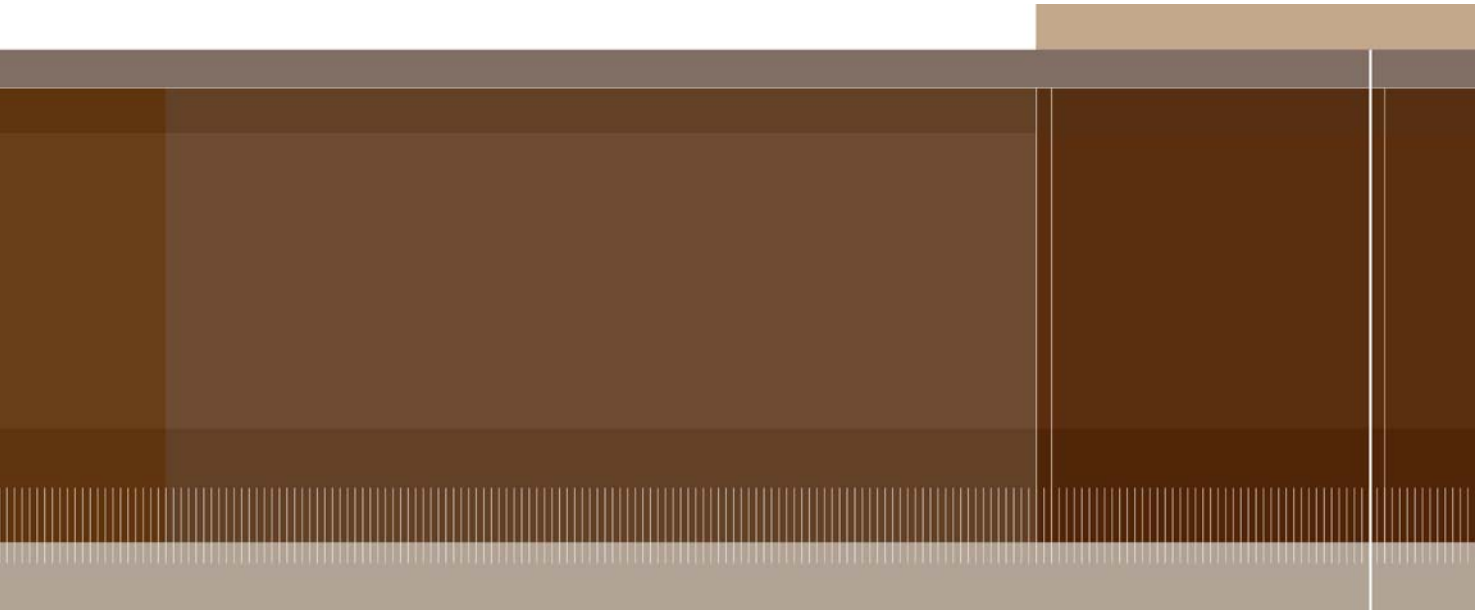
WORKING PAPER 1: PAPUA NEW GUINEA COUNTRY REPORT

EVALUATION OF AUSTRALIAN AID TO HEALTH SERVICE DELIVERY IN PAPUA NEW GUINEA, SOLOMON ISLANDS AND VANUATU

JUNE 2009



Australian Government
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ISBN 978-1-921285-76-9

Published by the Australian Agency for International Development (AusAID), Canberra, June 2009.

This document is online at www.ode.ausaid.gov.au/publications

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ACKNOWLEDGEMENTS

The team is grateful to all those in central and sub-national Government, the Churches, donor organisations, civil society organisations and in the community who gave generously of their time to meet with the evaluation team and to those who responded to our questionnaire. Particular thanks are due to Margaret George-Mavu and Winnie Samoa for organising the program in Port Moresby, and to the provincial health staff in Sandaun, Milne Bay and Western Highlands provinces for organising very useful visits by team members. Rose Raka Koyama and Nicola Blackford of the Department of National Planning and Monitoring accompanied the team on its field visits. A list of those who met with the team is at Annex 1 of this report.

LIST OF ABBREVIATIONS

AAP	Annual Activity Plan
ACR	Assessment at Completion Report
ADB	Asian Development Bank
AHEO	Assistant Health Extension Officer
AHSR	Annual Health Sector Review
AMC	Australian Managing Contractor
ART	Active Release Technique
ASR	Annual Sector Review (financial report in excel)
AusAID	Australian Agency for International Development
CBC	Christian Bretheren Church
CBSC	Capacity Building Service Centre
CHW	Community Health Worker
CMC	Christian Medical Council
CMIC	Consultation Monitoring and Implementation Council
CPHLP	Central Public Health Laboratory Project
CPP	Church Partnership Programme
DAC	Development Assistance Committee of the OECD
DHO	District Health Officer
DHS	Demographic and Health Survey
DNPM	Department of National Planning and Monitoring
DP	Development Partner (official aid agency)
DPLGA	Department of Planning and Local Government
DTP3	Third dose of diphtheria toxoid, tetanus toxoid and pertussis vaccine
GDP	Gross Domestic Product
GFATM	Global Fund against HIV/AIDS TB and Malaria
EPI	Expanded Program on Immunisation
EWFA	expected weight-for-age
GAVI	Global Alliance for Vaccination and Immunisation
GTFAM	Global Fund to Fight AIDS, TB and Malaria

HF	high frequency
HIES	Household and Expenditure Survey
HR	human resources
HRH	Human Resources Health
HSIP	Health Sector Improvement Program
HSPS	Health Sector Procurement Support
HSRF	Health Sector Resourcing Framework
HSSP	Health Services Support Programme
ICR	Independent Completion Report
IMF	International Monetary Fund
IMR	Institute for Medical Research
IMRG	Independent Monitoring and Review Group
LLIN	long-life treated bed nets
MDG	Millennium Development Goals
MDR	multi-drug resistance
MEMP	Medical Equipment Maintenance Project
MHGH	Mount Hagen General Hospital
MMR	maternal mortality rate
MONAHP	Medical Officers, Nurses and Allied Health-workers project
MOU	Memorandum of Understanding
MSB	Medical Supplies Branch
MSSP	Medical School Support Project
MTDS	Medium Term Development Strategy
MTEF	Medium Term Expenditure Framework
MTR	Mid Term Review
NDOH	National Department of Health
NEFC	National Economic and Fiscal Commission
NGO	Non-Government Organisation
NHIS	National Health Information System
ODA	Official Development Assistance
ODE	Office of Development Effectiveness

OECD	Organisation for Economic Co-operation and Development
PMTCT	preventing mother-to-child transmission
PNG	Papua New Guinea
PPP	Public-Private Partnerships Unit
PUP	Pharmaceutical Upgrading Project
SIA	supplementary immunisation activities
SMHS	School of Medicine and Health Services
SMRG	sector monitoring and review group
SNS	Social Network Service
SWAP	sector-wide approach
TA	technical assistance
TB	tuberculosis
TFR	total fertility rate
THS	Tertiary Health Support
U5MR	under-5 mortality rate
UNICEF	United Nations Children's Fund
UPNG	University of PNG
VGH	Vanimo General Hospital
WCHP	Women and Child Health Project
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

This working paper summarises the findings of a review of Australian support to health services in Papua New Guinea (PNG). It is one of three country case studies contributing to the Australian Agency for International Development's (AusAID) evaluation of Australian support for health service delivery in Melanesia, managed by AusAID's Office of Development Effectiveness (ODE).

Country context

PNG faces severe problems of physical access, making it difficult and very costly to deliver services, and difficult and costly for the population to access the services that are available.

Provinces have a high degree of autonomy, making it hard for central government to ensure that provincial governments allocate sufficient funding for health, and that they implement national health policies. In a country of extreme linguistic and ethnic diversity, policy reforms have to take account of the intense pressures on politicians and officials to promote the interests of their own clan or language group ('wantok.') The problems are exemplified by very unequal sharing of mineral extraction revenues between provinces.

Health sector performance

The 2006 Demographic and Health Survey (DHS) recorded an under-5 mortality rate (U-5MR) of 64, down from 100 in the 1996 survey, much higher than Solomon Islands and Vanuatu, where the U-5MR is below 40. Many of the most common causes—acute respiratory infection, bacterial meningitis, malnutrition and perinatal—are preventable.

The improvement in infant and child mortality does not seem to be attributable to improvements in rural health service delivery. Although access and utilisation of health services compare favourably with other low income countries, none of the health sector indicators in the Annual Health Sector Review (AHSR) show any trend improvement since 2002.[1] Immunisation coverage rates remain well below the levels required to prevent a resurgence of epidemic transmission of vaccine preventable disease.

The 2006 DHS reported a high maternal mortality rate (MMR) of 733 per 100 000, comparable to many African countries and far higher than the regional average. Although the methodology of the DHS makes this estimate difficult to interpret, the low frequency of antenatal care (60 per cent of pregnant women) and supervised delivery (37 per cent of births) and the challenges of distance, isolation, lack of transportation and an extreme shortage of skilled birth attendants highlight the hazards of childbirth in PNG.

Other areas of concern include a generalised HIV epidemic (estimated prevalence is 1.6 per cent among 15–49 year olds), with risk among women exacerbated by gender-based violence. There is a

[1] For discussion of data reliability, see Section 3.2.

high reported incidence of tuberculosis, while almost 10 per cent of admissions to health facilities are recorded as due to 'severe or treatment failure malaria'.

Frequent and extended stockouts of essential drugs and supplies are reported by every category of health facility. Access to antiretroviral therapy and distribution of long-life insecticide treated bed nets (LLINs) are improving quickly in some provinces, but use alternative supply systems.

Sector financing

Government spending represents 83 per cent of total health expenditure, unusually high by international standards, though informal user fees are not captured.2 About half of rural health services are delivered by provincial governments and half by the churches, but the churches derive most of their funding from Government.

Although Government made reasonable efforts to increase its own funding for the sector, a combination of sluggish economic growth and disappointing aid flows meant there was no increase in real per capita health spending between 2001 and 2006. The 2001–10 health plan could not be fully financed.

In 2004, AusAID helped Government put together a Medium Term Expenditure Framework (MTEF) to prioritise the plan to fit the available funding. It identified the inadequate goods and services budgets at provincial level and below as a binding constraint on service delivery. It proposed cutting back on new investment and on Technical Assistance (TA) in order to increase spending on operating costs. The pooled fund trust account introduced in 2004 responded to these priorities by directly financing provincial health spending, while making access to the pooled fund conditional on the provinces themselves allocating at least six per cent of their non-personnel recurrent budget to health. This resulted in provinces increasing their spending on health goods and services seven-fold between 2003 and 2006. However, spending by development partners did not increase. Total real per capita spending on health goods and services (including Provincial Government budget, the National Department of Health (NDOH) and development partners) was no higher in 2005 than the inadequate 2001 level. In the circumstances, it is not surprising that there has been little or no improvement in health outcomes or in service delivery.

Australian aid to the health sector

Australia is the main donor to the sector, though the Australian share in aid to the health sector has fallen from three quarters in 2001 to less than half in 2006. In the late 1990s, Australia had 19 separate activities in the health sector, some with multiple components. Government was concerned about high transactions costs and asked AusAID to support moves away from projects towards a sector-wide approach (SWAP). AusAID responded by providing TA for putting together a sector plan and medium-term budget, beginning to consolidate the number of activities, and developing a pooled funding mechanism—the Health Sector Improvement Program (HSIP) Trust Account—for financing the sector plan.

[2] WHO, 2008. The global and regional average is about 60 per cent. In most countries private expenditure financed from insurance or out-of-pocket contributions is higher.

Mainly because of lower than intended disbursements from the pooled fund, the level and pattern of Australian expenditure did not reflect the priorities AusAID helped to articulate. Total Australian aid to the health sector has fallen since 2002. The pooled fund trust account (which helps finance the government strategy) has represented less than 30 per cent of Australian aid. Two thirds of the expenditure being financed by AusAID is outside the Annual Activity Plans (AAP), and does not help to fill the financing gap, with the intended and actual expenditures often not reported to the PNG Government's National Department of Health (NDOH).3 The aid that Australia has provided has continued to be dominated by TA and capital expenditure managed by Australian contractors.

Performance of Australian aid

The main responsibility for delivering essential services rests with government staff at district level and below, but they struggle to fulfil this role with shortages of staff and inadequate resources for service delivery and management supervision. With the exception of the Women and Child Health Project (WCHP). Australian assistance rarely targeted this level or this constraint.

The continuing absence of sufficient non-salary operating budgets, and related shortages of drugs and frontline staff, has meant the investments in buildings, equipment and TA that account for most of Australia's aid inputs have inevitably struggled to achieve significant or sustainable impact on service delivery. This is not a reflection on the quality of much of the work that was carried out; the high frequency (HF) radio network, the new and rehabilitated facilities and much of the TA for developing systems and service protocols have all been of a high standard. The limited support that was provided with operating costs, notably the support for drug kits, was important in sustaining services in difficult times—although AusAID withdrawal before successor arrangements were firmly in place caused some disruption to drug supplies. For the provinces that have been successful in using it, the pooled fund has helped to support service delivery.

Nevertheless, with the benefit of hindsight, different choices about where AusAID inputs should be spent would probably have produced more sustained impact on service delivery. Specifically, increased support for operating costs at provincial and district level would have created a more balanced pattern of spending in which services could have expanded, and the investment and TA that was provided might have achieved more. AusAID exacerbated this lack of balance in the overall allocation of resources in the sector, mainly as an unintended consequence of an approach to financial management that made it impossible for the Agency to provide the required volume of operational support to provincial and district level services.

The main reason for falling Australian aid (and a significant explanation for slower than expected disbursement by other donors) is that the demanding financial and planning procedures established for the pooled fund have proved difficult for the NDOH or provinces to comply with, resulting in much lower than intended expenditure through this mechanism. A cautious approach was understandable in a country ranked 162 out of 179 on the transparency international corruption perception index. However, the consequence is that the trust account incurs high management costs to account for relatively low expenditure. It focuses government staff time on financial management rather than service delivery. Because it is a parallel system, it diverts attention away from financial

[3] Table 3.3.

management of the much larger resources being spent by the NDOH using government financial procedures.

Most seriously of all, the procedures have prevented badly needed funding from reaching those responsible for delivering services on time and in the amounts required. There is an urgent need to reform the approach, which does not necessarily mean increasing the risk of misappropriation. The concept of accountability needs to be broadened beyond financing issues to also consider accountability for delivering services.

Tackling poverty gender and inequality

There is a lack of data for analysis of poverty and inequality issues—there has been no Household Income and Expenditure Survey since 1996, and none of the performance indicators reported to the SWAP review are gender disaggregated. The extent to which poor and remote populations and women have unequal access to services can not at present be quantified.

AusAID supported significant work to address gender issues under the WCHP. Unfortunately, it was not adequately sustained. With no evidence of sustained improvements in any aspect of service delivery, AusAID support clearly did not achieve much impact on poverty and gender. Projects that spent mainly on TA and equipment and facilities could not in any event have made significant inroads on improving services for the poor without there also being additional resources for outreach and service delivery at district level and below.

Work supported by AusAID quantified big differences in provincial revenues and in the costs of delivering services, and resulted in proposals for distributing conditional grants to enable all provinces to deliver equivalent services. There would be a strong case for using trust account resources to accelerate progress towards this goal. To ensure that funds get quickly to service delivery level within provinces, it will be important to progress the proposed piloting of direct payments to district treasuries and to health facilities.

Opportunities and challenges for improving service delivery

The system is rather fractured across several dimensions—Government and province, provincial hospitals and provincial health departments, Government and church services, and provincial health departments and vertical programs. The Provincial Health Authorities Act, the proposed Christian Health Services Act, and the corporate plan point to approaches to tackling these issues, including more use of partnerships and Memorandum of Understandings (MOUs) with non-state providers.

Church health services provide and manage almost half of the country's health services. Key issues currently under debate include the adequacy of the government subsidy received through the Christian Medical Council (CMC), the limited capacity of the CMC Secretariat to monitor and report on the performance of its members, and the question of whether some form of performance-based contract, possibly managed by the newly established Public Private Partnerships (PPP) Unit or by provincial health authorities, should be introduced.

While good progress has been made on strengthening the medical workforce (notably in the paediatric and surgical sub-specialties), this represents only a small proportion of overall human resources for health. Insufficient attention to Human Resources for Health (HRH) planning, staffing budgets and

incentives have led to extreme shortages among obstetricians, midwives and all categories of front-line health staff, contributing to PNG's poor obstetric indicators and the closure of health facilities. The NDOH recognised this dilemma by making HRH the overarching theme for this year's National Health Conference.

There is no one size fits all approach to solving these problems in a country as diverse as PNG. Different circumstances may require varying staffing patterns, skills mixes, approaches to supervision and referral, and training for management, clinical and communication skills, as well as different relationships with non-state providers. Lessons learned need to be shared, perhaps through provincial and regional conferences where district and provincial teams review progress and organise mutual support or by encouraging supportive management structures for learning and problem solving. It will be important to involve relevant non-government actors to enable managers from all parts of the health system to learn from each other's experience.

Progressing the sector-wide approach

AusAID support in some areas, notably drug procurement and distribution, has made limited progress because of the lack of a supportive policy and institutional environment. The SWAP reviews were too cumbersome to be decision-making institutions, while the operating and finance committees are too junior. The recent establishment of a high-level steering committee with a limited and high priority agenda offers some prospect of more effective action, but will depend on establishing effective mechanisms for decision making and follow-through, and on the need for sustained leadership commitment.

The original intention of using the SWAP to program Government and development partner resources towards meeting the financing needs for implementing the sector program needs to be put in place. For AusAID, this would require a commitment to increased funding that should be entirely used for the sector strategy and the MTEF, preferably with early progress towards spending an increasing share of resources through a reformed trust account fully integrated with government financial and planning systems, and with more appropriate management structures. It would also require a more transparent approach to communicating future financing and reporting actual spending.

Technical assistance

Spending on TA has not produced results commensurate with the share of expenditure devoted to it. It is the SWAP reforms and action plans that should determine what capacity building support is needed (though those plans need to be reformed to become multi-year rolling, more strategic and more realistic about capacity and budget).

Future TA should be embedded within the overall NDOH-led process of sector reform and development, and within the partnership arrangements related to the SWAP.

Learning and adaptation

The team believes there are also opportunities to learn better from existing experiences, including what is working, to better cross-fertilise ideas across different service providers. This needs to include in particular lessons about how best to promote transparency and accountability through the dissemination of information, and how to maintain and reward staff working in remote and difficult environments. The distillation of these good practices might then also provide lessons about how to adapt the overall system to better support the ongoing emergence of locally driven solutions, appropriate to different cultural contexts.

Recommendations

The team's suggestions and recommendations are in Chapter 6.

CHAPTER 1: INTRODUCTION

1.1 Terms of Reference and methodology

The ODE is evaluating the effectiveness of AusAID's contribution to improving the delivery of essential health services for the poor on a sustainable basis. The purpose of this evaluation is to draw lessons about what has worked and what has not, to inform the development of improved approaches for the future. The evaluation is based on three country case studies conducted in Papua New Guinea (PNG), Solomon Islands and Vanuatu. This working paper summarises the findings from the PNG country case study.

The team defines the health sector to include promotive, preventive and curative health services, whether provided or financed by Government or by non-government sources. Interventions in other sectors—such as water and sanitation, transport, or education—are not included, although it is recognised that they can have major impacts on health outcomes.

During the 1998–2008 period covered by the evaluation, AusAID support has been moving towards a SWAP. A SWAP is a partnership between Government and donors to support health sector development and reform across the sector as a whole, meaning that (even more strongly than for projects) results can not be attributed to the activities of one donor. The team therefore looked at overall sector performance and the role AusAID has played as a main stakeholder contributing to performance.

The path to achieving service delivery outcomes (increased utilisation and coverage, reduced gender and poverty related inequity) and impact (improved survival, reduced morbidity, improved equity and social and financial risk protection) passes through a number of stations. These include appropriate inputs in the form of funding, plans and harmonisation, as well as effective processes for national plan implementation, capacity building, performance monitoring and accountability. In turn, these inputs and processes are expected to produce a sound health system (governance, human resources, medicines and supplies, information) and improved services (access, safety, quality, efficiency).4

Evaluating AusAID's contribution to effective health service delivery in the study countries entails collecting and analysing essential information on each of these elements, as well as on enabling and inhibiting contextual factors that help explain health sector performance.

The methodology of the study involved:

1. a literature review and analysis of available data (Annex 2) and a summary of previous AusAID evaluation work (Annex 5)
2. interviews with key informants (Annex 1 lists those interviewed)
3. field visits to sites selected for their ability to shed light on relatively good performance—Western Highlands, Sandaun, Milne Bay (Annex 4)

4 'Effective Aid, Better Health': report prepared for the Accra High Level Forum on aid effectiveness (September 2008), WHO, OECD, World Bank 2008.

4. participant observation at the national health sector conference, the development partners meeting, a Participatory Governance Workshop and Church Partnership Programme (CPP) planning meeting
5. debriefs with government partners and AusAID in PNG, and with AusAID staff in Canberra.

The team also attempted an email survey of individuals working on health sector issues within national and provincial government, Non-Government Organisations (NGOs) and the church medical services. The response rate to the survey was relatively low. Nevertheless, it enabled us to seek views from a wider group than would have been possible only through face-to-face interviews. The survey responses are summarised at Annex 3.

1.2 Structure of the report

The report starts with some brief background on the country (1.3) and on AusAID support to the health sector (Section 2), followed by discussion of how health services were financed (3.1) and what results have been achieved in health outputs and outcomes (3.2 and 3.3). Section 4 considers the performance of Australian aid in the sector over the period reviewed and Section 5 discusses opportunities and challenges for the future in terms of the health system and services (5.1) and the conduct of the aid relationship (5.2). Section 6 offers some tentative recommendations for consideration by AusAID and the NDOH.

1.3 Country context

PNG faces severe problems of physical access,5 making it difficult and very costly to deliver services, and difficult and costly for the population (especially the poor and infirm) to access services that are available.

Most health services are a provincial responsibility. Under the Organic Law on Provincial and Local Level Government of 1994, Central Government is unable to impose national policies or ensure that central government grants are spent on the health sector. Introduction of the PNG health function grant in 2004 enabled the Treasury to ensure a minimum level of provincial government funds were spent on health, but the National Economic and Fiscal Commission (NEFC) found that provinces under spent on districts and on goods and services.6

Low economic growth saw real public health spending per capita fall by 14 per cent between 2001 and 2005. Economic growth has picked up sharply from 2007 due to a natural resource boom, but this is expected to be short-lived, with the International Monetary Fund (IMF) projecting that mineral exports will halve as a share of Gross Domestic Product (GDP) between 2008 and 2011 due to declining prices and falling volumes of oil production. Little progress has been made in addressing constraints to non-mineral growth. These include weak and costly basic utilities, poor transportation, communication, and electric power infrastructure, low skills and literacy, high crime, weak governance

[5] 'Poverty and Access to Infrastructure in Papua New Guinea', Gibson J and Rozelle R, working paper no. 02–008 February, 2002, Department of Agricultural and Resource Economics, University of California Davis.
[6] NEFC, 'Cost! Capacity! Performance!', Review of all expenditure in 2005 by provincial governments, full report, October 2007.

including corruption (PNG places 162 from 178 countries on the corruption perceptions index7), a lack of law and order, land tenure concerns stifling investment, political interference in business, and a perceived lack of political will to adopt needed sweeping reforms.8 The IMF project that by 2012 PNG economic growth will return to the long-term trend rate of about 2.5 per cent, no higher than population growth. The brief period of higher economic growth has not translated into higher health sector spending, due to problems with spending the PNG funds allocated to health infrastructure and problems in meeting accounting requirements for spending pooled funds.

PNG is one of the most ethnically and linguistically diverse countries in the world. Political and social allegiance is based on linguistic groups. There are some positive effects on cohesion and social protection at wantok level, but there are also problems of conflict between groups and pressures on politicians and public servants to place the interests of their own group above those of the state as a whole, making it difficult to build and maintain support for national policy reforms. The problems are exemplified by unequal sharing of mineral extraction revenues between provinces. Tribal fighting has seriously disrupted health services in some parts of PNG. In the Southern Highlands, for example, it has resulted in prolonged closure of health facilities, including one of the major hospitals, while also being a major cause of death and morbidity in adults.9 The challenge for service delivery is to find institutional arrangements that encourage the inherent integrative and consensus building tendencies of PNG societies while discouraging tendencies towards conflict and fragmentation.10

[7] Transparency International Corruption Perceptions Index: http://www.transparency.org/policy_research/surveys_indices/cpi/2007

[8] IMF, 'PNG Article 4 Consultation', staff report, March 2008.

[9] Alpers, P & Running, G (2005), in PNG from 'Arrows to Assault Weapons in the Southern Highlands'.

[10] Harris (2007).

CHAPTER 2: AUSTRALIAN AID TO THE HEALTH SECTOR

2.1 Total aid to PNG and to the health sector

According to the Organisation for Economic Co-operation and Development (OECD's) Development Assistance Committee (DAC) figures, net aid to PNG in 2006 was equivalent to 5.5 per cent of gross national income. In recent years, Australia has provided more than 85 per cent of net aid. The health sector share in total aid peaked at 24 per cent in 2002, but fell back to 15 per cent by 2005. Real donor spending per head on the health sector has averaged about A$12 per head at 2008 prices and exchange rates, the brief spike in the value of aid in 2002 was not sustained in later years. Available data on donor spending after 2005 appears to be less complete, but does not seem to show any significant recovery in development partner spending. The 2008 MTEF envisages Development Partner (DP) spending of A$80 million, about Kina34 per head, slightly down on 2006. Actual spending is likely to fall significantly short of budgeted levels, based on past precedent.

Table 2.1 Net aid to PNG and to the health sector (AUD millions)

	2001	2002	2003	2004	2005	2006
Net ODA to PNG AUD Mns	413.3	344.1	328.7	382.3	354.9	415.4
AusAID to PNG AUD Mns	298.1	321.4	321.5	327.0	306.6	322.7
AusAID share in total net ODA (%)	72.1	93.4	97.8	85.5	86.4	77.7
Health ODA to PNG AUD Mns	60.6	81.4	56.4	64.9	54.7	83.2
Health share in total aid (%)	14.7	23.6	17.2	17.0	15.4	20.0
AusAID to health AUD Mns	47.7	59.7	54.3	44.3	38.6	38.9
AusAID share in health aid	78.7	73.3	96.3	68.3	70.5	46.8
Real DP health spend, 2008 AUD per head	12.1	17.3	10.8	11.8	9.8	13.5
Real AusAID health spend, 2008 AUD per head	9.5	12.7	10.4	8.1	6.9	6.3

Sources: '2005 Annual Sector Review' (prepared by the NDOH); 2006 figures are amounts appropriated in the budget. Data on total aid are comparable with OECD DAC figures. Aid estimates in subsequent NDOH sources appear less comprehensive. AusAID figures compiled from AusAID sources, financial year data converted to calendar year by assuming 50 per cent falls in each of the two adjacent years. Figures on real spend per head calculated using the IMF inflation and exchange rate data. Population assumed to be 5.9 million in 2006, growing at 2.5 per cent per annum.

Australian aid to the health sector also peaked in 2002–03 and has since been on a declining trend (real spending per head roughly halved between 2002 and 2006). This is not the result of deliberate policy, but reflects problems in using the pooled funding. The NDOH MTEF for 2008 envisages total development partner funding of Kina207 million (US$66 million) of which AusAID is expected to contribute Kina108 million (US$35 million), just over half of the total. The less dominant AusAID role in health relative to other sectors mainly reflects the growing importance of the Global Fund against HIV/AIDS TB and Malaria (GFATM), as well as significant support from the Asian Development Bank (ADB), New Zealand, WHO and the Global Alliance for Vaccination and Immunisation (GAVI).

2.2 Summary of Australian aid activities in the health sector

Over the period 1998 to 2008, Australia provided more than A$400 million in support to the health sector in PNG through more than 30 different activities funded under AusAID's country development program (Annex 5). During this time, AusAID supported an average of 15 different activities every year, with some projects comprising a large number of different components. In 2007–08, the number fell to below 1- for the first time (Figure 2.1). In spite of the number of different activities, around 85 per cent of annual expenditure was accounted for by four main activities in any given year. At its peak, AusAID support represented nearly one-third of public sector expenditure on health, but the share has subsequently fallen to about 20 per cent.11

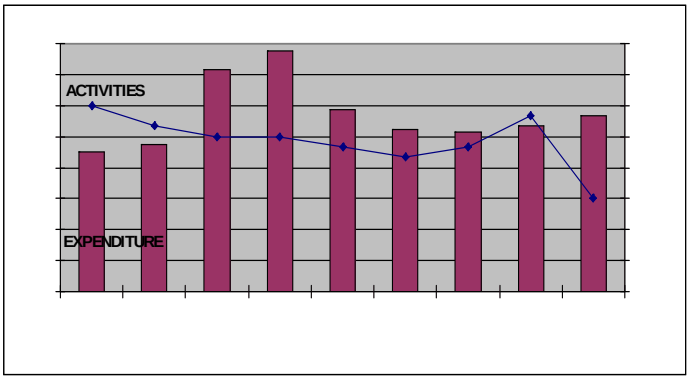


Figure 2.2 outlines the major activities supported by AusAID during the period. Given the breadth of Australian support, any summary will be inevitably imperfect. Nevertheless, a number of significant strands can be identified.

Maternal and child health

The WCHP was implemented through an Australian Managing Contractor (AMC) and featured a substantial advisory presence down to district level, with large numbers of local TA staff supplementing international advisers. The project was active in all 20 provinces in PNG. It focused considerable attention on improving service delivery down to the lowest level of the system (aid posts) and was instrumental in renewing the national immunisation program at every level, including national policy and procedures, rehabilitation of cold-chain equipment systems from national to district level and improved vaccine procurement and distribution. The approach to service level activity planning pioneered by the project was taken up in the National Health Plan, and aspects of it are still in evidence in some provinces. The WCHP incorporated a detailed approach to gender related issues including violence against women. At its completion in December 2004, the Health Services Support Project (HSSP) took over a number of elements of the WCHP for a further 12 months.

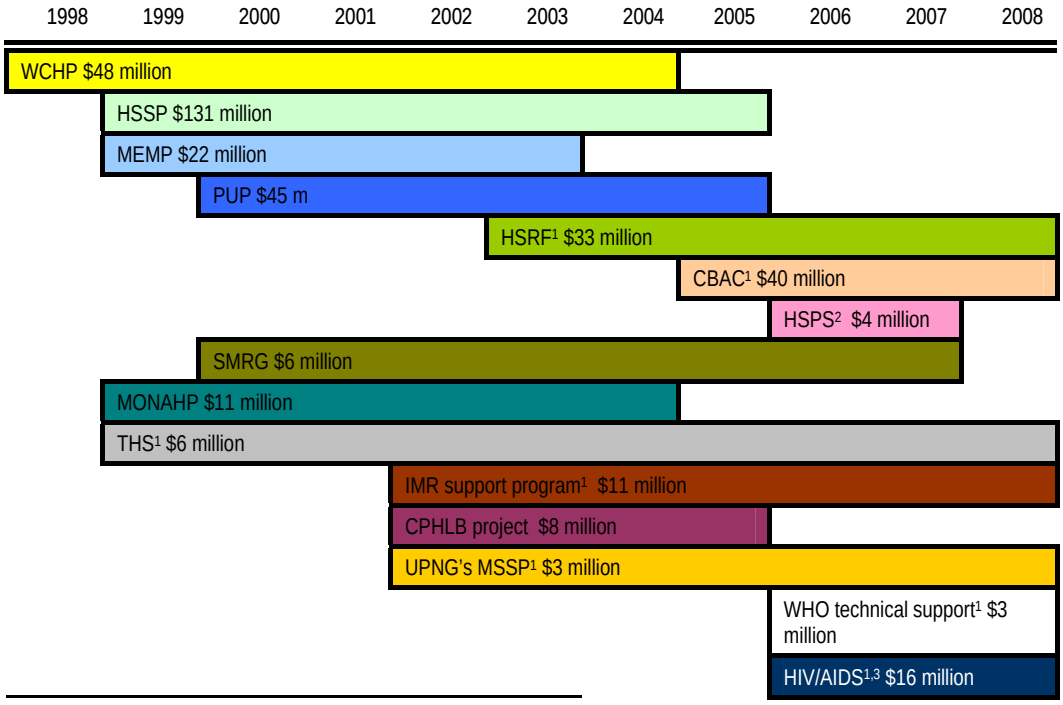
Drugs and medical supplies

Procurement and distribution of essential drugs and supplies have been long-running problems that received substantial attention from AusAID. The Pharmaceutical Upgrade Project (PUP) tried to tackle the overall problem through the provision of long-term technical assistance to the Medical Supplies Branch (MSB) and substantial financial support ($36 million) to upgrade pharmacies and stores and to supplement medical supplies. In addition, HSSP tried to tackle distribution issues at province level and below, including procuring drug kits through parallel routes from 2001 onwards to make up for the deficiencies in supplies from the national system. More recently, Deloitte were engaged to assist procurement within the MSB through the financial management support project

[11] Calculated from Table 3.2.

(2005–07) while the health sector procurement support project (2006–07) supported the supply and distribution of health centre kits.

Figure 2.2 AusAID support to the health sector in PNG: Major activities



Notes: 1 – ongoing activity
2 – Health Sector Procurement Support Project
3 – Health program response to HIVAIDS

Health workforce training and development

Support to the UPNG's School of Medicine and Health Sciences continued over the full period, moving from a project modality to core support and now to programmatic support for the School's strategic plan. Tertiary Health Services Support (THS) provided specialist teams and remained a project modality throughout. It is now being reshaped as a capacity building program jointly managed by the School of Medicine and Health Sciences (SMHS) and the NDOH, which will involve progressively less reliance on external clinical teams for direct service delivery. While pre-service and clinical health worker training is a clear priority in the National Health Plan, it was not prioritised in the 2008–2010 Strategic Plan and AusAID support for the SMHS has continued under parallel funding arrangements. There has been some support for Community Health Worker training through the Health Sector Improvement Program (HSIP), but the number of health workers being trained is insufficient for the country's needs. In contrast there has been a considerable amount of in-service training provided through the HSIP, largely to support implementation of national programs (e.g., HIV and immunisation).

Equipment and infrastructure development

The Medical Equipment Management Project (MEMP) ran in parallel with the HSSP and provided assistance to clear an equipment maintenance backlog, purchase a range of basic equipment for

facilities and train and support technicians to maintain it. When the MEMP ended in December 2003, a number of its elements were rolled into the HSSP. For its part, the HSSP also implemented a substantial program of infrastructure development for rural health services, supporting the construction of 136 new buildings (health centres, aid posts and staff housing), the renovation of 201 buildings and the provision of toilets for 230 health centres. Another significant output under the HSSP was the expansion of the national health radio network from two provinces to nation wide, connecting health facilities at district level and below to the Provincial Health Offices. AusAID also supported the construction of the Central Public Health Laboratory (CPHLP) and the Australia – PNG Incentive Fund has financed some additional health infrastructure.

Development of a SWAP

Following a study visit to Ghana in the late 1990s, the NDOH began to press AusAID to support the introduction of a SWAP—the Health Sector Improvement Program (HSIP). The NDOH's motivation was to reduce the management burden imposed by multiple donor projects; senior NDOH officers were spending most of their time managing donor support and consequently neglecting the government financed expenditure that accounted for two thirds of public sector health spending.12 In response, AusAID expanded the HSSP from a six-province project to a country-wide program of support for the Government's HSIP.

The HSSP was a hybrid, intended to pave the way to a full SWAP, while ensuring that the benefits of previous projects were not lost. Consequently, the HSSP supported disease control—malaria, HIV/AIDS and tuberculosis (TB)—hospital management capacity development and health promotion initiatives, in addition to the areas already discussed above. It also implemented a large program of TA, including financing some staff in line positions, to lay the foundations for the SWAP within the NDOH. The program covered a range of subjects, including planning and financial management. It provided key support in developing the National Health Plan 2001–10 and the MTEF for the health sector, as well as supporting aspects of sector policy. This included TA in defining the basic service package, treatment guidelines, and hospital standards—building on work started under the WCHP.

However, this hybrid approach attracted criticism. Some key initiatives from previous projects were not successfully sustained (for example, the attention given to gender issues in the WCHP appears to have lost momentum under the HSSP); the Independent Completion Report (ICR) criticised the HSSP for operating in practice as a bundle of projects, with many of the same disadvantages associated with the high-transactions costs and risks of non-sustainability associated with the previous approach.

The approach following the completion of the HSSP was intended to signal a further shift towards providing harmonised and consolidated support for the SWAP through two main channels: the Health Sector Resourcing Framework (HSRF), as the means of providing financial assistance to the SWAP; and the Capacity Building Service Centre (CBSC), as a substantial TA fund available to support SWAP implementation.

12 Interviews with senior officials active at the time.

Financial assistance to the SWAP

In 2000 the governments of PNG and Australia signed an agreement establishing the HSIP trust account as the means of supporting the HSIP. The design was based on an earlier ADB model and was the precursor to pooled funding. In 2003, the HSRF was set up as the main mechanism for AusAID to channel its financial assistance to the SWAP by way of a multi-donor trust fund. It is difficult to identify precisely the amount of financial assistance provided by AusAID to the SWAP but it appears to be around $84 million or 20 per cent of total Australian support during the period.13 Support through the resourcing framework now accounts for about 29 per cent of Australian assistance to the health sector. Support is aligned with PNG's National Health Strategic Plan which prioritises vertical programs rather than basic service delivery functions, and national rather than provincial functions.

Technical assistance

Obtaining a precise estimate of the amount of support provided in the form of TA is similarly difficult. Based on the 14 largest activities (accounting for 94 per cent of total expenditure over the period), it seems that almost half of total support (47 per cent or $192 million) was in the form of TA. Although by no means the only type, provision of staff in advisory and line positions was a strong feature of the TA program. For example, the four largest activities14—from 1999 to early 2006—provided more than 400 person years of advisory TA between them, two-thirds of which was from international (predominantly Australian) experts. TA has remained a major feature of the program through the CBSC, the largest single aid activity in the sector.

Continuation of support outside the SWAP

It is questionable whether the movement towards a SWAP has resulted in significant reduction in aid management transaction costs. Until 2007–08, there was only a small reduction in the number of discrete AusAID funded activities (Figure 2.1), and a number of other parallel activities remain in place:

- Institutional strengthening for the IMR and the SMHS at the UPNG. The IMR received core funding and the same is planned for the University.
- Support for the direct provision of specialist tertiary health services, by visiting teams of Australian volunteer medics.
- More recently, there has been a growth in support to the health sector HIV/AIDS response, and support related to the Torres Strait cross-border region.

In addition, Australia has also supported a number of other projects outside of the health sector but of varying degrees of relevance to health service delivery. These include the Church Partnership Program (CPP); the sub-national strategy (providing assistance to the Government's Provincial Performance Improvement Initiative); the PNG incentive fund; and the Advisory Support Facility.

13 This assumes all financial assistance under the pharmaceutical upgrade project was provided via HSIP.

14 HSSP; WCHP; PUP; MEMP.

CHAPTER 3: HEALTH SECTOR DEVELOPMENT 1998–2008

3.1 Health sector financing

Overall financing of the health sector

Government and churches each provide about half of the country's health services, but Government is the main source of finance for both, meeting more than 80 per cent of the costs of church health services. In 2006, the World Health Organisation (WHO) estimated that the Government financed 83 per cent of total health expenditure, which is very high by international standards—the global and regional averages are below 60 per cent and only 20 or so countries worldwide have a higher proportion.15 Churches and NGOs finance only eight per cent of total health expenditure from their own non-government sources. WHO estimate that private out-of-pocket expenditure accounts for a further seven per cent of total spending, with insurance and risk-pooling accounting for about one per cent. The figures for out-of-pocket expenditure are projected from a very old HIES (1996) and are subject to a large margin of error. National averages may also carry little meaning when physical access barriers in some areas are extreme, resulting in very high transport costs for those who do access services, and low utilisation by those on low incomes. With many aid posts having closed since 1996, it is likely that private transport costs to reach a health facility will have significantly increased.

Provincial governments are responsible for delivering health services, but there are extreme differences in the cost of doing so, related to the transport constraints in reaching remote populations and extreme differences in the financial resources available to the provinces. On the demand side, the high transport costs of reaching services discourage the poor and those distant from services from using them. Some of the solutions to these problems lie outside the health sector. The new Medium Term Development Strategy (MTDS) under preparation will include major investments to improve transport and communications. Although the affordability issue is masked at present by windfall gains from export prices, there remain difficult choices to be made in deciding what services can be provided in the medium-long term, and how best to deliver them in diverse environments.

The legislation recently passed by Parliament, based on recommendations from the NEFC, introduces for the first time a source of conditional government funding for health. The idea is to provide additional earmarked grants for non-salary operating costs, to enable all provinces to finance the same minimum package of essential services. No province will be left worse off than at present, but additional resources as they become available will be allocated to offset the disadvantages of the provinces facing high costs and low revenue sources. The approach covers a number of other sectors in addition to health. It remains to be seen how this will work in practice, and it was not in place during the period covered by this evaluation.

[15] WHO, 2008, World Health Statistics Report; http://www.who.int/nha/country/png.xls

The problem of insufficient funding

The 2001–2010 National Health Plan envisaged a substantial real increase in funding for the sector. This did not materialise, however. The initial increase in development partner spending in 2002 coincided with a sharp reduction in Government financed spending mainly due to a Government economic crisis (real GDP actually fell in 2002). The subsequent recovery in economic growth was very slow (modestly positive growth in per capita income was not achieved until 2005). In the circumstances, the steady recovery in real government health spending after 2002 is a creditable performance, but has been insufficient to offset a continuing decline in aid, with the result that total real spending in 2006 was only marginally up on 2001. In 2006, real spending per head was less than 90 per cent of the 2001 level (Table 3.1).

Table 3.1 Total health expenditure/appropriation (2001–05)—nominal and real Kina (millions)

	2001 exp	2002 exp	2003 exp	2004 exp	2005 exp	2006 app	2006 exp
Government	264.7	243.3	280.5	324.9	341.3	395.1	392.0
DPs	109.2	179.3	131.3	150.3	129.6	189.0	122.6
Total (nominal)	374.0	422.6	411.8	475.2	470.9	584.1	514.6
Share of total Government/DP Exp/App	10.6%	10.8%	10.5%	10.9%	9.6%	11.6%	8.7%
Government share of Exp/App	70.8%	57.6%	68.1%	68.4%	72.5%	67.6%	76.2%
REAL EXPENDITURE (base year 2001)							
Government	264.7	217.6	218.7	248.2	258.1	290.1	289.8
Development Partners	109.2	160.4	102.4	114.8	98.0	138.8	90.7
TOTAL (Real)	374.0	378.0	321.1	363.0	356.1	433.1	380.4
Total Real Exp/App per capita	69.8	68.9	57.0	62.7	59.8	70.8	62.2
Personnel Emoluments	179.1	167.6	159.7	170.4	156.6	166.8	
Goods/Services/Capital/Transfer	194.8	210.4	161.5	192.6	189.1	292.9	

Source: NDOH Planning and Administration, Final Annual Sector Review (ASR) report, 2006; 2006 Public Health Service Report—2006 actuals adjusted to add in an estimated Kina71 million of AusAID spending outside the trust account and not reported to the NDOH.

After it became evident that the level of resources envisaged in the National Health Plan was unlikely to be available, Government (with AusAID technical assistance) prepared a MTEF for 2004–06. This included a detailed costing exercise intended to inform the identification of funding priorities in a context where total funding was expected to decline further. The MTEF identified that the financial support most required in the difficult financial situation was for an increased goods and services budget, especially at province level. Although spending on personnel emoluments had also fallen, the MTEF prioritised goods and services spending on the argument that, although the continuing closures of aid posts due to staff shortages were regrettable, there was little point recruiting staff to keep them open without the necessary operating budgets to enable them to be effective.

In trying to boost provincial spending on health, the major constraint was the lack of a mechanism for influencing provinces to implement the policies and expenditure priorities envisaged in the National Health Plan. Although Central Government provides provinces with a health facilities grant, it does so

as an entitlement and lacks any sanctions to ensure it is spent in line with national health policy or even on the health sector.

The NDOH negotiated with the provinces in 2003 that six per cent of their non-salary and wage budget would be allocated to health, a condition that was reinforced in 2004 by making adherence to this a condition of access to donor funds in the HSIP trust account.16 To ensure the pattern of provincial health spending reflects the health plan priorities, donor pooled funds are only available to support activities included in an AAP. The AAP was intended to ensure spending in line with national priorities. In practice, it is a parallel exercise not integrated within the province's budgets and has become increasingly unrealistic, with a year-on-ear trend towards increasing the numbers of activities being included but a low and falling percentage of activities being started or completed.

Provincial health spending responded to the NDOH agreement, more than doubling health goods and services spending in 2004 and recovering to the levels seen in 2001. Table 3.2 shows the increase in provinces' own spending. The data the team has does not identify the share of the NDOH and donor spending that benefits the provinces. However, total real per capita goods and services spending has not increased.

Table 3.2 Goods and services spending 2001–06 Kina millions

	2001 exp	2002 exp	2003 exp	2004 exp	2005 exp	2006 budget	2006 exp
NDOH	44.3	20.9	38.7	53.5	75.2	74.8	109.0
Hospitals	16.7	12.7	13.0	13.9	16.4	24.2	26.9
Provinces	6.2	3.8	2.3	7.9	9.6	20.6	17.7
DPs	73.1	143.0	101.2	115.5	112.2	145.2	n.a.
Total	140.3	180.4	155.2	190.7	213.3	266.1	n.a.
Real goods and services spending per head	26.2	29.4	21.5	25.2	26.5		

Sources: NDOH Planning and Administration, 2006; ASR Report; Public Health Service Report 2006.

Table 3.3 shows government health spending and finance from 2006–08, but it comes from a different source and is not directly comparable. Budgeted expenditure shows that rapid growth in health spending was planned, but actual expenditure has lagged far behind budgeted levels. For government-financed spending, the shortfall was from the supplementary budget allocated for spending some of the windfall gains from high commodity prices. It was allocated to investment spending in the sector, and slow spending reflects a combination of the longer lead times required to implement investment projects, time taken to establish procedures for spending it, and the difficulty in agreeing how the funds should be allocated. The shortfall on donor funding is more severe in terms of the very low percentage disbursement, and reflects problems in using the pooled fund.

16 Health Sector Public Expenditure Review, 2004, July 2005.

Table 3.3 Government and donor planned and actual health expenditure 2005–08 Kina millions

	2006 budget	2006 exp	2007 budget	2007 exp	2008 budget	January to 31 May 2008
Government, excluding provincial government	471.2	300.4	574.7	362.9	586	92
DP	102.6	38.2	120.2	46.5	179	29
Total (nominal)	573.8	338.6	694.9	409.4	765	121
Est. AusAID spending not included		71.0		76.0		

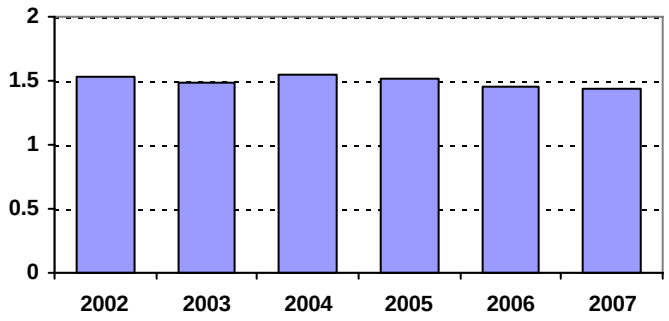
Sources: Hickey, R, master summary spreadsheet; June 2008 Finance Committee Agenda papers. Excludes Treasury payroll, provincial government expenditure from facilities grant and own sources. Donor commitment data is lower than in Table 3.1 for unknown reasons, and expenditure data is incomplete due to donors (including AusAID) not reporting directly managed spending.

3.2 Health system performance: outputs, outcomes, and management

Service delivery, access and utilisation

According to administratively collected data reported in the AHSR, access and utilisation of health services in PNG compares favourably with other low income countries, but it is lower than in Solomon Islands and not improving. The mean number of outpatient visits to a health centre or hospital has declined slightly in recent years to around 1.4 visits per person, ranging from 2.8 visits per capita in Western Province to about 1 in North Solomons and the Eastern Highlands (Figure 3.1).

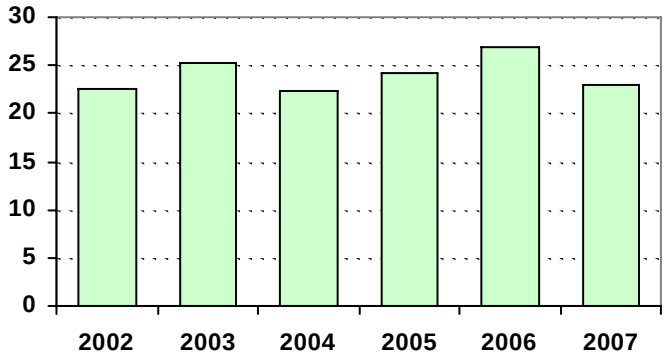
Figure 3.1 Outpatient visits per capita, PNG, by year, 2002–07



Source: AHSR 2008.

Outreach clinics also show no trend improvement (Figure 3.2).

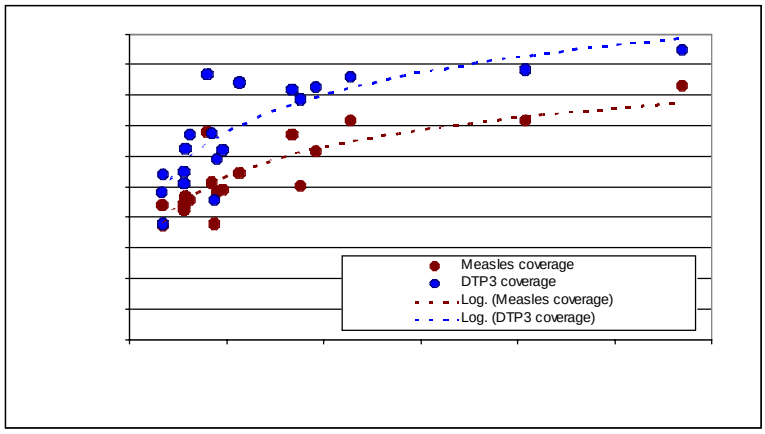
Figure 3.2 Outreach clinics per 1000 children under five years of age, PNG, by year, 2002–07



Source: AHSR.

The lack of improvement in the rate of outreach clinics is unfortunate, because they are particularly important for the most remote and disadvantaged communities and because the frequency of outreach appears to correlate with indicators of service delivery such as childhood immunisation coverage (Figure 3.3).

Figure 3.3 Effectiveness of outreach activities in strengthening measles and DTP3* vaccination coverage, by province, 2006



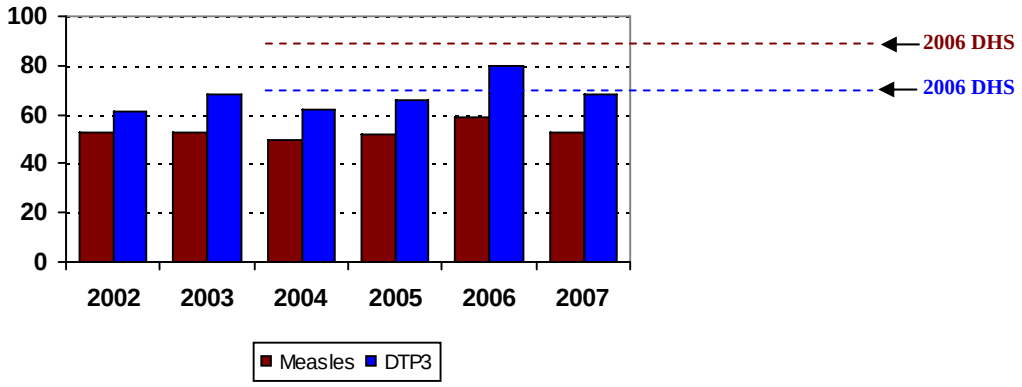
Source: AHSR. *Third dose of diphtheria toxoid, tetanus toxoid and pertussis vaccine.

Health system outputs

Data on immunisation coverage shows some differences between sources, but all of them show that it is too low, and has not improved in recent years, though there appears to have been a short-lived boost to coverage in 2006. The 2006 DHS suggests that, based on both inspection of parent-held immunisation cards and parental recall, only 54.6 per cent of children aged 12 to 23 months were fully vaccinated (i.e., had received bacillus calmette-guerin, measles and three doses each of DTP and oral polio vaccines), up from 38.7 per cent in the 1996 DHS. The rates of measles and DTP3 vaccine coverage fluctuate from year to year, but 2007 National Health Information System (NHIS) data shows no improvement in coverage since 2003 (Figure 3.4). The NHIS figures show big differences

between provinces. For DTP3, reported coverage in 2007 was only 68 per cent nationally, but was as low as 38 per cent in West Sepik, 45 per cent in Western Highlands and 48 per cent in Gulf.

Figure 3.4 DTP3 vaccination coverage among infants <1 year of age and measles vaccination coverage among infants 0–11 months of age, PNG, by year and data source, 1996 and 2002–06



Sources: AHSR and DHS.

For measles immunisation, the NHIS reports measles coverage for children under one year of just 59 per cent in 2006, falling to 53 per cent in 2007. Coverage of 90 to 95 per cent is needed to maintain group immunity or prevent the re-emergence of epidemic transmission. Low coverage resulted in frequent outbreaks in the Highlands, the North coast provinces and peri-urban communities in Port Moresby between 1997 and 2004; these outbreaks were associated with unexpectedly high attack rates among infants less than six months of age and case fatality rates up to 10 per cent in some centres and some age groups. Although PNG has not reported a confirmed case of measles since 2006, many children must be regarded as vulnerable and at least some communities must be regarded as at risk of outbreaks—irrespective of which data source is used.

The lack of progress on immunisation is despite a number of positive features. United Nations Children's Fund (UNICEF) and WHO have maintained ongoing technical and logistic support to the NDOH and provinces for cold-chain equipment and vaccine supplies, CBSC funding has been used to engage PNG specialists to manage the national Expanded Program on Immunisation (EPI). All primary, secondary and tertiary facilities visited by the team had all EPI vaccines in stock. Most had fully functional cold-chain equipment being monitored on a daily or twice-daily basis and most a back-up plan in the event of a refrigerator failure. All facilities also had a documented program for immunisation and other outreach activities (through two-yearly supplementary immunisation activities (SIAs) and outreach 'patrols').

Taken in conjunction with Figure 3.3, these observations suggest that limited accessibility to and from remote communities are the principal constraints to achieving higher vaccination coverage in PNG. Sustainability is clearly an issue, as strong or improving EPI performance in some provinces and some years remains sporadic and may be occurring at the expense of broader primary health care system development.

The 2006 DHS estimated the total fertility rate (TFR) at 4.3 children per woman—a slight decrease from the 1996 DHS and a 1991 survey (which reported TFRs of 4.8 and 5.3, respectively). The DHS reports that 35.7 per cent of married women use 'any' form of contraception; this is reported to be an

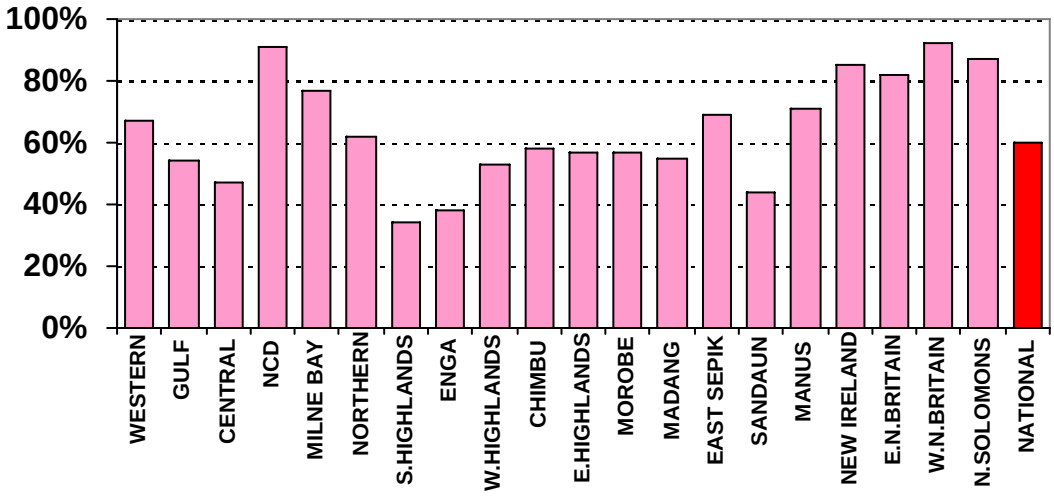
increase in contraceptive prevalence rate compared with 1999, when the corresponding usage rate was 25.9 per cent. However, this presumably includes 'traditional' and 'natural; methods that are less likely to be effective than 'modern' methods. Given that three quarters of men and women know how to access modern family planning commodities and information, contraceptive uptake rate is poor.

Use of family planning is highest in the Islands (45.3 per cent) and Southern (43.8 per cent) regions, followed by Momase (33.9 per cent) and the Highlands (24 per cent). There is also a gradient in contraceptive usage by educational status, with uptake almost twice as high among those respondents with post-primary education (45.9 per cent) compared with those without any education (25.5 per cent).

In the 2007 Sector Review, just 60 per cent of mothers reported at least one episode of antenatal care from a trained health professional—a doctor, midwife, nurse or trained health worker. Participation in at least one antenatal visit has been virtually flat over the past five years (56 per cent in 2002 and 58 per cent in each of the intervening three years). A minimum of four visits are required to achieve satisfactory care.

There are distinct regional differences in the attendance at antenatal care (Figure 3.5). The Islands, Milne Bay and the NCD perform strongest.

Figure 3.5 Proportion of pregnant women receiving at least one instance of antenatal care, PNG, by province, 2007



The 2006 DHS reports much higher antenatal care attendance—80.7 per cent in 2006 and 76.7 per cent 10 years earlier. However, responses included village birth volunteers as 'trained health professionals'.

Protection against neonatal tetanus is relatively consistent: among women attending for at least one antenatal care visit, 87 per cent had received at least one dose of tetanus toxoid as prophylaxis against neonatal tetanus in their baby. This proportion has been stable for the last five years, and estimates from the DHS are comparable.

Supervision of the delivery by a skilled birth attendant (i.e., a doctor, midwife or nurse), has been shown to be the single most effective intervention in preventing maternal mortality and perinatal morbidity. Nationally, just 37 per cent of mothers had the assistance of a skilled birth attendant during

delivery, a proportion that has remained virtually unchanged for five years. Only NCD, East New Britain, New Ireland, North Solomons and Manus provinces reported that more than half of mothers giving birth with the assistance of a skilled birth attendant. Nationally, the DHS reported that more than 80 per cent of mothers had assistance at delivery but, again, responses included unskilled birth attendants.

Health outcomes

Childhood morbidity and mortality

The DHS estimates that the IMR fell from 77 per 1000 live births in the 1996 survey to 49 in the 2006 survey, and that the U5MR declined from 100 to 64 during the same period. (Note that the 2006 and 1996 DHS used a nine-year recall period for both IMR and U5MR, so the year to which these estimates apply is imprecise).

The most common causes of child mortality in PNG include pneumonia, meningitis, severe malnutrition and perinatal causes (very low birth weight and birth asphyxia).

Almost 30 per cent of children less than five years of age weigh less than 80 per cent of their expected weight-for-age (EWFA), while only 1.4 per cent are severely malnourished (<60 per cent EWFA). In Gulf and Sandaun provinces, 3.5 per cent and 3 per cent of under-fives respectively are severely malnourished.

The pneumonia case fatality rate has fallen from above 3 per cent to around 2.5 per cent since the introduction of oxygen therapy in many community facilities.

The preliminary analysis of the 2006 DHS quotes an MMR of 733 per 100 000, which compares with a figure of 370 per 100 000 in the 1996 DHS. This is very high compared to the MMR in Sierra Leone and Timor Leste during their periods of political instability during the mid- to late-1990s. However, these numbers need to be interpreted carefully.

Because of the specific methodology used, based on asking respondents about the cause of death of all sisters who survived to age 12, the estimate does not purport to measure the current MMR. The headline figure of 733 relates to the rate of maternal deaths over many years—it tells nothing about the current rate or about the rate in any specific year. It does imply that historic MMRs have been very high by international standards and far higher than previous estimates suggested.

Maternal health care and outcomes do seem to have worsened since the mid-1990s. The challenges of distance, isolation, declining numbers of formal and informal health workers with obstetric training, the reported decline in supervised delivery (from 45 per cent of births in 1996 to around 40 per cent in 2007)17 and infrequent transportation to health facilities in an emergency—all factors noted during the team's field visits—are entirely consistent with the dire situation portrayed by the DHS data. There are consequently few reasons for expecting the rate to have improved.

All health workers questioned during field visits could recall between one and several maternal deaths occurring in surrounding communities during recent months. They cited remote geographic location,

[17] 1996 figure from National Health Plan. The 2008 Annual Health Sector Review gives 37 per cent of births delivered in a health centre or hospital in 2007. The 2006 Annual Health Sector Review suggests that an additional two to three pre cent should be added to this figure for village births supervised by a trained attendant.

the time when pregnancy complications were recognised and the absence of suitable transportation as the most important contributory factors. Whatever the current rate, it is clear that the MMR is far too high, and reducing it should be a high priority.

The national malaria incidence rate is reported as 10.92 per 1000 in 2006 and 8.92 per 1000 in 2007. Almost 10 per cent of admissions to health facilities are recorded as 'sever or treatment failure malaria'. Primary care facilities only report a case of malaria based on the most accurate means of diagnosis available: microscopy, rapid diagnostic test or clinical grounds (usually 'fever' alone). This variation in reporting criteria makes estimates of incidence unreliable and comparisons between and within provinces impossible. Much better surveillance is needed to inform progress towards malaria control.

Malaria deaths are recorded only for health facilities and, given access problems, are likely to greatly underestimate the true malaria case fatality rate.

Distribution of long-life insecticide treated bed nets (LLINs) is supported by the Global Fund to Fight AIDS, TB and Malaria (GFATM), but is proceeding slowly. To 2007, 29 districts had been covered at a ratio of 2.23 LLINs per household. There has been a slight decline in malaria incidence in those districts where LLINs have been distributed; however, this decline began approximately one year before net distribution commenced (suggesting either selection bias or—possibly—an effect from preparatory health promotion conducted in the lead-up to net distribution).

The presence of mono-component artemesinin drugs in most dispensaries visited by the team is of great concern. Given the widespread pharmaceutical supply problems in PNG, there is no assurance that these medications will be co-administered with another anti-malarial drug (as per the national protocol) and, if prescribed alone, there is a risk of resistance emerging to this most valuable cornerstone of future malaria elimination.

PNG has a generalised HIV epidemic, with overall prevalence in 2007 estimated to be 1.6 per cent of 15 to 49 year olds. There is almost equal representation of males and females (but infection among young women is the fastest rising group). The main mode of transmission appears to be unprotected intercourse with multiple partners. The majority of reported cases are from the NCD, followed by the Western Highlands, Morobe and Eastern Highlands provinces. The urban rate (1.38 per cent) is surprisingly somewhat lower than the rural rate (1.65 per cent), and infection rates are also increasing faster in rural areas. The access and service provision issues already noted in remote rural areas will further increase the challenges in addressing the epidemic. If current forecasts turn out to be correct, the prevalence in rural areas would reach 5.7 per cent by 2012, representing almost 200 000 people living with HIV.

Access to diagnosis and antiretroviral therapy is slowly being rolled out to provincial centres. The UN estimates that 38 per cent of eligible people living with HIV are receiving antiretroviral therapy, but no data on treatment adherence or clinical efficacy are reported.

PNG is estimated to have a TB incidence rate of 250 cases per 100 000. The rate is falling far short of the target to detect 65 to 80 per cent of TB cases and cure 85 per cent of those who are detected. The estimated detection rate in 2007 was just 17 per cent and has been falling; the cure rate has been improving but, at 60 per cent in 2006, remains short of the target. The estimated HIV prevalence among adults with TB is four per cent.

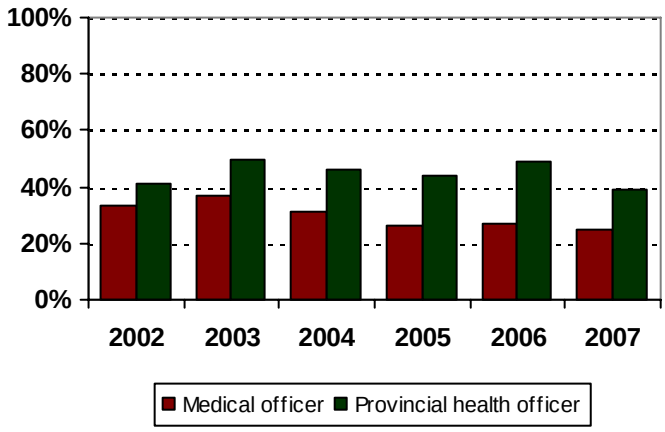
Multi-drug resistant TB (MDR-TB) has recently been reported from the Western Province, with importation across the open border with the Torres Straits Islands. Overall, more than 900 cases of MDR-TB were estimated to have occurred in PNG in 2006.

Health management and service delivery indicators

The overall national HIS reporting completion rate (i.e., reports received from health centres and hospitals) has been consistently around 89 to 90 per cent for the last five years (range 80 to 100 per cent for 2006).

Service indicators (e.g., for health centre supervisory and support visits) show a mixed trend between 2002 and 2007 (Figure 3.7): the overall frequency of medical officer visits has declined by almost 25 per cent since 2002, while the frequency of provincial health officer visits remained static over the same period. Most provinces report that less than one-third of health facilities receive a medical officer visit and less than half receive a provincial health officer visit.

Figure 3.7 Proportion of health facilities receiving at least one visit per year from a medical officer or provincial health officer, PNG, by year, 2002–07



Nationally, the HF radio network coverage has expanded from 68.2 per cent of health facilities in 2002 to 85.4 per cent in 2006. HF radios provide an alternative, less resource- and time-intensive means of clinic supervision; however, the frequency of medical officer and provincial health officer radio contacts with facilities is not reported.

The proportion of health facilities that experienced no more than a one-week stockout of any item in a package of eight essential drugs and medical supplies has remained static at between 55 and 60 per cent over the last five years.18

Conclusion—an overall lack of progress in improving health services and outcomes

In summary, there has been modest progress in reducing IMR and U5MR to levels comparable with countries with less serious challenges in delivering services, but it is difficult to attribute this to any improvement in health service delivery. Brief periods of improved performance (as in 2006) have not

[18] The eight essential items are: measles vaccine, ergometrine (for managing pregnancy-related haemorrhage), half-strength Darrows Solution (for intravenous rehydration), oxygen, amoxicillin, crystalline penicillin, chloroquine and paracetamol elixir.

been sustained, and none of the health service indicators in the AHSR show any trend improvement since 2002.

There is wide performance variation between provinces for services and coverage indicators that predominantly reflect provincial management capacity and approaches, but a much lower variation for functions that are controlled from the national level.

Because per capita spending on health has been falling, it is not surprising that overall output has not improved. Until the mid 2000s, this was due to a lack of funds for the health sector overall, but it is now due to failure to spend available funds on the right things and at the provincial and more peripheral level. Money is not the only issue, but it is hard to make progress without it. With a financing gap in the National Health Plan, the introduction of new programs outside the plan eats into already inadequate funding for core priorities, hence the sporadic spurts of progress when special initiatives are taken, but the failure to sustain and build on them.

CHAPTER 4: PERFORMANCE OF AUSTRALIAN AID

4.1 Support to health policy and plans

Table 4.1 summarises the strengths and weaknesses identified by the team regarding technical and financial support to government health policy and plans.

Developing the sector-wide approach

The approach initially taken by Australia to the design of their support to the SWAP did not reflect the principle of government ownership and leadership. Australia approached the design of the HSRF, their vehicle for supporting the SWAP, using a team dominated by Australian aid staff, with only one NDOH representative, and no involvement of other development partners. The initial proposals were rejected by the NDOH because they did not reflect the principles of the government's HSIP, particularly the desire to manage external donor support and have their capacity built to enable them to do so. At the time the design was undertaken, the current health sector MTEF was envisaging a reduction in TA spending in order to leave room for some expansion in goods and services spending. In comments on earlier drafts of the framework, the Government emphasised the importance of supporting the delivery of services in rural areas. What they were offered and accepted was a package dominated by the CBSC, a purely bilateral project, with the pooled fund trust account provided outside the government budget using a parallel and risk-averse approach to accountability, and providing limited funding for provincial services. It is not clear to the team that there was any significant movement away from a donor-driven approach based on project thinking (Box 4.1).

Box 4.1 HSRF stocktake

> 'More generally, the benefits of a SWAP, including thinking more strategically about a joint approach, donor harmonisation and linking to and incorporating the wider public sector reforms, may have not been fully realised. In the words of one stakeholder, AusAID "dropped the ball" regarding the SWAP. The focus on just CBSC means they have lost the opportunity for policy dialogue. The process was one of "narrowing to what AusAID was comfortable with.'

Source: HSRF stocktake, February 2006.

Policy dialogue

Within a SWAP arrangement, the intention is that both Government and DPs will jointly finance a single plan and budget. The 2001–10 National Health Plan set out the overall strategy, with AAPs as the basis for a budget and an MTEF that captures all sources of finance, including those directly managed by donors. The process requires effective forums to enable Government and DPs to coordinate their support (5.2 includes a fuller discussion of what is required).

The movement towards a SWAP did not initially put in place effective mechanisms for policy dialogue, or for managing implementation. AusAID and other DPs invested in twice yearly visits from an independent monitoring group, but there has been inadequate policy making and administrative machinery to ensure that recommendations are debated and, if agreed, followed up to implementation. The monitoring group has had little involvement from PNG nationals. The national conference and the DP meetings agree on 'resolutions' (often very general), but the necessary steps for turning these into monitorable actions were not clearly articulated and the list of resolutions not yet implemented

has grown progressively longer. Operational and finance committees were too low-level to address policy issues and suffered from crowded agendas. However, these problems have been recognised. In 2008, the independent monitoring group's recommendations were consolidated into a limited number of priorities and a high-level steering committee was revived, with an agenda focused on five major and long-standing issues.

There is a general question as to whether AusAID has made sufficient use of all available channels to press the case for action on issues critical to the success of aid to the health sector. AusAID's support for work of the NEFC in costing provincial service delivery has helped pave the way for significant policy change to enable all provinces to deliver equivalent services. In contrast, health sector performance was severely affected during the period examined by problems in drug procurement and distribution that required political will to confront vested and possibly corrupt interests, and clearly could not be solved by donor project interventions. This is now being addressed by the steering committee and political will appears to be in place, with action being taken based on a joint plan agreed to by Government and donors. More high-level attention might also have been devoted earlier to addressing delays and disruption contributed to by other departments, although recent efforts to address them may potentially alleviate the more serious problems (e.g., delegation of human resource management responsibility to the NDOH and Treasury's decision to release the annual health function grant in one tranche).

Alignment and harmonisation

DPs were expected to move over time towards using government financial systems, but in the interim would channel their aid in support of the government plan, and would provide necessary reporting on directly managed activities to enable Government to monitor spending.

In practice, much of Australian aid over the period was spent through parallel arrangements on activities not included in activity plans or the annual budget (Table 3.3). Over this period, Australia did not consistently inform Government of the resources available or report on actual spending.19 Australian aid continued to be dominated by projects managed by AusAID contractors, with a high TA content, a category of spending the MTEF recommended reducing. Very little has been spent in support of the non-salary recurrent budget at district and below, the priority emphasised in the MTEF and crucial for service delivery.20

Investments in facility upgrading and equipment were drawn from the National Health Plan, but it became increasingly evident that the success of these interventions (and of the whole health plan) was threatened by continuing problems in the procurement and distribution of drugs and by inadequate operating and staff budgets. AusAID stepped in to avert the worst consequences of the failures in drug procurement and distribution by directly procuring supplementary drug kits, a major contribution given the difficult circumstances. It also helped maintain performance in several areas by supplying staff in implementation roles (notably in the immunisation program). However, the HSSP—AusAID's main funding vehicle during 1999–2005—did not directly help to address the problem of inadequate operating budgets that the MTEF highlighted.

[19] January 2008 PHS report identifies AusAID as one of three donors that had not provided data on actual spending outside the HSIP's TA.

[20] 2004–06 MTEF and the ACR of the HSSP project.

The pooled fund trust account put in place in 2003 was intended to become the main mechanism for disbursing external development partner support to the SWAP, including responding to the MTEF priorities by channelling significant additional funding to provincial operating budgets. It is used not only by AusAID but also by other donors including the GFATM and New Zealand. Although Australia helped PNG to put together the sector plan, and subsequently the MTEF, the pooled fund did not develop into an effective aid instrument with which to support it, and accounted for only 30 per cent of AusAID spending.

Spending from the pooled fund has been at less than 40 per cent of levels assumed in the budget (Table 3.3).The design of the pooled fund reflected political concerns about fiduciary risk, in a domestic context in which the Australian media is highly critical of any suggestion of Australian tax dollars going astray. The risks in PNG were rightly perceived to be high, but the unintended consequence of establishing it with very demanding financial procedures is that the funds have proved difficult for the NDOH or provinces to access, resulting in much lower than intended expenditure, especially at province level (Box 4.2), with high management costs. The central scrutiny of local plans imposed a degree of rigidity that seems excessive given the need to adapt to radically different environments. And because it is a parallel system, it diverts attention away from financial management of the much larger resources being spent by the NDOH using government financial procedures. Most seriously of all, the bureaucratic procedures have prevented badly needed funding from reaching those responsible for delivering services on time and in the amounts required.

Box 4.2 Why has pool funding proved so difficult to disburse?

The pooled fund is based on an 'advance and replenish' system. With one quarter's funding in hand, cost centres are visited by accountants from the fund's Secretariat who review original documents for 100 per cent of the pool fund expenditure. No new funds are released until acquittals are complete. This is onerous in a situation where the pool funds are accounted for by health sector staff rather than by provincial or district treasuries. Most of those doing the work lack formal accounting or bookkeeping training. The approach has a built-in disincentive to using funds for expenditure at district level and below, where access problems make it harder to get back the original receipts and other documents required for accounting for expenditure. Some provinces have proved unable to provide the necessary accounting discharge to enable them to continue drawing on pool funds, while others have been reluctant to incur the work involved and the risk of attracting criticism for being unable to account for funds.

GFATM participation made the situation worse by adding requirements to the existing procedures such as detailed earmarking and separate planning, approval and reporting processes. The situation did not seem to be improving. For 2008, the funding required for the AAPs is estimated at Kina179 million, equal to the amounts recorded as appropriated by the DPs—actual disbursement in the first five months is just 16 per cent of this level.21

Table 4.1 Supporting health policy and plans

Issue	Strengths of AusAID support	Neglected or weaker areas
Policy dialogue	Independent monitoring group reports, twice yearly joint reviews, annual conference and DP meeting. Steering Group re-started in 2008 with focused agenda and senior representation.	Over-frequent reviews strain NDOH capacity, pre-2008 there was no process for debating, agreeing on or implementing recommendations. The National Conference and DP meeting was too unwieldy and operational and finance committees too low-level and lacking in focus.

[21] Finance Committee minutes, June 2008.

Issue	Strengths of AusAID support	Neglected or weaker areas
National planning and budgeting	Significant TA contributions to developing the plan and MTEF, defining and costing the health services to be delivered, building on a significant body of earlier work on treatment protocols, guidelines, service delivery plans etc. Annual activity plans introduced, theoretically linked to the MTEF and budget.	Declining aid disbursement caused plan to be underfunded, objectives unachievable. AAPs are unrealistic.
Province planning and budgeting	Trust account conditionality helped increase province goods and service spending. Insistence on annual activity plans provided some NDOH leverage over provincial health spending and priorities. Incentives for best performing and most improved provinces encourage performance review and peer competition. The NEFC work supported by AusAID offers prospect of a durable approach through equalisation grants to permit all provinces to deliver equivalent services. Service delivery planning approach developed with AusAID support still in use in some provinces.	AAPs are unrealistic (partly because of problems accessing trust account), not linked to province budgets, and not useful for planning service deliver. Direct TA to provinces on planning and budgeting not sustained, SWAP has not emphasised service delivery planning.
Progress to SWAP	Supported development of single plan and budget and put in place pool fund mechanism to help finance it.	AusAID did not allocate its own funds in line with the priorities of the plan. The design of the pool fund has made it difficult to spend. Most of AusAID still uses parallel procedures. Inconsistent reporting of planned or actual spending to the NDOH.

4.2 Support for service delivery—especially for women and the poor

Table 4.2 summarises the strengths and weaknesses of AusAID support for health sector service delivery. Additional funding (and, in most areas, staff) are a necessary but not sufficient condition for improving service delivery. Funds need to be supported with actions to overcome problems with drug and medical supplies, and require reasonably committed leadership, improved coordination between stakeholders, and consistency between different levels of government to convert them to better services. However, the absence of significant real growth in per capita expenditure has made it difficult to achieve sustained improvement. Promising interventions in areas such as immunisation have brought about short-term boosts to performance, but gains have not been sustained. Neglected areas, such as family planning, continue to be neglected.

The sector faced challenges in reconciling national policy with the need for local adaptation, and in ensuring that sufficient resources reach the lower levels of the health system where service delivery takes place.22 Few trust account resources reach the districts, though there are now plans to make payments direct to district treasuries and to health centres. Health service delivery poses specific management challenges which are often overlooked. At provincial and facility levels, planning and budgeting need to be more clearly oriented to supporting service delivery, including the effective allocation and mobilisation of operational funding and support for supervision and outreach (as well as facility based services).

There are some positive examples of effective work to support service delivery by provinces and districts, but these have often proved to be personality-dependent and hard to sustain or replicate. AusAID projects that spent mainly on TA and equipment and facilities were only helpful to a limited

22 NEFC provincial expenditure reviews.

extent because they did not help to address the most binding constraints of staff shortages and inadequate budgets for outreach and service delivery at district level and below. The NEFC's work (supported by AusAID) provides an opportunity to extend services to some of those not currently being reached, and it deserves to be supported with additional funds. This will not in itself solve the challenges of bringing services to the poorest 20 per cent, but a better distribution of resources with more for the provinces with the highest costs and lowest revenues is a necessary, but not sufficient, condition for beginning to do so.

The focus on poverty, gender and inequality issues has been relatively weak, and there is limited evidence of it being taken up in dialogue around the SWAP. There is a lack of data for analysis of poverty and inequality issues. There has been no HIES since 1996, and none of the performance indicators are gender disaggregated. Given the close correlation between poverty and access to infrastructure in PNG23 and the well-recorded fact that gender inequality is marked in PNG (see, for example, AusAID's 'Violence Against Women' evaluation), it is highly likely that poor and remote populations and women are disadvantaged in access to services, but it is difficult to quantify. The WCHP did useful work to introduce a gendered approach and to address gender-based violence, but the ICR did not find evidence of impact on health status or access to services, and this work was not adequately carried forward into the SWAP.

Services under the direct responsibility of the NDOH underpin service delivery by provinces and districts, but have not been carried out efficiently. Procurement and distribution of drugs and medical supplies by the MSB have been a long-running story of failure, rescued by AusAID with emergency procurements and the introduction of a parallel system for supplying drug kits. The drug kits played an important role in back-stopping services, but AusAID took this on reluctantly and withdrawal was associated with renewed drug shortages, which might indicate there was a need for more attention to planning the handover and ensuring that arrangements were secure before stopping support.

Table 4.2 AusAID impact on service delivery and inequality of access

Issue	Strengths of AusAID support	Neglected or weaker areas
Provincial and district services	WCHP work on service level planning. Performance incentives under trust fund. TA work with individual provinces and through regional teams, including regional reviews. Eligibility of Rural Outreach Programs for operational funding under the HSIP has resulted in a regular commitment in some provinces (at provincial and district levels). The CBSC provided some TA support for Provincial Health Act which, though voluntary, will help ease the coordination problems in the provinces that implement it. Independent Monitoring and Review Group (IMRG) recommended HSIP-TA should disburse some funds direct to district and facility level, but not yet in place.	WCHP work not sustained, Not clear if trust account prizes are much incentive given problems accessing the funds. No systematic approach to tackling local service delivery (realistic plans backed with money, drugs and medical supplies, staff incentives, supportive supervision, peer monitoring through regional meetings, community role in accountability, more use of contracting in FBOs and NGOs). Few trust account resources reach district and facility level. Attempts to support districts with TA had low population coverage and were not cost effective, especially as TA was not backed with resources.
Poverty and	Local service level planning and focus on gender	The WCHP's ICR was unable to confirm any evidence of

23 Gibson J and Rozelle S (2002), 'Poverty and Access to Infrastructure in Papua New Guinea', working paper no. 02–008 February, 2002, Department of Agricultural and Resource Economics University of California Davis.

Issue	Strengths of AusAID support	Neglected or weaker areas
gender	constraints featured quite strongly in the WCHP. It began to address the issue of violence against women through IEC materials and case management guidelines. The NEFC work offers a potential approach to addressing inequality between provinces in health services.	the positive impact on women's health or access to health services. Focus on gender and on local service planning not systematically reflected in the HSSP or the HSIP. The province planning approach does not adjust for differences in poverty profiles and gender dynamics between provinces and districts. AAPs are not supported by analysis of service delivery gaps. Violence against women not systematically addressed.
Drugs and medical supplies	Kits helped sustain access of provincial services to essential drugs; province level TA helped address distribution problems in some provinces. From 2008, AusAID has been working through the NDOH Steering Committee and other donors to implement a solution to long-running problems based on the action plan contained in a well-received joint government and donor study.	Handover to the NDOH was associated with renewed and severe drug shortages. ICRs reported coordination problems between the PUP and HSSP. The PUP persisted with a technocratic approach to a policy and fiduciary problem—could more have been done sooner to address the issue in high-level policy dialogue?
Immunisation	The WCHP project had a substantial impact on immunisation policy and procedures, improving vaccine procurement and distribution and renewing the cold-chain. AusAID is continuing to fill line positions through the CBSC.	No sustained improvement in coverage, related to budget and performance management weaknesses.
Family planning		A consistently neglected issue.
HIV	Some positive achievements in ART treatment (e.g., Tininga Clinic in Mount Hagen) has developed an effective ART treatment and PMTCT (preventing mother-to-child transmission) program with low drop-out rates. Currently, 670 adults living with HIV out of a total of 970 confirmed cases are on ART (with a very low 16 treatment defaulters). Of 22 pregnancies detected in HIV-infected women, 12 remain on follow up at less than 18 months post-delivery; two infants are known to have died and eight have been lost to follow up. Direct support and indirect support by way of the GFATM and Clinton Foundation has helped conduct training and establish systems for HIV-related care, treatment and support.	Issues of coordination, speed of response to requests. Major problems of predictability and sustainability of support by way of the GFATM. Very bureaucratic GFATM procedures (trust fund plus additional reporting requirements).

4.3 Impact of AusAID capital investment

Investments in physical facilities and equipment were well executed and received positive assessments at completion (Table 4.3). Sustainability is the main concern— lack of operating budget to get full value from the investments, inadequate maintenance budgets, lack of attention to asset management or to developing an equipment replacement program. The MEMP created capacity in biomedical equipment maintenance, but did not ensure continuing access to mentoring and spare parts to maintain the skills that had been developed.

The Australia – PNG Incentive Fund has also financed some health infrastructure outside the NDOH's facility development plan, with less positive results. The team visited Kudjip Hospital in the Western Highlands, where the new ward complex can not open until funding is found for the PGK

500,000 cost of sewerage not included in the project but essential to avoid discharging raw sewage into the community. The team also visited Alotau Hospital, Milne Bay, where hospital staff complained that designs were changed from their original request without sufficient consultation with the staff who will be using the new facility. The changes compromised infection control and the logical movement of patients, while the biomedical engineer was not consulted on the choice of new equipment—with potential consequences for future operation and maintenance.

Table 4.3 Impact of AusAID capital investment

Issue	Strengths of AusAID support	Neglected or weaker areas
Capital investment	Radio network had positive impact. Construction under the HSSP was highly rated at completion. The MEMP provided a useful injection of equipment to facilities, cleared a maintenance backlog, trained technicians in biomedical maintenance, and supported them with highly regarded mentoring visits from visiting Australian technicians. Some provincial hospital biomedical engineers continue to provide a good standard of preventive maintenance in spite of the resource limitations.	Priority to capital investment not in line with the MTEF. Unlikely to lead to higher service outputs or to be sustainable in the absence of increased operating budgets. Lack of maintenance, no program of renewal and replacement, asset management remains weak. The MEMP's Assessment at Completion Report (ACR) recommendation to continue the mentoring support from visiting technicians was ignored. Technicians trained by AusAID in biomedical maintenance were unable to maintain and exercise their skills in the absence of spare parts and of access to the means of keeping their skills current when technology is rapidly changing.[24] Capital investment under the Australia – PNG Incentive Fund had significant design flaws.

4.4 Technical assistance and human resources

TA has been extensive and wide-ranging, accounting for nearly half of AusAID expenditure. Although it made positive contributions, some of which have had lasting impact, the team's judgement is that the results are not commensurate with the level of spending. Expenditure of A$150 to A$200 million on TA has not produced a step improvement in performance or capacity. A better balance between TA and operating costs would arguably have achieved more.

TA in PNG has had a number of objectives, both explicit and implicit:

1. *Developing individual or organisational capacity*, within the limitations of existing policy and institutional arrangements. Much of the TA has been in the form of individual advisers working with government counterparts. Research on TA effectiveness has for many years argued that the counterpart approach is one of the least effective models of skill transfer,[25] and it is a little surprising to find that the CBSC, a program intended to be innovative, still places such reliance on it. It is expensive, it depends on advisers being able to pass on skills and counterparts willing and able to learn from them, and requires counterparts to stay in Post long enough to justify the cost of building their capacity. Most important, success depends on the assumption that capacity building will lead to improved performance, but (especially in PNG) the main causes of poor

[24] Discussions during Milne Bay and Western Highlands field visits.

[25] The counterpart model has been 'long recognized as being a highly imperfect instrument for transfer of know-how.' (Berg, E—lead author of the major World Bank evaluation of TA produced in 2000).

performance are not lack of skills but rather deeper-seated incentive, institutional and resource problems.

2. *Supplementing government capacity by filling skill gaps.* In earlier years, some capacity provision involved the supply of specialists with skills unavailable in PNG. For example, long-term development of the medical school was initially based on the presence of senior faculty staff from Australia, although successful capacity building has enabled these posts to be localised. However, capacity provision has mainly involved the supply of PNG nationals to fill positions for which there is a requirement, e.g., the immunisation program has a requirement, but no established position. The majority of staff paid for under the CBSC program are PNG nationals. It is a pragmatic way around the bureaucratic constraints of the government system, but it would be more cost-effective and sustainable to overcome the procedural blockage and have Government recruit and pay staff directly. This would save the costs of the AMC and give staff job security and a career path.
3. *Substituting for government capacity that nominally exists but is not working effectively*, normally because of the problems associated with the incentives discussed in '1' above. This frequently happens by default, when frustrated TA advisers end up doing the job in preference to providing advice that is not acted on. Sustainable benefits are unlikely to be achieved in the absence of action to address the deeper problems.
4. *Developing policies and systems, and supporting their introduction.* Success depends on there being sufficient government ownership to enable the reforms to be implemented, and sufficiently broad support for them to be sustained. The WCHP was an example of an approach that introduced new and more effective systems for service delivery within existing arrangements but without confronting major vested interests. It operated on a big enough scale to effect systemic change, and was able to finance the full package of inputs needed for delivering the program. It operated in all provinces from health centre to aid Post (community) level. The WCHP took a comprehensive approach to developing guidance at all levels, providing competency-based training and support for staff to use the tools, and building the capacity to sustain the required training. Many of the tools and approaches developed are still very much in evidence. It nevertheless suffered from limitations within the wider institutional environment; in particular sluggish growth in financial resources and continuing problems of drug supplies which prevented it from having a significant impact on service delivery.

   On the big policy reforms, AusAID TA has played an effective support role for reforms initiated within Government, but has been unable to force the pace where commitment is lacking. Recent strong government leadership on issues such as the reform of fiscal and institutional relationships with provinces and the procurement and distribution of drugs has provided an environment in which TA for difficult reforms can be effective. Earlier efforts to support drug procurement did not succeed because the leadership was at that time unwilling to address corruption and inefficiency.

   Where there is no willingness to reform, or where support is fragile, there may be scope for reinforcing the pressure for change by building the policy advocacy capacity of civil society. The performance of staff working in the health service is likely to respond positively to demand from communities for better services, and may respond to pressures and independent monitoring from faith based and other civil society organisations.
5. *Using TA to administer donor support.* Australian aid, through the CBSC, finances a Secretariat established specifically to support the financial management of donor pooled funds. This

arrangement has the unintended consequence of undermining government capacity by by-passing it and drawing resources away from building and managing the permanent government systems that will need to function long after donor funding has ceased.

The health workforce has been relatively neglected, especially for front-line staff, with insufficient staffing budgets and insufficient attention to human development planning and staff incentives—leading to staff shortages and forced closure of aid Posts. Closure of these Posts has risen gradually but steadily since 2004 (when available records begin). It is estimated that 827 or nearly one-third of all aid Posts were closed in 2007, up from 730 (27 per cent) in 2004. While good progress has been made on strengthening the specialist medical work force (notably in the paediatric and surgical specialties), this represents only a small proportion of overall human resources for health. The support to training institutions was not comprehensive or part of an overall strategy. Insufficient attention to HR planning, staffing budgets and incentives have led to extreme shortages among obstetricians, midwives and all categories of front-line health staff, contributing to PNG's poor obstetric indicators and the closure of health facilities. The NDOH recognised this dilemma by making HRH the overarching theme for this year's National Health Conference.

Table 4.4 AusAID support for technical assistance and human resource development

Issue	Strengths of AusAID support	Neglected or weaker areas
TA	Some evidence of positive impacts across most aspects of health services, from design and support of detailed plans, systems, operational guidelines, and support for curriculum development and in-service training. TA has also supported staff in critical line positions, notably in immunisation.	Not in line with MTEF priority that envisaged reduced TA to release funding for operating budgets, spending such a large share of the budget on TA has high opportunity cost to service delivery. Lack of impact on service delivery suggests TA was not very effective in helping staff plan, adapt, manage, coordinate, argue for resources etc. The plans are too detailed to be useful.
Medical research	The IMR core funding and TA has produced an effective institution producing high-quality research.	Though research may be high quality, the IMR has achieved limited impact on health policy and practice in PNG—greater focus on national health priorities[26] and better integration in the NDOH's planning and policy processes would assist.
Human resources (HR)	Good work on training curricula (e.g., for community health workers, village health volunteers and specialist doctors). SMHS positions previously filled by expatriates have now been localised. PNG is now self-sufficient for surgical and some sub-specialties. All provinces have at least one trained paediatrician. The SMHS has introduced a Master's Program in Rural Medicine, aimed at providing essential clinical, management and public health skills for doctors seeking posting at the provincial or district level.	There are insufficient health workers to staff rural facilities. An extreme national shortage of midwives, obstetricians and gynaecologists compromises PNG's ability to respond to the crisis in reproductive health—especially the high (and probably increasing) MMR. Although project support has been provided to the SMHS for almost 20 years, Australian assistance has only recently begun to address the need for core institutional support.

4.5 Broader participation: a neglected area?

The trust account payments made direct to church hospitals have helped to sustain the church services that account for nearly half of service delivery in PNG. It is arguable that more might have

[26] AusAID review.

been done to involve other partners in finding, and learning from, locally adapted solutions on how best to deliver services and how best to strengthen accountability by reinforcing the civil society and community role.

Table 4.5 Participation

Issue	Strengths of AusAID support	Neglected or weaker areas
Mix of service providers	Trust account support has sustained church services that were not getting resources through the provinces.	Problems of coordination remain in some provinces; there is a need to improve church expenditure and performance reporting. There is scope to support Government of PNG interest in further contracting of FBO/NGO and the private sector to deliver services (and strengthening umbrella organisations to facilitate this). There was also scope for strengthening the CMC to play a much more strategic role and link work done under the CPP more effectively to health policy.
Engaging civil society		There is scope to build capacity at community and national level to strengthen advocacy and voice, social accountability, Monitoring and evaluation, learning from more diverse experience and building more effective links with the Building Demand for Better Governance initiatives.

4.6 Adaptation and learning

AusAID does not appear to have developed a deliberate or focused strategy for systemic learning and sense making across initiatives, programs and sectors, to inform ways of working.

Part of the problem is that that the monitoring and evaluation system for TA 'appears to be directed towards fulfilling accountability requirements rather than a tool for learning about and modifying approaches to TA'.27 It was also argued to the team by existing and former employees of AMCs that linking targets to payment can lead to the problem that 'what gets measured gets done', resulting in a tendency to over-emphasise verifiable and reportable activities such as planning and off-the-job training and workshops.

Table 4.6 Learning and adaptation

Issue	Strengths of AusAID support	Neglected or weaker areas
Adaptation and learning	A number of initiatives are supported directly or indirectly by AusAID—such as the IMR, the CPP, the CBSC regional meetings in some provinces, the Consultative Monitoring and Implementation Council (CMIC), and the NEFC cost of services analysis which have contributed to improved learning, and some adaptation of approach.	No systematic comparing of experience across provinces, little formal feedback of experience, little involvement by civil society and churches in review of what works. Within AusAID, weak exchange and cross sector linkages and integration (e.g., between health, gender violence, governance and peace building) and potentially poor coordination and duplication (e.g., between the CBSC, Social Network Services (SNS), planned Regional Health Teams, and proposed Building Demand for Better

27 IMRG, report no. 3.

Issue	Strengths of AusAID support	Neglected or weaker areas
		Governance Program satellite centres). Target-driven culture, with payment linked to achieving specific milestones, can preclude experimentation, and discourage honest feedback by focusing on achieving deliverables specified in the contract, even though changing circumstances might have reduced their relevance.

CHAPTER 5: OPPORTUNITIES AND CHALLENGES

5.1 Revitalising health service delivery

Dealing with fragmentation

PNG's health care system is characterised by fragmentation along several dimensions. There is disconnect between hospitals and public health programs, between priority programs and basic health services, between government, churches and other non-state providers, and between the centre and different levels of the health care system. Under the Organic Law on Provincial and Local-level Governments, province, district and wards are the responsibility of different arms of Government.

The newly adopted 2007 Provincial Health Authority Act, gazetted in February 2008, is generally seen as the means for resolving most of these problems, bringing together not only hospitals and rural health services, but integrating Government and non-government providers within a coherent health care system. Because it is voluntary, there is no guarantee that the Act will be implemented throughout the country. At present, eight of 20 provinces have signalled their willingness to engage in the process of establishing PHAs. To increase this number will require skilled political negotiation.

The NDOH is putting in place a Provincial Health Streamlining (One System Tasol) Project to assist the provinces in implementing the PHA. It will be critical that the project team links up with other closely related initiatives, such as the Public Private Partnership Unit referred to in the Corporate Plan, and the proposed Regional Support Teams. Some streamlining of these newly created NDOH units/projects should be explored early on since in varying degrees they are all concerned with support to provinces and with better coordination with non-state actors in the health sector. Closer links with the Provincial Performance Improvement Initiative should also be explored.

Standards and guidelines will need to be revisited to provide a sound and realistic basis for a revitalised health service, and to inform performance frameworks which in turn would form the basis not only for new MOUs and contracts with non-state providers but also for possible performance agreements between the Provincial Health Authority and districts. Analytic work on appropriate mechanisms, informed by international experience, will be useful to define next steps.

Another issue deserving attention is the entire planning framework. The interrelationships between different plans and partnership agreements as set out in the new Corporate Plan need to be further scrutinised and perhaps simplified. With more flexible funding to be provided directly to district and health centre managers, agreeing on broad-based strategies and monitoring results achieved with available funding will become more important than the production of highly detailed plans and budgets.

The conditional grants that will be introduced in the 2009 budget in order to implement the NEFC proposals and provide an opportunity to improve provincial planning and relate it to realistic budgets. Whether it does so in practice depends in part on ensuring that the conditions attached to the grants are helpful in ring-fencing money for the health sector, without being so restrictive that they become difficult to use. The NDOH needs to engage with the NEFC on the design of the grants, including any required revision to the chart of accounts, to get the balance right. Ideally, provincial health departments should be consulted. If it is too late to do so before the scheme is launched in the 2009

budget, it will be important to review it with provinces during 2009, in time to permit some adjustment in the light of emerging experience.

Strengthening the provider network

The major non state actors in the formal delivery of services are the churches. Churches manage about 45 to 50 per cent of the health service, and a greater proportion of rural services.28 Churches also run two of the country's six universities and play a significant role in training health workers. They run six of the nine training schools for nurses, and 14 training schools for community health workers. Around 85 per cent of church facilities are wholly financed by government subsidies, with one to five per cent estimated to be coming from user fees.

There is a growing NGO sector in health, focusing mostly on HIV, with community-based and civil society organisations taking a broader approach to social development, social marketing and advocacy. Corporations are becoming increasingly important partners, undertaking projects under the mantle of Corporate Social Responsibility (for example as part of the ADB Rural Enclaves project) and providing health care not only for their employees but also for surrounding communities. The size of the private for-profit sector is unknown, but thought to be growing (especially with the arrival of private health insurance and employer subsidies to support access to private medical care for the large Australian and other expatriate population), and in need of adequate regulatory mechanisms.

One of the most burning issues in health service provision is coordinating Government and church health services and ensuring adequate funding for both. There continues to be some controversy regarding the relative performance of Government and church-run services but there does appear to be consensus that on the whole the churches do better in supporting and motivating their staff and in relating to communities. Some success factors cited by churches and cited in reviews of their work include:

> more effective recruitment, discipline and management of staff and facilities, and higher morale than government health staff
> an ability to retain staff through being able to offer non-wage emoluments such as housing, garden space, water and in some cases solar-powered electricity, and email radio access, as well as proximity to a church community and greater job satisfaction
> a greater degree of autonomy and financial flexibility
> being embedded in communities as part of people's lives, culture and spiritual health, and building from this

High performing provinces also exhibit a number of these characteristics, suggesting experiences may have wider relevance for Government Health Services facing challenges of staff retention and access to flexible funding, and might therefore inform policies in this area.

There is also a debate as to whether the government subsidy churches receive from the NDOH through the CMC is sufficient and whether churches experience undue difficulties in accessing HSIP funds.

[28] IMRG, report no.3, November 2007.

CMC members wish to ensure that the new Provincial Health Authority Act does not lead to them being funded from the provincial budget rather than directly by the NDOH as at present. The NDOH has proved a far more predictable source of funds. Similarly, church providers are extremely wary of the proposed Christian Health Services Act which seeks to promote a more integrated national health system, because they fear this would embroil them in overly cumbersome management and accounting systems and expose them to greater manipulation by local political interests.

Two aspects require attention. The first is the need to strengthen the skeleton CMC Secretariat to enable it to perform better as an umbrella organisation for Church Health Service providers, monitoring the performance of its members and engaging more effectively in policy dialogue with the NDOH and provinces as well as with the individual churches that make up their membership. The second relates to the new Public-Private Partnership (PPP) Unit and its approach to working with all non-state providers, including service delivery NGOs such as Susu Mama and St John's, and the possible use of performance-based contracts.

Strengthening district health systems

The fundamental issue for improving health service outputs and thus health outcomes is the establishment of functioning district health systems with a network of well-supported government and church health facilities coupled with outreach and community engagement. This is unlikely to be achieved by yet more planning and more workshops. However, there is a case for developing strategic district health plans better suited to guiding action than the AAPs which are often little more than an annotated budget with numeric targets rather than a strategic plan supported by a realistic resource envelope.

Supervisory visits from the provincial and district level districts to health facilities, coupled with on-the-job training and on-the-spot trouble shooting, will be essential for the system to function, for health workers to be motivated and adequate standards of quality of care to be provided. Regular supervision, mentoring and monitoring will also be critical from provinces to districts and from the NDOH's Regional Support teams (whether located in Port Moresby or in regional hubs) to the provinces.

HR is a key issue. Given the current absolute shortage of staff, about to be exacerbated by some 20 per cent of the workforce retiring within the next few years, the personnel requirements for adequate staffing of rural health facilities and for introducing an intensified system of support supervision, will be hard to meet. There is a need for an accelerated program for training community health workers and nurses.

Government may also wish to contract in service delivery NGOs to help meet the current need. At present, most NGOs focus on advocacy, social marketing and HIV but it would be worth exploring whether there are more health workers currently not employed by Government or by the churches (for example retired staff) who would consider working as part of an NGO if there were a market for doing this. Improvements in working and living conditions—with the latter largely beyond the control of the health sector—may attract more new entrants to the health sector, but will take time, particularly in remote areas. The development of the new National Health Plan provides an avenue for thorough exploration of these issues.

From district and community pilots to scaling up

Diversity is a much discussed key feature of PNG and calls for exploring different service delivery models suited to different environments within the country. A necessary but not sufficient condition for local level innovation in service delivery is local management of funds. Plans have been announced to begin a series of trials focusing on channelling resources directly to the district and to health centres in an effort to ensure that money and supplies are reaching where they are needed. The planned pilots offer an opportunity to also consider and experiment with different delivery models featuring varying staffing patterns, skills mixes, approaches to supervision and referral, and training for management, clinical and communication skills.

The team also saw some good examples of community-based health-for-development initiatives that have, by and large, arisen organically; sometimes prompted by the closure of the nearest aid Post, and sometimes proactively with support from a faith-based organisation or bilateral donor. It will be important to support and harness the way these programs address health promotion and environmental health priorities, especially during the expected lengthy process of rehabilitating other aspects of district and community level health services.

It will also be critical to ensure that the results of pilots are communicated early on and lead to scaling up of similar efforts across the country, with a built-in mechanism for sharing experiences and realistic estimates of resource requirements for large-scale implementation. Provincial teams in collaboration with the NDOH have a critical role to play in ensuring this happens. Periodic provincial and regional conferences, where district and provincial teams review progress and organise mutual support, are an excellent means for spreading innovation and should be revived or introduced.

Tackling medical supplies

Despite long-standing efforts and significant donor contributions, medical supply problems continue to hamper the effective delivery of health services. The establishment in late 2007 of a Ministerial Task Force representing both Government and development partners represents a real opportunity to take a more comprehensive approach to tackling the problem. The recommendations of a subsequent Technical Review Mission of international experts, outlined in a roadmap for reform, have been comprehensively accepted and adopted

The challenge now is to achieve some quick wins balanced with the relentless pursuit of long-term objectives. Given intractable problems of governance, contracting out elements of the required work is a key part of the solution. It is now up to Government and donor partners to move whilst seeking further consensus and agreement from key stakeholders. A working group on cost effective, quality and timely provision of medical supplies is now being established, and among the first steps to be undertaken is the continuation of the kit system for the next one to two years, as well as the immediate engagement of a Procurement Agent to guide the medical supply chain management function and assist the transition to outsourcing distribution.

Tackling the high maternal mortality rate

If a viable strategy to combat maternal mortality is to be put in place, it will be critical not only to effect the re-opening and effective functioning of health facilities close to communities, and to develop viable community—and facility—level strategies for Emergency Obstetric Care, but also to

better understand the relationship of MMR with factors such as age of marriage and first childbirth, polygamy, lack of access to family planning and illegal abortion. It will also be necessary to address demand side barriers, including the high out-of-pocket costs of getting to a facility and the high charges at some facilities.

With maternal deaths now the top priority to tackle, there is need for urgent action, including analytic work taking on board relevant international comparative information. The Minister has established a Taskforce on Maternal Health—it will be important that it develops clearly targeted recommendations.

Improving management and local learning

There is a widely held view that the system as a whole is not good at recognising what works and applying it appropriately. The current planning and monitoring and review process is over-deterministic,29 and emphasises upward accountability to the NDOH and development partners. Observers both inside and external to the health system have argued that there needs to be far more emphasis on developing solutions that will work with political, cultural, topographic and other constraints at the local level, and that can adapt to changing circumstances. This would be in line with much recent thinking and experience,30 and would also better reflect the diversity of PNG and the existence of a political culture based on the creation, use and maintenance of effective relationships.31

This requires a more flexible approach to planning and financial management, with a stronger focus on accountability for service delivery. It also means better capturing the lessons of experience, particularly the examples of successful innovation that are reaching a relatively large number of people.32 It also requires effective channels for sharing experience between communities, districts, provinces, Government and church facilities,33 and between the NDOH and the central agencies34 (Box 5.1).

The management arrangements nationally do not support timely problem solving. The CMC could be strengthened to play a greater coordination and management role at provincial and district levels. Similar mechanisms could be put in place to support government-run services and to encourage cross fertilisation. These arrangements should not be TA led, but rely on local capacity.

Box 5.1 Independent Monitoring and Review Group comments on learning from best practice

'The system is variously described and labelled as lacking in accountability, being in a state of inertia, lacking in transparency, and debilitated by competition (for funding) between stakeholders. However, situations were also found where (i) services/staff were accountable to their own villages or to district committees; (ii) inspirational leaders were identified, who were challenging the most destitute of situations with energy; (iii) collaborative practices between the public health and hospitals, between sectors, between government and private were evident.

29 The IMRG called this approach 'The Planners Dream'. See IMRG report no. 3 p.

30 Eyben R (2005), 'Donors' learning difficulties: Results, relationships and responsibilities', *IDS Bulletin* vol 36 no. 3 September, IDS (UK) or Guilt I, November (2007), 'Assessing and Learning for Social Change: A Discussion Paper', Institute of Development Studies (UK).

31 Harris (2207), PNG;'A Nation in Waiting, The Dance of the Traditional and Introduced Structures in a Putative State', World Bank.

32 For example, Pelto, M & Garap, S (2008), 'Towards Effective and Legitimate Governance: States Emerging from Hybrid Political Orders—Southern Highlands Province Draft Report', Australian Centre for Peace and Conflict Studies, See Hauck et al (2005), 'Ringing the Church Bell', ECDPM.

33 IMRG report no. 3, p.13.

34 IMRG report no.3, p. 20.

The challenge is to build on situations of best practice: (i) promote transparency and accountability through dissemination of information about public expenditure; (ii) provide services with a voice and advocacy through supporting OICs to develop health committees, with finance, training and guidelines; (iii) establish a Health Ombudsman, situated in a Complaints Unit within the NDOH to investigate and advice on issues that reach national level; (iv) identify, acknowledge, resource, and build on people and services of "best practice" through the development of model health centres; (v) the dissemination of achievements through the National Health Radio Programme; (vi) the development of learning networks in Districts.'

Source: IMRG (2008), report no. 4 p. 7.

5.2 Developing the sector-wide approach

The evolution of Australian aid has been from budget support in the post-independence period, towards project approaches that imposed high transactions costs and faced major sustainability issues, towards an increased focus on sector-wide working from around the year 2000.

The principles for a well-functioning SWAP are also relevant to all forms of aid, including project approaches, and are similar to the principles endorsed in the Paris Declaration on aid effectiveness and the PNG Declaration on Aid Effectiveness. The team therefore used them to review how the Australian aid approach to supporting the health sector has evolved alongside PNG health policies and plans, and the future opportunities and challenges.

Clear, nationally owned sector policy and strategy

The core of the SWAP approach is that Government and development partners jointly support the Government's policy, strategy, and expenditure program for the sector. In the case of PNG, this is the National Health Plan 2001–10.

The development partners will expect the right to be consulted on the content of the policies and plans and on the arrangements for implementing them, but the point of the exercise is to provide coherent arrangements for supporting a single plan that is owned by the Government. There is a process for jointly identifying what needs to be done and the financial and human resources required for doing it, and a joint process leading to agreement on how those resources will be financed and procured, and prioritised to fit within the resource envelope actually available.

Systematic arrangements for funding the strategy

To plan sustainable services, the NDOH needs to know what resources it has available, and needs to be able to allocate them to support the priorities of a health sector plan. This is the spirit of the Paris Declaration, and also of the PNG Declaration on Aid Effectiveness.

There is no single expenditure plan or budget at any level of the system. Multiple-funding routes that are not brought together make it difficult to program resources to the priorities of the plan. Although the HSIP Finance Committee has belatedly begun to discuss overall funding, it has not focused on identifying where the funding gaps are on the expenditure side and programming resources towards filling them. As argued in section 4, AusAID has exacerbated the problem by not reflecting the MTEF priorities when allocating funding, and by not reporting future spending intentions or actual expenditure.

Although the strategic directions focus strongly on service delivery in rural areas where more than 80 per cent of the population live,35 resource allocation in PNG's budget does not fully reflect service delivery priorities—urban services receive a larger share (36 per cent) than rural services (33 per cent), while the bulk of non-salary spending on 'rural services' is actually spent at province level, with little reaching districts and rural health facilities.36

The trust account conditionality has helped to increase province spending on goods and services, but a crude six per cent across all provinces does not relate spending to costs or to availability. There would be a strong case for allocating a major share of HSIP resources in the same way as proposed for the function grant, to accelerate progress towards all provinces having the finance required for delivering minimum service levels. The NEFC is reluctant to see donor funds used for core service delivery functions, but they already are in the health sector (as outlined in Table 3.1, donors finance more than half of goods and services spending). The team has seen that the current commodity windfall is unlikely to be sustained. Without donor resources, PNG will be able to make only slow progress towards enabling all provinces to deliver the NDOH defined minimum services.

AusAID has sometimes argued that aid should avoid financing core running costs for fear of creating aid dependence and undermining service sustainability. The team's view is that helping PNG to achieve a better balance between capital and current spending will improve sustainability, since it avoids adding to the running cost burden in the way that investments in new buildings and equipment would. For similar reasons, aid dependence could more easily be reduced over time if PNG avoids creating an excessive health sector infrastructure. Aid can be phased down as and when the growth of domestic revenue sources permits, and the SWAP dialogue provides a forum in which future funding can be discussed. The major advantage, though, is that concentrating AusAID on the highest spending priorities, irrespective of whether they are capital or recurrent in nature, will have the biggest positive impact on service delivery. This is also helpful to building sustainability in the broadest sense of establishing an effective state that commands the allegiance of the population.

A performance monitoring system that measures progress and strengthens accountability

By the standards of many other SWAPs, the NDOH has a good performance monitoring system, based around easy-to-understand forms filled in by more than 90 per cent of health facilities in PNG. The data is consolidated and published annually in the Assessment of Sector performance produced as an input to the health sector review. It includes data on health outputs, expenditure, financial management, and management indicators such as the number of supervisory visits. The data is all disaggregated by province. it is certainly used at national level—for example for identifying the best performing and most improved provinces and to determine incentives in the form of additional allocations of HSIP-TA resources. Milne Bay is also using the detailed returns at province level to compare and reward better performing facilities, and reported on the positive impact ranking had on staff and how this encouraged staff to want to improve their standing. Milne Bay is consistently the best performing province and is an exception, but this shows how better managed provinces can make use of the data.

Major gaps in existing data include:

[35] National Statistics Office of Papua New Guinea, Population and Social Statistics, www.nso.gov.pg

[36] 2006 PHS spreadsheet, provided by NDOH planning and administration.

1. a lack of gender disaggregation of any of the indicators
2. data on outpatient contacts does not include aid posts, still a major source of services in some provinces.
3. no hospital in-patient service statistics are included.
4. management data only covers provincial health offices; it does not include supervisory visits by churches or by district health offices.

Broad consultation mechanisms that include all significant stakeholders

There was substantial consultation undertaken in preparation of the health sector plan, and the SWAP itself has formal consultation mechanisms that include the major stakeholders. The main problem is how best to capture the views of those delivering services at lower levels of the system, both Government and non-government facilities. Although provincial representatives are invited to the National Health Conference, the limitation on numbers and the crowded agenda means this cannot meet the need. Other SWAPs, such as Ghana and Nepal, address this problem by preceding the national reviews with regional reviews that collect views for feeding in to the national forum. This is already happening to some extent through the regional teams under the CBSC, but it could be formalised as part of the annual SWAP cycle.

AusAID supports the CMIC—a mechanism designed to improve broad-based consultation with non-state actors in the processes of policy formulation and implementation. AusAID, along with others, has supported CMIC's Health Sector Sub-Committee37 to:

- improve liaison with central agencies to support the health MTEF
- secure changes in government health policy on financing health worker salaries and operational grants being paid on time directly to each church service account through the CMC
- lobby more effectively for an increased health budget
- lobby Government to include health projects under the tax credit scheme supported through resource development companies.

The CMIC has also attempted to broaden consultation through national and regional development forums, and is often requested to organise district-level forums. The CMIC is currently developing a project on social accountability and awareness-raising around the District Support Grants.

However the CIMC notes, as other observers do, that there are few civil society organisations able to effectively engage on policy consultations and undertake budget monitoring and analysis at a strategic level. As such the linkage between effective local community driven processes and higher levels of the systems are not as strong as they could be. There is a potential role for aid donors in helping to strengthen them, as well as build linkages between existing agencies, both inside and outside the health sector—such as the CMC, the Community Coalition Against Corruption, the PNG Media Council and Transparency International.

[37] Andrew, M (2008), 'Connecting Communities with Government', Paper Presented to the Workshop on Participatory Governance conference at DWU, 30 June to 1 July 2008.

A formalised, government-led process for aid coordination and dialogue at the sector level

Formal structures for coordination and dialogue with development partners are in place—two annual reviews, one reviewing performance and the other program resources; regular independent monitoring through the IMRG; and regular meetings of an operations committee and a finance committee. These formal structures have not, however, been effective in taking action on major issues. The recent establishment of a high-level steering committee with a focus on a small number of critical issues may be more effective, but will need continuous effort to sustain it.

The recent signing of a Partnership for Development between the governments of Australian and PNG provides a further opportunity to focus high-level attention on a more limited agenda of health sector issues. A sequence of actions needs to be completed before the partnership can move to the next level in the health sector, with a secure and regular supply of drugs being a key element that must be in place before investment of significant additional resources can bring about improved health service delivery.

An agreed process for moving towards harmonised systems for reporting, budgeting, financial management and procurement

Progress has been minimal, with the pool fund a major obstacle rather than a useful first step. The lack of progress is contrary to PNG expectations (e.g., the 2004–06 MTEF envisages an increased focus on using government systems while strengthening them). The problems experienced by HISP–TA are not out of line with the experience of other pooled funds, although the extent of the expenditure shortfall reinforces the other reasons for wishing to see a rapid transition to the use of government systems (Box 5.2).

Box 5.2 International experience of pooled funds

> 'To develop systems for supporting service delivery nationally with a common fund requires efforts similar to those needed to strengthen the mainstream government systems. Thus, common funds face the same capacity constraints and weaknesses as the systems that they attempt to side-step. Moreover, once common funds are created, they often, de facto, overshadow or even replace any domestic delivery systems that exist. As a result, the latter get little attention. Once created, this arrangement is difficult to take apart and the transition towards use of domestic systems may become permanently blocked.
>
> ... our research finds that in a typical low-capacity environment, common funds can focus the efforts of several donors and the lead sector institution for a lengthy period solely on the design and management of the common fund. This can have the effect of diverting attention away from vital sector policy issues and the strengthening of mainstream systems. Common funds can easily weaken domestic accountability systems. At important multi-stakeholder events, such as joint reviews, they can draw attention to the accountability demands of the funding modality itself …
>
> ...For all these reasons, the vision of common funds as 'transition mechanisms' towards more effective aid to service delivery is destined to fail. Common funds are typically much bigger operations than the individual projects they replace. To the extent that they retain many features of the traditional project approach, the detrimental effects on the coherence of policies and strength of systems in the host sector can therefore be worse than before. The move to common funds can do more harm than good.'[38]

The decision to set up pooled funding off-budget as a parallel fund stemmed from the ADB, but AusAID has not made significant moves towards using government systems. This is partly due to

38 Zainab Kizilbash Agha, and Williamson T, February 2008, Overseas Development Institute briefing note 36, 'Common funds for sector support, building blocks or stumbling blocks?

well-founded fears of the fiduciary risks. PNG is ranked 162 from 179 on the corruption perception index, and there are risks at all levels of funds being delayed, used for other purposes than intended, not reported on or accounted for properly, or misappropriated. Nevertheless, it is the government system that will be there long term and needs to be made to work. There is plenty of experience globally of approaches to strengthening government systems and providing checks and balances to enable them to work better.

Potentially relevant reforms include:

1. Allocating HSIP-TA in line with NEFC recommendations.
2. Move immediately to acquittals based on statements of expenditure reconciled to bank statements, abandoning the practice of 100 per cent on-site checking of original documents and basing the main assurance of financial accountability on annual audits. Commercial accounting firms could be contracted to conduct these on time. SWAP partners would need to ensure follow up of audit findings. During the year, less frequent visits should be used to conduct selective checking of transactions, weighted to provinces and the types of transaction posing the greatest risk.
3. Begin using the same financial management system as central and provincial government, sequenced to start with those provinces meeting minimum standards of financial management. HISP-TA money for those provinces would be disbursed and accounted for in exactly the same way as the additional grants for goods and services under the NEFC proposals. (The NDOH will wish to discuss with the NEFC and the provinces how best to ensure funds are spent as intended).
4. Implement and, once the system is shown to work, rapidly scale up the pilot of paying a portion of the grant direct to district or facility accounts. It will be important to liaise with the SNS program, which is also working to strengthen district financial management and to provide budget resources through district treasuries.
5. Supplement formal accounting with less formal approaches—conduct sample tracking surveys to check that funds arrive on time and in full where they are intended, and are appropriately used and accounted for; greater transparency, with details of budgets and in-kind receipts prominently displayed and announced in the media where appropriate; reinforcing the role of community representation and civil society to assess service standards and hold those responsible for delivery to account.
6. To minimise specific risks to the donor without holding up disbursements, AusAID could follow World Bank practice and call for repayment of amounts found to have been misappropriated or that cannot be adequately accounted for. Unlike now, the whole budget would not be hostage to the last few receipts needed to complete an acquittal. Instead, future disbursements would be reduced by the amount in dispute. This would not mean turning a blind eye to serious cases, but would reduce disruption caused by relatively minor accounting errors.

Any of these options would need to be accompanied by changes to the AAP process, to make it more useful for local management.

5.3 Technical assistance

The IMRG reviewed the approach to TA in their 2007 report and identified issues relating to the CBSC, including the lack of NDOH ownership, doubts about absorptive capacity and whether the

level of spending was excessive relative to other uses of the funds, a lack of innovation in the approach to providing support and a relatively narrow field of recruitment. There is a need for greater integration with government policy and plans. The CBSC currently has its own board, chaired by the Ministry with AusAID and the contractor represented, and has its own annual plan, prepared and approved independently of the overall NDOH planning and budgeting processes. This makes it harder than it needs to be to develop coordination between TA and other inputs.

In terms of the effectiveness of support to service delivery within provinces, the TA approach has gone through several evolutions and although there have been some local successes in addressing specific local problems, the overall results have been modest because the fundamental problems impacting on provincial health services have yet to be addressed (e.g., management relationships, access to drugs, and sufficient and timely finance). The required vision on how to support provincial services is now emerging through the provincial health authority act, the approach to provincial health grants and a clearer recognition of the responsibilities of provincial and district administrations. Regional teams to support the provinces are envisaged in the NDOH's Corporate Plan, and a close relationship with the CBSC teams and the Provincial Performance Improvement Initiative could be one way to provide ongoing support.

These experiences highlight the importance of embedding the work on capacity more within the overall Government of PNG-led process of sector reform and development, and within the partnership arrangements related to the SWAP. It is the SWAP reforms and action plans that should determine what capacity building support is needed, (though those plans themselves need to be reformed, to become multi-year rolling plans that are more strategic and realistic as regards to capacity and budget). The available support should also have built-in flexibility so it can respond to unanticipated needs. It should also be a joint enterprise between the Government of PNG and the DP partners.

CHAPTER 6: RECOMMENDATIONS

The main purpose of this country case study is to inform the synthesis—and the team's Terms of Reference do not call for specific country recommendations. The team offers these suggestions, but acknowledges that they are based on a short time in-country, and that many others have trodden the same ground in greater depth.

AusAID support

It is extremely important that AusAID supports the SWAP it helped to create by:

1. Shifting decisively towards channelling support to the Government's sector strategy, announcing multi-year funding levels in advance, supporting activities identified in the MTEF and the annual activity plans, and reporting actual expenditure.
2. Reforming HSIP-TA to ensure that planned funds can be spent, and moving rapidly towards using government financial management procedures. The suggestions in Section 5, and examining the experience of sector-budget support in countries such as Uganda and Ghana, may prove helpful.
3. Allocating HSIP-TA for provinces using the NEFC approach to accelerate progress towards all provinces having sufficient funds to deliver minimum services.
4. Supporting early implementation of piloting direct support to district treasuries and health facilities, including an emphasis on civil society monitoring and scaling up if successful.
5. Reducing the share of AusAID spent on TA, and bringing the TA program under Government of PNG leadership and fully within the SWAP.

The SWAP

6. Promoting opportunities for exchange of experience, including provincial and regional conferences involving Government and non-state actors.
7. Developing broader approaches to policy dialogue, including building the capacity of organisations such as the CMC and the CMIC to engage in advocacy.
8. Considering re-visiting the monitoring framework to introduce more gender disaggregated targets and indicators.

AusAID ways of working

9. Developing a more explicit learning strategy which allows 'weak signals' of success and failure to be spotted earlier and adaptation made more readily.

ANNEX 1: LIST OF PEOPLE INTERVIEWED

Name	Designation/organisation
Central Government	
Clement Malau	Secretary, NDoH
Pascoe Kase	Deputy Secretary, National Health Policy and Corporate Services, NDoH
Timothy Pyakaliya	Deputy Secretary, NDoH
Elva Lionel	Executive Manager (Corporate/HSIPMB), NDoH
Victor Aisa	HSIP Secretariat, NDoH
Vali Karo	Medical Supplies/HSIPMB, NDoH
Mr. Igo Baru	Medical Supplies, NDoH
Mr.John Levi	Curative Health, NDoH
Mr. Paul Aia	Disease Control, NDoH
Mr. Florian Yambilafuan	Director, Human Resources management, NDoH
Mr. Peter Eapaea	Finance Management Branch, NDoH
Dr. Garry Ou'u	Executive Manager Medical Standards, NDoH
Mr. Coleman Moni	Manager—Strategic Policy, NDoH
Dr. Isaac Ake	Adviser, NDoH
Angelica Braun	Director Planning, NDoH
Anna Irumai	Director, Monitoring and Research, NDOH
Victor Aisa	HSIP Secretariat, NDOH
Dame Carol Kidu,	Minister, Community Development
Jda Yuki	HR Manager, DPM
Thomas Webster	Head, National Research Institute
Paul Barker	Director, Institute of National Affairs
Dr. Nao Badu	CEO, NEFC
John Uware	Treasury
Manu Momo	Treasury
Elizabeth Tavatuna	A/S Bilateral and Commercial Branch, Treasury
Napa Ipave	A/S Fiscal, Treasury
Michael Awi	Acting Principal Budget Officer, Treasury
Lucas Alkan	A/G General Economic Policy, Treasury
Mrs. Dorriga Henry	Deputy Secretary, Finance
Mr. Zurenuoc	Secretary, Department of Planning and Local Government (DPLGA)
Mr, Russel Ikosi	Deputy Secretary, DPLGA
Mosilayola Kwayaila	Director-Aid Policy, Department of National Planning and Monitoring (DNPM)
Rose Raka Koyama	Assistant Secretary, DNPM
Nicola Blackford	ODI Fellow, DNPM
AusAID	
Margaret Thomas	Minister Counsellor
Susan Wilson	Counsellor—health sector
Bill Costello	Counsellor
Charlotte Smith	First Secretary
Peta Leeman	First Secretary
Gaye Moore	Second Secretary
Jessie Belcher	Second Secretary

Name	Designation/organisation
Margaret George Mavu	Program Officer
Winnie Samoa	Program Officer
Jimmy Morona	Senior Program Officer
Solstice Middleby	Development Program Specialist, Sub-National Strategy
Joanne Choe	Law and Justice
Keith Joyce	Transport
Charlie Vee	Transport
Charlotte Smith	Democratic Governance
Warren Turner	Economic and Democratic Governance
Anne Malcolm	Sanap Wantaim
Peter Izzard	
Susan Fergussion and Susan Ryle	
David Lowe	Education Sector
Other donors and UN Agencies	
Eigil Sorensen	WHO
Geoff Clark	WHO
Neil Brendan	ADB
Kel Brown	ADB
Tessa Temata	New Zealand's International Aid and Development Agency
Marianne Quinin	
Richard Duncan	EPI Technical Adviser, WHO, PNG
Dr Julian Bilous	EPI Senior Technical Adviser, WHO, Geneva
TA personnel	
Jane Thomason	Director, JTI International
Jeremy Syme	Team leader, CBSC
Dr. Maxine Whittiker	CBSC
Ron Hickey	Finance Adviser, CBSC
Brett Kirkwood	CBSC (Madang),
Trevor Gowland	CBSC (Milne Bay)
Jeremy Syme	CBSC (Port Moresby)
Balarishnadas	CBSC
Rex Hoy	PM Office and NEC
James Ogia	Adviser (Sandaun)
Churches and Non-government	
Joseph Sika	Secretary, CMC
Nathan Kili	Deputy Secretary, CMC
Ben Hayward	Baptists, Pacific Project Officer, Baptist World Aid Australia
Trevor Terina,	Health Secretary of the Poppondetta, Oro Province (phone interview), Anglican Health Services
Coretta Naig	Sanduan Provincial Council of Women
Professor Sir Isi Kevau	Dean, SMHS, UPNG
Professor John Vince	Deputy Dean (Postgraduate Studies), SMHS, UPNG
Professor Glenn Mola	Head of Obstetrics and Gynaecology, SMHS, UPNG
Dr Adolph Saweri	Physician, SMHS, UPNG

Name	Designation/organisation
Dr Ikau Kevau	Head of Surgery, SMHS, UPNG
Mr Paulus Ripa	Head, Medical Education Unit, SMHS, UPNG
Prof Mathias Sapuri	President and Obstetrician – Gynaecologist, PNG Medical Society and Pacific International Hospital
Bryan Cussens	CPP, Secretariat, Melbourne
Frieda Kana	Secretariat Coordinator, PNG CPP
Sir Peter Barter	Melanesian Foundation
Michael Douglas	Public Health Specialist
Sandaun Province	
	Provincial Administrator
Peter Ailoung	Planning Adviser, Provincial Government
Ferdinand Rayau	Finance, Provincial Government
Ambrose Sikre	Budget Office, Provincial Government
Simon Amo	Parliamentary Adviser, Provincial Government
Martin Kepi	Commerce Adviser, Provincial Government
Steven Kambase	Provincial Government
Desak Drorit	Provincial Health Adviser, Provincial Health Office
Lou Badni	District Administrator, Vanimo/Green District
Steven Yangs	Fisheries Co-ordinator, Vanimo/Green District
Aimo Opian Sanawe	Legal Officer, Provincial Government
Rose Uri	HIV/AIDS Coordinator, Provincial Government
Anthony Adolph Kajir	Education Adviser, Provincial Government
Julie Kai	Community Development Adviser, Provincial Government
Dennis Monipa	Coordinator Rural Health Services, Provincial Health Office
Paul Dopsie	CEO, Vanimo General Hospital (VGH)
Elias Kapavore	Director, Nursing Services, VGH
Alphonce Yalim	Director Finance, VGH
Dr. Stella Jimmy	Direct Medical Services (Paediatrician), VGH
Father Tomy Thomas	Vicar General, Vanimo Diocese
Michael Kalele	Accounts, Vanimo Diocese
Tom Yuankai	Health Secretary, Christian Brethren Church (CBC)
Ronald Upi	Staff Clerk, CBC
Norah Mourien	Accounts Clerk, CBC
Joe Besa	Office assistant, CBC
Barthasu Kipit	District Health Promotion Officer, Vanimo/Green District Administration (V/GDA)
Anselm Lohonibo	Nursing Office, V/GDA
Gibson Oleh	Acting/District Health Officer, V/GDA
Patrick Tai	Community Health Worker Supervisor, V/GDA
Joswald Enda	V/GDA
Gibson BenJaurion	V/GDA
Milne Bay	
Jack Puri	Provincial Health Adviser, Provincial Health Office
Richard Doana	Deputy PHA, Provincial Health Office

Name	Designation/organisation
Henry Balasi	Provincial Administrator, Provincial Government
Billy Naidi	Acting CEO, Alotau Hospital
Dr Paison Dakulala	Physician, Alotau Hospital
Dr Lucas Samof	Anaesthetist, Alotau Hospital
Dr Noel Yaubihi	Director of Medical Services, Anaesthetist, Alotau Hospital
Dr Westin Seta	Surgeon, Alotau Hospital
Dr Gilchrist Oswyn	Paediatrician, Alotau Hospital
Mary Diudi	Nursing Administrator, Provincial Health Office
Titus Stanley	Coordinator, Family health Services, Provincial Health Office
Wellington Miuu	Environmental Health Officer, Provincial Health Office
Margaret Losane	Family Planning Coordinator, Provincial Health Office
Agnes Tapo	Cold Chain Officer, Provincial Health Office
Rebecca Paul	Coordinator, Safe Motherhood, Provincial Health Office
Jocelyn Philip	Acting Health information Officer, Provincial Health Office
Theresa David	Medical Supplies Officer, Provincial Health Office
Esther Barnally	Coordinator, Dental Health Services, Provincial Health Office
Norbert Lawrence	Nursing Officer, Provincial Health Office
Judith Eddy	Environmental Health Officer, Provincial Health Office
Rex Wai	Assistant Health Extension Officer (AHEO), Kiriwina-Goodenough District
Alex Ilaitia	AHEO, Samarai-Murua District
Elekana Kenneth	District Coordinating Officer, Samarai-Murua District
Wame Yad	AHEO, Esa'ala District
William Joshua	District Health Officer (DHO), Kiriwina-Goodenough District
Alfred Kunwabe	DHO, Samarai-Murua District
Matthias Duambe	Nursing Officer, Guasope (Murua)
Esther Gibson	HEO, Urban Clinic, Alotau District
Jennifer Chare	DHO, Esa'ala District
Ninipe Kua	DHO, Alotau District
Bettina Ilaisa	Coordinator, Catholic Health Services
Olge Philemon	Coordinator, Uniting Church Health Services
Peter Neville	Chairman of the Board, Alotau Hospital
Hayden Abraham	District Administrator, Samarai-Murua District
Thomas Pilai	District Administrator, Esa'ala District
John Tailaweta	District Planner, Samarai-Murua District
Silita Kotauga	District Administrator, Alotau District
Eric Merde	Acting District Administrator, Esa'ala District
Genaia Elino	District Administrator, Kiriwina-Goodenough District
Helen Haluvea	Sister-in-Charge, Samarai CHC
Josita Dadavana	Nurse Dispenser, Samarai CHC
Jeffery Marigita	Community Health Worker (CHW), Samarai CHC
Wesley Madiu	CHW, Samarai CHC
Susan Mosakuna	Nursing Officer, Samarai CHC
Henry Philip	CHW (Disease Control), Samarai CHC
Dehu Oibi	CHW, Samarai CHC
Nusilani Yobi	CHW, Samarai CHC

Name	Designation/organisation
Christopher Katuelia	CHW, Samarai CHC
Cathleen Eric	Nursing Officer (Maternal and Child Health, Village Birth Attendants), Samarai CHC
Helen Libai	Sister-in-Charge, East Cape CHC
Letma Maika	Nursing Officer, East Cape CHC
Marlyne Steven	CHW, East Cape CHC
Roselyne Loseila	CHW, East Cape CHC
Gertrude Lemeki	CHW, East Cape CHC
Rev Lu Piper	Minister; CHW trainer, United Church, Ferguson Island
Western Highlands	
Michael Wandil	Provincial Administrator, Provincial Government
Mufi Korowa	Provincial Health Adviser, Provincial Health Office
Dr Petronia Kaima	Provincial HIV Coordinator, Provincial Health Office
Kerry Galang	Deputy Director, District Health Services, Provincial Health Office
Glenda Kondie	Coordinator, Promotive Health Services, Provincial Health Office
Robin Yakumb	Cold Chain Logistics Officer, Provincial Health Office
Matthew Zelly Ray	Outreach Services Coordinator, Mount Hagen General Hospital (MHGH)
Onda Kupri	Biomedical Engineer, MHGH
Kuni Hunpio	Manager, Tininga HIV/STI Clinic
Dr Anthony Nasai	Hospital Medical Officer, Enga Province (on training attachment at Tininga Clinic)
Dr Martin Saiavu	Paediatric Registrar, MHGH / UPNG SMHS
Dr Julieth Jacob	Paediatric Registrar, MHGH / UPNG SMHS
Dr Michael Landi	Paediatric Registrar, MHGH / UPNG SMHS
Dr Tony Sonson	Obstetrics and Gynaecology Registrar, MHGH / UPNG SMHS
Susan Lolopu	Midwife-in-Charge, MHGH
Joshua Meninga	Coordinator, Provincial AIDS Committee
Dr Michael Dokup	Director of Medical Services / ENY surgeon, MHGH
Dr Kevin Lapu	Surgical Registrar, MHGH / UPNG SMHS
Dr Maggie Kaupa	Paediatrician, MHGH
Dr Penge Oko	Resident Medical Officer, MHGH
Dr Waikesa Kalala	Surgical Registrar, MHGH / UPNG SMHS
Paula Ma	President, Provincial Women's AIDS Council
Baru Diriye	Health Secretary, Nazarene Hospital, Kudjip
Johnson Makaen	Laboratory Technician, Nazarene Hospital, Kudjip
Dr Scott Dooley	Medical Officer, Nazarene Hospital, Kudjip
Sister Miriam	Deputy Coordinator, Maria Kwin Centre
John Wain	Chairman, Domil Community
Bernard Gunn	Community Development Coordinator, Domil Community
Joseph Warai	Director, CBHC
Rose Wali	Community Health Educator, CBHC
Dr James Kintwa	CEO, MHGH
Bernard Likmari	Laboratory Technician, Public Health Laboratory, Provincial Health Office

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ANNEX 3: ANALYSIS OF QUESTIONNAIRES

Approach and limitations

The team attempted to use a questionnaire to reflect a broader sample of informed opinion. It was circulated to senior staff of the NDOH, provincial health departments, hospitals, churches, and NGOs, with options to respond online, by hard copy or by email. As expected, response was low (15 replies received from more than 80 distributed), so the results are not statistically representative. Nevertheless, the results are an added source of insight and views from individuals who have experience of AusAID support to health, and sufficiently strong views to take time to respond to the questionnaire. NGO staff and the one NDOH respondent were more critical than provincial and church staff. It is unclear if this represents a real difference in perception, a cultural difference, a greater caution about giving offence to a funding source, or simply an aberration given the small sample.

Table A1 Responses to the questionnaire

Type of organisation	No of replies	Average scoring of AusAID activities (out of a scale of 1 to 5, with 5 being the highest result possible)
Provincial health offices and hospitals	7	3.1
Church organisations	3	3.2
NGOs	3	2.8
Private	1	3.8
TA adviser	1	2.3
Total	15	3.2

Overall view of AusAID

When asked to give an overall rating from 1 (poor results for the money spent) to 5 (excellent results for the money spent), AusAID received an average score of 4 for its aid to health services, about the same as other donors (3.9), but significantly higher than the rating of PNG Government support (2.5). Respondents were slightly less positive about AusAID's coordination and harmonisation role (3.7). However, there seems to have been a strong politeness bias towards being positive, with comments on individual aid activities more mixed and, in some cases, critical.

View of individual AusAID activities

The questionnaire lists individual AusAID activities, and asks respondents to rate how well the activities have worked in supporting health services for the poor, using the same five-point scale.

Table A2 Views on AusAID program and projects

	No of responses	Average score
The Health Services Support Program: 1998–2006 (including: improved planning and information systems; community-level service; clinical care; health infrastructure; medical supplies; family health and disease control; and health promotion)	10	3.8
Health Sector Resourcing Framework: 2000–current, (including: budget support and financial accountability; policy dialogue; donor coordination; and procurement reform and support)	9	4.0
HIV support: 2000–current (*multiple activities*)	13	3.5
Health Capacity Building Service Centre: 2004–current	11	3.5
Women's and Children's Health Project: 1998–2004	11	3.8
Medical Equipment Management Project: 1999–2004	10	3.2
Pharmaceutical Upgrade Project: 2002–06	8	3.5
Central Public Health Laboratory Project: 2002–05	7	3.7
Tertiary Health Services Project: 1998–2003	5	3.6
Health Sector Procurement Support: 2006–07	7	3.3
Support to health service delivery through churches and NGOs	12	3.3
Totals	104	3.6

The most positive responses are for the financial support provided through the trust account under the HSRF. One respondent commented on it being '… very effective in terms of quarantine of funds to key areas for program[s] specific to improve outcome driven policies.' Other comments pointed out the small share of trust account finance reaching the districts—'… donors must come down to ... district and handle it where the need is ... Provincial health office is not where the need is ... can only supervise.'

Respondents recognise the accountability problems that have inhibited disbursement. One respondent commented that '… some AMCs are more interested in the acquittal of funds than in the [health] outcomes …', but most respondents tended to blame the responsible officials for inability to spend rather than the system itself— 'The accountability at the provincial health level are very poor, they can't acquit on time that hold back more developments.'; 'Provincial Health Advisors could not reach One Million Kina Mark in the HSIP programs due to incompetency and misuses.'. Another respondent commented on the lack of disciplinary action taken for misuse and non acquittals.

Above average ratings were also given to the WCHP and to the HSSP. The financial support under the WCHP was valued, though not sustainable or sustained ('I got K30,000 from WCHP in 2001 in ESP to conduct MCH programs for the 6 Health facilities and lasted me 4 months and that really boosted our Immunization coverage as well as Family Planning and Antenatal coverage'). The WCHP was commended as a competency based programme for health workers covering 'almost all parts of PNG ... right down to community level (Aid Post) coverage of 89 districts 366 HCs and 20 provinces.' It was commented that some of the manuals that were produced now need up-dating, and another respondent called for the re-starting of this 'excellent project.' One reply drew a contrast between the experience of capacity building through WCHP and CBSC—'… within the WCHP, there were activities set out with set timing and targets ... within the CBSC framework, staff within the project do not have a clear frame work on how and what form of capacity building they intend to do for their

counterpart.' The same respondent also comments of the CBSC—'This project has created a parallel health service system within PNG resulting in employment of huge number of staff (national and international). The output of these staff at this point in time is questionable ... The CBSC staff are supposed to capacity built our staff … but I have not seen or told about how this is going to be done ... Recruitment of staff (both national and international) who do not have the capacity to capacity built is another issue that is being experienced with this project. This results in the projects having to use clinicians who are already burdened with hospital clinical work to do the so called project activities.'

Most other specific comments were more positive, though most chose not to comment, and a hospital respondent remarked on the need to 'implement programs after numerous workshops.'.

The respondents were less positive about support to medical equipment, procurement, and support to the churches, where negative assessments come from the churches themselves and seem to mainly relate to dissatisfaction with the level of funding—though one province respondent commented that Government has lost out relative to churches in terms of the quality of facilities and staff housing.

The HIV support attracted adverse comments about slowness to respond to proposals.

Views about Australian aid to the health sector

Section C unpacks the underlying views by asking respondents to state whether they agree, disagree or have no opinion on various statements about AusAID. Table A3 summarises the responses where an opinion was given. Most respondents answered thoughtfully, although one may have thought the statements represented the team's view of the 'right' answer and simply ticked agreement to all. Another felt the need to apologise for mildly critical comments. It seems likely, therefore, that the reported replies gave a more flattering view than the respondents' true opinion, which makes the critical comments voiced all the more striking.

More than 90 per cent of respondents agreed that AusAID is predictable and reliable in amount and timing , supports an appropriate mix of service providers, and has provided appropriate assistance to build the skills of people working in the health sector. These replies may reflect respondent bias—those who replied are likely to be drawn from those most able to work the system and to access training and attract and account for resources.

More than 90 per cent of those giving an opinion also agreed that AusAID has helped increase the money spent on diseases and illnesses most commonly affecting poor people. However, at the other end of the scale, more than 40 per cent of respondents who stated an opinion disagreed with the statements that AusAID tackles 'the most important' obstacles to improving the health of the poor, or has helped to improve government's ability to maintain health outcomes for the poor. The discrepancy partly reflects recognition that factors outside the health system are binding constraints, as reflected by these comments:

> 'One of the root cause of ill-health is poverty and not many donors are willing to support this in PNG.'
>
> 'There are other factors which affects efficient health service provision. Infrastructure such as roads, bridges, airstrips and accessibility.'
>
> One respondent commented positively that:
>
> '… the funding given under HSIP enable us to reach the unreach in remote communities because cost of service delivery is expensive as we depend heavily on aeroplane.'

> Several respondents mentioned the need to solve transport constraints and suggested that some restrictions on what trust account funds could be used for were unhelpful:
>
> 'AusAID has tried to address the issue of women's health here in PNG but it has taken many years and women's lives lost before HSIP was willing to support the medical evacuation of women in pregnancy related emergencies.'

There is also a feeling that AusAID is supporting inputs into specific diseases, but is not supporting the building of primary health care systems:

> 'I think the evidence is that the priority for the DOH or AusAID is not rebuilding a primary health care network whether that be based on Village Health Volunteers or an increase in the number of Community Health Workers or Aid Post Orderlies.' [A church representative].

Other respondents commented on the need to strengthen supportive supervision.

More than 30 per cent of those expressing an opinion disagreed with the statement that AusAID support reflects a clear strategy based on good evidence of how Australian aid can best be used. Complaints mentioned included the difficulty of achieving changes once a program is approved. Several respondents complained that AusAID and their contractors do not listen to and respect local knowledge (example: '… organizational knowledge has often been ignored.'). For some programs AusAID staff have appointed contractors who spent money while ignoring what rural Medical Officers or Matrons told them (e.g., sending gas refrigerators or freezers into areas where local health managers knew they could not economically keep up gas supplies).

Another commented that '… gross paternalism prevents oz bureaucrats taking a clear look at the situation.'

With regard to support of a single national health strategy and expenditure plan, there was some scepticism: 'This is all a window dressing phrase—at the end of it all, these projects are here to support the Australian companies here in PNG as evident by the health indicators not improving in the last 20 years.' Another respondent commented: 'There is still a tendency to create parallel structures which make problems for health services.'

A church respondent commented that if there is a single national health strategy and expenditure plan, it '... appears to be a Port Moresby centric process e.g. a lack of engagement with Churches Medical Council during the process, rather than when Strategy & Expenditure Plans are presented, and also during implementation.' [team's emphasis]. Others also commented on the need for '… more bottom up planning as most times the district and the communities (Aid Post level) are being over looked.' One respondent commented that involving communities in planning would be more practicable with a three-year rather than an annual planning cycle.

There appears to be a feeling that responsiveness to informed local opinion was better when advisers were posted within provinces. One respondent was disappointed that the provincial adviser program was terminated after three years, even though he felt it was going well and needed further time and support.

More than 30 per cent disagreed with the statement that AusAID has helped the health department make better use of the money it spends. Several respondents commented on corruption and misuse and were sceptical about government use of funds:

'… spending more aid money through the current government system is not necessarily helping the poor.' [Church representative]

'Some government procedures does not work, too many bureaucrats and a lot of misuse happens and the goods and services does not reach the people.'

However, one reply pointed to the positive impact that use of government systems could have, with external scrutiny, help to build the system and make it less corrupt: 'Without it I would assume that favouritism, nepotism, wantoktism could have creep an defeat the purpose of AusAID support to PNG ... The Government system is used in financial management. By doing Government system has been strengthened and Officers now compliant to the financial procedures.' Use of government procedures was appreciated by this respondent because: '… PNG Government systems, processes are here to stay such as the National Supply and Tenders Board.'

Summarising these responses served to support much of the team's analysis. There is recognition of the need to build the health system, to focus on the district and facility level and to ensure resources get down to that level. There is strong support for involving communities, districts and provinces in a more participatory and bottom-up approach to planning, and for learning from local knowledge. There is also support for a more programmatic approach to TA and capacity building, and recognition that capacity once built needs additional resources for service delivery if it is to be effective. There is a sense that AusAID staff and contractors need to adapt their approaches to work more in a spirit of partnership and support for those on the ground delivering services, with greater openness and responsiveness to understand and help to address local problems.

Table A3 Views about Australian aid to health services in PNG

In my experience, Australian aid to health in PNG ...	# of responses stating an opinion	# agree	# disagree	Percentage agreeing
supports an appropriate mix of organisations providing health services	10	10		100
is predictable and reliable in amount and timing	7	7	0	100
has provided appropriate assistance to build the skills of people working in the health sector	13	12	1	92
has helped increase the money spent on the diseases and illnesses most commonly affecting poor people	11	10	1	91
uses approaches that can be affordably expanded	8	7	1	88
has helped to increase the money spent on under-serviced geographical areas or population groups	9	7	2	78
has helped to significantly improve government coordination with donors	9	7	2	78
has contributed to improved health outcomes for the poor	12	9	3	75
has enabled people (communities and individuals) to better communicate their needs for health services	12	9	3	75

In my experience, Australian aid to health in PNG …	# of responses stating an opinion	# agree	# disagree	Percentage agreeing
allocates resources via a government-led process, in support of a single national health strategy and expenditure plan	12	9	3	75
ensures costs of accessing Australian aid are not excessive for Government, service providers or users	8	6	2	75
tackles the most important obstacles to improving women's health	12	9	3	75
is based on realistic assumptions about what is feasible given cultural and political conditions	11	8	3	73
effectively manages the risk of funds being misused	11	8	3	73
is based on realistic assumptions given skills and resources available	10	7	3	70
responds to changing needs and evidence of what works (and what does not work)	10	7	3	70
reflects a clear strategy based on good evidence of how Australian aid can best be used	12	8	4	67
has helped the health department make better use of the money it spends	9	6	3	67
uses government procedures and, where this is not possible, works with Government to address the obstacles to this	13	8	5	62
has helped to improve Government's ability to maintain outcomes for the poor, even with reduced donor funding	11	6	5	55
tackles the most important obstacles to improving the health of the poor	12	6	6	50

ANNEX 4: PROVINCE REPORTS

PAPUA NEW GUINEA PROVINCIAL FIELD VISITS

19 JUNE TO 3 JULY 2008

Provinces visited and dates

Western Highlands—19 to 23 June 2008

Milne Bay—30 June to 3 July 2008

Sandaun—30 June to 4 July 2008

Purpose of visits

1. To review the organisation of the provincial health service, including annual activity planning and budgeting and the role of the provincial government in health service financing and management.
2. To identify progress towards implementation of the Provincial Health Authorities Act (*One System Tasol*).
3. To identify the principal health problems affecting the population of the selected provinces.
4. To identify the main challenges facing staff at provincial, district and rural health facilities in delivering primary and preventive health services to their catchment population, how they address those challenges, and the critical success factors where challenges are being met and/or performance is improving.
5. To gather data to help determine the effectiveness and appropriateness of direct and indirect Australian support for management and delivery of primary and preventive care health services in the selected provinces, seeking comparisons between better-performing and poorer-performing ones.
6. To examine the role of non-state providers in delivery of health services, and how they interact with government systems and Australian support.
7. In Western Highlands, to pilot core questions to be discussed with provincial and health sector managers and a draft framework for consultations with health workers, non-state providers, community based organisations and community members.

Basis for selection of provinces for field visits

Western Highlands

- scores poorly on National Health Plan indicators (unadjusted ranking 13, adjusted ranking equal 17)
- also scores poorly on education, reproductive health and gender-related outcomes
- accesses more HSIP funding than most other provinces

- reports of good provincial level management capacity, progress towards implementing Provincial Health Authorities Act
- reports of interesting community-based health for development and HIV home-based care activities
- significant involvement of non-state providers
  - two church-run district hospitals
    - Kudjip Hospital
    - Tinley Hospital
  - several community-based health-for-development and HIV projects
- significant logistic constraints for service delivery—no direct road access for most of population served
- Australia – PNG Incentive Fund support for refurbishment at Mount Hagen General Hospital and extension of Kudjip Hospital

Milne Bay

- high headcount poverty—three out of four districts are 'seriously disadvantaged' (PNG Rural Development Handbook), but doing well on health and morbidity indicators, labour force participation and gender equity, and above average on education, literacy and reproductive health indicators
- scores highly on National Health Plan indicators (unadjusted annual ranking consistently 1 or 2, adjusted ranking consistently 1)
- significant economic activity and development around Alotau
- significant logistic constraints for service delivery—large tracts of maritime and mountainous terrain, with no direct road access for most of the inland population and expensive and hazardous sea transport for the maritime population
- low involvement of churches as non-state providers
- Australia – PNG Incentive Fund support for refurbishment at Alotau Hospital

Sandaun

- poverty and mortality indicators are consistently high
- scores poorly on National Health Plan indicators (unadjusted ranking 18), but when adjusted for constraints, there is an indication of significantly better-than-expected performance (adjusted ranking equal 5)
- all four districts score worst on National Health Plan indicators, and are also in the World Bank's 20 lowest-ranked districts
- high involvement of churches as non-state providers
- absence of economic development means Sandaun highly dependent on internal revenue and grants
- significant logistic constraints for service delivery—direct road access only along North coast and at the eastern border with East Sepik Province

Consultations and sites visited

Western Highlands

- Provincial Administration (Administrator and Planning Officer)
- Provincial Health Office (Provincial Health Adviser, Public Health Program Managers)
- Mount Hagen General Hospital (CEO, Deputy Nurse Manager and staff)
- District Health Facility
  - Kudjip Hospital
- Community-based HIV care, treatment and support projects
  - Tininga Clinic, Mount Hagen
  - Provincial AIDS Committee, Mount Hagen
  - Maria Kwin Centre, Kudjip
- Community-based health-for-development projects
  - Community Based Health Care, Kudjip
  - Domil Village, North Wahgi

Milne Bay

- Provincial Health Office (Deputy Provincial Health Advisor, Public Health Program Managers)
- Alotau Hospital (Board Chairman, CEO, senior medical specialists and staff)
- District Administrators from four districts (attending workshop in Alotau)
- District Health Facilities
  - Samarai District Health Centre (nursing staff, community members)
  - East Cape District Health Centre (nursing staff)

Sandaun

- Provincial Administration
- Provincial Health Office
- Vanimo General Hospital
- District Health Facilities
  - Laitre District Health Centre
  - Lote Catholic Health Centre
- Church health services providers
  - Catholic Diocese, Vanimo
  - Christian Brethren Church, Vanimo

Relevant findings and observations from the field visits have been incorporated into the main body of the report.

ANNEX 5: TIMELINE AND SUMMARY OF EVALUATION EVIDENCE ON AUSTRALIAN AID ACTIVITIES FOR HEALTH

Program	WCHP *1998–2004 $48.5 million*
Objectives	(Revised) Purpose To build capacity for the achievement of family health initiatives in the National Health Plan through support at national, provincial, district, health facility and community level for programs in women's health and safe motherhood, child health, reproductive health and nutrition: 1. Improved institutional capacity at the national, district and facility levels to plan and manage family health services. 2. Fully operational and sustainable national cold-chain, and selective rehabilitation of health care facilities for the delivery of the EPI. 3. Support delivery of health care programs specifically for women and children. 4. Foster community involvement in and support for the health of women and children. Expected benefits Improved nutrition, increased immunisation coverage, improved service delivery through rehabilitation of equipment and facilities throughout PNG.
Design features	Bilateral project delivered by an AMC. Project located within NDOH Waigani with activities in all 20 provinces working at national, provincial and district levels. Also had Field Level Support Teams operating in 13 districts with offices based in Lae, Madang , Goroka, POM and Bougainville. Project included deployment of a large number of locally-engaged TA to complement the expertise provided by international advisers.
Implementation issues	2001 Redesign exercise to reflect Government of PNG capacity and pace of reform. After that, numerous contract amendments to address weaknesses in the original design as the governments of Australia and PNG moved to a SWAP. These weaknesses included the need for a stronger focus at the health facility level. 2003 review identified need to concentrate on service delivery at districts, health centres, aid posts, and in communities in the face of declining health indicators. Review team considers there is a risk that work on gender and domestic violence will not receive adequate attention under the proposed new modality (HRSF) of AusAID assistance.
Assessment at completion	Remainder of WCHP exit strategy activities commenced under the HSSP. Results included renewal of the national immunisation program at every level, including national policy and procedures, rehabilitation of cold-chain equipment systems from national to district level, improved vaccine procurement and distribution, and increased health worker skills, as well as new tools for better management and service delivery, included the development of service level activity planning model to strengthen outreach MCH activities and the introduction of rapid syphilis detection into antenatal care. The ACR notes original design and resourcing was inadequate: the goal of decreased mortality was pitched too high, and the limited resources were allocated at a central level at the expense of rural communities. The ICR notes that issues of HIV were not sufficiently considered in ACR and its impact on future ability to deliver and sustain services.
ICR quotes etc.	WCHP did 'exceptionally well in meeting the required activity outputs in the current PNG environment. However, this is a superficial measure: Numbers of people trained does not necessarily translate into better work practices …' 'Despite extensive training, it appears there remain significant perceived hurdles in accessing HSIP funding.' '… the most technologically appropriate [cold-chain] equipment was employed but whether it will be sustainable in the PNG environment is questionable.' '… provision of services to rural health programs, particularly at Aid Post level, was an important achievement of the project. This focus on the need to support rural and remote health services and the modelling of different methods of assistance at provincial and district level needs to be encouraged and supported beyond the project … there needs to be a balance struck between providing assistance to the central health system and building institutional capacity while ensuring provision of good service delivery in rural and remote areas by adequately resourcing and supporting the implementers. This issue will be important for AusAID to grapple with as it moves its program to a sector-wide approach.'

Program	HSSP 1999–2005 $120.5 million
Objectives	Goal to achieve sustainable improvements in health of the people of PNG, objectives to improve quality and access to health services, encourage and improve partnerships with LLGs, provincial and district administration, churches, communities, donors, training institutions, private sector, other stakeholders; and to facilitate transition from project based assistance to a SWAP for delivery of Australian aid to health.
Design features	Church representatives included in design process at all levels. Took explicit account of lessons from earlier ADB project, including national-province agreements and insistence on budget contribution from province. Was expanded from six to all provinces with NDOH pressure for a SWAP approach. Substantial funding managed by the NDOH, including construction $23 million (albeit with technical support to all stages and to accountability), but drug kits ($22 million) and radio network ($8 million) and TA were managed by the Australian contractor, while funds managed by the NDOH had TA advisory support at province and national level. Explicit recognition that sustainability would need sustained partnership for 15–20 years.
Implementation issues	Long design process caused some initial frustration. Government budget cuts the main sustainability issue, necessitated longer than intended support to drug kits, and pressure to fund line positions, which was agreed to while recognising it was not sustainable. Frequent contact across wide range of activities required shift of AusAID and contractor management to Port Moresby from Australia. HSSP advisers were fully engaged in supporting the development of AAPs, prioritisation and financial resource allocation, independent of who funded or implemented. 'The MTEF was ... one tool by which NDOH focused action on priority health problems', enabled NDOH, HSSP and AusAID to fight off pressure to fund cancer services and hospital capital works.'
Assessment at completion report	The ACR had positive assessments in all aspects ('good practice') except lack of sustainability recognised due to inadequate availability of funding for goods and services including medical supplies. Initial six supported provinces improved their ranking; immunisation coverage increased; high levels of satisfaction with capital works and radio network; good technical support with long-term impacts, e.g., CHW curriculum, treatment guidelines. The HSSP work on costing was undertaken to enable the NDOH to make a stronger case to Treasury and provincial government—and was later taken up by the NEFC and was the foundation for the potentially very significant work on equalisation grants.
ICR etc quotes	The ACR: 'There is no doubt that the AusAID staff pushed some boundaries in the Agency to enable the changes that were necessary.' 'Employing emergency measures to address critical problems, coupled with long-term comprehensive support to rebuild the health system over time.' 'HSSP assisted NDOH to analyse the country's burden of disease and translate this information into the strategic priorities of the MTEF and use that to guide the allocation of resources.' ICR comment on the ACR: '... it is arguable that a number of elements of HSSP became a TA/project fund and operated as a collection of projects (kits, planning improvements, infrastructure, provincial TA support) developed ... in response to NDOH need, using government systems in some cases (planning) parallel systems in others (the health centre kits) and NDOH-friendly hybrid systems in others (... infrastructure and pharmaceuticals through the HSIP trust account.' '[Some areas] continue to exhibit the distortions, inefficiencies, additional cost burdens and lost capacity building opportunities associated with a non-SWAP mode of assistance.'

Program	Equipment management project (MEMP), 1998–2003 with total costs at $22.5 million
Objectives	To improve procurement and general equipment management practices within the PNG health sector to ensure that appropriate and cost effective equipment is provided to both the primary and secondary health services. To ensure the reliability and continued operational efficiency of equipment used in the health sector through improved biomedical equipment maintenance and repair capacity and practices established in all provinces.
Design features	Bilateral project delivered by an AMC with four, long-term TA advisers and a visiting program with five components involving strengthening the capacity of NDOH, hospitals and provincial health services, strengthening links with the private sector, a program of repair and maintenance, and procurement.
Implementation	Additional project objective to supply urgent priority medical equipment procurement was added in

issues	September 2000. 2001 MTR found the MEMP is being successfully implemented though risks to sustainability are significant due to factors largely beyond the influence of the project—funding, staffing, and the role of the Health Facilities Branch were most significant. The MTR concluded that regardless of whether the next phase of the MEMP is independently contracted or rolled into the HSSP, the shift in emphasis for the project needs to be towards more direct support at provincial level with the majority of the time of all team members being spent in the provinces. If easier to accomplish with the MEMP being integrated into the HSSP then this would be the preferred option.
Assessment at completion report	ACR: > Improved NDOH capacity to plan, develop policies and standards related to equipment purchase, management and repair and to establish equipment monitoring practices and procedures. > Improved technical capacity in provincial hospitals (increased availability of medical equipment for clinical services from estimated 60 per cent at the start to 97 per cent in each of the provincial hospitals) and increased access to effective medical equipment support services in health centres. > Australian visiting technician repair and maintenance program enhanced project implementation, serving to clear a large backlog of medical equipment repairs and also provided an effective mentoring service to the newly graduated technicians at each hospital. The project's exit strategy recommends continuation of the visiting technician program as an excellent mentoring strategy to consolidate the transfer of technical skills achieved under the MEMP. Supply urgent priority medical equipment procurement over and above the planned rounds of procurement. The project also purchased basic medical equipment kits for 607 health centres at a value of $3.3 million. The project's flexible response to procurement also enabled the country-wide refurbishment of major central sterilisers and hospital morgues, critical to hospital functioning. Recurrent funding for spare parts and consumables, and lack of capital funding to reduce the average age of equipment in service will remain the primary operating impediments to maintaining the levels of medical equipment available. Without adequate recurrent funding for equipment maintenance and replacement the real gains achieved under the MEMP will be substantially diminished.
ICR quotes etc.	ACR: '… the need to ensure that computer time does not dominate repair and maintenance priorities …'

Program	Pharmaceutical Upgrade Project: *2002–2006 project $8.4 million plus Trust Account $36.2*
Objectives	Purpose 'To have an efficient and effective system of medical supplies procurement and distribution in place, an effective National Drug Policy program established and efficient administration of the Medicines and Cosmetics Act (1999) institutionalized.' Components/objectives > implementation of a new medical supplies system > implementation of the National Drug Policy > performance of the NMS contracting-out process > Pharmaceutical and Rational Drug Use Education. Two phases Phase 1 investigation and analysis of the existing medical supplies system Phase 2 contracting-out of procurement and/or distribution
Design features	Bilateral project delivered by an AMC based around 22 long- and short-term TA advisers (mostly international). About 50 per cent of the project costs were for personnel.

	Focus of activities—IST and capacity-building; procurement support for upgrading: AMSS (Lae), 18 hospital pharmacies, lab testing and National Drug and Poisons Information Centre.
Implementation issues	Design finalised in mid-1998 but team only mobilised in 2002. It appears certain members of senior MSB management were ambivalent/unsupportive before commencement. In 2001, prior to commencement, the NDOH contracted Deloitte to audit its financial and procurement systems. Early reviews of the issue resulted in use of HSSP to address needs at provincial level and contracting of Deloitte Touche to increase transparency at the national level. In 2001, the HSSP took over funding (from the ADB) of ready-made kits of essential drugs for aid Posts and health centres/hospitals (until 2006). The HSIP – MB has continued to procure medical supplies on behalf of the NDOH, in a parallel system to MSB using DP funds. Deloitte were engaged from 2003 to 2007 to assist with reforms and provide financial oversight and payment certification for the procurement of medical supplies in the MSB. In 2004, a major review found that the procurement system and tender process had been strengthened under the PUP. However, the medical supply system was not working effectively—inaccurate annual procurement estimates, no system to determine accurately the value of stocks nor to monitor expiry dates; no process for prioritising medical supplies against affordability concerns. Concluded that simply contributing more funds for procurement would not resolve problems in availability. The original design entailed significant changes in practice in spite of very limited counterpart capacity. The review recommended: more realistic, focused objectives addressing: procurement and tendering; national stock management system; management and planning; and policy and legislation. There were a series of short extensions after the initial two years (three months, nine months and 12 months). Final extension enabled the transition to the CBSC.
Assessment at completion	The ACR found that overall development impact was considered by the NDOH and the MSB to be positive. However, insufficient attention was given to planning activities with other key components of the health sector and it was too centrally focused. The ICR agreed there had been important improvements achieved in procurement processes, but other system constraints undermined the value of these gains. The original objectives (while technically valid) were overly ambitious; the overall impact was limited by its relatively short duration, a failure to develop other elements of the supply system, and the persistent poor institutional constraints at the national level. The ICR questioned the effectiveness of the approach (i.e., project-driven capacity development in the face of deep organisational weaknesses; a focus on policy/process at the national level, in the face of political and institutional disconnect between national and local levels; contractor-based delivery of prescribed outputs, in the face of efforts to develop a SWAP; a focus on procurement, in the face of equally limiting distribution constraints. The ICR found that the short-term nature of the extensions to the PUP inhibited long-term planning and engagement by the project team. It also identified potential contradictions between the three AusAID funded channels of support to medical supplies (e.g., while the roles of the HSSP (kit supply) and the PUP (procurement strengthening).were largely complementary, the approach of one potentially undermined the development of capacity of the other. Similarly, both the PUP and Deloitte were directed at many of the same issues (procurement strengthening). Rationalisation of PUP activities also resulted in key omissions (notably distribution), limiting the potential impact of the project. The ICR concluded that the medical supply system was not sustainable. Self-assessment by Deloitte with respect to their engagement suggests that overall objectives were satisfactorily achieved. However, areas requiring continued improvement were identified as: > limited financial and procurement capacity within the MSB > ineffective management supervision > limited internal management reporting > procurement/contract management > recruitment of qualified personnel > ineffective oversight by Financial Controller > development of key performance indicators.
ICR quotes etc.	'… high intensity effort of TA and systems development focused at national level yields limited benefit.' 'How can AusAID constructively engage with dysfunctional departments and governments and achieve results? … pushing additional [TA] into these environments is not producing the returns … the environment of support must be carefully assessed … Many things are technically desirable, but politically impossible.'

Program	Institute of medical research support program 2002–2007 *$8.3 million*
Objectives	> Support priority research to facilitate implementation by the Government of PNG of the National Health Plan 2001–2010, and where appropriate, the National HIV Medium Term Plan. > Provide a secure funding base for the IMR to broaden its collaborative partnerships and funding sources and, over time, progress towards budgetary autonomy.
Design features	AusAID provided support in the form of annual self-managed Accountable Cash Grants over a five-year period, provided six-monthly in advance, with release of any subsequent advance conditional on appropriate acquittal of expenditure (including six-monthly external audits). No TA or procurement support was provided.
Implementation issues	AusAID provided c. 40 per cent of IMR funds (with other contributors including the Government of PNG, WHO, the World Bank and the Welcome Trust (United Kingdom). The 2004 MTR was largely positive. The AusAID funding is proving to be very important and gives it a level of independence from external grant agencies. These bodies give grants for specific research projects which might not always be in high priority areas for PNG as a whole. The team noted that with AusAID funding there is a good balance between core support and program support. However, the MTR stated that more needs to be done, by both the IMR and the NDOH to ensure that the IMR's work is seen as relevant to the MTEF and the National HIV Medium Term Plan. Despite its engagement with the health sector, the Team was surprised to find little *formal* engagement of the IMR in the NDOH's planning and policy setting.
Assessment at completion	The ICR found that, overall, the program has performed well. The level of international funding support that the IMR has been able to mobilise has increased by a factor of six, though it recommended continued AusAID funding (albeit with a view to scaling down), given financial and technical risks linked to the reliability of external funding flows. The ICR noted the tension for the IMR in being able to compete internationally for grants and focus on PNG priorities. In some quarters, there was a perception that the IMR worked in relative isolation within the health system and that its outputs do not match the health priorities of PNG. The ICR concluded that relationships between the IMR and other key stakeholders needed to be significantly reinforced during the next phase of AusAID support. Phase 2 began in 2007.
ICR quotes etc.	'There is a stated desire from government-related agencies that the IMR be "more responsive to the priority needs of the community" … Whilst government agencies and committees formally involve the IMR, there appears to be little influence or synergy as a result.'