Prepared for the Australian High Commission, Port Moresby
by Human Development Monitoring and Evaluation Services

December 2021

Evaluation of Wok Bung Wantaim Strategy

Contact Details

Human Development Monitoring and Evaluation Services **Australian High Commission**

Name	Martin Aspin
Job title	Team Leader, Human Development Monitoring and Evaluation Services
Telephone	+61 450 758 158
Email	martin.aspin@hdmes-png.com

Name	Catherine Herron
Job title	First Secretary Health Security, Australian High Commission
Telephone	+675 70900146
Email	catherine.herron@dfat.gov.au

Document Review and Authorisation

Version	Date distributed	Issued to	Comments
1	21/09/2021	Catherine Herron - AHC	First draft final report for AHC review
2	20/12/2021	Chris Graham - AHC	Final version incorporating AHC feedback

Author(s) **Damien Sweeney, Dr Erin Passmore & Cynthia Nanareng**
Reviewer(s) **Liesel Seehofer & Martin Aspin**
Submission date **21 September 2021**
Reference no. **H2021**

Contents

Abbreviations and Acronyms

AHC	Australian High Commission [Port Moresby]
ANC	Antenatal Care
CCHS	Catholic Church Health Services
CHS	Christian Health Services
CHW	Community Health Worker
COVID-19	Coronavirus Disease of 2019
DDA	District Development Authority
DoF	Department of Finance [Papua New Guinea]
DFAT	Department of Foreign Affairs and Trade [Australia]
DNPM	Department of National Planning and Monitoring [Papua New Guinea]
DPLGA	Department of Provincial and Local Government Affairs
DPM	Department of Personnel Management [Papua New Guinea]
DSIP	District Services Improvement Program
DoT	Department of Treasury [Papua New Guinea]
EOIO	End of Investment Outcomes
FBB	Facility-Based Budgeting
GESI	Gender Equity and Social Inclusion
GoA	Government of Australia
GoPNG	Government of Papua New Guinea
HDMES	Human Development Monitoring and Evaluation Services
HFC	Health Facility Committee
HFG	Health Function Grant
HPHA	Hela Provincial Health Authority
HPHA PC	Hela PHA Partnership Committee
HSACC	Health Sector Aid Coordination Committee
HSSDP	Health Services Sector Development Program
KEQ	Key Evaluation Question
LLG	Local-Level Government
M&E	Monitoring and Evaluation
MIP	Monthly Implementation Plan
MOU	Memorandum of Understanding
MSPNG	Marie Stopes PNG
MTDP	Medium-Term Development Plan

NDoH	National Department of Health [Papua New Guinea]
NEFC	National Economic and Fiscal Commission
NGO	Non-Government Organisation
NHIS	National Health Information System
NHP	National Health Plan
OSF/OSL	Oil Search Foundation/Oil Search (PNG) Limited
PA	Provincial Administration
PAF	Performance Assessment Framework
PATH	PNG–Australia Transition to Health [program]
PCMC	Provincial Coordination Monitoring Committee
PCW	Provincial Council of Women
PHA	Provincial Health Authority
PLLSMA	Provincial and Local Level Services Monitoring Authority
PMU	Project Management Unit
PNG	Papua New Guinea
PPF	PNG Partnership Fund
PSIP	Provincial Services Improvement Program
SHP	Southern Highlands Province
SLA	Service Level Agreement
SLSS	Saving Lives, Spreading Smiles [program]
TA	Technical Adviser
TOC	Theory of Change
TOR	Terms of Reference
VHV	Village Health Volunteer
WBW	Wok Bung Wantaim [strategy]
WHO	World Health Organization

Executive Summary

Background

The Wok Bung Wantaim (WBW) strategy was a health system strengthening intervention implemented in Hela Province and Southern Highlands Province (SHP) of Papua New Guinea (PNG). It was initiated by the Oil Search Foundation (OSF) and co-funded by the Government of PNG (GoPNG), Government of Australia, and OSF. DFAT's grant allocation was initially AUD 7.4 million, but this was reduced to AUD 4.6 million in 2019. The grant was originally managed as part of the PNG Partnership Fund (PPF), and more recently by the PNG–Australia Transition to Health (PATH) program. The project ended on 30 June 2021.

WBW's goal was ultimately to improve frontline health services by championing a partnership approach, to increase health service utilisation and improve health outcomes. WBW sought to: 1) improve coordination between PNG Government at the national, provincial, and district levels; 2) support effective health financing; 3) improve quality service delivery; and 4) increase community engagement in health service planning and governance.

Evaluation Purpose and Methodology

The Australian High Commission (AHC) in PNG commissioned an independent evaluation of WBW, to assess the effectiveness of the strategy, document lessons learned, and consider the transferability of the strategy to other provinces. The evaluation was undertaken between April and September 2021.The evaluation methods included a document review, interviews with 44 stakeholders, quantitative assessment of the impact on health service utilisation and outcomes, and case studies.

Findings

Partnership approach

WBW used a 'partnership approach' based on the Collective Impact model to achieve systems change. It demonstrated a level of alignment to some, but not all, of the principles of the Collective Impact model. Interviewees commented on the extent to which WBW demonstrated a 'true partnership', noting that OSF drove implementation in a 'top-down' and 'transactional' manner, in contrast with the Hela Provincial Health Authority (HPHA) Partnership Committee, which illustrated the collaborative and relationship-building skills of the HPHA CEO. The evaluation found that the partnership brokering workshop in the first year was successful, but follow-up workshops would have further embedded and consolidated partnership values and practices. The evidence points to WBW playing a critical role in establishing a vision for accelerating health system strengthening within HPHA. OSF provided important financial, administrative and resource support, critical to the efforts of health service delivery and systems strengthening in Hela. Their role as a 'backbone' to support Collective Impact should continue to move towards resourcing and building the capacity of the PHA itself to fulfil this function.

Effectiveness against outcomes

WBW has contributed to accelerating positive changes under the three End of Investment Outcomes (EOIOs). A key achievement, attributable to WBW, is the roll-out of facility-based budgeting (FBB) in

35 facilities. This enabled facilities to have better control of their planning, budgeting and service delivery, and improved accountability of service plans and expenditure with monthly reports submitted to the Expenditure Screening Committee. This was a key achievement, as it enabled the CEO and Executive Directors to have full overview of all government and church-run facilities. There has been an increase in Health Function Grants (HFGs) to HPHA since 2017, and while this cannot be attributable to WBW, it is likely that WBW contributed to improved financial processes such as timely and consistent reporting, and transfer of funds from the HPHA to facilities. The sustainability of progress against this outcome is relatively strong, but is dependent on sufficient GoPNG funding for follow-up disbursements to HPHA. Ongoing capacity building on FBB will also strengthen the sustainability of this outcome.

There is evidence of improved frontline service delivery, through funding improvements in health facilities, capacity building of frontline staff, and Service Level Agreements (SLAs) with church service providers and also non-government organisations (NGOs) like Susu Mamas and Marie Stopes PNG (MSPNG). However, the sustainability of service delivery agreements, in particular with NGOs, is dependent on the ongoing availability of funding, as noted in the WBW Sustainability and Exit Strategy. The HPHA CEO has also been engaging with church organisations and NGOs to review the SLAs to strengthen the partnership approach, and move them away from transactional relationships.

During the WBW period, there have been a range of improvements in health outcomes in Hela, which were greater than improvements in areas where WBW was not implemented. The WBW strategy, taken in combination with other activities in Hela PHA, contributed to increased use of frontline health services, especially antenatal care visits, vaccinations, and outpatient care; an increased share of outpatient care being provided in primary health services; and an increased share of facility-based deliveries. International literature suggests a range of flow-on benefits from such improvements, including improved maternal and infant health outcomes. The sustainability of improved health outcomes is dependent on the availability and disbursement of sufficient funding across the decentralised health system, including for infrastructure, equipment and medicines, staffing, and for services provided by delivery partners.

Community engagement activities were impacted by external factors and reduced funding. However, WBW contributed to a greater focus on Gender Equity and Social Inclusion (GESI) at HPHA, and supported the Hela Provincial Council of Women (PCW) to engage and advocate more effectively.

The literature on the Collective Impact model notes the need for longer timeframes to achieve systems change (e.g. at least five plus years), something that was backed up by the views of a number of interviewees. This evaluation found that the WBW Program Logic should have aligned with the World Health Organization (WHO) health systems strengthening pillars, and the WBW Monitoring and Evaluation (M&E) Framework was not fit-for-purpose, with too many indicators and unrealistic expectations considering the timeframe and level of investment. This may have been a factor in some of the interviewees' criticism of OSF's 'top-down' approach to WBW.

Transferability of the WBW model

For WBW to be successfully replicated in other provinces, two fundamental features of the partnership approach would need to be in place. Firstly, a well-resourced backbone support organisation is required to lead coordination, communication, partnership brokering, and project management. Secondly, strong PHA leadership and management is critical. WBW's successes in Hela reflect the strong contributions of the PHA Board and CEO in bringing together key stakeholders and driving change. For an approach such as WBW to succeed in other PHAs, it is important that the PHA

already has strong leadership, which can be further supported and strengthened through the WBW model.

While priority activities would depend on the unique needs of each PHA, WBW's achievements in Hela suggest the following activities could be adopted by other PHAs to strengthen their capacity to manage and deliver health services:

- **Improved coordination:** Establish formal mechanisms for coordination and communication between partners, such as a PHA Partnership Committee; use Service Level Agreements as a mechanism for promoting partnership; provide DPLGA LLG workshops at the district level to engage with local Members of Parliament, District Development Authorities, and local-level governments.
- **Effective health financing:** Adopt facility-based budgeting; and strategically allocate top-up funding from donors and partners to address key gaps.
- **Sustainable quality health services:** Focus on capacity building of PHA staff, covering both technical and partnership-brokering skills; engage with NGOs to address gaps in service delivery; and ensure the PHA has project management and infrastructure technical expertise.
- **Community engagement:** Engage with Provincial Councils of Women to promote women's participation in decision-making.
- **Cross-cutting foundational activities:** Conduct a baseline assessment of PHA functioning and capacity; and ensure access to high-quality Technical Advisers.

Recommendations

Based on the findings identified in the main report, the review team makes the following recommendations for OSF, PHAs, PATH and the AHC when undertaking health system strengthening in PNG.

1. **The AHC – either through PATH or future investment partners – should provide advocacy and technical support to strengthen GoPNG national-level coordination mechanisms.**

   While WBW was an effective approach for health system strengthening at the provincial level, it was less successful in engagement and coordination at the national level. National-level coordination is essential to promote financing reforms, facilitate joint planning and accountability, ensure timely funding flows from national level to provinces and PHAs, and to address aspects of health system strengthening that are largely coordinated at the national level (e.g. medical supplies, health information systems and budget allocations). Mechanisms such as PLLSMA, HSACC, PCMCs, and NEFC and others, are critical for national-level coordination but many of these are driven by GoPNG agencies, with varying degrees of capacity and conviction. Supporting and strengthening these mechanisms should be a focus of future efforts by either the AHC and its health investments so that initiatives at the sub-national level can be empowered and more functional. The AHC could consider advocacy and support to GoPNG to progress the Review of Laws Affecting Health Governance and Service Delivery consultations and options paper, to advance the structural changes required to fully empower PHAs.

2. **OSF and other investment partners, when developing health systems strengthening programs, should ensure that designs and implementation are closely aligned with the WHO six pillars of health system strengthening principles, where appropriate. This could be achieved, for example, by framing the design document and program logic around the relevant pillars, engaging technical experts in health system strengthening to advise on the design, and aligning**

existing investment planning, implementation and progress reporting to the principles of each pillar, where possible.

While WBW aimed to strengthen the health system in Hela and Southern Highlands PHAs, it did not systematically address all six WHO pillars of health system strengthening. The WHO six pillars are the standard framework and approach for health system strengthening, and all six pillars are fundamental for a functioning health system. WBW targeted and contributed to accelerating positive changes in some key health system pillars – particularly in sub national financing, service delivery, staff capacity and leadership and governance. However, WBW implemented few activities in the other two health system pillars (access to medical products and technologies, and health information systems), largely because these are coordinated at the national level, where WBW's engagement was limited.

3. **If future investments in health system strengthening adopt a Collective Impact approach, the AHC and OSF should ensure that where possible investments address all five key elements of Collective Impact. This could be achieved by, for example, engaging technical experts in Collective Impact to advise on program design, develop a Collective Impact strategy during the inception phase to inform implementation, and actively work with partners and other donors to promote the Collective Impact approach amongst stakeholders. In particular, OSF and PATH should prioritise partnership brokering activities to establish the foundation for a Collective Impact approach.**

   There is a growing body of evidence on Collective Impact's ability to influence systems change and contribute to population level change. Collective Impact has five key elements: (1) a common agenda, (2) shared measurement system, (3) coordinated plan of action, (4) continuous communication, and (5) a backbone support organisation. Evidence from Collective Impact practice demonstrates that in addition to the five conditions, there are additional principles of practice that should be followed to put collective impact into action.[1] While several stakeholders considered WBW to align with a Collective Impact approach, it addressed some – but not all – elements and principles of Collective Impact. For example, while it strengthened coordination and communication between partners, coordination and communication are likely to have been stronger if there was a coordinated plan of action or shared measurement system agreed between partners, both of which are key elements of the Collective Impact model. OSF, if continuing WBW, and PATH/AHC, in planning and designing health systems strengthening, should be guided by these principles of practice and the five conditions, as it is more likely to achieve sustainable improvements in provincial health systems. Adoption of a Collective Impact approach may necessitate changes to M&E, and accountability and reporting processes, given that under a Collective Impact approach changes are due to the collective efforts of stakeholders, rather than attributable to a single actor.

4. **The AHC, when designing investments in health system strengthening or seeking to replicate WBW-style strategies in other provinces, should where possible design and fund investments for longer time periods to allow systems change to be realised.**

   WBW was funded as a three-year strategy – a period some stakeholders noted was too short for achieving the level of change required. Given that health system change takes time, a longer

[1] https://www.collectiveimpactforum.org/sites/default/files/Collective%20Impact%20Principles%20of%20Practice.pdf

investment period (five years or more) is more likely to allow systems change to be realised sustainable.

5. **The AHC, when designing future investments in health system strengthening or implementing WBW-style strategies in other provinces, should actively and consistently engage with implementing partners on sustainability at the design, implementation and reporting phases. This could be achieved, for example, by including sustainability as a specific consideration in the program logic, ensuring partners implement sustainability-focused activities throughout the implementation period, and requiring all partners to monitor, reflect and report on sustainability-related achievements.**

   DFAT's Investment Design Quality Criteria require that investment designs identify what sustainable benefits the investment aims to generate and strategies to achieve these, as well as identifying and addressing constraints to sustainability. Implementation of a sustainability strategy is also a criteria for assessing investment effectiveness as part of annual Investment Monitoring Reports. In the case of WBW, we found little evidence of sustainability being strategically considered or communicated with stakeholders during the funding period, which decreases the likelihood that improvements will be sustainable. While it can be reasonable to assume that the improvements in PHA capacity and processes will be sustained, many interviewees expressed concerns about sustainability, particularly regarding the need for ongoing funding of health services (a challenge also noted in the WBW Sustainability and Exit Strategy), lack of succession planning for PHA leadership and senior executive, and the lack of common understanding amongst stakeholders of what sustainability would look like for WBW or how it could be achieved. A more explicit sustainability strategy may have helped address these challenges.

6. **The AHC, either directly or through PATH, should develop guidance materials on effective and/or sustainable approaches to PHA strengthening, or to health system strengthening more broadly.**

   Sustainability is an ongoing challenge especially if WBW-style strategies are implemented in other provinces. It is also likely to be a shared challenge across PHAs, PATH projects, and across the AHC's health portfolio more broadly. As such, there may be value in developing guidance materials on sustainability, to promote a shared vision and evidence-based approach to sustainability across investments. The guidance could, for example, articulate a shared definition of sustainability, provide guidance to implementing partners on DFAT design and monitoring requirements regarding sustainability, share lessons learned from WBW, and provide examples of sustainability approaches that have been successful elsewhere. Such guidance could be shared with AHC staff, implementing partners, sub-grantees, PHAs and other stakeholders as relevant.

1 Introduction

1.1 Background

Wok Bung Wantaim (WBW) was a health system strengthening intervention implemented in three districts of Hela Province, and Nipa-Kutubu District in Southern Highlands Province (SHP). It was initiated by the Oil Search Foundation (OSF) to demonstrate whether improved health outcomes could be achieved by applying a partnership approach to access available Government of Papua New Guinea (GoPNG) funding.

WBW was co-funded by OSF and DFAT through the PNG Partnership Fund (PPF), and most recently through the PNG–Australia Transition to Health (PATH) program. DFAT's grant allocation was initially AUD 7.4 million, but was later reduced to AUD 4.6 million in 2019. OSF contributed an estimated AUD 2 million between 2018 and 2021. The grant commenced in May 2018 and ended on 30 June 2021.

WBW's goal was to improve frontline health service delivery through implementation of an innovative partnership model, to ultimately increase health service utilisation and improve health outcomes. WBW had three End of Investment Outcomes[2]:

1. Strategic allocation of funding and resources for health.
2. Improved frontline service delivery.
3. Improved health outcomes.

The key underlying assumption was that there was adequate public funding available in the PNG system, to support health service delivery in Hela Province (and Southern Highlands Province). The Theory of Change (TOC) indicated that, if the coordination processes and mechanisms, financial and accountability systems, and partnerships work effectively, GoPNG funding could be more easily accessed, leading to improved frontline services. The WBW Program Logic and Theory of Change are provided in Annex 1.

The End of Investment Outcomes were to be achieved by focusing on four implementation components:

Component 1 – Improved coordination: The strategy sought to improve coordination between PNG Government at the national and provincial levels to support better financing.

Component 2 – Effective health financing: The strategy sought to improve decentralised funding flows; for example, by tracking funding flows, addressing national and provincial roadblocks to the flow of funds, identifying funding requirements of frontline facilities, and training frontline facility leaders to manage and account for funding use.

[2] The WBW Completion Report identifies three EOIOs, presented here, but the WBW Program Logic and Theory of Change presented in Annex 1 has only one EOIO, being 'the strategic allocation of all available funding and resources for health supports improved frontline delivery for communities in Hela and SHP'. This in turn contributes to the goal of 'reduced maternal and child health morbidity and mortality'. WBW's M&E Framework reports on the three EOIOs, but has different intermediate output and outcome statements than that presented in the Program Logic.

Component 3 – Sustainable quality health services: The strategy sought to increase Provincial Health Authority (PHA) capacity for leadership and governance to support sustainable quality service delivery and accountability and foster strong and resilient partnerships to deliver improved service delivery to communities.

Component 4 – Community engagement: The strategy sought to increase community engagement in health service planning and governance, identifying and addressing barriers to health service utilisation, and increasing women's leadership and social inclusion.

OSF termed the project as an innovative partnership approach aimed at working through government systems and structures, to bring together stakeholders and maximise contributions for improvements in service delivery. The lead implementing partners were OSF in partnership with the Hela and SHP PHAs, supported by Susu Mamas, Marie Stopes PNG (MSPNG), and the Burnet Institute (until early 2020). The Department of Provincial and Local Government Affairs (DPLGA), National Department of Health (NDoH), and Department of National Planning and Monitoring (DNPM) were also key partners at the national level.

The WBW project commenced in May 2018. Initial focus was to be on the Hela PHA, which had recently been approved in October 2016. Early on, implementation was affected by a severe 7.5 magnitude earthquake in Hela Province in February 2018, and later by the COVID-19 pandemic from March 2020, both leading to some adjustments and reprioritisations. Implementation commenced in SHP on a smaller scale in mid-2019.

1.2 Evaluation Purpose

The Australian High Commission (AHC) in PNG commissioned an independent end-of-investment evaluation of WBW. This evaluation seeks to assess and verify WBW's outcomes, and identify what worked and what challenges remain, to inform the transferability of the approach to other provinces. OSF has also completed an end-of-investment report, in parallel to this evaluation.

An early assessment of WBW was undertaken as part of the *PPF Health Review* (March 2019), and noted the need for a contribution analysis of all the partners to better understand who and what contributed to change, better clarify attribution results, and illustrate how elements can be replicated in other provinces.

The purpose of this evaluation is to:

- **Prove:** assess the effectiveness of the strategy and examine the fidelity of the strategy to the Theory of Change and Program Logic.
- **Generate knowledge:** document key lessons and factors that supported achievements or contributed to failures, and examine how transferable these are to other settings.
- **Improve:** generate recommendations based on the lessons learned. This includes consideration of whether lessons can be scaled, replicated or leveraged by future investments, such as future programming by OSF and initiatives under the new DFAT-funded PATH program.

1.3 Evaluation Scope

This evaluation covers the lifespan of the project from May 2018 to 30 June 2021. While the scope of the evaluation Terms of Reference (TOR) includes both Hela Province and SHP, the evaluation team focused on Hela, as greater progress was achieved in this province compared with SHP, providing

richer lessons and learning. The Key Evaluation Questions (KEQs) have been revised from those in the original TOR to reduce duplication; this revision was approved by the AHC on 30 August 2021.

2 Methodology

2.1 Overview

Due to COVID-19 travel restrictions and containment measures, the evaluation was conducted remotely from Australia. The evaluation team consisted of a Team Leader, one Technical Specialist, and two Policy and Research Officers based in PNG.

2.2 Key Evaluation Questions

The KEQs respond to the evaluation purpose, and cover the evaluation criteria of approach, effectiveness, sustainability, and transferability.

Evaluation Questions

- KEQ 1: What was WBW's partnership approach and how important was it for effecting health systems strengthening?[3]
- What was the partnership approach?
- What partnerships were developed (including their importance, and strength/sustainability)?
- What was the role of OSF in the partnership approach?

- KEQ 2: To what extent have WBW outcomes been effective and sustainable? [4] Definition of program outcomes in relation to objectives.
- Progress against each of WBW's implementation components:
  - Improved coordination
  - Effective health financing
  - Sustainable quality health services

- KEQ 3: To what extent has the investment in WBW contributed to improvements in health outcomes?

- KEQ 4: To what extent can the WBW strategy be transferred to other settings, and/or leveraged to advance the broader health sector objectives, including those supported by DFAT under PATH?
- How well did the program TOC and Program Logic hold true?
- What success factors and lessons can be transferred to other settings (including policies, procedures, and guidelines that would assist other PHAs to replicate the benefits of WBW)?

[3] **Partnership approach** refers to implementing partners (e.g. OSF), donors (e.g. DFAT, WHO, and UNICEF), and local partners collaborating in the design, planning and implementation of the program, providing opportunities for sharing and synergies across partners.

[4] **Effective** refers to the extent to which the intervention achieved its objectives, and its results, including any differential results across groups. **Sustainable** refers to the extent to which the net benefits of the intervention continue, or are likely to continue, beyond the intervention. These definitions align with OECD DAC criteria – see https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm.

2.3 Data Collection and Analysis

The evaluation used a mixed-methods approach and drew on multiple data sources, including:

Document review: The evaluation team reviewed WBW program documents, progress reports and the completion report, and other documents produced by WBW, DFAT, GoPNG, and international organisations and researchers. The document review provided initial evidence for each KEQ, and was used to guide the development of the other data collection tools. Data from the document review was analysed following the Context-Mechanism-Outcome approach[5], and against the KEQs and sub-questions. It should be noted that this evaluation did not seek to assess the accuracy of all claims of achievement made in WBW progress reports. Rather, the evaluation sought to identify the *main* achievements of the project documented in the progress reports, and verify these through triangulation with other documentation and interviews.

Key informant interviews: Fifty-seven key stakeholders were invited to be interviewed, of which 44 agreed to participate in semi-structured interviews. Interviews were initially conducted in May and June 2021, with additional interviews conducted in September 2021 to respond to AHC feedback on the preliminary findings report and collect more detailed information from a small set of key stakeholders. Interviewees were purposively selected, and included representatives from implementing partners and PHAs in the selected WBW program sites, and other development partners where relevant (see Annex 2). Interviewees were asked to provide, and granted, their informed consent to being interviewed, and quotes and data have been de-identified. The interview approach followed the Australasian Evaluation Society Code of Ethics. Data from the key informant interviews and focus group discussions were analysed using a thematic analysis approach, against the KEQs and sub-questions.

Economic evaluation: The economic evaluation focused on Hela PHA, and assessed the impact on health outcomes and health service utilisation, based on information available in the National Health Information System (NHIS) dataset; the impact on financing flows, based on information from multiple sources, including a) interviews with PHA, OSF and NDoH staff, b) budget documents of the Department of Treasury (2019, 2020, 2021) and Hela and Southern Highlands PHAs, and c) WBW expenditure data from OSF six-monthly reports to DFAT; and anticipated longer-term health impacts, based on a literature review. Summary findings from the economic evaluation are presented in this report, particularly in KEQ 3. The full economic evaluation report has been provided to AHC separately.

Case studies: Two case studies were produced about the Partnership Committee and the value of PHA leadership. These case studies were selected by the evaluation team in consultation with OSF and the AHC, to highlight key activities and achievements and underlying success factors.

Information from the multiple data sources was triangulated to produce reliable answers to the KEQs. A report of preliminary findings (Aide Memoire) was submitted to the AHC on 24 June 2021. This final report incorporates AHC feedback on the report of preliminary findings.

2.4 Limitations

The main limitations were:

[5] See https://www.betterevaluation.org/en/approach/realist_evaluation.

Remote evaluation: The evaluation was conducted remotely, because the evaluation team were unable to travel to PNG or to the provinces to undertake site visits due to COVID-19. The overall data quality lacks the depth and nuance of information that can be gathered through face-to-face discussions. COVID-19 created delays in the interview schedule, as in-country events took precedence over remote dial-ins. When interviews were secured, the time pressure reduced the capacity to build rapport with interviewees, limiting contextual and granular detail. A second round of interviews was undertaken with key interviewees to compensate for some data limitations.

Access to data and documentation: HDMES experienced difficulties in accessing complete and timely documentation, resulting in delays. Financial reports and Health Facility Booklets have not been available, and coupled with difficulties accessing people in Hela, this has constrained the understanding of funding allocations from the multiple players and cross-analysis between infrastructure and equipment investments with service outcomes.

Limited data for economic evaluation: Economic evaluation of WBW was hampered by a range of data limitations:

- As the Southern Highlands component of the project was launched only in mid-2019, the economic evaluation focused on the impacts of WBW in Hela Province, which had the benefit of the full project period for implementation.
- WBW was closely integrated with a range of activities conducted by the Hela PHA, making it impossible to know whether and which changes in outcomes were due to WBW specifically.
- Two major external shocks – the 2018 earthquake and the emergence of COVID-19 – are likely to have detrimentally influenced program outcomes. These cannot be controlled for without comprehensive data and advanced statistical methods.
- There was limited data on health service utilisation and health outcomes, and the evaluation team were only able to access NHIS data from 2017 to 2020 for SHP and Hela Province, against all facilities in PNG for 2018 and 2019. This greatly limited the range of analysis that could be undertaken. Limited financial data was available and detailed data on health sector allocations was unavailable from the District Services Improvement Program (DSIP), Provincial Services Improvement Program (PSIP), and local government. HFG allocations to Hela were available (and comparable) for 2018 and 2019 only. Allocations for medicines and supplies, as reported in the mSupply system, were only available for 2020 and are thus not included in this report.

Due to these limitations, the economic evaluation was unable to separate the impact of WBW activities from the broader activities of Hela PHA and other stakeholders in Hela. The results in the report describe the impact of WBW in combination with other projects and activities in Hela. The data limitations also meant that it was not possible to calculate the rate of return on investment or conduct a formal cost-benefit analysis.

3 Findings

This section presents the evaluation findings against the KEQs. It is important to consider the concept of attribution and contribution in discussing findings against outcomes (KEQ 2 and 3), and how this affects lessons and transferability (KEQ 4).

Attribution is the idea that changes observed are solely due to an intervention. Contribution is the idea that an intervention helped lead to observed changes, but there are other contributing interventions and factors.

In the case of WBW, there were a range of organisations and other donor-funded projects working in Hela Province and SHP (detailed in KEQ 1) and contributing to health system strengthening. WBW therefore *contributed* to observed changes in most cases. Changes *attributed* to WBW are identified as such. This is important in considering the transferability of the strategy, or elements of the strategy, to other settings.

3.1 KEQ 1: What was WBW's partnership approach and how important was it for effective health systems strengthening

OSF explained WBW's partnership approach as being based on the Collective Impact model to achieve systems change. Collective Impact recognises that individual programs working in isolation from each other are not sufficient to overcome complex or 'wicked' problems. WBW demonstrated a level of alignment with some of the five principles of the Collective Impact model, but not to others. A few interviewees commented on the extent to which WBW demonstrated a 'true partnership', noting that OSF drove implementation in a 'top-down' and 'transactional' manner. OSF's private sector approach to 'getting things done' and its grant accountability are likely to have contributed to some of these criticisms about its partnership style.

A partnership approach, which brings multiple and diverse participants together to work towards a shared vision, is critical for systems change. At the provincial level, WBW was able to bring stakeholders together, especially through the Hela PHA Partnership Committee (HPHA PC), which provided a successful and well-functioning forum for planning, training and initiatives. There are, however, limitations to partnerships, with some interviewees who operated outside of the Partnership Committee having limited understanding of what WBW was about, and national-level engagement suffering due to scheduling conflicts and departmental changes.

This evaluation found that the partnership brokering workshop in the first year was successful. Repeated and follow-up sessions would have been beneficial to consolidate and strengthen partnership values and practices. Interviewees noted that the partnership approach is organisationally appropriate, if supplemented with structural change, resources and realistic timeframes. Many commended the PHA CEO for his engagement, negotiation, and inclusion skills, and others noted that the boundaries between OSF and the PHA were at times blurred, requiring a more nuanced approach from OSF. The structure and presence of a Partnership Committee within the HPHA was a valuable forum for sub-national players. The Provincial and Local Level Services Monitoring Authority (PLLSMA) and Health Sector Aid Coordination Committee (HSACC) at the national level could have provided stronger support if there were fewer external and shifting priorities.

Collective Impact is a useful and practical model for partnerships focused on health system strengthening. The evaluation found that Collective Impact can be driven by the PHA as a backbone organisation, if supported with an entity or executive team that provides project or grant management functions. A needs assessment and targeted activity plan around organisational processes, technical capacity and operational gaps would further support the partnership approach at the PHA level and build the foundation for longer-term solutions. The literature on Collective Impact notes the need for extended timeframes to achieve systems change (e.g. at least five years), something that was backed up by the views of a number of interviewees.

3.1.1 What was the partnership approach?

The WBW strategy is based on a partnership model, with implementing partners (in this case OSF and HPHA) and local partners **collaborating in the design, planning and implementation** of the program, and providing shared opportunities and synergies across partners. The *PPF Health Grants Review* (2020) noted that OSF described WBW as aligning with the Collective Impact approach.[6]

WBW program documents identified a large number of partners and stakeholders:

Partners and Stakeholders

National

- National Department of Health (NDoH)
- Department of National Planning and Monitoring (DNPM)
- Department of Provincial and Local Government Affairs (DPLGA)
- National Economic and Fiscal Commission (NEFC)
- Department of Personnel Management (DPM).
- Provincial Health Authority (PHA)
- Provincial Administration (PA)
- Provincial Coordination Monitoring Committee (PCMC)
- District Development Authorities (DDA).

Donors

- Government of Papua New Guinea
- Government of Australia
- Oil Search Foundation (OSF).

Service providers

- Hela and Southern Highlands Provincial Health Authorities
- Catholic Church Health Services (CCHS)
- Christian Health Services (CHS)
- Marie Stopes PNG (MSPNG) and Susu Mamas
- Health Services Sector Development Program (HSSDP).

Community organisations

- Health Facility Committees (HFCs)
- Hela Provincial Council of Women (PCW).

[6] HDMES. (2020). *PPF Health Grants Review*, p.21.

The extent to which the different partners and stakeholders actively engaged in the partnership is explored in detail later in this report.

Collective Impact is a model in which multiple entities work together to address complex or 'wicked' problems. It is recognised internationally as an effective way to bring about change.[7] Collective Impact is useful when tackling health system strengthening, as it moves from an individual 'silo' approach towards multiple players, inclusive of donors, government, and key health stakeholders all working towards a shared agenda.[8] While many projects in PNG seek to work in this manner, few succeed.

There are five key elements in the Collective Impact model. The following table maps WBW's strategy and implementation against these elements.

Collective Impact modet and the WBW alignment

Common agenda.

Multiple organisations have a shared vision for change, and a mutual agreement on how to achieve that vision. WBW aligned with the GoPNG agenda. At the policy level it was guided by the Medium-Term Development Plan (MTDP) 3 and National Health Plan (NHP), and contributed to the reform agenda of the DNPM, DPLGA, and NDoH partnership frameworks. These included the National Service Delivery Framework, Partnership Framework for Service Delivery and Rural Development, and the National Health Sector Partnership Policy. Reports and interviewees acknowledged that leadership on the strategic vision and plan was strongest with DPLGA. While WBW engaged with the NDoH, some interviewees felt the engagement could have been stronger. The NDoH Partnership Unit expressed minimal involvement, but details and reasons for this could not be corroborated. Leadership around the common agenda excelled at the provincial implementation level, through a proactive PHA and effective PHA Partnership Committee.

Shared measurement system.

There is a shared set of performance measures for tracking the project's progress and success, maximising transparency, accountability, and commitment. There was no shared measurement system used across all of the partners. OSF developed a Monitoring and Evaluation (M&E) Framework for WBW to report on their grant to DFAT, but this was not co-developed and used by the HPHA Partnership Committee or others, and consequently number of interviewees questioned the extent to which WBW was a true partnership. Having a shared measurement system could have supported greater levels of trust, transparency, and co-accountability. A number of interviewees indicated that some of WBW's claims of success were not solely attributable to WBW, but rather a contribution and opportunistic convergence during the project's timeframe.

Coordinated plan of action.

While each organisation's activities may be distinct, activities are complementary and donors, partners and government all working together towards the same goal. There was no formally articulated coordinated plan of action endorsed by all players and national departments, for example, around the WBW Program Logic, although there was a grant plan that implicitly followed the PNG MTDP and NHP. For example, WBW coordinated with Susu Mamas, MSPNG, and the Health Services Sector Development Program (HSSDP), but does not appear to have coordinated with the DFAT-funded Saving Lives, Spreading Smiles (SLSS) project run by UNICEF, which also focused on

[7] See https://www.collectiveimpactforum.org/what-collective-impact and https://aifs.gov.au/cfca/publications/collective-impact-evidence-and-implications-practice.

[8] See https://chwi.jnj.com/news-insights/the-case-for-a-collective-impact-platform-approach-to-health-systems-strengthening.

maternal and neonatal health in Hela. In spite of this, the HPHA successfully directed WBW through the Partnership Committee, providing a sub-national forum for planning and coordination needs. Activities were cemented in annual and monthly implementation plans and driven by HPHA Directors, District Managers, and church and NGO partners.

The use of Service Level Agreements (SLAs), contracts and Memoranda of Understanding (MOUs) with church and NGO partners further consolidated stakeholder buy-in and leveraged action and commitment to the WBW plan and deliverables. It was widely acknowledged that partners were happy to provide services under the HPHA umbrella, but there was a view that the HPHA should be the sole and direct contract lead, not OSF. Some felt this created confusion around accountability and reporting.

Continuous communication.

Open and continuous communication helps build trust and maintain commitment to a common agenda.The HPHA Partnership Committee provided a good forum for sub-national communication. Many stakeholders expressed positive views about the quarterly meetings and noted these were well organised, well attended, and enabled mutual support and accountability between partners and the HPHA. Meetings covered shared systemic barriers, constraints and solutions, high priority areas (e.g. the earthquake recovery and COVID-19 responses), and operational matters such as outreach schedules, immunisation planning, and policy initiatives such as GESI and clinical governance. Some interviewees at lower services levels noted that they were unclear as to what WBW was, likely due to a lack of cascading communication internally.

Communication with national agencies was undertaken in a dual manner. HPHA executives engaged with central agency departments on a needs basis around operational matters, such as Corporate Services with Department of Treasury (DoT), Department of Finance (DoF), and DPM. Higher-level communication between central agencies to improve coordination and engagement through PLLSMA and HSACC were often undertaken by OSF, which became the key link between the national and PHA level. The level of effectiveness of this communication is unclear, as these entities were affected by multiple external matters.

Backbone support organisation.

A central organisation provides coordination between partners, ensuring funding and activities are coordinated, and that partners interact effectively. From WBW documents, OSF partnered with the PHA, and both acted as the lead agencies. As the grant manager, OSF played the role of the backbone organisation, but within Hela Province the HPHA provided the core and essential elements that facilitated the backbone interactions between partners. The close working relationship between HPHA and OSF enabled effective mobilisation of resources, and administrative and technical support to address health sector needs. This was reiterated by interviewees and noted in the *PPF Health Grant Review* (2020). Some interviewees, however, felt this relationship was unclear, creating some confusion around legitimacy, accountability, and transparency. There was a strong view that the HPHA CEO provided a transformative approach to partnership management, whereas OSF was described by a number of people as 'top-down', 'transactional', and 'overbearing'. There was wide feedback that the PHA CEO, Executive Team, Senior and District Managers, and the three WBW Technical Advisers (driving Finance, SLAs, and Decentralisation activities), all played a vital role as a team and core agency, providing cohesion, collaboration, and mutual respect between partners within Hela.

As a Collective Impact approach, WBW highlights a range of lessons for future programming. Firstly, a backbone support organisation is essential to the success of the Collective Impact approach. If the WBW model were to be rolled out to other provinces, this would require a nominated, and appropriately resourced, support organisation and clarity around the legitimate lead roles. Secondly,

evidence confirms that a Collective Impact approach can make a strong contribution to systems and population-level change, but this takes time and continued resourcing. A study of eight Collective Impact initiatives found the time between inception and impact ranged from 4 to 24 years.[9] A number of interviewees noted WBW had good intentions, but was overly ambitious in its targets and timeframe.

3.1.2 What partnerships were developed (including their importance and sustainability)?

The partnership approach was core and central to WBW's strategy. At the sub-national level, the **Hela PHA Partnership Committee was established at the beginning of WBW and strengthened over the project.** The HPHA PC welcomed new partners to the province, such as NGOs, and cemented and formalised the existing presence and contribution of the churches. All WBW stakeholders were included in the HPHA PC to facilitate coordination and collaboration. Membership included the public, private corporate, and faith-based sectors. The HPHA PC played a vital role in the collaboration and coordination of partners, in partnership management, and in strengthening, brokering and initiating new conversations, connections and opportunities. The HPHA Partnership Committee Case Study provides details of how this entity supported sub-national engagement and drove activities.

Case Study 1: HPHA Partnership Committee

A core deliverable of WBW was to enhance partnerships at the provincial, district, and local levels to improve health services and reach more communities. To this end, the HPHA PC was conceived in 2018 by the PHA CEO. It was established to enable all service providers in Hela to meet with the PHA in a consistent and formal manner on a quarterly basis, to improve cross-collaboration and coordination. Membership included a wide array of PHA office bearers, such as the CEO and Public Health Director, NHIS Manager, District Health Managers, Christian Health Service and Catholic Church Health Service partners, as well as the Provincial Administration, District Development Authorities, NGOs, Oil Search Foundation, and other corporate organisations such as, most recently, Exxon Mobil. The committee is chaired by the Deputy Chair of the PHA Board, and is a sub-committee of the PHA Board.

Most PHAs are required to establish a partnership committee, but the HPHA PC was widely noted as a well-functioning platform. Many commented that it offered communication, collaboration and accountability, both vertically and horizontally, across stakeholders. The mechanism was used by the PHA to align plans and priorities among service delivery partners, and facilitate engagement with political entities such as the DDAs and Open Members. Through the Partnership Committee, service providers were empowered to elevate operational matters with the PHA officers, align under new strategic and policy initiatives, and link and communicate between themselves.

Under the auspices of the CEO, the HPHA PC drove a range of key WBW initiatives. Successes included: the negotiation and roll-out of the Terms of Reference for Health Facility Committees; progressing Service Level Agreements with locally-based church health services; facilitating the Facility-Based Budgeting training and system in 35 facilities; and engagement on the GESI policy and roll-out of the Clinical Governance Framework. Other achievements included decisions on facility upgrades and priority activities, such as the polio campaign and COVID-19 responses. The

[9] Kania, J. & Kramer, M. (2011). Collective Impact. *Stanford Social Innovation Review*, Winter 2011. https://ssir.org/articles/entry/collective_impact.

District Health Managers provided a key sub-leadership role driving activities and responses after committee meetings.

Representation from the provincial government was particularly important. A key informant stated that this committee was important in gathering support from the Provincial Administration, as it offered an interface for advocacy and information. Engaging the PA through the HPHA PC provided a formal avenue to share priorities and needs, and articulate national directives. Moreover, the Partnership Committee played a vital role in the informal lobbying of DDAs. Through the Partnership Committee, DDA CEOs were exposed to PHA plans and needs, and could more easily consider and respond to PHA concerns. An example of this was when the Open Member for the Koroba-Kopiago District made funding available for infrastructure projects. In 2019, he allocated PGK 1.6 million and a further PGK 1.2 million in 2020, resulting in the upgrade of five facilities, one district hospital, and a literacy centre. More recently, the Tari-Pori DDA pledged PGK 600,000 to support improvements to a selection of aid posts and community health posts in the Tari-Pori district.

Under WBW, support for the committee included travel, logistics, and venue hire. The sustainability of the Partnership Committee is considered by interviewees to be moderately high, as the system and partnerships have been established, with clear accountability to a functioning PHA Board. Furthermore, momentum has been established on the back of infrastructure developments, strengthened service delivery, formalisation of processes, and alignment on priorities. Concerns for sustainability in the face of executive or senior management changes are valid. Succession planning and empowering high-performing middle managers should be prioritised to ensure the HPHA PC continues to provide value to stakeholders and health services in Hela Province.

Under WBW, **Service Level Agreements** played a critical role in formalising partnership arrangements between the **HPHA** and **Christian Health Services** and **Catholic Church Health Services**. Progress for many of these was led by the WBW Technical Consultant, a previous NDoH staff member, and they were negotiated by the PHA CEO. These were used to consolidate arrangements, clarify roles and responsibilities, and outline the schedule of services and funding arrangements (e.g. some Christian Health Service facilities were offered top-up funding from the PHA Health Function Grants to boost Church Health Grant allocations – see section 3.2.4). Overall, many facility managers were positive about these SLAs, as they enabled the church and government services to co-deliver on provincial priorities and better align services. Documents and interviewee evidence suggests that the formalised relationship between the HPHA and churches is strong and sustainable, asserting that '*systems are now in place to support this relationship*'.

Challenges do remain. An interviewee noted that while their relationship with the HPHA was strong, there was still a '*sense of stubbornness or non-cooperative attitude by district health staff to coordinate and liaise with the church facility health staff*'. The same interviewee noted that partnership also means holding non-performing district-level staff accountable for their actions, and '*inaction needs to be addressed*'. Interviewees repeated well-known frustrations with the impact of central agency bottlenecks (e.g. disbursement of funding allocations, medical supplies and medical equipment), which they fear will continue to impact negatively at the PHA level. Other interviewees were wary of the inclusion of the private sector in the SLAs and noted a lack of mutual transparency around funding contributions. The HPHA is now undertaking a review process of SLAs to identify what has worked and what can be improved, which many will welcome.

Another key deliverable of WBW was the use of **innovative partnerships with NGOs.** This was achieved through the engagement of **Susu Mamas** and **Marie Stopes PNG** (MSPNG). Prior to WBW, neither of these organisations had worked in Hela and brought much-needed supplementary women's and children's health services, sexual and reproductive health services and capacity building to Hela. There was wide acknowledgement that this was a positive initiative, as not all PHAs have the clinical and technical capability to deliver the full spectrum of services required for remote and rural populations. Supplementing public capacity with additional NGO support was seen as a positive step that other PHAs could consider.

Susu Mamas was invited to deliver maternal and child health services out of Pai Health Facility in Tari, and worked directly with the HPHA CEO. In the spirit of partnership, Susu Mamas secured funding from multiple sources to prepare the facility for services, after it was damaged by the 2018 earthquake. This included obtaining Incentive Funds for rainwater tanks, staff salaries and equipment from WBW, support from Open Members for the earthquake repairs, support from the DDA for rent of the Pai Health Facility, and from Susu Mamas fundraising for repair work and commissioning to ensure compliance with GoPNG standards. These repairs took up most of the project period, and Susu Mamas commenced service delivery in 2020. Susu Mamas remains dependent on external funding to continue essential services. While the WBW Sustainability and Exit Strategy notes that the no-cost extension will provide Susu Mamas with direct funding up to the end of 2021, the HPHA is seeking to secure a funding base for Pai Health Facility into 2022.

MSPNG was contracted to deliver sexual and reproductive health services and training in Hela. While there is strong evidence of a good relationship between HPHA and MSPNG, interviews and the WBW Sustainability and Exit Strategy acknowledge that MSPNG's ability to deliver services and capacity building relies on continuity of funding (MSPNG is currently funded in Hela through DFAT's PATH investment). It appears there has been insufficient effort to date to link MSPNG to other sources of funding.

Working as NGOs, outside of the public system, both Susu Mamas and MSPNG each had to manage contextual difficulties. A volatile environment, high rent and exorbitant operational costs (such as fuel), in addition to a limited recruitment pool, resulted in both NGOs facing similar challenges manifested in different ways. Susu Mamas had to work with multiple parties on infrastructure and repairs, and subsequently only commenced service delivery in 2020. Half of the time and effort was allocated to project managing infrastructure, rather than delivering the services that Susu Mamas do best. MSPNG delivered outreach services, but was forced to decamp and operate out of Mount Hagen to manage costs. One interviewee noted that although the two NGOs are providing necessary services and are part of the Partnership Committee, there was not much transparency in the way MSPNG worked, as it did not report to the PHA, but to OSF as the contract holder. Another interviewee indicated that, while the public dimension of the partnership was promoted, the relationship was managed in a service provider model.

At the national level, WBW did not engage with the same depth as at the provincial level. National engagement was **strongest with the DPLGA**, which plays a central role in the decentralisation agenda. WBW supported the successful delivery of DPLGA training in each of the three Hela Districts. This enabled local-level government (LLG) members to have greater clarity on the roles of elected Ward Councillors and LLG Presidents, and also better understand the functions of DDAs and their Boards, as well as the relationships between DDAs, PAs and PHAs, and the National Service Delivery Framework and DSIP funds. This training provided participants with a clearer understanding of the multiple roles, responsibilities, powers and authority, and how each linked with the other. Importantly, it also elevated reporting requirements such as S119 reporting, which is central to

acquittals and HFG allocations. A key result of this training was bringing together and linking the DDAs with the health sector under the HPHA, and through the HPHA PC led to greater involvement of the DDA in health projects and the contribution of funding.

WBW documents discuss the need for coordination and partnership management at the national level to address NDoH and central agency functions, and how these impact on PHA's sub-national capacity. It appears however, from interviews, that there was not a wide nor clear awareness of WBW at the national level, beyond key people at the senior level. For example, the Partnership Unit at NDoH had minimal involvement in the planning or implementation of WBW, which was mostly undertaken with DPLGA.

WBW engaged with the NDOH led **Health Sector Aid Coordination Committee** (HSACC) and DPLGA led **Provincial and Local Level Services Monitoring Authority** (PLLSMA), mostly led by OSF as the representative of the public private partnership approach. These committees were engaged to provide oversight of WBW and to advocate for public private partnerships as a viable solution for health sector investment. The impact of WBW's engagement in both of these is not known, as the evaluation team lacked related documentation and information.

It is well understood that PHAs are impacted in different ways by government departments' capacity to address systemic issues through strategic and operational change. WBW's efforts to engage at this level, while not fully clear, appear to have been driven by the desire to seek greater cohesion and coordination for WBW to address systemic challenges including timely and regular financial disbursements, staff recruitment, legacy payroll issues, and medical supply chain. In the end, many of these matters were addressed through one-on-one engagement between the HPHA Directors and relevant Government Officers. Changing the legal and structural framework that underpins these constraints was taken up by WBW through supporting the logistical and advisory costs of the consultation workshop and follow up work. The **Review of Laws Affecting Health Governance and Service Delivery** Consultation and Options Paper) provides the basis for opportune learnings and valuable actions.

3.1.3 Other health projects in Hela

It is important to acknowledge other health-focused projects in Hela, as these also contributed to health systems strengthening and population health outcomes. Two examples are listed below. WBW coordinated with the DFAT–ADB co-funded Health Services Sector Development Program (HSSDP), but it is less clear whether there was coordination with the DFAT-funded Saving Lives, Spreading Smiles (SLSS) program, which also contributed to maternal health and newborn care outcomes.

Project/Donor and Project contribution to health system strengthening

Health Services Sector Development Program (HSSDP)/ADB HSSDP seeks to strengthen health services in PNG through direct investments in health systems. This includes the eNHIS or national digital health information system, management training, clinical governance, medical supplies, and health infrastructure. WBW provided logistical support for the HSSDP Advisers to travel to Hela. The HSSDP team designed and delivered valuable training in Clinical Governance (for over 70 staff), Social Safeguards and Gender (for over 200 staff), Middle Management Development training (for over 80 staff), and the development of the new Kopiago Health Centre. HSSDP partnered with the Open Member to fund a road, minimising freight costs for the construction; worked with the Hela PHA to develop and pilot the Clinical Governance Framework and Patient Referral Guidelines for

Rural Health Services; and conducted an orientation program for incoming PHA Board members. HSSDP also supplied schematic designs for the new Emergency and Outpatient Departments at Tari Hospital and provided full design documentation for the Community Health Post at Juni, partnering with Exxon, to fund and project manage the construction.

Saving Lives, Spreading Smiles (SLSS)/DFAT SLSS is a maternal and newborn care project, focused on preventing and managing post-partum haemorrhage and neonatal hypothermia.

SLSS was co-funded by DFAT and UNICEF, and co-implemented by UNICEF and NDoH. SLSS worked directly with the Hela Provincial Government and Koroba-Kopiago District Authorities, church health services, and local NGOs to strengthen local capacity in hospitals and health facilities to deliver the package of maternal and newborn care, including trialling the Baby Kol Kilok (neonatal hypothermia alert device) and Kangaroo Mother Care. Additional elements delivered in Korobo-Kopiago included promoting antenatal care and facility deliveries, assessing and removing bottlenecks in the delivery of maternal and newborn care services, and empowering communities through Village Health Volunteers supporting home care. The recently completed SLSS Review (HDMES, 2021) noted that the program supported five health facilities in Hela, and trained 12 Community Health Workers (CHWs) and 48 Village Health Volunteers in 50 wards. One interviewee noted the importance of SLSS's positive impact in addressing maternal health and child morbidity in their district, and that it had significant impacts on facility-based supervised births, antenatal care, and neonatal survival.

3.1.4 What was the role of OSF in the partnership approach?

OSF was the grant manager and a core support to the HPHA, which was the implementing partner. Multiple interviewees noted that OSF had a strong on-ground presence[10] in Hela, and its longstanding support of Hela's health system meant it had a close relationship with the HPHA and Hela Provincial Government. OSF's influence at the national level was also noted as important in linking with national and sub-national partners.

Undoubtedly, OSF brought considerable resources, management, financial and technical expertise to the project and was able to recruit and fund the required people to facilitate impetus. The 2016 appointment of the then Oil Search (PNG) Limited (OSL) Managing Director to the position of HPHA Chairman, followed with the appointment of experienced managers, such as Dr James Kintwa (HPHA CEO in 2017), and Dr Anthony Wal (Director of Curative Services in 2017), and a variety of other Medical Doctors and Administrators, drawn to work in Hela through top-up salaries and other incentives OSF could afford, injected much-needed leadership capacity. Under WBW, the appointment of specific roles such as a Finance Adviser, Decentralisation Adviser, and SLA Governance and Contract Advisers further drove momentum and the establishment of systems, through activities such as the Facility-Based Budgeting training and the DPLGA LLG workshops across Hela. OSF also funded the salaries of the three Project Management Unit staff (PMU)[11] who managed all capital works projects and the scoping and delivery of renovations in health facilities.

A number of interviewees noted that OSF's direct financial support was critical in supporting health infrastructure repairs and maintenance, service delivery through NGO partners, and top-up salaries and incentives for key roles. DFAT's revised funding to WBW was AUD 4,575,001, to which OSF contributed an additional AUD 2 million, between 2018 and 2021. This extra funding is likely to have

[10] The OSF office in Hela is located in the Provincial Hospital.
[11] One manager and two assistant manager positions.

been critical in strengthening the project's capacity to drive change and needs to be recognised when looking at the transferability of the strategy in other provinces. Additionally, OSF would have made multiple in-kind contributions, such as the representation on the PHA Board, national engagement, and technical and administrative grant management.

OSF brought a '*private sector approach*', in that it planned and followed up on activities, which led to most infrastructure projects being completed in a timely manner. A number of interviewees noted OSF's support on infrastructure was a critical contribution to health system strengthening in Hela, especially in light of the devasting impacts of the 2018 earthquake. OSF's described approach as 'top-down' was likely a positive element in these developments, but when transferred to collective meetings it was not conducive to a true partnership.

As noted earlier, OSF adopted the role of 'backbone' organisation, as part of the Collective Impact model. While this support is critical for driving systems change and achieving population-level improvements, the approach acknowledges that leadership style and capacity for responding to challenges and differences with reflective nuance is important, as it can 'make or break' success.[12]

Overall, the evidence indicates OSF played a critical role in establishing the vision for accelerating health system strengthening in Hela, in partnership with key leaders from the PHA Executive and Board. OSF's grant application clearly indicates it sought to work in a partnership approach, and within national and sub-national systems and frameworks, but the extent to which it was able to achieve the desired partnership approach is disputed. As noted earlier, criticism of OSF's approach may be linked to the grant accountability and ambitious timeline expectations.

A number of interviewees noted that having an organisation like OSF or another development partner was a benefit, but what was even more critical was having the right leadership and effective governance. Strong PHA leadership at the Executive and Board levels, combined with a strong PHA Partnership Committee, are key to driving transformative change. OSF's long-term support of the HPHA offers a model for a PHA-led backbone function as long as it is more transparent and accountable to partners, and able to remain over a long timeframe, required to achieve systems change.

3.2 KEQ 2: To what extent have WBW outcomes been effective and sustainable?

WBW has contributed to accelerating positive changes under the three End of Investment Outcomes identified in the WBW Completion Report (refer to Footnote 1 regarding differences in EOIOs between WBW Program Logic and the completion report).

The WBW Completion Report notes a 60% increase in national government funding to the HPHA since 2017, which is significant compared with other provinces. However, some interviewees noted the increase in HFGs were due to a variety of actions that were already in motion pre-WBW which came to fruition at the same time as WBW: the endorsement of the HPHA in October 2016; a full year of foundational work in 2017; the upgrade of Tari Hospital from a Level 3 to Level 4 Hospital; the 2018 earthquake; and the addition of more than 350 staff in the government ALESCO payroll system. These all culminated to support the additional flow of funds, at the time of WBW.

[12] See https://www.fsg.org/publications/understanding-value-backbone-organizations-collective-impact.

A key achievement linked to WBW, is the commencement of FBB (outlined under KEQ 1). This introduced a Chart of Accounts, improving the ability of facilities to develop annual and monthly implementation plans, operationalise activities with funding, and be accountable to the HPHA through monthly reports to the Expenditure Screening Committee. In this way, WBW contributed to improved financial processes within the province. The sustainability of progress against this outcome is relatively strong, but dependent on continued and sufficient funding from GoPNG to the PHA. Ongoing capacity building on FBB will also strengthen the sustainability of this outcome.

There is strong evidence of improved delivery and uptake of frontline services under WBW, through the coordinated convergence of multiple and synergistic activities. These include infrastructure upgrades; facility funding systems and processes; training and capacity building of frontline staff; the HPHA Partnership Committee; and SLAs with church health services and NGOs, like Susu Mamas and MSPNG. As noted in the WBW Sustainability and Exit Strategy, the sustainability of these developments is dependent on the ongoing availability of GoPNG funding. The HPHA CEO has been engaging with DDAs and others to access follow-up funding. Additionally he will review the SLAs to maintain and strengthen the partnership approach.

It is important to note that WBW's Monitoring and Evaluation Framework differed from the Program Logic, with more specific Intermediate Outcome statements, and different outputs statements. The M&E Framework had a total of 50 indicators, which is too many, and the appropriateness of many of the indicators are questionable. Overall, the WBW M&E Framework is not fit-for-purpose and this may have impacted how OSF implemented WBW to meet its perceived accountability to DFAT.

Collective Impact (see section 3.1.1) notes that sustainable systems change is a multi-year effort. WBW developed a Sustainability and Exit Strategy, but this was done towards the end of the investment period, rather than at the commencement. Developing such a strategy at the outset may have prompted WBW partners to better manage and track the measures required to support the sustainability of activities and outcomes.

3.2.1 Definition of program outcome in relation to objectives

WBW documents presented a Program Logic, Theory of Change, and an M&E Framework with different output and outcome statements. Having a clear program logic developed from the outset, that is accepted by all program partners is important, as it links the concept of 'shared vision' with a 'plan of action' (discussed earlier as part of Collective Impact, and also later elaborated on in this report). A good program logic, developed through a participatory process with key partners, serves as both a clear communication tool and the foundation for a shared measurement system. The lack of a consistent and accepted logic, upon which the results framework is based, makes it challenging for the evaluation team to clearly understand what WBW was about and *specifically* sought to achieve.

WBW is a health system strengthening strategy, but the program logic and narrative do not reference or align to the widely-used WHO six health systems strengthening pillars[13] nor WHO's Universal Health Coverage[14]. WBW's EOIOs include 'Improved health outcomes' but this should sit at a higher level, as population-level change is the result of other outcomes (e.g. WHO's six pillars and

[13] See https://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf - see Annex 3 for evaluation team's alignment of WBW strategy to WHO pillars

[14] Universal health coverage (UHC) (who.int)

UHC) Moreover, this would have provided a structured approach to discussions that draw from national and international directions.

Health system strengthening, particularly in a complex setting like PNG – and even more so in a rural and geographically challenging province like Hela – is a long-term endeavour, and WBW's activities and outcomes should be assessed within that perspective. WBW had a relatively short implementation period for what can be described as over-ambitious expectations, particularly considering the grant allocation was significantly reduced.

Understanding WBW's achievements and effectiveness is complicated due to a number of factors. The M&E Framework presented in the progress reporting and completion report has different outputs and more specific Intermediate Outcome statements, as well as different End of Investment Outcomes than what are presented in the Program Logic document and the Theory of Change. Additionally, WBW reporting is inconsistently structured against the Program Logic and M&E Framework.

The M&E Framework has a total of 50 indicators, which is too many, in particular for a systems change intervention implemented over a short timeframe, with reduced funding. Additionally, a number of the indicators are not appropriate for the output/outcome statement that they are seeking to measure. The results presented in the M&E Framework don't distinguish between contribution and attribution.

Annex 4, developed by the evaluation team, presents the output and outcome statements from the M&E Framework in a program logic format, along with the number of indicators against each output and outcome statement, and the percentage expenditure allocated to each component.[15] This was developed to help interpret what WBW sought to do and achieve.

3.2.2 Progress towards End of Investment and Intermediate Outcomes

As described in the Introduction, WBW's Completion Report identifies three End of Investment Outcomes: 1) Strategic allocation of funding and resources for health; 2) Improved frontline service delivery; and 3) Improved health outcomes (however, note critique of this as an EOIO in previous section). The strategy was framed around four components, with four Intermediate Outcomes. Key achievements and findings against the EOIOs and each of the four implementation components are presented in the table below, based on the review of documents and interviews.

More details of achievements and challenges are described in greater detail throughout this report. As previously noted, the issue of contribution and attribution is important to consider, and this was noted by a number of interviewees and is discussed further in later sections.

End of Investment Outcomes (EOIOs) Summary findings

EIO1: Strategic allocation of funding and resources for health GoPNG funds flowed over the course of WBW, with higher HFG allocations in 2018 and 2019 than in 2017. A number of interviewees were insistent these improvements were not attributable to WBW, and the result of pre-WBW activities and actions. FBB enabled more effective and efficient funding from the PHA to health facilities. It enabled health facilities to strategically plan ahead and respond to community needs, e.g. to fund ambulance transfers for medical emergencies. FBB also embedded financial

[15] A total of 84% of WBW expenditure went towards the four components, with 12% to M&E and 4% to project management.

processes which contributed to the HPHA's ability to account for funds in a timely manner, leading to continued transfer of funds.

EIO2: Improved frontline service delivery The provision of frontline service delivery was improved through continued support. This was achieved through repairs and improved infrastructure, supplementary medical supplies, availability of operational funds, a supportive and functional Partnership Committee, and improved alignment with church and NGO providers.

EIO3: Improved health outcomes It is difficult to assess the extent to which WBW contributed to population health outcomes, considering the short implementation timeframe and synergy of other programs. For example, the WBW Completion Report identifies improvements in supervised births, but as noted earlier SLSS is likely to have also contributed to this. One interviewee noted that infrastructure improvements in a number of commissioned maternity wings could not have led to more supervised deliveries, as these are still closed and not operating. Access to the Health Facility Booklets would have helped the evaluation team to draw out observations. Health outcomes are described in greater detail under KEQ 3, section 3.3.

Implementation components and Intermediate Outcomes, Summary findings

Component 1: Improved coordination

Existing government mechanisms make the National Service Delivery Framework effective, providing a strong foundation for planning, finance allocation and accountability. WBW contributed to improved coordination at the provincial level, through a range of activities. The introduction to Hela of two new NGO partners, Susu Mamas and MSPNG, bolstered the existing range of services. The DPLGA workshops in all three districts improved understanding of the delegated roles and responsibilities between the PHA, LLG and DDAs, and supported a clearer understanding of the governance, funding, and delivery powers and authority of each entity. WBW also helped formalise partnerships with church health services (refer component 3), cementing their role in service delivery in Hela. Coordination at the national level was weaker given the shifting and changing dynamics and priorities.

Component 2: Effective health financing

All available funding for frontline health service delivery is identified, planned, budgeted at appropriate levels, reaches health facilities, and is tracked and reported through the PHA.Many interviewees acknowledged the positive impact that resulted from the implementation of FBB, which enabled health facilities to confidently develop costed annual and monthly implementation plans. The establishment of the Expenditure Screening Committee, to which monthly expenditure and service stats were submitted, enabled executive oversight and risk management.

Interestingly, the achievements in effective health financing component were the result of only 7% of the WBW expenditure.

Component 3: Enhancing partnerships to deliver sustainable quality health services

System strengthening and capacity development is achieved for improved management, governance, accountability and service delivery. WBW's largest share of expenditure was allocated to this component, which covered capacity building, SLAs, church and NGO providers, and investment in infrastructure improvements. The capacity building of both administration and frontline staff has contributed to a stronger health system, and the SLAs with churches have enabled improved coordination and quality of health services across the network of providers. The agreements with the NGOs have helped fill a gap in service delivery, in particular family planning, through MSPNG. OSF funded an infrastructure Project Management Unit within the HPHA that enabled infrastructure works to be undertaken in an efficient manner.

Component 4: Community engagement

Communities are influencing health service planning and service delivery and holding governments to account for results at the local level.This component had the lowest percentage expenditure, and many activities were put on hold or cancelled due to external factors, such as the earthquake, the pandemic, and tribal fighting. The Terms of Reference for Health Facility Committees (HFCs) were finalised through the HPHA Partnership Committee but these faced multiple difficulties in the roll-out, such as communities seeking sitting fees. Interviewees noted that existing HFCs in church-run facilities were more successful and provided lessons for more effective community engagement. WBW contributed to a greater focus on Gender Equity and Social Inclusion through the HPHA-led policy and strategy, and supported the Hela Provincial Council of Women.

3.2.3 Improved coordination – what worked and remaining challenges

WBW has contributed to improved coordination at the sub-national level, providing provincial actors with a clearer understanding of their roles and responsibilities within the health system(see Case Study 2 and Figure 1). A wide range of respondents noted that prior to WBW, there was limited coordination between the HPHA, DDAs, health facilities and church health services. The key activities that facilitated improvements included the establishment of SLAs, DLPGA training, FBB systems and processes, and the HPHA PC. The increased coordination contributed to ongoing joint planning within the PHA and with the District Health Managers, such as co-planning the use of DDA funds to renovate health facilities and open essential aid posts. An incidental advantage of this was readily available support and cross-collaboration during periods of increased service demand or skills shortages. One area that did not achieve full results was the development of fully functioning Heath Facility Committees. The Partnership Committee is addressing this, and has started working on management approaches to community sensitivities and expectations.

Interviewees noted that the effectiveness of sub-national coordination was largely due to the leadership skills of the HPHA CEO, who was particularly strong in relationship building and delegating to his technical leads. Many interviewees noted that the pool of capable leaders at the PHA Executive and Board level, such as the Director of Curative Services, Public Health and Corporate Services, was critical for driving organisational and transformative change. It is important to note that OSF provided financial incentives to key PHA leadership roles, and a number of Medical Doctors, to more easily recruit and retain staff with much-needed skills in Hela, which is considered a challenging and remote province.

To build the leadership pool, the HPHA developed a Change Management Plan that advocated for the District Health Managers to increasingly assume leadership oversight of partnerships within the PHA. One interviewee noted the need to review and monitor progress against this Plan. The Evaluation team have not had access to this document but if it includes succession planning, this is a useful and necessary element.

There was limited improvements in coordination at the national level, which ultimately seeks to build shared leadership of projects and address sub-national bottlenecks with key offices, thereby developing institutional sustainability. A submission to support and co-lead the WBW initiative was put to the DPLGA *Provincial and Local Level Government Services Authority* (PLLSMA) in 2019. This outlined the project's history, intentions and 2018 successes. It is not known what the outcome of this submission was, although the WBW Completion Report indicates the committee met infrequently (twice in three years) and did not have time to address the submission.

A similar approach was adopted with the NDOH *Health Sector Aid Coordination Committee* (HSACC,). OSF was included as a representative of the WBW and the public-private partnership model. Again,

the Completion Report acknowledges that this engagement was less than effective, challenged by factors beyond WBW's control.

There may be a need for partnership brokering at the national level, to make such committees more effective, given that there are multiple dynamics and priorities at play. An effective PLLSMA and HSACC are important in addressing key barriers around donor funding and decentralised health system strengthening. A number of interviewees noted that national-level engagement was driven by OSF rather than PHA representation, leading to questions about the extent of the partnership approach and the sustainability of any benefits from the engagement.

Case Study 2: Leadership

In 2018 the Board of the Hela Provincial Health Authority (HPHA) appointed Dr James Kintwa as the HPHA Chief Executive Officer. With prior experience as a Medical Doctor and Chief Executive Officer in a neighbouring province, the HPHA Board understood the importance of having a strong administrative and technical leader, to embed robust systems and lead a team, if Hela was to have a well-functioning PHA. Given that the Hela PHA was only approved in October 2016, the primary focus of 2017 was to have all the major roles, policies and systems in place, to help deliver health services under the Provincial Health Authority reform for 'one system tasol'.

Early on, the CEO acknowledged he was only one person in the whole system, and that having a supportive team of senior and middle managers was of critical importance. In addition, following approval from the Board in 2017, the HPHA launched its Change Management Plan in 2018, in recognition that to deliver to external commitments, it was important to empower key staff in the PHA, and align them with WBW.

A partnership brokering workshop was facilitated in early 2018 with the CEO, key senior staff and select partners, in attendance. This was considered of value because it facilitated an opportunity for the PHA senior leaders and external partners to link in a neutral environment, consolidating the WBW vision and how each could be part of the plan. In synergy with this, the HPHA Change Management Plan recognized a CEO needs a strong team to deliver to responsibilities, with cohesion and commitment.

The Health Services Sector Development Project (HSSDP) was engaged to provide their standard three-day Health Middle Management Development Workshop in April 2019. The training sort to give a rapid and broad overview of key aspects of leading and managing teams, and how attendees were all part of the HPHA organization. Content covered a range of areas, aimed at how staff could be more effective managers and role models, and future health service leaders. This included practical guidance on how to communicate more effectively, such as engage, align, and empower staff; shared characteristics of high performing teams; setting operational plans, goals, and budgets which are realistic and achievable; identifying their own work capabilities from purely an operational focus to a more strategic perspective; and developing essential skills and confidence necessary to be effective service leaders in PNG Health. The workshop was delivered to 88 participants comprising of the PHA Senior Management team, managers at the different departments of the hospital, both clinical and administrative leads, District Health Managers, Officers in Charge of facilities of both Government and church run facilities. It was well received with many participants providing positive feedback. A follow up workshop was run 10 months later (February 2020), and a sample of 29 attendees shared how they were implementing lessons learnt from the initial workshop, in their day to day work. These included improved communication, shifting their management approach to a more democratic style, working towards more effective teamwork, and cash flow management.

In combination with these broad reaching activities, the HPHA CEO leveraged FBB, HPHA Partnership Committee and SLAs to execute plans in an inclusive and transformational manner. From the very outset, the PHA Board and CEO recognised that people, individuals and teams, drive systems and strengthen partnerships. Much credit was given to the CEO who used both his personal and professional skills to drive initiatives forward, in an inclusive and embracing manner – *'not just with lip service, but in real terms'*. Many interviewees and one of the district health managers, who was especially empowered and successful in advancing the project priorities, stated that there has been a lot of progress made in the Hela PHA due to the type of leadership demonstrated at the PHA level.

When asked about the sustainability of WBW, the CEO expressed that all success rests on people and having the right people to drive these initiatives is of primary importance. He recognised that people ensure that systems continue to function, and that is why the Hela PHA was successful these past years. With ongoing guidance, mentorship and training, improvements can continue to be made going forward.

When asked about leadership and sustainability of the PHA system strengthening process implemented in the Hela PHA, the CEO commented *'The project is conceptualised within a team and everyone is involved in all facets of the project starting at the implementation phase. Some delegation has to happen, it is not left with the CEO but a team of leaders from the PHA at the provincial level so it's not only one person involved in this project but the team that is involved and taking ownership and realizing it's an important strategy that can deliver outcomes for the health sector.'*

3.2.4 Effective health financing – what worked and remaining challenges

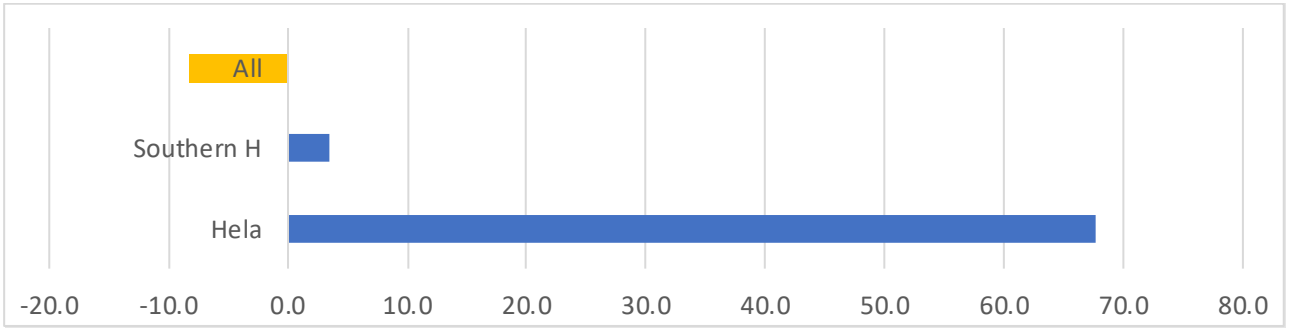
Health financing in PNG is complex, with several central agencies involved in disbursement of funds to the provincial, PHA and health service levels. GoPNG provides grants through three streams - Operational (OG), Health Function (HFG) and Project (PG). Given their extensive network of remote and rural frontline facilities, the Christian and Catholic health services receive GoPNG-funded Church grants (CG). These various funding streams deliver the core funding for PHAs to maintain operations and deliver services. In addition, there is the GoPNG District Service Improvement Program, as well as Provincial funds available through the elected Open Members. Finally, donors and the private sector offer another funding opportunity. HPHA has enjoyed the support of all these funding sources, with OSF providing consistent an ongoing support over decades, in addition to GoPNG funding and now donor funding through the DFAT allocation to WBW.

Hela was among 12 provinces that began receiving direct HFGs in 2018. The data indicates that Hela experienced a 68% increase in HFGs from 2017 to 2019, where other provinces had an 8% decline, and Southern Highlands had a small increase of 3.5% (Figure 2). Given the WBW program was effectively launched only in May 2018, the 2018 flow is unlikely to have been a result of WBW. This was confirmed by one interviewee, who noted that the flow of HFGs cannot be credited to WBW, as HPHA engaged in a range of activities and actions to receive these funds such as a full year of foundational work in 2017 and submission to the NEC, after being endorsed in 2016; the upgrading of Tari Hospital from a Level 3 to 4 Hospital; recovery after the 2018 earthquake; and the registration of over 350 staff in ALESCO, the Government payroll system. These all culminated to support the flow of Government funds, at the time of WBW's commencement.

Revenue reporting from HPHA financial statements indicates overall funding to HPHA more than doubled from 2017 to 2019, from PGK 12.7 million in 2017 to PGK 31.3million in 2019 (Figure 3). This funding was from a range of sources, including national government grants (e.g. NDoH Hospital

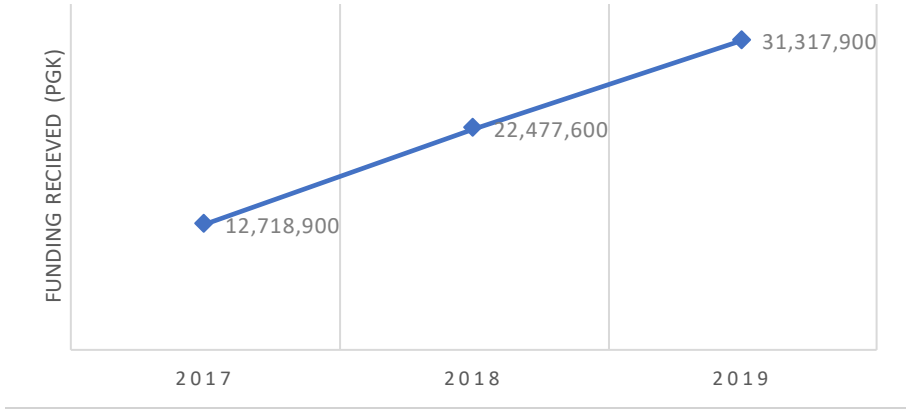
Redevelopment Grant), direct salary funding from the national Department of Finance, provincial government grants, donor funding from DFAT, UNICEF and WHO, and in 2019, direct funding support from OSF. The vast majority of Hela PHA's funding is from national government, constituting 100% of Hela PHA receipts in 2017, 84% in 2018, and 90% in 2019.[16] This seems to suggest that funding flows into the PHA have improved.

Figure 2: Change in HFG allocations in 2019, over 2017 in PNG (percent)



Source: Government of PNG, budget documents, various years.

Figure 3: Funding received by Hela PHA, 2017–2019



Source: Hela PHA Financial Statements, 2017–2019.

There is strong evidence, from WBW reports, the PPF Health Review (2019), and interviewees, that WBW's support in improving financial systems in HPHA, particularly through the introduction of FBB across health facilities, was effective in improving the strategic allocation of HFGs at the sub-national level. The WBW Finance Adviser supported the establishment of FBB, and WBW provided training on planning, budgeting and management to District and Facility Managers. PGK 1.2 million has been released to 48 facilities (government and church-run) in 2019, based on their respective appropriation through FBB.

[16] Aid donor funding was PGK 2,398,800 in 2018, PGK 3,221,800 in 2019, and not reported in 2017.

One interviewee noted that one of the barriers they faced was the difficulty of working with the PHA Corporate Services. Funding was often late and, since most of the staff in the Corporate Services were not health workers, they were unaware of how to prioritise activities and fund accordingly. Another interviewee noted that not all health facilities received FBB training, although they would have liked to, due to scheduling conflicts. This demonstrates the importance of ongoing training across all staff to support the implementation of FBB.

It is essential to acknowledge, as one interviewee noted, that while there have been big improvements in financial flows, PHA funding is still largely dependent on centrally available funding This is an important consideration, as the underlying assumption of WBW is that there is sufficient money in the health system, which is contestable, especially following the COVID-19 impacts on the PNG economy.

Critically, in HPHA's case, key leadership and clinical roles are funded by OSF, outside of WBW. The ability of the HPHA to function as effectively at the administration level, and deliver the specialist clinical services, without OSF's financial incentives, is questionable. This highlights the importance of engaging national-level stakeholders such as DPM around salaries and incentivisation for recruitment in locations that are both geographically remote and a high security risk. The CEO has often had to deal with threats to his safety, as a result of making professional decisions.

The WBW Completion Report acknowledges the lack of transparency around the extent of DSIP and PSIP funds allocated to health under WBW. Progress reports noted DSIP and PSIP contributions towards health infrastructure improvements. One interviewee noted that while DSIP funding to health had improved, PSIP funds made available to the PHA were a one-off made available through OSL royalties.

Interview data indicates that the effective involvement of DDA CEOs in the HPHA Partnership Committee supported additional DSIP funds for health. The committee functioned effectively in engaging the DDA CEOs and Open Members around PHA plans and priorities in a more transparent manner than previously experienced.

3.2.5 Sustainable quality health services – what worked and remaining challenges

Delivery of quality health services was a key feature of WBW and absorbed the greatest proportion of expenditure (59%). Activities included SLAs to formalise partnerships with the Christian and Catholic Church Health Services; contracting NGOs such as Susu Mamas and MSPNG; providing training and mentoring of administration and frontline staff; and undertaking significant infrastructure repairs and developments.

The formalisation of partnerships with church health organisations, which manage over 70% of health facilities in rural and remote areas of Hela (see also section 3.1.2), was important to facilitate more effective coordination of health service providers, and provided the governance framework for HFGs to flow to church health organisations, thereby improving their access to top up funds for operations. It also set in place the foundations for more transparency between the PHA and church health services. To drive this, WBW funded a National Adviser to work under its AIHSS grant. Interviewees commented that this person's technical and relationship building skills were important in negotiating and finalising the SLAs. While the SLAs were between the church organisations and HPHA, OSF's role in the process, specifically the role of OSF's contract/legal team, led to some confusion about the HPHA – OSF relationship on the part of church organisations. Continued partnership brokering would have gone some way to allay these perceptions.

WBW supported the engagement of Susu Mamas, a local NGO, to deliver the full suite of maternal and child health services: ante-natal and post-natal care, immunisation, nutrition, sexual and reproductive health services, and medical referrals to Tari Hospital for at risk mothers. To do this SSM had to repair and manage the Pai Health Facility.[17] This introduced a new NGO into the health service network, supplementing government and church-run facilities. Susu Mamas provided highly valued services within the Tari Town catchment, decreasing the burden on hospital services. Susu Mamas held an SLA with the HPHA and an MoU with OSF. Susu Mamas is part of the HPHA Partnership Committee, and Pai health facility.

The commissioning of the Pai health facility, previously in disrepair, demonstrates at a micro-scale how Collective Impact can lead to change. Under the agreement with the HPHA, Susu Mamas organised and paid for infrastructure development,[18] sourced labour from Hope Institute, rent through the Tari-Pori DDA, water tanks through the Incentive Fund (under the OSF arrangement), and financial support for staff salaries and equipment from WBW. Susu Mamas indicated that WBW is providing no-cost extension funding to the end of 2021 and the HPHA is seeking future funding for continuity of services. SSM highlighted their challenge in coping with the administrative burden of multiple donors, with smaller scopes and targeted funding packages, presenting accountability and reporting problems.

MSPNG had never worked in Hela prior to WBW, mostly due to the high costs of delivering services in Hela, and the counter-cultural social norms around family planning services.[19] in such a patrilineal society. At the request of OSF and support of the HPHA CEO, MSPNG negotiated a service delivery contract with OSF[20], and an MOU with the HPHA. MSPNG was tasked to deliver sexual and reproductive health and family planning services through a static and outreach model, but due to constraints this changed to a rotational outreach model from Hagen, with 20 days in province, and 10 days out of province. This limited services to outreach, but continued family planning outcomes in remote and rural areas. MSPNG also delivered capacity building in contemporary family planning to health facility staff[21]. This was well received and additional training is planned with financial support from OSF.

In 2021, MSPNG's commitment in Hela was extended, but directly funded by PATH. The Hela CEO saw the training of health workers in family planning as very significant, as this boosted the capacity of the PHA to deliver these services in a more sustainable manner going forward. He indicated an interest in additional support from MSPNG in 2022, bolstering the competence of the MSPNG trained cohort (18 staff) with a refresher course in Long Acting and Reversible Contraceptives as well as training a second cohort of health workers. OSF will fund this capacity building as part of the ongoing support to HPHA, and this will enable over 30 facilities to deliver family planning in Hela on an ongoing permanent basis, reducing the reliance on MSPNG outreach.

WBW fully supported the upskilling in midwifery of 13 Community Health Workers (CHWs) across nine facilities, to provide skills that were previously unavailable in those facilities. It was noted that the capacity building made a vast difference in facility-based deliveries and improved early referrals. The need for additional training was noted, as 13 CHWs provide only a small and limited impact, at

[17] Pai is a health facility in the grounds of the Hope Institute in Tari, a development of a previous Open Member.

[18] The WBW Completion Report (p32) indicates that the Tari-Pori DDA funded renovations, but this is disputed by an interviewee.

[19] MSPNG already had a contract with OSF to deliver services in Kutubu.

[20] MSPNG was funded through OSF's contribution to WBW.

[21] MSPNG certified 37 health workers in Hela by March 2019 on family planning interventions and provided ongoing mentoring.

the population level. Providing this is capacity in every rural health centre would have a significant impact.

The WBW data indicates an increase in DSIP funds flowing to health, specifically around infrastructure improvements. As previously noted, the allocation of DSIP and PSIP funds to health are not reported to the PHA and so quantifying these impacts was not possible at the time of the evaluation. A number of interviewees indicated WBW and OSF, contributed funding to health service infrastructure improvements (e.g. Purnei Health Centre maternity wing), as well as health equipment. Improvements in health facilities were also supported by Santos and Exxon. All of these contributions undoubtedly supported outcomes assisting the WBW effort, and will continue to produce positive impacts. One interviewee however noted that many of the upgraded maternity wings had yet to open, and the old maternity wings were still being used. Thus, the improvements in these health indicators in these facilities cannot be solely attributed to the infrastructure improvements, but to other WBW activities and other projects such as SLSS.

WBW supported the staffing of the infrastructure PMU within the HPHA.[22] This included one project manager, and two assistant project managers to manage the amount of capital works delivered through WBW and others, and other funding. An interviewee noted that the PMU freed PHA staff from the project management tasks and administration, to be able to concentrate on other activities. While there is a preference for OSF to maintain funding for the PMU, it was noted that future capital works could include a project management line item that would allow the PHA to fund staff to undertake the PMU's tasks.

All these improvements can be classified as products of a public private partnership model, underpinned by the WBW focus on partnerships, but this could be better advanced and developed through the application of Collective Impact. Using the Collective Impact approach would ensure the weaknesses of the WBW model are addressed, such as sustainability and deeper partnerships at the national level. The availability of continued funding, including government, donor and private sector, will impact on the sustainability of WBW achievements, under the HPHA. The WBW Sustainability and Exit Strategy acknowledges the challenge of ongoing funding, which was also reiterated by many interviewees.

Indeed, a key learning of WBW is that sustainability and exit strategies are critical in development programs and often only seriously addressed in the latter part of implementation timeframes. Ideally, these should be built into the design, with a strategy developed around sustainability (distinctly separate from exit) at inception and monitored closely throughout the project life cycle. Moreover, given that achieving sustainability is a multiple partner activity and multi-dimensional effort, there would be value in having a sustainability framework that donors and recipients alike could refer to, work to and discuss with PNG counterparts and central agencies. This would help to embed a more holistic view of what sustainability is, that is, more than just financial independence, and identify the key elements, opportunities, and potential milestones, specific to PNG.

Community engagement – what worked and remaining challenges

Reports and interviewees indicated that there was limited progress in this component due to external factors, including the earthquake recovery, tribal fighting, COVID-19 travel restrictions, and community perceptions about incentives ("sitting fees") versus voluntary community commitment

[22] WBW reporting indicates the PMU managed, among others, the Accident and Emergency Ward, medical store, renovations of Kelabo, Guala, Wanapkipa, Pureni and Fugwa maternity wards, and rebuilding of Koroba maternity ward.

This project component sought to engage communities in the governance and direction of their health facility using a bottom-up approach, linking communities with the health system and agenda through a formally endorsed PHA Health Facility Committee (HFCs) Terms of Reference. HFCs are not new in PNG, and consist of community leaders in the catchment population providing maintenance and repairs, identifying and promoting local needs and contributing to the strategic direction and scheduling of the health facility activities. WBW acknowledged that HFCs have always existed but many were working in an ad-hoc manner, without a structured input to the types and frequency of services provided. The Terms of Reference for the HFCs were finalised through the PHA Partnership Committee and the HPHA CEO and key advocates invested significant amounts of time pitching the bottom up approach in exchange for a more consistent, structured commitment. It was recognised more collaboration and sensitisation would be needed by the PHA District Managers, and local champions, speaking the same language, before the HFCs and their benefits could be more fully realised.

WBW supported improvements in Gender Equity and Social Inclusion (GESI) within the HPHA through funding of a GESI Adviser and supporting the Hela Provincial Council of Women. It was well recognised that GESI in Hela is challenging given the volume of social warfare and gender-based violence, flowing from local social norms and tribalism. As a result of WBW GESI activities, the HPHA Board approved the WBW-supported HPHA GESI Policy and Strategic Action Plan (2019–2020) with PHA. While WBW provided some disparate training and scholarship opportunities, a number of interviewees confirmed GESI remains a significant challenge. WBW acknowledged that support for women's leadership was ongoing, and collaboration with the PCW to build male advocacy for women's rights and include women in peacemaking and security strategies needed further work.

3.3 KEQ 3: To what extent has the investment in WBW contributed to improvements in health outcomes?

During the WBW period, there were a range of improvements in health outcomes in Hela, which were greater than improvements in areas where WBW was not implemented. These included increased use of frontline health services, antenatal care visits, vaccinations, and outpatient presentations; an increased share of outpatient care being provided in primary health services; and an increased share of facility-based deliveries. International literature suggests a range of flow-on benefits, including improved maternal and infant health outcomes.

It is challenging to assess the extent to which WBW contributed to these improvements. WBW is likely to have contributed to these improvements; for example, through WBW's support to planning, increased funding to health facilities, establishment of Service Level Agreements with clear targets, refurbished infrastructure in maternity wards in six health facilities, and upskilling Community Health Workers. However other broader PHA and donor activities are likely to have also contributed.

This section considers the impact of WBW on health service utilisation and health outcomes, noting that it may be too soon to confirm significant changes in these outcomes. The answer to KEQ 3 is drawn from an independent economic evaluation of WBW undertaken by the Nossal Institute in July 2021. As noted in section 2.3, the economic evaluation focused on Hela PHA only, and described the combined impact of WBW and broader PHA and donor activities in Hela. While the initial intent of the economic analysis was to calculate the return on investment for WBW and conduct a formal cost-benefit analysis, this was not possible due to data limitations.

For analysis of the potential impact of WBW, the following outcomes were assessed: number of stillbirths, number of measles vaccinations, number of pregnant women making their first antenatal

care (ANC) visit and fourth ANC visit, number of facility-based deliveries, number of outpatient visits, and the number of patient transfers. Outcomes are reported on a per capita basis, based on the most recent (2011) census for PNG. Two main comparisons were conducted: a pre-post comparison of outcomes in Hela from 2017 to 2020; and a 'difference in difference' analysis comparing the change in outcomes in Hela with the change in outcomes in Southern Highlands from 2017 to 2020.

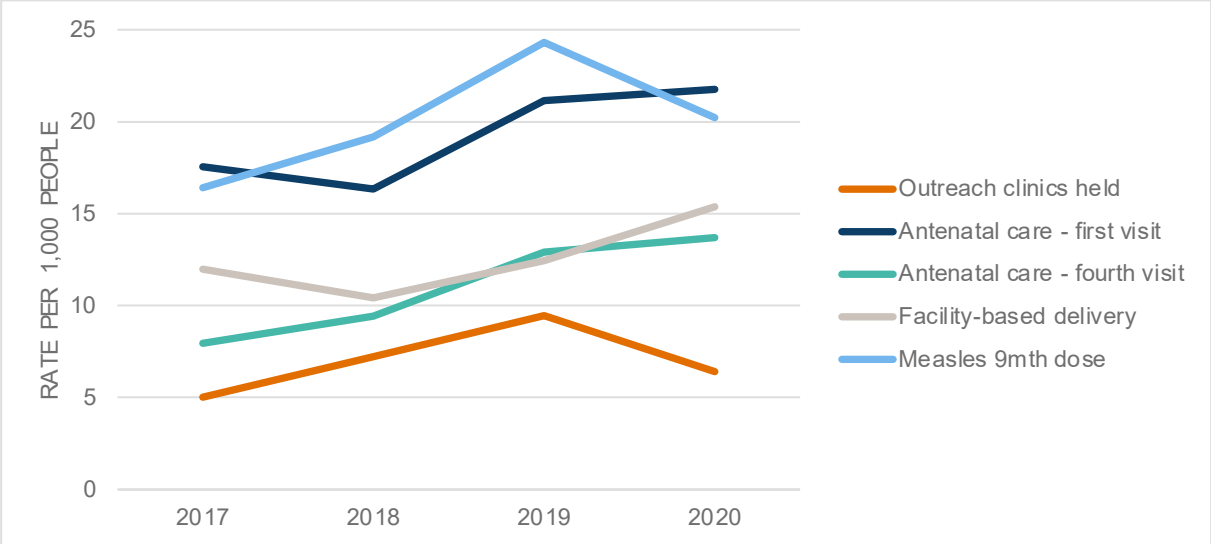
3.3.1 Pre-Post Comparison of Hela District

During the WBW implementation period, there was an increase in a range of indicators of frontline health service utilisation in Hela. All indicators of health service use increased from 2017 to 2019. For example, in 2017, the average number of outpatient visits in Hela was 1.59 per 1,000 people, but this rose to 1.77 in 2019. The number of outreach clinics conducted almost doubled. The number of women making their fourth antenatal care (ANC) visit rose by 63%, from approximately 8 per 1,000 people in 2017, to 13 per 1,000 people in 2019, and first ANC visits rose by 21%. The number of deliveries in healthcare facilities rose from 11.9 per 1,000 people in 2017, to 12.4 per 1,000 people in 2019. The number of children (per 1,000 people) receiving their nine-month measles vaccination rose by almost 50% from 2017 to 2019.

The data for 2020 was confounded by the impact of COVID-19, which affected resource flows for operational expenses, and reduced the number of outreach clinics. Despite these challenges, rates of antenatal care (first and fourth visits) and facility-based deliveries continued to improve in 2020.

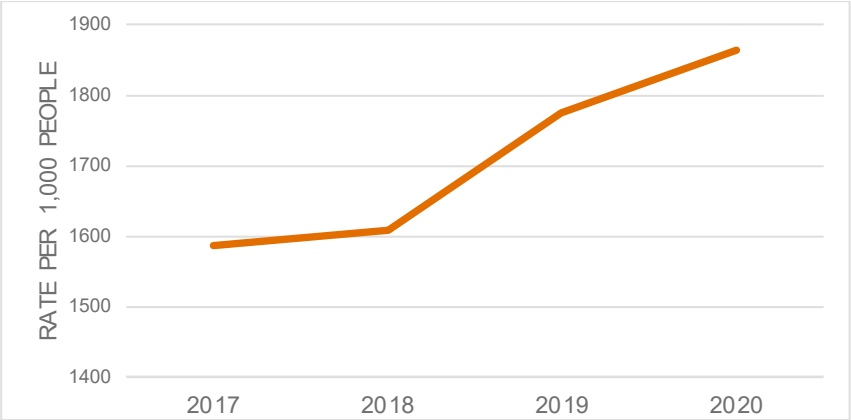
It is concerning that there was an increase in the rate of stillbirths from 2017 to 2020; however, this likely reflects an increase in reporting due to more births being facility-based, rather than a true increase in stillbirths.

Figure 4: Rates of health service utilisation, 2017–2020, Hela



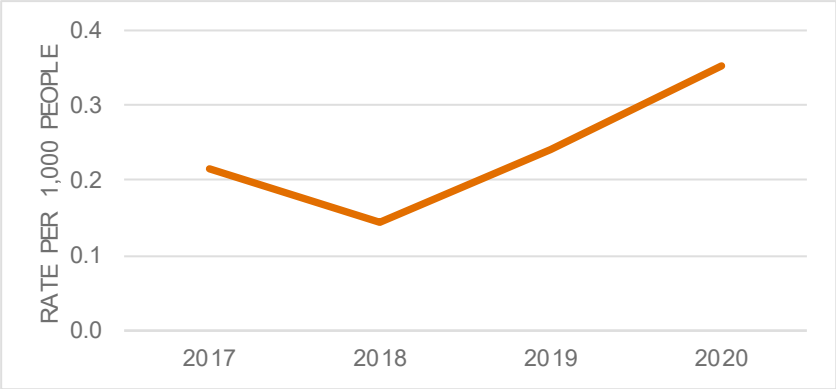
Source: NHIS data provided by Don Lewis (OSF).

Figure 5: Rates of outpatient services, 2017–2020, Hela



Source: NHIS data provided by Don Lewis (OSF).

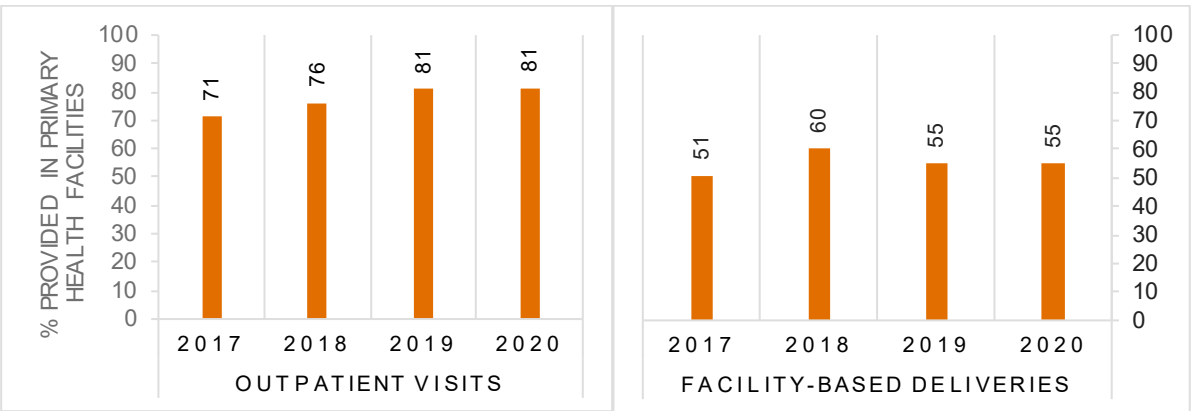
Figure 6: Rates of stillbirths, 2017–2020, Hela



Source: NHIS data provided by Don Lewis (OSF).

Data on the share of health services provided at primary health facilities (Level 1– Level 3)[23] indicates that during the WBW period, there was an increase in the share of services provided at primary health facilities (as opposed to hospital-based care). The share of outpatient visits at primary health facilities rose from 71% in 2017 to 81% in 2019; and the share of deliveries at primary health facilities increased slightly, from 51% in 2017 to 55% in 2019.

Figure 7: Share of outpatient services and deliveries provided in primary health facilities (Level 1–Level 3), Hela, 2017–2020



[23] Level 1 is an Aid Post, Level 2 a Sub Health Centre and Level 3 a Health Centre

Source: NHIS data provided by Don Lewis (OSF).

3.3.2 Impact in Hela Province versus non-WBW districts

We also compared results for Hela Province with results in the four districts in Southern Highlands Province where WBW was not implemented (i.e. districts other than Nipa-Kutubu), for the period 2017 to 2019 (Figure 8). While utilisation increased in both Hela Province and SHP, the increase was greater in Hela Province (where WBW was implemented) than in SHP (where WBW was not implemented). Some of these differences between the provinces are quite large. For example, the increase in fourth ANC visits in Hela was seven times larger than in Southern Highlands; and four times larger for first ANC visits. The increase in measles vaccination rates in Hela between 2017 and 2019 was twice that in Southern Highlands; and the increase in outreach services 2.5 times as high. In terms of stillbirth rates, the changes over time (between 2017 and 2019) were similar in both provinces.

Figure 9 reports the share of outpatient services and deliveries that were at primary health facilities. In Hela, the share of outpatient services and deliveries that were at primary health facilities increased from 2017 to 2019. By comparison, in Southern Highlands there was a slight increase in the share of outpatient services and a decrease in the share of deliveries at primary health facilities. This provides further evidence of potential improvements in services in Hela during the period the WBW program was implemented.

The increase in measles vaccination rates is particularly noteworthy, given recent World Bank data (2019) shows that PNG has the lowest vaccination rates in the world for infants[24]: 37% for measles, 35% for DPT (diphtheria, pertussis and tetanus), and 35% for hepatitis B. Vaccination rates have plummeted in PNG in the last 15 years; for example, measles vaccination rates have decreased from 82% in 2005 to 37% in 2019. Moreover, despite significant donor efforts to increase vaccination rates in recent years, rates have not improved, remaining stable from 2017 to 2019. For example, measles vaccination coverage was 38% in 2017 and 37% in 2019[25]. In this context, the observed increase in vaccination in Hela is particularly significant.

Figure 8: Rates per 1,000 people for indicators of health service utilisation and health outcomes, Hela Province versus Southern Highlands Province, 2017–2019

[24] Howes, S. & Mambon, K. (2021, August 30). PNG's plummeting vaccination rates: now the lowest in the world? *Devpolicy Blog*. https://devpolicy.org/pngs-plummeting-vaccination-rates-now-lowest-in-world-20210830/?fbclid=IwAR1cUIxJa3DSkW0B2TVwT4YMdUEA8zWR7TpS0mvvJItqx5vJg20CnXmDKgM.

[25] Given the NHIS is used for these observations, data management (collation, entry, tabulation and reporting) are critical elements that may impact on these outcomes. Poor data management often constrains outputs, while consistent and accurate data management provides greater visibility. WBW made a concerted effort to ensure quality data was captured and reported.

Source: NHIS data provided by Don Lewis (OSF)

Figure 9: Proportion of outpatient visits and deliveries provided at primary health facilities (Level 1–Level 3), Hela Province and Southern Highlands Province, 2017–2019

Source: NHIS data provided by Don Lewis (OSF).

3.3.3 Anticipated longer-term health impacts

It is likely that the observed increases in utilisation of healthcare services in Hela should translate into improved maternal and child health outcomes. Research indicates a range of expected improvements, including:

Reduced infant mortality: An analysis of almost 600,000 observations on infant mortality, from 193 Demographic and Health Surveys (DHS) in 69 low- and middle-income countries, concluded that a single visit to an ANC provider was associated with a 1.07 percentage point reduction in infant mortality; and that four ANC visits (plus a skilled provider) was associated with a 1.49 percentage point reduction in infant mortality.[26] Applying these rates to Hela[27], this suggests the observed increase in ANC visits could have prevented between 10 and 23 infant deaths in Hela in 2019 alone.

Reduced incidence of low birth weight: The same analysis also found that a single ANC visit was associated with a reduced likelihood of a low-birthweight baby by 3.82 percentage points; and four ANC visits was associated with a reduced likelihood of a low-birthweight baby by 6.65 percentage points.

Reduced maternal morbidity and mortality: A systematic review of the Ethiopian literature concluded that a single ANC visit is likely to be result in 75% decline in 'maternal near misses'.[28] In another systematic review, increased use of antenatal care is also associated with a lower risk of birth complications, especially among women considered to be at risk.[29]

[26] Kuhnt, J. & Vollmer, S. (2017). Antenatal care services and its implications for vital and health outcomes for children: Evidence from 193 surveys in 69 low-income and middle-income countries. *BMJ Open*, 7:11. doi.org//10.1136/bmjopen-2017-017122.

[27] Full details of these calculations are provided in Mahal J. & Ishida M. (2021, August). *An economic evaluation of the WBW Program*.

[28] Turi, E., Fekadu, G., Taye, B., Kejela, G., Desalegn, M. Mosisa, G., Etafa, W., Tsegaye, R., Simegnew, D., & Tilahun, T. (2020). The impact of maternal care on maternal near-miss events in Ethiopia: a systematic review and meta-analysis. *International Journal of Africa Nursing Sciences*, 13, 100246.

[29] Carroli, G., Rooney, C., & Villar, J. (2001). How effective is antenatal care in preventing maternal mortality and serious morbidity? An overview of the evidence. *Pediatric and Perinatal Epidemiology*, *15*(S1), 1–42.

3.4 KEQ 4: To what extent can the WBW be transferred to other settings, and/or leveraged to advance the broader health sector objectives, including those supported by DFAT and PATH?

For WBW to be successfully replicated in other provinces, two fundamental features of the partnership approach would need to be in place. Firstly, a well-resourced plan and backbone support organisation is required to lead coordination, communication, partnership brokering, and project management. The backbone organisation does not necessarily need to be a private sector organisation, and a number of interviewees suggested that it should not be one. This role could be filled by the PHA itself, if adequate resourcing and capacity-building support were available. Secondly, strong PHA leadership and management is critical. WBW's successes in Hela reflect the strong contributions of the PHA Board and CEO in bringing together key stakeholders and driving change. For an approach such as WBW to succeed in other PHAs, it is important that the PHA already has strong leadership, which can be further supported and strengthened.

While priority activities would depend on the unique needs of each PHA, WBW's achievements in Hela suggest the following activities could be adopted by other PHAs to strengthen their capacity to manage and deliver health services:

Improved coordination: Establish formal mechanisms for coordination and communication between partners, such as a PHA Partnership Committee; use Service Level Agreements as a mechanism for promoting partnership; and engage with local Members of Parliament, District Development Authorities, and local-level governments.

Effective health financing: Adopt facility-based budgeting; and strategically allocate top-up funding from donors and partners to address key gaps.

Sustainable quality health services: Focus on capacity building of PHA staff, covering both technical and partnership-brokering skills; engage with NGOs to address gaps in service delivery; and ensure the PHA has project management and infrastructure technical expertise.

Community engagement: Engage with Provincial Councils of Women to promote women's participation in decision-making and advocate for more female leaders.

Cross-cutting foundational activities: Conduct a baseline assessment of PHA functioning and capacity; and ensure access to high-quality Technical Advisers.

3.4.1 How well did the program TOC and Program Logic hold true?

The key underlying assumption underpinning the WBW Theory of Change was that while adequate GoPNG funding was available to support health service delivery in Hela Province and Southern Highlands Province, the full amounts rarely flowed to the PHA and health facilities. If the coordination processes and mechanisms, financial and accountability systems, and partnerships are working effectively, then existing funds will flow and lead to improved frontline service delivery. We suggest this assumption has partially held true. WBW was effective in improving the strategic allocation of funding and resources for health in Hela, as well as contributing to improved financial management systems at the PHA and facility level, which consolidated the PHA's capacity to access funding. The significant increase in Hela PHA's revenue during the WBW implementation period (from PGK 12.7 million in 2017 to PGK 31.3 million in 2019) suggests funding indeed was available

that was not previously flowing to the PHA. The efforts of the HPHA Board and Executive had a significant impact on GoPNG funding, as well as availability of DoT funds. However, while funding has increased, interviewees reported that funding is still not adequate to support the continuation of high-quality service delivery, with one interviewee noting that the overall health system remains underfunded by GoPNG. WBW's significant expenditure on infrastructure and salaries for clinical and leadership staff further emphasises that additional resourcing (above GoPNG funding) is required for continued health system strengthening.

As noted earlier, the Program Logic and Theory of Change could have been improved by aligning to WHO six pillars of health system strengthening. Additionally, it would have been better for these to be developed in collaboration with partners, for example through the HPHA Partnership Committee, as part of establishing a common vision, coordinated plan of action and shared measurement system.

3.4.2 What success factors and lessons can be transferred to other settings?

A Collective Impact model such as WBW can be effective to improve coordination, funding flows, PHA capacity, and health service delivery. Stakeholders had mixed perspectives on the transferability of WBW. Several interviewees agreed that WBW could be replicated in other provinces and would result in similar improvements in PHA functioning, provided strong PHA leadership and backbone support were in place. Others felt that the presence of OSL in Hela was a critical factor in WBW's success, and that it could not be replicated elsewhere. This section presents activities that worked well under WBW, which could be considered for roll-out to other provinces under a Collective Impact approach to health system strengthening. Section 4 makes broader recommendations for overall program design and strategy.

Key features of the partnership approach at the provincial level

Based on the evidence of what worked well in Hela and lessons learned, the evaluation team suggests the following as key features of the partnership approach that would need to be in place for implementing a Collective Impact model in other provinces. Mechanisms for promoting coordination between partners are further explored in the following subsection.

A well-resourced backbone support organisation is required. Acknowledging the close partnership between OSF and the HPHA, OSF as the specified backbone organisation for WBW played a critical role in building partnerships and leveraging resources to strengthen the Hela PHA. Through its longstanding presence and existing relationships in Hela, OSF was well-placed to serve effectively as a partner organisation. When seeking to replicate a similar model in other PHAs, the backbone organisation would ideally have an existing positive relationship with the PHA and other provincial stakeholders, organisational capacity in both project management and partnership brokering, and a good understanding of the social and political context – without these capacities, relationships and trust-building will be a lengthy process. While stakeholders noted the value of OSF's 'private sector approach' in setting standards for planning, accountability and timeliness, the backbone organisation does not necessarily need to be a private sector company. Instead, the PHA itself could fulfil this role, if adequate resourcing and capacity-building support were available. This could be achieved by building the capacity of the PHA Board and CEO to lead partnership brokering, coordination, communication and shared measurement systems; and strengthening PHA project management offices, already within the PHA structure, to provide administrative, technical and project management support. This is likely to be more sustainable than funding an external organisation to do this role.

Strong PHA leadership and management is crucial. Stakeholders noted that the PHA Board and CEO played critical roles in bringing together key players at the provincial and district levels, creating a shared vision, and establishing and reinforcing a positive organisational culture. For a Collective Impact model such as WBW to succeed in other PHAs, it is important that the PHA already has strong leadership, which can be further supported and strengthened. It should be noted that a wider roll-out of a Collective Impact model would require a large pool of skilled health administrators to fill PHA leadership roles. This has inherent associated risks that insufficient staff are available, or that skilled staff are 'poached' from other roles or provinces.

Priority activities for PHA strengthening

Priority areas for the PHA and provincial-level health system strengthening would of course vary depending on the unique needs of each PHA. However, there were program elements that stakeholders considered particularly useful under WBW, which could be adopted by other PHAs to strengthen their capacity to manage and deliver health services. These elements are grouped under each of WBW's implementation components. The evaluation team has also compiled a list of policies, procedures and documents that may be useful to other PHAs seeking to implement WBW, and these are provided in Annex 5.

Improved coordination

Establish formal mechanisms for coordination and communication between partners. The Hela PHA Partnership Committee included representatives from the PHA, churches, DDAs, and OSF. This Partnership Committee was an effective mechanism for sub-national information sharing, and shared problem-solving, consultation and alignment with provincial planning. Such Partnership Committees also exist in other PHAs, and can be strengthened in the manner that has occurred in Hela.

Use formal agreements as a mechanism for promoting partnership. Establishing Service Level Agreements between the PHA and church health facilities was an essential mechanism for clarifying roles and responsibilities, promoting partnership and transparency, and facilitating the flow of government funding to church health services.

Engage with local Members of Parliament, District Development Authorities and local-level governments, as a mechanism to increase local-level participation and voice in governance, policy and planning. WBW supported the decentralisation agenda by engaging the DPLGA to deliver workshops in each district, to great success. This assisted the Hela PHA to engage directly with these authorities, rather than engaging indirectly through the Provincial Administration. This direct engagement seems to have contributed to increasing funding allocations through Provincial and District Service Improvement Programs, and direct contributions from Members of Parliament. WBW's support to DPLGA training and induction to LLG members were recognised by stakeholders as a critical turning point in clarifying roles and responsibilities, linking DDAs with the health sector under the HPHA and the Partnership Committee, and ultimately leading to greater involvement of the DDA in health projects and contribution of funding.

Effective health financing

Adopt facility-based budgeting. Through WBW technical support, both Hela and Southern Highlands PHAs have embedded FBB into their financial management systems. Stakeholders noted FBB was a cornerstone of broader financial reforms in PHAs, as the process requires detailed planning and budgeting at the facility level, in turn promoting greater accountability, improving the equitable and strategic allocation of funding to health facilities, and contributing to improved service delivery as budgets reflects actual funding required for each facility to remain fully operational and have

adequate medical supplies. The Effective Financing component was only 7% of WBW's overall expenditure, of which FBB was the main achievement, suggesting technical support for FBB provides good value for money.

Strategically allocate top-up funding from donors and partners to address key gaps. While WBW demonstrated that PHA functioning can be improved using existing government funding, OSF provided top-up funding to address key funding gaps and support continued service delivery in the face of funding delays and shortfalls. GoPNG is the main funder for Hela PHA, and most other PHAs. However, OSF co-contributions and targeted top-ups made a significant difference to PHA functioning. For example, the pre-WBW investments in OSF funded Board, leadership and executive roles paid dividends in subsequent years. OSF also provided funding for the repair and maintenance of health infrastructure, and for service delivery through NGO partners, which would not have otherwise happened. Similarly, OSF provided funding for incentive packages that seem to have played a major role in attracting doctors to work in Hela, and solely funded the Project Management Unit, which appears to have been effective and efficient mechanism for managing infrastructure projects. While some successes of WBW could be replicated without additional donor inputs, this will be increasingly challenging as COVID-19 places additional limitations and uncertainty on GoPNG funding to PHAs.

Sustainable quality health services

Focus on capacity building of PHA staff, as a mechanism for sustainability. While capacity building needs vary across PHAs, particular areas of focus are likely to include financial management at PHA and facility level and infrastructure project management (as noted above); strengthening capacity of leadership and management staff, particularly the PHA CEO and Board; and strengthening capacity of frontline health staff such as CHWs. In addition to strengthening technical skills, there may be a need to strengthen 'soft' skills in relationship building and partnership brokering.

Engage with NGOs to address gaps in service delivery. With WBW support, Hela PHA successfully engaged Susu Mamas to manage Pai Health Facility, and MSPNG to deliver family planning services. The establishment of formal partnership agreements contributed to the partnerships, promoting coordinated rather than parallel service delivery. Sustainability of these partnerships requires more careful consideration or alternate funding mechanisms, as NGO partners' ability to deliver services and capacity building relies on ongoing funding.

Ensure the PHA has project management and infrastructure technical expertise. Infrastructure upgrades were a major component of WBW's work. The Project Management Unit in Hela PHA took a lead role in managing infrastructure projects from procurement to completion, as well as overseeing facility upgrades – addressing a key capacity gap within the PHA. Other PHAs may lack the technical expertise to successfully oversee infrastructure projects, and benefit from capacity building and support in this area.

Community engagement

Engage with Provincial Councils of Women to promote women's participation in decision-making. PCWs are an existing PNG Government mechanism for promoting women's voice and participation in decision-making, and programs should seek to actively engage with PCWs from the design phase.

Cross-cutting foundational activities

Conduct a baseline assessment of PHA functioning and capacity. A baseline study undertaken for WBW by Burnet Institute in late 2018 was reported to be useful for understanding the state of partnerships, policy context, and financing arrangements of the PHA. A similar approach is likely to

be useful for other PHAs, both to establish the PHA's organisational readiness to engage in a strategy such as WBW, as well as to inform work planning by identifying the PHA's strengths, weaknesses, and priorities in relation to health system strengthening.

Ensure access to high-quality Technical Advisers. OSF's financial and technical resources made it possible to mobilise the required technical skills to support systems changes and capacity building. Capable Technical Advisers with a good understand of provincial and national systems were crucial for driving key activities such as implementation of FBB, and developing SLAs – which were in turn critical in enabling HFGs to flow to health facilities. For a Collective Impact model to be rolled out successfully to other PHAs, adequate funding is required to attract skilled Technical Advisers; and may need to be scaled to reflect the remoteness of each participating province.

3 Recommendations

The WBW pilot provides lessons for stakeholders addressing health system strengthening. Based on the findings identified in the main report, the review team makes the following recommendations for OSF, PHAs, PATH and the AHC when undertaking health system strengthening in PNG. These should be considered in conjunction with section 3.4.2, which identifies specific key actions that could be taken by PHAs at the sub-national level. The first recommendation relates to national-level approaches and the others to sub-national level.

1. **The AHC – either through PATH or future investment partners – should provide advocacy and technical support to strengthen GoPNG national-level coordination mechanisms.**

   While WBW was an effective approach for health system strengthening at the provincial level, it was less successful in engagement and coordination at the national level. National-level coordination is essential to promote financing reforms, facilitate joint planning and accountability, ensure timely funding flows from national level to provinces and PHAs, and to address aspects of health system strengthening that are largely coordinated at the national level (e.g. medical supplies, health information systems and budget allocations). Mechanisms such as PLLSMA, HSACC, PCMCs, and NEFC and others, are critical for national-level coordination but many of these are driven by GoPNG agencies, with varying degrees of capacity and conviction. Supporting and strengthening these mechanisms should be a focus of future efforts by either the AHC and its health investments so that initiatives at the sub-national level can be empowered and more functional. The AHC could consider advocacy and support to GoPNG to progress the Review of Laws Affecting Health Governance and Service Delivery consultations and options paper, to advance the structural changes required to fully empower PHAs.

2. **OSF and other investment partners, when developing health systems strengthening programs, should ensure that designs and implementation are closely aligned with the WHO six pillars of health system strengthening principles, where appropriate. This could be achieved, for example, by framing the design document and program logic around the relevant pillars, engaging technical experts in health system strengthening to advise on the design, and aligning existing investment planning, implementation and progress reporting to the principles of each pillar, where possible.**

   While WBW aimed to strengthen the health system in Hela and Southern Highlands PHAs, it did not systematically address all six WHO pillars of health system strengthening. The WHO six pillars are the standard framework and approach for health system strengthening, and all six pillars are fundamental for a functioning health system. WBW targeted and contributed to accelerating positive changes in some key health system pillars – particularly in sub national financing, service delivery, staff capacity and leadership and governance. However, WBW implemented few activities in the other two health system pillars (access to medical products and technologies, and health information systems), largely because these are coordinated at the national level, where WBW's engagement was limited.

3. **If future investments in health system strengthening adopt a Collective Impact approach, the AHC and OSF should ensure that where possible investments address all five key elements of Collective Impact. This could be achieved by, for example, engaging technical experts in Collective Impact to advise on program design, develop a Collective Impact strategy during the inception phase to inform implementation, and actively work with partners and other donors to promote the Collective Impact approach amongst stakeholders. In particular, OSF and PATH**

should prioritise partnership brokering activities to establish the foundation for a Collective Impact approach.

There is a growing body of evidence on Collective Impact's ability to influence systems change and contribute to population level change. Collective Impact has five key elements: (1) a common agenda, (2) shared measurement system, (3) coordinated plan of action, (4) continuous communication, and (5) a backbone support organisation. Evidence from Collective Impact practice demonstrates that in addition to the five conditions, there are additional principles of practice that should be followed to put collective impact into action.[30] While several stakeholders considered WBW to align with a Collective Impact approach, it addressed some – but not all – elements and principles of Collective Impact. For example, while it strengthened coordination and communication between partners, coordination and communication are likely to have been stronger if there was a coordinated plan of action or shared measurement system agreed between partners, both of which are key elements of the Collective Impact model. OSF, if continuing WBW, and PATH/AHC, in planning and designing health systems strengthening, should be guided by these principles of practice and the five conditions, as it is more likely to achieve sustainable improvements in provincial health systems. Adoption of a Collective Impact approach may necessitate changes to M&E, and accountability and reporting processes, given that under a Collective Impact approach changes are due to the collective efforts of stakeholders, rather than attributable to a single actor.

4. **The AHC, when designing investments in health system strengthening or seeking to replicate WBW-style strategies in other provinces, should where possible design and fund investments for longer time periods to allow systems change to be realised.**

   WBW was funded as a three-year strategy – a period some stakeholders noted was too short for achieving the level of change required. Given that health system change takes time, a longer investment period (five years or more) is more likely to allow systems change to be realised sustainable.

5. **The AHC, when designing future investments in health system strengthening or implementing WBW-style strategies in other provinces, should actively and consistently engage with implementing partners on sustainability at the design, implementation and reporting phases. This could be achieved, for example, by including sustainability as a specific consideration in the program logic, ensuring partners implement sustainability-focused activities throughout the implementation period, and requiring all partners to monitor, reflect and report on sustainability-related achievements.**

   DFAT's Investment Design Quality Criteria require that investment designs identify what sustainable benefits the investment aims to generate and strategies to achieve these, as well as identifying and addressing constraints to sustainability. Implementation of a sustainability strategy is also a criteria for assessing investment effectiveness as part of annual Investment Monitoring Reports. In the case of WBW, we found little evidence of sustainability being strategically considered or communicated with stakeholders during the funding period, which decreases the likelihood that improvements will be sustainable. While it can be reasonable to assume that the improvements in PHA capacity and processes will be sustained, many interviewees expressed concerns about sustainability, particularly regarding the need for ongoing funding of health services (a challenge also noted in the WBW Sustainability and Exit Strategy), lack of succession planning for PHA leadership and senior executive, and the lack of

[30] https://www.collectiveimpactforum.org/sites/default/files/Collective%20Impact%20Principles%20of%20Practice.pdf

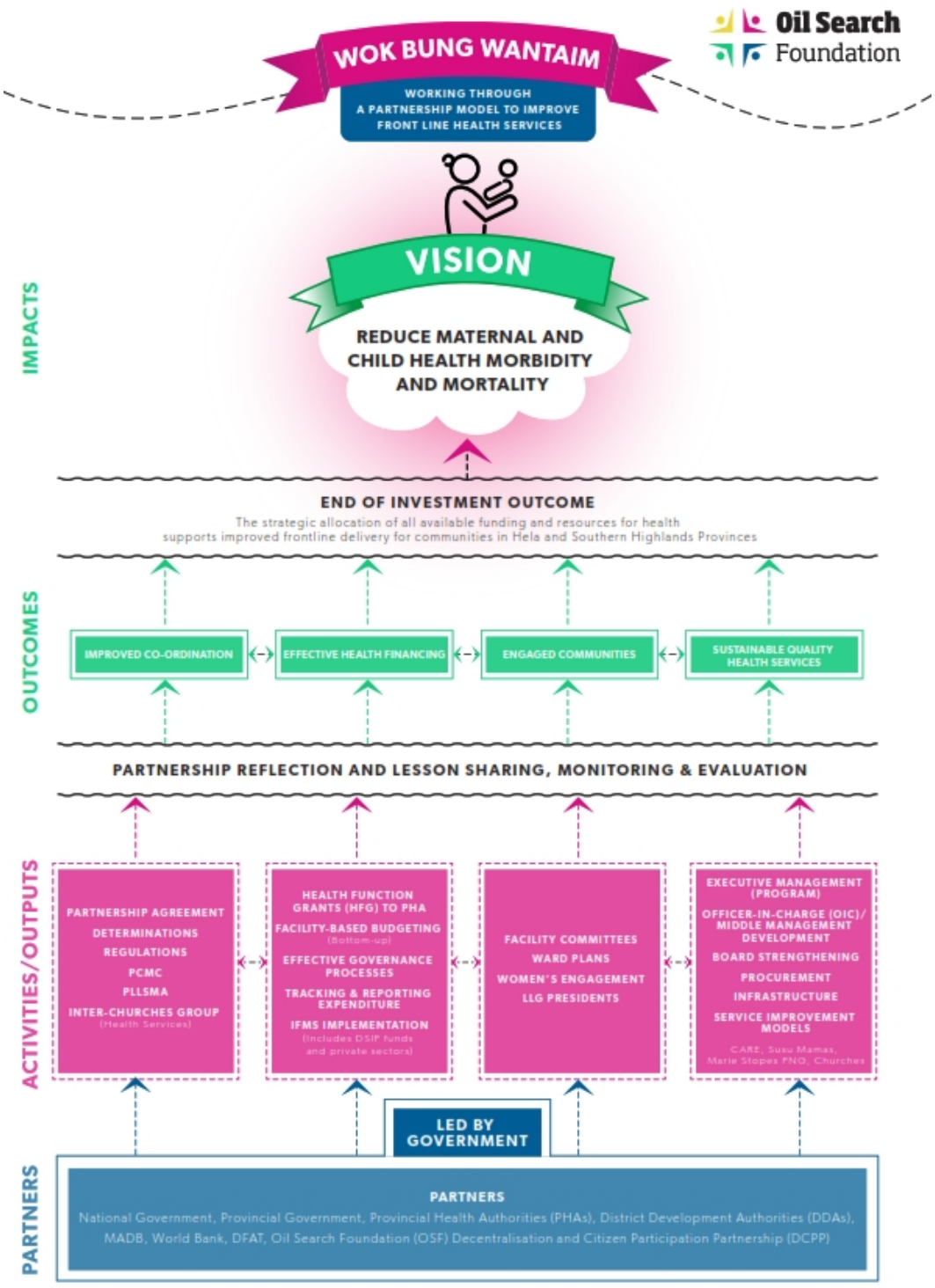
common understanding amongst stakeholders of what sustainability would look like for WBW or how it could be achieved. A more explicit sustainability strategy may have helped address these challenges.

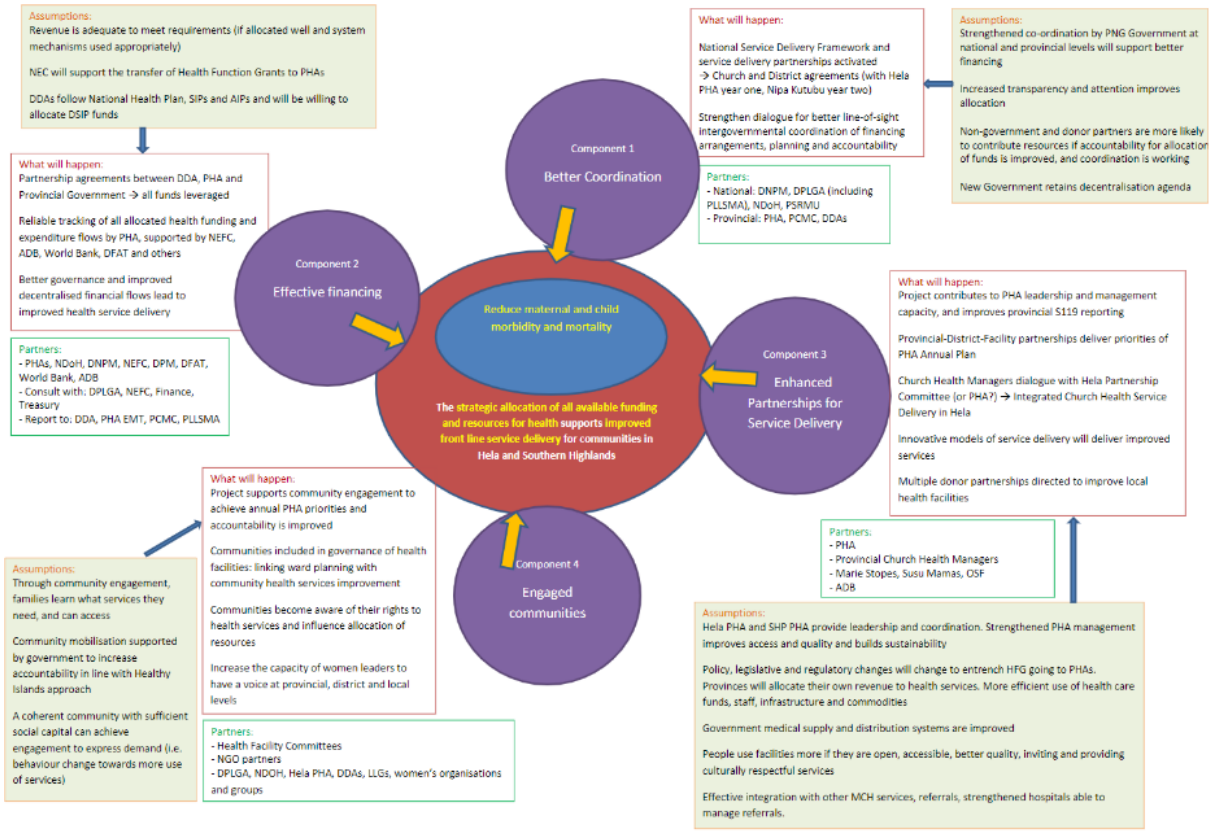
6. **The AHC, either directly or through PATH, should develop guidance materials on effective and/or sustainable approaches to PHA strengthening, or to health system strengthening more broadly.**

   Sustainability is an ongoing challenge especially if WBW-style strategies are implemented in other provinces. It is also likely to be a shared challenge across PHAs, PATH projects, and across the AHC's health portfolio more broadly. As such, there may be value in developing guidance materials on sustainability, to promote a shared vision and evidence-based approach to sustainability across investments. The guidance could, for example, articulate a shared definition of sustainability, provide guidance to implementing partners on DFAT design and monitoring requirements regarding sustainability, share lessons learned from WBW, and provide examples of sustainability approaches that have been successful elsewhere. Such guidance could be shared with AHC staff, implementing partners, sub-grantees, PHAs and other stakeholders as relevant.

Annexes

Annex 1 – WBW Program Logic and Theory of Change




Assumptions:
Revenue is adequate to meet requirements (if allocated well and system mechanisms used appropriately)
NEC will support the transfer of Health Function Grants to PHAs
DDAs follow National Health Plan, SIPs and AIPs and will be willing to allocate DSIP funds
What will happen:
Partnership agreements between DDA, PHA and Provincial Government -> all funds leveraged
Reliable tracking of all allocated health funding and expenditure flows by PHA, supported by NEFC, ADB, World Bank, DFAT and others
Better governance and improved decentralised financial flows lead to improved health service delivery
Partners:
- PHAs, NDoH, DNPM, NEFC, DPM, DFAT, World Bank, ADB
- Consult with: DPLGA, NEFC, Finance, Treasury
- Report to: DDA, PHA EMT, PCMC, PLLSMA
Component 2
Effective financing
What will happen:
National Service Delivery Framework and service delivery partnerships activated -> Church and District agreements (with Hela PHA year one, Nipa Kutubu year two)
Strengthen dialogue for better line-of-sight intergovernmental coordination of financing arrangements, planning and accountability
Partners:
- National: DNPM, DPLGA (including PLLSMA), NDoH, PSRMU
- Provincial: PHA, PCMC, DDAs
Assumptions:
Strengthened co-ordination by PNG Government at national and provincial levels will support better financing
Increased transparency and attention improves allocation
Non-government and donor partners are more likely to contribute resources if accountability for allocation of funds is improved, and coordination is working
New Government retains decentralisation agenda
Component 1
Better Coordination
Reduce maternal and child morbidity and mortality
The strategic allocation of all available funding and resources for health supports improved front line service delivery for communities in Hela and Southern Highlands
Component 3
Enhanced Partnerships for Service Delivery
What will happen:
Project contributes to PHA leadership and management capacity, and improves provincial S119 reporting
Provincial-District-Facility partnerships deliver priorities of PHA Annual Plan
Church Health Managers dialogue with Hela Partnership Committee (or PHA?) -> Integrated Church Health Service Delivery in Hela
Innovative models of service delivery will deliver improved services
Multiple donor partnerships directed to improve local health facilities
Partners:
- PHA
- Provincial Church Health Managers
- Marie Stopes, Susu Mamas, OSF
- ADB
Assumptions:
Hela PHA and SHP PHA provide leadership and coordination. Strengthened PHA management improves access and quality and builds sustainability
Policy, legislative and regulatory changes will change to entrench HFG going to PHAs. Provinces will allocate their own revenue to health services. More efficient use of health care funds, staff, infrastructure and commodities
Government medical supply and distribution systems are improved
People use facilities more if they are open, accessible, better quality, inviting and providing culturally respectful services
Effective integration with other MCH services, referrals, strengthened hospitals able to manage referrals.
What will happen:
Project supports community engagement to achieve annual PHA priorities and accountability is improved
Communities included in governance of health facilities: linking ward planning with community health services improvement
Communities become aware of their rights to health services and influence allocation of resources
Increase the capacity of women leaders to have a voice at provincial, district and local levels
Partners:
- Health Facility Committees
- NGO partners
- DPLGA, NDOH, Hela PHA, DDAs, LLGs, women's organisations and groups
Assumptions:
Through community engagement, families learn what services they need, and can access
Community mobilisation supported by government to increase accountability in line with Healthy Islands approach
A coherent community with sufficient social capital can achieve engagement to express demand (i.e. behaviour change towards more use of services)
Component 4
Engaged communities

Annex 2 – List of stakeholder organisations interviewed

ORGANISATION -Number of stakeholders interviewed

AUSTRALIAN HIGH COMMISSION - DFAT -2

OIL SEARCH FOUNDATION -9

NDoH -1

DPLGA -1

DNPM -3

DEPT OF TREASURY -1

PROVINCIAL HEALTH AUTHORITIES -10

DISTRICT LEVEL -2

CHURCH HEALTH ORGANISATIONS -9

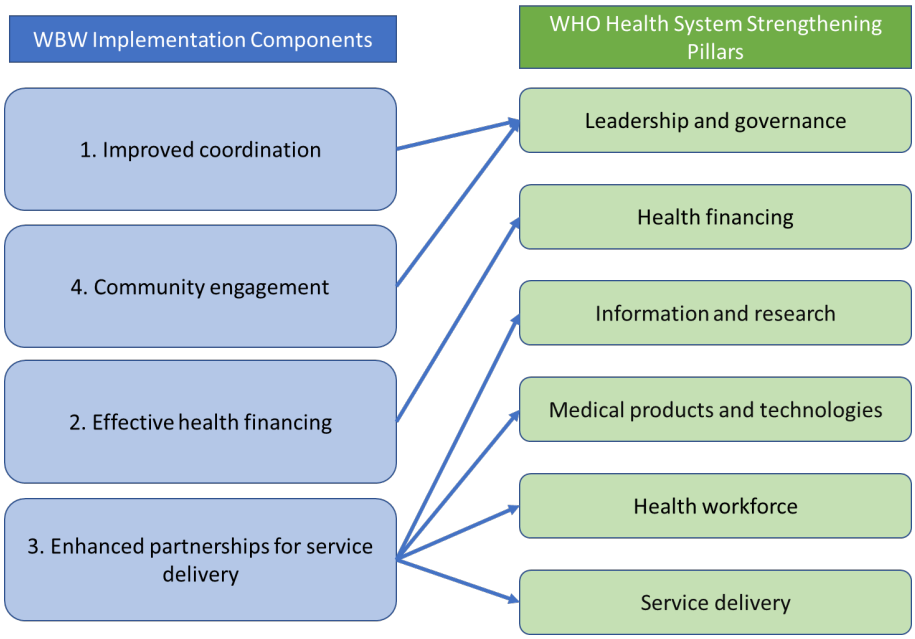
IMPLEMENTING PARTNERS -3

OTHER PARTNERS-2

Total-43

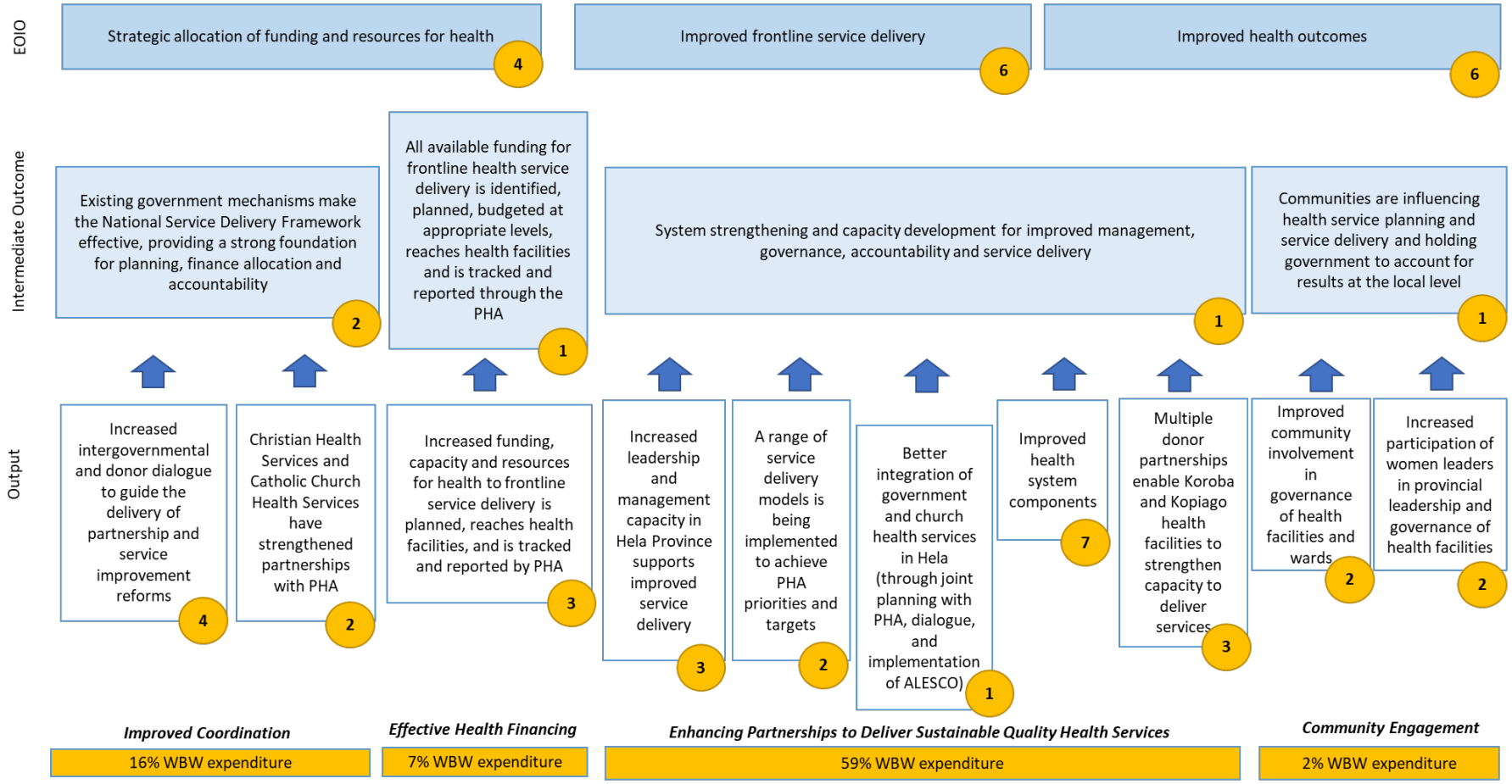
Annex 3 – Alignment of WBW to WHO pillars

The following is the evaluation team's alignment of the WBW strategy to WHO's 6 pillars for health systems strengthening



Annex 4 – WBW M&E Framework as a program logic

The evaluation team converted the WBW M&E Framework into a program logic format to show how the framework does not align fully to the WBW program logic in Annex 1. Circles next to output and outcome statements indicate the number of indicators associated with particular statements. The diagram also presents the percentage expenditure per component (remaining percentage expenditure allocated to M&E and program management).



Annex 5 – List of policies, procedures and documents for PHAs to implement WBW

This evaluation identified a range of policies, procedures and guidelines that would assist other PHAs to replicate WBW. It is suggested that these documents could be collated by the AHC, and provided to PHAs as part of the AHC's approach to health systems strengthening. Relevant documents include:

Overarching National Policy Documents

- Department of Implementation and Rural Development – PSIP, DSIP, and LLGSIP, Administrative Guidelines.
- Health System Design for a Modern PNG: Review of Laws Affecting Health Governance & Service Delivery Policy Options Paper.
- PNG Medium Term Development Plan III
- PNG National Health Plan 2011-2020
- PNG Vision 2050
- Terms of Reference of the Health Sector Aid Coordination Committee (HSACC).

Provincial Level Documents

- Hela PHA Annual Reports 2017, 2018, 2019, 2020
- Hela PHA Change Management Plan 2017
- Hela PHA Standard operating procedures (e.g. for tendering, procurement, finance and asset management, travel and security).
- Hela PHA Strategic Action Plan for GESI (2019-2020)
- National Department of Health Review of PNG Health Related Law: Moving Towards Integrated Health Governance and Service Delivery.
- Partnership Agreements between the PHA with other partners.
- Terms of Reference for the Hela Partnership Committee
- Terms of Reference for the Expenditure Screening Committee
- Terms of Reference for the Health Facility Committee
- Service Level Agreements (between Hela PHA and church-runs services)

Facility Level Documents

- Health Facility Data Booklet
- Facility Based Budgeting documents
- Patient Referral Guidelines