GEDSI, and KRQ6, on MERLA.

Annex 16 – Accessibility: Written version of Figure 2 on Page 13

Title: PATH Review Phases

There were four phases.

Phase 1 was Planning, which covered: HDMES Inception; Document Review; AHC Inception Draft; and MTR Plan. The deliverable under this phase was the MTR Plan.

Phase 2 was Data Collection, which covered: MTR Team; Coordination Key; Informant Interviews; Provincial Visits; and Document Review. The deliverable under this phase was the Aide Memoire.

Phase 3 was Analysis, which covered: Thematic Analysis; Contribution Analysis; and Root Cause Analysis. The deliverable under this phase was the Draft MTR.

Phase 4 was Reporting, which covered: MTR Drafting Quality; Assurance Reflection; Workshop MTR; and Finalisation. The deliverable under this phase was the Final MTR.

Annex 17 – Accessibility: Written version of Figure 3 on Page 17

Title: Alignment of PATH key program themes with health and development policies

There were four PATH key program themes: Partnership for development; Strengthen health leadership; Essential health services and health security; and Women in Leadership.

The development policies listed under 'Partnership for development' were: Paris Declaration; Accra Agenda; Sustainable Development Goals; CEDAW; and International Health Regulations.

The development policies listed under 'Strengthen health leadership' were: PNG-Australia CSEP; and PNG Medium-Term Development Plan III.

The development policies listed under 'Essential health services and health security' were: NGP 2021-2030; HPP 2018-2023; and Maternal & Neonatal Health, HIV & STI, and Immunisation Strategies.

The development policies listed under 'Women in leadership' were: GoPNG GESI Policy; and DFAT Gender Equality & Women's Empowerment Strategy.

Annex 18 – Accessibility: Written version of Figure 4 on Page 46

Title: Leadership of the PATH program from inception to December 2023.

The table summarises leadership challenges across three time periods: 1) Inception and COVID-19, October 2022 to April 2022; 2) Implementation, April 2022 to November 2022; and 3) Consolidation, from November 2022 to December 2023.

For DFAT, fragmented context and high-risk context were challenges through Inception & COVID-19 and Implementation. Low trust in investment/management was a challenge through Implementation and Consolidation.

For PATH, lack of accountability was a challenge for Inception & COVID-19. Lack of management was a problem for Implementation. Micro-management was a challenge for Consolidation.

For Abt, the following were challenges across all time periods: poorly targeted support; recruitment gaps; and staff capabilities (skills, TORs, and backstop).

For NDoH, COVID-19 response focus was a challenge for Inception & COVID-19. Across Implementation and Consolidation, challenges were: lack of relationship with PATH; and direct DFAT engagement.

Annex 19 – Accessibility: Written version of Figure 5 on Page 57

Title: Iterations of the PATH Intermediate Outcomes

The graphic shows the iterations of the PATH Intermediate Outcomes over three versions, through a logic diagram. There were seven areas in the first version, which reduced to five in the second version, and three in the third version.

The two areas that were dropped from the 1st version are Bottleneck and Equity. Bottlenecks stated: Policy, PFM and governance system bottlenecks at central and local levels, which hinder provincial health delivery system performance, and are resolved. Equity stated: Locally led approaches that increase access to quality and integrated essential services by women, girls, people with disability, and marginalised populations, tested and scaled.

There were an additional two areas dropped from the second version: accountability and essential services. In Version 1, Accountability stated: More policy relevant information available and used by government, PHAs and communities to plan, budget, monitor and drive performance and quality. In Version 2, Accountability stated: Evidence and learning used to drive improved performance and service quality by PHAs, health facilities, communities, NDoH and central agencies.

In Version 1, Essential Services stated: Efficient and effective integrated locally led models of primary health care service delivery are demonstrated with PHAs, local government and partners. In Version 2, Essential Services stated: Improved quality and equitable access of essential services, which are increasingly integrated and transitioned to PHA management.

The three areas that were kept in all three versions were: PHA Leadership; Women in Leadership; and Healthcare Workforce.

In Version 1, PHA Capacity stated: PHA Boards & management capable of leading reform, managing & coordinating health delivery system finances, health workers, partnerships and service providers. In Version 2, PHA Capacity stated: PHA and BDoH Boards and management more effectively govern, manage, lead and coordinate the delivery of health services in selected provinces In Version 3, PHA Capacity was retitled PHA Leadership, and stated: Leaders and technical personnel in PHAs/BDoH are performing mandated functions.

In Version 1, Women in Leadership stated: Improved systems to support women in leadership roles in the provincial health delivery system, influencing policy, planning and budgeting of health services in selected provinces. In Version 2, Women in Leadership stated: Improved systems to support women in leadership roles in the provincial health delivery system, influencing policy, planning and budgeting of health services in selected provinces. In Version 3, Women in Leadership stated: More women in leadership positions are influencing health care decisions.

In Version 1, Health Security & Pandemic Response stated: Improved provincial health system capabilities to plan and implement measures for prevention, detection of, and response to, TB, malaria, HIV and COVID-19. In Version 2, Health Security & Pandemic Response stated: Improved prevention, detection and response to preventable diseases and other emerging infectious diseases by PHAs and BDoH. In Version 3, Health Security & Pandemic Response was retitled Healthcare Workforce, and stated: Health care service delivery managers, practitioners and research personnel are performing mandated functions.

Annex 19 – Accessibility: Written version of Annex 1 on Page 66

Title: PATH Program Logic (2023)

The overarching Goal (NHP) was: Preventing ill health, identifying and addressing health risks and emergent diseases and providing accessible and affordable quality health care to all.

There were three Objectives of the DFAT Portfolio Plan, below the Goal, which were: 1) Improved rural primary health care through stronger health systems; 2) Health Security and Communicable Disease control; and 3) Integrated client centred sexual reproductive health services.

The diagram reflected a dotted 'Line of Accountability' between the Objectives and End of Investment Outcomes.

There were two End of Investment Outcomes: 1). PHAs more able to lead provincial health reform and manage effective, efficient, equitable and quality health services in selected provinces; and 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.

There were three Intermediate Outcomes. 1) PHA Leadership: Leaders and technical personnel in PHAs/BDoH are performing mandated functions. 2) Women in Leadership: More women in leadership positions are influencing health care decisions. 3) Health Care Workforce: Health care service delivery managers, practitioners and research personnel are performing mandated functions. IO1 and IO2 sat under EOIO1. IO2 and IO3 sat under EOIO2.

There were six outputs that sat under all Ios. 1) Governance and collaboration structures/mechanisms established and functional. 2) Evidence-based policies and plans developed and operationalised. 3) Public financial management compliance corrective actions implemented. 4) Processes and procedures established and utilised. 5) Service delivery models expanded, especially for under-served populations. 6) Opportunities for women leaders and leaders with disabilities expanded.

There were three Projects under IO1: PHA Support Project (PHASP); Expanded Program of Support for health Services Improvement Program (EPS-HSIP); and eNHIS & eTB Module Rollout – Helicopter Support Project (eNHIS/eTBM HSP).

There was one Project under IO2: Sapotim Lida Project (SLP).

There were eleven Projects under IO3: Accelerated Immunisation and Health Systems Strengthening Project (AHSS); Partnering for Strong Families Project (PSF); Sexual and Reproductive Health Integration Project (SRHIP); Western Integrated Primary Health Care Project – Logistics/Management (WIPHCP-L/M); Tuberculosis Program (TBP); Trilateral Malaria Project (TMP); Snakebite Partnership Project (SPP); Laboratory Support Program (LSP); Health Education and Clinical Services Project (HECS); Strengthening Health Workforce Education Project (SHWE); and Kompiam Hospital Redevelopment Project.

There were seven inputs underneath all IOs: Funding for operational support commodities, human resource capacity development; Human resources (embedded Tech. Advisors, essential research/technical personnel through direct budget support); PATH personnel (Port Moresby & co-located in demonstration PHAs/BDoH); Frants to implanting organisations; Contracted services from

external laboratories; Research teams; and Donated commodities (e.g. snakebite & marine creature bite antivenomes).

Annex 20 – Accessibility: Written version of Annex 10 on Page 83

Title: Location of PATH projects Implemented by Province (as at August 2023)

The graphic includes a map showing how projects were spread across Provinces.

Nations Projects were: HECSP3 (UPNG SMHS); EPSHSIP (PATH); SHWEP (UTS); LSP (C-19SEROS-PNGIMR, C-19WGSP-UMDI, MALP-CPHL, MALP-PNGIMR, PNGSPP-UMCCTL, TBP-PNGIMR, TBDSTP-QMEL); and NHSP (NDoH, Office of Minister, UNAIDS).

In the Islands, there were projects in AROB, East New Britain, Manus, New Ireland, and West New Britain.

Projects in AROB were: PHASP (PATH); EPSHSIP (PATH); eTBMP (PNGRSC); SLP (CARE); AIHSS (BCHS); and SRHIP2 (CCHS).

Projects in East New Britain were: PHASP (PATH); EPSHSIP (PATH); eTBMP (PNGRSC); SLP (CARE); and AIHSSP (EHPHA).

Projects in Manus were EPSHSIP (PATH).

Projects in New Ireland were: EPSHSIP (PATH); MALSS (TMP PNGIMR); and C-19SS (PNGIMR).

Projects in West New Britain were EPSHSIP (PATH).

In Momase, there were projects in East Sepik, Madang, Morobe, and West Sepik.

Projects in East Sepik were: EPSHSIP (PATH); AIHSSP (STC); and SRHIP2(CCHS).

Projects in Madang were: EPSHSIP (PATH); AIHSSP(WVPNG); PSFP2 (MSPNG); SIRHIP2 (CCHS); MALSS (TMP PMGIMR); and C-19SS (PNGIMR).

In Morobe, projects were: PHASP (PATH); EPSHSIP (PATH); eTBMP (PNGRSC); SLP (CARE); AIHSSP (WVPNG); PSFP2 (CCHS); MALSS (TMP PNGIMR); and C-19SS (PNGIMR).

In West Sepik, projects were: PHASP (PATH); EPSHSIP (PATH); SLP (CARE); AIHSSP (CHAI); SRHIP2 (CCHS); MALSS (TMP PNGIMR); and C-19SS (PNGIMR).

In the Highlands, there were projects in Eastern Highlands, Enga, Hela, Jiwaka, Simbu, Southern Highlands, and Western Highlands.

Projects in Eastern Highlands were: EPSHSIP (PATH); PSFP2 (MSPNG); AIHSSP (EHPHA); and SRHIP2 (CCHS).

Projects in ENGA were EPSHSIP (PATH), and KHRP (EBHS).

Projects in Hela were EPSHSIP (PATH).

Projects in Jiwaka were EPSHSIP (PATH), and AIHSSP (STC).

Projects in Simbu were: EPSHSIP (PATH); PSF (MSPNG); MALSS (TMP PNGIMR); and C-19SS (PNGIMR).

Projects in Southern Highlands were: EPSHSIP (PATH); AIHSSP (OSF); and SRHIP2 (CCHS).

Projects in Western Highlands were: PHASP (PATH); EPSHSIP (PATH); SLP (CARE); AIHSSP (WHPHA); PSFP2 (MSPNG); and SRHIP2 (CCHS).

In Southern, there were projects in Central, Gulf, Milne Bay, NCD, Northern (Oro), and Western.

Projects in Central were: EPSHSIP (PATH); AIHSSP (CHAI); PSFP2 (MSPNG); and SRHIP2 (CCHS).

Projects in Gulf were EPSHSIP (PATH), and AIHSSP (OSF).

Projects in Milne Bay were: EPSHSIP (PATH); MALSS (TMP PNGIMR); and C-19SS (PNGIMR).

Projects in NCD were: PHASP (PATH); EPSHSIP (PATH); PSFP2 (MSPNG); SRHIP2 (CCHS); CTHP (PSPNG); MALSS (TMP PNGIMR); C-19SS (PNGIMR); and C-19 SSSP (NSJC PNG).

Projects in Northern (Oro) were PESHSIP (PATH).

Projects in Western were: PHASP (PATH); EPSHSIP (PATH); eTBMP (PNGRSC); SLP (CARE); AIHSSP (WVPNG); SRHIP2 (CCHS); WRIPHCP (YWAM); RID TB2 (BI); STOP TB2 (WVPNG); MALSS (TMP PNGIMR); and C-19SS (PNGIMR).