



Australian Government
Department of Foreign Affairs and Trade

PNG HEALTH CONSULTATIONS 2025 BRIEFING NOTE

FOR EXTERNAL CIRCULATION – FEBRUARY 2026

DISCLAIMER

The following slides represent the views of independent consultants advising DFAT on possible future investments

DESIGN BACKGROUND

DESIGN BACKGROUND AND PURPOSE



- The *Papua New Guinea–Australia Health Partnership Strategy 2024–2034* (HPS) was developed to guide the DFAT bilateral health program in Papua New Guinea (PNG) over the next 10 years
- The Strategy supports the goal of the Government of PNG’s (GoPNG) *National Health Plan 2021–2030*: ‘Preventing ill health, identifying and addressing health risks and emerging diseases, and providing accessible, quality healthcare for all’.
- The HPS sets out three pillars of effort:
 - Integrated Service Delivery
 - Health Infrastructure for Systems Strengthening and;
 - Knowledge and Innovation for Change.

HIGH-LEVEL CONTEXT

- PNG's health system continues to face fragmented service delivery, uneven Provincial Health Authority (PHA) capacity, workforce shortages, infrastructure gaps, and persistent gender and geographic inequalities in primary health care (PHC) utilisation.
- Provincial performance varies significantly, with pressures in high-demand areas and difficulty reaching remote communities.
- GoPNG priorities include strengthening PHA leadership, advancing integrated primary health care, and improving governance and accountability at the national level.
- DFAT remains a major, trusted partner in governance, workforce, infrastructure, and financing, with an opportunity to align support more closely with national reforms, including outcomes of the National Health Plan mid-term review.

IN COUNTRY CONSULTATIONS

IN-COUNTRY CONSULTATION OVERVIEW

- The design team includes Australian High Commission (AHC) staff and independent design consultants
- Design in-country consultations were held over 2 weeks in November 2025, complementing on going engagements with NDoH, PHAs, UN agencies, and implementing partners, including previous consultations to develop the Health Partnership Strategy 2024-2034
- Over 100 individuals consulted - see next slide for more information
- Consultations were facilitated using different methods:
 - Key informant interviews
 - Group discussions
 - National Health Plan Mid-Term Review
 - Virtual consultations

IN-COUNTRY CONSULTATIONS:

- National Department of Health:
 - Minister for Health
 - Senior Executive Management Team
 - Clinical Chiefs
 - Program Managers
- Provincial Health Authorities CEOs (19/22 PHAs)
- AHC Health Team
- Faith-based Organisations and Non-government organisation Service Providers
- University of Technology Sydney (WHO Collaborating Centre)
- Technical Advisors
- New Zealand High Commission
- Asian Development Bank
- World Bank
- WHO Country Office
- Gavi
- Santos Foundation
- National Health Plan mid-term review consultants

INITIAL FINDINGS

CROSS SECTOR

- Appetite for change; requires different ways of working
- Limited coordination at national and PHA level
- Fragmentation in service delivery; churches essential but structurally disconnected
- DFAT has a comparative advantage to convene; opportunity to play more of a leadership role
- Fragmented DFAT investments result in missed opportunities for strategic engagement with GoPNG and joint planning
- PHA reform still in progress, with National Department of Health (NDoH) adjusting to standard setting and regulatory role; missing middle between NDoH ↔ PHAs
- Low health financing per capita, with relatively low government contribution. Donor Partner funding also decreasing.
- Human resource challenges are significant and extend from national to PHC levels
- Limited consideration of gender inequality across the health system, despite the influence of gender inequality on health outcomes

SERVICE DELIVERY

- Limited progress on improving utilisation of primary health services, e.g. antenatal care (ANC), facility births, immunisation levels.
Emerging development partners focus on integrated PHC and use of supply and demand incentives to improve utilisation
- Integration of essential services remains aspirational; referral pathways inconsistent. Emerging development partners focus on integrated PHC and use of supply and demand incentives to improve utilisation.
- Closure of facilities (63% of health posts) is a significant issue, primarily due to staff vacancies and limited maintenance/infrastructure gaps
- PHA leadership, managerial and technical capacity and performance vary widely. The recurrent budget prioritises staffing, goods and supplies, with limited budget for operations
- District systems weak, and an emerging focus of some development partners.
- Increased appetite of development partners and GoPNG to link communities with the health system (facilities, outreach, volunteers, Healthy Islands)

INFRASTRUCTURE AND SYSTEMS STRENGTHENING

- DFAT has significant infrastructure investments across the country, which have high visibility
- Infrastructure remains as a political priority. Leaders within NDoH/PHA called for focus on refurbishment/maintenance of facilities (Levels 1-4)
- Facilities often upgraded without full consideration of workforce, accreditation and recurrent costs
- Significant challenges in human resources at the national level in workforce planning, regulation and quality of training providers, and registration of health workers, including new graduates
- There are HR management issues, throughout the cycle from recruitment, retention and retirement. Fiscal space also limits adequate resourcing of key functions
- Training ≠ workforce deployment; need a considered approach to continuing professional development linked to registration
- There are supply chain governance gaps
- Public financial management (PFM) systems at the national and provincial level need to be strengthened, including HSIP Trust Account governance - this is critical to increasing development partner confidence.
- The health information system is fragmented, lacking interoperability and only used in a limited way for evidence-informed decision making

DRAFT RECOMMENDATIONS

WHAT REMAINS CONSISTENT IN AUSTRALIA'S APPROACH..

- Service delivery support will focus on high burden diseases and integrated primary health care
- Continued focus in provinces where Australia has specific commitments including Bougainville and Western Province
- Continued focus on infrastructure, including through an ongoing co-financing partnership with the Asian Development Bank and GoPNG.
- Continue to fund high priority technical roles

AND WHAT CHANGES...

- Focus on an integrated package of primary health care services provided in community and lower-level facilities (L1-L3/4), likely to focus on ANC
- Infrastructure done in a way that also supports broader strategic objectives
- Strong focus on Provincial Partnerships, and strengthening links to NDoH and sub-national governments
- Elevated focus on gender and increased attention to climate concerns
- Enhanced ability to be a responsive development partner
- Clarity on geographic prioritization, complementing other development partners

POSSIBLE PRINCIPLES FOR SELECTION OF TARGET PROVINCES

- Service need and coverage gaps
- Willingness to reform & partner (mutual accountability)
- Minimum PHA operational functionality
- Synergies with development partners
- Potential for learning & national replication
- Stability & enabling environment
- Engagement with churches, NGOs, and private partners
- Stronger & effective engagement with NDoH

GOVERNANCE

GOVERNANCE STRUCTURES

- Opportunity to have more strategic, high-level engagement with government and other development partners, looking across various investments in the health sector
- Partnership frameworks at national and PHA level
- Interaction with the new Aid Management and Partnership Coordination Branch, NDoH



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